United Nations Development Programme

Local Action for Universal Access in the Response to AIDS

A discussion paper on the capacity of local authorities in Europe and the Commonwealth of Independent States to respond to the epidemic

November 2009

Contents

This publication was produced jointly by the Capacity Development Practice and the HIV/AIDS Practice, UNDP RBEC, November 2009

For more information, please contact: Joe Hooper, Capacity Development Specialist, UNDP Bratislava Regional Centre joe.hooper@undp.org and Shombi Sharp, Regional HIV/AIDS Team Leader for Europe and the CIS shombi.sharp@undp.org

Lead author: Anna Bengtsson
Contributing author: John Macauley, UNDP Bratislava Regional Centre
Contributors: Anna Gyurjyan, Programme Associate, UNDP Armenia; Nelli Cholakhyan, Executive Director, Armenian National AIDS Foundation; Gaukhar Zhorabekova, HIV/AIDS Focal Point, UNDP Kazakhstan; Vladimir Gordeiko, Ph.D. Project Manager, Governance of HIV/AIDS project, UNDP Ukraine; Katerina Rybalchenko, Programme Manager, UNDP Ukraine

Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CSO	civil society organization
CD	capacity development
CIS	Commonwealth of Independent States
HIV	human immunodeficiency virus
IDU	injecting drug user
MARP	most-at-risk populations
MSM	men who have sex with men
NGO	non-governmental organization
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
SW	sex workers
UA	Universal Access

1. Introduction

1.1 Universal Access in the Europe and CIS Region

The global HIV epidemic appears to have stabilized, but in the Europe and the Commonwealth of Independent States (CIS) region, the number of people living with HIV (PLHIV) continues to grow. Although the HIV prevalence in the region remains relatively low compared to other regions with more advanced epidemics, at the same time, it has been spreading faster than anywhere else in the world in recent years. It is estimated that 1.5 million adults and children were living with HIV in the region in 2007 – a figure that has more than doubled since 2001 (630,000 people). Some countries are more affected than others, but no county is untouched – people in the area are increasingly mobile, and HIV recognizes no national boundaries. Almost 90 percent of those infected live in either the Russian Federation (66 percent) or Ukraine (21 percent).[1] The growing epidemic means that more PLHIV in the region are facing health consequences, stigma, discrimination and social exclusion on a daily basis.[2]

In 2006, governments of the Europe and CIS region affirmed their support for the Declaration of Commitment on HIV/AIDS, and agreed to set ambitious national targets for scaling up to achieve Universal Access to HIV prevention, treatment, care and support by 2010. Universal Access (UA) means that all people have access to education and counseling, multi-sectoral prevention, care and support services, and health services, including medicines.[3] The progress of a country towards achieving UA is typically illustrated by progress made in the following four key areas of national HIV response: treatment coverage (antiretroviral treatment - ART), care and support, prevention (including testing), and national commitment (including resource expenditure).[4]

Valeria, HIV positive mother and activist in Ukraine
UNAIDS

What does "access" mean in the concept of Universal Access?

"Access" is a broad concept that measures three dimensions of key health sector interventions: availability, coverage and outcome and impact. Availability is defined in terms of the 'reachability' (physical access), affordability (economic access) and acceptability (socio-cultural access) of services that meet a minimum standard of quality. Making services available, affordable and acceptable is an essential precondition for universal access. Coverage is defined as the proportion of the people needing an intervention who receive it. Coverage is influenced by supply (provision of services) and by the demand from those who need services. Outcome and impact are defined in terms of behavioral change, lower infection rates or higher survival rates and are the result of coverage, modulated by the efficiency and effectiveness of interventions. In addition to the availability, coverage and outcome and impact of interventions, other aspects also determine the attainment of universal access, including whether the services are provided in an equitable manner and their quality, acceptability and effectiveness.

Source: Towards Universal access: Scaling up priority HIV/AIDS interventions in the health sector. Progress Report 2008. WHO, UNAID, UNICEF, 2008.

So far, all countries in the region have developed national multi-sectoral HIV/AIDS strategies that integrate UA targets, and have put in place national level AIDS committees or commissions with representation from various sectors according to the "Three Ones" principle.[5] International donors have increased contributions to HIV efforts in the region from US$ 12 million in 2003 to an estimated US$ 60 million in 2006, including a sharp increase in 2005 from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Domestic HIV funding has doubled in the same period, to US$ 60 million in 2006 for CIS countries except for the Russian Federation where domestic funding has risen even more dramatically (up to US$ 320 million in federal allocations in 2007).[6]

Despite the increased funding, the epidemic continues to grow. An important cause of this is that many Governments in the region do not have the capacities to ensure effective governance and service delivery related to the HIV response or to advocate for the realization of individual rights and protection required to save their lives.[7] There are several obstacles for countries in the region to do so, which include:

- lack of multi-sectoral approaches linking different stakeholders - HIV is still viewed as an issue to be dealt with solely by health authorities without involvement of other Ministries;

- lack of approaches looking at short-term and long-term horizon - decision makers continue to have a short-term perspective when planning and budgeting for prevention and response activities and support to people living with HIV; and

- weak/variable quality of health systems and their implementation capacity.[8]

At the root of these problems are capacity deficits across a wide array of areas including unclear or overlapping mandates, insufficient or incorrect staffing capacities, no performance management systems, fragmented systems of data collection, strategies that are insufficiently grounded in epidemiology, and weak representation of civil society in decision-making processes.[9] The capacity constraints pose a real challenge to implementing national strategies for the achievement of UA. These must follow a "Know your epidemic" approach that is anchored in the best available evidence base and avoids the temptation towards politically or organisationally expedient responses.

In terms of impact, while the HIV epidemic in the Europe and CIS region has evolved in different ways across sub-regions and within a diverse range of epidemiological, socioeconomic and political contexts, one characteristic remains the same - its burden is disproportionately carried by injecting drug users (IDU), sex workers (SW), their respective sexual partners, and to a lesser extent by Men who have sex with men (MSM) – e.g. most-at-risk populations (MARP) who are often already marginalized by society and criminalized by the state. Additionally, a risk population that is emerging as a result of the economic downturn are migrant workers returning from countries with a high prevalence of HIV. Programme interventions targeting the above communities in the four key areas of response to achieve UA is therefore particularly important to fight the epidemic.

1.2 The Impact of the Economic Crisis

Though global in nature, the economic crisis is having profound impacts locally within the countries of the Europe and CIS region.[10] For example, as economies slow down, migrant workers are returning home in greater numbers. Tajikistan for example is seeing the largest scale of worker return as construction, transport and other industries in Russia collapse. Generally speaking, many of the migrant workers have been working in countries with higher HIV prevalence. Since migrant workers are away from their families for longer periods of time, they tend to engage in risky behaviour which makes them more vulnerable to HIV. A study of Tajik workers in Moscow noted that many are having unprotected sex with commercial sex workers, and that although some of the migrants have basic knowledge about HIV, the migrants' ability to protect themselves from acquiring HIV is compromised by harsh living and working conditions as a consequence of being unprotected by law in Russia.[11]

But from the perspective of ensuring Universal Access, there are a range of issues affected by the financial crisis. While considerable progress has been made in the Eastern Europe and CIS region (mostly middle income countries) in recent years to increase the scope and quality of services and set targets for the achievement of Universal Access to prevention, care, treatment and support services by 2010 this progress can be considered fragile and depends largely on external financing. In those few countries that have managed to invest significant domestic resources, including the Russian Federation, unanticipated budgetary pressures due to the global crisis may jeopardize spending on marginalized most-at-risk populations, including injecting drug users, sex workers, men who have sex with men and mobile populations, who are both the most politically controversial and the most important in terms of effective responses to the concentrated epidemics of the region.

