Governmental Relationships and HIV/AIDs Service Delivery

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ARV	Anti-Retroviral Drug
ATIC	AIDS Training and Information Centre
CBO	Community Based Organisation
CD	Chief Director
DAC	District AIDS Council
DDG	Deputy Director General
DG	Director General
DHA	District Health Authority
DHC	District Health Council
DHS	District Health System
DoE	Department of Education
DoF	Department of Finance (later National Treasury)
DoH	Department of Health
DMT	District Management Team
DPLG	Department of Provincial and Local Government
DPSA	Department of Public Service Administration
DSD	Department of Social Development
EHS	Environmental Health Services
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HST	Health Systems Trust
IDC	Inter-Departmental Committee on AIDS
IDMT	Interim District Management Team
IDP	Integrated Development Plan
IEC	Information, Education and Counselling
IGR	Intergovernmental Relations
IMC	Inter-Ministerial Committee on HIV/AIDS
LAC	Local AIDS Council
LG	Local Government
LGDoH	Local Government Department of Health
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MEC	Member of the Executive Council
MHS	Municipal Health Services
MinMEC	Minister and Members of the Executive Council meeting
NCOP	National Council of Provinces
NdoH	National Department of Health
NGO	Non-Governmental Organisation
NHAC	National Health Advisory Committee
NHC	National Health Council
NHS	National Health System
NPCOH	National Portfolio Committee on Health
PAC	Provincial AIDS Council
PDoH	Provincial Department of Health
PEP	Post Exposure Prophylaxis
PHA	Provincial Health Authority
PHAC	Provincial Health Advisory Committee
PHC	Provincial Health Council
PHC	Primary Health Care
PHRC	Provincial Health Restructuring Committee

PMTCT	Prevention of Mother-To-Child Transmission
RDP	Reconstruction and Development Programme
SANAC	South African National AIDS Council
SMT	Strategic Management Team
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

Introduction

This research project examined inter-governmental relations in the health sector in South Africa. It focused on HIV/AIDS services but the intention was to use HIV/AIDS as a tracer or probe of broader health system functioning. The main objectives of the research were to describe what HIV/AIDS services are provided, how the different functions are allocated between government actors, and how they are then coordinated.

The study was conducted in two parts. Phase 1 was completed in the second half of 2002 and provided a broad National Overview of HIV/AIDS activities in the national, provincial and local spheres of government. Phase 2 was done in early 2003 and consisted of detailed Case Studies from three different tracer municipalities. The research methodology was mainly qualitative and exploratory and included literature review, document analysis and key informant interviews.

The key results of the project can be summarised by considering the following questions:

1. Why is coordination important in decentralisation reform?
2. How do we describe governmental relations?
3. How are HIV/AIDS roles and responsibilities allocated?
4. How are HIV/AIDS services coordinated?
5. What are the strengths and weaknesses of the current arrangements?
6. What contextual factors influence these relationships?
7. What is the impact on HIV/AIDS service delivery?
8. How can governmental coordination be improved?

1. Why Is Coordination Important In Decentralisation Reform?

Health sector decentralisation involves a shifting of power between central and peripheral levels. As authority is transferred from the centre towards the periphery, roles and responsibilities of each level of the system have to be re-aligned. The redistribution of responsibilities requires new mechanisms of coordination to ensure that all levels work together coherently to support service delivery and enable health system goals to be achieved. The fragmentation that results from health decentralisation is noted frequently in the health systems literature but how the problem should be addressed and what needs to be done to improve integration and coordination have received much less attention.

2. How Do We Describe Governmental Relations?

Governmental relationships are extremely complex. New conceptual frameworks and definitions are required to even begin talking about governmental coordination. The conceptual approaches developed in this study attempt to summarise the key governmental and extra-governmental actors involved in HIV service provision; the different categories of coordination; and different coordination mechanisms. The research focused primarily on inter-governmental coordination but also commented on intra-departmental, inter-departmental, political-administrative, inter-provincial, inter-municipal, inter-sectoral and referral coordination relationships (see Section 5.3.1). We describe the formal mechanisms, such as structures and meetings, that have been developed to coordinate HIV activities but also consider the importance of informal organisational relationships in governmental coordination.

3. How Are HIV/AIDS Roles And Responsibilities Allocated?

The Constitution allocates health responsibilities to all three spheres of government: general health services are shared between the national and provincial spheres, provinces are exclusively responsible for ambulance health services, and the local sphere is made responsible for municipal health services (MHS) but without defining what they are. Given the Department of Health's (DoH) commitment to the development of a District Health System (DHS), most earlier DoH policy documents focus on the functions of the national, provincial and district levels and are not completely clear how this relates to local government. A decision of the Health MinMEC in early 2001 suggested that the local sphere would ultimately be responsible for district governance and that MHS would be defined as primary health care, implying a significant role for local government in the provision of HIV/AIDS services. However, in the final version of the Health Bill submitted to parliament in June 2003, local government is only directly responsible for environmental health services, which does not include HIV services, though the Bill does make provision for additional functions to be delegated to competent municipalities. The HIV/AIDS National Strategic Plan is the most important blueprint for the government's HIV/AIDS strategy. It outlines a comprehensive package of interventions but is less clear on how the different responsibilities will be allocated and coordinated. The Plan is mainly concerned with involving other departments and sectors in the campaign against HIV/AIDS, and makes almost no mention of the different spheres of government.

Nevertheless, there was reasonable consensus among the respondents about the roles of the different actors in relation to the HIV/AIDS programme. The National Department of Health (NDoH) was seen to have a legitimate role in steering the HIV/AIDS programme. Both national and provincial respondents said that the main role of the Provincial DoH (PDoH) was to modify national policies according to provincial realities. Local government informants mentioned their role in the provision of clinic services, advocacy, training, home-base care (HBC), and NGO support. Hospitals and clinics were described as being responsible for clinical service provision, particularly the treatment of STDs and opportunistic infections. NGOs were mentioned as legitimate and important HIV/AIDS actors, particularly in the provision of home-base care (HBC) for AIDS patients but also for education, counselling and training.

4. How Are HIV/AIDS Services Coordinated?

The Constitution provides the broad legislative framework for inter-governmental relations and outlines a system of co-operative governance in which shared objectives and values are most important in coordinating relations between the three spheres. The Local Government White Paper also emphasises the need for cooperative inter-governmental relations and further suggests that local government can play an important role in government service integration at the local level, particularly through the development of local Integrated Development Plans (IDPs). The two main mechanisms identified in the National Health Bill to improve inter-governmental coordination are requirements for integrated planning processes between the three spheres of government, and the formalisation of a number of inter-governmental structures - the National Health Council (NHC), the National Health Advisory Committee (NHAC), and their equivalents at the provincial and district levels. The HIV/AIDS Strategic Plan also highlights the importance of coordination structures, particularly the South African National AIDS Council (SANAC) for inter-sectoral coordination, and the Interministerial Committee (IMC) and Interdepartmental Committee (IDC) on HIV/AIDS for inter-departmental coordination. The Plan suggests that these structures could be duplicated at the provincial and district levels but does not directly address coordination

between the three spheres of government beyond listing local government as one of the sectoral representatives in SANAC.

When asked about how HIV services are coordinated most informants referred to specific coordination structures although other mechanisms were also occasionally mentioned (see Section 5.3.2). The major focus in HIV coordination has been on national-provincial coordination, inter-departmental coordination and inter-sectoral coordination. National–provincial coordination has been improved through mechanisms such as the Strategic Plan; regular meetings between programme directors from the two levels; specific conditional grants to support priority activities; and the appointment of national personnel at provincial level. A number of respondents noted that the framework provided by the Strategic Plan had been important in supporting HIV coordination. As one official noted:

> *"I think the strength of it is the fact that, you know, we are guided by the strategic plan. There's something that gives us the direction of where we're going to…So that there is a sort of continuity, so that you don't find every year, you are suddenly doing something totally different, that there's some broad framework within which you can operate. And it gives everyone a sense of where they can slot into the different activities." (National HIV programme official)*

Inter-sectoral and inter-departmental coordination have been facilitated by the establishment of the HIV-specific coordination structures outlined in the Strategic Plan. Most of these structures are now supported by dedicated personnel and secretariats within the DoH. Coordination of HIV/AIDS services between provinces and local government has not been formalised though relationships were generally described as cordial. For example, some interviewees described how they were occasionally involved in campaigns or projects together, and attended each others' meetings when invited. Few respondents spontaneously mentioned broader coordination structures such as the Provincial Health Authority (PHA). The PHA was generally depicted as a political structure dealing with tensions related to DHS development and rather removed from day-to-day health service functioning. A number of interviewees confirmed the importance of informal relationships as mechanisms of coordination within the HIV/AIDS programme. As one responded said:

> *"Sometimes it works far better to bypass channels and to phone a person directly and ask them for assistance. That is a very effective manner, although its not always the correct way, but we do get things done in that manner" (Provincial official*

5. What Are The Strengths And Weaknesses Of The Current Arrangements?

Respondents identified strengths and weaknesses in relation to what HIV/AIDS services are provided, how HIV roles and responsibilities functions are allocated, and how they are coordinated.

HIV/AIDS Service Package

Most of the officials interviewed were quite positive about the progress that has been made in the implementation of the HIV programme over the last year or two. They pointed to improvements in public awareness, condom provision, the expansion of voluntary, counselling and testing (VCT) sites, the introduction of home-based care (HBC), and the strengthening of STI and TB services. A number commented on the importance of the five year Strategic Plan in providing a comprehensive and detailed plan of action.

However, some people felt that progress has been too slow while others argued that curative services have not had enough attention. Priority activities within the HIV/AIDS programme have generally become structured into separate, fairly vertical, sub-programmes - such as

the VCT and HBC - with reasonably well-defined packages of interventions. This has facilitated implementation but has also served to divert attention from broader systems support and developmental issues. A provincial HIV director explained:

> *"Because if you look at it now from the Strategy it is only a health issue and yet when you look at HIV/AIDS it is an developmental issue."*

Allocation of HIV/AIDS Roles and Responsibilities

The HIV Strategic Plan does not clearly specify the roles and responsibilities of the different spheres and actors with regard to HIV services. A provincial HIV director noted:

> *"Its the issue of not having a clear policy that differentiates the roles of each level of government. It's not clear what people are supposed to do. I think for me if we would have a clear policy on HIV/AIDS that says these will be the responsibilities of national, these would be provincial…for all the spheres of government"*

Over time the respective roles of the national, provincial and regional/district levels have become reasonably defined in practice. There has been some deconcentration of responsibility along the national–provincial–regional axis but most of the strategic direction and authority within the HIV/AIDS programme remains at the centre. A number of respondents complained that the national and provincial levels were still too involved in programme implementation. Despite the Constitutional obligation to help 'lower' spheres to fulfil their objectives, the national and provincial levels have tended to focus on directing and controlling rather than supporting and developing the levels below them.

The role of local government in HIV service provision remains an important area of uncertainty. Though there is significant variation between municipalities, HIV activities at the local government level remain fairly limited and no HIV responsibilities have been specifically devolved to the local sphere. Many local government respondents felt that the resources and advantages of local government were not being adequately utilised in the government's HIV/AIDS strategy. They argued that the local sphere provided better access to communities and community based organisations, were better situated to mobilise and integrate local resources, and would facilitate a more developmental approach to HIV/AIDS.

HIV/AIDS Coordination

Coordination and integration has clearly been identified as a priority within the DoH and the HIV/AIDS programme and is receiving attention and resources. Partly reflecting the priorities outlined in the Strategic Plan, most attention has focused on improving National-Provincial coordination, inter-departmental coordination and inter-sectoral coordination. Other categories such as intra-departmental coordination and Provincial-Local coordination have received less attention. With regard to HIV services, interactions between provincial and local officials appear to be limited to very local initiatives and very specific issues. Many local government services function quite independently of the national programmes even when there is significant overlap of activities such as in the setting up of VCT sites or contracting with NGOs. In the absence of formal relationships local government managers often have to rely on informal and personal connections which was not seen as ideal.

A number of different coordination mechanisms have been utilised. The Strategic Plan seems to have been particularly influential while coordination structures have varied in their effectiveness; some structures have played a critical role whereas others exist in name only. Nevertheless, the structures have tended to proliferate. In some instances, the establishment of new structures appears to have become an end in itself, hindering coordination rather than facilitating it. As one official complained: *"There is no coordination of the coordination."*

Most coordination initiatives have focused on political channels of coordination which don't necessarily result in improved coordination of service delivery. Similarly, the nature of the coordination required is rarely specified. Many respondents suggested that simple communication would address many of the current problems. On the other hand, some provincial and local interviewees argued that there were lots of discussions about programme operations but little space for coordinated strategic thinking and problem-solving among senior managers.

6. What Contextual Factors Influence These Relationships?

Inter-governmental relations and the coordination of HIV services reflect the present context of public sector transformation in South Africa. Some important factors include the current political imperatives for service delivery; the prolonged process of local government restructuring; and the historical legacy of apartheid on municipal level capacity. Within this changing environment governmental relations are clearly still in a process of evolution and development.

The current organisation culture of the public sector is also relevant. For example, the nature of the bureaucracy tends to favour formalisation and structural solutions to coordination problems while the prevailing political culture is partly responsible for the emphasis on accountability to politicians and the current centralisation tendencies within government.

At the DoH level, a key contextual factor has been the policy process with regard to DHS development. The prioritisation of the district level as well as the uncertain and changing debate about the role of local government within the DHS has definitely contributed to the poor integration and coordination with the local sphere.

Lastly, certain contextual factors contributing to the observed relationships and dynamics are unique to HIV/AIDS. HIV/AIDS is seen as requiring broad, multi-sectoral responses which significantly increases the number of actors involved and the complexity of coordination. Also, the urgency of the HIV crisis in South Africa accounts for the preoccupation with implementation and service delivery rather than slower more developmental approaches.

7. What is the impact on HIV/AIDS service delivery?

The focus of the HIV/AIDS Strategic Plan has been on the rollout of a series of national HIV priority sub-programmes, particularly VCT and HBC. There has clearly been progress in these areas and their implementation has been fairly well-coordinated, at least between the national and provincial departments. Of concern is that the priority sub-programmes have tended to become rather centralised and verticalised and are sometimes seen as ends in themselves. The establishment of structures to support inter-departmental and inter-sectoral coordination has also been a department priority, but has not yet had much impact on HIV/AIDS programme implementation.

The Strategic Plan has been helpful and influential in determining the direction of the HIV/AIDS strategy. The danger, however, is that where the Plan is weak or deficient, the programme will be too. So, aspects such as supporting curative HIV services at clinics and hospitals, or improving provincial-local coordination or intra-departmental integration have been relatively neglected. A few officials voiced their concerns about the limited space for strategic engagement and review of current strategies and initiatives.

Many facility level managers interviewed seemed ill-prepared to take on the extra workload being allocated to them in relation to HIV services. Their concerns related to basic infrastructure and broader systems support are not adequately addressed within the current HIV/AIDS plan. Informants outside the HIV/AIDS directorate commented on the poor coordination within the department on HIV issues. They also complained that HIV/AIDS was receiving a disproportionate share of the attention and resources and that other PHC priorities should not be neglected.

Lastly, the limited interaction and involvement of local government is understandable in the light of the uncertainty regarding DHS development as well as the concerns about municipal capacity and the arrangement of fiscal federal relations. Nevertheless, failing to take full advantage of the resources and more developmental approach of local government may be particularly detrimental for HIV/AIDS services.

8. How Can Governmental Coordination Be Improved?

This study attempted to explore the complexity of governmental relations and coordination. The frameworks and approaches developed in relation to the coordination of HIV/AIDS services are helpful in highlighting some of the tensions and tradeoffs that need to be considered in improving health system coordination in South Africa:

- There may be a number of different objectives for governmental coordination. One assumption is that the primary concern is to achieve national coherence in health service delivery but this is a rather top-down approach that overlooks the importance of political governance and accountability. There is a tension between achieving short term delivery objectives - through mechanisms such as centralisation and verticalisation - and broader, more long term developmental goals - such as the strengthening the local sphere of government. This tradeoff is also reflected in the need to balance the oversight and control role of the national and provincial spheres with their developmental and support responsibilities.
- A prerequisite for improving coordination is to clarify the roles of all the different actors in the provision of health services, particularly within the local sphere.
- The nature of coordination required also needs to be defined. Some relationships simply need better communication and information-sharing whereas others may require joint decision-making.
- A more balanced approach to the different categories of coordination is necessary. Inter-departmental and inter-sectoral coordination are clearly important but more immediate priorities may be to facilitate integration within the DoH and to improve coordination between the provincial and local spheres of government.
- Political buy-in and leadership are critical to the success of health interventions, but administrative channels of coordination also need to be developed to ensure that coordination of actual service delivery takes place. The absence of forums for strategic engagement of senior officials from all three spheres of government is a particular concern. A further strategy would be to focus on improving political – administrative relationships.
- Formal structures are frequently seen as the solution to coordination problems though they have not been uniformly successful. There also needs to be more attention to the *"coordination of coordination"* which requires defining clear responsibilities and relationships between different coordinating structures. Other mechanisms of

coordination, such as information dissemination or integrated planning, should not be neglected.

- There appears to have been little explicit emphasis on trying to develop shared values between the different spheres of government, the approach to cooperative governance outlined in the Constitution. Respondents spoke more of the competition and rivalries between levels than a shared project of government delivery. Shifting to more financial mechanisms of coordination, such as conditional grants and service level agreements, may actually serve to undermine the development of such cooperative relations.
- Consideration needs to be given to process issues in the design of inter-governmental relationships, for example by ensuring that actors affected by the changes participate in their development. Flexibility and incremental learning through experimentation will probably be more helpful than technical expertise in organisational design.
- Lastly, it should not be forgotten that though coordination is important, the opportunity costs of resources spent on coordination mean that minimal rather than maximal systems may be appropriate.

CHAPTER 1: INTRODUCTION

1.1 Background and Rationale

Any form of health sector decentralisation involves a balance of power between central and peripheral levels (Mills, 1994). It is generally assumed that decentralisation can promote the standard goals of equity and efficiency by bringing greater flexibility into management and, in particular, making management more sensitive to the needs of service users (Hambleton, 1998). However, as authority and responsibilities are transferred from the centre towards the peripheral levels of an administrative system, authorities and responsibilities at each level of the system are also re-aligned. This re-definition of roles must enable all levels to work together coherently to support service delivery and enable health system goals to be achieved (PHRplus, 2002).

International experience indicates that a common problem of decentralisation programmes is that the roles of the different levels may be neither clearly or appropriately re-defined as part of the process of decentralising nor effectively implemented (Thomason *et al.*, 1991). Within a decentralised system the central level should retain functions related to setting national frameworks, but give up responsibility for translating these frameworks into service delivery and adopt a facilitatory, rather than command, style of management. However, the central level often fails to adapt to its new role and the associated ways of relating with other parts of the health system. By retaining too much authority, even whilst transferring responsibilities to the periphery, the central level can undermine the attainment of expected goals (Mercado *et al.*, 1996). At the same time, if too much authority is transferred to the periphery, national goals of equity and coherence may be undermined (Collins and Green, 1994). Finally, the fragmentation of responsibilities and authorities between health system levels can directly undermine service delivery – as may occur when the management, and associated funding flows, of clinics and hospitals are allocated to different administrative levels (Kohlemainen-Aitken and Newbrander, 1997).

These problems may be exacerbated when, as in South Africa, decentralisation of health sector functions is only one component of wider political decentralisation. Although local government structures may facilitate local level accountability and inter-sectoral coordination, they inevitably increase the complex web of inter-relationships within which, and through which, health management decisions are made (Gilson *et al.*, 1994; Thomason *et al.*, 1991). When both management and governance/political responsibilities are decentralised there is also real potential for the relationships between those responsible for governance and management within any one tier, to conflict with relationships between tiers. The consequences may include fragmented resource flows, conflicting views over the relative priority to be given to health versus other services or between specific health services, and competing lines of authority, outwards to political structures and upwards to management supervisors (Gilson and Mills, 1995). These types of problems may, in turn, lead to fragmented service delivery structures, budget fluctuations or other changes likely to undermine service delivery.

As a result it is generally recommended that, within decentralised systems:

- careful attention be paid to coordinating governance and management responsibilities and authorities within and across governance tiers;
- clarifying the roles and responsibilities of each tier in relation to key management functions;
- authority matches function or responsibility at every level of the health system;

- the central level has an enabling role, providing the vision and strategic guidance within which the peripheral levels deliver services, but retains responsibility for resource allocation between geographical areas;
- the specific needs of health care provision are considered in delineating the roles of each management level in order to prevent service delivery fragmentation.

There is surprisingly little literature on the exact mechanisms that are appropriate to support the integration of activities within complex organisations. A key distinction may be to differentiate mechanisms to coordinate activities within an organisation from processes appropriate to inter-organisational relationships. Hierarchical relations within an organisation may be coordinated by processes such as rules, direct supervision and professional values (Mintzberg, 1983) and facilitated by specific structures for joint planning, budgeting and task coordination (Cummings and Worley, 2001). Inter-organisational relationships may be coordinated by collaborative partnerships, the market or specific contracts (Williamson.O., 1996). Whether relationships between tiers of government should be seen as intra- or inter-organisational is unclear, but this distinction provides a useful starting point to think about appropriate integrating mechanisms.

Another factor that must be considered within an analysis of health system decentralisation is the set of informal relationships that shape the practice of decision-making and so influence the overall functioning of the system (Atkinson *et al.*, 2000). Informal relationships include those based on friendship or other factors rather than formal role allocations. They may be between people within a professional group, from the same geographic area or between those who have trained at the same organisation or in a particular disciplinary perspective. The factors affecting the influence these relationships have over the practice of decision-making include the organisational culture of the health system, the extent of trust between key actors and the practices of communication. Broader analysis of public sector organisational capacity, and its weaknesses, emphasises the importance of such issues over the practice of decision-making (Hildebrand and Grindle, 1994; Bennet and Mills, 1998; Mills *et al.*, 2001). At the same time some of the key factors associated with these informal relationships may also represent informal mechanisms of coordination. Effective communication is likely to be necessary for effective coordination, and trust, for example, has been identified as an important basis of organisational relationships (Coulson, 1998). These informal mechanisms of coordination may support the formal allocation of roles and responsibilities across tiers, or may undermine them.

In addition, it is commonly recognised that organisational, administrative and behavioural factors influence the performance of decentralised systems (Rondinelli and Nellis, 1986). For example, a hierarchical managerial culture may continue to influence decision-making practice long after formal decentralisation of responsibilities. The top-down style of policy implementation within South Africa has, therefore, been identified as a barrier to decentralisation (Gilson *et al.*, 1996). In addition, distrust between governance levels has already been identified as a factor influencing provincial-local government relationships in South Africa in ways that may be detrimental to service delivery (Klugman and McIntyre, 2000). Finally, poor communication is a common weakness of the South Africa health system. Poor communication between clinics and hospitals undermines referral practices, poor communication between management levels undermines budget development in support of service delivery (Brijlal and Gilson, 1997) and poor communication of new policies to front-line health workers and the public undermines their implementation (Gilson *et al.*, 1999).

Reflection on international experiences in the context of South Africa suggests that a critical influence over the pattern, practice and outcomes of health system decentralisation will be the evolving inter-relationships between national, provincial and local governments.

1.2 Aim and Objectives

The aim of this research project was to explore inter-governmental relationships in the health sector in South Africa. To focus the enquiry it was decided to use HIV/AIDS services as a tracer or probe of health system functioning.

HIV services are of critical importance in South Africa at present. Many aspects of HIV/AIDS services are similar to other health programmes, but HIV also has some specific peculiarities. Nevertheless, the use of HIV/AIDS provided some useful initial insights into inter-governmental health service coordination in South Africa.

The specific objectives of the study were to:

1. Identify the key tasks needed for HIV service provision.
2. Describe the official allocation of roles and responsibilities to different actors in the system.
3. Elucidate the formal mechanisms to coordinate activities between different actors.
4. Describe the informal relationships that influence the provision of HIV services.
5. Evaluate the impact of these relationships on HIV service delivery.

CHAPTER 2: METHODOLOGY

2.1 Conceptual Frameworks

Two initial conceptual frameworks were developed to guide the research process.

2.1.1 Relationships and Service Delivery

The first framework provides an outline of the main relationships in health service delivery and is represented diagrammatically in Figure 2.1.

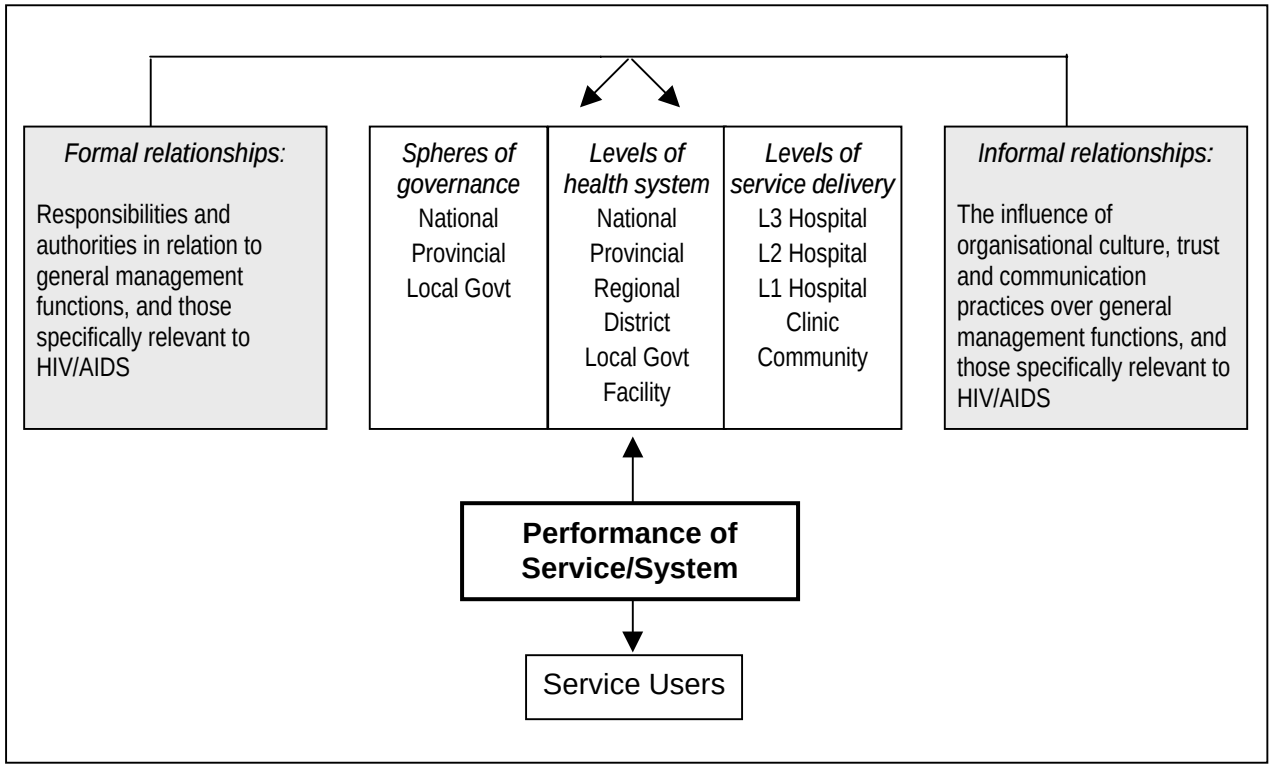


Figure 2.1 : Main health system relationships

The figure is based on the understanding that the performance of any health system results from the interaction between users and service providers (facilities and health workers), and not solely from action within the health system. It, therefore, indicates that the user/provider relationship must be considered within this assessment in order to trace the impacts of decentralisation on health system performance. It specifically raises the question: what services and management support actions are necessary to enable positive interactions between the health system and service users, and so ensure effective/good service delivery?

Second, it emphasizes that as governance and health service management structures are distinct, the inter-action between these structures within each level of the governance system is itself a potentially important influence over the relationships between management tiers.

Third, it shows that the relationships between governance/management levels will be investigated by considering key issues associated with both formal and informal relationships around a set of management functions.

Fourth, given the international experience of decentralisation described above, the key focus of investigation with regard to formal relationships will be the allocation of responsibilities and authorities between governance/management tiers. At the same time, investigation of informal relationships will focus on the influence of management culture, trust and communication practices over the practice of management and service delivery.

2.1.2 HIV/AIDS Service Delivery

The second framework provided an initial assessment of the key tasks in the provision of HIV/AIDS services by a process of 'backward mapping'. The sequence of 'backward mapping' involved:

i. The definition of the main HIV service outcomes;
ii. The definition of the HIV service package provided by frontline providers to achieve those outcomes; and
iii. The identification of processes at higher levels needed to support frontline HIV service delivery.

These different aspect of HIV service delivery are shown in Figure 2.1.

The expected outcomes of HIV/AIDS services include:

- Improved quality of life of those living with HIV/AIDS
- Reduced impact of HIV/AIDS on families and communities
- Reduced rates of infection in the community.

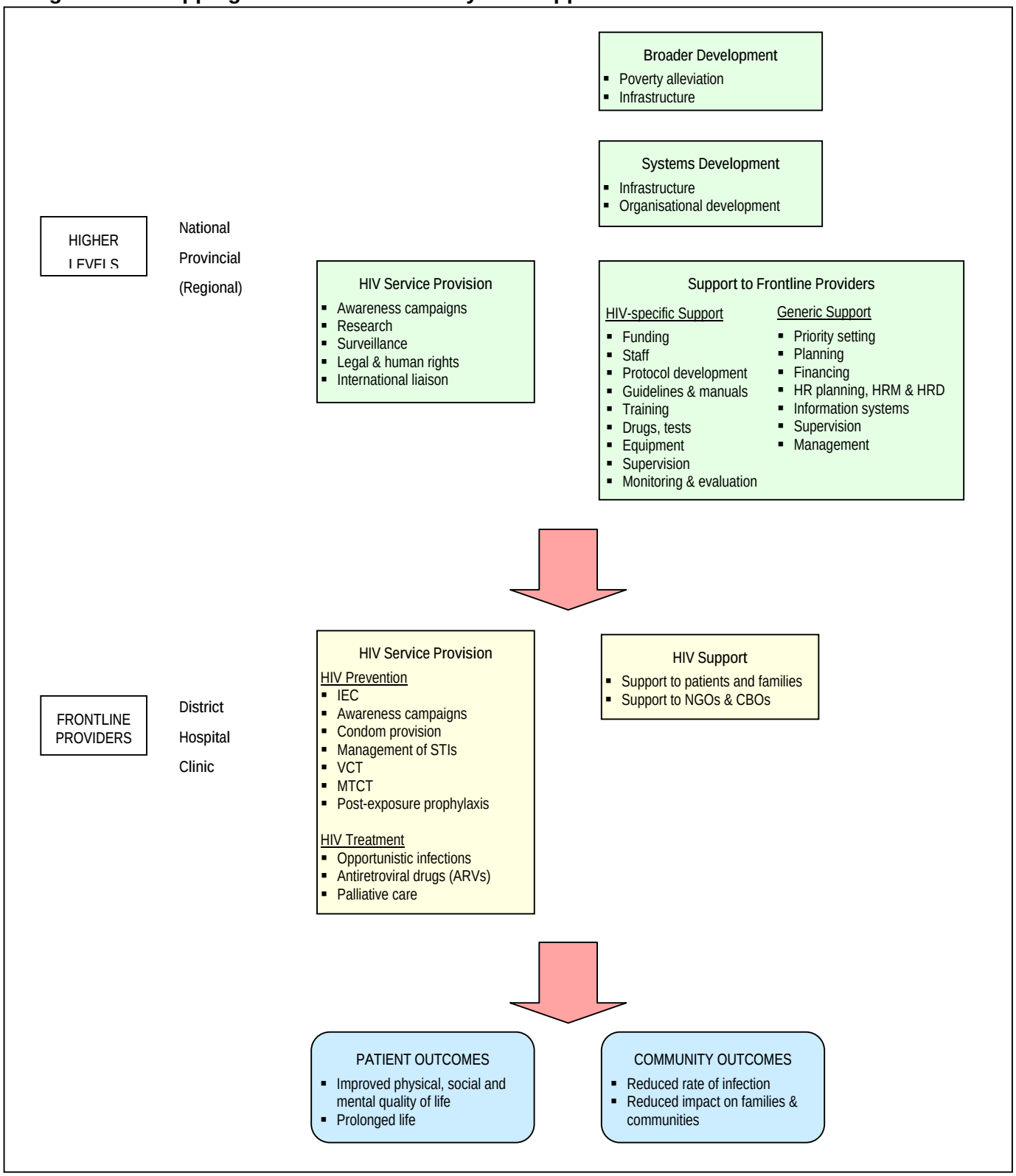
In order to achieve these objectives facilities and district level services need to provide a basic package of preventive and therapeutic services (Figure 2.1) including:

- An information, education and communication (IEC) programme.
- Provision and distribution of condoms.
- Effective diagnosis and treatment of sexually transmitted infections (STIs).
- Voluntary confidential counselling and testing (VCT) for HIV.
- Comprehensive mother to child prevention (MTCT), including short course antiretroviral therapy and breast milk substitutes.
- Effective diagnosis and management of opportunistic infections, including TB.
- Provision of effective anti-retroviral drugs (ARVs)
- Provision of palliative care including home based care (HBC) programmes.

Frontline workers are also required to provide support to families and non-governmental organisations (NGO) and community based organisations (CBOs) in the community.

The main role of higher levels of the system is to support service delivery by frontline providers though certain components of the HIV service package, such as research or international liaison, may be more effectively delivered by higher level authorities (Figure 2.1). Frontline providers require both HIV-specific support, such as the development of guidelines for the management of opportunistic infections or the provision of VCT training, as well as generic organisational support to ensure the effective and efficient management of health facilities and services. Lastly, broader health systems development and societal development are also important in supporting HIV service provision by frontline providers.

Figure 2.1: Mapping of HIV service delivery and support needs



2.2 Research Methods

2.2.1 The Local Government and Health (LGH) Research Project

This study formed part of a larger research project exploring key issue in the decentralisation and devolution of health services to local government, the Local Government and Health (LGH) project. The LGH project involved a consortium of research organisations and was composed of seven research Briefs (Figure 2.1). This study constituted Brief IV of the project.

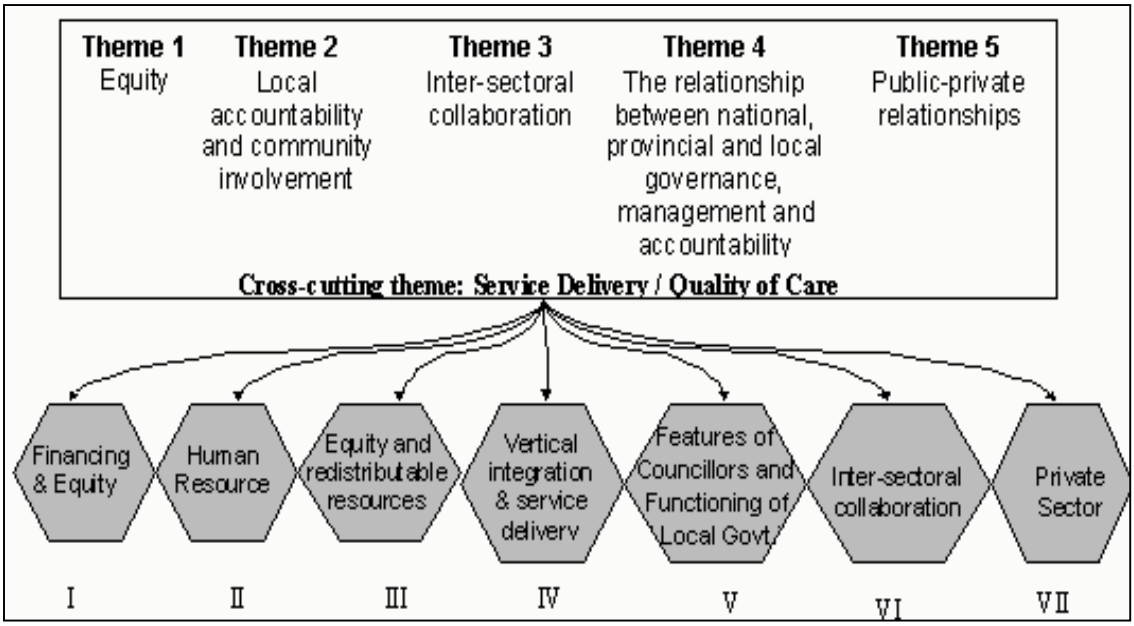


Figure 2.1: Local Government and Health Research Briefs

Research for the LGH project was focused on nine tracer District Councils, one from each of the nine provinces. The tracer municipalities were selected by the Health Systems Trust, the key partner and funder of the project.

2.2.2 Overall Study Approach

An overview of the research methodology used in our study (Brief IV) is presented in Figure 2.1.

The initial frameworks were helpful but the research, nevertheless, maintained an open, exploratory approach. The project was designed in two phases. Phase 1 was intended as a broad National Overview focusing on the formal organisation and coordination of HIV services. Phase 2 consisted of three Case Studies which provided additional information on formal interactions but also facilitated the exploration of informal processes and referral relationships.

