The Role of Local Government in Combating HIV/AIDS in South Africa: An Institutional Analysis

A mini-dissertation prepared in partial fulfilment of MComm Degree in Economics by

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Executive Summary

To date the South African government's HIV/AIDS response has been largely focused at the national and provincial level. This response has been largely ineffective despite significant increases in funds allocated to combating the epidemic. In addition, local government's role has been effectively ignored even though the ongoing process of transformation is broadly aimed towards a more decentralised government.

However, the theoretical evidence shows that the local sphere is crucial to an effective and efficient response. Fiscal federalism theory suggests that while the macroeconomic stabilisation and income distribution functions are most appropriately discharged at central government level; the allocative function is best accomplished by local government. Thus at the local level, where decentralisation encourages competition between local governments, HIV/AIDS responses would tend to be more dynamic and innovative, as well as designed specifically to meet the specific characteristics of a particular district.

Although there may be an argument that the merits for a decentralised approach are mostly normative, the empirical evidence also tends to be supportive. The effects of HIV/AIDS are mostly felt at the local level, with family members of people living with or dying from HIV/AIDS being the hardest hit by its effects. Also in dealing with HIV/AIDS, successful responses internationally have largely been at the local level, giving further support to a more decentralised HIV/AIDS response.

The national government has significantly increased budget allocations for the fight against HIV/AIDS. Further increased funding may not be necessary if a decentralised approach is supported by local institutions which encourage good governance, and support the development of partnerships with key stakeholders where capacity and skills are lacking within local government. These same institutional arrangements would help ensure that increased funding actually does translate into service delivery to affected communities.

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Introduction

Since the first cases of HIV/AIDS were reported twenty years ago, nearly 58 million people have been infected and 22 million have died worldwide. The HIV/AIDS pandemic is no longer just a health issue. There is growing consensus in the international community that its effects are also social and economic, impacting on productivity, human capital accumulation, competitiveness and investment[1]. Thus in all countries government has an important role to play in the fight against the HIV/AIDS epidemic. This role is even more pronounced in developing countries given the public good dimensions of health care, underdeveloped private health care provision and widespread poverty.

Given that the public sector has an obligation to respond[2] effectively, the question arises as to the division of labour between the various spheres of government. At a national level, the role may be primarily one of leadership, policy formulation, and resource allocation, but at the local level the role is much more immediate and intimate. This is because local government has direct responsibilities to the well defined population it serves. These responsibilities inherently have the potential to impact on the epidemic and introduce opportunities to interact with groups which may be at the forefront of the epidemic, both in terms of being susceptible to infection as well as being the service providers at the roots level.

Coupled with the looming threat of HIV/AIDS, fiscal decentralisation is also emerging as a significant trend amongst both industrial and developing countries in an attempt to improve performance of their public sectors, and South Africa is no exception. Sub-national tiers of government are no longer merely spending agencies for the fulfilment of national policies, but can develop and customise policies specific to their regions and meet policy objectives through more efficient resource allocation. In the area of health in particular, the formalisation of health districts in terms of the National Health Act of 2003 will create greater latitude for local and provincial governments to exercise some discretion in how they choose to deliver basic health services. The

[1] See Nattrass 2003, Whiteside and Sunter, 2000
[2] Typically this includes prevention, treatment, research and monitoring activities.

implementation of fiscally decentralised health districts will also condition local government's institutional response to the HIV/AIDS epidemic.

Thus far, national responses to the HIV/AIDS epidemic have proven to be largely ineffective, with infection rates continuing to increase. It is not only at the central level that there is need for a strategic response framework, since given the characteristics of the virus, ultimately responses will have to include local government. I will argue, within the framework of fiscal federalism and the new institutional economics, the merits of re-focusing government's efforts against the epidemic from national to a more local level.

Methodology

To date an overall national policy, despite significant increases in funding, has had very little effect on infection levels. Although it is widely predicted that the epidemic will stabilise soon, this levelling off will mainly be due to the natural attrition profile of the disease, rather than any successful government intervention (Fourie, 2006). In particular Fourie shows that in the South African experience, it has been civil society, the private sector and the biomedical community who have been more powerful and more involved in the shaping of a public policy response, and forced to intervene in the absence of any centralised leadership.

Using the theory of fiscal federalism along with current reforms within government the merits of a local HIV/AIDS response will be considered. In addition to this, HIV/AIDS will be discussed in terms of its key characteristics and how they necessitate a response which is closer to the community.

The main arguments against decentralisation have no compelling economic foundations, but rather lie in the problems that have arisen from its implementation in less developed countries[3]. Even though fiscal decentralisation may remove or mitigate some form of government failure, it may introduce other forms (Ajam, 1999). This section will cover these issues as well as the institutions

[3] The problems that have arisen will be dealt with in section 3.

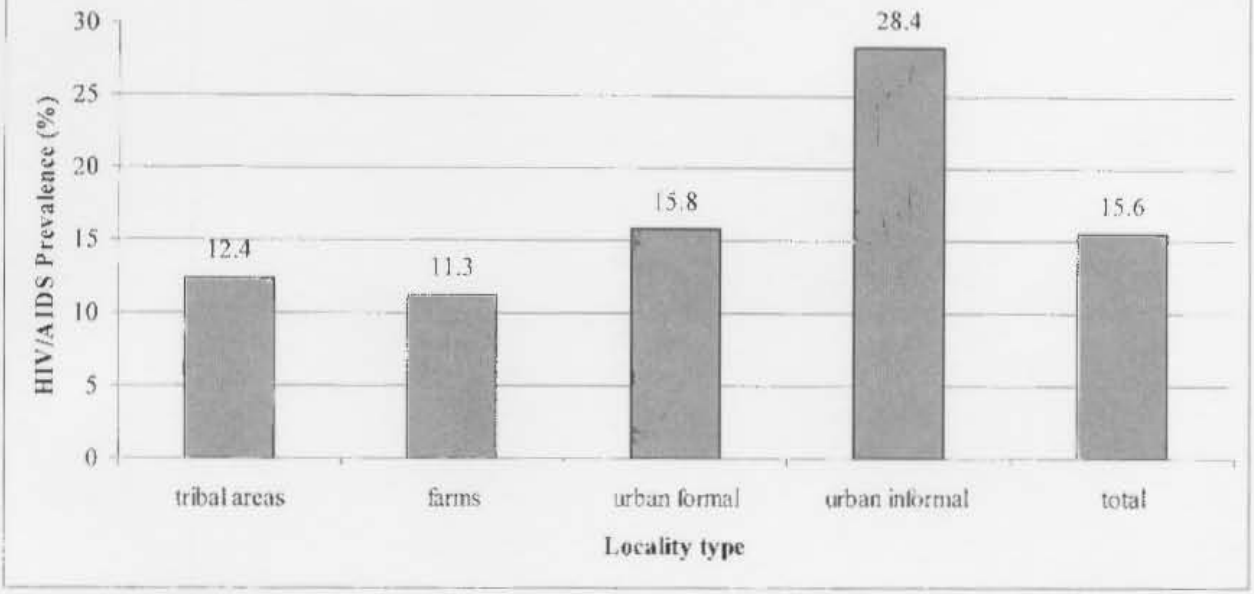
necessary for the system (and thus the HIV/AIDS strategy) to be effective. This will include the role of public participation and partnerships in the fight against the epidemic as well as fiscal discipline and the role of competition (amongst districts) in policy development.

Underlying the analysis would be an emphasis on the formal and informal "rules" of interaction, the roles of the various stakeholders, the information they may have at their disposal, and how these collectively shape their incentives. The incentive compatibility of an institutional framework of framing a HIV/AIDS response is crucial to its effectiveness and sustainability.

The choice of a system of governance also involves such principles as political participation, protection of individual's rights and the development of various civic virtues. These principles are crucial to the design of effective institutions. This section will outline the impact good governance has on HIV/AIDS responses and will serve as the backdrop for a review of current local government responses to HIV/AIDS.

There is growing evidence to suggest that HIV/AIDS is concentrated mostly in urban areas. More than a third of sub-Saharan Africa's population live in urban areas with up to two thirds of African urban dwellers living in informal urban settlements (UNDP, 2002) A population-based survey completed by the HSRC in 2002 showed that rural areas had significantly lower infection rates (HSRC. 2002).

Table 1: HIV/AIDS prevalence among persons aged 15-49 years by locality type, South Africa 2002



Source: HSRC, 2002 "Nelson Mandela HSRC Study of HIV/AIDS: Full Report South African national HIV prevalence, behavioural risks and mass media. Household Survey 2002" Cape Town, Human Sciences Research Council

From the above table we can see that HIV prevalence is higher in urban than rural areas and significantly higher in urban informal areas. These urban informal settlements usually have fewer basic services such as sanitation, piped water, electricity, refuse management and poorer access to education, welfare and health services. Municipalities often find it difficult to plan and deliver services to such communities since these areas are characterised with frequent disputes over land ownership and rights. With a high population density and generally lower standards of health as a result of poor services, these areas are more susceptible to infectious diseases such as Typhoid, Cholera and HIV/AIDS (Kelly, 2004).

Thus given the trend in urbanisation and the concentration of HIV/AIDS within urban areas, I will review current local government responses in the major cities in an attempt to gain some insight into

the potential of local government to effectively implement an HIV/AIDS response in a decentralised setting.

The review was to be based primarily on the views expressed by HIV/AIDS co-ordinators of various local governments (mainly metros). Initially, this was to be in the form of a questionnaire sent out to the various HIV/AIDS co-ordinators, however this proved unsuccessful. Surveys were not completed for various reasons ranging from time constraints to simply forgetting to fill out the survey to one co-ordinator stating as a reason "I deleted the mail."

With the questionnaires being unsuccessful in obtaining views from co-ordinators, telephonic interviews was the next method adopted. Given that the interviews were to take place between the relatively short period of November 2006 and January 2007[4] it was difficult to get in contact with co-ordinators. In one instance where a co-ordinator was contacted, she explained that she was unable to dedicate time specifically to the interview, and that this is probably the main reason why I was having difficulty in contacting co-ordinators in other districts. Also it was almost impossible to contact co-ordinators in the first place, some contact numbers obtained from the main switch board of the municipalities either simply did not exist, or the number was almost always engaged or was simply not answered.

As a last resort to gain some form of empirical research, NGOs in the various local government districts were contacted telephonically in an attempt to gain some insight into the current responses by local government. However, this too proved difficult but was mainly as a result of the high turnover rate of staff within NGOs and as a result staff were simply not sufficiently informed about their local government activities. Also where staff was of the ability to answer questions relating to local government HIV/AIDS responses, they were not available due mainly to time constraints.

Given the difficulty in obtaining empirical research, the review is based primarily on the Integrated Development Plans (IDPs) of the various municipalities (four metros and two local municipalities) and reports prepared by other researchers and academics.

[4] The start of the telephonic interview process in November was as a result of personal issues beyond the control of the author and the end , January was as a result of an impending deadline (16th February)

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1. Local government's role in combating HIV/AIDS

1.1 The theoretical perspective

What is the appropriate role for local government vis-à-vis national and provincial government? This section draws on the theoretical literature to isolate factors relevant for this decision.

The traditional theory of fiscal federalism lays out the general normative framework for the assignment of functions to different levels of government and the appropriate fiscal instruments for carrying out these functions (Oates, 1999). Here demand for public services varies across (and within) jurisdictions. Decentralisation provides incentives and possibilities for local governments to generate better knowledge about the preferences of the people because they are closer to them. Also, since the community is closer to local government than national, they have a comparative advantage (in terms of information) over national government and can thus better control the activities of politicians and bureaucrats (Bruno and Bohnet, 1993).

Decentralised levels of government have their motivation in the provision of goods and services whose consumption is limited to their own jurisdictions. In this regard the relationship between government and citizens can be modelled as a 'principal-agent' problem[5]. The 'principals' – residents within the jurisdiction of a level of government – appoint 'agents' to those governments to advance their interests in having suitable public goods and institutional frameworks which facilitate commercial and civil interaction.

An efficient level of output of a local public good is likely to vary across districts as a result of both differences in preferences and cost differentials. By customising outputs of such goods and services to the particular preferences and circumstances of their constituencies, decentralised provision increases economic welfare above that which results from the more uniform levels of such services that would be provided by a centralised government. Maximising overall social welfare thus requires that local outputs vary accordingly (Oates, 1999).

[5] The central dilemma is how to get the employee or contractor (agent) to act in the best interests of the principal (the employer) when the employee or contractor has an informational advantage over the principal and has different interests from the principal (Stiglitz, 1987).

For example, key to developing a customised HIV/AIDS policy within the local government's boundaries is an understanding of the social conditions which exist therein. This understanding is crucial especially since we have seen how the levels of infection vary between rural and urban areas and between formal and informal urban areas. It is not difficult to see[6] that the forms of social organisation in informal urban areas (and urban areas generally) are likely to increase the risks of HIV/AIDS infection to those living in these areas (Sullivan, 2005).

Indeed, the complex nature of informal urban settlements with its distinct lack of social capital[7] makes it relatively difficult for central government to develop and implement a differentiated HIV/AIDS policy for each of the municipalities within its borders.

With the opportunity for public participation greater at the local level it is thus necessary to examine the potential tradeoffs between goals of economic efficiency and political participation in policy development processes of local government. The total cost in a politically institutionalised decision making system includes resource costs and preference/frustration costs. Thus we need to determine the number of participants which contribute to the decision making process in order to arrive at a minimal cost situation.

Frustration costs are costs imposed on the minority which have to accept the majority decision which is not in line with their preferences. When a unanimous agreement is required to make a decision, frustration costs will be zero since each individual will not willingly allow others to impose external costs on him when he can effectively prevent this from happening. However, as unanimity is reached, resource costs will progressively increase at an increasing rate as more time and effort will be needed (for bargaining) to secure a collective decision. In the other extreme case, where one individual dictates the collective action for the state, or in the name of the state, resource costs will be minimal. As we move closer to one individual making the collective decision, frustration costs

[6] It should be noted here that very little research has been done in this area due mainly to unavailability of disaggregated data (Manning, 2003).

[7] Informal urban settlements are characterised by diverse nationalities, languages and cultures making community development difficult. There is also a general lack of social practices and conventions which amount to systems for coping and ordered social living, such as support offered by extended family and traditional community support systems (Kelly, 2004)

will increase as the majority are excluded from any input in the process. In determining the lowest total cost (frustration and resource costs) the optimal amount of participants can be established (Oates, 1999; Buchanan and Tullock, 1962).

Within the context of developing an HIV/AIDS response local government needs to recognise the importance of minority groups, since their associated frustration costs may be significantly high. Although the temptation may exist for local government to develop policy based on the majority's decision, the effectiveness and efficiency of any HIV/AIDS response strategy may be compromised. HIV/AIDS responses in Central America and the Caribbean have recently recognised that there needs to be an increased focus on marginalised groups since there inclusion in policy development and implementation is crucial in promoting safe behaviour and expanding treatment where it is needed most (Sullivan, 2005).

There are potentially two main positive effects of fiscal federalism. Firstly, the higher intensity of inter-jurisdictional competition creates incentives for policy innovations. Here, innovations can be tested in districts where there is demand from the constituents and where the conditions are favourable. Also, innovations which follow a bottom-up pattern are expected to be cheaper and more successful than experiments imposed top-down (von Hayek, 1978). The competitive environment of a decentralised system could enable the development of new and innovative HIV/AIDS strategies. Also, those local governments which seem to be failing in their policy responses can be voted out or the citizens may simply move to another jurisdiction.

Secondly, governments which pursue their own (special) interests and not necessarily that of the electorate (Graves, 2003) or simply indulge in anti competitive behaviour (such as free-riding) may be punished as it may induce inter-jurisdiction migration. Since citizens and capital have better possibilities for exit from a jurisdiction than in a centralist state, local governments are forced to be more aware of the preferences of citizens and enterprises if they want to prevent them from moving to other jurisdictions that offer better packages of taxes and public services (Hirschman, 1970). This effect is reinforced when citizens in a jurisdiction have the right to decide about the tax burden themselves (Hirschman, 1970; Adamovich and Hosp, 2003).

Exit is a viable solution for the citizens as long as there are some outside options available to them. However, the citizens, with nowhere to go, could utter their discontent directly to local government by exercising their "voice" (Hirschman, 1970). Here citizens may put up with local government's poor performance and, if not improved upon, could result in them being voted out in the next election.

This second effect encourages competitive behaviour amongst local governments, but what if local governments cannot compete? This is particularly important given the wide variation in fiscal capacity and operational capacity across municipalities in South Africa. Here the role of intergovernmental grants needs to be clarified within this context. From an income redistribution point of view, there is evidence which suggests interpersonal transfers are relatively more efficient than intergovernmental grants (Breton, 1996). However, intergovernmental grants are needed to stabilize the outcomes of competition among local governments[8].

Intergovernmental grants contribute to competitive stability by allowing all local governments to compete with each other on a more equal footing than they could without them. If the grants were interpersonal instead of intergovernmental, the relative positions of local governments would be unchanged by grants, even if that of their constituents was[9] (Breton and Fraschini, 2003).

