Chapter 10
Local-Level Responses to HIV/AIDS in South Africa

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10.1 Introduction

There has been little documentation of the scope and scale of local-level responses to HIV/AIDS in South Africa, although it is apparent that across cities, towns, villages and isolated rural homesteads there have been growing efforts to mount responses to the epidemic. Individuals, informal associations, civil society organisations, businesses and some government departments are supporting or promoting local efforts to address the spread and impact of the epidemic at local level.

In this chapter we review the role of local-level responses in HIV prevention and AIDS responses in South Africa and how these might be optimised. We examine the significance of 'locality' in HIV/AIDS responses, and two main ways in which local responses to HIV/AIDS have been promoted in South Africa: through civil society initiatives and local government. We make a case for a locality-based approach to HIV/AIDS and then develop an overview of the state of local-level responses.

10.2 A Local-Level Orientation to HIV Infections and AIDS Responses

10.2.1 HIV Prevalence at Human Settlement Level

Recent reviews aimed at understanding HIV transmission barely mention the human geography of the epidemic. The characteristics of human settlements and communities, including housing, living conditions and spatial characteristics of neighbourhoods, and the cohesion of communities, have been largely neglected in HIV epidemiology and, ultimately, in HIV-prevention planning.

Much of the work that has been done relates to early understanding of the HIV epidemic when HIV infections were understood as concentrated in, or associated with, particular localities, notably mining hostels, and the implications of labour migration. Now that South Africa is experiencing a generalised epidemic, the dynamics of HIV infections have grown more complex and the effects of another,

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underlying set of influences, related to community living conditions, are becoming clearer, although it is yet to be fully recognised and understood.

There has been surprisingly little analysis of the differences in HIV prevalence that are often found across communities in close geographic proximity. An exception is a study on the heterogeneity of antenatal HIV prevalence data in the Western Cape Province, which shows remarkable variations in HIV distribution across the districts of the province (Shaikh et al., 2006). In 2005, nearby communities within the Cape Town Metro ranged in antenatal HIV prevalence from 32.6% in Khayelitsha to 5.1% in Mitchell's Plain (Shaikh and Smit, 2005). Shaikh et al. (2006) conclude that the province does not have a single epidemic, but that sub-epidemics within the province are spreading and maturing at various rates.

It has been well established that there is a relationship between urbanisation and HIV prevalence in Africa. A 2005 review of antenatal seroprevalence data across the African continent shows 1.7 times greater median-value HIV prevalence in urban areas (Garcia-Calleja et al., 2006). Comparisons of rural versus urban HIV prevalence, using antenatal clinic data from ten southern African countries (Asamoah-Odei et al., 2004), also found that HIV is more prevalent in urban areas.

In South Africa, HIV prevalence is much higher in urban informal settlements than in other types of settlements (Shisana et al., 2005). There was 5.1% annual HIV incidence in urban informal settlements in 2005 compared to 0.8% HIV incidence in urban formal settlements. Furthermore, these areas accounted for 29% of new infections in the country in 2005 (Rehle et al., 2007). This is all the more notable considering that less than 9% of the South African population lives in urban informal settlements.

To understand high prevalence in informal urban areas (and hence to mount appropriately targeted prevention campaigns), we need to examine the social conditions in situations of rapid urbanisation. This topic remains under-researched. Most research on this subject has focused on social conditions at the individual and household level, and there has been little articulation of the relationship between community living conditions and HIV prevalence.

It is not adequate to ascribe the observed differences across settlement types to behavioural or cultural differences. Although it makes sense to expect behavioural correlates of infection, the determinants of both risk exposure and prevention behaviour must be systematically related to the systemic and structural conditions in the life circumstances of individuals, couples and families within communities. Risk behaviours are systematically elevated in particular types of communities and meaningful prevention behaviours are correspondingly systematically reduced. We need a more nuanced understanding of locality types, which goes beyond the four settlement types – urban formal, urban informal, rural formal, rural informal – used as South Africa's population census categories.[1]

[1] These four categories were used in the two national HSRC-led national HIV surveys.