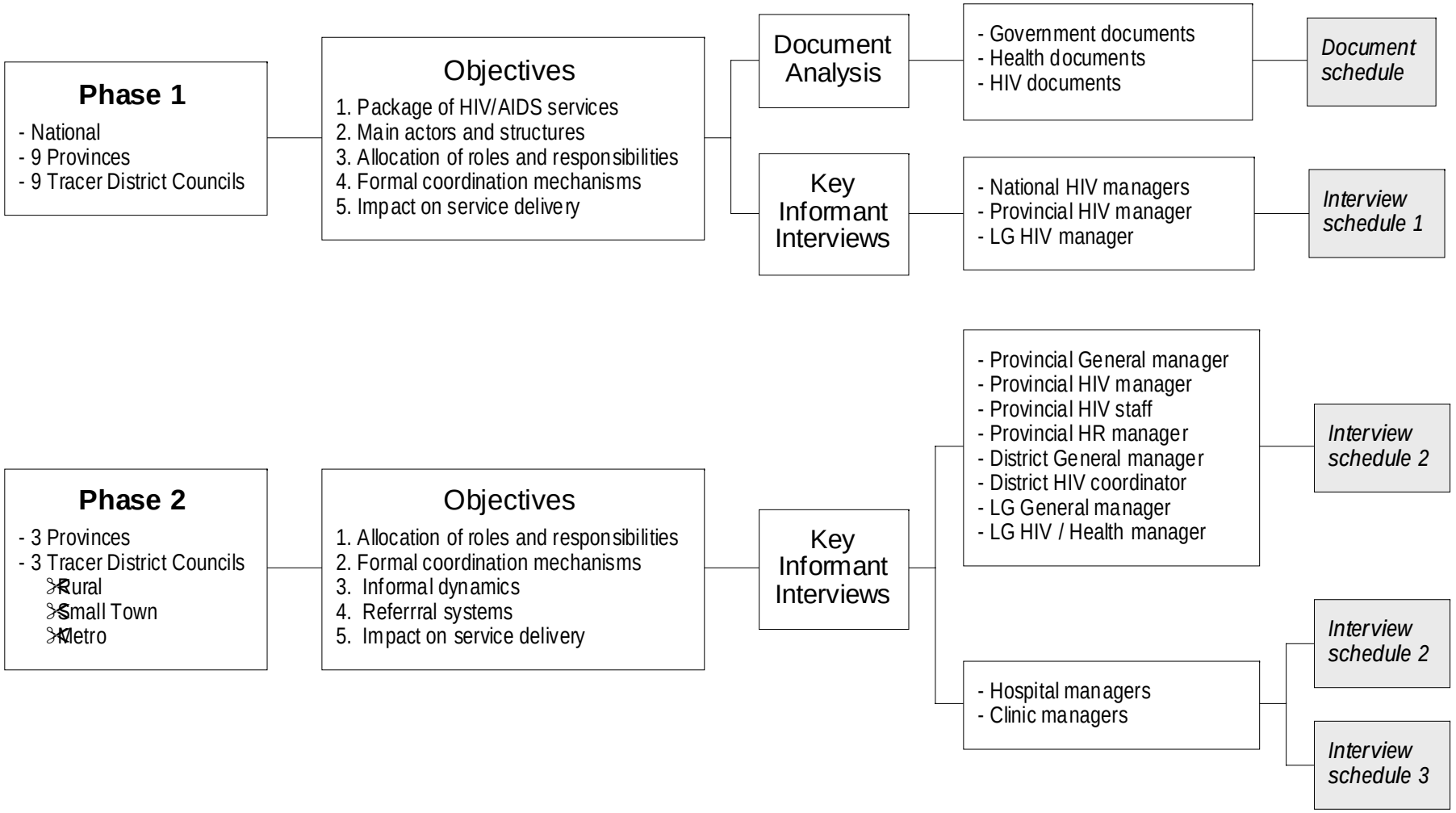


Figure 2.1: Overview of research methodology

2.2.3 Methodology Details

As shown in Figure 2.1, the research methodology consisted of document analysis and key informant interviews.

As part of the National Overview, we collected all policy documents, legislation and governmental reviews related to HIV services and inter-governmental relations. In effect this required identifying documents specific to HIV services as well as more generic Department of Health (DoH) documents and legislation, and even documents relevant to broader governmental relations. All documents were explicitly coded and analysed using themes derived from the study objectives.

The Phase 1 key informant interviews focused on national, provincial and local HIV coordinators. Participants from the National department were identified by the Chief Director of the HIV programme. At the provincial level, interviews were conducted with the HIV programme Director. The local government informants were obtained from the nine tracer municipalities. If no-one was officially allocated to HIV services, we interviewed the senior health official in the municipality. Sometimes interviews were conducted with a health official from one of the Local Councils, or a local government councillor if they were identified as the most appropriate person to comment on HIV services within the District Council. A semi-structured interview schedule was used for the Phase 1 interviews (Schedule 1 in the Appendix). Face-to-face interviews were conducted with national officials and respondents from the three provinces selected for the Case Studies. The rest of the interviews were done telephonically.

The three tracer municipalities selected for the more detailed Case Studies in Phase 2 were Tshwane in Gauteng, Thabo Mafotsanyane in the Free State, and Alfred Nzo in the Eastern Cape. The three sites were chosen to be representative of a metropolitan council, a district consisting of small towns, and a rural area respectively. In each Case Study site, we aimed to interview all HIV programme coordinators at the provincial and district levels, all hospital managers and the clinic managers from a random selection of five clinics in each district. We also spoke to selected general line managers and support staff from the provincial and local departments where possible. The interviews utilised a critical incident methodology to identify different roles and relationships relevant to HIV service provision (Schedule 2 in Appendix). Facility level informants were also asked about referral mechanisms and relationships (Schedule 3). Face-to-face interviews were conducted in all cases.

Written permission for the study was obtained from the national DoH and each of the nine provinces. However, individuals were still free to decline to be interviewed or for their interviews to be recorded. Most of the face-to-face interviews were conducted by two interviewers. When informants agreed, the interviews were taped and then transcribed verbatim. The interview transcripts or interviewer notes were coded and analysed using a ‘grounded’ approach (Miles and Huberman, 1994).

CHAPTER 3: OVERVIEW OF RESULTS

3.1 Document Analysis

The document analysis focused on legislation, policy documents and governmental reviews at Governmental, Department of Health, and HIV Service levels. The key documents reviewed (not a comprehensive list) are listed in Table 3.1.

Table 3.1: Main documents included in the analysis

Level	Documents
Government	▪ Constitution of the Republic of South Africa, 1996 ▪ White Paper on Local Government , 1998 ▪ Presidential Review Commission Report, 1998 ▪ Provincial Review Report, 1997 ▪ The Intergovernmental Relations Audit, 1999 ▪ Local Government Transition Act, 1993 [32/h} ▪ Local Government Demarcation Act, No 27 of 1998 ▪ Local Government Municipal Structures Act, No 117 of 1998 ▪ Local Government Municipal Systems Act, No 32 of 2000
Health	▪ ANC Health Plan, 1994 ▪ A Policy for the Development of a District Health System for South Africa, 1995 ▪ Towards a National Health System, 1995 ▪ White Paper for the Transformation of the Health Service in South Africa, 1997 ▪ Review of Public Health Service Delivery, 1999 ▪ Northern Province Health Services Act, No 5 of 1998 ▪ Free State Provincial Health Act, No 8 of 1999 ▪ Eastern Cape Provincial Health Act, No 10 of 1999 ▪ KwaZulu Natal Health Act, No 4 of 2000 ▪ Gauteng District Health Services Act, No 8 of 2000 ▪ National Health Bill, Various drafts (Particularly Nov 2001, Sep 2002, Jun 2003) ▪ Health Sector Strategic Framework, 1999-2004
HIV	▪ NACOSA National AIDS Plan for South Africa, 1994-1995 ▪ HIV/AIDS & STD Strategic Plan for South Africa, 2000-2005 ▪ National STD & HIV/AIDS Review, 1997 ▪ Interim Findings on the National PMTCT Pilot Sites

3.2 Key Informant Interviews

Overall, a total of 68 in-depth key informant interviews were conducted for the study, as summarised in Table 3.1. Despite repeated attempts, three provincial and four local government HIV coordinators (of the 9 tracer sites) were not interviewed during Phase 1. The local government respondents were from Metropolitan, District and Local Councils and the facility interviews included a combination of hospitals, provincial clinics and local government clinics.

Table 3.1: Summary of key informant interviews

		Number of Interviewees					
		National	Provincial	Local Govt	Regional / District	Facility	Total
Phase 1		4	6	5			15
Phase 2	Free State		6	1	2	10	19
	Eastern Cape		6	3	3	7	19
	Gauteng		3	2	2	8	15
TOTAL		4	21	11	7	25	68

3.3 Analysis and Synthesis

As outlined in Section 1.2, the primary objectives of the analysis were to identify the package of services and support required for HIV service provision, how those roles and responsibilities are allocated between government actors, and then how the different activities are coordinated and integrated. The analysis also aimed to explore the informal relationships that influence the provision of HIV services and consider the implications of all these results for HIV service delivery.

This analysis is complicated by the fact that the HIV/AIDS programme is located within the Department of Health (DoH) which, in turn, is located within the South African government system. Clearly, the functioning of the HIV/AIDS programme will be influenced by the underlying health system as well as broader governmental relations so that the analysis needs to consider activities, role allocation and coordination mechanisms at each of these levels. Also, because of the priority given to HIV/AIDS, HIV activities are not confined to the HIV programme and are also being addressed in other divisions of the DoH and other parts of government. In addition, HIV/AIDS is being tackled through generic management processes as well as HIV-specific programmes and structures at the different levels. Figure 3.1 attempts to represent some of this complexity. The implication of this is that HIV/AIDS services are not simply a probe that reflect broader health system or governmental relations but that there are more complex inter-relationships between the three levels of analysis. These basic insights underlie much of the analysis that follows.

3.4 Structure of the Report

The chapters that follow explore the same fundamental questions relating to HIV/AIDS services - what package of services is prioritised, how responsibilities are apportioned, how activities are coordinated, and the relevance of informal processes - from a number of different perspectives. Chapter 4 focuses on the document analysis and outlines the legal and policy framework relating to HIV service organisation and coordination. The findings from the Phase 1 key informant interviews are summarised in Chapter 5 which provides initial insights from national, provincial and local government actors. The three case studies in Chapters 6 to 8 then present a more detailed picture of these dynamics from a broader range of respondents, including frontline health care providers. Lastly, the key findings of the research are summarised in Chapter 9, which also considers the limitations and some of the key analytical themes of the study.

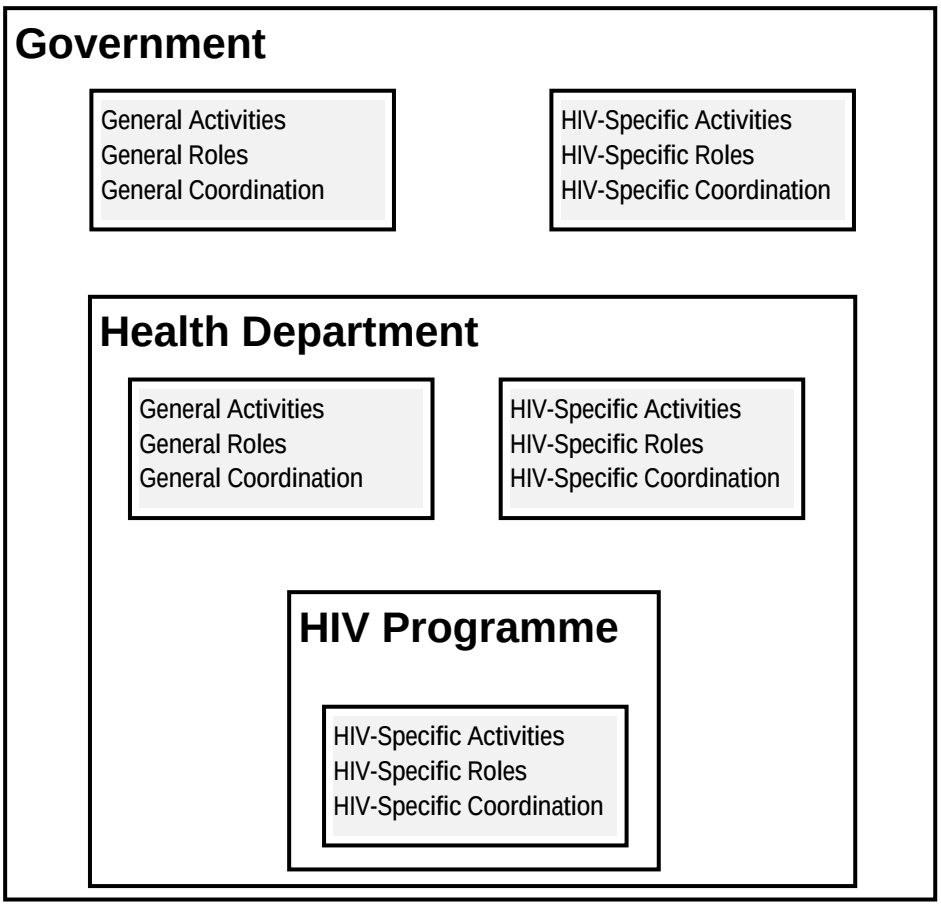


Figure 3.1: Analytical framework representing different levels of analysis

CHAPTER 4: DOCUMENT ANALYSIS

This section focuses on the formal legal and policy frameworks relating to what HIV services are provided, how functions are allocated, and how they are coordinated. As outlined in Chapter 3, this requires a consideration of policies at the HIV programme level as well as legislation and policies related to the functioning of the Department of Health (DoH) and government in general. At the government level, relations are regulated by the Constitution as well as recent local government legislation. In the absence of new legislation, the White Paper for the Transformation of the Health Service (hereafter referred to as the Health White Paper) and the draft National Health Bills are the key documents informing National health system functioning and reorganisation. At the HIV programme level, the National HIV/AIDS & STD Strategic Plan (hereafter referred to as the Strategic Plan) provides the most recent blueprint for HIV/AIDS activities. Some of the key aspects of these frameworks that are relevant to HIV/AIDS are summarised in Table 4.1.

4.1 HIV/AIDS Service Package

The Constitution and the local government legislation outline the general service package of government and local government respectively, but obviously make no direct reference to HIV services. Similarly, the various drafts of the National Health Bill specify the functioning of the National Health System in some detail but do not deal with individual programmes such as HIV. However, both the Health White Paper and the Health Sector Strategic Framework document have sections summarising the DoH's HIV/AIDS intervention package (Figure 4.1). The more recent HIV/AIDS Strategic Plan provides a detailed service package for HIV/AIDS, with 15 goals in four main priority areas, as summarised in Table 4.2.

The policy documents do comment on the support needed to implement the identified package of interventions. Implementation strategies mentioned in the White Paper and Strategic Framework are shown in Figure 4.1. The HIV/AIDS Strategic Plan provides detailed implementation strategies for each objective. Some common support mechanisms listed in the document include:

- Resource mobilisation
- Guideline development
- Production of materials
- Training
- Monitoring and evaluation.

The Strategic Plan also identifies five critical areas for effective delivery:

1. Authority and political will at all levels
2. Structures for delivery and coordination
3. Financial, human and technical resources
4. Capacity development in management and monitoring and evaluation
5. Communication.

Other systems issues (such as infrastructure or health system restructuring) are mentioned less frequently although all three health documents make reference to broader developmental issues related to HIV in arguing for the need for intersectoral action. For example, the White Paper argues that:

> *"It is recognised that HIV/AIDS cannot be prevented without addressing the socioeconomic factors which underlie its spread. The cause and impact of AIDS extends beyond the health sector, requiring the commitment of and intervention by all sectors - the State, private sector, non-governmental organisations (NGOs) and community-based organisations (CBOs)." (Section 9)*

Table 4.1 : Legal and policy frameworks for the organisation and coordination of HIV/AIDS services

	Level			
	Government		Department of Health	HIV Programme
Key Documents	▪ Constitution	▪ Local Government White Paper ▪ Municipal Structures Act ▪ Municipal Systems Act	▪ Health White Paper ▪ National Health Bill ▪ Health Sector Strategic Framework	▪ HIV/AIDS & STD Strategic Plan
HIV Service Package	▪ Provisions of government ▪ HIV not mentioned	▪ Objectives of local government ▪ HIV not mentioned	▪ Objectives of the DoH ▪ Some mention of HIV priorities	▪ Detailed outline of HIV service package
Allocation of Roles	▪ General roles of national, provincial and local spheres ▪ Health as a shared competency	▪ More developmental language for role of local government	▪ General roles of national, provincial, and district levels of the health system	▪ Some allocation of roles between sectors ▪ Little on roles of different spheres
Coordination	▪ Principles of co-operative governance ▪ Composition and functions of national cabinet and provincial executive councils ▪ Emphasis on shared values rather than structures ▪ Procedures for coordination of legislative and fiscal coordination ▪ IGR legislation to be developed	▪ Emphasis on local integration through integrated development planning (IDP) process	▪ Formalisation of IGR structures at national and provincial levels (NHC, NHAC, PHC, PHAC, DAC) ▪ Coordination of planning	▪ Establishment of implementation structures (SANAC, PAC, IDC)

See text for abbreviations

Health White Paper, 1997

Central Objectives	Key Strategies	Implementation Strategies
▪ Prevent the spread of the epidemic through the promotion of safer sexual behaviour, provision of condoms and control of STDs ▪ Protect and promote the rights of people living with HIV or AIDS by ensuring that discrimination is outlawed ▪ Use the mass media to popularise key prevention concepts and develop life skills education for the youth ▪ Reduce the personal and social impact of HIV/AIDS through the provision of counselling, care and social support, including social welfare services for persons with HIV/AIDS, their families and the community ▪ Mobilise and unify local, provincial, national and international resources to prevent and reduce the impact of HIV/AIDS.	▪ Life-skills programme targeted to the youth ▪ Use of mass communication media to popularise key prevention concepts in AIDS ▪ Appropriate treatment and management of patients seeking treatment for STDs ▪ Improved access to barrier methods ▪ Promotion of appropriate care and support	▪ Developing human resources ▪ Ensuring safe blood supplies ▪ Capacity for effective communication and health promotion ▪ Capacity for monitoring and evaluation ▪ Universal precautions ▪ HIV/AIDS surveillance ▪ Coordination of activities

Health Sector Strategic Framework, 1999

Key Objectives	Implementation Strategies
▪ Strengthen current efforts to prevent the spread of the virus through for example, social mobilisation and increasing public awareness, especially targeting the youth; ▪ Curtail any further rise in the epidemic and commence a downward trend; ▪ Actively participate in the international effort to develop appropriate vaccines; ▪ Provide affordable packages of care and support for those infected or affected; ▪ Ensure that effective care and support is available for AIDS orphans; and ▪ Declare HIV/AIDS a national emergency if not a global emergency.	▪ Establishment of a National AIDS Council comprising government and civil society representatives to co-ordinate HIV/AIDS activities and the establishment of similar co-ordinating mechanisms at provincial and local government levels; ▪ Strengthen the Interdepartmental Committee on HIV/AIDS to ensure that all government departments have medium and long-term plans to mitigate the impact of the epidemic amongst their employees and sectors within their ambit of influence; ▪ Increase the use of community and home based care, and strengthen the support and referral mechanisms for patients and their care-givers;

Figure 4.1: HIV/AIDS service package in earlier health policy documents

Table 4.2: HIV/AIDS service package in the HIV/AIDS Strategic Plan, 2000-2005

Priority Area	Goals	Objectives
Prevention	1. Promote safe and health sexual behaviour	▪ Promote improved health-seeking behaviour and adoption of safe sex practices ▪ Broaden responsibility for the prevention of HIV to all sectors of government and civil society ▪ Implement HIV/AIDS prevention for migrants ▪ Develop and implement counselling and care programmes for all national government departments ▪ Improve access to and use of male and female condoms, especially among 15-25 year olds
	2. Improve the management and control of STDs	▪ Ensure effective syndromic management of STDs in the private sector ▪ Ensure effective syndromic management of STDs in the public sector ▪ Collaborate with traditional healer to improve health-seeking behaviour for STD treatment ▪ Increase access to youth friendly reproductive health services
	3. Reduce MTCT	▪ Improve access to HIV testing and counselling in ANC clinics ▪ Improve family planning services to known HIV positive women ▪ Implement clinical guidelines to reduce the transmission of HIV during childbirth and labour
	4. Address issues relating to blood transfusion and HIV	▪ Maintain a safe blood transfusion service
	5. Provide appropriate post-exposure services	▪ Provide services for needlestick injuries and occupational exposure ▪ Investigate options to reduce HIV/STD transmission resulting from sexual assault
	6. Improve access to VCT	▪ Increase the number of VCT sites ▪ Increase the number of people seeking VCT
Treatment, care and support	7. Provide treatment, care and support services in health care facilities	▪ Improve treatment, care and support for people living with and affected by HIV/AIDS ▪ Establish poverty alleviation projects to address the root causes of HIV/AIDS, STDs, and TB ▪ Ensure appropriate practices in the private sector for the care and treatment of HIV positive clients
	8. Provide treatment, care and support services in communities	▪ Develop and implement models of community/home-based care ▪ Increase acceptability to community/home-based care
	9. Develop and expand the provision of care to children and orphans	▪ Develop and implement programmes to support the health and social needs of children affected by HIV/AIDS ▪ Implement measures to facilitate adoption of AIDS orphans
Research, monitoring and evaluation	10. Ensure AIDS vaccine development	▪ Support efforts to develop a Clade C HIV vaccine
	11. Investigate treatment and care options	▪ Review and revise policy on anti-retroviral use for reducing MTCT ▪ Conduct research on the cost-effectiveness of other forms of non-retroviral treatment and prophylaxis ▪ Conduct research on the effectiveness of traditional medicines
	12. Conduct policy research	▪ Conduct HIV/AIDS studies in selected departments and provinces ▪ Conduct research to determine HIV incidence
	13. Conduct regular surveillance	▪ Develop mechanisms for capacity development of provincial and district staff ▪ Conduct national surveillance on HIV and STD risk behaviours, especially among youth
Human and legal rights	14. Create a supportive and caring social environment	▪ Develop a National Inter-sectoral campaign on openness and acceptance of people living with HIV/AIDS ▪ Create a legal and policy environment which protects the rights of all persons infected and affected by HIV/AIDS ▪ Monitor human rights abuses and develop mechanisms for redress
	15. Develop an appropriate legal and policy environment	▪ Develop policy and legislation relating to HIV/AIDS and employment ▪ Develop policy an legislation relating to HIV/AIDS commercial sex workers and sexual assault

4.2 Allocation of Roles and Responsibilities

4.2.1 The Constitution

The Constitution is important in setting the broad legislative framework for intergovernmental relations. Fundamentally, the Constitution divides the South Africa government into three spheres with separate legislative and executive authorities in each sphere, as well as providing for an independent judicial authority.

> *"In the Republic, government is constituted as national, provincial and local spheres of government which are distinctive, interdependent and interrelated." (Section 40(1))*

In addition to defining the roles of the different legislative and executive authorities, the Constitution also outlines the allocation of responsibilities between the three spheres of government. However, the allocation of roles and responsibilities between the national, provincial and local spheres is quite complex and overlapping at the same time as being rather vague and generic. Functions listed in Schedule 4 of the Constitution are shared between the national and provincial spheres whereas provinces have exclusive authority over areas listed in Schedule 5. Local government has responsibility for the functions listed under Parts B of both Schedule 4 and 5.

To demonstrate this, the allocation of health responsibilities according to the Constitution is summarised in Table 4.1. The interpretation of this allocation is that general health services are shared between the national and provincial spheres, provinces are exclusively responsible for ambulance health services, and the local sphere is responsible for environmental health (Schedule 5 Part B functions) as well as municipal health services (MHS), although the Constitution does not define MHS further.

Table 4.1: Constitutional allocation of health functions

	Part A: National / Provincial Responsibilities	Part B: Local Responsibilities
Schedule 4: Functional areas of concurrent National and Provincial competence	▪ Health services	▪ Municipal health services
Schedule 5: Functional areas of exclusive Provincial competence	▪ Ambulance services	▪ Cleansing ▪ Control of public nuisances ▪ Licensing and control of food handling ▪ Municipal abattoirs ▪ Refuse removal and waste disposal ▪ Street trading

There are further complexities. National or province may assign any of the Part A functions to local government if it would be more efficiently administered at the local level and the municipality has the capacity to administer it (Section 156(4)). Also, although the spheres are meant to be distinctive rather than the hierarchical, the Constitution makes provision for national government to intervene in provinces (Section 100(1)), and for provinces to intervene in municipalities (Section 139(1)) if they are failing to perform adequately.

Lastly, the Constitution provides additional information on the responsibilities of the local sphere of government. It defines the functions of local government as:

- to provide democratic and accountable government for local communities;
- to ensure the provision of services to communities in a sustainable manner;
- to promote social and economic development;
- to promote a safe and healthy environment; and
- to encourage the involvement of communities and community organisations in the matters of local government.

The national and provincial spheres are given the added responsibility of supporting the local sphere in fulfilling these objectives.

> *"The national government and provincial governments, by legislative and other measures, must support and strengthen the capacity of municipalities to manage their own affairs, to exercise their powers and to perform their functions." (Section 154(1).*

4.2.2 Local Government Documents

The White Paper on Local Government and the resultant legislation emphasise the developmental role of local government but generally follow the Constitutional framework in outlining the role of the local sphere of government. However, the White Paper notes some of the difficulties with the Constitutional definition and points to the need for cooperative intergovernmental relations in overcoming these problems.

> *"The constitutional definition of local government's powers and functions in relation to provincial and national government, is, however, ambiguous in some respects, and requires further clarification. This situation is further complicated by the fact that most powers and functions have several components, not all of which are best performed by the same sphere of government." (Section A2.5)*

The White Paper also highlights the multiple, complex roles and responsibilities that the national and provincial government have to fulfil with respect to the local sphere. These are summarised in Table 4.1. Lastly, the White Paper comments favourably on proposals by the DoH to decentralise significant functions to local government as part of the development of the District Health System (DHS).

Table 4.1: Multiples role of the national and provincial spheres with regard to local government

National Government Roles	Provincial Government Roles
▪ A strategic role ▪ Coordinating the transition ▪ Providing a legislative framework for local government: ▪ Providing a framework for municipal capacity-building and supporting municipalities ▪ Support for key institutions ▪ Local government finances ▪ Monitoring and oversight ▪ Intervention	▪ A strategic role ▪ A development role ▪ An intergovernmental role ▪ Regulatory role ▪ An institutional development and capacity-building role ▪ A fiscal role ▪ An intervention role

(From Section C1.3.1 and C1.3.2)

4.2.3 Department of Health Documents

The allocation of health roles and responsibilities between the three spheres of government is complicated by the DoH's commitment to the development of a District Health System (DHS), which may or may not coincide with local government (Pillay, 2001). The Health White Paper provided a listing of the functions of the national, provincial and district levels (Table 4.1). The more recent drafts of the National Health Bill have a more comprehensive list of functions, but only for the national and provincial departments (Table 4.2). Echoing the Constitution, the responsibilities are now divided into Parts A and B, although Part B national responsibilities can be delegated to provinces, and Part B provincial functions can be delegated to district councils.

Disagreements concerning Chapter 5 of the Health Bill, which deals with the DHS, are one of the main reasons for the delay in finalising the Bill. In the White Paper and earlier drafts of the Health Bill, local government was seen as one of the possible governance options of the DHS. For example, the November 2001 version of the Health Bill states that:

> *"The District Health Authorities referred may be-*
> *(i) a municipality;*
> *(ii) a provincial department; or*
> *(iii) a body constituted in terms of provincial health legislation" (Section 43(2))*

In that draft, municipal health services (MHS), the constitutional responsibility of local government was defined as follows:

> *"The following constitutes municipal health services and must be rendered by the municipalities:*
> *(a) environmental health services;*
> *(b) promotive and preventive health services; and*
> *(c) other municipal health services, in addition to those referred to in subparagraphs (a) and (b), that are rendered by other municipalities at the time of coming into operation of this Act." (Section 44(1)).*

More recent drafts of the Health Bill (September 2002 and June 2003 for example) are a little different. The district governance structure is now referred to as the District Health Council and is more of a collaborative structure involving both local and provincial representatives. Within the health district, municipalities will be responsible for MHS, now simply defined as environmental health services, and the province will be responsible for all other health services (See also Pillay *et al.*, 2001).

Table 4.1: Allocation of health functions (Health White Paper, 1997)

National Department	Provincial Department	Health District
▪ Provide leadership in the formulation of health policy and legislation, including the development of a NHS; ▪ Provide leadership in quality assurance, including the formulation of norms and standards; ▪ Build the capacity of the provincial health departments and municipalities, to enable them to ensure the provision of effective health services; ▪ Ensure equity in the allocation of resources to the provinces and municipalities and their appropriate utilisation; ▪ Provide leadership in planning for and the strategic management of the resources available for health care; ▪ Provide services which cannot be cost-effectively delivered elsewhere; ▪ Develop coordinated information systems and monitor the progress made in the achievement of national health goals- ▪ Provide appropriate regulation of the public and private health sectors, and regulate health-related activities in other sectors; ▪ Support the provinces and municipalities in ensuring access to cost-effective and appropriate health commodities; and ▪ Liaise with national health departments in other countries and international agencies.	▪ The provision of regional and specialised hospital services, as well as academic health services, where relevant; ▪ Appropriate human resource management and development; ▪ The rendering and coordination of medical emergency services (including ambulance services); ▪ The rendering of medico-legal services; ▪ The rendering of health services to those detained, arrested or charged- ▪ The planning and management of a provincial health information system, ▪ Quality control of all health services and facilities; ▪ The screening of applications for licensing and the inspection of private health facilities, ▪ The formulation and implementation of provincial health policies, norms, standards and legislation, ▪ Interprovincial and intersectoral coordination and collaboration; ▪ Coordination of the funding and financial management (the budgetary process) of district health services, ▪ The provision of technical and logistical support to health districts; ▪ The rendering of specific provincial service programmes, e.g. Tuberculosis programmes, ▪ The provision of non-personal health services; ▪ The provision and maintenance of equipment, vehicles and health care facilities; ▪ Effective consultation on health matters at the community level- ▪ The provision of occupational health services; ▪ Research on, and the planning, coordination, monitoring and evaluation of the health services rendered in the province; and ▪ That functions delegated by the national level are carried out.	(a) Health care ▪ Ensuring health promotion services-, ▪ Providing for collaboration with other sectors of Government and NGOs in promoting health and ensuring the rendering of health services in the health district" ▪ Providing for community participation in health promotion and health service provision; ▪ Ensuring the availability of a full range of PHC and other relevant health services in communities, clinics, community health centres, district hospitals and other facilities; ▪ Ensuring primary environmental health services, the promotion and maintenance of environmental hygiene; the prevention of water pollution; enforcement of environmental health legislation, i.e. Regarding sanitation, housing, smoke, noise, fitter, food hygiene and occupational hygiene, and the identification and control of local health hazards. ▪ Rendering essential medico-legal services; and ▪ Ensuring services to those arrested and charged, in collaboration with the relevant authorities. (b) Administrative, financial and support services ▪ Ensuring the provision of support services essential to the rendering of health services, including: the accommodation for staff, where necessary; appropriate facilities for the rendering of maternal and mental health services, essential medicines, essential diagnostic services, transport; and the maintenance of equipment, facilities and other assets- ▪ Establishing and managing the health district's budget in accordance with national and provincial policies and guidelines, and purchasing services as appropriate, and ▪ Ensuring the promulgation of health by-laws. (c) Planning and human resources ▪ Monitoring and evaluating health and health service provision, ▪ Gathering, analysing and managing health information at the district level; ▪ Providing for appropriate human resource development- and ▪ Ensuring the performance of any other health function or duty assigned to the health district.

Table 4.2: Allocation of Health functions (National Health Bill, September 2002)

Schedule 1: National Functions

PART A

1. Formulating national health policy and legislation.
2. Liaising with national health departments in other countries and with international agencies.
3. Formulating policy for and allocating resources to academic health complexes.
4. Determining guidelines for donor funding.
5. Determining and issuing norms and standards on matters including -
   a. nutritional intervention;
   b. environmental conditions that constitute a health hazard;
   c. human tissue blood, blood products and gametes;
   d. sterilisation and abortion;
   e. providing health services, including social, physical and mental health care;
   f. health care for convicted persons and persons awaiting trial;
   g. genetic services; and
   h. any other matter that affects the health status of people in more than one province.
6. Promoting adherence to norms and standards for the training of medical, dental and auxiliary health staff.
7. Identifying national health goals and priorities and ensuring the monitoring of progress in their implementation.
8. Participating in the equitable allocation of financial resources through the development of formulae and other methods.
9. Planning, developing and regulating human resources for health care and health professions.
10. Planning the development of all public and private hospitals and related institutions.
11. Determining priorities for health research conducted by national research institutions created by Act of Parliament or within the Department and funded wholly or partly by the State.
12. Controlling and regulating the cost and financing of health services.
13. Regulating medical aid schemes or such insurance, including fee structures.
14. Evaluating, regulating and registering drugs and other substances.
15. Evaluating, regulating and registering the acquisition and use of health technology
16. Facilitating the arrangement of national tenders or contracts for the procurement of health supplies and services
17. Coordinating emergency services during national disasters.
18. Developing a National Health Laboratory Service.
19. Creating, coordinating and monitoring a framework for national health laboratory services.
20. Ensuring the provision of forensic pathology, forensic medicine and related laboratory services.
21. Ensuring the provision of Occupational Health Services.
22. Designing national systems and methods for quality management.
23. Ensuring the provision of highly specialised services which cannot be rendered economically and efficiently at provincial level.
24. Regulating, licensing and monitoring blood transfusion services.
25. Ensuring inter-sectoral and inter-departmental collaboration.

PART B

1. Promoting health, healthy lifestyles and healthy policies.
2. Ensuring the promotion of community participation in the planning, provision and evaluation of health services.
3. Ensuring the use of health systems research in the planning, evaluation and management of health services.
4. Regulating foodstuffs, cosmetics, disinfectants and hazardous substances.
5. Regulating, licensing and controlling ionised radiation, non-ionised radiation and electromedical devices.
6. Regulating, licensing and monitoring public and private hospitals and related institutions.
7. Ensuring the provision of indoor and outdoor environmental pollution control services.
8. Ensuring the provision of services for the management, prevention and control of communicable diseases.
9. Ensuring the provision of services for the management, prevention and control of non-communicable diseases.

Schedule 2: Provincial Functions

PART A

1. Formulating and implementing provincial health policy, norms, standards and legislation.
2. Ensuring the provision of secondary hospital services.
3. Ensuring the provision of specialised hospital services.
4. Ensuring the provision of health services in academic health centres.
5. Ensuring the planning and management of a provincial health information system.
6. Ensuring the screening of applications for licensing and the inspection of private health establishments.
7. Ensuring inter-provincial and inter-sectoral coordination and collaboration.
8. Ensuring the coordination of funding and financial management of District Health Authorities.
9. Ensuring the provision of technical and logistical support to District Health Authorities.
10. Ensuring research on, and the planning, coordination, monitoring and evaluation of health, and of the health services rendered in the province.
11. Ensuring that nationally delegated functions are carried out.
12. Planning and developing human resources for health care and ensuring the regulation of health professions.
13. Planning the development of all public and private hospitals and related institutions.
14. Controlling and regulating the cost and financing of health services.
15. Ensuring the provision of port health services.

PART B

1. Ensuring the provision of comprehensive primary health care services.
2. Ensuring the provision of community hospital services.
3. Ensuring appropriate human resources management and development.
4. Ensuring the rendering and coordination of medical emergency services.
5. Ensuring the rendering of forensic pathology, forensic clinical medicine and related services including the provision of medico-legal mortuaries and medico-legal services.
6. Ensuring the rendering of health services to persons who have been detained, arrested or charged.
7. Ensuring quality control of all health services and facilities.
8. Ensuring the rendering of specific provincial service programmes.
9. Ensuring the provision of non-personal health services.
10. Ensuring the provision and maintenance of equipment, vehicles and health care facilities.
11. Ensuring effective consultation regarding health matters at community level.
12. Ensuring the provision of occupational health services.
13. Promoting health, healthy lifestyles and healthy policies.
14. Ensuring the promotion of community participation in the planning, provision and evaluation of health services.
15. Ensuring the use of health systems research in the planning, evaluation and management of health services.
16. Ensuring the provision of indoor and outdoor environmental pollution control services.
17. Ensuring the provision of services for the management, prevention and control of communicable diseases.
18. Ensuring the provision of services for the management, prevention and control of non-communicable diseases.

4.2.4 HIV/AIDS Strategic plan

The HIV/AIDS Strategic Plan describes a comprehensive package of interventions (see Section 4.1) but is less clear on how the different responsibilities will be allocated and coordinated. Interestingly, at the same time as being concerned with involving other departments and sectors in the campaign against HIV/AIDS, it makes almost no mention of the different spheres of government.

The plan does make some attempt to indicate where other departments and sectors should be involved, but the formulations remain rather vague and generic. For example, a section from the plan is shown in Table 4.1. Although the lead agencies are identified it doesn't really specify who is supposed to do what. Again, there is not indication which level or levels of the DoH might be involved.

Table 4.1 : Formulation of HIV/AIDS strategic plan

Goal	Objective	Selected Strategies	Lead Agencies
Promote safe and health sexual behaviour	Promote improved health-seeking behaviour and adoption of safe sex practices	a) Produce and disseminate IEC material and message to different stakeholders b) Implement life skills education in all primary and secondary schools c) Increase the number of trade unions who have implemented HIV/AIDS & STD policies and programmes d) Facilitate and support the trucking industry's AIDS High Transmission project	Department of Education Department of Health NGOs Department of Labour Youth sector

Although the intention is *"not a plan for the health sector specifically, but a statement of intent for the whole country, both within and outside government"* (pg 1), the document remains a rather health-orientated plan and other organisations and government departments are exhorted to *"use this document as a basis to develop their own strategic and operational plans".* One the other hand, by focusing on extra-departmental stakeholders, the plan provides inadequate direction for provincial and local health departments in specifying the different internal roles and responsibilities with regard to HIV/AIDS.

4.3 Coordination and Integration

4.3.1 The Constitution

The Constitution provides some generic principles for intergovernmental relations, outlines certain structures and processes for the coordination of legislative and fiscal relations between the three spheres, but then concludes that a further Act of Parliament is required to establish structures and institutions to facilitate intergovernmental relations and provide mechanisms for the resolution of intergovernmental disputes (Section 41(2)).

Chapter 3 of the Constitution discusses a system of co-operative government, where common objectives and values are important in coordinating relations between the three spheres. For example, Section 41(2) states that:

> *All spheres of government and all organs of state within each sphere must co-operate with one another in mutual trust and good faith by:*
>
> *i. fostering friendly relations;*
> *ii. assisting and supporting one another;*
> *iii. informing one another of, and consulting one another on, matters of common interest;*
> *iv. co-ordinating their actions and legislation with one another;*
> *v. adhering to agreed procedures; and*
> *vi. avoiding legal proceedings against one another.*

The Constitution is a bit more specific on the coordination of legislative responsibilities between the national, provincial and local spheres of government. The National Parliament consists of the National Assembly and the National Council of Provinces (NCOP), where the role of the NCOP is to:

> *"represent the provinces to ensure that provincial interests are taken into account in the national sphere of government. It does this mainly by participating in the national legislative process and by providing a national forum for public consideration of issues affecting the provinces." (Section 42(4))*

With regard to local government, Section 154(2) states that

> *"Draft national or provincial legislation that affects the status, institutions, powers or functions of local government must be published for public comment before it is introduced in Parliament or a provincial legislature, in a manner that allows organised local government, municipalities and other interested persons an opportunity to make representations with regard to the draft legislation."*

In addition, up to 10 representatives from the different categories of municipalities may participate when necessary in the proceedings of the NCOP, although they may not vote (Section 67).

4.3.2 Local Government Documents

The White Paper on Local Government emphasises the importance of intergovernmental relations which it defines as:

> *"the set of multiple formal and informal processes, channels, structures and institutional arrangements for bilateral and multilateral interaction within and between spheres of government" (Section C1.2).*

It comments that *"poor coordination between service providers could severely undermine the development effort" (Section B1.2)* and outlines a number of principles of cooperative government as well as the objectives of intergovernmental relations (Table 4.1).

