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ABSTRACT

The primary goal of this study was to survey local government HIV/AIDS projects in South Africa. A total of 240 questionnaires were sent to local municipalities nationally between May and July 2002. A total of 44 municipalities returned their questionnaires, covering 53 projects. Most projects focused on prevention and awareness and the majority had awareness/prevention/information as part of their objectives as well as their activities. Home/community-based care was also prominent. It seems that in the future the focus of programme development will shift in this direction. Major constraints were a lack of funds, transport and trained personnel. Future emphasis must thus be put on these components. In addition government needs to put more resources into local government HIV/AIDS programmes since this tier will be the nodal point for national combatting of the HIV/AIDS epidemic.

Keywords: local government, HIV/AIDS, home/community-based care, Department of Social Development.

RÉSUMÉ

Le but principal de cette étude fut de sonder des projets du VIH/SIDA dans le gouvernement local en Afrique du Sud. Deux cents quarante questionnaires ont été envoyés aux municipalités locales du pays à partir du mois de mai jusqu'au mois de juillet 2002. Au total, 44 municipalités ont renvoyé leurs questionnaires. Ce derniers couvrent 53 projets. La plupart de projets se sont concentrés sur la prévention et la prise de conscience alors que la majorité de projets incluent la prise de conscience, la prévention et l'information parmi leurs objectif et leurs activités. Les soins à domicile ou dans la communauté étaient également saillants. Il semble que dans l'avenir le développement de programme se focalisera vers cette direction. Les contraintes majeures furent le manque de fonds, du transport et du personnel qualifié. De ce fait, dans l'avenir l'accent doit être mis sur ces facteurs. De plus, le gouvernement doit procurer davantage des ressources pour les programmes du VIH/SIDA au gouvernement local vu que cette étape sera le centre d'intérêt vis-à-vis le combat national contre l'épidémie du VIH/SIDA.

Mots clés: le gouvernement local, le VIH/SIDA, les soins à domicile ou dans la communauté, le Département de Développement Social.

Introduction

HIV/AIDS will affect each and every municipality in South Africa in some way or another. The disease will decrease life expectancy, increase the infant mortality rate, intensify the need for health care, fuel poverty, widen existing inequalities between rich and poor residents, increase the proportion of orphans, and alter

the existing age distribution. In sum, the disease will most likely escalate socio-economic and health needs while at the same time undermining municipalities' capacity to provide for such needs. The rates base will be severely cut down as an increasing number of poorer households struggle to pay for services. At the same time a combination of rising needs, less money

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and the loss of skilled staff will place added pressure on already stretched resources. This will further undermine the capacity of local governments to carry out their core functions of local service delivery. (Educational & Training Unit, 2001; Whiteside & Sunter, 2000; World Bank, 2003). The CDE (2003) warns that the situation will be aggravated by what they call 'unfunded mandates'. Municipalities will accordingly be expected to assume greater responsibility for a mounting range of programmes (including health, housing, water and land reform) without receiving additional resources from national or provincial government (UMP, 2001). The multi-faceted impact of HIV/AIDS leaves local governments with no other choice but to become involved.

Local governments are increasingly expected to perform a more central role in responding to the HIV/AIDS epidemic. As the level closest to communities, they are responsible for ensuring a good quality of life for citizens and for promoting sustainable social and economic development. Even though many programmes have been launched in the recent past, few projects have been successful and sustained. Not surprisingly, local governments are typically hamstrung by competing demands for human and financial resources. Although local responses to HIV/AIDS have been highlighted as an important component in the fight against the disease, little has thus far been done to understand the challenges local governments face in dealing with HIV/AIDS.

The main aim of this study was to survey the HIV/AIDS projects undertaken at local government level nationally. In particular, the study sought to assess the spatial distribution of these projects, identify opportunities for improvement of services, provide pointers for strengthening local government capacity, develop a database of local government HIV/AIDS projects, and lastly, encourage the establishment of more HIV/AIDS-related projects.

Local government policy framework in South Africa

Governance in South Africa is constituted as three distinctive yet interdependent and interrelated spheres of government on national, provincial and local level. There are presently 284 municipalities in South Africa. These newly demarcated entities amalgamated

843 racialised structures, and incorporated urban and rural areas into a single (often much larger) municipal system (Atkinson, 2003). According to Naudé (2003) this change in size (determined by the Demarcation Act of 1999) was primarily driven by economies of scale imperatives.

