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Mahlangu, Brenda Pinky

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EXPLORING A MULTISECTORAL AND MULTILEVEL RESPONSE TO HIV AND AIDS IN SOUTH AFRICA

Brenda Pinky Mahlangu

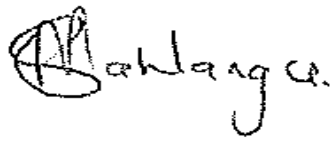
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Submitted to the Faculty of Health Sciences, University of the Witwatersrand, in fulfilment of the requirements for the degree of
Doctor of Philosophy

September 2019.

DECLARATION

I, Brenda Pinky Mahlangu, declare that this thesis is my own work. This thesis is being submitted for the degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg, and has not been submitted before for any degree or examination at this or any other University.



Signature of candidate Date: 27 September 2019

DEDICATION

To my husband Maanda, no amount of acknowledgment could adequately represent what is due to you for the support you gave me. Thank you for your patience, taking care of our children, and for your endurance during the lonely moments when I was consumed in this work. To my children, Vhutali and Ndivho, you missed many play dates and fun moments that we could have spent together, I am forever indebted to you! To my dear mother who passed away at the peak of the writing of this work, how I wish you could see me in my red regalia; I am thankful for the years I have spent with you, with each day having prepared me to where I am, and what I have achieved today. You will forever be in my heart!

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ORIGINAL PAPERS

I. Mahlangu, P., Vearey, J., Thomas, L., and Goudge, J. (2017). Implementing a multi-sectoral response to HIV: a case study of AIDS councils in the Mpumalanga Province, South Africa. *Global Health Action, 10*(1), 1387411. doi: 10.1080/16549716.2017.1387411

II. Mahlangu, P., Vearey, J., and Goudge, J. (2018). Multisectoral (in)action: towards effective mainstreaming of HIV in public sector departments in South Africa. *African Journal of AIDS Research, 17(4),301-312*. doi: 10.2989/16085906.2018.1536069

III. Mahlangu, P., Goudge, J., and Vearey, J. Towards a framework for multisector and multilevel collaboration: case of HIV and AIDS governance in South Africa. *Global Health Action,* 12 (1). doi.org/10.1080/16549716.2019.1617393.

ABSTRACT

Background: A multisectoral approach (MSA) - which brings together government, civil society, and the private sector to work together towards a common goal - is considered a key strategy to address complex societal problems. Such problems can never be effectively addressed by one sector acting alone, they require integrated efforts of multiple sectors. As such, there has been a widely acknowledged call for a multisectoral approach to respond to development and health issues, including HIV and AIDS. Adoption of MSA promises a number of benefits including cost- and risk- sharing, drawing from the intellect and skill of multiple actors, and the scope to address a problem from varied angels. While highly recommended, implementation of MSA in Southern and Eastern Africa (SEA) has been poor. There has been limited reflection and documentation of experiences of MSA. There are evidence gaps regarding what works and does not work in practice. South Africa's national response to HIV is premised on MSA, detailed in the National Strategic Plan (NSP) on HIV. This approach centres the role of AIDS Councils, comprised of civil society, government and the private sector, which are meant to coordinate and oversee implementation of a multisectoral response to HIV at all three levels of government (national, provincial and local level). Furthermore, all government departments are expected to mainstream HIV in their work - develop HIV plans detailing how each department plans to address vulnerability and HIV risk internally in the workplace and externally in communities.

Aim: Drawing from the South African experience of a multisectoral response to HIV, this qualitative study explores the challenges in implementing a multisectoral approach and makes recommendations on how they can be addressed. The four objectives of the research are to (1) explore how AIDS Councils coordinate implementation of the multisectoral response to HIV at national, provincial and local level, (2) reflect on how selected government departments have

integrated HIV in their work, and explore the extent to which mainstreaming augments the multisectoral approach to HIV, (3) to develop a framework to inform multisectoral action in practice, (4) and to draw from the key findings and make recommendations for an integrated governance response to HIV and AIDS.

Methods: The four objectives of the study are addressed using qualitative techniques for data collection and analysis. These include identifying and reviewing key policy documents, conducting key informant interviews with officials from government departments, focus group discussions with members of AIDS Councils, participant observations during development of the national HIV plan (NSP), during development of HIV plans of government departments, and during meetings of AIDS Councils. A review and synthesis of existing frameworks, models and approaches to MSA was conducted which, along with the empirical work, informed the development of the framework for a multisectoral response to HIV proposed in this research.

Key findings: In paper 1 and 2 the gaps that contribute to the poor implementation of a multisectoral approach to HIV are identified and discussed. Paper 1 highlights the challenges experienced by AIDS Councils who are meant to coordinate implementation of MSA at national, provincial and local level. Findings from the study have highlighted that a lack of capacity and a lack of an enabling environment (i.e. limited human and financial resources and political will) hinders effective implementation of the multisectoral approach. Limited resources, a lack of political support, and the lack of a framework to inform and guide the implementation process are some of the key challenges identified. Paper 2 highlights the challenges associated with a Whole of Government approach to HIV. Poor coordination of the HIV response vertically between levels of government in departments (e.g. national, provincial and local), and poor collaboration on HIV programmes across departments (e.g. health, social development, education) within the

government sector are some of the key issues. While progress has been made in mainstreaming HIV in non-health departments, there is limited evidence to indicate that the mainstreaming approach augments the multisectoral approach to HIV. As such, this research makes recommendations to take forward the mainstreaming approach, to ensure that it contributes to the multisectoral approach to HIV in South Africa. Furthermore, findings from the review of existing frameworks, models and approaches on multisectoral action highlight the limited focus on describing the process of multisectoral collaboration. The focus in the literature is on structure and not the process of collaboration, and those that describe the process do so without consideration of the governance mechanisms – such as how communication, conflict and power dynamics should be managed - that are critical in the process of effective collaboration. The proposed framework for multisectoral and multilevel collaboration developed in this research aims to address implementation challenges in practice. The framework suggests seven elements that are critical in a process of multisectoral collaboration: (1) preconditions, (2) key drivers, (3) mechanisms, (4) structure, (5) administration, (6) execution and (7) evaluation.

Implications: Together, this work contributes to literature, policy and practice. This multidisciplinary approach and reflection adopted in this study advances thinking about the MSA process in the literature. The findings contribute to an existing gap regarding poorly documented reflections on MSA. Based on the results of this PhD, a framework for multisectoral and multilevel collaboration was proposed.

Key words: Multisectoral approach, HIV, governance, collaboration, South Africa, qualitative research.

LIST OF ABBREVIATIONS

AC	AIDS Council
AIDS	Acquired Immune Deficiency Syndrome
DAC	District AIDS Council
DBE	Department of Basic Education
DOH	Department of Health
DOHS	Department of Human Settlements
DPSA	Department of Public Service and Administration
DSD	Department of Social Development
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IGR	Intergovernmental Relations
KII	Key Informant Interview
LAC	Local AIDS Council
LMICs	Low and Middle-Income Countries
MAP	Multi-Country AIDS Programme
MSA	Multisectoral Approach (Action)
MSC	Multisectoral Collaboration
NAC	National AIDS Council (Commission)
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
NSP	National Strategic Plan
PAC	Provincial AIDS Council
PhD	Doctor of Philosophy
SA	South Africa
SANAC	South African AIDS Council
SDGs	Sustainable Development Goals
SEA	Southern and Eastern Africa
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TaSP	Treatment as Prevention
TB	Tuberculosis
UNAIDS	Joint United Nation Programme of HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organisation

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Chapter 1: Introduction and background

> "The challenges facing public health, and the broader world context in which we struggle, have become too numerous and too complex for a business-as-usual approach."
>
> Dr Margaret Chan, WHO Director-General (2012).

1.1 Overview

In this chapter, I will "set the scene" for my research. I provide background on the epidemic of HIV and AIDS, reflect on the drivers and progress on the response to HIV and AIDS globally, in Southern and Eastern Africa (SEA), and in South Africa (SA). The concept of multisectoral action will be defined, locating it within the governance and health literature. I will then present a review of experiences from countries that have adopted the multisectoral approach in their national response to HIV, and discuss the factors that contributed to success and failure in implementation. Multilevel, another key concept in this research, will be discussed later in the overview of South Africa's response to HIV. The aim of this review is to highlight the gaps in the literature, to present the problem statement and justification of the research, and to state research question, aims and objectives of the study.

1.2 Background of the HIV and AIDS epidemic

While significant progress has been made, HIV and AIDS remains a global health issue (UNAIDS, 2017). An estimated 36.9 million people are living with HIV globally; 59% were on treatment and 47% had suppressed viral loads in 2017 (UNAIDS, 2018). Southern and Eastern Africa remains the region most affected by the HIV epidemic, accounting for 45% of the world's HIV infection and 53% of people living with HIV globally (UNAIDS, 2018). HIV and AIDS is amongst the top ten leading causes of death in low income countries (World Health Organization, 2018b). Of the

Southern African countries, South Africa remains at the epicenter of the HIV epidemic, with approximately 17% of the global burden of HIV infection (UNAIDS, 2014b). South Africa had the highest percentage of new HIV infections (33%), and AIDS related deaths (29%) amongst SEA countries in 2017 (UNAIDS, 2018).

Approximately, about 7.9 million people were living with HIV at the end of 2017 in SA. The HIV prevalence among adults aged 15 to 49 years was 20.6 percent; 26.3 percent among females and 14.8 percent among males (Human Science Research Council, 2018). About 150,375 people died of AIDS related illnesses in 2016. The HIV burden varies widely by geography, age and gender and amongst key and vulnerable populations (Republic of South Africa, 2017). There are differences in the prevalence of HIV in the nine provinces in South Africa. Some provinces have higher prevalence of HIV compared to others: KwaZulu-Natal (27%), followed by Free State (25.5%), Eastern Cape (25.2%) and Mpumalanga province (22.8%). The Northern Cape and Western Cape have the lowest HIV prevalence, at 13.9% and 12.6% respectively (Human Science Research Council, 2018). Within provinces, people living in urban informal areas have the highest HIV prevalence (19.9%), followed by residents in rural informal areas (13.4%) (Shisana et al., 2014). HIV incidence has decreased from the 2012 estimates, yet remains high, particularly among female youth aged 15-24 years (Human Science Research Council, 2018). The high burden of HIV has also been found amongst female sex workers, men who have sex with men, injecting drug users, and inmates (Republic of South Africa, 2017).

1.3 Drivers of the HIV and AIDS

A combination of social, economic, political, and environmental factors - referred to as social and structural drivers - increase susceptibility to HIV infection (Gupta et al., 2008). These social and structural drivers, also referred to as the social determinants, constitute the social processes and arrangements, social and cultural norms, values, networks, structures and institutions, that operate in concert with individuals behaviour and practices to influence health (Auerbach et al., 2011). The Commission on the Social Determinants of Health (CSDH) defines the social determinants as "the full set of social conditions in which people live and work", that are responsible for health outcomes and inequities in health (World Health Organization, 2010). The definition of the social determinants by the CSDH recognises health as more than the absence of sickness, and considers the critical role of the socioeconomic, political and other factors that need to be considered in the design and implementation of the response to HIV. As explained by the World Health Organisation (WHO), health is the state of complete physical, mental, and social well-being and not just the absence of sickness (World Health Organization, 2006).

While individual level factors, such as having multiple concurrent partners and inconsistent condom use, are risky behaviors associated with increased risk and susceptibility to HIV infection, other social and structural factors which are beyond the control of the individual also plays a critical role in increasing vulnerability to HIV infection (Chen et al., 2007). Such factors include gender inequality, poverty, prevailing cultural and social norms, policy frameworks that do not promote access to good health, and other factors (Seeley et al., 2012).

It is widely established that a comprehensive response to HIV is one that addresses the social and structural drivers of the HIV epidemic (Seeley et al., 2012, Pronyk and Lutz, 2013a). However, addressing the social and structural drivers is complex because they are hard to measure, and interact with other biological, psychological, and behavioural factors (Auerbach et al., 2011). Action on the social determinants of health, including HIV requires integrated efforts of multiple sectors to address the social, economic, political and environmental factors that increases susceptibility to HIV infection (World Health Organization, 2008).

Social and structural drivers and their impact on HIV, and how these would map with possible mainstreaming and a multisectoral response

Examples of social and structural drivers of HIV include poverty, gender inequality and livelihood insecurities, lack of access to basic services (water and sanitation and functioning health systems) (Gibbs et al., 2012, Seeley et al., 2012, Parkhurst, 2013). A multisector response to HIV requires that sectors implement strategies to increase women's economic empowerment and tackle the gender norms underlying women's HIV risk (Seeley et al., 2012, Gibbs et al., 2012). Implementation of structural interventions that addresses the socio-economic factors that makes women vulnerable to HIV (by engaging in risky sexual behaviour) is a critical component of a multisectoral response to HIV (Pronyk et al., 2008, Kim et al., 2008, Ashburn et al., 2008).

In South Africa, a number of evidence based interventions have been documented. For example, Intervention with Microfinance for AIDS and Gender Equity (IMAGE), an intervention combining microfinance, gender and HIV training, showed reductions in levels of intimate-partner violence,

but there did not affect the rate of unprotected sexual intercourse with a non-spousal partner (Pronyk et al., 2006). A trial was conducted in rural Mpumalanga, South Africa, where they gave cash transfers to high school girls on condition that they attend or stay in school (Pettifor et al., 2016). School attendance significantly reduced risk of HIV acquisition, irrespective of study group (Pettifor et al., 2016). Stepping stones is another intervention which aims to improve sexual health by using participatory learning approaches to build knowledge, risk awareness, and communication skills and to stimulate critical reflection (Jewkes et al., 2014). There was no evidence that Stepping Stones reduced the incidence of HIV, but it showed reduction in HIV risk behaviour in men (Jewkes et al., 2014). Providing access to basic services such as water and sanitation, and to health is vital to sustain life and to maintain a healthy and hygienic environment; especially amongst those that are living with HIV and AIDS, who have an increased risk of contracting opportunistic infections such as diarrhoea (Republic of South Africa, 2007).

1.4 Progress on the response to HIV and AIDS

Accelerating progress on prevention and treatment is at the top of the global AIDS response, endorsed in several key policy documents and development frameworks including the 2030 Agenda for Sustainable Development (UNAIDS, 2018). Political declarations have been signed by countries recommitting to address the HIV epidemic (United Nations, 2006, United Nations, 2011). The introduction of Treatment as Prevention (TasP) has supported the global response to HIV (WHO, 2012). Evidence suggests that starting HIV treatment early has the dual benefit of keeping people living with HIV healthy, and preventing HIV transmission (Eaton et al., 2012,

WHO, 2012). As such, many countries, including South Africa, have now adopted the gold-standard policy of treat all that test HIV positive regardless of their CD4 count (UNAIDS, 2017).

The 90-90-90 targets have become a central pillar and an advance to the global response to HIV treatment (UNAIDS, 2017). These targets reflect a fundamental shift in approach to HIV treatment, moving from a focus on the number of people accessing antiretroviral therapy towards maximizing viral suppression among people living with HIV (UNAIDS, 2017). All countries are involved in ensuring that by 2020 90% of all people living with HIV know their HIV status, 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy have viral suppression (UNAIDS, 2014a).

The introduction of TasP and the 90-90-90 targets has had a great return on investments on the global response to HIV: more and more people know their status, treatment coverage has improved, and more people have a suppressed viral load(UNAIDS, 2017). There has been a reduction in AIDS related deaths, and a downward trend in new HIV infections (UNAIDS, 2017). Globally, since 2010 AIDS-related mortality has declined by 34%, new HIV infections declined by just 18%, and less than 1 million people died of AIDS-related illnesses in 2017 (UNAIDS, 2018). The global progress on the response is also reflected in parts of the world which have the highest burden of HIV. AIDS-related mortality declined by 42% from 2010 to 2017, and a reduction in new infection in SEA because of the rapid pace of treatment (UNAIDS, 2018).

South Africa is amongst the countries with the largest HIV treatment programme, with 3.7 million people initiated on antiretroviral therapy as of December 2016 (Johnson, 2012, Shisana et al.,

2014). Substantial progress has been made in prevention of mother to child transmission, with the infection rate estimated at 6% in 2016 (Republic of South Africa, 2017). Domestic funding on HIV and AIDS has increased over the years (Republic of South Africa, 2017). Among children, new infections have declined 47% since 2010. New infections among young women (aged 15–24 years) have declined by 17%, reaching 360 000 in 2016. A decline of 16% to 250 000 was also observed among young men between 15- 24 years in 2016. While South Africa's response reflects progress, over 7 million people were living with HIV in 2016 (Republic of South Africa, 2017). Whilst the HIV statistics presented above reflect some progress in the global, SEA and South Africa's response to HIV, efforts to prevent new HIV infections continue to lag behind, compared to reduction of AIDS-related deaths (UNAIDS, 2018). The challenge remains that women and girls in SEA are still disproportionately infected by HIV (UNAIDS, 2018). Reduction of new HIV infections, especially amongst women and girls, is critical and should be one of the key focus areas in the response to HIV.

HIV prevention interventions

To date, a number of interventions have been implemented to address the epidemic of HIV including biomedical, behavioural and structural interventions. There is evidence that no single method is fully effective, but that HIV prevention interventions are most effective when they are used in combination (Grabowski et al., 2017, Justman et al., 2017). Advances in the global response are attributable to a combination of prevention strategies that have evolved to prevent HIV acquisition over the years. (Kharsany and Karim, 2016, Kurth et al., 2011). Biomedical interventions to HIV prevention have made incredible contribution in fast-tracking the response to HIV, and evidence of their effectiveness continues to emerge (Karim, 2014). An HIV vaccine

remains an ideal hope, which if found, can become an additional important biomedical intervention (Rotheram-Borus et al., 2009, Doria-Rose et al., 2014).

Behavioural interventions have been implemented and aimed to increase knowledge that can be used to protect individuals from engaging in risky sexual behaviors (Kennedy et al., 2010). While behavioural interventions are necessary, on their own, they are not sufficient to prevent HIV (Coates et al., 2008, Crepaz et al., 2006). Their focus on an individual is found to be limited and fails to address the social, economic, environmental and political factors which increases vulnerability and limits ability of individuals to protect themselves (Seeley et al., 2012, Parkhurst, 2013). For example, studies from sub-Saharan Africa highlight existence of harmful masculine gender norms amongst men who view themselves as dominant over women, thus having multiple sex partners, refusing to use condoms, and engage in alcohol and substance abuse, putting themselves and their partners at greater risk of acquiring HIV (Dworkin et al., 2013, Fleming et al., 2016). The masculinities displayed in this example speak to the social factors embedded in cultural practices that affords men certain privileges and entitlement over women, who are expected to be submissive even when their safety is compromised (Mfecane, 2013, Jewkes et al., 2011).

While the initial response to the HIV epidemic in South Africa and in other parts in SEA were dominated by a biomedical and behavioural interventions led by the health sector, there is now increasing recognition of the importance of structural interventions which requires action by health and other sectors to address the social and structural drivers of HIV (Parkhurst, 2013, Pronyk and Lutz, 2013b, Seeley et al., 2012). The multisectoral approach operationalises structural

interventions to address the complex interplay of the social and structural drivers of the epidemic (Rasanathan et al., 2017, Dean et al., 2013, Commonwealth Secretariat, 2003).

1.5 Multisectoral action on HIV and AIDS

There is increasing advocacy across disciplines about the importance of a multisectoral approach in addressing complex issues such as poverty, unemployment, HIV and AIDS, gender based violence. Many scholars have argued that these, and other health and development issues, can only be effectively addressed through pooling of resources, knowledge and expertise, and coordinated action by multiple sectors (Lee et al., 2018, Mikkelsen, 2015, Pelletier et al., 2018). Multisectoral action is perceived as an enabling tool to facilitate mutual gain, and sharing of resources and risks (Tangcharoensathien et al., 2017). Multisectoral action (MSA), defined as action by multiple sectors including both government and nongovernmental actors, and health and non-health sectors, has become widely recognized as essential for addressing complex problems in society including health, development and other issues (Kanchanachitra et al., 2018, Salunke and Lal, 2017, Tangcharoensathien et al., 2017, Wickramasinghe, 2017). The key emphasis in MSA is the joint action by various sectors (public, private, and non-governmental – including local and international organisations, academia and communities) working together towards a common goal (Kickbusch and Gleicher, 2012). MSA requires mediation of relationships, and engagement across organisational boundaries, between diverse sectors who share a common goal, but have distinct mandates, values and resources (Bennett et al., 2018).