10.2.2 Variation in HIV/AIDS Responses at Community Level

There is rationing of ART services in South Africa (Jacobs et al., 2008) according to geographic catchment areas that do not include specific considerations of need, such as the geographic concentration of the HIV epidemic. This has perpetuated long-standing inequities between urban and rural environments and across urban communities (McIntyre et al., 2006; Rangaka, 2007). There are other significant disparities in HIV/AIDS services and responses across settlement types in South Africa, including awareness of antiretroviral therapy, having been tested for HIV and access to forms of HIV/AIDS education media (Shisana et al., 2005). Access to welfare and social support services and efficient bureaucracies is poorer in more remote areas and in urban areas with weak infrastructure and pressure on services due to rapid population influx, such as informal settlements. Basic services essential to care and support differ significantly by place of residence. These factors together mean that not only is HIV epidemiology significantly affected by place of residence, but so too is the likelihood of efficient and effective responses. All basic municipal services, including access to shelter, water and electricity, follow a similar pattern of unequal distribution (Kelly and Ntlabati, 2007), leading to vastly differing contexts of living in close proximity to one another.

Communities may also differ in their responses to HIV/AIDS according to qualities of social interaction. The concept of social capital offers some promising leads in understanding the relationship between HIV/AIDS responses at a community level.'Social capital' – the shared norms and values within a society that enable its members to engage in collective action towards the common good – was first used by sociologists to describe the ability of individuals to access benefits or resources through the social networks to which they belong (Bourdieu, 1985; Coleman, 1988; Loury, 1977). Now the concept is often drawn upon to explain why certain communities may be, for example, more or less prosperous, safe or healthy than others.

Two main forms of social capital are noted in the literature – 'bonding capital,' which resides within relatively homogeneous groups and accounts for their closeness and solidarity, and 'bridging capital,' which describes linkages that reach beyond the confines of the close community and intersect with other homogeneous groupings', for example, as exemplified by networks for people with HIV/AIDS. It has been argued that the cohesiveness of a society is dependent on the existence of 'bridging capital' (or 'cross-cutting ties') (Narayan, 1999).

HIV/AIDS may undermine social cohesion by straining households, kinship ties and various community structures (OSAA, 2003). In many societies, HIV/AIDS adds to household costs, endangers livelihoods and food security, deepens poverty, increases the vulnerability of women and children and leads to the adoption of coping mechanisms such as the selling of household assets, which can result in irreversible destitution. These processes may strain community safety nets, undermine extended kinship ties and alter civic and cultural norms, including values linked to reciprocity and collective action.

Bonds within communities may help to prevent large-scale AIDS epidemics and to mitigate the impact of HIV/AIDS in areas of high prevalence. Linkages have been

made between levels of social capital and public health. Societies with high social capital and social cohesion may have better overall population health (Kawachi, 2001; Wilkinson, 1997). The pathways through which social capital may act to shape health are contested, but may include social networks (sharing of health-related information; emotional and physical care and support), civic engagement and activity (community advocacy on health issues and needs), and normative processes that shape health-related behaviours and lifestyle choices and bolster people's sense of self-efficacy. Bridging social capital, through the activities of civil society organisation, may act as cross-cutting ties which link otherwise isolated communities to knowledge, resources, services and opportunities which they might not otherwise have access to (Nauta, 2004).

In South Africa, one of the few studies in this area (Campbell et al., 2002) investigated whether there is a link between associational membership and HIV prevalence in a large South African township. The study found that HIV prevalence was lower among some age and gender groups belonging to specific types of associations (such as sports clubs), but was higher among those belonging to other groups, such as *stokvels* (savings associations). Their findings may reinforce concerns about 'negative social capital' – *stokvels*, for example, were linked with alcohol consumption and a greater likelihood of sexual activity with casual partners.

Noting the various structural determinants of HIV transmission in South Africa (including poverty, migration and gender inequality), Pronyk (2002) has suggested that strengthening the stock of social capital in South African communities could mitigate HIV transmission and impact. According to Pronyk (2002), social networks may help to diffuse health-related information (e.g. in relation to risk reduction), to shape community norms and showcase positive role-modelling behaviours and to provide members with material, emotional and social supports which ensure a measure of stability and could therefore mitigate high-risk behaviours. Communities with high social capital may also be more able to advocate for people's health needs, create a more tolerant and positive environment for people with HIV/AIDS and join together to undertake collective action in response to challenges.