Municipalities are split into six category A municipalities (metropolitan councils), 231 category B municipalities (local municipal areas), and 47 category C municipalities (district councils). The latter governs a local government district. District municipalities encompass a number of local municipalities (category B), as well as district management areas (DMAs). The latter areas are mostly rural areas not directly governed by local municipalities. Metropolitan councils (category A municipalities) govern in the six metropolitan areas.

In addition to creating the aforementioned structures, local governments are obliged to fulfil a 'developmental' role (Atkinson, 2003; Naudé, 2003). This new developmental function of local government is defined in the White Paper on local government (South Africa, 1998, p15) as 'working with citizens and groups within the community to find sustainable ways to meet their social, economic and material needs and to improve the quality of their lives'. Integrated development plans (IDPs) are meant to guide municipalities in their transition towards becoming development agencies by empowering local authorities to prioritise and focus their activities and resources according to the needs of the people. Municipalities are expected to live up to the standards set by their IDP. However, in reality, many municipalities are not up to the challenge. Atkinson (2003) and Ambert (in Kelly, 2003) contend that tight deadlines (municipalities were required to hand in their IDPs by March 2002), inappropriately skilled consultants, a general lack of leadership and strategic direction, restricted involvement by national or provincial line departments, and limited public participation combined to create impractical 'wish lists' bearing little resemblance to socio-economic realities. In the process real development questions, including poverty alleviation strategies and cross-cutting issues such as support for HIV/AIDS planning and forums, were largely neglected in many IDPs.

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This disregard of HIV/AIDS came amid attempts to ensure that the impact of HIV/AIDS is considered in planning, by including a section on the disease in the guidelines for IDP development. In fact, the guidelines called for HIV/AIDS to be addressed at the analysis, strategy, project, integration and approval phases. Very few IDPs however address the disease in any depth. An evaluation of IDP training shows that HIV/AIDS was not really covered in the training of officials responsible for IDPs; that the HIV/AIDS components of IDPs are not well developed nor build on community consultation; and are often oblivious of available resources and best practices and policies (Kelly, 2003; South Africa, 2003).

Despite the clear importance of HIV/AIDS for municipalities, many are hamstrung by internal resource and capacity problems and the feeling that national and provincial governments are not doing enough to support the developmental role, that they are in fact further weakening local governments by placing additional demands on them (Atkinson, 2003). In particular, local governments are not receiving sufficient support in dealing with the epidemic (World Bank, 2003). Local authorities are still plagued by power struggles between various tiers of government and a lack of unity between national, provincial and local structures (Kelly, 2003; Medical Research Council, 2000). The result is often a duplication of services in some areas and a complete lack of services in other areas. The inertia is exacerbated by the general indifference towards mainstreaming HIV/AIDS in development initiatives (South Africa, 2003).

The framework within which all sectors should develop their HIV/AIDS responses is set out in the National HIV/AIDS and STD Strategic Plan for South Africa (2000–2005) (South Africa, 2000). The primary goals of the plan are to reduce the number of new infections and to reduce the impact of the epidemic on individuals, families and communities. Four areas are identified, namely: prevention; treatment, care and support; human and legal rights; and monitoring, research and surveillance. Although preventing new infections must remain paramount, being more cost effective than treatment (Whiteside & Sunter, 2000), the apparent lack of success of prevention thus far means that municipalities will

increasingly be called on to deal with the impact associated with the illness and death of large numbers of people. The 'new' developmental role demands that local governments provide strong leadership, establish openness, co-ordinate efforts, and create effective partnerships with stakeholders, residents and private businesses. These are precisely the elements that make local government responses advisable (Kelly, 2003). It is realised that HIV/AIDS is not merely a health problem and that a multi-sectoral approach is hence indispensable.

