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Collaboration between District Health Management Team (DHMT) and District Technical Committee (DTC) in the Management of HIV Activities in Eastern Province in Kenya

Githiaka, John Mwangi

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Collaboration between District Health Management Team (DHMT) and District Technical Committee (DTC) in the Management of HIV Activities in Eastern Province in Kenya

John Mwangi Githiaka

A research report submitted to the Faculty of Management, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Master of Management (in the field of Public and Development Management).

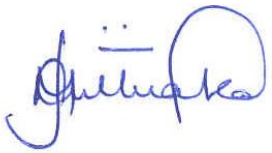
March, 2012

ABSTRACT

HIV is a key problem in Kenya and a national response has been designed to address it. The key implementing agencies for HIV response include the National AIDS Control Council (NACC) and Ministries of Health (MOH). The district structures for these agencies are district technical committee (DTC) and district health management team (DHMT) respectively and the HIV policy framework envisages collaboration between these committees. The purpose of this study was to assess the perceptions of DTC and DHMT members on their collaboration and the factors that foster and those that hinder this collaboration. The study found that DHMT and DTC members are familiar with these committees and feel that they should collaborate. They collaborate in various areas including planning and review fora, implementation of HIV activities, information management, technical support to implementers and sharing resources. However gaps exist in the collaboration and these can be addressed by strengthening on these gaps. The factors affecting collaboration include policy leadership, sensitisation on roles of the committees, joint activities, funding, information sharing and team relations.

DECLARATION

I declare that this report is my own, unaided work. It is submitted in partial fulfilment of the requirements of the degree of Master of Management (in the field of Public and Development Management) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.



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John Githiaka

04 April, 2013

DEDICATION

To my heavenly Father who enabled me and to my family - dear wife Agnes, sons Joseph, Israel (RIP) and Baraka, and daughter Neema.

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LIST OF ABBREVIATIONS

ACU	AIDS Control Unit
AMREF	African Medical & Research Foundation
AIDS	Acquired Immune Deficiency Syndrome
AOP	Annual Operational Planning
ART	Antiretroviral Therapy
ASAL	Arid and Semi Arid Land
BCC	Behaviour Change Communication
CACC	Constituency AIDS Control Committee
CBO	Community Based Organisation
CBS	Central Bureau of Statistics
CEDPA	Centre for Development and Population Activities
CSO	Civil Society Organisation
DASCO	District HIV/AIDS and STIs Coordinator
DC	District Commissioner
DDO	District Development Officer
DHMB	District Health Management Board
DHMT	District Health Management Team
DHSF	District Health Stakeholders Forum
DMOH	District Medical Officer of Health
DPHO	District Public Health Officer
DTC	District Technical Committee
FO	NACC Provincial Field Officer
GOK	Government of Kenya
HCBC	Home and Community Based Care
HIV	Human Immunodeficiency Syndrome
HMIS	Health management information system
IAEN	International AIDS Economics Network
IEC	Information Education and Communication
IMF	International Monetary Fund
JAPR	Joint Annual Programme Review
KAIS	Kenya AIDS Indicator Survey
KHPF	Kenya's Health Policy Framework

KNASP	Kenya National HIV and AIDS Strategic Plan
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOHs	Ministries of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MOTS	Modes of Transmission Survey
NACC	National AIDS Control Council
NASCOP	National HIV/AIDS and STIs Control Programme
NGO	Non-governmental Organisation
NHSSP II	The Second National Health Sector Strategic Plan (2005-2010)
OI	Opportunistic infection
OP	Ministry of State for the Office of the President
OVC	Orphans and Vulnerable Children
PASCO	Provincial AIDS and STIs Coordinator
PDP	Provincial Director of Planning
PDPHS	Provincial Director of Public Health and Sanitation
PHO	Public Health Officer
PLHIV	People living with HIV
PMO	Provincial Medical Officer
PMTCT	Prevention of mother to child transmission of HIV
PS	Permanent Secretary
RTI	Research Triangle Institute
SWAp	Sector Wide Approach
UNAIDS	Joint United Nations Agency for HIV and AIDS
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infection
TOWA	Total War Against AIDS
VCT	Voluntary counselling and testing
WAD	World AIDS Day

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1.0 INTRODUCTION AND BACKGROUND

Since Kenya's independence, elimination of disease and promotion of health has remained a priority national goal (GOK, 1965). Further, since 1980s HIV and AIDS emerged as an international and national policy problem with significant negative effects on health and development (Greener, 2002; Piot et al., 2001). For example, HIV related cases constitute a high proportion of disease burden, workload and inpatient occupancy at health facilities thereby straining health resources (Bollinger et al., 1999; MOH, 2001). In addition, life expectancy declined since 1980s partly due to HIV (Central Bureau of Statistics [CBS], 1981; 1994; 2001; 2008). Furthermore related infections and deaths are still high (MOH, 2008).

In the 1990's the spread of HIV and AIDS and its consequences on health escalated. In 1999, AIDS was declared a national disaster and to address it a national response was formulated. In line with international framework of HIV response, a single national coordinating body was formed namely the national AIDS control council (NACC). Thereafter, NACC developed formulated the Kenya National HIV and AIDS Strategic Plan (KNASP) and a monitoring and evaluation framework. The KNASP is the key policy document on HIV and AIDS and since 1999 there have been three KNASPs namely KNASP I (2000-2004), KNASP II (2005/06-2009/2010) and KNASP III (2009/2010-2012/2013). The main goal in KNASPs is to reduce the prevalence of HIV. For example, KNASP II (2005/06 – 2009/2010) aimed to sustainably reduce the prevalence of HIV through improved and coordinated national response while KNASP III (2009/2010 -2012/13) aims to deliver on universal access to services so as to attain a HIV free society (NACC, 2009).

A significant proportion of HIV activities happen in the health sector. The health sector is structured into two components namely the formal health care system and the community. The formal health care system consists of health facilities and services whereas the community component consists of health activities at individual, household and community levels.

The key implementers of the HIV response are NACC and Ministry of Health (MOH). The MOH through the National HIV and AIDS and Control Programme

(NASCOP) implements the health sector HIV services such as HIV counselling and testing, and care and treatment. On the other hand, NACC implements the community HIV services such as community HIV prevention and social protection of vulnerable populations. Furthermore, NACC is responsible for overall coordination and strategic information for the HIV response.

The NACC structure consists of a national secretariat and decentralised structures including a Field Office at provincial or regional level headed by a Field Officer, a district technical committee (DTC) at district level and a constituency AIDS control committee (CACC) at constituency level. The CACC implements the community HIV activities with technical oversight of DTC. Furthermore these NACC structures are responsible for overall coordination and strategic information. Detailed roles of DTC and CACCs are outlined in chapter 4.

On the other hand, the MOH implements the health sector HIV services. The MOH is structured into a headquarters, provincial and district levels. The respective health management structures include the national level secretariat, provincial health management team (PHMT) and district health management teams (DHMT). Furthermore, the MOH implements the health sector HIV services through NASCOP. NASCOP is represented in the health management structures by a national secretariat, Provincial AIDS and STIs Coordinator (PASCO) and district AIDS and STIs Coordinator (DASCO) respectively. The PASCO is a member of PHMT whereas DASCO is a member of DHMT.

Although the health sector and community HIV services are differentiated, integration in these responses and consequently collaboration between DHMT and DTC is envisaged. Some strategies employed to enhance this collaboration include representation of one management committee in the other where for instance, the chairperson of the DHMT is a member in the DTC.

However, there is limited knowledge on how members of DHMT and DTC perceive their collaboration and which factors foster and which hinder this collaboration. This study aimed to assess these issues thereby contribute to better understanding on the collaboration between DTC and DHMT. This knowledge will inform policy and

practice and aid decision making for enhancing the collaboration between DTC and DHMT in the implementation of health sector and community HIV responses.

This research report is divided into six chapters. This first chapter outlines the introduction and background, research problem, purpose statement, research questions, significance of the study and its limitations. Chapter two is a review of literature consulted on collaboration between DTC and DHMT. Chapter three discusses the research methodology including the research design and methods, sampling, data management and strategies for enhancing reliability of data. Chapter four presents findings of the study whereas chapter five is the analysis and discussion of the findings. Chapter six outlines the conclusions and recommendations arising from the findings of the research data and literature reviewed. The last two sections include the references on literature and documents consulted and the annexes.

1.1 Problem Statement

HIV and AIDS and the related health consequences are issues of national priority in Kenya and a national response was been formulated to address them. Two key components in the HIV response include health sector and community HIV activities. The health sector HIV services delivery is implemented by MOH and at district level these services are managed by the DHMT. On the other hand, the community HIV component is implemented and coordinated by NACC and at district level it is managed by the DTC. However, at the lowest community level, it is implemented and coordinated by CACC with technical and supervisory support by DTC. Furthermore, NACC is also responsible for the overall coordination of the HIV response.

Although the implementation of the health sector and community HIV services is differentiated, the policy framework envisages integration in these responses and thereby collaboration between DHMT and DTC. However, there is limited knowledge on the perception of members DHMT and DTC on the collaboration between the two committees and the factors that foster and those that hinder this collaboration.

1.2 Purpose Statement

The purpose of this study was to assess the perception of members of DHMT and DTC on the collaboration between the two committees in the implementation and

management of the health sector and community HIV activities. The study also aimed to assess the factors that foster and those that hinder this collaboration. The study would contribute to better understanding of the collaboration and inform policy makers and implementers on how to enhance collaboration between DTC and DHMT.

1.3 Research Questions

This study was guided by the following questions;

1. How do DHMT and DTC members perceive the collaboration between the two committees in the management of health sector and community HIV services?
2. What factors foster collaboration between the DHMT and DTC?
3. What factors hinder collaboration between the DHMT and DTC?

1.4 Research Objectives

This research aimed to assess the issues on the between DHMT and DTC by collecting and analysing data that would contribute to better understanding of the collaboration. The study also aimed to use this knowledge to recommend improvements to the functioning of the collaboration between DHMT and DTC and hopefully influence policy makers and implementers to adopt measures that will enhance this collaboration and thereby the integration in the HIV response.

1.5 Significance of the Study

In spite of the differentiated implementation and management structures of the health sector and community HIV services, the policy framework envisages integration in these services and thereby collaboration between DHMT and DTC. However there is limited knowledge on the functioning of the collaboration. This study will enhance knowledge and understanding on how members of DHMT and DTC perceive the collaboration between these committees and outline the factors that foster and those that hinder their collaboration. This knowledge will assist in designing strategies that will enhance collaboration between DHMT and DTC in the implementation of the HIV response. The collaboration numerous benefits help to reduce duplication of efforts, enhance efficiency in resource utilisation and sharing of information among other benefits.

1.6 Limitations of the Study

This study aimed to assess the perceptions of members of DHMT and DTC on the collaboration between the two committees and the factors that foster and those that hinder this collaboration. It was not an exhaustive study of the functioning of the collaboration between the two committees. First, the study outlined the areas where DTC and DHMT are collaborating but did not undertake a detailed description of the same. Secondly, the study identified the factors that foster and those that hinder collaboration between DTC and DHMT but did not describe these areas. Also it did not describe other areas of further collaboration such as issues related to governance, tools and processes. Thirdly, there was limited literature on prior research conducted in the collaboration of DHMT and DTC and therefore this study explored what the key issues in the collaboration are. Finally, this study conducted in Eastern Province depicts issues that are generally encountered in collaboration. However, the findings may not be representative of the situation in other parts of the country.

1.7 Challenges in the Study and Mitigation

Various challenges were encountered while conducting this study. First the administrative structures changed with the creation of several "new" districts through sub-division of larger ones. However for the purpose of this study, the initial list of districts at the start of the study was retained as the sampling frame.

Secondly, after 2008 national elections, changes were effected in the structure of the health sector. For example, the MOH was split into Ministry of Public Health and Sanitation (MOPHS) and Ministry of Medical Services (MOMS). The initial MOH was headed by the Provincial Medical Officer of Health (PMO) at the province and the health sector HIV issues were handled by the provincial HIV and AIDS and STIs Coordinator (PASCO). In the new structure both MOPHS and MOMS were each headed by a provincial Director. The health sector HIV services are handled under the MOPHS which is headed by the provincial director of public health and sanitation (PDPHS). The PASCO role was retained under the supervision of PDPHS. In this study the PDPHS and PASCO were interviewed as key informants.

Thirdly, during the study the national policy on HIV i.e. KNASP II was revised to KNASP III which took effect as from 2009. The transition affected certainty with

which findings could be held feasible. However, there was continuity in the policy imperatives in KNASP III and it did not affect the feasibility of the findings. Furthermore, the implementation framework for the HIV response did not significantly change and hence it was possible to proceed with the study.

2.0 LITERATURE REVIEW

This chapter reviews literature and documentation on the operations of DTC and DHMT and their collaboration. Firstly literature on collaboration and coordination between agencies working in the public sector is delineated where first; modes of social coordination and governance are outlined. Secondly, partnership as a mode of coordination in the public sector is underscored. Thirdly, key issues in collaborative partnerships related to perceptions about partnerships are outlined. According to the available literature, these issues include conceptualisation of partnerships, the functioning of partnerships in collaborative spaces and the factors that affect partnerships including those that foster and those that hinder collaboration in partnerships. In addition, relevant policies and guidelines are reviewed outlining the structure of the HIV response, the operations of DHMT and DTC and their collaboration in the implementation and management of the HIV response.

2.1 Social Coordination and Governance

Collaboration between agencies and improvement of the interagency working and coordination is a key policy priority (Sloper, 2004). Three modes of social coordination and governance include hierarchies, markets and networks (Frances et. al., 1991). These modes provide a useful framework for analysing public service delivery and the environments in which collaborations take place (Wendy and Hudson, 2004). In the 1960s and 70s, hierarchy was the dominant means of public service delivery and intra-agency coordination was achieved through features of bureaucracy including vertical integration, defined spans of control and authority, command and control leadership, and functional frameworks that stressed on rules, routines and standard operating procedures (Wendy et al., 2004). However, challenges were experienced in communication and coordination between agencies and between functions and departments within bureaucracies often leading to compartmentalised operations. Furthermore, bureaucracies were usually rigid, unresponsive or not adaptable to changing circumstances. In addition, bureaucracy emphasised more on procedures than on results.

In the 1980s, focus shifted to markets and competition mode of operation in the delivery of services (Wendy et al., 2004). Parts of public sector were privatised and

others exposed to market operation, competitive tendering. Often, large multi-functional bureaucracies were divided into networks of specialised agencies. Coordination was achieved through the market system whereby price mechanisms and contract law were the key means of regulating relationships. However, although cooperation between agencies to produce synergies or larger market share was common, it was often limited by suspicion of competitors and desire for independent action and control.

Nonetheless, competition in the public sector experienced challenges due to various reasons. First, public agencies operating competitively co-existed with significant hierarchical control from central government such as in setting and regulating their performance standards (Robinson and Lengrand, 1994; Flynn et al., 1996; Wistow et al., 1996; Ranade, 1998). Secondly, sub-division of agencies introduced more players in the policy sphere and this made service delivery and a holistic approach to service delivery more difficult. The sub-division also made the whole system more challenging and complex to steer in one direction. Thirdly, competition and contract culture often promoted self interested conduct among agencies as opposed to the public good and resulted low trust relationships rather than high trust.

Partly due to these challenges with market mode of operation in the public sector, in the 90s emphasis changed to networks and partnerships as the dominant mode of coordination (Wendy et al., 2004). Further, as compared to bureaucracies and markets, partnerships networks proffer harnessing of comparative strengths, are relatively flexible and often offer high commitment among the parties (Frances et. al., 1991). However partnerships are more complex as a mode of social co-ordination or governance (Lowndes et al., 1998).

2.2 Partnerships in Public Sector Coordination

Partnerships refer to people and organizations from different sectors or departments working together to attain a common goal (Roussos et al., 2000). Collaborative partnerships are employed in implementation of policies and programmes in sectors such as private and non-profit (Skelcher, 2000). Collaboration is also employed in social settings (Huxham et al., 2000).

Collaborative partnerships are prevalent in the public sector where it is also referred to as inter-agency coordination (Wendy et al., 2004). These partnerships involving multiple organizations emerged as a means of governing and managing public interventions (Lowndes, 1998). Further, collaborative partnerships have become an important strategy and organisational form in implementation of public programmes including in community health (Roussos et al., 2000). In Kenya, partnership collaboration is emphasised in implementation of health and HIV interventions. For example, MOH (2006) noted that achievement of the health sector goal of reversing the deteriorating health indicators would entail partnership among stakeholders. Further NACC (2005) and NACC (2009) emphasised that the response to HIV and AIDS is multi-sectoral requiring collaboration of stakeholders.

The imperative for partnership collaboration resulted from a recognition that organisational individualism is inadequate to deal with increased and complex task scope of multi-sectoral issues encountered in the sector (Alter and Hage, 1993). The multifaceted nature of these issues necessitates formation of often complex collaborative mechanisms for addressing them (Wendy et al., 2004). Furthermore, good results in the public sector are obtained from cooperation of many organisations with interdependent functions and the rigorous and continuous inter-organisational cooperation characterise success in public management rather than focussed pursuit of individual organisational objectives (Metcalfe and Richards, 1990).

Partnerships address the challenges inherent in fragmentation (Skelcher, 2000). Further, partnerships enable harnessing of comparative strengths, are relatively flexible and often offer high commitment among the parties (Frances et al., 1991). This was also highlighted by the International Monetary Fund, IMF (2007) who added that partnerships enhance complementarities and synergy in the implementation of programmes.

2.3 Conceptualisation of Partnerships

Conceptualisation of collaboration refers to the delineation of members' knowledge and perceptions on the collaborative partnership. Aspects of conceptualisation include perceptions of partners regarding the partnership including how they define partnership success. A harmonised understanding of the partnership among members

results in more stability and potential success for the partnership in attaining its goals. Other aspects in conceptualising partnerships include partnership growth and partnership types.

In the public sector, conceptualisation of the state has changed over time. The state's collaborative institutions have become a core strategy in public policy (Skelcher, 2000). Collaborative partnerships bring together actors from diverse sectors which operate between and around the institutions of government (Skelcher, 2000). As noted earlier, the partnership network of linkages is often formed to address the challenges inherent in fragmentation.

Conceptualisation also entails a delineation of how public or state actors operate in collaborative settings. Partnerships are a dynamic organisational form and are exercised through various processes and relationships operating in collaborative spaces to attain integrated goals. Collaborative spaces refer to the policy and spatial sphere where different players come together to participate in the influencing, development or implementation of public policy (Skelcher, 2005).

A key aspect in conceptualising partnerships is delineation of what constitutes its success. Mohr et al. (1994) outlined the primary characteristics of partnership success to include first partnership attributes of commitment, coordination, and trust. Secondly it includes communication quality and participation finally the conflict resolution through collaborative problem solving. Further, Dowling et al. (2004) also noted that success of partnerships may be conceptualised in two ways, first as process issues, for example how partners collaborate to address joint aims and secondly, how sustainable the partnership is. Sustainability is key aspect in partnerships since as Mohr et al. (1994) observed, many partnerships do not last long after their formation and this affects the attainment of longer term partnership goals.

2.4 Functioning of Partnerships

A key aspect in partnerships is how they function i.e. the processes and the outcomes. Partnerships are a dynamic institutional form and in assessing them, emphasis has been more on process issues than on outcomes. However, Dowling et al. (2004) noted that there is a need to focus also on outcomes of a partnership rather than merely on

the internal mechanics of administrative structures and decision-making. However Brinkerhoff, (2002) noted that partnership processes are also important in addition to the outcomes and further noted that relationships play a key role in the exercise of partnerships. Furthermore, Brinkerhoff (2002) noted that currently there are hardly any evaluation frameworks are specifically targeted at evaluating partnership relationships as compared to partnership programmatic outcomes.

