

**Local government and HIV/AIDS in
South Africa**

Multi sectoralism, mainstreaming and
partnering: towards a local government
response to HIV/AIDS

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government response to HIV/AIDS

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TABLE OF CONTENTS

1.	THE HIV/AIDS EPIDEMIC	1
2.	THE POLITICAL IMPACT IN SOUTHERN AFRICA	2
3.	SOUTH AFRICA	3
4.	LOCAL GOVERNMENT	6
5.	JOHANNESBURG	10
6.	OTHER MUNICIPALITIES	12
7.	CONCLUSION	13

LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	African National Congress
CBO	-	Community-Based Organisation
GDP	-	Gross Domestic Product
HIV	-	Human Immunodeficiency Virus
IDP	-	Integrated Development Plan
JAC	-	Johannesburg AIDS Council
MTCT	-	Mother to Child Transmission
NACOSA	-	National AIDS Convention of South Africa
NGO	-	Non-Governmental Organisation
STD	-	Sexually Transmitted Disease
TAC	-	Treatment Action Campaign

1. THE HIV/AIDS EPIDEMIC

HIV/AIDS has been reported from every inhabited continent in the world - it is a global epidemic. According to statistics, approximately 36 million people worldwide are living with the virus, 25 million of whom are in sub-Saharan Africa.¹

This has significant implications for the Southern African region in terms of adult deaths, life expectancy and population growth rate. Furthermore, because HIV/AIDS is prevalent among young adults (25-29 years of age)², there has been a distinct rise in the number of orphans, child and pensioner-headed households. Notwithstanding the impact of the HIV/AIDS epidemic on the region's demographics - there have also been a number of social implications.

Education sectors have reported a drop in the supply and demand for educational services. Zambia, for example, tracks the number of teacher deaths due to HIV/AIDS for 1998 at 1 331. Zimbabwe on the other hand records an actual shrinkage in the primary school sector projecting that there will be a 10% reduction in the number of primary school attendees by 2010.³ Provision and extension of education is a fundamental and basic goal of all developing countries. The HIV/AIDS crisis is compounding existing challenges to this goal.

Health care costs for HIV/AIDS patients are projected to be on the rise. Even countries within the region who do not yet provide antiretroviral therapy to HIV positive patients still have to contend with costs for palliative care, opportunistic infections such as tuberculosis and counselling and information provision for patients, as well as costs for preventative measures such as the provision of free condoms. World Bank projections for palliative care, opportunistic infections and antiretroviral therapy per patient per year are \$19, \$33 and \$190 respectively.⁴ This is sure to burden already stretched or ineffective budgeting for health care in the region.

The economic effects of the HIV/AIDS crisis are potentially staggering. Illness and death across the labour force will effectively mean a drop in economic growth rates as well as a drop in income levels. This will affect long-term economic growth which will also be in jeopardy because of the erosion of the institutions and policies that support economic frameworks due to the loss of skills.

Various studies conducted in the region have given rise to concern. For example, households in Zambia affected by HIV/AIDS have reported a 30-35% lower annual income

¹ Barnett T, Whiteside A. *Aids in the Twenty-First Century: Disease and Globalisation*. Hampshire: Palgrave Macmillan, 2002: 9. These statistics are as of the end of 2001.

² Barnett, Whiteside. 121.

³ The Policy Project for Bureau for Africa, Office of Sustainable Development, US Agency for International Development. *HIV/AIDS in Southern Africa: Background, Projections, Impact and Interventions*. 2001: 33.

⁴ The Policy Project for Bureau for Africa, Office of Sustainable Development, US Agency for International Development. *HIV/AIDS in Southern Africa: Background, Projections, Impact and Interventions*. 2001: 30.

