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HIV / AIDS AND LOCAL GOVERNANCE IN SUB SAHARAN AFRICA

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The Urban Management Programme (UMP) represents a major approach by the United Nations family of organisations, together with external support agencies, to strengthen the contribution that cities and towns in developing countries make towards economic growth, social development and the alleviation of poverty. The programme develops and promotes appropriate policies and tools for municipal environmental management, poverty alleviation and good governance. Through a capacity building component the UMP supports the establishment of an effective partnership with national, regional and global networks and external support agencies in applied research and dissemination of information and experiences of best practice and promising options.

Foreword

During the first year of Phase IV (2002), The UMP Regional Office for Africa (UMP-ROA) decided that within the knowledge management framework, emphasis should be given to the production of key publications. UMP-ROA is therefore proposing to produce, in collaboration with the regional anchor institutions, a series of 4 Occasional Papers. These papers will define and analyse a range of urban management challenges being experienced in the region. They will also allow the programme to capitalise on its experiences, and will strive to raise the awareness of certain key stakeholders working in the urban management sector.

HIV/AIDS is the most recent theme to be added to the existing UMP thematic areas of urban governance, urban poverty, urban environment and gender equity. It is therefore an opportune moment to develop the first UMP-ROA occasional paper on HIV/AIDS and local governance in Sub Saharan Africa.

HIV/AIDS has had a horrific impact in Africa. 2.3 million Africans have died of AIDS and the life expectancy on the continent has dramatically decreased. It has become one of the major causes of infant and child mortality on the continent. This epidemic touches all social classes. It destroys families and has, dramatically increased the number of orphans. It has negatively impacted on economic and development progress across the continent and national development policies now need to take into account HIV/AIDS at all levels. The inability of populations to access medical drugs, the difficulties in effecting behaviour change within the social, economic and cultural realities of Africa have reinforced the poverty of the continent's populations.

Objective of this Paper

The objective of this paper is to highlight the challenges faced by Governments in the wake of the HIV/AIDS epidemic in sub-Saharan Africa. Case studies from South Africa and Cote d'Ivoire are presented in order to demonstrate how different countries are responding to the epidemic. These case studies review the national context and outline the responses being undertaken by all levels of government, as well as at the local level by NGOs, private, civil society and religious and faith-based affiliations. The national context in many countries has a direct bearing on the quality of the local response. In South Africa, for example, the controversies have limited the responses to the epidemic in a collective and coherent manner. What is evident in these two case studies (as well as with the rest of the continent), is that the role of local government in this epidemic is fairly recent and will require assistance from central government, NGOs, the private sector, civil society, donor agencies, HIV/AIDS programmes, etc. in dealing effectively with HIV/AIDS in the workplace and the community.

Chapter 1 of this paper highlights important facts about HIV/AIDS. Chapter 2 outlines suggestions for a local government response to HIV/AIDS, from both an internal and external perspective. Finally, Chapter 3 includes case studies and an overview of a regional 'localised' response in sub-Saharan Africa

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CHAPTER 1: HIV / AIDS AND SUB SAHARAN AFRICA

HIV / AIDS – Myths and Realities

People infected by the Human Immunodeficiency Virus (HIV) can look and feel healthy. Beneath the surface, however, the virus attacks their immune system, lowering their immunity to illnesses and disease. HIV usually leads to AIDS (Acquired Immunodeficiency Syndrome), which is diagnosed when a person has developed a number of opportunistic illnesses, such as pneumonia, tuberculosis, diarrhoea, skin rashes and sores. People who are HIV positive (infected) usually die within 10 years of getting the virus as there is still no cure for AIDS.

The HIV virus is carried in semen, vaginal fluids, breast milk and blood. The main method of transmitting HIV is through sexual intercourse (vaginal, anal or oral) with someone who already has the virus without using a condom (unsafe sex). The virus can also be passed from a HIV positive mother to her baby during pregnancy or through breast milk, and by infected blood entering the blood stream during a blood transfusion or organ transplant or by sharing needles or razors with an HIV positive person. The virus cannot be transmitted through using the same bowls, cups or toilet as an HIV infected person, as the virus cannot survive for a long time outside the body. Touching a HIV infected person also cannot transmit the virus.

HIV infected positive people can continue to live a normal, productive and healthy life for a long time before they succumb to AIDS. By seeing a doctor as soon as they are sick and eating healthy foods (avoiding fried foods), the body is better able to fight off opportunistic diseases. HIV positive mothers can avoid passing on the virus to their children by taking antiretroviral therapy during their pregnancy or by having a caesarian operation instead of natural childbirth and by avoiding breast-feeding.

Currently AIDS cannot be cured. A number of antiretroviral drug therapies, such as AZT or Nevirapine, can help to reduce the virus in the body and to rebuild the immune system. However, not everyone responds well to the drugs, which can have powerful side effects. In many countries these drugs are unavailable or very expensive. Many people believe that AIDS can be cured through certain actions, such as having sex with a virgin. This is a myth and has dangerous consequences leading to the further spread of AIDS.

Caring for HIV positive people when they develop AIDS is a difficult task, both physically and mentally. A person with AIDS needs regular health check ups and should be kept as healthy as possible. Energy foods and exercise are important, as is a caring home environment. Home carers should protect themselves by wearing gloves (plastic bags) on their hands when they clean the infected person's body fluids such as blood and urine. Blood spills should be cleaned with bleach and water. It is also important for home-carers to talk to someone about their feelings and worries as AIDS cases in the household contribute to growing levels of stress within the family.

It is recommended that everyone have an AIDS test and practice safe sex (using a condom) with their partners to avoid transmitting the virus unknowingly to family members and other partners. Many people are scared of HIV positive people as they don't understand the disease.

Women suffer disproportionately from the burden of HIV infections in the family and the community. They provide most of the home based care for people with AIDS and they are, in many cultures, not able to negotiate safe sexual practices with their husband, nor are they

able to inherit land or property following the death of a husband. Women are also targets of domestic sexual abuse and rape which can lead to them becoming infected with the virus.

A number of sociological factors, known as the 'ecology of AIDS', have been identified. These factors tend to drive the epidemic and increase the incidence of HIV transmission. These sociological factors include:

- Disempowerment of women which limits their ability to demand condom usage with each sexual act;
- High levels of illiteracy;
- Widespread and abject poverty;
- High rates of unemployment that result in people entering commercial sex work;
- High levels of migrant labor (transportation sector, mining, commercial plantations);
- High prevalence of TB and sexually transmitted diseases that compromise the immune system and make HIV transmission easier, and;
- Situations of conflict and movement of refugees.

The AIDS Epidemic in Sub-Saharan Africa

The statistics

Globally, Sub Saharan Africa is the region most affected by the epidemic and AIDS is now the leading cause of death in Sub-Saharan Africa. In 2001, AIDS killed 2.3 million African people. In 2001, 3.4 million people in the region became infected, meaning that 28.1 million Africans now live with the virus. The majority of new infections occurred in young adults and in particular in young women, and most of these people do not yet know they carry the virus. HIV infection in Africa is mainly through unsafe heterosexual sex (without a condom) and through parent-to-child transmission.

Sub-Saharan Africa is experiencing diverse epidemics in terms of scale and maturity. However, in general terms, the average life expectancy in the region has dropped from 62 years to 47 years due to AIDS. In the countries worst affected by the epidemic, Botswana, Malawi, Mozambique and Swaziland, the average life expectancy is less than 40 years.

In Southern and Eastern Africa, many countries show HIV prevalence rates in 2001 to be more than 30% - nearly 1 out of every 3 people. Antenatal clinics in urban Swaziland registered prevalence rates of 32.2% and in urban Botswana the registered prevalence rate was 43.9%. Regional epidemiology strongly supports a focus on contexts of mobility, urban poverty and social exclusion in relation to the HIV/AIDS epidemic. However, prevention responses in certain areas are bearing fruit: the downward arc in prevalence rates in Uganda is continuing and antenatal clinics in urban areas have registered a fall in HIV prevalence from 29.5% in 1992 to 11.25% in 2000. Indications in Zambia show that HIV prevalence is declining among urban residents, particularly young women aged between 15-24.

In West Africa where AIDS cases surfaced much later than East and Southern Africa, 5 countries are now showing national adult prevalence rates over 5% (1 in 20 people): Burkina Faso, Côte d'Ivoire, Nigeria, Togo and Cameroon. In Senegal, prevalence rates have been kept down with continued political support and leadership and integrated prevention programmes.

Even as countries upgrade and expand their response to the epidemic, the high prevalence rates in Sub-Saharan Africa mean that reducing the human toll will be a gradual and long-term process.

Young adults still show a dangerously limited knowledge and understanding of AIDS in many countries in Africa. In recent UNICEF studies, more than 70% of adolescent girls (15-19 years old) in Somalia and more than 40% in Guinea-Bissau and Sierra Leone had never heard of AIDS. The studies also found that more than 40% of adolescent girls in Kenya and Tanzania harbor serious misconceptions about how the HIV virus is transmitted. However, recent research in South Africa suggests more than 95% of the population know how AIDS is transmitted and that it is incurable, indicating that knowledge and awareness is only part of an effective prevention strategy.