The multisectoral approach has been widely advocated in the global response to HIV, as it aims to bring together multiple actors, to address an issue in a coherent and integrated manner (Gavian et al., 2006, Hellevik, 2012b, Pawinski and Lalloo, 2006). There is consensus that effective responses to most challenges can be achieved through integrated efforts which involve a wide range of actors (Kickbusch and Behrendt, 2013). Noted in the literature is that the concept of MSA is used interchangeably with many other terms, in various disciplines. Terms such as intersectoral action, joined-up governance, public-private partnership, collaborative action are also used to refer to MSA. While related, not all of these terms have a similar meaning with MSA. Table 1 defines some of these related terms.

Table 1: Definition of key terms

Public private partnership	A partnership between government and the private sector where efficiency in the delivery of the service is a key defining factor (Wong et al., 2015).
Multisectoral approach	Refers to deliberate collaboration among various sectors (e.g., government, civil society, and private sector) and departments (e.g., health, environment, and economy) to jointly achieve a policy outcome (Salunke and Lal, 2017).
Multisectoral action	Action involving multiple sectors including government, working together with non-government sectors towards a common goal (Jerling et al., 2016).
Multisectoral collaboration	A collaborative relationship, bringing together private-sector, government, and non-government organisations to tackle a range of complex social problems (Hardy et al., 2006).
Collective action	Collective action refers to action taken together by a group of people whose goal is to enhance their status and achieve a common objective. Collective action differs from individual action by one person, and centres around the actions of the group.
Collaborative or collective impact	Combined effort by a group of stakeholders undertaking activities in an area where each stakeholder excels, in ways that support and is coordinated with

	the action of others (Hanleybrown et al., 2012). Achieving a common goal through collective action makes this concept similar to multisectoral action
Collaborative governance	One or more public agencies engage non-state actors in a collective decision making process that is formal and aims to make or implement public policy (Ansell and Gash, 2008).
Intersectoral action	Describes a collaboration involving the health department with other non-health government departments such as education, social welfare, housing and others (Shankardass et al., 2012).Intersectoral action describes collaboration within government as a sector.
Cross sector collaboration	Sometimes referred to as multisectoral collaboration, describes integrated action by two or more sectors with varying approaches and ways of doing things including government, civil society and the private sectors working together towards a common goal (Bryson et al., 2006). Cross sector collaboration describes collaboration between government and other sectors outside of government.

1.6 Lessons learned from implementation of a multisectoral approach to HIV and AIDS in Southern and Eastern Africa

Multisectoral action has been adopted in programmes and policies aimed to address a range of issues in SEA. These include non-communicable diseases, nutrition, early childhood development, maternal health, education, gender, and other health and development issues (Juma et al., 2018, Jerling et al., 2016, Rasanathan et al., 2015, Lee et al., 2018). Most importantly, for this study, the multisectoral approach has been adopted in national responses to HIV and AIDS in countries in SEA. The rationale is that HIIV is complex and anything short of a multisectoral response is inadequate (Morah and Ihalainen, 2009). UNAIDS - through the Three One's principles, the World Bank - through the Multi-Country AIDS Programme (MAP), and the Global Fund - through the Global Fund to Fights AIDS, TB and Malaria (GFATM), have played a crucial role in

advocating for adoption of the multisectoral approach on HIV in countries in SEA (World Bank, 2006, UNAIDS, 2004, Copson and Tiaji, 2002). As a condition for funding (from these international organisations), countries are expected to set-up multisectoral governance structures, develop multisectoral national HIV plans, and establish country level monitoring and evaluation mechanisms.

National AIDS Councils or National AIDS Commissions (NACs) have been set-up in countries to function as multisectoral governance structures constituted by government, civil society, and the private sector. Working together, the NACs mandate includes policy formulation, resource mobilisation, coordination, and monitoring and evaluation of multisectoral responses to HIV and AIDS (Gavian et al., 2006, Morah and Ihalainen, 2009, Hongoro et al., 2008). Different models were used in constituting the NACs; some NACs were largely driven by national departments of health whilst some were located in the President's or Prime Minister's office (Hongoro et al., 2008, Morah and Ihalainen, 2009, Munro, 2008).

1.6.1 Successes and challenges of National AIDS Councils

Some NACs have, to varying degrees, been successful in implementing their mandate of coordinating multisectoral responses to HIV (Morah and Ihalainen, 2009, Hongoro et al., 2008). There is a general consensus in the literature, Senegal and Uganda are often presented as examples of success in the coordination of HIV responses by NACs (Putzel, 2003, Morah and Ihalainen, 2009). A number of factors have contributed to success, including having a strong civil society sector, and political leadership and support that created an enabling environment for NACs to

function effectively (Putzel, 2004c). In Senegal, the NAC worked closely with the department of health, and the relationship was an enabler for success (Morah and Ihalainen, 2009).

The literature further notes a number of challenges which limit NACs in SEA to function optimally and to fulfil their mandate. These include a lack of power to hold ministries/departments accountable, power struggles and unclear roles between NACs and departments of health, and difficulty in mobilizing resources, which perpetuates overreliance on external funding (Morah and Ihalainen, 2009). The location of NACs in the departments/ministries of health makes some NACs to be viewed as structures of departments of health instead of multisectoral governance structures (Munro, 2008). Most lack skill and experience, and have high turnover of staff. They have multiple reporting structures, and monitoring and evaluation frameworks that look good on paper but are not implemented, while some AIDS Councils had no resources to implement their plans (Hongoro et al., 2008).

There is confusion about the role of NACs, as to whether their function is either coordinators, implementors, or both. The is also confusion as to which factors explain their struggle to integrate HIV into the broader development agenda (Munro, 2008). The coordination role of NACs is about ensuring that all stakeholders - involved in the response to HIV - implement HIV programmes in a harmonised and integrated manner. Whilst the implementation role is about the NAC being the implementer of HIV programmes. While initially funded externally by the Global Fund, the US President's Emergency AIDS Relief Plan, and the World Bank, the diminishing AIDS funding in SEA has been reported as one of the contributing factors to the failure of NACs to function in the best way possible (Hongoro et al., 2008, Morah and Ihalainen, 2009).

Different views have been expressed about the value-add of NACs in the response to HIV. Some authors see NACs as an organisational template, enforced by funders; while others have argued that NACs are not doing what is needed- which is coordinating the HIV response (Putzel, 2004a, England, 2006) Based on these and other reasons, there is a proposition by some scholars to restructure or to abolish NACs (England, 2006, Putzel, 2004a). In supporting the argument of abolishing NACs, England's (2006) thesis was that multisectoral efforts on HIV through NACs shifts focus on other key issues needing to be addressed. On the contrary, other scholars argued that NACs are critical, and undertaking an essential task of coordinating multisectoral efforts in countries (Hongoro et al., 2008, Morah and Ihalainen, 2009). More research and country case studies on the role and effectiveness of NACs in the implementation of the multisectoral approach to HIV is needed in order to make evidence informed assessment. Furthermore, while the experience of NACs provides valuable lessons, little is known about the work of the other sub-national levels of NACs (provincial, district and local AIDS Councils/Commissions) in the response to HIV in countries. This is a gap that needs to be addressed given that government in most African countries is constituted as a federal system, with different tiers/spheres of government.

1.6.2 Multilevel response to HIV

Multilevel is conceptualised in this research to refer to the multiple levels of government, which are the key areas in which the research has focused. South Africa is a federal state constituted by three spheres or level of government (national, provincial and local government). The three spheres

of government in South Africa have distinctive, but interrelated responsibilities and functions (Republic of South Africa, 1996).

National government is responsible for developing policy frameworks, defining norms and standards for service provision, and distributing revenue in an equitable manner; provincial and local governments are responsible for implementing most public functions and for putting into effect (implement) the policies developed at national level (Republic of South Africa, 2003, Schneider and Stein, 2001). Any policy process in South Africa should involve all the three levels of government, that are expected to function in a cooperative, interrelated and interdependent manner (Republic of South Africa, 1996). In studying implementation of the multisectoral response to HIV in South Africa, I designed the research to be multilevel and explore all the three levels of government for an in-depth overview. Failure to include all the three levels in this research would have been a limitation, given the different functions that each level has in relation to others.

1.6.3 Multisectoral approach, governance and health

If implemented well, a multisectoral approach would contribute to improvement in health and address the social determinants of health (Juma et al., 2018). MSA also relates to governance (Rasanathan et al., 2017). Governance is an evolving concept which has multiple definitions (Stoker, 1998, McQueen et al., 2012). In this research, governance is understood as a process of governing that involves multiple sectors (i.e. non-governmental sectors, private sectors, and communities) beyond government (Siddiqi et al., 2009). The UNDP (1997) defines governance as "complex mechanisms, processes and institutions through which citizens and groups articulate

their interests, mediate their differences and exercise their rights and obligation" (UNDP, 1997: 9). The concept of governance also describes the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals (Dodgson et al., 2002).

Governance is now recognized in low and middle income countries as a key determinant of health (Siddiqi et al., 2009, World Health Organization, 2010). There is an established understanding that addressing health determinants requires a broad array of actors in improving health outcomes (World Health Organization, 2018a, Sedibe et al., 2018). There is evidence that comprehensive health responses are those that involve integrated efforts of government working together with other non-government actors (Kanchanachitra et al., 2018, Rasanathan et al., 2017). Accordingly, there is now a growing interest in studying the relationship between governance and health in its varied scales, including global health governance, governance for health, health governance, and other associated links (Kickbusch and Gleicher, 2012). Governance reflects in various global, regional, and national policy frameworks aimed at improving health and wellbeing (World Health Organization, 2018a). These include amongst others, the 2030 agenda on Sustainable Development, 2016 Political Declaration on HIV and AIDS, and the Health 2020.

1.6.4 Governance and HIV

Governance is "a key and decisive factor in the outcome of efforts to respond to the HIV and AIDS epidemic" (UNDP, undated). Good governance is described as one of the determining factors of success in the HIV response (Kar, 2014, Putzel, 2004b). Evidence from countries has also established that effective governance is essential for an effective HIV response (World Health

Organization, 2018a, Kar, 2014). Tackling the epidemic successfully depends on how well national responses are managed, funded and implemented (United Nations, 2001). Political will and leadership are essential to ensure that national resources are allocated for HIV related priorities and for mobilization of multi-stakeholders in the response to HIV (United Nations, 2001, Putzel, 2003). All sectors of government and non-government sectors have a key role to play in ensuring that HIV is integrated in their policies and programmes (United Nations, 2001).

While the link between governance and HIV has been established in the literature, little is known about the process, mechanisms and structures required to facilitate effective governance of HIV (i.e. how to action (Gavian et al., 2006, Hellevik, 2012b). In most reviews of HIV policies, governance is often cited to be amongst the essential factors to enable successful implementation; yet little evidence or guidance about what it is, and how to do 'good HIV governance. This is a gap for further exploration to expand the knowledge and to contribute to our understanding and implementation of the multisectoral approach to HIV. Renewed insights and literature about the contemporary governance of HIV is critical as new developments and advances in the global response – including those focused on TasP and on meeting the 90-90-90 targets continue to emerge.

1.7 Problem Statement and justification of the research

While the global efforts to address HIV to date are commendable, progress in Southern and East African countries including South Africa is far slower than what is required to meet the goal of ending AIDS by 2030. Responses to HIV and AIDS have remined slow and inadequate, while new

infections continue to emerge (UNAIDS, 2018). It is widely established in theory that MSA is needed to respond to the complex challenge of HIV and AIDS (Bennett et al., 2018, Salunke and Lal, 2017). Yet little is known about how MSA works in practice. There has been limited reflection to understand factors that facilitate and hinder its effectiveness (Gavian et al., 2006). Moreover, documentation of country experiences in implementing a multisectoral approach to HIV in SEA has been limited (Hellevik, 2012a). Evidence gaps regarding documentation of lessons learned from implementation of MSA remains to be filled. Without a thorough reflection on the process and documentation of experiences, evidence about effectiveness of MSA on HIV approach remains scattered and blurry, with limited knowledge about what works (and does not work), which can be used to inform theory, policy and practice.

The literature specific to low and middle income countries has made limited progress in understanding how best to support implementation of multisectoral action (Rasanathan et al., 2017, Bennett et al., 2018). While NACs have been at the centre of coordination of the multisectoral approach on HIV in countries, there are no guidelines to inform their function (Putzel, 2004a). As a result, countries have embarked on a process of self-discovery, through trial and error.

1.8 Research question

The research question that is addressed in this research is: what is needed to effectively implement a multisectoral and multilevel approach to HIV in South Africa?

1.9 Aim and objectives

1.9.1 Research aim

This research aims to explore implementation of the multisectoral approach to HIV at national, provincial and local level in South Africa, and to develop a guiding framework to inform its implementation.

1.9.2 Research objectives

- To reflect on the experience of AIDS Councils in South Africa in implementing a multisectoral approach to HIV and AIDS in practice (at national, provincial and local level)
- To explore South Africa's experience on mainstreaming HIV and AIDS - in health and non-health sectors at national, provincial and local levels- and its contribution in augmenting a multisectoral approach to HIV
- To develop framework that will inform multisectoral and multilevel approach to HIV and AIDS
- To draw from key findings and make recommendations for an integrated governance response to HIV and AIDS in South Africa.

1.10 Structure of the thesis

This chapter (Chapter 1) has set out the scene for the study, presenting the literature review for my research, which includes an overview of the HIV epidemic, highlighting the progress made in the global response, the interventions used, and more importantly the remaining gaps that precipitated the need for a multisectoral approach to HIV - the key focus of this study. The chapter describes

the multisectoral approach, and how it relates to the concept of governance and health, which is also a critical concept in this research. In exploring implementation of the multisectoral approach, this research focuses at national, provincial and local level, referred to as multilevel. The research question, aim and the objectives of the research are then outlined in this chapter 1.

The key concepts and frameworks that have informed the research process are discussed in chapter 2. Chapter 3 presents and discusses the conceptual framework underpinning the research. The conceptual framework has been developed to assist in understanding the complexities of the multisectoral approach and its application to practice, drawing from various approaches in public administration, policy and governance studies and in public health research. The conceptual framework was applied in the framing of the research objectives, but most importantly used to inform data collection, analysis and synthesis of the research findings.

An overview of research methods used in this research are then presented in Chapter 4**.**

This research was done through publication route. The detailed findings of the study are presented in paper 1, 2 and 3 attached as appendices. The synthesis of key findings of the research are presented in Chapter 5**.** As a collective, the papers highlight the complexities of implementing a multisectoral approach at multiple levels, and make recommendations on how to address the challenges of multisectoral action at multilevel drawing from a case study of implementation of a multisectoral approach to HIV in South Africa. Another key contribution of the study is the proposed framework for multisectoral and multilevel collaboration detailed in paper 3.

Chapter 6 is a discussion section where the key findings of the study are discussed in relation to the existing literature. This chapter present an integrating narrative of the research, theoretical contributions and implication of the findings to policy and practice. The limitations of the study are also detailed in this chapter 6.

The recommendations and conclusion are presented in chapter 7.

Chapter 2: Review of the thoeritical and conceptual frameworks

This chapter presents and discusses the key concepts and frameworks that have informed the research. These are outlined below.

2.1 Multisectoral action and Multilevel governance

There are two central concepts in this work: multisectoral action and multilevel governance. This research has explored multisectoral action at multiple levels of government in South Africa. Multisectoral action – which describes two or more sectors coming together to work towards achieving a common goal - has been discussed in detail in chapter 1. This research is a multilevel study exploring different levels of government. Multilevel governance is used in this research to refer to the three levels of government, namely national, provincial and local level, which are central in the implementation of MSA in South Africa.

In South Africa government is constituted of three levels or spheres (national, provincial and local, which are distinctive, interdependent and interrelated. The three levels of government have different functions and responsibilities that are provided in the Constitution of 1996. While national level is responsible for policy development, implementation happens at provincial and local level. Given these varied responsibilities, this research is a multilevel study that has focused at all three levels of government to understand how the multisectoral approach is implemented. Through the work of AIDS Councils and government departments at national provincial and local level, the research was able to explore factors that enable and hinders effective implementation of the multisectoral approach, and made recommendations to address the challenges.

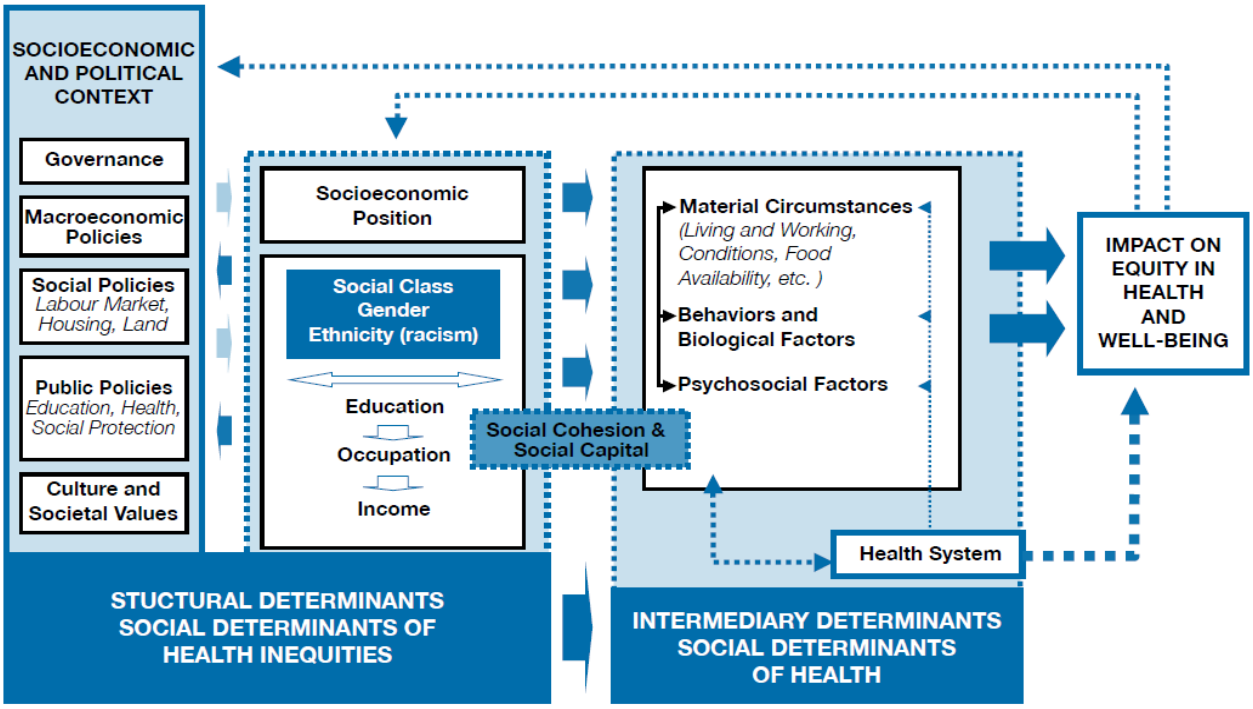
2.2 The Social Determinants of Health Framework

Social determinants of health are understood as "the social conditions in which people live and work" (WHO Commission on SDH 2005a, p. 4), which may have an impact on population or individual health. A comprehensive health response requires that we not only provide health service, but also address the underlying, social, economic and political determinants of poor health (WHO, 2005). The structural determinants manifest at various levels including at global, national and community levels, while the social determinants can be at the community and individual level (WHO, 2008). The Commission on Social Determinants of Health (CDSH) developed a framework (showed in Figure 1) which describes how health outcomes are influenced by both the social and structural determinants (World Health Organization, 2010). Together, the two (social and structural determinants) influence equity in health and wellbeing (World Health Organization, 2010). The structural determinants of health encompass the socioeconomic and political context including governance, policies, cultural and social values, and socio-economic position; whilst the social determinants of health encompass material circumstances, psychosocial circumstances, behavioral and/or biological factors (World Health Organization, 2010).

The CSDH framework provides guidance regarding the need for intersectoral policy approaches to address the social and structural drivers (World Health Organization, 2010). The CSDH framework was applied in this study to conceptualize the multisectoral collaboration process required in addressing HIV. The CSDH framework provides key direction for action in accelerating the response to HIV, directing focus on creating an enabling socioeconomic and political environment for implementation of HIV interventions, and on tackling the material circumstance, behavioural, psychological and biological factors which contribute to risk and

susceptibility to acquisition of HIV. A social determinants framework can be used as an all-encompassing tool to conceptualize prevention and response, taking into consideration the complex and multiple drivers of the HIV which prompts for multisectoral action.