The possible links between social capital and HIV/AIDS, particularly the 'positive' effects of social capital in curbing the spread of the epidemic, have been discussed more extensively in the case of Uganda, which is widely held up as an example of a society in which broad-based social mobilisation has helped to curb the spread of the epidemic. Thornton (2003) has chronicled the unique synergy of governmental and community action that emerged in Uganda during the early stages of the epidemic, paying particular attention to the role of community networks, churches and other structures in spreading information about HIV/AIDS, supporting affected individuals and families and reducing stigma. Thornton (2003) argues that the success of the Ugandan response can be attributed to the open and proactive position of the Ugandan government in relation to the epidemic, a decentralised approach which devolved control over AIDS programmes to the grassroots, a free press which openly addressed AIDS, the active engagement of religious communities and the proliferation of grassroots AIDS-related organisations. According to Thornton (2003), 'Major international donors provided most of the financial

resources, but very little of the actual implementation. Overwhelmingly, Ugandans themselves identified the problems, generated solutions, and integrated these into close knit networks of mutual support that brought to bear the concerted action of society at large' (p. 2).

Jamil and Muriisa (2004) have also considered the role of social capital and community responses to AIDS in Uganda, arguing that non-governmental organisations (NGOs) concerned with fostering social relations between people with HIV/AIDS and communities (as opposed to more 'individualised' approaches to HIV/AIDS response, such as counselling and testing) have played a crucial role in building social capital in the Ugandan context. Organisations that emphasise social support, empowerment, care and reduction of stigma and exclusion have helped to facilitate the inclusion of people with HIV/AIDS, have made a difference in the lives of their beneficiaries and have promoted social solidarity in the face of the epidemic.

10.3 A Review of Local Responses to HIV/AIDS

Inasmuch as there is need to understand HIV epidemiology in more localised terms, we must think further and more seriously about how to localise responses to the epidemic. The idea that responses must manifest 'on the ground' and in the context of people's lives is by no means new or novel. But there has been insufficient critical examination of how this has developed and been supported.

We consider two broad areas: (1) civil society responses to HIV/AIDS at local level; and (2) local government initiatives to support local responses.

10.3.1 Civil Society Responses to HIV/AIDS at Local Level

10.3.1.1 A Regional Orientation

The past two decades has seen a steady deepening of the involvement of civil society organisations in the provision of social services, emergency and humanitarian relief, and development programmes in many countries. Although there is a long history of social service provision by non-governmental institutions and church-based health-care systems in some sub-Saharan African countries dating back more than a century, the role of non-state actors has become much more pronounced and widespread during the 1980s, when Structural Adjustment Programmes severely curtailed levels of spending and constrained the capacities of states. Fuelled in part by an economic and governance climate that favoured outsourcing roles to non-state 'service providers,' NGOs moved into this gap and began to take over the provision of services in certain sectors, such as health, sanitation, education and rural development – in some cases, surpassing the role of the state itself (Clayton et al., 2000). During the 1990s, NGOs emerged as one of the main vehicles for delivering official development aid to its intended beneficiaries (Fowler, 2000).

Worldwide growth in numbers of civil society organisations over the past two decades has been termed a global 'associational revolution' (Salamon, 1994). There has been limited documentation of the size and scope of development of the civil society sector, but certainly in East and southern Africa during the early 1990s, donor agencies 'discovered' civil society and embraced it both rhetorically and programmatically. Although development agencies in donor countries have long channelled some support to their own international development NGOs for work overseas, the 1990s saw a major shift from 'support for NGOs' to the less clearly defined 'support for civil society'. Civil society came to the forefront as part of a package of normative concepts, including 'good governance,' 'partnership' and 'participation' (Wickramasinghe, 2005), which have since become embedded in development assistance strategies.

Research in seven East and southern African countries (Birdsall and Kelly, 2007; Kelly and Birdsall, 2008) shows that growth in numbers of HIV/AIDS-oriented civil society organisations commenced in the early 1990s, and reached a peak between 1996 and 2004, where some countries experienced growth well in excess of 1,000 civil society organisations. Growth was a response to the emerging realities of HIV/AIDS at community level and increasing funding support for civil society responses on the part of international donors.

There is much we don't know about the extent, shape and impact of community responses to HIV/AIDS. There has been little systematic study of local-level responses to HIV/AIDS, although the grey literature contains many case studies of locally oriented projects. Some of the clearest successes in confronting the HIV epidemic have been linked to the active role played by local-level actors (Low-Beer and Stoneburner, 2004; Panos, 2003; Rau, 2006; Thornton, 2003).