2.4.1 Partnership Growth

Partnerships are dynamic and evolve over time. This evolution along a phased continuum is useful in conceptualising the growth of the partnership where each phase has different characteristics. Lowndes et al. (1998) outlined a four-stage partnership life cycle in which partnerships develop along four stages namely pre-partnership collaboration, partnership creation, partnership programme delivery and partnership termination stages. A different mode of governance i.e. network, market or hierarchy, predominates at each stage. The key challenge for partnerships lies in managing the interaction of different modes of governance, which at some points will generate competition and at other points, collaboration.

Furthermore, Snow et al. (1993) outlined a related growth model whose stages include network design (corresponding to pre-partnership collaboration and partnership creation), network operations and third network maintenance (these two correspond to partnership programme delivery). Each stage requires a unique set of skills. For example in network design and network operations stages which often overlap, enterprenuerial, negotiation and contractual skills are required. On the other hand, network maintenance requires a network caretaker who performs the role of sustaining and enhancing the partnership network and developing a sense of community among its members. As Snow et al. (1993) noted, a partnership will operate effectively only when members voluntarily behave as if they are all part of a broader organization sharing common goals and benefits.

2.4.2 Partnership Types: Coordination and Co-evolving Partnerships

Partnerships may also be conceptualised based on their aims and their complexity. In earlier times partnerships formed with the aim to deliver on common pre-set and agreed goals and partner conduct needed to achieve these goals was relatively known

and predictable (Wendy et al., 2004). These partnerships addressed issues related to coordination such as reducing duplication, adding value through pooling of resources and to achieve synergies through better fit for the partners (Pratt et al., 1999).

However, in recent times partnerships handle more complex issues cutting across multiple sectors such as social and economic and these partnerships have an imperative on joined up interventions which mobilize the entire system to address issues that present major challenges to the government (Wendy et al., 2004). In this kind of collaboration which Pratt et al. (1999) called co-evolving partnership, collective goals are usually less well defined than the objectives of coordination, have longer time frames and the partner conduct needed to achieve the partnership objectives are less predictable. The partners are usually trying to collectively develop a common programme with a shared goal, based on an understanding of the entire system and the interdependence of its parts. The concept of co-evolution is based on the understanding that partners in the entire system evolve together and the fate of each individual depends of the fate of the entire system.

Co-evolving partnership collaboration is more dependent on commitment of the partner agencies and individuals than coordinating partnerships. It requires more pragmatism and awareness on the challenges and constraints and how these can be addressed. Pratt et al. (1999) outlined the conditions that are necessary for co-evolving partnerships and the first is developing of relationships whereby people take time to delve and open up. The second condition is shifting of mental paradigms so that partners view themselves as part of a whole and hence not shift blame other parts of the system. The third condition is diversity whereby bringing together persons drawn from different levels and organizations often facilitates new possibilities to emerge. The fourth condition is prospects where it is recognised that change is often driven by passion and energy not merely finances and that joint purpose is the source of coherence. The fifth condition is iteration and this means that people will often need try over and over. The sixth condition is leadership which facilitates mutual ownership and responsibility for the whole as well as one's individual behaviour. The final condition is future and this refers to incentives which expand future possibilities and help people see their future as linked.

2.4.3 Organisational Self Interest and Decision Criteria in Inter-agency Relations

Cooperation has increased even in areas which traditionally did not collaborate (Wendy et al., 2004). This cooperation could be attributed to the expected benefits to be accrued by collaborating such as in managing competition and technology transfer (Kantor, 1994). In some organizations collaboration is necessitated by having to manage complexity in relationships occasioned by inter-dependency of an organization towards other stakeholders (Lorenz, 1991; Snow et al., 1993). In such circumstances, although competition is not outwardly evident, the decision by these organizations to collaborate follows considerations that are based on the individual organization's self interest. Furthermore, in other organisations cooperation is a means of dealing with uncertain environments and this collaboration is also based on the organizations' self interest rather than on any shared goals (Pratt et al., 1999).

Wendy et al. (2004) observed that finding legitimate reasons for collaboration is uncommon and highlighted the Benson (1975) concept of resource dependency to outline the situations in which collaboration is likely to occur. Benson (1975) had observed that in collaborative interactions in service delivery, organisations will defend their own interests and conflict will occur where these interests are incompatible. Benson (1975) noted that these interests entail resources and the two key resources that are central in the inter-organisational collaboration and these are money and authority. Further Benson (1975) suggested that organizational decision-makers are oriented to the acquisition and retention of an adequate supply of resources.

Wendy et al. (2004) used the findings on organizational orientation and outlined the decision criteria which govern inter-agency relations. First is fulfilment of programme needs and this means that agencies are hesitant to engage in tasks or to abide by practices which impede the attainment of their current programmes. Secondly is maintenance of a key sphere of influence and this means that agencies will seek to maintain control over a set of important activities. This sphere of influence is characterized by one or more of the features of exclusiveness, autonomy and dominance. Thirdly is the maintenance of a predictable and dependable pattern of resource flows and this means that organisation prefer their partnership to operate in a

predictable way where the organisation can expect reliable flow of resources. Fourth is the continued application and defence of the agency's way of doing things. This indicates the partners' commitment to the agency's patterns of doing things, its conceptualisation of problems and description of tasks and its modes of interventions.

Furthermore, Lawler et al. (1975) also detailed a set of determinants in partnerships success and noted that these influenced a partner's choice to be in a partnership. These determinants include the perceived utility and anticipated conflict in the partnership, the perceived probability of success and gains from the partnership, and the attitudinal concurrence between the partners. However, of the above factors, Lawler et al. (1975) noted that concurrence of attitudes was the most important determinant.

Furthermore, Benson (1975) distinguished between what he referred to as equilibrium and disequilibrium situations in partnerships. Equilibrium situations refer to where a policy domain is structured in such a way that the individual organizations are able to maintain sufficient supplies of funds and authority without competition or sphere conflicts. The self sufficiency of individual organisations in equilibrium situations makes them less inclined to collaborate with others. On the other hand, non-equilibrium situations refer to where organizations are forced into competitive situations and have to actively struggle to maintain these resources. The implications of this is that organizational existence is marked by a constant struggle for survival and sphere control, and collaboration will often be engaged in where there is some shared gain to be obtained from doing so.

The possibility to obtain inter-agency collaboration to achieve collective goals for the public good therefore appears limited by Benson's model but can take place if there is an expectance of a mutual benefit. However the balance of gains is usually skewed towards the dominant partner (Guest, 2001).

2.4.4 Leadership and Governance in Partnership Collaboration

Leadership and governance of partnerships to achieve integrated programme goals is fraught with challenges related to the management of diverse and often incongruent interests of various partners (Weiner et al., 1998; Guest et al., 2001). This challenge is

exacerbated by the fact that collaborative partnership structures usually have complex accountability relationships with various public bodies as well as other actors (Skelcher, 2000).

Leadership in collaborations may be conceptualised as stemming from three leadership media namely structures, processes, and participants (Huxham et. al., 2000). Further, Huxham et al. (2000) stressed that leadership moves a collaborative agenda forward and even where attempts have been made to foster collaboration in the partnership, concerted efforts are necessary to make the governance of partnerships effective in meeting the desired objectives.

Skelcher (2005*)* investigated the relationship between democratic practices and the design of institutions operating in collaborative spaces. Partnerships were described as organizational expressions of institutional make up for collaboration and these provide flexibility and allow stakeholder engagement. But Skelcher (2005) also observed that partnerships are loosely coupled to representative democratic systems and noted that governance of collaborative spaces is conducted through a dominant set of delineated institutional practices. Further Guest (2001) presented a framework for analysis of a partnership at work and highlighted the principles, practices and outcomes of partnerships. Though he supported a mutual gains model between the collaborating partners, he however showed that the balance of advantage is usually skewed towards the dominant partner.

2.4.5 Reticulists in Partnership Collaboration

Reticulists are persons whose steadfastness and charisma drives the successful development of collaborative initiatives (Wendy et al, 2004). Their roles compare to those of change agents in managerialist literature (Friend et al., 1974). They possess enduring commitment to change and infuse power to change (Degeling, 1995). They design and develop policy networks, identify the potentials for associations and linkages and build coalitions and alliances with other committed and powerful persons within their own and other organizations.

Reticulists often do not have key managerial roles across organizational boundaries as partnership coordinators or developers (Wendy et. al., 2004). Instead Ranade (1998)

called them boundary spanners and noted that their roles differ from those of conventional management. For example they manage across and upwards rather than downwards and usually manage a few people. Secondly, they influence and motivate others over whom they have little control. Thirdly, they mobilize resources owned by others. Fourth they develop trust between and among partners who have different interests, view points and organizational imperatives. Fifth, they attain substantive results that keep partners committed to the network while they advance the broader partnership goals. Finally they maintain relationships and communication networks across agencies at various levels.

Ranade (1998) outlined the skills and characteristics of these boundary spanners and noted that they all have substantive experience of inter-sectoral work. Reticulists hold a broad array of inter-personal and social skills which come in handy in their brokerage role. These skills include facilitation whereby their knowledge on processes and stages in partnership development gives them the savvy and patience to see through partnerships growth. Secondly, the boundary spanners have steering skills which enables them to focus and align different partners into a productive direction in the partnership. Thirdly, these persons have negotiation skills that are characterized by a political incisiveness on the interests and concerns of different partners. This combined with their ability to negotiate mutually beneficial agreements enables the partnership to move forward even in challenging situations. Fourth, the boundary spanners possess communication and inter-personal skills that enable them relate to different persons at different levels and communicate appropriately. Fifth, they possess entrepreneurial flair that enables them mobilize resources to advance innovative projects and fledgling initiatives. Finally, boundary spanners possess mediation skills that come in handy in explaining partner behaviour and resolving conflicts.

However, Hardy et al. (1996) noted that where collaborative initiatives have been achieved through reticulist activity, the key actors need to be maintained for continuity.

2.5 Factors Affecting Collaboration in Partnerships

Various factors foster collaborative partnerships while other factors hinder it. Sloper (2004) outlined the facilitators of and barriers to interagency working and the outcomes of co-ordinated services. Although Sloper (2004) found little evidence on the effectiveness of multi-agency working itself or of different models of such working in producing improved outcomes, reviews of evidence on multi-agency working provided consistent findings on facilitators and barriers. These included among others clear objectives, roles and responsibilities and schedules that are agreed upon between the partners, a multi-agency steering group, commitment of the organizations involved and effective systems of communication and information sharing. In addition, support and training for staff in new ways of working was proposed as well as promotion of inter-professional programmes of continuing education to help to remove barriers to joint working.

As earlier noted in Wendy et al., 2004, finding legitimate reasons for collaboration among organisations is uncommon and Benson (1975) had highlighted the concept of resource dependency that outlined the situations in which collaboration is likely to occur. In collaborative interactions, organisations' decisions and actions are made based on considerations of own interests which entail resources key among which are money and authority.

2.5.1 Factors that Foster Collaboration

Various factors foster collaboration and thereby enhance integration in partnerships. Lawler et al. (1975) outlined the determinants in partnerships success. These included the perceived utility and anticipated conflict in the partnership, the perceived probability of success and gains from the partnership, and the attitudinal concurrence between the partners. However, the concurrence of attitudes was noted the most important determinant. This was supported by Snow et al. (1993) who further observed that partnerships operate effectively when the partners voluntarily behave as if they are all part of a broader organization sharing common objectives and rewards.

Furthermore, Mohr et al. (1994) outlined what he referred to as primary characteristics of partnership success. The first is partnership attributes of commitment, coordination and trust. The second is communication quality and

participation and the third is conflict resolution through collaborative problem solving.

In addition, Benson (1975) had earlier observed that collaboration is more likely to happen if agencies increase the efficiency with which resources are utilized and how additional resources are awarded and especially where these are made conditional on the achievement of collaboration. However he also noted that while agencies may collaborate so as to access these resources it is not usually warranted if they would continue to operate effectively to achieve their often ambitious goals over longer time frames. This was observed by Lowndes and Skelcher (1998: 328) who stated that, "There is a vast difference between a package of money and real inter-agency working. You can have the first with outright enemies". Benson (1975) therefore suggested that success in collaboration is pegged on negotiated deals which hold the potential for mutual benefits. Furthermore, he stressed that supervisory structures have a role to organize the local environment to provide a facilitating framework for collaboration.

Further still, organizational flexibility is necessary for effective collaboration for example in the construction of joint programmes (thereby giving up an extent of definitional prerogative), joint resourcing (thereby giving up an extent of resource control) and joint working (giving up an extent of control over staff time, effort and loyalty (Charlesworth et al., 1996). Furthermore, in such collaborations more faith and trust is required than is often engendered in the contract culture (Wendy et al., 2004).

The implementation of collaborative partnership programmes requires effective intergovernmental coordination mechanisms to ensure that the different departments or agencies operate in a harmonious and coordinated fashion (Minehart et al., 1999). An example is employing harmonised guidelines processes and tools (Huxham et al., 2000). As Buchert (2001) noted, the coordination of approaches aimed at integration of the individual partners' processes leads to more enhanced integration at the partnership level. The integration reduces duplicated vertical programmes and bureaucracies that often create bottlenecks and impede effective implementation

(Unger et al., 2003). In addition, the integration minimises duplications especially in those interventions that cross cut related interventions (Price et al., 2000).

In inter-agency collaborations which also involve inter-professional collaborating, challenges are often experienced due to the different professional orientations (Easen et al., 2000; Johnson et al., 2003). In such instances, collaboration is enhanced by holistic integrated systems of goal setting, authority and multi-disciplinary service delivery rather than a narrow focus on structural integration alone (Johnson et al., 2003).

Furthermore wider sharing of information among different agencies leads to and results in collaboration and integration and saves resources that would be otherwise be expended in collecting information that is available with the other agency (Mohr et al., 1994).

2.5.2 Factors that Hinder Collaboration

Various factors hinder collaboration and integration in partnerships. Collaboration poses a challenge to an individual organization such as in having to forfeit some autonomy and invest own resources in building relationships with other organizations (Hudson, 1987). Further, even where there is basis for collaboration there are many barriers to surmount (Wendy et al., 2004). Hardy et al. (1992) identified the barriers to collaboration and these include structural, procedural, financial, professional, and status and legitimacy and these are outlined in figure 1 in the annex.

Further, from the view point of an individual organization, collaboration is a challenge and Hudson (1987) identified two major issues. First each agency forfeits part of its liberty to act autonomously and is forced to invest some of its limited resources in building relationships with other organizations even when the expected gain on that investment is often not apparent and substantive. Furthermore collaboration sometimes means that agencies share credit with other organizations for achievements and in other instances, even forfeiting all recognition to the other organization (Huxham and Macdonald, 1992).

Furthermore, organizations often face a stronger top-down imperative to be more stringent in pursuing their own objectives and performance targets (Wendy et al., 2004). In these instances, public agencies are faced with two way pressure of having to perform on delivering on their performance targets while at the same time participate in inter-organisational partnerships. In most instances, these organizations will prioritise delivery in their core mandates and participation in the partnership is seen as subsidiary in terms of rewards and resources. Further, Wendy et al. (2004) also noted that even where these agencies acknowledge the potential benefits of partnership in helping them fulfil their own objectives, many experience frustration as linkages do not occur easily.

In other instances, collaborative inertia is also a challenge whereby significant time and effort is spent in agreeing even on the minute details in the partnership, creating understanding of different partner perspectives and negotiating a common purpose (Huxham, 1995). The situation is further complicated where the partnership involves other sectors who may not be able to bear the costs. Such examples include voluntary sector agencies who may not have insufficient administrative capacities to engage effectively with partnerships (Lowndes et al., 1997; Ranade, 2000) and the community representatives who may often be volunteering their time and cannot afford financial costs involved with participation in the partnership.

Whereas Le Grand and Bartlett (1991) noted that a key criticism of quasi-market operation in the health and social care is the high transaction costs involved in the specification, negotiation and monitoring of contracts, however, Wendy et al. (2004) also noted that transactions costs for networks and partnerships can be equally high.

Finally, differing professional orientations where each conceptualise their practice differently often impede on collaboration (Easen et al., 2000; Johnson et al., 2003).

2.6 The Policies and Guidelines on HIV and Operations of DTC and DHMT and their Collaboration

Health is an issue of national importance. This is also noted by Ngigi et al. (2006). Further HIV and AIDS is a policy problem that affects multiple sectors (Piot et al., 2001; Greener, 2002). In Kenya, it has affected various sectors including health. In

2009 AIDS was declared a national disaster and a national response to it was designed. The policy framework on this response to HIV is outlined mainly in NACC (2005) and NACC (2009). Two key components in the HIV response include health sector services and community HIV activities implemented by MOH and NACC respectively (NACC, 2009). The policy framework for HIV envisages multi-sectoral collaboration among stakeholders (NACC, 2005; NACC, 2009). Furthermore, the policy envisages integration in the health sector and community HIV components and thereby collaboration between MOH and NACC structures especially at district level (MOH 2008; NACC, 2009). These structures are DHMT and DTC respectively and their collaboration is a partnership arrangement that aims to realise a coordinated response. In addition, NACC is responsible for the overall coordination of stakeholders.

NACC (2007) outlines the guidelines for the operations of DTC and CACCs. These NACC structures mobilise and coordinate a multi-sectoral response against HIV. The DTC (and CACC) is a multi-disciplinary committee constituting of multiple stakeholders and departments including women, youth, persons living with HIV, health, education, agriculture, NGOs and CBOs and private sector. The DTC provides technical and supervisory support to CACCs who in turn coordinate community based HIV activities in the constituency.

Furthermore, MOH (2007) which outlines the guidelines for provision of health sector HIV services such as HTC, PMTCT and care and treatment for HIV, also notes that partnerships is key to the achievement of objectives of the health sector. Some strategies outlined to enhance the partnerships include strengthening sector coordination and participation structures, implementing sector governance structures and linking governance structures to strategies of the national development plans.

In addition, the policies and guidelines outline the initiatives to actualise this imperative for collaboration between NACC and MOH and thereby DTC and DHMT. These initiatives mainly outlined in NACC (2007) and NACC (2009) include first guidelines on the constitution of DTC and DHMT which provide for cross representation of one committee in the other. For example, two DHMT members i.e. DMOH and DPHO are incorporated as members of the DTC. In addition, CACC

coordinators who are usually drawn from a health discipline such as public health, clinical or nursing are employees of the MOH but who are seconded to work with NACC. In addition to performing their public health roles within MOH, they also coordinate community based HIV activities.

Secondly, NACC (2009) outlines the roles and functions of NACC and MOH and consequently the respective committees i.e. DTC and DHMT. For example, MOH is responsible for delivery of health sector HIV services and MOH (2007) outlines the roles of MOH in carrying out this responsibility. On the other hand, NACC (2009) notes that NACC is responsible for community HIV services as well the overall coordination of HIV activities by various stakeholders.

Thirdly the NACC (2009) outlines the budgetary requirements and financing arrangements to effectively implement this multi-sectoral HIV response.

Fourth, NACC (2009) outlines that NACC is responsible for coordination, strategic information and M&E. Furthermore, NACC (2007) outlines some of the participation fora that provide for consultation and collaboration. These include WAD, JAPR and are convened by NACC.

Within the HIV sub-sector, there is an elaborate intra-agency coordination mechanism. The hierarchy of structures consist of CACC at the community level, the DTC at district level, the Field Officer at the Regional / Provincial level and the NACC Secretariat at the National Level. These CACC coordinator, district development officer, NACC Field Officer and Director respectively provide key role in coordinating the planning, implementation, and monitoring and evaluation of community HIV initiatives at their respective levels.

In coordinating the inter-agency coordination between NACC and MOH, there is not an elaborate documented framework for collaboration to enhance partnership and coordination and these often depend on initiative of the leadership. In addition collaborative initiatives often do not follow a standardised coordination framework. Furthermore, MOH (2007) noted a commitment to strengthen partnership arrangements.