Figure 1: Social Determinants of Health Framework



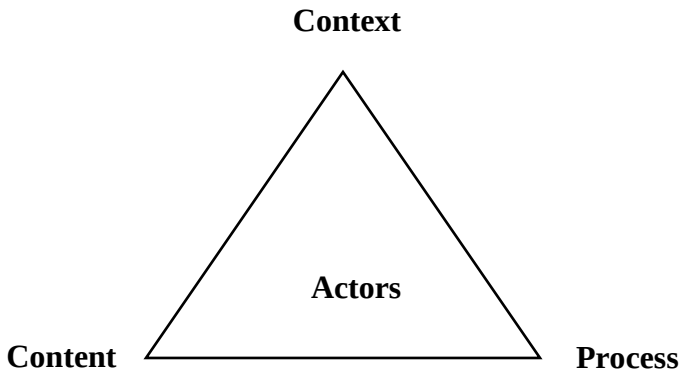
Source: WHO (2010).

2.3 Walt and Gilson policy analysis triangular framework

The Walt and Gilson framework shown in Figure 2 is an analytical model which is used to understand the process of implementation of the multisectoral approach (Walt and Gilson, 1994). The framework has been widely used in health policy research to analyse a number of health issues including mental health, health sector reform, tuberculosis, reproductive health and antenatal syphilis control (Gilson and Raphaely, 2008). It is grounded in a political economy perspective, focused on four related factors critical to understanding public and health policymaking and implementation: actors, policy content, contextual factors and process. (Walt and Gilson, 1994).

The framework was used to reflect on the actors, the content, the context and the process involved in implementation of the multisectoral approach aimed to achieve the goals of the National Strategic Plan on HIV in South Africa. In particular, the research focuses on the multisectoral implementation process involving government, civil society and the private sector on implementation of the multisectoral approach to HIV. Through the application of the policy analysis triangle, I explored the relationship (interrelatedness) between the four factors (content, actors, context, and process) and how together, they contribute or influence implementation of MSA.

Figure 2: Policy triangle - a model of policy analysis



Source: Walt and Gilson, 1994.

2.4 Multisectoral collaboration frameworks, models and approaches

The study also draws from the applicable multisectoral collaboration frameworks, models and approaches from the existing literature in public health, governance and in public administration. This was done in order to draw from the advances and contributions made in understanding multisectoral action and collaboration to address complex social problems such as HIV and other development issues of the 21st century. In understanding the phenomenon of collaboration, this research draws from the literature on collaborative governance (Ansell and Gash, 2008, Emerson et al., 2012), cross sector collaboration (Bryson et al., 2006, Bryson et al., 2015), collective impact (Hanleybrown et al., 2012), governance of multisectoral action (Rasanathan et al., 2017, Kar, 2014) multisectoral approaches in public health (Kanchanachitra et al., 2018, Tangcharoensathien et al., 2017), and the literature on collective action (Hardin, 2015, Ostrom, 2007, Olson, 2009).

Together, this literature was used in developing the framework for multisectoral and multilevel collaboration which aims to contribute to knowledge about multisectoral action or collaboration. Collaboration is a collective activity that is often used interchangeable with other terms such as cooperation and coordination (Elliot, 2007). Understanding the difference between coordination, cooperation and collaboration provides insight about collective action (Gulati et al., 2012). While all the three concepts refer to collective activity aimed at a shared pursuit, they have different connotations (Elliot, 2007). To coordinate is to harmonise activities or processes, and to bring in order to parts of a whole (Elliot, 2007). In coordination, the benefit of working together is not critical, but each part needs to know what, when, and how to do what needs to be done (Figueiredo, 2008). Cooperation defines a process where all stakeholders recognizes the benefit of working together and are willing to engage in collective efforts, provided individual aims and autonomy will not be sacrificed (Figueiredo, 2008). Collaboration represents another level of collective action where stakeholders have a common mission or shared goal, work together to find solutions that will benefit all of them (Thomson and Perry, 2006, Figueiredo, 2008).

2.5 Whole of Society and Whole of Government approaches

In this study, we recognised that given the broad array and complexity of HIV determinants, there are various actors that have a role in the response to HIV. As such the Whole of Society (WoS) and Whole of Government (WoG) approaches were applied to frame the study. MSA as a process is explicitly embedded in the WoG and WoS approaches (Kickbusch and Gleicher, 2012).

The Whole of Government also referred to as joined up government or network governance is a term describing a group of responses to the problem of fragmentation, designed to increase integration and coordination in the public sector (Christensen and Lægreid, 2007). In the WoG approach, public sector agencies work across portfolio boundaries, formally and informally, to achieve a shared goal and an integrated government response (Kickbusch, 2010). The Whole of government approach helped clarify the critical role of non-health departments within government that have a role in addressing the social and structural determinants of HIV. HIV is approached not as a health department issue, but a developmental issue that concerns other departments within the government sector. The WoG approach allowed us to think about and unpack the horizontal relations between departments which is critical in strengthening the government response to HIV (Christensen and Lægreid, 2008). A whole of government approach also acknowledges the diffusion of responsibilities between levels of government (vertical), which is useful to understand South Africa's federal system with three spheres of government (national, provincial and local) that are interconnected. We were able to examine through the application of the WoG, relations (horizontally) between government departments, and (vertically) between levels of government. Christensen and Lægreid (2008) work was also drawn in to further our understanding of the government sector response, and how the vertical and horizontal coordination is undertaken on the response to HIV.

The Whole of Society approach expands the WoG approach, emphasising the important role of non-government sectors such as the private sector and civil society and communities in addressing complex societal problems (Kickbusch and Gleicher, 2012). The WoS describes collaborative

governance efforts where all sectors of society work towards a common goal (Kickbusch and Behrendt, 2013).

The WoG and WoS approaches are implemented in a context where there is a need to address complex societal problems and complex policy issues (Kickbusch and Gleicher, 2012). WoG has mainly been applied in the health sector, but its popularity and application is growing in the field of development. Both WoG and WoS approaches are needed when society is facing a problem for which disaggregated interventions have failed, and integrated efforts of a range of national actors is required. Effective implementation of these governance approaches requires a shared understanding of the problem and a shared commitment to its possible solutions, and must be adapted to the context where they apply (Kickbusch and Behrendt, 2013). In this study, the two approaches provided guidance regarding the unpacking the multisectoral action between stakeholders horizontally, across the whole of society (public sector, private sector and civil society) and vertically across the whole of government (between departments and levels of government). Both approaches are key and provide a multisectoral framework that can be used when developing interventions to tackle the social and structural determinants of HIV (Kickbusch and Behrendt, 2013).

2.6 Health in All Policies

With the shift to the understanding of health as being more than a bio-medical issue came the awareness of the importance of other actors in improving health and wellbeing (Baum and Laris, 2010). Within the health sector, Health in All Policies (HiAP) was developed to ensure that all public policies in health and other government departments (sectors) systematically took the health

implications of decisions, sought synergy and avoided harmful health impacts (World Health Organization, 2013). It aims to achieve policy coherence (in part through Health in All Policies) and to improve effectiveness and efficiency, with a focus not only on policies but also on programme (implementation) and project management (World Health Organization, 2014). Implicit in the HiAP is recognition that addressing the social, economic and other determinants of health requires interventions outside the health sector (Cook et al., 2013). While health gains might not be a priority for other sectors, health is a critical indicator of social and economic development (Ollila et al., 2013). HiAP provides a framework that can be used to bring in non-health sectors to address determinants of health. It was integrated in this work to conceptualize and reflect on how non-health department can engage in the multisectoral response to HIV, which has for the long-time been understood as a health sector issue.

2.7 Mainstreaming of HIV

2.8 Vertical and horizontal coordination

Mainstreaming is one of the key concepts applied in this study which emphasises working across sectors. The concept of mainstreaming is widely used across a range of development sectors more so in gender, disability and old age (Daly, 2005, Seddon et al., 2001, Perrig-Chiello and Hutchison, 2010). Mainstreaming is defined as the process of analysing how a particular issue impacts on sectors now and in the future, both internally and externally, to determine how the sectors should respond based on their comparative advantage (Elsey et al., 2005). The aim of mainstreaming is to integrate health and other developmental issues in policies and programmes of various sectors to address direct and indirect causes, and to achieve joint outcomes (Esley and Kutengule, 2003).

The mainstreaming process facilitates multisectoral action, only when it is implemented as a continuous process and not as a once-off intervention (Esley and Kutengule, 2003) on issues that are not a direct function of sectors. Given the connection between the concept of mainstreaming to multisectoral action, it was critical that we reflect on the experience of non-health departments and how they integrate HIV in their policies and programmes, to understand the extent to which the mainstreaming approach contributes to multisectoral action.

2.8 Vertical and horizontal coordination

Christensen and Laegreid provide a theoretical description of the different forms of coordination in a multilevel system. They distinguish between external-internal dimensions of coordination and vertical-horizontal dimensions of coordination (Christensen and Lægreid, 2008). Vertical coordination describes a hierarchical relationship which can be from upwards (central or national government) to downwards (local government), while horizontal dimension describes a network based system of coordination between organisations on the same level (Christensen and Lægreid, 2008). This thesis draws from the later dimensions of coordination (vertical- horizontal dimensions), which are used to reflect on the relationship between and within the different levels of government involved in the multisectoral response to HIV.

2.9 Collective action

One of the concepts related to multisectoral action is collective action. Collective action describes action taken together by a group of people whose goal is to enhance their status and achieve a common objective (Hardin, 2015, Ostrom, 2007). Through their work, Ostrom, Olson, and others

contribute to our understanding about collective action, including key factors that affect the likelihood of successful collective action (Hardin, 2015, Olson, 2009, Ostrom, 2002, Ostrom, 2007). Olson (2009) discusses the logic of collective action and challenges the assumption of most group theories stating that individuals would simply and voluntarily engage in a group, and pursue a common goal until the end. He argues that no self-interested person would contribute to the production of a public good. Rather that rational, self-interested individuals will not act to achieve common or group interests, unless there is coercion or a special device to make individuals act in their common interest (Olson, 2009). The basis for his argument was that one who cannot be excluded from obtaining the benefits of a collective good, once the good is produced, has little incentive to contribute voluntarily to the provision of that good (Olson, 2009). According to Olson the size of a group is not so important, but how noticeable each person's actions are. It is about each member's contribution to the group that is important instead of the size of the group (Olson, 2009).

In her work on Governing the Commons, Ostrom (2007) writes about the tragedy of the commons, and the prisoner's dilemma to describe problems that individuals face when attempting to achieve collective benefits. She explains the "free rider" risk that is likely to result from collective action (Ostrom, 2007). When members in a group cannot be excluded from the benefits that are likely to be achieved in a group, each person is motivated not to contribute to the joint effort, but to free-ride on the efforts of others (Ostrom, 2007). Drawing from Ostrom's work we learn that the risk of "free riders" might be amongst the factors that inhibit MSA if it is not taken into account.

The Tragedy of the Commons

The tragedy of the commons describes the challenge that is likely to happen when there is common ownership of various natural resources. It symbolizes the degradation of the environment, which is expected whenever many individuals use scarce resources in common (Ostrom, 2007). It describes the challenge in an "open to all system" where users have access to common pool resources, and there is least care upon the resources. The tragedy is in the likelihood of deterioration of the common, where everyone thinks primarily about themselves, and hardly about the common interest (Ostrom, 2007). The tragedy of the common is likely to manifest in any multisectoral effort, where a group might initially be established to achieve a common goal, and as time progresses, individual sector's interest become a priority over the group's interests. Awareness and establishing mechanisms to manage the tragedy of the commons is important in multisectoral efforts.

The Prisoner's dilemma

A prisoner's dilemma is a non-cooperative game in which all players have complete information about the game (Ostrom, 2007). They understand the structure of the game, and the benefits attached to outcome. Communication among the players is prohibited or impossible, unless it is modelled as part of the game. If any verbal agreements are taken, none of those are binding to members. For a two players game, players can either choose to "cooperate" or to "defect". Cooperate strategy allows both players to benefit, but on the defect strategy, each player opts for self-interest which would allow the greatest benefit to him or her. When both players choose their dominant strategy, to defect, they produce an equilibrium and they obtain zero profit (Ostrom, 2007). A Pareto- optimal outcome results when there is no other outcome preferred by at least one

player that is at least as good for the others. In the two-person prisoner's dilemma game, both players prefer the (cooperate, cooperate) outcome to the (defect, defect) outcome. Thus, the equilibrium outcome that would result is Pareto-inferior. The Prisoners dilemma challenges our understanding about rationality, particularly the presumption that individual rational strategies (choices) lead to collectively rational outcomes; which is not always the case. The Prisoner's dilemma suggests that cooperation is impossible for rational players (Ostrom, 2007). As we explore multisectoral action, we should continuously assess and monitor the level of cooperation by rational sectors involved, and how that impacts on the outcome of the process.

Theories of collective action

In her work on Governing the Commons. Ostrom (2007) discuses two theories of collective action (theory of the firm and theory of the state). The two theories respond to the three problems of collective action and provide an explanation for one way in which collective action can be achieved. The three problems are (i) the problem of supply that relates to the question about which kind of institution to choose, and what rules to govern collective action amongst the group; (ii) the problem of credible commitment: which is about the likelihood that some participants in a group may want to increase their benefits and breaking the rules, leading to an assertion that a long-term commitment can't be made; and the (iii) the problem of mutual monitoring which states that individuals will not monitor themselves, even if they set up the rules themselves (Ostrom, 2007).

The theory of the Firm

In the theory of the firm, an entrepreneur recognizes an opportunity to increase the return that can be achieved when individuals are involved in an interdependent relationship (Ostrom, 2007). He

then negotiates contracts with participants and specify how they are to act in a coordinated, rather than independent manner. Each participant voluntarily chooses whether or not to join the firm, but gives the entrepreneur discretion over some choices, as an agent of the entrepreneur. After paying each agent, the entrepreneur retains residual profits (or absorbs losses) (Ostrom, 2007).The entrepreneur is highly motivated to efficiently organize the activity and to ensure that agents have contract that will induce them to act so as to increase the returns, while he/she monitors the agents' performances (Ostrom, 2007). The entrepreneur can terminate contracts for non-performance at his or her discretion to his benefit, and the participants or agents get payed for their work by the entrepreneur and he gets the return of the work (Ostrom, 2007). The entrepreneur has the goal of highest efficiency and gets any surplus, and he has an incentive for efficient organizing and monitoring the participants (Ostrom, 2007).

The theory of the State

This theory posits a ruler or state that recognizes that substantial benefits can be obtained by organizing some activities (Ostrom, 2007). The ruler has the monopoly on the use of force, and can use coercion as the fundamental mechanism to organize a diversity of human activities that will produce collective benefits (Ostrom, 2007). The ruler gets cooperation from subjects by threatening them with severe sanctions if they do not provide the resources, and uses the resources obtained to increase the general level of economic well-being of the subjects (Ostrom, 2007). Rulers, like entrepreneurs, keep the residuals; subjects, like agents, may be substantially better off as a result of subjecting themselves to the coercion exercised by rulers (Ostrom, 2007). The only risk for the ruler is the likelihood of rebellion from individual participants should he apply measures that are too oppressive (Ostrom, 2007).

In both the theory of the firm and the theory of the state, the burden of organizing collective action is undertaken by one individual (the entrepreneur or the ruler), whose get the returns from the surplus generated (Ostrom, 2007). Both involve an outsider taking responsibility for supplying the needed changes in institutional rules to coordinate activities and allow for collective action (Ostrom, 2007). They make credible commitments to punish anyone who does not follow the rules of the firm or the state. They also monitor the actions of agents and subjects to be sure they conform to prior agreements (Ostrom, 2007). These theories raise the question whether multisectoral structures should be self- organizing or whether there is a need for an entrepreneur or the ruler who will set the rules and coordinate activities to allow for collective action. What are the chances that a multisectoral structure will voluntarily act on its own to achieve a common goal without enforced cooperation by either a Firm or a State? Both theories thus suggests ways in which multisectoral arrangements (collective action) can come administered, how credible commitment (by sectors) can be enforced, and the need for monitoring of the process (Ostrom, 2007).

Chapter 3: Conceptual framework of the study

In Chapter 2 I have outlined and discussed the key frameworks and concepts, which have informed the research. This Chapter is a continuation of chapter 2, where I discus the conceptual framework underpinning the research. The conceptual framework draws from the key frameworks and concepts discussed in chapter 2.

3.1 Conceptual framework

This research draws from the theories of collective action, and from models, frameworks and approaches on MSA from disciplines other than public health. The study draws from the two theories of collective action: the theory of the firm and the theory of the state. While not specific to MSA process, the two theories of collective action: the theory of the firm and the theory of the state informed understanding about collective action and group behaviour. Existing frameworks and approaches to MSA that were relevant to this work were developed in public administration, and not specifically designed to study public health issues (Ansell and Gash, 2008, Bryson et al., 2006, Emerson et al., 2012, Hanleybrown et al., 2012). Within the field of public health, a number of key concepts were found, and these concepts have been used by other scholars in their deliberation about the multisectoral approach (Kanchanachitra et al., 2018, Rasanathan et al., 2015, Sanni et al., 2018). While the concepts were useful, they were not comprehensive to explain and inform the process of MSA implementation in practice. In the light of this gap, I have developed a conceptual framework that has informed this research. The conceptual framework is presented in Figure 3.

The fundamental premise of my conceptual framework is that it highlights the complexity involved in the process of multisectoral action – involving sectors with different ways of working. The conceptual framework further illustrates the complexity of implementing multisectoral action at multilevel of government (national, provincial and local level), which makes the process even more challenging to ensure there is coordination harmonisation of activities. This research also draws from key frameworks and concepts (applicable in this research) in public administration, public health and governance literature. Drawing from this multidisciplinary literature has allowed me to engage with the complexities of the process of multisectoral action. The review of existing frameworks relevant to MSA in public administration highlighted a limitation in the existing frameworks, which are focused on defining preconditions and perquisites of MSA, with a limited attention to process. This research fills the gap by defining key process elements that are essential for effective implementation of the multisectoral approach to HIV (discussed in paper 3 and 4). We draw from the governance literature, Whole of Society and Whole of Government approaches, and literature in public health, Health in All Policy and Mainstreaming (paper 1 and 2) that speaks to the process of multisectoral action. The social determinants of health framework (in box 2) has further enabled me to engage with the complexity of the MSA, clarifying the causes of poor health, highlighting the importance of addressing the social and the structural drivers when addressing health (box 1). The application of the social determinants of health framework in strengthening implementation of the multisectoral approach to HIV draws attention to extend focus beyond the health sector, and consider the essential role of other non-health sector.

