German HIV Practice Collection

Bringing the AIDS Response Home

Empowering District and Local Authorities in Lesotho, Tanzania and Mpumalanga, South Africa

gtz Strengthening the German contribution to the global AIDS response

On behalf of Federal Ministry for Economic Cooperation and Development

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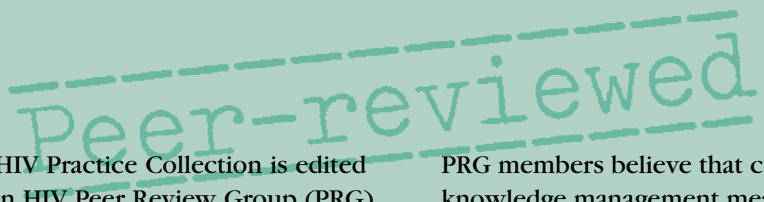
Title photo: CMAC members from different councils participating in a refresher training for writing fundable proposals, September 2004

The German HIV Practice Collection



The German HIV Practice Collection is edited by the German HIV Peer Review Group (PRG), an initiative launched in September 2004 by AIDS experts working in German and international development cooperation. The aim of this group is to collaboratively manage knowledge about good practice and lessons learnt in German contributions to AIDS responses in developing countries.

Based on a set of jointly defined criteria for 'good practice' (see text box), PRG members assess different ways of responding to AIDS that have been submitted to them for peer review. Approaches that meet the majority of the criteria will be documented, published and widely disseminated as part of this Practice Collection. While some of the documented practices cannot fully meet, as yet, the criteria for 'good practice" (i.e. several external evaluations and multiple replications in different countries), all of them represent examples of 'promising practice' that may inform and inspire other actors in the complex and dynamic fields of HIV prevention, AIDS treatment, impact mitigation, support and care.

Selection Criteria

- Effectiveness
- Transferability
- Participatory and empowering approach
- Gender awareness
- Quality of monitoring and evaluation
- Innovation
- Comparative cost-effectiveness
- Sustainability

PRG members believe that collaborative knowledge management means 'getting the right people, at the right moment, to discuss the right thing'. Through the peer review, discussion and dissemination of innovative approaches, German development cooperation supports essential principles of capacity development:

- The process is organised as a transparent and mutual learning experience involving AIDS experts of German organisations, their partner institutions in developing countries and AIDS experts working for multilateral organisations.
- It provides planners and practitioners with a range of practical, evidence-based programming models.

- It focuses on the results of the reviewed approaches, looking at their achievements, challenges and lessons learnt.

PRG membership is open to AIDS experts and development cooperation planners and practitioners with an interest in German contributions to the AIDS response in developing countries. For more information, contact the Secretary of the Peer Review Group at at aidsprg@gtz.de or go to http://hiv.prg.googlepages.com/home

Executive Summary

While the latest estimates indicate the AIDS epidemic is declining in two of the 50 sub-Saharan African countries and stabilizing in many others, the prevalence rates and number of new infections per year are still at extremely high levels. Due to AIDS, some countries have seen their average life expectancies cut nearly in half and are experiencing development reversal for the first time in their histories. In addition, there is alarming new evidence that, in some countries, young women are several times as likely as young men to become infected with HIV.

In 2001, the UN General Assembly's Declaration of Commitment on HIV/AIDS called on bilateral and multilateral institutions to provide substantially increased financial and technical support to developing countries as they scale up their responses to AIDS as quickly as possible. It called for mainstreaming of AIDS policies and programmes into all national development instruments and all sectors of government and the economy. At the 2005 World Summit and again at the 2006 High Level Meeting on AIDS, the UN General Assembly reaffirmed the Declaration of Commitment and resolved to aim for universal access to prevention, treatment, care and support by 2010.

GTZ notes that urban neighbourhoods and rural communities have always been at the front lines of the epidemic, since they are where the people infected with and affected by HIV live and where prevention, treatment, care, support, and impact mitigation can be delivered to those people.

In a number of countries in sub-Saharan Africa, GTZ works in partnership with national, provincial, district and local governments committed to "bringing the AIDS response home" by mainstreaming the AIDS response into the activities of district and local government. This involves building district and local government capacity to respond by providing training and follow-up, including technical support to AIDS-related activities.

This report describes how, with GTZ's technical support, the Kingdom of Lesotho, the United Republic of Tanzania and the Province of Mpumalanga in the Republic of South Africa have been empowering districts and localities to respond to AIDS. The approach, in all three cases, has been learn-as-you go. Methods and tools are developed and applied and, then, when they do not work as well as hoped, they are refined or replaced with new methods and tools. The processes of empowerment are ongoing. While it is too early to tell what the long-term results will be, the immediate results have been impressive. They include strategies and mechanisms that are streamlining the flow of available money to the front lines and putting it to work where it is most needed.

With this publication and the accompanying toolbox (on CD-ROM), GTZ shares lessons learned and methods and tools used in Lesotho, Tanzania, Mpumalanga and invites readers to use and adapt them in whatever ways may be appropriate for other settings.

The results also include methods and tools – marked in the text with this symbol ► – that can be adapted for use in other countries, provinces, districts and localities.

Bringing the AIDS Response Home

At the epicentre of the global AIDS epidemic

In 2005, the 50 countries of sub-Saharan Africa accounted for 11% of the world's total population but 64% (almost two-thirds) of the world's total number of people living with HIV. An estimated 24.5 million sub-Saharan Africans were living with HIV and an estimated 2.7 million became newly infected that year, while an estimated 2.0 million died of AIDS. The epicentre of the global AIDS epidemic continued to be in the southern part of sub-Saharan Africa. The 10 countries with the world's highest rates of HIV prevalence among adults 15-49 years old – ranging from 10.7% to 33.4% – included all five countries of the Southern Africa sub-region, the four southernmost countries of the Eastern Africa sub-region and the southernmost country of the Middle Africa sub-region[1].

While the latest estimates indicate that the epidemic is declining in two sub-Saharan countries – due to successful prevention but also due to the deaths of so many infected people – and stabilizing in others, the prevalence rates and the numbers of new infections each year are still at extremely high levels. In addition, there is alarming new evidence that young women are continuing to become infected at very much higher rates than young men. Estimates based on an extensive household survey are that, among 15-24 year-olds in South Africa, the rate of new infection during 2005 was 0.8% among males but 6.3% (nearly 8 times higher) among females[2].

Building the global response to AIDS

AIDS emerged as a new disease in 1981 and its primary cause, HIV, was discovered a year later. As the AIDS epidemic spread from country to country, the general public and their political leaders were slow to respond. Facing up to the facts was difficult because HIV is transmitted through sexual and other activities that are sometimes illegal, strictly taboo or widely disapproved or that are simply considered too personal and embarrassing to be discussed in public, even if widely practiced in private. The first cries for a response usually came from people infected with HIV or at high risk of infection, their families and friends, and advocacy groups they established or that took up their cause. The first and most vigorous response usually came from within their own neighbourhoods and communities – from the clinics, hospitals, social service agencies, and formal or informal care and support networks located there.

1 UNAIDS (2006). 2006 Report on the global AIDS epidemic. Geneva, Joint United Nations Programme on HIV/AIDS.
2 HRSC (2005). South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey. Johannesburg, Nelson Mandela Foundation (NMF) and Human Sciences Research Council (HSRC) of South Africa.

As the epidemic continued to spread year after year, it showed no signs of reaching the plateau that epidemics normally reach in just a few months or years before they begin to decline. Clearly, AIDS was an exceptional disease that called for an exceptional response. In September 2000, the UN Millennium Summit established 8 Millennium Development Goals and one was to combat AIDS, with the target of halting and reversing the epidemic by 2015.[3] In June 2001, a Special Session of the UN General Assembly followed up with the Declaration of Commitment on HIV/AIDS, which commits donor countries (acting bilaterally and through multilateral institutions) to providing developing countries with substantial increases in financial and technical support as they take urgent action to scale up their responses to AIDS.[4]

At the 2005 World Summit[5] and the 2006 High Level Meeting on AIDS, the UN General Assembly reviewed progress on the Millennium Development Goals and the Declaration of Commitment on HIV/AIDS and agreed to aim "towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010."[6]

Building each country's response to AIDS

The Declaration of Commitment on HIV/AIDS called on developing countries to "integrate HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies, national budget allocations and sectoral development plans."[7] For the sake of brevity, such integration is often referred to as "mainstreaming AIDS." As financial support for the response increased, however, it became evident that there was far too much duplication and waste and there were major gaps in the overall response in each country. Many different bilateral and multilateral institutions had their own mechanisms for allocating money and technical support and many different country-level partners had reached no mutual agreement on strategies or mechanisms for coordinating and monitoring and evaluating their activities.