By the end of the year 2000, 12.1 million children in Africa had lost their mother or both parents to the epidemic and this figure is forecast to double over the next decade. More and more infants are being born HIV-positive in badly affected countries and child mortality rates are rising dramatically. In Zimbabwe, 70% of deaths of children under the age of 5 are due to AIDS.

The impacts

The impact of the HIV / AIDS epidemic in Sub-Saharan Africa is reversing years of development actions at all levels and throughout society. In a continent already burdened by huge socioeconomic challenges and poverty, the AIDS epidemic is threatening human welfare and social stability. AIDS is the biggest threat to implementing the African Renaissance through such initiatives such as NEPAD.

Poverty levels in Sub Saharan Africa are extremely high with three-quarters of the continent's population living on less than US $2 a day. Economic hardships and programmes of structural adjustment have caused public health services to be cut back and have privatized many municipal services with resulting higher costs for access, marginalising the poor both in urban and rural locations.

The most devastating impact of HIV / AIDS in Sub Saharan Africa is that it contributes to impoverishment, aggravates forms of social inequality and deepens the vicious cycle of poverty already very present in the region.

Impact on the household

The poor suffer most from the impact of AIDS. The death of wage earners and young adults (potential wage earners) means that many households become impoverished and fragmented as children are sent away to extended family members to be looked after or, in contrast, find themselves heads of households at a young age. Providing these children with food, housing and education in the face of disintegrating traditional safety nets and depleting government services will demand resources for many years to come. In Uganda, 25% of households are caring for an AIDS orphan, and this seriously stretches family resources.

Caring for AIDS sufferers is a considerable drain on already tight household budgets. In urban areas in Côte d'Ivoire, spending on school education fell by half, food consumption went down by 41% per capita and health care expenditure more than quadrupled in households where a family member had AIDS. In Rwanda, annual per capita health care expenditures for households with AIDS patients was US $63 compared to average households where health care expenditure was US $3.

Almost everywhere the burden at the family and community level falls on women, particularly the very young and elderly. In Swaziland, school enrolment is reported to have fallen by 36% due to AIDS, with girls most affected as they are required to assume family responsibilities of caring for the sick. In Zambia, more than 50% of care givers to people with AIDS were females with wives spending more than 13 hours per day with the patient, greatly diminishing their capacity to generate income for the household. As households struggle to

cope with the impacts of AIDS they sell more assets to pay for healthcare and funeral costs, thereby eroding their asset base and deepening the cycle of poverty.

Impact on the economy and business

As AIDS affects mainly young working adults there is a generalized impact on economic productivity. The specific impacts on business depends, to an extent, on the benefit package offered by individual firms but includes:

- Absenteeism;
- Hiring replacement workers;
- Cost of treatments and funerals;
- Reduced productivity;
- Retraining of workers;
- Providing family pensions.

A survey of 15 firms in Ethiopia over a 5-year period has shown that 53% of all illnesses among staff were AIDS related. In Zimbabwe, a law was passed that funerals could only be held on weekends as the sheer number of funerals was becoming disruptive to the economy. Production loss due to AIDS on a Malawi tea plantation in 1995/1996 was shown to be 3% of gross profit. The cost of AIDS to business is higher in labor intensive business, commonly the mainstay of African economies, such as commercial farming, transportation, wood processing, mining and construction.

For general retail business the HIV/AIDS epidemic also leads to an erosion of the purchasing power of their client base, as affected households are impoverished. For example, retail stores, which currently provide goods on a credit arrangement, may have to stop providing this service or increase their costs as 'high risk' populations are unable to meet the payment requirements. Some retail business may have to close certain stores in an attempt to keep economically solvent resulting in a loss of local employment opportunities.

Many people in Sub Saharan Africa earn their livelihood through small-scale / home-based businesses in both the informal and formal sector. AIDS is having devastating effects on small businesses as self-employed people either become ill with AIDS themselves or have to look after someone in their household who has AIDS, thereby spending more time away from work and spending more of their financial resources on health care. The risk of business failure and loss of livelihoods becomes much greater in these circumstances.

Most African countries depend on a small number of highly skilled personnel to manage the economy and provide core government and private sector services to populations. In most African countries the health, education, police and army seem to be the government sectors disproportionately affected by HIV/AIDS. Badly affected countries are losing these skilled personnel to AIDS at an alarming rate. 12% of all educators in South Africa were estimated to be HIV positive in 2000 and in Botswana 4% of children have lost a school teacher to AIDS. In Zambia, deaths among health care personnel has increased 13 fold between 1980-1990 largely as a result of HIV infections. The loss of skilled personnel greatly reduces the quality and quantity of basic services that the government can deliver and contributes to the rising costs of accessing infrastructure, deepening the cycle of poverty in areas affected by the AIDS epidemic. It is also harder and more expensive to replace such skilled workers.

The International Response to the AIDS epidemic

At the United Nations Special Session on HIV / AIDS in June 2001, governments pledged to pursue a series of benchmark targets as part of a comprehensive response to AIDS at the global level. New resources are also being allocated, such as the Global Fund for AIDS, as well as contributions from national governments, the private sector and NGOs.

The agreed UN targets are:

- To reduce HIV infection among 15-24 year olds by 25% in the most affected countries by 2005 and globally by 2010;
- By 2005 to reduce the proportion of infants infected with HIV by 20% and by 50% by 2010;
- By 2003 to develop national strategies to strengthen health care systems and address factors affecting the provision of HIV – related drugs, including affordability and pricing. Also, to urgently make every effort to provide the highest attainable standard of treatment for HIV / AIDS, including retroviral therapy in a careful and monitored manner to reduce the risk of developing resistance;
- By 2003 to develop and by 2005 implement national strategies to provide a supportive environment for orphans and children affected by HIV / AIDS;
- By 2003 to have in place strategies that begin to address the factors that make individuals particularly vulnerable to HIV infection, including: under development, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self protection, and all types of sexual exploitation of women, girls and boys, and;
- By 2003, to develop multisectoral strategies to address the impact of the HIV / AIDS epidemic at individual, family, community and national levels.

CHAPTER 2 : HIV / AIDS AND LOCAL GOVERNEMNT

In 2001, 34% of Sub Saharan Africa's rapidly growing population of 611 million lived in urban areas. As more and more people live in urbanized areas, the demands on municipal infrastructure will continue to increase greatly. Against this backdrop of rapid urbanization, the decentralization movement in Sub-Saharan Africa is becoming a reality, with increasing responsibilities for urban services and products being devolved to local government.

Local governments capacity to respond and take up these responsibilities are being constrained by the availability of financial and technical resources and more recently by the devastating impact of the HIV / AIDS epidemic.

The role of Local Government

In most Sub-Saharan African countries, local government, as the level of government closest to communities, is responsible for ensuring a good quality of life for citizens and for promoting sustainable social and economic development. Local Government provides political leadership and a development vision for an area and builds partnerships with the local stakeholders to implement and take forward this vision.

In most instances Local Government responsibilities cover areas such as:

- Provision of administrative infrastructure and services;
- Provision of water and sanitation infrastructure and services;
- Provision of road and transport infrastructure and services;
- Provision of health and education infrastructure and services;
- Provision of social and welfare infrastructure and services;
- Provision of economic infrastructure (markets) and services;
- Provision of land for residential, business or other uses such as burial grounds, and;
- Regulations to ensure a healthy and safe environment.

In order to provide these services and products, local government collects rates or taxes from citizens and is responsible for managing these public funds in a transparent and accountable way. Already, many Local Governments in Sub-Saharan Africa are battling with the very limited financial resources available to implement their mandate. In the wake of the HIV / AIDS epidemic and the associated impoverishment of households, it will become harder and harder for Local Governments to raise the resources necessary to provide basic services, thereby increasing the impoverishment of the community as a whole.

It should not be forgotten that local government is also an important employer. As an employer, therefore, it has a number of responsibilities towards its staff, including providing them with a healthy and safe working environment and access to information and training to enable them to develop as individuals. Local Government staff who develop AIDS will be significantly restricted in their ability to perform and deliver services.

Reviewing these areas of responsibilities, it is clear that Local Government has a significant role to play in managing the impacts of the HIV / AIDS epidemic which are being felt in Sub-Saharan Africa. Local Governments are themselves feeling the impacts of the epidemic, which are negatively affecting their ability to provide basic services and infrastructure at the local level.

Indeed it is unlikely that the UN targets outlined in the comprehensive global response will be achieved if Local Governments do not actively take forward a response to the epidemic.