level than unaffected households. In Zimbabwe, funeral costs are reported to be burdening households living below the poverty line. The agricultural sector is also feeling the effects of HIV/AIDS. A Zimbabwean study showed that the death of a breadwinner due to AIDS cut the marketed production of maize in small scale farming and communal areas by 61%. This trend has also emerged in other parts of the region. A Malawian study evaluated the costs of HIV in terms of medical services, funeral costs, death benefits and absenteeism to be 3,4% of the gross profit of a tea estate between 1995 and 1996. In terms of the corporate sector, a study in Botswana found that the impact of HIV/AIDS on firms was an increase in sick leave, medical costs and a loss of productivity. A South African study examined the expected impact on employee benefits and thus on corporate profits - it found that the total cost of benefits would rise from 7% of salaries in 1995 to 19% in 2005. A South African study also predicts that by 2010 the level of GDP will be 17% lower in a "with HIV/AIDS" scenario as opposed to a "without HIV/AIDS" scenario.⁵

2. THE POLITICAL IMPACT IN SOUTHERN AFRICA

The political impact of HIV/AIDS in Southern Africa is twofold. Not only will it affect the institutions of government, but it will affect governance in that priorities and expenditures will have to be re-evaluated.

Widespread illness and death of citizens will impact significantly on democratic processes. There will be a distinct strain on voting, a vital tenant of the democratic process, for the simple reason that AIDS-related deaths will claim the lives of registered voters between elections. This will also necessitate the constant reworking of voters rolls. Alongside this there will be the dilemma of the loss of personnel and skills within the election organizing body, not to mention the death of politicians resulting in the need for by-elections or a dependence on deputies. Notwithstanding actual voting, there may well be a reduced incentive for citizens to want to vote given that the advent of HIV/AIDS brings with it added pressures of reduced life spans and reduced incomes owing to deaths of breadwinners. This is a factor worth noting in the light of the fact that most Southern African countries fought long and hard to bring the democratic vote to their disenfranchised populations. Indeed theorists argue that the effect of HIV/AIDS on citizens may manifest politically in two ways. Citizens may either fall to feelings of powerlessness and hopelessness and cease from participating in their democracies altogether; or they may be inclined to support any entity that promises alleviation of the problem whether or not this entity is democratically elected.⁶

⁵ The Policy Project for Bureau for Africa, Office of Sustainable Development, US Agency for International Development. *HIV/AIDS in Southern Africa: Background, Projections, Impact and Interventions*. 2001: 35.

⁶ Mattes B. *Governance and HIV/AIDS*. A Paper delivered at the Regional Governance and AIDS Forum hosted by IDASA/UNDP HIV Development Project for Southern Africa, 2-4 April 2003.

Southern African democracies face three specific challenges from the epidemic: prevention, dealing with the HIV/AIDS infected and dealing with the impact of HIV/AIDS on society, the economy and the polity.⁷ Prevention will entail intensive information and education campaigns regarding the nature of HIV and ways to curtail its spread. Dealing with those already infected is a much bigger challenge, not just in terms of medical resources and personnel, but also in terms of counselling patients and monitoring the onset of opportunistic infections and adherence to antiretroviral therapy.

The impact of HIV/AIDS in the region includes the increasing number of orphans and the social, economic and political effects outlined above. These impacts could seriously affect development. Indeed, some analysts postulate that governments will be so consumed with dealing with the crisis that they will be unable to allocate resources to effectively deliver other services. And services that continue to run will be affected by a loss of skill and capacity.⁸

3. SOUTH AFRICA

The HIV/AIDS crisis was placed on the African National Congress (ANC) agenda well before it came to power in 1994. The ANC-led government has, however, failed up until this point to implement an effective policy to deal with the HIV/AIDS crisis in the country.

In 1991 when the Health Secretariat of the ANC was unbanned, the apartheid government's Department of National Health and Population Development formed the National AIDS Convention of South Africa (NACOSA) which drew together political parties, trade unions, the business sector, civic associations, government departments, health workers and academics. After the 1994 elections the ANC-led government, led by President Mandela, endorsed a formal strategy for NACOSA under the Minister of Health, Dr Nkosazana Dlamini-Zuma. But what followed was a disillusioning experience for what some had hoped would be rapid implementation of a strategy that would have South Africa setting an example for others.⁹

By 1996 it became clear that the plan was failing, with HIV levels having doubled from 7,6% in 1994 to 14,2% in 1996.¹⁰ The failing plan was compounded by Minister Dlamini-Zuma's refusal to make nevirapine available to HIV-positive pregnant women in order to prevent mother to child transmission (MTCT). Her justification for this was that nevirapine had yet to undergo the requisite testing in South Africa in order to ascertain its safety for public

⁷ Whiteside A. *The Current Status of HIV/AIDS in Southern Africa*. A Paper delivered at the Regional Governance and AIDS Forum hosted by IDASA/UNDP HIV Development Project for Southern Africa, 2-4 April 2003.