Social consequences linked to the economic crisis such as rising unemployment, poverty and inequality could drive an increase in the same risk behaviors, including injecting drug use and sex work that helped drive an explosive increase in the spread of HIV in the region in the mid 1990s'. The risk of long-term damage from a relatively short or medium term crisis is exceptionally apparent in field of HIV, where each momentary failure to prevent HIV infection results in a lifetime commitment to treatment and care, and where each failure to provide that treatment and care is a matter of life and death. This is very much apparent at the local level since this is closest to citizens who need support the most. A recent World Bank and UNAIDS report titled "The Global Economic Crisis and HIV prevention Programmes: Vulnerabilities and Impact ,"[12] clearly states that the economic crisis will continue to negatively impact the region and will most likely lead to the disruption of HIV prevention and treatment programmes. The report presents results of a survey conducted in late March 2009 looking at the impact of the crisis in 71 countries including eleven countries from Eastern/ Central Europe and the Commonwealth of Independent States. In nearly all regions, respondents of the survey expected the most adverse effect on prevention efforts among marginalized most-at-risk populations –

injecting drug users, sex workers, and men who have sex with men, who tend to get lower priority than, say, pregnant women and children. This was most pronounced in the Eastern Europe and Central Asia (ECA) countries (7 out of 11). Also, over half the countries in Eastern/Central Europe and the Commonwealth of Independent States (55 percent) expect to be affected in the next twelve months (6 of 11countries). This group includes countries which have been extremely affected by the economic crisis with large exchange rate devaluations substantially increasing the cost of antiretroviral drugs and other health supplies.

The envisaged impact of the crisis will be mainly through budget cuts for HIV leading to the potential collapse of health care systems and available antiretroviral treatment. Cuts in treatment can prove to be very dangerous since those who stop treatment become far more infectious and disrupted treatment diminishes drug effectiveness, requiring use of extremely costly second-line drugs and placing additional demands on health systems to monitor their use. Interruptions or cuts in treatment will also result in more people with HIV-related illnesses and reduced household income may push more patients towards public health services at a time when their budgets are being cut. Reductions in health budgets might also influence the ability to maintain salaries of health workers, and cause shortage of drugs and other essential health supplies. The issue of cuts in external aid in situations where the HIV response is very much dependent of external aid is also one of great importance since national/local authorities and their development partners will need to identify impending cash flow interruptions and provide bridge financing that, at the very least, prevents treatment interruptions.

On the other hand, even though the economic crisis might immensely influence the capacity of governments (both at the national and local levels) to delivery on their commitments (targets) to achieving Universal Access for prevention, treatment and care for all by 2010, it will definitely lead countries to push for more efficiency and cost effectiveness, which will help to better prioritize resources allocated across HIV treatment and prevention programmes. This is also very much in line with the latest thinking and concept around HIV programming "Know your epidemic" which encourages focus on targeted interventions addressing those who are most vulnerable and likely to be affected by the virus. Thus the crisis may provide an opportunity for further exploring the role of local authorities in addressing HIV.

1.3 Recognizing the key role of local action in the national response

It is notable that much of the international and national government response in the Europe and CIS region has been focused at the national level, with little recognition given to the role that local authorities[13] can and do play. What is also clear is that the epidemic in the region is manifesting itself amongst specific groups of the population that local authorities are potentially in the best position to serve due to their proximity. The purpose of this paper is to explore the capacity strengths and weaknesses of local authorities that promote or hinder their effective involvement in HIV prevention and response; this is done with the aim of improving governance and service delivery related to the national HIV responses - and ultimately contribute to the achievement of UA targets in the region. In essence, this paper is merging three fields of study – HIV, local governance, and capacity development[14] – in order to promote discussion and further study if warranted.

The focus on local authorities is especially relevant for the Europe and CIS region - given the growing emphasis upon decentralization, democratization and civil society participation to varying degrees by country- as they are ideally situated to coordinate and lead effective responses to the HIV epidemic at local level.[15] The potential of local authorities has generally been underemphasized and unrecognized by donors and Governments in the Europe and CIS region, and their contributions are often excluded and neglected in HIV analysis and reporting. While the text is primarily concerned with local authorities, it must be recognized that such authorities do not exist in isolation from the central level and thus analysis has also been included focusing on the impact of the on-going decentralization/ de-concentration/delegation processes in the region. In particular, it is important to understand how these processes influence local governments' capacity to participate effectively in national HIV response.

While a full fledged capacity assessment of local authorities and detailed account of the past contribution of local authorities to the achievement of UA in the region are beyond the scope of this paper, the following pages highlight potential capacity strengths and weakness that can affect local authorities' abilities to combat the epidemic.[16] To support this investigation, sub-national level case examples of local action in the HIV response are included, contributing to a better understanding among international, national, and local partners on the capacities necessary for local authorities in their efforts to prevent and respond to HIV and guide capacity development investments. These case examples show that there is work ongoing in this area that can be learned from and brought to scale.

2. Methodological background and definitions

2.1 Defining 4 key areas of the national response where local authorities can most contribute to the achievement of Universal Access

No guidelines exist for states on how to engage local authorities in the formulation, implementation and monitoring of national UA targets - an area to a great extent determined by macro-level considerations as well as the context of local governance and decentralization context in a country. There is however a growing body of evidence from experiences with local governments in Africa and South-Asia, which is of general relevance for the Europe and CIS region. The work of the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL)[17] has been deemed particularly successful by the UN and the World Bank amongst others, as they have developed a model for community and local authority governance and management of HIV response on a local level. The focus of AMICAALL on effective governance and political leadership is essential for an effective response to AIDS and relevant also for the Europe and CIS region - there is a fundamental link between institutional capacities, broad-based participation and accountability, on the one hand, and evidence of progress in responding to AIDS on the other.[18] Conclusions stemming from AMICAALL's work have thus been incorporated into the final part of this paper that suggests how CD can be integrated into local authority activities to enhance their contribution to Universal Access. According to AMICAALL, there are at least four broad key activities where local authorities can contribute effectively to the achievement of UA target; as these are broad activities, they have been adapted to the regional and sub-regional context of Europe and the CIS. The activities are:

- Providing leadership. In the Europe and CIS region they can speak out publically to remove stigma, raise awareness, and assist in mobilizing resources for response.
- Supporting collaboration. More specifically adapted for the region this means "Ensuring appropriate organizational arrangements (structure/systems/processes) to support collaboration between state and non-state actors for more effective response to HIV.
- Facilitating support for national policies and strategies. In the Europe and CIS, this means Facilitating support for adapting national policies/strategies into local service provision for treatment, prevention, HIV testing, and awareness raising.
- Gathering of strategic information, including monitoring and feedback for programme evaluation.

For local authorities to be able to assume these roles and to deliver the services relevant to the achievement of UA targets, capacity must exist within the entire system of service delivery which includes the enabling environment (policy, legislation), the organization, and the individual levels.[19]

2.2 The impact of decentralisation on local governments' involvement in the response to HIV

Many countries in the Europe and CIS region have and continue to undergo decentralization processes and other reforms as they move towards more inclusive and effective systems of governance. Simply defined, decentralization is the transfer of authority and responsibility for public functions from the central government to subordinate or quasi-independent government organizations and/or the private sector. In general, there are four commonly recognized forms of decentralization possible within a unitary state: deconcentration, devolution, delegation, and privatization.[20] Often these are mixed and – especially relevant for the Europe and CIS region - point to a process of evolution from centralized to decentralized governmental organization. In addition to these forms, decentralization can be political[21] , fiscal, or administrative (or a combination of all or two of these).

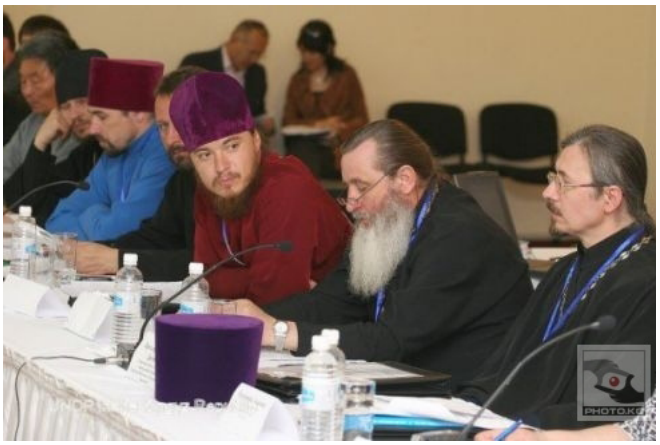
Local Self Government in the Europe and CIS Region

According to the United Cities and Local Governments, three groups of local self-government can be distinguished in the Europe and CIS region:

1. Where local self-government is legally autonomous and institutionally separate from the structures of state power, and local government is seen as an institution through which the local community decides on local issues (Russia, Armenia and Azerbaijan);
2. Where the process of the formation of local self-government is still not concluded - where reforms have barely been implemented, or simply have not been achieved up to now (Georgia, Kyrgyz Republic, Moldova and Ukraine); and
3. Where local issues are still in the hands of state bodies, and local self-government exists only at the very lowest level: villages, districts of cities (Kazakhstan, Tajikistan, Turkmenistan and Uzbekistan).