In April 2004, at the Consultation on Harmonization of International AIDS Funding, representatives from developing countries, bilateral and multilateral institutions and other international partners endorsed the "Three Ones" principles to guide each country's response: one AIDS framework, one AIDS coordinating authority and one AIDS monitoring and evaluation system. In March 2005, a follow-up meeting reviewed progress and established a Global Task Team that recommended a number of ways that multilateral institutions could provide more effective support to countries in order to accelerate progress on implementing the "Three Ones" and progress toward universal access to prevention, treatment, care and support.[8]

Mainstreaming AIDS in all sectors, at all levels

Arising from the Global Task Team's recommendations, the 2006-2007 Consolidated UN Technical Support Plan[9] and UNAIDS Technical Support Division of Labour[10] designate UNDP as the lead UN-system partner on "development, governance and mainstreaming" and the ILO, UNAIDS Secretariat, UNESCO, UNFPA, UNHCR, UNICEF, WHO, and World Bank as the other main UN-system partners. An implementation guide for countries defines "mainstreaming" as:

> *'a process that enables all development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplaces.'* [11]

3 United Nations (2000). United Nations Millennium Declaration: United Nations General Assembly, 55th session, 6 September 2000. New York: United Nations.
4 United Nations (2001). Declaration of Commitment on HIV/AIDS: United Nations General Assembly, special session on HIV/AIDS, 25-27 June 2001. New York, United Nations.
5 United Nations (2005). 2005 World Summit Outcome. New York, United Nations.
6 United Nations (2006). Draft Political Declaration, 2 June 2006. New York, United Nations.
7 UN (2001). Declaration of Commitment on HIV/AIDS: United Nations General Assembly, special session on HIV/AIDS, 25-27 June 2001. New York, United Nations Department of Public Information and UNAIDS.
8 UNAIDS (2006). 2006 Report on the global AIDS epidemic. Geneva, Joint United Nations Programme on HIV/AIDS.
9 UNAIDS (2005). The 2006-2007 Consolidated Technical Support Plan for AIDS. Geneva, Joint Programme on HIV/AIDS.
10 UNAIDS (2005). UNAIDS Technical Support Division of Labour: Summary and & Rationale. Geneva, Joint United Nations Programme on HIV/AIDS.

The development actors or partners within countries include (or potentially include) national, district and local governments and all of their ministries, departments, divisions, and agencies and also include groups and networks of people living with HIV, civil society organizations, and private businesses and industries at the national, provincial, district and local levels. Mainstreaming mobilizes them and enables them to:

- Understand the causes and effects of HIV, especially as related to their usual work and their workplaces
- Determine how they might address the causes and effects, taking advantage of any comparative advantages they may have
- Work with others to coordinate efforts, pool resources and add value to their own efforts – for example, support a civil society organization by giving it the contract to develop and deliver a workplace programme on HIV.

Mainstreaming AIDS in the work and workplaces of multiple partners, across all sectors at the national, provincial, district and local levels is an effective way of:

- Harnessing the competences and resources of all public, private and civil society partners with potential to contribute to a country's AIDS response
- Addressing the structural and systemic causes of vulnerability to HIV – for example, the vulnerability of girls to infection because they are subject to sexual exploitation and assault in schools and on the way to and from schools
- Enhancing the sustainability of the AIDS response by embedding it in the policies and programmes of many different partners, so the weaknesses or failures of a few partners are not so damaging
- Turning AIDS from a development challenge to a development opportunity by adding to the resources and improving the performance of partners. This mean that they are more able to contribute not only to the AIDS response also to responses to the other development issues they address is the normal course of doing their work.[12]

11 UNDP, UNAIDS, World Bank (2005). Mainstreaming HIV and AIDS in sectors and programmes: an implementation guide for National responses. New York, Geneva, Washington, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme and World Bank.
12 Adapted with permission from "Mainstreaming AIDS in Development: Why and How to Do It", UNAIDS/UNDP/WB (2006)

Why strong district and local AIDS responses are essential

In most countries, the first response to AIDS comes from within the neighbourhoods and communities where the epidemic emerges and begins to spread. The front lines of the epidemic remain in just these places where HIV prevention, care, treatment and support and impact mitigation are delivered to the people who need them. While national strategies, coordinating mechanisms and monitoring and evaluation systems are essential they must reach down to the district and local levels and both support and be supported by district and local strategies, coordinating mechanisms and inputs to monitoring and evaluation.

In 1999, the mayors and municipal leaders from ten sub-Saharan African countries launched the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa, which now has chapters in 13 countries. In those countries and others, national AIDS authorities have come to recognize district and local governments as key partners.[13] They are closer to the front lines of the AIDS epidemic than national governments and they are better-placed to understand unique local circumstances, needs, social structures, attitudes, and traditions. They can apply such understanding in the search for the most appropriate and practical solutions to the problems – pervasive in sub-Saharan Africa – of severely limited infrastructure and human resources in public health, social and other services.

At the same time, district and local governments usually lack the financial and technical capacity – i.e., qualified staff or access to technical support – enabling them to mount effective responses to AIDS. For this reason, it is essential that mainstreaming reach down to their levels.

GTZ's commitment to district and local mainstreaming

The German Technical Cooperation Agency or Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), a government-owned company, supports some 2700 development projects and programmes in more than 130 countries, has offices in half of those countries and employs some 10,000 people, of whom more than 8,000 are citizens of the countries in which the projects and programmes are located.

In early 2003, GTZ launched a worldwide HIV workplace programme to serve all of its own employees and their families. In addition, it requires the mainstreaming of AIDS into all of its work in sub-Saharan Africa. The GTZ Africa department has fully implemented the two pillars on which effective mainstreaming rests: 1) a comprehensive workplace programme for its own employees and 2) contributions to the AIDS response that are consistent with GTZ's expertise and responsibilities in all its development projects and programmes. To support its project and programme managers, GTZ has produced a toolbox called "Mainstreaming HIV/AIDS: How we do it."[14] It describes and provides background documentation on GTZ's mainstreaming activities in different sectors.

Many of the projects and programmes supported by GTZ are in partnership with national, provincial, district and local governments and committed to building district and local capacity to respond to AIDS. The following chapters describe three examples of GTZ-supported district and local capacity-building in sub-Saharan Africa.

13 See the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICALL) web site at: http://www.amicaall.org/.

14 GTZ (2005). Comprehensive Toolkit: "Mainstreaming HIV/AIDS: How we do it." (DVD). Eschborn, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH.

In Lesotho, Making Community Councils the Gateways to Fighting AIDS

The context

Socio-economic conditions

Known as Africa's "Mountain Kingdom," the Kingdom of Lesotho is surrounded by South Africa. Its lowlands, foothills, mountains, and valleys are home to an estimated 1.8 million people. Most live in rural areas, often accessible only by foot, mule or all-terrain vehicle. In 2002, after several years of civil unrest, Lesotho underwent constitutional reforms followed by peaceful multiparty parliamentary elections.

Lesotho's economy is based mainly on subsistence agriculture, especially livestock, though it exports grains. Its official unemployment level hovers at around 40% and many of its men work in mines in South Africa. The Human Development Report 2005 ranks Lesotho at number 149 on the list of 177 countries covered. The United Nations Population Division estimates that, without AIDS, the average life expectancy would be 63.9 years but, with AIDS, it is only 32.9 years and the population is declining.[15]

The state of the AIDS epidemic

Based on the results of the Lesotho Demographic and Health Survey 2004 and of the Ministry's sentinel surveillance at antenatal clinics in urban areas, the prevalence rate among adults 15-49 was 23.2% at the end of 2005 and had stabilized at a very high level.[16] The prevalence rate was higher in urban areas (29.1%) than in rural areas (21.9%) but it was consistently high throughout all 10 Districts of Lesotho. Among adults under 40 years old, the prevalence rate was higher among women than men. Among 15-19 year olds, 2.3% of men but 7.9% of women were HIV-positive; among 20-24 years olds, 12.2% of men but 24.2% of women were HIV-positive. Prevalence peaked at 43.9% among women 35-39 years old.

The 2004 survey found that only 12% of the population knew their HIV status and that knowledge of their status varied from 4.7% among women with no education to 95.1% among men with at least some secondary education. By the end of 2005, there were 22 sites providing antiretroviral therapy to around 8,400 people. This meant that around 14% of the estimated 58,000 people in urgent need of antiretroviral therapy were receiving it.[17]

The national AIDS response

In December 2002, Prime Minister Pakalitha Mosili challenged resident representatives of UN-system organizations to provide Lesotho's newly elected Government with good advice on how it should scale up the country's response to AIDS. Lesotho's Expanded Theme Group on HIV/AIDS engaged in a process of dialogue, debate and consultation that, within a few months, resulted in the publication of a policy document entitled Turning a Crisis into an Opportunity: Strategies for Scaling Up the National Response to the HIV/AIDS Pandemic in Lesotho.[18] In October 2003, the Cabinet of Ministers adopted this as an official working document guiding the national response to AIDS and also adopted its recommendations: 1) to establish a

15 United Nations (2005). World Population Prospects: The 2004 Revision. New York, United Nations Department of Economic and Social Affairs, Population Division.

16 UNAIDS (2006). 2006 Report on the global AIDS epidemic. Geneva, Joint United Nations Programme on HIV/AIDS.

17 WHO (2006). Progress Report on Global Access to HIV Antiretroviral Therapy: A Report on "3 by 5" and Beyond. Geneva, World Health Organization.

18 Kimaryo, S et al, Editors (2004). Turning a Crisis into an Opportunity: Strategies for Scaling Up the National Response to the HIV/AIDS Pandemic in Lesotho. A Publication of the Partnership of the Government of Lesotho and the Expanded Theme Group on HIV/AIDS, Lesotho. New Rochelle, New York, Third Press Publishers.

National AIDS Commission; 2) to make the existing Lesotho AIDS Programme Coordinating Authority (LAPCA) the Commission's Secretariat; 3) to "core stream" the fight against the epidemic in all sectors and levels of government "as a matter of urgency."