Civil society action on HIV/AIDS long predated the idea of 'comprehensive programming' and the large-scale funding that is now enabling its implementation. Many of the activities that have become institutionalised in national- and global-level plans were in fact pioneered on the ground by community welfare organisations, churches and groups of infected and affected people (Rau, 2006). The official embrace of civil society organisations as 'partners' in multi-sectoral response, public acknowledgement of their contributions and attention to the need to make funding and resources available to them have all lagged behind civil society organisations practical involvement in HIV/AIDS response activities.

Civil Society Organisations have commonly been cited as the leading forces in the evolution of community-based models of care and support to affected people and households, including orphaned children (Foster, 2002; 2004; Iliffe, 2006; Rau, 2006). In the absence of strong social safety nets, associations of community members have proliferated across the continent to meet social and material needs. Formal policies and frameworks – for example, national plans for support to orphans and vulnerable children – were only promulgated years after the burden of support had effectively, and by default, devolved to communities (Iliffe, 2006; Rau, 2006).

Foster (2002, 2004) describes the spontaneous, informal and 'ordinary' actions that are undertaken within African communities to support orphans and vulnerable children. He notes that such community initiatives are usually started by small

groups of motivated individuals who are driven by a sense of obligation to care for those in need, against a backdrop of limited or non-existent public services. According to Foster (2002), these initiatives, which are 'non-sensational and almost invisible to outsider and insider alike' (p. 99), generally share the same fundamental principles: reciprocity and solidarity; consensus-based decision making (particularly around understandings of vulnerability and identifying those who need care); self-reliance (resources mobilised locally); local leadership; voluntarism (altruism emanating from sense of community ownership); and innovation in problem solving. Local-level faith-based organisations' involvement in orphan care is burgeoning, and initiatives already supporting significant numbers of children are expanding without large-scale funding and technical assistance, and with considerable resources in the form of volunteer support. The study concludes that the cumulative impact of this local-level activity is significant and that, in the long run, local actors are better placed to respond to changing needs in orphan care than are large, external agencies (Foster 2004).

Epstein (2007) suggests that it is not finance, or technical solutions, or programme management expertise that has made the critical difference in reducing HIV incidence and improving impact mitigation. The key to successful AIDS projects resides in 'something for which the public health field currently has no name or program. It is best described as a sense of solidarity, compassion, and mutual aid that brings people together to solve a common problem that individuals can't solve on their own' (Epstein, 2007, p. xii). Collective efficacy, or the capacity for people to come together and help others they are not necessarily related to, and which surpasses what individuals can do for themselves, may be the key concept here. This spirit of collective action and mutual aid is difficult to measure or quantify, but may be the decisive feature of successful HIV/AIDS projects. This does not discount the value of higher levels of action and leadership, the provision of essential technologies and services and the need for strategic development.

There are profound implications for the way in which local HIV/AIDS responses are developed, conducted and supported, which will be addressed below.

10.3.1.2 The South African Context

South Africa has a strong history of an active civil society sector, which in the past has operated through community-based activism and human-rights advocacy. This is to some extent mirrored in the HIV/AIDS field by South Africa's advocacy-oriented 'Treatment Action Campaign' (see Chapter 11, this volume). But this is in many respects an exception to the norm. There has been considerable evolution of civil society structures and forms of organisation in the post-apartheid era (Nauta, 2004), which has seen strong emergence of semi-professional non-governmental organisations involved in service delivery, diversification and specialisation of community-based organisations and growth of faith-based organisations addressing a wide range of social issues at a service-delivery level.

The only attempt to take stock of the size and scope of the non-profit sector in South Africa (Swilling and Russell, 2002) reports on a 1998 national survey. The research identified 98,920 non-profit organisations with the majority (53%) being less formalised community-based organisations concentrated in poorer communities. The non-profit sector at the time employed 645,316 full-time workers and in 1998 mobilised nearly 1.5 million volunteers.

A provincial-level appraisal (Humphreys, 2005) found that there were 2,341 registered non-profit organisations in the Eastern Cape in 2004. Of these organisations, however, fewer than 5% had a stated objective that was linked to HIV/AIDS. But this data reflects only a fraction of the total number of organisations involved in supporting or providing AIDS response services. Many civil society organisations are not registered as non-profit organisations with the Department of Social Development, and most small towns in South Africa have community service organisations engaged in HIV/AIDS response work (Birdsall and Kelly, 2005).