Source: Decentralization and Local Democracy in the World. Chapter: Eurasia. Author: T.Y. Khabrieva & L.V. Andrichenko & V.A. Vasiliev. United Cities and Local Governments (UCLG), 2008

As each country in the region faces a unique context of decentralisation, HIV response on a local level requires very specific and country-led solutions that take into account the particular form of decentralisation in the specific country. The decentralization process involves both new opportunities and challenges for local authorities in the region to engage in national HIV response. On one hand, local authorities and civil society have increased opportunities to participate in the governance of institutions and services that are critical to addressing HIV. Their increased involvement ideally should allow policies to build on local strengths and sub-national capacities, while at the same time acknowledging limitations that might undermine well-intentioned programmes that lack feasibility and acceptability in the community, following the principles of "Knowing Your Epidemic." In practice however, the legacy of the post-Soviet system of centralized policy and decision-making continues to influence the evolution of sub-national governments in the region, and also impact on the capacity of local authorities to develop effective and sustainable HIV programmes. Situations exist where there are overlapping functions and shared competencies between national and sub-national levels, or where there is a lack of a clear relationship between functions, responsibilities and resources, whether generated locally or transferred from higher levels.[22]



Faith based organizations participating in HIV prevention and awareness

3. A framework for local authorities to support achievement of National Universal Access targets

This section of the paper moves from the theoretical to the practical – examining key activities that local authorities can undertake to support the achievement of national UA targets, and the capacities that make this possible. As noted previously, there are 4 key areas of national response to achieve UA; these are Prevention[23], Treatment coverage[24], HIV Testing and Knowledge of transmission[25]. Also as noted above, there are four main roles that local authorities can play in addressing HIV: providing leadership, supporting collaboration, facilitating support for national policies and providing services, and information gathering, monitoring and feedback. The following section of this paper takes the role of the local authorities as a driver and examines the key capacity assets and weaknesses at the enabling environment, organizational, and individual levels that support to impede their contribution to each of the 4 key areas of national response to achieve UA

3.1 Providing leadership

Leadership is key to an effective and functioning organization, but tends to be an ambiguous concept based heavily in the mores of a culture and often defined by the mandate of the leader within a public institution. Leadership is considered one of the key capacities within UNDP's capacity development paradigm. Leadership of the HIV response tends to be driven organizationally by National AIDS Councils or other steering/coordinating bodies. As such coordination bodies exist less frequently at the local level, leadership is often more ad hoc and related to the specific initiative of individuals in positions of influence.

To promote prevention of HIV, local government leaders[26] can speak openly in public about issues related to HIV in their communities, across varying levels of political and cultural sensitivity. Such issues that are often more politically palatable include for example how HIV is transmitted, where and how HIV testing can be undertaken, as well the importance of prevention of mother-to-child transmission (PMTCT)[27] and enforcing Blood Safety programmes in the health sector, and using HIV Life Skills Education in Schools and teen centres. As the epidemic in the region is mainly concentrated among specific populations at risk, however, local leaders can be especially effective in addressing the need for evidence-informed prevention programmes targeting injecting drug users, sex workers and men who have sex with men. Yet the high levels of stigma and discrimination that prevail against these populations presents a significant barrier. Increasing support for the

establishment of prevention programmes for injecting drug users, often called Harm Reduction (needle exchange and substitution therapy)[28] represents an especially critical hurdle for achieving UA in the region. Local leaders speaking in public can also contribute to awareness raising among the general population on what treatment, care and support services that are available in their communities to people living with HIV and their families.[29]

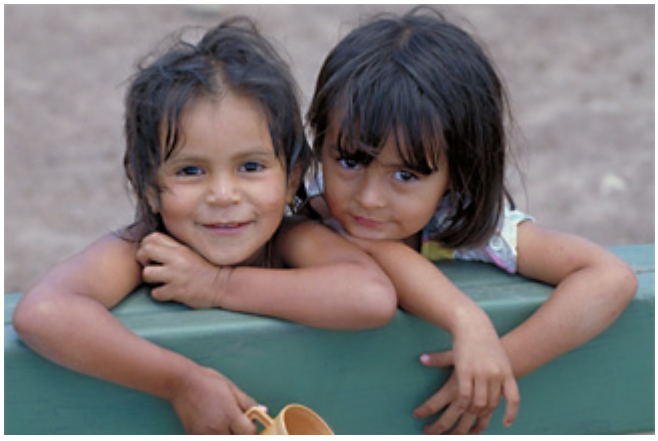
In the Europe and CIS region, people living with HIV in general, and injecting drug users, sex workers, and men who have sex with men in particular, are very reluctant to come forward and seek treatment due to stigma and discrimination among health workers, police and law enforcement agencies for example.[30] This demands that local leaders do not shy away from highlighting their particular experiences and needs, when talking about these services. Only by improving access of most-at-risk populations to antiretroviral therapy, and to treatment of tuberculosis and HIV, can UA be achieved in the region.[31]

Leadership Raising Awareness on HIV in Uzbekistan

HIV is spreading rapidly in Uzbekistan. Almost 91 percent of all reported infections were diagnosed between 2001 and mid-2003, bringing to more than 2,500 the total number of reported HIV cases (UNAIDS). Uzbekistan hosts one of the youngest epidemics in the world with young people, between 15-34 years of age, accounting for two-thirds of the cases .Men account for most of the infections - more than 85%. Injecting drug use was the cause of the majority of infections – about 90 percent - as in other countries of the region. There are around 25,000 registered drug users, though the UN estimates the number to be at least 60,000. In 2006, in response to the alarming spread of HIV amongst young people, senior officials from all levels of sub-national government from the Termez, Urgench, Samarkand, Bukhara, Namangan and Ferghana regions embarked on an awareness raising campaign at the local level, targeting Heads of educational institutions. The senior official held a series of meetings in the municipalities where they discussed how to strengthen partnerships with CSO and organisations working with the rights of people living with HIV to prevent HIV in particular among young people.

Source: WorldBank webpage on HIV/AIDS in ECA: http://go.worldbank.org/QRSYKZ5TA0 and UNAIDS .

Local leaders can also publicly recognize the present and future challenges that HIV poses to municipalities (e.g., breakdown of families, loss of staff productivity in public and private sector, increased costs of health services, loss of community members, challenges to municipal service delivery from lower local revenues and higher demand). This can increase the support from domestic and external partners for long-term investment in HIV response, as well as mobilizing human and financial resources for development of appropriate services.[32] Equally important is to manifest leadership within the administration itself, as well as among its service delivery partners, where HIV activities can be prioritized, for example through development of a HIV Work place Policy and Programme/Code of Practice and prevention policies addressing HIV work, and support can be provided to HIV Focal Points and Task Teams. In the Russian Federation for example, a National Policy on HIV/AIDS and the World of Work was prepared by the Ministry of Health and Social Development, which was distributed to the 88 regions of the Federation for implementation. In addition, by holding formal public consultations on issues such as strategies, action plans, and project identification and development related to HIV, local governments can ensure representative stakeholder engagement and democratic legitimacy of decisions, and at the same time ensuring that the local response meet the needs of the community, according to the principle of "Know Your Epidemic". Lastly, leadership is required to define the overall vision of how the local government will strategically respond to HIV in a multi-sectoral and coordinated fashion.