In August 2005, Parliament passed legislation establishing the National AIDS Commission and the Government launched a review of the national response leading to development of a National AIDS Policy, a Strategic Framework 2006-2010 and a unified monitoring and evaluation system for HIV and AIDS programmes. Meanwhile, the AIDS epidemic affects every aspect of life in Lesotho. Its social, economic and institutional consequences will be increasingly serious if the tide cannot be turned soon.

GTZ support to Lesotho's AIDS response

Under the Lesotho-German bilateral agreement for development cooperation, GTZ and other German development agencies focus on "Decentralized Rural Development." Successful decentralization, however, depends on the presence of competent administrative personnel and active civil society representatives at the district and local level. The AIDS epidemic has an enormous and disastrous impact on Lesotho's political and administrative system through the loss of skilled and experienced employees. This compromises the government's ability to provide services at the same time as it increases demand for services to curb the epidemic and mitigate its impacts.

In that context, GTZ began supporting AIDS-related initiatives when it participated in developing the document Turning a Crisis into an Opportunity. When the Cabinet of Ministers adopted the recommendation to "core stream" AIDS, the Expanded Theme Group agreed that GTZ's contribution should focus mainly on implementation of that recommendation, still within the context of its main focus on "Decentralized Rural Development." In December 2003, GTZ outlined a new plan for its Lesotho programme, with the following mainstreaming elements:

- Support for the Ministry of Local Government's programme to empower Lesotho's Interim Community Councils to respond to AIDS as they evolve into permanent Community Councils – known as the "Gateway Approach."

- Continuing support for the Ministry of Public Services' programme to mainstream AIDS through the development and implementation of workplace programmes in all sectors and levels of government and by training public servants to become HIV and AIDS competent .

- Continuing support for mainstreaming AIDS into the Capacity Building for Land Management – for example, by ensuring that the new Land Bill will address AIDS-related issues such as the property rights of widows and orphans.

In the following, the focus will be on the first of these three elements, the Gateway Approach to getting local responses to AIDS off the ground.

The Gateway Approach to empowering Community Councils

Defining the vision, goals and objectives

Lesotho has ten Districts, each with its own District Council. In 2002, Lesotho's Ministry of Local Government began implementing a decision to divide each District into Community Council areas and subsequently each area into Electoral Divisions. There are typically from 10 to 15 Electoral Divisions and one representative from each is voted into the Community Council. A House of Chiefs in each area votes two chiefs onto the Community

Council. Each Community Council sends two representatives to sit on the District Council. There are 128 Community Councils and one City Council– for Maseru, the national capital. The Community, City and District Councils and their staff carry some of the responsibilities previously carried by central government. Prior to the first local government elections in April 2004, Interim Community Councils had been appointed and given limited responsibilities.

Since 2003, GTZ has worked in close cooperation with the Ministry of Local Government on continuously developing the 'Gateway Approach' to mainstreaming AIDS into local government. The Gateway Approach has the following elements.

Vision. Community Councils are the Gateways to Lesotho's holistic fight against the AIDS epidemic. They coordinate the development of Community Council Action Plans in which HIV and AIDS and their impacts are addressed across all sectors, based on the priorities and needs of their areas. They also coordinate and monitor implementation of the plans by governmental and non-governmental service providers.

Goal. A platform on which the resources and activities of all stakeholders, from Global Fund to social responsibility programmes of businesses, are brought together and coordinated to address the needs of the population. On this platform the stakeholders develop and implement strategies for fighting the AIDS epidemic within their respective mandates by involving communities and their representatives from the outset. A demand based approach with mainstreaming throughout promotes and supports community-based initiatives and innovations, introduces and affirms the principle of subsidiarity,[19] encourages self help, and aims for sustainability of the approaches chosen.

19 Subsidiarity is the principle that, when appropriate, central governments give local governments control over matters that of primarily local concern.

Objectives:

1. To make councillors, council staff and other local leaders HIV and AIDS competent

HIV and AIDS competence requires that each of them knows what HIV is and how it is transmitted; how infection can be prevented; how infection can be managed through testing, treatment and care; that being infected is not an automatic death sentence; how HIV-positive people can live long and productive lives.

2. To empower local governments (District and Community Councils) to be the Gateways in the fight against HIV and AIDS

Local governments perform a coordinating role in the development of action plans based on community priorities and monitor their implementation through the support of service providers. Questions that can help local stakeholders understand what roles they can play in the fight against HIV and AIDS include: what aspects of their work may facilitate the spread of HIV, what aspects may inhibit the spread of HIV, what aspects contribute to the impact of HIV, what aspects may mitigate the impact.

3. To promote a demand-driven system at local, district and national levels

In a demand-driven system, the priorities of community members in need of services are enshrined in action plans that inform and guide all local, district and national authorities and service providers as they plan and deliver services – all within the framework of national AIDS policies and strategies.

The pilot project in the District of Qacha's Nek

In late 2003, GTZ and the Ministry of Local Government launched a pilot project to begin establishing the Gateway Approach in the mountainous District of Qacha's Nek. The District had 21 Interim Community Councils at the time, some serving several tiny and remote villages and rural settlements where people in need of medical treatment were accustomed to walking for two or three days to the nearest clinic. The aim was to build Councils' capacity to address the AIDS epidemic and use the lessons learned from that experience to develop guidelines for the capacity building of Councils throughout Lesotho.

There were two stages to the pilot project:

- First, training workshops providing councillors and other community leaders with basic knowledge and skills in fighting HIV and AIDS
- Second, evaluation of the impacts – that is, assessment of the extent to which Councils were applying the lessons learned in the workshops.

For the first stage, the Karolelano ea Tsebo Facilitators' Association (KaTseFA), a non-governmental organisation based in Lesotho, collaborated with GTZ and the Ministry of Local Government on planning and conducting the workshops. Each of the 21 Interim Community Councils was asked to invite 50 people – councillors, chiefs and village headmen, traditional healers, women, herd-boys, and representatives of civil society organizations including faith-based ones – to participate. Two Bosotho facilitators,[20] supported by a technical advisor from the German Development Service (DED), conducted the workshop for each Council. Each workshop consisted of presentations and exercises leading participants to:

- Acknowledge the existence and understand the basics of HIV and AIDS
- Appreciate that there is no reason to fear people living with HIV
- Become proactive in changing their own circumstances and those of their families and communities for the better.

Each workshop lasted for seven full days, with facilitators sleeping on floors in village schools and local women supplying them with food.[21] The workshops asked participants to:

- Reflect on the causes and consequences of HIV and AIDS, including impacts on people in their villages, and reflect on effective responses, including prevention, treatment, care and support (including creation of a supportive environment where people feel safe and comfortable when, for example, they seek voluntary counselling and testing)
- Reflect on existing services in their communities and other opportunities for mitigating the impacts, with particular consideration given to issues of land allocation and natural resource management so as to ensure the secure supplies of nutritious food needed to keep both HIV-positive and HIV-negative people healthy, resistant to infection and able to reap the full benefits of any treatment they may be receiving.
- Consider structures and procedures (including traditional ones) through which people in their communities might assess needs for services, plan to meet those needs, marshal the resources for implementation, and then monitor the resulting services.
- Establish, from among the most knowledgeable and committed people present, HIV and AIDS Impact Mitigation Committees to advise the Community Council.
- Proceed toward development of a Community Council Action Plan for the Community Council with HIV and AIDS mainstreamed across each and every priority project.
- Proceed toward development of a result-oriented monitoring and evaluation system for the Community Council.

20 In Lesotho, the nationality is Mosotho (singular) or Basotho (plural). The facilitators were Basotho proficient in the main language, Sesotho.
21 Subsequently, training has evolved into two separate workshops. Each lasts for five days and the second one focuses on planning.

Results of the pilot project

From September to December 2004, interviews with 390 of the 650 trained Community Council members found that roughly half of the objectives had been achieved. Specifically:

- Community Councils had established HIV and AIDS Impact Mitigation Committees, an indication of leadership and commitment by councillors and many others.

- Councillors were now HIV and AIDS competent and prepared to fight the AIDS epidemic within the limits of Community Councils' legislated powers.

- Leaders and the population within each Community Council area were more unified and prepared to work together. However, they were unclear as to who was responsible for doing what and so not taking action. In addition, some chiefs (the traditional leaders) resisted believing in the existence of HIV and AIDS and saw the new Community Councils as competition that threatened their traditional authority. They were actively blocking community mobilization against AIDS by, for example, saying no one was to talk to children and youth in their areas about such "dirty" things.

- There were few signs of progress toward development of action plans for each village and Community Council. The obstacles were lack of clarity as to who was responsible for spearheading planning processes, lack of knowledge about how to go about planning and lack of resources to do it.

- There was no progress toward establishing monitoring and evaluation systems which, in any case, would normally be provided for in plans and established during the course of implementing those plans.

The conclusion was not that the pilot project had failed. On the contrary, it had succeeded in demonstrating that attitudes about HIV and AIDS could be changed and in identifying the challenges that had to be met through the next stages of getting the Gateway Approach well established.

Developing guidelines for "Quick and Smart" planning

The pilot project demonstrated the need for a planning methodology that is easy to understand, practical and achieves results within a short time frame. The Community Councillors elected on 30 April 2004 have four-year terms and they need to develop Community Council Action Plans as quikkly as possible in order to take full advantage of opportunities to get financial support for projects and programmes that benefit the people living in their areas.