Box 3 alludes to the challenges to which the multisectoral approach aims to address in relation to the epidemic of HIV and AIDS in South Africa. The policy analysis triangle adopted from Walt

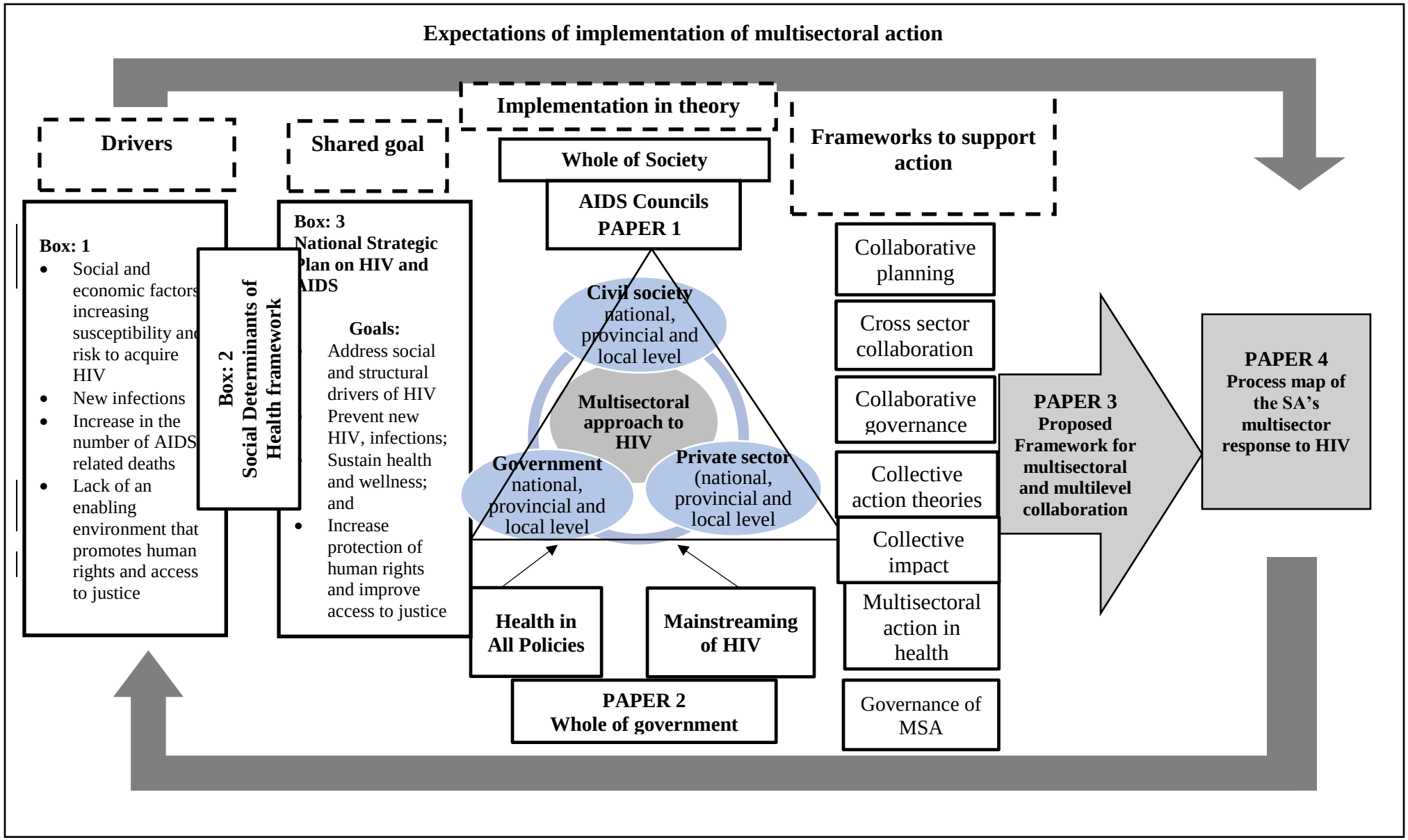
and Gilson (1994) depicts the interconnection between the actors involved, the context in which MSA is implemented (Paper 1 and 2). As highlighted in the findings of the research, implementation of the multisectoral approach does not happen in isolation. The context (e.g. resources, leadership, political support, coordination and collaboration) can either create an enabling environment or hinder effective implementation of MSA. The research findings have also illustrated the importance of capacity and skill amongst actors involved in the process of MSA, to be able to undertake critical task that are required in the process such as reporting, monitoring and evaluation (Paper 1 and 2).

The conceptual framework also illustrates the process used in the development of the framework for multisectoral and multilevel collaboration that is proposed in this research. While informed by the findings of the research, the framework proposed in this research draws from the existing frameworks, models and approaches on MSA. The key frameworks, models and approaches includes collaborative planning, cross sector collaboration, collaborative governance, collective impact, multisectoral collaboration in health and governance in health discussed in paper 3. While the frameworks and approaches have benefitted the study, this research also fills the gap that has been found in the existing frameworks, which is elaborated in paper 3.

In consolidating the PhD work, the conceptual diagram illustrates how the end connects to the start of the research process. The framework proposed in this research informs the recommendations on how to strengthen the design, implementation and evaluation of South Africa's response to HIV through a process map that will be detailed in paper 4 (which was not yet published at the time when the thesis was finalised). Furthermore, I have used two thick arrows in the conceptual

diagram to indicate how the findings of this research can be used to inform the next NSP on HIV in South Africa. The conceptual framework indicates the importance of learning and adjustment as a critical component of the process of implementing a multisectoral approach.

Figure 3: Conceptual framework of the study



Chapter 4: Methodology

This chapter describes the methodological approach that was used to answer the four aims of this doctoral research including techniques that were used for data collection and analysis. The chapter also provides detailed information about how the study was designed and conducted. Together, this doctoral work aims to contribute to the literature on multisector collaboration, and provides evidence based recommendations to inform implementation of the multisector approach in practise. This is a multilevel study of implementation of the multisectoral approach to HIV at national, provincial and local level in South Africa.

4.1 Study design

This study used a qualitative research design to address the four objectives of the research which aimed to explore the multisectoral approach, and its implementation in practise, using a combination of qualitative methods. Qualitative research was selected as a suitable method for this study given its descriptive nature that allowed us to study the process and meaning through the lived and subjective experiences of participants (Atieno, 2009, Berg et al., 2004). A richer understanding of the multisectoral process requires a complex description of events to provide an in-depth analysis of how the process unfolded in practise. To achieve this, an exploratory case study design was used to understand how the multisector approach is implemented in practise, including a reflection of its challenges to make recommendations on how they can be addressed. A case study method is desirable to understand the "how" and "why" of the phenomenon under investigation (Yin, 2009).

4.2 Study sites

The research draws from South Africa's experience in implementing the multisector approach on the response to HIV and AIDS. South Africa is amongst the countries in the sub-Saharan region which bear the heavy burden of HIV, and a Commonwealth country where a multisector approach on the HIV response has been under implementation for more almost two decades, making it an interesting case to investigate. Government in South Africa is made up of three spheres, national, provincial and local level governments. The three spheres of government have distinctive roles, responsibilities and function. National government is responsible for policy development, while province and local government are responsible for policy implementation. The research was conducted at all three levels of government for an in-depth exploration of the policy process from development at national, to implementation at provincial and local level, and to unpack the complexities of multisector collaboration when multiple levels of government are involved. Inclusion of three levels of government was motivated by an interest to understand the intergovernmental relations on the multisectoral response to HIV and AIDS.

Mpumalanga province in South Africa was purposively selected for an in-depth exploration of implementation of the multisectoral response. The province with three of its districts (Ehlanzeni, Gert Sibande and Nkangala) and six of its local municipalities (Umjindi, Nkomazi, Chief Albert Luthuli, Msukaligwa, Emalahleni, and Victor Khanye) were included in the study based on their availability and willingness to participate in the research. Mpumalanga is one of the four provinces in South Africa with a high HIV prevalence (22.8%) among adults aged 15– 49, after Kwazulu-Natal (27%), Free State (25.5%) and Eastern Cape (25.2%) provinces (Human Science Research Council, 2018).

Research was undertaken with multisectoral structures at all three levels of government as shown in Table 2.

Table 2: AIDS Councils at national, provincial and local level

National level	**Provincial level**	**District level**	**Local level**
South African AIDS Council	Mpumalanga Provincial AIDS Council	Ehlanzeni District AIDS Council	Barbeton Local AIDS Council
			Nkomazi Local AIDS Council
		Gert Sibande District AIDS Council	Msukaligwa Local AIDS Council
			Chief Albert Luthuli
		Enkangala District	Victor Khanye Local AIDS Council
			Emalahleni Local AIDS Council

South Africa has also adopted a developmental approach to HIV and AIDS which recognises the critical role of non-health sectors in the response to HIV, as such, the research aimed to explore how the multisector approach to HIV in health and non-health departments within the government sector, and this included: health, education, housing, human settlements, cooperative governance and traditional affairs and social development departments. Within each government department, the study aimed to explore how the multisectoral response to HIV is coordinated at various levels (national, provincial and local), and to explore intergovernmental relations and collaborations on the response to HIV between departments (health, education, human settlements, cooperative

governance and in social development). Table 3 summarises the methodologies used and the study populations. Details on the specific methods are provided in the published papers (Paper I-III).

Table 3: Overview of study population, data sources and methodologies

Paper published	Study population and data sources	Summary of methodology
I	12 Key Informants including HIV Coordinators and District Technical Advisors	Semi structured, in-depth interviews, using thematic content analysis
	67 AIDS Council members who participated in 6 FGDs at District and Local level	Focus group discussions, using thematic content analysis
	9 Strategic and implementation plans of AIDS Councils at national, provincial and local level	Document review, using Walt and Gilson's policy analysis framework
	2 NSP policy processes, 1 PAC meeting, 3 LAC meetings and	Participant observations, documenting notes, using thematic content analysis
II	9 officials from government departments	In-depth interviews, analysed using thematic content analysis and Christensen and Lægreid framework
	4 HIV and AIDS plans of selected national departments	Document review, using Walt and Gilson's policy analysis framework
	3 department's policy dialogues and 1 national policy development process	Participant observation documenting notes, using thematic content analysis
III	Review of existing literature and frameworks on multisector collaborations	Review and synthesis of existing frameworks on multisector collaboration
	Informed by the findings of paper I & II	Use synthesis and reflection on findings from paper I & II to develop a framework

4.3 Selection of participants and sourcing of documents

In order to select participants to include in this research, the process of mapping was conducted, into two phases. I spoke to people we know who were involved in the HIV response even those that were not based in the departments of interest, who referred us to key contact people. Government departments were also contacted to explain the study and to ask for the relevant people to speak to at national level, who provided names of key contacts at provincial and at local level. A literature search of key HIV and AIDS policy document was done, going through the websites of government departments, while some of the documents were made available by key informants during interviews.

4.4 Data collection

Document review (I, II, III)

A document review was conducted, also as a primary method of data collection about how the process of multisectoral action on the HIV response is understood, the planned approach and how it was actually implemented in various government departments in South Africa. This was done through the review of policy documents, strategies and progress reports on the multisector approach. We also reviewed key documents of AIDS Councils at various levels of government and this included the AIDS Councils operational plans, and the minutes of some of the meetings that were previously held to acquire background information about the context in which the AIDS Councils operate. The documents provided supplementary research data. The information and insights that were derived from the documents contributed valuable knowledge base about the content of the policy documents, the planned process and the actual implementation of the multisectoral approach on the response to HIV in South Africa (Bowen, 2009).

A total of 13 key HIV and AIDS policy documents were reviewed (See Table 4). The process started with identification of documents to be reviewed, and followed by the review process. A document review guide (appendix 1) which was developed based on the objectives of the research and the conceptual framework of the study was used to systematically review the documents. The documents were treated like a respondent providing relevant information to the researcher. The researcher "asked" questions then highlighted the answer within the text (O'Leary, 2014).

Table 4: List of documents reviewed

AIDS Councils	
South African National AIDS Council	• Let our Actions count: South Africa's National Strategic Plan for HIV, TB and STIs 2017 - 2022 • National Strategic Plan on HIV, STIs and TB (2012 – 2016) • Enhanced progress report of the National Strategic Plan on HIV, STIs and TB (2016) • Financing the South African National Strategic Plan on HIV, STIs and TB (2014) • HIV & AIDS and STI Strategic Plan for South Africa (2007 – 2011)
Provincial AIDS Council	• Mpumalanga Strategic Plan for HIV and AIDS, STIs and TB (2012 – 2016)
District AIDS Councils	• Ehlanzeni AIDS Council Strategy (2012 – 2016) • Gert Sibande AIDS Council Implementation Plan (2012 – 2016)
Local AIDS Councils	• Nkomazi Implementation Plan (2012 – 2016) • Barbeton AIDS Council Implementation Plan (2012 – 2016) • Msukaligwa Implementation Plan (2012 – 2016
Government departments	
Department of Health	HIV Prevention Plan (2012 – 2016)
Department of Social Development	HIV and AIDS Prevention Strategy (2012 – 2016)

Department of Education	Integrated Strategy on HIV (2012 – 2016)
Department of Human Settlements	Not available at the time of data collection and writing-up of findings
HIV mainstreaming guidelines	
Department of Public Service and Administration	Guidelines for Gender Sensitive and Rights-Based Mainstreaming of HIV in Public Service
Department of Cooperative Governance and Traditional Affairs	Framework for an Integrated Local Government Response to HIV and AIDS (2012)

One of the limitations with the document review method was the lack of sufficient detail that we could derive from the review. The documents reviewed did not provide all the information we required to answer the research question. As such, other methods were used to elaborate and dig deeper into the issues that were prompted through the process of document review.

Focus group discussions (I, III)

Focus group discussions were held with six groups of AIDS Council members at district and local level. The group size was between 8 and 12 and the sessions facilitated by the researcher. Data collected from FGDs consisted of voice recorded group discussions among 8- 12 participants who shared their thoughts and experiences on the multisector approach and its implementation at local level**.** The focus groups not only provided information about the participants' experiences but also allowed participants' space to discuss the differing individual experiences to make collective sense of them. The process allowed the researcher an opportunity to observe participants engaging in interaction (Berg et al., 2004). An FGD guide (See appendix 2) based on the objectives and the conceptual framework of the study was used to structure the discussion, while allowing participants space to elaborate on any other issues related to our discussion.

Key informant interviews (II, III)

After the mapping exercise was conducted to identify key informants which were purposively selected based on their involvement in the response to HIV beyond the HIV workplace programme in departments, and their knowledge of the topic under investigation, we called and emailed to set-up interviews with the respondents. A total of 20 in-depth interviews were conducted using an interview guide (appendix 3) structured according to the objectives, and the conceptual framework of the study. The interviews were used as a method to get new data and also to further explore the issues which were raised by the review of documents, which were unclear in the documents. We were aware of the possibility of reactivity and respondent bias which could influence the process, and when such biases were suspected, respondents were referred to the information in the documents, to seek clarity where there were contradictions.

Participant observations (I, II, III)

I was a participant in both AIDS Council meetings at provincial, district and local level, and also attended three of the workshops by government departments aimed at developing a departmental strategy for HIV and AIDS. Participant observations allowed for naturalistic observation of interaction (Jorgensen, 2015). Unlike FGDs and interviews, this method allowed the researcher to observe and note what participants could not speak about, but which one can observe such as power dynamics, the tone used during the meetings, and other crucial information needed to understand the process and context in which the multisectoral approach is implemented. The rationale about being a participant was to partly manage the pressure that comes with being observed for participants, however, acknowledging that some could have still altered their behaviour and responses by virtue of having an external person participating in their meeting. To

manage the process, the researcher made conversation aimed to build trust before the meetings and workshops to normalise my presence (Bonner and Tolhurst, 2002).

4.5 Data management

Data from FGDs and interviews which was audio recorded was stored in a safe and secure place prior to being transcribed and translated verbatim by the researcher. After transcription, all transcripts were electronically stored, and also in hard copies which were filed and stored safely. Notes from the document review and participant observations were typed and electronically saved as a backup, while hard copies were filed and stored in a safe place. The researcher also ensured that all the signed consent forms were stored in a safe place, only accessible to the researcher.

4.6 Data analysis

The analysis of data collected from documents reviewed, interviews, FGDs, and participant observations were analysed using both deductive and inductive approaches. A deductive approach involve using a structure or predetermined framework to analyse data, while an in the inductive approach there is no predetermined structure or framework, data is used to derive the structure of the analysis (Burnard et al., 2008). The inductive approach was comprehensive and suitable to use in areas of the study where nothing was known about the study phenomenon, while the deductive approach was suitable when some parts of the study were known. Because of our knowledge of the structure of government in South Africa, we knew that coordination both vertically between spheres, and horizontally between departments. The deductive approach followed the framework

of Christensen and Lægreid (2008) which was used to structure the objectives, to collect and organize the data for analysis. While relying on the framework to structure the process, we allowed the themes to emerge from the data, which was in a limited form compared to what would have emerged using an inductive approach (Burnard et al., 2008).

An inductive approach was adopted to undertake a thematic content analysis method, which was used to systematically transform a large amount of text that were organized to allow us to identify themes and categories that emerge from the data (Fereday and Muir-Cochrane, 2006, Erlingsson and Brysiewicz, 2017, Burnard et al., 2008). The process involved reading and re-reading the data to gain a general understanding of what the participants said or were expressing. The text was then divided into smaller parts which were used to formulate codes which were grouped to construct categories and to generate the themes pertinent in addressing the objectives of the study (Dahlgren and Emmelin, 2004, Burnard et al., 2008).

As we undertaken the data analysis process, we were cognisant of the potential presence of biases, both in a document reviewed and from the researcher, to constantly ensure that we preserve the credibility of the research (O'Leary, 2014, Bowen, 2009). To manage researcher bias, the analysis process also involved my supervisors who constantly discussed the codes and the themes that were emerging from the process. While I was the main person who did the analysis, having two other people involved made the process to be transparent and rigorous.

4.7 Ethical considerations

Ethics approval (M120657) to conduct the study was obtained from the University of Witwatersrand Human Research Ethics Committee (See appendix 4). The research conformed with the ethical principles of voluntary participation, no harm to participants, and we requested written informed consent for participation, audio recording and for reporting on the job profile of some participants. The informed consent form is attached as appendix 5. Before each interview and the group discussion, the researcher informed the participants about the purpose of the study, procedures involved, risks and benefits of the study and their rights as informants. Participants were also given study information leaflet (appendix 6) allowing time for them to read the leaflet and ask questions. A written consent was signed by the participants expressing willingness and permission to participate in FGDs and interviews. All interviews and FGDs were conducted in confidence and anonymity was guaranteed to ensure that the names of participants are not used in any published or unpublished material.

4.8 Positionality of the researcher and reflexivity

I had no previous relationship with the participants who were involved in the study. As an outsider (not a policy-maker, and not a member of an AIDS Council), the process of identifying and securing appointments, particularly KIIs was not easy. Some participants (mainly policy-makers) were not willing to participate, after several invites and follow-up on email and over the phone. I would argue that personal characteristics including race and ability to speak Swati, Zulu and Ndebele allowed for access to AIDS Councils, where most members spoke in native languages

during focus group discussions. Because I was able to speak in their languages, AIDS Council members were willing, and free to speak and express their views.

All the participants that were interviewed and whom I had discussions with were aware that I was a researcher conducting research for my PhD. In my interaction, when conducting interviews, I assumed a position of a being a listener, interested in learning more about the work that participants were involved in. As a participant observer in AIDS Council meetings, I was also given an opportunity to introduce myself and the reason why I participated in those meeting, which was to learn more about the AIDS Councils and how they operate or function. I also made verbal and written contributions like everybody else during the policy development processes in which I participated. Throughout the data collection process, I had to keep myself in check not to dictate my views and opinions in the interviews, and to keep an open mind in order to capture new information (Bourke, 2014). I constantly reminded myself that the informants understood their work, challenges and successes, better than I did and that the exercise of interviewing them was to access their subjective views and perspectives (Bourke, 2014). I was curious and probed for the meanings of the narratives of the participants (Denzin and Lincoln, 2005). Therefore, rather than assuming the meaning of what was said, I often probed as follows: *"you have said that…, or did I hear you correctly when you said that…".* I probed in order to ensure that I do not impose my interpretation and understanding about what was said, but to learn from the participant's expert position (Berger, 2015). I was also cautious of potential biases when analysis the data, and made deliberate effort to stick to what was said by the participants by including quotes to support conclusions drawn from interviews and focus group discussions.

Chapter 5: Findings

This chapter presents a synthesis of research findings. The detailed findings of the study are presented in the three published papers that are attached as appendices (appendix 7, 8 and 9).