⁸ Barnett, Whiteside. 299.

⁹ Marais H. 'To the Edge.' *AIDS Review*. Centre for the Study of AIDS. University of Pretoria, 2000.

¹⁰ Van der Vilet V. *South Africa Divided Against AIDS: A Crisis of Leadership*. in Kauffman AD and Lindauer DL (eds). *AIDS and South Africa: The Social Expression of a Pandemic*. New York: Macmillan, 2004.

consumption. She was eventually compelled to do so after a court action by AIDS activists, the Treatment Action Campaign (TAC).

After the second democratic election in 1999 and under the helm of President Mbeki, the health portfolio was given to Minister Manto Tshabalala-Msimang. In May 2000 the Department of Health initiated its HIV/AIDS/STD Strategic Plan for South Africa.

The plan set forth the following strategies:

- An effective information, education and communications strategy;
- Increased access to and acceptability of voluntary HIV counselling and testing;
- An improvement in STD management and the treatment of opportunistic infection;
- The promotion of increased condom use to prevent STD and HIV infection; and
- An improvement in the care and treatment of HIV positive persons and persons living with AIDS to promote a better quality of life and limit the need for hospital care.¹¹

The plan was therefore very much more focused on prevention and management of HIV/AIDS rather than on treatment programmes for HIV/AIDS infected people. Once again AIDS activists, notably the TAC, criticized this stance and advocated for affordable antiretroviral therapy in public healthcare facilities.

In July 2002, the South African government established a Task Team to investigate the treatment, care and support for those infected and affected by HIV/AIDS. Following the report of the Task Team in August 2003 which included the option of antiretroviral therapy for people with HIV/AIDS, Cabinet instructed the Department of Health to develop an operational plan on an antiretroviral programme by the end of September 2003.

The plan aims to:

- Ensure that the great majority of South Africans not infected with HIV/AIDS remain uninfected through messages of prevention, changing life styles and behaviour;
- Enhance efforts in the prophylaxis and treatment of opportunistic infections and improved nutrition;
- Uphold effective management of those HIV-infected individuals who have developed AIDS-defining illnesses through appropriate treatment of AIDS-related conditions (including the possibility of using antiretroviral therapy in patients presenting with low CD4 counts to improve functional health status and to prolong life) and suitable palliative and terminal care where treatment has run its course.

¹¹ *HIV/AIDS/STD Strategic Plan for South Africa 2000-2005*. Department of Health, 2000.

Despite a standing commitment to prevention, the plan set forth a schedule for the roll-out of antiretroviral therapy in public hospitals across South Africa to begin in September of 2003¹² (roll-out actually only began in April 2004).

The reasons for the roll-out taking so long in South Africa have, in most quarters, been explained by President Mbeki's personal belief that HIV does not cause AIDS - a view that has earned him a bad reputation both locally and internationally with regard to the HIV/AIDS pandemic. Whatever justifications are offered for Mbeki's views, it has meant that prevention strategies were privileged over treatment strategies.

This effectively disillusioned people who were HIV positive or living with AIDS as they were relegated to a future of hopelessness. The government's lack of focus on treatment also compounded the stigma associated with being HIV positive or having AIDS, as well as failing to deliver to South African citizens their basic right to health care.

Current policy which involves roll-out is also fraught with challenges. Identified roll-out sites, comprising a certain number of hospitals in each province, are not all fully capacitated to handle the burdens on staff, medication and equipment.

The fragile nature of antiretroviral therapy itself is also a challenge. Patients are required to adhere very closely to medication, failure to do so will result in immunity to the medication rendering it ineffective. At this point it is questionable whether the government has built strong enough structures to facilitate patient counselling and monitoring to sustain effective antiretroviral therapy.