To be able to compete on a more equal footing is not the same as providing the citizens of every province with the same bundle of governmentally supplied goods and services: the same schooling facilities and programmes, the same health services, the same number and quality of public libraries, the same number of hectares of public parks, and so on. That would amount to a denial of the very nature of decentralization and federalism. For a government to be able to compete on a more equal footing means to be capable of providing a volume and quality of goods and services that yield to its citizens a level of utility reasonably comparable to those provided in other jurisdictions without

[8] This does not mean that these transfers do not have effects on income distribution, on mobility, on the expenditure patterns of recipient governments, and on other variables, but it means that grants programmes should be analyzed and evaluated in terms of their contribution to the stability of horizontal intergovernmental competitive outcomes, not on some other basis.

[9] Unless of course the local tax rates were such as to fully recapture, district by district, the sums granted by central governments, but this both complicated and not constitutional in a democracy.

having to resort to unduly burdensome levels of taxation relative to the levels collected elsewhere (Breton and Fraschini 2003).

Views against fiscal federalism caution, that in a competitive environment, there may be a breakdown in public services since local governments may be forced into lower taxes continuously. This form of destructive tax competition will most likely occur when sub-national governments lower their taxes to attract mobile factors of production from other jurisdictions (Musgrave, 1959).

Linked to this idea is that fiscal federalism impedes redistribution as people with higher income tend to avoid taxes by moving to other districts with lower taxes (Oates, 1999). Also, typically fiscal federalism is advocated for ethnically and geographically divided societies and thus there is the potential for increasing claims for more autonomy, thus endangering the unity of the federal policy (Adamovich and Hosp, 2003). It is also argued that smaller districts cannot take advantage of economies of scale, however, *no* empirical studies that verify these arguments have been found (Oates, 1999; Adamovich and Hosp, 2003)

The other concern about fiscal federalism is that it can undermine macroeconomic stability through ineffective policy coordination, and softening of budget constraints leading to a lack of fiscal discipline. In this sense, hard budget constraints on sub-national governments and the commitment of central government to enforce them is crucial (Mckinnon, 1997; Weingast, 1995). Sub-national governments should have neither the capacity to create money nor access to unlimited credit. Central government should not bail them out in situations of fiscal distress. Hard budget constraints in terms of debt financing acts as a disciplining mechanism on decentralised fiscal behaviour, and lower levels of government must then seek to rely more on own sources of revenue and not be overly dependant on assistance from central government (Mckinnon, 1997).

In this decentralised system, central government should have the basic responsibility for the macroeconomic stabilisation function and for income redistribution. This is based on the premise that there exist fundamental constraints on lower levels of government. With no monetary and exchange rate "powers" and with highly open economies that cannot contain much of the expansionary impact of fiscal stimuli, provincial and local governments simply have very limited

means for macroeconomic control of their economies. Similarly, the mobility of economic units can seriously constrain attempts to redistribute income. In addition to these functions, the central government must provide certain national public goods that provide services to the entire population of the country (Oates, 1999).

Here local government would be responsible for the allocative function (Groenendijk, 2001), and in this regard is best suited to deal with the HIV/AIDS epidemic. The competitive environment of a decentralised system could enable the development of new and innovative HIV/AIDS strategies. Also, those local governments which seem to be failing in their policy responses can be voted out or the citizens may simply move to another jurisdiction.

In addition to fiscal federalism being a trend in both industrial and developing countries, public private partnerships (PPPs) have also become popular in a number of countries[10]. Multi-level governance implies that government (be it central, provincial or local) increasingly is a co-producer of policies together with the private sector, forming policy networks, using public-private partnerships and/or interactive policy-making arrangement concepts (Groenendijk, 2001). This is especially true for HIV/AIDS responses, where NGOs, private sector firms, community based organisations and agencies have contributed significantly in combating the epidemic.

PPPs are intended to harness the incentives of private markets to the public interest criteria of the state. By entering into PPPs to supplement or replace government services, government can extract the comparative advantage private firms have in providing services at a lower cost, and thus reduce government spending and borrowing (Parker and Hartley, 2002).

However, despite potential benefits, contracting between local government and potential partners will occur under conditions of imperfect information. Given the limited amount of potential contractors and asymmetric information, behaviour between contractors could be characterised by bounded rationality, opportunism and asset specificity. Transaction costs thus may be significant as

[10] In terms of fiscal federalism developing more into a governance theory, amongst other things, a link should be established with literature on public-private partnerships, of which resource-exchange and risk-division are the key concepts (Groenendijk, 2001)

imperfect information enables parties to operate opportunistically exploiting any information asymmetry (Williamson, 1975).

The result of bounded rationality and opportunism is the risk that either of the parties to a transaction or series of related transactions will try to exploit his or her information advantage. The result of opportunistic behaviour may be adverse selection, the ex ante choice of an inferior option, or moral hazard, increasing the ex post risk that one party will exploit the terms of the contract to the disadvantage of the other party (especially where one party to the contract has committed to an asset, that is, asset specificity).

One approach to controlling the behaviour of agents is to set down agreed rules usually in the form of written contracts. Transaction costs will be lower the more 'good information' is available to the contracting parties before (ex post reputation) and during (ex ante trust) the performance of the contract. Therefore, it is rational for parties to seek out information that will improve their contracting ability and to enforce the agreed upon contractual obligations.

Reputation and trust may not, however, be sufficient for effective partnerships. Partnerships may need to be supported by sanctions for deviant behaviour (Grabher, 1993). Reputation and trust must be supplemented by mechanisms that minimise the risk of misplaced trust in small numbers bargaining. The contract is one such mechanism supported by legal redress although where there is trust there should be less need for detailed and formal contracting.

The effectiveness of decentralisation will ultimately require that those involved in the system act in good faith, that government officials pursue economic efficiency even when it adversely affects their own status, power and income. But as the 'public choice' literature demonstrates (Buchanan, 1972), motivation in the public sector is likely to involve at least some element of self-interest. To this extent, transparency and community participation in monitoring will serve as important enforcement mechanisms and may significantly diminish principal agent problems.

This section has outlined the theoretical merits of decentralisation. In the next as well as the subsequent section on best practice the paper will cover the empirical evidence that exists to support

a more decentralised approach to a HIV/AIDS response. Although there may be theoretical evidence for the positive effects of a local government driven response to HIV/AIDS, caution needs to be exercised in transplanting successful systems from country to developing country and potential pitfalls will also be covered.

The following section will examine the merits of decentralising HIV/AIDS policy within the South African public sector context.

1.2 The South African perspective

HIV/AIDS affects millions of South Africans. Several studies have been conducted to estimate the prevalence of HIV in South Africa, ranging from 5 million to 6.5 million in 2006. In 2002 AIDS accounted for 40% of all deaths in SA and over half the deaths in KwaZulu-Natal (52%) and Mpumulanga (51%) (HSRC, 2002). The ASSA2003 AIDS and Demographic model projects that 5.4 million out of 48 million South Africans were HIV positive in mid 2006, a prevalence rate of around 11%. The model further shows that the prevalence rate in the country and provinces is reaching a plateau with KwaZulu-Natal the highest (estimated antenatal plateau of 40%), the Western Cape, Limpopo and Northern Cape around 17%, and the rest of the provinces expected to level off or peak at around 35%.

At present the South African HIV/AIDS policy is rooted in the social sector (health, education and social development departments). This is reflected in the fact that both national and provincial health departments receive the largest amounts of the HIV/AIDS funds available, which amounts to 85% of the total HIV/AIDS funds available for the whole social sector. (South Africa, 2005a)
HIV/AIDS spending in the health sector is geared towards achieving the goals and objectives of the Comprehensive Plan for HIV/AIDS (CPHA), which is effectively South Africa's response to HIV/AIDS. The CPHA is driven and funded primarily at the national level, but is implemented at provincial level with secondary resources from provincial budgets. Like most HIV/AIDS response strategies, the main activities of the Plan include prevention; treatment, care and support; research, monitoring and evaluation.

The CPHA rollout started in April 2004. The development and rollout of the programme was made financially feasible mainly as a result of the significant decreases in the cost of anti-retroviral (ARV) treatment (South Africa, 2003). When the programme was launched it was estimated that about 500 000 South Africans had AIDS defining illness and were in need of anti-retroviral therapy (Dorrington et al, 2004). Also, the programme required that government, the Department of Health specifically, balance quality of care and effective and quick mitigation of the HIV/AIDS impact. By the end of 2004/5, only 42 000 people, which was less than the target of 53 000, had been placed on treatment. However, by the end of 2005 the number of patients on treatment increased to a total of 200 000 people, with the private sector contributing 90 000 to this total (JCSMF, 2005).

Since there is no cure for HIV/AIDS, the Plan concentrates its efforts on prevention requiring government to sustain and scale up prevention activities. In response to this, the Department of Health increased the budget for the HIV/AIDS communication campaign, Khomanani Caring Together, from R90 million in the 2003/04 and 2004/05 to R165 million for the next two years (2005/06 and 2006/07) (South Africa, 2004b)

Funding

There are three main types of HIV/AIDS-specific allocations in the health sector. These are: the budget of the HIV/AIDS Directorate in the national Department of Health (coming from the national equitable share); Conditional Grants (CGs) for HIV/AIDS interventions coming from the national government to provinces; and HIV/AIDS specific funds in provincial budgets, also known as the equitable share (ES) allocations. The latter two categories are two funding channels for health related HIV/AIDS interventions delivered at provincial level.

Table 2: Provincial Budgets (Nominal) HIV/AIDS Sub programme (includes CG, ES and discretionary allocations, 2003/04 –2008/09

Province R'000	Audited		revised estimate	MTEF estimate		
	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Eastern Cape	72,729	115,170	180,817	237,543	249,420	261,891
Free State	34,223	75,911	86,394	152,703	163,706	176,346
Gauteng	118,043	288,252	348,646	515,445	541,218	587,517
KwaZulu-Natal	246,701	348,537	543,304	808,391	991,292	1,075,420
Limpopo	32,919	77,049	93,805	175,861	184,654	194,736
Mpumalanga	22,731	56,421	106,222	135,794	150,217	170,801
North West	41,392	64,618	119,626	194,316	218,932	245,416
Norhern Cape	11,255	26,913	44,049	70,103	76,033	80,966
Western Cape	38,146	94,394	126,754	150,954	158,502	166,912
Aggregated Total	**618,139**	**1,147,265**	**1,649,617**	**2,441,110**	**2,733,974**	**2,960,005**

Source: AIDS Budget Unit – IDASA calculations from Provincial Budget Statements

From the above table we can see that provincial budgets have been consistently increasing, indicating national governments commitment to strengthening its HIV/AIDS response. On aggregate the budgets initially enjoyed large nominal growth, with 86%, 48% and 44% for 2004/05, 2005/06 and 2006/07 respectively with a sharp decline for the next two periods of 12% and 8 % for 2007/08 and 2008/09.

Table 3: Health Comprehensive Plan HIV/AIDS Conditional Grants, 2003/04 –2008/09

Province R'000	Audited		revised estimate	MTEF estimate		
	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Eastern Cape	38,934	98,970	159,005	218,021	228,922	241,421
Free State	30,144	69,969	100,874	142,265	149,378	157,534
Gauteng	55,275	134,231	185,048	252,695	265,330	279,817
KwaZulu-Natal	85,591	186,348	251,468	344,304	361,519	381,258
Limpopo	28,962	77,430	125,899	175,861	184,654	194,736
Mpumalanga	26,287	53,840	81,392	107,479	112,853	119,015
North West	32,891	70,981	100,921	142,316	149,432	157,591
Norhern Cape	11,268	31,881	48,050	68,603	72,033	75,966
Western Cape	24,204	57,962	82,451	115,670	121,454	128,085
Aggregated Total	**333,556**	**781,612**	**1,135,108**	**1,567,214**	**1,645,575**	**1,735,423**

Source: Division of Revenue Act, 2006

The conditional grants for HIV/AIDS serve as the financial backbone to provincial multi-sector responses to the AIDS epidemic in South Africa. Spending of the funds is limited to specific areas identified by the national government for which the provincial departments have to develop appropriate business plans. In the CG spending process the role of the national departments is to provide technical assistance, coordination and programme support to the provincial social service departments; while the provinces actually implement the programmes, using the CG funds.

In table 3 KwaZulu-Natal has the largest allocation of conditional grants and this applies also to the equitable share and discretionary allocations. This is mainly as a result of the high prevalence rate in the province. Provincial government departments have shown major efforts in delivering HIV/AIDS interventions. This is indicated by the health sector's HIV/AIDS allocations in the provincial health department budgets (including conditional grants) totalling R8.1 billion for the 2006/7 – 2008/9 Medium Term Expenditure Framework (MTEF). R4.9 billion of the total MTEF funds is sourced from the National Treasury's conditional grant for the comprehensive plan.

Table 4: Equitable Share and Discretionary Allocations for HIV/AIDS

Province R'000	Audited		revised estimate	MTEF estimate		
	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Eastern Cape	33,795	16,200	21,812	19,522	20,498	20,470
Free State	4,079	5,942	0	10,438	14,328	18,812
Gauteng	62,768	154,021	163,598	262,750	275,888	307,700
KwaZulu-Natal	161,110	162,189	291,836	464,087	629,773	694,162
Limpopo	3,957	0	0	0	0	0
Mpumalanga	0	2,581	24,830	28,315	37,364	51,786
North West	8,501	0	18,705	52,000	69,500	87,825
Norhern Cape	0	0	0	1,500	4,000	5,000
Western Cape	13,942	36,432	44,303	35,284	37,048	38,827
Aggregated Total	**284,583**	**365,653**	**514,509**	**873,896**	**1,088,399**	**1,224,582**

Source: These figures are determined by subtracting conditional grant amounts from the provincial Subprogramme budgets. IDASA calculations

The commitment to the Plan by provinces is reflected by the amounts they have allocated. R3.2 billion of the total MTEF funds for the period 2006-2009 (or 40 per cent) is discretionary allocations from the provinces' own budgets (i.e. they are not conditional grants from national government). Of the total discretionary allocations KwaZulu-Natal allocates the largest lump sum from its own health budgets, amounting to R1.8 billion for the medium term

Additional funds are made available by provinces from their own equitable share budgets. Unfortunately these additional funds are spent according to the provinces' priorities and are thus regarded as discretionary. Discretionary funds are difficult to monitor because there are no clear lines of reporting between provincial and national departments and provinces are not bound to report their discretionary HIV/AIDS spending explicitly to the National Treasury (Ndlovu, 2006).

The conditional grants are responsible for approximately 85% of direct expenditure for HIV/AIDS in the country. They are largely successful as funding channels for delivering funds to provincial departments for HIV/AIDS interventions identified as priority items by national government.

Table 5: Health HIV/AIDS Conditional Grant Expenditure 2004/05-2005/06

Province R'000	total available	unaudited provincial actual payments	percentage difference	total available	unaudited provincial actual payments	percentage difference	percentage nominal growth of budget available
	2004/05			2005/06			
Eastern Cape	98,970	83,896	85%	159,005	161,489	102%	61%
Free State	69,969	67,924	97%	100,874	96,398	96%	44%
Gauteng	134,231	134,986	101%	185,048	207,328	112%	38%
KwaZulu-Natal	186,348	186,348	100%	251,468	239,550	95%	35%
Limpopo	77,430	69,283	89%	125,899	94,110	75%	63%
Mpumalanga	53,840	56,492	105%	81,392	90,019	111%	51%
North West	31,881	31,881	100%	100,921	104,941	104%	217%
Norhern Cape	70,981	64,618	91%	48,050	57,652	120%	32%
Western Cape	57,962	74,649	129%	82,451	92,649	112%	42%
Aggregated Total	781,612	770,077	99%	1,135,108	1,144,136	101%	45%

Source: Expenditure figures are based on National Treasury's Statements of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2005 and 31 March 2006

From table 5 we can see that unaudited actual health HIV/AIDS conditional grant expenditures indicate that six of the nine provinces overspent on their conditional grants for 2005/6. Only the Free State, KwaZulu-Natal and Limpopo spent less than 100 per cent, recording 96 per cent, 95 per cent and 75 per cent respectively. Provinces that over spent may have reported conditional grant spending that included non-conditional grant funds from their own budget that then appears as over spending and they may have also reported rollovers (unspent funds) from previous financial years. As a result, the figures may not give a true reflection of the levels of spending on conditional grants.

Hickey et al (2003) reported that in 2002/3 the Department of Health moved towards a more flexible conditional grant for HIV/AIDS. Since then, provinces have been allowed to allocate the conditional grant funds to a list of activities or components of spending. Since the provinces have greater flexibility on the allocation of these funds to the component services and interventions, the utilisation of the health HIV/AIDS conditional grant does not ensure that spending is according to cost estimates performed by the National Department of Health. Despite this, spending analyses indicate that provinces have spent more on aggregate in 2005/6 than in 2004/5 (Ndlovo, 2005). Significant amounts of resources have been allocated for ARV treatment in the conditional grant budgets. The available South African spending information for the health sector HIV/AIDS interventions is not disaggregated to show how much was spent on each of a number of relevant

interventions or sub-programmes. However, judging from an August 2004 National Treasury document reviewing government finances (South African 2004a), sufficient finances were allocated by the National Treasury to provincial governments to fund the Plan. The report states that a sum of R300 million had been allocated to the comprehensive HIV/AIDS programme.