2.6 Summary

This chapter reviewed literature and documentation on the coordination and collaboration in the public sector and on the collaboration of DTC and DHMT. It was noted that inter-agency coordination is a policy imperative in the public sector. Social coordination and governance was introduced and the modes of coordination between agencies working in the public sector outlined including bureaucracies, markets and networks and partnerships. Further, it was noted that the collaboration between DHMT and DTC in the management of the HIV responses is a partnership arrangement. Key issues in collaborative partnerships were outlined including first the conceptualisation of partnerships where various issues on partnerships were outlined including definition, emergence of partnerships, their operation, partnership growth and the types of partnerships i.e. coordination and co-evolving partnerships.

Secondly, literature was reviewed on the functioning of partnerships in collaborative spaces to achieve collaborative goals. It was noted that focus of partnerships has tended to be on the processes rather than the outcomes. It was also noted that partnerships are dynamic and they evolve through growth stages namely pre-partnership collaboration, partnership creation, partnership programme delivery and partnership termination. Further, the role of leadership and governance in pushing forward the goals of the partnerships was highlighted. The role played by reticulists in partnership development was also underscored.

Further still, literature was reviewed on the factors that affect collaboration in partnerships either by fostering or hindering the partnership collaboration. Issues that hinder partnership success were highlighted noting that in partnerships, decisions are based on organisational self-interest.

In addition, the relevant policies and guidelines were reviewed outlining the structure of the HIV response, the operations of DHMT and DTC and their collaboration in the implementation and management of the HIV response.

The above outline of literature aided understanding and provided a theoretical background on the key issues investigated in this study. First is the conceptualisation

of partnerships and this entailed a delineation of the knowledge and perceptions that the members of DHMT and DTC have regarding the two committees and their collaboration. The second issue is the functioning of partnerships in collaborative spaces and this entailed a review of the areas in which DHMT and DTC collaborate in and which they do not. The third issue is the delineation of the factors that affect collaboration and this entailed outlining the factors that foster collaboration as well as those that hinder it.

3.0 RESEARCH METHODOLOGY

This study employed the research methodology discussed below.

3.1 Research Design

The study was diagnostic and exploratory and employed qualitative research design. This design was due to the nature of the study and determinants as outlined by Merriam, 1998. Further, understanding was sought on poorly understood phenomenon and on the difference between stated and implemented policies (Marshall and Rossman, 1995). For example, understanding was sought on perceptions of members of DTC and DHMT on collaboration between the two committees vis a vis the state of collaboration as envisaged in the policies and guidelines. In addition, understanding was sought on unspecified issues such as the factors that affect the collaboration.

3.2 Sampling

This study was conducted in Eastern Province of Kenya. These diverse districts were divided into three clusters based on socioeconomic, demographic and health characteristics. The first cluster consisted of urban and peri-urban districts which have well established DTCs and DHMTs and good access to health and HIV services. The second cluster consisted of rural agricultural districts which have a settled population that engages in agricultural activities. These often had functional health and HIV committees and fair access to health and HIV services. The third cluster consisted of arid and semi arid (ASAL) districts which have dry weather and nomadic pastoralism as the main economic activity. These districts usually have barely functional DTCs and DHMTs and inadequate access to services.

Further in each of the three clusters, the districts were further categorised into two i.e. older and newer districts. This was because earlier on some districts had been sub-divided. The districts that had been in existence longer than a year were considered old and usually had more established structures while newly created ones had more nascent committees. As Lowndes (1998) noted, collaborative partnerships grow over time and hence collaboration between DHMT and DTC in the old and new districts could be at different stage of partnership growth.

From each category of districts in each of the three clusters, one district was selected and thereby a total of nine (9) districts were selected for the survey. In each of the selected districts, a questionnaire was administered to two key members of DHMT and DTC. These respondents included the chairpersons of DHMT and DTC i.e. the district medical officer of health (DMOH) and district commissioner (DC) respectively. In addition, the questionnaire was administered to a second key member of DHMT and DTC and these included the district HIV and AIDS and STIs coordinator (DASCO) and district development officer (DDO) respectively. The DASCO is the health sector focal person for HIV and AIDS within the DHMT whereas the DDO is secretary to the DTC.

In addition, provincial heads of the relevant government departments were selected as key informants. These included the Provincial Director of Public Health and Sanitation (PDPHS), the Provincial AIDS and STIs Coordinator (PASCO), NACC Provincial Field Officer (FO) and the Provincial Director of Planning (PDP). The PDP is the provincial head of DDO.

3.3 Research Methods

The following research methods were employed;

3.3.1 Documents Review

The key documents on the policy framework and operational guidelines for health and HIV in Kenya were reviewed. These documents include;

a) The Kenya National HIV and AIDS Strategic Plans III (2009/2010 – 2012/2013)

b) The Kenya National HIV and AIDS Strategic Plans II (2005/06 – 2009/2010)

d) The Second National Health Sector Strategic Plan (NHSSP 2 2005-2009/2010)

c) The Ministry of Health HIV/AIDS Decentralisation Guidelines (MOH, 2009)

f) Guidelines for the Field Operations at NACC Decentralised Structures (NACC, 2007)

g) The Second National Health Sector Strategic Plan - Roadmap for Acceleration of Implementation of Interventions to Achieve Objectives of the NHSSP II. Nairobi: MOH (2007)

3.3.2 Questionnaire Survey

Semi structured questionnaires were administered to chairpersons of DHMT and DTC i.e. DMOH and DC respectively. The questionnaire was also administered to another key member of DHMT and DTC and these included DASCO and DDO respectively. Furthermore, a questionnaire was administered to CACC coordinators in the constituencies within the selected districts. The CACC coordinators operate at the lowest decentralised level (i.e. constituency) under the supervision and technical support of DTC and DHMT respectively. The CACC coordinators provided perspectives on collaboration between DHMT and DTC and how this collaboration affects implementation at this level.

3.3.3 Key Informant Interviews

Key informant interviews (KII) were conducted with provincial heads and these provided a perspective on the policy and strategic leadership that they provide to DTC and DHMT. Using interview schedules, interviews were conducted with four respondents who included the NACC FO, PDPHS, PDP and PASCO.

These different qualitative methods were employed in the study for various reasons. First, there was limited prior information on collaboration between DHMT and DTC and the variety of methods provided a richer diversity of information on collaboration.

Secondly, the different methods enabled triangulation whereby findings from one source were validated using responses from a different source. For example DTC members stated that they experience funding challenges and this was confirmed by interviews with NACC FO who noted that flow of funds from national to decentralised levels was often irregular. Furthermore the CACC coordinators also stated that DTC was inadequately funded to effectively support the constituency level.

Thirdly, different data sets provided diversity of perspectives on the collaboration between DHMT and DTC. For example, the documents review outlined the policy and operational framework for the collaboration. On the other hand, the survey with CACC coordinators outlined the operational issues faced by the decentralised constituency level as a result of inadequate collaboration. On the other hand, the KIIs

with provincial heads provided a policy and strategic perspective on the collaboration noting that the policy envisages collaboration.

Finally, the different data sets provided information that allowed for comparison between the aspired and the perceived state of collaboration as noted in Marshall and Rossman (1995). The documents review outlined the collaboration envisaged in the policy and operational framework where the policies stated that DHMT and DTC should collaborate and outlined the roles for each of the committees. This envisaged collaboration was also reiterated by the key informant interviews with provincial heads of health and HIV. On the other hand, the questionnaire survey with DHMT and DTC members outlined perceptions of less than optimal collaboration. These findings were similarly noted in the questionnaire survey with CACC coordinators and also in KIIs with the provincial heads.

3.4 Data Management

The key activities in data management in the various research methods are discussed below.

3.4.1 Documents Review

Key health and HIV policies and guidelines were reviewed using a review checklist. Latest versions of these documents were utilised so as to outline the most current information. Key issues on DTC and DHMT outlined included the committees' structure and composition, roles and functions, operationalisation of the committee's functions and modes of collaboration.

The data was presented in outline notes, a map, photographs, tables, flow diagrams and illustrations. These are outlined in chapter 6.

3.4.2 Questionnaire Survey

a) Data Collection

The survey tools were self administered and collected information on perceptions of DHMT and DTC members on their collaboration including how they conceptualise collaboration, the factors that foster and those that hinder collaboration. Tools were delivered to respondents who took 20 minutes to complete. While collecting the tools,

clarifications were done with the respondents on any unclear issues and the tools fully filled.

b) Data Sorting

The tools were then sorted into respondent categories and serialised. Thereafter, for the structured responses in the questionnaire each unique response was recorded and similar responses were clustered.

c) Data Entry

Furthermore, a data entry structure was created in SPSS version 16.0 for Windows (SPSS Inc. 2008.) and dummy data used to pre-test the structure after which refinements were made.

The structured questionnaire responses were keyed in into this data file and each questionnaire was a unique record identified by the serial number.

The input data was verified by running random record entries. Furthermore, a run of the entire data set was done to highlight any missing and invalid values and data set was cleaned.

The data was presented in frequency tables, cross tabulations of the various variables and descriptive tables.

c) Data Analysis

Simple analyses were run in *SPSS* and preliminary analyses included frequencies such as the number of respondents who gave a similar response to a question on the perception on the collaboration between DHMT and DTC.

For the unstructured sections of questionnaire, the responses were outlined and reductively sorted. For example, descriptive and explanatory responses on the perceptions of DTC and DHMT members on their collaboration were aggregated. The broad themes and emerging trends in the aggregated responses were then outlined.

3.4.3 Key Informant Interviews

The KIIs were conducted by the researcher in the respondents' offices and each interview took approximately 15 minutes. The respondents answered the questions on how they conceptualise collaboration, the factors that foster and those that hinder collaboration. The key informants provided information from a policy level perspective.

The responses were listed and sorted, and similar responses aggregated together. Emerging themes and trends on responses were then outlined, as well as outlining concurrence or difference on these issues.

Data was presented as outline summaries, descriptive tables, flow diagrams, illustrations, and photographs.

3.5 Strategies for Enhancing Reliability of Data

The following strategies were employed to enhance reliability of data;

3.5.1 Pretesting of Data Collection Tools

A pre-test of the tools was conducted and the feedback was used to fine tune the tools before their final utilisation.

3.5.2 Pretesting of Data Entry Structure

Using dummy data, trial runs were conducted on the data entry structure and the output was used to fine tune the structure.

3.5.3 Triangulation

The data collected using one method was validated using data obtained using another method. Different methods were used on different respondents to collect data on an issue and thereby assessed whether there was concurrence or conflict. Secondly, the different data collection methods were sequenced in such as way as to allow subsequent clarifications and confirmations. For example, review of documents was done first to outline the operational framework. This was followed by the questionnaires survey to DTC and DHMT members and CACC coordinators. Finally interviews were conducted with the key informants. Thereby, responses from questionnaires were compared and corroborated with responses from key informant interviews and documents reviewed.

3.5.4 Probing Techniques

While conducting interviews, reinforcing and variant questions were posed to assess the consistency in responses and also to clarify or confirm responses.

3.6 Summary

This study of perception of members of DTC and DHMT on their collaboration was a qualitative exploratory and diagnostic study. It entailed first a review of the policies and guidelines for the operations of DTC and DHMT including their collaboration. Secondly, questionnaire survey was conducted with DTC and DHMT members to outline their perceptions on these committees and their collaboration. In addition, questionnaires were administered to CACC coordinators to obtain the perspective of DTC-DHMT collaboration from the decentralised constituency level. Finally, KIIs were conducted with the provincial heads and these provided a policy level perspective on the collaboration between DTC and DHMT.

Quality assurance was done at various stages of data processing including data collection, entry, analysis and presentation so as to ensure validity and reliability of the data. Strategies employed to enhance reliability of data included pretesting of data collection tools and data entry forms, field data verification, data cleaning, input validation and triangulation.

Processing of structured data was done using *SPSS* and preliminary analyses included running of the frequencies of various responses and this was followed by cross-tabulation of the various fields to obtain relationships between variables. Unstructured data was analyses deductively by aggregating responses and noting emerging trends. Presentation of data was done using various methods and these include descriptive tables, flow diagrams, illustrations, maps and photographs.

4.0 FINDINGS

This chapter outlines the findings of this study on perceptions of members of DTC and DHMT on the collaboration between these committees. A review of policies and guidelines on the operations of DTC and DHMT is outlined delineating the imperative and the framework for collaboration between these committees. This is followed by an outline of the perceptions of DTC and DHMT members on their collaboration.

4.1 The Policy and Operational Framework for DHMT and DTC and their Collaboration

The policies and guidelines reviewed outlined the policy and operational framework for health and HIV and the collaboration between DHMT and DTC.

4.1.1 The Policy and Operational Framework for the Health Sector

Since Kenyan independence, elimination of diseases and promotion of health has remained a key national goal. The MOH is responsible for designing and implementing policies and programmes for providing health services (Ngigi et al., 2006). In 1994 the MOH developed the Kenya's Health Policy Framework (KHPF) as the blueprint for future health sector policy and development. The KHPF strengthened the policy role of MOH, adopted strategies to reduce disease burden and defined an essential cost effective health care package. To operationalise the KPHF various National Health Sector Strategic Plans (NHSSP) were formulated. The first Plan was NHSSP I (1991-2004) which emphasized decentralization of health care services delivery to rural areas. Later the NHSSP II (2005-2010) was developed and it focused on the essential key priority packages based on disease burden and the required support systems to deliver these services. The NHSSP II structured the health sector into community and formal health care system (GOK MOH, 2005). The community level consists of health activities at individual, household and village levels whereas the formal health care system consists of MOH headquarters, provinces and districts. The headquarters formulates policies and strategies, and provides overall coordination in the health sector. The provincial tier coordinates between MOH headquarters and the districts and oversees implementation of health policy in the province, maintains quality standards and provides support supervision to the district. The district level

implements health activities and is managed by the district health management teams (DHMT)

The District Health Management Team (DHMT)

NACC (2009) states that MOH is responsible for the provision of health sector HIV services. Further, MOH (2009) outlines the imperative for collaboration with others in provision of these services. In addition, it outlines the roles of DHMT in implementing these services and these include;

a) Plans for district needs and advocate for support and resources
b) Sets district targets for HIV related activities
c) Coordinates and aligns partners and HIV/AIDS service delivery organizations to prevent duplication and gaps in service delivery and maximize on resource mobilization and utilization.
d) Supports health facilities to set targets for HIV related activities
e) Supports implementation of HIV and AIDS related activities
f) Ensures equitable distribution of resources and health services
g) Develops a district-wide human resource management plan
h) Provides support supervision and coordinates mentorship and training activities
i) Consolidates health management information system (HMIS) data from the health facilities and transmits the same to the provincial level
j) Identifies, sets up, strengthens and coordinates activities in collaboration with the provincial team
k) Supports the integration of services
l) Sources funding for, establishes, supports and maintains patient care networks such as referral, commodities e.t.c.

The above roles of DHMT place an imperative on this committee to collaborate with others in enhancing provision of services.

4.1.2 The Policy and Operational Framework for HIV and AIDS

In the 1980s, HIV was viewed in limited scope as a health issue and initiatives to control its spread were implemented by MOH. The Kenyan policy on HIV developed in tandem with the international policy. In 1988 the WHO formed the Global Programme on AIDS and in 1989, the MOH developed guidelines for disclosing HIV status. Further, in 1997 the Joint United Nations Programme on HIV/AIDS (UNAIDS) was formed and in the same year, the government established policy

guidelines on AIDS in Kenya in which it recognized the need for a national agency to coordinate HIV and AIDS activities (GOK, 1997). Further, in the same year, a 15 year national HIV and AIDS policy was approved and the National AIDS Council formed.

In 1999, HIV and AIDS was declared a national disaster and the National AIDS Control Council (NACC) was created to coordinate a national response to HIV. In 2000, NACC developed a multi-sectoral Kenya National AIDS Strategic Plan (KNASP I) 1999-2004 as the action framework for HIV and AIDS. In addition, a national M&E system was developed to provide a common framework for evaluating performance. After implementation for 5 years, in 2005 KNASP I was revised and KNASP II 2005/06 – 2009/2010 was developed.

Furthermore, following a resurgence in HIV prevalence and emergence of new trends in infections (MOH, 2007; NACC, 2008), KNASP II was revised in 2009 and KNASP III 2009/2010 – 2012/2013 (NACC, 2009) developed. KNASP III emphasised on a multi-sectoral partnership collaboration where different partners implemented different activities based on their comparative advantage. Four thematic areas referred to as pillars were outlined. These include health sector service delivery implemented by MOH, sectoral mainstreaming of HIV implemented by the Ministry of Planning and National Development and community HIV activities implemented by NACC. Furthermore NACC is also responsible for governance and strategic information.

NACC (1999) underscored the mandate of NACC of developing policies, strategies and guidelines on HIV and AIDS, mobilising resources for HIV and AIDS activities, coordinating and supervising implementation and M&E of HIV and AIDS programmes and leading in HIV and AIDS advocacy. To enhance coordination of the HIV response, NACC created an institutional framework shown in figure 7 in the annex. The institutional framework consists of AIDS Control Units (ACUs) in government ministries and departments, CACCs at community level, DTCs at district level and NACC Field Offices at provincial or regional levels. The national level provides policy and strategic leadership to the national HIV response. The province level headed by NACC FO coordinates with implementers in the province and provides technical support to DTCs at the district. The DTCs provide technical and

supervisory support to CACCs at the constituency level. The institutional framework also recognizes contributions of other implementing organisations including community based organisations (CBO), faith based organisations (FBO), non-governmental organisations (NGO) and the private sector in the HIV response.

The District Technical Committee (DTC)

The DTC is a multi-sectoral technical committee whose role is to ensure that HIV and AIDS is mainstreamed in the district development programmes (NACC, 2007). DTC meets monthly and reports to the provincial Field Office and NACC Secretariat on quarterly basis. The DDO is secretary to the DTC and reports on HIV and AIDS issues in the district. The key functions of DTCs include:

a) Technical support to CACCs and the implementing organisations
b) Capacity building for CACCs and implementing organizations
c) Oversight in the formation and operationalisation of CACCs
d) Receive, review and approve proposals for funding
e) Mobilise stakeholders to participate in planning and coordination fora such annual Joint HIV and AIDS Programme Review (JAPR) and World AIDS Day (WAD)
f) Monitoring and evaluation of HIV and AIDS activities in consultation with the CACCs and other HIV and AIDS stakeholders
g) Develop and maintain a health management information system (HMIS)
h) Compile and disseminate district-level data on HIV in consultation with CACCs and stakeholders
i) Supervise CACCs and HIV and AIDS implementing organizations
j) Convene regular meetings with CACCs and implementing organizations to ensure effective delivery of KNASP

4.1.3 The Policy and Operational Framework for Collaboration between DHMT and DTC

As noted earlier, the DTC and DHMT have complementary roles in implementation of the HIV response. NACC (2009) mandates NACC to implement community based HIV activities and also provide overall coordination, supervision and M&E of HIV and AIDS activities. At district level, the DTC mobilises a multi-sectoral team to mainstream HIV and AIDS programmes in all aspects of development (NACC, 2007).

On the other hand, the MOH provides health sector HIV services (NACC, 2009). Further, MOH (2009) outlines the role of DHMT in implementation of HIV and AIDS activities at the district.

Various initiatives have been designed to enhance collaboration between DHMT and DTC. The first is policy imperative for collaboration. MOH (2005) stated that fostering of partnerships is key to achieving the goal of providing health services. Secondly, it noted that recognising of each ones roles and responsibilities, the stakeholders must collaborate and coordinate their actions. Thirdly, MOH (2005) noted that collaboration would ensure a coordinated intersectoral support for community action, improved partnerships between the private and public sectors and also improve intersectoral collaboration with other government agencies. Further, NACC (2009) outlined the MOH as responsible for implementing the health sector HIV services. Further, MOH (2009) stated that DHMT shall map resources and partner with other stakeholders to develop an operational plan to realise the goal of universal access to HIV services. On the other hand, NACC (2005) and NACC (2009) also outline the imperative for multi-sectoral collaboration in the HIV response.

Secondly, the guidelines for operations of DHMT and DTC outline initiatives to enhance collaborative working between DHMT and DTC. An example is representation and involvement of one committee in the other where for example the chairperson of DHMT (DMOH) is a member of DTC. However, the DASCO is not a member of DTC yet he is the focal person for HIV activities implemented by the DHMT. On the other hand, the CACC coordinator chairman is a member of DTC.