Current statistics according to a national HIV antenatal sero-prevalence survey conducted in 2002 indicates that 5,3 million South Africans were HIV positive by the end of 2002. This is an increase from the 2001 figure of 4,74 million.¹³ The table below indicates a steady rise in the number of HIV positive ante-natal patients presenting in South African clinics during the period 1994-2002, by province.¹⁴ Aside from continued use of nevirapine to prevent Mother to child transmission, it is hoped that the government roll-out will increase the lifespan of HIV positive patients while giving them a better quality of life and curtailing the AIDS mortality rates for South Africa.

¹² Operational Plan for Comprehensive HIV and AIDS Care. Management and Treatment for South Africa.

¹³ *National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa 2002*. Directorate Health Systems Research, Department of Health, South Africa.

¹⁴ *HIV/AIDS Statistics*. Health Economics and HIV/AIDS Research Division (HEARD), University of Natal, 2003.

PROVINCE	ESTIMATED % HIV POSITIVE									
	1994	1995	1996	1997	1998	1999	2000	2001	2002	
KwaZulu-Natal	14,4	18,2	19,9	26,8	32,5	32,5	36,2	33,5	36,5	
Mpumalanga	12,1	18,3	15,8	22,6	30,0	27,3	29,7	29,2	28,6	
Gauteng	6,4	12,0	15,5	17,1	22,5	23,9	29,4	29,8	31,6	
Free State	9,2	11,0	17,5	19,6	22,8	27,9	27,9	30,1	28,8	
North West	6,7	8,3	25,1	18,1	21,3	23,0	22,9	25,2	26,2	
Eastern Cape	4,5	6,0	8,1	12,6	15,9	18,0	20,2	21,7	23,6	
Northern Province	3,0	4,9	7,9	8,2	11,5	11,4	13,2	14,5	15,6	
Northern Cape	1,83	5,3	6,6	8,6	9,9	10,1	11,2	15,9	15,1	
Western Cape	1,2	1,7	3,09	6,3	5,2	7,1	8,7	8,6	12,4	

4. LOCAL GOVERNMENT

HIV/AIDS is not only a health problem but a development crisis, with an impact not only on community members' health but on nearly all aspects of community development. In South Africa the sphere of local government has been defined by the new concept of developmental local government, which is a critical element of the process of transformation of local government. Developmental local government, according to the March 1998 Local Government White Paper, is 'local government committed to working with citizens and groups within the community to find sustainable ways to meet their social, economic and material needs and improve the quality of their lives'¹⁵.

Indeed, the Local Government Municipal Structures Act promotes "democratic and developmental local government, in which municipalities fulfil their constitutional obligations to ensure sustainable, effective and efficient municipal services, promote social and economic development, [and] encourage a safe and healthy environment by working with communities in creating environments and human settlements in which all people can lead uplifted and dignified lives."¹⁶ The Local Government Municipal Systems Act goes further, directing that municipalities have the duty to:

- use their resources in the best interests of the local community;
- provide, without favour or prejudice, democratic and accountable government;
- encourage the involvement of the local community;

¹⁵ Layman T. 'Good Governance and Public Sector Accountability.' *AIDS and Governance in Southern Africa: Emerging Theories and Perspectives*. (Based on a report on the IDASA/UNDP Regional Governance and AIDS Forum, 2-4 April 2003.) IDASA/UNDP, 2003

¹⁶ Local Government Municipal Structures Act 117 of 1998, preamble.

- give members of the local community equitable access to the municipal services to which they are entitled;
- promote and undertake development; and
- promote a safe and healthy environment and respect the rights of citizens protected by the Bill of Rights.¹⁷

Municipalities are required to draw up Integrated Development Plans (IDPs) which take into consideration existing national or provincial policy. The challenges to local government brought on by the onslaught of HIV/AIDS are many and varied. They include:

- changes in demographic structures due to adult deaths;
- reduced life expectancy;
- increases in infant mortality;
- increased demand on the health care system;
- increased poverty exacerbating inequalities;
- a growing numbers of orphans;
- growing numbers of uncared for aged;
- increases in the demand for burial plots;
- changing income and expenditure patterns;
- reduced ability of households to pay for services, rates, rents and taxes;
- decreased productivity due to increased absenteeism;
- a loss of skills;
- higher employment benefits; and
- the threatening of investments in training and education.