Also the National Treasury (2006) reported that the treatment component of the comprehensive HIV/AIDS plan has been expanded to 192 sites in all 53 health districts and in more than 170 local municipalities, compared to only 139 accredited facilities in 2004/5. As of December 2005, more than 110 000 patients were on ARV treatment in the public sector.

Although this indicates that government is increasing its spending on ARV treatment, a critical analysis by Nattrass (2006) shows that the government is failing in terms of meeting the goals of the Plan. At the time the CPHA was rolled out, it proposed to have 54,000 people on treatment by March 2004 at a total cost of R296 million (South Africa, 2003)

By March 2005, a year later than schedule approximately only 43000 people were on treatment, 80% of the initial target. Despite the failure to meet the target, more funds were allocated for 2005/06 to ensure that there was enough for ARV treatment for 150 000 people, whilst making the commitment to increase the budget for the rollout as it progressed (South African , 2005b). The South African government was on pace to meet this target with 111 786 people receiving treatment by December 2005.

However of this figure less than half the total patients were fully covered by the government budget with the Global Fund, PEPFAR and various other NGO partnerships relieving the pressure on government. Furthermore, if it is assumed that the average contribution of donors to the public sector projects is 50% of the total costs, then at least a quarter of the budget allocated for treatment was not used for that purpose (Nattrass, 2006).

Although human resources may be a constraint in expanding ARV treatment to meet unmet demand, leadership at the national level is a major constraint. Despite the financial commitment to the response, the Health Minister Manto Tshabalala- Msimang (and the president) has showed very little support for the expansion of ARV treatment (Nattrass, 2006; Fourie, 2006).

In addition to not meeting ARV treatment targets we have already seen that overall, government seems to be losing the fight against HIV/AIDS. In a review of South Africa's response, Fourie (2006) describes it so far as "a dismal failure". He suggests that even though it is widely accepted that the epidemic will stabilise soon, this levelling off would have had little to do with the efforts on the part of government. Indeed the efforts on the part civil society, the private sector and biomedical community have been far more powerful and involved in shaping the public policy response.

Given that the national response has not been effective, the role of local government will be examined to determine if a more decentralised approach is more suitable to South Africa.

Local government

Transformation of the South African fiscal system since 1994 has been broadly in line with the fiscal federalism theory. The new system of intergovernmental fiscal relations, precipitated by the adoption of the 1996 Constitution, has aimed to make municipalities more accountable, financially sustainable and able to deliver critical services to all residents. This is consistent with the constitutional vision of the developmental role of local government and the policies outlined in the 1998 White Paper on Local Government. Changes have included: rationalisation from 843 to 284 municipalities, new legislation on operational and financial management, and re-assignment of powers and functions between municipalities outside the metropolitan areas. While these changes create many opportunities, municipalities also face internal pressures[11], as well as external pressures such as poverty, unemployment and HIV/AIDS.

[11] These pressures includes rising personnel expenditure, which takes up the largest share of municipal budgets, totalling R22.8 billion in 2003-04, 32.9 per cent of operating income. This item has also increased rapidly in the past three years, rising at 10.6 per cent in 2002-03;12.6 per cent in 2001-02 and 15.2 per cent in 2000/2001 despite of the fact that the number of employees has not increased since the new demarcations in 2000 (RSA, 2004a). Rather, they probably reflect the cost of amalgamation, which has tended to place upward pressure on wages and salaries to the highest level, without corresponding improvements in productivity or expansion in service delivery (RSA, 2003a). Also recent surveys by the Department of Provincial and Local Government have raised concerns over the issue of revenue collection by municipalities. Municipalities have accumulated R24.3 billion in outstanding debtor balances or unpaid consumer bills. This accumulation over the recent past represents approximately 10 per cent of the total operating budgets for the last five years (RSA, 2003a)

In this new system of intergovernmental fiscal relations, local government is a sphere of government in its own right, with a number of exclusive powers and other powers which are concurrent competencies with other spheres of government. The relationship between the three spheres of government is no longer hierarchical, and is based on cooperation between three overlapping planning, budgeting and implementation processes. Local government is the level of government that is closest to the people. The residents or citizens of a municipality elect a Council to represent their interests in a democratic and accountable manner and to oversee the delivery of affordable basic services by the administration. Particularly in developing countries local government is responsible for promoting sustainable social and economic development (RSA, 2001).

As per the Constitution (152(1)) the objects of local government are:

- to provide democratic and accountable government for local communities;
- to ensure the provision of services to communities in a sustainable manner;
- to promote social and economic development;
- to promote a safe and healthy environment; and
- to encourage the involvement of communities and community organisations in the matters of local government.

The area of jurisdiction of local government is called a municipality. As directed by the Constitution, the Local Government: Municipal Structures Act of 1998 contains criteria for determining when an area must have a Category A municipality (metropolitan municipalities) and when its municipalities fall into categories B (local municipalities) or C (district areas or municipalities).

There are six metropolitan municipalities in the biggest cities in South Africa: Johannesburg, Cape Town, Durban, Pretoria, Port Elizabeth and the East Rand. They have more than 500 000 voters and the metropolitan municipality co-ordinates the delivery of services to the whole area. There can also be sub-councils of a metropolitan council. For example, the Cape Town metropolitan council has 8 sub-councils, such as Helderberg, Tygerberg, and South Peninsula, and these are further divided into wards.

There are 231 local municipalities, that fall outside of metropolitan districts and each municipality is broken into wards with people represented by a ward councillor. District municipalities are made up of a number of local municipalities that fall in one district.

District municipalities administer and make rules for a district which includes more than one local municipality. There are 46 District Councils in South Africa. There are usually between 4-6 local municipalities that fall under one district council. For example, the Overberg District Municipality is made up of four local municipalities, namely, Theewaterskloof, Overstrand, Cape Agulhas and Swellendam local municipality.

The purpose of district municipalities and local municipalities sharing the responsibility for local government in their areas is to ensure that all communities, particularly disadvantaged communities, have equal access to resources and services. This will help some Local Municipalities who don't have the capacity (finances, facilities, staff or knowledge) to provide services to their communities. It will also help to cut the costs of running a municipality by sharing resources with other councils. In this sense the 'richer' areas will help the 'poorer' areas.

Integrated development plans (IDPs) give operational substance to the strategic objects of local government described above (see Appendix C). Funding for local government activities come mainly from user charges, property rates, levies and intergovernmental grants. Other sources of funding, which are also significant, include traffic fines, rental of housing stock, interest on investments and recovery of outstanding debt (RSA, 2004a).

Municipalities in South Africa on average obtain about 86 percent of their income from their own revenue sources, while around 14 percent of municipal budgets consist of national and provincial transfers to municipalities. However, some municipalities in poorer areas of South Africa can be dependent for over half of their budget (up to 92 percent) on allocations from national revenue[12].

Allocations from national revenue consist of the local government equitable share and conditional grants. The national budget divides revenue received at a national level between the three spheres of government (national, provincial and local). This is called the equitable share of national revenue. Some of this goes to local government as the local government equitable share. The total local government equitable share is split between all the municipalities using a formula. The formula takes into account the differences in revenue raising capacity between municipalities, and historical and geographic developmental imbalances. No conditions are attached to the use of the equitable share, but it is understood that the purpose of equitable share is to enable municipalities to cover the costs of providing basic services to the poor. This is in contrast to conditional grants.

[12] National Treasury, 2004a "Trends in Intergovernmental Finances: 2000/01 – 2006/07" pg 29-30

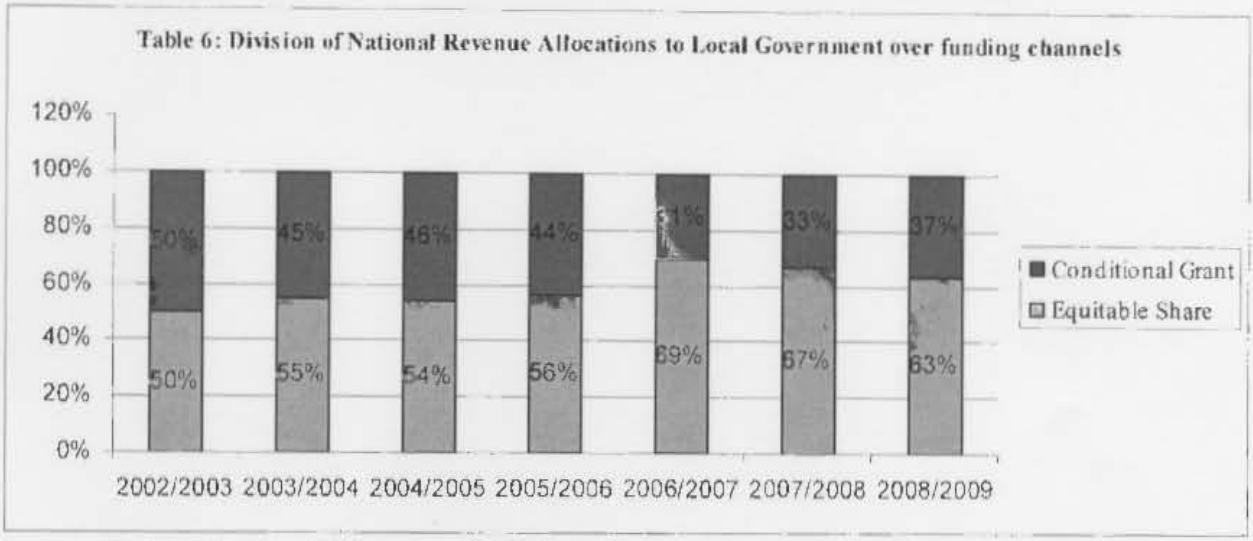
In addition to the equitable share, a portion of local government funding from nationally collected revenue comes in the form of conditional grants. Local government spending from conditional grants is subject to stricter conditions than spending from municipalities' equitable share or own revenue. Here departments (transferring authorities) specify what the funds should be spent on, and the procedures that must be followed in spending them.

Table 6: Division of Revenue over the three spheres of government

Division of available funds (R1bn)	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
	outcome			revised estimates	medium term estimates		
National Departments	**129**	**148**	**168**	**196**	**214**	**233**	**254**
Provinces	**107**	**122**	**137**	**154**	**176**	**196**	**217**
Equitable Share	94	107	120	135	151	168	187
Conditional grants	13	15	13	19	25	28	30
Local government	**8**	**11**	**13**	**16**	**26**	**30**	**35**
equitable share	4	6	7	9	18	20	22
conditional grants	4	5	6	7	8	10	13
Total	244	281	318	366	416	459	506
Percentage share							
National Departments	52.9	52.7	52.8	53.6	51.4	50.8	50.2
Provinces	43.9	43.4	43.1	42.1	42.3	42.7	42.9
Local government	3.3	3.9	4.1	4.4	6.3	6.5	6.9

Source: Budget Review 2006

As we can see from the above table, allocations to local government have been growing. The medium term estimate shows that it would have more than doubled from 3.3% in 2002/2003 to just over 6% in 2008/09. This increase suggests a commitment to decentralisation. However for the period 2006/07 to 2008/2009 the growth is rather marginal.



Source: Budget Review 2006, own calculations

Municipalities have more discretion over how to spend funds that they receive from the equitable share, than over conditional grants. Thus decentralisation would require that an increasing proportion of national revenue funds to local government be channelled through the equitable share rather than conditional grants. Table 6 shows how funds to local government from national revenue have been increasingly channelled through the equitable share rather than conditional grants, particularly in 2006/07. This further suggests that government is committed to decentralisation through increasingly funding local government through the equitable share.

In a setting of perfect information it would, in principle, be possible for national government to develop an effective differentiated HIV/AIDS policy, obviating the need for a decentralised approach. However, there are clear asymmetries in information. Given the dynamic characteristics of the epidemic[13] as well as the uneven incidence of the disease across the country[14], municipalities may have superior information to national government. Being much closer to the community and geography of their jurisdiction, they may possess a greater understanding of the likely impact of the epidemic within their borders, and can formulate a response which is more effective than a more uniform national level response. The degree of differentiation of a national response could also be limited due to political pressures. Political constraints exist to the extent that there would be limits to provide higher levels of treatment in some jurisdictions than others (Oates, 1999).
For these reasons local government is ideally suited for the creation of partnerships to develop prevention and care programmes for communities affected by HIV/AIDS. Since the councillors are

[13] See Appendix A: Key characteristics of HIV/AIDS
[14] See Appendix B: People most at risk

the politicians directly elected to serve the local community, the municipality can react to the needs of the community more quickly than provincial or national government, whose efforts have proven to be largely ineffective (Kenyon et al, 2001).

Despite this argument, decentralisation may introduce new challenges at all stages of the response strategy. These include the potential pitfalls and costs associated with public participation. Even where public participation is beneficial, municipalities may lack the capacity to develop and implement differentiated HIV/AIDS responses. Where municipalities wish to enter into PPPs to compensate for a lack of capacity, there is the possibility that there may be no appropriate partners, especially since non-governmental organisations (NGOs) seem to concentrate in urban rather than rural areas. Even if suitable potential partners are available, municipalities may not be able to manage these partnerships effectively. Also there is the potential for HIV/AIDS to widen the gap between rich and poor jurisdictions further. In a decentralised setting, this may threaten equity goals since poorer jurisdictions may find it more difficult to respond to the epidemic. These challenges will be expanded upon during the course of this paper.

2. Impact of HIV/AIDS on local government

The effects of the epidemic may largely filter through to local government by impacting on its capacity to effectively govern, its service delivery ability and the level and nature of demand for government services. Municipalities provide a large proportion of essential basic services and represent one of the primary opportunities for public participation and decision-making at a community level. If the epidemic causes municipal governments to falter or fail, the implications for service provision, for public support of democracy, for law and order, and for political stability could be significant (Kelly 2004, Mattes 2003).

Although it is generally accepted that HIV/AIDS will affect every level of government, the risks facing local government is significant relative to that facing national or provincial government. In addition to the epidemic, local governments in South Africa are already facing many challenges. There is an absence of critical skills in many municipalities hindering institutional development and service delivery. In very poor communities this is exacerbated where municipalities are unable to generate revenue to sustain key basic services of water, electricity, sanitation and refuse removal. In addition to this South Africa's local government transition over the past few years has put a major strain on many municipalities who are struggling to come to terms with the new municipal boundaries and governing structures.

The most direct impact of HIV/AIDS on governing capacity will be through infected and affected government employees. Evidence suggests that AIDS already does and increasingly will directly and significantly affect the South African civil service at a national level.

There is little reason to believe that state employees are more or less immune to HIV infection than the rest of the population. While the greatest number of infections and deaths are projected to occur in the unskilled and semi-skilled part of the workforce, skilled and highly skilled sectors will nevertheless be hit heavily. In South Africa, HIV infection rates have been projected to peak at 23% of skilled and 13% of highly skilled workers by 2005. By 2015 this will result in a skilled workforce that is 18% smaller, and a highly skilled force that is 11% smaller (HSRC, 2002)

Thus, the pandemic is likely to significantly reduce the number of policy-makers, national legislators, local councillors, election officials, soldiers and civil servants—including doctors,

nurses, teachers, ambulance drivers, fire fighters and police. South African government reports conclude that AIDS will have become the leading cause of death among public servants by 2002, resulting in an estimated 250,000 deaths in the public service by 2012, or 23% of the present workforce of 1.1 million employees (Ensor, 2001).

The impact of HIV/AIDS will also affect representative institutions, which may put into question the legitimacy of local level democracy. High levels of absenteeism could undermine the representation of the metro council, even robbing some wards (or party constituencies) of their representation in this governing body (Manning, 2003).

Both absenteeism and turnover also represent a reduction in available skills and a loss of experience and training. Moreover, councillors who are elected by wards must be replaced through by-elections, which have a significant economic cost and are likely to have a lower turnout than regular elections, thereby limiting the electoral mandate of those newly-elected individuals. Moreover, if one party is more heavily-affected by HIV/AIDS than other parties then the quality of representation for that party's constituency may suffer, and the balance of power may change (Manning, 2003).

The provision of key basic services is in many ways the most important function of local governments, and the effect of HIV/AIDS on the capacity of governments to deliver services is potentially substantial.

In a case study conducted by Manning on the eThekwini Municipality in KwaZulu Natal, she outlines the effects of HIV/AIDS on various departments in local government. The department of cemeteries and crematoria is rather susceptible with most (177 of the 213) of the staff employed being low skilled gravediggers or general workers. This means that the department's workforce is likely to be very susceptible to HIV infection with low skilled workers generally living in informal urban settlements. The department is also somewhat vulnerable to the impact of employee absenteeism and turnover, because all employees receive in-house training from the department. Thus, employee turnover imposes a significant cost on the department, which must not only recruit but also train replacement workers. The department is also vulnerable to the impact of excessive absenteeism, because it must provide a timely service even if certain key staff are missing.

In contrast, the department of housing does not seem to have experienced any impact from HIV/AIDS on its personnel. The department has a relatively small (highly skilled and experienced) staff and uses contractors for most of its actual construction work. Thus in terms of impacts the housing department is probably much less susceptible to HIV/AIDS than a department with a large, low-skilled workforce, but it is also much more vulnerable. Any one individual would be difficult to replace, and thus the department's operations would be quite vulnerable to any losses.