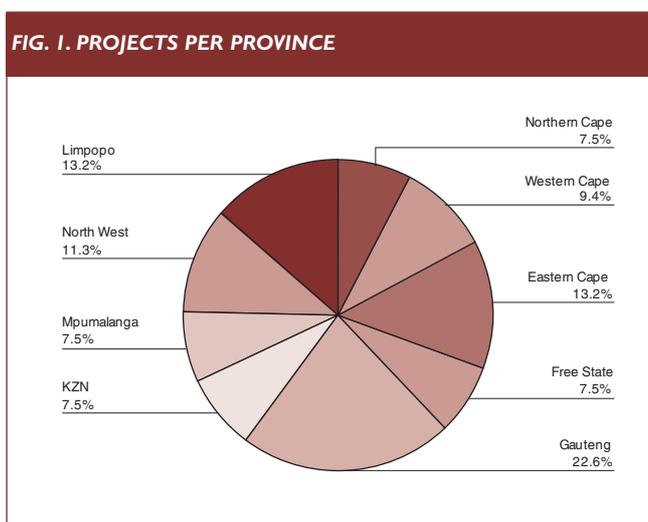
Methodology

The study is the result of efforts by the Chief Directorate: Population and Development (Department of Social Development) to survey all the HIV/AIDS projects undertaken at local government level nationally during 2002. A population universe was compiled of information retrieved from the demarcation board website (www.demarcation.gov.za). Municipal managers were noted as contact points and it was decided to direct all future correspondence to them. Initially local governments were only requested to submit copies of their HIV/AIDS business plans or programmes. Due to poor reaction and many incomplete responses, a short questionnaire was developed to elicit information. Local governments were particularly asked to confine their answers to ongoing or completed activities, not planned ones. The questionnaire asked municipalities to list the name(s) of any project(s) they might have implemented or completed, together with its main aims, objectives, activities, achievements and shortcomings or constraints. In addition, local governments were asked to indicate their main source of funding for the project, and the total budget in rands. Questionnaires were faxed or e-mailed directly to municipal managers. Due to incorrect or missing information on the universe, only 240 municipalities were contacted. Forty-four municipalities responded to the questionnaire between May and July 2002. The responses were captured using the Inmagic computer programme and analysed through SPSS between November 2002 and January 2003. Although the low coverage prevents generalisation to other municipalities, the results of the survey do provide a clear idea of the situation concerning HIV/AIDS projects at local government level during the early part of 2002.

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Results

A total of 44 local governments, running 53 projects between them, responded to the questionnaires. Although it is difficult to explain this exceedingly low response rate (less than 20%), one can speculate that it was negatively influenced by the concurrence of the survey with the frantic months before and after the IDPs were submitted. Additionally, many municipalities without any specific HIV/AIDS programmes did not return the questionnaires. It is unfortunate that existing integrated local authority responses by the local councils, in particular the metropolitan areas of eThekweni (Manning, 2003) and Johannesburg, were not reported. The distribution of projects by province is presented in Fig. 1.



The majority of projects for which responses were received were situated in Gauteng province (23%), followed by the Eastern Cape and Limpopo provinces with 13% each of the 53 projects. The provinces in which the lowest number of projects was reported were the Northern Cape, Mpumalanga, KwaZulu-Natal and the Free State. Municipalities in these provinces reported about four projects per province. Many of these programmes developed in an unsystematic fashion over time in response to particular needs. This, together with the poor participation of local governments relative to local NGOs, points to an urgent need to develop local government responses to HIV/AIDS (Kelly, 2003).

Local governments reported a wide variety of aims for the projects. This is presented in Table 1. Not

surprisingly the single largest proportion of projects (20%) listed prevention as the main aim. This was followed by awareness, and home-based and community-based care (HCBC) at 14%. Other important aims include education (12%), reducing impact (10%) and coordination and empowerment of people, both at 6%. In general it is clear that most projects are still primarily aimed at prevention rather than impact mitigation. This is difficult to understand given the severe need for care in communities.

TABLE 1. AIMS

	N	%
Awareness	7	14
Education	6	12
Prevention	10	20
Coordination	3	6
Partnership	1	2
Youth empowerment	1	2
HCBC	7	14
PWA	2	4
Access to treatment	2	4
Reduce impact	5	10
Service identification	1	2
Train prisoner counsellors	1	2
Capacitate people	3	6
Multidisciplinary care	1	2
Total	50	100

More than a quarter (28.4%) of reported local government programmes listed awareness/prevention/information as an objective. This is indicated in Table 2. This was, not surprisingly, followed by training/education and HCBC, which both stood at 13.8%. Other significant objectives were the creation of PWA (people living with AIDS) support groups, establishing