In many countries, AIDS programmes and initiatives have focused on national level responses through assistance to Government line Ministries, which has by the nature of Government administration restricted the response to sectoral areas. It is now understood that multisectoral strategies are required to effectively address the HIV / AIDS epidemic, moving away from the belief that HIV / AIDS is a purely health issue. Local Government, by its nature and the extent of its responsibilities at the local level, provides the best conduit for developing and implementing such multisectoral strategies. As with many other areas of social and economic development, it is clear that locally developed and owned strategies to address HIV / AIDS will also be more effective and sustainable in the long term.

KEY IMPACTS OF HIV/AIDS AT LOCAL GOVERNMENT LEVEL

The epidemic will. ……	The epidemic could……
Reduce the projected number of people and change the demographic structure of the population	Compromise the ability to deliver services (due to increased demands for services and support and increased loss of personnel due to AIDS)
Reduce life expectancy	Increase bad debts
Increase infant mortality	Divert government and community expenditure into health and welfare
Increase the demands on the health care system	Create a skills and labour shortage
Increase poverty and exacerbate inequalities	Increase child labour / child prostitution / children dropping out of school as orphans/child headed households seek money/ food/protection
Result in large numbers of orphans, street children and child-headed households	Increase homelessness through evictions due to inability to pay rent and taxes
Increase the number of aged who need care (loss of adult children) and who are caring for descendants	Jeopardize political legitimacy and social stability if local political and institutional systems are seen as inadequate in their response to HIV/AIDS
Increase the number of burial plots required	
Affect income and expenditure patterns	
Reduce the ability of households to pay for services, rates, rents, taxes	
Threaten productivity due to increased absenteeism, loss of skills, higher employment benefits	
Threaten investment made in training and education	

Local Government and HIV / AIDS in Urban Areas

Urban environments pose a particular context for the management of the HIV / AIDS epidemic. Urban areas typically bring high population densities together and increase interaction between diverse groups. Urban populations are often mobile and in areas of Sub Saharan Africa, where migrant labor systems are well-established, urban nodes are key areas of interaction between populations.

Today up to two-thirds of African urban dwellers live in informal settlements with inadequate transport, water, sanitation, electricity and health services. Crime and particularly violent crime against women (including domestic violence) are worsening in many African cities and

towns as living conditions deteriorate. The capacity of urban areas to generate employment and provide social services is failing to keep pace with the rapidly growing urban population. These conditions have led to an environment where all diseases, including HIV / AIDS, spread much quicker.

Urban areas are also not self-contained entities. Although information is not available to make a generalization about the relative incidence of HIV / AIDS in urban and rural areas, the epidemic has been able to span both populations. Many urban dwellers who develop HIV / AIDS return home to rural families to be nursed and inversely many rural dwellers with HIV / AIDS leave for urban areas in order to avoid the stigma of AIDS in a rural community or in the hope of accessing medicines. Civil strife and natural disasters across Sub Saharan Africa have also contributed to rural-urban migration and disrupted the stability of rural populations.

Urban areas can, however, also provide opportunities for the management of the HIV / AIDS epidemic in Africa. As Ms Anna Kajumulo Tibaijuka, the Executive Director of UN-HABITAT said in her statement at the United Nations Special Session on HIV / AIDS in June 2001,

> 'cities are not only the incubators of HIV / AIDS. They can also provide opportunities for better education, information and prevention of its risks. Beyond prevention, housing and adequate living conditions have been established as critical in the success of care and treatment regimes for HIV / AIDS. Pro-poor participatory urban governance is an integral past of the UNCHS campaign on good urban governance, and as UN focal point for cities and local authorities, UNCHS will encourage Mayors and associations of cities to strengthen their efforts in combating HIV / AIDS.'[1]

A Local Government Response to HIV / AIDS

A Local Government response to the HIV / AIDS epidemic can be best reviewed by defining two clear areas of action:

- Action *internally* targeting local government employees, and;
- Action *externally* targeting the wider community.

The internal response – a workplace response

The internal response to HIV / AIDS can also be considered as a general workplace response. This response aims to integrate HIV / AIDS as a priority into workplace policies and to put in place a comprehensive programme for HIV / AIDS prevention and care.

A workplace response must be built around the principles of equality and equity, non-discrimination, responsibility, inclusion and human dignity. Employees living with HIV / AIDS must at all times be accorded the same rights and career opportunities as all other employees and must be ensured of confidentiality regarding their HIV status. Testing for HIV should be with the informed consent of the employee and accompanied by counseling. A successful work place response is best developed through consultation and participation from employees and their representatives.

[1] Refer to UN-HABITAT E-Newsletter Volume, 1 Issue 2 - website www.unhabitat.org

Prevention responses in the workplace should focus on the following areas:

- Information and education for all employees in order to develop their understanding of HIV / AIDS and overcome stigma and prejudice in the workplace. On-going awareness activities are essential to reinforce the message. Methodologies such as peer education can be implemented to further disseminate information on HIV / AIDS.
- Personal protection to employees who render First Aid as there is a small risk of HIV transmission in an accident situation. Training should be provided to advise on procedures to be used in these situations. Drivers are vulnerable to road accidents and should be provided with a minimum First Aid kit.
- Employees should have access to barrier methods, such as condoms, which provide protection against HIV infection. Where possible, condoms should be available at a minimum cost.
- Employees should be encouraged and supported to undertake HIV testing as part of their personal responsibility to protect their loved ones. Confidential HIV testing must be accompanied by counseling, providing an opportunity to review lifestyle options. Employees should also be encouraged to seek treatment of sexually transmitted diseases (STDs) as untreated STDs greatly increase the risk of HIV transmission.

Care responses in the workplace should address the following areas:

- Counseling for employees is valuable in assisting people infected with HIV or affected by HIV to cope with issues related to the infection.
- Health packages provided by the local government should, where possible, provide medical interventions / drugs which can prolong and improve the lives of HIV positive employees.
- The local government must act decisively to protect the rights of people living with HIV / AIDS and ensure that discrimination is not practiced in the workplace. HIV infected employees are entitled to the same benefits as uninfected employees.

Management responses should focus on the following areas:

- Undertaking regular (annual) impact assessment to inform the HIV / AIDS work place programme of the impacts of the epidemic, including an assessment of financial costs associated with the epidemic. This impact assessment is valuable for strategic planning within the local government and can also feed into a review of employee benefits in the context of HIV / AIDS.
- A skills succession plan should be developed to ensure that key management and technical skills are not lost to the local government through the loss of certain employees, thereby negatively affecting the performance of the local government.
- The political and public leadership structures within the local government should use all appropriate occasions to demonstrate to employees their support for the HIV/AIDS workplace programmes.

Implementation of a workplace response requires that an official be mandated to lead the HIV / AIDS workplace programme. This official may require support from a group / task team of employees from across the local government structure.

An ideal person to manage such a programme would display the following qualities:

- Seniority within the local government structure, preferably within management and development areas;
- An interest in HIV / AIDS and an understanding of the issues;
- Credibility with key stakeholders and with local communities;

- Leadership qualities;
- Good inter-personal, facilitation and communication skills, and;
- Experience of planning and financial control and an understanding of higher tiers of government.

Within the workplace, as within the larger community, a number of barriers can be encountered in taking forward an HIV / AIDS response. These barriers include issues such as denial of the problem, apathy from employees, inappropriate attitudes to people living with HIV / AIDS, inadequate resources and lack of information. These barriers can be very frustrating and it is important to take steps to address them early on. Continuous advocacy and action (even small gestures) to demonstrate how change can occur is crucial. Building a team of like-minded people who share the same goals can also be effective in taking a response forward.

The external response – a strategy for a city

Local Government is responsible for protecting and promoting the health of its citizens. Within the context of the HIV / AIDS epidemic, this responsibility broadens to encompass: minimizing the personal and social impact of HIV / AIDS, challenging discrimination against people living with HIV / AIDS and supporting the mobilization of communities and community responses to the epidemic.

Developing an HIV / AIDS strategy is a good way to guide local government actions in addressing the HIV / AIDS epidemic. An HIV / AIDS strategy for a city essentially describes a framework for a local response to the epidemic. The strategy is usually built around the following key stages:

- discussion and analysis of the HIV / AIDS problem;
- identification of core values and guiding principles for the local government;
- identification of priority areas for action as well as roles and responsibilities, and;
- compilation of indicators to monitor success.

It is recommended that any HIV / AIDS strategy be developed in a participatory manner, using methodologies such as the UMP City Consultation process.

A city consultation is a participatory event on a city-wide level. The city consultation brings together stakeholders to create a better understanding of issues, to agree on priorities and to seek local solutions built around broad-based consensus. The city consultation is normally held after a preparatory phase (situational analysis and development of a city profile study) and leads into an action-planning phase (prioritisation of activities) within an overall participatory process.

The city consultation has the following main purposes:

- To identify, review and expand upon urban issues of priority which affect the sustainable growth and development of the city;
- To bring together key actors from the public, private and popular sectors in order that they agree on the need for, and commit themselves to jointly develop, an improved city management process which is built on partnerships and which cuts across sectors to promote sound development;
- To demonstrate a process of defining priority concerns and identifying key actors and a methodology to establish the participatory cross-sectoral working group approach;
- To agree on a mechanism for developing an appropriate institutional framework, for strengthening and maintaining the process, and for linking these activities to existing structures, as well as demonstrating the necessity for pooling resources in order to address the priority issues; and
- To mobilise social and political support and to obtain the commitment necessary to operationalise the cross-sectoral working group approach in addressing the agreed priority issues.