To some extent, these documents see local government as an important locus and mechanism of governmental coordination and service integration. Critical to this function is the idea of local Integrated Development Plans (IDPs) introduced in the White Paper.

> *"One of the most important methods for achieving greater coordination and integration is integrated development planning. Integrated development plans provide powerful tools for municipalities to facilitate integrated and coordinated delivery within their locality." (Section B1.2)*

The process of developing IDPs is detailed in the Municipal Systems Act and includes the obligation to coordinate planning with the national and provincial spheres.

Table 4.1: Principles of cooperative government and intergovernmental relations

Principles of Cooperative Government	Objectives of Intergovernmental Relations
▪ Collectively harnessing all public resources behind common goals and within a framework of mutual support. ▪ Developing a cohesive, multi-sectoral perspective on the interests of the country as a whole, and respecting the discipline of national goals, policies and operating principles. ▪ Coordinating their activities to avoid wasteful competition and costly duplication ▪ Utilising human resources effectively. ▪ Settling disputes constructively without resorting to costly and time-consuming litigation. ▪ Rationally and clearly dividing between them the roles and responsibilities of government, so as to minimise confusion and maximise effectiveness	▪ To promote and facilitate cooperative decision-making. ▪ To coordinate and align priorities, budgets, policies and activities across interrelated functions and sectors. ▪ To ensure a smooth flow of information within government, and between government and communities, with a view to enhancing the implementation of policy and programmes. ▪ The prevention and resolution of conflicts and disputes.

(From Section C1.1 and C1.2)

4.3.3 Department of Health Documents

The two main mechanisms identified in the National Health Bill to address intergovernmental coordination are, firstly, the formalisation of a number of intergovernmental structures, and, secondly, requirements for the integration of planning processes between the different spheres of government.

The names, composition and functions of the proposed intergovernmental structures have changed significantly over time. The proposals of the September 2002 version of the Bill are shown in Figure 4.1. The National Health Council (NHC), replacing the existing MinMEC structure, mainly coordinates between politicians from the national and provincial spheres although there is provision for one representative of organised local government, namely the South African Local Government Association (SALGA) (previous drafts had three SALGA representatives). The National Health Advisory Committee (NHAC), replacing the existing Provincial Health Restructuring Committee (PHRC), is a similar structure for health officials from the national and provincial departments, again with one representative from local government [1]. Similar intergovernmental structures will be established at the provincial and district levels. Metropolitan and District councillors will participate in the Provincial Health Council (PHC) and Local councillors will be represented in District Health Council.

In anticipation of the new Health Act, or in accordance with their own provincial Health Acts, provinces have already begun establishing such structures at the provincial and district levels, although there is significant variation in their titles, composition, authority and functioning (Hall, 2002).

[1] In the version of the Health Bill introduced into parliament in June 2003, officials were full members of the NHC and PHC rather than only *ex officio* members. The purpose of the NHAC and PHAC then becomes a little unclear and the Portfolio Committee on Health eliminated these structures from the final version of the Bill which was then passed by the National Assembly in November 2003.

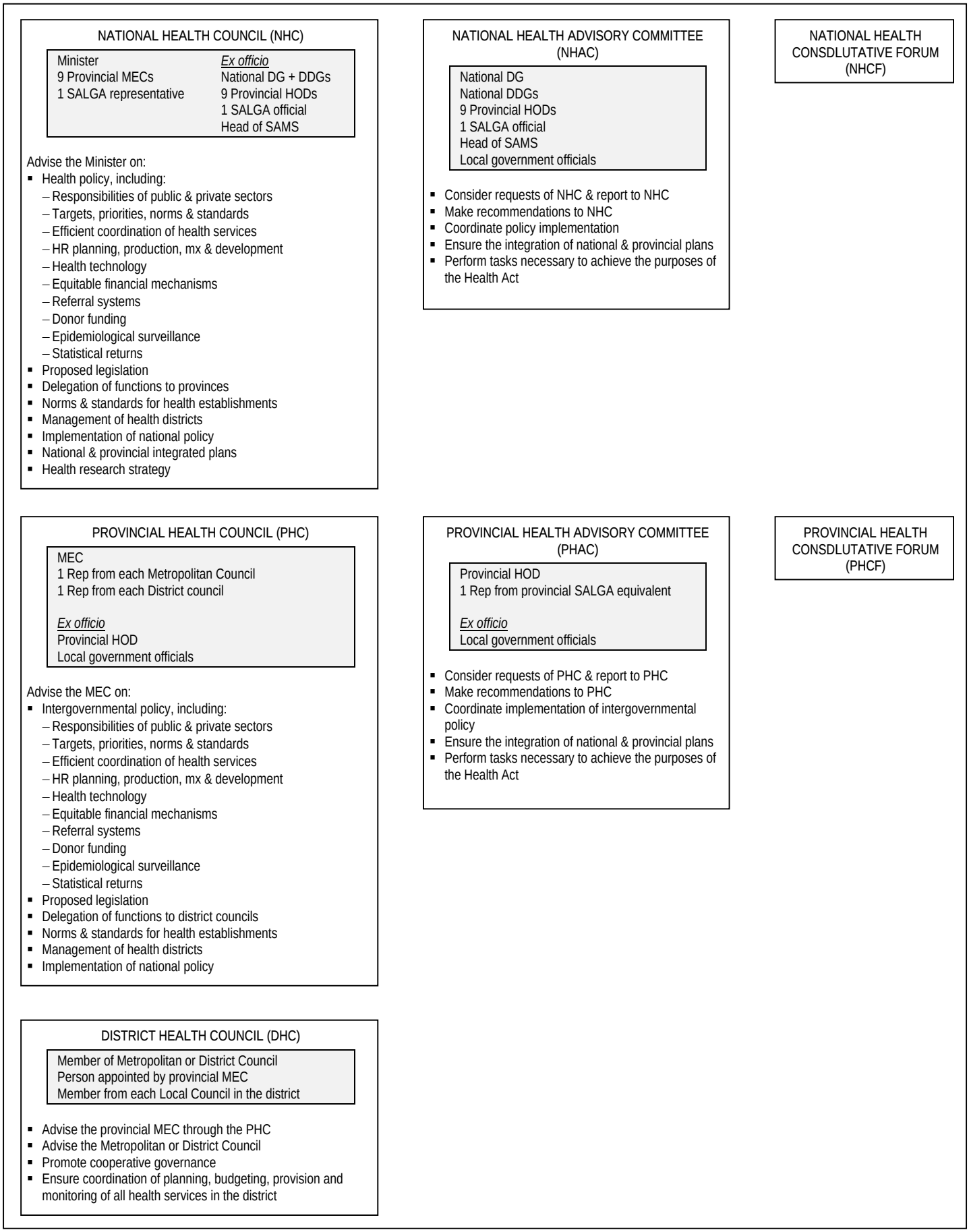


Figure 4.1: Proposed new health intergovernmental structures (Health Bill, 2002)

The National Health Bill also emphasises the importance of coordinated planning between the national and provincial spheres. The national and provincial departments are required to produce annual health plans, and the national Director-General (DG), the NHAC and PHAC are all tasked with ensuring the integration of the national and provincial plans. In the latest version of the Bill, district and metropilitan municipalities are required to develop an annual district health plan and submit this to the provincial Member of the Executive Committee (MEC). However, the Bill also notes that:

> *"Plans must be developed with due regard to national and provincial health policies and the requirements of the relevant integrated development plans prepared in terms of the Local Government Municipal Systems Act." (Section 42(3))*

and proposes that further details of the process of consultation and authorisation need to be provided in provinical health legislation.

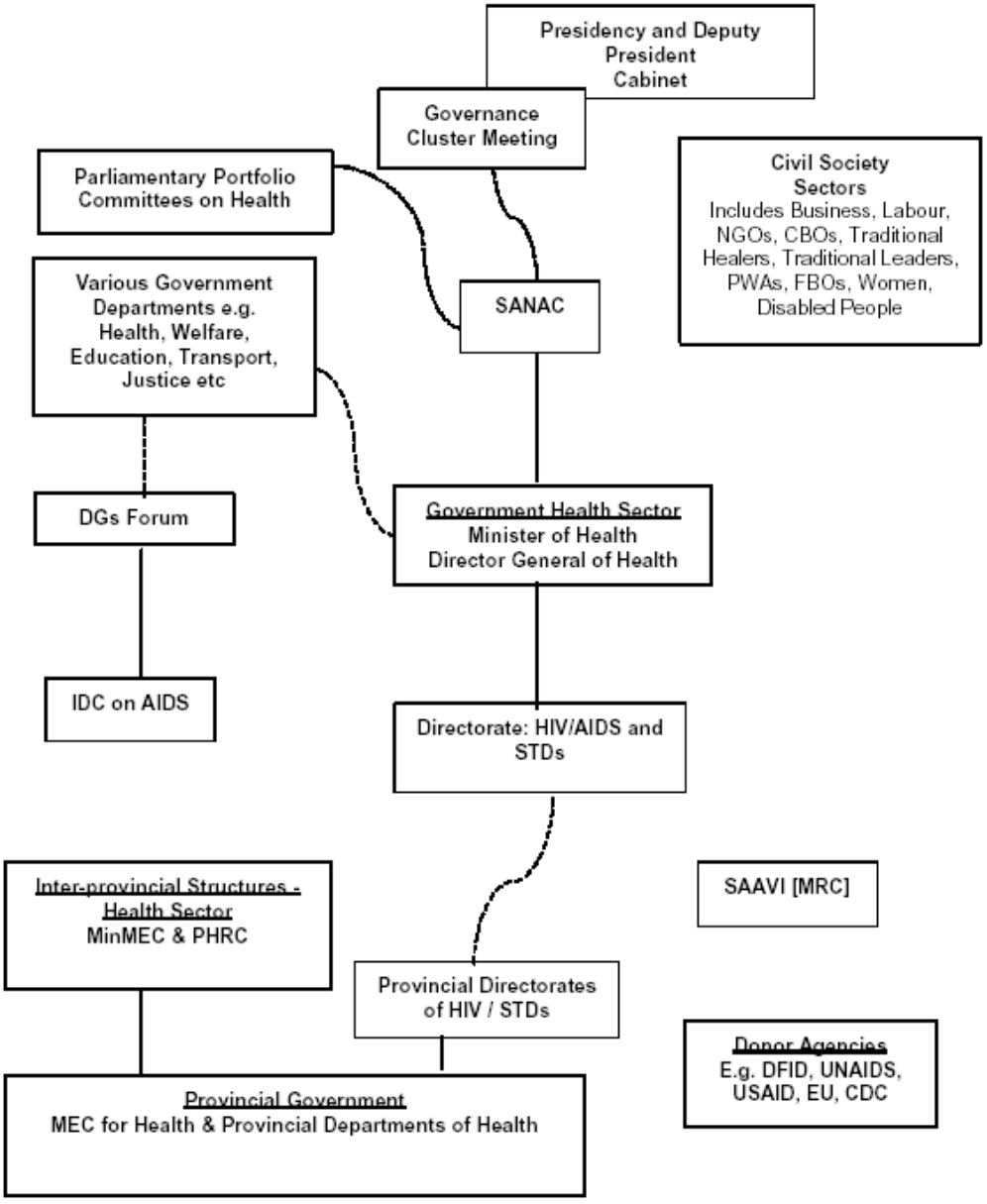


Figure 4.2: Structures relevant to HIV/AIDS

From (Department of Health, 2000)

4.3.4 HIV/AIDS Strategic Plan

The Strategic Plan identifies a number of intergovernmental structures as being important in the strategy against HIV/AIDS (Figure 4.2). The structures identified focus mainly on inter-departmental and inter-sectoral coordination at the national level although MinMEC, the PHRC and the provincial HIV/STDs directorate are recognised as important mechanisms for feeding in perspectives from the provincial level. The plan does not discuss structures for coordinating with local government.

The South African National AIDS Council (SANAC) and the Interdepartmental Committee on HIV/AIDS (IDC) are seen as the most important structures to guide the implementation of the Strategic Plan (pg 24). The composition and objectives of SANAC are summarised in Figure 4.1. It is interesting that local government is listed as one of the sectoral representatives rather than a government representative.

The Plan advises that structures such as SANAC, the IDC, and the Interministerial Committee on HIV/AIDS (IMC) *"should be considered for duplication within provinces"* (pg 24). At the district level, the Plan suggests the establishment of District HIV/AIDS Committees which should include representation from community-based committees and local government.

4.4 Conclusions

The document analysis provides some insights into the formal legal and policy frameworks relating to what HIV services are provided, how functions are allocated, and how they are coordinated. Early DoH documents outlined the basic components of the HIV/AIDS programme but the HIV/AIDS Strategic Plan now provides a detailed formulation of programme interventions, services and priorities.

The Strategic Plan is less specific about the allocation of roles and responsibilities between actors, particularly with regard to the different spheres of government. However, DoH policy documents provide some general guidance on the allocation of functions between different levels of the health system, while the Constitution defines the broad parameters for governmental roles.

The importance of coordination is highlighted in all three sets of documents although they tend to focus on different aspects of coordination. The Constitution emphasises basic values and principles of inter-governmental coordination but also introduces certain structures for inter-governmental and inter-departmental coordination. The new Health Bill focuses on structures for inter-provincial and inter-governmental and integrated planning processes whereas the HIV Strategic Plan prioritises the replication of structures for inter-sectoral and inter-departmental coordination.

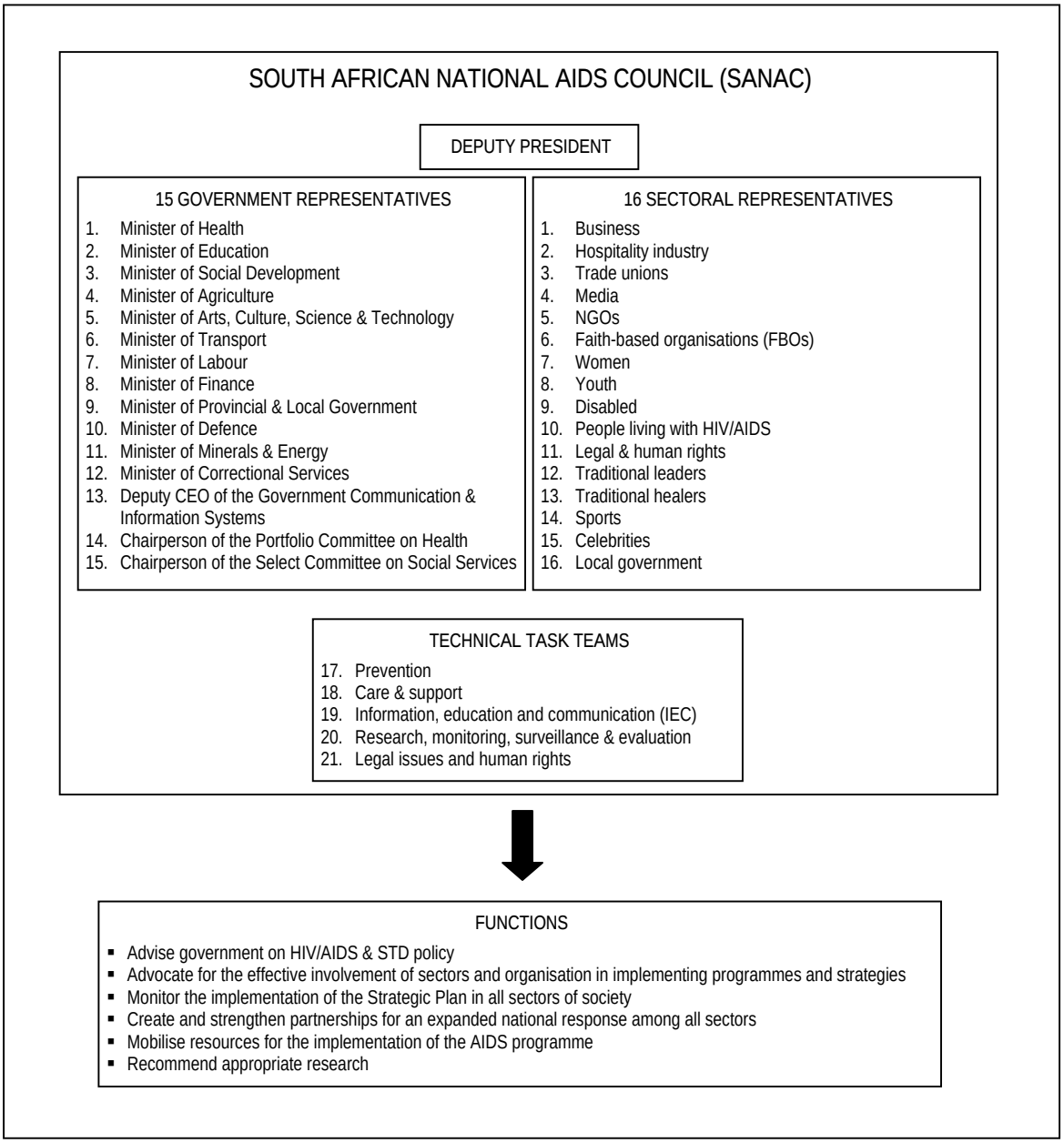


Figure 4.1 : Structure and functions of SANAC

CHAPTER 5: NATIONAL OVERVIEW

This chapter presents the results of the key informant interviews conducted in Phase 1 of the study. The interviews were conducted with senior officials responsible for HIV/AIDS services at the national, provincial and local levels across the country (Table 3.1). Although some of the informants had only recently been appointed to their positions, all of them have been working in the area of HIV/AIDS, either in government or the NGO sector, for many years.

The chapter is organised into four parts. The first section deals with the key components of the HIV/AIDS programme in South Africa. The next part outlines the different actors involved in the delivery of HIV/AIDS interventions and how the roles and responsibilities are allocated between them. The third section then explores how the activities are coordinated and integrated between the different actors while the last section highlights some of the informal dynamics and processes mentioned by the informants.

5.1 HIV Service Package

This section of the chapter focuses on what the senior officials see as the key priorities for addressing HIV/AIDS as well as their perceptions about the current strengths and weaknesses of the HIV programme in South Africa.

5.1.1 Priority Interventions

> *"I would say that the main objective of the programme is to try and reduce the number of infections, especially new infections." (Provincial HIV director)*

When asked about the key objectives and strategies of their HIV programmes, most respondents repeated what is in the National HIV/AIDS Strategic Plan. The main goal was generally stated as decreasing the incidence, or sometimes the prevalence, of HIV. A few interviewees added that women and youth were a particular priority. One provincial director also mentioned *"mitigating the impact of HIV on families and communities"* which is the second goal in the Strategic Plan.

The priority services identified by the majority of respondents are summarised in Table 5.1. This is somewhat shorter than the Strategic Plan list (see Table 4.2), but also seems to reflect what programme staff, at least at the national and provincial levels, prioritise in their day-to-day functioning. So, for example, at the time of the interviews, there was little mention of prevention of mother-to-child transmission (PMTCT) programmes or providing post-exposure prophylaxis (PEP). One interviewee did say that the priority was:

> *"prevention, trying to reduce the prevalence, but also linking it with care and support, which would include treatment." (Provincial HIV director)*

but it was not completely certain that she was promoting the use of antiretroviral therapy rather than simply trying to be comprehensive in her categorisation.

Table 5.1 : Priority components of HIV/AIDS package

Prevention	Treatment, care and support
▪ Information and education ▪ Condom distribution ▪ Effective management of STIs ▪ Provide VCT	▪ Implement HBC ▪ Treatment of opportunistic infections

The importance of developing partnerships with other stakeholders was mentioned by a number of informants. As one official noted:

> *"And then without partnerships we cannot actually make a difference. We have to involve as many stakeholders as is possible so that we can make a difference. Partnership becomes a key element in both prevention and management of the disease." (Local government official)*

Few interviewees identified broader health systems or developmental goals as immediate priorities for their programmes, although they were occasionally mentioned as important problems.

5.1.2 Main Strengths and Weaknesses of The HIV Programme

Respondents were asked to reflect on the main strengths and weaknesses of the HIV programme. The issues that were mentioned are briefly summarised here. The more detailed discussions on problems related to role allocation and coordination are presented in Sections 5.2.3 and 5.3.3.

Most of the officials interviewed were quite positive about the progress that has been made over the last year or two in the implementation of the HIV programme. On the other hand, a few were also fairly critical in identifying current shortcomings.

A number of people commented on the importance of the five year Strategic Plan in providing a framework for their activities as well as facilitating coordination between roleplayers.

> *"I suppose, I think the strength of it is the fact that you know, we are guided by the strategic plan. There's something that gives us the direction of where we're going to, for you know the five-year period, which ends in 2005. So that there is a sort of continuity, so that you don't find every year, you are suddenly doing something totally different, that there's some broad framework within which you can operate. And it gives everyone a sense of where they can slot into the different activities." (National official)*

However, there is a danger that national level frameworks and priorities may be a little removed from the realities on the ground. As one national official noted:

> *"Some of the weaknesses I think, which is inherent in any national programme, not just HIV/AIDS, is the fact that you are slightly removed from the actual implementation level. And so, essentially what you're doing is you're creating guidelines and policies and standards etc, for something where you are not involved in every single day."*

Nonetheless, there has clearly been progress with implementation on the basis of the Strategic Plan. As one provincial official said:

> *"HIV services, it depends, because we need to understand that HIV services are very broad. Within government the strengths are that we have got personnel, not completely but we do have personnel to run programmes and to run services for the provincial level or at district level. We have budgets to run our programmes, we have strategies and plans in place which have been negotiated, consulted with different stakeholders to be implemented by different people at different levels. We have structures both at premier level or at, or structures that include politicians to make sure that we deliver on what we have set ourselves in terms of our plans. And those are the plusses. And we do have a wealth of networks with NGOs which also help*

us to provide the services in areas where or in places where health per se cannot be reach those people."

The informants argued that the additional resources had also resulted in advances at the service delivery level. The areas of significant progress were noted as:

- improved public awareness,
- provision of condoms,
- expansion of voluntary, counselling and testing (VCT) sites,
- introduction of home-based care (HBC), and
- the strengthening of STI and TB services.

However, there have also been problems with implementation of the HIV/AIDS programme. One person felt that progress has been too slow:

"The one weakness is; all those things are there, but we should have got there much quicker, we should have been already much further. I think that's the one thing. It's a matter of, you move, but the point is, would you have done things differently, couldn't you have moved faster?" (National official)

and another was concerned about the increasing reliance on volunteers within HIV/AIDS services.

"A weak point is that we rely mostly on volunteers for VCT, who we don't pay. We capacitate them and then they go to greener pastures, and we are left at zero again" (Provincial HIV director).

One local government health official was more critical of actual service delivery in facilities and communities. She felt that HIV/AIDS treatment and care had not been adequately mainstreamed into general patient care at hospitals and clinics, and that while HBC was an important advance, it was being viewed as a cheap alternative to institutional care and was not receiving adequate resources within the HIV/AIDS programme.

A number of interviewees suggested that participation within the HIV/AIDS programme had been broadened, that there is now wider ownership of the HIV problem beyond the health sector. The new relationships with NGOs and community based organisations (CBOs), mainly in relation to HBC, were seen as particularly important.

"There is a lot of commitment from communities, ordinary communities, ordinary people on the ground, and the partnerships that we have formed. You know I believe that in [this province] we have really made headway, that everybody is just trying to see how best they can help with the HIV epidemic." (Provincial HIV director)

The various inter-governmental structures identified in the Strategic Plan (see Figure 4.2) were thought to be critical for implementation and the establishment of these structures was receiving significant attention at all levels.

"I think, you know, for now, the structures in place to deal with HIV/AIDS, for example the Local Aids Council …will facilitate the implementation of the strategies, the HIV/AIDS strategies." (Local Government official)

Interestingly, other interviewees felt that one of the key weaknesses of the programme was that other government departments were still not adequately involved, that HIV/AIDS was still seen predominantly as a health issue. They argued that even if inter-governmental structures have been established, it is always the DoH that has to drive the process and provide the direction and resources to make things happen. One provincial informant also commented that more stakeholders makes the coordination and integration of initiatives more difficult.

In explaining their difficulties, many of the officials blamed broader systemic and capacity problems. A critical weakness was the lack of skilled human resources but other problems such as inadequate budgets, poor information systems, the absence of monitoring and evaluation systems, transport difficulties, and the bureaucracy of government were also mentioned. For example, a local government official complained:

> *"We have a limited budget. For example, in our district we don't a special allocation for HIV/AIDS programmes. We mainly depend on grants. There is a lot of red-tape in accessing the budget – there is a lot processes that are followed in order to get the budget and sometimes that is a constraint…..And we have limited resources, human and transport. Human, like I am saying we don't not have HIV/AIDS coordinators and its very difficult to implement when you ... I mean to coordinate. There is also too much work placed on especially the nurses that are working at the facilities, they have got to run all the programmes and it is rather too much for them."*

One or two people suggested that the focus of the HIV/AIDS programme was too narrow, not sufficiently developmental, and didn't pay adequate attention to the social situation within rural and urban communities. A provincial director explained:

> *"Like one of the key areas that we felt that is not clearly defined, is how you link the issue of poverty to HIV/AIDS. So we have one of our strategies being poverty alleviation, so that we would be able to link that policy in the strategy. Because if you look at it now from that strategy, you would look at the strategy, it is only a health issue and yet when you look at HIV/AIDS, it is an developmental issue."*

Lastly, one respondent, alluding to the national political controversies linked to the President, argued that a key problem was still the lack of senior political leadership. She said:

> *"I think one of the downsides of the programme is clearly the lack of leadership. And the confusing messages that have come out at very high levels, I think that's a concern. Hearing from experiences of other countries, certainly it was a turning point for them and their AIDS programmes, once leadership came from the very top and clear guidance was given and statements were made. So I think South Africa suffers unfortunately there, we haven't got that sort of leadership coming through." (Local Government official)*

5.2 Roles and Responsibilities

The first part of this section summarises some of the actors involved in HIV service provision. We then describe the interviewees' perceptions of the roles and responsibilities of the different actors in relation to HIV/AIDS and lastly highlight some of the identified problems with the allocation of roles and responsibilities.

5.2.1 Actors Involved in HIV/AIDS

During the document analysis and interviews it emerged that the initial conceptual framework (Figure 2.1) did not adequately address the complex array of actors involved in HIV/AIDS services in South Africa and that important relationships were not confined to the vertical dimension. A slightly more detailed framework was developed which is presented in Figure 5.1.

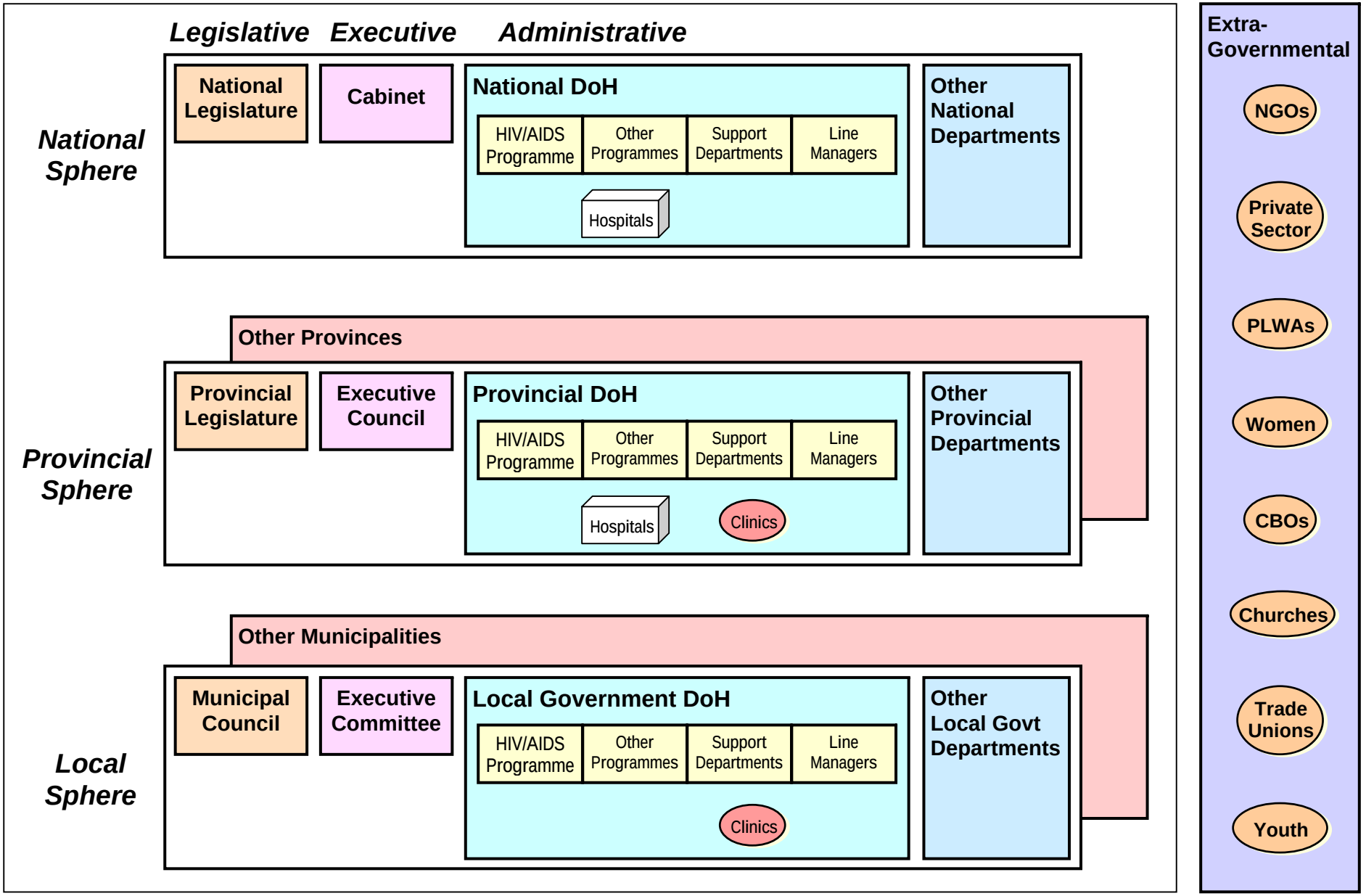


Figure 5.1: Actors involved in HIV/AIDS services

Various aspects of the horizontal dimension are shown in the diagram. Governance – management relationships are more accurately described by the constitutional division between the Legislative, Executive and the Judiciary. However, in the Constitution, implementation is simply the responsibility of the political Executive, whereas in reality the actual work is done by government officials. This bureaucratic component of government has been labelled as the Administrative in the figure.

The executive/administrative component is divided (horizontally) into different government departments. The Department of Health (DoH) is the primary focus of this study, but other government departments are also actively involved in the government's HIV strategy. There are also further horizontal relationships within the DoH. Again, the HIV programme might be most central in HIV/AIDS services but other directorates and units also have an important role to play. To reflect the different types of roles and relationships, these other internal DoH actors have been categorised as:

- Other health programmes, such as Maternal & Child Health (MCH) or Chronic Diseases;
- Support departments, which refers to units responsible for generic support functions such as human resource management, financial management, information systems etc; and
- Line managers, who are the officials directly responsible for the management of regions, districts or facilities.

As discussed in Section 4.2.1, the health function is shared across the three spheres of government so that there are actually Departments of Health at each of the three levels. In Figure 5.1, the vertical dimension is simply represented by the national, provincial and local spheres although, again, the reality is more complicated. As outlined in Figure 2.1 the health system does not fit neatly into these constitutional spheres - it has additional levels such as regions, districts and sub-districts; and specific networks for referral of patients between facilities that cut across spheres and levels.

The local sphere of government is also more complex than portrayed in Figure 5.1. Since 2000, local government has been organised into Metropolitan Councils (Category A municipalities), District Councils (Category C municipalities) and Local Councils (Category B municipalities) (Sutcliffe, 2000). The Metropolitan Councils are in the large cities where they have exclusive legislative and executive authority. Throughout the rest of the country, each District Council is made up of a number of Local Councils so that the legislative and executive authority is shared between the two Councils in these areas. The allocation of health responsibilities between these different categories of municipality, particularly between District Councils and Local Councils, is still being sorted out. Also, Section 163 of the Constitution provides for what is termed organised local government (the national South Africa Local Government Association (SALGA) as well as provincial equivalents) which often acts as an intermediary level representing local government in relationships with the other spheres of government.

Lastly, there are the sectoral actors outside government that are playing an increasingly important role in the response to HIV/AIDS. Some of the main stakeholders in this category are shown in the diagram.

Different combinations of these actors are obviously involved in many government projects. However the complex range of actors involved in HIV/AIDS is particularly unusual, as is the concerted effort that has gone into trying to coordinate and integrate activities between them.

5.2.2 Allocation of Roles and Responsibilities

This section outlines what key informants saw as the role of the different actors in relation to the HIV/AIDS programme. The discussion focused mainly on the vertical dimension, the allocation of roles and responsibilities between the three spheres, but also tried to explore the functions of other important actors.

5.2.2.1 National Department of Health (NDoH)

There was reasonable consensus among the respondents about the roles of the NDoH. These are summarised in Table 5.1.

Table 5.1: Identified roles and responsibilities of the NDoH

Area	Functions
Steering	▪ Leadership ▪ Provide strategic direction ▪ Policy development ▪ Define norms & standards
Support	▪ Develop guidelines & protocols ▪ Provide technical support to provinces ▪ Training
Financing	▪ Mobilise resources ▪ Allocate resources ▪ Provide resources for national programmes (conditional grants) ▪ Funding of NGOs
Oversight	▪ Monitoring & evaluation
Other	▪ Coordination ▪ International liaison ▪ Research

The NDoH was seen to have a legitimate role in steering the HIV/AIDS programme. This involved providing leadership and broad strategic development as well as defining national policies. However, policy development requires consultation as well as providing adequate support for implementation of the policies, mainly through the development of guidelines and the provision of training. For example, a national official described their role as follows:

> *"Being at the national level it obviously means that we're not at the implementation level, so our role and function is mainly towards policies, guidelines, standards etc. You know, making sure that the plan that we have is something that's appropriate for the whole country."*

This is quite similar to the provincial perspective:

> *"Well, to me, national are supposed to be looking at broader policy issues, which then should filter down to provinces. I think also that they develop like guidelines, to say this is how things should be done." (Provincial HIV director)*

A number of informants listed resource mobilisation and resource allocation as the responsibility of the NDoH. The NDoH clearly has an important role to play in lobbying resources for HIV/AIDS from the National Treasury but within current South African fiscal federal relations, allocations to provincial and local health departments are generally made by provincial legislatures and municipal councils rather than national government. The

identified role of the NDoH in resource allocation probably reflects the fact that an increasing proportion of provincial HIV/AIDS budgets are being funded directly from the NDoH, in the form of conditional grants. At present, separate conditional grants are being provided for VCT, HBC, PMTCT, step-down care and provincial management. In addition, to ensure the implementation of these nationally-identified priority programmes, the NDoH has also provided staff to provinces. An official in the national directorate explained these developments as follows:

> *"No, for instance, a lot of what we've done, ….and I think some of the new interventions specifically, VCT home-based care, PMTCT. Provinces said; 'Fine it's good for you to draw up this plan but we don't have the people to do this'. So we said; 'Fine, we'll appoint people from our budget and second them to the provinces. So we'll pay for that and we'll give you the resources. So we're not just giving you the money through the conditional grants but we're also giving you the people to run this'. So it's doing all of those steps. Setting up the training materials, setting up the training sessions, paying for all of that etc. So it goes a little bit beyond just having a document and then saying to the province, go ahead and do it. We're finished, we've done our bit."*

Initially NGOs providing HBC and other HIV services were funded directly by the NDoH. This practice has continued although funding to NGOs is now also occurring at the provincial and local levels. A national official commenting on their main responsibilities said:

> *"The second thing would be the NGO funding where we provide funding to NGOs…. because some provinces have very small budgets for NGO funding. So it's one way of I suppose of ensuring a bit more equity."*

This was confirmed by a provincial respondent:

> *"The NGOs, they do support finances for NGOs, especially with [this province], we have an NGO funding programme which is fully, basically 100%, supported by national. So we do work with NGOs because what we do we send out a call for funding and then they send in applications. … We screen them, then we approve those, we can actually approve who meet the requirements and who have all the necessary documentation. Then we send them to national where they are finally addressed. So we basically need support from the national office in a big way."*

The coordination and integration of HIV services was specifically mentioned as a national level function. The NDoH was also identified as being responsible for monitoring and evaluation, international liaison and facilitating national research.

5.2.2.2 Provincial Department of Health (PDoH)

Both national and provincial respondents said that the main role of the PDoH was to modify national policies according to provincial realities (Table 5.1). The following quotes demonstrate the significant consensus on this point:

> *"It also to take your guidelines, your programmes, your strategies and adapt them to local circumstances. Because in many respects I think at the national level you sort of operate on the one size fits all principle. You draw up one strategy, one plan but we know that the country is not, conditions aren't the same everywhere and different issues are a priority for different provinces. So the role of provinces is to really adapt that and make sure that it's appropriate for whatever the circumstances are in that specific province." (National official)*

> *"And then provinces also to develop their own policies that are line with those of the national Department of Health. And also we have to ensure that now we disseminate*

or we create an environment that is going to allow us to implement those policies." (Provincial HIV director)

"What I'm saying is that we do have the national guidelines, but national strategy….it's more of a guideline … it's not cast in stone that you have to implement it. Like what we have done with the province, looking within the characteristics of the province, what we have done, we have customised that plan to suit our needs." (Provincial HIV director)

"Remember at national, services are not delivered. National is a policy-making body and coming up with strategies. Provinces are the ones who have got to customise strategies and put in plans to operationalise these national strategies and policies." (Provincial HIV director)

Table 5.1: Identified roles and responsibilities of the PDoH

Area	Functions
Steering	▪ Adapt national policies programmes to provincial circumstances ▪ Develop plans to operationalise policies and strategies
Support	▪ Provide appropriate environment for implementation ▪ Training ▪ Capacity development
Financing	▪ Mobilise resources at provincial level ▪ Allocate provincial resources
Service provision	▪ Hospital services
Coordination	▪ Establish and support inter-governmental coordination structures ▪ Serve as channel to district, local government ▪ Feed local dynamics up to national
Oversight	▪ Monitoring and evaluation of implementation

Provinces were also perceived as providing an important link between the policymakers at national level and the policy implementers in districts and local government. An informant at the national level clarified:

"Yea, because I mean, we don't have any formal link at a national level in a programmatic area with the district level. There's no platform for us to interact on. And so province needs to be that conduit to ensure that services reach and resources reach the lowest possible level." (National official)

A provincial director described a more active role in coordinating with local government and other actors:

"I think coordination, designing or developing strategic plans and operational plans. And also, I mean, when I said coordination, it's co-ordinating between province and local government and also coordination between government, private sector and other sectors like NGOs, faith based organisations, any other organisations within civil society" (Provincial HIV director)

The establishment of Strategic Plan implementation structures, such as the Provincial Aids Council and the Interdepartmental Committee, was mentioned by more than one informant as an important responsibility of the PDoH.