In early 2005, GTZ began providing financial and technical support to planning by the Ministry of Local Government, the Qacha's Nek District Council and the Qacha's Nek District Planning Unit. Initially, they worked with just one Community Council, developing and testing the "Quick and Smart" planning methodology. As a result of this work, the Ministry of Local Government and GTZ published the Guidebook for Quick and Smart[22] in October 2005. It outlines a two-month planning process that includes:

1. A one-day orientation workshop for District staff

2. A two-day pre-planning workshop with representatives and key staff from Community and District Councils (including District Planning Units) and from selected non-governmental organizations

3. A two-day "area-wise" training workshop for from two to four Area Planning Support Teams

22 Ministry of Local Government and GTZ (2005). Guidebook for Quick and Smart: Community Council Planning Approach. Maseru, Ministry of Local Government and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH.

4. A two-day workshop for each Community Council, where they are informed about the planning process, asked to begin the process of filling out Community Fact Sheets, trained in the use of the Lipitso Information Collection Kit, and agreed to subsequent steps and schedules, including sending letters about the Lipitso to the Chiefs (Lipitso are traditional village meetings.)

5. A month for Community Councillors to have two-day Lipitso in each of the Council's Electoral Divisions

6. A five-day workshop for each Community Council using the information from its Community Fact Sheet and from its Lipitso to produce a Community Council Action Plan, ending with approval by the Community Council

7. Submission of Community Council Action Plans to the District Council.

► The Guidebook for quick and smart planning can be downloaded at http://hiv.prg.googlepages.com/bringingtheaidsresponsehome and provides detailed instructions for all of the above steps.

2006 and beyond

All District and Community Councils in Lesotho's four southern Districts are now HIV and AIDS competent. In addition, there are Community Councils in all ten Districts with some experience with Quick and Smart planning. The lessons learned in the Qacha's Nek District were used to refine the approach taken in Mohale's Hoek District and the process of refinement has continued and will continue into the future.

Each District has a District Development Coordinating Committee responsible for drawing up the District Development Plan. Members include representatives from line ministries of the national government, from District Council staff and from selected non-governmental organizations. It is crucial for these committee members to be HIV and AIDS competent and have a thorough understanding of mainstreaming and the Quick and Smart planning approach. Curriculum has been developed for training District Development Coordinating Committees and it was piloted in the Mohale's Hoek District in June 2006.

The aim is to link community priorities with available financial resources. This makes the preparation of plans urgent, since the national budget for the next fiscal year will be prepared in November 2006. At the district level, links must be made with available funding from Ministry of Local Government's budget, from other ministries' budgets, from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and from other multilateral and bilateral sources.

As of July 2006, Lesotho's National AIDS Commission and its partners are close to finalizing a new National AIDS Policy and Strategic Framework 2006-2010 and both of these documents call for a comprehensive multisectoral approach to "four domains": 1) prevention, 2) care, treatment and support, 3) impact mitigation and 4) a supportive environment where systemic development issues (rural development, poverty, gender equality, etc) are being addressed. The documents recognize the important role District and Community Councils have to play in accelerating implementation so that universal access to services can be achieved as quickly as possible. The Government of Lesotho is factoring in the costs of rolling out the Gateway Approach as it prepares the new national budget.

In Tanzania, District and Ward Empowerment through Capacity Building

The context

Socio-economic conditions

The United Republic of Tanzania has a population of more than 38 million people. Most live on the mainland but half a million live on the islands of semi-autonomous Zanzibar. On the mainland, Muslims outnumber Christians by a small margin and there are also many adherents to indigenous belief systems, while some 99% of Zanzibar's population is Muslim.

More than 80% of Tanzanians live in rural areas and most depend on subsistence agriculture for their livelihoods. Many also participate in commercial agriculture, and agricultural products account for around 45% of GDP and 85% of exports. Services account for almost 40% of GDP, though they employ far fewer people. Mining for gold and other minerals accounts for much of the remaining GDP. The Human Development Report 2005 ranks Tanzania at number 164 on the list of 177 countries covered. The United Nations Population Division estimates that, without AIDS, the average life expectancy would be 58 years but, with AIDS, it is only 46 years.[23]

The state of the AIDS epidemic

According to the latest UNAIDS estimates, the prevalence rate among adults 15-49 was 6.5% at the end of 2005. There were 1.4 million people living with HIV and, of those, 1.3 million were adults and 710,000 (54.6% of the adults) were women.[24] The 2003-04 Tanzania HIV/AIDS Indicator Survey found that HIV prevalence among adults 15-49 varied among the mainland's 21 regions from a low of 2.0% to a high of 13.5% and averaged 10.9% in urban areas and 5.3% in rural areas. In most regions the prevalence rate was higher among women, averaging 12.0% in urban areas and 5.8% in rural areas.[25]

Knowledge of how HIV transmission can be prevented was comparatively high, with 87% of adults identifying abstention and 68.9% of men and 62.3% of women identifying both faithfulness to one partner and the regular use of condoms. However, risk-taking behaviour was high, too, with 23% of women and 46% of men reporting sexual encounters with a non-marital, non-cohabiting partner within the past 12 months. There are many indications that women, in particular – especially if they are poor, have little education and/or live in rural areas – are at high risk of infection and in urgent need of information and education about all matters related to HIV and AIDS.

By the end of 2005, around 7% of the estimated 315,000 Tanzanians in urgent need of antiretroviral therapy were receiving it. As in most other sub-Saharan African countries, this was far short of the "3 by 5" target.[26] There were 98 sites (96 on the mainland, 2 on Zanzibar) providing therapy and the Government of Tanzania was scaling up its efforts to make therapy more widely available by increasing the number of sites, particularly in rural areas.

The national AIDS response

In 1985, the Government of Tanzania established the National AIDS Control Programme in the Ministry of Health and adopted the first of a series of short- and medium-term AIDS plans that focused mainly on the health sector. In 2000, the President declared the AIDS epidemic "a national disaster." In 2001, Acts of Parliament approved a National Policy on HIV/AIDS, established the Tanzania Commission for AIDS (TACAIDS) and called for all Districts and Wards to establish multisectoral AIDS committees. TACAIDS worked with a broad range of stakeholders to develop mainland Tanzania's Multisectoral Strategic Framework on HIV/AIDS 2003-2007. It sets nine goals for four strategic areas: 1) cross-cutting issues, including provision of an enabling environment; 2) prevention, including a focus on gender issues; 3) care, treatment and support; 4) mitigation of the socio-economic impacts of AIDS.

23 United Nations (2005). World Population Prospects: The 2004 Revision. New York, United Nations Department of Economic and Social Affairs, Population Division.

24 UNAIDS (2006). 2006 Report on the global AIDS epidemic. Geneva, Joint United Nations Programme on HIV/AIDS.

25 National AIDS Commission Tanzania (2005).2003-04 Tanzania HIV/AIDS indicator survey 2003–2004. March. Dar es Salaam and Calverton, Tanzania Commission for AIDS, National Bureau of Statistics, ORC Macro.

26 WHO (2006). Progress Report on Global Access to HIV Antiretroviral Therapy: A Report on "3 by 5" and Beyond. Geneva, World Health Organization.

Since 2001, the funding of the AIDS response from domestic sources (public spending and out-of-pocket spending by affected people) has more than doubled and, together with substantial increases in funding from international sources, this has enabled significant progress. Successful information and education campaigns have increased the demands for condoms, Voluntary Counselling and Testing (VCT) and antiretroviral therapy far beyond the country's current capacity to meet those demands. The main challenge, now, is to accelerate access to services as quickly as possible in the rural districts, wards and villages where most of Tanzania's population lives. Tanzania is meeting this challenge by building the capacities of District and Ward multisectoral AIDS committees. With funding from the World Bank, it is establishing Regional Facilitating Agencies that provide local government and civil society organizations with technical support and also facilitate the distribution of funding to service providers.

Training Council and Ward Multisectoral AIDS Committees

What are CMACs and WMACs?

Mainland Tanzania, for which TACAIDS is responsible, is divided into 21 administrative regions and they are divided into 123 Districts, Towns, Municipalities and Cities. Each has a Council and is divided into several Wards, which in turn have up to eight villages. The 2001 Act of Parliament that established TACAIDS also called for all Councils to establish Council Multisectoral AIDS Committees (CMACs) and for Wards to establish Ward Multisectoral AIDS Committees (WMACs).

The Act specifies that each CMAC will have the Council's Deputy Chairperson as its Chairperson, the Council's Director (chief administrative officer) as its Secretary and additional committee members, as follows: Members of Parliament from each of the District's electoral divisions; Councillors from each of the District's Wards; the District's AIDS coordinator; representatives of people living with HIV (one man, one woman), youth (one boy, one girl), faith-based organizations (one Muslim, one Christian), the network of NGOs involved in HIV and AIDS interventions (one), and other sectors (one). Subsequent to the Act, it was decided CMACs should add members representing the health, education, community development, and agricultural sectors.

CMACs are the key mechanisms for planning and coordinating community-based responses to AIDS and they:

- Support Wards and villages in establishing and running their own AIDS committees
- Increase community awareness of HIV and AIDS
- Assess the HIV and AIDS situation within their jurisdictions (numbers of people with HIV broken down by characteristics, factors contributing to new HIV infection and so on)
- Advise Councils and other authorities at higher and lower levels on appropriate by-laws, policies, programmes and projects
- Assess the interests of capabilities of partners and potential partners in the response to AIDS.

Building the capacity of CMACs, through training and support of their members and other means, is essential if they are to carry through on the tremendous responsibility assigned to them by the Government of Tanzania. With that in mind, in February 2003, the President's Office, Regional Administration/Local Governments division (PO-RALG), and TACAIDS sent a circular to all Councils giving them basic information and asking them to take immediate action to establish CMACs by appointing members and calling meetings.