More information: Tools to Support Participatory Decision Making, Urban Governance Toolkit Series, UN HABITAT, 2001. www.unhabitat.org

The city consultation process is based on the following principles:

- **Inclusiveness**: a city consultation aims to bring together all key stakeholders.
- **Demand driven**: a city consultation is structured and facilitated to lead to concrete outputs while remaining open and responsive to stakeholders needs.
- **Bottom-up**: a city consultation is not based on statutory or administrative processes but draws it legitimacy from the collective will of participating stakeholders.
- **Co-operation not confrontation**: a city consultation promotes co-operation and the pooling of information and resources.
- **Conflict resolution**: a city consultation promotes better understanding of different interests and finds common ground and mutually acceptable solutions.
- **Continuous**: a city consultation is not 'an end to itself' but the launching of a process for action.
- **Flexibility**: a city consultation process has been successfully used in many different socio-cultural contexts, at different scales and intensities. For case studies of city consultation processes in Africa refer to Overview of the Urban Management Programme, Regional Office for Africa Phase III report, 2001. http://umproa.undp.org

A number of key areas can be identified where local government policy will change in response to the HIV / AIDS epidemic. These strategic areas are outlined below:

- Education and information to prevent HIV / AIDS transmission and reduce associated stigma and discrimination, including means to reach illiterate people;
- Orphans - provision of foster care or child care institutions or review social welfare policies such as age required to access grants;
- Care for people with AIDS and the terminally ill - either home based or institutional;
- Changing health facilities / staffing to cope with HIV / AIDS infections – improve access to STD treatment, HIV testing and related counseling;
- Land requirements for cemeteries / burial plots will increase and land requirements for new residential / business development will decrease;
- Ability of households to pay for local government services (water, sanitation, refuse) and decreasing locally raised revenue;
- Reduction in school attendance – inability to pay fees or children withdrawn to provide care to sick family members or to run income generation enterprises;
- Welfare policies (are they still appropriate in light of impacts of HIV / AIDS?);
- Housing policies (do they take into account changing family structures due to HIV/AIDS impacts? Women's right to access and ownership?) and increasing sale of informal real estate as households liquidate assets;
- Risk reduction programmes for groups at high risk such as commercial sex workers or children in difficult circumstances;
- Programmes to reduce violence against women and children and urban design to increase safety for women and children;
- Programmes to promote income generation activities and/or forms of social assistance;
- Discussion and debate around predominant social-cultural and social-economic practices that may increase the risk of HIV transmission in the community.

There are also a number of specific functions that Local Government can carry out in order to support a city strategy for HIV / AIDS. Such functions could include:

- Demonstrate leadership commitment on HIV / AIDS and publicly acknowledge the seriousness of the epidemic;
- Mobilize community leaders and the private sector to participate in a local partnership against HIV / AIDS;
- Increase awareness, support debate and encourage action in prevention and care for people living with HIV / AIDS and strengthen community responses in these areas;

- Identify networks and processes to prioritize HIV / AIDS as an on-going issue;
- Provide care and support to people living with HIV / AIDS in a non-discriminatory environment – equal access to housing, social services, education, freedom of movement, right to justice etc., and;
- Monitor the impact of local interventions to address HIV / AIDS.

In all of the above-mentioned responses, it is vital to ensure that women are supported and empowered to fully participate. This is essential as women, as documented earlier, bear the burden of the HIV / AIDS epidemic.

CHAPTER 3: HIV/AIDS RESPONSES IN SUB-SAHARAN AFRICA

South Africa – A Case Study

South Africa is a middle income developing country with an abundance of natural and rich mineral resources. These rich mineral resources are the main strength of the economy and accounts for two thirds of exports. It has a well-developed legal, communication, financial and transport sectors as well as a modern infrastructure that promotes urbanisation and a stock exchange that is ranked among the 10 largest in the world.

The legacy of apartheid is the biggest obstacle to developmental work in the country today and its long-term effects are present within the various sectors of South African society. Apartheid created feelings of resentment, hate and despair with a culture of violence and stigma. Unequal structures were also created within society where the majority of 'black Africans' suffered the most while the wealth was in the hands of the 'white' minority. These unequal structures have significantly contributed to the spread of HIV/AIDS.

The majority of the 'black' population still live in appalling poverty stricken conditions (50% below poverty line) with no access to basic services and high levels of illiteracy, unemployment and crime. All of this hampers poverty alleviation and HIV/AIDS prevention and contributes to the spread of HIV/AIDS. South Africa is still faced with overcoming the disparities between rich and poor: in 2001 South Africa has the sixth highest income inequality in the world, and in the meantime poverty is exacerbating the spread and impact of the HIV epidemic.

The statistics

Population	43, 586.097
Population Growth	0.26%
Total Literacy Level	81.8%
Adult Male Literacy Level	81.9 %
Adult Female Literacy Level	81.7%
Population below Poverty line	50% (2000 est)
Unemployment rate	30% (2000 est)
GDP	2.2% (2001 est)
Inflation rate	5.0% (2002)
People Living with HIV/AIDS	4 200 000
Adults Living with HIV/AIDS (15-49)	4 100 000
Adult Prevalence Rate	24.5% (2000)
Women Living with HIV/AIDS (15-49)	2 300 000
Children Living with HIV/AIDS (0-14)	95 000
AIDS Orphans (cumulative)	420 000
AIDS Deaths	250 000

The HIV/AIDS epidemic in South Africa

South Africa has one of the world's most severe HIV epidemics. The national Department of Health estimates that 1 in 9 South Africans are infected with HIV. The HIV prevalence rate in 1990 was 0.8%, and 24.5% in 2000, illustrating the rapid spread of the epidemic and the severity of the issue.

A number of studies have been carried out in South Africa to assess the nature and impact of the HI/AIDS epidemic in order to develop an effective response. HIV vulnerable groups

have been identified in a gender specific manner, understanding the gender implications of HIV transmission in Africa.

In South Africa, most vulnerable males are those who demonstrate high mobility, who live or work away from their families and who have some disposable income. In contrast, most vulnerable females are those who live in disrupted urban or peri-urban settlements (with little social cohesion) and who have no other economic alternative than to exchange sex for food, gifts or money. This has led to the identification of high transmission areas, particularly around mines, plantations, trading centers, cities on major highways and refugee camps.

Other high transmission areas in the South African context include inner city sex work neighbourhoods where sex workers and their clients are involved in overt and discrete commercial and transactional sex, and prison, where sex is highly coercive and a currency of exchange (blankets, drugs, protection). Juvenile prisoners are at particular risk in South African prisons.

South Africa youth's three greatest concerns are crime (72%), AIDS (70%) and child abuse (62%). Studies suggest that youth begin sex relatively young (24% were sexually experienced by the age of 15), face high levels of coercion to have sex (39% of sexually experienced girls), have significant numbers of sexual partners and use condoms irregularly, putting them at high risk of HIV transmission. Youth with lower income and education and rural youth engage in greater levels of risk behavior, reinforcing the association between HIV/AIDS, poverty and marginalisation.

South Africa's national response to HIV/AIDS

South Africa has made significant strides in addressing the HIV/AIDS epidemic. Pre-1994, the South African government's initial response was to address the HIV/AIDS issue within the domain of the Department of Health, thereby excluding a multi-sectoral strategy. Since 1994, however, positive changes have taken place, although at a slow pace. Notably, there has been an evolution from the health centred approach to a government HIV/AIDS/STD & Strategic plan for South Africa (2000-2005). This strategic plan (as a policy manual as well as an operational manual with set indicators) encompasses a multi-sectoral approach in the fights against HIV/AIDS. The five priority areas are:

1. Prevention, Treatment Care and Support;
2. Human rights and legal issues;
3. Research, surveillance, monitoring;
4. Evaluation and information, education and social mobilisation, and;
5. Youth.

The broadening of responsibility to all sectors of government and civil society has resulted in the establishment of provincial, district and local HIV/AIDS councils, committees and forums. The intention is to foster closer collaboration between government, private sector, civil society and communities in the fight against the HIV/AIDS epidemic, thereby maximising efficiency and effectiveness. Provinces are expected to utilise this strategic plan by constructing comprehensive and province-specific plans, which they will then use for local authorities and districts. The South African National AIDS Council (SANAC) oversees the implementation of the Strategic Plan and the national response to the epidemic. Most municipalities within the various provinces have initiated activities in the areas of information, education and awareness campaigns; prevention; treatment, care and support services.

Civil society groups in the area of HIV/AIDS have also launched a national Partnership against AIDS to co-ordinate the action. All levels of government and most sectors within civil

society have embraced the Partnership, including women's groups, traditional leaders, faith-based organisations, youth, parastatals and the private sector. Artists, celebrities and the media also support the Partnership.