However, some people saw the provincial level as more than a simple conduit, but as having a critical role in supporting districts and local governments, particularly through training. A provincial HIV director claimed:

> *"We are building capacity at district level and also at NGO level."*

A district manager agreed:

> *"Let's say if a project has to be implemented like voluntary counselling and testing, they will then assist the district in training trainers. And then it will also be monitoring, because on a quarterly basis they monitor how district perform, with regards to implementation, and also give support if there are weak areas, then they assist in addressing whatever problems might be and then also they come to districts to just look at what is happening."*

One respondent noted that the PDoH was responsible for hospital service provision and a national official argued that the PDoH needed to be active in mobilising resources at the provincial level:

> *"I think the role of provinces, once again to, theirs is also to mobilise resources, within that province, make sure that the fund flows go where they must, because we can only go as far as saying, okay, province you get R20 million for whatever. And it's then the responsibility of that province to make sure that that money reaches where it's supposed to be."*

5.2.2.3 Local government DoH (LGDoH)

The main identified responsibilities of the local level are shown in Table 5.1.

Table 5.1: Identified roles and responsibilities of the LGDoH

Area	Functions
Service provision	▪ Implementation ▪ Clinic services ▪ Prevention
Coordination	▪ Serve as channel to communities ▪ Integrate local level resources
Support	▪ NGOs ▪ CBOs
Broader development	▪ Infrastructure ▪ Poverty alleviation

A few respondents at the national and provincial levels glibly referred to local government as the level of implementation or service delivery:

> *"And then even within provinces local government is the sphere were service delivery actually takes place."(Provincial HIV director)*

> *"If now we decide, as the province that is our role, we can ask local government to implement it for us and we can use them as agent to do that, either by devolving the function to them or us, there's this thing delegation and assignment, so one can do that." (Provincial HIV director)*

An interviewee from local government provided more detail on the range of HIV/AIDS services provided at the local level:

Well, apart from the obvious ones like primary health care and the running of home-based care programmes, and DOTS on the medical side of things - I think in addressing the impact of AIDS on communities and in mobilising communities to firstly come up with programmes of their own to solve their own needs, but also to be able to support communities in addressing those needs. I'm thinking in particular in terms of orphans, nutrition, yes, home-based care which I have already mentioned, strategies to alleviate poverty, food production, all other issues that go around HIV and AIDS. The issue of help for traumatised women and rape victims, etc, that also relates to AIDS. I think those would be better run at local government level in a lot of areas. Certainly where there is local government with some capacity, I feel that they would have a useful role to play there. But on the whole, local government has been sidelined.

Other informants also mentioned local government clinic services and the role played by AIDS Training and Information Centres (ATICs) in providing education, condoms, VCT services, and training.

In addition to providing training to NGOs, local government might be able to have a much more hands-on approach to developing and supporting NGOs:

"And if an area doesn't have an NGO that satisfies that strategy, the co-ordinator conscientises the community and we….we train the people in that community on HIV/AIDS facts, where we deal with attitudes, beliefs and the information so that they come with identifying the problems that they have and we encourage them then to come together and make a constitutional business plan to formulate an NGO." (Local government official)

The local level of government was also seen as providing particular advantages such as providing direct access to communities, being able to mobilise and integrate local resources, and facilitating a more developmental approach to HIV/AIDS:

"How do I explain that? I think local government has a critical role to play in dealing with AIDS. I think it has a role to play in coordination and rationalisation of services at local level. They have a role to play in reaching out directly into communities and to be able to target responses at the local level with the involvement of other role players at the local levels such as the business sector, the NGO sector and community based organisations." (Local Government official)

"Because that's where we can truly start looking at integrating HIV/AIDS and also looking at it from a development perspective. So that you can actually say, we need to strengthen our PMCTC programme but we can't do that because we don't have roads, and we don't have water and there's no electricity. So we need to all be working together towards the same goals. And that, you know, looking at the development perspective and not just focusing purely on the health aspects of it." (National official)

5.2.2.4 Health Facilities

Again, facilities were often described as being responsible for HIV service delivery without specifying what that meant. Some of the more specific suggestions are shown in Table 5.1.

Table 5.1: Identified roles and responsibilities of hospitals and clinics

Area	Functions
Hospitals	▪ Treatment of opportunistic infections ▪ Providing post-exposure prophylaxis (PEP) ▪ Providing palliative care in step-down facilities
Clinics	▪ IEC and AIDS awareness ▪ Treatment of opportunistic infections ▪ Treating STIs ▪ Providing VCT services ▪ Linking with and supporting NGOs

For example, one of the respondents explained the role of clinics as follows:

> *"In the clinics they are participating in implementing the HIV/AIDS strategies. For example, they are managing surveillance of STIs and the management of STIs ….. And then we also have education going on, as a preventative strategy. We have health promoters based in facilities and then nurses are involved in the campaigns, they are also participating. We have in - not in all facilities - but five facilities, especially health centres where we have voluntary counselling and testing sites, where they participate in counselling clients." (Provincial official)*

5.2.2.5 Support staff and line managers

Although it may vary from one province to the next, the human resources (HR) department does not seem to play a major role in the HIV/AIDS programme at present. One respondent mentioned that their HR department had done some training for health workers but more frequently this has been done by outside NGOs or consultants. Guidelines and manuals for training have been provided by the national department and the coordination of training has generally been managed from within the HIV/AIDS directorate.

Interviewees at all levels commented on the role of DoH financial support staff in internal procedures for the approval of programme budgets.

> *"There is a financial control committee where we give budget inputs as a programme, those budget inputs have to be considered with other budgets inputs from other programmes. And then with the recommendations from that FCC through to the Chief Financial Officer and the head of the department." (Provincial HIV director)*

> *"My department makes a suggestion of, say, R120 000 for the following projects, then it goes to the financial committee, which has the Director of Finance on it, the Town manager and the Mayor and other politicians. And then they accept or approve or amend the suggestion, then it goes to the council for approval." (Local government official)*

The Directorate of Health Economics and Financing (DHEAF) in the NDoH is in charge of the allocation and management of conditional grants to provinces for HIV services. DHEAF is also responsible for monitoring of the grants with provincial departments having to submit monthly reports on grant activities and expenditure. Two provincial HIV/AIDS directors informed us that the NDoH has now seconded financial support staff to their directorates in order to improve the management and control of the conditional grants.

Other internal programmes and units were occasionally mentioned by the informants. So, for example, the quality assurance unit at the NDoH has been involved in the definition of the

HIV service package and guideline development; and the MCH directorate was mentioned in connection with PMTCT services and PEP for rape survivors. One respondent commented that it was important to consult with line managers before implementing changes:

> *"There has to be a process. Say, for example, there's a proposal which maybe let's say it comes from the HIV programme, we say this and this within and this must be implemented, we would have to circulate that to the line managers for inputs. And then come up with a concept document after their inputs, present it at their meeting, from there present it at a top management meeting where it would be approved." (Provincial HIV director)*

5.2.2.6 Other government departments

It was frequently argued that other government departments needed to be more involved in the HIV/AIDS strategy. Departments were engaged in a process of trying to define their roles:

> *"They do have HIV/AIDS programmes depending on what is their core business or function." (Provincial HIV director)*

> *"In this province what we've done is identified the roles that they play, what is the role of Health, what is the role of Welfare, the role of Agriculture, so all of those we have put them down." (Provincial HIV director)*

The Department of Social Development (DSD) and Department of Education (DoE) were most frequently identified as important role players with reasonably clear responsibilities (Table 5.1).

Table 5.1: Identified roles and responsibilities of other government departments

Department	Functions
Social Development	▪ Social grants ▪ Poverty alleviation ▪ AIDS orphans ▪ NGO support
Education	▪ Health education ▪ Life skills training
National Treasury	▪ Resource allocation ▪ Conditional grants
Public Service Administration	▪ Government workplace HIV programmes

The responsibility of government as an employer and the need for all departments to develop workplace HIV programmes is beginning to receive attention in all three spheres of government. Although officially the responsibility of the Department of Public Service Administration (DPSA) and the Department of Provincial and Local Government (DPLG), the workplace programme is being driven by the NDoH through the Interdepartmental Committee (IDC):

> *"But now one other thing is that each department needs to have a programme for its employees, because even employees within government are also affected and some are infected.…We developed a general workplace policy for the province, then each department has been given that to look at it. And also even local government has said they must now, we did give them in the last meeting, said they must also have the workplace policy, then based on it they can also now develop theirs that*

would suit their conditions but the broader spectrum of how they should be implementing that. We have provided that guideline." (National official)

5.2.2.7 Other sectors

Non-governmental organisations (NGOs) were described as legitimate and important actors in HIV/AIDS activities. Government programmes are increasingly turning to NGOs to provide services not currently available in formal health system particularly the provision of home-base care (HBC) for AIDS patients. However, they are also playing an significant role in education, counselling and training (Table 5.1).

Table 5.1: Identified roles and responsibilities of NGOs

Area	Functions
Prevention	▪ IEC, campaigns ▪ Condom distribution ▪ Counselling ▪ VCT
Patient care and support	▪ HBC services ▪ AIDS orphans
Training	▪ Counsellors, carers ▪ Other NGOs ▪ Health workers

The following quotes demonstrate the importance that HIV managers now afford to the NGO sector:

"Like we talk of home based care, so that's a service that you can work with non-governmental organisations. Voluntary counselling, they can provide assistance there. And also fighting TB, which is now the dual epidemic, they can assist with that. And also you can work, even in the issue of rape, you can work with NGOs, same with faith based organisations, they can also provide it….And also they can help in campaigns and social mobilisation, because most, especially small community based organisations, if you have a buy-in from them coming from local area, they assist you there and you are able to reach out. (Provincial HIV director)

"Okay. In my district the NGOs have played a very important role in ensuring the implementation of some of the key strategies. For example they are very much involved in condom distribution. They are also participating in education, especially on HIV/AIDS and STIs. And then they also participate in campaigns – like if you want to have the whole AIDS day, and they are very supportive and they do participate. "(Local Government official)

"NGOs are looking after training other NGOs on various aspects. We've got NGOs that are doing support groups, PWA support groups, who are already clubbing together. We're looking to their own needs. And among them we'll train some to do counselling. Among them we'll train some to do home-based care. Those who are ill already can be visited at home and given the aid they require. And right now what is coming is NGOs who are looking after orphan needs because we are having more and more HIV/AIDS orphans, though they might not be infected themselves but they have been left by parents who are HIV positive." (Local Government official)

The only other sector mentioned with any frequency was the academic / research / consultancy sector. Clinicians have been playing a role in protocol development, researchers have been supporting health system development and various consultancy groups have

been doing tool development and training. The AIDS Law project was mentioned in relation to addressing discrimination against HIV-positive people.

> *"Its again the clinical services people, you will get people from academic health complex which would involve the hospital and the university. And then also people from the institutions would be involved. " (Provincial HIV director)*

> *"Yes. I mean HST [Health Systems Trust] does a lot of work for us. Work on VCT, work on home-based care, work on, mainly of course, on the PMTCT which is what they've been getting the most funding for. But one of the reasons we work so much with HST is because they have that understanding of the health sector. And they do work at a sort of local level as well. They bring in that sort of expertise for us." (National official)*

5.2.3 Problems with Roles and Responsibilities

The problems mentioned under role allocation can be grouped into three inter-related areas: firstly, that the roles and responsibilities of some actors are not clearly defined; secondly, that actors disagree on the allocation of responsibilities; or, thirdly, that certain responsibilities have not been addressed or allocated to particular actors. Table 5.1 provides some examples of each of these and will form the basis of the discussion that follows.

Table 5.1: Identified weaknesses in the allocation of roles and responsibilities in HIV services

Problem	Details
1. Roles not clearly defined	▪ Roles of different spheres not clearly specified ▪ Role of local government is very unclear ▪ Roles of different departments not clearly specified
2. Tensions in role allocation	▪ National (and provincial) levels too involved in implementation ▪ Local government not involved enough in implementation ▪ Problems with horizontal allocations within and between departments
3. Neglected roles	▪ Inadequate attention to support role ▪ Inadequate attention to systems and developmental issues

5.2.3.1 Roles not clearly defined

A common complaint was that the roles of the different spheres and of different departments had not been clearly specified. The main blueprint of the HIV/AIDS programme, the National Strategic Plan, was identified as being a bit vague on this point. An official in the national directorate said:

> *"Obviously, I don't think we can contradict our strategic plan because it says what needs to be done, but it doesn't say who needs to do it."*

A provincial HIV director agreed:

> *"Its the issue of not having a clear policy that differentiated the roles of each level of government. It's not clear what people are supposed to do. I think for me if we would have a clear policy on HIV/AIDS…that says these will be the responsibilities of national, these would be provincial…for all the spheres of government."*

Although the Strategic Plan claimed to be a plan for the whole country and not just the DoH, one interviewee didn't think that it had been particularly successful in this objective:

> *"But to a certain extent, if you look at the strategic plan, it's not a really comprehensive plan. It's a health plan which just sort of scratches a bit on the*

outskirts. Even though the Ministry of Health or the Department of Health was in charge of producing it, it could have been done differently." (National official)

The fact that the process was driven by the DoH might explain why the allocation of responsibilities to other government departments, and their acceptance of those roles, was inadequate.

Many respondents complained about the uncertainty regarding the role of local government in the District Health System. The process of local government reorganisation and shifting NDoH policy on implementation of the DHS have resulted in significant confusion about the general health service responsibilities of local government. In early 2001 it seemed as if local government would be responsible for all primary health care (PHC) services but by early 2003 the position had changed and current proposals suggest that local government will only legally be responsible for environmental health care. However, it will also be possible for provinces to delegate additional PHC responsibilities to particular municipalities on the basis of individualised assessments and negotiations. Given these developments, it is not surprising that respondents felt that the roles and responsibilities of local government within the HIV/AIDS programme have not been clearly defined.

5.2.3.2 Tensions in role allocation

Three main problems were identified in relation to this issue: that the national level was too involved in implementation; that local government was being ignored or sidelined; and that the DoH (and the HIV directorate in particular) still bore most of the responsibility for HIV/AIDS activities (Table 5.1). On one level, these problems are related to the first point, that the roles of different actors have not been clearly specified, however, they also reflect the fact that actors have different opinions about their respective roles.

5.2.3.2.1 The role of the national level

The NDoH (and sometimes also the provincial level) was described as being too involved in implementation with little real decentralisation of responsibility. Interestingly, national and provincial informants were able to identify these tendencies themselves:

"I think there is like national level, if you look at the different units to a different extent but in general there's too much of a misdirection. I don't know where that comes from, whether it's internally driven or externally driven. But a misdirection towards getting too much involved in implementation." (National official)

"HIV should be treated as part of primary health care and it should go to the lowest level of government and be well managed there and then the province can concentrate on what its supposed to do. Because right now at province we are not only doing policy formulation and monitoring and what, we are also involved in the operational implementation issues by running some of the projects at the provincial level, things that could be well managed at a local level." (Provincial HIV director)

These tensions partly derive from a rather top-down implementation process within the HIV/AIDS programme. Over time HIV programme activities have become organised into a series of nationally-driven, rather vertical programmes, each focusing on a separate area, such as VCT, HBC or PMTCT, with their own staff, guidelines and budgets. A national interviewee explained it like this:

"And again it is this unit specifically. See, this VCT programme essentially is a national initiative. Province supposedly bought in but the real commitment didn't come out, so we developed things like conditional grants. So we actually directed -

like the World Bank is related to Africa - we direct. We will give you the money provided you do x with it.“

This type of approach was identified by some informants as being too prescriptive:

“I suppose national is responsible for policy-making, although one would like to see that as being somewhat less prescriptive and dogmatic, but rather in terms of giving direction and support and advice as opposed to controlling and limiting.” (Local Government official)

However, a national official justified the strategy, arguing that there would have been little progress without it:

“Well, if you have a strong vision and you really believe the written agenda is the best, then you do it. And I think it’s partially appropriate. I think that without this probably the AIDS programme of the province would be not working, I know. But it required national to get too much involved in implementation work.”

5.2.3.2.2 The role of local government

Different perspectives on the appropriate role of local government in HIV/AIDS service provision result in similar tensions. Local government informants argued that they should be playing a larger role in HIV/AIDS, that the advantages and resources of the local sphere of government had not been adequately recognised:

“But I think that some of the activities taken at that level, at the moment, would have been better if they simply took those funds and those resources and passed them through to local government to implement them at local level, that's in terms of particularly things like nutrition, home-based care support and community outreach programmes.” (Local Government official)

“I think it is possibly a lack of understanding of the potential role of local government. I think they tend to look at local government in the sense of just providing health services and they don't look at local government in its entirety…. We have identified roles for various departments against AIDS, in a struggle against AIDS. They all have a role to play which I don't think is fully understood from national and provincial health departments. I think they tend to look at local government very narrowly in terms of, 'Oh they have a clinic', you know? I don't think they appreciate the wider role that local government could play.” (Local Government official)

“Certainly when one's addressing an epidemic as large as AIDS, the magnitude of this, to not harness all available possible resources, is really not going to achieve success…. The size of the problem is such that you have to drag in every single possible resource that you can. The bringing in of local government is really highly conspicuous by its absence, and it's an entire sphere of government which is not having its resources harnessed and not being brought into the programmes. I'm not sure why, really, I think it's probably because of a lack of understanding within health departments as to the role they could play.” (Local Government official)

However, some national and provincial managers were not convinced that local government should be given more responsibility for HIV services, citing ongoing internal transformation, uncertain dynamics between district and local councils, as well as significant capacity constraints:

“When we look at local government….there seems to be lack of coordination and suspicion and competency problems, and basically people not working together.” (National official)

"There is this concept of the devolution of services to local government. We haven't, as yet, implemented this concept. But, what I see, I would say, the impact would be…. the local at this moment, they do not have capacity in terms of understanding the whole concept of the HIV/AIDS strategy. And the second thing is, I don't think they have the budget to deal with HIV. And then, capacity in terms of supporting coordinators. I think that will also be a problem because they themselves need to be capacitated" (Provincial official)

A local government health official responded that these types of arguments were a superficial and short-sighted response to the problem:

"It depends how you define capacity of course. There is an argument that if these local governments are given the resources that they will have the capacity, that capacity relates to resources…. One can support the development of capacity through transfer of resources, through allocation of funds, through skills transfer, through seconding staff or various measures to assist local government to develop capacity. But to say they don't have capacity, therefore they never will have capacity, therefore nothing should happen through them, is not addressing the problem - it's perpetuating it."

5.2.3.2.3 The role of other departments

The National Strategic Plan identifies the building of partnerships with other actors as an important priority. HIV programme managers frequently expressed concerns that other divisions within the DoH and other government departments were not as involved as they should be. Seemingly other actors were not always convinced that their role and their participation was as important as the HIV programme though it was.

"Ja, I think it's not that we don't have good relationships [with the MCH and Hospital directorates], it's that those are the units that have been slow in saying, yes, we have a role and responsibility in terms of addressing HIV/AIDS and our role should be X or Y." (National official)

"One other problem that we had, is that other departments, it took them long to see their role, what their role is because people in other, what have they got to do with HIV/AIDS. It's a health issue, why should we be part of that" (Provincial HIV director)

We didn't ascertain the views of other government departments on these dynamics. However, a respondent from local government suggested that perhaps the DoH's expectations of other actors was unrealistic:

"People say it's nice to get it out of health. But what we find is while you can get other departments involved, the people with an interest in actually leading it and running with it, tend to be the health officials. So we can rope in people from Engineers and Parks and Traffic or whatever, but to expect them to lead the programme and run with it, I don't think they will, because they don't see it as their core business. Look it's not necessarily a bad thing, provided the other departments come in and recognise the role they have to play. I think that will be as much as what we can hope for. I can't see the traffic police actually running with the AIDS programme. But if we can get them to contribute and be part of it and see that they have a role to play, then I think we'll have to be grateful for that."

5.2.3.3 Neglected roles

The third area of weakness relates to roles identified by respondents as being relevant but which are not really emphasised within the current package of services. This includes aspects such as providing more locally-driven support as well as tackling broader systems and developmental issues related to HIV/AIDS.

The rather top-down, prescriptive forms of support currently provided by the NDoH (and provinces) was discussed in Section 5.2.3.2 . The alternative would be a more bottom-up, locally-driven approach to capacity development where, for example, lower levels were supported in the identification, planning and implementation of their own solutions. One or two informants suggested that there was inadequate attention to this sort of role:

> *"So far what I've seen is that the link between the province and the national is in terms of financial assistance and training and basically capacity building some of the areas, but not all of them, especially with management, they hardly support management in terms of building capacity … to actually manage the programme. They discuss issues around the programme itself but not how to manage the programme." (Provincial HIV director)*

> *"But I would like to see them play more of a supportive role than a controlling role, but then that's my philosophy about of government in general. Even at local government level we certainly would pursue a supportive role as opposed to a controlling role. And I think that's what one would like to see from other levels of government." (Local Government official)*

The failure to address systems and developmental issues may also undermine progress. Defining responsibility for these functions may be difficult but they do need to be considered as part of the HIV/AIDS programme of activities.

> *"Functions are functioning fairly well - but the problem is movement of personnel to deliver services that destabilises service delivery, the movement of nurses, the movement of programme directors, the restructuring of some of the processes, destabilises services." (Provincial HIV director)*

> *"We have the HBC programme within our rural areas where there is no safe water. In that programme, for the programme to be successful, I mean, …one of the problems is ….how do you do that in rural areas where there is no safe water without exposing [the carers] to the disease. So one of the issues we said, let's look at what other issues impact on this delivery …like infrastructure, we've also included issues of infrastructure. Planning for infrastructure, we should take cognisance of HIV/AIDS issues…. We've started this process last year. Because the year before that, we were just implementing according to the national guidelines. So …. we evaluated that and looked at it. I mean, what it is that we feel in the province we need to do, like one of our problems when you come to voluntary, counselling and testing, which is one of the strategies for the country, the problem is we don't have infrastructure. There's no space for counselling. So if we don't address those issues, how are we going to address HIV." (Provincial HIV director)*

5.3 Coordination and Integration

In this section, we first present some terminology for discussing different aspects of coordination and a categorisation of the main coordination relationships of interest. We then focus on how HIV services are coordinated and integrated, by focusing on the main mechanisms and structures involved in different categories of HIV coordination. The last part

of this section outlines the key problems in relation to HIV coordination identified by the respondents.

5.3.1 Describing Coordination

Section 5.2.1 introduced a framework to identify the range of actors involved in HIV service provision and to discuss their different roles. This framework now has to be extended to describe how activities are coordinated between actors

5.3.1.1 Terminology

It is useful to focus on the relationships between actors or groups of actors. However, coordination relationships are multi-faceted and can be described and categorised in a number of different ways (Watts, 2001). Some of the characteristics of coordination that we have focused on and the terminology we have used to discuss these characteristics are summarised in Table 5.1. Relationships may be characterised as *horizontal* or *vertical* depending on whether the actors involved in the relationship are at the same level or at different levels of government. Respondents also differentiated between *internal* and *external* liaison where internal liaison relates to coordination within government (although sometimes referring more specifically to coordination between departments), whereas external liaison involves coordination with actors outside of government. We have attempted to cluster coordination relationships into broad *categories* on the basis of the main actors involved. This categorisation is described in more detail below. The *mechanism* of coordination refers to how activities are coordinated between actors. A number of structures have been established to facilitate governmental coordination but other mechanisms are also important. It is also helpful to differentiate between different *channels* of coordination depending on which part of government is involved. Frequently, it is the executive members of government (politicians) rather than the administrative staff (officials) that participate in coordination structures. Lastly, we can focus on the *nature* or objective of the coordination relationship which can be viewed as a continuum ranging from no relationship to joint decision-making.

Table 5.1: Different ways of characterising governmental coordination relationships

Characteristic	Description	Examples
Dimension	Whether relationship is at same level or between levels	▪ Horizontal ▪ Vertical
Domain	Whether relationship is within government or with actors outside of government	▪ Internal ▪ External
Category	Main categories of governmental relationships	▪ Inter-governmental ▪ Intra-departmental ▪ Inter-departmental ▪ Inter-sectoral
Mechanism	Means of coordination	▪ Coordination structures ▪ Meetings ▪ Informal relationships
Channel	Main route of coordination	▪ Legislative ▪ Executive / Political ▪ Administrative
Nature	Nature of the relationship	▪ Independent ▪ Information sharing ▪ Consultation ▪ Accommodation ▪ Joint decision-making

5.3.1.2 Categories of Coordination

Nine main categories of coordination relationships are represented in Table 5.1 and Figure 5.1. This is not an exhaustive list but covers the main areas of interest in the study.

Strictly speaking, *inter-governmental* coordination refers to relationships between the three spheres of government. *Intra-departmental* coordination covers a number of different relationships that occur within the DoH, for example horizontal coordination within the HIV/AIDS directorate, and between the HIV/AIDS programme and other directorates or divisions including other programmes, support departments and line managers. Certain vertical relationships within the DoH - such as coordination between provinces, regions and districts - would also be characterised as *intra-departmental* because they generally fall within a single sphere of government (Table 5.1). Another unique aspect of coordination within the DoH relates to the importance of *referral relationships* between health facilities. *Political-administrative* coordination focuses on the relationships between DoH administrators and politicians, from the executive as well as the legislative arms of government. The HIV programme is also particularly concerned with involving other departments and other sectors of society through *inter-departmental* and *inter-sectoral* initiatives. Lastly, *inter-provincial* and *inter-municipal* coordination refers to the need for standardisation and sharing of experiences between the nine provinces and between different municipalities.

Table 5.1: Main categories and types of coordination relationships

Domain	Dimension	Category	Description	Important Relationships
Internal	Vertical	Inter-governmental	Between spheres of government	National – Provincial Provincial – Local National – Local
		Intra-departmental	Between levels of health system	Provincial – Region Region – District District – Facility
		Referral relationships	Between referral levels	Hospital – Referral hospital Hospital – Clinic
	Horizontal	Intra-departmental	Within HIV/AIDS directorate	VCT – HBC HIV – TB
			Between directorates	HIV – Other programmes HIV – Support departments HIV – Line managers
		Political-administrative	Between politicians and officials	Senior politicians – Senior officials Legislature – Officials
		Inter-departmental	Between different government departments	DoH – Treasury DoH – Education DoH – Social Development
		Inter-provincial	Between provinces	With adjacent provinces With other provinces
		Inter-municipal	Between municipalities	With adjacent municipalities With other municipalities
External	Horizontal	Inter-sectoral	Between government and other sectors of society	Government – NGOs Government – Private sector

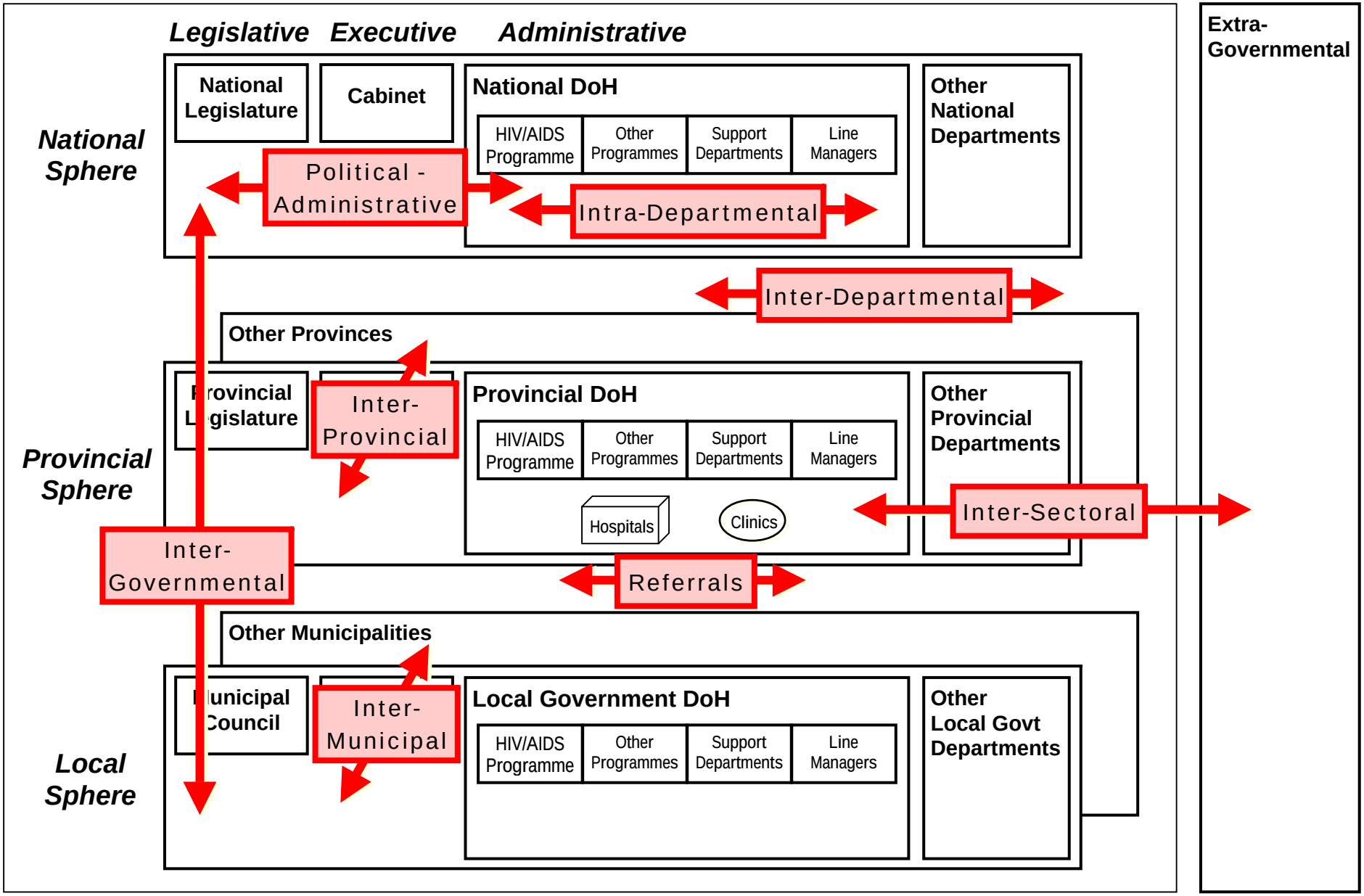


Figure 5.1: Main categories of coordination

5.3.2 Coordination and Integration of HIV services

When asked about how HIV services are coordinated most informants pointed to specific coordination structures although other mechanisms were also occasionally mentioned (Table 5.1). We examine HIV/AIDS coordination, first by describing the main structures and mechanisms of coordination, and then by summarising which mechanisms are important in each of the different categories of coordination.

The interviews in Phase 1 focused more on formal inter-governmental, inter-departmental and inter-sectoral collaboration. Aspects such as referral relationships, intra-departmental coordination and informal coordination mechanisms featured more prominently in the Phase 2 case studies and will be discussed in more detail in Chapters 6 to 8.

Table 5.1: Main coordination mechanisms

Mechanism	Details
Structures	▪ Implementation and coordination structures ▪ Forums ▪ Committees
Coordination units	▪ Dedicated units ▪ Dedicated staff
Management	▪ Internal meetings ▪ Hierarchy ▪ Management and leadership
Communication system	▪ Information dissemination ▪ Memos and circulars
Planning system	▪ Shared 5 year plan ▪ Annual plans ▪ IDP process
Financial system	▪ MTEF ▪ Annual budgets ▪ PFMA processes ▪ Conditional grants
Standardisation	▪ National guidelines ▪ Uniform training manuals ▪ Information systems, reporting mechanisms
Contracts	▪ Service level agreements

5.3.2.1 Structures for the Coordination of HIV services

Inter-governmental, inter-departmental and inter-sectoral coordination have generally relied on specific structures, forums or committees to facilitate coordination between actors (Table 5.1, see also Figure 4.2). Firstly, there are general structures to coordinate broadly within government as well as within different departments, including the DoH. Many of these structures have evolved and changed since 1994 and Table 5.1 reflects the current status quo. These general governmental and DoH structures may discuss or deal with HIV/AIDS although that is obviously not their primary focus. Secondly, in the last five years a number of HIV-specific coordination structures have also been established. The introduction of such specific coordination mechanisms is almost unique to HIV/AIDS. As one NDoH official stated:

> *"Well, with HIV, because of this dimensional problem, because of the bridges they create, that's the problem. There are so many other structures at play, which I don't think happens with another health issue."*

Table 5.1: Main coordination structures - Current

	Level	Structure	Category	Channel
General Government Structures	National	1. Cabinet	Inter-departmental	Political
		2. DGs forum	Inter-departmental	Administrative
		3. Cluster committee	Inter-departmental	Political
		4. DGs cluster committee	Inter-departmental	Administrative
		5. Presidential coordinating committee (PCC)	Inter-governmental Inter-provincial	Political + Administrative
	Provincial	6. Executive Council	Inter-departmental	Political
		7. DGs forum / Interdepartmental management committee (IDMC)	Inter-departmental	Administrative
		8. Cluster committee	Inter-departmental	Political
		9. DGs cluster committee	Inter-departmental	Administrative
	Local	10. Executive committee	Inter-departmental	Political
General Health Structures	National	11. MinMEC	Inter-governmental Inter-provincial	Political
		12. Provincial health restructuring committee (PHRC)	Inter-governmental Inter-provincial	Administrative
	Provincial	13. Provincial health authority (PHA)	Inter-governmental Inter-municipal	Political
		14. Provincial health advisory committee	Inter-governmental Inter-municipal	Political
	Local	15. District health authority (DHA)	Inter-governmental Inter-municipal	Political
HIV-Specific Structures	National	16. South African National AIDS Council (SANAC)	Inter-sectoral Inter-departmental	Political
		17. Interministerial committee on AIDS (IMC)	Inter-departmental	Political
		18. Interdepartmental committee on AIDS (IDC)	Inter-departmental	Political
	Provincial	19. Provincial AIDS Council (PAC)	Inter-sectoral Inter-departmental Inter-governmental Inter-municipal	Political
		20. Interministerial committee on AIDS (IMC)	Inter-departmental	Political
		21. Interdepartmental committee on AIDS (IDC))	Inter-departmental	Administrative
		22. Focal persons sub-committee	Inter-departmental	Administrative
	Local	23. District AIDS Council (DAC)	Inter-sectoral Inter-municipal	Political
		24. Local AIDS Council (LAC)	Inter-sectoral Inter-departmental	Political

Table 5.1 also highlights that each structure may address more than one category of coordination, and that there are usually separate, but analogous, structures for politicians and senior officials. Most structures were initially set up at the national level but are now being duplicated at provincial and local levels. However, there is significant variation between provinces and municipalities in the existence, name, composition and functioning of these structures. The most common terminology is reflected in the Table.

5.3.2.1.1 General Government Structures

These structures obviously address broad policy and strategic issues, including HIV/AIDS. They may also be important in linking HIV programmes to other government priorities such as local development or poverty alleviation. However, most DoH and HIV officials have little

understanding of the workings and decisions of this area of government. The national Cabinet includes the Presidency and national Ministers and serves an important inter-departmental coordination function. The Director-Generals (DGs) Forum is a parallel structure for the administrative heads of departments. One national respondent suggested that the DGs Forum was more active in HIV/AIDS coordination than the cabinet. At the provincial level, the Premier and Members of the Executive Council (MECs) make up the provincial Executive Council. Most provinces have structures analogous to the DGs Forum although the terminology varies from one province to the next. Within local government executive authority may be vested in an executive mayor, an executive council or the municipal council itself. The Cabinet and Executive Councils are constituted in terms of the Constitution and the Municipal Structures Act specifies the options for local executive governance, but most of the other structures shown in Table 5.1 have no formal legal status at present (see Section 4.3).

Following the recommendations of the 1998 Presidential Review Commission departments have also been grouped into clusters to improve inter-departmental collaboration. The Ministers and DGs within each cluster meet separately to discuss cluster-specific issues. The Social Cluster (which includes the Departments of Health, Social Development, Education, Housing, Arts & Culture, and Sport) and the Governance Cluster are the two cabinet committees that are most involved in HIV/AIDS. Each cluster is also supported by its own policy unit located in the Presidency. At the municipal level, health is rarely a separate department but usually combined with other social services although there is no uniform arrangement across municipalities. Also, coordination between divisions or departments at the local level generally occurs through management mechanisms rather than formalised structures.

The last general government coordinating structure listed in Table 5.1 is the President's Coordination Committee (PCC). The PCC replaced the Intergovernmental Forum (IGF) and includes the President, the Minister of Provincial and Local Government, the nine provincial premiers, and related DGs. Therefore it functions as an inter-provincial and inter-governmental structure (although limited to national-provincial coordination because local government is not directly represented).

5.3.2.1.2 General Health Structures

MinMEC consists of the national Minister of Health, the nine provincial health MECs and three representatives from the South Africa Local Government Association (SALGA) whereas their administrative counterparts make up the Provincial Health Restructuring Committee (PHRC). MinMEC and the PHRC, therefore, facilitate both inter-provincial and inter-governmental coordination. These structures meet every six weeks and frequently discuss HIV/AIDS issues. A national HIV/AIDS official suggested that these structures were actually more important in determining HIV/AIDS policy than the internal HIV-specific programme meetings:

> *"There is MinMEC and there is PHRC. To my understanding, HIV/AIDS is a standing item on the agenda of both meetings. To a certain extent those discussions are parallel to those discussions happening at the national AIDS meeting. But I would believe that most of the coordination, more than the national meetings, is actually happening in those forums. Because we're living in a centralised system, where it is more important what the top guys say or think, than what people who work here think."*

The Provincial Health Authority (PHA) and District Health Authority (DHA) represent similar coordinating structures at the provincial and district council levels. As discussed in Section

4.3.3, PHA and DHA-like structures have been established in a number of provinces, albeit with differences in titles, composition and authority, and some are even legally constituted structures in terms of provincial legislation.

However, as shown in Figure 4.1, the Health Bill proposes a new set of Health coordination structures. The terminology has been revised, (for example, MinMEC and PHRC will be known as the National Health Council and National Health Advisory Council[1] respectively, and the PHA becomes the Provincial Health Council), and there are some changes in composition (for example, SALGA will only have one representative on national structures rather than three). The Bill is also careful to ensure that these new structures are constituted to advise the executive rather than having any authority of their own, as is currently the case with the PHA structures in certain provincial legislation (Hall, 2002).

5.3.2.1.3 HIV-Specific Structures

The HIV-specific structures have been established to improve inter-departmental and inter-sectoral coordination of the government's HIV/AIDS strategy and are mostly broad political structures (Table 5.1).