The baseline survey

As a step toward developing a training programme for CMACs, TACAIDS established a Quality Assurance team that collaborated with GTZ and evaplan/ University of Heidelberg (a consulting firm) and HealthScope Tanzania (another consulting firm) on

designing and carrying out a survey to establish baseline information against which to measure the results of training. The survey instrument was a "Pre- and post for CMACs," with questions to determine CMAC members' levels of knowledge about TACAIDS, HIV and AIDS, needs for and barriers to AIDS advocacy, and other areas to be covered in the trainings (see below) to ensure their AIDS competence.[27] This same instrument could be used after training, to find out what members had learned and what their needs for additional training might be.

A sample of eight District Councils was selected for participation in the survey using such criteria as high prevalence of HIV, large numbers of refugees, large areas without services, and lack of donor support. For each District Council, nine of the 19 appointed or potential members of their CMACs were interviewed, five in a group session and four individually. The survey was conducted by four interviewers, supported by two supervisors, from 22 April to 16 May 2003. It found that:

- Five out eight District Councils had not appointed members to their CMACs but were able to identify potential members for the interviews. Only one District Council could show that the CMAC had ever had a meeting. A majority of appointed or potential CMAC members did not know what their roles and responsibilities were. Many did not know about TACAIDS and its role in responding to the AIDS epidemic. Most did not refer to the circular or any other documents that had been sent to inform and guide their participation in the CMACs. Some said that they did not see the point of CMACs.

- Most appointed or potential CMAC members had little knowledge about HIV and AIDS and related issues, such as the factors that put adults and youth at risk of infection, socio-cultural attitudes and practices that may contribute to risk, and stigma and discrimination.

- Most were unable to describe practical approaches to such tasks as planning a youth awareness campaign and running a training workshop. Most were able to identify resources, other than money, available in their communities but few knew how to begin developing a budget that would help them gain access to financial resources within or outside their communities. Most could not see the importance of monitoring and evaluation, though some had been involved in AIDS-related projects and programmes. Few could name basic elements of a good project or programme proposal.

27 TACAIDS, evaplan/UH (2003). Pre-test and Post for CMACs. Dar es Salaam, Tanzania Commission for AIDS, evaplan/University of Heidelberg.

- None of the District Councils had arranged for initial orientation or training workshops for their CMACs. Failures to circulate or read information (partly due to low levels of competence in the relevant language), lack of budgets for meetings and failures to assign a staff person with responsibility for making things happen were among the reasons for lack of action on CMAC appointments, meetings and workshops.[28]

On this basis, the survey identified: 1) the need for research into socio-cultural attitudes and practices of major ethnic groups as they relate to HIV and AIDS, 2) the need for District multisectoral AIDS strategies, developed through consultations with a broad range of stakeholders, 4) the need to build the capacity of Regional Administrative Secretariats to support, monitor and evaluate council AIDS activities within each of mainland Tanzania's 21 administrative regions, 5) the need for further CMAC capacity building.

Developing training material

The baseline survey also constituted an assessment of learning needs for the development of training course material. Through a series of workshops, a group of educators and other professionals – representing organisations involved in developing and implementing in Tanzania's response to AIDS – outlined the course concept, drafted the curriculum and developed training modules. The process was exceptionally participatory and is described in full on a CD ROM.[29] The modules were tested in two Districts and then refined.

The result, can be downloaded at http://hiv.prg.googlepages.com/bringingtheaidsresponsehome was four training manuals, with 10 training modules plus a field guide, as follows:

Book 1
1. Advocacy
2. Basic Facts, Prevention and Control of HIV/AIDS
3. Sociocultural Factors and Concepts

Book 2
4. Team Building, Leadership and Partnership
5. Resource Management
6. Participatory HIV/AIDS Planning
7. Participatory Monitoring and Evaluation

Book 3
8. Proposal Writing and Assessment
9. Report Writing Skills
10. Communication and Facilitation

Book 4 Field training guide.[30]

28 TACAIDS (2003). Baseline Assessment Study Results: Quality Assurance of CMACs Training. Dar es Salaam, Tanzania Commission for AIDS, Healthscope Tanzania, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH – BACKUP Initiative, evaplan/University of Heidelberg.

29 Participants were from PO-RALG, TACAIDS, Mzumbe University, evaplan/University of Heidelberg, Iringa Primary Health Care Institute, African Medical Research Foundation, CARE, UNAIDS, TANESA (Tanzania Netherlands Project to Support AIDS control in the Mwanza Region), and GTZ. A description of the process is available on CD ROM on the evaplan/University of Heidelberg website at [please provide direct link to the actual item, not just to the website.

30 TACAIDS, GTZ BACKUP, evaplan/UH (2004). Training Manuals for HIV/AIDS Committees at Local Government Authorities. Dar es Salaam, Tanzania Commission for AIDS, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH – BACKUP Initiative, evaplan/University of Heidelberg.

Facilitating and evaluating training workshops

In December 2003, TACAIDS recruited 50 training facilitators who were given a four-day course on how to use the modules in training workshops. The agreed approach was to cascade down through a series of workshops that began with Regional Administrative Secretariats, moved on to CMACs and would eventually cover WMACs and, possibly, village AIDS committees. In early 2004, a three-day training workshop was held for the Regional Administrative Secretariats and focused on modules that would help the support, coordinate and monitor the work of CMACs. From March through late May 2004, 14-day training workshops were held for each of the CMACs.

In June 2004, the training facilitators, representatives from TACAIDS and the development partners participated in a two-day workshop to draw lessons from the experience of training CMACs. The main lessons were:

- Because they had been refined through pre-testing in two Districts, the 10 training modules had proved to be user-friendly and relevant.
- Workshops are more successful when there are several facilitators with diverse skills, beliefs, ages, and experiences, increasing the likelihood that they will be able to communicate with participants of varying background, belief, language, and literacy.
- The circulation of written policies and guidelines has to be followed up with more personal communications or else people are likely to ignore or misinterpret them.
- CMACs are weakened when people appointed as members are not genuinely committed to the AIDS response and when members are appointed for one-year terms and then replaced by new members with no training or experience. (Though they were members of CMACs, few Members of Parliament attended the training sessions.)
- Stigma and discrimination and discomfort with open discussion of HIV and AIDS and related activities are still prevalent, even among members of CMACs, with some indicating that they would prefer not to have people living with HIV on their committees.

Planning the next steps

In July 2004, TACAIDS, evaplan/University of Heidelberg and the GTZ Health Programme in Tanzania held a one-day workshop with all the stakeholders involved in this initiative.[31] After breaking into three working groups, they came together and agreed on a plan of action for the next 6 to 12 months. Elements included:

- **Technical assistance to CMACS** 1) select 10 of the training facilitators used for the workshops and give them additional training as providers of technical support to CMACs while they develop strategic plans, programmes to counter stigma and discrimination and so on, 2) develop a checklist to support CMACs, helping them keep track of their actions and procedures – reports to Council, frequency of meetings, actions to develop profiles of the district's AIDS epidemic, etc, 3) develop tools and indicators for monitoring CMACs, 4) collaborate with Regional Administrative Secretariats on taking further steps to put monitoring and evaluation in place, 5) facilitate development of 5-year strategic AIDS plans for districts, 6) provide training and support to district AIDS coordinators (most of whom were the district Community Development Officers, by this stage).

- **Training WMACs** 1) with help of the training facilitators, identify 6 members from each CMAC and train them to facilitate training workshop for WMACs, 2) focus especially on the modules most relevant for WMACs – for example, helping them understand the important role they can play in monitoring and evaluation, 3) adapt the modules to the local context – for example, the need to address particular socio-cultural practices.

- **The role of TACAIDS** 1) build the capacity of Regional Administrative Secretariats to support CMACs, 2) possibility have Regional Administrative Secretariats appoint focal persons on AIDS, such as the Regional Community Development Officers, 3) strengthen linkages between PO-RALG and TACAIDS, 4) strengthen linkages between District AIDS Coordinators and District Planning Officers and Directors, through joint training, 5) raise District Council and public awareness of TACAIDS and its work.

- **Political will** 1) develop tailor-made peer education programmes targeting a variety of leaders and getting them to accept their ownership of and duty to address HIV and AIDS – for example, Members of Parliament, Regional Commissioners, Regional Administrative Secretaries, District Councillors, District Management Teams, 2) as an immediate step, hold joint PO-RALG/TACAIDS orientation workshops for each of those categories of leader, using the most relevant training modules, 3) organize a forum and establish a coalition of organizations engaged in AIDS advocacy and leadership development.

31 Fulgence, B (2004). Council AIDS Multisectoral Committees' Capacity Building: Report of the Planning Meeting Held on July 23rd 2004 at Kibaha. Dar es Salaam, Tanzania Commission for AIDS, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, evaplan/University of Heidelberg.

The workshop participants agreed that providing technical assistance to CMACs during their next 6 to 12 months was crucial, in order to make sure their training was applied and that they continued to learn through practical experience until they became expert at addressing HIV and AIDS in their districts, wards and villages. Sustaining the CMACs efforts beyond their next 6 to 12 months would require training and supporting Regional Administrative Secretariats so they could provide continuous support to CMACs.