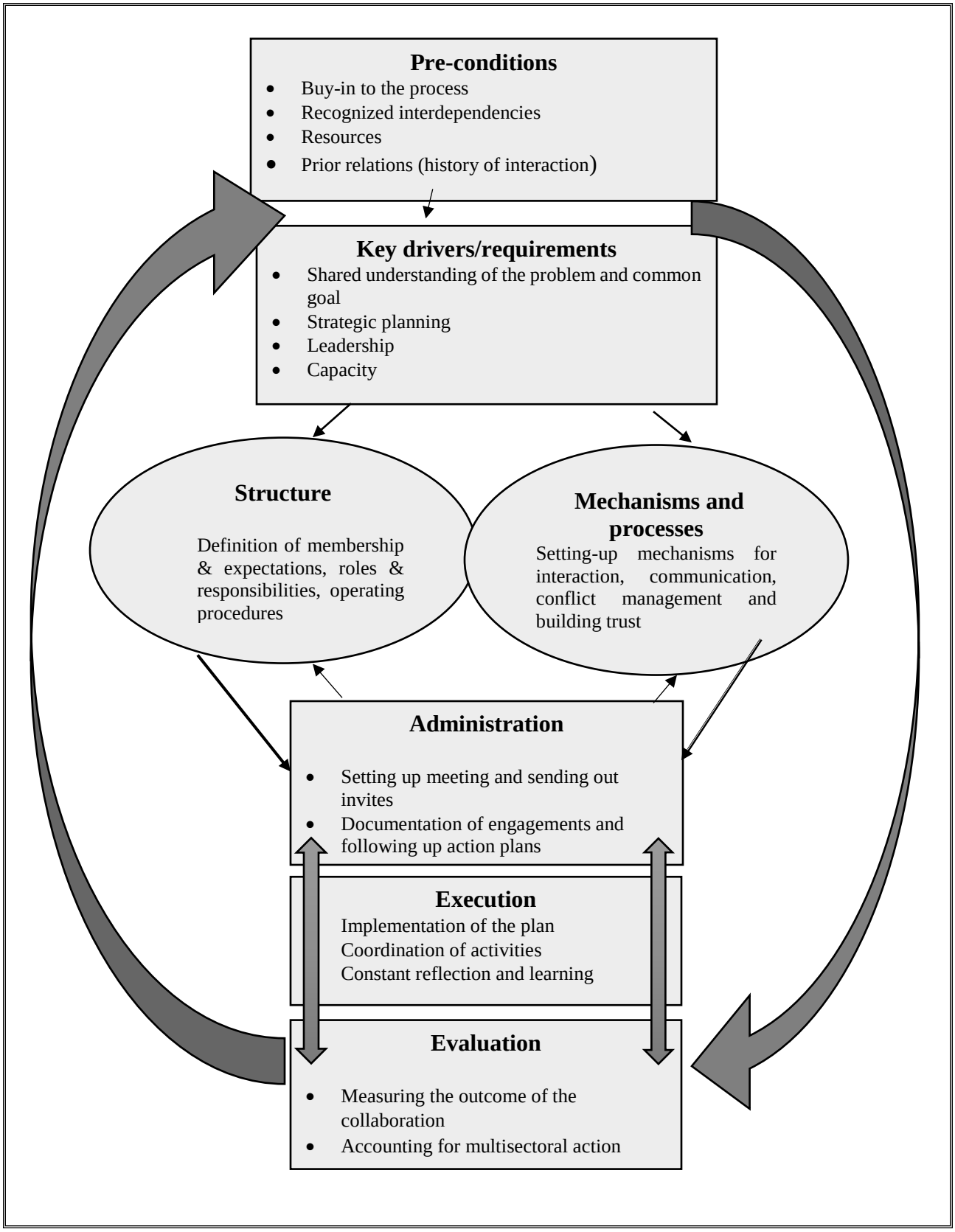
5.1 Synthesis of findings

Through the case study of the multisectoral response to HIV in South Africa, the research has shown that bringing together multiple sectors to work towards a common goal remains a challenge. It is not an end in itself, but a process that requires deliberate effort, and a structured process, which requires application of certain mechanisms in order to make it work. In paper 1 and 2 I have identified and discus the gaps that contribute to poor implementation of a multisectoral approach to HIV. In particular, paper 1 highlights the challenges experienced by the multisectoral governance structures (AIDS Councils) who are meant to coordinate implementation of the multisector approach at national, provincial and local level. The paper indicates that a lack of capacity and a lack of enabling environment hinders effective implementation of the multisectoral approach. Limited resources, lack of political support, and lack of a framework to inform the implementation process also limited effective implementation. As a result of these, and other factors, AIDS Councils, mostly at subnational level, were found to be weak and not able to function optimally. The design of the structure and how it operates has a major influence on the overall outcome of the collaborative. Paper 1 further sets out the critical governance principles that are required for effective governance of HIV, and begins a discussion about the value-add of AIDS Councils in the multisectoral approach to HIV (Paper 1).

Paper 2 reflects on the HIV mainstreaming approach, assessing its ability to augment multisectoral action on the response to HIV. It assesses progress made in mainstreaming HIV both in health and in non-health sector departments, exploring factors that have enabled and hindered the process. Complexities of a Whole of Government approach to HIV are highlighted, in particular, documenting factors that both enabled and hindered vertical coordination between levels of government, and horizontal collaboration between departments. Unlike in the past where HIV was an issue that only concerns the department of health, non-health sector departments are now involved in the response to HIV, have integrated HIV in their policies and programmes. The challenge is that some are still working in silos and that limits the mainstreaming approach to fully augment the multisectoral approach to HIV in South Africa. The research has indicated that both coordination and collaboration are critically important in facilitating an effective Whole of Government response to HIV. Thus, a model aimed to strengthen a whole of government response to HIV is proposed. It consists of a three-step process which not only encourages integration of HIV in policies and programmes of non-health sector departments, but coordination and collaboration on the HIV response. The model proposed in paper 2, aims to take forward the mainstreaming approach, and its contribution to the multisectoral approach to HIV.

Drawing from the findings from paper 1 and 2, and the synthesis of existing frameworks, models and approaches on multisectoral action which has been done in paper 3, I propose a framework for multisectoral and multilevel collaboration (see Figure 4). The framework describes seven key components critical in a process of multisector collaboration: preconditions, key drivers, mechanisms, structures, administration, execution and evaluation.

Figure 4: Framework for multisectoral and multilevel collaboration



The framework draws from the multidisciplinary literature in public health, governance in health and in public administration, making it unique and dynamic to engage with the complex challenges of modern society, including the social and structural drivers of HIV. The diagrammatic representation of the structure and process of multisector collaboration makes the framework to be easy to understand, approaching collaboration as a process that allows for learning and improvement, given that there is continuous monitoring and reflection on the outcome through-out the process.

Together, the findings of the research, presented in the three papers, not only have implications on how we understand the phenomenon of multisectoral action in theory, but on how we should approach implementation of the multisectoral collaboration in practice, which is currently poor in most LMICs. Paper 1 and 2 offered a qualitative set of evidence explaining the reason behind poor implementation, which contributes to the literature about the complexities of multisectoral action. Paper 3 contributes to the literature aimed to find ways to make MSA work given, its challenges. The proposed framework adds to the gaps in the existing literature on frameworks, models and approaches to MSA, and speaks to practice, outlining the process that needs to be followed to enhance implementation. Its contribution is also reflected in the suggested recommendations which are aimed to strengthen implementation of the multisectoral approach to HIV in South Africa which has been used as a case study in this research. The proposed recommendations are not only limited to South Africa, but can be implemented in other similar settings.

5.2 Thesis themes

From the synthesis of the findings of the research presented in the three papers, four themes emerged: (1) governance of HIV; (2) challenges in implementing a multisectoral approach; (3) designing, implementation and sustaining multisector collaboration process in practice; and (4) beyond HIV to other complex health and development issues. The themes will be further discussed in chapter 6. Table 5 presents the thesis themes and show how the research themes connect to the three papers.

Table 5 : Thesis themes and the original papers

Theme	Paper I AIDS Councils and their experience in implementing a multisector approach	Paper II Mainstreaming of HIV and its contribution in augmenting a multisector approach	Paper III Framework for multisector and multilevel collaboration
1. Governance of HIV	Limited focus on processes and mechanisms of governing beyond establishment of governance structures: • lack of representation and perceptions of inequality between sectors; • poor relations and power dynamics between sectors; • lack of political leadership and support at local level; and budget constraints (unfunded mandate)	Cross cutting impact of HIV, threatening effective functioning of government departments Struggle to integrate HIV to service delivery planning and budgeting processes in some Lack of accountability or punitive measures to enforce compliance Success on TasP and 909090 requires adherence to treatment (adherence dependent on a number of social and structural factors that cannot be addressed by one sector acting alone	Key principles of good governance essential in implementation of the multisectoral approach

Theme	Paper I AIDS Councils and their experience in implementing a multisector approach	Paper II Mainstreaming of HIV and its contribution in augmenting a multisector approach	Paper III Framework for multisector and multilevel collaboration
2. Challenges in implementing a multisector approach at multiple levels	AIDS Councils experience number of challenges limiting effective implementation of multisector approach: a lack of capacity amongst members; national level structure is weak and cannot provide needed support; lack of guiding framework to inform establishment and functioning of the structure (SoPs); membership is continuously changing, affecting continuity; and lack of decision making powers amongst representatives of organisation	Implementation of Whole of government approach in SA has been weak: Poor coordination within and poor collaboration between departments Unclear roles and responsibilities between departments Poorly coordinated reporting systems Lack of participation in IGR structures and in ACs	Table 1 and 2 in the Framework makes recommendations to address the challenges
3. Design of multisector collaboration process in practise	The current model of AIDS Councils is not effective	The call for all government to mainstream HIV is idealistic (poor fit for departments' mandate does not fit neatly Not all government departments should be involved in external mainstreaming (Call for rethinking of the Whole of government approach to HIV in SA) A model to take forward a mainstreaming approach that will make a positive contribution on the multisectoral approach is suggested	Framework for multisector and multilevel collaboration Recommendations to inform the MSA in practice are proposed through the framework that has been developed. Drawing from the work, recommendations to strengthen South Africa's multisector response to HIV are proposed
4. Beyond HIV	MSA is necessary and possible (a thorough pre-analysis/reflection needs to be done before a decision to engage in it is taken)	Current silo approach to mainstreaming does not augment whole of government response and limited in its ability to augment MSA: strategy to encourage and incentivize collaborations required	MSA is challenging and not a panacea, effective implementation should be a structured process, informed by context

Chapter 6: Discussion

The thesis themes have been used to organise this discussion chapter. I start by discussing the four thesis themes (governance of HIV; challenges in implementing a multisectoral approach; designing, implementation and sustaining multisector collaboration process in practice; and beyond HIV to other complex health and development issues) and how they relate to the literature. The chapter proceeds by a discussion of the implications of the research findings to theory, policy and practice; and concludes by highlighting the limitations of the research. As a whole, the research contributes to the body of literature about the complex process of multisectoral action, and makes recommendations aimed to strengthen its implementation in practice.

6.1 Governance of HIV

The link between governance and HIV has become more widely understood and acknowledged (Kar, 2014). There are published reviews on the impact of the epidemic and the demand it places on government services, including how government is affected, due to increase in the number of AIDS related deaths amongst employees (De Waal, 2003, Poku, 2011). Others have emphasised the critical role of (good) governance on the efforts to control the prevalence and address the impact of HIV (Putzel, 2004b, Whiteside, 2002).

Our research has indicated that governance remains key in improving the response to HIV and AIDS. In line with the literature, our findings highlighted the importance of effective governance to accelerate the response to HIV (Godsäter and Söderbaum, 2017, Kar, 2014). Political commitment, sufficient investment of financial resources, and having a political champion driving

the agenda of multisectoral action on HIV were some of the key governance factors to facilitate effective implementation of MSA. While the study has highlighted these essential governance factors, we found that they were lacking in some levels of government. Our data has highlighted challenges at district and local level where political commitment, leadership and resourcing of multisectoral response is poor, slowing down effective implementation. While the interconnection between HIV and governance seems to be established at national level in South Africa, its operationalization at lower levels of government remains a challenge. Focus has mainly been on establishment of multisectoral governance structures, with no support to facilitate optimal functioning. Multisectoral governance structures with representation from government, the private sector and civil society were established to coordinate the multisectoral response to HIV. However, established with a limited focus on governance processes and mechanisms to ensure that they effectively function, particularly at district and local level of government. As a result, implementation of the multisectoral approach to HIV was lagging at subnational. This research has highlighted that governance of HIV is not only about establishment of structures which constitute various sectors; but is also about setting-up processes and mechanisms to facilitate effective collaboration and working relations between sectors. What I call, key governance considerations for multisectoral action.

The findings presented in paper 1 have highlighted governance considerations required to facilitate multisectoral action on the HIV response. These include making the process participatory for all – where all sectors are valued and their contribution recognized, capacity building and empowerment of individuals that are representing sectors, resourcing of the structure, building trust and good relations between sectors, and accountability. Collaborative structures that function outside of

these key governance considerations are likely to fail to achieve the purpose which they are set-up for. The multisectoral approach to HIV was implemented without systems put in place to enforce compliance and accountability at provincial and local level, which we argue are also key governance considerations for effective implementation of a multisectoral approach to HIV. Because of this limitation, there was no commitment to implementation of the multisectoral response to HIV, with some local AIDS Councils being established with no plans to inform their work. Some were just getting-by, without structured plans detailing objectives, activities, and a monitoring, evaluation and reporting framework. As a result, a number of activities that were undertaken as part of the response to HIV at local level were not included in the NSP progress report, yet so much work is been done.

Through this theme, the research reiterates the importance of governance in the HIV response, and how it should be approached. Governance in the HIV response describes three critical components: governance structure, processes and mechanisms. Governance is not only setting-up structures constituted by government and non-government sectors; equally important are the mechanisms and processes – that are essential to facilitate collaboration between sectors. Similarly to what has been found in other studies, the research confirms that leadership is the most important element in governance of HIV (Kickbusch and Gleicher, 2012, Putzel, 2004b). Other critical considerations include setting-up processes and mechanisms to ensure good working relations between sectors such as building trust and defining communication and conflict resolution plans. This research has also highlighted the importance of ensuring that leadership in multisector collaboratives should be associated with both an individual and the institution (sector), for continuity, in case the individual resigns from the sector they are representing.

Governance is also embedded in context (Barten et al., 2010). It should not be seen as something that is universally applicable nor a one-size fit all (UNDP, 2014). As a governance process, multisectoral action is not spared from the contextual influences in which it is implemented (Emerson et al., 2012). The contextual factors such as the political and policy environment can present as a barrier or an enabler to effective implementation of the multisectoral approach. Thus, it is important that the governance considerations proposed in this research are interpreted and aligned in context to which they are applied. The context in which these considerations are applied would, to an extent, determine their effectiveness (or not) in strengthening multisectoral action on the HIV response.

While deliberations about governance and HIV are not unique to this study (De Waal, 2003, Putzel, 2004b, United Nations, 2001, Kar, 2014), it is important that we continuously reflect. Governance is a dynamic process that changes over time (Barten et al., 2010). It is crucial that our thinking about governance of HIV adapts and aligns with the developments in the global response to HIV. Rethinking about governance of HIV undertaken in this PhD is timeous, as we engage with advances in the approach to HIV prevention, particularly in the context of TasP, the 90-90-90 and the SDGs. It is an era that requires advocacy and reinstating the crucial role of non-health sectors in the response to HIV. The prevention focus of TasP and the 90-90-90 approaches should not shift focus and the need to involve non-health sectors in the global response to HIV. Addressing the social and structural drivers of the epidemic remains critical and should be integrated and find space in the prevention focused TasP and the 90-90-90 approaches.

6.2 Challenges in implementing the multisector approach

This research has noted that multisectoral action is used synonymously with many other concepts that are used in various disciplines. While the terms are different, they all refer to the process of bringing together two or more distinct sectors to work together towards a common goal. There is no confusion about what MSA means in theory. But this research highlights enormous challenges in implementation of MSA in practice. Bringing together government, civil society and the private sector to coordinate implementation of the multisectoral response to HIV in South Africa was characterised by a number of challenges. I have found that there was no guiding framework to inform the setting-up and operation of AIDS Councils. Lines of accountability were unclear. Members did not have all the necessary skills to enable them to make a meaningful contribution. Some sectors were represented by junior people, with no authority to make decisions or implement resolutions from AIDS Council meetings in their organisations. There were no systems to enforce commitment from members, which compromised continuity and progress, given the short 5-year time frame of the NSP. We also found that AIDS Councils do not have legitimacy to hold other stakeholders, that are meant to be involved in the responsible to HIV, accountable. A necessary requisite for someone or a group that is meant to undertake a task of coordination. The current model of funding AIDS Councils, through municipalities is also a challenge. Municipalities have other competing priorities. HIV and AIDS is either allocated a limited budget, or is an unfunded mandate in some municipalities.

These challenges were also reported amongst NACs in other countries in Africa (Kenya, Ghana, Tanzania, Zimbabwe and Lesotho) where location (either in the President's Office, Premier's Office or Ministry of Health), funding, poor monitoring and evaluation systems and lack of clarity

on roles and functions limited their ability to optimally coordinate the multisectoral response to HIV (Hongoro et al., 2008, Munro, 2008). The research conducted by the Centre for Municipal Research and Advise in South Africa found that some AIDS Councils are unclear of their mandate, as a result, they struggle to advise, support and strengthen local government in their response to HIV (Maredi, 2011, Versteeg, 2008). The literature also shows that the challenges of multisectoral action observed in this study are not unique to HIV, but also noted in multisector collaborations aimed to address other issues (Wickramasinghe et al., 2018).

While this research confirms findings from other research regarding the challenges of MSA, data from this study has highlighted that the extent of the problem is even more exaggerated amongst AIDS Councils at sub-national level of government (districts and local municipalities). For example, capacity and resources was not indicated as a challenge at the national and provincial AIDS Council but an issue at district and local level. What this research and others have also shown is that while MSA is a required ideal, its implementation in practice is complex. MSA aims towards a difficult ideal bringing together sectors with differing institutional logics, interests and values (Rasanathan et al., 2017, Bryson et al., 2006, Huxham et al., 2000). What was unique in the pointing of the challenging nature of implementing MSA in this study is that it highlighted how the process even gets more complicated at lower levels of government, where there are limited skills and capacity for coordination, and multisectoral structures out-numbered by civil society sector with limited involvement of other sectors, there is lack of clarity about the process, and a lack of enabling environment to facilitate effective implementation.

Different views are documented in the literature about MSA. In their reflection, others argued that collaboration represents an ideal to which we aspire but sometimes fall short of achieving" (Thomson and Perry, 2006). Because of the challenging nature of implementing MSA in practice, Huxham and Hibbert (2008) questioned whether the multisectoral approach should be adopted at all in addressing challenges in society. On the contrary, optimistic views were also expressed about MSA. There are those that argue that MSA is the only the approach that allows for addressing issues in an integrated manner, drawing from resources, capacity and skill of various actors (Hardy et al., 2006, Gavian et al., 2006). Others have proposed that other alternative methods should be exhausted first, and that sectors should collaborate when there is some kind of collaborative advantage to be gained (Huxham and Vangen, 2005).

While this research has noted the challenges of implementing a multisector approach, i assert that MSA is key in addressing the complex societal issues. Only through multisectoral action can we effectively address the upstream causes (social and structural drivers) of ill-health (of HIV). As noted by others, MSA is not a panacea (Huxham and Hibbert, 2008, Vangen et al., 2015). MSA is not only about establishing a multisectoral structure. It should be approached as a process that requires proper planning, and effort to make it work. The challenge remains in finding ways to address the implementation challenge to be able to tap into the full potential of MSA. As such AIDS Councils are still relevant. However, establishing them should not be seen as end in itself. In most countries in Africa, AIDS Councils need to be reconfigured. Efforts need to be invested in establishing systems and mechanisms for effective collaboration. Multisectoral action on HIV should be a structured and a well-thought through process for it to be effective. Considering the challenges that comes with collective action including the"free rider" risk that is likely to be

present in the process (Olson, 2009, Ostrom, 2007). Experiences of successful implementation of MSA in the literature note the importance of enabling environment at national level, ensuring that there are clear guidelines for engagement, capacity and resources for effective MSA (Juma et al., 2018). Findings from this study suggests that efforts to strengthen AIDS Councils should not only be focused at national level, but attention be given to sub-national level structures (district and local level) where the challenges are even exaggerated.

6.3 Design and implementation of multisector collaboration

The findings from this study challenge the assumption that the multiple stakeholders who engage in multisector collaboration know what needs to be done when they engage in collaboration. The findings also challenged the underlying assumption that establishment of multisectoral governance structures is an end in itself, and that it will produce intended outcomes without a clear guiding process. As a contribution to theory and practise, a framework for multisectoral and multilevel collaboration is proposed to inform the multisector collaboration process from conceptualisation to the end of the process (see Figure 4). The framework provides clarity about how multisector collaborations should be designed; how implementation should be undertaken, and informs monitoring and evaluation of the of the process. The research contributes to the currently existing gap in the literature about conceptualisation, planning and implementation of multisector collaboration as cited by several scholars (Glandon et al., 2018, Bryson et al., 2006, Thomson and Perry, 2006).

The findings indicate what should be the key elements in the design of multisector collaborations, which are: buy-in from all actors involved, recognised interdependencies amongst sectors, resources, good relations, shared understanding of the problem, working towards a common goal, having a plan that will inform the process, and ensuring members of the collaborative have capacity to accomplish the task. Related to the design, the research has indicated the importance of leadership in collaboratives. Effective leadership inspires commitment and action (Woulfe et al., 2010). The research has also shown how lack of leadership hinders effective multisector collaboration in practice. Leadership in a multisectoral collaborative should not be a 'government only' task, but a shared responsibility across sectors. The literature supports the notion of shared leadership as a key factor that sustains collaboratives (Rasanathan et al., 2018).

Given the limited leadership capacity identified in the study context and in many other similar contexts, shared leadership will require building leadership capacity across sectors and levels of government (Rasanathan et al., 2017). Effective multisector action requires a shift from only having a government sector in the leadership role, which can create an impression that the collaborative is a government dictated initiative. Governance is about moving away from having government being the dominant actor, but establishing a working relationship between all sectors, as equally important stakeholders.