The national Inter-Ministerial Committee on AIDS (IMC) includes all the Ministers and Deputy Ministers and is chaired by the Deputy President. IMCs have also now been established in some of the provinces. The Inter-Departmental Committees on AIDS (IDCs) is supposed to be the administrative counterpart of the IMC, but at the national level departments are represented on the IDC by the so-called HIV focal persons rather than the heads of the departments. The national IDC has also tended to focus more specifically on workplace HIV issues in relation to government's role as an employer. Some provinces have followed this model while in others the provincial IDC consists of the departmental heads and the focal persons constitute a sub-committee of the IDC but are responsible for most of the operational work of the committee. In most places, the DoH provides the secretariat for the IDCs. A national DoH informant described the national IDC as follows:

> *"The Social cluster is DGs and their Ministers. There is an inter-departmental committee of HIV/AIDS which is a much, much smaller kind of unit, really. I mean, it's the doers. The other ones out there are the decision-makers, and we are the doers."*

He also described how the national IDC came to focus on workplace issues:

> *"We reached a decision to focus on HIV/AIDS workplace programmes in government departments. Now, how we reached the decision is that there was a desperate need to focus and we found out by looking at the composition of the inter-departmental committee that most departments have sent their labour relations officers, human resource practitioners, people working on human resource management side in their departments as IDC reps. So they were not people by any means suited to discuss broader policies like, whatever…the defence capacity of the Department of Defence in relation to AIDS, or the role of Treasury to ensure that all departments budget adequately for HIV/AIDS. You know, all those strategic things. It was people who work in support functions with relation to the staff. It's an impossibly difficult task, we are all rather junior people with no budgets. With very, very few exceptions the people who come have ten functions, one of which is HIV/AIDS, and are not going to spend too much time on AIDS? Then we decided that's what we have to do, what we'll focus on is HIV/AIDS workplace programmes." (National official)*

[1] As noted previously, the NHAC was eliminated during the Bill's passage through parliament which means that there will now be a single structure, the NHC, replacing MinMEC and PHRC.

As noted above, the local sphere of government is more inter-departmental by nature. However, some of the local government respondents mentioned specific inter-departmental HIV/AIDS task teams and structures within their municipalities but it is unclear whether this is typical of local government throughout South Africa.

The South African National Aids Council (SANAC) has become the most important HIV/AIDS coordinating structure. The composition and functions of SANAC were summarised in Figure 4.1. SANAC was primarily established as a broad, political, inter-sectoral structure. The government representatives tend to operate as a single block within SANAC but the council does play some role in facilitating inter-departmental coordination. SANAC has a limited inter-governmental function because there are no provincial representatives and local government is only allocated one sectoral representative. The NDoH provides the secretariat for SANAC.

All provinces now have Provincial Aids Councils (PACs) while District AIDS Councils (DACs) and Local AIDS Councils (LACs) have only been established in certain areas. The PDoH has been the major player in establishing and supporting these structures although they are generally chaired by the most senior politician at each level. The PACs, DACs and LACs are also primarily concerned with inter-sectoral coordination but have slightly different additional coordination responsibilities depending on their composition. For example, in addition to the provincial department and sectoral representatives, PACs also generally have political representatives from district councils and would, therefore, also be able to contribute to inter-governmental and inter-municipal coordination (at least at the district municipality level). DACs don't really have an inter-departmental function but would play some role in coordination between different local municipalities represented on the council. In most areas, LACs are still in the planning and early development stage but some municipalities have had less formalised inter-sectoral HIV forums or steering committees for some time.

5.3.2.2 Other Mechanisms of Coordination

Table 5.1 lists a number of other mechanisms that are important in HIV/AIDS coordination.

The prioritisation of the new HIV-specific coordination structures within the HIV/AIDS programme has resulted in the establishment of dedicated coordination units at the national and provincial levels. Staff responsible for external and internal liaison have been appointed as part of Government Aids Action Programme (GAAP). HIV liaison staff together with senior HIV officials have generally constituted the secretariat to the AIDS councils, IMCs and IDCs, and have been directly responsible for the mobilisation, establishment and support of these structures.

Much of the internal DoH and HIV programme coordination occurs through general management processes such as meetings, hierarchical managerial relationships, communication systems, and procedures for annual planning and budgeting.

Regular meetings between national and provincial HIV staff constitute the most important mechanism of coordination within the HIV/AIDS programme. These national meetings facilitate inter-governmental coordination (at least between national and provincial spheres, local government is not represented) as well as inter-provincial coordination since they provide an opportunity for provincial counterparts to share information and experiences. There are actually a number of different national meetings. The main national HIV programme meeting involves deputy-directors and upwards from all the national and provincial HIV/AIDS directorates. Some interviewees indicated that this large group was supposed to meet every quarter but in practice actually seems to meet about twice a year. Specific sub-programme managers (including VCT, HBC, and PMTC) from the national and

provincial departments meet every two months. Some of the priority sub-programmes have additional national structures involving a wider range of actors, such as the PMTCT steering group, that also usually meet bi-monthly when the provincial managers are in Pretoria.

Meetings and hierarchical management processes are also important for intra-departmental coordination between the HIV programme and other staff. A number of senior management meetings occur at both the national and provincial levels. The nature and composition of these various meetings usually follow the specific departmental hierarchies and organograms. This means that provincial HIV/AIDS directors generally get to meet with their immediate colleagues, usually the other programme directors, but that coordination with other staff, such as support staff and line managers, has to occur through their superiors in yet higher level management meetings or by direct contact between the individuals concerned. Also, all of these meetings address general management issues rather than HIV/AIDS specifically. Therefore, the extent to which they are able to facilitate HIV coordination will vary considerably. Some health departments appear to have experimented with specific HIV committees or task-teams but these appear to be more ad-hoc meetings than regular, formal processes.

A number of respondents argued that the framework provided the 5-year strategic plays an important role in facilitating coordination between different actors. However, the annual planning and budgeting cycles are also important because of the well established and participative procedures for evaluating, integrating and finalising plans and budgets within departments but also to some extent between national and provincial actors. The focus on financial accountability through developments such as the Public Finance Management Act (PFMA) means that financial systems and treasury departments are playing an increasing role in governmental coordination. As outlined in Section 5.2.2.1 much of the funding for the HIV programme is in the form of conditional grants which are an effective mechanism for directing and coordinating activities. Conditional grant budgets are allocated to provinces by the NDoH. As mentioned in Section 5.2.2.5 , the Directorate of Health Economics and Financing is primarily responsible for the allocation and monitoring of HIV conditional grants.

The national DoH has actually appointed staff at the provincial level for VCT, HBC, internal and external liaison, as well as more recently for the financial management of conditional grants. This is an even more direct method of ensuring coordination between the two levels, because these individuals have been accountable to national as well as provincial HIV managers.

> *“So the national deputy director in charge of VCT has got contact with the provincial VCT co-ordinators….They were actually initially nationally appointed, and I think they were then referred to.. as national staff.” (National official)*

However, the original argument for adopting this approach appears to be that it was easier and quicker to add staff the NDoH establishment, rather than specifically to improve coordination. It is important to note that conditional grants and the secondment of staff from one level to another have generally been limited to the national-provincial component of inter-governmental coordination and are unusual outside the HIV/AIDS programme.

Another, less direct, method of coordination mentioned by respondents is through the standardisation of procedures and processes in the form of national standards and guidelines. Lastly, contracts provide a formal mechanism for coordination between parties. Although contracts have been developed for relationships with NGOs, the expected service level agreements between provincial and local governments have not yet materialised.

5.3.2.3 Mechanisms and Categories of Coordination

Table 5.1 summarises the identified coordination mechanisms for each of the main categories of coordination. Most of these mechanisms were discussed in the previous section, this section simply picks up on a few issues raised by Table 5.1.

Table 5.1: Main coordination mechanisms by category of coordination

Category of Coordination		Coordination Mechanisms
Inter-governmental	National – Provincial	▪ General structures (MinMEC, PHRC) ▪ National HIV meetings ▪ National programme meetings ▪ Consultation in policy development ▪ Planning and budgeting processes ▪ Conditional grants ▪ Appointment of national staff to provincial level ▪ HIV newsletter ▪ Standardised guidelines, manuals ▪ National reporting mechanisms
	National – Local	▪ Very limited engagement ▪ General structures (SALGA reps on MinMEC & PHRC)
	Provincial – Local	▪ Mostly informal ad-hoc ▪ Structures (PHA) ▪ Planning processes (? Participation in IDP development)
Inter-departmental		▪ General structures (Cabinet, Exec council, cluster committees) ▪ Dedicated coordination units ▪ HIV-specific structures (IMC, IDC)
Inter-sectoral		▪ HIV-specific structures (SANAC, PAC, DAC) ▪ Dedicated coordination units ▪ Contracts with NGOs ▪ NGO forums, consortia
Inter-provincial		▪ General structures (MinMEC, PHRC)
Inter-municipal		▪ General structures (PHA, DHA) ▪ HIV-specific structures (PAC, DAC)
Intra-departmental		▪ Management meetings ▪ Direct engagement
Political-Administrative		▪ Direct engagement ▪ Presentations to legislature

In terms of the different categories of HIV coordination, the major focus has clearly been on improving national-provincial coordination, as well as the establishment of structures to facilitate inter-departmental and inter-sectoral coordination. In these initiatives the HIV/AIDS programme appears to have been relatively successful. Many of the proposed coordination structures have been established and units are in place to support their functioning. A interviewee from the national HIV directorate commented on the improvement in their relations with provincial colleagues:

> *"I think we do have good relationships with the provinces. I think they were more stressful and tense when I started year three years ago. There was still problems….I think it had to do with roles and responsibilities and being clear about who's supposed to do what.* ***…****It's much better now. Once you start giving people resources, they also feel better about things. So giving them people and money certainly helps I think."*

In relation to national-provincial coordination, in addition to the mechanisms discussed previously, respondents also mentioned a HIV newsletter produced and circulated by the NDoH. A national official also described how provincial counterparts were involved in national policy development, and that these consultative processes were not confined to the national meetings and structures outlined above. For example, in discussing the development of the national strategic plan, she said:

> *"So, we would have the draft plan and then we would send it out for comments and we would get comments back. And then we would draft another one. So it went through quite a laborious process." (National official)*

Direct engagement about HIV services between the national and local spheres is extremely limited, although the national IDC has been providing HIV training to local government councillors.

Coordination of HIV/AIDS between provinces and local government is mostly informal and limited to direct interaction between municipality officials and their district or regional counterparts. A local government respondent noted:

> *"At the most senior level there is no formal structure relating local government with province - there hasn't been for eighteen months. So we never meet as local government with the provincial department of health as a senior level, that has been stopped"*

However, relationships were generally described as cordial, and many interviewees, from both spheres, described how they were occasionally involved in campaigns or projects together, and attended each others' meetings when invited.

Broader coordination between senior provincial and local actors within health also seems poorly developed. Few respondents spontaneously mentioned structures such as the Provincial Health Authority (PHA) when asked about mechanisms for provincial-local coordination, even in provinces where they have been established. On prompting, the PHAs were depicted as removed political structures dealing with tensions related to DHS development and with little involvement in day-to-day health service functioning. Similarly, few provincial informants had actually been consulted or involved in the development of Integrated Development Plans (IDPs) by local government.

In relation to inter-sectoral coordination, provinces have developed a variety of mechanisms for coordinating with NGOs involved in HIV service delivery. Ultimately, most provinces have formal contractual relationships with NGO providers. However, in order to facilitate their relationships with NGOs, some provinces have also promoted the establishment of NGO networks; have provided training and support to NGOs; and have set up new monitoring and evaluation systems. For example, a provincial HIV director commented that it was easier to deal with the NGOs now that they were organised into consortia:

> *"One other thing, with NGOs, one of the other issues is to have a proper body in the province to co-ordinate their work, to have one to talk in the one voice rather than dealing with these different groups."*

5.3.3 Problems with Coordination

When asked to identify the main coordination problems in the HIV/AIDS programme, informants mentioned generic coordination problems as well as problems with specific relationships. These are summarised in Table 5.1 and Table 5.1 respectively. The previous section suggested that national-provincial relations, inter-departmental coordination and inter-sectoral coordination have received the most attention to date. Nevertheless,

interviewees pointed to certain weaknesses in these initiatives. They also noted that certain important areas such as the relationships with local government, and intra-departmental coordination had been neglected.

Table 5.1: Generic coordination problems

▪ Roles not clearly defined ▪ Coordination mechanisms incomplete ▪ Poor communication ▪ Poor consultation ▪ Proliferation of structures ▪ Structures not working

5.3.3.1 Generic Issues

Some coordination problems stem from the problems in the allocation of roles and responsibilities (Section 5.2.3). This is particularly true of inter-governmental relationships with local government.

The problem of coordination has only recently begun to receive attention within the DoH. One interviewee argued that it needed to be taken more seriously and required dedicated personnel as well as funding:

> *"And therefore if coordination is not funded you don't know who's doing what in your area, you might find that we end up in trouble" (Provincial official)*

Another respondent recognised that progress had been made but suggested that the current system of coordination was incompletely specified, particularly within the National Strategic Plan. For example, he complained:

> *"So if you were to have a master plan which clearly outlines roles and responsibility. If you look at a strategic plan, the strategic plan writes something about the IDC, but it doesn't write anything about provincial IDCs. We would assume it's more or less the same, but it's a big omission.." (Provincial official)*

Informants at all levels identified problems with general communication. A national official acknowledged that provinces frequently complained about the NDoH not providing them with adequate information and not visiting them. She said:

> *"The one thing that we, from our side, that we try and sort of, because, I must say, some of the things that we're really bad at is communication. If the Minister suddenly takes the decision that you know, whatever decision she takes, we're not always that good at feeding it through to everyone."*

Another common issue was that the level above was described as very demanding but often didn't communicate among themselves. Here is a district official complaining about the province:

> *"And, also uncoordinated communication. You find at province you have about six coordinators, one looking at each programme, whereas at district level I have got to see to condom expansion, VCT, home based care, you know, running all at one time. And these managers at province, they all want reports at the same time and it is so difficult."*

Lack of consultation, particularly in relation to the development of budgets, was also mentioned by several interviewees:

"The budget that is coming from the national office, which is very, very specific, it does not accommodate some of the things which we have to do in the province. You'll find that they will only accommodate NGOs, home based care, VCT, the mother to child transmission… So you'll find that those are the only things that the national will support us. But what about the other things? " (Provincial HIV director)

"At times you'll find that the provincial office is just deciding what they should be doing, not even consulting with the relevant role players or the relevant staff that is there. And at times you'd be shocked to hear the budget that you'd find there. And we said, "Who came up with this budget, we were never consulted?" and "How can they budget for this?" …Because these are things that we work with every day and we know the challenges and we know where the loopholes are and we'd like to actually make an input but we are never consulted." (District manager)

Lastly, concerns were raised about the proliferation of coordination structures, a number of which were not really functioning (see below). People argued that they had become an end in themselves, so that their role and usefulness was unclear:

"You know at times there's a directive from the national government, they say this has to be done, and people put structures in place, not even giving the people the latitude to understand what are they doing. And people are just driven by putting structures in place. And not having had the latitude to say after we've actually put these structures in place, what then?" (District manager)

Another informant argued that there was no *"coordination of the coordination"*, and that the linkages between the existing structures needed to be defined:

"For example, there is the National Aids Council, there is the Social Cluster….There are various national and provincial departments, there are provincial IDCs, there are provincial AIDS councils, there are district AIDS Councils, there are local AIDS Councils. So there is a huge number of structures, but there is to my knowledge, no functional relationship between SANAC and the provincial AIDS councils. And no functional relationship between the IDC and the Social Cluster. And no functional relationship between the IDC and SANAC. And no functional relationship between national IDCs and provincial IDCs." (National official)

Table 5.1: Coordination problems related to specific categories of coordination

Category of Coordination		Coordination Problems
Inter-governmental	National – Provincial	▪ Poor communication ▪ Inadequate consultation ▪ Difficulties with national staff at provincial level
	National – Local	▪ Inadequacy of SALGA representation
	Provincial – Local	▪ Uncertain roles ▪ Poor communication ▪ Lack of formal coordination mechanisms
Inter-departmental		▪ Junior departmental representatives on IDC
Inter-sectoral		▪ SANAC not working well ▪ PACs still weak ▪ Poor progress with establishment of DACs
Inter-municipal		▪ Mostly informal connections
Intra-departmental		▪ Limited integration ▪ HIV/AIDS seen as HIV issue

5.3.3.2 National – Provincial Coordination

The only specific problems raised with regard to national-provincial coordination related to the national staff that had been seconded to provincial HIV directorates. The dual responsibilities to the national and provincial level created management as well as logistical problems:

> *"If they don't want to do something they say; 'you're not the boss of me, I get paid by national , you can't tell me what I should be doing'" (Provincial HIV director)*

> *"There were lots of practical problems. Like if you were to go for a meeting, you need to book a car, you need to phone to Pretoria, Pretoria needs to organise a car for you to drop it off, and you know all this nonsense" (National official)*

This arrangement is being changed and provinces have to incorporate these officials onto their provincial organograms.

5.3.3.3 National – Local Coordination

At present, the formal interaction between the national and local spheres is limited to the SALGA representatives on MinMEC and the PHRC. Most local government respondents were unhappy with their distance from the NDoH and being represented by SALGA:

> *"I never see national ever, ever. We used to have a structure where, many years ago, we used to meet regularly with national and heads of major local government areas. That was stopped. We then tried to re-establish it for the major urban areas and that was stopped. And then we were told that they would only deal with three people from SALGA, which is the South African Local Government Association. I think that relationship really, because it's so narrow, only impacts on the councils where those three people come from….but it's not easy for the rest of us to benefit from that relationship. ….It is inadequate representation, really"*

> *"And when you're talking local government, of course, there are three of four people representing eight hundred municipalities all with totally different situations and political leadership. It's really a difficult representation."*

A national official also commented on the limitations for national policymaking when they are so removed from reality on the ground:

> *"For me integration also - the fact that, from the national level, we don't have any formal link with the district level. There's nothing that brings us there. … I do think that you can't really draw up plans and strategies and policies unless you have a good understanding of the issues. I was reminded of this again two weeks ago when I went to the Eastern Cape in the Bizana area. Now we always talk about transport being an issue in HIV/AIDS service provision but you sit in your city with your cars and your taxis and everything, and your buses and what-have-you. And I think that we sometimes forget exactly what that means. Now going to this community and driving for an hour and forty-five minutes on a really, really bad, bumpy dirt road, up and down hills, and mountains and valleys… to finally get to this community where there is no water, there's no electricity, there's no infrastructure, there's no clinic, there's nothing. And then realising again, what it means to say that we need integrated planning, because if you become ill, with anything, it doesn't even have to be HIV/AIDS, how do you get to a service that can address that for you if there are no taxis, there is no regular infrastructure for you to be able to access anything?"*

5.3.3.4 Provincial – Local Government Coordination

The key problem in relations with local government is the uncertainty regarding district health system (DHS) development. As one provincial HIV director said:

> *"I think the key challenge is the implementation of the district health system. Once the district health system can be in place, I think most of the things will fall into place. Right now, we interact with local government in a haphazard manner."*

A local government interviewee expressed concern that the impasse was not going to be resolved while interactions were limited to lower level officials:

> *"The level at which we interact with province is sometimes the problem. I think sometimes we are interacting at the lower level and those relationships are characterised sometimes by competition, by fear….people are insecure about their jobs and their roles, there's a lot of insecurity….No official has ever transformed an organisation in such a way that they lose their own job. And to put transformation at the level of people who have their own vested interests, it's always going to be a problem….I would prefer to see it done at a higher level…I think they would be more objective and they would be more rational."*

Many respondents agreed that there was a need to develop more formal mechanisms of coordination between provincial and local government health departments:

> *"So, I think then also we - I'm trying to find the right words - lack of sort of formal platforms or anything between province and local level - that for me is an issue. Because how do you ensure that this integration takes place if you don't have any sort of formal mechanism to actually address these issues?" (National official)*

> *"Well in fact, in general there are absolutely no structures, then clearly there's no management taking place of the process; because you can't manage health services between province and local government if there is no structure which links province and local government to the high level." (Local Government official)*

5.3.3.5 Inter-Sectoral and Inter-Departmental Coordination

Weaknesses were noted in relation to the actual functioning of the new coordination structures, particularly SANAC, the PACs and the IDCs. As one provincial interviewee said:

> *"Provincial Aids Council don't know what they are doing. You find that we've got the Premier, apparently at times he hardly knows why he is there and what is the structure for."*

Another respondent argued that the problem was due to difficulties in the political-administrative interface:

> *"Our [Provincial] AIDS council, at the moment, it's not fully functioning, because one of its weaknesses is that I think, what also national has found, is that its secretariat is within health here …Which is too much a job to be responsible for that as well. They should be having their own secretariat to drive that process. Because we, as officials, we cant be driving the politicians because that's made up of MEC's and everybody." (Provincial HIV director)*

However, other people thought that more structures would overcome the problems:

> *"The province has been very slow in setting up District AIDS councils. And I suppose in some ways you can understand it because people are, people think; 'Ag, one more body that does nothing.' But I see that as a specific problem" (National official)*

The major weakness in relation to IDCs has been getting senior administrators to participate so that most government departments are represented by junior officials with limited decision-making authority.

5.3.3.6 Intra-Departmental Coordination

As discussed in Section 5.2.3.2 , part of the problem is that other units and divisions do not see HIV/AIDS as their responsibility:

> *"We still have this sort of attitude where HIV/AIDS is the problem of the HIV/AIDS unit, it's not my issue. If you're sitting in oral health, HIV/AIDS is not my problem." (National official)*

However, other interviewees saw it more as a breakdown in coordination; that different groups were furiously doing their own thing, in silos or in parallel, without coordinating with each other:

> *"Well, let's just say, let's look at….one of the issues that for us in HIV/AIDS is quite crucial is that we're saying that we need to have a human resource plan that can address HIV/AIDS. Because people are leaving the system, people are getting ill. So there's that attrition rate. And you're not – new people are not just going to fall out of the air, they are not just going to pop up suddenly, and we're seeing that enrolment at Nursing Colleges etc, is coming down. So you need a strategy that can deal with it because the reality is that there are health care workers that are infected, and are going to die some day. But the HR unit does its own thing and HIV/AIDS does its own thing. So that integrated planning is still lacking both at the national and certainly at the provincial level. I think we're still working in silos" (National official)*

> *"Mostly I think what hinders progress is the parallelism - finding that one department are doing something on their own which has been structured, which is the brainchild of that particular department. The other department is doing something else and there might be a bit of overlap… there are some conflicts or disputes which result and, I mean, it's parallelism. Because everyone is concerned about the challenge of HIV/AIDS and everyone tries at all cost to do something." (Provincial official).*

As a separate issue, another informant commented that coordination problems were not necessarily solved by having large national meetings with all the stakeholders:

> *"They become so boring and mundane, you know, it deals with all these boring issues... the bigger the platform the worse it gets" (National official)*

5.4 Informal Dynamics

This last section highlights briefly the importance of informal processes in the organisation of HIV services.

A number of interviewees noted that informal mechanisms were also important in coordination:

> *"Sometimes it works far better to bypass channels and to phone a person directly and ask them for assistance. That is a very effective manner, although its not always the correct way, but we do get things done in that manner, ja." (District manager).*

"Well, I mean, those are actually not structures, which are formally there, and even the meetings might not be contracted formally. But I mean we do have some consultations, which are informally time and again." (Provincial official)

This seems particularly true of relations with the local sphere although local government respondents did not necessarily see this as ideal:

"So… there is no formal contact, okay? If we say informally, my informal dealings, and I think the politicians' informal dealings with the Minister and the Superintendent General, when we meet informally, yes, we have good relationships and they tend to be supportive, informally. So on that level, yes, it's reasonably okay. However, those people are inaccessible. So one might bump into them by accident, occasionally. There is no way in which you can actually officially and formally meet them, it is not possible. So it is sort of accidentally that we bump into each other at various events and then one has an opportunity to talk to them, and then, yes, you get quite positive results from them. But it's all very ad hoc and informal and casual." (Local Government official)

"So informally, in truth, I'm contacted at local [council] level. I do have contact with the other local authority health services in the area, but that isn't co-ordinated really through the district council structure. It's just something that has come about through historical connections." (Local Government official)

Another respondent argued that a balance between formal and informal processes is important for programme flexibility and local problem-solving:

"We brainstorm ideas together, I mean, we sit around as a group. It's slightly informal, it's not a highly structured group that we have. I find some of the new structures, like the provincial AIDS council meetings a little bit overly bureaucratic, personally. Ours is very informal….We do have a strategy which is being followed quite closely … it's quite detailed, plans with times and with budgets. But we throw in new ideas all the time, and what we find is to bring people together from these very diverse backgrounds, we kind of cross-fertilise in an amazing way, and come up with quite innovative and different schemes. There's a lot happening here in AIDS." (Local Government official)

A few people commented on aspects of the public sector's organisational culture and its influence on HIV programme functioning and coordination:

"The other really, really slowing-down factor I would just ascribe to bureaucracy. What I'm referring to is the pains it takes to get the smallest thing sorted out.…[All the] control systems are ineffective and just slowing down delivery, they impact on all of us and all our programmes. When I work with other government departments, to get a meeting together of government officials somewhere, where you need to do anything that requires travel and overnight stay, it's difficult, because the Department of Health is not allowed to pay for officials' travel and accommodation in other departments." (National official)

"Its not just easy to say that you are just going to change the organogram and put people in. I think the government structure is also causing some problems in this bureaucracy" (Provincial HIV director)

"Well in the Health Department, being a doctor is the be all and end all of everything." (National official)

Lastly, one respondent related mistrust to the tendency to try and control rather than support partners in the HIV programme:

> *"This is why I'm quite sensitive about the issue of support versus control. When one works with the NGOs, there's a lot of sensitivity to get over and a lot of mistrust of government structures. And one of the areas of mistrust is that government will try and control their activities and that we will say, this is what we want you to do, this is what we don't want you to do, this is what you can do, this is what you can't do." (Local Government official)*

5.5 Conclusions

The national, provincial and local informants interviewed in Phase 1 provided additional information on the actual functioning and coordination of HIV/AIDS services. The interviews highlighted the complex array of actors involved in HIV service provision and the difficulties this presented for the allocation of role and responsibilities as well as coordination.

There was reasonable agreement between actors about the roles of the different spheres in relation to HIV service provision although the specified roles were often fairly vague and generic. Decentralisation has been limited to some shifting of responsibility from national to the PDoH, albeit within fairly controlled parameters. There was still significant disagreement about the role of local government as well as how much the national and provincial levels should be involved in implementation.

Coordination and integration is being addressed within the HIV/AIDS programme although the focus has mainly been on national-provincial, inter-departmental and inter-sectoral coordination. Political structures and internal meetings are the most important mechanisms of coordination within HIV/AIDS at present. Improving internal horizontal coordination and the establishment of formal structures to coordinate between provincial and local governments were identified as key priorities for HIV coordination. Lastly, the informants identified the importance of informal processes and dynamics in governmental coordination and functioning.

Many of these themes are explored further in the next three chapters which focus on the results of the three case studies.

CHAPTER 6: EASTERN CAPE CASE STUDY

6.1 Background

This chapter is an attempt to describe and analyse the health system in the Eastern Cape, particularly the part of the system concerned with the delivery of HIV/AIDS services, through the lenses of coordination and integration. The relevance of this attempt to come to grips with the functioning of the system is perhaps underscored by the fact that an interim management team was deployed in the province to improve the performance of the departments of education, roads and public works, social development and health (Eastern Cape Government, 2003a). The interim management team submitted its first substantive report to the premier and the province's executive council in April 2003 and at the time it expressed its concern about, among other things, leadership and management in the relevant departments (Eastern Cape Government, 2003a; Eastern Cape Government, 2003b). Human resource management was identified as a second challenge with, for example, 34% of the positions in the department of health being vacant. It was said that the turnaround plan for health would focus on improving the management of health services, improving targeted health services in the eastern region and improving back-office support to health institutions (Eastern Cape Government, 2003b).

The activities of the department of health in the Eastern Cape are grouped into eight programmes, with district health services and provincial hospital services constituting the core. This case study is based largely on information obtained in interviews with officials from the provincial HIV/AIDS directorate, officials based at the level of the provincial health sub-districts, personnel at the facility level and officials from the Alfred Nzo district municipality. This is a rural local government structure and one of six district municipalities in the province (Hall, 2002). The Alfred Nzo district municipality is situated in the north-east of the province and as such it forms part of the eastern side of the province, which is, for reasons that have to do with the geography of apartheid, regarded as generally having less resources than the western side of the province (Hall, 2002). It is also in the unusual position of having one part of its territory completely surrounded by territory belonging to the province of KwaZulu-Natal and there seems to be some complaints around patients from the Eastern Cape using facilities in KwaZulu-Natal and vice versa.

While it is important not to lose sight of the more local contextual factors, an understanding of the coordination and integration of health services also requires attention to larger structural factors and processes. In this case the plans for a district health system and the local government transition process of the recent past seem to be of particular relevance. The department of health in the Eastern Cape has demonstrated its commitment to the idea of a district health system and at a meeting in December 2001 it was decided, among other things, that services would be devolved to metropolitan and district municipalities (Hall, 2002). More recently, *"equitable access to a comprehensive, integrated health service in a district health system for all communities in the province"* was identified as one of the main focus areas for the 2003/4 financial year (Goqwana, 2003). As will be shown more concretely below, the idea of the district health system has shaped the design of the system and the interaction between different spheres of government. It is here that the reorganisation of local government also needs to be borne in mind, particularly its interim status in the period from 1994 to 2000 and disparate resources and levels of experience between local governments.

The first section of this chapter is devoted to a discussion of the roles and responsibilities of those concerned with the delivery of HIV/AIDS services. The idea is not only to identify roles and responsibilities, but also to begin to describe how different people in and parts of the system are connected. With the identified roles, responsibilities and inter-linkages in the system more or less described, the second section will focus more explicitly and in greater detail on integration and coordination. The third section will briefly pick up on the issue of informal relationships and dynamics.

6.2 Roles and Responsibilities

Like some of the earliest computers that had to be manually wired for the desired tasks to be performed, the "programming" or management of health services, or even the subset of HIV/AIDS services, in the Eastern Cape is not an entirely straightforward matter. It is clear that there are myriad criss-crossing wires or roles and responsibilities that serve to connect people in the system and that these are intimately linked to certain enabling or disabling actions and conditions. The complex nature of the system is, in itself, neither surprising nor unique. Although writing within a different context, Hay (2002) seems to hit the nail on the head when he points out that the state is made up of multiple agencies and institutions that enjoy some freedom of action and thought from a centre, with many of these institutions being complex and differentiated systems themselves. Nevertheless, this complexity remains relevant, both as a challenge in terms of understanding and portraying the system and as something to bear in mind when thinking through and critically assessing the integration of and coordination between different parts of the system. As a first step in getting to grips with the system and understanding the full richness of its interrelationships, it is necessary to understand the roles and responsibilities of the various relevant stakeholders. For the purposes of this case study, no interviews were conducted with officials who are based at the national department of health, which means that the description of this level's roles and responsibilities was drawn from the accounts of a range of other officials.

6.2.1 National Level

The national department of health seems, firstly, to have a big hand in the setting of parameters for or the steering of other role players in the health system. Examples of this range from the drawing up of a framework with criteria for the selection of voluntary counselling and testing (VCT) sites and the provision of home-based care manuals to the training of master trainers in the field of home-based care. While perhaps not written down as an explicit set of criteria or a list of prescriptions, the national department of health's role of kick-starting programmes and handing over some of the responsibilities to other spheres, may also serve as a mechanism for, perhaps in some ways less explicitly, charting and maintaining a certain course. An official based at the provincial head office in Bisho explained, for example, that the VCT programme had begun as a nationally driven process, but that it was now being run by the provincial department of health, the difference being that they had moved past the piloting into an expansion phase. One could perhaps argue that parameters were created and that they are likely to be sustained to some degree in the sense that the programme as a whole was kick-started in a certain way, imbued with a certain logic, put on a certain trajectory.

Secondly, the national department of health plays what may perhaps be referred to as a support role. While the frameworks, manuals and training mentioned above in all likelihood represent attempts at coordination, these measures could perhaps simultaneously be understood as providing some degree of support to their recipients or users through, for

example, the transmission of knowledge or the reduction of uncertainty. In addition, the national department also gets involved in things such as programmatic workshops on VCT, sexually transmitted infections (STI's) and the prevention of mother-to-child-transmission (PMTCT) of HIV/AIDS. It seems quite clear, therefore, that support is often provided through quite standardised and collective measures, but what is less clear is the place and weight in the system of more flexible, context-bound problem solving.

There is some evidence of the usefulness of certain meetings called by the national department of health, particularly in the sense that officials based in the provincial department are able to get some help there, although this may come from provincial counterparts. In addition, the national department seems to call ad-hoc meetings to discuss specific problems and it is also possible to call national officials to discuss problems. On the other hand, there are also those who associate their meetings with the national department with reporting back, as opposed to sitting down and solving problems. A senior official in the provincial department expressed her misgivings about the support being received from the national department in the following way:

> *"National has been coming down here to support us as a province, in terms of our planning and strategies and whatever. But some of us are a little bit despondent about that, because we're saying: it's easy for you to come in and say [name of official] do A, B, C, and D and then… you come back …and you say how far are you? My feeling is, until we all dirty our hands in this province, national comes down and works with us side by side, because sometimes I have a feeling that people do not really understand what we are faced with as a province. They think that things can just work as smoothly as anywhere else in the country and yet the Eastern Cape provinces are different, because it's a different province altogether."*

Lastly, the responsibilities of the national department of health include financial allocations or disbursements to the provincial government level, among others. In the Eastern Cape, for example, the provincial department of health has received money from the national sphere for the reproduction of training manuals that are used in the VCT programme. In this case, the money was made available by means of a conditional grant, which seems to have certain roles and responsibilities attached to it, such as drawing up a business plan, liaising with the treasury in order to access the funds and submitting regular reports. Furthermore, the national department is also funding some NGOs in the Eastern Cape. This funding seems to be directed towards more developed or established NGOs.

The national department of health's roles and responsibilities appear to bring it in direct contact mostly with the officials situated within the HIV/AIDS directorate in Bisho. Some of these linkages were described above, but this picture would not be complete without a reference to the group of officials employed by the national department and based at the provincial level, whose roles and responsibilities seem to relate to both coordination and to taking forward programmes. The officials in the provincial HIV/AIDS directorate seem to be more centrally located in the sense of actively managing relationships with the national sphere of government, their own sub-district offices, and local government.

6.2.2 Provincial Level

The roles and responsibilities of the provincial HIV/AIDS directorate mirror those of the national department of health in significant ways. These commonalities are undoubtedly pertinent, but it is also at this point that the more local arrangements and idiosyncrasies that impact on coordination and integration will come into clearer view.

Before discussing in greater detail the roles and responsibilities of the provincial department of health and other role players it is necessary, in order to avoid confusion, to state more explicitly what labels will be used and what these will refer to. This is necessary, partly because the terminology of the people who work in the system is not always consistent. As has already been stated, there is a provincial HIV/AIDS directorate based in Bisho. Secondly, there are what officials in the HIV/AIDS directorate refer to as the Umzimvubu and Umzimkulu districts, local service areas or sub-districts. Here one finds provincially employed officials such as district managers and communicable disease coordinators. It seems as if officials sometimes refer to the Umzimvubu and Umzimkulu sub-districts because when combined, they cover the same geographical area as the Alfred Nzo district municipality, a local government level at which the provincial department of health has no structure. These provincial entities will here be referred to as sub-districts. Some of those based at this level seem to share this language to the extent that they refer to their own level as the district or local health service area. In this case the term sub-district is apparently reserved for further sub-divisions such as Mount Ayliff, Mount Frere and Maluti in the case of Umzimvubu. Here, these further sub-divisions will be referred to here as areas.

The discussion of the roles and responsibilities of the national department of health was kicked off with the argument about it setting parameters for or steering other role-players, but it is not clear to what extent the provincial department plays a similar role in its own distinctive way (Figure 6.1 below provides an organogram of the provincial HIV/AIDS directorate). With regard to the criteria for VCT sites originally mentioned there was a sense of translating it into something that would be suitable for the province. A few things were added, but these appear to be quite minor: the province, for example, had to be specific about the number of people to be trained on counselling and testing, while the other guidelines just specified that people had to be trained. A similar argument could perhaps also be made with regard to the reproduction of training manuals alluded to earlier. The hand of the provincial department is, therefore, not always that visible.

Like its national counterpart, the provincial department of health has roles and responsibilities in relation to funding and as is the case on the central level, these responsibilities extend to both NGOs and other governance levels within the health system. In the case of the sub-districts, which fall under the provincial domain, most of the HIV/AIDS programmes are reportedly funded through the departmental head office in Bisho. Interestingly, money is also flowing to district municipalities. This is the case in the VCT programme, where local governments are being given money for training. There is also an attempt to work with NGOs through district municipalities by giving these municipalities monitoring responsibility. The provincial department has designed a format for a bi-monthly financial report from the district municipality to account for funds that have been transferred, which involves the local government's main health manager, the municipal manager and a finance officer. From one provincial perspective, this relationship with local government was judged to be working well, but a local government representative pointed to a problem with the funds arriving very late in the financial year, which makes it very difficult to spend the money properly. The roles and responsibilities with regard to NGOs also seem problematic in another sense. One provincially based official said that *"we found that we have not decentralised as such, in terms of our coordination with the NGOs",* meaning that NGOs will at some times coordinate directly with this official or a colleague. The HIV/AIDS directorate funds about thirty NGOs, whose involvement range from home-based care and peer education to STI's. Tertiary institutions that assist with training and Aids Training and Information Centres (ATICs) also receive funding.