Within local government itself, there may well be a compromised ability to deliver services should increased numbers of local government employees become infected by HIV/AIDS. The pandemic might also result in an increase in bad debts, the creation of a labour and skills shortages and the need to divert expenditure from other budget items (such as education and infrastructure) into health and welfare.¹⁸

¹⁷ Local Government Municipal Systems Act 32 of 2000, Section 4.

¹⁸ *Making the Linkages : HIV/AIDS Urban Local Government and The Urban Management Programme in Sub Saharan Africa*. A Discussion Paper by the UMP Regional Office for Africa.

It is clear that HIV/AIDS can no longer be regarded merely as a health issue, but must also be considered as an issue that has ramifications in the social, political and economic spheres. This is a useful point to note because although the Constitution gives local government jurisdiction over “municipal health services”¹⁹, the advent of a district health system still remains largely undefined, especially as to which institution or sphere of government should assume strategic, financial and administrative responsibility for it. Local government has thus far assumed responsibility only for environmental health services such as waste management, food inspection etc.²⁰ The cross-cutting effects of HIV/AIDS, however, require a multi-sectoral response to the crisis, and this provides much more scope for the involvement of local government. Indeed, it could be argued that local government is well poised to facilitate a multi-sectoral response to HIV/AIDS.

Assessing the scope and scale of HIV/AIDS in a given area is the starting point for preventing, containing and dealing with its many effects. Municipalities are perfectly placed to gather data regarding infection levels, local risk factors, for example prostitution, in the area and vulnerable groups, for example women and children. Given their mandate to encourage community participation and forge links with local constituencies, they are also well placed to share these findings with the public, NGOs, CBOs, faith based organisations and local groups in order to illicit public comment and factor in specific community concerns when drafting responses to the issues. It should, however, be noted that local government authorities in South Africa have been pronounced administratively weak and so may struggle, at this point, to facilitate activities such as data gathering. Also, although all the mechanisms for encouraging community participation are in place (such as the division of municipalities into wards and elected ward councillors), it is questionable whether these measures are consolidating as techniques to facilitate consultation.

In terms of prevention, local government is once more well placed to facilitate campaigns to provide information about HIV/AIDS to local schools, churches and community groups. The provision of free condoms at schools and hospitals could also be intensified if made a priority by municipalities.

Dealing with people already infected with HIV/AIDS will prove more of a challenge for local government, not just in terms of care and treatment in local clinics and hospitals, but also with regards to the long-term management of HIV/AIDS patients in terms of adherence to antiretroviral medication, the dilemmas around medication sharing and the issue of stigma attached to what is seen as a purely sexually transmitted disease.

Civil society actors such as the TAC have already begun a process of training councillors to make home visits to patients on antiretroviral therapy in order to assess their adherence to medication, their nutritional status and their social situation, i.e. are they affected by stigma and is this, in turn, affecting their adherence to medication (there have been reports

¹⁹ Constitution of South Africa Act 108 of 1996. Section 156 (a) together with Schedule 4 (b).

²⁰ Groenwalt L. ‘One Size Does Not Fit All : Health Services and Local Government’, *Policy Issues and Actors*. Centre for Policy Studies, 2003.

that patients afraid of the stigma attached to being HIV positive refrain from taking their medication for fear of being seen). Patients have also been known to share their medication with family members who have had difficulty accessing medication of their own - this severely affects the treatment pattern. Strict adherence to medication is also more successful if there is social support for it, e.g. patients who have friends or family members reminding them to take their medication are more likely to adhere - home visits by councillors encourage this and help set up social networks for patients on medication.²¹ Clearly interventions of this nature will fall under services and are best facilitated at a local level.

Local Government should ideally have a twofold response strategy to HIV/AIDS - the first internal and the second external.²² The internal strategy would recognise the risks posed to staff and capacity and would involve setting up support programmes within the municipality while developing policies for the workplace which encourage care and support of those infected with and affected by HIV/AIDS and fight discrimination against people with HIV/AIDS. HIV/AIDS threatens to reduce the workforce and skills base of municipalities. Municipalities will also need to begin to prepare for the possible loss of politicians and officials to the disease. This will have a series of ramifications as politicians, especially ward councillors, are elected and not appointed, while officials hold very specific skills.