TABLE 2. OBJECTIVES

	N	%
Awareness/prevention/information	49	28.4
Training/education	24	13.8
HCBC	24	13.8
Health and social services	13	7.5
Research and statistics	4	2.4
PWA/support groups/human rights	17	9.8
Coordination & collaboration	6	3.4
Community participation	12	6.9
Youth/peer groups	9	5.2
VCT & counselling	9	5.2
Identify orphans	3	1.8
Job creation	3	1.8
Total	173	100

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human rights (6.9%), establishing health and social services (7.5%) and community participation (6.9%). To a lesser extent emphasis was put on identifying orphans and job creation, both at 1.3%.

Most activities in these projects were related to training/education (26%), followed by awareness and information activities (25%). HCBC (13%) and counselling (12%) also played a prominent role. Gardening and prevention of mother to child transmission (PMTCT), both at 2%, were emphasised to a lesser extent. This is indicated in Table 3.

	N	%
Awareness & information	41	24.9
Training/education	43	26.2
HCBC	22	13.4
Counselling & VCT	20	12.2
Research & statistics	6	3.7
Workplace policy	4	2.5
PWAs & support groups	4	2.5
Identify vulnerable children	4	2.5
PMTCT	3	1.8
Project planning & development	14	8.5
Gardening	3	1.8
Total	164	100

Just over a quarter (25.2%) of projects reported education and training as achievements (Table 4). This was followed by HCBC and support group activities (16%) and awareness and information (15%). Fewer achievements were recorded in the fields of openness and attitude change (9%) and programme establishment (7%).

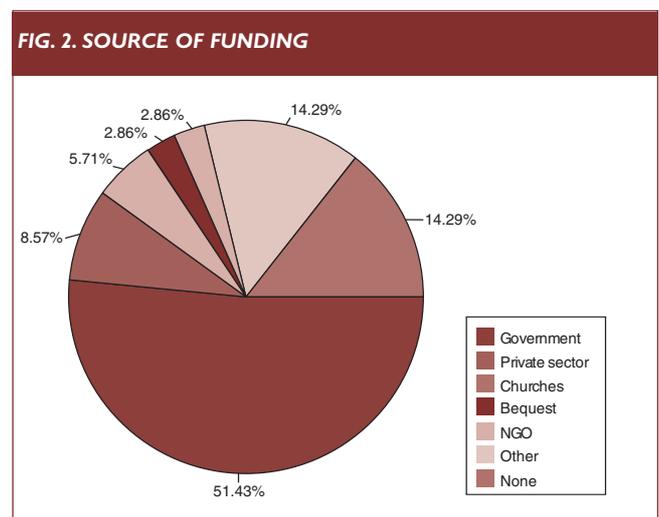
With regard to constraints, funding, not surprisingly, seemed to be the most significant constraint (37%)

	N	%
Awareness & information	13	14.9
Education & training	22	25.2
HCBC & support groups	14	16.2
Community involvement & forums	11	12.7
Networking, cooperation & partnerships	13	14.9
Openness & attitude change	8	9.2
Establishment of programmes	6	6.9
Total	87	100

(Table 5). This was followed by a lack of equipment in a distant second place at 17%. Other constraints that could be viewed as important were staff shortages (10%), a lack of trained personnel, transport problems and stigma and ignorance, all at 9%. Communication did not seem to be a major constraint for most local government programmes (2%).