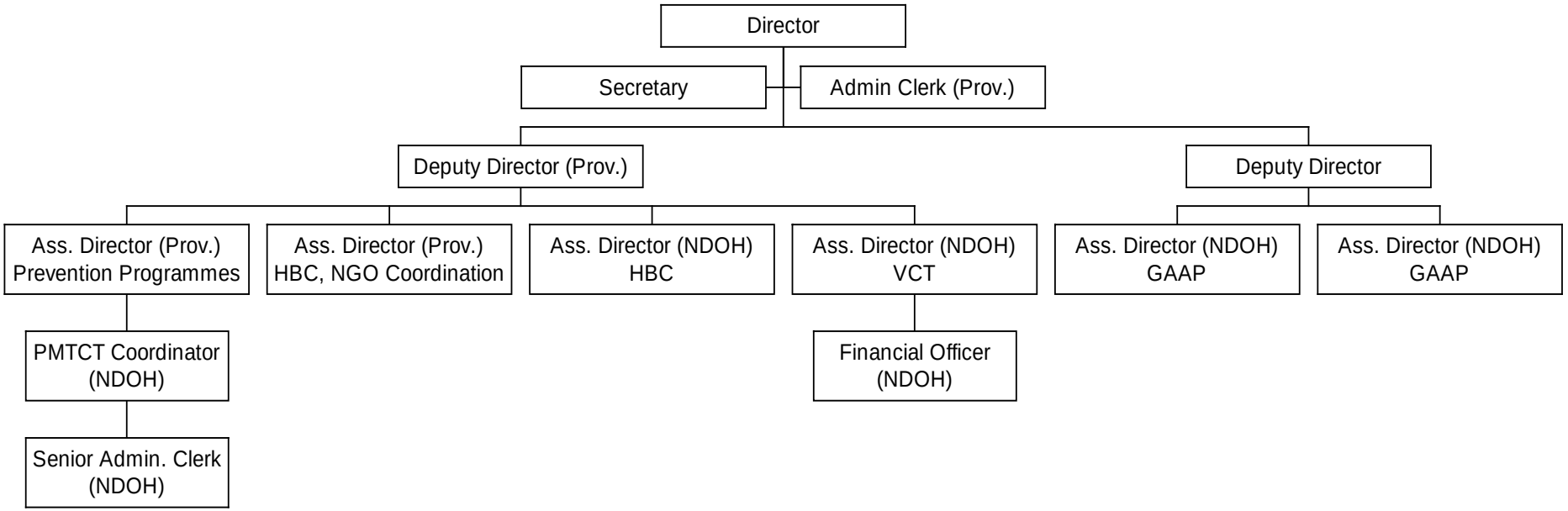


Figure 6.1: Organogram of the HIV/AIDS Directorate

Apparently, provincial officials are not equally comfortable with all the dimensions of their financial roles and responsibilities. One official expressed a lack of capacity and knowledge with regard to things such as budgets and tender processes and attributed it to a combination of a real lack of capacity and insufficient induction into the workings of the system. Another expressed a problem around budget management and reporting and articulated the need for more people to fulfil this function. Someone was pressed on the issue of the treasury being too strict and inflexible, but did not respond in a way that indicated major tensions.

Officials from the provincial head office in Bisho also see themselves as playing a support role. One of the more senior officials perhaps provided the fullest expression of this idea within the context of a discussion about top-heavy organisational structures:

> *"Because these people (at the service delivery level) should tell you what they need. You provide them with their needs. That's how the whole thing came up, that is how we felt as a province, that these people should be telling you that we on the ground, these are the problems, this is what we want to do. So they feed on us and then we support them. So we should be providing that support, rather than being at head office and only giving out orders down on the ground to say this is what should be happening."*

The funding of certain activities could be viewed as one element of this support role, but it is certainly not limited to this. The development of a fuller picture requires, for example, activities such as workshops and training to be worked into the equation as well.

At the level of the provincial HIV/AIDS directorate, officials' roles and responsibilities seem to be defined in terms of the coordination of training, for example on home-based care or voluntary counselling and testing, with the actual trainers mostly being based at other levels. This role brings them into contact with trainers working at the sub-district level, both government and NGO employees. As has already been stated, training-related support also flows to local government, tertiary institutions and ATICs. In addition to programme-specific training, there is also a mention of sub-district officials being supported through management leadership courses, which suggests more general training that goes beyond the requirements of any specific programme. While training can, of course, take place in the workshop setting, workshops are also used to other ends such as informing people about certain programmes, communicating to them what is expected of them, telling them about ways of working with the provincial head office, providing them with a space for reporting back and sharing their experiences, and bringing together officials from the sub-districts and local government.

The provincial head office's support role also extends to volunteers and it seems, for example, as if they are being advised and helped to register as community-based organisations so that they can obtain access to funds outside the department of health. In some situations the support role involves a certain degree of very practical, day-to-day problem solving or management. Within the VCT programme, provincial officials are acting as intermediaries between sites and the Port Elizabeth depot, because the sites haven't yet been given the necessary codes that will allow them to order supplies and access funds for payment.

Perhaps the most bottom-up of all the provincial support initiatives is the one involving the teams of so-called Champions. The task of these teams, led by officials with the rank of director or higher, is to visit local areas, to listen to people's needs rather than to inspect, to champion the bottom's needs. One official explained:

> *"So we have formed those teams, that when they have problems they know that at least they have someone that they can relate to in Bisho. Maybe they sent some*

documents, there's something they want, but they cannot get it. Then they call you and say look we've sent these but we are not getting any reply, can you trace it for us?"

These teams seem to have the potential to disrupt normal lines of communication and it is not known whether they have been successful or not.

The provision of appropriate and adequate support is arguably a key role or responsibility, and so is the exercising of the monitoring and evaluation function. It is clear that the provincial department of health in the Eastern Cape is embedded in a web of accountability relationships. In the case of the bi-monthly financial report discussed above, the primary line of reporting seems to run from the district municipality to the head office of the provincial department of health, but it is not possible to separate this from the functions performed by the municipality or to divorce it from the provincial official's concern to report to his/her supervisors. Reference was also made above to the report back element of meetings between the national and provincial departments, which points to yet another dimension of accountability. Sometimes the line of accountability stretches quite explicitly from the service delivery level to the national department of health. This seems to be the case with the nationally appointed monitoring officers who will reportedly be visiting nationally funded NGOs and also with the VCT programme where an official based at the provincial level gathers information from sites on the number of test kits used, people tested and support groups established for reporting in a specified format to both the provincial and national departments. Political representatives' monitoring and evaluation of administrative functionaries should also not be forgotten. In the Eastern Cape there is a portfolio committee on health where officials present their strategies and according to one official this committee shows great interest in the HIV/AIDS programme. The political representatives who sit on this committee are of course supposed to be accountable, among others, to the communities that elected them to office. While by no means a complete map of all accountability relationships, the above examples illustrate that many people play the role and have the responsibility of being the person reported to, while simultaneously reporting to another part of the system. It also provides a glimpse of the hierarchies operating in the province and this is relevant because hierarchy seems to have a material impact on the ability of various parts of the system to coordinate and integrate their activities.

6.2.3 District and Sub-District Level

While the existence of a relationship between the provincial HIV/AIDS directorate and the sub-districts has already been alluded to, it is arguably more accurate to say that for many of the officials based at the head office, the sub-districts are quite important coordinates on the map of the bigger health hierarchy. Some, for example, identify ensuring the implementation of policies at the level of the sub-district as a responsibility. It is also clear that there are a number of contact points between the provincial HIV/AIDS directorate and the sub-districts, for example through interaction around planning processes, through so-called cluster meetings (the scope of which extend beyond HIV/AIDS) and through meetings with programme managers at the sub-district level. Like the other levels of the health system that have already been discussed, the sub-districts shoulder some of the responsibility for things such as training and financial matters. From the point of view of trying to understand coordination and integration, it may be most productive and interesting to use two actors – the district manager and the communicable disease coordinator – as the entry points into this sphere of the health system.

At the level of the provincial HIV/AIDS directorate, there seems to be quite a significant degree of consensus among officials with regard to the challenges faced by the communicable disease coordinators and suggestions for the alternative allocation of roles

and responsibilities. The communicable disease coordinators are typically described as having their hands full or as being overloaded and this is because their responsibilities extend beyond HIV/AIDS to TB and other communicable diseases. The preferred option is to have a separate official at the sub-district level responsible for HIV/AIDS and it seems as though work is being done to put this proposal into practice, with some actually stating that this strategy has already been approved. The current allocation of roles and responsibilities to the communicable disease coordinators dates back to the time when one official based at the provincial head office managed TB and HIV/AIDS. This managerial role has subsequently been split in two, without the same change being effected at the level of the sub-district.

The image of the communicable disease coordinator as quite an overburdened official juggling an array of roles and responsibilities seems, then, to be essentially uncontested. If one were to simply enumerate the practical roles and responsibilities of these officials the list would include, among other things, visits to facilities, assisting with the preparations for HIV/AIDS awareness days, reporting back to the provincial HIV/AIDS directorate about expenditure on these awareness days and working with NGOs. Also quite interesting is their interaction with local government and other government departments. One communicable disease coordinator, for example, reported meetings with traditional leaders and councillors, while another discussed a structure called the Inter-departmental HIV/AIDS Committee (IDHAC), which brings together various government departments and NGOs at the local level, as well as meeting with the Alfred Nzo district municipality in preparation for an Aids day. The responsibilities of the IDHAC seem to revolve around the running of workshops to create more awareness and the monitoring of health provider training with regard to counselling. There is a suggestion that the district council representatives have not been playing their part in the IDHAC. The communicable disease coordinators' interaction with NGOs and other governmental entities highlights the fact that they not only juggle multiple responsibilities with regard to vertical programmes within the department of health, but that they, like other officials, serve very much as entry points to or the public faces of the department of health. In thinking about their linking role, the context of functional integration between provincial and local government, already alluded to above, should not be forgotten because the communicable disease coordinators apparently also have a role to play in this scenario. According to Hall et al. (2002), a circular issued at the end of 2001 requested the province's health managers at the sub-district level to report to district municipal managers in order to begin the process of functional integration. This, however, led to confusion, with people finding themselves accountable to two authorities.

In response to a question about how the provincial HIV/AIDS directorate's relationship with the district municipality around home-based care fitted in with the directorate's link to the communicable disease coordinators, one official from the provincial head office explained that they had originally worked with the provincial health sub-districts. With the advent of the district municipality, however, came the understanding that the provincial structures needed to report to a bigger forum, the district municipality. It seems as if the district managers, who head up the sub-districts, also have to be thrown into the functional integration mix, because there is some evidence of meetings with officials from the district municipality and of district managers reporting to the health managers at district municipality level. It seems as though this integration is not working equally well in all areas, with the problems including a lack of regular meetings and confusion around communication. In addition, the relative newness of district municipalities seems to be a factor, and it seems as though there is also the possibility of officials at the level of the provincial health sub-district finding themselves in the awkward position of, as it were, serving two masters. An official from the provincial HIV/AIDS directorate explained:

"So what happens, was that those people who have been working with, that are supposed to be coordinating with the Alfred Nzo, but you should know that it's still a process, it's not easy because we found that even Alfred Nzo is still starting. So you'll find that sometimes we'll be coordinating with some of the health districts, but at the same time the Alfred Nzo should know what is happening, until there are fully fledged and functional, then those functions can be devolved to them."

The picture painted here does not appear to be radically different from the one presented in the research referred to in the previous paragraph.

6.2.4 Local Level

Local government's place in the system has thus far only been discussed intermittently and a fuller description of it requires, among other things, references to both perceptions around the implementation of the district health system and local government transition in South Africa. In a certain sense, the interaction thus far around the development of a district health system casts the district municipality in the role of the aspiring health service provider. A district municipality official, for example, reported a meeting where the province communicated the message that primary health care would be devolved to local government, but according to this official changing management at the provincial level has also delayed this process. At the time the interviews were conducted, the feeling was very much that the devolution of primary health care was going to happen, but in phases. The district municipality also expressed its readiness to take on this responsibility, provided that the necessary staff and money would be forthcoming. Judging by the assertion of an interviewee from the district municipality that they're *"supposed to have an intensive programme for VCT",* there is space and the intention to move into service delivery independently of the devolution of health responsibilities. All this perhaps sheds more light on the attempts at functional integration discussed above and as will be demonstrated shortly, it has also impacted upon the district municipality's budgetary processes. As is the case with the plans for a district health system, the local government transition also appears to be directly linked to both financial matters and the current allocation of roles and responsibilities. The district municipality's activities used to be organised in three sections - human resources and administration, planning and engineering, and finance – with issues of poverty and social development being dealt with by the human resources section. More recently, though, a new directorate for social development was created and this structure's focus now includes health, poverty, public safety and community development. The appointment of directors of social services and development by district municipalities in the Eastern Cape is also picked up on in the work of Hall et al. (2002). Questions remain, though, about capacity and experience at this level. When asked about the availability of officials to provide support, one interviewee mentioned an administrative officer, a secretary, a committee clerk, and the fact that a post for a community officer had just been advertised.

For the district municipality the demarcation of local government boundaries has led to a reduced budget. The exact scope of this was not provided, but the revenue base appears to have shrunk to between 40% and 60% of its former size. In addition, a local government official said that they had refrained from drawing up a holistic health budget because of the uncertainty about that function. They opted for an HIV/AIDS budget instead, because it is a cross-cutting issue and it doesn't require them to wait for the province. Financial responsibility is something that local government shares with other spheres, but this is not the only similarity. Like other actors in the health system, the district municipality has a hand in training and awareness activities, with the latter sometimes apparently involving the transfer of funds to the sub-district for events such as the lighting of candles. Like the provincial department of health, the local government has horizontal relationships with some of its peers. It also mirrors other parts of the health system in that its operations are shaped

by vertical accountability relationships. One accountability relationship between the district municipality and the provincial HIV/AIDS directorate has already been touched on, but this could of course be supplemented with reference to the accountability relationships within the administrative structures of local government and between the administrative functionaries and the standing committee on health. It seems that the district municipality would like to see some changes in the arrangements concerning NGOs, especially in the sense of being more involved in the selection and approval processes for emerging NGOs from the area.

6.2.5 Facility Level

The provision of services such as VCT and PMTCT is perhaps the most obvious place to start a discussion of the roles and responsibilities of facilities. A first thing to note in this regard is that service delivery seems to be quite patchy. Towards the end of 2002, for example, the province had just over a hundred operational VCT sites. The MEC's health policy speech for the 2003/4 financial year, delivered in March 2003, shows that voluntary counselling and rapid testing has been expanded from 37 to 141 medical sites and 4 non-medical sites (Goqwana, 2003). Perhaps both these figures should be viewed against the backdrop of the total resources of the province, which include 92 hospitals, 28 community health centres and 711 clinics. The argument about the limited nature of VCT services is also supported by more anecdotal evidence. One official from the area level, for instance, sketched a scenario wherein only a limited number of clinics were able to take blood for HIV testing because of the unavailability of transport with which to send the blood to the hospital. In the case of the clinics taking blood, nurses on their way home delivered it after work, with the test results being collected in the same way. The argument around patchy service provision could, it seems, also be plausibly extended to PMTCT. With regard to the PMTCT programme, two research sites got underway in August 2001 and at the time of the delivery of the MEC's health policy speech the programme was available in 12 hospitals and 76 clinics in the six district municipalities (Goqwana, 2003). Task teams at the provincial, district and facility levels, which involve diverse stakeholders, are involved in the implementation of PMTCT.

Facilities obviously do not exist in a social and organisational vacuum and while their roles and responsibilities around the delivery of services such as VCT and PMTCT put them in contact with patients, their networks are much wider. Firstly, they link up with some elements of the wider community, for example in providing training to volunteers and coordinating their activities. At least one facility reported attempts to interact with learners in school and in this case it seems as though communication between the facility personnel and teachers are informally structured around the latter's collection of condoms. Some facilities report interaction with tribal authorities and local government, while the message from others is that local politicians are not involved in HIV/AIDS services.

Secondly, there are relationships between facilities, but this will be dealt with in greater depth in the following section on coordination. Thirdly, there seems to be a fair amount of interaction between facilities and the sub-district, especially the communicable disease coordinator. Some facility-based personnel report taking part in meetings with the communicable disease coordinator, being visited by the communicable disease coordinator, discussing matters such as awareness events with the communicable disease coordinator or attending HIV related workshops that the sub-districts involve them in. It is not always easy to gauge the quality of facilities' relationships with the sub-districts. When asked about this, one person working in a facility responded as follows: *"They are free. They just talk and we communicate with them when there's a problem."* While quite nebulous, this statement nevertheless implies quite a good relationship. This same person, however, later claimed to be receiving *"not that much"* support from the sub-district, except with regard to certain

workshops. The issue around the amount and quality of support received from the sub-district surfaced in more than one interview. Another interviewee, for example, reported receiving no support from the sub-district with regard to debriefing and the training of volunteers.

In the fourth instance, facilities can also connect directly with the provincial HIV/AIDS directorate. An example of this would be the submission of VCT statistics to both the communicable disease coordinator and Bisho. Sometimes people working in facilities are critical of the role of the provincial department, as is evidenced by the statement that VCT guidelines had been imposed. Lastly, there is some evidence of facility-based personnel coming into contact with officials from other government departments, especially with regard to the accessing of grants by members of the public.

6.2.6 Conclusions

Given all the above, it seems justified to think of the system around the provision of HIV/AIDS services as a complex one made up of many different actors and inter-linkages. As far as problems and things to look out for are concerned, there seems to be a need to think and act on different levels. Firstly, there are what could perhaps be described as performance problems where roles are played and responsibilities discharged in a way that is practically problematic and inadequate. Perhaps the failure to transfer money in time could serve as an example of this. This type of problem takes on a slightly different shape when factors that are perhaps a bit more intangible come into play. Attempts to help that come across as prescriptive or decontextualised perhaps fall into this category. Lastly, it seems necessary to think about things that could perhaps be described as system design issues. The in-between nature of things with regard to functional integration and district health system development are examples of this, as well as things such as the arrangements around NGOs. At issue here, in essence, is the most appropriate allocation of roles and responsibilities across different spheres of government.

6.3 Coordination and Integration

A few officials display quite a keen awareness of problems with and issues around coordination and integration. One, for example, expressed the wish that a certain HIV/AIDS programme should not be isolated or vertical. Another offered the following more general assessment in response to a question about HIV/AIDS services at clinics:

> *"Ja, there is some hope, there is some hope. Because I think the problem we have at the department or as a government, is that we seem to be isolating HIV/AIDS, you know, thinking that it can work on its own. And my strongest belief is that HIV/AIDS cannot work on its own, unless we achieve the other issues that are related to HIV infections are also taken care of. Like the extent of poverty in this province, that also needs to be taken care of."*

The coordination and integration of HIV/AIDS services has to some extent already been discussed, albeit in a rather limited and sometimes not very explicit way. If nothing else, the preceding section contains many clues about the kinds of instruments, activities and structures that will be explored in somewhat greater depth in this section.

Many of the instruments and activities that, arguably, relate to coordination have already been mentioned in the above. It should by now be clear, for example, that meetings and workshops are central dimensions of organisational life within the health system. Meetings and workshops take place at various levels of the system and they quite often involve

different combinations of, among others, officials from the provincial health sub-districts, NGOs, traditional leaders, local councillors, officials from the national department of health, local government officials, provincial political representatives and government departments other than the department of health. With regard to meetings, questions about coordination are raised, however, by not infrequent remarks to the effect that meetings are not functioning as they were intended to. While someone raised the issue of meetings being ignored, the more common problems seem to be around meetings that are not happening as they should because of staff shortages or transport problems or because of officials who cannot make it to meetings because they have been "called" by someone higher up in the hierarchy. While there are clear examples of meetings that are functioning well, this problem does seem to affect most levels of the system in one way or another.

Other mechanisms that could be associated with coordination and that have also already been mentioned, include training (the definition of which could perhaps be expanded to include health education provided to patients), guidelines and manuals, visits, budgets and financial allocations, the reporting of certain information, the piloting of interventions or programmes and interactions and documents concerned with planning. Planning, however, does not guarantee integration and coordination in implementation. A senior official from the provincial department of health explained, for example, that officials from different directorates work together to a certain extent when they draw up their plans, but added that the problem is more around implementation and people running in their own directions during this phase. This account seems, to a certain extent, to support the conviction of the province's interim management team *"that the province does not lack in planning and resourcing, but in execution"* (Eastern Cape Government, 2003a). It is not only different parts of the department of health that should be running in the same direction, but also different government departments. One interviewee commented about the workings of the national integrated plan and there was also a mention of an inter-departmental liaison officer, but this was not explored in detail.

Something that has not yet been touched on and that is undoubtedly a factor in the coordination of HIV/AIDS services is the issue of referral relationships. Referrals are taking place between medical facilities, from medical facilities to NGOs, and to the department of social development for the purpose of accessing grants. Referrals may also be taking place from NGOs to the department of health and other departments. One provincial official spoke about NGOs *"linking the people on the ground with the department"* and within the context of a reference to the identification of problems by NGOs also stated that *"it is for them to link those people to the relevant department."* While some described referral relationships as working well, complaints about inadequate feedback and patients' struggle to find transport to hospital were also aired. Another problem seems to be that NGOs don't necessarily cover whole geographic areas, which may leave some patients in the lurch. Furthermore, information from one interview suggests that a certain financial arrangement may be acting as a disincentive for cooperation and coordination between health facilities. The official spoke about the need for good relationships between hospitals and clinics and used the example of a clinic and a hospital each laying claim to a certain resource such as milk for themselves, while this resource is in fact used to serve the same mothers and babies. This behaviour may be related to the fact that institutions are treated as cost centres:

> *"Maybe this issue of separating budgets – don't you think that has got an impact that the clinic needs to know what is its budget, and the hospital. So nobody wants to incur costs on behalf of the other one. I think that must also be having – it must have something to do with it because as a hospital I know these medicines are for me."*

It seems as if there are attempts from within the provincial HIV/AIDS directorate to make these rigid divisions more porous by, in certain instances, arguing that funds are not meant for a hospital, but for a service, which includes the hospital and surrounding clinics.

The coordination and integration of HIV/AIDS service delivery could be looked at from the perspective of more or less discrete mechanisms and activities, or one could be interested in obtaining a broader, more systemic view. In the latter case, one would need to keep in mind things such as transport problems, the state of facilities, and staff shortages. The issue of paying an incentive to nurses in rural areas was raised in interviews, but its impact is not known. The rural nature of the province and all the potential consequences of this, which go beyond transport and the like, also seem relevant. An official explained:

> *"Our province is so rural that some of our clinics are about fifty kilometres from the nearest town, and the nurse who is actually functioning that clinic finds herself so isolated, being away from everything else. She has to leave her family behind, she has to leave her children behind. Sometimes, if she has to take them with her, the level or the standard of education in those villages that she has to take her kids to…it's really frustrating. Because even the teachers…so we find ourselves facing such major problems."*

Information from one interview suggests that it is one thing to get nurses to come to a small rural town such as Mount Frere, but that it is quite another to get them to go to outlying clinics. This suggests that a general concept such as the rural nature of the province may not always appropriately capture the nature of the challenges faced in the delivery of services.

In the Eastern Cape, the widely shared notion, at least at the level of the provincial HIV/AIDS directorate, of an inverted pyramid forms an indispensable part of this bigger picture. The image of the inverted pyramid is most often invoked in discussions about the relationship between the national department of health and the provincial HIV/AIDS directorate and the communicable disease coordinator is perhaps most often identified as the person situated at the bottom tip of the inverted pyramid. This was also so in the case of the official who used the image of the inverted pyramid in a description of the interaction between the province and the communicable disease coordinator.

Basically, the inverted pyramid communicates the ideas of a management structure that is top-heavy and a lack of people as one moves closer to the service delivery level. From a provincial perspective, the problems in the relationship with the national department range from the latter having more staff than the former and national officials' inadequate coordination among themselves to provincial managers not being informed about national officials' interaction with their personnel and the vertical nature of national programmes. An official based at the provincial directorate explained:

> *"Because we found that they have got more people at national level sometimes, and as you come to the provinces, the structure becomes leaner. It's worse if you are going into the districts, you know. And quite a lot of people were employed you know, in different programmes, and each and every one is pushing that her part or her side should be working."*

With more specific reference to the position of the communicable disease coordinator, the same official added, among other things:

> *"Sometimes you understand when that person is angry with you. You understand because they are just pushing through you, of course to push it down."*

The implementation of HIV/AIDS programmes seems, therefore, to be driven to a large extent by strong vertical pressure applied by those that are located higher up in the health system hierarchy. The relatively vertical organisation of activities is, however, not simply a function of pressure from the top. This can be illustrated by one provincial official's identification of the need for TB and HIV/AIDS to be managed by the same person because

of their close association. This interviewee then explains that officials from the two fields are so busy that they hardly ever have time to talk, perhaps indicating both the relative isolation or separation of the programmes and the more horizontal dimensions of the issue. To point to the vertical pressure in the system is also not to say different programmes or streams of activities never cross paths. In fact, they do meet and at least sometimes this seems to give rise to both a kind of stasis or slowdown in the health bureaucracy and a sprout of activity leading in an alternative direction. This could perhaps be illustrated with reference to the problems of the VCT programme.

One of the VCT programme's problems is that sites do not have enough space for proper counselling to be done. Consider, for example, a scenario where four nurses share one consulting room, making it virtually impossible to create the necessary level of privacy. The VCT programme has also encountered staff related problems. A first dimension of this relates to the potential difficulty of getting trainers, who have other line functions as well, to take on training sessions, to leave their work environments for the required time of about three weeks. A second dimension concerns the difficulties that health workers experience in attending the training because of staff shortages at the clinic level and a third dimension is about actually getting the time-consuming counselling done in a sometimes very pressured facility environment. With regard to the issue of staff shortages at the facility level, it was reported that the employment of staff is the responsibility of the primary health care directorate. Similarly, within the context of a discussion about clinics that do not meet the requirements for a VCT facility, an interviewee reported working with the responsible division to check on the process of clinic development. Apparently, one strategy was to purchase containers for sites with inadequate space, but this was halted. The VCT programme, therefore, could only move so far before beginning to encounter more generic health system problems such as staff shortages and inadequate facilities, problems that cannot be solved overnight and that depend for their resolution on the action and progress of those in other programmes and departments. Arguably, this dynamic leads to an implementation slowdown as different parts of the health bureaucracy, neither with the power to necessarily quickly dissolve the contradiction, meet. This kind of scenario raises questions about planning and the integration of and coordination between different parts of the system. All wheels, however, do not stop turning and solutions are sought and found in other places. Within the context of the kind of issues mentioned above, interviewees, for example, spoke about trying to refer people to the "relevant agents" (this seemed to refer to NGOs) and engaging with communities with a view to developing non-medical sites such as churches. It is, however, not clear how much attention is paid to the potential implications of this for integration and coordination. That this is something to think about is perhaps illustrated by the situation around lay counsellors, where the province found itself in the position of having a budget for lay counsellors, but lacking the necessary payment and administration system to go with that.

Many of the roles, responsibilities and issues discussed above hint at the importance of hierarchy in the system for the delivery of HIV/AIDS services. The idea of an inverted pyramid quite explicitly demonstrates one way in which hierarchy can influence the organisation and delivery of services, but there are also other examples of how hierarchy impacts on the functioning of the system and the inter-linkages, or absence thereof, between people. Within the context of a discussion of communication between the provincial HIV/AIDS directorate and the national department of health one interviewee used the example of compiling a document with information needed by the national department and explained how protocol dictates that one has to work through one's immediate supervisor to get the document signed by the director before sending it off. An official from the area level stated more bluntly that they were not allowed to communicate with Bisho and that they had to work through the sub-district office. While not necessarily inappropriate, arrangements

such as these do raise questions about the role of gatekeepers, the optimal flow of information and the consequent ability of various parts of the system to integrate and coordinate their activities. The exact situation around the reliance on hierarchy and formalism is not always clear, especially because of its apparent absence in some places where it may be expected. One official, for example, made the following comment about the role of the MEC:

> *"Our MEC is very involved with our programmes. He knows our programmes and it's so easy for us to at any minute to go and discuss, and at times when we've got difficulties and some other problems on the implementation, he plays a very important role."*

6.4 Informal Dynamics

While the functioning of the system concerned with the delivery of HIV/AIDS services is clearly dependent on certain formal structures, roles and interactions, the picture of how different people and spheres relate to each other would not be complete without a consideration of the more informal connections and dynamics. Some of these issues have, of course, already been touched on. The above discussion, for example, provides many clues about the prevailing organisational culture. It has also already been shown how the informal efforts and actions of officials help the system to tick over. This is the case when nurses drop off blood at the hospital on their way home after work or when an official spends her own money on public transport because the department of health is not always able to provide her with the necessary official transport when the need arises. Like formal structures, roles and responsibilities, more informal connections bring together people from various parts of the system.

An official from the Alfred Nzo district municipality, for example, reported being in contact with other district municipalities in order to learn about their programmes and in this way build their own capacity. Some provincial officials also have informal relationships with officials working at the national department of health, with these relationships sometimes stretching back to the days before the parties occupied their current positions. Officials based at the level of the provincial HIV/AIDS directorate also spoke about their informal relationships with other provinces. In general, it seems as if other provinces are happy to provide support or advice. *"Sometimes we phone each other and we ask when we've got a problem. We share,"* said one official. There was a suggestion, though, that the provinces' different systems prevent solutions from simply being transferred from one place to the next.

6.5 Conclusions

This case study clearly demonstrates how structural and contextual factors, whether they come in the form of a district health system, a process of local government transition or an inverted pyramid, influence the roles, responsibilities and interactions of the multitude of actors within and outside government who are engaged in the delivery of HIV/AIDS services. In looking at the activities of the various actors, it seems necessary to acknowledge that effort has gone into and progress has been made in implementing an HIV/AIDS service package. It is also clear, however, that there are gaps in service delivery. To the extent that these gaps are the result of factors such as staff shortages, it perhaps indicates that HIV/AIDS programmes and services are subject to much the same constraints as other programmes and services. The inadequate reach of services also serves to drive home the message that coordination and integration, while undoubtedly important, will only get one so

far down the road. To be successful, even perfectly coordinated and integrated services need to connect to users or patients. What lies ahead, therefore, is not simply the challenge of solving coordination and integration problems around a relatively static set of roles, responsibilities and services, but the effective coordination and integration of a system, the scope and complexity of which is likely to increase further.

CHAPTER 7: FREE STATE CASE STUDY

7.1 Background

The Free State was formed by the amalgamation of the Orange Free State, Qwa Qwa and part of Bophutatswana. There is a general perception that the Free State has done reasonably well since 1994, and is usually counted among the better performing provinces. The Free State Provincial Department of Health (PDoH) is similarly viewed quite favourably when compared with other provincial departments.

To some extent this reflects the fact that transformation in the Free State has been less complex and less problematic than elsewhere. For one thing, the former homeland areas were fairly small and easily incorporated. There are still some areas of under-development but generally the province is not that badly off in terms of infrastructure and development. The province and PDoH have also been lucky in having strong and consistent leadership that has been able to manage the complex balance between following national processes and acting independently in order to identify better local solutions. In so doing, they have often developed interventions that have then served as best practice for other provinces.

HIV/AIDS is one of the major challenges facing the province. In the annual antenatal survey, the HIV seroprevalence rate for the Free State is generally the second highest in the country. The extent of the HIV crisis is openly acknowledged and features prominently in provincial policy documents on HIV/AIDS (Free State Provincial AIDS Council, 2002).

In the interim phase of local government restructuring, the Free State DoH was organised into five health regions and 14 health districts. As a result of the final demarcation process local government in the Free State was reorganised into five district municipalities and 20 local municipalities. The PDoH has moved fairly quickly to rearrange itself into five health districts following the district council boundaries. The health districts are generally managed by provincial staff from the former health regions but there have been some attempt to extend management and governance to include local government officials and councillors. The Free State Provincial Health Act was passed in 1999 and provides for the establishment of the Provincial Health Authority (PHA), Provincial Health Advisory Board (PHAB), and District Health Authorities (DHAs) in each district (Hall, 2002). The composition and relationship between these structures is shown in Figure 7.1.

This Case Study explores the organisation and coordination of HIV/AIDS services in the Free State by focusing on one of the five district council area - Thabo Mafotsanyane. Interviews were conducted with HIV managers and general managers at all levels of the health service, from the provincial department down to facilities and local government.

The basic demographic and health service information for Thabo Mafotsanyane is summarised in Table 7.1. The new health district represents two of the previous health regions. The district generally consists of small towns scattered amongst commercial farming areas. However, infrastructure is good throughout the District, with good roads, telephone and electricity networks. There are now five local councils (Category B municipalities) in the area. Harrismith, in the Maluti a Phofung local council area, is the largest town in the district.

In the public sector, there are 10 hospitals and 71 clinics in the district (Table 7.1). The District Health Authority has already been established and provincial and local authorities are working towards the functional integration of health services.

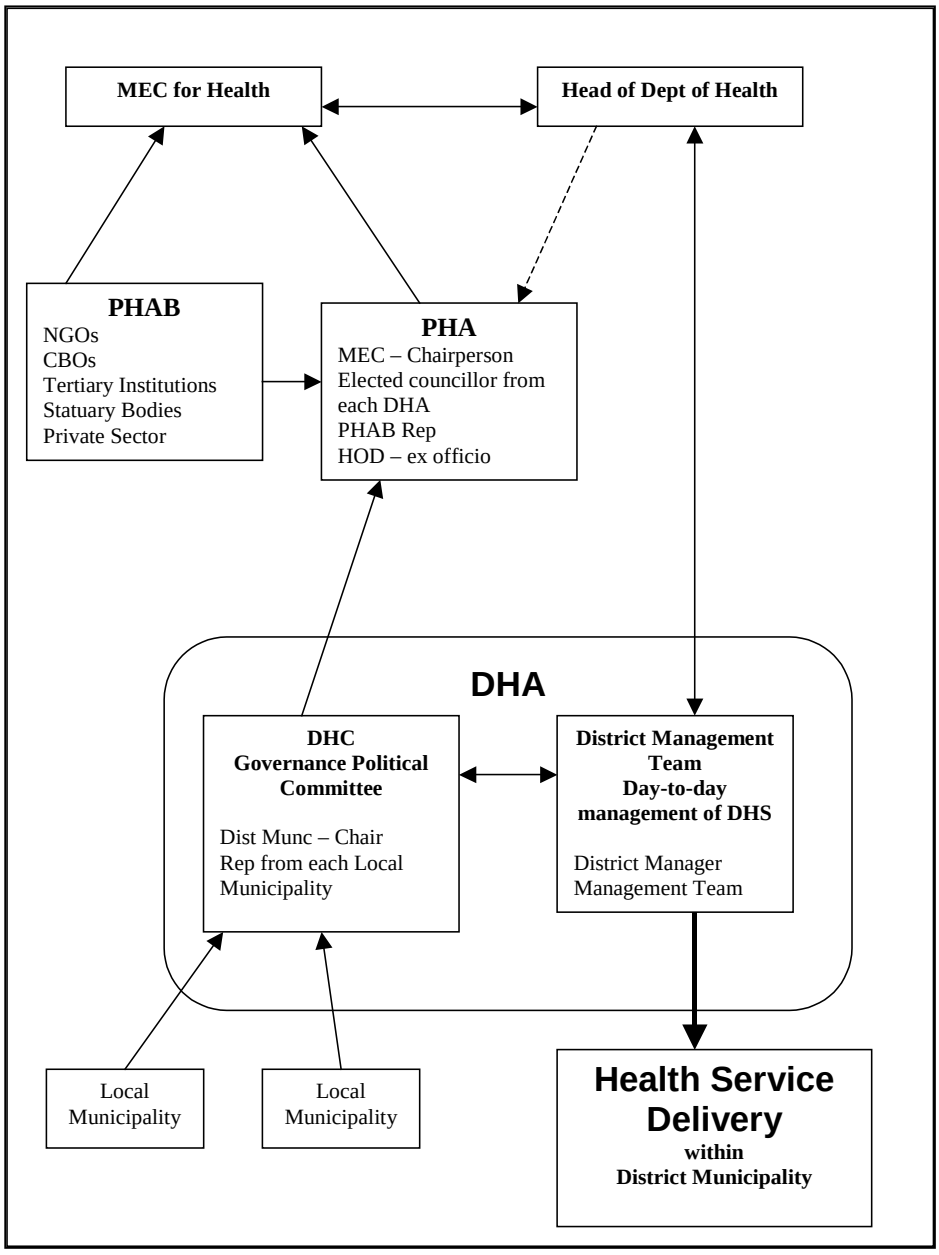


Figure 7.1: Health governance structures in the Free State

Source: (Hall, 2002)

The first part of this chapter describes the organisation and activities of the provincial HIV/AIDS programme and how the different roles and responsibilities have been allocated between different actors. The next section focuses on coordination mechanisms and coordination problems within the HIV/AIDS programme while the last section discusses informal processes and dynamics.

Table 7.1: Characteristics of Thabo Mafotsanyane, 2002

	Geographic and Demographic Characteristics							Health Facilities									
Local Council	DMA Number	Population	Area (sq. km.)	Main Town	Former Authority	Rural/ Urban	No. of wards	EMRS	Hospitals			CHCs	Fixed Clinics			Mobiles	
									District	Regional	Private		Prov	L/A	Pvt	Prov	L/A
Setsoto	FS191	119,112	5,966	Senekal	Homeland + RSA	Rural	16	4	3			1	-	13		5	-
Dihlabeng	FS192	116,302	4,739	Bethlehem	Homeland + RSA	Mixed	17	3	1	1	1	1	-	11	1	6	-
Nketoana	FS193	69,756	5,611	Reitz	Homeland + RSA	Rural	9	2	1				-	6		4	-
Maluti a Phofung	FS194	383,337	4,421	Harrismith	Mostly homeland	Mixed	34	2	2	1			28	6		9	-
Phumelela	FS195	49,151	7,548	Vrede	Homeland + RSA	Rural	7	2	1				-	7		2	-
Total	DC19	738,328	28,347				83	13	8	2	1	2	28	43	1	26	-

DMA: Demarcation authority
EMRS: Emergency medical rescue services
CHC: Community health centre
Prov: Province
L/A: Local authority
Pvt: Private

7.2 Roles and Responsibilities

7.2.1 Organisation of HIV/AIDS Services

The organogram of the provincial DoH is shown in Figure 7.1. The department is divided into three main sections or clusters: facility, district and divisional line managers fall under 'Clinical Health'; human resources and health programmes make up 'Health Support'; and Financial services form the third cluster. The HIV/AIDS and Communicable Diseases directorate includes TB, sexually transmitted diseases (STDs) and chronic diseases in addition to HIV. HIV/AIDS programme activities at the district level are implemented by generic Communicable Disease Coordinators who officially report to the District Manager in each district.

When asked about the priority components of the Free State HIV service package, provincial respondents generally mentioned interventions outlined in the National Strategic Plan, namely condom provision, VCT, HBC, and inter-sectoral liaison. The structure of the provincial AIDS directorate also reflects the priority given to these components in the provincial HIV/AIDS programme (Figure 7.1).

7.2.2 Allocation of Roles and Responsibilities

There was reasonable consensus among all respondents about the roles of the different levels as shown in Table 7.1.