In the case study, Manning illustrates how the department of fire and emergency services is perhaps a worst-case scenario in terms of the potential for the epidemic to affect a department's capacity to effectively provide services. The department's workforce, composed predominately of young, single men, may be highly susceptible to HIV infections. The high level of personal risk involved in a fire fighting career, and the possible 'risk-taking ethos' of fire fighting personnel, may also correlate with risky sexual behaviour and, consequently, higher rates of HIV infection (A similar risk-taking dynamic is believed to contribute to the high levels of HIV infection among military personnel.)

In addition to being highly susceptible, the department is also highly vulnerable to the impacts of losing employees. Although fire departments in Durban have no problem with recruiting new fire fighters, it takes years to create fire fighters with enough skills to pass knowledge onto younger members through informal training. Thus, AIDS-related turnover adds yet another hurdle to an already tremendous challenge.

The above examples illustrate that local government departments can easily be affected by the epidemic. In general, many workplaces within local government may become less productive. Even before HIV-positive individuals begin suffering from AIDS-related morbidity, the knowledge of their status can cause acute psychological trauma. Feelings of hopelessness and frustration that often accompany knowledge of infection will certainly affect the focus and productivity of some workers. Even among workers who are not infected, morale can be highly compromised within the workplace (McPherson and Hoover, 2000).

At the same time that the epidemic is undermining the capacity of government institutions, it will also cause a change in the level and nature of demand for government services. Sectors such as health, welfare, and burial services will face rising demand as a result of HIV/AIDS, while a number

of other sectors – such as housing and education – may experience a fundamental change in the types of services that are being demanded.

HIV/AIDS can also affect the public's demand for services – potentially changing both the level and the nature of demand – and, consequently, hinder effective strategic planning. This, in turn, can downgrade the city's governing and service-provision capacity in the medium- to long-term. Without an accurate understanding of how the HIV/AIDS epidemic would progress and what its impact would be, a municipality would be hard-pressed to plan appropriate municipal services into the future. In fact, the municipality is operating with very limited municipal level information about the epidemic, because statistics are based primarily on the government's national antenatal clinic survey, and cannot be broken down to a local level. These are concerns that have been expressed by officials in the eThekwini Municipality in interviews with Manning.

Overall, HIV/AIDS has the potential to derail careful strategic planning, even when an attempt is made to take the epidemic into account. If the epidemic affects population growth or otherwise changes demographics in some significant way – by prompting populations to relocate, for instance, and changing the population densities of different areas – the city may invest now in services that prove to be under utilised, or may under-invest in certain areas.

At a departmental level, the impact of HIV/AIDS on the public's demand for services, and the implications for strategic planning, is even more evident. The most obvious impact would be in the department for cemeteries and crematoria. With further increases in HIV/AIDS related deaths, the increased demand for burial sites will put pressure on these functions as well as result in the depletion of usable land. The housing department may also experience a substantial demand-side impact from HIV/AIDS, with the epidemic potentially creating new and unique housing problems for the department to meet. For example, it would have to formulate strategies on how to meet the unique housing needs of orphans, child-headed households, and the ill or disabled – all groups that are growing rapidly as a direct result of the HIV/AIDS epidemic.

Governments may also face declining revenue bases, thanks to the economic impact of HIV/AIDS and a possible decline in citizen compliance with taxation and rate payment. Moreover, rising demand in heavily-affected sectors, such as health, may begin to drain resources from other areas. As a United Nations General Assembly Roundtable stated, 'HIV/AIDS has a disastrous impact on

the capacity of Governments to deliver basic social services. Human resources are lost, public revenues reduced and budgets diverted towards coping with the impact' (United Nations, 2001).

For example, the number of old people who will need care may increase since many of them will lose the adult children who may have been helping to support them. This coupled with the increased number of orphans as a result of the epidemic, would significantly increase demand for welfare and health services as the number of infected increases. This increase in demand for health and welfare services, accompanied by decrease in municipal revenues will result in expenditure meant for economic development, such as Local Economic Development programmes or infrastructural development and maintenance, being shifted to health and welfare (Education and Training unit, 2001).

As can be seen from the above brief analysis, there is a wide range of potential impacts on local government, however there is very little data to draw support from, which further aggravates the problem of strategic planning. Statistics released by government are generally only disaggregated to provincial and regional level. As a result, not a lot is known about HIV/AIDS at local level and the sampling methodologies used to develop national statistics frequently do not allow disaggregation to anything finer than provincial or regional levels. Here, particular local governments usually have to extrapolate their HIV prevalence rates from national statistics, and such research efforts are often plagued by untested assumptions. Further, it is costly to conduct such modelling studies, which means that frequently areas under jurisdiction of local government will not know how they differ from other local communities.

3. International experience of local government responses: an institutional perspective on best practice

We have seen from the theoretical background that the major benefits of decentralisation stem from the efficiency gains from innovation and competition. Although these gains are primarily based on traditional principles of economics, experience shows that these potential benefits may be lost due to poor implementation. In this regard, these gains are dependant on the development of political and institutional mechanisms to ensure that local government is aware of the needs of the community, allocates public resources accordingly, delivers services to address these needs, and are held accountable to those who finance service delivery - and to the communities themselves. This section will review some of the institutions which have been recognised as crucial for local government responses against the HIV/AIDS epidemic.

3.1 Public Participation

As noted earlier, local government is closer to the community than national. Thus a more decentralized political system is more conducive to public participation, not only in terms of policy making, but also in the implementation of these policies. In determining the extent of the public's role in HIV/AIDS policy development, we need to analyse the total costs (frustration and resource costs) associated with public participation.

Within the context of HIV/AIDS and its characteristics, preference/frustration costs may be very high where responses are designed without public participation, since crucial benefits could be lost. The participation of people living with HIV/AIDS (PLWHA) (and other minorities such as sex workers) promotes de-stigmatisation when they are involved in policy making and running programmes. PLWHA remind others of the human dimensions of the epidemic and their presence in policy meetings serves to mitigate the subtle forms of prejudice which may otherwise operate in programme development and planning. Their involvement in project teams also creates credibility and trust in the organisation in the eyes of the community of people affected by HIV/AIDS (Chazan, 2006). This makes public participation crucial, especially in South Africa where HIV/AIDS has

reached epidemic proportions and its effects are felt by more than those who are infected with the virus.

Not only are frustration costs reduced, but also resource costs[15]. To make the most use of its resources (time, money, information) local government will want to encourage broad participation and cooperation. In the case of conducting a situation analysis, local government may find that participation by different groups/individuals may contribute to a much richer analysis resulting in more cost-effective interventions. For example, municipal officials could propose buying new ambulances to fight HIV/AIDS but it turns out that the road stops 1 km from the clinic, so ambulances are not of much use. The nurses dropped off by taxi are vulnerable to rape and so the clinic is understaffed. A better use of resources would be to spend money on security for nurses immediately, as well as laying a new road and installing streetlights.

NGOs may provide input on community issues and priorities, for example, a gender training group may conduct a participatory assessment activity that highlights how women learn about HIV/AIDS and what challenges they face. Sharing information with the local government may facilitate a targeted program to address gender-based challenges. Municipal officials may have a clear understanding of sector-specific HIV/AIDS risks, for example, a parks manager may identify a certain public area that is being used by intravenous drug users. Sharing information with local government may facilitate a localised needle exchange program[16]. People Living with HIV/AIDS can offer a valuable perspective on care and stigma. Interviews with PLWHA may reveal that voluntary counselling and testing (VCT) sites are not being used because of breaches in confidentiality by clinic staff. Sharing information with local government may encourage the development and enforcement of confidentiality procedures (Kelly, 2004).

Other examples can be seen in Burkina Faso. Here the National AIDS Program has been using the Priorities for Local AIDS Control Efforts methodology to gather local information by mapping high transmission areas at the district level in two districts. The methodology is simple and inexpensive yet produces valuable programmatic information.

[15] Also see 3.4 Partnerships

[16] Although this example is not particularly relevant to South Africa, the principle can be extended to other minorities who are considered to be high risk.

First, a small local team is selected to carry out the project. Using participatory discussion techniques, they determine where sexual encounters are most likely to occur. After identifying these 'hot spots', the team visits the sites to conduct informal surveys about what knowledge people have about HIV/AIDS, whether condoms are available and/or used, and what other information may be available. This information is then compiled and used in preparing targeted interventions to address the identified unmet needs (World Bank, 2003).

An understanding of the HIV/AIDS epidemic, as it affects the district, should underpin the development of a HIV/AIDS strategy. However, for this response to be effective it must be informed by high quality information. Expensive in-depth research may not be necessary, as a good sense of the local HIV/AIDS situation can be developed using existing national and local data and conducting participatory assessments.

From the above we can see community participation should start at the earliest stage of policy development. In terms of the degree of participation, local government should try to incorporate as many stakeholders as possible in HIV/AIDS policy development. We have seen the benefits of reducing frustration costs from increased participation, with no significant increase in resource costs, although this may not always be the case.

An increase in public participation may result in an increase in opportunity costs since the whole process may be time consuming. This time may have been used to respond to the epidemic. Resource costs may also increase, for example, public halls may need to be booked for public hearings, and consultants may have to be hired to conduct surveys. Also participation may prove not be useful, for example, those people living with HIV/AIDS may be too distraught to make a constructive contribution, and other sectors of the community may simply not wish to participate in the process, such as traditional healers and the wealthy. Furthermore, under apartheid, municipalities were really responsive to only a small sector of the community. There is thus very little tradition of broad-based participation, and municipalities may not have the skills to facilitate effective public participation (for example, such as conflict resolution). The communities affected by HIV/AIDS may not be organised sufficiently to engage effectively with municipalities, and the community leaders who emerge might not be representative or legitimate. Simply identifying with whom the municipality should be engaging introduces a significant transaction cost.

Another way in which HIV/AIDS may impact on democracy is by reducing public participation. Some analysts have argued that HIV/AIDS will make it more difficult for citizens to participate in democratic governance, because being ill or coping with the impacts of AIDS – caring for infected loved ones or orphaned children, for instance – will reduce the time and resources available for people to involve themselves in civic life and democratic processes (Willan, 2000). For instance, people infected and affected by HIV/AIDS may be prevented from participating in elections, the most central component of democracy. Voter registration requirements will be particularly burdensome for people with AIDS-related illnesses and for their caregivers, who may find it impossible to make the necessary trips to complete registration processes and to vote (Youde, 2001). Moreover, limitations on time, resources, and mobility are not the only possible barriers to the participation of people living with HIV/AIDS; the epidemic may even decrease the motivation for these individuals, or their caregivers, to get involved with democracy (Willan, 2000).

It is also possible, however, that rather than reducing participation, personal experience with AIDS might mobilise some individuals to become more involved in democratic processes, in an attempt to mobilise needed government services or HIV/AIDS programmes. There are many examples of such mobilisation in the South African context, from political advocacy organisations like the Treatment Action Campaign to community-level efforts to provide care and support to those infected and affected by HIV/AIDS.

One of the most significant features of the HIV/AIDS policy in South Africa in recent years has been the prominent and vigorous actions of the Treatment Action Campaign, a movement that grew directly out of government inaction over ARV provision. While civil society involvement in public policy is essential, there are problems may result. In his book on HIV/AIDS policy in South Africa, Fourie (2006) recognises that activists have been vital agents for change, and have done much for the expansion of AIDS treatment, however the relationship between national government and the group has been increasingly confrontational.

This has, he suggests, led ultimately to a destructive rather than constructive relationship, driving the two increasingly further apart. Antagonism between the two groups, which could most profitably work together in a relationship of constructive criticism, has continued into Mbeki's presidency. It has often centred round Mbeki's insistence to seek to re-appraise the science of HIV/AIDS, with support from "renegade" scientists and refusing to implement the necessary ARV treatment

programmes so badly needed. Civil society in reaction has attempted to bypass the government through the judicial system[17]. AIDS treatment has become an increasingly political issue with sharp lines drawn between a government focusing on prevention and a civil society focusing on treatment.

Although there are significant benefits in involving key stakeholders in government led HIV/AIDS responses, their involvement may introduce new problems. Also, public participation should not end at the policy development phase of the response, but should ideally carry on to implementation and then further ensuring that those leaders and government officials who are responsible for spending the public's money act in a transparent manner and are held accountable for the decisions they make. If municipality's capacity to engage with communities in terms of the planning and budgeting processes is weak, then engagement in respect of implementation is likely to be weaker still, despite the legislation permitting this being in place (for example, community participation in performance management in terms of the Municipal Systems Act of 2000).

3.2 Accountability

Decision makers in national government, local government, the private sector and other local community groups must be held accountable to the people and to all institutional stakeholders. Those with the power to make important constitutional decisions would have to be accountable for their attitudes by seeing those who are affected by the epidemic as a source of ideas, experiences and solutions rather than a source of problems.

Local elections strengthen the accountability of elected officials to citizens. However, their effects are limited because they occur infrequently and depend on the electoral system. Electoral cycles and term-limits encourage elected officials to spend on visible projects (roads, bridges) rather than lower-profile, intangible longer-term investments. The accountability of civil servants to (elected) local governments may also prove difficult to achieve, for professionals in health, education, agriculture and other fields often have considerable incentives to evade control and resist reform

[17] See Jones, 2004 for the court case between the Treatment Action Campaign and the South African government.

(Shick, 1999). These people generally have high academic qualifications and may feel reforms may threaten their sophisticated life-style practices[18] (World Bank, 2001).

Thus local elections are a necessary but not sufficient means to ensure accountability. They need to be complemented by instruments of voice and restraint between elections, such as local political parties, organised interest groups, civil society and the media.

For effective participation and accountability, especially between and beyond elections, there is a need for enhanced mechanisms of 'voice' at the local level[19]. Transparency in managing public affairs, producing reliable and timely information, and effective channels of influence are examples of such mechanisms. Public meetings; formal redress procedures; opinion surveys; and issue-specific *ad hoc* councils are other examples. Higher levels of participation tend to increase the demand for transparency (disclosure) and thus deter corruption (DIFD, 2002). This is because communities have an informational advantage over central government to hold local governments' and NGOs accountable. However they need to be empowered to do so. There needs to be the promotion of active local participation, especially in South Africa where the apartheid system compromised civic-community values such as co-operation with fellow citizens, respect for government, and the rule of law (Ajam, 1999). This is compounded by the lack of literacy and numeracy of many communities, and a lack of understanding of how to engage meaningfully with complicated budget and integrated development planning (IDP) processes (Chazan, 2006)

With decentralisation and the increase in public participation, some economists have suggested that corruption may increase, since there may be more opportunities at the local level. Firstly, local officials usually have more discretionary powers than national decision-makers. Secondly, local bureaucrats and politicians are likely to be more subject to pressing demands from local interest groups in matters such as taxation (Prud'homme, 1995; Tanzi, 2000a). In the context of principal agent theory, more decentralisation may increase corruption, in terms of raising the individual's propensity to accept bribes. It also has a twofold effect on incentives to monitor corrupt activities by higher levels. Firstly, it causes a loss in control, reducing the higher levels' willingness to monitor.

[18] However, even if civil servants were committed to dealing with the epidemic, the issue of HIV/AIDS may not be the community's main concern. Often issues such as employment, crime, poverty and corruption are more important concerns to communities than HIV/AIDS.

[19] This is especially true where the exit cost is higher due to such considerations as loyalty towards the district (Hirschman, 1970) or the high cost of moving to another district (Ajam, 1999)

Secondly, it also increases the bribe paid to lower levels, enhancing their propensity to corruption and raising higher levels' monitoring (Carbonera, 2000)

However competition between levels of government may, in fact, lead to less corruption. This is because decentralisation contributes to more honest and efficient[20] government by providing for competition between sub-jurisdictions (Breton, 1996). Given the potential for corruption at local level, it is still uncertain whether the overall amount of money diverted by corrupt means increases. States with a significantly decentralised institutional structure may suffer less from the damaging effects of corruption than states with a more intermediate level of institutional centralisation (Shleifer and Vishny, 1993). Thus a local response may not necessarily stimulate greater corruption than what presently exists in South Africa.

3.3 Local government fiscal discipline and mainstreaming-

Central to most of the literature on implementation of politically decentralised systems is the commitment of central government to enforce hard budget constraints on sub national governments (Mckinnon, 1997a; Weingast, 1995). In this sense, lower level governments neither have the capacity to create money nor have access to unlimited credit and central government does not bail them out in situations of fiscal distress. In addition, fiscal rules often limit sub-national borrowing to capital rather than current expenditures, as is the case of section 230 of the South African Constitution.

Hard budget constraints in terms of debt financing acts as a disciplining mechanism on decentralised fiscal behaviour, and lower levels of government must then seek to rely more on own sources of revenue and not be overly dependant on assistance from central government (Mckinnon, 1997a). However, the real challenge is not necessarily financial, but the shortages of qualified human resources and the lack of effective operational systems to get drugs, condoms, and information out to the people. Also, the capacity to absorb large sums of money, especially in smaller districts, may simply not be there.