The above clearly demonstrates government's response in realising the seriousness of the HIV/AIDS on human development and on the economy. Yet, further development in this field is being hampered by the political stand on the HIV/AIDS drugs issue.

Political leadership on HIV/AIDS issues

People living with HIV/AIDS are protected by the South African Constitution (Act 108 of 1996), which is the supreme law of the country. Within this Constitution is the Bill of Rights (chapter 2), which clearly outlines a number of basic human rights applicable to all citizens and therefore extends to people living with HIV/AIDS.

People in South Africa have the following rights according to the Constitution:

- The right to have access to health care services, including reproductive health care;
- The right not to be unfairly discriminated against, either by the state or by another person;
- The right to bodily and psychological integrity, which includes the right to security and control over the body;
- The right not to be subjected to medical or scientific experiments without the person's own informed consent;
- The right not be refused emergency medical treatment;
- The right to a basic education;
- The right to privacy;
- The right not to have privacy of one's communication infringed.

Despite its comprehensive strategy against HIV/AIDS and the millions spent on campaigns, the South African government has come under the spotlight both internationally and nationally for its health policy. In particular, it does not provide anti-retroviral drugs such as Nevirapine to HIV pregnant women in public health care facilities and clinics even though a German pharmaceutical company, Boehringer-Ingelheim offered the anti-retroviral drug Nevirapine free to the South African government.

The government's reluctance to provide Nevirapine for wide-scale use is based on the view that little is known about the longer-term effects, particularly the toxicity levels of the drug. In addition to this, the government feels that it lacks the infrastructure and resources to administer and monitor the benefits of the drug. Because of this, the government intends a gradual phasing in of the drug for wide-scale use. In the meantime, they will continue promoting pilot studies and clinical tests before wide-scale distribution. At present, there are 18 research and training sites nationally that offer the Nevirapine to HIV pregnant women.

AIDS activists groups argue that making Nevirapine available would prevent the mother to child transmission (MTCT) and save thousands of new-born babies each year in South Africa.

In 2001, a landmark court case was filed against the government by the Treatment Action Campaign (TAC) to force the government to make Nevirapine freely available to HIV pregnant women. In July 2002. after a ten month legal battle between TAC and the Minister of Health, the Constitutional Court ruled in favour of the Treatment Action Campaign in the mother mother-to-child transmission prevention. Another breakthrough is the government's decision to provide Nevirapene to rape survivors within the next few months. Earlier in

2001, TAC was previously an ally of the government in a legal battle against pharmaceutical companies to provide affordable drugs to developing countries.

Breaking ranks with the national government are the Kwa-Zulu Natal, Western Cape, Eastern Cape and Gauteng provinces, who have taken a stand by making Nevirapine available at most hospitals. According to recent media reports, doctors are already prescribing drugs in defiance of government policy, as they believe they have a moral obligation to save lives. Other provinces are reluctant to follow suit and will only act once they receive direct orders from the national government.

Another area of concern in South Africa is President Thabo Mbeki's theory in which he questions the link between HIV and AIDS. He has never stated that HIV does not cause AIDS but has rather questioned whether HIV is the only virus that causes AIDS. He believes, as many other dissidents do, that there are also other factors to consider when attributing a syndrome to one causal factor: HIV can cause immune deficiency, but should not be looked at as the sole cause of immune deficiency. Poverty and disease, which are widespread in Africa, need to be taken into consideration. Other factors, such as migration, gender imbalances and social deprivation, that influence the extent and rate of the epidemic, must be looked at. President Mbeki believes that one has to search beyond the western view of the causes of AIDS and provide an African solution to an African problem. A Presidential AIDS Advisory Panel has been set up to investigate questions concerning HIV/AIDS in the African context.

The controversies surrounding the different approaches to HIV/AIDS within South Africa should not detract from the success of the vigorous prevention campaigns that government has committed itself to. What is needed, and will take time, is strong national political leadership and commitment to ensure the success of the strategic plan objectives.

Responses by the private sector

In December 2001, South African business executives signed a pledge committing their companies to fighting the spread of HIV/AIDS and helping educate their employees and customers about the epidemic. The pledge was signed in Cape Town by 42 companies, the Western Cape government and the City of Cape Town administration. Some of the companies included large national co-operations such as Woolworths, Metropolitan, South African Breweries and Pam Golding Properties.

Metropolitan, an insurance giant in South Africa, has an AIDS Research Unit that was founded in 1995 as a response to the need for HIV projections for various businesses. This has now been extended to other African Government departments, the SA National Department of Health, Gauteng local governments and many major corporations within South Africa. "The emphasis has been on the impact of AIDS on the economy, but perhaps the emphasis should shift to how businesses can impact on AIDS" says Steven Kramer, head of Aids research at Metropolitan.[2]

Fleetwatch, South Africa's leading transport magazine, focuses on the trucking industry. It has, in collaboration with other various transport partners committed itself to the fight against the HIV/AIDS pandemic. Fleetwatch's strategy in partnership with Engen (Petrochemicals) conducts monthly workshops for the trucking industry. The aim is to educate management and drivers on HIV/AIDS issues. The South African Medical Research Council reports that HIV prevalence among truckers is currently 56%.

[2] Refer to http://careers.iafrica.com/careerjunction/aidsimpact/853696.htm

Also in the transport industry, Daimler Chrysler South Africa (DCSA) has recently embarked on a multimillion Rand HIV/AIDS workplace strategy.

Responses by civil society

There are multitudes of HIV/AIDS awareness activities and campaigns currently undertaken by non-profit organisations, church groups, charitable organisations and other groups in South Africa. This case study will only be able to provide an overview of a few activities.

Trade Unions: COSATU
The Congress of South Africa Trade Union (COSATU) is a trade union movement that was launched at the end of 1985. Today, it has 19 affiliated trade unions with a combined membership of around 1.8 million. COSATU and its affiliates have comprehensive HIV/AIDS policies and programmes in place. One example is a manual produced for its members entitled "COSATU Campaign Against HIV/AIDS: A guide for Shop Stewards".

COSATU recognises that the effects of HIV/AIDS are more harmful to the poorer sections of society, the constituency from which its membership base is mainly drawn. A South African workplace study reported on at the Durban International AIDS conference indicated that the HIV prevalence rate was much higher among semi-skilled (14.7%) than skilled employees (3.3%). This has provided the impetus to initiate and implement programmes, projects and awareness campaigns on HIV/AIDS issues and its impacts. It also takes into account the inequities in gender relationships within patriarchal South African society, which highlights the vulnerability of women to infection.

NGO's and Advocacy groups: LoveLife, TAC
LoveLife, launched in September 1999, is one of the largest and most ambitious HIV prevention efforts in the world today. Its target group is 12-17 year olds in which it aims to reduce the incidence of HIV by at least 50 percent over the next five years.

Major funding for LoveLife is provided by the Henry J Kaiser Family Foundation and the Bill and Melinda Gates Foundation. Other funders include the South African Government and UNICEF. In 2001, the Kaiser Family Foundation pledged 100 million a year and the SA government R25-million a year for three years (R375 million in total). A consortium of four non-governmental organisations are responsible for implementing the message of LoveLife: Advocacy Initiatives, Health Systems Trust, Planned Parenthood Association of South Africa and the Reproductive Health Research Unit. The advisory board comprises leading South Africans and chaired by Ms Zanele Mbeki. Other prominent South Africans enlisted in LoveLife's campaign are Nelson Mandela and Archbishop Desmond Tutu.

To be able to meet its objective, LoveLife makes use of high-powered media with a nation-wide drive to develop adolescent friendly health services, outreach and support programmes. They combine traditional marketing techniques with the best principles of public health education, as behaviour change requires internalisation to bring about the desired changes. Focusing on changing pervasive values and attitudes among adolescents to sex, sexuality and gender relations is fundamental for it's objective to be successful.

Some of their programmes include:

- S'Camto- a multi-part television series aired on SABC1, produced by young people for young people. It deals with issues of self-actualisation and healthy living.
- Codi : Loud and Clear –a weekly children's television series encouraging parents to talk to their kids about HIV/AIDS and other difficult issues

- ScamtoPRINT – a weekly national radio magazine broadcast on Metro FM and with partnerships with Yfm and most ethnic language radio stations.
- National youth education and outreach programmes – using two LoveTrains and two mobile broadcast units.
- Thethajunction – a toll-free national sexual health helpline.

LoveLife has been inundated with requests from organisations and groups who wish to participate in the LoveLife initiative. Thus it created the franchise concept (social franchising with no financial transactions), a demand driven approach that needs to be complemented by a more grassroots approach (e.g. youth and community-based activities). By using this franchise option, LoveLife is attempting to use their multi-media, multi-pronged prevention strategies to filter down through communities into individual lives.