Table 7.1: Identified roles and responsibilities

	Level			
	National	Provincial	District	Facility
Steering	▪ Provide strategic direction ▪ Policy development ▪ Define national norms & standards	▪ Adapt national policies for province ▪ Provincial policy development	▪ Disseminate provincial policy	
Support	▪ Develop guidelines and protocols	▪ Training ▪ Capacity development ▪ Provide support to districts & NGOs	▪ Support local needs	
Funding	▪ Resource allocation			
Service Provision		▪ Establish VCT sites ▪ Implement HBC	▪ Operationalise policy at district level ▪ Support clinics	▪ Treat opportunistic infections ▪ Provide counselling
Other		▪ Serve as channel to districts ▪ Monitoring & evaluation ▪ Internal & external liaison		▪ Link to community groups

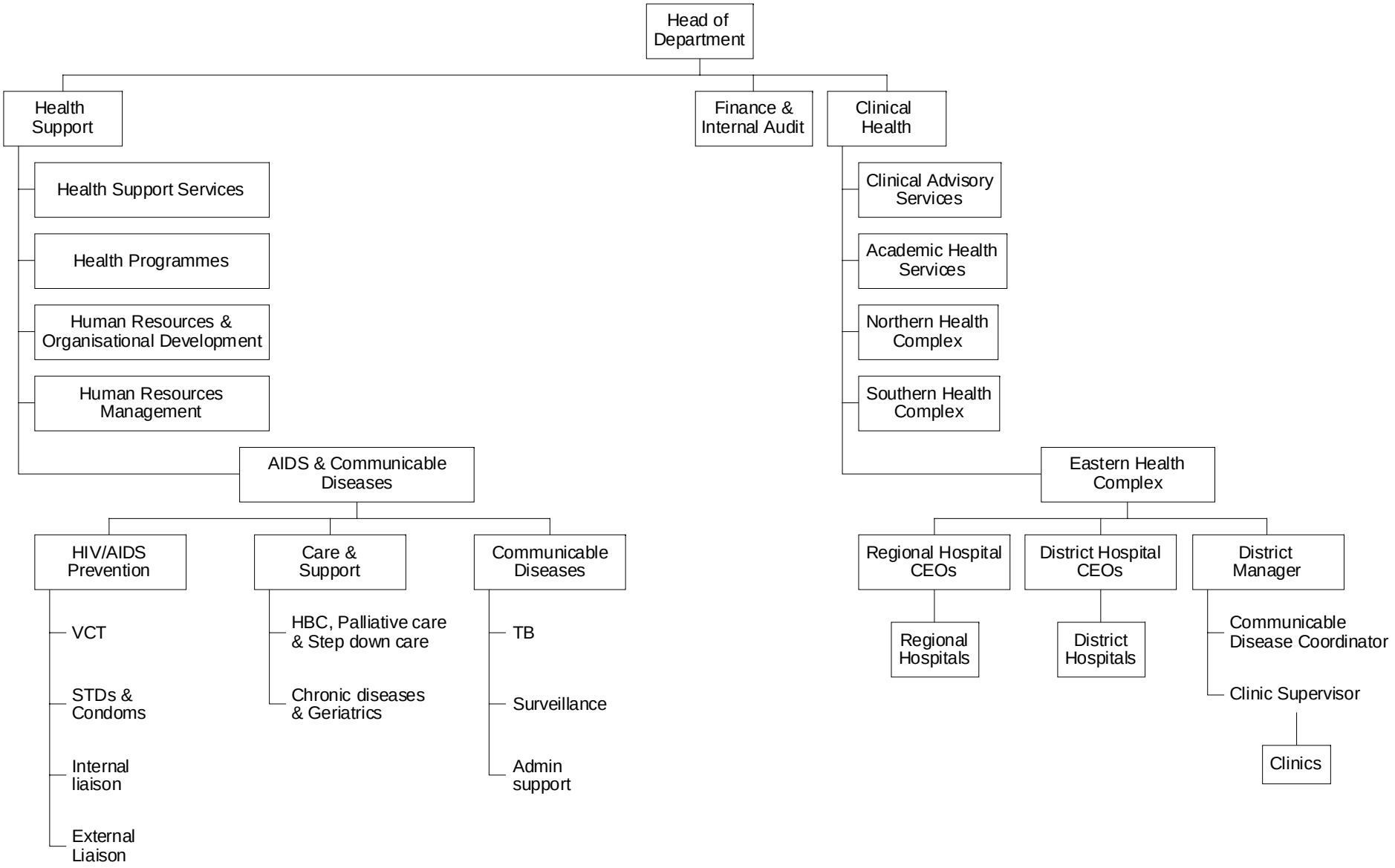


Figure 7.1: Organogram of the Provincial DoH

According to the interviewees, the main functions of the NDoH are to steer and support the HIV/AIDS programme. This includes deciding on the main strategies, formulating these into national policies, defining national standards, and then producing guidelines and manuals to support implementation. A few people also thought that the NDoH played an important role in resource allocation to provinces.

A provincial official summarised the role of the provincial level as follows:

> *"We're mainly responsible for policy development at the provincial level based on national policies, of course. We are designing programmes in collaboration with the districts and the NGOs. We are building capacity at district level and also at NGO level."*

Provincial-level policy development was often described as taking national policies and adapting them to the provincial conditions. In practice, this mainly seemed to involve minor modifications of national guidelines and training manuals:

> *"But then we have to look at that and practicalise it in terms of our own situation and say this is what we can do, but national is necessarily taking the lead in terms of developing those guidelines for the province." (Provincial official)*

> *"Okay, for the training for the curriculum, it's developed by national, but there's a minimum standard. So when it comes to the province we as the province we can develop it further… but the guidelines are coming directly from the national department." (Provincial official)*

The main activities of the provincial HIV/AIDS programme related to the priority programmes outlined in the National Strategic Plan. Over 120 new VCT sites had been established and provincial officials were directly responsible for the identification and evaluation of the potential sites, the training of health workers and lay counsellors (although usually outsourced to specialised training NGOs), and the provision of HIV test kits. In relation to HBC, the provincial department was already in its second cycle of funding to NGOs. In the last year they had facilitated the organisation of NGOs into regional consortia, evaluated the proposals received, allocated the available financial resources, developed contracts and established a monitoring and evaluation system. They were also busy contracting with a private consultancy to provide support and financial management training to the NGOs that were receiving funding. The managers responsible for internal and external liaison were extremely busy supporting the Provincial Aids Council (PAC), Inter-Ministerial Committee on AIDS (IMC) and Inter-Departmental Committee (IDC).

The Communicable Disease Coordinator in each district is responsible for operational implementation. One respondent described their role as *"disseminating provincial policy"* and they did seem more focused on implementing directives from above rather than identifying and meeting the needs of those below. However, for some people, being told what to do and how to do it means that they feel supported by the level above:

> *"Yes. To be honest in terms of the support personally now, I think I've got a lot of support especially from the province." (District official)*

Local government was responsible for most of the clinics in Thabo Mafotsanyane (Table 7.1). The local authority clinics had made some progress in expanding the range of services provided in order to deliver comprehensive PHC. Local government was also responsible for the three AIDS Training and Information Centres (ATICs) in the province which played an important role in the training of lay counsellors and carers. Lastly, respondents said that local government had participated in provincial campaigns, such as the annual HIV/AIDS Day activities.

Facilities were seen as being responsible for clinical service provision as well as community outreach. One clinic worker described their role as follows:

> *"Condom distribution, STD treatment, treatment of opportunistic infections, caring for those who are sick, you know, like establishing support groups where possible."*

A number of other important actors were identified by the interviewees. NGOs are obviously planning a significant role in the provision of HIV services in the Free State. NGOs are largely responsible for HBC and the coordination of lay counsellors but some are also involved in training and support. One provincial official noted that various consultants and academics had contributed to the development of guidelines and monitoring systems.

Governmental actors outside of the HIV/AIDS programme also play a role. A number of programme members said that it was important to involve and work with line managers in the Clinical Health Cluster, particularly district managers. The budget committee and provincial treasury were referred to in relation to programme resource allocation and financial management. With regard to other government departments, the Department of Education was seen as contributing to lifeskills training and the Department of Social Development is responsible for social grants and general poverty alleviation which impact on people infected and affected by HIV.

Interestingly, political support was mentioned by a number of respondents as being critical to the HIV/AIDS programme in the Free State.

> *"I think the involvement of the Free State Provincial Government in the programme is quite a strength for us, with the active involvement of the Premier, the active involvement of the Executive Council." (Provincial official)*

7.2.3 Problems with Roles and Responsibilities

The two main problems expressed were uncertainties about the role of local government and difficulties with the implementation of VCT at the clinic level.

People were confused by the debates concerning the role of local government in the provision of PHC services. Interviewees, from all levels, were still under the impression that the responsibility for PHC services was going to be transferred to the local level. The vacillation and delay in the implementation of the district health system has also impacted on implementation of the HIV/AIDS programme. As a provincial HIV/AIDS manager explained:

> *"The district health system is not yet fully implemented in the province, so that is why at some point you will see an overlap of some of the things that need to be done maybe at district level, we also take them to facility level because the system is not yet in place and fully functional."*

Other informants were critical of local government's response to the HIV/AIDS epidemic. One observer claimed that there was no real plan for HIV at the local level. A hospital manager was sceptical of that some of the new municipalities had the capacity to deliver health care services:

> *"You know, we have got a problem, we have got a real problem with that. Because the local government didn't understand anything about health services before. It's now that they are trying to understand what is going on in health."*

Most of the clinic managers interviewed expressed some misgivings about the additional roles and responsibilities that were being placed on them in relation to the management of

HIV/AIDS patients. Nurses were most concerned about the implementation of VCT and the counselling of HIV/AIDS patients, arguing that they did not have the staff, the space, the training or the time to take on these responsibilities:

> *"It's a very, very big problem for us because, you know, counselling takes quite a lot of time and with the limited personnel and because counselling is such a big important part in the HIV story. How they will handle it all depends on the counselling. It will be very nice if we can have lay counsellors but currently, no, we don't have." (Clinic manager)*

> *"So the problem of HIV and AIDS…. problem number one is the shortage of staff. Like I'm working here, I'm working alone and I'm the only person who has any training and I'm working alone" (Clinic manager)*

Some managers were critical of their superiors in failing to provide adequately for implementation at the service delivery level whereas others were confident that their problems were being dealt with by somebody or other in the levels above:

> *"Well, I think they are doing their best but you know, I think someone is not doing his job somewhere, I don't know who. Because of the fact that they are supposed to train the counsellors for counselling of the patient, you know, so that the patient can be tested. But now I understand that we've got the test for testing, but you know it's not going to help us in a way to have the test without someone who can counsel the patient. So this has been going on for a long time now." (Clinic manager)*

> *"The counselling, the government or the province are busy with the voluntary workers, so I think it's just time. I know the policy is out although we must still put in our needs and our things, and what also worries us currently a bit will be the circumstances under which they will come and work, you know, the confidentiality and these things. This must be the nitty gritty that must be sorted out. But the provincial government is busy on this, so I think – well, not think – it's on the table already." (Hospital manager)*

The comment about confidentiality relates to the misgivings of a number of interviewees about the increasing reliance on voluntary workers within the HIV/AIDS programme.

Lastly, one or two respondents expressed concerns about the slow rollout of PMTCT services and a few mentioned that the provincial HIV/AIDS programme has had limited success in getting other sectors to take more responsibility.

7.3 Coordination and Integration

7.3.1 Coordination Mechanisms

In keeping with the National Strategic Plan, the main priority in the Free State has been the establishment of coordination structures to support inter-departmental and inter-sectoral coordination of HIV/AIDS (Table 7.1).

> *"As I said the various structures are giving guidance, to the successful implementation of the HIV/AIDS programme in the province. "* (*Provincial official)*

> *"The Free State Provincial AIDS Council embraces the national strategy plan, which promotes the establishment of inter-sectoral structures at different levels." (Free State Provincial AIDS Council, 2002)*

Table 7.1: Coordination structures in the Free State

	Level	Structure	Category	Channel
HIV-Specific Structures	Provincial	1. Provincial AIDS Council (PAC)	Inter-sectoral Inter-departmental Inter-governmental Inter-municipal	Political
		2. Interministerial committee on AIDS (IMC)	Inter-departmental	Political
		3. Interdepartmental committee on AIDS (IDC))	Inter-departmental	Administrative
		4. Focal persons sub-committee	Inter-departmental	Administrative
	Local	1. District AIDS Council (DAC)	Inter-sectoral Inter-municipal	Political
General Health Structures	Provincial	1. Provincial health authority (PHA)	Inter-governmental Inter-municipal	Political
		2. Technical committee of PHA	Inter-governmental Inter-municipal	Administrative
		3. Provincial health advisory board (PHAB)	Inter-sectoral	Political
	Local	1. District health authority (DHA)	Inter-governmental Inter-municipal	Political
General Government Structures	Provincial	1. Executive Council	Inter-departmental	Political
		2. Interdepartmental management committee (IDMC)	Inter-departmental	Administrative

Structures for inter-departmental coordination of HIV services have been in place for a number of years already. The provincial Interministerial committee on AIDS (IMC) was established in October 1999 and includes the MEC from seven provincial departments (Free State Department of Health, 2000):

- Health
- Education
- Social development
- Local government and housing
- Tourism, environmental affairs and economic affairs
- Arts, sports, culture, science & technology
- Public works, roads & transport.

A number of interviewees commented that the IMC was the most successful structure for HIV/AIDS coordination in the Free State, it was meeting regularly and appeared to be working well:

> *"The IMC's working, it's a good functional structure. Everybody seems to be quite happy with it, they've got into the groove and it's become a regular talking platform you know, regarding HIV issues." (Provincial manager)*

The Interdepartmental Committee on AIDS (IDC) is the administrative counterpart of the IMC consisting of the HoDs of those departments. A more junior official has been designated as the HIV 'focal person' for each department and collectively these representatives constitute a sub-committee of the IDC.

The Free State Provincial AIDS Council (PAC) was established in February 2000 (Free State Provincial AIDS Council, 2002). It is chaired by the Premier of the province and has 25 members (Premier, 5 MECs, 5 District Council Mayors, 14 sectoral representatives). Although the primary objective of the PAC is inter-sectoral coordination, given its composition it may also aid inter-departmental, inter-governmental and inter-municipal coordination.

The provincial HIV/AIDS directorate has been directly responsible for the establishment and support of these committees. In the case of the PAC this has required extensive mobilisation in each of the sectors in order to identify and elect sectoral representatives. The HIV/AIDS programme currently serves as the secretariat for the IMC, IDC and PAC. Much of the coordination responsibility falls on the two officials, appointed from the NDoH, who are responsible for internal and external liaison (See Figure 7.1).

In the Free State, the general PDoH and government structures (Table 7.1) appear to have played less of a role in HIV/AIDS coordination. As discussed earlier the Provincial Health Authority (PHA) and District Health Authorities (DHAs) have been set up in the Free State, but neither the HIV managers nor the general managers we interviewed could tell us much about their functioning even though senior PDoH officials constitute a technical committee of the PHA. The Provincial Health Advisory Board (PHAB) is an interesting general inter-sectoral body for health, but has only met once or twice, and did not feature in respondents' comments about HIV/AIDS coordination.

Internal DoH coordination mainly occurs through a number of regular meetings (Table 7.2). The HIV/AIDS directorate meet together once a week and also meet with all the district HIV coordinators every two months. The large national HIV meeting is supposed to be held every quarter but specific sub-programme managers (VCT, HBC, PMTC) go to Pretoria for a meeting every two months. These national meetings not only facilitate national – provincial coordination but allow managers to interact with their colleagues from other provinces. One of the sub-programme managers said:

> *"It's an important meeting, I can say, because it's a learning experience that you can assess your province, how far you are."*

Table 7.2: Coordination meetings in the Free State

	Meetings	Frequency	Category
HIV-Specific Meetings	1. HIV Directorate meeting	Weekly	Intra-departmental
	2. Meeting with district communicable disease coordinators	Bi-monthly	Intra-departmental (Vertical)
	3. National sub-programme managers meeting	Bi-monthly	Inter-governmental Inter-provincial
	4. National HIV meeting	Quarterly	Inter-governmental Inter-provincial
General Meetings	1. Health support cluster meeting	Weekly	Intra-departmental
	2. Senior management meeting	Weekly	Intra-departmental

Other coordination mechanisms identified most frequently were the framework provided by the national strategic plan and the use of information circulars. PDoH informants were particularly proud of their efforts to improve coordination with NGOs. The Free State had spearheaded an initiative to organise NGOs into regional consortia which greatly simplified and improved the selection, contracting and monitoring of NGOs.

Surprisingly, interviewees at the facility level reported few problems with referrals in relation to HIV services. Earlier problems seem to have been sorted out and systems had been developed to improve communication. For example, when asked about the referral relationship between hospitals and clinics, a clinic nurse said: *"We're not experiencing any problems,"* and a hospital manager answered:

> *"Very good. We really don't have problems. In the beginning there were a few problems regarding the filling in of the referring letters. Sometimes the doctors were*

reluctant to fill in the form and give it back to the referring hospital, but now it's regtig working very well."

7.3.2 Problems with Coordination

The coordination problems identified by Free State informants are summarised in Table 7.1.

Table 7.1: Problems with coordination in the Free State

Category		Coordination Problems
Inter-governmental	National – Provincial	▪ Poor communication ▪ Problems with national staff at provincial level ▪ Lack of national leadership ▪ Never visit provinces ▪ No forum for strategic engagement
	Provincial – Local	▪ No formal relationship ▪ Not a priority in liaison ▪ Organisational differences
Intra-departmental	Provincial – District	▪ Overloaded district HIV coordinators
	HIV – Support staff	▪ Limited interaction
	HIV – Line managers	▪ Limited interaction
Inter-departmental		▪ Too many structures ▪ IDC not working well ▪ HIV still seen as DoH responsibility
Inter-sectoral		▪ PAC not working well ▪ Overwhelmed by politics
Referral relationships		▪ No formal engagement between hospitals and clinics ▪ Difficulties with HIV patients

The most frequent complaint about the NDoH was that they did not communicate adequately with the province, or, in fact, among themselves:

"Maybe I can say, maybe at national, it's also part of the slow communication and coordination at national level. You'll find that - let me make an example, we're waiting for home based care feedback on the conference we attended in last May." (Provincial official)

"They don't communicate and co-ordinate with each other. And that creates a real problem." (Provincial official)

The secondment of national staff to the provincial department may have increased the integration of national and provincial activities but also initially caused some tensions at the provincial level. However, the problems appear to have been resolved and it has now been agreed that the national personnel will be moved to the provincial establishment from 2004.

"Ja, basically we report both in the province and national, because national that is the one which is putting bread on our table." (Provincial official)

"Yes, actually I'm on the national organogram now, but with effect from next year… I'll be on the provincial organogram.… You know what, in the beginning it was a little bit of confusing you know, a matter of whom are you accountable to." (Provincial official)

Some senior officials raised more fundamental concerns about the National – Provincial relationship. For one thing, they were much less enthusiastic than programme staff about the large national HIV/AIDS meetings:

> *"It's a mass meeting because they invite everybody from all the provinces, down to deputy directors level, they get them. And then they have a three day session there, on HIV/AIDS. Ja it's massive, I mean they really pile a whole lot of people. To me those meetings are totally fruitless. I mean my staff enjoy it, they go there and get free meals. They enjoy it."*

They also complained that senior NDoH HIV/AIDS staff never came to the Free State to find out what was going on or what was needed, unlike some of the other national programmes (the TB programme was mentioned) which visited the province more frequently. One informant suggested that the national level was too involved in the national political HIV debates to worry about provinces:

> *"My impression about the national HIV/AIDS directorate, they've just got too absorbed with their own political strife and struggles, that it's consuming so much energy, that what's happening in the provinces is really irrelevant." (Provincial official)*

However, another official thought that it was related to the fact that the NDoH was more interested in telling provinces what to do, rather than listening and supporting them to solve their own problems. This respondent argued that this approach failed to draw on the substantial experience and insights of provincial staff, and that the NDoH might actually benefit from more strategic engagement with provinces:

> *"There is no opportunity at strategic level to have discussions you know. It's mostly for operational staff. The national meeting is mostly an operational meeting, it's not a strategic meeting where we can sit down and review things and say which way? And that's the level which I think we miss quite a bit…. You know national comes up with these things, and we just carry them out, you know? If fact if you look back at HIV/AIDS, have we really stopped anything? We haven't stopped anything. We just assume everything is working, and I can tell you now it's not always." (Provincial official)*

Interestingly, local government informants made the same arguments about their relationships with the provincial department – there was some operational interaction at sub-district and facility level but little formal engagement higher up the system. They also complained that their expertise and resources were being neglected by the provincial department.

Interviews with PDoH officials confirmed that relationships with local government were fairly infrequent and limited to ad-hoc, issue-specific interactions rather than regular coordination:

> *"So it's really on an ad hoc basis but there are no formal meetings where I meet with local government, not yet." (Provincial official)*

> *"I just say, with local government at the moment, we communicate and co-ordinate whenever there's a specific issue, like now when we deal with STIs, we communicate with local municipalities because some clinics are local, the local municipality clinics. And whenever there's some other issues that they want to find out from us, we communicate with them." (Provincial official)*

This was even true for the larger, more established municipalities which were investing significant resources in their own HIV/AIDS programmes and strategies. For example, this exchange was with a programme coordinator based in Bloemfontein, the capital city and largest municipality in the province:

Q: Bloemfontein must have somebody who is responsible for HIV services?
A: Definitely, there must be someone.
Q: But you don't know who that is?
A: I don't. The only person that I liaise with is from the Department of Local Government and Housing. (Provincial official)

Clearly this problem is related to the ongoing uncertainty about DHS development and the role of local government mentioned in Section 7.2.3. People have been reluctant to build relationships that may be changed by later policy developments.

> *"So I think once the district health system can be in place and can be functional, it can improve the way we co-ordinate things and the way we implement programmes." (Provincial official)*

However, in the meantime, because of the urgency related to HIV/AIDS, each sphere of government has actively been developing strategies and interventions, largely independently of each other.

Also, improving coordination with local government was not identified as a priority in the National Strategic Plan and, therefore, has not been the focus of the new coordination structures and initiatives within the HIV/AIDS programme:

> *"Local government? I would say in the internal liaison they don't feature much really." (Provincial official)*

Where attempts have been made to interact more with municipal health services, they have been thwarted by political tensions and suspicions as well as the different approaches and organisational systems of local government:

> *"My thinking is, we have tried to incorporate them… but I would think, that's my own perception, that people have a fear of the unknown, that perhaps we want to swallow them or whatever." (Provincial official)*

> *"But now what I have experienced is this, there's a problem especially with the local government clinics, for example there are policies that are different from the Department of Health. If we're supposed to have a meeting for the lay counsellors in the Department of Health we will take [them] along in the cars, but the feedback that I got from the clinic sisters, is that because those clinics are municipality clinics, their policy does not allow them to transport the lay counsellors, because they are not their employees, you understand? Also issues such as some of the clinic sisters cannot go to certain trainings, because they don't have Department of Health personnel numbers." (Provincial official)*

One of the problems expressed in regard to intra-departmental coordination is that there is inadequate coordination between health programmes, such as HIV/AIDS, and line managers. To some extent, this reflects the organisational design of the PDoH (see Figure 7.1). Health programmes and the support units are in the same cluster and, therefore, have slightly better relationships, but the structure of the organogram doesn't really allow for interaction between staff in the Health Support Cluster with those in Clinical Health.

Another intra-departmental issue relates to the vertical relationship between provincial staff and the district HIV/AIDS coordinators. Both groups expressed concerns that all programme activities were focused on one individual at the district level. For example, a provincial coordinator said:

> *"No, we use one HIV/AIDS coordinators, who do everything VCT, STI's. So I meet with the district HIV coordinators, we don't have district VCT coordinators which is*

one of the pressures that I have, because you know these people are doing a lot of things and at times I need information and they will tell me that no they're busy with something else you know."

Of course the fragmentation into multiple vertical initiatives, each with their own specialised coordinator at district level, may not be an ideal solution either.

A number of provincial interviewees also complained about the proliferation of the inter-departmental and inter-sectoral coordination structures:

"Ja, a bit confusing. It's very confusing. There's so many structures." (Provincial official)

"Because I foresee a situation that they'll end up having so many, so many, so many structures that we fail again to co-ordinate." (Provincial official)

As discussed in the previous section, the IMC appears to be functioning well but that is not true of the IDC and PAC. The main issue with the IDC is that the HoDs either don't attend or delegate the responsibility to some junior official. Respondents argued that the other departments were unclear about their roles, had not enthusiastically taken up HIV/AIDS issues, and still felt that HIV was a DoH responsibility:

"I would say that the IDC … it needs review is the Free State, it's not functioning as it's supposed to. Because more often the heads of department, ninety percent of them will apologise for the meetings … who won't be able today to make decisions, and then that delays in your implementation sometimes of the resolutions, which is also going to impact on the next IMC meeting." (Provincial official)

"The weaknesses is that to a certain extent, although that has improved quite significantly, but to a certain extent HIV/AIDS is still seen as a health problem. In terms of other departments, when you get the appointments, for example, of people that are supposed to be HIV/AIDS focal persons in those departments, the levels differ and in some departments you find that is a person that is not in decision-making structures." (Provincial official)

However, another interviewee from the IDC secretariat suggested that inter-departmental politics was also part of the reason for the poor participation:

"We struggle, even with the letterhead. Because we don't know which letterhead - at first we were using the letterhead of the Department of Health and I saw some reluctance from the people. Even from other departments when I interact with other departments, they say 'Health has an equal footing, so Health cannot ask me to come for a meeting'. But when you send it on the Premier's letterhead, it's different. They will come." (Provincial official)

The latest proposal is that the IDC be disbanded and that HIV be put on the agenda of the general HoDs meeting, which is known as the Inter-Departmental Management Committee (IDMC) (Table 7.1).

The PAC has been meeting but attendance and commitment have also been a problem. Some interviewees said that the PAC was unclear about its purpose and noted that it had not yet come up with a coherent strategy for HIV/AIDS in the province. They were also concerned that the PAC had focused mainly on health issues.

"And the issues that came out [of the PAC review] is that people felt that in the first term of office, they only knew that they had to attend the meeting and go out of the meeting. So there was no flow and they were not fully involved. So that's when we decided, no, this is not going to work. We will continue have this thing lasting for

years and years and people will never participate. And we will never achieve anything out of it.“ (Provincial official)

The PAC secretariat was committed to trying to improve the situation but were struggling with the political dynamics of the Council.

“So I think it’s up to the secretariat to make it work. So somewhere, somehow we are a little bit blocked because of politics. You cannot take the decisions. You really feel this is exactly what’s supposed to be done, but because of political issues you have to via a long process just to get an approval for petty issues.” (Provincial official)

Lastly, a few facility managers did raise problems with the existing referral relationships. One issue seemed to be that some facilities did not have mechanisms for regular communication and interaction which resulted in misunderstanding and mistrust:

“You know it's a bit of a tricky question, in fact there is a lot of misunderstanding between us, that's me and the hospital you know. Because we don't like have a meeting between us and the doctors and the, you know, the nursing staff of the hospitals.” (Clinic manager)

It was also noted that HIV/AIDS poses particular challenges for referral relationships:

“Well everybody knows on what forms they should write when transferring a patient… To say the patient was in hospital, this is the treatment he is getting. So the clinics can know what is wrong with the patient, but we are not allowed to say HIV positive, because of the confidentiality.” (Hospital manager)

“But now I'm saying if the patient has now been tested and found out he is HIV positive. Is he still going to be referred or not? …. I don't know how to put it. To say to the patient; ‘No, I can't do anything anymore because you are HIV positive there is nothing we can do. So I'm not going to refer you because your HIV is positive’.” (Clinic manager)

7.4 Informal Dynamics

Informal mechanisms of coordination were mentioned in relation to intra-departmental coordination and relationships with local government. The Free State DoH was also unusual in purposively trying to foster informal relationships to solve particular coordination problems rather than always resorting to structural solutions.

This quote from a senior manager demonstrates how an informal process has facilitated coordination within the Health Support Cluster:

“We go out and we have a nice lunch at our own expense - it's not at government expense. So once a week, we meet and we discuss things in general. It's more a social meeting. And that's a critical meeting, because it literally - a lot of things pop out which I usually don't get to hear about…And we actually resolve most of the problems in those meetings. And if it's a coordination problem, I mean you’ve got a programme going on, then someone will say ‘You know that I want to get involved with that.’ And then they go and network afterwards to make sure that the things work out. So we try and raise issues of strategic importance in those Monday meetings even though it's a social thing. So at least the people can become aware of it and they realise that they need to talk to each other. And then we have our monthly cluster meeting. That's with minutes, formal minutes and everything. We

find that actually we deal with most of the stuff at that informal meeting, so by the time it comes here, we only need half a day" (Provincial official)

The notion that the structure of the organogram may impede certain forms of intra-departmental coordination was discussed earlier. This is particularly true when the organisational culture is very hierarchical, as is typical of public sector bureaucracy. For example, a manager in the HIV/AIDS programme explained why he didn't coordinate with staff in line management:

"Protocol doesn't allow me to be communicating or to interact directly with those people." (Provincial official)

Even at lower levels of the system, the sense of hierarchy is particularly entrenched, so that staff members only really interact with the people directly above or below them in the organogram. A hospital manager was surprised when we asked about her relationship with the provincial department:

"I think on a higher level, yes. Unfortunately, because I'm only a Hospital Manager, we don't interact that much. But, as I said, my complex manager and those people, I think they do. (Hospital manager)

Again, senior PDoH management has been actively trying to change the culture:

"There were problems in beginning you know when everybody started finding their turf. I think we've moved beyond that. People now seem to interact and talk to and share with who they want to talk to… we've really moved to that level of trying to create a culture where people really have the freedom to interact." (Provincial official)

This has been part of an initiative to get the Health Support and Clinical Health Clusters to engage more with each other:

"In senior management, there was very little interaction [between programme staff and line managers] taking place - besides the top management. So by actually joining them, it actually encourages the senior managers to interact with each other, and to be part of each others meetings and discussing and debating together…. Ja put it on the agenda and let them interact you know? I certainly believe what we are trying to do is that people start developing a relationship you know? At least talking to each other, because by developing a relationship between the two groups, it actually improves, I think, the communication and awareness." (Provincial official)

In the absence of formal relationships with local government, managers often have to rely on informal and personal connections:

"As I'm saying, nothing official, it's something very unofficial. When we are sitting at home, because we've got friends at local government, we've got relatives there, when you're talking at home you might say: 'Hey you guys want to be involved in this or that'. It's nothing official." (Provincial manager)

Even without personal contacts, the relationship with municipalities were described as friendly and collaborative:

"I think despite the fact that certain things are not clear, like we said in terms of local government, but people still do work together. When you approach municipalities they are never negative to say 'We are not involved in this structure' or whatever. They always collaborate in terms of campaigns and activities that are in their areas." (Provincial official)

However, in relation to local government, the argument was generally in favour of more formalisation:

"So I think the challenge for us is to formalise that, because the willpower is there for people to do the work, it's just that we need to formalise relations, particularly with local government and try and involve them more. And, for me, the other challenge also is for all the spheres of government to have a specific AIDS programme, not only react to campaigns and invitations and all that. So it's a challenge on how do we assist them to get to that stage where they also take ownership of the HIV/AIDS programme." (Provincial official)

The political – administrative interface was also sometimes described as a rather large divide. Officials involved in the secretariats of the PAC, IMC and IDC found the experience quite demanding:

"I had never dealt with politicians, you know, sat down with politicians. So that was the biggest challenge. The politicians have their own language, their own way of doing things, their own way of willing things to be done. So that was the biggest challenge." (Provincial official)

"The heads of department [in the IDC] are officials. Politicians, sometimes they'll come with a political kind of a suggestion which is not favourable in practice. And then the IDC will also challenge it and say: Please can you bring this to the attention of the IMC, that we feel that it should be done this way or that way" (Provincial official)

Occasionally informants mentioned other informal dynamics or aspects of the current organisational culture. Issues such as race, gender and political credentials continue to play a significant role in influencing organisational relationships:

"And I think the management, they have to change that side, because I'm not being a racist, but it seems to me that we can put black people in the management of the hospital, maybe things will change. Because, black people, they don't have any say in the hospital." (Clinic manager)

"In the African context we don't….I'd rather confide in a man rather than a woman." (Provincial official)

"Because I'm a former activist …. So I don't trust people who I realise that now they are not committed." (Provincial official)

7.5 Conclusions

The Free State case study focused more on dynamics and relationships at the provincial level. The interviews demonstrated the significant attention that has been directed towards inter-sectoral and inter-departmental coordination within the national HIV/AIDS programme. The successes and failures of different coordination structures were noted. The limited formal engagement with local government was again identified as a particular problem within the organisation and coordination of HIV/AIDS services. Facility level interviews highlighted the difficulties that frontline providers were experiencing in implementing aspects of the HIV/AIDS package and the relevance of broader systems development to the HIV programme. Lastly, the Free State case study was interesting in revealing the important role that informal processes and dynamics can play in coordination.

CHAPTER 8: GAUTENG CASE STUDY

8.1 Background

This case study focuses on the City of Tshwane Metropolitan Municipality (CTMM) in the Gauteng province. It is one of three Metropolitan municipalities and three District Councils in the province. It is situated in the Northern part of Gauteng and it lies adjacent to Bonjanale district municipality (North West) in the north, Mostweding district council in the east, the North West province on the western border, and Johannesburg Metro in the south. Tshwane Metro has not yet been officially sub-divided into sub-districts as the process is awaiting a council decision. In the interim it has been demarcated into 5 sub-districts: the North, Central, Southern, Odi and Moretele sub-districts.

Since 1994 there have been dramatic changes in the organisation of local government - the number of municipalities within the country have been reduced with an emphasis on amalgamating local authorities from former “white areas” with those from former “black areas”. Tshwane Metro, like many other health authorities in South Africa, has inherited a fragmented health system. Health services in the area are provided by three different health authorities. The Gauteng and North West Provincial Health Departments render the bulk of curative services and public programmes, while CTMM is responsible for environmental health services, preventative and promotive services as well as limited curative services in some clinics.

In terms of health care facilities, there are a total of eight community health centres (CHCs) and 43 clinics in the area (CTMM DoH, 2002a). Gauteng Health Department (GHD) is responsible for 24% of these facilities, while the CTMM is responsible for 39% and North West Health Department (NWHD) is responsible for 37% (Table 8.1). The area is also served by five district hospitals.

Table 8.1 : Distribution of facilities between different health authorities

TYPE	Gauteng Province	Tshwane Metro	North West Province	TOTAL
District Hospital	3	0	2	5
CHC	3	0	5	8
Clinic	9	20	14	43
Total	15	20	21	56

The total population of the City of Tshwane in 2002 was about 2,2 million (CTMM, 2002). Health needs and health status differ markedly between population groups. Over 70% of the population are not covered by medical insurance and 20.4% are classified as poor (CTMM DoH, 2002b; CTMM, 2002). Blacks specifically from the areas of Ga-rankuwa, Themba, and Shoshaguve have the highest rates of poverty.

8.2 Contextual Factors

Recent health sector reforms in South Africa were highlighted by some senior health managers within CTMM as having a major effect on service rendered at the local level. The

implementation of District Health System (DHS) requires that local authorities should provide a comprehensive package of health services. According to most senior managers and coordinators interviewed, this will require:

(a) effective coordination in service provision between different spheres of government;
(b) effective inter-provincial and inter-sectoral collaboration; and
(c) coordination of funding and financial management in all spheres of government.

After the demarcation of new municipal boundaries in 2000, the City of Tshwane was amalgamated from 14 previous municipalities and councils. This amalgamation has resulted in confusion between services providers in terms of their roles and responsibilities. At the time of the interviews organisational structures within the municipality were not yet finalised and most people were still acting in their positions which has further compromised coordination and service delivery. A new organisational structure is in the process of being developed. Staff shortages in facilities and other service provision points was also highlighted as an important factor affecting the municipality's ability to provide HIV/AIDS services.

Currently within CTMM there is no structural integration with either of the two provincial health authorities (that is the Gauteng Provincial Health department and the North West Provincial Health department). Therefore functional integration has been promoted as an interim mechanism of coordination until devolution takes place. Joint management structures were established at the district and sub-district level to facilitate joint planning, coordination, rationalisation of services and implementation. New administrative regions have not yet been demarcated but the three health authorities involved in service delivery have resolved to use the current "health sub-districts" for planning and service delivery in the interim.

Intersectoral collaboration has been highlighted as important in terms of dealing with the HIV/AIDS pandemic and the municipality is working closely with other sectors, particularly Social Development, Education and Housing. The aim of this intersectoral collaboration is to improve the socio-economic status of people infected and affected by HIV/AIDS.

8.3 Roles And Responsibilities

8.3.1 Allocation of Roles and Responsibilities

8.3.1.1 National Department of Health (NDoH)

According to the informants, a key role of the NDoH is to allocate and transfer conditional grants to the provincial department for home based care. The NDoH has also developed materials to support the training of home based carers, including a 59-day curriculum that is used when training volunteers. Another stated role for the national department was to provide policy guidelines to the provincial departments which they would then use as the basis of their own guidelines to districts.

In relation to the NDoH's role in the coordination of HIV services, one senior provincial manager stated that:

> *"The national department introduced an integrated programme of dealing with HIV/AIDS. Through this programme different national government departments i.e. education, social development, housing, agriculture, home affairs, and health department work together in order to address the HIV/AIDS pandemic."*

8.3.1.2 Provincial Department of Health (PDoH)

Specific roles and responsibilities have been assigned to the PDoH with regard to HIV/AIDS service provision. As stated by the Health White Paper, the PDoH must, amongst other functions, facilitate inter-provincial and inter-sectoral coordination and collaboration, and must coordinate the funding of district health services.

There are a number of roles played by the provincial department to facilitate coordination of HIV services. The PDoH is responsible for overall planning in the HIV/AIDS programme but then forwards those plans to the regional level where they are implemented. What was not clear was to what extent the implementers (regional office) were consulted when this planning took place.

The PDoH also provides the legal contracts to be used when contracting home-based care (HBC) services providers (primarily NGOs) though the contracts are actually administered and monitored by the regional level. The HBC coordinator at the provincial level is responsible for developing the business plan, managing the budget, and ensuring that HBC is in implemented in the community. The NGO coordinator based in the regional department is tasked with the responsibility of monitoring and evaluating NGOs that are funded by the provincial department The role of these NGOs in HIV/AIDS services is to provide basic health care services and the training of volunteers and nurses.