Thirdly, joint planning, coordination and review fora have been designed and various stakeholders are expected to participate. An example is the joint HIV/AIDS Annual Programme Review (JAPR) which is a forum that is convened by NACC and which brings together implementers to review and plan HIV and AIDS activities. Another key forum is the World AIDS Day. However, optimal participation in these fora has not yet been realised.

4.2 The Perceptions of DHMT and DTC Members on these Committees and their Collaboration

Questionnaires were administered to DHMT and DTC members as well as CACC coordinators. In addition, KIIs were conducted with provincial heads of health and HIV. The data collected assessed the respondents' knowledge and opinions on the following issues;

a) Definitions of DHMT and DTC and their roles.

b) Definition of collaboration.

c) Opinion on whether DHMT and DTC should collaborate or not and the reasons for it.

d) Opinion on whether the current framework for DHMT and DTC is adequate to support their collaboration.

e) Strengths in the framework, the factors that foster collaboration, and how these can be enhanced.

f) Gaps in the framework and factors that hinder collaboration.

Twenty five (25) members of DHMT and DTC drawn from 11 districts responded to the questionnaire representing a 69.4% response rate. These included four DCs, seven DMOH, seven DDOs and seven DASCO drawn from the districts outlined in annex 3.2. In addition, six CACC coordinators responded to the questionnaire. Furthermore, the FO, PDPHS, PDP and PASCO were interviewed as key informants. The findings are outlined below.

4.2.1 Knowledge on DHMT and DTC, and their Roles

a) <u>Definitions of DHMT and DTC</u>

The respondents defined DHMT and DTC by stating in full the abbreviations and also stating the definition of the committee.

i) Definition of DHMT

Similar patterns were observed on definition of DHMT by the three categories of respondents. For example, six DHMT and DTC members gave correct definition and abbreviation for DHMT whereas 16 respondents gave the correct abbreviation only and four gave correct definition only. This is outlined in annex 1.3. On the other hand, among the CACC coordinators, one respondent gave correct abbreviation and definition while four gave the correct abbreviation only. However one respondent

gave an incorrect definition of DHMT. For the key informants, two respondents gave the correct abbreviation and definition while two gave the correct definition only.

ii) Definition of DTC

The respondents had scanty knowledge of DTC. For example only four DTC and DHMT members stated a correct abbreviation and definition for DTC while 14 stated the correct abbreviation and four stated the correct definition. Notably one chairperson for DTC (DC) gave incorrect definition of DTC while one chairperson of DHMT (DMOH) stated not knowing what DTC is. These responses are outlined in annex 3.4.

On the other hand, most CACC coordinators (five) stated the correct abbreviation for DTC and one gave the correct definition.

For the key informants only one respondent gave correct abbreviation and definition of DTC and one gave correct definition while another gave correct abbreviation. One respondent stated not knowing what DTC is.

b) Roles and Functions of DHMT and DTC

The respondents outlined roles of DHMT and DTC as outlined below.

i) Roles and Functions of DHMT

The DHMT and DTC members outlined 52 correct responses on roles of DHMT. The DMOH and DASCO were well versed with the roles of DHMT giving a total of 28 correct responses. Notably the DDOs exhibited the highest knowledge of these roles giving a total of 20 responses. The DCs had the least knowledge - two DCs stated two roles each while the other four DCs stated one role each. The key roles highlighted include running and managing health facilities to deliver health services, planning on health issues in the district, conducting supportive supervision, and coordinating health activities in the district. More detailed results are outlined in annex 3.5.

The knowledge pattern among DTC and DHMT members was similar to that of CACC coordinators and of the provincial heads where each outlined 15 roles. However, while the roles stated by CACC related mainly to coordination, supervision and M&E roles of DHMT, the provincial heads stated roles mainly related to management and coordination.

ii) Roles and functions of the DTC

The DHMT and DTC members gave 47 correct responses on roles of DTC. The DDOs gave most responses (21) followed by DCs who stated 11 responses. The

DMOH and DASCO stated eight and seven roles respectively. The key roles highlighted include coordinating HIV and AIDS activities, providing technical support on HIV and AIDS to CACCs and other HIV stakeholders, conducting coordination fora such as JAPR and WAD, and supervising HIV and AIDS activities. The detailed results are outlined in annex 3.6.

On the other hand the CACC coordinators stated 16 roles of DTC mainly related to coordination, supervision, technical support and M&E.

The key informants stated 9 roles of DTC mainly related to coordination and supervision of HIV and AIDS activities.

4.2.2 Knowledge and Opinion on Collaboration

a) Definition of Collaboration between DHMT and DTC

The DHMT and DTC members defined collaboration between the two committees. The DDOs gave the highest number of correct responses (10) followed by DCs who gave four. The DMOH and DASCO gave six correct responses each. Two DMOH and one DASCO stated not knowing what the collaboration is. The definitions outlined included DHMT and DTC working together in harmonised roles to achieve the objective of the HIV and AIDS response with each team working in its core area, and DTC and DHMT working in complementarity and consultation. The detailed responses are outlined in annex 3.7.

On the other hand, the CACC coordinators stated 10 correct responses on collaboration while the key informants stated seven correct responses.

b) Opinion on whether DHMT and DTC should collaborate

Most DHMT and DTC members stated that the two committees should collaborate and only one member (a DDO) stated that they should not. Similarly most CACC coordinators (five) stated that DTC and DHMT should collaborate while one respondent stated that they should not. On the other hand, all key informants stated that DHMT and DTC should collaborate reiterating that these committees must work together in so as to realise the objectives of the fight against HIV.

c) Reasons why DHMT and DTC should collaborate

The DHMT and DTC members outlined the reasons why the two committees should collaborate and these included to: harness a larger pool of human and material

resources; harness each other's comparative advantages; facilitate joint activities; enhance coordination, efficiency and effectiveness in operations; and enhance optimal utilisation of resources by minimising overlap and duplication. The detailed reasons are outlined in annex 3.8.

Furthermore, the CACC coordinators also noted that there is the need for concerted collaboration to attain better results in the fight against HIV and AIDS. They stated that they receive support from both DTC and DHMT on transport and logistical facilitation, office space, planning, supervision and technical support, data and information on HIV/AIDS, commodities and supplies. However, four respondents stated that collaboration between DTC and DHMT is inadequate and that this affects the support received from the two committees. Further, all respondents stated that this support would improve if the DTC and DHMT collaborate better because then they would be better acquainted with each others' roles, provide better coordination support, achieve better allocation of resources avoiding duplication and would hold regular joint meetings to improve planning and coordination of HIV/AIDS activities and avoid conflicts.

In addition, the key informants noted that collaboration between DTC and DHMT is key to success in the fight against HIV since it is a multi-sectoral problem. They stated that the two committees should collaborate so as to promote complementary working, harness the teams' comparative advantages, enhance harmony in operations, and promote multi-sectoral approach to the HIV and AIDS response.

4.2.3 Perception on the Current Status of Collaboration

The respondents outlined their opinions outlined below on the current state of collaboration between DHMT and DTC.

a) <u>Opinion on Whether DHMT and DTC are Currently Collaborating</u>

Most DHMT and DTC members (fifteen) stated that the two committees collaborate whereas four respondents stated that they do not. This is outlined in annex 3.9. Similarly most CACC coordinators stated the DTC collaborates with DHMT and only one respondent stated that the two committees do not collaborate. On the other hand, all key informants stated that DTC and DHMT collaborate.

b) <u>Areas in which DHMT and DTC are Collaborating</u>

The DHMT and DTC members outlined areas in which the two committees collaborate. These include implementing community activities, holding meetings and sharing information. It was notable that the World AIDS Day is an activity that most members participate in. More information on these areas is outlined in annex 3.10.

Furthermore, the respondents stated the extent to which they collaborate in key areas of joint meetings, sharing information and plans, sharing of expertise and personnel and joint supervision and M&E. A combined total of 46% of respondents stated that they always and sometimes collaborate whereas a combined total of 45% said they rarely and never collaborate. Detailed responses are outlined in annex 3.11.
On the other hand, one key informant rated the collaboration between DTC and DHMT as good, two rated it as average and one rated it as poor.

d) Other Areas in which DHMT and DTC have collaborated well

The DHMT and DTC members highlighted other areas in which the two committees collaborate well. These include implementation of HIV activities, WAD, sharing information, reports and holding regular meetings. These are outlined in annex 3.12.

e) Areas in which DHMT and DTC do not collaborate well

Most DHMT and DTC (72%) could identify areas in which they have not collaborated well. These included holding regular consultative meetings, joint planning, implementation, support supervision and M&E, and sharing information among others. These are outlined in annex 3.13.
Similarly most CACC coordinators (four) stated that current collaboration between DTC and DHMT is inadequate and noted that the two committees could collaborate more. They outlined the areas of inadequate collaboration which were similar to those cited by DTC and DHMT members. Further, they added capacity building activities such as training as an important area in which collaboration has not happened well.

f) Reasons why DHMT and DTC have not collaborated well

The DTC and DHMT members outlined the reasons why the two committees do not collaborate. One DTC member stated that the DTC is dormant because since creation of this new district and launch of DTC, no funds have been provided to run the DTC.

A DHMT member stated that the framework for collaboration was unclear whereas another DHMT member stated that he does not know about DTC and its roles.

Further the CACC coordinators noted that DHMT members were not well acquainted with roles of DTC and CACC and thereby do not provide adequate support to CACC coordinators to discharge their duties. Secondly, the DTC does not convene regular meetings and this affects coordination of HIV and AIDS activities. Thirdly, DHMT perceives that DTC and CACC have a large allocation of funds and can operate independently.

4.2.4 Perception on the Aspired State of Collaboration

a) Opinion Whether DHMT and DTC could Collaborate more or better

Most DTC and DHMT members stated that the two committees can collaborate more and also said they preferred to see more collaboration. However, two respondents (DASCOs) stated that DTC should work alone independent of the DHMT. Similarly all CACC coordinators stated that DTC and DHMT could collaborate more. Further the key informants also stated that DTC and DHMT could and should collaborate.

b) Areas in which DHMT and DTC can collaborate more or better

The DTC and DHMT members outlined the areas in which the committees could collaborate more. The areas stated were largely the ones they had indicated as having been unable to collaborate well in. In addition, the respondents also wanted to collaborate more in budgeting for HIV activities; mobilisation of resources and funding of local organisations. These are outlined in annex 3.14.

The key informants outlined similar areas of collaboration as those cited by DTC and DHMT members and further emphasised the following areas: clarify roles and functions of DHMT and DTC and its members; hold joint meetings and fora; share data, information and plans; conduct joint planning and implementation of activities; conduct joint coordination and supervision; have representation and participation of members of one committee in the other committees e.g. DDOs and CACCs in DHMT, DASCO in CACCs; and share resources.

4.2.5 Factors that Foster Collaboration

The DHMT and DTC members outlined the factors that foster their collaboration and these included the coordination role played by NACC, team spirit, adequate financing, transparent utilisation of funds, and sensitisation on the roles of the two committees. These factors are further outlined in annex 3.15. Furthermore, as outlined in annex 3.16, members of DHMT and DTC stated that the above factors would also enhance future collaboration between the two committees.

On the other hand, the CACC coordinators stated factors including sharing of information, commitment, leadership (such as DTC chair using his authority to convene meetings), holding joint consultative meetings, joint planning, implementation and M&E, understanding of each team's roles and complementarities, adequate financing, accountability, team work and representation of members of one committee in the other.

The key informants on the other hand outlined the policy and leadership factors that foster collaboration. These included first, policy direction and leadership on collaboration from the top. This would include harmonising of district goal and vision. They also stated the harmonisation and streamlining of mandates of NACC and MOH and outlining the collaboration framework. Secondly, is sensitisation on each team's roles and functions. Thirdly is adequate resource facilitation to carry out collaborative activities. This would also include having a harmonised funding framework for health and HIV activities and enhancing transparency on resource allocation and utilisation. Fourthly, is promotion of team work and collaboration among and between members of DHMT and DTC.

Furthermore, the provincial heads stated that the collaboration framework has strengths which include first the existence of policies and guidelines which outline structure, function and roles of both the committees as well as individual committee members. Secondly is the existence of diverse technical capacity and skills in the two committees e.g. DTC in coordination, M&E and DHMT in health issues. Thirdly is the good facilitation that exists from MOH and NACC to discharge mandates. The fourth strength is commitment by development partners (donors) to provide funding.

Further still, the provincial heads outlined ways in which these can be enhanced to support collaboration between DHMT and DTC. The factors outlined were similar to the ones that DHMT and DTC members said would facilitate collaboration. These factors include: sensitisation of DTC and DHMT and communities on the roles of the two committees and their collaboration; holding regular joint meetings; provision of adequate financial and other resources to carry out activities (e.g. funds, computers, motor bikes); conducting joint activities; and harmonising approaches by different players.

4.2.6 Factors that Hinder Collaboration

The respondents noted that there have been gaps in the collaboration between DHMT and DTC in the implementation of HIV activities in the districts and outlined the factors that hinder the collaboration. These factors largely mirrored the ones that foster collaboration and included: inadequate team spirit and cooperation; inadequate understanding or sensitisation on roles and functions and complementarities including among the departmental heads as one stated "I only hear DTC at the World AIDS Day and at JAPR"; inadequate team operations; inadequate joint meetings and other fora; inadequate sharing of information, inadequate availability of data especially in new districts; and financing challenges such as inadequate and irregular flow of funds as well as unharmonised funding frameworks and changing administrative structures. These factors are outlined in annex 3.17.

Furthermore the CACC coordinators highlighted the factors that hinder collaboration between DHMT and DTC and these were very similar to the ones outlined by DHMT and DTC members. The key factors included: inadequate sensitisation on roles and functions for each committee and its members; lack of commitment by some members on HIV / AIDS activities; inadequate stakeholder meetings and other sharing forums for the teams to share; inadequate information availability, sensitisation and prioritization of HIV (priority given to other sectors security, relief); inadequate resources including funds, logistical facilitation such as vehicles to carry out joint activities; and inadequate M&E for ongoing projects. Other factors mentioned included the conception that HIV and AIDS is an MOH issue, perceptions of superiority of each team over the other and attitude.

On the other hand, the key informants also outlined factors that hinder collaboration that were similar to those stated by DHMT and DTC members. These factors or gaps were related to first, the vision and policy leadership on collaboration and the implementation framework. Secondly there were issues related to team functioning e.g. rivalry between the two committees and non-cordial working relationship between some members of DHMT and DTC. For example a respondent stated that "DASCO and CACC Coordinator do not see eye to eye" while another stated that "CACC coordinators are overshadowing the DASCOs and stealing the show". Thirdly, there were issues related to funds including the funding framework and the adequacy of the funds. Other factors include sharing of information and the lack of implementation of the existing policies. These factors are outlined in annex 3.18.

4.2.7 Ways of Addressing the Gaps in the Collaboration between DHMT and DTC

The key informants outlined ways in which the gaps in the collaboration framework can be addressed. These included first sensitisation on roles and functions of the two committees and the collaboration framework. Secondly is provision of adequate financing and addressing other related challenges such as harmonising funding frameworks. Thirdly is enhancing representation and participation of one committee in the other and also involvement of other stakeholders e.g. DDOs and CACC coordinators in DHMT; DASCO in CACCs. Fourth is more involvement of stakeholders in the formulation and revision of collaboration policies and guidelines. Fifth is enhancement of holding joint meetings and other fora and joint implementation and M&E of activities, and support supervision of CSOs. These issues are outlined in annex 3.19 and 3.20.

Similar sentiments were expressed by the CACC coordinators who also stressed the need to sensitise on importance of multi-sectoral collaboration, clarify the collaboration framework.

Furthermore, the provincial heads also stated similar measures. They highlighted on need to provide leadership and guidance for collaboration from the top acting as role models at NACC and NASCOP senior most level, unity of vision and purpose necessary is so as not 'pull in different directions'. However, one respondent noted that collaboration is fraught with challenges and stated that "although collaboration is good, I don't think sharing of resources between DTC and DHMT is feasible"

5.0 DISCUSSION

This chapter is an analysis and discussion of findings on the perceptions of members of DTC and DHMT on their collaboration. The findings were from a review of policies and guidelines on operations of DHMT and DTC, a questionnaire survey on members of DHMT and DTC as the primary respondents, a questionnaire with CACC coordinators and KIIs with provincial heads of health and HIV functions. The key terms employed in this study are defined. Then a synthesis of the results from the various sources and emerging trends are outlined and these are then compared with the literature.

The discussion addresses the research questions. First, the policy and operational framework for DHMT and DTC and their collaboration is discussed. Thereafter, the perceptions of DTC and DHMT members on their collaboration are discussed.

5.1 The Policy Framework for the Operations of DTC and DHMT and their Collaboration

HIV and health care issues of national importance. This is also noted by Ngigi et. al. (2006). There has been an elaborate policy framework on health and HIV outlined in policies such as NACC (2005) and NACC (2009). These have been developed in response to the evolving health and HIV situation in the country. Further, there is also an elaborate operational framework for health and HIV. For example, the key implementers of the HIV response are outlined as MOH and NACC and the respective implementing structures at the district are DHMT and DTC.

Collaboration is a key strategy in implementation of public interventions. This is also noted in the policy framework for HIV which envisages multi-sectoral collaboration among stakeholders (NACC, 2005; NACC, 2009). NACC (2009) envisages partnership collaboration by NACC and MOH with each responsible for its delineated roles. For example, MOH through DHMT is responsible for health sector HIV services whereas NACC through DTC (and CACC) is responsible for community HIV activities. NACC is also responsible for the overall coordination of stakeholders.

The operational framework for DTC and DHMT is also well articulated. For example, NACC (2007) outlines the guidelines for the operations of DTC and CACCs

including their composition, structure, roles and functions. These NACC structures mobilise and coordinate a multi-sectoral response against HIV. The DTC (and CACC) is a multi-disciplinary committee constituting of multiple stakeholders and departments including women, youth, persons living with HIV, health, education, agriculture, NGOs and CBOs and private sector. The DTC provides technical and supervisory support to CACCs who in turn coordinate community based HIV activities in the constituency.

The MOH also has elaborate policies on the provision of health services and these policies also emphasise on partnership collaboration. For example, MOH (2005) which outlines the framework for provision of services, highlights partnership with other stakeholders as a key strategy in order to achieve the goal of reversing the trends on the deteriorating health indicators including on HIV and AIDS. Furthermore, MOH (2007) which outlines the guidelines for provision of health sector HIV services such as HTC, PMTCT and care and treatment services also notes that partnerships is key to the achievement of objectives of the health sector. Some strategies outlined to enhance the partnerships include strengthening sector coordination and participation structures, implementing sector governance structures and linking governance structures to strategies of the national development plans.

From the foregoing, it is therefore a NACC and MOH policy imperative for the two agencies to collaborate. This conforms to Sloper (2004) who noted that collaboration between agencies is a key imperative and priority for the improvement of interagency working and coordination.

In order to actualise this imperative for collaboration between NACC and MOH and thereby DTC and DHMT, various initiatives have been designed and incorporated into the operational framework and these are contained in the operational guidelines for DHMT, DTC and CACC.

The first is in the constitution of implementation structures. The guidelines outline the composition of the implementation structures (DTC, CACC) and provide for representation of one committee in the other. For example, two DHMT members i.e. DMOH and DPHO are incorporated as members of the DTC. In addition, CACC

coordinators who are usually drawn from a health discipline such as public health, clinical or nursing are employees of the MOH but who are seconded to work partly with NACC. In addition to performing their public health roles within MOH, they also coordinate community based HIV activities.

However, these representations across is inadequate. For example, DASCO who is the key MOH personnel involved in the provision of HIV services at the district is not incorporated as a member of the DTC. Hence there is need for enhanced of the representation. This was also echoed by the respondents to the questionnaire survey.