The Treatment Action Campaign (TAC), an HIV/AIDS activist group, was launched in December 1998. Funding is mainly in the form of donations from local and international donors, but it will not except donations from the South African Government or Pharmaceutical Companies. The main objectives of TAC are:

- Improve the affordability and quality of health-care access for all;
- Prevent and eliminate new HIV infections, and;
- Ensure access to affordable and quality treatment for people with HIV/AIDS.

TAC intends to achieve it's objectives by promoting treatment awareness and treatment literacy among all people and through campaigning for AZT and Nevirapine for all pregnant women to prevent mother to child transmission of HIV. TAC maintains visibility through posters, pamphlets, meetings, street activism and letter writing, and targets pharmaceutical companies asking them to lower the costs of all HIV/AIDS medications.

TAC has also successfully maintained pressure on the South African government to fulfil its HIV/AIDS obligations. It is known as the most vociferous and effective "opposition party" to government concerning its HIV/AIDS policies. Their dynamic leader, Zachie Achmat, a gay 39 year old, HIV-positive AIDS activist founded the TAC to give a voice to all unheard HIV-positive sufferers. He has vowed publicly, despite his ailing health, not to take any drugs himself until the government makes anti-retroviral drugs available at all public hospitals and clinics.

Religious/Faith-based affiliations

Sparrow Ministries is an interdenominational ministry of help whose purpose is to alleviate the pain and suffering of destitute, terminally ill adults and children. Relying on funding from the public, it founded a hospice called Sparrow Nest 10 years ago to support destitute terminally ill AIDS patients. The hospice has not been able to accommodate the increase intake of patients.

In February 2002, Sparrow Ministries officially opened South Africa's first AIDS VILLAGE – Sparrow Rainbow Village for adults and children afflicted with AIDS. The Western Metropolitan Local Council donated the land for the village, which houses facilities such as a hospice, clinic, pharmacy, kitchen, dining-room and a self-supporting sector (separate from the village). Funds are currently being raised to include an education and nursery centre. Sparrow Ministries provides patients with medical, psychological, social and spiritual care and allows sick people with AIDS to die with dignity and care.

The Catholic Church in South Africa has banned the use of condoms and brands it as promoting promiscuity whereas the Anglican Church in South Africa views condom use as a preventative measure. This, they say is not to encourage promiscuity – their calling is for

people to abstain from sex or be faithful and only encourages use when one cannot be faithful.

In September 2001, church leaders and the country's largest labour organisation and the Treatment Action Campaign pledged their support to embark on a joint mission to overcome the "denial syndrome of HIV/AIDS" in South Africa's official circles.

The Archbishop of Cape Town, Njongonkulu Ndungane, stated that HIV/AIDS should be declared a state of emergency in all African countries. In a joint press statement on AIDS, September 20, 2001, the Anglican Church, Southern African Catholic Bishops Conference (SACBC), COSATU and the Treatment Action Campaign (TAC) pledged their support to building an "effective alliance of civil society to prevent new HIV infections and ensure that people living with HIV/AIDS get life-prolonging and effective treatment".

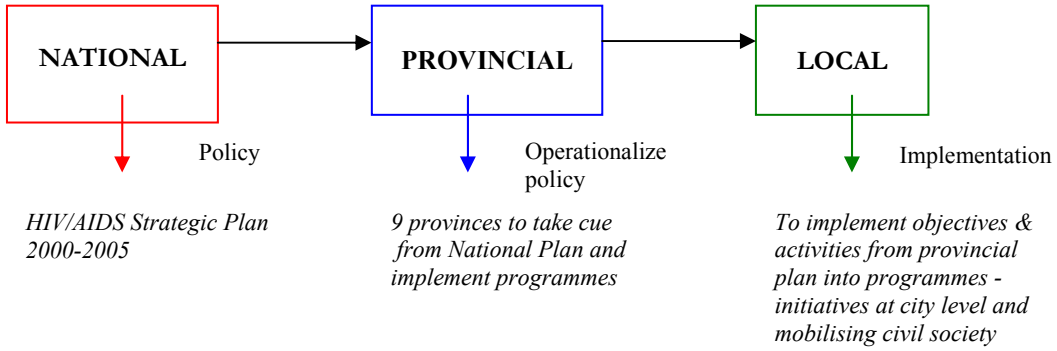
Suggestions by this 'alliance' are included in a document entitled Our Vision, Our Hope. The following objectives are outlined:

- A working group to develop shared campaigns to overcome denial syndrome;
- Work with representatives of civil society in the South African National AIDS Council (SANAC);
- Use co-operation, common purpose and courage to replace the cycle of controversy and denial, and;
- Building an effective alliance of civil society.

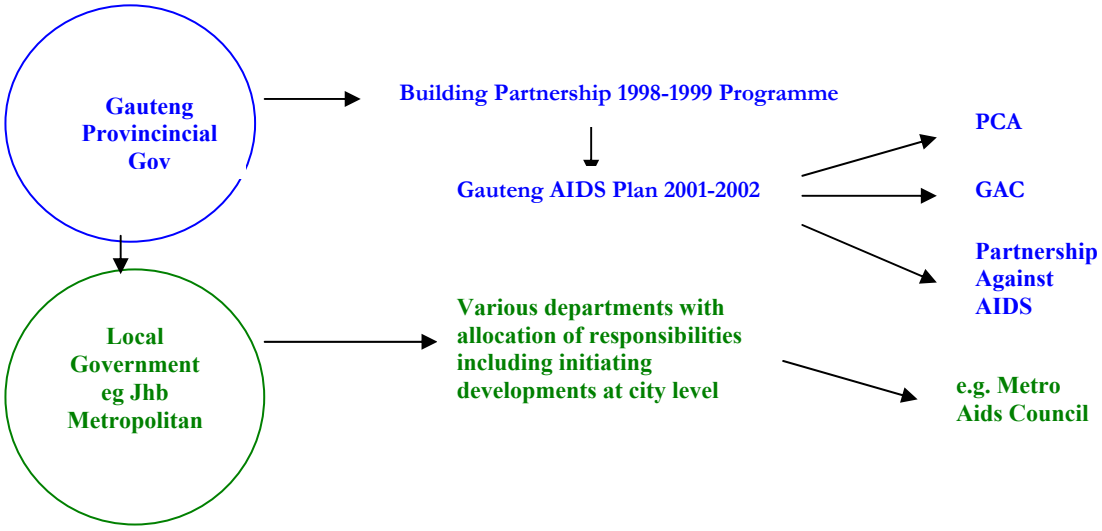
Responses by Local Government: focus on Gauteng

Gauteng, meaning 'Place of Gold', is the smallest of the nine provinces in the country but is the most densely populated (8 million) and the centre of economic life. The province generates over 40% of the GDP for Gauteng, 16% for South Africa and 10% for Africa, and attracts a considerable number of migrants from South Africa and the region. HIV prevalence in Gauteng in 2000 was 29.3% compared to 36.2% in Kwazulu-Natal (the highest prevalence rate in the country) and 8.7% in Western Cape (lowest prevalence rate in the country). Both Gauteng and Kwazulu-Natal have observed significant increases in HIV prevalence between 1999 and 2000.

In South Africa, 'Health' is a responsibility of the Provincial Government. The subsequent decentralisation of AIDS functions to local government in South Africa is as below:



Gauteng local government AIDS programmes



Building Partnership 1998-99 Programme

Initiated in 1998, the programme's strategy was as follows:

- Becoming an AIDS aware employer;
- Raising the political profile of HIV/AIDS;
- Developing a multi-sectoral strategy, and;
- Developing inter-departmental co-operation.

The Programme was successful in many ways but lacked an independent evaluation of these successes. It formed the foundation for the Gauteng AIDS plan.

Gauteng AIDS Plan 2001-2002

The Gauteng Provincial Government has, in keeping with the Strategic Plan for South Africa, adopted a multi-sectoral approach to their HIV/AIDS Programme. They are also responsible for directing resources to areas where they are most needed. This plans builds on the previous plan but with a renewed commitment: -

- To intensify prevention programmes;
- To provide comprehensive care for people living with HIV/AIDS;
- To ensure mobilisation of all sectors in the fight against HIV/AIDS (incl. local authorities), and;
- To give more focus to children.

Premier's Committee on AIDS (PCA)

In line with the multi-sectoral response, Gauteng's new structures for developing leadership on HIV/AIDS have resulted in the formation of a Premier's Committee on AIDS. This committee is chaired by the Premier and consists of all Members of the Executive Council and Heads of Department. The PCA was formed by the Gauteng Provincial Government to fight HIV/AIDS at the highest level of provincial government. Its role is to provide strategic leadership and co-ordination of Gauteng government's AIDS programme and to ensure that every Department addresses the HIV/AIDS issue. Its key focus areas are:

- Government workplace programmes;
- Policy and services plans for home based care and community based care to support families affected by HIV/AIDS;
- Local AIDS programmes;
- Prevention of Mother to Child Transmission Services, and;
- Implementing monitoring and evaluation programmes to assess progress.