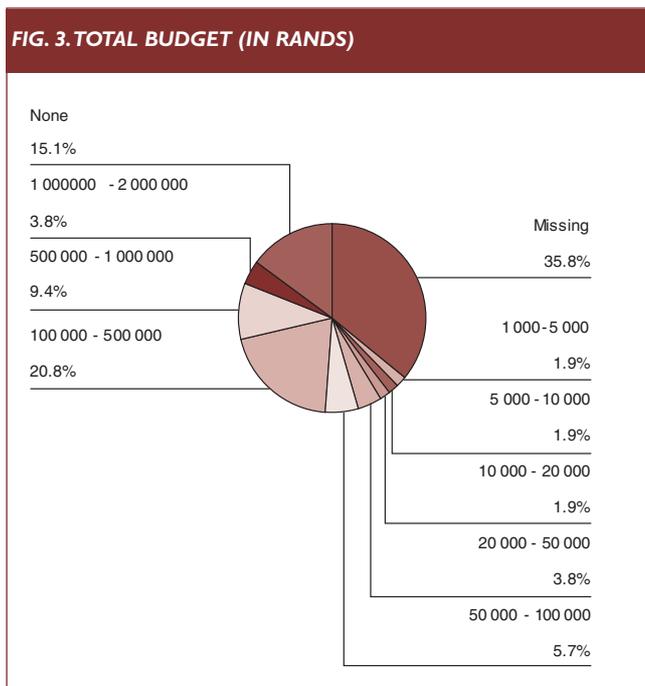
	N	%
Lack of trained personnel	9	8.7
Lack of equipment/material	17	16.5
Budget/funding	38	36.8
Staff shortage	10	9.7
Transport problems	9	8.7
Shortage of office space	5	4.8
Stigma & ignorance	9	8.7
Lack of cooperation	4	3.8
Communication problems	2	1.9
Total	103	100

Responding municipalities were also asked to list each project's main source of funding (Fig. 2). It is significant that slightly more than a half (51%) of projects were funded by the government. Funding agencies included in the 'other' category and the private sector were respectively funding 14% and 9% of reported projects. About 14% of projects contended that they received no funding at all. This is significant as it means that funding is a problem when it comes to programme implementation. Just over a third of responding local governments did not complete this particular question.



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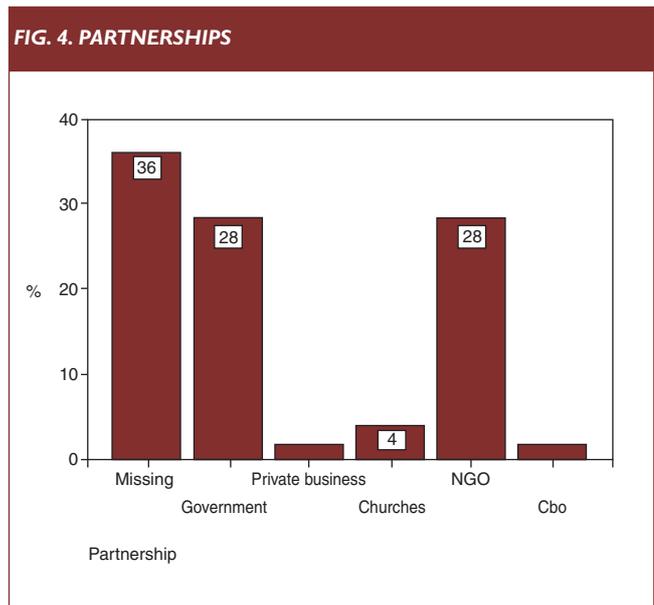
Regarding budget spending, more than a fifth (21%) of the reported local government projects fell into the R100 000 - R500 000 category, followed by nearly a tenth (9%) in the category R500 000 - R1 million (Fig. 3). Only 4% projects had a budget in the region of R1 million and above. It is again important to note that 36% of projects did not indicate any source of funding and that 15% indicated no budget at all. This again raises important questions about the lack of money for projects.



With regard to partnerships, Fig. 4 indicates that government and NGOs were the main partners in most projects, with both standing at 28%. Churches, with a total of 4%, followed this. It is important to note that 36% of projects either indicated that they had no partners or did not give any data for this category.

Discussion

Although only 44 municipalities responded, responses were received from right across South Africa. It is unfortunate that only the metropolitan areas of Tshwane and Buffalo City responded to the survey. In addition, it is disconcerting to note that a large proportion of programmes are still aimed at prevention, rather than care and support. The latter programmes will inevitably become more important as the epidemic starts to reach a peak nationally.



Although the study showed that only 24% of the reported projects were aimed at amelioration and care, this is definitely set to change as the disease reaches maturity and the need for treatment increases. In addition, government recently announced that an antiretroviral service point will be opened in every local municipality before 2008 (IRIN Plus News, 2004). While this extension of treatment is sure to be accompanied by some additional funding and capacity, it might nevertheless stretch service delivery in local authorities beyond breaking point. As it stands, inadequate primary health care facilities at the local level drive many HIV patients to tertiary health care facilities, thus overburdening the tertiary sector. Numerous studies have showed home-based care and household coping mechanisms to be a priority focus areas. These are however difficult to target and by no means a conclusive solution. Due to the legacy of apartheid, rural poverty and migrant labour, local government structures cannot rely on existing household and community networks for the care of people living with HIV/AIDS (Kelly, Parker & Gelb, 2002). To be successful, networks will have to be encouraged and fostered on a continuous basis.