The results, assessed one year later

One year later, in July 2005, the GTZ BACKUP Initiative[32] and evaplan/University of Heidelberg collaborated with TACAIDS on providing supportive follow-up to the trained CMACs. The CMACs of the seven District Councils and one City Council in the Mbeya Region were chosen as pilots. Two facilitators were recruited and provided with three days of training plus three tools: 1) terms of reference,[33] 2) a questionnaire for assessing the CMACs' capacities to develop multisectoral AIDS plans[34] and 3) the template for an analytical report for submission to TACAIDS.[35]

The facilitators visited each CMAC for three days to:

- Conduct structured interviews with key members of each CMAC
- Examine the CMAC's multi-sectoral AIDS plans
- Identify the CMAC's needs for technical support
- Facilitate better collaboration among key people
- Initiate dialogue about meeting the budget needs of the CMAC and the WMACs
- Deliver training manuals with drafts of a special WMAC component and initiate technical support for getting WMACs established and trained
- To support the next steps in planning the way forward, and
- To prepare analytic reports to TACAIDS.

The facilitators' final report[36] summarized the findings for each District and City Council and noted these achievements:

- Six of the eight CMACs had had at least three meetings over the past year, though one had had no meeting. Average attendance was 77% and all seven CMACs that had met also had adopted and implemented resolutions on such matters as establishing and training WMACs, doing profiles of the district's epidemic, promoting AIDS awareness in schools, developing information/education/ communication material, and so on.
- The new Regional Facilitating Agency had already begun providing technical support to six CMACs and was scheduled to visit the other two during the next month (August 2005). Results included the mapping and assessment of AIDS-related services and facilities provided by civil society organizations and assessment of training needs of those organizations and local government.
- Seven CMACs had developed multisectoral AIDS plans and four had submitted their plans to TACAIDS for analysis.
- Four of the Districts had facilities providing antiretroviral therapy; all eight had at least five civil society organizations providing AIDS-related services; among the services being provided by them and government facilities were Volunteer Counselling and Testing (VCT), support for orphans, sensitization on care and treatment of people living with HIV, home-based care, treatment of sexually transmitted disease (STI), prevention of mother-to-child transmission (PCMT), and public awareness.

32 The GTZ BACKUP Initiative helps countries take advantage of the opportunities provided by global initiatives to respond to HIV and AIDS, tuberculosis and malaria.

33 TACAIDS, evaplan/UH (2005). Terms of Reference for Facilitators to do the CMACs follow up. Dar es Salaam, Tanzania Commission for AIDS, evaplan/University of Heidelberg.

34 TACAIDS, GTZ BACKUP, evaplan/UH (2004). Follow up of CMACs Activities at Council Level, questionnaire for the capacity assessment of CMACs in developing multi-sectoral HIV/AIDS plans. Dar es Salaam, Tanzania Commission for AIDS, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH – BACKUP Initiative (Building Alliances Creating Knowledge Updating Partners), evaplan/University of Heidelberg.

35 TACAIDS, evaplan/UH (2005). Analytical Report: Follow up activity of CMACs. Dar es Salaam, Tanzania Commission for AIDS, evaplan/University of Heidelberg.

36 TACAIDS (2005). Report of Supportive Follow Up of CMACs – Mbeya Region. Dar es Salaam, Tanzania Commission for AIDS.

- There were a combined total of 138 Wards in the eight Districts and all had taken steps to establish WMACs; the composition of 30 WMACs was verified and the training of 26 WMACs had begun. The Wards had all acted on their own to establish WMACs after receiving the guidelines. In one Ward, all villages had established Village Multisectoral AIDS Committees.

- Since the CMACs had been established and trained, they had retained 85% of their members. Six, however, had no persons living with HIV among their members and such persons were recruited during the facilitators' visits.

The final report also noted a number of remaining challenges:

- The agendas for CMAC meetings often included items that were not strictly related to the CMACs' duties. Minutes were often not distributed in time for members to have read them before the next meeting. 4 CMACs had no meeting calendars and members were often given short notice of meetings, meaning they were unable to attend because they had other commitments. Most CMACs reported that Members of Parliament had never attended their meetings.

- Most CMACs had not divided up their responsibilities by assigning specific roles to specific members and many CMAC members remained unclear as to exactly what their roles were meant to be.

- CMACs reported that, while they had developed multi-sectoral AIDS plans and proposed AIDS projects and programmes in a variety of sectors, only items pertaining to the health sector got through Councils' planning and budgeting processes. One result was that the plans of some civil society organizations were not incorporated in the Council Development Plan and a knock-on effect was that some civil society organizations were bypassing CMACs and going directly to the Council Management Team with their proposals.

- Five CMACs had no collaboration with civil society organizations (CSOs). In most Districts, CSOs did not collaborate with each other through networks. Most CSOs were not well informed about the National Policy on HIV/AIDS, the Multisectoral Strategic Framework on HIV/AIDS 2003-2007 and the support those documents provide for their endeavours.

- WMACs were in the early stages of development and Village Multisectoral AIDS Committees were even less developed.

- Twenty members of CMACs had never been trained and the same was true of two of the Council HIV and AIDS Coordinators (CHACs) who were acting, in effect, as Secretary to CMACs. CHACs were sometimes not members of the District Council's Management Team and so not tied into budgetary and planning processes and not skilled at budgeting. Shortage of financial resources and equipment were prevalent

- Upcoming elections meant there was likely to be significant change-over of Members of Parliament and District Councillors and therefore of CMAC members. The new members would be in need of training.

The final report made recommendations addressing the above challenges, emphasizing the need for CMACs and their partners to keep learning from their experiences and building their capacities to respond to AIDS as effectively as possible.

For the financial year 2006-2007, Tanzania's Ministry of Finance has made funding available for Councils to undertake AIDS-related activities, based on their populations and levels of poverty. This means that, for the first time, CMACs will have opportunities to put their learning into practice and plan multisectoral activities knowing there will be sufficient money available to support those activities.

In Mpumalanga, Mainstreaming AIDS in Provincial, District and Local Government

The context

Socio-economic conditions

One of nine provinces in the Republic of South Africa, Mpumalanga covers 6.4% of the country's area and is home to 6.9% of its population, or more than 3.2 million people.[37] Situated in the north eastern part of the country, it borders on Mozambique and Swaziland. It suffers from high rates of unemployment, ranging from 24.8 to 30.1% over the 2001 to 2005 period.[38] South Africa's 2001 census found that 27.5% of Mpumalanga's adults who were more than 20 years old had never attended school and another 15.5% had attended but not completed primary school.[39]

According to the South Africa Human Development Report 2003, Mpumalanga had higher than the country's average per capita Gross Domestic Product, but it also had higher than the country's average income inequality. An estimated 54.8% of its population lived below the national poverty line. Largely due to the AIDS epidemic and its average life expectancy had declined from 62.3 years in 1990 to 46.0 years in 2003.

The state of the AIDS epidemic

In 2005, a household survey on HIV and AIDS questioned and gave HIV tests to far more South Africans than any previous survey had done and found that HIV prevalence was still increasing but at a slower rate than in the past.[40] Of the nine provinces, Mpumalanga had the highest rate of HIV prevalence (23.2%) among adults 15-49. Among those less than 35 years old, the prevalence rate was much higher among females than among males. For example, among 20-24 year olds, 6.0% of men but 23.9% of women were HIV-positive; among 25-29 year olds, 12.1% of men but 33.3% of women were HIV-positive.

The survey found that, throughout South Africa, race is an important factor in HIV prevalence largely because of the socio-economic inequalities between the races. Poor people often live in informal housing settlements, where HIV prevalence is much higher than elsewhere. Countrywide among adults 15-49, HIV prevalence was 13.9% in formal settlements, whether urban or rural, but 25.8% in informal urban settlements and 17.3% in informal rural settlements.

By the end of 2005, an estimated 235,000 or 21% of all South Africans in urgent need of antiretroviral therapy for AIDS were receiving therapy, through public or private health services. Among those receiving it, 93% were still alive after one year, an indication that treatment and care are of high quality when available.[41]

37 Statistics South Africa (2005). Mid-year population estimates, South Africa 2005. Pretoria, Statistics South Africa.
38 Statistics South Africa (2005). Labour force survey September 2005. Pretoria, Statistics South Africa.
39 Statistics South Africa (2005). Primary tables Mpumalanga Census '96 and 2001 compared. Pretoria, Statistics South Africa.
40 HRSC (2005). South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey. Johannesburg, Nelson Mandela Foundation (NMF) and Human Sciences Research Council (HSRC) of South Africa.
41 WHO (2006). Progress Report on Global Access to HIV Antiretroviral Therapy: A Report on "3 by 5" and Beyond. Geneva, World Health Organization.

The national AIDS response

The Government of the Republic of South Africa recognized the need for a multi-sectoral response to AIDS in 1997 and, after extensive consultations, produced the National Strategic Framework for HIV and AIDS and STIs 2000-2005. In 2000, Cabinet established the South African National AIDS Council (SANAC) as a mechanism for building greater co-operation between government and civil society in implementation of the plan. Since 2004, the federal government has been implementing the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment,[42] calling for involvement of the nine provinces.[43] The Plan calls for significant new investments to reduce the burden on health facilities and staff, first, through prevention and, second, through keeping HIV-positive people healthy with good nutrition, healthy lifestyles, prevention and treatment of opportunistic infections, and proper management of drug regimes.

Though the federal government has been encouraging the nine provinces and their districts and municipalities to establish their own AIDS councils since 2001, the South African National AIDS Council (SANAC) itself has not been a very strong and effective vehicle for multisectoral engagement and coordination. Many provinces, districts and municipalities established AIDS councils as early as 2001 but many of these councils soon became inactive. Such was the case with the Mpumalanga AIDS Council and the province's District and Local Municipal AIDS Councils. Since early 2004, due in part to new impetus given by the federal government's Operational Plan and in part to mounting pressure from civil society organizations, AIDS councils at all levels have been reviving throughout South Africa.