There have been a few attempts to research the scope and scale of community-level responses to HIV/AIDS in South Africa (Birdsall and Kelly, 2005; Campbell et al., 2005; Russell and Schneider, 2000; Teljeur, 2002). It is clear that over the last 10 years at least, localised projects have emerged across the country to fill gaps in HIV/AIDS service provision in almost every area; but most commonly in prevention education, HIV support groups, home-based care, support for orphans and vulnerable children and impact mitigation through activities such as food-gardening or savings schemes. But there are also civil society organisations providing more technical services such as antiretroviral therapy and other biomedical services, and developing high-end mass-media communications. The types of organisations range from strongly regulated and highly professional to threadbare organisations with little training and limited connections to the HIV/AIDS industry, international funders or government, as well as volunteer associations.

The number of such initiatives can only be guessed at, but counting the members of a few networks, civil society sub-partners of the PEPFAR funding programme and a number of multi-site programmes, a count of 1,000 organisations is quickly passed. The final tally may be a few multiples of this: especially if those organisations not primarily oriented to HIV/AIDS but having a significant component of HIV/AIDS in their objectives are counted.

In 2000, many of these initiatives were in their infancy and quite ‘precarious,’ operating with limited resources, in single communities, with only occasional and limited external support and often not working with reference to guidelines or external parameters. This situation appears to have regularised due to the need to meet operating and reporting demands of funders. Funding can force organisations to formalise and this often requires organisational development. Serving this need are capacity-building efforts on the part of funders with the help of organisational development programmes.

Supported by international funding, there has emerged a growing group of national NGOs that have multiple projects in different communities, and they have effectively become sub-granting agencies to smaller community-based organisations. They build the capacity of these organisations to implement standard

programmes, often allowing variations in how a basic programme is implemented, but requiring reporting on a standardised set of outputs.

But there remain many organisations that are based in a single community, focused largely on support activities such as promoting household food production, income-generating projects and community savings schemes. The scale of organisations in this category, many of which receive only occasional funding, is not known. Also many such community support activities fall under churches or community organisations that are not primarily HIV/AIDS oriented, and may not be recognised, even in the area of their operation, as significant contributions to harnessing community resources for AIDS response.

It is also significant that there has been no attempt to understand the contributions of volunteers, which are not always part of civil society organisations. There is likely a significant contribution to more formal programmes through education of others about access to formal services, provision of psychological and spiritual support, monitoring of health and basic health care (Campbell et al., 2005; Kelly and Mzizi, 2005). This work is often done with few supplies, little support and no compensation. Such volunteer carers exist in many communities across South Africa and represent an already mobilised, but under-utilised resource for AIDS support.

Civil Society Organisations in South Africa are beset by multiple challenges, and they often become chaotic and unmanageable (Birdsall and Kelly, 2005). They are often led by well-intentioned community members who have insufficient management and planning capacity to ensure that their organisations are strategically and sustainably developed. It is often funding opportunities rather than local needs and organisational capacity that determine what they undertake.

Looking beyond South Africa and HIV/AIDS responses, it has been said that global institutions have 'consumed' local initiatives and formations and local civil society organisations have increasingly struggled to define and sustain their own agendas in the face of financial dependency on external sources of funding (Fowler, 2001; Wickramasinghe, 2005). The result is a high end of professional organisations and networks led by experts, who effectively become prime partners of major funders. Ultimately they become sub-granters to smaller organisations, including single-community organisations, with few inter-organisational linkages, little community contact and inadequate training for what they undertake.

There are encouraging signs that the HIV/AIDS civil society sector in South Africa is becoming progressively more organised. There are active civil society networks in the following sectors: disability sector, children affected by AIDS, law and human rights, men's and women's issues, faith-based responses, traditional healers, traditional leaders, people with HIV/AIDS and higher education, among others. The structure of the National AIDS Council and the emerging provincial AIDS councils allow for and encourage organised representation by sectors; although the complexity and layering of the civil society sector makes notions of representation difficult to envisage, except at local level. The most promising efforts towards this end have been conducted at local government level. These will be reviewed below.