The PDoH provides guidelines to the regional office and the district management teams to be followed for monitoring the NGOs. The monitoring of NGOs requires consultation with a number of different stakeholders in order to learn from previous mistakes with monitoring and evaluation. The other stated objectives of the monitoring system are to identify and provide capacity where needed; to motivate for capacity building programmes; and to strengthen service provision by NGOs. Working relationship between the NGOs and senior provincial and regional managers was generally, but not always, described as positive. Older NGOs with long-standing relationships were trusted by the provincial department:

> *"When we work with NGOs we consider them as our partners because they assist us in HIV services provision.. We monitor them to ensure that they comply with the policies and regulations of the department of health regarding service provision."*

On the other hand, certain NGOs were viewed with suspicion. As one provincial manager stated :

> *"Some NGOs are corrupt, we fund them for a specific purpose and that purpose is HIV services provision but when we visit them to evaluate them we would find that they are not doing what they are supposed to do."*

8.3.1.3 Local government

The Metropolitan Council is the main decision-making structure at the local level, and this includes decision-making in relation to HIV/AIDS. Councillors within the municipality play a major role in determining budget allocation process for HIV/AIDS. Even though HIV has been identified as a Council priority, informants suggested that the final budget allocations for HIV/AIDS services did not adequately reflect this. Councillors are also involved in various HIV/AIDS programmes, for example participating in HIV/AIDS awareness campaigns initiated by the local authority or provincial health department.

Senior health managers at the local level also provide support to NGOs responsible for training and HBC. A number of HIV/AIDS activities are undertaken through the local ATIC, which is funded from the CTMM budget. The ATIC provides counselling and testing services, supports service provision at clinics, and has developed material for HIV/AIDS training. The

ATIC supports facilities in terms of training nurses in VCT and HIV testing. It has also provided guidelines for clinics on VCT and HIV testing but it is not clear how widely these have been used. At present, there is no audit system to ensure that the guidelines are followed by clinic nurses. When asked about the VCT guidelines from ATIC one facility manger stated that:

> *"I presume that in the clinic we do have and use those guidelines but I am not sure.. let me not lie."*

There is also an intersectoral team within the municipality, made up of different managers from different sectors. One of the stated roles and responsibilities of this team is to arrange different meetings and workshops to discuss HIV related issues and to organise, plan and coordinate aids programmes at the local level.

8.3.1.4 Facilities

Health facilities within the local authority provide counselling, HIV testing, and treatment of opportunistic infections. Most of these services are provided in collaboration with NGOs. For example, many clinics refer their HIV/AIDS patients to local NGOs for care and support though a few with sufficient capacity have established their own support groups. A number of VCT sites have been established and nurses are being trained in the use of rapid test kits. There are also some facilities within the local authority providing PMTCT. Most facilities have health advisors who are responsible for HIV/AIDS health promotion activities within the facility. The health advisors also organise and coordinate HIV/AIDS awareness campaigns in collaboration with the ATIC.

Despite all these activities, a number of facility managers noted that there is still a gap between what the facilities can offer and what HIV/AIDS infected patients need. The provision of medical treatment and antiretroviral drugs were mentioned as particular areas requiring attention. Clinic managers commented on the difficulties of having to explain to their patients that the clinics only have a limited role in HIV/AIDS service provision. The lack of communication between the hospitals and clinics seemed to aggravate the confusion and frustration amongst facility managers. As noted by one clinic manger:

> *"Even if we refer patients to the hospital for treatment and medication, we do not get feedback from the hospitals and when the patients come back to us expecting us to give them food parcels and certain drugs it becomes difficult for us…. At the end of the day we end up not knowing who can accommodate patients within our health system."*

Through volunteers some facilities also provide physical care for the terminal ill patients in the communities. These volunteers provide support, counselling and refer families for further health care and support to other sectors or NGOs. All volunteers are supposed to receive training from ATIC before they enter the community.

8.3.1.5 Horizontal Roles and Responsibilities

Different government departments have different roles and responsibilities in relation to HIV/AIDS. The PDoH has identified the importance of a holistic approach to HIV and the involvement of other departments in dealing with HIV. The Departments of Education, Social Development, Health, Housing, Home Affairs and Agriculture were mentioned as important partners in addressing HIV issues at the provincial and municipal levels.

In the interviews, the specific roles of the Department of Education were identified as attending to the educational needs of children; involving HIV/AIDS in the curriculum; and

developing HIV awareness campaigns or health promotion activities in schools. The Housing Department was highlighted as having an important role to play in terms of providing shelter for those people left homeless (i.e. children) after death due to HIV/AIDS. The Department of Home Affairs was viewed as an important department since it handles critical documents such as birth and death certificates. The Departments of Social Development and Health Department were mentioned in relation to disability grants and the provision of health care services respectively.

Coordination between these departments is improving which has made it easier to refer an HIV positive person to the correct department for assistance. An integrated approach to service delivery would help to ensure that HIV positive people can access grants, health care and support services at a single location. In Gauteng a pilot study has been initiated to have certain government departments (Housing, Home Affairs, Heath, Social Development) under one roof so as to improve access for HIV positive people. One provincial manager noted that:

> *"Previously, a person with HIV requiring services would find it difficult to access those services and some would die without even accessing any service. Now that different government departments are working together and are under one roof people have access."*

NGOs like Hospice and Friends for Life were also identified as contributors to HIV services. Hospices provide terminal care to HIV positive people and support family members in dealing with death. Friends For Life is an NGO that supplies food for HIV positive people who cannot buy food for themselves. Religious organisations were mentioned as playing an important role in HIV/AIDS awareness campaigns and HBC services. Church leaders also provide spiritual support to individuals who are ill.

8.3.2 Problems with Roles and Responsibilities

The most commonly stated problem by regional and district HIV programme coordinators was the lack of support from middle managers in the regional department. Hierarchical processes of decision-making and authorisation were mentioned as particular obstacles. One regional coordinator stated that:

> *"Sometimes it is difficult for me to do what I am supposed to do because I need authorisation from my manager and I can only get that authorisation if he/she understands what the project is about and if she/he views that project as important or not"*

Although decision-making has theoretically been decentralised and coordinators have been led to believe that they can take certain decisions on their own this has not proved true in practice. As noted by one coordinator:

> *"There is a problem about decision making is in this region, we are just reduced into nothing, as a coordinator you are just treated like a baby with minimal authority. For everything that you want to do you must get authorisation from our managers."*

These two quotes highlight a number of different issues:

(a) they indicate the feelings of ineffectiveness and lack of confidence by coordinators in authority and decision-making processes;
(b) they suggest that senior managers sometimes do not understand the need or importance of specific HIV initiatives;
(c) they imply a lack of effective consultation between the actors involved and indicate problems related to communication and trust;

(d) they point to the existence of conflictual relationships between coordinators and middle managers; and lastly
(e) they indicate the confusion and frustration of coordinators particularly in relation to the decentralisation process.

These dynamics were claimed to have a significant effect on the implementation of HIV/AIDS programme activities:

> *"When I first joined the regional department as HIV programme manager I had to start from scratch. It was difficult for me especially because I did not have support from my manager. When I needed to go to facilities, it was impossible for me because I was denied access by the people on top. I was told that I needed to give six weeks notice to my top manager in order for me to be allowed to go to the facilities. That meant I would wait for six weeks before I could start doing my job in the facilities."*

Problems are also experienced by senior managers in relation to carrying out their duties. It was stated that HIV/AIDS issues are politicised within the region. These politics results in conflictual relationships and a lack of trust between coordinators, programme managers, senior managers and the regional director. Racism was also highlighted as an issue constraining people in the performance of their duties. One regional coordinator stated that:

> *"Racism and HIV/AIDS politics are high here. Senior black managers are put on binoculars and that creates an unpleasant environment to work in… If people think you are having too much power they end up frustrating you by involving you in many HIV/AIDS sub-programmes and you will end up being overworked. This is all because top managers are trying to minimise your power… if you do not see eye to eye with your senior manager you will not find joy in your work."*

Difficulties in the relationships between political councillors and administrators were also mentioned by some actors as a source of frustration and a constraint on HIV service provision.

8.4 Coordination and Integration

8.4.1 Coordination Mechanisms

8.4.1.1 Provincial Department

At the provincial level, the Provincial Aids Council (PAC) facilitates coordination of HIV services between different spheres of government and between different actors. Through this structure several actors (regional mangers, local managers, local government councillors, etc) are involved in discussions around HIV/AIDS. There are also monthly and bi-monthly meetings between provincial and regional HIV programme managers.

Provincial HIV/AIDS coordinators involve the local government in their planning activities. Even though the provincial department does not have regular meetings with the local authority, structures such as the PAC have improved communication and interaction between the PDoH and the local sphere.

A number of people interviewed in the regional office stated that formal coordination of HIV services is not an easy process. However, many respondents also referred to the successful

coordination of activities related to World HIV/AIDS day, where different stakeholders from different spheres of government work together in planning and implementation.

8.4.1.2 Local Government

Within the local authority there is some discussion about the need to establish District Aids Councils (DACs) to coordinate activities at the district level. At the time of the interviews, the City of Tshwane had drafted guidelines for the functioning of District Aids Councils which were awaiting ratification by the Metropolitan Council. The composition and functioning of the DACs will be similar to that of the Provincial Aids Council.

Coordination of HIV/AIDS projects within the local authority is carried out through an integrated intersectoral approach. At the metropolitan level health and welfare fall under one manager responsible for Social Development. She works with other sectors on an intersectoral team to deal with issues related to HIV/AIDS. Informants indicated that there was significant political commitment to addressing HIV at the municipal level and that this improved the coordination of HIV activities. One senior manager said:

> *"In the intersectoral team there are two seniors politicians that participate. And within Social Development the portfolio incumbent have specifically prioritised HIV services provision for the department."*

The municipal intersectoral team has also attempted to engage with managers from the provincial departments of health as well and the regional office in a number of local meetings and workshops.

8.4.1.3 Facilities

At lower management levels, clinic managers meet together on a monthly basis to discuss service provision though these meetings obviously do not focus exclusively on HIV services. Coordination between facilities and hospitals seems to be less formalised although in some areas monthly meetings between the hospital and the facilities are used to coordinate referrals. Clinic managers also commented on their close cooperation with the ATIC and their involvement in HIV/AIDS awareness campaigns and World HIV/AIDS events.

8.4.2 Referral Relationships

The development of appropriate referral mechanisms to facilitate interactions between clinics, hospitals and the community has frequently been identified as a priority. The referral system within CTMM, as described in the interview data, is represented in Figure 8.1. Clinics in Tshwane refer their HIV patients to hospital (mainly Kalafong and Pretoria West), Hospice, ATIC and other government departments. Inter-clinic referrals are unusual because of the limited resources at this level. There is minimal referral to private health care institutions because most of the HIV patients seen at municipal facilities do not have access to medical aid.

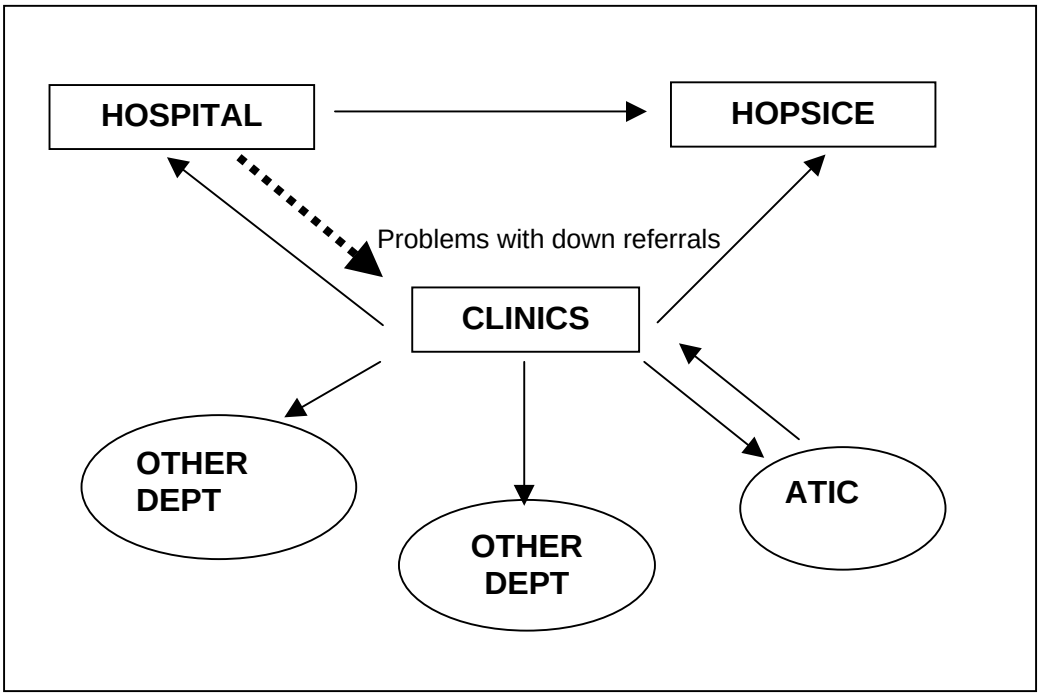


Figure 8.1 : Referrals within CTMM

Again, referral relationships between hospitals and clinics was the only area identified as problematic. As one clinic manager said:

> *"Once we refer a patient to the hospital, they do not advise us on what was done to that patient, so there is no feedback from the hospital. In attempts to deal with this problem we have taken the issue up with our top mangers."*

The lack of feedback results in inadequate information about patient care and causes confusion for patients. Most clinic managers felt that better communication was needed between clinics and hospital personnel. This has already been addressed in some sub-districts with clinic managers reporting significant improvements in communication and collaboration with hospitals.

Referrals to home-based care NGOs were generally viewed as positive. Referrals occur in both directions: NGOs refer patients to clinics and the clinics refer patients back to the NGOs. The constant interaction between facilities and NGOs has ensured that problems are dealt with and relationships remain good. As mentioned previously, the ATIC works closely with facilities through the training of volunteers. Referrals to Social Development services were reported as working well.

8.4.3 Problems with Coordination

Informants identified a number of problems in inter-governmental and inter-departmental coordination of HIV services. These included:

- **Lack of communication:** Certain units within the PDoH do not communicate effectively with other actors. The lack of communication results in the duplication of services, poor organisation, and inadequate coordination of HIV services. As stated by one regional coordinator:

"There is no integration between departments within the region, for example I do not know when last did I attend ITC meeting and this is all because of poor communication and planning."

- **Staff shortages:** Respondents from the regional office as well as clinics reported that they were sometimes not able to attend meetings or workshops because they had insufficient staff to cover for their absence. A regional coordinator stated that *"due to the staff shortage problem it is difficult to coordinate HIV activities competently."*

- **Lack of administrative support:** The regional unit tasked with coordinating HIV services has inadequate resources and is over-worked.

- **Organisational hierarchy**: The hierarchy has already been mentioned as hindering the coordination of HIV services. Formal protocols and lines of communication are slow and cumbersome.

8.5 Informal Dynamics

8.5.1 Trust

Generally a fair amount of trust exists between the PDoH and local government. What is less clear is the level of trust between different HIV services providers within each sphere of government. Several problems have been highlighted as affecting effective internal coordination of HIV services, for example the lack of trust between regional HIV coordinators and their senior mangers.

The allocation of funds to NGOs was viewed as a source of tension in relationships between the PDoH and NGOs. The PDoH is not able to fund all NGOs that apply for funding and NGOs that do not receive funding are sometimes quite forceful in voicing their grievances with the department.

Inter-sectoral relationships have been improving. Home affairs and the Agriculture department were identified as the most difficult departments to work with because they do not attend the workshops and meetings organised by the PDoH.

8.5.2 Racism, Bureaucracy and Hierarchy

As outlined in the previous sections, the organisational culture of the regional office appears to undermine, rather than support, HIV service delivery. Issues relating to bureaucracy, hierarchy, politics and racism were mentioned by informants. The lack of decentralisation and feeling of disempowerment featured frequently in the interviews:

"The minimal powers that we have does not influence decision making around HIV services provision issues. The other problem that we have as coordinators is the organisational hierarchy whereby decisions are only taken by people at higher levels."

This was not the case in the CTMM where there is clear political support for HIV service provision and organisational relationships were generally described as positive.

8.6 Conclusions

The CTMM Case Study describes the complexities of coordinating HIV service provision within a Metropolitan Council area. The situation is further complicated by the fact that Tshwane is a cross-border municipality. The local government DoH has significant capacity and expertise to contribute to HIV service delivery in the area but still functions fairly independently of the HIV programme managed by the province and regional office. Attempts have been made to improve functional integration, but the structural conditions create significant obstacles to improving inter-governmental coordination of HIV services.

The case study has also highlighted the importance of informal dynamics and the intra-departmental coordination of health care services. The organisational and managerial culture of health departments is critical to effective HIV service provision.

CHAPTER 9: DISCUSSION

This chapter attempts to integrate the findings from the different components of the study, discuss some of the contextual factors that contribute to the observed relationships and dynamics, and consider the relevance of the study to HIV/AIDS service delivery. The last section of the chapter then suggests some approaches to improving governmental coordination.

9.1 Overview of Findings

Table 9.1 highlights some of the main findings of the study by summarising the strengths and weaknesses identified by respondents in relation to what HIV/AIDS services are provided, how HIV roles and responsibilities functions are allocated, and how they are coordinated.

Table 9.1 : Summary of strengths and weaknesses

	Strengths	Weaknesses
HIV/AIDS Service Package	▪ Comprehensive outline provided by 5-year HIV/AIDS Strategic Plan ▪ Well-defined priority interventions (condom provision, VCT, HBC) ▪ Progress with implementation of priority interventions	▪ Implementation too slow ▪ Little on treatment ▪ Neglect of broader systems and development roles
Allocation of Roles and Responsibilities	▪ General health roles are defined ▪ Functions of different actors in relation to HIV/AIDS has evolved over time ▪ Reasonable consensus on roles, particularly in relation to national and provincial levels ▪ Some attempt to define roles of other departments and other sectors	▪ HIV roles and responsibilities of different actors not formally defined ▪ Some tensions in role allocation ▪ Role of local government unclear and unstable ▪ Limited decentralisation of responsibility ▪ Focus on directing and controlling rather than support and development ▪ Limited attention to service delivery at facilities
Coordination and Integration	▪ Coordination of HIV/AIDS services is receiving attention and resources ▪ Framework provided by Strategic Plan ▪ Improvement in National – Provincial coordination ▪ Inter-departmental and inter-sectoral coordination being addressed	▪ Objectives of coordination not clearly specified ▪ Weak communication systems ▪ Poor Provincial – Local coordination ▪ Less attention to intra-departmental coordination ▪ Reliance on structures for coordination ▪ No coordination of coordination ▪ Focus mostly on political channels of coordination

The National Strategic Plan provides a fairly comprehensive and detailed plan of action in relation to HIV/AIDS. Current activities in HIV service provision are focused more on prevention and support than on curative services. The priority activities have generally become structured into separate, fairly vertical programmes - such as the voluntary counselling and testing (VCT) and home based care (HBC) programmes - with reasonably well-defined packages of interventions. The vertical, programmatic focus also means that that broader systems support and development is not a significant component of the current HIV package.

According to the Constitution, government is divided into the legislative, executive and administrative arms as well as national, provincial and local spheres. However, in reality, government delivery of services such as HIV requires the coordination of a more complex array of actors including other programmes, support services and line manages within the DoH, different government departments, nine provinces, 284 municipalities, a multitude of NGOs, the private sector and civil society (Figure 4.1). This complexity clearly complicates the allocation of roles and responsibilities and attempts at integration. A further difficulty is the nested nature of government organisation and hierarchy. For example, the HIV programme is located within the Department of Health (DoH) which in turn is part of broader government. Responsibility for HIV service delivery and coordination may simultaneously be allocated to each of these levels (Figure 3.1).

The generic roles of the three spheres of government are outlined in documents such as the Constitution, Health White Paper and Health Bill. However, the specific roles and responsibilities of the different spheres and actors with regard to HIV services are not clearly specified in DoH policy including the HIV Strategic Plan. Over time the respective roles of the national, provincial and regional/district levels have become more clearly defined, at least in respect of the priority programmes. A particular area of uncertainty is the role of local government in HIV service provision (not to mention the allocation of responsibilities between district and local municipalities). There is also less clarity about the exact roles of different government departments and actors from other sectors although the Strategic Plan attempts to provide some initial suggestions. Certain functions, such tackling the broader systemic problems underlying curative service delivery, remain unallocated.

There has been some deconcentration of responsibility along the national – provincial – regional axis but most of the strategic direction and authority within the HIV/AIDS programme remains at the centre. A number of respondents complained that the national and provincial levels were still too involved in programme implementation (Section 5.2.3.2.1). HIV activities at the local government level remain fairly limited although there is significant variation between municipalities. In general, few responsibilities have been specifically devolved to the local government level. Despite the Constitutional obligation to help local government fulfil its objectives (Section 4.2.1), the national and provincial levels have tended to focus on directing and controlling rather than supporting and developing the levels below them. Similarly, the rollout of national priority programmes by provincial and district officials has taken precedence over supporting facility-based HIV services.

Coordination and integration has been identified as a priority within the DoH and the HIV/AIDS programme and is now receiving attention and resources. However, the attention paid to different categories of coordination has been uneven resulting in variable improvements in coordination.

Within inter-governmental relations, few people at the national, provincial and regional levels identified integration as a major problem and these levels appear to be working reasonably well together in the implementation of the priority HIV programmes. National–provincial coordination is achieved through mechanisms such as the framework provided by the National Strategic Plan; regular meetings between programme directors from the two levels; specific conditional grants to support priority activities; and the appointment of national personnel at provincial level. On the other hand, coordination and integration with local government is quite weak. Local government HIV services appear to function almost independently of the national programmes even when there is significant overlap of activities such as where municipalities are setting up VCT sites or contracting with NGOs for the provision of HBC. One possible exception is the participation of municipal departments in

HIV/AIDS Day campaigns organised by the national and provincial departments. Responses from staff at hospitals and clinics were mixed. A few mentioned referral problems and some complained of broader systemic problems undermining HIV service delivery, such as staffing and transport problems.

A number of specific structures, such as the National AIDS Council (SANAC) and Interdepartmental Committee (IDC), have been set up to facilitate inter-sectoral and inter-departmental HIV activities. Many of these structures are now supported by dedicated personnel and secretariats from within the DoH. However, the structures vary in their effectiveness; some have played a critical role in coordination whereas others exist in name only. Nevertheless, they have tended to proliferate, for example SANAC and the IDC have been replicated at provincial level, and provinces are now trying to establish District Aids Councils and even Local Aids Councils. In some instances, the establishment of new structures has become an end in itself, hindering coordination rather than facilitating it.

Most coordination structures involve political leaders which doesn't necessarily result in improved coordination at the service level. In general, intra-departmental coordination of administrative staff has received much less attention. Some intra-departmental coordination is achieved through internal management processes but organograms and hierarchies are significant obstacles to certain coordination relationships.

Lastly, the interviews demonstrated the importance of informal relationships in influencing and replacing formal coordination mechanisms. Informal processes constitute an important component of the organisational life of health systems.

9.2 Some Explanatory Factors

Some of the contextual factors which are responsible for the relationships and dynamics discussed in the last section are summarised in Table 9.1.

Certain influences seem unique to HIV/AIDS. The urgency of the HIV crisis in South Africa clearly drives some of the preoccupation with implementation and delivery rather than slower developmental approaches. Similarly, HIV/AIDS is seen as requiring broad, multi-sectoral responses which significantly increases the number of actors involved and the complexity of coordination. Lastly, the national political debates relating to HIV/AIDS are responsible for the tentative approaches to PMTCT and ARV provision.

At the DoH level, a key contextual factor has been the policy process with regard to district health system development. The focus on the district level as well as the uncertain and changing debate about the role of local government within the DHS must have contributed to the poor integration and coordination with the local sphere. With regard to HIV services, interactions appear to be limited to the very local processes and very mundane issues. However, it must also be stated that HIV service development and DHS implementation are only a small component of the wide-ranging health sector reforms being developed and implemented in South Africa at present.

Table 9.1: Important contextual factors

Level	Factors
HIV	▪ Crisis of HIV epidemic in South Africa ▪ Complex array of actors involved ▪ Political debates about HIV strategy
Health	▪ Ongoing health sector reform ▪ Focus on district level development ▪ Delays in DHS development and implementation
Government	▪ Urgency of delivery ▪ Poor institutional capacity, particularly at local government level ▪ Slow process of local government reorganisation ▪ Inter-governmental relations in transition ▪ Political culture ▪ Nature of the bureaucracy ▪ New public management tendencies
Broader context	▪ Period of change and transition ▪ Nature of transition ▪ International policy environment

Intergovernmental relations and the coordination of HIV services are also influenced by the present context of change and transformation at the public sector level. Some important factors include the current political imperatives for service delivery; the historical legacy of apartheid on the systems of government in South Africa; and the prolonged process of local government restructuring. Within this changing environment, governmental relations are still in a process of evolution and development.

The organisation culture of the public sector is also important. The nature of bureaucracy tends to favour formalisation and structural solutions to coordination problems and the current political culture influences aspects such as the emphasis on accountability to politicians and the centralisation tendencies of government. The enthusiasm for new public management approaches underlies some of the preoccupation with control, performance and financial coordination mechanisms.

Lastly, the HIV/AIDS programme is affected by the broader socio-political environment in South Africa as well as the policy prescriptions of international actors such as WHO or UNAIDS.

9.3 Impact on HIV/AIDS Services

The focus of the HIV/AIDS Strategic Plan has been the rollout of a series of national HIV priority programmes, such as VCT and HBC, and improving inter-departmental and inter-sectoral involvement in the campaign against HIV. There has been some progress in the establishment of VCT sites and HBC providers and their implementation has been fairly well-coordinated, at least between the national and provincial departments. Structures to integrate HIV activities between different departments and with actors outside of government have been established, but have had limited impact on the HIV/AIDS programme to date.

The Strategic Plan has been very helpful and influential in determining the direction of the HIV/AIDS strategy. The danger, however, is that where the plan is weak or deficient, the programme will be too. So, aspects such as supporting curative HIV services at clinics and hospitals, and improving inter-governmental and intra-departmental coordination have

received much less attention. Some officials voiced their concerns about the limited space for strategic engagement and review of current strategies and initiatives.

Many facility level managers interviewed seemed ill-prepared to take on the extra workload being allocated to them in relation to HIV services, particularly the provision of counselling and interactions with NGOs and CBOs. Their concerns related to basic infrastructure and broader systems support were not yet being addressed within the HIV/AIDS programme. Referral relationships seem to be improving but problems were still identified in connection with HIV/AIDS patients.

The limited interaction and involvement of local government is related to concerns about capacity at the local level and indecision regarding DHS development. Nevertheless, failing to take full advantage of the resources and more developmental approach of local government may be particularly detrimental to HIV/AIDS services.

Lastly, informants outside the HIV/AIDS programme frequently complained that HIV/AIDS was receiving a disproportionate share of the attention and resources. The impact on other health service and PHC priorities needs to be carefully considered.

9.4 Improving Governmental Coordination

This study has demonstrated the complexity of governmental relationships and coordination. Hopefully, the frameworks and approaches presented in this report, help to identify some of the aspects that need to be considered in improving governmental coordination.

A prerequisite requirement for improving coordination is to clarify the roles of the different actors in relation to HIV service provision. The Strategic Plan make some attempt to address this but neglects a number of important actors. For example it makes little mention of the roles and responsibilities of the different spheres of government.

A fundamental difficulty is that the design of coordination systems is not simply a matter of choosing the one best strategy. There are a number of tensions and tradeoffs that need to be considered and strategic decisions need to made about short-term as well as long-term priorities (Table 9.1).

Table 9.1: Tensions in governmental coordination

Area	Tensions / Balances
Objectives	▪ Service delivery vs governance ▪ National integration vs local accountability ▪ Top down direction vs bottom up support ▪ Short term delivery vs long-term development
Categories	▪ Inter-departmental and inter-sectoral vs intra-departmental
Channels	▪ Political vs administrative
Mechanisms	▪ Structures vs other mechanisms ▪ Formal vs informal processes ▪ Use of financial mechanisms
Nature	▪ Nature of relationship required ▪ Communication vs joint decision making
Processes	▪ Minimal vs maximal approaches ▪ Participative vs top-down ▪ Formalisation vs ad-hoc development

There may be a number of different objectives in governmental coordination. We initially assumed that the primary concern was national coherence in HIV service delivery, but this may need to be tempered slightly. For one thing this is a rather top-down understanding and may undermine proper political accountability and governance at the provincial and local levels. There is a difference in viewing intergovernmental coordination as a tool to facilitate the implementation of national level programmes or as something that is necessary to support service delivery at the bottom. There may also be a tension between achieving short term delivery objectives, through mechanisms such as centralisation and verticalisation, and broader, more long term developmental goals. These tradeoffs are also reflected in the need to balance the oversight and control roles versus the developmental and support responsibilities of the national and provincial spheres of government.

A more balanced approach to the different categories of coordination may be essential. Inter-departmental and inter-sectoral coordination are clearly important but more immediate priorities may be to facilitate horizontal and vertical interaction within the DoH as well as improving coordination between the provincial and local spheres of government.

Similarly, political buy-in and leadership may be critical to the success of HIV/AIDS interventions, but developing channels for administrative coordination are also important to ensure that coordination of actual service delivery takes place. Another strategy would be to focus on improving political – administrative relationships.

Formal structures are frequently seen as the solution to coordination problems. However, the coordination structures developed for HIV/AIDS services have not been uniformly successful. The history of intergovernmental coordination in South Africa since 1994 is littered with such failed structures and it is still difficult to predict which ones will be successful {31,72}. Other mechanisms of coordination may also need to be considered. For example, one of the most important coordination mechanisms in HIV/AIDS services is the National Plan. Also, in relation to intra-departmental coordination, the formal nature of organisational structure and bureaucracy facilitates certain relationships while preventing others, but the solution to these difficulties is unlikely to be more structural change. More innovative mechanisms of coordination, such as those outlined in the Free State case study, may need to be developed. However, where structures are created there needs to be more attention to the *“coordination of coordination”* which requires defining clear responsibilities and relationships between the different coordinating structures

There also appears to have been little explicit emphasis on trying to facilitate the Constitutional approach to inter-governmental coordination which is to ensure that different spheres of government share the same values and principles. Some respondents spoke more of the competition and rivalries between levels rather than their shared project of government delivery. It is unclear how more financial mechanisms of coordination, such as conditional grants and service level agreements, will influence these relationships between different spheres of government.

Some consideration needs to be given to process issues in the design of inter-governmental relationships, for example by ensuring that actors affected by the changes participate in their development. A flexible dynamic approach needs to be adopted since it is impossible to sit down and design the perfect system of coordination, it generally requires significant experimentation and development over time.

Lastly, it should be remembered that although coordination is important, there are opportunity costs to spending resources on coordination, and that minimal rather than maximal responses may be more appropriate.

9.5 Limitations of the Study

Some of the limitations of the study include:

- It was mainly an exploratory study which aimed to provide initial insights into the dynamics of governmental coordination as related to health systems.
- Therefore, the study provides a broad but superficial understanding of HIV/AIDS programme functioning and coordination. None of the components was evaluated in any detail.
- The research methodology was restricted to document analysis and key informant interviews. More in-depth qualitative techniques, such as participant observation, may better illuminate what is really going on in the HIV/AIDS programme.
- The study did not objectively evaluate the quality of HIV programme functioning or HIV service delivery.
- The project included a limited number and range of interviews. We did not speak to everyone involved in the HIV/AIDS programme and certain details or nuances may have been missed.
- Only three case studies were conducted and these are unlikely to be representative of all provinces and municipalities in South Africa.

9.6 Conclusions

The study provided some useful initial insights into the actual organisation and coordination of HIV/AIDS services. It highlighted the complex array of actors involved in HIV service provision and the difficulties this presents for the allocation of role and responsibilities as well as coordination. The frameworks developed help to discuss how governmental coordination may be improved but also point to the need for further research in this area.

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APPENDIX

KEY INFORMANT INTERVIEW SCHEDULES

SCHEDULE 1: ALL RESPONDENTS (PHASE 1)

Questions	Probe
1. What is your current position? 1.1. How long have you been in this job?	
2. Could you tell me a bit about your background?	– Professional training – Past experience
3. What do you see as the main objectives of the HIV programme? 3.1. How does the HIV programme contribute to transformation in South Africa?	
4. What are the key strengths and weaknesses of the HIV programme at the moment?	
5. We are trying to understand the responsibilities of the different groups involved in the planning and provision of HIV services. What is your department responsible for?	– Roles & responsibilities of their own level
6. Which other groups play a role in the provision of HIV services?	– Vertical and horizontal actors
7. In relation to HIV services, what are the roles and responsibilities of the different levels of the health system?	– Focus on HIV roles – Different vertical players: ▪ National ▪ Provinces / Regions ▪ LG (As, Bs, Cs) ▪ Hospitals ▪ Clinics ▪ NGOs
8. Do each of the levels do what they are supposed to do?	– Explain – Why / Why not (if time available)
9. How will changes in the definition of LG services impact on the roles and responsibilities of the different levels?	
10. How are HIV services coordinated and integrated across the levels of the health system?	– Formal mechanisms and processes – Structures (Committees, MinMEC, PHRC) – Meetings – Coordination within admin component
11. Which level is it most important for you to coordinate with?	
12. Are there informal mechanisms that help to coordinate work across the different levels?	– Explain – Communication channels, personal contacts
13. What hinders efforts to coordinate and integrate HIV service provision **between** the different levels?	
14. In relation to HIV activities, what are the roles and responsibilities of the different groups and departments **within** the (n*ational/province/LG)* level?	– Horizontal players: ▪ Colleagues ▪ Administrators ▪ Politicians ▪ Treasury ▪ Other sectors
15. Do each of these groups do what they are supposed to do?	– Explain – Why / Why not (if time available)
16. How are HIV activities coordinated and integrated **within** the (n*ational/province/LG)* level?	– Structures
17. Which group is it most important for you to coordinate with?	
18. Are there informal mechanisms that help to coordinate work **within** the (n*ational/province/LG)* level?	– Explain – Communication channels, personal contacts
19. What hinders efforts to coordinate and integrate HIV service provision **within** the *national/province/LG* level?	

We would like to discuss some specific aspects of HIV services in a bit more detail. For each indicate:

Has it been happening?

Who are the different groups involved?

Who is responsible for what?

How the work is coordinated and integrated between the different groups?

Questions	Probe
20. Decision-making about the package of HIV services to be delivered by clinics? 20.1. Has it been happening? 20.2. Who are the different groups involved? 20.3. Who is responsible for what? 20.4. How the work is coordinated and integrated?	– Vertical & horizontal roles – Coordinating structures – Ask about role of : ▪ National ▪ Province ▪ Clinic staff
21. The allocation of funds for HIV services? 21.1. Has it been happening? 21.2. Who are the different groups involved? 21.3. Who is responsible for what? 21.4. How the work is coordinated and integrated?	– Vertical & horizontal roles – Coordinating structures – Ask about role of : ▪ National ▪ Province ▪ Treasury
22. The development of guidelines for HIV patient management at hospitals? 22.1. Has it been happening? 22.2. Who are the different groups involved? 22.3. Who is responsible for what? 22.4. How the work is coordinated and integrated?	– Vertical & horizontal roles – Coordinating structures – Ask about role of : ▪ National ▪ Province ▪ Hospital staff
23. The training of clinic staff in HIV management? 23.1. Has it been happening? 23.2. Who are the different groups involved? 23.3. Who is responsible for what? 23.4. How the work is coordinated and integrated?	– Vertical & horizontal roles – Coordinating structures – Ask about role of : ▪ Province ▪ HR
24. The supervision of HIV staff at clinics? 24.1. Has it been happening? 24.2. Who are the different groups involved? 24.3. Who is responsible for what? 24.4. How the work is coordinated and integrated?	– Vertical & horizontal roles – Coordinating structures – Ask about role of : ▪ Province ▪ District ▪ HR

SCHEDULE 2: ALL RESPONDENTS (PHASE 2)

Introductory Questions	Probe
1. Can you tell me a bit about yourself?	– Job title – Professional training – Employment history – Personal values
2. We are trying to understand the responsibilities of the different groups involved in the planning and provision of HIV services. What is your role in the HIV programme?	– Own role – Link to HIV activities if not core responsibility
3. How do you interact and coordinate your work with the other levels, departments and groups that are involved in HIV services?	– Coordination mechanisms? – Structures? – Informal mechanisms?
4. What do you think are the most important developments that have occurred since you have been involved in HIV services?	– Choose one development / event for detailed exploration. Try to explore all the main themes getting examples where possible. – Details of critical event? ▪ When it occurred? ▪ Why is it important? – Different roles and coordination related to critical event? ▪ Different horizontal and vertical actors? ▪ Why involved? Why not? ▪ How was work coordinated? ▪ Did coordination work? Why? Why not? ▪ Which coordination mechanisms were most helpful? ▪ What structures were established? Are they working? Why? Why not? ▪ Relationships with other actors not directly mentioned? – Functions of focus in relation to critical event? ▪ How was it identified as a priority? ▪ How did planning happen? ▪ How were budgets determined? Where did the money come from? ▪ How did guidelines get developed? ▪ How did training occur? ▪ How is monitoring and evaluation occurring? – Support received ▪ Who? How? – Lessons about successes and failures
5. Do you trust the other levels, departments and groups involved in HIV services to do their work properly?	– Who is trusted? Who is distrused? – Why? – Possible determinants: Relationship, history, shared values, networks
6. We will be coming back again early next year. Is there anyone else you think we should speak to?	

If open-ended Critical events question doesn't work, can then try some more closed questions:

Introductory Questions	Probe
1. Which relationships are working well?	– Give examples to demonstrate how they are working – Why are they working? – Shared values, vision, trust between actors – How are they working? – Which coordination mechanisms are most helpful? – What structures have been established? Are they working? Why? Why not?
2. Which relationships are not working so well?	– Give examples to demonstrate how they are not working – Why aren't they working? – Lack of shared values, vision, trust between actors – What structures have been established? Why are they not helping?
3. If not mentioned, ask specifically about relationships with: ▪ Local government ▪ National ▪ Hospitals and clinics ▪ Politicians ▪ Other directorates / sub-directorates (HR, Finances, Hospitals, MCH etc)	
4. Have you been supported in your work?	– What support? How? – By whom? – Any support from level above? What?
5. Have you been involved in the VCT (voluntary counselling and testing) programme? (IF YES). Can you explain how the VCT programme has been implemented?	– How? Why not? – How was it identified as a priority? – How has planning happened? – How are the budgets determined? Where does the money come from? – How did guidelines get developed? – How did training occur? – How is monitoring and evaluation occurring? – For each identify actors involved? (Esp national, LG, facilities, politicians, civil society). Why and how they were involved? – Successes and failures

SCHEDULE 3: ADDITIONAL QUESTIONS ON REFERRALS FOR HOSPITAL AND CLINIC MANAGERS (PHASE 2)

Introductory Questions	Probe
1. Could you explain the referral relationships for HIV care?	– Who refers to you? Why? How frequently? – Who do you refer to? Why? How frequently?
2. If not mentioned, ask specifically about referral relationships with: ▪ Hospitals ▪ CHCs ▪ Other clinics ▪ LG ▪ NGOs ▪ Private sector	
3. How is the referral system working?	– Problems and reasons
4. How did these referral relationships develop?	– Processes, guidelines, formal structures