Within the Mpumalanga Provincial Government, the Department of Health and Social Services (DHSS) has principle responsibility for overseeing the development and implementation of AIDS policies and programmes. While it has been responding to HIV and AIDS more vigorously in the past two years, it still fails to take full advantage of the federal government funding available for its response.

Mainstreaming in Mpumalanga Rural Development Programme

Launched in 2001, the Mpumalanga Rural Development Programme (MRDP) has three principle partners – the Mpumalanga Provincial Government, German Technical Cooperation Agency (GTZ) and German Development Service (DED) – and a number of implementing partners, including several departments and two district municipalities. Its main aims are to improve service delivery and support economic development and sustainable natural resource development in the province's rural "poverty pockets." Achieving these aims involves working closely with Local Municipalities and their constituent communities.

The decision to have an HIV and AIDS component as part of the MRDP followed all partners' recognition that the AIDS epidemic had serious implications for the entire programme. They agreed to mainstream responses to HIV and AIDS in the MRDP, itself, and in the core programmes of partner institutions. The MRDP mainstreaming process links the three levels of government (provincial, district and local) and all departments of government and also links civil society to government through AIDS councils and the Home Based Care (HBC) programme.

At the level of the Mpumalanga Provincial Government, the MRDP has provided technical assistance to:

- Mainstreaming HIV and AIDS mitigation measures into the work of all government departments
- Implementing an HIV and AIDS workplace policy for all government employees
- Strengthening the Provincial Government's support for Home Based Care (HBC)
- Strengthening the Provincial Government's support for Voluntary Counselling and Testing (VCT).

42 Department of Health (2003). Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. Pretoria, Department of Health, Republic of South Africa.

43 SADC (2003). SADC HIV and AIDS Strategic Framework and Programme of Action 2003-2007. Gaborone, Southern African Development Community.

At the level of District and Local Municipalities, the MRDP has provided technical assistance to:

- Mainstreaming HIV and AIDS
- Reviving and strengthening District and Local AIDS Councils and support development of District and Local strategies on HIV and AIDS.

Mainstreaming in provincial government departments

Between August 2003 and March 2004, MRDP supported a series of "mainstreaming" workshops for provincial government departments.[44] As they were the experts in their own work, it was important to give them ownership of the mainstreaming process at the outset by involving senior and middle managers in planning the workshops before participating in them. Given that the structure, operating style and work of each of the departments were unique, content and process of the departmental workshops were adapted to the specific demands of the different departments.

The workshops were built around three questions:

1. How the epidemic is likely to affect the department's goals, objectives and programmes?
2. How the spread of HIV is caused by or contributed to by the department?
3. Where does the department have a comparative advantage to contribute to limiting the spread of HIV and mitigating the impact of the epidemic?

The introductory workshop

An introductory workshop on 4 August 2003 had participants from all departments plus the Office of the Premier. It consisted of presentations and exercises encouraging participants to:

- Reflect on the causes and consequences of HIV and AIDS
- Consider how their departments were already responding to AIDS (e.g., by contributing to economic development and so reducing the poverty that contributes to the spread of HIV) and how they were already linked to each other through networks to cooperate on certain matters
- Consider how they might use existing networks or build new networks for collaboration on the development and implementation of AIDS strategies that build on the comparative advantages of each department
- Formulate recommendations for actions their departments could take, individually and collectively, to contribute to the AIDS response.

44 MRDP (2003, 2004). HIV/AIDS Mainstreaming in Mpumalanga/RSA: Implementing a new strategy within the Provincial Government. Series of unpublished reports on workshops assisted by the Centre for Advanced Learning in Rural Development (SLE), Humboldt University, Berlin. Nelspruit, MRDP (GTZ and Mpumalanga Office of the Premier).

Seven departmental workshops

Over the following months, there were seven one- or two-day workshops for each of the following departments: 1) Public Works, Roads and Transport; 2) Local Government, Traffic Control and Traffic Safety; 3) Social Services; 4) Agriculture, Conservation and Environment; 5) Finance and Economic Affairs; 6) Education; 7) Health. Each consisted of presentations and exercises encouraging participants to:

- Discuss ways their department may be contributing to impacts of the epidemic. For example, participants from the Department of Public Works, Roads and Transport noted that lack of coordination in public transport schedules leaves people stranded overnight in places without safe and adequate sleep-over possibilities, exposing them to risk of sexual assault and HIV infection.

- Discuss ways their department might respond to HIV and AIDS internally, in its workplaces, and externally, in its work. For example, the Department of Public Works, Roads and Transport noted that they have opportunities to distribute condoms; provide referrals to AIDS-related services; influence contractors who may discriminate against HIV-positive people in their own workforce; give priority in their own planning and budgeting to developing and improving infrastructure for AIDS-related services.

- Develop proposed operational plans for the main units of the department. These plans identified activities, indicators for monitoring and evaluation, persons responsible, target dates for achievement, budgets, and linkages to potential partners in other government departments and to organizations outside government. They also noted institutional constraints (e.g., lack of financing) that might have to be taken into account before finalizing these plans.

- Formulate recommendations for action by their department. These typically covered formation of task teams, accountable to senior management, to drive the mainstreaming process forward; designation of main personnel responsible at headquarters and elsewhere; ways of linking and collaborating with other partners in provincial, district and local governments and outside of government;

For each department, a fact sheet was formulated, highlighting the specific impact of HIV and AIDS on the deparment's area of work and ways in which the department might contribute to an effective AIDS response:

► The resulting series of 9 fact sheets on mainstreaming a responds to HIV and AIDS can be downloaded at
http://hiv.prg.googlepages.com/bringingtheaidsresponsehome

Mainstreaming in district and local government

The MRDP supports two District Municipalities, Ehlanzeni and Nkangala, and their constituent Local Municipalities as they build their capacity to respond to AIDS within the context of their development programmes. Their aim is to integrate AIDS strategies into their Integrated Development Plans and to coordinate the AIDS-related activities of all stakeholders in their communities – provincial government departments, their own operations and civil society organizations, including community-based ones that provide services.

Nkangala workshop

In 2004, Nkangala and its Local Municipalities resolved to solicit the support of community-based organizations and other stakeholders and revive and strengthen their dormant AIDS councils and then develop strategies for their responses to AIDS. They asked the MRDP to support these endeavours by assisting them in planning and facilitating a mainstreaming workshop.[45] Participants in the workshop identified the following opportunities to contribute to an effective local AIDS response:

- They are at the front lines of the epidemic, where its impacts are felt and where AIDS-related services are delivered to the people who need them. The Integrated Development Planning process in each District and Local Municipality gives them opportunities to participate in assessing needs and planning for such services.

- They are also well-placed to understand and counter local traditions and attitudes that contribute to stigma and discrimination and to development programmes to counter those phenomena; to identify and intervene in situations (e.g., eviction from housing) that call for an urgent response; to identify and involve traditional healers and popular community leaders in contributing to the AIDS response

- They can assist with the establishment and support of community-based organizations that establish and operate Home Based Care centres, youth-friendly clinics and facilities and services supported by national and provincial programmes.

- They can mainstream HIV and AIDS measures into their own workplaces and work.

The workshop for the municipalities used the same exercises that had proved useful in the workshop for provincial government departments, described earlier, and, like them it concluded with participants developing recommendations for action.

Nkangala AIDS summit

In June 2006, with two years of experience applying the lessons from the workshop described above – and soon after the Local Government elections – Nkangala District Municipality held a summit bringing together political leaders and staff from South Africa's Department of Provincial and Local Government, key departments of the Mpumalanga Provincial Government, the District and its Local Municipalities, and private businesses and civil society organizations operating in the district. The aims of this summit were:

- To create awareness around Local Government responses to HIV and AIDS

- To share experiences and lessons and consider ways they could harmonize and coordinate their efforts

- To review the role and status of the District and Local AIDS Councils and consider their needs for broader representation and technical support

- To review South Africa's national AIDS policies and strategies and consider how it can be implemented in Nkangala

- To develop a strategic framework for Nkangala to respond to HIV and AIDS.

The key outcomes of the summit will be presented to the District Council in the form of resolutions. Once approved by District Council, these will be binding for the district and its local municipalities.

45 *MRDP and Nkangala District Municipality (2004). Nkangala District consultative workshop: Mainstreaming HIV/AIDS mitigation measures, 18 June 2004. Nelspruit, MRDP (GTZ and Mpumalanga Office of the Premier).*

Support for District and Local AIDS Councils

Over the past six years, many District and Local Municipalities in Mpumalanga have established District and Local AIDS Councils. To get them well-established and operational, the MRDP has provided a number of them with technical support in:

- Developing terms of reference and preparing and facilitating induction workshops Applying for funding for capacity building and other activities
- Assessing impacts of AIDS on their areas, mapping and assessing existing services and the need for new services, developing strategies and action plans, and identifying needs for resources and coordinating structures and processes.

Results and the way forward

Most departments in the Mpumalanga Provincial Government have responded to issues raised in the training workshops by upgrading the positions of their focal persons on HIV and AIDS (i.e., their Gender Focal Persons, whose responsibilities cover a number of issues) and giving them more staff support and budgets to carry out their duties. In addition, half of the provincial departments have mainstreamed AIDS strategies into their five-year strategic plans – naming AIDS as a key challenge and outlining strategic goals, objectives and activities to meet the challenge.