An obvious point of departure for municipalities would be to commence their own treatment projects for their HIV positive personnel, thus ensuring that medication is provided and adhered to in order to ensure that municipal staff stand a better chance of increased life spans and a decent quality of life while preserving the skills and capacity base of the municipality.

The external strategy would include mainstreaming responses to HIV/AIDS and developing partnerships with external organisations in a bid to deal with its effects.

Mainstreaming would necessitate the coming together of various departments to consider ways in which they could alleviate the effects of the onslaught of HIV/AIDS. For example, referral systems could be established at testing and counselling centres providing patients with easier access to treatment and care facilities. Advocacy and awareness campaigns could be initiated in schools, hospitals and community centres to fight stigma and encourage prevention. HIV/AIDS will affect district and local municipalities with regards the growth in numbers of orphans, child-headed households, grandparents being forced to take care of grandchildren after losing children who were in fact the wage earners and resultant increases in poverty and hunger. These factors may place a strain on welfare and poverty alleviation programmes and require added subsidies for people infected with or affected by

²¹ Findings from fieldwork done amongst TAC activists and members. Friedman S, Mottiar S. 'A Moral to the Tale: The Treatment Action Campaign and the Politics of HIV/AIDS'. *Globalisation, Marginalisation and New Social Movements in Post Apartheid South Africa*. Centre for Civil Society, 2004.

²² *Local Government Responses to HIV/AIDS: A Handbook*. Cities Alliance, UNDP, UNHabitat, AMICAAL, World Bank, 2003.

HIV/AIDS. This could be supported by a local government orphan's school fund or specific insurance policies for health and housing as well as nutrition subsidies.

Developing partnerships with external organisations would enable local government authorities to access skills and resources which are either not available to them or which do not fall within their mandate. For example, the TAC has worked closely with people infected with and affected by HIV/AIDS and has developed specific responses to their various needs, including training councillors to make home visits and assess those on medication, as well as training newly diagnosed patients (usually at local clinics) on issues of antiretroviral adherence, good nutrition and opportunistic infections such as tuberculosis. The TAC has also run a very successful in-house treatment project for its members. Local government authorities may find it useful to contract out services (as it is entitled to do according to legislation) to organisations such as the TAC in areas such as training and counselling where it has yet to make inroads. Likewise, collaboration with local authorities could enhance the work of organisations such as the TAC because it would give them access to public service staff, funds, public venues and legitimacy with community members.

Evidence from various municipalities in South Africa suggest that local authorities are beginning to feel the impact of HIV/AIDS and are beginning to institute some of the responses discussed above. Most municipalities have named HIV/AIDS in their IDPs - many of them have even put in place broader strategies for HIV/AIDS.

5. JOHANNESBURG

The Johannesburg City Council has acknowledged that;

The HIV/AIDS epidemic is posing major challenges in all sectors in South Africa. The city of Johannesburg is acknowledging this epidemic that is decreasing life expectancy of its inhabitants, increasing numbers of orphans, decaying family and community structures and increasing demands on scarce resources. It is challenged to establish a concerted, integrated effort incorporating all sectors to curtail the spread of the disease and to provide comprehensive services to all people infected and affected by HIV/AIDS.²³

Indeed Johannesburg was one of the first municipalities to establish an AIDS Council, the Johannesburg AIDS Council (JAC). The JAC aims to:

- create a platform to review matters related to HIV/AIDS in the city of Johannesburg;
- monitor and evaluate the inter sectoral response to HIV/AIDS in the city;

²³ The City of Johannesburg HIV/AIDS Programme of 2003: 3.

- advise the City of Johannesburg on ways and means of improving the HIV/AIDS programme;
- assume an advocacy role highlighting issues related to prevention and care of HIV/AIDS; and
- contribute materially towards the training of AIDS activists, home-based care initiatives and other outreach programmes.