Kazakhstan: Leading for a Strategic Response to HIV

In Kazakhstan, the largest country in Central Asia, local leadership proved crucial to addressing HIV. From 1997 to 2008, 9,378 HIV cases were reported in Kazakhstan, reaching rates of 54.0 per 100,000 population. Approximately 30 percent of people with HIV are aged between 20-29 years; 68 percent of them are males, although incidence among women is on the rise. Official data report that 72.7 percent of HIV cases occurred due to unsafe drug injection practices, 19 percent account for sexual transmission. Officially, 640 people developed AIDS and 506 of them died. In 2006, in southern Kazakh city of Shymkent experienced a sudden outbreak of HIV among children under the age of three. More than 130 children had contracted the virus, which causes AIDS, through tainted blood transfusions while hospitalized for other ailments. In response to the outbreak, the Oblast and Municipal leadership developed a regional response strategy and programme aimed at preventing further spread of the epidemic, as well as provision of care and support to people living with HIV and measures to fight stigma and discrimination, and an effective model of coordination between the provincial towns and oblast centres in the South and the Shymkent.

Sources: "South Kazakhstan Outbreak Led to Anti-HIV Programs" UCLA Center for European and Eurasian Studies. http://www.international.ucla.edu/euro/article.asp?parentid=99736 and UNAIDS 2008 Report on the Global AIDS Epidemic. July 2008.

3.2 Ensuring appropriate organizational arrangement to support collaboration between state and non-state actors for effective response to HIV.

Local government, alone, cannot respond effectively to HIV, but can cooperate with the existing local response managed by civil society organizations, private sector and other communities in order to make the overall response more effective. Through cooperation with various actors (including with various deconcentrated national bodies) a local authority can access skills and resources that are not available within or are not within the mandate of the local government. For example, in the case of conducting a local HIV situation analysis, the participation by different groups can contribute to a much richer analysis. The inclusion of civil society organizations in the process can lead to the provision of more detailed information on community issues and priorities related to most-at-risk populations. Private sector actors working within a certain sector, for example tourism and transport, may have a better understanding of sector-specific HIV risks. And lastly, but crucially, people living with HIV can offer a valuable perspective on accessibility, affordability and quality of care, as well as issues of stigma. The involvement of a variety of stakeholders in the design and delivery of health and social support services, accompanied by accountability mechanisms, can improve the quality of and access to HIV related services as they become more responsive to local needs and conditions. For example, by contracting out HIV related services to a civil society organization which has local expertise, great outreach and trust within the community, local government can contribute towards the achievement of UA on a local level as it may allow for an increased access to prevention and care for most-at-risk populations. This may result in a more effective allocation of local government resources towards programmes that are better targeted and have a bigger impact on the HIV epidemic (such as IDU and SW programmes). At the same time, it may motivate HIV service providers to work better together to share limited resources and come up with innovative solutions, for example in the form of partnership and collaboration between the Government, civil society, and the private sector.

Ukraine: The Impact of Local Partnerships.

Ukraine, population 46 million has an estimated 430,000 people living with HIV (as of 2007); this is roughly 1.6 percent of the population of adults aged 15-49. 44 percent of HIV cases occur amongst women, and an estimated 19,000 deaths were due to AIDS in 2007. The experience of the "All-Ukrainian Network of PLHIV" is an interesting example of how valuable a civil society partner can be to local authorities. The Network was formed in the late 1990s by people living with HIV alarmed at the rapidly growing HIV epidemic in their country and the lack of resources and support for themselves and others living with HIV. Since then, the Network has grown rapidly and steadily. The network has established a structure consisting of a central office at the national level as well as local branches tied up to local action groups in every oblast of Ukraine. As a result, it has established and sustained agreements for HIV support services for people living with HIV in collaboration with authorities and service organizations at both national and local level. In 2006, it provided services and support to more than 14,000 people living with HIV in a wide range of areas including providing access to treatment, awareness raising and advocacy events, and other activities. The network is currently engaged with 23 regional administrations and 44 municipalities.

Source: UNAIDS Best Practice Series. A Nongovernmental Organization's National Response to HIV: the Work of the All-Ukrainian Network of People Living with HIV. UNAIDS, 2007.

The capacity of a local authority to engage stakeholders and collaborate with private and civil society communities for service delivery on a local level is to a certain extent determined by the legislative and policy context, including the local governance context of the country. For example, is there a framework in place for fiscal decentralisation? Do budgets exist to support start-up projects and programme development activities on sub-national level? Is there a legal mechanism for government to fund non-government organizations for service provision via the state or sub-national budget?

As local government systems in many countries in the region are at a rudimentary stage of development, legislation and/or practice guidelines related to HIV governance and service delivery on a local level may not always exist, and when they do, ongoing reform often ensures a degree of uncertainty, as do accepted lags between legislative decentralization reform and practice. Such irregularity and uncertainty become especially problematic in planning new services and integrating services. In the Russian Federation for example, according to Federal Law, medical care for HIV positive citizens is provided based on the Program of State Guarantees for Free Medical Care to Citizens of the Russian Federation. However, free drugs and outpatient treatment are provided by specialized medical institutions based on the procedures established by the federal or regional (local) government creating a situation where access to treatment may differ considerably throughout the country, greatly depending on the regional budget. In practise then, access to free treatment for many people may be limited.[33]

The local authority's capacity to negotiate about policies and budgets with regional and central authorities, as well as with service delivery partners is another issue that might create obstacles or open doors for local HIV collaboration and initiatives.[34] In Ukraine for example, there is no mechanism for social services contracting, with the result that municipalities are not able to form official agreements with civil society organizations for service provision. Moreover, by law treatment for HIV (including antiretroviral therapy disbursement and diagnostics such as CD4 testing) is only provided at special AIDS centers, a situation that prevails in many countries of the CIS. And HIV testing is carried out through local AIDS centres, which are subordinate to the Ministry of Health rather than the relevant municipality.

The capacity to engage stakeholders and collaborate for service delivery can be supported also by the establishment of coordination structures at the local level that promote the engagement and communication among the local HIV response multiple-stakeholders. It can be set up between the authority and HIV stakeholders in the private and civil society community, between the local, regional and national level, as well as between local governments (the extent of inter-municipal cooperation is determined by the enabling environment). This will reduce the risk of creating duplication of activities, and increase the chances of creating synergies between complimentary services offered by the various actors in a community. In Ukraine for example, there is a coordination structure set up not only a the regional level, but also at the municipal level throughout the country, with local AIDS councils that include officials from key governmental sectors such as health, education, labour, information, and other, as well as a range of local civil society and faith-based organizations (there is less involvement of the private sector). Another example is the municipalities in Uzbekistan which set up Regional Coordination councils on HIV in 2007, (that were later abolished due to a new national coordination structure set up in the beginning of 2009). In Russia, a number of regions, including Altai Krai and Volgograd, have established multi-sectoral coordination committees to strengthen the local response to HIV.

Partnership between departments and across the tiers and spheres of government are critical to development of sustainable local responses. Still, much remains to be learned about the conditions under which local governments and civil society organization partnerships[35] for delivery of health and social development services related to HIV programs are effective, efficient, sustainable - and to what degree they are complementary to or possibly duplicating local government activities and decentralized programmes.[36] In the Europe and CIS region, such partnerships are a relatively new feature and not widely applied in the area of HIV service delivery on a local level – they seem to exist mainly in small-scale cooperation and funding agreements which link civil society organizations and the Government on a central level.[37] Still, partnerships between the Government and non-state actors (including public-private partnerships) have been highlighted as an important way to overcome especially the stigma against people living with HIV and to implement the necessary services for the achievement of UA in the region.[38] One example of this is Croatia, where local governments in several urban centres provide direct financial support to HIV related programs implemented by non-governmental organizations (e.g. harm reduction, peer education, and community based activities aimed at promoting reproductive health care). For local authorities to develop their capacity to engage in and sustain partnerships for service delivery, at the level of enabling environment it is valuable to have legislation in place that eases tax burdens on non-profit organizations, and that allow direct public funding of civil society organizations to carry out services for key populations at risk, as well as

the removal of legal barriers on the freedom of association and expression of civil society organizations and key populations at risk.

At the level of the organization, the administration should be capable of effectively managing partnerships with the private sector and civil society. This requires the elaboration of internal guidelines and procedures facilitating collaboration with partners for service delivery, in terms of placing tenders, contracting and procurement systems, and ensuring programmatic and financial accountability (for example who is responsible for and financing the monitoring and evaluation of the services, as well as for ensuring inclusion of most-at-risk populations and other).