With technical support from MRDP:

- Two Local Municipalities have appointed HIV and AIDS Coordinators.
- Six Local AIDS Councils have developed HIV and AIDS strategies. One of these is approved by the Local Municipal Council and approval of the others is pending.
- Political leaders in Local Municipalities are more aware of HIV and AIDS and are getting more involved in AIDS-related activities. For example, the Mayor, Speaker and Councillors are getting actively engaged in reviewing HIV and AIDS strategies developed by Local AIDS Councils.

Through 2006 and 2007, MRDP's mainstreaming support to Provincial Governments departments will focus on implementation of selected projects of three key departments: Agriculture, Local Government and Housing, and Economic Development and Planning. For example, it will support a project to promote food security and gardening and, with the German Development Service (DED), support capacity building of the Small Enterprise and Development Agency, including its capacity to promote and support workplace programmes to respond to HIV and AIDS.

The MRDP's continuing support to District and Local Municipalities will include:

- Supporting AIDS Councils in carrying out their activities, including developing and reviewing AIDS strategies
- Training Municipal Councillors (starting in July 2006) to mainstream the AIDS response into their Integrated Development Plans
- Supporting capacity building of District and Local AIDS Councils they can participate in the Integrated Develop Planning process and make sure that HIV and AIDS programmes and projects are budgeted
- Supporting a workshop for all District and Local AIDS Council members, givig them an opportunity to share experiences and lessons learned
- Mainstreaming the AIDS response into the Local Economic Development Strategy of one district.

Drawing Lessons from Lesotho, Tanzania and Mpumalanga

Achievements, so far

GTZ's role is to provide technical assistance and thus facilitate the work of its partners in national, district and local government, civil society and private enterprise. Its achievements in supporting HIV and AIDS initiatives in Lesotho, Tanzania and Mpumalanga can be measured largely in terms of its success at getting them established and launched. Continuing success will depend on carry-through by its national, provincial, district, and local government partners in those countries and on their partners in civil society and the private sector. It will also depend on continuing financial and technical support by the international partners, including GTZ.

Meanwhile, GTZ's partners in Lesotho, Tanzania and Mpumalanga have been pioneers in the move to decentralize and mainstream the AIDS response and give it solid foundations on the front lines of the epidemic, in the communities where service providers meet the people who need HIV and AIDS prevention, treatment and care and impact mitigation. They have been learning by trial and error and taking measures to correct errors as they go.

The main challenges and some ways of meeting them

Cooperative development partners everywhere will be familiar with the kinds of challenge GTZ and its partners have been facing in Lesotho, Tanzania and Mpumalanga. The main ones are:

Lack of money The 2006 Report on the global AIDS epidemic confirms that, globally and within most developing countries, the money available for the response to AIDS has increased substantially over the past five years but much of the money never reaches the front lines of the epidemic where AIDS-related services are delivered to the people who need those services. There is urgent need to simplify bureaucratic processes, to support governments in accessing the money and managing expenditure, to streamline the flow of money to the front lines of the epidemic, and to put it to work in communities. That will require hard work from both ends, from the international level on down and from the local level on up.

=> **Getting prepared to put the money to work** It is a matter of utmost urgency that community-based stakeholders work together and demonstrate that they are well-prepared to put any available money to work, by completing their needs assessments and action plans and by lining up programmes and projects that need financing. With these at the ready, they can become strong advocates on their own behalf.

Lack of capacity Lack of financial resources and consequent lack of well-qualified human resources, facilities, equipment and supplies mean that most people are receiving far less than the basic health, education and other services promised in international agreements that have been ratified by donor countries and developing countries.

=> **Making do with what is available**
Many stakeholders in Lesotho, Tanzania and Mpumalanga have recognized that, given constraints imposed by their limited resources, the best course of action is to look for local solutions that rely less on fully-qualified professionals and on facilities, equipment and supplies of the highest standards. With technical support, trained paraprofessionals and volunteers can provide many of the services that might otherwise be provided by professionals and can do so using the most basic of facilities, equipment and supplies. In the health sector, for example, they can deliver Voluntary Counselling and Testing (VCT) door to door or in almost any kind of local centre, including a school, and they can also deliver care, monitoring patients' use of prescribed medicines and helping keep them healthy and resistant to infection by ensuring they are well nourished.

High turn-over in personnel Problems common to Lesotho, Tanzania and Mpumalanga are high turnover among elected officials, staff and volunteers in government at all levels and in civil society organizations. In addition, there is often political interference so the most qualified and dedicated people are not always the ones occupying key positions. As a result, it is difficult to maintain continuity in the planning and delivery of programmes and there are many delays and inefficiencies due the constant need to bring new people "up to speed."

=> **Quick and smart planning** Lesotho's Quick and Smart approach to planning holds the promise of becoming a highly effective way of assessing needs and priorities on the front lines of the epidemic, in the communities where people needing services live. It is easy to understand by everyone, so there is no steep learning curve for novices, and it is time-constrained, so most key people that are there at the beginning of the planning process will still be there at the end of it.

=> **Grounding the response in communities** In general, the population of small rural communities is fairly stable and so is the leadership. While people may come and go from elected councils, they nevertheless remain in their communities and tend to serve in other capacities, perhaps as leaders of community-based organizations that provide services. When the response to AIDS is planned from the community up and much of the implementation ultimately consists of service delivery within those same communities, then there is less need to worry about high turn-over and lack of continuity at higher levels of government.

Fear, stigma and discrimination At the workshops in Lesotho, Tanzania and Mpumalanga, even counsellors in community-based VCT programmes and "focal persons" on HIV and AIDS in government ministries spoke of their fear of getting tested for HIV, being exposed by failures to keep the results confidential and being subject to stigma and discrimination. Often, too, there was much discomfort about the whole subject of HIV and AIDS and the sexual attitudes and behaviours that can result in transmission. This discomfort sometimes made it difficult to engage in open discussions and to seek practical solutions to the problems of delivering prevention, treatment and care and impact mitigation – problems that often touched on the issues of gender equity, women's empowerment and the rights of children, including orphans.

=> **Getting to the roots** Fear, stigma and discrimination are highly personal and, at the same time, very social. They are tied to the traditions, cultural values, religious beliefs, and popular attitudes found in any particular community. The community's chiefs, elders, traditional healers, faith-leaders, and natural opinion leaders (people whose personal qualities command respect) may contribute to fear, stigma and discrimination but that means they are also well-placed to counter the same phenomena. Programmes of information, education, dialogue, and debate are best designed and delivered at the community level, in close collaboration with the people already mentioned and with women, men and youth. That way, they can get at the roots of fear, stigma and discrimination and proceed to root them out.

Learning but adapting

Lesotho, Tanzania and Mpumalanga Province are all part of the Southern African Development Community (SADC) and yet they are very different places, each with its unique governmental structures, cultural traditions, socio-economic conditions, and patterns of HIV and AIDS. Clearly, there is no one-size-fits-all way of responding to AIDS that would work for all three countries but, through SADC and other African and international organizations, they collaborate on their responses and learn from each other's experiences.

This publication summarizes how the three countries have developed decentralized responses to AIDS. The accompanying Toolbox contains several of the essential tools they have used in planning and implementing their response. It is unlikely that the partners against AIDS in any other country would be able or even want to follow their examples exactly or use their specific tools, as is, but GTZ sincerely hopes the partners in other countries will find their examples and tools useful as they plan and implement their own decentralized response to AIDS.

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www.sadc.int/
(See link at bottom of menu on left)

Tanzania Commission for AIDS (TACAIDS)
www.tacaids.go.tz

Tools

The following tools and materials were developed in the course of this project and can be downloaded at

http://hiv.prg.googlepages.com/bringingtheaidsresponsehome

For Lesotho:
- Community Council Action Plan. A template for use by any Community Council.
- Guidebook for Quick and Smart Community Council Planning.
- Lipitso Information Collection Kit: to assist Community Councillors to collect community priorities.

For Tanzania:
10 Training Manuals for HIV/AIDS Committees at Local Government Authorities

For Mpumalanga Province:
A series of 9 fact sheets for Mainstreaming a response to HIV and AIDS with local and provincial governments

Abbreviations

AIDS	Aquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
BACKUP	Building Alliances Creating Knowledge Updating Partners
CARE	Cooperative for Assistance and Relief Everywhere
CHAC	Council HIV and AIDS Coordinators
CMAC	Council Multisectoral AIDS Committee
CSO	Civil Society Organisations
DED	Deutscher Entwicklungs Dienst
DHSS	Department of Health and Social Services
DVD	Digital Versatile Disc
GDP	Gross Domestic Product
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HBC	Home Based Care
HIV	Human Immundeficiency Virus
ILO	International Labour Organisations
KaTseFA	Karolelano ea Tsebo Facilitator's Association
LAPCA	Lesotho AIDS Programme Coordinating Authority
MRDP	Mpumalanga Rural Development Programme
NGO	Non Government Organisation
NMF	Nelson Mandela Fund
PCMT	Prevention of mother-to-child transmission
PO	President's Office
RLAG	Regional Administration/Local Government's division
SADC	Southern African Development Community
SANAC	South African National AIDS Council
STI	Sexuallly Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TANESA	Tanzania Netherlands Project to Support AIDS control in the Mwanza Region
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United NationsEducational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WMAC	Ward Multisectoral AIDS Committee

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