These objectives form the basis of the municipality's HIV/AIDS programme, the key components of which are:

- An inter-sectoral collaboration in response to the crisis amongst government departments, faith based organisations, NGOs, sports clubs, media, civic groups, youth and women's groups and people living with HIV/AIDS;
- Community mobilisation towards non-discrimination and promotion of openness and disclosure around issues of HIV/AIDS; and
- Care services such as HIV testing, counselling and support.

In terms of inter-sectoral collaboration, Johannesburg has been divided into eleven administrative areas headed up by coordinators who are tasked with consulting all stakeholders in their areas to ensure that plans are implemented and evaluated jointly. The outcomes of this initiative still require research. There is also a move towards strategic partnering such as the partnership between the city of Johannesburg, the Gauteng Provincial Government and the Reproductive Health Research Unit at the University of the Witwatersrand. The Unit aims to develop an integrated model of health and social services as well as training and research for urban inhabitants in a high HIV prevalence setting.

Community mobilisation initiatives have been very strong - all eleven of the city's administrative areas were visited during 2002. For example, area 7, which included Hillbrow, Berea, Yeoville, the inner city and Jeppestown had 160 volunteers who visited 13 831 homes and reached 169 000 people with a campaign on prevention, treatment and care; some 8 500 condoms were distributed. It remains to be seen, however, whether this kind of mobilisation will be continuous.

Furthermore, the Gauteng Department of Education implemented a life skills programme in 84% of high schools and 76% of primary schools in 2002. Also, workplace AIDS programmes were run by the Occupational Health and Safety Unit and reached more than a hundred employees between 2001 and 2002.

As regards care services, there are currently 14 HIV testing and counselling centres in Johannesburg, but support for people living with HIV/AIDS, including psycho-social support, nutrition, income generation projects and referrals to appropriate services according to need, has been left up to NGOs, as has home-based care. Home-based care is seen as a way

to reduce the burden on hospitals and clinics and for this reason there is a provincial government fund to train home-based care councillors - but these councillors are drawn mostly from the NGO sector and it is reported that, "at the moment the service is available but patchy".²⁴

Likewise not much attention has been given to treating and educating patients with regards to opportunistic infections such as tuberculosis. The importance of opportunistic infections cannot be understated as patients whose immune systems are compromised by HIV are far more prone to infections which, if not checked, prove fatal.

Furthermore those requiring social and financial assistance because of the onslaught of HIV/AIDS are not dealt with at the local level but rather referred to the provincial department for social grants, namely care dependency, foster child and child support grants.

6. OTHER MUNICIPALITIES

Amongst the other municipalities that have set up AIDS Councils is the Ethekewini municipality (Durban) which has, for the most part, viewed the epidemic as a health issue. Ethekewini municipal representatives cite the need to move away from mere awareness of HIV/AIDS to behavioural change in prevention campaigning and treatment and information programmes. They add that related issues such as tuberculosis and other opportunistic infections and home-based care also need to be considered.

The Mangaung municipality (Bloemfontein) has begun to feel the effects of a shortage of burial space. It conducted a survey of funerals in its jurisdiction and found that 70-80 AIDS-related funerals were taking place per week. It also tracked an increase in pauper funerals. HIV is listed as a priority in the municipality's IDP while an HIV/AIDS strategy has also been completed and there are three AIDS Training and Information Centres in its jurisdiction.

The Nelson Mandela municipality (Port Elizabeth) also has an active AIDS Training and Information Centre and has analysed HIV/AIDS-related data and concluded that HIV/AIDS-related deaths and infections will affect revenue income for the municipality and that non-payment for services in this respect is already a problem.

The Msunduzi municipality (Pietermaritzburg) is really quite advanced in its awareness of the HIV/AIDS crisis in its jurisdiction. It seems to have a thorough statistics base and thorough analysis of this has reported that 60% of deaths related to AIDS are in the economically active age group 20-39 while 36% of sexually active people are HIV positive. The municipality has calculated that high rates of absenteeism will result in a loss of productivity which will in turn affect the local economy. Service delivery will also be affected and budget priorities will have to be turned toward health. Orphans will also be a

²⁴ The City of Johannesburg HIV/AIDS Programme of 2003: 16.

problem as will the elderly left without breadwinners. This will lead to the need to change the way housing is developed while the welfare systems will be inundated.