Gauteng Aids Council (GAC)

Also in line with a multi-sectoral approach, the Gauteng Aids Council (GAC) was established by the Gauteng Provincial Government and is chaired by the Premier. The council members are drawn from various sectors e.g. local government, youth & women organisations, unions, religious sector, business, sports bodies, musicians traditional and faith healers, the media civics and People Living with AIDS. The aim of the council is to develop an integrated response to the pandemic and co-ordinate a government response with leaders from across civil society.

The GAC is tasked with devolving its functions to local authorities led by the executive mayors in the three metropolitan councils: Johannesburg, Ekurhuleni and Tshwane. Currently, approximately 60% of the Local governments in Gauteng have now developed AIDS plans.

Partnership Against AIDS

The Gauteng Provincial Government is contributing to the Partnership Against AIDS across many departments in the following focus areas:

All Departments

- Work on internal workplace AIDS programmes
- Incorporate HIV/AIDS in communications
- Integrate AIDS into strategy, policy and services
- Work with relevant sectors

Education Department
- The lifeskills programme in schools
- Social Services and Population Development
- Support to affected children
- Welfare grants
- Services for children (fostering, adoption, legal issues)
- NGO services, including children's homes
- Development of community-based care for orphaned children

Health Department
- Clinic and hospital services
- NGO services, including support groups, counselling and peer education
- Home-based care services and hospice beds
- Condom supply
- Voluntary Counselling and Testing (VCT) and MTCT service

Inter-Sectoral Aids Unit (located in the Health Department)
- Support to unions and the private sector
- Support to all government department (national, provincial and local)
- Support to civil society sectors

Sports Recreation, Arts and Culture
- AIDS awareness through sports, arts and libraries

Public Transport, Roads and Works
- AIDS awareness in the transport industry (taxis, truckers, bus drivers, train drivers, etc)

Development Planning and Local Government
- Supports development of local programmes by local government

The Johannesburg Metro Aids Council

Johannesburg is the economic centre of South Africa, a dynamic city with a population of 2.5 million. Statistics from Johannesburg Hospital show that HIV prevalence in the city is high and increasing rapidly: 30% of pregnant mothers tested are HIV-positive, 40% of children admitted to the paediatric wards are HIV-positive and 75% of paediatric deaths are AIDS related. In 1999 the overall HIV prevalence rate for Johannesburg was 26%, higher than the provincial prevalence rate in the same year (23.9%). The city has approximately 76 000 orphans, a number which is projected to rise to 139 000 by 2010 due to HIV/AIDS.

Faced with the startling figure of HIV/AIDS orphans and an increase in the number of deaths in Johannesburg, the City of Johannesburg formed The Metro Aids Council, launched on 3 November 2001.

The Metro Aids Council has representatives from various sectors and serves as an advisory body for the Johannesburg Mayor, Amos Masondo. Since the AIDS Council is still in its infancy stage, there are no initiatives underway. However, it is anticipated that from 2002, the council will actively be involved in the formation of projects and programmes to address the HIV/AIDS impact in the workplace and in the community.

The Metro Aids Council aims to:

- Create a platform to review matters related to HIV/AIDS in the city of Johannesburg;
- Co-enjoin all the City's inhabitants in the war against HIV/AIDS and visibly demonstrate support to those infected and affected;

- Actively review, monitor and evaluate the intersectoral response to HIV/AIDS in the City, and;
- Advise the City of Johannesburg on ways and means of reducing the impact of HIV/AIDS.

Côte d'Ivoire – A Case Study

Gaining independence in the 1960s, Côte d'Ivoire is situated in West Africa and shares its border with Ghana, Liberia, Guinea, Burkina Faso and Mali. Côte d'Ivoire is the most prosperous country in the west Africa region and attracts many foreign workers: currently 20% of the population are non-nationals. On 25 December 1999, Côte d'Ivoire suffered a coup d'Etat that put in place a military leader. Since the presidential elections in 2000, democracy has been restored to the country.

Côte d'Ivoire is the number one producer of cacao world wide and the fourth largest producer of coffee. The country's economy is therefore very dependant on the fluctuations of the international markets. Despite repeated attempts by the government to diversify the national economic base, agricultural production still dominates.

In rural areas, 42% of the population live below the poverty line compared to 21% of the population in urban areas. Poverty in Côte d'Ivoire is characterised by lack of access to productive land, credit facilities and basic services. 10% of the population live in absolute poverty and are located in the savannah region and the forest region in the East.

The number of refugees currently living in Côte d'Ivoire is indicative of the social crises taking place in neighbouring countries. In 2001, 124 915 refugees were registered including 121 574 Liberians, mainly located in the western part of the country, straining the existing infrastructure. Such immigration movements have contributed to regional integration but are also, in their current unmanaged state, accompanied by the traffic of arms, drugs and prostitutes particularly child prostitutes. This context is highly favourably to the rapid transmission of HIV/AIDS.

The statistics

Population	15.980,50
Population growth	2,58%
Total literacy level	48,5%
Population below poverty line	40%
Unemployment rate	NA
Life expectancy	45,1
HIV/AIDS prevalence rate	10,5%-12,5%
Average urban prevalence rate	12,8%-15,1%
Average rural prevalence rate	6,7%-8,4%
Number of people living with HIV/ AIDS	1 million
HIV/AIDS death	420.000 (2000 est)
HIV/AIDS orphans	320.000
Estimated economic cost of HIV/AIDS	60 billion/year (11% of the ministry of health budget)

The HIV/AIDS epidemic in Côte d'Ivoire

Côte d'Ivoire is the West African country most affected by the HIV/AIDS epidemic. This can be explained by its geographical location and economic context, which has caused it to become an attractive country to many migrants in the region and beyond. In two decades, HIV/AIDS has become the leading cause of death in the country. The national HIV prevalence rate is 12%. HIV/AIDS is not only a health problem but has become a social and developmental issue as young people are particularly affected. The population between the ages of 15-45 show the highest rate of infection.

The education sector is one of the most exposed: 6 teachers in Côte d'Ivoire die from HIV/AIDS every week. A recent study jointly carried out by UNICEF and UNAIDS showed that for 1.7 million students, 23 000 would have lost a teacher to HIV/AIDS.

The gender dimension of the disease in Côte d'Ivoire has also evolved. In the 1980s, there were 4 infected men to every woman. This has now passed to one infected man to every woman infected.

Reviewing the statistics, HIV prevalence in Côte d'Ivoire is growing. In 1997 it was estimated that 800 000 people were HIV positive, and in 2000 this figure grew to 1 million. These figures need to be carefully analysed to understand the nature of the epidemic in the country. The growing HIV prevalence rate is not only attributable to the fact that more people have become infected but also and more importantly to the fact that voluntary testing and testing at antenatal clinics has increased.

The reaction of Ivoirians to HIV has considerably evolved. In the early 1980s HIV/AIDS was a taboo subject and was not addressed at any political level. However, faced with growing HIV prevalence rates, mentalities have changed. A number of radio and television emissions targeting youth have been aired with the support of UNAIDS focusing on condom use as the epidemic is mainly spreading through promiscuous sex.

Côte d'Ivoire's national response to HIV/AIDS

As a first step, the national response to the epidemic focused on changing the behaviour of certain individuals or groups who were considered high risk. Information-education campaigns formed the basis of this approach. Emphasis was also placed on promoting condom use, treating sexually transmitted diseases and increasing the security of medical interventions, especially blood transfusions. Through information-education campaigns, women were encouraged to take their own preventative measures when the relationship between themselves and their sexual partner was not equal or favourable.

These strategies of risk reduction through prevention and awareness raising were in place since the start of the national fight against HIV/AIDS. The strategies were successful in many respects but need to be reinforced as this type of initiative has limits in reducing the impact of the epidemic. Often these campaigns have not been able to keep up with the evolving needs of communities.

The Coup d'Etat in 1999 considerably affected the ability of the country to respond to HIV/AIDS. Issues of national stability were the priority for the government and the donor community also stopped all financial flows to the country. It has only been since 2001 that development efforts have started up again, including the fight against HIV/AIDS.

Political leadership on HIV/AIDS issues

The government of the Republic in Côte d'Ivoire created a Ministry, reporting to the Prime Minister, charged with the management of the HIV/AIDS epidemic in the country. This Ministry is responsible for driving the National Strategic Plan Against HIV/AIDS 2002-2004, produced in 2001.

The National Plan has identified 11 priority intervention areas following the analysis of the situation in Côte d'Ivoire:

1. Awareness raising directed at youth;
2. Vulnerability of women to the epidemic;
3. Prostitutes and their partners;
4. Awareness raising of mobile populations;
5. Sexually transmitted diseases;
6. Condom use;
7. Stigma attached to people living with HIV;
8. Cultural and traditional practices;
9. Poverty reduction;
10. Care and support for people living with AIDS, and;
11. Strengthening the national capacity to respond to the epidemic.