As always, funding and budgeting were identified as serious constraints. Despite these complaints, under-spending at particularly the provincial level remained an 'urgent and critical' problem, scarcely 6 months before the study under consideration was completed. According to Stoppard (2001) provinces only managed to spend 36.5% of the total HIV/AIDS grants that

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were available to them in 2001. Meanwhile local government projects battled, according to the result of this study, to collect adequate funding for the programmes. This should however not come as a surprise. A World Health Organisation Report for 2000 (2 years before the study) ranked South Africa 57th when it came to the availability of funding and resources for health, but only 175th regarding the efficiency of health care delivery (Kelly, Parker & Gelb, 2002). Although the situation might have improved since 2000, the fact remains that local authorities will remain hesitant to take on functions requiring substantial funding, significant re-allocation of funds or the re-deployment of staff if severe staff and resource constraints are not addressed to start with. Municipalities cannot deal with HIV/AIDS without the cooperation and support of other government departments, religious, welfare and community organisations and volunteers. To become 'developmental', local governments are expected, amongst other things, to maximise social and economic development, integrate and coordinate development activities, empower communities, and provide leadership. In line with the principles of the IDPs, local governments should play a coordinating role in identifying and mobilising key actors in each community. Local government is by its very nature and extent of responsibilities arguably the best conduit for developing and implementing multisectoral strategies.

In particular, more should be done to involve the private sector in these projects. Only 6% of projects under study were funded by the private sector. It is crucial to emphasise the mutual advantage of joint ventures to private sector companies. There is a tendency among many companies and private business concerns to view social and economic development issues as separate, rather than inherently intertwined. Although there are encouraging signs that the private sector has developed a comprehensive understanding of the impact of HIV/AIDS on productivity, the buying power of populations and the sustainability of many industries, a recent study by the Bureau for Economic Research has shown that most businesses have hitherto failed to respond to the HIV/AIDS epidemic (*Sunday Times*, 2004). Many analysts only expect businesses to start doing so once the disease begins to impact on their bottom line. This sluggish response however is expected to change with the strengthening of state responses.

As can be expected, the study shows that government and NGOs are the most important partners in projects. A significant percentage of projects (36%) had no partners. Although this points towards some ingenuity on the side of the local governments involved, it does not really provide long-term solutions to a very serious problem. Local governments first need to rally support from a variety of sources for programmes to have any lasting developmental impact.

Conclusion and recommendations

Local governments are likely to be the focal point of the fight against the HIV/AIDS epidemic for some time to come. It is thus of paramount importance for both the government and civil society as a whole to channel resources — human as well as financial — towards the initiatives undertaken by local government.

Local municipalities appear to have definite problems incorporating HIV/AIDS programmes into their local IDPs. The whole idea of IDPs and HIV/AIDS is new to them, and there seems to be a lack of capacity with regard to this issue. The Departments of Provincial and Local Government, Health and Social Development should spend more time empowering these local municipalities regarding project development and implementation. In particular, they need to address the lack of HIV/AIDS programmes in provinces with high sero-prevalence rates, i.e. Kwazulu-Natal, Mpumalanga and the Free State.

It is no surprise that funding seems to be a major constraint for most projects. It is evident that the private sector does not play a prominent role in this regard. Mechanisms should be put in place to channel more funds from the private sector as well as international donors to local municipal projects. Municipalities should use cooperative ventures in which partners have bought into the idea of HIV/AIDS programmes as an integral part of social and eventually economic development strategies. Most of the aims, objectives and activities focus on awareness and prevention. This is to be expected and in line with current practice. However, more needs to be done to promote and strengthen HBCB and other mitigation strategies. Until the antiretroviral treatment points are located in every municipality, HBCB programmes will remain an important part of the fight

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against the epidemic. While it is too late to reverse the adverse effects of the epidemic, it is still possible to reduce its impact and duration.

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