At the level of the individual, it is important to ensure that there are sufficient, suitably qualified and experienced staff (departments and/or specific job holders) to perform the tasks related to the management of partnership. If the personnel of the local authority have no previous experience of managing this type of partnership, some form of capacity development might be required for them to carry out their tasks effectively.

In order to facilitate more inclusive approaches with a broader range of stakeholders engaged in the local response, it is important that local authorities have accountability mechanisms in place to monitor service delivery carried out by government and non-government institutions. Without such arrangements, it is difficult for citizens to hold their local government accountable for progress or lack of progress to achieve Universal Access in their communities. At the organizational level, the local authority administration must define clearly who is responsible for which service and how implementation of that service will be monitored and evaluated (this could be tied to specific departments or job holders). –This requires that specific policies legislative provisions are in place that provide for stakeholder and client participation.

3.3 Facilitating support for national policies/ strategies and providing services

Local authorities can contribute to the achievement of Universal Access by working to adapt national HIV strategies and policies to the local epidemiological situation and specific needs of the community in line with the principle of "Know Your Epidemic". Ensuring that national efforts are translated into local services for treatment, prevention, HIV testing, and awareness raising that reach the right people in the community (especially most-at-risk populations). This work allows for the national response to become better targeted and have a greater impact on the epidemic in the region.
For a local authority to develop the capacity necessary to undertake the supportive role described above, it must have a mandate to provide services within the national HIV response. This is determined by the legal and policy context (the enabling environment) of the country, including the local governance context, which defines what are the responsibilities of local authorities to provide the required services on a local level (for example provide treatment services such as antiretroviral therapy, engage in prevention through information campaigns, and carry out HIV tests). The financial and political authority of the local government in relation to providing these services is also determined at this level, for example to what extent a local government can decide on the type of services, if it can enter into public-private partnerships and extract fees and/or taxes from citizens on a local level to finance these services.

Local Authorities: The Case of the Missing Mandate?

The variety of legal and regulatory frameworks in the Europe and CIS region related to local authorities and their role in combating HIV varies greatly. In Russia for example, as harm reduction is not stipulated in law, regions and local authorities have no obligation to undertake harm reduction activities. In addition, the country has an extensive vertically organized system of federal, regional and local AIDS Centers that run under the auspices of the national Ministry of Health, potentially reducing sensitivity to local contexts. In Uzbekistan, HIV testing services are run by the Regional AIDS Centres that are supported both by the Ministry of Health and local municipalities, thus giving the local authorities a key role in providing service to meet national UA targets. In Kyrgyzstan, decision making related to HIV is still very centralized, with the result that prevention and medical services are in practice mostly offered in the capital Bishkek, but not in the rest of the country (apart from testing facilities). In addition, local leaders often do not recognize the importance of treatment services, making it very difficult to establish it at the local level. As a result there is de facto no mandate for local authorities in Kyrgyzstan to support achievement of national UA targets.

Source: Regional Capacity Assessment in the HIV/AIDS Area in Eastern Europe and the CIS.

Given that the local authority has a mandate to provide services related to HIV – it must also have the necessary motivation to implement it. The greatest constraint in providing motivation is often related to budget allocation –the local authority may not have been provided with sufficient funding to carry out its mandate, or with the adequate resources (fiscal or human) to develop their skills as needed – this works as disincentives for the local authority to carry out their work. In Russia for example, there is often a problem for public health centres to support HIV positive women in the postnatal period, as local funding for milk formulas to substitute breastfeeding is lacking. Motivation to provide HIV services at local level might be affected also by fiscal, administrative, regulatory, market and financial incentives and disincentives stemming from on-going decentralization processes.

At the level of the organisation, it is equally important to ensure that the local authority has the capacity to plan and spend budgets, and monitor and evaluate resources as they are being spent on delivery of HIV related services. Establishing systems that enhance the accountability of the local authority and its partners as service providers also provides motivation; for example systems that allow for the Central level and citizens to track public expenditures to see if they reach service providers, and the introduction of performance management at the organizational level, can help local governments to set priorities and oversee the provision of more flexible and appropriate service. In Tajikistan 2006 for example, there was no separate budget line for HIV in the national health budget, which made it difficult to determine how much exactly was being spent on HIV. The "demand" for accountability in the community can also be enhanced at the organizational level, by ensuring easy access for the public (including media) to information related to budgets, actual expenditure, performance targets and monitoring, as well as related to service delivery partnership arrangements.[39] Local authorities can also publish details from stakeholder consultations, results from client surveys, and planned changes regarding HIV response in local media.

In addition to mandate and motivation to participate in the national HIV response, for a local authority to develop the capacity necessary to undertake the supportive role described initially, it must also have the means to carry out its mandate. At the organizational level, this requires establishment of structures and processes within the authority and key partner organizations for planning and management of HIV programmes and service delivery.[40]

Ukraine: Integrating Local perspectives in National Plans

Ukraine has made great strides to ensuring that the National Programme on HIV/AIDS 2009 - 2013 fully incorporated local needs in perspectives. To ensure effective participation of the local authorities, the National Government held trainings in each municipality/oblast to develop the skills and knowledge of local authorities, including the local HIV/AIDS coordination councils, to undertake vulnerability assessments and to develop local Action Plans for HIV/AIDS response. The trainings were followed up by meetings where the same officials together developed recommendations for the draft National Programme on HIV/AIDS which were submitted to the to the National Committee on AIDS and Tuberculosis of the Ministry of Health, and included into the draft Law of Ukraine regarding the new National HIV/AIDS Programme, which was consequently approved by the Cabinet of Ministers of Ukraine on June, 2004.

Source: Regional Capacity Assessment in the HIV/AIDS Area in Eastern Europe and the CIS. Final Country Assessment Report for Kyrgyzstan, p. 35. Sanigest International and UNDP BRC, Slovak Republic 2006

In the Europe and CIS region HIV is gradually being addressed as a multi-sectoral issue, with responses shifting accordingly from the exclusive domain of Ministries of Health to specialized units responsible for overseeing the mainstreaming of HIV responses in multiple sectors. To support this process at a local level, local authorities may set up system of HIV focal points within its administration, to ensure multi-sector coordination of communication between its various departments, as well as from the regional and Central level of the Government. In this way, local authorities can ensure sustainable involvement in the national HIV policy and decision-making process, which may increase its opportunities to access funding, and at the same time provide guidance for national policy and service development related to HIV at the local level. As described in the above paragraph however, the effectiveness and efficiency of the organizational arrangements of the local authority described in this paragraph may be low, because of restrictions at the level of enabling environment. Ukraine for example, has the architecture for coordination in AIDS that provides for multi-sectoral coordination among governmental and non-governmental partners at the national, regional and local/municipal levels. In practice, however, this does not necessarily always function as designed or intended. For example, the vertically structured systems for planning and implementation of state programmes within Ministries and between sectors create serious barriers to multi-sectoral

collaboration and hamper the flexibility that is so essential to an effective response to AIDS. The extensive bureaucracy with high costs and slow management processes have also hampered the Government's response to AIDS at all levels in Ukraine, and the management of the National AIDS Programme continues to be dominated by medical specialists who have limited experience in planning and management.[41]

Lastly, depending on the nature of service delivery (for example whether it is public, public-private, public- SCO, and other) a local authority must have appropriately trained staff in place to be able to carry out technical tasks such as planning, budgeting, management, oversight and evaluation. At the individual level, capacity development of individual staff might also be needed in the form of training. In Armenia for example, 335 NGO personnel and 532 persons from Government Ministries and the Municipalities in the districts of Yerevan and staff from the Governors offices in the region (marzpetaran) and urban and rural communities (hamainkner) participated in trainings in 2004 where they learned how to plan, implement, monitor and evaluate HIV prevention activities, maintain good public relations and establish partnerships to make project and programmes more effective and efficient. Joint round tables were also held by local authorities in the marzer with non-governmental organizations and community elders to discuss potential partnerships for service delivery and joint-action plans for HIV Prevention.Training is a frequent activity of donor supported programmes, but does not in itself always lend to improved capacity of the organization in which the trainees work. Providing adequate incentives within organizations, such as increases in remuneration, or linking training to career growth, can also be important to ensure that trainees apply learned skill and effect change.