Secondly there is a clear delineation of roles and functions to the committees and the members. For example, NACC (2009) notes that MOH is responsible for delivery of health sector HIV services such as counselling and testing, and care and treatment. MOH (2007) outlines the roles of MOH in carrying out this responsibility. On the other hand, NACC implements the community HIV services as well the overall coordination of HIV activities by various stakeholders.

However, there is inadequate sensitization on the roles and functions to the committees and other district and provincial leaders. This was especially noted among the DTC and DHMT members.

Furthermore, whereas the guidelines exist for the operations of DTC and CACC on one hand and MOH on the other hand there are no explicit guidelines outlining the especially complementary roles and implementation framework for the collaboration between the two key committees.

Further still, in other instances such as with DDOs, although they were well versed with their roles, there was inadequate allocation of time for them to discharge their duties. The DDOs were too committed in other functions to give adequate attention to HIV

Thirdly was the financing arrangements. The policy outlines the budgetary and financing requirement to effectively implement this multi-sectoral HIV response.

However, the financing is often inadequate to fully implement the response. Furthermore differentiated financing arrangements for NACC and MOH often impede on implementation of collaborative activities.

Fourth is on governance. The policy outlines NACC as responsible for coordination, strategic information and M&E. However, while NACC did a good job at this role, there is need for more stakeholders' involvement. This was also voiced by the respondents who stated that that they want to be more involved in the development, implementation and M&E of the policy.

Fifth is the participation fora. The policy provides for fora for consultation and collaboration in fora such as WAD, JAPR. Many respondents stated that they participate in these fora. However, optimal participation is often hindered by a perception that JAPR and WAD is a NACC and HIV issues. For example, some DHMT members stated felt that while theirs is a working committee, the DTC is talking committee.

Lastly, where attempts have been undertaken to enhance partnership and coordination, these often depend on initiative of the leadership and often do not follow a standardised coordination framework. Furthermore in other instances as noted in MOH (2007), although commitment has been shown to strengthen partnership arrangements, implementation issues such as full and timely discussion and disclosure of financial decisions have not yet been realised.

5.2 The Perceptions of DHMT and DTC Members on these Committees and their Collaboration

This section discusses the perception of DHMT and DTC members on their collaboration. First, the knowledge and opinions of these committee members regarding the DTC and DHMT and their collaboration is discussed. This is followed by a discussion on the key issues in the functioning of partnerships as they operate in collaborative spaces and on the factors that foster and those that hinder collaboration.

5.2.1 Knowledge and Opinions of DHMT and DTC Members Regarding their Committees and their Collaboration

Perception of DTC and DHMT members on their collaboration refers to the knowledge, opinion and experience that these members have on their collaborative partnership. In assessing these perceptions, both process and outcome issues as well as factors affecting partnership success were considered. This is supported by Dowling et al. (2004) who noted that these are the three key issues usually considered while conceptualising partnerships i.e. processes, outcomes and partnership success. The knowledge and opinions of the DTC and DHMT members on their partnership collaboration is discussed below.

a) Definition of DHMT and DTC

Both DTC and DHMT members are well familiar with the DHMT although DHMT members had a marginally higher knowledge of their committee. Conversely more DHMT than DTC members are familiar with the DTC. Further, this knowledge pattern among DTC and DHMT members was similar to that of their respective provincial heads. For example, the provincial heads were well versed with both DHMT and DTC but were marginally more knowledgeable on DHMT than on DTC. This similarity on knowledge patterns among DTC and DHMT members and the provincial heads indicates a trickledown effect from the provincial level to the district. Further, the less knowledge on DTC over DHMT could be because the DHMT has been in existence much longer since the 1980s whereas DTCs were formed in 2008. On the other hand, the CACC coordinators are well familiar with both DTC and DHMT although there was marginally higher familiarity with DTC. This is attributed to the fact that the CACC coordinators work more with DTC than DHMT.

b) Roles and Functions of DTC and DHMT

The DTC and DHMT members are well versed with roles and functions the two committees. This was also the case with the provincial heads and CACC coordinators indicating a similarity in the knowledge across the provincial, district and constituency levels. However, the three respondent categories had different orientations on the roles and functions outlined. While the DTC and DHMT members outlined roles related to planning, management and support supervision of health

facilities and services, the CACC coordinators stated roles related to coordination, supervision and M&E. The provincial heads on the other hand stated roles related to overall management and coordination.

Furthermore, both DHMT and DTC members were well versed with roles of their own committees. However, DHMT members were more knowledgeable on roles of own committee than on roles of DTC. Further members of both DTC and DHMT knew more roles of DHMT than of DTC. As noted earlier, the more knowledge on DHMT is because DHMT has been in existence longer that DTC. Further still, the DDO was highly knowledgeable on the roles of both DTC and DHMT. This could be attributed to the fact that as secretary to DTC as well as the other development committees in the district, the DDO coordinates with these committees and hence is privy to information on activities of other committees in the district.

Similarly the provincial heads were more knowledgeable in the roles of the committee under their direct jurisdiction. The FO exhibited significantly higher knowledge on roles of DTC whereas the PASCO was significantly more knowledgeable in the roles of DHMT. Conversely, the two provincial heads had less comprehension of the roles played by the other committee outside their jurisdiction. Further, the PDPHS and PDP were well versed with the roles performed by DHMT but were less conversant with DTC. This disparity in knowledge on roles DHMT and DTC could be attributed to various factors. First, these senior level officials are often more involved with generalised policy and strategic health and development issues respectively. The specific HIV policy and strategic issues are handled by the respective technical heads at the province (i.e. the FO and PASCO respectively) while the operational management is handled by the DTCs and DHMTs respectively. For example, while the PDP is the technical head of the DDOs, the implementation and management of HIV interventions is handled at the district level by the DTC of which the DDO is secretary and hence the high knowledge levels exhibited by the DDOs. On the other hand, PDPHS handles general health policy and strategy issues and delegates technical HIV management issues to the PASCO who in turn works with the DHMTs.

On the other hand, the CACC coordinators were marginally more knowledgeable on the roles of DTC than DHMT. This could be due to the fact that the CACC coordinators are usually seconded from DHMT (MOH) to work with NACC with

technical and supervisory support of DTC. The CACC coordinators also receive support from DHMT such as in commodities and supplies e.g. condoms. However, they noted that DHMTs are usually not well acquainted with roles of DTC and CACCs and hence do not provide adequate support to them (CACC coordinators).

Furthermore, the CACC coordinators stated roles related to coordination, supervision, monitoring and evaluation. This is because the responsibilities of CACC coordinators are of a similar nature i.e. coordination, supervision, monitoring and evaluation of HIV activities at the decentralised constituency level.

b) Definition of Collaboration between DHMT and DTC

The definitions outlined by DTC and DHMT members concurred with Roussos et. al., (2000) who defined partnership collaboration as people and organizations from different sectors or departments working together to attain a common goal. The DTC and DHMT members were well versed with definition of collaboration although, DHMT were marginally more knowledgeable with collaboration than DTC. The higher knowledge by DHMT members could be because they are drawn from the same professional sector i.e. health. The DTC on the other hand is a multi-disciplinary committee whose members come from different professions with different professional orientations and this often hinders effectiveness of collaboration. As noted in Easen et al. (2000) and Johnson et al. (2003) differences in professional orientations and how each conceptualises their practice may hinder inter-professional collaboration and thereby effectiveness in inter-agency collaboration. Furthermore, frequency of meetings for DTC and DHMT could also explain the difference in knowledge levels on collaboration. The DHMT meets more frequently hence shares information while DTC meets less frequently and hence less sharing of information.

Further the provincial heads who work directly with DHMT and DTC i.e. PASCO and FO respectively were more versed with collaboration. This could be due to the operational insights gained in the multi-sectoral approach of the HIV and AIDS interventions and the inter-disciplinary nature of HIV and AIDS and STIs integrated initiatives handled by the FO and PASCO respectively.

Conversely, the CACC coordinators had basic knowledge on collaboration. They stated more operational aspects of collaboration such as sharing of information, participation in joint meetings and fora, and participation of members of one committee in the other. This is because the CACC coordinators operate at the operational implementation level.

c) Opinion Whether DHMT and DTC Should Collaborate and Reasons for it

Most DHMT and DTC members felt that the two committees should collaborate more. This view concurred with the provincial heads who also stressed that collaboration between DTC and DHMT is a policy imperative for success of the HIV response. Similarly Sloper (2004) also noted that collaboration between agencies is a key imperative and improvement of interagency working and coordination a policy priority. Further, the provincial heads added that collaboration enhances working together on HIV since it is both a health and a multi-sectoral issue. This concurs with Alter and Hage (1993) who observed that collaboration addressed the challenge of organisational individualism which is inadequate to deal with complex task scope of multi-sectoral issues encountered in sectors such as HIV and AIDS.

The DTC and DHMT members outlined the reasons below for collaborating and these were similar to the ones stated by the provincial heads. First, collaboration would create a larger multi-disciplinary team to enhance implementation of the multi-sectoral HIV response by providing a common front for lobbying, advocacy, mobilisation of resources. This aligns with the multi-sectoral collaboration envisioned in NACC (2005) and NACC (2009a). In addition, this concurs with Skelcher (2000) who noted that collaborative partnerships bring together actors from diverse sectors to operate between and around the institutions of government. The respondents further noted that collaboration would enhance the quality of implementation. This is supported by Pratt (1999) who noted that a key aim in partnerships is to add value in implementation of interventions.

Secondly, collaboration would promote understanding of each committee's roles in the HIV response and thereby each committee will work in its core competence area, complement and support the other. This would also enhance synergy, team work and conflict resolution. Various literature support this view where for example Frances et

al., (1991) observed that partnerships facilitated harnessing of comparative strengths, are relatively flexible and often offer high commitment among the parties. Further, Mohr et al. (1994) outlined commitment, coordination and trust as key attributes for partnership success in addition to conflict resolution through collaborative problem solving. Further still, IMF (2007) who noted that partnerships enhance complementarities and synergy in implementation of programmes. In addition, Metcalfe and Richards (1990) similarly observed that good results in the public sector are obtained from cooperation of organisations with interdependent functions.

Thirdly, collaborating would facilitate DHMT and DTC to have joint planning, implementation and M&E thereby avoiding fragmented operations. This is also envisioned in MOH (2005) which notes the need for joint programme for work and financing. Further, joint planning and implementation is also envisioned in NACC (2005) and actualised in the joint HIV and AIDS annual review (JAPR) process. The respondents outlined the JAPR as a process that enhances interaction and sharing of information among the stakeholders. This view is also supported by Skelcher, (2000) who observed that partnerships addressed the challenges inherent in fragmentation.

Fourth, collaboration enhances integration in implementation of activities and thereby optimal utilisation of resources by avoiding duplication of functions and overlapping of activities. This is also echoed by Pratt (1999) and Unger et al., (2003) who noted that coordination and integration reduce duplication and allows for optimal resource utilisation. Unger et al., (2003) also noted that integration reduces duplicated vertical programmes and bureaucracies that often create bottlenecks impeding effective implementation. In addition, Price et al., (2000) observed that integration in collaborations minimise duplications especially in related interventions that cross cut.

Fifth, collaboration facilitates provision of technical support and coordination to initiatives implemented by stakeholders and thereby improves quality of services provided. Both DTC and DHMT are responsible for ensuring stakeholders coordinate and implement quality programmes. This concurs with policy where for example, DHMT maintains standards for care and treatment interventions as outlined in MOH

(2008) whereas DTC coordinates quality implementation by actors of community HIV and AIDS activities as outlined in NACC (2005) and NACC (2009a).

Sixth, collaboration of DHMT and DTC enhances efficiency and effectiveness of the HIV interventions through facilitation of multi-sectoral collaboration and coordination of various implementers. This is also envisaged in NACC (2005), NACC (2009a), MOH (2005) and MOH (2008) which outline the imperative for partnership collaboration for effectiveness in provision of HIV services.

5.2.2 Status of the Collaboration between DHMT and DTC

The DTC and DHMT members as well as the provincial heads and the CACC coordinators concurred on the state of collaboration between DHMT and DTC. They all stated that the two committees are collaborating but also noted that they could collaborate more. This concurred with MOH (2007) which outlined the imperative for collaborating while noting that there are inherent challenges in operationalising the collaboration. Further, the CACC coordinators added that the sub optimal collaboration between DTC and DHMT affects the effectiveness of technical and supervisory support that the two committees provide to the CACC coordinators in line with NACC (2009b).

a) Areas in which DHMT and DTC are currently collaborating

The DHMT and DTC members outlined the areas in which the two committees are currently collaborating. They also outlined the areas in which they are not collaborating well and in which they could improve their collaboration. These were similar to those outlined by the CACC coordinators. The most cited area is in implementation of HIV prevention and support activities such as community mobilisation, awareness creation, HTC and support to orphans and vulnerable children (OVC). The second area is in conducting the World AIDS Day (WAD) activities. Thirdly is holding joint meetings such as occasional briefings by DMOH to the DTC. The fourth area is in data collection and processing, information sharing and dissemination. The fifth area is representation and involvement of one committee in the other such as participation of DMOH in DTC. The sixth area is participation in the JAPR process. The other areas of collaboration include conducting of the district

health stakeholders' forum (DHSF), in health information management, in providing technical support to implementers and in sharing resources including personnel.

Participation in coordination fora was cited as a key area that provides opportunity for DHMT and DTC collaborate. These fora include joint planning and review initiatives such as JAPR, AOP, WAD and stakeholders meetings among others. Furthermore, conducting briefing meetings and participation of members of one committee in the other committee were also cited as important ways in which collaboration is facilitated. These sentiments concurred with Charlesworth et al. (1996). However sharing of information, plans and budgets, joint supervision and M&E rarely happens and this concurs with Hardy et al., 1992.

b) Areas in Which DHMT and DTC have not Collaborating Well and Could Improve on

Most DHMT and DTC members concurred that they have not collaborated optimally. Further, it was notable that one respondent stated that there is no collaboration between DTC and DHMT while another stated that DTC in the new district has never met. Further still a CACC coordinator concurred stating that DTC and DHMT do not collaborate while the other CACC coordinators stated that the collaboration between DTC and DHMT is inadequate.

The respondents outlined the areas below as the ones in which they have not collaborated well on and outlined these areas as the ones to improve collaboration on. It was interesting to note that these areas cited for sub optimal collaboration were also the same ones that the DTC and DHMT had stated as areas they are collaborating in. This indicated that the respondents felt that although they are collaborating in these areas, this collaboration can be enhanced.

First area is on joint meetings. It was stated that DTC does not convene regular meetings and this affects coordination of HIV and AIDS activities area. The DTC and DHMT members cited a need for more regular joint consultative meetings and other fora involving partners and stakeholders to share and plan on HIV and AIDS issues.

The second area is conducting joint planning, budgeting and implementation of activities. Some cited activities include HCBC, VCT, trainings and capacity building of CACCs and other implementing organisations.

The third area is conducting joint coordination, support supervision and M&E of activities. Joint provision of technical support to the implementing organisations (CSOs) was also cited as a key related area of collaboration.

The fourth area is in data, communication and information sharing. Related issues mentioned include conducting joint data collection such as in surveys, information processing, sharing and dissemination, and provision of feedback. This was also noted in Mohr et al. (1994) who observed that collaboration and integration leads to more sharing of information among different agencies and thereby saves some agencies resources that would otherwise be used in collecting information that is available with the other agency.

The fifth area of collaboration is in the sensitisation on roles and functions of the two committees and also outlining their complementary aspects. For example, the DHMT had been inadequately acquainted with roles of DTC and CACC and thereby were unable provide effective support to CACC coordinators as expected.

The sixth area is related to funds and other resources and entailed various issues such as resource mobilisation, allocation (e.g. funding of organisation) and utilisation (e.g. in transparent utilisation). Further there was a desire to share resources such as funds, personnel and materials among the two committees and funding of CSOs. These resource issues in collaboration concur with Wendy et al. (2004) who observed that finding legitimate reasons for collaboration is uncommon and highlighted the Benson (1975) concept of resource dependency to outline the situations in which collaboration is likely to occur. Benson (1975) had observed that in collaborative interactions in service delivery, organisations will defend their own interests and conflict will occur where these interests are incompatible. The two key resources inter-organisational collaboration are money and authority. Further Benson (1975) suggested that organizational decision-making is oriented to the acquisition and retention of an adequate supply of resources.

The seventh area is team work and networking among DHMT and DTC. Enhanced representation and participation of one committee in the other was cited to enhance collaboration. Examples stated include inviting DDO to DHMT when discussing HIV issues, participation of CACC coordinator in DHMT and DASCO in CACC and DTC. Furthermore DTC members stated that they could collaborate more with DHMT in funding of CSOs, capacity building of CACCs and other implementing organisations and in promoting cordial working relationship between officers such as CACC coordinators and DASCOs.

Finally, collaboration would be enhanced through provision of policy direction and leadership for the joint working. As Weiner et al., 1998 and Guest et al., 2001 observed, leadership and governance of partnerships to achieve integrated programme goals is fraught with challenges related to the management of diverse and often incongruent interests of various partners.

Furthermore, the CACC coordinators outlined similar sentiments as DTC and DHMT above. In addition they stated that DTC and DHMT have not collaborated well in prioritization of HIV and AIDS, joint planning and in audit of activities of implementing partner organizations.

The above sentiments by DTC and DHMT members and CACC coordinators were echoed by the provincial heads who stated that although DTC and DHMT are collaborating there are gaps in the collaboration.
Further, the provincial heads also expressed varied opinions on the current framework for collaboration with one stating that it is sufficient to support the collaboration, while another stated that the framework needs updating and another stated that the framework is inadequate to support the collaboration.

5.2.3 Factors that Foster Collaboration between DHMT and DTC

The DHMT and DTC members, provincial heads and CACC coordinators outlined very similar factors that foster collaboration in between DTC and DHMT. These factors concurred with Sloper et al. (2004) and included structural, procedural,

financial and professional orientations related factors. These factors were aligned to the issues outlined by Hardy et al. (1992).

Most respondents preferred to see enhanced collaboration between DTC and DHMT. Further they outlined the factors that fostered collaboration in the past and noting that these would also enhance future collaboration. The most cited factor is sensitisation on the roles and functions of DHMT and DTC. This would also include outlining the collaboration framework that spells out the complementary roles of the two committees in the HIV response. This was also noted by Sloper (2004) who observed that clear delineation of roles and responsibilities is a key factor in enhancing collaboration.

The second factor is facilitation with adequate financial and other resources for carrying out collaborative activities. This also includes sharing of resources and utilising them while heeding the values of efficiency, transparency and accountability. This concurs with Benson (1975) who noted that collaboration is likely to happen if agencies increase the efficiency with which resources are utilized efficiently. Sharing of other resources such as technical expertise was noted to enhance collaboration.

The third factor is provision of policy direction, vision and leadership for collaboration and this concurred with Huxham et al. (2000) who noted that leadership pushes forward the collaborative agenda. Further, Benson (1975) suggested that success in collaboration is pegged on negotiated deals which hold the potential for mutual benefits and this is a role that is mediated by the leadership in the collaboration. The coordination role of NACC structures including DTC and CACC was cited as key. Other issues include the proactive initiative to collaborate, leadership by key personnel especially chairpersons of DHMT and DTC, communication on the multi-sectoral nature of HIV and its response and the inter-relatedness of health and HIV.

The fourth factor was enhanced team work, networking and linkage of various actors such as implementing organisations to DHMT and DTC. Team work would emanate from “a common vision that the fight is against a common opponent HIV” according to a respondent.

The fifth factor is enhancement of the operational framework for collaboration. An example is through conducting joint initiatives such as consultative meetings, joint planning or harmonising of work plans, joint implementation of activities, joint M&E and supportive supervision. Benson (1975) suggested that success in collaboration depends on negotiated deals which hold potential for mutual benefits. He further stressed that supervisory structures have a role to organize the local environment to provide a facilitating framework for collaboration.

The sixth factor relates to communication and information sharing. Key issues include data collection, information processing, sharing and dissemination, and provision of feedback. The information shared is broad range and includes such things as communication of as work plans and reports.