[20] see sections 3.3 and 3.5 for efficiency gains from decentralisation

Achievements in countries such as Uganda, where prevalence especially among young people has been significantly reduced, are due largely to NGOs and the community members themselves with the assistance of a strong political leadership without the involvement of large sums of money (Hanson, 2003). In Pingxiang city, one local official believes that while funding is important, it is more important that the city and local government consistently "create an enabling environment for HIV prevention (Gu and Hong, 2001).

Money is certainly helpful, but systems to handle the funds must first be put in place. Although the treatment programs are important (from a human rights and political point of view), they may only marginally contribute to prevention of new infections and are only a limited part of a comprehensive HIV/AIDS strategy. The problem therefore is not necessarily a matter of finance, but rather how local government mainstream expenditures can be re-oriented to combating HIV/AIDS.

Mainstreaming HIV/AIDS involves embedding HIV/AIDS responses into the on-going activities of departments rather than making it a special issue to be separately dealt with, thus it does not involve shifting resources and activities exclusively to intervention based activities. Mainstreaming[21] is a delicate balance as it is an exercise that should be based on an active awareness of HIV/AIDS but maintains focus on the organisation's core activities. Given the above, satisfactory outcomes in mainstreaming require dedicated (not necessarily more) technical and financial resources as well as monitoring and evaluation of the process (Mullins, 2002).

Mainstreaming addresses both the direct and indirect aspects of HIV/AIDS within the context of the normal functions of an organisation. It is essentially a process whereby a organisation analyses how HIV/ AIDS can impact it now and in the future, and considers how its policies, decisions and actions might influence the longer term development of the epidemic and the organisation itself (UNAIDS, 2005).

Crucial to the success of HIV/AIDS mainstreaming is the commitment to the process by political leaders, especially where there is a high turnover of these leaders. Thus there is a need to institutionalise leadership through the establishment of structures and processes in local government

[21] An example of mainstreaming is illustrated in the appendix B, it involves the co-operation and establishment of partnerships with other levels of government.

institutions[22]. The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL) works towards mainstreaming HIV/AIDS responses in municipal functioning rather than establishing separate structures. This sometimes requires placing coordinators within municipalities as a first step in establishing a multi-sector approach. The Alliance's experience shows that a local government HIV/AIDS response requires strong leadership along with capacity building and partnership development (World Bank, 2003).

The Alliance's engagement with municipalities follows a sequenced process, beginning with a sensitisation workshop where municipal leaders are introduced to ideas about what they might do in their capacity as municipal leaders. This is followed by a launching of municipal initiatives, accompanied by a program development process and resource mobilisation. Then attempts are made to find ways of strengthening the municipal framework for a multi-sector response. This is done with special sensitivity to the need to avoid imposing additional burdens on already burdened structures (World Bank, 2003).

Also in terms of institutionalising leadership, it is important that a set of formal and informal institutions be established that embody the right sort of incentives for public decision makers. These rules must make the costs of responses fully visible as their (potential) benefits in such a way that make these decision makers accountable (Shah, 1998).

3.4 Partnerships

Fighting HIV/AIDS is not the main activity of local government, and we have already emphasised the importance of public participation in its HIV/AIDS response. In extending this idea, the role of partnerships is now examined. Given the limited resources and skills base, local government cannot fight the battle against the HIV/AIDS epidemic alone. Developing partnerships (or mobilising human resources) with NGO's and other levels/departments of government can be an efficient way to access skills and resources that are not available within a particular municipality. The kind of partnership that the municipality will decide upon will depend on the type of service the partner is providing and the capacity of the partner. In this regard, in order to deal with these decisions, there

[22] Not only should the Council be involved, but also all the successive layers of management. In the South African context, the role of the city manager, assisted by the IDP officer, would be critical. Existing forums like IDP forums could be used to respond to these issues, instead of creating new structures.

needs to be the development of contract management capacity, in terms of information (for example, in respect of monitoring and evaluation systems) as well as human capacity, within local government.

However, despite potential benefits, contracting between local government and potential partners will occur under conditions of imperfect information. This may be significant as imperfect information enable parties to operate opportunistically, exploiting any information asymmetry.

A partnership between a Ugandan NGO concerned with providing voluntary counselling and testing (VCT) services and the local government set out a framework for working together to provide VCT services and training in a district capital. The NGO is to provide training and support to staff in three municipal clinics where VCT will be provided by government services and laboratory testing services. The local government is to provide consumables involved in testing procedures and close co-operation in referring to and from primary health care clinics. They also agree to work together in other areas of mutual interest. Although the reasons have not been given, local government has mostly (although not completely) failed to meet its commitments to provide the consumables (World Bank 2003)

The partnership between the Ugandan NGO and local government took the form of a memorandum of understanding. In spite of local government's failure to meet its obligations, in other respects the agreement seems to have worked well and the partners feel that the partnership has been more or less successful. The NGO recognises the financial difficulties facing the local government (World Bank, 2003). Essential to the partnership is a sense that the partners are pooling resources to deal with a problem about which they need to co-operate. The delivery of consumables, while important, is secondary to this sense of joint obligation.

A stronger and more legally binding agreement would have been inappropriate and may have eroded the spirit of necessary co-operation, which has survived, as has the hope on both sides that local government might ultimately meet all of its commitments. When there are risks of non-delivery, the flexibility of a memorandum of understanding may be a more promising framework of agreement than a legally binding contract (World Bank, 2003).

These principles apply to intergovernmental partnerships with national and provincial government as well, where the spirit of co-operative governance has been institutionalised within the Constitution[23] and procedures set in place in the event of disputes between the various spheres[24].

Partnerships reveal the potential for collaboration between the government and non-governmental sector. This can be a two-way learning process as it is generally acknowledged that NGOs are further ahead in devising appropriate responses to the impacts of HIV/AIDS than government bodies. Also, given the impact of HIV/AIDS on institutional capacity at every level, such collaboration signals a practical pooling of resources. Despite the potential benefits from partnerships with NGOs in dealing with the broad common aim of combating HIV/AIDS, local government and NGO objectives might not be perfectly aligned.

NGOs are often foreign funded and the nature of the relationship with donor agencies can define the entire project trajectory. For example, in one case in Uganda it was the donor's unwillingness to continue funding orphans' school fees which led to the development of farm schools training (a blessing in disguise perhaps, but this has not helped solve the problem of school attendance). In the case of another NGO, the selective and erratic nature of donor funding led to the virtual collapse of the project. In contrast, other projects have had a successful relationship with donors, although funding is often short-term and sporadic (White, 2002).

Also in terms of finances and flow of funds, these partnerships can be further constrained by long and complicated financial controls procedures. For example, in the Public Finance Management Act of 1999, it says that any accounting officer transferring money to any third party organisation must ensure that they have adequate financial management procedures in place. The natural inclination of accounting officers is not to want to deal with anyone but the established NGOs.

Transaction cost analysis supplemented by consideration of economies of scale and scope provides a powerful framework for analysing government's HIV/AIDS response strategy, but is not necessarily sufficient. Response decisions must consider internal resources and skills, transaction costs, economies of scale, as well as the motivation for collaboration. In the light of the impact of

[23] Chapter 3 of the Constitution of the Republic of South Africa 1996

[24] For example, the Intergovernmental Relations Framework Bill of 2004 tries to establish a framework for the national, provincial and local governments to promote and facilitate intergovernmental relations and to provide for mechanisms and procedures to facilitate the settlement of intergovernmental disputes.

HIV/AIDS, donors now more than ever, need to recognise the implications of short-term funding and the withdrawal of funds, and the need for a flexible funding base to respond to changing situations amongst partner communities and organisations.

3.5 Competition and policy innovation

One of the arguments for decentralisation is the potential gains from experimenting with a variety of policies for addressing the HIV/AIDS epidemic, this is especially true when local governments are competitive and thus have both the ability and incentive to innovate (Adamovich and Hosp, 2003). Modern democratic governments are composite structures made up of a large number of autonomous or semi-autonomous elected and non-elected centres of power. Beyond this even if the production of goods and services by public sector bodies requires and involves coordination among centres of power, these centres still compete with each other[25] (Breton, 1996).

However, competition creates an information externality in that districts that adopt new and experimental policies generate valuable information for others. Thus there is scope for free riding which may hamper innovation (Strumpf, 1997). But there is evidence which suggests otherwise. In the area of climate policy, where climate change is viewed as a global public good, it is rational not to incur any costs of emissions reduction programs and free ride on the supply of others. When even at the international level it is impossible to prevent free-riding it is presumably just as problematic at the local level, if not more so, to convince municipalities to reduce their greenhouse gas emissions unilaterally (Kousky and Schneider 2003).

Yet, the large number of cities involved with the Cities for Climate Protection campaign demonstrates that at the local level, free-riding has been much less of an impediment than theorized. At a minimum, free riding has not prevented action. Five possible explanations are hypothesized:

- mitigation activities do not necessarily, or are not perceived to, entail costs;
- additional benefits can be captured locally even when the larger scale climate benefits are shared;
- municipalities are altruistic and are reducing greenhouse gas emissions even when to do so is not "economically rational" and;

[25] Although anti-competitive behaviour is sometimes successful, as in the marketplace, this is due mainly to an absence of competition generally (Breton and Fraschini 2003).

- local officials respond to citizen pressure to undertake policy action, thereby realizing political, if not economic, benefits (Kousky and Schneider 2003).
- Also, fiscally induced migration may also act as a mechanism for reducing free-riding.

Even though free riding may not be an issue, not all local governments may be able to compete because of wide variations in fiscal capacity and operational capacity across municipalities. To this extent intergovernmental grants may help in developing an enabling environment for all districts to compete in such a way that the benefits of constructive competition are maximised and the potential negative effects of destructive competition are minimised.

To visualize how an intergovernmental grants programme can help stabilize competition, consider how it would affect the flow of policies over districts after its initial introduction. Assume, therefore, that a local government innovates by introducing a new policy that receives support not only in the district in which it is implemented, and henceforth serves as a benchmark (Breton and Fraschini, 2003).

The expected response within the competitive paradigm is for others to follow, but one or more districts may not be able to follow because they lack the necessary resources to do so. This is the case in most countries, provinces, and districts, where there is an uneven process of developing and rolling out local government HIV/AIDS response strategies. Some local governments may have strong donor or leadership-driven support for developing local government HIV/AIDS response strategies, while others may be hindered by obstacles that delay their ability to develop similar strategies (World Bank, 2003). Presumably, labour, capital and/or technology will leave these jurisdictions, worsening their position relative to the pre-innovation one, while improving that of the host. That describes instability and an intergovernmental grants programme can prevent this from happening.

Although this may contradict my initial view that additional funding may not be necessary, intergovernmental grants are only one of many ways to improve the playing field. The World Bank supported National AIDS Programme in Uganda has started to facilitate horizontal district-level learning and training. Designed to be inexpensive and informative, District AIDS Councils (DAC) are encouraged to identify districts that may be further along in strategy development and implementation, and to set up information-gathering site visits with poorer performing districts (World Bank, 2003).

The development of Technical Networks is another example of finding solutions to knowledge sharing issues. The DAC is responsible for channelling funds from the National AIDS Council to support community-level micro-projects. Depending on the size of the district the DAC may receive an unmanageable number of proposals that range from education and prevention to care and counselling. To facilitate a thorough and critical analysis of proposals, some DACs have supported the creation of Technical Networks. Comprised largely of local experts engaged in various HIV/AIDS-related work, the Technical Network fills in the knowledge gaps that the DAC might have with regards to the technical merits of the community-level micro-projects. The Technical Network is invited to review the community proposals on a monthly basis and give their recommendations to the DAC. Both the district-level learning initiative and the Technical Networks illustrate innovative approaches to the need for knowledge sharing and capacity building at the local government level (World Bank, 2003).

In conclusion, this review of best practice has highlighted which institutions are necessary for a successful HIV/AIDS response. Also important is that these institutions and practices have been developed in developing countries, thus making them more suited to South Africa. However they cannot be created within a vacuum. In this regard, an overall environment of good governance needs to exist for the development of these specific institutions.

4. The impact of governance characteristics on HIV/AIDS

It is not easy to link HIV/AIDS and good governance, this indicated by a recent study which failed to show the correlation (Hsu, 2000), however, researches have recognised the relationship between good governance and HIV/AIDS[26]. Also the epidemic in South Africa has reached a scale that necessitates a shift from indifference and hostility to a better response evolved from partnerships and learning from experiences of other countries, local authorities, urban stakeholders and the civil society.

The choice of a system of governance involves such principles as political participation, protection of individual's rights and the development of various civic virtues (Oates, 1999). These political rights, as well as socio-economic rights, have shaped the constitutional dispensation within which municipalities operate. Some of these governance principles may have been dealt with in the previous section.

In terms of human rights, the rule of law would require supportive ethical, legal and human rights frameworks to be implemented fairly and impartially, not only at the national but also at provincial and local level, ensuring that the most isolated groups have access to legal channels. In the context of the HIV/AIDS epidemic, promotion and protection of human rights and promotion and protection of health are fundamentally linked. When human rights are not promoted and protected, it is harder to prevent HIV transmission and the impact on individuals and communities is worse (Jones, 2004). In Thailand the rule of law has been identified as one of the critical mechanisms in building a resilient HIV/AIDS response. The government blocked a legislative proposal that would have stigmatised PLWHA and lifted a ban on the entry to Thailand of foreign nationals known to have HIV/AIDS (Panyarachun, 2003).

People are more vulnerable to infection if they do not have access to information about how HIV is transmitted and the means to prevent transmission. Without adequate medical care and treatment, nutrition, shelter, and income, people with HIV are more susceptible to anxiety, poor health, and disease. Also without the participation of people affected by the epidemic, prevention programs and support services are less likely to work for the people who need them.

[26] See de Waal, 2003 and Patterson, 2001

As a result of the stigma associated with HIV/AIDS and with populations affected by the epidemic, people experience discrimination in the community, at work, in housing, in immigration, and in accessing health and social services. For example, a hostility index developed in a study in India revealed that almost 90 per cent of respondents harboured at least one hostile view, and more than half held three or more such views (Ambati, Ambati and Rao, 1997). Failure to promote and protect human rights has made the HIV/AIDS epidemic worse for many populations. This includes the subordination of women and girls and hostility towards homosexuals, drug users and sex workers.

The rule of law could potentially induce some behavioural modification by reducing most forms of discrimination, particularly those relating to women and minority groups, through empowerment of women in order to reduce abuse, trafficking and the space for women to negotiate their sexual rights. The rule of law should protect marginalised groups who are less likely to be cared about or even acknowledged by society's decision makers because of the stigma attached to the infection. Without the rule of law to protect those who are infected, the wall of silence becomes thicker and a great obstacle to prevention and care, indirectly jeopardising other programmes and plans implemented as a response to the HIV/AIDS epidemic (OHCHR & UNAIDS 2002). Those who draft the legislation often have no immediate or direct links with those at the grass-root levels, and therefore good governance would ensure that the rule of law involves those at the local levels (Canadian HIV/AIDS legal network, 2004).

Good governance also stresses full participation of all constituents, since municipalities cannot deal with HIV/AIDS alone. This would include community participation and involvement in the dialogues with local governments and authorities, NGOs and other civil society groups in the challenge of addressing HIV/AIDS. Full participation would help in reducing frustration costs ensuring that policies and programmes planned to address the challenges of HIV/AIDS will be people-centred, and gender-sensitive, without leaving out fringe communities or informal sectors which are so often ignored by governments.

Female prostitutes in particular are perceived as the bridge between an HIV-infected "underworld" and the "general population". Accordingly policy-makers and the media, justify draconian legal measures and moral intolerance in the protection of public health. However, few if any of these measures reduce a prostitute's own risk of contracting HIV. Also, measures to control the sex trade - such as increased criminal penalties and mandatory testing will further erode prostitutes' ability to

negotiate safe sex and further alienate them from public health initiatives, thus HIV risks would be increased rather than reduced (Bastow, 1996; OHCHR & UNAIDS 2002).

In Brazil, projects have been introduced with the goal to reduce the incidence of HIV/STD infection among prostitutes through the promotion of safer sexual behavioural patterns and improving personal risk assessment skills of both the prostitutes and their clients. The Project reached approximately 10,000 prostitutes and clients in 300 commercial sex sites with effective HIV/STD communication programming provided through print materials and safer sex training workshops, and established a referral system which supports STD services to these groups. (Parker, 2000)

Equally important, people living with HIV/AIDS are often ignored because they have already been infected and many macro level policies target only prevention. Negative responses and attitudes towards PLWHA are strongly linked to general levels of knowledge about HIV/AIDS and, in particular, to the causes of AIDS and routes of HIV transmission. In most societies, AIDS is associated with groups whose social and sexual behaviour does not meet with public approval. In the same study by Ambati, Ambati, and Rao (1997), 60 per cent of respondents believed that "only gay men, prostitutes, and drug users can get AIDS." In some communities, people with AIDS have been chased out or attacked. However, people living with HIV/AIDS for some time (during the incubation) can prove to be a valuable asset since they could provide mental support and counselling services to those who might have a hard time accepting the HIV positive test results.