3.4 Information gathering, monitoring and evaluation, and feedback

Local authorities can play an important role to adapt evidence-informed responses to the local setting, in line with the principle of "Know Your Epidemic". By systematically analysing up-to-date information on the HIV profile of its community, and through monitoring and evaluation[42] local authorities can better assess the impact of HIV programmes on the lives of people living in the community, and identify gaps that need to be addressed in meeting UA targets for coverage and quality of prevention, treatment, care and support services. While the local authority and its partners are learning from the M&E result, and as their conclusions are fed back into their work as well as into the work of the Central level, local needs and priorities may be better reflected in future national HIV policies and programmes. Well-targeted research and M&E by local authorities can thus increase the efficiency of the overall national HIV response, and thereby contribute to the achievement of Universal Access.

At the level of enabling environment, the capacity of a local authority to gather information, undertake M&E, and feed back information into the HIV work of the Government and its partners, is generally shaped by national policies and legislation, including legislation related to local governance that determines its role as services provider and its financial resources. It is also determined by legislation relating to public health and disease control of importance for service provision of HIV treatment, prevention, testing and awareness raising. Although the involvement of local authorities in for example epidemiological surveillance may be limited, as it is largely carried out at the Central level (Ministry of Health) or by specialized institutions (for example National Centers of Disease Prevention and Control), local authorities can still contribute in the gathering of up-to-date information on the HIV profile of its community through research and surveys (including, biological and behavioral indicators, and qualitative research), which is of major importance to reduce the epidemic in a country. In Uzbekistan for example, local authorities in all regions of the county participated in sentinel surveillance among most-at-risk populations in 2007 to assess specifically the knowledge and HIV transmission among injecting drug users, sex workers and men who have sex with men. Also in Serbia, municipalities in the country participated in a MARP survey undertaken in 2008.

At the organizational level, the capacity of a local authority to gather information, undertake M&E, and feed back information into the HIV work of the Government and its partners, depends on the ability to collect and manage data as well as on the ability to analyze and learn from it. To ensure effective management of data collection in programmes and services, the local authority (together with partners if the programme and service is carried out in partnership with civil society organizations and private sector) must have regulations/standards in place for how data collection, as well as how M&E activities will be undertaken, and must define by whom, when, as well as how it will be funded. Ideally, the enabling environment contains national policies and guidelines with standards for monitoring and evaluation that a local authority can rely upon, if it is involved in provision of these services through public institutions (hospitals, dispensaries and schools) or in partnerships with civil society organizations or private sector. Equally important is to determine how the M&E results will be disseminated, to whom, when, and how it will be used - for example to evaluate outcome of HIV treatment and care programmes, to design health policies on health care

financing and models of delivery, to develop human resources and procurement systems and other.

From a perspective of UA – for local authorities to monitor progress towards UA on a local level it is important that the indicators that are being monitored and evaluated reflect the priorities not only of the local authority but also of the national M&E frameworks, and especially national targets set to achieve Universal Access by 2010. In addition, disaggregation of data in terms of gender, transmission route, age, and other factors allow local authorities to monitor progress on stigma and discrimination, as well as to identify the needs of particular populations and assess the effectiveness of targeted interventions for most-at-risk populations for example. Local authorities should also make sure that the result of M&E is fed back to the National AIDS Council / Committee and to line ministries on a Central level (for example with help of the local HIV focal point, and/or coordination council/committee) to ensure that local perspectives and recommendations regarding HIV services in the community are taken into account by the Central level in future programme design.

At the individual level, to develop the capacity for high quality and standardized gathering of information and M&E, local authorities and/or its service delivery partners must have the appropriate knowledge, skills and technology in place. This include for example supervision of data management (including planning, implementation and communication), collection of statistical data and evaluation, as well as knowledge of various methods, such as surveys of users of services, focus group/discussion groups, interviews, monitoring of operational processes, analysis of program documentation and minutes, and monitoring of resource allocation.

4. Summary and Recommendations

In the midst of an economic crisis whose impacts on Universal Access in the Europe and CIS are becoming all too clear, an opportunity exists to build off the nascent work of local authorities in contributing to Universal Access and develop a systematic approach that will assess and develop local capacities for this function. The rationale is clear:

- The epidemic in the region is manifesting itself amongst specific populations.
- The current principles of "Know your epidemic" encourages focus on targeted interventions addressing those who are most vulnerable and likely to be affected by the virus.
- Local authorities – due to their proximity to local populations – are well placed to provide services that will contribute to meeting UA targets in the country.
- Even without a local service provision mandate, local authorities can still play an important role in coordinating national efforts, building inclusive planning processes with local stakeholders and providing leadership to reduce stigma.

As in any crisis, the search for more efficient and effective ways of providing services has highlighted an opportunity to examine the role of local authorities and the capacities needed to contribute to the meeting of national UA targets. It is clear from the analysis presented in this paper that there are already examples of local authorities playing this role (Ukraine and Kazakhstan for instance). But the potential for action in this area far exceeds current activity. Indeed, it is notable that much of the international and national government response in the region has been focused at the national level, with little recognition given to the role that local authorities can and do play.

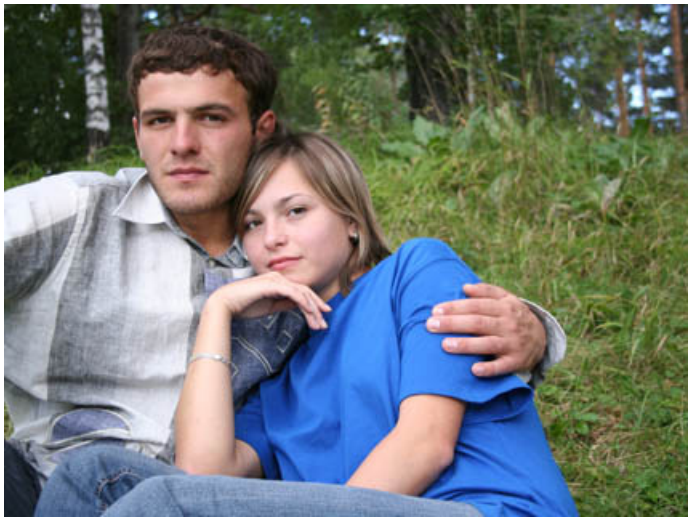
The purpose of this was to promote discussion of the role local authorities can play in contributing to the achievement UA. This paper does not purport to provide answers, rather only to make an argument that this rather overlooked area could be valuable in halting and reversing the spread of the epidemic in the region. A range of actors are involved in supporting national efforts to achieve UA, and as such it is hoped that this paper can serve as an input into discussions on how to advance the work in this area. Additionally, it is necessary to learn from the ongoing work, and scan globally and regionally for best practices that can be adapted to the varied national and sub-national contexts in the

region. To this end, a series of steps have been proposed below in order to carry this work forward, and ultimately contribute to the achievement of UA targets throughout the Region:

1. Convene a multidisciplinary meeting to discuss the concepts put forth in this paper. This meeting would convene experts from the fields of HIV, local governance, capacity development, and most importantly local counterparts working to achieve UA targets or take other action against AIDS at the local level. As a short three day symposium, this would vet the central premises of this paper and aim to build momentum in countries across the region to develop an agenda for action.

2. Development of a capacity assessment methodology for local authorities to contribute to Universal Access achievement. Excellent work has been conducted on capacity assessments at the national level in this area, but an adapted methodology for the local level is not available. Ideally, through existing experience in two countries in the region (chosen for varying degrees of decentralization or deconcentration and current work in the area of contributing to UA target achievement) a methodology could be developed and tested in other local authorities in the same two countries. Key here would be to integrate the capacity assessment and subsequent responses within existing national planning and budgeting mechanisms, and/or secure sufficient donor financing to ensure that the responses can be followed through.

3. Launching of finalized methodology for all countries across the region. Ideally, application of the methodology would be accompanied by a regional funding window to which countries could apply for the technical support needed to undertake such assessments and implement the responses.