Different conceptions exist in the literature about structure in multisector collaboratives (Sedgwick, 2016, Bryson et al., 2006). Definition of membership, and specification of roles and responsibilities as critical structure components in multisector collaboratives. Accountability becomes blurry and a likelihood of shifting responsibility when roles are not defined (Rasanathan

et al., 2018, Boston and Gill, 2011). Findings from this research has indicated that effective multisector collaboration requires that processes and mechanisms of communication, conflict resolution, decision making and managing power imbalances need to be predefined. Failure to do so impacts on commitment and ownership of the process. The research has also confirmed the interconnectedness of structure and process, and how each cannot be effective in facilitating multisectoral action without the other (Bryson et al., 2006). Structure without defining mechanisms and processes for effective multisectoral action is insufficient, while mechanisms and process will not be effective without a well set-up structure.

Implementation of multisectoral action should be a planned and a structured process, and not expected to just happen as a result of establishment of the multisector governance structure. Stakeholders involved in multisector collaboration should engage in a process and invest efforts to make MSA to work. Otherwise, it becomes structure without function. Our data has shown that resources are a critical enabler for effective implementation of MSA (Juma et al., 2018). Resources critical in multisector collaborations includes both human resource and financial resources (Woulfe et al., 2010). Multisectoral structures that had limited resources in our research struggled to function optimally, with data highlighting problems with a single sector funded collaborative initiative. A joint financing model that is not only dependent on a government sector is needed to sustain multisectoral collaboration. This was similarly found in other studies which noted that co-financing, human resource and integrated tracking system were key areas to facilitate implementation of the multisector approach in other settings (Zaidi et al., 2018).

Given the limited clarity about measuring outcome of multisector collaboration in the literature, findings from this research emphasise the importance of making monitoring and evaluation of multisector efforts to be a continuous and not a once-off process only undertaken at the end. We have learned from the research how M&E becomes a challenging if it is not imbedded in the planning and the design of multisector collaborative. Addressing this challenge requires a culture shift away from silo competitive approach to embracing integrated effort in health and development work.

This PhD has also highlighted that bringing together two or more sectors to work towards a common goal is a task that requires internal administration of the process. It is a task that needs dedicated people to do it. This research has shown how some collaboratives struggle to function effectively where there was no dedicated person to undertake internal coordination and to ensure that the collaborative operates smoothly. Administration of the collaboratives is supported in the literature, indicating the need for backbone support, and that such people need a certain skill to be effective (Hanleybrown et al., 2012).

A framework for multisectoral and multilevel collaboration has been developed in this PhD (See Figure 4). It can be used to inform design, implementation, monitoring and evaluation of multisectoral collaborative. The framework contributes to the existing gap and need for guidance on " MSA execution in practice" across "multiple levels". While the framework can be adapted for similar settings, it can be used to inform practice amongst AIDS Councils involved in implementation of the multisector response to HIV in South Africa. The framework shows how a generic set of ideas can be adapted for practice.

However, it is important to note that frameworks are representation of reality, and not reality itself. Their application to specific issues and context requires translation. Like other framework, the framework proposed in this study would require translation and application to a specific issue and context. Furthermore, because of the diversity of multisector collaboratives in practice; design should be informed by context (Bryson et al., 2015). Mapping of the profile of actors involved, including strengths and resources they bring to the collaborative is also essential (Rasanathan et al., 2017). Willingness to collaborate is central to the process. Negotiation, which requires good communication and listening skills is critical in all stages of multisector collaboration (Koschmann et al., 2012). Table 6 informed by the framework proposed in this research, makes recommendations about that can be used to strengthen implementation of the multisectoral response to HIV South Africa. The table describes a synthesised set of constructs from experiences of AIDS Councils in South Africa, thus providing ideas that can be adapted for practice.

Table 6: Mapping South Africa's multisector response to HIV and AIDS

	Guiding questions/statements	**What is needed**	**What will it take to achieve**
Preconditions	How to encourage recognised interdependencies	Platform for interaction and engagement for improved collaboration on programmes within government and between sectors	Strengthening IGR structures to enable effective whole of government approach, and structures that bring together government with non-government sectors to allow for an effective whole of society approach
	How to encourage buy-in	Framing of the issue which the collaborative aims to address critical. Sectors should also see how they will	Proper framing, clear communication of the problem

	Guiding questions/statements	What is needed	What will it take to achieve
		benefit, and participation be based on comparative advantage instead of involving everyone	
	What funding model should be used	Co-funding/ contribution to the response by all actors involved, based on the comparative advantage	All actors including civil society and the private sector pulling their weight
	Type of relations needed	Characterised by equality and respect for others and their views, and embracing the concept of ones instead of rivalry	Investing of time and effort to build relations between sectors instead of making implicit assumptions about non-existent good relations
Key drivers/ requirements	How to arrive at shared understanding of the problem and common goal	There should be a process of negotiation, debating and clarification of expectations of sectors in relation to the mandate of the AIDS Council	Open negotiation and engagement process that is formalised and facilitated
	Strategic planning	Time should be set aside by all levels of AIDS Councils to develop their plans defining the goals, activities and M&E and reporting framework at the beginning of the collaborative	Empowering AIDS Council members with skills on strategic planning, and holding them accountable to ensure all are operating on a defined plan
	What form of leadership is needed	The leadership role should be rotated between sectors. Undertaken by an individual with credibility who will act in this role, committing both him/her and his/her organisation for continuity The currently used model of political leaders sharing AIDS Councils is good practice but the role should be rotated to other sectors	Building leadership skills across sectors to ensure a pool of good leaders across sectors
	What capacities are needed	Dialogue and negotiation skills to allow deliberations; coordination, M& E and reporting skills	Continuous training to build capacity and polishing the skill through practice
Structure	How should the governance structure be set-up and operate	• Defined membership including roles and responsibilities of individuals and sectors for accountability • Clear SOPs that will inform day to day interaction	A guiding framework to inform the setting-up and operation of AIDS Councils

	Guiding questions/statements	What is needed	What will it take to achieve
Mechanisms	What collaboration mechanisms are critical for effective multisector response to HIV	• Regular interaction that is planned • Effective communication and conflict management strategy and approach to address power dynamics • Being intentional about building trust, celebrating small achievements throughout the process	A credible and multisector agenda driven leader who will champion and oversee the process based on principles of good governance including participatory and transparent decision making, respect and equality of voice
Administration	How should the administration of the AIDS Council be undertaken	Appointment of an administrative team that will do internal coordination of the collaborative, working together with the leader; • Lead the process of development of the strategy or plan defining the aim and activities, and an M&E framework with clear indicators and targets • Convene the actors and making logistical arrangements • Document meetings, and follow-up action plans • Drive the monitoring, evaluation and reporting process • Documentation of engagements and following up action plans	Skilled, and remunerated cadre of people who will dedicate time to do the task, which cannot be done by volunteers
Execution	What are the key activities during implementation of the plan	• Overseeing the process to ensure that stakeholders are delivering on what is expected of them and that there is no duplication of activities • Conduct monitoring to reflect, learn and to adjust and realign activities as required	Commitment from all sectors involved, and a credible leader who will oversee the process

	Guiding questions/statements	What is needed	What will it take to achieve
Evaluation	How should AIDS Councils be assessed, and how should they account	• Contribution of the structure in achieving the goals of the NSP should be assessed at mid-term and at the end of the NSP process • Sectors should be accountable on their, linked to their role and contribution. This should be done on a quarterly basis, with annual reflection, and overall assessment at the end of the NSP process after five years.	An involved national level structure that will oversee the process and capacitated sub-level structures (with representation from sectors that are) capacitated to undertake M&E and reporting.

6.4 Beyond HIV to other complex health and development issues

MSA is not only a key strategy for addressing HIV and AIDS, but also many other complex health and development challenges. These include non-communicable diseases, nutrition, child and maternal health, climate change, poverty and other issues (Sekamatte et al., 2018, Aarts et al., 2011, Rasanathan et al., 2015, Östlin et al., 2006, Jerling et al., 2016, Juma et al., 2018). While the scope and nature of these issues differ, all of them are attributable to underlying social drivers and risk factors that lie outside the control of one sector, and require integrated effort of multiple sectors.

Key findings, and lessons learned from the case of HIV in this study is relevant and applicable to other health and development issues that are listed above. The framework for multisectoral and multilevel collaboration proposed in this research can be used to inform and guide the MSA process in nutrition, non-communicable diseases, child and maternal health, climate change and other issue, from design to evaluation of the process.

6.5 Theoretical contributions

Through a reflection on South Africa's experience on implementation of the multisectoral approach, this doctoral research fills the gap in the literature where little is known regarding where to focus in supporting implementation of MSA in practice. Similar to what others have found, this research highlights complexities of implementing a multisectoral approach in practice. The research has documented challenges involved in bringing together government, civil society and the private sector to work towards a common goal. Paper 1 documents the issues which includes amongst others poor planning and design of the structure, lack of leadership and a framework that will guide the process, power issues in the relationship, and the lack of trust amongst the sectors involved. The challenges of multisectoral action were further discussed in Paper 2, which makes a contribution regarding strengthening a whole of government approach to HIV (as a key component of MSA), noting the critical role of coordination and collaborations within government for an effective government multisector response to HIV.

The PhD also contribute to the literature on governance of HIV, in particular, proposing essential governance considerations for an effective multisectoral response to HIV. While governance has been mostly considered as a political term with not much connection to the public health discipline, the multidisciplinary approach to the concept of MSA, adopted in this doctoral research, has highlighted the important role of good governance to support effective implementation of MSA. The research suggests that establishment of multisector governance structures (e.g. AIDS Councils) by itself, is not multisectoral action. AIDS Councils are a structure or a vehicle for multisector action. Establishment of these structures (AIDS Councils) alone is not adequate for multisectoral action, but requires that governance mechanisms and processes are defined and

effected to make multisector collaboration to work. Multisectoral collaboration does not just happen as a result of setting-up multisectoral governance structures; it requires deliberate planning and investment of efforts to make it achieve what the process is set-up to achieve

This doctoral research also contributes insights on how multisectoral action should be approached in practice. MSA is not an end in itself, but a process that requires intentional and structured planning from design, implementation and evaluation. It should be approached as an iterative process that will require flexibility, learning and modification, and be informed by the context in which is implemented. A framework that was developed to inform the process of multisectoral and multilevel response to HIV in Paper 3 is also a key theoretical contribution of this doctoral research. It fills a gap that has been documented in the literature about the need to develop MSA frameworks that are specific to low and middle-income countries. Scholars have argued that the body of literature regarding frameworks and approaches to MSA has most entirely focused on high income countries (Bennett et al., 2018, Rasanathan et al., 2017). Drawing from the data collected from the South African context, the framework can also be used to inform other LMICs similar to South Africa.

6.6 Implications for policy and practice

The study has not only reflected on the process of multisectoral action and highlighted the challenges thereof, the framework proposed in this research can be used by policy makers and practitioners to inform their work. The framework provides a road-map to help navigate the complex process of multisectoral and multilevel collaboration. Policy makers and practitioners can

use the framework to inform design, implementation, monitoring and evaluation of multisectoral collaborations. As noted in this research and by others, the framework does not suggest that multisector collaboration is easy. The findings suggest the need for more deliberations, and to find innovative ways to make multisector collaborations to work, given that no one sector can adequately address the complex health and development challenges of the 21st century.

The visual description of the framework (Figure 4) and discussion of the process of multisector collaboration provides a tool that can be easily used by practitioners to inform their day to day work. One of the key lessons from this study was that political leadership and support creates an enabling environment for effective implementation of MSA. Going forward policy makers need to consider this crucial role and be sensitised on how the governance decisions adopted could hinder or facilitate effective implementation of MSA in practice. This finding points to an urgent need to develop capacity of political leaders who understand and support MSA and its connection to good governance of HIV. While the focus of this doctoral research is on HIV, the policy implementation issues discussed in this work are also applicable to other health and development issues. Recommendations from this work can be used to inform policy makers working on other issues beyond HIV.

6.7 Study limitations

The study was conducted following qualitative research methods which provided rich contextual data from the perspective of the actors involved in the MSA process. However, the study would

have benefitted from utilisation of a mixed-methods approach which would have allowed for triangulation drawing from both quantitative and qualitative data.

The use of the case study methodology employed in this research limits ability to generalize the findings of the research. While the detailed analysis of the three districts within Mpumalanga province provides rich data for the PhD, I also acknowledge that I will not be able to generalize the findings across all the nine provinces in South Africa. The focus on one province does not allow for comparison to see how the implementation is undertaken in other provinces in South Africa.

While the research aimed to reflect on the process of MSA, failure to reflect on the outcome is a limitation. The research could have benefitted from data that would have been collected at the end of term of the NSP to reflect on the outcome of the process from the perspective of policy-makers. This would have provided more information that will enhance our understanding of the process, including what worked and did not work.

This research has proposed a framework which was further applied in Table 6 which describes a synthesised set of constructs from experiences of AIDS Councils in South Africa. The table provides ideas on how the framework can be adapted for practice amongst AIDS Councils in South Africa. This level of specificity is only limited to AIDS Councils and has not focused on other issues, given the focus of the research on HIV and AIDS.

Chapter 7: Recommendations and Conclusion

7.1 Recommendations

The SDGs have ushered the renewed interest for multisectoral action and present as a window of opportunity for strengthening implementation of the multisector approach to a wide range of development and health issues. However, research has shown that most multisector collaboratives are poorly implemented in practice, with very few that have been effective in achieving their goal. There are three major recommendations that have emerged from this this study. Firstly, strengthening governance of HIV, which includes finding innovative ways to support implementation and to make multisectoral collaborations to work effectively is needed. This requires going-back to the principles of good governance including participatory and transparent decision making, equality and respecting of the views of all sectors, effective communication, conflict resolution, accountability and other critical principles. Effective governance of HIV will ultimately strengthen efforts to address the social and structural determinants of HIV, a necessity in achieving the goal of ending AIDS by 2030.

Secondly, there is a need to support implementation and address challenges of MSA in SEA through building capacity of those that are involved in its implementation in practice. Focus should be directed at subnational level (districts and locals), where multisectoral governance structures entrusted with coordinating multisector collaboration processes have limited capacity and skills, and there is lack of an enabling environment to facilitate effective implementation of the multisectoral approach.

Thirdly, there is a need to invest efforts to test existing frameworks, including the one proposed in this PhD, which can be used to inform the process of MSA theory development. Currently, there is no theory, that we know of, to study MSA, and this is a gap to be addressed in future research.

7.2 Conclusion

The opportune policy window for MSA is extensive, and recently reinvigorated by the SDGs which aims achieve health and development outcomes through an integrated approach. What is currently lacking is support for implementation of the multisectoral approach. This research and many other studies have shown that implementing a multisectoral approach is challenging, and that we have not done enough to overcome the complexities that are involved in its implementation. We argue in this research that focus has mainly been on establishment of multisectoral structures, and a neglect of key governance mechanisms and processes, which if considered, would facilitate effectiveness multisectoral action. Establishment of multisectoral structures (AIDS Councils) to coordinate implementation of the multisectoral approach has been the main focus in many LMICs (including South Africa), with not much attention to the process of multisectoral action. Unfortunately, the research has shown that these structures experience a number of challenges that impact on effective implementation of a multisectoral approach.

As a contribution to the literature, policy and practice, a framework for multisectoral and multilevel collaboration has been developed to inform the MSA process. The framework describes seven elements that are proposed to increase the likelihood of successful multisector action. Contrary to existing frameworks which adopt a silo disciplinary approach, the framework proposed in this research draws from the multidisciplinary literature in public health, governance and health and

public administration. The framework can be used as a guide for both policy makers and practitioners that are involved in implementing multisectoral approaches to address complex health and development challenges.

The lack of a theory specific to multisectoral action that has been found in the literature during the time when this study was conducted presents as a gap and a focus for future research. Theoretical conceptualisation of multisectoral action is needed to advance knowledge and understanding of the phenomenon of multisectoral action, building from the existing theories of collective action. Future research is also needed to deliberate on multisectoral collaboration outcome using longitudinal and prospective design to advance knowledge of the process of MSA.

References

AARTS, M.-J., JEURISSEN, M. P., VAN OERS, H. A., SCHUIT, A. J. & VAN DE GOOR, I. A. 2011. Multi-sector policy action to create activity-friendly environments for children: a multiple-case study. *Health Policy,* 101**,** 11-19.

ANSELL, C. & GASH, A. 2008. Collaborative governance in theory and practice. *Journal of public administration research and theory,* 18**,** 543-571.

ASHBURN, K., KERRIGAN, D. & SWEAT, M. 2008. Micro-credit, women's groups, control of own money: HIV-related negotiation among partnered Dominican women. *AIDS and Behavior,* 12**,** 396-403.

ATIENO, O. P. 2009. An analysis of the strengths and limitation of qualitative and quantitative research paradigms. *Problems of Education in the 21st Century,* 13**,** 13-38.

AUERBACH, J. D., PARKHURST, J. O. & CÁCERES, C. F. 2011. Addressing social drivers of HIV/AIDS for the long-term response: conceptual and methodological considerations. *Global public health,* 6**,** S293-S309.

BARTEN, F., AKERMAN, M., BECKER, D., FRIEL, S., HANCOCK, T., MCGRANAHAN, G., MWATSAMA, M., RICE, M., SHEUYA, S. & STERN, R. 2010. Governance for Health Equity in Urban Settings. Global Research Network on Urban Health Equity.

BAUM, F. & LARIS, P. 2010. Improving health equity: action on the social determinants of health through Health in All Policies. *In:* KICKBUSCH, I. & BUCKETT, K. (eds.) *Implementing Health in All Policies: Adelaide 2010.* South Australia: Department of Health, Government of South Australia.

BENNETT, S., GLANDON, D. & RASANATHAN, K. 2018. Governing multisectoral action for health in low-income and middle-income countries: unpacking the problem and rising to the challenge. *BMJ global health,* 3**,** e000880.

BERG, B. L., LUNE, H. & LUNE, H. 2004. *Qualitative research methods for the social sciences,* Pearson Boston, MA.

BERGER, R. 2015. Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative research,* 15**,** 219-234.

BONNER, A. & TOLHURST, G. 2002. Insider-outsider perspectives of participant observation. *Nurse Researcher (through 2013),* 9**,** 7.

BOSTON, J. & GILL, D. 2011. Joint or Shared Accountability: Issues and Options. Working Paper 11/03. Wellington, New Zealand: Institute of Policy Studies

BOURKE, B. 2014. Positionality: Reflecting on the research process. *The qualitative report,* 19**,** 1-9.

BOWEN, G. A. 2009. Document analysis as a qualitative research method. *Qualitative research journal,* 9**,** 27-40.

BRYSON, J. M., CROSBY, B. C. & STONE, M. M. 2006. The design and implementation of Cross-Sector collaborations: Propositions from the literature. *Public administration review,* 66**,** 44-55.

BRYSON, J. M., CROSBY, B. C. & STONE, M. M. 2015. Designing and implementing cross-sector collaborations: Needed and challenging. *Public Administration Review,* 75**,** 647-663.

BURNARD, P., GILL, P., STEWART, K., TREASURE, E. & CHADWICK, B. 2008. Analysing and presenting qualitative data. *British dental journal*, 204**,** 429.

CHEN, L., JHA, P., STIRLING, B., SGAIER, S. K., DAID, T., KAUL, R., NAGELKERKE, N. & INVESTIGATORS, I. S. O. H. A. 2007. Sexual risk factors for HIV infection in early and advanced HIV epidemics in sub-Saharan Africa: systematic overview of 68 epidemiological studies. *PloS one,* 2**,** e1001.

CHRISTENSEN, T. & LÆGREID, P. 2007. The whole-of-government approach to public sector reform. *Public administration review,* 67**,** 1059-1066.

CHRISTENSEN, T. & LÆGREID, P. 2008. The challenge of coordination in central government organizations: The Norwegian case. *Public organization review,* 8**,** 97.

COATES, T. J., RICHTER, L. & CACERES, C. 2008. Behavioural strategies to reduce HIV transmission: how to make them work better. *The Lancet,* 372**,** 669-684.

COMMONWEALTH SECRETARIAT 2003. Guidelines for implementing a multi-sectoral approach to HIV and AIDS in Commonwealth countries. London, United Kingdom: Commonwealth Secretariat Health section.