The last factor is representation and participation of members of one committee in the other and these include for example more DHMT members in the DTC and more active participation of DASCO in DTC.

Similar sentiments as the above were expressed by the CACC coordinators who also emphasised on commitment and professionalism and enhancement of joint activities.

Moreover the provincial heads stated similar factors and emphasised various issues. These include policy direction and "leadership from the top" with the "top officials being role models of collaboration". This concurs with Huxham et. al (2000) who noted that leadership is paramount in pushing forward the collaborative agenda. Secondly the provincial heads also highlighted need for streamlining funding frameworks. This was echoed Hardy et al. (1994) who noted that differences in funding mechanisms and bases as well as differences in the stocks and flows of resources hinders effective collaboration and coordination. However, one key informant stated that sharing of resources may not be feasible stating that; "although collaboration is good, I don't think sharing of resources between DTC and DHMT is feasible". The respondents also stressed the importance of harmonising understanding on the vision and goal for the district. They also stated the need to enhance harmony and unity of vision and purpose rather than "pulling in different directions".

Furthermore, the provincial heads highlighted the strengths in the current framework in respect to supporting collaboration. These strengths include the existence of policies and guidelines outlining the structure, function and roles of the committees and its members. Secondly is diverse technical capacity and skills possessed by the two committees e.g. DTC in coordination, M&E and DHMT in health issues. Third strength is good facilitation from NACC and MOH to discharge the respective mandates. Finally is commitment by development partners (donors) to provide funding. Further still, the provincial heads noted that the strengths can be enhanced to better support collaboration between DHMT and DTC through sensitisation of DHMT and DTC on policies and guidelines outlining the roles and functions, strengthening capacity building initiatives including trainings, and provision of more resources e.g. funds, computers and vehicles to facilitate implementation of initiatives. Other ways include holding joint meetings and implementing joint activities.

5.2.3 Factors that Hinder Collaboration between DHMT and DTC

Wendy et al., (2004) observed that even where there is basis for collaboration there are many barriers to surmount. The DTC and DHMT members outlined various factors hinder collaboration between the two committees. These factors were also echoed by the CACC coordinators as well as the provincial heads. The issues were converse of those that foster collaboration and concurred with Hardy et al. (1992)

The first factor is inadequate sensitisation on roles and functions of the two committees. This concurs with This was also noted by Sloper (2004) who observed that clear delineation of roles and responsibilities is a key factor in enhancing collaboration. Many members of DTC and DHMT did not sufficiently know the roles and functions of their committee as well as the other committee. For example, some DHMT members are not acquainted with roles of DTC and CACC. It was notable that two respondents stated that they do not know what DTC is and what its roles are. The provincial heads were also inadequately sensitised on the roles, functions and complementarities of DHMT and DTC where one respondent was not conversant with what DTC is.

The second factor noted by DTC and DHMT members and emphasised by the provincial heads relates to funding. First the funds are inadequate and their flow is erratic or irregular making it hard for committees such as DTC to function such as to facilitate meetings facilitate CACC coordinators on issues such logistics for joint activities, supportive supervision and M&E. In some newly created districts, DTC had been formed but were dormant because no funds had been disbursed to conduct the DTC activities. Further as Wendy et al. (2004) observed networks and partnerships often have high transaction costs and inadequate financial facilitation means they are unable to function. Secondly, un-harmonised and differentiated funding structures did not encourage collaboration. A provincial head stated that differentiated funding mechanisms for DHTC and DHMT had led to formation of "turfs" and reluctance to collaborate and share resources and information. Hudson (1987) observed that individual organization are often reluctant to collaborate as this poses a challenge of having to forfeit some autonomy and invest own resources in building relationships with other organizations even where apparent benefits are not very obvious. Further, as Hardy et al. (1992) observed, differences in funding mechanisms and bases as well as differences in the stocks and flows of resources act as barriers to effective collaboration and coordination. Thirdly, suspicion and a perception of lack of transparency, accountability and efficiency in utilisation of resources hindered collaboration. As Benson (1975) noted, collaboration is enhanced if there is efficiency in utilization of resources. Fourth, different perceptions regarding the funding also hinder effective collaboration. For example, DHMT perceived that DTCs and CACCs have high allocation of funds and can operate independently and the DHMTs were not motivated to collaborate.

The third factor hindering collaboration is inadequate vision, policy direction and leadership for collaboration. First, a respondent lamented that there was a loss of focus on the overall vision of fight against HIV and AIDS. Secondly, several respondents stated that they do not have a clear understanding on the policy direction on collaboration while other respondents stated that there is no harmonised understanding and vision on collaboration and "each person interprets it their own way". Thirdly, other respondents stated that there is inadequate leadership from the top to drive the collaboration whereby one stated that different leaders at the top are "pulling hard but on different directions". Fourth, there was inadequate commitment

by some members towards HIV and AIDS activities as compared to other more pressing or immediate concerns. For example some CACC coordinators observed that in some areas there was low prioritization of HIV activities as compared to issues such as security and food security. This inadequate commitment often emanates where organizations often face a stronger top-down imperative to be more stringent in pursuing their own objectives and performance targets (Wendy et al., 2004). In these instances, the agencies are faced with two way pressure of having to perform on delivering on own performance targets while at the same time participate in inter-organisational partnerships. More often than not, these organizations will prioritise delivery in their core mandates and participation in the partnership is seen as subsidiary in terms of rewards and resources. Fifth, a respondent cited complacency among some committee members as a result of a perception of lower risk due to decline in HIV prevalence. The key role of leadership in collaboration was outlined by Huxham et al (2000) who noted that leadership moves a collaborative agenda forward. Where attempts are made to foster collaboration in a partnership, concerted efforts are necessary to make the governance of partnerships effective in meeting the desired objectives.

The fourth factor hindering collaboration relates to staffing issues and inadequate team work. First differences in attitudes among the different committees hindered collaborative working. For example, a respondent highlighted the presence of "egocentricism" among the committees and members and perceptions of superiority of each committee over the other. This bred rivalry and "turfs" between DHMT and DTC. Secondly, competition between DTC and DHMT hindered collaboration, support of one team to the other and sharing of information. Lawler et al. (1975) noted that concurrence of attitudes was an important determinant of effective collaboration. Thirdly, some key officials were overcommitted and often overloaded with other competing responsibilities often impeding prioritisation of collaboration. For example, the chairpersons of DTC and DHMT (i.e. DC, DMOH respectively) and DDO were noted to be too committed to give adequate attention to collaboration effort. A DTC member stated that the secretary of DTC (i.e. DDO) is usually overwhelmed with many work demands and does not give adequate attention to the work of DTC and issues on HIV. Fourth and as also highlighted by key informants, some respondents stated that some committee members took advantage "using the

other committee to further own committee's agenda". This often hinders collaboration where as Huxham and Macdonald, (1992) observed, collaborating often means that agencies share credit with other organisation for achievements and in other instances, even forfeiting all recognition to the other organization. Fifth were occasional personality differences among key members of the committees especially chairpersons and these often hindered collaboration. Finally some committee members had divided allegiances. For example, whereas the DMOH was a member of both DTC and DHMT, the allegiance was to the "mother" i.e. MOH. This issue was also echoed by CACC coordinators who also noted that at their level, they have divided between employing and seconding agency (MOH), paying agency (NACC) and supervising agency (MOH-DPHO or NACC-DDO). This issue is related to the challenge outlined in Skelcher (2000) that collaborative partnership structures usually have complex accountability relationships with various public bodies as well as other actors.

Fifth, differences in perceptions and orientation of the two committees often hindered collaboration. For example, some respondents viewed DHMT as a "working committee" comprised of health professionals and DTC as a mixed "talking" committee and this affects collaborative working between the two committees. As noted in Easen et al. (2000), different professional orientations and thereby different conceptualisations of practice often hinders effective collaboration. Johnson et al. (2003) also observed that inter-agency collaborations are fraught with more challenge where inter-professional collaboration is also entailed. Furthermore, there were some conceptions among some committee members that HIV and AIDS is an MOH issue as opposed to being a multi-sectoral issue thereby impeding the initiative to collaborate.

The sixth factor is an inadequate operational framework for the collaboration between DTC and DHMT. First there is an adequately clear collaboration implementation framework. This echoed Minehart et al. (1999) who noted that implementation of collaborative partnership programmes requires effective intergovernmental coordination mechanisms to ensure that the different agencies operate in a harmonious and coordinated fashion. An example also noted by Huxham et al. (2000) is employing harmonised guidelines processes and tools. Further as Buchert (2001) noted, coordination of approaches aimed at integration of the individual partners'

processes leads to enhanced integration at the partnership level. However, the respondents also noted that where there is policy and framework guidance, these are sometimes inadequately implemented. Secondly, is inadequate joint meetings and fora between the two committees and with other stakeholders. Thirdly, is inadequate joint activities such as joint planning, implementation, M&E. Fourth, there is limited time to meet and discuss on HIV and AIDS as no specific time has been scheduled for collaborative activities. Fifth, few members of one committee are represented in the other committee. For example, few DHMT members are involved in the DTC and those involved do not give adequate feedback to rest of DHMT. Sixth, differences in planning and financing frameworks also impede collaboration. As noted Hardy et al. (1992), differences in planning horizons and cycles as well as differences in budgetary cycles and procedures does not foster coordination between agencies.

The seventh factor hindering collaboration is inadequate communication and information sharing. For example, there is inadequate district data especially in new districts, inadequate information systems and data banks on HIV/AIDS, inadequate sharing of information, inadequate M&E for ongoing projects and inadequate fora for the two committees to share the information that they have.

A final factor that negatively affected collaboration was transitional administrative issues for example the rapid change in administrative through creation of new districts. New districts meant new DTC and DHMT and there was a challenge in collaboration where many staff and structures are still non-existent. Furthermore, in some "new" districts DTCs had not yet been formed. A factor experienced in these situations is collaborative inertia. As noted by Huxham, (1995), in partnerships significant time and effort is often spent in agreeing on details in the partnership, creating understanding of different partner perspectives and negotiating a common purpose. Secondly Wendy et al. (2004) also noted that even where different agencies acknowledge the potential benefits of partnership in helping them fulfil their own objectives, many experience frustration as linkages do not occur easily.

5.2.4 Ways in Which Collaboration Can Be Enhanced

The respondents and especially the provincial heads further outlined the ways in which the gaps in the framework can be addressed. First is having a clear framework

on collaboration. Furthermore the stakeholders should be involved more in the formulation and / or revision of collaboration policies & guidelines.

A second way of addressing the gaps is sensitisation on the existence, roles and functions of DHMT and DTC especially to new staff as well as others. As one key informant put it, “I only hear DTC at the World AIDS Day and at JAPR”.

Thirdly, the respondents stated that the funding frameworks should be harmonised on such issues as sources, procedures whereby there would pooled or basket funding. This view is supported by Hardy et al. (1992).

The respondents also mentioned the need to enhance representation and participation of one committee in the other e.g. DDOs and CACC coordinators be represented in DHMT. Some respondents especially noted the need to strengthen the support of DTCs to DASCOs. Furthermore, some respondents stated the need to involve more stakeholders in DTC.

Finally, the respondents stated that monitoring and evaluation of policy implementation would help to address the gaps in the framework.

Summary

This chapter discussed the findings on the perceptions of DTC and DHMT on their collaboration.

First, the policy and operational framework for DHMT and DTC and their collaboration was discussed. There is an elaborate policy framework that outlines NACC and MOH as the key agencies for the implementation of the HIV response and DTC and DHMT are the decentralised district structures for NACC and MOH respectively. Furthermore, there is also an elaborate operational framework for operations of DHMT and DTC and their collaboration. These frameworks guide the operations of the two committees and their collaboration.

Secondly, the knowledge and perceptions that DTC and DHMT members have on the two committees and their collaboration were discussed. There were notable

similarities in the knowledge patterns among DTC and DHMT members and also among provincial heads as well as with the CACC coordinators.

Thirdly, various factors that affect the collaboration were discussed. Some of the factors foster collaboration and these include first sensitisation on the roles and functions of DHMT and DTC as well as the collaboration framework and the complementary roles. The second factor is adequate facilitation with financial and other resources for conducting collaborative functions. Thirdly is provision of policy direction, vision and leadership for collaboration. Fourth is enhanced team work, networking and linkage of various actors such as implementing organisations to DHMT and DTC. Fifth is enhancement of the operational framework through conducting joint initiatives. Sixth is communication and information sharing. Finally is representation and participation of members of one committee in the other.
Similar sentiments as the above were expressed by the CACC coordinators who also emphasised on commitment and professionalism and enhancement of joint activities.

Moreover the provincial heads stated similar factors and emphasised policy direction and "leadership from the top", streamlining funding frameworks, enhance harmony and unity of vision and purpose in the fight against HIV. The provincial heads highlighted the strengths in the current collaboration framework and these include the existence of policies and guidelines, diverse technical capacity and skills and commitment by development partners (donors) to provide funding.

Secondly the factors that hinder collaboration were discussed and these include first inadequate sensitisation on roles and functions of the two committees. The second factor relates to funding such as inadequate funds and its erratic or irregular flow and differentiated funding frameworks. Thirdly is inadequate vision, policy direction and leadership for collaboration. Fourth is staffing issues and inadequate team work such as differences in attitudes, "egocentricism", rivalry and "turfs" wars, competition, mistrust, inadequate prioritisation of collaboration etc. Fifth, is differences in perceptions and orientation about the committees, different professional orientations Sixth is inadequate operational framework for collaboration such as lack of a clear collaboration implementation framework, fora, inadequate joint activities inadequate time for collaborative activities inadequate representation of one committee in the

other committee and differences in planning and financing frameworks. Seventh is inadequate communication and information sharing.

Finally, various issues were outlined by the three categories of respondents as being key to effectiveness of collaboration and coordination between DHMT and DTC. The first is joint consultative meetings between NACC and MOH structures. It was noted that the lack of or inadequacy of these planning and review meetings contributed to hindered collaboration. Conversely the respondents noted that holding of such meetings contributes to enhanced coordination. Furthermore it was noted that participation in the existing joint fora and initiatives such as JAPR, AOP and WAD among others provided opportunity for collaboration among NACC and MOH as well as other stakeholders. Secondly is joint implementation of activities as well as monitoring and evaluation, and technical support and supervision of implementers. Thirdly is participation and involvement of one committee in the other and some suggestions raised included incorporation of DASCO in the DTC. Fourth is sensitisation on the roles and functions of the two committees. Fifth is addressing of the funding issues including adequacy, frequency as well as the funding frameworks. Sixth is leadership and direction for collaboration including clarifying the complementarities in the work of the committees as well as the collaboration framework. The seventh is team working related issues whereby the two committees endeavour to work harmoniously.

On the other hand the three categories of respondents exhibited different emphases on the issues affecting collaboration between the two committees. The provincial heads largely outlined the policy framework and leadership related issues. Members of DHMT and DTC on the other hand outlined management related issues whereas the CACC coordinators outlined operational issues. This emphasis by different respondent categories reflects the level of operation of the respective respondent categories.

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusions

This study brought to the fore various issues on DMHT and DTC and their collaboration. First, DTC and DHMT members are generally familiar with definition and roles of their own committees but are not familiar with those of the counterpart committee. There is a marginally higher knowledge on DHMT than on DTC. The key roles mentioned for DTC are related to coordination, technical support and M&E of HIV and AIDS activities whereas those of DHMT are related to planning, implementation, supervision and M&E of health and HIV activities.

Secondly, DHMT and DTC are familiar with collaboration and feel that it is an important policy and operational issue. This view is supported by the provincial heads and CACC coordinators who also noted that collaboration is necessary for effective implementation of HIV and AIDS response. Further government policies and guidelines outline the imperative for multi-sectoral collaboration.

Thirdly, most DHMTs and DTCs collaborate in some areas and such include organising some joint events such as the World AIDS Day (WAD), Joint AIDS Programme Review (JAPR), stakeholders fora and other activities, sharing information and resources, dissemination / sharing, reports, membership of DMOH in DTC assumes interaction hence collaboration with DHMT, trainings, technical support / advise. Furthermore some strengths in the collaboration framework were highlighted by the provincial heads and these include first the existence of policies and guidelines outlining the structure, function and roles of both DTC and DHMT. Second is diverse technical capacity and skills possessed by the two committees, for example DTC in coordination, M&E and DHMT in care and treatment issues. The third is facilitation from MOH and NACC to discharge mandates and finally there is commitment by development partners (donors) to provide funding.

However, there are other areas where gaps exist in the collaboration between DHMT and DTC. These areas include in sensitisation on the roles of each committee in the fight against HIV and AIDS; holding regular joint meetings; planning and implementing joint activities; conducting joint support supervision and M&E; joint

data collection and sharing of information; and joint budgeting, mobilisation and utilisation of funds and other resources.

The factors contributing to inadequate collaboration between DTC and DHMT include inadequate understanding by the departmental heads as well as members DHMT and DTC on the roles and functions and complementarities of the two committees; unclear policies, guidelines and collaboration framework and inadequate sensitisation of the same; inadequate joint meetings and activities; inadequate and irregular funding; inadequate sharing of information and inadequate interpersonal and team relations. Other issues include complacency due to the drop in HIV prevalence rates, different perceptions on orientation of the committees where DHMT is viewed as a "working team" while DTC is viewed as "a coordinating team", inadequate involvement of some key personnel e.g. DASCO not in DTC.

6.2 Recommendations

The collaboration between DHMT and DTC will be enhanced by addressing gaps in areas such as holding regular joint meetings and implementing joint activities, joint support supervision and M&E, sharing information and resources, joint technical advice to the implementing organisations joint budgeting and funding, resource mobilisation.

The following factors should be considered in order to enhance collaboration between DTC and DHMT: sensitisation on the importance of multi-sectoral collaboration and enhancement of joint forums for the two committees; outline the framework of collaboration between DTC and DHMT; provide leadership and vision from the top for collaboration; sensitise members of DTC and DHMT on the policies and guidelines that outline the roles and functions of two committees; address funding issues including the adequacy and consistency of funding, and harmonising the funding structures; and enhancing the participation of members of DTC and DHMT in the two committees through cross representation in various committees.

The key issues in the collaboration between DHMT and DTC can be divided into five categories. First is policy, strategy and leadership for collaboration and this also entails dissemination of the policies and guidelines on the operations of the DTC and

DHMT as well as provision of policy direction on the operationalisation of the collaboration. Secondly is the joint planning implementation and M&E. Thirdly is communication and sharing of information. Fourth is the fostering of good team and interpersonal relations. Finally is the addressing of funding issues related to the funding frameworks, adequacy and flow of funds.

In summary there need to further recognise that coordination and collaboration is a key imperative for success of the HIV and AIDS response. Focus should be on the key issues in collaboration outlined above which include policy leadership, sensitization on roles and functions, integration of planning, implementation and M&E, addressing team dynamics and sharing of information and resources.

6.3 Knowledge Gaps for Further Research

Various areas were noted as having knowledge gaps and in which further research is necessary to delineate the key issues. The first area is a review of effectiveness of the use of CACC coordinators who are public health officers seconded from MOH to work with NACC coordinating community based HIV activities while at the same time performing their MOH roles.

Secondly is a review of effectiveness and challenges of using the DDOs to provide technical and supervisory to CACCs. The DDOs coordinate all development activities in the district and are secretary to numerous district committees including district development committee (DDC), district technical committee (DTC) and district executive committee (DEC) among others. The DDOs are thus overwhelmed with responsibility and may it was noted that they face difficulty in effectively performing their roles in supporting CACCs.

Thirdly, there is a need to assess the effectiveness of the linkage between health facility based services provided by MOH and community based HIV activities coordinated by the CACCs. This followed from the fact that effectiveness of collaboration between DHMT and DTC follows a strengthened system of linking the community based activities and health facility services.