Russia Federation - UNAIDS/S.Drakborg

5. Resources

AMICAALL 2007. AMICAALL Toolkit. Local Governance and AIDS. Available at: http://www.amicaall.org/publications/amicaalltookit2_eng_final.pdf

AMICAALL 2008. Presentation held at the 6th Forum of the World Alliance of Cities Against Poverty (WACAP), Athens, Greece 2008. Round table 3: HIV. Available at: http://www.amicaall.org/publications/presentations/AYANDA%20WACAP%20NOTES_ENGLISH.pdf

European Centre for Disease Prevention and Control (ECDC) and the WHO/Europe 2008. HIV/AIDS Surveillance in Europe – 2007. Available at: http://ecdc.europa.eu/en/files/pdf/Publications/20081201_Annual_HIV_Report.pdf

The European Charter of Local Self government. Available at: http://conventions.coe.int/Treaty/EN/Treaties/Html/122.htm

European Parliament resolution of 15 March 2007 on local authorities and development cooperation (2006/2235(INI)). Available at: http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2007-0083+0+DOC+XML+V0//EN

Sanigest International and UNDP Bratislava Regional Center (BRC) Slovak Republic, 2006. Regional Capacity Assessment in the HIV/AIDS Area in Eastern Europe and the Commonwealth of Independent States.

United Cities and Local Governments (UCLG), 2008. Decentralization and Local Democracy in the World. Chapter: Eurasia. Author: T.Y. Khabrieva & L.V. Andrichenko & V.A. Vasiliev. Available at: http://www.cities-localgovernments.org/gold/gold_report.asp

UNAIDS Universal Access Issues Paper. Available at: http://data.unaids.org/topics/UniversalAccess/UniversalAccess_Issues_Jan2006.pdf

UNAIDS 2008. Report on the global AIDS epidemic. Available at: http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/

UNAIDS 2007. Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators: 2008 reporting. Available at: http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf

UNAIDS 2009. Hidden HIV epidemic amongst MSM in Eastern Europe and Central Asia. Available at: http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090126_MSMUkraine.asp

UNAIDS 2007. A Nongovernmental Organization's National Response to HIV: the Work of the All-Ukrainian Network of People Living with HIV. Available at: http://data.unaids.org/pub/Report/2007/jc1305_ukraine_en.pdf

UNAIDS Ukraine 2008. Comprehensive External Evaluation of the National AIDS response in Ukraine. Consolidated Report. Zero draft.

UNAIDS and WHO 2008. Eastern Europe and Central Asia: AIDS epidemic update: regional summary. Available at: http://data.unaids.org/pub/Report/2008/jc1529_epibriefs_eeurope_casia_en.pdf

UNAIDS and WHO 2008. Progress on Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. Available at: http://www.euro.who.int/Document/SHA/Dublin_Dec_Report.pdf

UNDP BRC Slovak Republic 2008. Regional HDR. Living with HIV in Eastern Europe and the CIS. The Human Cost of Social Exclusion. Available at: http://europeandcis.undp.org/rhdr.aids2008/

UNDP 2007. Responding to HIV/AIDS in Europe and the CIS: 4th RBEC Community of Practice Meeting Concept Note.

UNDP 2008. E-discussion on HIV/AIDS with the Capacity Development networks.

UNDP Bureau for Development Policy (BDP) 2006. Governance of HIV/AIDS Responses Issues and Outlook. Available at: http://www.undp.org/hiv/docs/alldocs/1599-Governence-brochure.pdf

UNDP/BDP/CDG 2007. Supporting Capacity Development: The UNDP Approach. Available at: http://capacity.undp.org/index.cfm?module=Library&page=Document&DocumentID=6211

UNDP BRC and Oslo Governance Centre, 2008. Accountability and Voice for Service Delivery at the Local Level. A background paper for UNDP's regional training event Developing Capacities for Accountability and Voice. Available at: http://www.undp.org/oslocentre/docs08/sofia/AV%20in%20local%20service%20delivery%20UNDP%20final.pdf

UNDP Capacity Development Practice Bratislava Regional Center, Slovak Republic, 2008. Methodology for the assessment of capacity of municipalities in Turkey and the Western Balkans to deliver services. Available at: http://europeandcis.undp.org/cd/show/6826AAEC-F203-1EE9-B89A10A15D-CBFB84

World Bank - Urban Development Unit, Local Government and HIV/AIDS Initiative; Cities Alliance; UNDP - Urban Management Programme; AMICAALL 2006. Local Government Response to HIV/AIDS: A Handbook. Available at: http://www.worldbank.org/urban/hivaids/

World Bank 2006. Local Government Responses to HIV/AIDS: A Training Toolkit (CD-ROM). Available at: http://info.worldbank.org/etools/docs/library/134438/ALGAF/Algaf_cd/index.htm

World Bank 2006. Supporting Local Governments Responses to HIV/AIDS: Positions, Priorities and Possibilities. Available at: http://www.worldbank.org/urban/hivaids/kelly.pdf

The World Bank, Washington, D.C. 2005. Committing to Results: Improving the Effectiveness of HIV/AIDS assistance. An OED Evaluation of the World Bank's Assistance for HIV/AIDS Control. Available at: http://web.worldbank.org/WBSITE/EXTERNAL/EXTOED/EXTIEGHIVAIDS/0,,contentMDK:21017592~pagePK:64168427~piPK:64168435~theSitePK:2832150,00.html

Web links:

The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMIICAAL) - http://www.amicaall.org

The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMIICAAL) programme in Ukraine http://www.amicaall.org/ukraine/eg/index.htm

Information on "Universal Access and Process available at: http://data.unaids.org/pub/Report/2006/Considerations_for_target_setting_April2006.pdf http://www.unaids.org/en/PolicyAndPractice/TowardsUniversalAccess/default.asp

Information about the "Three Ones" principle available at: http://search.unaids.org/Results.aspx?q=Three+Ones&x=0&y=0&o=html&d=en&l=en&s=false

Setting UA Targets Guidelines. Available at: http://www.unaids.org/en/PolicyAndPractice/TowardsUniversalAccess/SettingsNationalTargets/ and http://data.unaids.org/pub/Report/2006/Considerations_for_target_setting_April2006.pdf

Web page of the "Universal Access AIDS Campaigning – Keep the Promise," available at: http://www.ua2010.org/en/UA2010.

Open Society Institute. Local Government and Public Service Reform Initiative - http://lgi.osi.hu/

World Bank - http://www.worldbank.org/urban/hivaids/

6. Endnotes

1 The annual numbers of newly reported HIV diagnoses are rising in Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Tajikistan, and Uzbekistan (which now has the largest epidemic in Central Asia). *2008 Report on the global AIDS epidemic.* UNAIDS 2008.

2 *Regional HDR. Living with HIV in Eastern Europe and the CIS. The Human Cost of Social Exclusion.* UNDP BRC Slovak Republic, 2008.

3 In principal, through Universal Access, transmission of HIV can be prevented and that support for people living with HIV (as well as their care-givers and families) can be provided. Also through UA, AIDS-affected families can be supported in mitigating the effects of the illness and death on their own households and communities. For more information see: Web page of the "Universal Access AIDS Campaigning – Keep the Promise." http://www.worldaidscampaign.org/en/In-country-campaigns/Europe/How-G8-Can-Keep-the-Promise-of-Universal-Access-by-2010

4 For the full indicator definitions, see *Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators: 2008 reporting*. UNAIDS 2007.

5 The "Three Ones" principle includes: One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority, with a broad-based multi sectoral mandate; and One agreed country-level Monitoring and Evaluation System

6 *Progress on Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia.* UNAIDS and WHO 2008.

7 *Regional Capacity Assessment in the HIV/AIDS Area in Eastern Europe and the Commonwealth of Independent States.* Sanigest International and UNDP Bratislava Regional Center (BRC) Slovak Republic, 2006.

8 *Ibid.*

9 *E-discussion on HIV/AIDS with the Capacity Development networks.* UNDP, February 2008.

10 According to the IMF World Economic Outlook, the CIS, SEE and EU New Member States have been impacted the hardest of all regions in the world in terms of GDP growth. See: http://www.imf.org/external/pubs/ft/weo/2009/01/index.htm

11 *"Unprotected Tajik Male Migrant Workers in Moscow at Risk for HIV/AIDS."* Journal of Immigrant and Minority Health. Vol. 10. No.5. October 2008

12 http://data.unaids.org/pub/Report/2009/jc1704_econcrisis_hivresponse_en.pdf

13 In this document, the term "local authorities" refers to all bodies of local government at the sub-national

14 UNDP defines capacity development as "the process through which individuals, organizations, and societies strengthen and maintain the capabilities to set and achieve their own development objectives over time." *Supporting Capacity Development: The UNDP Approach.* UNDP/BDP/CDG, 2007-06.