COOK, S., ZHANG, S. & YI, I. 2013. Health and development: challenges and pathways to HiAP in low-income countries. *In:* LEPPO, K., OLLILA, E., PE˜NA, S., WISMAR, M. & COOK, S. (eds.) *Health in All Policies: seizing opportunities, implementing policies.* Finland: Ministry of Social Affairs and Health

COPSON, R. W. & TIAJI, S. 2002. The Global Fund to fight AIDS, Tuberculosis and Malaria: Background and Current Issues. The Library of Congress: Congressional Research Service

CREPAZ, N., LYLES, C. M., WOLITSKI, R. J., PASSIN, W. F., RAMA, S. M., HERBST, J. H., PURCELL, D. W., MALOW, R. M. & STALL, R. 2006. Do prevention interventions reduce HIV risk behaviours among people living with HIV? A meta-analytic review of controlled trials. *Aids,* 20**,** 143-157.

DAHLGREN, L. E. & EMMELIN, M. 2004. M; Winkvist, A.(2004). *Qualitative methodology for international public health, Umea University: Print & media*.

DALY, M. 2005. Gender mainstreaming in theory and practice. *Social Politics: International Studies in Gender, State & Society,* 12**,** 433-450.

DE WAAL, A. 2003. How will HIV/AIDS transform African governance? *African affairs,* 102**,** 1-23.

DEAN, H. D., WILLIAMS, K. M. & FENTON, K. A. 2013. From theory to action: applying social determinants of health to public health practice. SAGE Publications Sage CA: Los Angeles, CA.

DENZIN, N. K. & LINCOLN, Y. S. 2005. *The Sage handbook of qualitative research*, Sage Publications, Inc.

DODGSON, R., LEE, K. & DRAGER, N. 2002. Global health governance: a conceptual review. United Kingdom Centre on Global Health

DORIA-ROSE, N. A., SCHRAMM, C. A., GORMAN, J., MOORE, P. L., BHIMAN, J. N., DEKOSKY, B. J., ERNANDES, M. J., GEORGIEV, I. S., KIM, H. J. & PANCERA, M. 2014. Developmental pathway for potent V1V2-directed HIV-neutralizing antibodies. *Nature,* 509**,** 55.

DWORKIN, S. L., TREVES-KAGAN, S. & LIPPMAN, S. A. 2013. Gender-transformative interventions to reduce HIV risks and violence with heterosexually-active men: a review of the global evidence. *AIDS and Behavior,* 17**,** 2845-2863.

EATON, J. W., JOHNSON, L. F., SALOMON, J. A., BÄRNIGHAUSEN, T., BENDAVID, E., BERSHTEYN, A., BLOOM, D. E., CAMBIANO, V., FRASER, C. & HONTELEZ, J. A. 2012. HIV treatment as prevention: systematic comparison of mathematical models of the potential impact of antiretroviral therapy on HIV incidence in South Africa. *PLoS medicine,* 9**,** e1001245.

ELLIOT, M. A. 2007. *Stigmergic collaboration: a theoritical framework for mass collaboration* Doctor of Philosophy, The University of Melbourne.

ELSEY, H., TOLHURST, R. & THEOBALD, S. 2005. Mainstreaming HIV/AIDS in development sectors: Have we learnt the lessons from gender mainstreaming? *Aids Care,* 17**,** 988-998.

EMERSON, K., NABATCHI, T. & BALOGH, S. 2012. An integrative framework for collaborative governance. *Journal of public administration research and theory,* 22**,** 1-29.

ENGLAND, R. 2006. Coordinating HIV control efforts: What to do with the national AIDS commissions. *The Lancet,* 367**,** 1786-1789.

ERLINGSSON, C. & BRYSIEWICZ, P. 2017. A hands-on guide to doing content analysis. *African Journal of Emergency Medicine,* 7**,** 93-99.

ESLEY, H. & KUTENGULE, P. 2003. HIV/AIDS mainstreaming: A definition, some experiences and strategies. London, United Kingdom Department for International Development.

FEREDAY, J. & MUIR-COCHRANE, E. 2006. Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods,* 5**,** 80-92.

FIGUEIREDO, A. D. 2008. Sustainability of E-Collaboration. *In:* KOCK, N. (ed.) *Encyclopedia of E-Collaboration.* United States of America: Information Science Reference.

FLEMING, P. J., DICLEMENTE, R. J. & BARRINGTON, C. 2016. Masculinity and HIV: Dimensions of masculine norms that contribute to men's HIV-related sexual behaviors. *AIDS and Behavior,* 20**,** 788-798.

GAVIAN, S., GALATY, D. & KOMBE, G. 2006. Multisectoral HIV/AIDS Approaches in Africa: How are they evolving. *In:* GILLESPIE, S., ED. (ed.) *AIDS, poverty, and hunger: Challenges and responses.* Washington, D.C.: International Food Policy Research Institute.

GIBBS, A., WILLAN, S., MISSELHORN, A. & MANGOMA, J. 2012. Combined structural interventions for gender equality and livelihood security: a critical review of the evidence from southern and eastern Africa and the implications for young people. *Journal of the International AIDS Society,* 15**,** 1-10.

GILSON, L. & RAPHAELY, N. 2008. The terrain of health policy analysis in low and middle income countries: a review of published literature 1994–2007. *Health policy and planning,* 23**,** 294-307.

GLANDON, D., MEGHANI, A., JESSANI, N., QIU, M. & BENNETT, S. 2018. Identifying health policy and systems research priorities on multisectoral collaboration for health in low-income and middle-income countries. *BMJ global health,* 3**,** e000970.

GODSÄTER, A. & SÖDERBAUM, F. 2017. Civil society participation in regional social policy: The case of HIV/AIDS in the Southern African Development Community (SADC). *Global Social Policy,* 17**,** 119-136.

GRABOWSKI, M. K., SERWADDA, D. M., GRAY, R. H., NAKIGOZI, G., KIGOZI, G., KAGAAYI, J., SSEKUBUGU, R., NALUGODA, F., LESSLER, J. & LUTALO, T. 2017. HIV prevention efforts and incidence of HIV in Uganda. *New England Journal of Medicine,* 377**,** 2154-2166.

GULATI, R., WOHLGEZOGEN, F. & ZHELYAZKOV, P. 2012. The two facets of collaboration: Cooperation and coordination in strategic alliances. *The Academy of Management Annals,* 6**,** 531-583.

GUPTA, G. R., PARKHURST, J. O., OGDEN, J. A., AGGLETON, P. & MAHAL, A. 2008. Structural approaches to HIV prevention. *The Lancet,* 372**,** 764-775.

HANLEYBROWN, F., KANIA, J. & KRAMER, M. 2012. Channeling Change: Making Collective impact Work. *Stanford Social Innovation Review***,** 1 - 9.

HARDIN, R. 2015. *Collective action,* London, Routledge.

HARDY, C., LAWRENCE, T. & PHILLIPS, N. 2006. Swimming with sharks: creating strategic change through multisector collaboration. *International Journal of Strategic Change Management,* 1**,** 96 - 112.

HELLEVIK, S. 2012a. *Multisectoral Coordination of HIV/AIDS Programmes. A Study of Tanzania.* Thesis submitted for completion of doctoral studies University of Oslo.

HELLEVIK, S. B. 2012b. The pattern and challenges to multisectoral HIV/AIDS coordination in Tanzania. *International Review of Administrative Sciences,* 78**,** 554-575.

HONGORO, C., MTURI, A. J. & KEMBO, J. 2008. Review of national AIDS councils in Africa: findings from five countries. *SAHARA-J: Journal of Social Aspects of HIV/AIDS,* 5**,** 192-200.

HUMAN SCIENCE RESEARCH COUNCIL 2018. The Fifth South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2017: HIV Impact Assessment Summary Report. Cape Town, South Africa: HSRC.

HUXHAM, C. & HIBBERT, P. 2008. Hit or myth? Stories of collaborative success. *In:* O'FLYNN, J. & WANNA, J. (eds.) *Collaborative Governance: A new era of public policy in Australia?* Australia: Australian National University E Press.

HUXHAM, C. & VANGEN, S. 2005. *Managing to collaborate: The theory and practice of collaborative advantage,* London, Routledge.

HUXHAM, C., VANGEN, S., HUXHAM, C. & EDEN, C. 2000. The challenge of collaborative governance *Public Management an International Journal of Research and Theory,* 2**,** 337-358.

JERLING, J., PELLETIER, D., FRANZO, J. & COVIC, N. 2016. Supporting multisectoral action: Capacity and nutrition leadership challenges facing Africa. . *In:* COVIC, N. & HENDRIKS, S. L. E. (eds.) *Achieving a nutrition revolution for Africa: the road to healthier diets and optimal nutrition.* Washington D.C International Food Policy Research Institute (IFPRI).

JEWKES, R., GIBBS, A., JAMA-SHAI, N., WILLAN, S., MISSELHORN, A., MUSHINGA, M., WASHINGTON, L., MBATHA, N. & SKIWEYIYA, Y. 2014. Stepping Stones and Creating Futures intervention: shortened interrupted time series evaluation of a behavioural and structural health promotion and violence prevention intervention for young people in informal settlements in Durban, South Africa. *BMC public health,* 14**,** 1325.

JEWKES, R., SIKWEYIYA, Y., MORRELL, R. & DUNKLE, K. 2011. Gender inequitable masculinity and sexual entitlement in rape perpetration South Africa: findings of a cross-sectional study. *PloS one,* 6**,** e29590.

JOHNSON, L. F. 2012. Access to antiretroviral treatment in South Africa, 2004-2011. *Southern African Journal of HIV Medicine,* 13.

JORGENSEN, D. L. 2015. Participant observation. *Emerging trends in the social and behavioral sciences: An interdisciplinary, searchable, and linkable resource***,** 1-15.

JUMA, P. A., MAPA-TASSOU, C., MOHAMED, S. F., MWAGOMBA, B. L. M., NDINDA, C., OLUWASANU, M., MBANYA, J.-C., NKHATA, M. J., ASIKI, G. & KYOBUTUNGI, C. 2018. Multi-sectoral action in non-communicable disease prevention policy development in five African countries. *BMC public health,* 18**,** 953.

JUSTMAN, J., REED, J. B., BICEGO, G., DONNELL, D., LI, K., BOCK, N., KOLER, A., PHILIP, N. M., MLAMBO, C. K. & PAREKH, B. S. 2017. Swaziland HIV Incidence Measurement Survey (SHIMS): a prospective national cohort study. *The Lancet HIV,* 4**,** e83-e92.

KANCHANACHITRA, C., TANGCHAROENSATHIEN, V., PATCHARANARUMOL, W. & POSAYANONDA, T. 2018. Multisectoral governance for health: challenges in implementing a total ban on chrysotile asbestos in Thailand. *BMJ global health,* 3**,** e000383.

KAR, M. 2014. Governance of HIV/AIDS: implications for health sector response. *International journal of health policy and management,* 2**,** 39.

KARIM, S. S. A. 2014. The HIV epidemic: progress and challenges. *South African Clinicians Society Conference.* Cape Town: CAPRISA.

KENNEDY, C. E., MEDLEY, A. M., SWEAT, M. D. & O'REILLY, K. R. 2010. Behavioural interventions for HIV positive prevention in developing countries: a systematic review and meta-analysis. *Bulletin of the World Health Organization,* 88**,** 615-623.

KHARSANY, A. B. & KARIM, Q. A. 2016. HIV infection and AIDS in Sub-Saharan Africa: current status, challenges and opportunities. *The open AIDS journal,* 10**,** 34.

KICKBUSCH, I. 2010. Health in all Policies: the evolution of the concept of horizontal health governance. *In:* KICKBUSCH, I. & BUCKETT, K. (eds.) *Implementing health in all policies: Adelaide.* South Australia: Department of Health, Government of South Australia.

KICKBUSCH, I. & BEHRENDT, T. 2013. Implementing a Health 2020 vision: governance for health in the 21st century. Making it happen. Copenhagen, Denmark: WHO Regional Office for Europe.

KICKBUSCH, I. & GLEICHER, D. 2012. Governance for Health in the 21st century. Copenhagen, Denmark: WHO Regional Office for Europe.

KIM, J., PRONYK, P., BARNETT, T. & WATTS, C. 2008. Exploring the role of economic empowerment in HIV prevention. *Aids,* 22**,** S57-S71.

KOSCHMANN, M. A., KUHN, T. R. & PFARRER, M. D. 2012. A communicative framework of value in cross-sector partnerships. *Academy of Management Review,* 37**,** 332-354.

KURTH, A. E., CELUM, C., BAETEN, J. M., VERMUND, S. H. & WASSERHEIT, J. N. 2011. Combination HIV prevention: significance, challenges, and opportunities. *Current HIV/AIDS Reports,* 8**,** 62-72.

LEE, B. X., EISNER, M. P., PRABHU, M. & DIKE, C. C. 2018. Violence, justice, and health: implications for a multisectoral collaboration. Springer.

MAREDI, R. 2011. AIDS councils-are they promoting public participation and partnership at the local sphere of government in South Africa? *Journal of Public Administration,* 46**,** 1257-1273.

MCQUEEN, D., WISMAR, M., LIN, V. & JONES, C. 2012. Introduction: Health in All Policies, the social determinants of health and governance. *In:* MCQUEEN, D. V., WISMAR, M., LIN, V., JONES, C. M. & DAVIES, M. (eds.) *Intersectoral governance for health in all policies. Structures, actions and experiences.* Copenhagen: The European Observatory on Health Systems and Policies.

MFECANE, S. 2013. Can women 'refuse'condoms? Dilemmas of condom negotiation among men living with HIV in South Africa. *Culture, health & sexuality,* 15**,** 269-282.

MIKKELSEN, B. 2015. *The globally recognised need for multisectoral action to tackle non-communicable diseases- ways and means to make it happen.* Masters University of Oslo.

MORAH, E. & IHALAINEN, M. 2009. National AIDS Commissions in Africa: Performance and Emerging Challenges. *Development Policy Review,* 27**,** 185-214.

MUNRO, G. D. 2008. *National AIDS Commissions and Country Coordinating Mechanisms: Perceptions of function of the two national HIV governance structures in Lesotho.* Master of Philosophy University of Stellenbosch

O'LEARY, Z. 2014. *The essential guide to doing research (2nd edition),* Thousand Oaks, California, Sage Publications Inc.

OLLILA, E., BAUM, F. & PEÑA, S. 2013. Introduction to Health in All Policies and the analytical framework of the book. *In:* LEPPO, K., OLLILA, E., PE˜NA, S., WISMAR, M. & COOK, S. (eds.) *Health in All Policies: Seizing opportunities, implementing policies.* Finland: Ministry of Social Affairs and Health.

OLSON, M. 2009. *The logic of collective action: Public goods and the theory of groups,* London, Harvard University Press.

ÖSTLIN, P., ECKERMANN, E., MISHRA, U. S., NKOWANE, M. & WALLSTAM, E. 2006. Gender and health promotion: A multisectoral policy approach. *Health promotion international,* 21**,** 25-35.

OSTROM, E. 2002. "Common-pool resources and institutions: Toward a revised theory,". *In:* GARDNER, B. & RAUSER, G. (eds.) *Handbook of Agricultural Economics.* Oxford: Elsevier.

OSTROM, E. 2007. *Governing the commons: The evolution of institutions for collective action, 20th printing,* New York, Cambridge University Press.

PARKHURST, J. O. 2013. Structural Drivers, Interventions, and Approaches for Prevention of Sexually Transmitted HIV in General Populations. *AIDS Support and Technical Assistance Resources (AIDSTAR-One).*

PAWINSKI, R. A. & LALLOO, U. G. 2006. Multisectoral responses to HIV/AIDS: applying research to policy and practice. *American journal of public health,* 96**,** 1189-1191.

PELLETIER, D., GERVAIS, S., HAFEEZ-UR-REHMAN, H., SANOU, D. & TUMWINE, J. 2018. Boundary-spanning actors in complex adaptive governance systems: The case of multisectoral nutrition. *The International journal of health planning and management,* 33**,** e293-e319.

PERRIG-CHIELLO, P. & HUTCHISON, S. 2010. Health and well-being in old age: the pertinence of a gender mainstreaming approach in research. *Gerontology,* 56**,** 208-213.

PETTIFOR, A., MACPHAIL, C., HUGHES, J. P., SELIN, A., WANG, J., GÓMEZ-OLIVÉ, F. X., ESHLEMAN, S. H., WAGNER, R. G., MABUZA, W. & KHOZA, N. 2016. The effect of a conditional cash transfer on HIV incidence in young women in rural South Africa (HPTN 068): a phase 3, randomised controlled trial. *The Lancet Global Health,* 4**,** e978-e988.

POKU, N. K. 2011. HIV/AIDS and Governance in Africa. *Report from Africa: Population, Health, Environment, and Conflict.* Washington DC: Wilson Center.

PRONYK, P. & LUTZ, B. 2013a. Policy and programme responses for addressing the structural determinants of HIV. *Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order,* 1.

PRONYK, P. & LUTZ, B. 2013b. Policy and programme responses for addressing the structural determinants of HIV. *Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order.* London: Strive research consortium.

PRONYK, P. M., HARGREAVES, J. R., KIM, J. C., MORISON, L. A., PHETLA, G., WATTS, C., BUSZA, J. & PORTER, J. D. 2006. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. *The lancet,* 368**,** 1973-1983.

PRONYK, P. M., KIM, J. C., ABRAMSKY, T., PHETLA, G., HARGREAVES, J. R., MORISON, L. A., WATTS, C., BUSZA, J. & PORTER, J. D. 2008. A combined microfinance and training intervention can reduce HIV risk behaviour in young female participants. *Aids,* 22**,** 1659-1665.

PUTZEL, J. 2003. Institutionalising an emergency response: HIV/AIDS and governance in Uganda and Senegal. Report submitted to the Department of International Development London, United Kingdom: London School of Economics and Political Science.

PUTZEL, J. 2004a. The global fight against AIDS: how adequate are the national commissions? *Journal of International Development: The Journal of the Development Studies Association,* 16**,** 1129-1140.

PUTZEL, J. 2004b. Governance and AIDS in Africa: Assessing the International Community's "Multisectoral Approach"*. *American Political Science Association.* Chicago: Crisis States Research Centre of the Development Studies Institute, London School of Economics and Political Science.

PUTZEL, J. 2004c. The politics of action on AIDS: a case study of Uganda. *Public Administration and Development,* 24**,** 19-30.

RASANATHAN, K., ATKINS, V., MWANSAMBO, C., SOUCAT, A. & BENNETT, S. 2018. Governing multisectoral action for health in low-income and middle-income countries: an agenda for the way forward. *BMJ global health,* 3**,** e000890.

RASANATHAN, K., BENNETT, S., ATKINS, V., BESCHEL, R., CARRASQUILLA, G., CHARLES, J., DASGUPTA, R., EMERSON, K., GLANDON, D. & KANCHANACHITRA, C. 2017. Governing multisectoral action for health in low-and middle-income countries. *PLoS Medicine,* 14**,** e1002285.

RASANATHAN, K., DAMJI, N., ATSBEHA, T., DRISSE, M.-N. B., DAVIS, A., DORA, C., KARAM, A., KURUVILLA, S., MAHON, J. & NEIRA, M. 2015. Ensuring multisectoral action on the determinants of reproductive, maternal, newborn, child, and adolescent health in the post-2015 era. *bmj,* 351**,** h4213.

REPUBLIC OF SOUTH AFRICA 1996. The Constitution of the Republic of South Africa - No 10. 108 of 1996. Pretoria, South Africa: Government printers

REPUBLIC OF SOUTH AFRICA 2003. The machinery of government: structure and functions of government Pretoria, South Africa: Government printers.

REPUBLIC OF SOUTH AFRICA 2007. Framework for Development and Governance Responses to HIV and AIDS. *In:* DEPARTMENT OF PROVINCIAL AND LOCAL GOVERNMENT, E. A. D. D. (ed.). Pretoria, South Africa: Government printers.

REPUBLIC OF SOUTH AFRICA 2017. Let our actions count: South Africa's National Strategic Plan for HIV, TB and STIs 2017- 2022 Pretoria, South Africa: Government printers.

ROTHERAM-BORUS, M. J., SWENDEMAN, D. & CHOVNICK, G. 2009. The past, present, and future of HIV prevention: integrating behavioral, biomedical, and structural

intervention strategies for the next generation of HIV prevention. *Annual review of clinical psychology,* 5**,** 143-167.

SALUNKE, S. & LAL, D. K. 2017. Multisectoral approach for promoting public health. *Indian Journal of Public Health,* 61**,** 163.