Despite the benefits of full participation, there are also pitfalls. Firstly, caution needs to be exercised when decisions are based on the majority vote, since the result may actually discriminate against the most vulnerable groups of the society, that is, increase frustration costs. Kerala State has the highest level of educational attainment in India. However, well educated parents in Kerala voted against admitting to school children from families with PLWHA. This was done despite the parents having been provided with clear, scientific information that enrolling AIDS-affected children would not pose a danger to other school children. The local education authority accepted the majority decision, thus resulting in further discrimination against people living with HIV/AIDS or there family members, infringing on their rights (Jayasree 2003).

Secondly, although local government may embrace full participation of all its constituents, the possibility exists that some may not want to participate in the process. For example, there is the

potential for traditional healers to be unwilling to participate, since they have always been rather suspicious of modern (western) medicinal practises. The former thinking the latter will steal their knowledge and client base. This has profound implications for policy development since traditional healers are respected in their communities, especially in rural areas. Where policy is developed and implemented without their constructive participation, responses may proof to be ineffective (UNAIDS, 2000).

Good governance also relies on the main actors of those in charge to be responsive in terms of responsiveness providing easy and affordable access to medical treatment, rehabilitation and other forms of support for those living with HIV/AIDS. The community must also have similar easy access to any new information on the HIV/AIDS epidemic as soon as it becomes available. Good governance would oblige municipal leaders, local governments, local agencies and national policy makers to respond with a variety of tools and approaches to stem the epidemic, with emphasis placed on participatory involvement of the people (Citynet, 2002).

The focus in some democracies tends to be on the electoral process within the democratic structure. This results in compartmentalisation of delegated authorities for different sectoral matters. Also, politicians tend to focus on the shorter term solutions because of the electoral cycles. As a result of this, HIV/AIDS responses may lack co-ordination, with solutions that may be short term with little incentive to develop longer term solutions (Hsu, 2004)

Since HIV/AIDS has a longer term impact than other epidemics, fighting the epidemic requires long term strategic vision with accompanying responses and a systems approach where multi-sectoral engagements and cross-sectoral collaboration are necessary (Hsu, du Guerny 2002)

In Thailand, the government has been slow to respond to HIV/AIDS transmission through injecting drug use. Since illegal drug use is a serious criminal offence in Thailand, drug users are handled by the National Narcotics Control Board. Law enforcement is the approach used by the Board in response to drug use with little attention paid to HIV prevention responses, which is the responsibility of the Ministry of Public Health. Lack of co-ordination and collaboration between these agencies has resulted in continued HIV/AIDS transmission among drug injectors (Hsu, 2004).

The Role of Local Government in combating HIV/AIDS: An Institutional Analysis

This example illustrates the need to cut through administrative boundaries to enhance multi sector collaboration in responding to HIV/AIDS. Bureaucratic structures should not be a barrier to protecting people's health and well being. In this example, a systems response would be one that engages the collaboration of multiple sectors, that is, the Board, Ministry of Health, the judiciary, social workers, NGOs and the drug users themselves.

The importance of the rule of law to protect those who are infected (and their family) and the greater community reinforces the importance of transparency that requires the flow of information. The community has a right to know about HIV/AIDS, its modes of transmission and the best way of protecting themselves. Transparent policies do not simply mean the distribution of HIV information, but also provision of information regarding procedures and opportunities that will assist in personal life-skills building and decision making. This means that the community would have access to available information necessary to guide their decision-making as it pertains to the way they make a living and build their lives, for example, information relating to job markets in order to improve employment chances. (Hsu, 2002)

A lack of transparency by local government may prove to exacerbate the HIV/AIDS epidemic. The Pinxiang City in south-east China believes in local government consistently "creating an enabling environment for HIV prevention". When Pingxiang began its all-out HIV prevention campaign, several government officials from other districts ridiculed them for "airing family dirt to the public". Such reluctance to disclose local AIDS situations and to initiate prevention measures is illustrated by officials from a district 120 km outside of Pingxiang. This district's officials have concealed their actual HIV prevalence because they feared that discussing it would damage their image and dissuade investors. The misrepresentation and denial has been detrimental to that district's citizens. Due to the local government's reluctance to discuss HIV, people lack knowledge and awareness of HIV transmission and prevention. HIV prevalence among drug users tested for HIV in that county has increased from 0.7% in 1997 to 50% in 2000 with the situation now critical (Gu and Hong, 2001).

Also within the framework of good governance, equity would ensure that marginalized groups, like sex workers, are also entitled to the most basic health services and other support services provided to HIV/AIDS patients. Marginalized groups are often the most vulnerable to infection because they are often left out in the flow of HIV/AIDS information dissemination or awareness programmes

implemented at the macro-levels (Bastow, 1996). The micro-levels of good governance, with various active NGOs, and civil society groups working among the people, would have access to many of these marginalized groups.

Sex workers, injecting drug users and illegal immigrants are especially susceptible to HIV because of the proportional lack of information and services available to them because of their socially "inferior" status. Equity in this sense must also ensure that women have support and negotiation space if they choose abstinence in their sexual encounter with their husbands.

Examples of marginalisation can be seen in India where significant levels of discrimination, both overt and covert, were identified in health care. In an attempt to avoid having to provide care, health care staff passed patients from hospital to hospital. There was uncertainty among health care staff about basic HIV-transmission information and about the need for, and purpose of, universal precautions. Staff, particularly those with a secondary care role, held exaggerated fears about the infectiousness of HIV, which profoundly affected their ability to provide good care. No matter how miniscule the risk of infection, treatment interventions were often selected not on the basis of what was best for the patient, but on what would prevent any risk of infection whatsoever. Staff's negative views about people with HIV also affected the care provided (Bharat, Aggleton and Tyrer, 2001)

In order to implement policies and programmes that respond effectively and efficiently to the HIV/AIDS epidemic, these policies and programmes must address the immediate needs of the community at the local levels. The most effective and efficient actors would be those who work closest to the people. These local actors would be able to identify, strengthen and use local capacity to facilitate community groups working amongst the people (either as educators, counsellors or those who disseminate information) who are capable of scaling up and adopting best practices from another city or region on how to stem the epidemic.

5. Review of South African local government HIV/AIDS responses

As a result of the problems mentioned in obtaining qualitative empirical research, the review of current local responses is admittedly brief and relies heavily on the IDPs[27] of the various municipalities and reports by other researchers and academics.

The IDP document is punted as the primary instrument for guiding and supporting service delivery and investment decisions of municipal and other stakeholders and role players. The concept, approach and method of IDPs is being held as a key instrument to achieve developmental local governance for decentralised, strategic, participatory, implementation orientated, co-ordinated and integrated development (Feldman and Ambert, 2003). The IDP Guidelines argues that not only is preparing an IDP a legal requirement in terms of the legislation but that it is actually the instrument of choice for discharging municipalities' major developmental responsibilities to improve the quality of life of citizens. Thus a review of the IDP[28] may be valuable in assessing local government responses since decisions by municipalities will be based on this document.

In terms of human rights, people with HIV/AIDS in South Africa are protected by the Bill Of Rights[29] and have the same rights which protect all citizens.

- There can be no discrimination against anyone who has HIV/AIDS.
- They have the right to medical treatment and care from our health and welfare services.
- Children with HIV are allowed to attend any school.
- No one can be fired from a job just because they are HIV positive
- No one can be forced to have an HIV test at work or before getting a job.
- Test results cannot be shown to anyone else without the permission of the person who had the test.
- Pregnant women with HIV have the right to make a choice about their pregnancy.

[27] Refer to Appendix F for a summary of the review of the responses
[28] The IDPs that were reviewed include the City of Cape Town, Johannesburg, eThekwini, Buffalo City and Tshwane
[29] The Constitution of the Republic of South Africa, Chapter 2, Act 108 of 1996

However, even though the South African constitution and the HIV/AIDS epidemic do not discriminate, people still do. Stigma is strongly associated with visiting certain health facilities, including VCT and ARV treatment sites. Fear of stigma and discrimination deter people from testing and consultation, resulting in a delay in knowing one's HIV status and the initiation of treatment. Disclosure within the community is often indirect, e.g., food parcels and feeding formula obtained from the clinic being seen as strong indications of an HIV-positive status. In a research report by Padarath et al (2006) community members in all sites studied[30] reported informally diagnosing people with HIV based on physical symptoms and other signs. Diagnostic criteria included weight loss, rashes and hair loss.

In addition, specially allocated VCT and HIV treatment rooms may further prevent uptake of treatment for fear of being identified as HIV-positive. Padarath reports that in some instances a lack of space is said to compromise the confidentiality of VCT and act as a deterrent to testing and counselling. There also appears to be reluctance among people to use services where local community members are employed for fear that the confidentiality of their status would be compromised.

The Department of Health (2005c) has also expressed concern about discrimination, especially with regard to women and the spread of HIV/AIDS.

> *"The right to choose is most violated in those places where women exchange sex for survival as a way of life. We are not talking about prostitution, but rather a basic social and economic arrangement between the sexes that results on the one hand from poverty affecting men and women, and on the other hand, from male control over women's lives in a context of poverty. For example, in many instances the male is the breadwinner and brings the money home. If his wife or partner does not do as he asks, he can use his status as breadwinner to withhold money from her."*

Women experience HIV at a multitude of levels. Entrenched patriarchy and poor socioeconomic conditions make women particularly vulnerable to infection. Since they fear being blamed for infecting their partners, some women keep their HIV-positive status secret from their husbands, often out of fear of violence or abandonment.

[30] The study was undertaken in four areas in the provinces of KwaZulu-Natal and Limpopo. The study collected information on some of the critical barriers to community participation in HIV and antiretroviral services. One urban and one rural community or municipality was chosen in each province for the study.

In all the cities reviewed, there is a general recognition of the inequalities that exist with regard to the protection of women's rights, especially with regard to HIV/AIDS, however the responses do not emphasise this point. We have seen that a human-rights based approach to HIV/AIDS is crucial to any response, and the municipalities reviewed have recognised this, especially with regard to the protection of women's and the children's rights in the context of HIV/AIDS.

Also, even though HIV/AIDS infected people have the same rights as all citizens, certain rights are not covered by the Bill of Rights. For example, do people have a right to be able to know about their infection status and is this right being respected at all levels? Do couples have a right to marry and have children when one of them is known to be infected? It is therefore important that the community and the local stakeholders decide what is local government's role and responsibility with respect to individuals, couples and communities whilst challenging the epidemic.

Indeed in terms of public participation, not only in the context of human rights, the role of the various stakeholders in local government responses is vital and this has not been ignored by local government. For example, the City of Johannesburg is committed to the inclusion of the community in developing policy (not only HIV/AIDS policy) having overcome initial problems in fostering a participatory democracy at local level. In terms of HIV/AIDS policy, the City recognises that no reduction in the rate of increase in HIV prevalence is possible without the active participation of communities. In the City of Cape Town, Multi-Sectoral Action Teams (MSATs) have been established in each of the eight sub districts of the Cape Town metro, indicating its commitment to public participation. These teams bring together various local stakeholders on HIV/AIDS and TB NGOs, community based organisations, local business, faith based organisations, local officials, councillors and sub-council managers so as to develop and drive a local plan in response to the epidemic, with the focus being to mitigate the social, economic and human impacts of the epidemic.

However, despite the inclusion of key stakeholders in HIV/AIDS responses of the various local governments, there is little indication of the actual input into the process and the eventual outcome. This may indicate that there may be capacity lacking in dealing with the concerns of the various stakeholders, and converting this into detailed needs that have to be addressed. This is reflected in some IDPs as undefined projects with very little detail (bullet point projects) such as "HIV/AIDS

awareness and prevention" and "providing for orphans". Specific outputs, target communities and anticipated impact are seldom described.

In Cape Town for example, its HIV/AIDS and TB programme vision for 2020 is that all sectors will be involved in "developmental interventions" to fight HIV/AIDS/TB, however in saying that, no mention is made of minority groups such as sex workers, drug users and immigrants. This is also evident in eThekwini and Tswana municipalities where reference is simply made to the inclusion and involvement of key stakeholders and partners. Also the commitment by the various local governments to align policy with that of provincial government may in fact reduce the effectiveness of the inputs of the various stakeholders, since local government may value alignment of the strategy more than the input of the stakeholders. Moreover, the participation of the community is limited to the extent that only their needs are expressed in the IDPs. For example, in all IDPs there seems to be only programmes for the support and care for those infected with the disease, and no mention of them as a valuable input in the design of responses.

Also, traditional leaders are mentioned as one of the groups to be included in the response strategies, but not to the extent that it is occurring at provincial level. This is of concern given the status of traditional leaders in their respective communities. In KwaZulu Natal traditional leaders have strengthened the province's initiatives against HIV/AIDS and are joining three other provinces - Eastern Cape, Free State and the North West Province - that have already launched their provincial traditional leaders HIV/AIDS chapter. Here there is recognition that traditional leaders have certain strengths that they bring to the fight against HIV/AIDS. They are well placed to convey AIDS messages, especially in rural areas, as they are respected in the community and have good access to their people (RSA, 2002)

All local governments reviewed mentioned HIV/AIDS in their analysis of the current situation. However, lack of early commitment and initial concern by the local authorities has meant a missed prevention opportunity as a result of the late start. In the IDPs reviewed, analysis as to the causes and (socio-economic) impacts of HIV/AIDS has been conducted with plans in place to deal with the epidemic. For example, Buffalo City municipality undertook an Employee HIV/AIDS Prevalence Study in 2004. The results showed that HIV/AIDS prevalence was at 10.3% of the municipality's workforce. The cost to the municipality per employee lost to the epidemic was estimated to be on average two years' salary. Despite this high cost, Buffalo City took the view that 90% of the

workforce was not infected, and thus an opportunity existed to invest (profitably) in prevention and treatment of HIV/AIDS.

Typical programmes that are already in place in the municipalities reviewed include health education, condoms, voluntary counselling and testing, prevention of mother-to-child transmission programmes, STD treatment, women and child health services (adolescent and youth friendly), HIV support groups and treatment of HIV opportunistic infections, but these are mainly health sector responses. In saying this, the municipalities have recognised that a health sector response is not sufficient, and in their IDPs there are clear intentions to develop a more multi-sectoral response.

The City of Cape Town HIV/AIDS and TB co-ordinating committee, chaired by the Mayoral Committee Member for Health, Amenities and Sport, brings together on a monthly basis representatives of political parties, relevant directorates, unions, the sub district MSATs, the provincial interdepartmental AIDS Committee and Provincial department of Social Services. The committee's function (amongst others) is to drive the mainstreaming of HIV/AIDS in the Cape Town metro. In Johannesburg, the Health department, in conjunction with other city departments, intends to conduct a two year Johannesburg-specific HIV/AIDS and STI prevalence, awareness and impact investigation, and use the information to assess the implications for prevention campaigns and care services, demand for household infrastructure services, and the scale of the City's social package. Also in the City of Tshwane, HIV/AIDS is considered in several departments when decisions are made, these include Housing, the department of Local Economic Development and the Department of Marketing and Communication.

The late start by municipalities should be seen in the context of the role of local government in the delivery of basic services. These services are increasingly being provided by non-public means, thus mitigating some of the losses of an early start. The growth of non-governmental HIV/AIDS service provider organisations registered in Uganda has grown by more than 500% between 1990 and 2003. This is probably the case in South Africa, although there has been little research on civil society responses to HIV/AIDS[31]. Also the commitments of large business interests to HIV/AIDS responses has grown with mining houses, the parastatal sector, the automotive assembly industry and the financial services sector leading the way (Kelly, 2004).

[31] The Medical Research Council (MRC) has launched a research programme on local level responses, with civil society responses identified as one of the areas of research (MRC, 2003), also see Chazan (2006) for an overview of various initiatives by community based organisations.

Local governments may wish to develop strategies for actively managing these resources through development of partnerships between LG and civil society and business, however there are both opportunities and risks associated with partnerships. The opportunities involve increased human and capital resources flowing into the pool of resources available locally for HIV/AIDS response. For example, the Msunduzi Municipal AIDS Strategy is a co-ordinated partnership between the Msunduzi City Council, the Children in Distress Network (CINDI), Lifeline, and more than sixty NGOs working in the area. To set the process in motion, a workshop was convened to identify what was needed to address the AIDS epidemic in the area. Priority areas for action that were identified were each spelt out in terms of objectives, activity, timeframe, partners, and progress indicators (Clark, 2002)

Crucial to the success of the campaign was addressing the needs of the NGOs which, as a result of the Council's "open-door" policies, are able to raise issues at the highest level. For example, if an organisation dealing with the training of home-based care workers requires a building from which to operate, the Council will try to identify suitable premises. This scheme has had some positive benefits for urban renewal. Historic buildings that were derelict have been restored by NGOs through their own funding. A disused government office near Edendale Hospital was made available to the CINDI Network. Here, care kits containing basic medicines and antiseptics are assembled and given to home-based care workers trained by CINDI partners (World Bank, 2003).

The risks of partnerships are an unregulated, unsystematic and poorly integrated set of responses. Also the development of partnerships may prove difficult, because of the existing negative attitude towards co-operating with government; and may prove difficult to maintain because of the bureaucratic nature of local government services and the highly focused, efficient and cost effective way of community based organization (CBO) service delivery.