The strategic plan places emphasis on the responsibilities and the engagement of local government in the fight against HIV/AIDS, in order to increase the involvement of social and political leaders and to reinforce the training and research capacity at the local level.

With regard to accessing anti-retroviral drugs, Côte d'Ivoire has benefited from one of the first initiatives to make these drugs more accessible in Africa. Since 1997, people living with HIV have been able to access anti-retroviral drugs at a cost of $7 per month instead of $280 per month.

At the national level, the central government is becoming more and more involved in the management of the HIV/AIDS epidemic in the country. The wife of the current president is actively engaged in information-education campaigns and works in collaboration with UNAIDS. Even though the danger of the epidemic is now recognised at all levels of government, the political will has to be translated into an effective financial effort to address the issue.

Responses by the private sector

Studies in 1993 among companies operating in Abidjan showed that the cost of the AIDS epidemic was between 0.8-3.2% of the total salary budget. This expense is believed to have increased with the rising prevalence rates in the country.

In Abidjan, the Ivoirian Electricity Company (CIE) approached an NGO called Amepouh, well known for their HIV/AIDS counselling experience, to investigate how they could assist in raising awareness amongst employees of the HIV/AIDS epidemic. After recognising that more and more employees were sick due to AIDS related illnesses, the CIE social welfare department created an HIV/AIDS unit in 1994. The unit is comprised of a doctor, a social worker, the director of human resources and 3 members of trade unions. The unit's objectives are to inform and educate on HIV/AIDS and to create a system of medical and psycho-social care. Since 1994, 21 such units have been created by CIE throughout the country.

The awareness programmes carried out with the support of NGOs have had a positive impact on the behaviour of employees. The most demonstrable example of this is the creation of a solidarity fund that allows HIV positive staff to access anti-retroviral drug therapies. It also allows staff to undertake a HIV/AIDS test. The solidarity fund is maintained through monthly financial contributions from each staff member and these monthly contributions vary from $1.50 to $71, depending on level of the individual's post.

An evaluation of the CIE campaign showed that between 1991-2000, 48 944 staff were reached and a reduction in the number of STD cases was also recorded: 795 cases in 1995 to only 288 cases in 2000.

The response by the CIE is quite exceptional as most companies have not developed a response to HIV/AIDS. Many staff fear revealing their HIV positive status as they often become victims of discrimination and are dismissed immediately. Insurance companies will not provide insurance for AIDS related illnesses and many families become impoverished through the loss of income and resulting medical expenditures.

Following the example of CIE, two major Ivorian companies (SODEFOR, SODECI) have recently introduced an HIV/AIDS awareness programme for their employees. These initiatives are new but they point to the fact that the general population is becoming more and more concerned with HIV/AIDS.

Responses by civil society

NGOs and advocacy groups

With regard to social mobilisation of communities, NGOs and associations play a fundamental role in Côte d'Ivoire. Community initiatives are for the most part launched by HIV positive people or people affected closely by HIV/AIDS. Like many other countries in the region, action on HIV/AIDS was carried out by NGOs well in advance of any action by the government. The ability of NGOs to mobilise communities has indeed contributed to the success of information-education campaigns and changes being carried out in political and judicial circles. NGO action has also contributed to the provision of care and support to people living with HIV/AIDS and the increased lobbying on their behalf.

The majority of NGOs, such as Ruban Rouge, Amepouh (Association of Women living with HIV/AIDS), Retro-ci and Club des Amis, have based their action on information, education and advisory services to communities with a strong accent on promoting condom use.

NGOs in Côte d'Ivoire are being confronted with financial difficulties as the national government is placing less and less funds at their disposal. Most of their funding comes from the private sector, private individuals, overseas development agencies or international NGOs.

In Côte d'Ivoire there is very limited interaction between NGOs and local government. Despite the creation of a national Ministry for HIV/AIDS, NGOs represented by a national co-ordinating association COSI feel they have not really been consulted on the elaboration of the national strategy or the implementation of the strategy's objectives.

NGOs find they are competing with the National Strategy and particularly with agents from within these Ministries who, as soon as they know there is a budget for HIV/AIDS work, create an NGO. In this context, NGOs find they work in the margins of government action and their activities are not well integrated into the national strategy.

Religious affiliations
The two dominant religions in Côte d'Ivoire are Christianity and Islam and both have adopted the same stance on HIV/AIDS. Although the epidemic is frequently addressed in sermons in Mosques and Churches, abstinence is preached as the most effective method of prevention and condom use is not encouraged.

Responses by local government: the city of Abidjan

Côte d'Ivoire has 198 local governments (communes), including the city of Abidjan. Each commune is headed by a municipal council, the members of which are elected by direct universal suffrage. Now that the urban population has been incorporated into communes, the process is being extended to more rural areas. Since 2001, Abidjan has the status of a district.

The city of Abidjan created an HIV committee (COLSIVA) in 1996 and entered the committee into the budget allocations. COLSIVA is a partnership established between the city of Abidjan and the COSI to implement HIV/AIDS related activities within the city of Abidjan. Since 1998,Abidjan actually made a financial contribution to COLSIVA and these funds were then distributed among various NGO activities in the city. In 1998 the contribution was $3 500, in 1999 $2 100 and in 2002 $2 100 (contributions were stopped during the political instability experienced 2000-2001).

During the X International Conference on AIDS and STDs in Africa, Abidjan hosted the first International Symposium on Mayors and the role of Local Government in the fight against HIV/AIDS (December 1997). This symposium was organised in collaboration with the Union of Cities, the association of Communes in Côte d'Ivoire (UVICOCI), UNDP, UNAIDS and UN-HABITAT through UMP. At this occasion, the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa was created (see end of this chapter for more information).

The commune of Yopougon, Abidjan
Yopougon launched an awareness programme on HIV/AIDS targeting youth in schools in 1999. This programme was formed on the basis of the peer-educator concept: young students were chosen to become peer-educators and were given training in HIV/AIDS issues and STDs. The peer educators were then able to talk to other students about these issues in an informed manner. 250 peer-educators were trained during 1999.

Since the creation of this programme, HIV/AIDS units were established in each school, out of these, 24 units have been able to initiate activities such as workshops, debates and information meetings.

In 2000, the municipality gave $7 400 to further support this programme. These funds have allowed an information centre to be created with documentation on HIV/AIDS and STDs. The centre has a games room and a film room to allow films on the above issues to be screened.

Regional Response - A Case Study

The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa emerged in 1997 as a result of a regional 'localised' response undertaken by local governments/municipal leaders in sub-Saharan Africa.

The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa was formed to promote an expanded, multi-sectoral response to the HIV/AIDS epidemic at the local level. It works

in partnership with civil society organizations and communities. To date, the Alliance has established national chapters in Burkina Faso, Côte d'Ivoire, Namibia, South Africa, Swaziland, Tanzania, and Uganda. The Alliance Secretariat Offices are located in Windhoek, Namibia and a sub-regional office is being established in Abidjan, Côte d'Ivoire.

In collaboration with UNDP/UNAIDS, the Alliance developed a multisectoral strategy called AMICAALL -- *The Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level* --, which translates the goals of the Alliance into concrete actions in countries and communities by addressing HIV/AIDS in cities and town in an integrated way. It calls for a locally led, multi-sectoral approach that complements and supports national policies. AMICAALL creates a context for exploring appropriate solutions and decision making by communities, local government authorities and civil society partners, all working together. The strategy aims at strengthening local capacity to sustain community efforts by focusing on *people* rather than on the *virus*.

The AMICAALL strategy is based on certain core principles. AMICAALL is:

- **Inclusive**—involving a broad range of stakeholders;
- **Responsive**—reacting to locally-articulated needs and brokering dialogue among local people, municipalities, policy-makers and decision makers;
- **Gender Sensitive**—responding to the different experiences of men and women in terms of vulnerability, response and impact, and;
- **Dynamic**—local action informs policy, and changes in policy facilitate a more enabling environment for sustained responses; and strengthened management systems at the local level provide foundations for scaling up the response to the epidemic.

AMICAALL National Programmes are currently underway in Swaziland and Uganda, and further details on these programmes follow. National Programmes are also in the development phase in Burkina Faso and Namibia.

The Alliance and AMICAALL National Programmes are being assisted by the UN-AMICAALL Partnership Programme which was set up in April 2001 under the umbrella of the International Partnership Against AIDS in Africa (IPAA) with support from UNAIDS. The Programme is facilitated by a small team based in Geneva and supported by a team of associates around the world. The UN-AMICAALL Partnership Programme is providing support in the following areas:

- Promotion of AMICAALL strategy;
- Advocacy and promotion of private/public partnerships;
- National AMICAALL Programme development technical assistance;
- Resource mobilisation;
- Documentation and dissemination of lessons learned, and;
- Institutional support to the Alliance Secretariat.

The goals of the Alliance are being achieved, on the ground, through the AMICAALL country programmes. Here, countries are working through local officials, civil society and private sector partners to institutionalize HIV/AIDS into the service delivery agenda of local authorities and promote action at the community level.

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