SANNI, S., WISDOM, J. P., AYO-YUSUF, O. A. & HONGORO, C. 2018. Multi-Sectoral Approach to Noncommunicable Disease Prevention Policy in Sub-Saharan Africa: A Conceptual Framework for Analysis. *International Journal of Health Services***,** 0020731418774203.

SCHNEIDER, H. & STEIN, J. 2001. Implementing AIDS policy in post-apartheid South Africa. *Social Science & Medicine,* 52**,** 723-731.

SEDDON, D., LANG, R. & DAINES, V. Mainstreaming disability issues into development studies-in theory and practice. 14th Annual meeting of the disability studies association, Winnipeg, Canada, 2001.

SEDGWICK, D. 2016. Building collaboration: Examining the relationship between collaborative processes and activities. *Journal of Public Administration Research and Theory,* 27**,** 236-252.

SEDIBE, M., NYGREN-KRUG, H., MCBRIDE, B. & BUSE, K. 2018. The future of global governance for health: putting rights at the center of sustainable development. *In:* MEIER, B. & GOSTIN, L. (eds.) *Human rights in global health.* Unites States of America: Oxford University Press.

SEELEY, J., WATTS, C. H., KIPPAX, S., RUSSELL, S., HEISE, L. & WHITESIDE, A. 2012. Addressing the structural drivers of HIV: a luxury or necessity for programmes? *Journal of the International AIDS Society,* 15.

SEKAMATTE, M., KRISHNASAMY, V., BULAGE, L., KIHEMBO, C., NANTIMA, N., MONJE, F., NDUMU, D., SENTUMBWE, J., MBOLANYI, B. & ARUHO, R. 2018. Multisectoral prioritization of zoonotic diseases in Uganda, 2017: A One Health perspective. *PloS one,* 13**,** e0196799.

SHANKARDASS, K., SOLAR, O., MURPHY, K., GREAVES, L. & O'CAMPO, P. 2012. A scoping review of intersectoral action for health equity involving governments. *International journal of public health,* 57**,** 25-33.

SHISANA, O., REHLE, T., LC, S., ZUMA, K., JOOSTE, S., ZUNGU, N., LABADARIOS, D. & ONOYO, D. 2014. South African national HIV prevalence, HIV incidence, behaviour and communication survey,2012. Cape Town, South Africa: HSRC press.

SIDDIQI, S., MASUD, T. I., NISHTAR, S., PETERS, D. H., SABRI, B., BILE, K. M. & JAMA, M. A. 2009. Framework for assessing governance of the health system in developing countries: gateway to good governance. *Health policy,* 90**,** 13-25.

STOKER, G. 1998. Governance as theory: five propositions. *International social science journal,* 50**,** 17-28.

TANGCHAROENSATHIEN, V., SRISOOKWATANA, O., PINPRATEEP, P., POSAYANONDA, T. & PATCHARANARUMOL, W. 2017. Multisectoral actions for health: challenges and opportunities in complex policy environments. *International journal of health policy and management,* 6**,** 359.

THOMSON, A. M. & PERRY, J. L. 2006. Collaboration processes: Inside the black box. *Public administration review,* 66**,** 20-32.

UNAIDS 2004. The Three Ones: Driving concerted action on Aids at the country level. Geneva: UNAIDS

UNAIDS 2014a. 90-90-90: An ambitious treatment target to help end the AIDS epidemic. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS.
UNAIDS 2014b. The Gap report. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS.
UNAIDS 2017. Global AIDS Update: Ending AIDS, progress towards the 90-90-90 targets. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS).
UNAIDS 2018. Miles to go: Closing the gaps breaking barries righting injustices Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS).
UNDP 1997. Reconceptualising governance: discussion paper 2. New York: Management Development and Governance Division. Bereau for Policy and Programme Support.
UNDP 2014. Discussion Paper: Governance for Sustainable Development Integrating Governance in the Post-2015 Development Framework: . New York, United States of America: United Nations Development Programme.
UNDP undated Governance of HIV/AIDS responses: issues and outlook. New York: UNDP.
UNITED NATIONS. 2001. *HIV/AIDS - a governance challenge* [Online]. New York: United Nations Available: http://www.un.org/ga/aids/ungassfactsheets/html/fsgovernance_en.htm.
UNITED NATIONS 2006. Political Declaration on HIV/AIDS Geneva, Switzerland: UNAIDS.
UNITED NATIONS 2011. Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS Geneva, Switzerland: UNAIDS.
VANGEN, S., HAYES, J. P. & CORNFORTH, C. 2015. Governing cross-sector, inter-organizational collaborations. *Public Management Review,* 17**,** 1237-1260.
VERSTEEG, M. 2008. Local AIDS Councils: how can they be more effective. Cape Town: Isandla Insttitute.
WALT, G. & GILSON, L. 1994. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning,* 9**,** 353-370.
WHITESIDE, A. 2002. Poverty and HIV/AIDS in Africa. *Third world quarterly,* 23**,** 313-332.
WHO 2008. Commission on Social Determinants of Health: Report by the Secretariat.
WHO 2012. Programmatic update: Antiretroviral Treatment as Prevention (TAsP) of HIV and AIDS. Geneva, Switzerland: World Health Organization.
WICKRAMASINGHE, K. 2017. Multisectoral action for noncommunicable diseases – what, why, how? . *Diverse perspectives on science and medicine* [Online]. Available from: http://blogs.plos.org/globalhealth/2017/07/multisectoral-action-for-noncommunicable-diseases-what-why-how/ [Accessed 9 June 2018].
WICKRAMASINGHE, K., WILKINS, E., FOSTER, C., FADHIL, I., HAMMERICH, A., SLAMA, S., EL BERRI, H., ELIMAM, M., ADIB, S. & AL-MUDWAHI, M. 2018. The development of national multisectoral action plans for the prevention and control of noncommunicable diseases: experiences of national-level stakeholders in four countries. *Global health action,* 11**,** 1532632.
WONG, E. L., YEOH, E.-K., CHAU, P. Y., YAM, C. H., CHEUNG, A. W. & FUNG, H. 2015. How shall we examine and learn about public-private partnerships (PPPs) in the health sector? Realist evaluation of PPPs in Hong Kong. *Social Science & Medicine,* 147**,** 261-269.
WORLD BANK. 2006. *The Multi-Country AIDS Program: Context and Objectives* [Online]. World Bank. Available:

http://siteresources.worldbank.org/EXTAFRREGTOPHIVAIDS/Resources/717147-1181768523896/ch1.pdf [Accessed 19 October 2016].
WORLD HEALTH ORGANIZATION 2006. Constitution of the World Health Orginization adopted by the International Health Conference held in New York from 19 June
to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States. Geneva, Switzerland: WHO.
WORLD HEALTH ORGANIZATION 2008. Closing the gap in a generation. Health equity through action on the social determinants of health. Geneva, Switrzerland: Commission on Social Determinants of Health.
WORLD HEALTH ORGANIZATION 2010. A conceptual framework for action on the social determinants of health. Social determinants of health discussion paper 2. Geneva, Switzerland: World Health Organisation.
WORLD HEALTH ORGANIZATION 2013. Health in All Policies (HiAP) Framework for Country Action *The eight global conference on Health Promotion* Helsinki, Finland: WHO.
WORLD HEALTH ORGANIZATION 2014. Health in All policies: Helsinki statement, framework for country action. Geneva, Switzerland: World Health Organisation.
WORLD HEALTH ORGANIZATION 2018a. Concept note: Assessment tool for governance for health and well-being. Copenhagen, Denmark: WHO Regional Office for Europe.
WORLD HEALTH ORGANIZATION 2018b. Global Health Estimates 2016: deaths by cause, age, sex, by country and by region, 2000-2016. Geneva: World Health Organization.
WOULFE, J., OLIVER, T., ZAHNER, S. & SIEMERING, K. 2010. Multisector partnerships in population health improvement. *Preventing Chronic Desease,* 7**,** 7.
YIN, R. K. 2009. Case study research: Design and methods (applied social research methods). *London and Singapore: Sage*.
ZAIDI, S., BHUTTA, Z., HUSSAIN, S. S. & RASANATHAN, K. 2018. Multisector governance for nutrition and early childhood development: overlapping agendas and differing progress in Pakistan. *BMJ global health,* 3**,** e000678.

List of appendices

Appendix1: Document review guide

1. **AIDS Councils**

- What is the mandate of the AIDS Council on HIV and AIDS?
- How is AIDS Council structured?
- Review institutional plan that guides their function and coordination of multisectoral approach to HIV
- Understanding and approach to coordination of implementation of the multisectoral approach to HIV
- What is the experience in implementing a multisectoral approach to HIV

2. **Government departments**

- Does the department have an integrated strategy for HIV and AIDS?
- What are the main components of the strategy?
- What are the main components of the HIV and AIDS implementation plan?
    - Who is responsible for implementation?
    - Are roles and responsibilities clearly defined?
    - What activities and programmes?
    - Is there a budget for HIV and AIDS activities?
    - What are the targets and indicators?
    - What mechanism for monitoring and evaluation?
    - What reporting mechanism, how to who, when?
- Coordination of implementation of the response
- Collaborations on the HIV response
- What are the roles and responsibilities of different actors, and who defines them?
- Experiences in coordinating and collaborating on the HIV programmes

3. Multisectoral and mainstreaming approach

- How is the multisectoral and mainstreaming approach defined and understood?
- How is the process of multisectoral and mainstreaming approach envisaged?
- How multisectoral action and mainstreaming implemented in reality?
- Progress made in implementation of multisector and mainstreaming approach
- Where are the challenges in implementation of multisectoral and mainstreaming approach?
- Recommendations to address challenges in implementation of multisectoral and mainstreaming approach

Appendix 2: Focus Group Discussion guide

Municipality……
Date of interview…….

1. **AIDS Council mandate and function**

- What is the mandate of the AIDS Council on HIV and AIDS?
- How is AIDS Council structured?
- Is there an institutional plan that guides the function of the Council?
- To whom does the Council report to, when, and how?
- Can you name some of the sectors that regularly attend meetings?

2. **South Africa's HIV and AIDS policy**

- Can you tell me more about the role of the AIDS Council on the HIV and AIDS response?
- What approach/strategy to address HIV in South Africa?
- The literature shows that HIV is higher in urban areas, compared to rural areas, does this finding apply in your province?
- If yes, is there a strategy to address urban HIV?
- If yes, can you tell me more about some of the activities and programmes for an urban HIV specific response?

3. **HIV and AIDS policy development process**

- How is the HIV and AIDS policy developed? (events, context, timing)
- Who is involved in the development process?
- What were the steps or key elements in the policy development process?
- What are the roles of different actors, and who defines them?
- What is the role of the AIDS Council in the development process?
- Who coordinated the development process?
- Can you reflect on the Councils role in the development process?

- How cooperation On the HIV and AIDS response ensured?
- Is the AIDS Council responsible for coordinating the development process?
- If yes, how is this task undertaken, and what are some of the challenges?
- How are the challenges addressed?
- What are some of the positive and negative elements of the development process and how?

4. HIV and AIDS policy implementation process

- Who are the actors responsible for implementation of the HIV and AIDS policy?
- What are some of the key contributions of the AIDS Council on the HIV response?
- What are the challenges experienced in fulfilling the mandate?
- Are there mechanisms in place to address the challenges?
- What is the role of political actors on the HIV and AIDS response?
- What are the steps or key elements in the policy implementation process?
- What are some of the implementation constraints / issues that people who implement the policy experience?
- What recommendations can you suggest for improving implementation constraints?

We have come to the end of the interview, thank you so much for your time.

Appendix 3: Indepth interview guide

Department……

Position……

1. Awareness on HIV and AIDS in the department

- Is the department aware of the consequences of HIV and AIDS on development and service delivery?
- Has the department assessed the impact of HIV and AIDS on the department's functioning?

2. Strategy to address HIV and AIDS

- Does the department have a strategy for HIV and AIDS?
- What are the main components of the strategy?
- Research shows that HIV is highly concentrated in urban areas; does the strategy have any focus on HIV and AIDS in urban areas?
- What urban HIV and AIDS programmes is the department involved in?
- Who is responsible to oversee implementation of the department's strategy?
- Does the department have an implementation plan to execute the HIV strategy?
- What are the main components of the HIV and AIDS implementation plan?
    - Are roles and responsibilities clearly defined?
    - What activities and programmes?
    - Are there special key populations that the plan is targeting?
    - Is there a budget for HIV and AIDS activities?
    - What are the targets and indicators?
    - What mechanism for monitoring and evaluation?
    - What reporting mechanism, how to who, when?

3. Multilevel cooperation on HIV and AIDS within the department

- Is there alignment on the HIV and AIDS response within the department (from national, province and local level)?
- Please explain the collaboration process, how its established and coordinated?
- Who facilitates the collaboration?
- What evidence on cross sector programmes on HIV and AIDS?
- Are there any specific key populations that the programme targets, if yes, please give examples stating which programmes, and who are the target groups?
- Is the alignment also executed in urban HIV and AIDS related programmes?
- How is the alignment coordinated, by who, and what are the roles of different levels (national, provincial and local)?
- How is the alignment coordinated, by who, and what are the roles of different levels (national, provincial and local) on the urban area's HIV and AIDS response?
    - What are the roles and responsibilities of different actors, and who defines them?
    - What has been the impact of the programmes?
    - Does the department collaborate with other government sectors on HIV and AIDS programmes?

4. Horizontal collaborations on HIV and AIDS between government departments

- Does the department collaborate with other government sectors on HIV and AIDS programmes?
- Please explain the collaboration process, how its established and coordinated?
- Who facilitates the collaboration?
- What is the nature of the collaboration?
- Are there any specific key populations that the programme targets, if yes, please give examples stating which programmes, and who are the target groups?
- Are roles and responsibilities clearly defined? If yes, give evidence (examples)? Who define roles and responsibilities of different government departments?

- What makes you and other departments collaborate?
- Can you indicate the level of coordination and integration (information, budget, and in other areas)?

5. Challenges of vertical and horizontal collaborations

- What are some of the challenges you experience working with other levels within your department?
- What are some of the challenges you experience working with other government departments?
- Are sectoral mandates limiting?
- How do you overcome challenges/issues about sectoral mandates as a department?
- What are the benefits and challenges of collaborations within government departments?
- How are challenges addressed?
- What are the benefits and challenges of collaborations between government and non-government actors?
- How are the challenges addressed?
- What recommendations would you suggest for both vertical and horizontal collaborations on the HIV response?

We have come to the end of our interview, thank you for your time

Appendix4: Ethical clearance

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Ms Brenda P Mahlangu

CLEARANCE CERTIFICATE	**M120657**
PROJECT	Exploring an Effective Multisectoral and Multi-level Policy Response to HIV in Urban South Africa, through the Social Determinants of Health, and and a Healthy Urban Governance Lens: The Case of the Free State and EC Prov.
INVESTIGATORS	Ms Brenda P Mahlangu.
DEPARTMENT	School of Public Health
DATE CONSIDERED	29/06/2012
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 27/08/2012 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Dr Liz Thomas

DECLARATION OF INVESTIGATOR(S)
To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

Appendix 5: Informed consent

I hereby confirm that I have been informed by _____about what my involvement in this research would entail. I have also received, read and understood the information sheet regarding the study. I am aware that the results of the study will be processed into a research report. In view of the requirements of research for a doctoral degree, I agree that the data collected in this study can be processed in a computerised system by _____. I also understand that the study has purposively sampled individuals with specific experience in the HIV policy process. I give consent to participate as is necessary for the research.

I may, at any stage, without prejudice, withdraw my consent and participation in the interview. I am not required to give a reason for withdrawal. I have had sufficient opportunity to ask questions, and declare myself prepared to participate.

1. I confirm that I have read and understood the information sheet for the above study and have had opportunity to ask questions. yes /No
2. I understand that my participation is voluntary, and that I am free to withdraw at any time without giving reasons. yes /No
3. I agree to take part in study. yes /No
4. I agree to the interview being audio recorded. yes /No

PARTICIPANT:

I have read this consent form (or had it read and explained to me), and all of my questions have been answered to my satisfaction. My signature below confirms that I agree to take part in the study.

Printed Name Signature Date and Time

INTERVIEWER:

I, _____, herewith confirm that the above participant has been fully informed about the nature of the study.

Printed Name Signature Date and Time

Appendix 6: Study information leaflet

Study title: Exploring a multisectoral and multilevel response to HIV in South Africa: case of Mpumalanga province in South Africa

Good day, my name is Pinky Mahlangu**.** I am doing research on the development, implementation and outcomes of HIV and AIDS policy in South Africa, by focusing specifically on the Mpumalanga province and its districts and local municipalities. I am undertaking this research for academic reasons to fulfil requirements for a doctoral degree at the University of the Witwatersrand. I am requesting your participation in this process, as a way of helping me answer my research question. In this study want to explore and learn more about a multisectoral and multi level approach to HIV and AIDS, and how its development, implementation and outcomes are coordinated within and between government and non-government actors.

I am inviting you to take part in this study. Through your participation and in answering my questions not only do you take part in the study, but you also help me answer my research question.

The study is a qualitative case study design that involves interviews as a source of data collection. The interview will only take about 45 – 60 minutes of your time. As standard procedure, I ask all individuals to be interviewed, to read through the consent form (which I will also give to you) and if they are happy with all the information contained in the consent form as well as agree to participate, we sign it, and commence with the interview. If you no longer feel comfortable to respond to some of the questions and want to withdraw from the interview, I respect their decision, and cancel the interview immediately.

I will be asking open-ended questions that will allow you space to give tell me whatever information you think is relevant for me to know, but will be asking you question as outlined in the interview schedule that I have developed for our interview. I will be asking open-ended questions to create the space for you to tell me whatever information you think is relevant, but the questions will still be asked according to an outlined interview schedule developed specifically for this purpose.

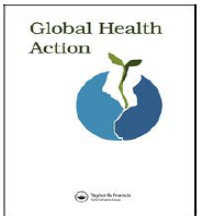
I will answer any questions and share any additional information that you might want to know throughout the process and as the research progresses. I will also share with you the findings of the study after I have submitted my research report.

Your participation is voluntary. Refusal to participate will involve no penalty, and you may discontinue participation in the interview at any time, without penalty. There are no risks involved in participating in the study. There are no benefits of being in the study

Every effort will be made to keep personal information confidential. However, absolute confidentiality of data collected from you cannot be guaranteed. Personal information may be disclosed if required by law. Organizations that may inspect and/or copy my research records for quality assurance and data analysis include groups such as the Research Ethics Committee, and people who supervise me on this project.

For further information, you can contact me on 083 859 2459, or email me at pinky.mahlangu@gmail.com. You can also contact my supervisors to report any complaints or problem on 011 717 3431.

Appendix 7: Paper 1



Global Health Action

Taylor & Francis
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ISSN: 1654-9716 (Print) 1654-9880 (Online) Journal homepage: http://www.tandfonline.com/loi/zgha20

Implementing a multi-sectoral response to HIV: a case study of AIDS councils in the Mpumalanga Province, South Africa

Pinky Mahlangu, Jo Vearey, Liz Thomas & Jane Goudge

To cite this article: Pinky Mahlangu, Jo Vearey, Liz Thomas & Jane Goudge (2017) Implementing a multi-sectoral response to HIV: a case study of AIDS councils in the Mpumalanga Province, South Africa, Global Health Action, 10:1, 1387411, DOI: 10.1080/16549716.2017.1387411

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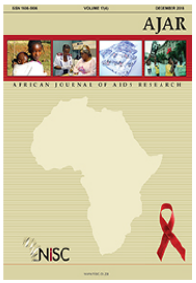
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Appendix 8: Paper 2



African Journal of AIDS Research

Taylor & Francis
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Multisectoral (in)action: towards effective mainstreaming of HIV in public sector departments in South Africa

Pinky Mahlangu, Jo Vearey & Jane Goudge

To cite this article: Pinky Mahlangu, Jo Vearey & Jane Goudge (2018) Multisectoral (in)action: towards effective mainstreaming of HIV in public sector departments in South Africa, African Journal of AIDS Research, 17:4, 301-312, DOI: 10.2989/16085906.2018.1536069

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Appendix 9: Paper 3



Global Health Action

Taylor & Francis

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Towards a framework for multisector and multilevel collaboration: case of HIV and AIDS governance in South Africa

Pinky Mahlangu, Jane Goudge & Jo Vearey

To cite this article: Pinky Mahlangu, Jane Goudge & Jo Vearey (2019) Towards a framework for multisector and multilevel collaboration: case of HIV and AIDS governance in South Africa, Global Health Action, 12:1, 1617393, DOI: 10.1080/16549716.2019.1617393

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Appendix 10: Turnitin report

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