7.0 REFERENCES

Benson, J. K. (1975) 'The Inter-Organisational Network as a Political Economy', *Administrative Science Quarterly*, 20 (June), pp.229-49

Bollinger, L., Stover, J. and Nalo, D. (1999) The Economic Impact of AIDS in Kenya, The Futures Group International, Research Triangle Institute (RTI), The Centre for Development and Population Activities (CEDPA)

Brinkerhoff, J. M. (2002) Assessing and improving partnership relationships and outcomes: a proposed framework, The George Washington University, Washington, DC 20052, USA

Charlesworth, J., Clark, J. and Cochrane, A. (1996) Tangled Web? Managing Local Mixed Economies of Care, *Public Administration*, 74 (Spring), pp.67-88.

Degeling, P. (1995) The Significance of "Sectors" in Calls for Urban Public Health Inter-Sectoralism: An Australian Perspective, *Policy and Politics*, 23/4, pp289-301.

Dowling, B., Powell, M, Glendinning, C. (2004) Conceptualising successful partnerships, *Health & Social Care in the Community* 12 (4)

Flynn, R. Williams, G. and Pickard, S. (1996) Markets and Networks: Contracting in Community Health Services. Buckingham: Open University Press.

Frances, J., Levacic, R., Mitchell, J. and Thompson, G. (1991) Introduction, in Thompson, G., Frances, J., Levacic, R. and Mitchell, J. (eds.), *Markets, Hierarchies and Networks: The Coordination of Social Life* (London: Sage).

Friend, J., Power, J. and Yewlett, C. (1974) Public Planning: The Inter-Corporate Dimension, (London: Tavistock).

Greener, R. (2002) AIDS and Macroeconomic Impact, in Forsyth, S. (ed.): *State of The Art: AIDS and Economics*, International AIDS Economics Network (IAEN), 49-55.

Guest, D. and Peccei, R. (2001) Partnership at Work: Mutuality and the Balance of Advantage. *British Journal of Industrial Relations*, Volume 39, Number 2, pp. 207-236(30) (Blackwell Publishing)

Hardy, B, Turrell, A. and Wistow, G (1992) *Innovations in Community Care Management* (Aldershot: Avebury).

Hudson, B. (1987) Collaboration in Social Welfare: A Framework for Analysis, *Policy and Politics*, 15/3, pp. 175-8.

Huxham, C. (ed.) (1995) *Creating Collaborative Advantage* (Sage: London)

Huxham, C. and Macdonald, D. (1992) 'Introducing Collaborative Advantage' *Management Decision*, 30/3, pp.50-56

Huxham, C. and Vangen, S. (2000) Leadership in the Shaping and Implementation of Collaboration Agendas: How Things Happen in a (Not Quite) Joined-up World *The Academy of Management.* Vol. 43, No.6, pp. 1159-1175

Joint United Nations Programme on HIV/AIDS (2004) *"Three Ones" Key Principles – Coordination of National responses: Guiding Principles for National Authorities and their Partners.*

Joint United Nations Programme on HIV/AIDS (2005) *AIDS epidemic update*

Lawler, E. J. and Youngs, G.A. (1975) Coalition formation: an integrative model. *Sociometry*, 38, 1/17.

Lowndes, V. and Skelcher, C. (1998) The Dynamics of Multi-organizational Partnerships: an Analysis of Changing Modes of Governance. *Public Administration 76 (2) Journal*, Vol. 43, No. 6, pp. 1159-1175

Metcalfe, L. and Richards, S. (1990). Improving Public Management. *London: Sage*.

Ngigi A. and Macharia D. (2006). Health Sector Policy Overview Paper, May 2006, IT Power East Africa
(http://www.enable.nu/publication/D_1_7_Kenya_Policy_Overview.pdf)

Marshall, C. and Rossman, G. B. (1995) Designing qualitative research (2nd ed.) Thousand Oaks, CA: Sage

Merriam, S. B. (1998). Qualitative Research and Case Study Applications in Education. Jossey-Bass Publishers: San Francisco.

Mohr, J. and Spekman, R. (1994). Characteristics of Partnership Success: Partnership Attributes, Communication Behavior and Conflict Resolution Techniques in *Strategic Management Journal*, Vol. 15, No. 2 (Feb., 1994), pp. 135-152, John Wiley & Sons

Nadler, D. A. (1977). Feedback and Organisation Development – Using Data Based Methods Addison-Wesley Pub Co

Piot, P., Bartos, M., Ghys Peter, D., Walker, N. and Schwartländer, B. (2001) The global impact of HIV/AIDS in *Nature* Volume 410 (19 April 2001)

Republic of Kenya, Central Bureau of Statistics (CBS), Ministry of Planning and National Development (2003). *The Kenya Demographic and Health Survey*, Nairobi*:* Government Printer

Republic of Kenya, Central Bureau of Statistics (CBS), Ministry of Planning and National Development (2001) *Population distribution by administrative areas and urban centres*, Kenya 1999 Population and Housing Census. Vol. 1., Nairobi*:* Government Printer

Republic of Kenya, Central Bureau of Statistics (CBS), Ministry of Planning and National Development (1994*) Kenya Population Census, 1989* Vol. 1, Nairobi*:* Government Printer

Republic of Kenya, Central Bureau of Statistics (CBS), Ministry of Finance and Planning (1981) *1979 Population Census,* Vol. 2, Nairobi*:* Government Printer

Republic of Kenya, Central Bureau of Statistics (CBS), Ministry of Finance and Planning (1970) *1969 Population Census* Vol. 4. , Nairobi*:* Government Printer

Republic of Kenya, Ministry of Health (MOH, NASCOP) (2009) *The Ministry of Health HIV/AIDS Decentralisation Guidelines*, Nairobi*:* Government Printer

Republic of Kenya, Ministry of Health (MOH) (2007). The Second National Health Sector Strategic Plan - Roadmap for Acceleration of Implementation of Interventions to Achieve Objectives of the NHSSP II, Nairobi*:* Government Printer

Republic of Kenya, Ministry of Health (MOH) (2001). AIDS in Kenya – *Background, Projections, Impacts, Interventions, Policy.* 6th ed., Nairobi*:* Government Printer

Republic of Kenya, Ministry of Health (MOH) (1999). The Second National Health Sector Strategic Plan: 2005-2010, Nairobi*:* Government Printer

Republic of Kenya, Ministry of Health (MOH) (2006). Joint Programme of Work and Funding 2006/07 – 2009/10 for the Kenya Health Sector, Nairobi*:* Government Printer.

Republic of Kenya, NACC (2005). The Kenya National HIV/AIDS Strategic Plan 2005/06 – 2009/10, Nairobi*:* Government Printer

Republic of Kenya, NACC (2009a) The Kenya National HIV/AIDS Strategic Plan 2009/10 – 2012/2013. Nairobi*:* Government Printer

Republic of Kenya, NACC (2007) Guidelines for Field Operations at the NACC Decentralised Structures, 5th ed., Government Printer

Republic of Kenya, NACC (2007) Guidelines for the Field Operations at NACC Decentralised Structures Nairobi: Government Printer

Republic of Kenya, NACC (2007). The Kenya HIV and AIDS Indicator Survey, Nairobi: Government Printer

Republic of Kenya, Republic of Kenya (1965). Sessional Paper No. 10 of 1965 on African Socialism and Planning, Nairobi*:* Government Printer

Ranade, W. (ed.) (1998). Markets and health care: a comparative analysis, Addison Wesley Longman, London, , pp 223.

Robinson, R. and LeGrand, J. (1994) Evaluating the NHS reforms (London: King's Fund Institute, Newbury, pp. 288

Roussos, S. T. and Fawcett, S. B. (2000) A Review of Collaborative Partnerships as a Strategy for Improving Community Health in *Annual Review of Public Health* Vol. 21: 369-402 (May 2000)

Skelcher, C., Mathur, N., Smith, M. (2005). The Public Governance of Collaborative Spaces: Discourse, Design and Democracy *Public Administration* 83 (3)

Sloper, P. (2004). Facilitators and barriers for co-ordinated multi-agency services Child*: Care, Health and Development* 30 (6)

Wendy, R. and Hudson, B. (2004), Conceptual Issues in Interagency Coordination, in Snape S and Taylor P *Partnerships between health and local government* (London: Frank Cass & Co. Ltd)

World Health Organisation (1948). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

8.0 ANNEXES

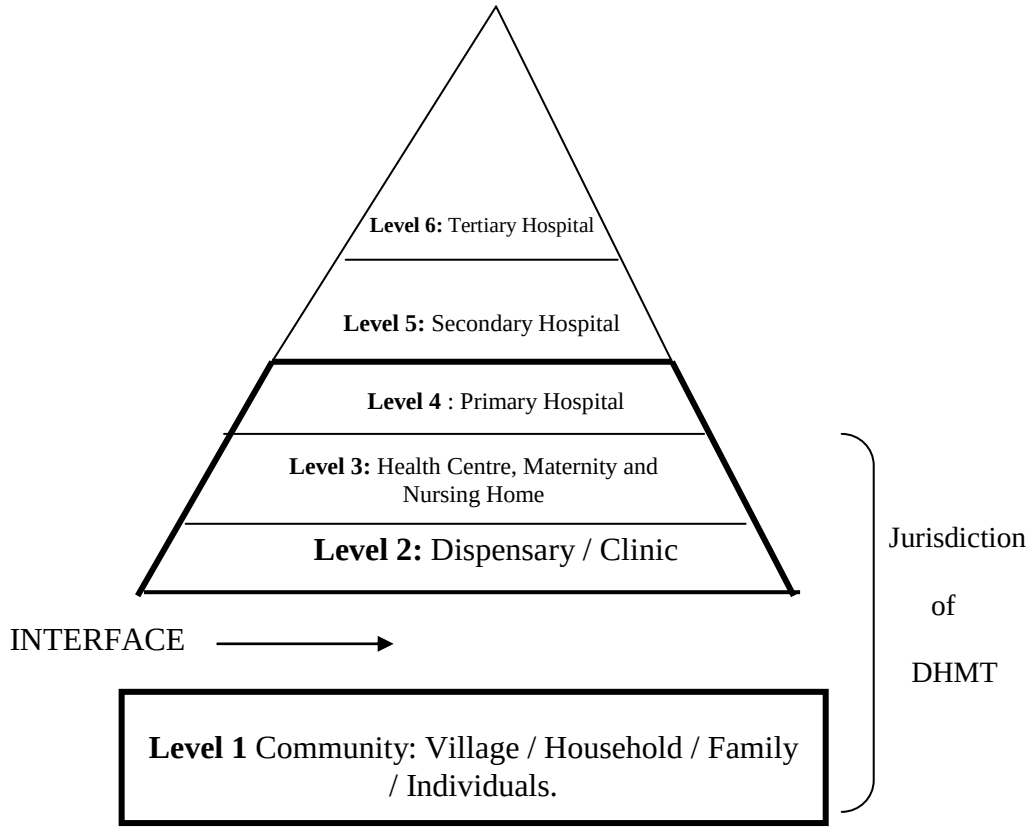
8.1 ANNEX 1: FIGURES AND TABLES

Figure 1: **Five Categories of Barrier to Collaboration**

Structural
Fragmentation of responsibilities across inter-agency boundaries
Fragmentation of responsibilities within agency boundaries
Inter-organisational complexity
Non-coterminosity of boundaries
Procedural
Differences in planning horizons and cycles
Differences in budgetary cycles and procedures
Financial
Differences in funding mechanisms and bases
Differences in the stocks and flows of resources
Professional
Differences in ideologies and values
Professional self interest
Threats to job security
Conflicting views about user interests and roles
Status and Legitimacy
Organisational self interest
Concerns for threats to autonomy and domain
Differences in legitimacy between elected and appointed agencies

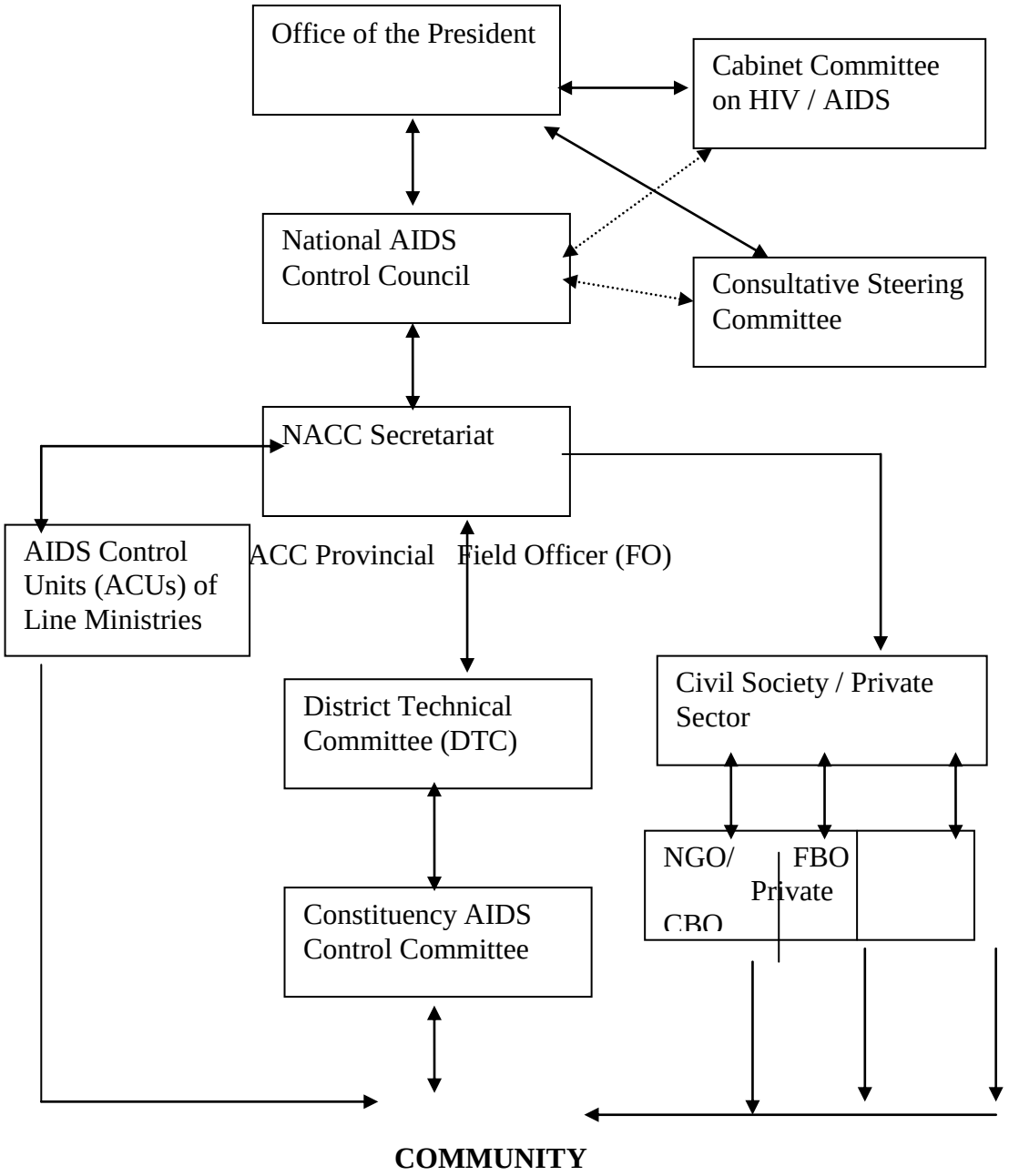
Source: Hardy et. al., 1992

Figure 2: Levels of Care in the Kenya Essential Package for Health (KEPH)



Adapted from MOH (2005)

Figure 3: The National AIDS Control Council Institutional Framework



Adapted from NACC (2005)

3.1: Districts and Constituencies in the Eastern Province in Kenya

Districts	*Constituencies*
1. Embu	1. Manyatta 2. Runyenjes
2. Tharaka	3. Tharaka
3. Mbeere	4. Siakago 5. Gachoka
4. Meru South	6. Nithi
5. Maara	
6. Imenti South	7. South Imenti
7. Meru Central	8. Central Imenti
8. Imenti North	9. North Imenti
9. Tigania	10. Tigania East
	11. Tigania West
10. Igembe	12. Igembe 13. Ntonyiri
11. Isiolo	14. Isiolo North
12. Garbatulla	15. Isiolo South
13. Laisamis	16. Laisamis
14. Marsabit	17. Saku
15. Chalbi	18. North Horr
16. Moyale	19. Moyale

3.2: Respondents to the Questionnaire to DTC and DHMT

District name	*Cluster type*	*Type*	*Respondent*				
			DC	*DMOH*	*DDO*	*DASCO*	*Total*
Embu	Peri-Urban	Old	0	1	1	0	2
Imenti North	Peri-Urban	New	1	1	1	0	3
Meru South	Peri-Urban	New	0	1	0	0	1
Mbeere	Rural	Old	0	0	0	1	1
Igembe	Rural	Old	0	0	1	1	2
Tigania	Rural	Old	0	1	0	1	2
Maara	Rural	New	1	1	1	1	4
Mwala	Rural	New	0	0	1	0	1
Marsabit	ASAL	Old	1	1	1	1	4
Moyale	ASAL	Old	1	1	1	1	4
Chalbi	ASAL	New	0	0	0	1	1
Total			*4*	*7*	*7*	*7*	*25*

3.3: Definitions of DHMT

Respondent	*Frequency*			
	Gave correct abbreviation and correct definition	Gave correct abbreviation only	Gave correct definition only	*Total*
DC	1	2	1	*4*
DDO	3	2	2	*7*
DMOH	2	4	1	*7*
DASCO	0	7	0	*7*
Total	***6***	***16***	***4***	***25***

3.4: Definition of DTC

Respondent	*Definition of DTC*					
	Gave correct abbreviation and correct definition	Gave correct abbreviation only	Gave correct definition only	Gave incorrect definition	Do not know	No response
DC	0	3	0	1	0	0
DDO	3	1	2	0	0	1
DMOH	0	4	2	0	1	0
DASCO	1	6	0	0	0	0
Total	*4*	*14*	*4*	*1*	*1*	*1*

3.5: Roles and Functions of the DHMT

Role	*Respondents' frequency*				*Total*
	DC	*DDO*	*DMOH*	*DASCO*	
Runs and manages district health facilities to deliver medical services	2	3	4	3	*12*
Deliberates on health issues in the district	1	1	2	3	*7*
Conduct supportive supervision	1	2	2	2	*7*
Coordinates health activities in the district	1	3	3	0	*5*
Fight HIV /AIDS, STIs and leprosy	0	1	2	2	*5*
Conducts annual planning	0	2	1	1	*4*
Conducts M&E of health activities in the district	0	3	1	0	*4*
Manages resources (funds, commodities & supplies)	0	2	0	0	*2*
Deploys staff	0	1	0	1	*2*
Collects, collate and provide health data and information (statistics) to other stakeholders	1	1	0	0	*2*
Ensures provision of quality services which are accessible and acceptable	0	0	0	1	*1*
Conducts training	0	1	0	0	*1*
Total	*6*	*20*	*15*	*13*	*52*

3.6: Roles of the DTC

Role	*Respondents' frequency*				*Total*
	DC	DDO	DMOH	DASCO	
Coordinates HIV and AIDS activities in the district	3	6	3	2	*14*
Provides technical support on HIV and AIDS to CACCs and other HIV stakeholders	2	2	2	0	*6*
Conducts forums such as Joint HIV and AIDS programme review (JAPR), World AIDS Day (WAD)	0	5	1	0	*6*
Supervises HIV and AIDS activities	1	2	1	1	*5*
Compiles data on HIV and AIDS activities	1	2	0	1	*4*
Monitors (M&E) HIV and AIDS activities	1	3	0	0	*4*
Implements HIV/AIDS activities	1	0	1	1	*3*
Assists community groups in resource mobilisation, writing proposals, reviewing proposals	0	0	0	2	*2*
Undertakes sensitisation and advocacy on HIV and AIDS	2	0	0	0	*2*
Conduct regular meetings	0	1	0	0	*1*
Total	*11*	*21*	*8*	*7*	