Since 1995, the municipality has had an employee HIV/AIDS programme in place which offers testing and counselling. It currently runs an extensive awareness campaign and works closely with NGOs. For example, an NGO holding home-based care training for volunteers was given a free venue by the municipality in the form of disused municipal offices. Also an NGO dealing with orphans requested administrative help from the municipality for obtaining birth certificates in order to apply for social grants - the municipality now has a representative within its offices to deal with this issue meaning that the NGO no longer has to go the long route through the Department of Home Affairs.²⁵

7. CONCLUSION

It is often argued that HIV/AIDS is just another chronic disease and that it does not pose as great a potential for disaster as is forecast. This argument would bear merit if adequate structures were in place to contain infection rates and mitigate the effects on people infected with and affected by HIV/AIDS. As has already been argued, local government, as that structure of government closest to the people, is well placed to respond to the challenge. Containment through prevention is a technique that has already been recognised by most municipalities and, as evidenced by campaigns of the nature of the Johannesburg municipality, are running fairly widely and successfully, although whether or not the outcome will have an effect on HIV infection rates is yet to be seen. Mitigating the effects of HIV/AIDS has as much to do with providing people with antiretroviral medication as it has to do with ensuring that they are taught how to adhere to their medication, supplement their dosage with good nutrition and exist within social frameworks that support their treatment regimes. Once again, municipalities are beginning to recognise the need to address these issues, but have yet to consolidate mechanisms to support them, the treatment of opportunistic infections and home-based care being cases in point. Municipalities such as Msunduzi, however, have made headway in terms of partnering with other organisations to fill the gaps in their responses to HIV/AIDS.

Now that antiretroviral medication is available in public hospitals, the advent of treating and prolonging the lives of those who are HIV positive is very much a reality, provided that roll-out and treatment plans are successful. Obviously this will mitigate projected dire effects on the social, economic and political spheres, but will require that responses to the specific needs of HIV positive people be answered in the very near future. Local government,

²⁵ *City Responses to HIV/AIDS*. Workshop hosted by the South African Support and Learning Network, 22 April 2002.

if strengthened and supported, is ideally placed to play a strategic role with respect to integrated planning and service delivery mitigating the effects of HIV/AIDS.²⁶

A starting point for municipalities, as has already been discussed, may be to follow the lead of the TAC's in-house treatment project where the municipality would set up a fund and support network for its HIV positive employees ensuring their medication, treatment, nutrition and social support. This would not only preserve the capacity and skills of the municipality, but would also make it and its employees aware of the greater challenges around treating HIV/AIDS. Also, creating this microcosm for treating HIV/AIDS within a municipality would render it the most capable political entity to respond to the crisis around the pandemic. Furthermore, a municipality's commitment to treatment on this level would signal a serious political will in containing and treating HIV/AIDS. Achieved at local levels, this would go a long way to eradicating the reticence towards treatment of HIV/AIDS that has, up to this point, permeated from the national level.

Multi-sectoralism and mainstreaming has also begun to take root within some municipalities as a method of responding to the effects of HIV/AIDS across the social, economic and political spectrum. The Msunduzi municipality's response to the crisis is a case in point. It has formed partnerships with various local organisations responding to the effects of HIV/AIDS, recognising that these organisations fill a gap and that their efforts need to be supplemented whether it be through venue facilitation or administrative support. Likewise, the Johannesburg municipality has integrated awareness and treatment campaigns across the education and commercial sector, ensuring that its prevention plan is carried out across the board. Should mainstreaming consolidate effectively within municipalities such as Msunduzi and Johannesburg, it may well be possible to begin a series of cross-municipal initiatives which, apart from ensuring that responses to HIV/AIDS are felt over a wider area, would also render local government in South Africa the most powerful tool for responding to the effects of HIV/AIDS and implementing broader HIV/AIDS policy.

²⁶ Findings from the *Programme for the Development of Local Government Leadership in the Partnership against HIV/AIDS*, 19 November 2002.