15 The European Charter of Local Self government further notes that preferably the authorities closest to the citizens should exercise public responsibilities, as they are best positioned to note the needs of the citizens, respond effectively to them, and are held accountable by them.

16 For a complete methodology of such an assessment (focus on national level) and assessments undertaken in Croatia, Kyrgyzstan, Moldova, Russia, Tajikistan, see: *Regional Capacity Assessment in the HIV/AIDS Area in Eastern Europe and the Commonwealth of Independent States.* Sanigest International and UNDP BRC Slovak Republic, 2006, as well as the World Bank in Africa - S*upporting Local Governments Responses to HIV/AIDS: Positions, Priorities and Possibilities.*

17 The work of the AMICAALL and their programme the Initiative for Community Action on AIDS at the Local Level was initially supported by UNDP and UNAIDS. It is a unique mechanism for collective action on AIDS at the community/ municipal level operating in 13 African countries which has also been used as an operational model in other regions of the world including in Ukraine.

18 *Governance of HIV/AIDS Responses Issues and Outlook.* The Bureau for Development Policy (BDP), UNDP 2006.

19 According to UNDP, the enabling environment includes the legal, regulatory and institutional frameworks, power structure and influence, ethos, incentives/constraints, interaction of groups/network, and social capital. The Organizational level provides the framework (e.g. systems, procedures and rules) for individuals to connect and achieve goals beyond individual capacities. This is a collective manifestation of individual capacities.

20 *Deconcentration* is the transfer of functions and resources to local level units of the same administrative system while power remains at the centre. *Devolution* is the transfer by legal or constitutional provision of functions, resources and power to the community level. *Delegation* means that the Government temporarily assigns specific functions to an institution such as a health or education board. *Privatization* involves transfer or surrender of responsibilities of state enterprises to private entities.

21 **Political decentralization** aims to give citizens or their elected representatives more power in public decision-making. It is often associated with pluralistic politics and representative government, but it can also support democratization by giving citizens, or their representatives, more influence in the formulation and implementation of policies. **Administrative decentralization** seeks to redistribute authority, responsibility and financial resources for providing public services among different levels of governance. It is the transfer of responsibility for the planning, financing and management of public functions from the central government or regional governments and its agencies to local governments, semi-autonomous public authorities or corporations, or area-wide, regional or functional authorities. Dispersal of financial responsibility is a core component of **fiscal decentralisation**. If local governments and private organizations are to carry out decentralized functions effectively, they must have an adequate level of revenues – either raised locally or transferred from the central government– as well as the authority to make decisions about expenditures.

22 *Decentralization and Local Democracy in the World.* Chapter: Eurasia. Author: T.Y. Khabrieva & L.V. Andrichenko & V.A. Vasiliev. United Cities and Local Governments (UCLG), 2008.

23 Core indicators for prevention include: MTCT, MARP Programmes, HIV Life Skills, Education in Schools; Blood Safety

24 Core indicators for treatment coverage include: ART, Co-management of TB & HIV treatment; Survival after 12 months ART

25 Core indicators for knowledge of transmission include: Youth, MSM, IDU, SW

26 Local government leaders include for example Mayors, Councilors, Chief Executive in Office (CEO), as well as Executive Management Committees, and legislative bodies on local level, such as Municipal councils.

27 The implementation of PMTCT programmes has been rapidly scaled up in many countries in the region but has not managed to move from increased access towards increased quality of services and ensuring better access to routine services for MARP. *2008 Report on the global AIDS epidemic.* UNAIDS 2008

28 All countries in the region have to varying degrees embraced the principle that the potential double harm of injecting opiates and HIV, Hepatitis C/B infection can be reduced by politically courageous "Harm Reduction" policies - most successful is Croatia which has introduced methadone countrywide. *ibid.* However, some countries that have adopted Needle Exchange Programmes have failed to complement this with the other internationally recognized pillar of Harm Reduction: Opiate Substitution Therapy.

29 Few countries have policies or strategies in place addressing the needs of orphans and vulnerable children. This is especially concerning in countries such as the Russian Federation and Ukraine where the numbers of children affected by HIV are climbing rapidly. *ibid.*

30 While most countries in the region have laws in place to protect the rights of PLHIV, there is a broad lack of protection for particular groups such as prisoners, IDUs and SW. As a consequence there might be epidemics thriving among these groups, for example among MSM, that are kept hidden and underreported due to a reluctance to reveal the cause of

their infection for fear of stigmatisation. *Hidden HIV epidemic amongst MSM in Eastern Europe and Central Asia.* UNAIDS 2009.

31 The GFATM funds have allowed for a dramatic expansion in provision of antiretroviral therapy (ART) in the region Still, only 17 percent of persons in need of ART were receiving it as of December 2007, and only a handful of countries including Uzbekistan and Kazakhstan provide ART drugs to more than 20 percent of those in need. Ukraine has a particularly poor coverage rate at just 8 percent. Only 16 percent of adults and children with advanced HIV in Russia were receiving ART in 2007, despite the treatment being free, though this figure increased roughly five percentage points each year since 2005. *2008 Report on the global AIDS epidemic*. UNAIDS 2008.

32 *Local Government Response to HIV/AIDS: A Handbook*. World Bank - Urban Development Unit, Local Government and HIV/AIDS Initiative; Cities Alliance; UNDP - Urban Management Programme; AMICAALL 2006.

33 *Regional Capacity Assessment in the HIV/AIDS Area in Eastern Europe and the CIS. Final Country Assessment Report for the Russian Federation*, p. 86. Sanigest International and UNDP BRC, Slovak Republic 2006.

34 In the Europe and CIS region, leadership challenges on Central level particularly lie in enforcing programmes for structural reforms to health systems, and to institute harm-reduction programmes and other HIV programmes related to injecting drug use. As such it might be especially challenging for local authorities to roll out programmes and services on a local level that touch upon these issues. *Progress on Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia.* UNAIDS and WHO 2008.

35 Examples of such partnerships are corporatisation, public-public partnerships (between municipalities), contracting out, leases and concessions and transfer of ownership. Common areas of partnership are technical assistance programmes, service partnership agreements, monitoring and evaluation services, and programme management services. *Supporting Local Government Responses to HIV/AIDS: Positions, Priorities, and Possibilities.* World Bank.

36 *Committing to Results: Improving the Effectiveness of HIV/AIDS asistance. An OED Evaluation of the World Bank's Assistance for HIV/AIDS Control,* p. 32. The World Bank, Washington, D.C. 2005.

37 In addition, donor funding is often embedded in terms of 'partnerships', but the conditions and legislative framework of such partnerships are most of the time based on temporary arrangements (for example Memorandum of Understanding) that suit the relatively limited scale of involvement at the program and project level – which is contrary to what the capacity development approach seeks to achieve.

38 *Regional HDR. Living with HIV in Eastern Europe and the CIS. The Human Cost of Social Exclusion*, p. 53-54. UNDP BRC Slovak Republic, 2008.

39 For more examples of how accountability for service delivery can be enhanced on a local level, see: *Accountability and Voice for Service Delivery at the Local Level.* A background paper for UNDP's regional training event Developing Capacities for Accountability and Voice. UNDP BRC and Oslo Governance Centre, 2008.

40 More generally, at the organizational level, the local authority needs to take into account the so called "core issues" that foster or hinder organisational effectiveness, such as human resources, business process, IT infrastructure, and business unit structures, and how the organization works with knowledge and learns from its own and others experiences.

41 *Comprehensive External Evaluation of the National AIDS response in Ukraine. Consolidated Report. Zero draft.* June 2008, UNAIDS Ukraine.

42 Monitoring is the regular assessment of ongoing activities and progress and covers all aspects of program activity and involves systematic collection of information relating to inputs, activities/processes and outputs. Evaluation is the periodic assessment of overall achievements and concerns the outcomes and ultimately the impact of a program. Frequently evaluation uses program-monitoring data, but it also involves a specific and often independent program of research.