3.7: Definition of Collaboration between DTC and DHMT

Definition of Collaboration between DTC and DHMT	*DC*	*DDO*	*DMOH*	*DASCO*
Working together in harmonised roles to achieve the set objective of fighting HIV and AIDS	2	7	5	5
Each team working in its core area (DHMT in general interventions including HIV and AIDS; DTC in advocacy, mobilisation and counselling)	1	1	0	1
The DTC and DHMT working in complementarity, consultation	1	2	1	0
Total	4	10	6	6
do not know	*0*	*0*	*2*	*1*

3.8: Reasons why DTC and DHMT should collaborate

Reasons why DHMT and DTC should collaborate	*DC*	*DMOH*	*DDO*	*DASCO*	*Total*
To create a large multidisciplinary team (each committee to work in its competence area complementing each other) to fight HIV	3	2	4	2	*11*
To fight HIV more effectively and efficiently and hence meet objectives; enhance coordination of activities and improve management of HIV and AIDS interventions	0	5	2	4	*11*
To enhance optimal utilisation of resources by avoiding duplication of functions and overlapping of activities	0	3	2	2	*7*
To facilitate joint planning and M&E e.g. in JAPR	0	1	2	2	*5*
To improve the quality of service provision	0	3	0	2	*5*
To share information, data, statistics	0	1	3	0	*4*
To inform, involve and give guidance to stakeholders on HIV /AIDS activities	0	1	0	2	*3*
To enhance smooth working in the fight against HIV	1	1	1	0	*3*
To promote understanding of each other's roles in the fight against HIV and AIDS	0	0	1	0	*1*
HIV and AIDS is both a health and a multi-sectoral issue hence the need to collaborate	0	0	1	0	*1*

3.9: The Current State of Collaboration between DTC and DHMT

Respondent	*Frequency*		
	DTC works together with DHMT	*DTC works on its own independent of DHMT*	*No response*
DC	3	1	0
DMOH	3	2	2
DDO	5	1	1
DASCO	4	2	1
Total	*15*	*6*	*4*

3.10: Areas in which DHMT and DTC are Collaborating in

Areas in which DTC and DHMT are Currently Collaborating	*Frequency*				*Total*
	DC	DMOH	DDO	DASCO	
Implementing of HIV/AIDS and other activities e.g. awareness creation, VCT, community mobilisation, freedom from hunger activities, OVC support	2	6	0	1	9
World AIDS Day (WAD) commemoration	0	1	3	4	8
Occasional meetings e.g. quarterly briefing (on issues of health) to DTC by DMOH	2	1	0	3	6
Data collection, information sharing, dissemination	1	1	4	0	6
Involvement of DMOH in DTC in district management of HIV and AIDS	1	1	1	1	4
Joint AIDS Programme Review (JAPR)	0	0	2	1	3
District health stakeholders forum (DHSF)	0	0	1	1	2
Health management information system (HMIS)	0	0	1	0	1
Providing technical support / advise	0	1	0	0	1
Sharing resources, personnel	0	0	1	0	1

3.11: Level of collaboration between DTC and DHMT in key areas

Area of Collaboration	*Frequency*			
	Always	Sometimes	Rarely	Never
Hold regular joint / consultative meetings	4	9	4	4
Share information on our plans, budgets	2	6	7	6
Implement joint activities	3	10	1	7
Share information and reports on our activities	2	6	7	6
Share expertise / specialist personnel	5	9	3	4
Share resources (e.g. vehicles, venues)	4	7	6	5
Hold joint support supervision / monitoring visits	1	8	4	8
Total	*21*	*55*	*32*	*40*
%	*12*	*34*	*20*	*25*

3.12: Areas in which the DHMT and DTC have collaborated well

Areas in which the DHMT and DTC have collaborated well	*Frequency*				*Total*
	DC	DMOH	DDO	DASCO	
Collaboration in implementation of HIV activities e.g. distribution of condoms, VCT, PMTCT, BCC / health education, trainings	2	3	4	1	10
Organising WAD commemoration	1	2	1	3	7
Sharing information, reports	0	1	3	1	6
Holding regular meetings	1	1		3	4
Organising JAPR	0	0	1	1	2
Mobilising resources e.g. community proposals writing and review	0	0	0	1	1

3.13: Areas which the DHMT and DTC have not collaborated well

Areas in which DHMT and DTC have not collaborated well	*Frequency*				*Totals*
	DC	DMOH	DDO	DASCO	
Holding regular joint meetings	1	0	2	5	8
Organising / implementing joint activities e.g. trainings	0	3	3	1	7
Information collection (e.g. surveys), sharing, dissemination; giving feedback	0	2	3	0	5
Joint M&E, support supervision	0	0	1	2	3
Resource mobilisation, Funding of CSOs	0	0	1	1	2
Sharing resources	1	0	0	0	1
Technical advice to the implementing organisations (CSOs)	0	0	1	0	1
Budgeting	0	0	1	0	1
Sensitisation on the roles of each team	0	0	0	1	1

3.14: Areas in which DTC and DHMT can collaborate better

Ways of collaborating	*Frequency*				
	DC	*DMOH*	*DDO*	*DASCO*	*Totals*
Regular consultative meetings / fora to deliberate and plan on HIV and AIDS issues	4	2	2	2	10
Information sourcing, compilation, sharing	0	1	3	3	7
Support supervision, M&E of HIV and AIDS activities	0	2	2	2	6
Planning, budgeting and implementation of activities e.g. HCBC, VCT, trainings, capacity building of CACCs and other implementing organisations etc	0	0	2	4	6
Mobilisation of resources, funding of local CSOs	1	0	2	1	4
Sensitisation on roles of DHMT and DTC and their complementarities	1	0	0	1	2
Sharing of resources personnel, materials, funds	1	0	0	0	1
Have representation and participation of one committee in the other e.g. invite DDO to DHMT when discussing HIV issues, CACC coordinator participates in DHMT and DASCO in CACC.	0	0	1	0	1

3.15: Factors that Facilitated Collaboration in the Past

Factors that facilitated past collaboration	*Frequency*				*Totals*
	DC	*DMOH*	*DDO*	*DASCO*	
Team spirit e.g. unity among members, effective communication, networking	0	2	1	2	5
Availing of resources	0	2	0	1	3
Transparency and Accountability	0	2	1	0	3
Sensitisation on the existence and roles of DHMT and DTC, and their complementary roles in HIV management	2	0	0	0	2
Information sharing	0	0	1	0	1
Representation and participation of one committee in the other e.g. DMOH in DTC	0	0	1	0	1
Conducive environment	0	0	1	0	1
Inter-relatedness of health and HIV	1	0	0	0	1

3.16: Factors that would facilitate better future collaboration

Factors that would facilitate better future collaboration	*Frequency*				
	DC	DMOH	DDO	DASCO	*Totals*
Joint consultative meetings and fora	1	3	2	3	10
Joint support supervision and M&E of activities	0	1	2	3	6
Sharing of information and plans	0	2	2	0	4
Availing more resources / funding of activities	1	1	2	0	4
Sensitisation of the two committees on roles	0	1	2	0	3
Joint planning / harmonising work plans and implementation	0	2	1	0	3
Sharing resources	0	0	0	2	2
Joint regular capacity building of the two teams	1	0	1	0	2
Involvement of one committee in the other e.g. participation of DASCO in DTC	0	0	0	1	2
Linkage of actors in HIV to the DHMT	0	0	0	1	1
Good team and interpersonal relationship	0	1	0	0	1
Share expertise / technical knowledge	0	0	0	1	1

3.17: Factors that Hinder Collaboration between DHMT and DTC

Factors that Hinder Collaboration between DHMT and DTC	*Frequency*				*Total*
	DC	DMOH	DDO	DASCO	
Inadequate team work / cooperation i.e. "egocentricism"	1	0	2	2	5
Inadequate sensitisation on roles & functions of the two committees and complementarities (especially DTC) even among departmental heads	1	1	2	1	5
Inadequate joint meetings, low frequency of DTC meetings	0	1	1	2	4
Information: Inadequate sharing of information, inadequate district data especially in new districts	0	3	0	0	3
Inadequate funds and irregular flow of funds (e.g. to facilitate meetings, allowances)	0	0	0	2	2
Some members overcommitted hence don't give adequate attention to DTC e.g. DDO	0	0	1	1	2
Complacency due to the drop in HIV prevalence	1	0	0	0	1
Different composition & orientation of the committees (DHMT as a implementing team while DTC is a coordinating team)	0	0	1	0	1
Lack of implementation of joint activities	0	1	0	0	1
Changing administrative structures e.g. creation of new districts – new DTC, new DHMT	0	1	0	0	1
Removal of DTC from Ministry of Health to Office of the President	0	0	0	1	1
Lack of transparency	0	0	0	1	1
Inadequate involvement of DHMT in the DTC. Those involved do not give feedback to rest of DHMT	0	0	0	1	1

3.18: Factors that Hinder Collaboration as Outlined by the Key Informants

Weakness/ Gap in the Framework	*Frequency*
<u>Collaboration implementation framework</u> No clear collaboration implementation framework	*3*
Inadequate sensitisation on roles and functions of the committees	*3*
Inadequate policy, vision, leadership and direction on collaboration	*2*
Unharmonised understanding on collaboration - each interprets own way	*2*
<u>Team operation</u> Some officers not in cordial working relationship e.g. "DASCOs and CACC Coordinators do not see eye to eye", "CACC coordinators overshadowing the DASCOs and stealing the show"	*2*
Rivalry between DHMT and DTC	*2*
Personality differences among committee members especially chairpersons	*1*
Competition between DHMT and DTC and stakeholders' representation	*1*
Conflict of interest / Some members taking advantage "using committee to further own agenda"	*1*
Divided allegiances e.g. CACC coordinators allegiance to agency employing (MOH)? or paying (NACC)? or supervising (MOH-DPHO or NACC-DDO)?	*1*
<u>Funding issues</u> Differentiated funding structures leading to "turf" operations	*1*
Un-harmonised / differentiated funding structures	*1*
Inadequate and /or erratic funding / flow of resources	*1*
<u>Others</u> Competing priorities on overcommitted / overloaded key officials e.g. DC, DDO, DMOH	*2*
Resistance / reluctance to share information	*1*
Good policies and guidelines but not implemented	*1*

3.19: Ways in Which Gaps in the Collaboration Framework can be Addressed

Addressing the Gaps in the Collaboration Framework	*Frequency*
Sensitise members of DTC and DHMT on their roles and functions and on the collaboration framework	*2*
Have a clear framework on collaboration	*1*
Harmonise funding frameworks (sources, procedures), probably basket funding	*1*
Enhance cross representation or participation in committees e.g. DDOs and CACC Coordinators in DHMT; DASCO in CACCs	*1*
Involve stakeholders more in the formulation and / or revision of collaboration policies & guidelines	*1*
Monitoring and evaluation of policy implementation	*1*
Totals	

3.20: Other Comments by DTC and DHMT members

Comment	*Frequency*				*Total*
	DC	DMOH	DDO	DASCO	
Joint meetings / fora for DHMT and DTC should be organised to foster good working relationship	1	1	2	1	5
Lack of funds has hindered operations of the DTC hence need to provide funds	1	0	0	2	3
There is need to sensitise the roles and functions of the committees (especially on DTC)	1	0	0	1	2
DTC and DHMT can work together so as to realise the objectives of Total War Against AIDS (TOWA)	*0*	*0*	*1*	*1*	*2*
There has been a big gap between DTC and DHMT in the implementation of HIV activities in the districts	*0*	*0*	*1*	*1*	*2*
There is need for DTC and DHMT to collaborate so as to realise better implementation of projects	*0*	*1*	*0*	*1*	*2*
Newly created district, DTC was launched but is dormant because no funds were disbursed by NACC	0	0	1	0	1
Newly created district hence DTC not yet formed	0	0	1	0	1
DTC is well positioned in IEC, BCC	0	0	1	0	1
Involve more stakeholders in the committees esp. DTC	0	0	0	1	1
Strengthen DTC support to DASCOs	0	0	0	1	1

8.2 ANNNEX 2: DATA COLLECTION TOOLS

8.2.1 Schedule for Key Informant Interviews (KII)

ASSESSING THE COLLABORATION BETWEEN DTC AND DHMT IN THE MANAGEMENT OF HIV ACTIVITIES

Schedule for Interview With;

1. Provincial Director of Public Health and Sanitation (PDPHS),
2. Provincial AIDS and STIs Coordinator (PASCO)
3. Provincial Director of Planning (PDP)
4. National AIDS Control Council (NACC) Provincial Field Officer

Title of Interviewee: _____

Date of interview: _____

Time of interview: _____

Name of Interviewer: _____

Notes to the Interviewer

1. Introduce yourself to the respondent and state the purpose of the interview.
2. Then, ask the respondent for consent to be interviewed.
   If s/he agrees to be interviewed, set a time frame for the interview and stick to it (this interview should normally take between 25 and 30 minutes).
3. Proceed with the interview and accurately record the responses.
4. At the end of the interview, thank the respondent for his / her time.
5. Confirm that all questions are answered.

Please enter responses in the spaces provided

1. What do you understand by
   a) DHMT

   b) DTC

2. What are the roles of
   a) DHMT

   b) DTC

3. How do you define collaboration between DTC and DHMT?

4. In your opinion should DTC and DHMT collaborate?

Yes	No

If Answer to Q4 is Yes, why should DTC and DHMT collaborate? *List*

5. If Answer to Q4 is No, why should DTC and DHMT not collaborate? *List*

6. Is the current framework (i.e. structure, mechanism and roles) adequate in supporting the collaboration between DTCs and DHMTs?

Yes	No

7. What are some of the strengths in the framework (in respect to supporting the collaboration between DTCs and DHMTs)? *List*

8. How can these strengths in the framework be enhanced? *List*

8. Are there some weaknesses / gaps in the framework?

Yes	No

9. What are the key weaknesses / gaps in the framework?

10. What are some of the ways in which these gaps / weaknesses can be addressed? *List*

11. How would you gauge the collaboration between DTCs and DHMTs?

Very well	Well	Average	Not so well	Not well at all

12. In what ways can the DTCs and DHMTs collaborate better? *List*

13. What factors enhance/foster collaboration between the DTCs and DHMTs? *List*

14. What factors hinder collaboration between the DTC and DHMT? *List*

15. Any other comments? List

8.2.2 Questionnaire for administration to DTC and DHMT members

ASSESSING THE COLLABORATION BETWEEN DTC AND DHMT IN THE MANAGEMENT OF HIV ACTIVTIES

Questionnaire to be administered to;

1. Chairperson of DTC i.e. District Commissioner (DC)
2. District Medical Officer of Health (DMOH)
3. District Development Officer (DDO)
4. District AIDS and STIs Coordinator (DASCO)

Questionnaire No. :_____

Title of Respondent: _____

Date: _____

Note to the Respondent

The purpose of this questionnaire is to collect information that will aid understanding of the current state of collaboration between District Technical Committee (DTC) and the District Health Management Team (DHMT).

Responding to this questionnaire is voluntary. The information provided will improve understanding of the collaboration and how it can be improved to enhance the management of HIV interventions.

Please fill in your responses in the spaces provided.

1. How do you define
   a) DHMT

   b) DTC

2. What are the roles of
   a) DHMT

   b) DTC

3. How would define the collaboration between DTC and DHMT?

4. In your opinion should DTC collaborate with DHMT?

Yes	No

5. If Answer to Q4 is *Yes*, Why should the DTC collaborate with DHMT?
   List reasons for collaboration

6. If Answer to Q4 is *No*, Why should the DTC not collaborate with the DHMT?
   List reasons for not collaborating

7. Does the DTC collaborate with the DHMT?

Yes	No

8. Which statement better describes the current state of DTC working with (or independent) of the DHMT? *Tick one selection*

Option (*Choose 1 or 2)*	Tick one
1. In the DTC for this district, we usually work on our own, independent of the DHMT	
2. In the DTC for this district, we usually work together with the DHMT	

9. Which statement better describes the future expectations of DTC working with (or independent) of the DHMT? *Tick one selection*

Option (*Choose 1 or 2)*	Tick one
1. In the future we (DTC) would prefer to work on our own , independent of the DHMT	
2. In the future we (DTC) would prefer to work in collaboration with DHMT	

10. Are there areas that you are currently collaborating?

Yes	No

If Answer to Q10 is *Yes* go to Q11 (if the Answer to Q10 is *No*, go to Q12

11. In which areas are you collaborating? *List*

12. Are there ways in which you could collaborate more or better?

Yes	No

13. If *Yes*, what are the ways that you can collaborate? *List*

14. Ways in which we are collaborating (*Tick the most appropriate)*;

	Ways in which we are collaborating	*Tick the most appropriate*			
		Always	Sometimes	Rarely	Never
a)	We hold regular joint / consultative meetings				
b)	We share information on our plans, budgets				
c)	We implement joint activities				
d)	We share information and reports on our activities				
e)	We share expertise / specialist personnel				
f)	We share resources (e.g. vehicles, venues)				
g)	We hold joint support supervision / monitoring visits				
h)	Other areas: Specify				

Factors that encourage and foster the collaboration

15. Are there some areas that the DTC has collaborated well with the DHMT? Y/N

Yes	No

16. What are some of these areas? *List*

17. What factors foster collaboration? *List*

18. Could DTC collaborate more or better with the DHMT?

Yes	No

19. In what areas / ways have the DTC and DHMT been unable to collaborate better or more? *List*

20. What factors hinder collaboration? *List*

21. Any other comments.

8.2.3 Questionnaire for administration to CACC Coordinators

ASSESSING THE COLLABORATION BETWEEN DTC AND DHMT IN THE MANAGEMENT OF HIV ACTIVITIES

Questionnaire to be Administered to Constituency AIDS Control Committee (CACC) Coordinator

Questionnaire No. :_____

Title of Respondent: _____

Date: _____

Note to the Respondent

The purpose of this questionnaire is to collect information that will aid understanding of the current state of collaboration between District Technical Committee (DTC) and the District Health Management Team (DHMT).

Responding to this questionnaire is voluntary. The information provided will improve understanding of the collaboration and how it can be improved to enhance the management of HIV interventions.

Thanks for taking time to complete this questionnaire.

Please fill in your responses in the spaces provided.

1. How do you define
   a) DHMT

   b) DTC

2. What are the roles of
   a) DHMT

   b) DTC

3. How do you define collaboration between DTC and DHMT?

4. Is there any support that you receive from DTC?

Yes	No

5. What kind of support do you receive? *List*

6. Is there any support that you receive from DHMT?

Yes	No

7. What kind of support do you receive? *List*

8. Is the support that you receive from DTC and / or the DHMT affected by the state of collaboration between the two committees (DTC and DHMT)?

Yes	No

If answer to Q8 is Yes, move to Q9; If the answer is No, move to Q10.

9. How is the support to you receive from the DTC and DHMT affected by collaboration between the two committees? *Explain*

10. Would the support that you receive from DTC and / or DHMT be improved if the two committees (DTC and DHMT) collaborated better / more?

Yes	No

11. How would collaboration between DTC and DHMT improve the support you receive from the DTC and /or DHMT?

12. In the area that you work in, does the DTC collaborate with the DHMT?

Yes	No

13. What statement best describes the current collaboration between the DTC and DHMT? *Tick one selection*

Option (*Choose 1 or 2)*	Tick one
1. The current collaboration between DTC and DHMT is adequate for supporting my operations	
2. The current collaboration between DTC and DHMT is not adequate for supporting my operations	

14. Can the DTC and DHMT collaborate more / better?

Yes	No

15. In what ways can the DTC and DHMT collaborate more/better? *List*

16. Are there some factors that foster more / better collaboration between the DTC and the DHMT? Y/N

Yes	No

If answer to Q16 is *Yes*, go to Q17; If the answer is *No*, go to Q18.

17. What are these factors that foster collaboration between the DTC and DHMT? *List*

18. Could DTC collaborate more or better with the DHMT?

Yes	No

19. In which areas / ways has the DTC been unable to collaborate better or more with the DHMT? *List*

20. What factors have hindered the realisation of this more / better collaboration? *List*

21. Do you have any other comments?

Thanks for taking the time to answer the questions