Even if local government wishes to enter into partnerships, credible potential partners may simply not exist, this is especially true in rural towns. Also despite some initiatives, community involvement in HIV/AIDS activities in South Africa is surrounded by a host of challenges including lack of leadership, lack of credibility and the fact that many people still need to be convinced of the dividends of community involvement. Given the stigma associated with HIV/AIDS, community involvement might result in secondary stigmatisation. Support groups are widely considered

beneficial in assisting people living with HIV/AIDS to cope with the burden of the disease. However, there are challenges to establishing support groups, retaining members, and sustaining groups over time in areas where resources are limited and the disease remains highly stigmatised (Padarath et al, 2006, Chazan, 2006)

In terms of transparency local government should ensure that there are avenues for those who are infected to continue finding employment and that national governments share important information on HIV/AIDS (policies and programmes) with local governments, who in turn make this information easily accessible for NGOs, civil society groups, educational channels, informal and formal sectors and private enterprises. In Johannesburg the lack of access to information was identified (and is currently being addressed) as a major factor contributing to the spread of HIV/AIDS, especially in rural areas. Also Johannesburg was the first local government in Gauteng to establish and launch an AIDS council and has since shared information and experiences with other local councils and supported them in establishing their AIDS councils (Johannesburg, 2003). Co-operation amongst neighbouring municipalities in this regard may prove beneficial given the limited capacity and resources. For example sharing of situation and impact studies may help in reducing duplication.

Overall, the effectiveness and efficiency of responses is more difficult to assess given that most responses are only starting to address the epidemic. Looking forward, the reduction of the number of reported cases will be the first indicator of effectiveness.

In terms of resources spent on HIV/AIDS awareness and prevention, a clear indicator to measure effectiveness would be the knowledge the community has on modes of transmission, and if ways to prevent transmission are being exercised. For example where condoms are distributed, surveys may be conducted to gain an idea if condoms distributed are actually used.

Although effectiveness of the responses may require further study, we can already observe some inefficiency in terms of the awareness and preventative measures. Awareness campaigns, although mentioned in all IDPs as one mechanism to fight HIV/AIDS, make little mention of target (high risk) groups, such as drug users and sex workers. Also these campaigns are mainly aimed at prevention, people who are already infected may also need to be made aware of their rights, and the mechanisms available to them should they feel their rights are being infringed upon. Moreover, much of the

information regarding HIV/AIDS is in print form, and illiteracy may prove to be a barrier in educating (poor) communities.

Since local government cannot fight the epidemic on its own, the governments reviewed all stated an intention (if they not doing so already) to align HIV/AIDS strategies with those of provincial and national government. Given that there is already evidence that local governments have problems capturing and interpreting the information gathered regarding HIV/AIDS, this could result in them sheepishly following national government's strategy. Thus there is a risk that there may be little incentive for the development of innovative policies at local level, further compromising the efficiency and effectiveness of responses.

It is evident within all the IDPs reviewed that the various local governments are only starting to implement HIV/AIDS strategies. This has resulted in the crucial loss of a prevention opportunity because of a late start. Also, responses by local authorities have been rather limited to the extent that they have not been taken much further than the health department at a local authority level.

Where mainstreaming of HIV/AIDS into core activities is taking place, the reality is that local governments do not have the capacity and skills to do this. Thus the potential synergies of integrated planning are not being realised, nor are HIV/AIDS activities mainstreamed into the core operational activities of housing, infrastructure provision etc. Also, there is a lack of awareness by many sections of the local authorities of the likely impact on service provision and the ongoing tension between national, provincial and local levels with respect to responsibilities and action may hinder current and future programmes.

Local governments have recognised the importance of good governance practises. Looking forward, although there is a willingness for these municipalities to adopt best practice responses against HIV/AIDS, a lack of capacity and skills may be a binding constraint. This is not where the problem necessarily ends. Further inspection of the IDPs reveals local governments simply are not able to address strategic objectives, such as local economic development and poverty[32]. While this may be

[32] Indeed, in some areas HIV/AIDS was not considered a major priority issue, for example in Bloemfontein, where HIV/AIDS prevalence is significantly higher than most other areas, HIV/AIDS is considered to be a moderate priority behind that of economic development and crime.

as a result of a lack of skills to deal innovatively with these issues, it also seems to be a systemic response to the current framework for intergovernmental fiscal relations (Ambert, 2004).

The transformations since 1994 in the intergovernmental system have been simultaneously decentralised and centralised in nature. Although local governments have been given exclusive powers, a closer inspection of the financing of local government reveals that the system has centralised characteristics. It is frequently claimed that over two-thirds of municipal activity is self-funded, however, this is not necessarily the case in individual municipalities, especially in Eastern Cape, KwaZulu-Natal and Limpopo[33] (RSA, 2004).

In these municipalities, it is likely that unconditional grants (equitable share) may be absorbed by personnel expenditure and other municipal expenditure accounts. This leaves little discretionary resources for municipalities to implement and sustain locally developed solutions for local objectives. While conditional grants can be used for national and provincial goals, their use is largely predetermined (Feldman and Ambert, 2003). Also national priorities and policies to alleviate poverty exert significant additional budgetary pressures on municipalities, particularly those related to free basic services (RSA, 2004a).

Thus with the limited scope of the national response to HIV/AIDS, it is almost inevitable that this will be reflected at the local level, especially where nationally or provincially developed programs are the popular source of local project definition and implementation. While some institutional capacity building relating to HIV/AIDS is necessary, it is also unlikely that it will fundamentally challenge the entrenched pattern of municipal dependency on pre-determined programmes to be implemented through national and provincial conditional grants (Feldman and Ambert, 2003).

Thus based on the IDPs and research by other academics, a fully decentralised approach may simply not be possible at this stage. However, further research in terms of interviews with NGOs and local government HIV/AIDS co-ordinators may provide further insight.

[33]Nationally, transfers as a percentage of the overall budget is highest in Bohlabela (Limpopo) at 92 per cent and the lowest in Cape Town at 3 per cent (RSA, 2004a)

6. Conclusion

The South African government has seemingly failed in its HIV/AIDS response at a national level despite progressively increasing its budget allocation. This paper has shown that decentralisation, with emphasises on public participation could mean that these increases may be unnecessary, even wasteful as some districts may find it difficult to absorb the increased funding.

Also, from the above analysis, we have seen the merits of moving government's efforts from national to local level, more specifically, how decentralisation can result in HIV/AIDS responses which are better matched to the needs of jurisdictions. Decentralisation provides incentives and possibilities for local governments to generate better information about the effects of the epidemic on vulnerable groups because they are closer to them. Also increased competition improves allocative efficiency by forcing local governments to develop innovative and dynamic HIV/AIDS responses. In this regard the improvement of information dissemination between and across the various spheres of government, and community participation may improve the competitive environment.

Although the epidemic has reached alarming proportions, an HIV/AIDS response cannot be the main activity of local government. In this regard, institutions which enable public participation in the development, execution and monitoring of HIV/AIDS responses are vital for the success of these responses. The establishment of forums which involve all sectors of the population especially those who are HIV positive in the development of HIV/AIDS policy can greatly reduce stigma as well as frustration costs. There are movements in the metropolitan councils to involve the public, however emphasis needs to be placed on the inclusion of minority groups in these structures if any response is to be effective.

In terms of execution we have seen the benefits of pooling resources to fight the HIV/AIDS epidemic through the use of PPPs, especially in district and local municipalities where capacity may be lacking. These include significant reduction in costs as well as the development of innovative HIV/AIDS policies. In saying this, mechanisms such as contracts, although they may make agreements between local government and its partners legally binding, must be supported with the spirit of co-operation and understanding if the common goals related to HIV/AIDS are to be achieved.

The public also has a vital role in monitoring the activities of local government, and holding the officials accountable for their activities, especially in the regard of fiscal discipline. Even though the community has an informational advantage over national government in overseeing local government activities, they need to empowered in not only voicing their dissent, but also in being able to take action such as voting out officials. This may indeed be the case in South Africa where local participation has been compromised as a result of apartheid.

The review of some of the major South African local government responses indicates that currently local governments simply may not be ready to handle a more decentralised approach, although further research is required in this regard. Also decentralisation may remove some of the problems associated with a centralised approach, but may introduce new problems. Capacity at the local level is an issue raised by many municipalities which are already trying to cope with existing external challenges of basic service delivery, poverty alleviation, crime and unemployment.

Decentralisation encourages public participation, and this in itself may prove to be a problem. An increase in public participation may result in an increase in opportunity costs as the process may be time consuming. Public participation may also simply not be useful as communities struggle to deal with the epidemic and may not be able to make a constructive contribution, in the extreme case they may even become confrontational. Also public participation may not increase as South Africa has inherited a tradition where broad based participation in local government activities was almost non existent under the apartheid regime. There are also inherent risks in formulating partnerships with various stakeholders as these partnerships will be established under conditions of imperfect information. Potential partners may also simply not exist in certain areas, especially in rural areas where there may be lack of established NGOs and community based organisations.

Leadership at all levels of government is crucial to the success of a decentralised approach. Although decentralisation may circumvent some problems that occur at national level, it may also inherit some of the problems, this is especially true when it comes to the commitment of political leaders. If there is a lack of commitment to respond effectively and efficiently to HIV/AIDS at a national level, the potential may exist for local governments to adopt a similar stance. In this sense, a local ANC Executive Mayor may simply want to avoid tackling the epidemic given that the top ANC leadership refrains in doing so. Also given that there are other priorities and challenges at local level, local

leaders may simply lack the incentive to deal with HIV/AIDS. The lack of incentives for local leaders may be compounded by the fact that local level leaders simply

Since 1994, the transformations in the intergovernmental system have been simultaneously decentralised and centralised in nature. For HIV/AIDS responses to be truly decentralised, finance mechanisms should at least enable local governments to develop solutions to local problems/priorities, especially in the smaller districts which have little to no ability to generate own revenue. This could be affected through increases in unconditional grants relative to conditional grants.

However, transformation and the development of a more decentralised system may take some time, and more short to medium term measures are required. Here the role of the public should be emphasised, especially in districts where capacity and finance is lacking. Even in the most rural settings in Uganda, good governance practices, especially that of public participation in developing and maintaining institutions can overcome most capacity constraints that the local government may face. These rural districts may fall short in competing with larger metropolitan districts. In this regard the Johannesburg metropolitan has led in sharing information and experiences with smaller local councils and helped them establish mechanisms to deal with the epidemic.

In the long run, with a more decentralised system and the adoption of best practice by local government, the role of national government should primarily be that of stabilisation and income redistribution. However local governments cannot be left to their own devices. The success of decentralisation depends on the ability of national government to enforce hard budget constraints, as these constraints force local governments to manage their budgets more carefully. Related to this, national government must adopt the role of the guardian of competition in enforcing general rules for sub-national governments. Also in this role as guardian the role of (unconditional) intergovernmental grants may help in stabilising competition amongst local governments. Finally, justifiable socio-economic rights of people living with HIV/AIDS would require monitoring by national government.

In the cities reviewed, the benefits of early prevention strategies have been lost. However, these councils are recognising the importance of public participation and are also conducting more comprehensive studies on the impact of HIV/AIDS on their districts. Looking forward there is a

need to take current responses further than the health departments into other core operational activities to realise potential benefits from a more mainstreamed approach. Within the context of a more decentralised intergovernmental system the development of a decentralised HIV/AIDS strategy[34] with due consideration to best practice may help in reversing these prevention losses; but more importantly it may be a significant improvement on the current national response.

[34] Even though the brief review of local government responses has yielded that they may be incapable of dealing with a decentralised HIV/AIDS response, more in depth research may be required to confirm this.

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8. Appendices

8.1 Appendix A: Key Characteristics of HIV/AIDS

- AIDS is a new epidemic. It was first recognised as a specific condition only in 1981 and it was not until 1984 that the cause (and a test to detect it) was identified.
- It has a long incubation period. Persons who are infected by the virus may have many years of normal productive life, although they can infect others during this period.
- The prognosis for people infected with HIV is currently bleak, with no possible cure yet to be found.
- The scale of the epidemic is also different from most other diseases. The latest data indicated that in some urban settings more than 30% of antenatal clinic attendees are infected.
- The disease is found mainly in two specific age groups, infants and adults aged between 20-40 years. In the developing world, slightly more females than males are infected, and women are infected and develop the disease at a younger age than men.
- HIV and other diseases are linked, both in terms of causing HIV/AIDS to spread (other sexually transmitted diseases increase the rate of STI transmission tenfold) and resulting from HIV infection (tuberculosis incidence has increased and is directly related to HIV).
- In general the epidemic is still spreading. In some southern African countries it may have peaked in urban centres, but it continues to spread in the rural areas (Loewensen and Whiteside 1997).

AIDS moves through different stages. People who get HIV can stay healthy for many years and most infected people do not even know that they are HIV positive. There are no visible signs to show that a person is infected. They can pass the disease on to other people by having unprotected sex with them (sex without a condom).

The second phase of the disease is when you get AIDS and start becoming ill more easily. The immune system is weak and cannot fight viruses and infections effectively. As the body's defence system weakens, symptoms appear, alone or severally. They include: chronic fatigue or weakness,

diarrhoea, minor skin infections, respiratory problems, sustained weight loss, persistent swelling of the lymph nodes and the deterioration of the central nervous system.

As the immune system weakens, more severe diseases manifest themselves, such as cryptococcal meningitis, tuberculosis, pneumocystic pneumonia and cancers, such as Kaposi's sarcoma. This more severe phase can continue for about two years before death, with progressively longer periods of illness that may be interspersed with periods of remission (Loewensen and Whiteside, 1997).

Poor people tend to become ill and die much sooner than wealthier people. This is because of poor nourishment, bad living conditions and poorer health care. As a result the median time from infection to development of AIDS in industrialised countries is 10-11 years; in sub-Saharan Africa it is estimated to be 5-10 years, with most infected children dying before their fifth birthday (Ainsworth and Over, 1994).

8.2 Appendix B: People and areas most at risk

People most at risk

Anyone can get AIDS, but some people are more vulnerable because they do not have the power to say no to unprotected sex or because of their risky lifestyles. The groups who are most vulnerable and have the highest infection rates are:

- Young women between 15 and 30 years old: many of the women in this age group are in unequal relationships or are exposed to sexual violence.
- Sexually active men who have more than one partner: although polygamy [having more than one wife] is a custom followed only by some men, many others have a wife and a girlfriend or casual sexual partners. They may get the virus from a casual partner and pass it on to their wife.
- Migrant and mine workers: they are separated from their families for most of the year and many of them have sex with sex workers.
- Transport workers: they travel a lot and many of them use the services of sex workers.
- Sex workers: they are exposed to many partners and are sometimes powerless to insist on safe sex.

- Drug users who share needles: one person who is HIV positive can infect a group of people who share the same needle unless it is sterilised in between. Many drug addicts also become sex workers to pay for their drugs.
- People who practice anal sex: the anus is easily injured during sex because it has no natural lubrication and the virus can be passed on unless a condom is used. Gay men are a vulnerable group.
- Men and women who have other sexually transmitted diseases are also more vulnerable because they often have open sores on their private parts (Education and Training Unit)
- There is not a significant difference in infection levels between races. Research by the HSRC has dispelled the myth that HIV/AIDS is a black disease with a high percentage of infections amongst the white community (HSRC, 2002).

Areas most at risk

The following are recognised as factors that can contribute to areas having a high rate of infection:

- Areas on or close to a main transport route: areas next to major national roads or transport routes tend to have a higher rate of infection because of the presence of male transport workers who often have a number of different sexual partners. Such areas also often have a higher number of sex workers.
- Concentrations of migrant workers: migrant workers, especially those who live in single sex hostels away from their families, have a higher rate of infection than most other sectors of the population. This may be because of the fact that sex workers are commonly used by migrant workers. The rural areas that migrant workers return to at holiday times are also high-risk areas.
- Sex industry: areas that have a developed sex industry tend to have a higher rate of infection. Sex workers are among the most vulnerable because they have so many sexual partners and they are sometimes forced to have sex by clients who refuse to use condoms. They also often work in areas where there is a mobile population.
- War: areas where there is war and as a result a high rate of violence, women are especially more vulnerable to rape. The term "war" includes cross-border wars, civil wars and areas where there is a high level of conflict.

- High incidence of crime or gang activity: many gang members and criminals use rape as a weapon. Violence against women is usually higher in high crime areas. Criminals themselves are a vulnerable group because of spending time in prison and drug use.
- Disrupted family and communal life in an area can also lead to increased HIV/AIDS because of the lack of a stable sexual partner.
- High levels of poverty and inequality: the rate of AIDS is very much higher among poor people. The heritage of Apartheid in terms of inequality in relation to wealth, access to jobs, food and health contributes to higher levels of AIDS in poor areas.
- High levels of other sexually transmitted diseases (STDs): the presence of sexually transmitted diseases makes people much more vulnerable to AIDS. In some areas there is a much higher incidence of STDs.
- Low status of women: women are more vulnerable to AIDS than men. In areas where women do not have the power and status to say no to unsafe sex with their partners, the incidence of AIDS is much higher.
- Polygamy or multi-partner relationships: in areas where polygamy is a common practice or where social custom allows a high number of different partners for men the incidence of HIV/AIDS is much higher.
- Resistance to condom use: members of religions and cultures that oppose or resist the use of condoms are more susceptible to HIV/AIDS (Education and Training Unit, 2001).