10.3.1.3 Support for Local-Level Responses

Government Engagement with Civil Society Responses

There have been numerous symbolic expressions (e.g. summits and declarations) of the need for partnerships between government and civil society: notably the 1998 national 'Declaration of Partnership against AIDS'. However, these did not make a notable impact on cooperation between government and civil society working in the HIV/AIDS field, which, until recently, with some provincial and local government exceptions, have been *ad hoc*, often adversarial and inconsistent.

The official national response to HIV/AIDS in South Africa has traditionally relied strongly on provincial public health systems for interventions such as condom distribution, voluntary counselling and HIV testing, prevention of mother-to-child transmission and the roll-out of antiretroviral therapy. Inadequacies in government responses in these areas have led to massive involvement of civil society in filling the gaps and extending services; and in the face of this, there are signs of growing tendencies to increase and systematise processes for working together with civil society agencies in fulfilling these functions. Recent consultative processes leading to development of a new National Strategic Plan have shown evidence of a more collaborative relationship between government and civil society, expressed mainly through the South African National AIDS Council, which has among its objectives to create and strengthen partnerships for an expanded national response to HIV/AIDS in South Africa. It employs a full-time 'NGO sector coordinator' and expresses a desire to engage the civil society sector. But the efforts of some provincial health departments to engage civil society predate such developments by a number of years (Kelly and Marrengane, 2004). Gauteng and Western Cape provinces are notable for initiating programmes for coordinating and supporting community-level HIV/AIDS responses 5 or more years ago: engaging with communities directly, through civil society organisations and also cooperation between provincial and municipal government structures.

In other provinces, there has been some government funding for community-level HIV/AIDS responses. For example, in 2007, the Eastern Cape Department of Health (ECDOH) funded 212 NGOs and community-based organisations to provide home-based care and provided stipends to over 2,000 community health workers based in clinics to provide basic care and support services to people affected by HIV/AIDS at community level (EC DOH, 2007). However, during our own fieldwork, we have found that such funding is often provided 'once-off' and with no follow-up or attempt to develop longer-term services through these organisations, or to assess the quality and effectiveness of such support. Even when there is a longer-term relationship between government and civil society organisations, such relationships have been unreliable and unpredictable.

Looking beyond the health sector, the National Department of Social Development, with international donor support, has over the past 3 years conducted a pilot programme in five provinces, involving capacity building of 140 'home- and community-based care' organisations. The programme is currently being evaluated with a view to adopting it as a large-scale national programme to engage

community-based organisations in partnerships with the Department, involving capacity-building and financial support. This innovative programme constitutes a significant interest on the part of a national government department in enlisting civil society actors to fulfil primary government functions.

It has been suggested above that civil society organisations and programmes of action have substituted for government inadequacies. But it is also unsurprising, even given political will, that government services are not capable of meeting existing and future needs. Now that a large array of civil society organisations are in place and progressively more organised, there is need for a significant effort to ensure coverage, equity and quality of support and services.

No matter how strong they are civil society initiatives cannot and should not be seen as an alternative to the state in issues of development and service delivery (OSAA, 2003). An interesting situation prevails in South Africa, not unlike the situation in other hyper-epidemic countries in east and southern Africa. The civil society sector has grown to scale independently of the state, and efforts to work together have not led to enduring and predictable cooperative relationships. It is a major challenge to ensure that government and civil society efforts complement and support each other, and it will require a specific and enduring programme of support to ensure this, which must begin with recognition of the vast, if not yet specifically researched, scale and scope of the sector.

Funding

Research on the civil society funding environment in other countries (Birdsall and Kelly, 2007) shows how the emergence of the new stratum of local-level initiatives has been driven by unmet needs as well as drawn by funding opportunities, and the effectiveness of the civil society sector continues to be sensitive to changes in the funding environment

There has been very little research on funding for civil society HIV/AIDS responses in South Africa. There is apparently no consolidated information about the amounts being spent by provincial departments on civil society support, and the donor funding matrix maintained by the National Department of Health (Ndlovu, 2005) keeps tally only of the amount of external funding provided to the department.