8.3 Appendix C: The mainstreaming of HIV/AIDS responses into core activities of local government

Local government works in conjunction with two other spheres of government, namely national and provincial government. According to the Constitution, the nine provinces possess legislative and executive powers jointly with the national government. This section covers these powers and how HIV/AIDS can be mainstreamed within them.

The Role of Local Government in combating HIV/AIDS: An Institutional Analysis

1. Administrative infrastructure and services

- This would involve the provision, display and dissemination of information and education materials on HIV/AIDS prevention. Also, the local government must ensure that non-discrimination policies are implemented and monitored in all areas of LG work.

2. Water and waste infrastructure and services

- Local government should collaborate with local hospitals and parks to ensure that there is a system for safe disposal of needles and effective waste management.

3. Road and transport infrastructure and services

- This involves condom distribution and prevention messages on public bus routes and at bus depots (for drivers, truckers).
- Also, contracts awarded for road building should include HIV/AIDS awareness activities for road builders.

4. Health (primary health care) and education (excluding tertiary institutions) infrastructure and services

- Local government must ensure that all health workers have adequate information about HIV/AIDS.
- Support needle exchange programs where IV drug use is prevalent.
- Establish a referral system for all HIV/AIDS related testing, counselling, treatment and care as well as a referral system (with departments. of social welfare and education) for vulnerable families.
- Include HIV/AIDS awareness training in school curriculum.
- Provide referral system between schools and adolescent health services.

5. Social and welfare infrastructure and services

- Coordinate with health department to establish a referral system for families affected by HIV/AIDS.
- Support micro-credit and insurance programs for people and families affected by HIV/AIDS.
- Set up a school-fees fund for orphans.

6. Land/Buildings for residential business or other uses such as burial grounds

- Identify and assist in meeting the housing needs that may result from HIV/AIDS (e.g., those taking in orphans, child-headed households).
- Integrate HIV/AIDS awareness activities into slum upgrading projects.
- Identify buildings that may be used in HIV/AIDS projects.
- Address the growing need for burial plots (due to deaths from HIV/AIDS) within the planning of land uses.
- Support the establishment of burial societies.

7. Agricultural extension (in some cases)

- Identify families affected by HIV/AIDS and provide additional subsidies.
- Provide training in AIDS prevention and nutrition to semi-urban agricultural areas
- Investigate the use of less-labour intensive farming technologies for families affected by HIV/AIDS.

8. Economic infrastructure (markets) and services

- Use market infrastructure to display HIV/AIDS prevention messages.

9. Regulations to ensure a healthy and safe environment

- Fight HIV/AIDS stigma through legislation, advocacy, and awareness campaigns.

10. Libraries, parks, sports and recreation

Integrate HIV/AIDS awareness and anti-stigma messages into public leisure events (World Bank, 2003).

8.4 Appendix D: Questionnaire

Cover Letter

Re: Invitation to participate in a study on local government HIV/AIDS responses

Dear Sir/Madam

I am inviting you to participate in my empirical research to study local government HIV/AIDS responses. Along with this letter is a short questionnaire that asks a variety of questions about these HIV/AIDS responses. I am asking you to look over the questionnaire and, if you choose to do so, complete it and send it back to me. It should take you about 5-10 minutes to complete.

The results of this project will be to establish whether local government is capable of formulating and implementing a successful HIV/AIDS response. I hope that the results of the survey will be useful for this study

I do not know of any risks to you if you decide to participate in this survey and I guarantee that your responses will not be identified with you personally. I promise not to share any information that identifies you with anyone outside my research group.

The survey should take you about 10 minutes to complete. I hope you will take the time to complete this questionnaire and return it. Your participation is voluntary, regardless of whether you choose to participate, please let me know if you would like a summary of my findings.

If you have any questions or concerns about completing the questionnaire or about being in this study, you may contact me. This study is part of my empirical research in completing my dissertation in the fulfillment of the MComm (Economics) degree.

Regards

Adenaan Albertus

Local Government HIV/AIDS Responses Questionnaire

1. Where does the municipality rank HIV/AIDS in its overall public policy (1- most important 8- least important)

- Housing
- Poverty Alleviation
- Enviromental Management
- HIV/AIDs
- Water and Sanitation
- Disaster Management
- Local Economic Development
- Other policies

2. Is there any input from the public (NGOs, CBOs, private business and other key stakeholders) in terms of policy development and implementation (from research in initial stages of development to partnerships in implementation and monitoring)?

3. If there is any input, provide a brief description of this input.

4. Are there any specific groups that are targeted in this process, such as minority groups? If not what do you think are the reasons for this.

5. What degree of importance do you attach to this input versus the inputs from other sources, such as national or provincial government? (1- most important 5- least important)

- National government
- Provincial government
- Public
- Donors
- Other

6. Has the municipality conducted situation analysis and has this been beneficial in aiding responses?

7. Has the municipality developed responses outside of the health sector? Provide a brief description of these responses.

8. Is there any relationship between the municipality and other municipalities in terms of collaboration and co-ordination of HIV/AIDS responses? Provide a brief description of these responses.

9. Is the municipality aware of HIV/AIDS responses from other agencies within its jurisdiction?

10. Is there any relationship between the municipality and these agencies in terms of co-ordination and collaboration? Provide a brief description of this collaboration/co-ordination.

11. Where co-ordination and collaboration exists (or the intention to do so) has the municipality identified opportunities and risk?

12. Has the municipality developed strategies which include specific goals to be achieved and to diminish risks?

14. What factors do you consider as significant barriers to an effective and efficient response to HIV/AIDS?

8.5 Appendix E: Telephonic interview

Introduction

Thank you for taking the time to speak with me. I am a Masters student in Economics at the University of Cape Town. I am looking into the role of local government in HIV/AIDS responses in South Africa. This research is to get a preliminary sense of whether local government currently has the potential to deal with HIV/AIDS responses should the South African government move towards a more decentralised approach.

The findings of this research will form part of the qualitative empirical research of my Masters paper.

Before we start

- The whole interview should not take more than 15 minutes.
- You can choose not to answer any questions or to end the interview at any time.
- If you chose to end the interview, you can decide whether the information up to that point can be used in my paper
- All the information from this research will be confidential.
- I might want to cite the interview at some time in the future. Is that okay with you? What would you prefer: that I refer to you by name and institution, or that I keep your name and institution private?
- You can also provide me with information that you would like me to keep off the record.
- If you are interested, I will provide you with the final draft of this paper. You can also get in touch with me directly for more information, or if you have questions.

The Role of Local Government in combating HIV/AIDS: An Institutional Analysis

Questions

1. Can you briefly describe your position?

2. I am going to ask you a few questions regarding policy formulation and public participation
   - Where does the municipality rank HIV/AIDS in its overall public policy?
   - What kind of input does the public, such as NGOs, business and CBOs have in the development of HIV/AIDS policy?
   - Has the input been useful in policy formulation, has there been any changes to policy as a direct result of public participation?
   - Has the changes proved to be fruitful?

3. In terms of partnerships
   - With whom has local government developed partnerships with?
   - Can you describe the nature of these partnerships?
   - Have you had any problems and how have they been resolved?

4. Given the stigma and discrimination surrounding HIV positive individuals in South Africa...
   - Has the municipality identified vulnerable groups such as drug users, sex workers and immigrants?
   - Does the municipality have measures (or programmes) in place for the empowering and protection of those who are infected and affected by the epidemic?

5. Mainstreaming is a topical issue with regards to a more multi sectoral response to HIV/AIDS...
   - Can you give me a few examples of mainstreaming of HIV/AIDS activities within the municipality?
   - Have you seen any benefits from mainstreaming HIV/AIDS responses?

6. In terms of the effectiveness of HIV/AIDS policy...
   - Given that local government responses are closely aligned to that of provincial and national government, do you think you may miss the development of innovative policies that could have been developed at the local level?
   - It is generally accepted that HIV/AIDS is continuing to spread, would you say local government responses has contributed significantly in trying to curb the spread of HIV/AIDS?
   - What are the major constraints facing local government in tackling HIV/AIDS?

7. Thank you for participating in this interview, is there any final comments you wish to add?

8.6 Appendix F: Review of IDPs of selected municipalities

In terms of the Systems Act of 2000 municipalities are required to lead and manage a plan for development. This includes the allocation of resources, to the provision of fundamental municipal services, to eradicate poverty, boost local economic development, create employment and promote the process of reconstruction and development. The plan should link, integrate and coordinate other sector specific plans, while taking development proposals into account. It should be aligned with the municipality's resources and capacity, while forming the policy framework on which annual budgets are based. The Integrated Development Plan must be compatible with national and provincial development plans and planning requirements so as to give effect to the principles of co-operative government contained in section 41 of the Constitution (RSA, 2000).

The IDP is a dynamic document which is reviewed annually. This review of the IDP begins the process of aligning the budget to the IDP and the macro-strategy. The IDP process involves assessing the current situation in the district's jurisdiction area. This would include analysing such external factors such as population, economic sector, health, crime and political agendas.

The next stage of the IDP is assessing and prioritising the needs of the community. Crucial to this is public participation, which can be done through household surveys, listening campaigns and census results. Then goals are set to meet these needs, and programmes are then established to achieve objectives and measure its performance.

These programmes, also known as sector plans, are detailed plans or frameworks which are drawn up by departments within the core administration to support the goals or vision of local government. These include local economic development, poverty alleviation, housing, HIV/AIDS, transport, environmental management and disaster management These sector plans are cross-sectoral in the sense that they cross departmental planning by linking physical, social, institutional and economic components of planning and development with a management and implementation structure.

Review of IDPs of selected municipalities

Factors considered in IDP review	Buffalo City	City of Cape town	eThekwini (Durban)
Responsiveness	Developed a HIV/AIDS Cross Cutting Strategy in 2004.	A comprehensive HIV care programme has been implemented, with screening for Anti Retrovirals (ARV) done at 70% of City clinics. The City has ARV sites in Langa and Hout Bay, as well as Du Noon. Currently, the comprehensive package of HIV care is provided at 81% of clinics, exceeding the target of 70%.	The municipality has responded to the epidemic with activities in place since 2000, however, the policy was initially fragmented in nature.
Prevalence Indicators	For the Eastern Cape, HIV prevalence was estimated to be 14.7% in 2004 and 16.7% in 2006. A survey by the City showed HIV prevalence amongst the workforce to be 10.3% in 2004	HIV prevalence in the Western Cape was estimated to be 13.1% in 2003 to 15.4% in 2004 with 33% and 30% in Khayelitsha and Nyanga respectively.	It is estimated that HIV/Prevalence among antenatal clinic attendees was around 40% in 2005, the highest rates in the country.
Equality (Human Rights Protection)	Protection of human rights with regard to women and children emphasised.	Protection of rights with regard to women and children emphasised	In an effort to promote care, acceptance and protection of human rights, the City is committed to supporting community initiatives through improving access for people infected and affected by HIV/AIDS to appropriate therapy and support.
Public Participation	The strategy makes provision for two forums to assist with the implementation, monitoring and evaluation of the strategy. The Interdepartmental Forum for dealing with HIV within the organisation and the Intersectoral Forum for coordinating programmes and initiatives in the broader community. Both enjoy the highest political and administrative commitment.	Multi-Sectoral Action Teams (MSATs) have been established in each of the eight sub districts. They bring together all the local stakeholders on HIV, Aids and TB NGO), CBOs, local business, faith based organisations, local officials, councillors and sub-council managers so as to develop and drive a local plan to mitigate the social, economic and human impact of HIV/AIDS and TB.	The City regards public participation in HIV/AIDS responses as crucial, especially the involvement and input of traditional healers and other community stakeholders.
Partnerships	Partnerships with South African Cities Network, Sida and VNG (foreign agency) where there is sharing of knowledge, skills and resources.	Although there is a strong partnership with the province in terms of providing ARV treatment, it is unclear from the IDP the extent the role of partnerships, with other key stakeholders, will play in the overall strategy.	The City is committed to creating and strengthening partnerships with NGOs, the private sector and the community.
Mainstreaming of HIV/AIDS	The cross cutting strategy attempts to respond to the epidemic through embedding HIV/AIDS into all the municipalities operations as service provider and employer, for example, HIV/AIDS responses incorporated into Housing and Youth Development programs	Eleven departments have or are in the process of developing and implementing plans dealing with HIV/AIDS as a mainstream strategy. These include amongst others the City Police, City Parks, Electricity, Solid Waste and Transport	Mainstreaming of HIV/AIDS has occurred across many of the departments within the City, especially with regard to HIV/AIDS awareness activities, both internally and externally.
Challenges and Concerns	The City has a serious infrastructure backlog and difficulty in attracting and retaining technical and critical staff.	Despite a seemingly well developed HIV/AIDS response, the City is concerned it is not impacting on the continually increasing HIV/AIDS infections.	The City has expressed concerns about whether it can sustain an HIV/AIDS strategy despite significant strides made over the years.
HIV/AIDS as a Priority	HIV/AIDS is one of 7 cross cutting issues the City intends to mainstream by supporting the different directorates to consider and take account of these issues, others include poverty , gender equality and youth development	Although the City considers HIV/AIDS a priority, the Mayoral Listening Campaign revealed that low income housing, crime and job development are considered important issues by key stakeholders and residents of the City, with HIV/AIDS a low priority.	HIV/AIDS is considered as one of eight key development challenges facing the municipality. Other challenges include high levels of crime, low levels of literacy and skills development, low economic growth and unemployment.

Review of IDPs of selected municipalities (continued...)

Factors considered in IDP review	City of Johannesburg	City of Tshwane	Manguang (Bloemfontein)
Responsiveness	In 2001, the Johannesburg AIDS council was formed in an attempt to co-ordinate on-going responses at that time from various stakeholders. Subsequently, the Johannesburg's HIV/AIDS Strategy was formulated with its focus on prevention, community mobilisation, and care and support for those infected.	The Tshwane AIDS Unit was formed in 2002, within the Health Department, and was consequently given the responsibility to develop a comprehensive AIDS Plan and to co-ordinate its implementation dealing both with internal and external HIV/AIDS responses.	Although an HIV/AIDS campaign was launched in 2002, the municipality has only very recently committed large sums of money to the strategy.
Prevalence Indicators	In 2000, it was estimated HIV/AIDS prevalence in the City was 10.5%	More than 200 000 people in the district are infected, with a prevalence rate of 15.3% in 2010 predicted if no action is taken.	In 2001 the HIV prevalence amongst antenatal women was 29%.
Equality (Human Rights Protection)	The City has identified commercial sex workers, youth, informal settlements and hostels as areas that require special focus in its HIV/AIDS strategy.	Unclear from the IDP if any target groups have been identified with regard to treatment and protection of human rights	It is unclear from the IDP whether the municipality has considered human rights in its campaign. It does mention stigma around HIV/AIDS is a concern within its district.
Public Participation	Overall, the City is committed to community participation in creating a participatory democracy at the local government level. This is done within wards, ward committees and through regular public meetings.	Through ward committees, the City fosters community participation and actively encourages maximum participation of the entire community on several issues, including HIV/AIDS.	The City has identified community mobilisation in the municipality's affairs as crucial and is in the process of developing institutions, such as forums, to encourage public participation.
Partnerships	The AIDS Council attempts to mobilise and coordinate prevention, care and support responses from sectors, organisations and departments. The City is working closely with communities to strengthen their capacity to manage and mitigate the effects of HIV/AIDS. Strategic partnerships with NGOs and sectors, involved in HIV/AIDS work, are coordinated at City level and through the City's regional structures, these include formal partnerships with the University of the Witwatersrand, represented by the Reproductive Research Unit in the Hillbrow Health Precinct Project, and the City of Paris in the Jabavu Clinic Vusa-Bantu project.	Several partnerships have been developed with external stakeholders including BMW and FORD, the taxi industry, NGOs and CBOs, private agencies, tertiary institutions and the Gauteng Military Service.	In general, the City recognises the role partnerships play in achieving the goals of the IDP, however very little detail given regarding the role of partnerships in its HIV/AIDS campaign.
Mainstreaming of HIV/AIDS	The City is committed to mainstreaming HIV/AIDS activities as it recognises that mainstreaming is essential in reducing HIV prevalence. The health department along with other city departments will conduct biannual surveys on HIV/AIDS, and use the information to assess the implications for targeting of prevention campaigns and care services; demand for household infrastructure services; and the scale of the City's social package.	The city recognises mainstreaming as important to the strategy, HIV/AIDS is considered in several departments when decisions are made, these include Housing, the department of Local Economic Development and the Department of Marketing and Communication.	It is unclear from the IDP if mainstreaming of HIV/AIDS responses is occurring.
Challenges and Concerns	Strengthening the capacity of communities to deal with the HIV/AIDS epidemic.	A key constraint to the City in general is a reduction in its equitable share funding.	Making HIV/AIDS a priority in the municipality despite high a HIV/AIDS prevalence rate.
HIV/AIDS as a Priority	Mayoral Priorities for the period 2006-2011, based on extensive input and research from various stakeholders. These are Economic growth and job creation, Health and community development, housing and services, safe and clean city, well governed and managed city and HIV/AIDS	Several wards regard HIV/AIDS as a priority amongst other priorities such as crime, unemployment and housing.	HIV/AIDS is a moderate priority with economic development and security major priorities