The total amount of funding provided by donors to South African HIV/AIDS responses has grown significantly. The US President's Emergency Plan for AIDS Relief (PEPFAR) has allocated US$ 591 million to support comprehensive HIV/AIDS prevention, treatment and care programmes in South Africa for the 2009 financial year. In 2007, there were over 90 prime-partners and 300 sub-partners, and given the 49% increase in funding since then, the number in 2009 is likely to be considerably higher. Some of these are government institutions, but most are non-state actors. Not all of the prime partners are South African, and in 2005, a little more than half were South African entities and the remainder international, mainly American. Most of the larger non-state recipients are international NGOs, which sub-grant within South Africa. Other large-scale funding programmes, including the Global Fund to Fight AIDS, TB and Malaria have also provided large amounts

to non-state actors in South Africa and the UK Department for International Development has funded the Department of Social Development pilot programme for support of community and home-based care programme.

It has been shown in other countries that international funding agreements and modalities of assistance can have a profound impact on the growth and development of civil society agencies working in the HIV/AIDS field (Birdsall and Kelly, 2007; Kelly and Birdsall, 2008). It is likely that South African civil society is being shaped in ways that have not been documented or discussed, and there is reason to question the sustainability of a large cohort of funded organisations, many of which are largely service providers rather than organisations based in and staffed by community members. The result is a far cry from the model of community response discussed above (see 10.3.1.1).

There has been little understanding of how civil society organisations would best develop: for example, whether they should strive for specialisation in particular areas or whether they should grow progressively more comprehensive. A study of civil society organisations in South Africa (Birdsall and Kelly, 2005) showed that many are beset by multiple challenges and often grow into increasing chaos and unmanageability. They struggle to meet the reporting requirements of multiple funders and it is often funding opportunities rather than local needs and organisational capacity that determine what they undertake. It is as well that there have emerged a good number of organisational development service providers to support the many new and growing organisations (Goudge et al., 2003).

Some models are emerging that tie funding to capacity-building and try to fund into the capacities of organisations to deliver services at appropriate levels. A good example among these is Ikhala Trust, a small grant-making facility that operates as a micro-fund for existing community-based organisations operating within the Eastern Cape. The trust assesses and builds on existing community 'assets' and targets smaller organisations which tend to be overlooked by donors. It not only provides seed funds, but assists in building organisational management capacity and linkages. This approach raises the possibility of intermediary civil society organisations or networks raising block grants from donor agencies, including government, which are then disbursed as multiple small grants to successful community-based organisations and providing assistance to promote their efficiency and effectiveness.

Given the scale of civil society involvement in HIV/AIDS responses, the funding and development of the sector should receive much more attention.

Model-Driven Approaches

An encouraging development that has accompanied the growth of civil society engagement in HIV/AIDS responses is systematisation through model-driven approaches.

This has happened in most areas of HIV/AIDS responses with the possible exception of HIV prevention. Arguably, the most successful general programme of local-level responses across the country is home-based care, which is also the area in which provincial governments have most closely engaged civil society as a service

provider (principally Hospice Palliative Care Association of South Africa). The Integrated Community-Based Health Care model of hospice has established a model and standard for services in this area.

There have emerged a range of service models that are adaptable for conditions in different communities. Notable are models for supporting community responses to the needs of orphans and other children made vulnerable by HIV/AIDS. Richter et al. (2004) discussed ways in which external agencies can best support local-level work with orphans and vulnerable children. Also, the 'Isibindi' community care model has been developed and promoted by the National Association of Child Care Workers and is being implemented by community-based organisations throughout the country, as well as provincial government. Yet another model has been developed and implemented by the national NGO Nurturing Orphans of AIDS for Humanity in multiple community sites throughout South Africa.

Rather than rely on innovation in each new site, community-based responses, which are guided by tried and tested models and which can be supported to grow and adapt at community level, appear to be the most viable approach. This promising trend which marries strategic development with community engagement and ownership appears to be growing apace in South Africa.

10.3.2 Local Government Responses

The National Strategic Plan 2007–2011 does not specifically define the role of local government in HIV/AIDS response. It is left to provinces and municipalities to work out how to support local responses and to find ways of co-ordinating their efforts.

However, through an August 2008 resolution, the South African National AIDS Council committed itself to developing provincial and local AIDS council guidelines. This follows an April 2007 launch by the Department for Provincial and Local Government (DPLG) of the 'Framework for an Integrated Local Government Response to HIV and AIDS'. This document promotes a common understanding of what development and governance responses to HIV/AIDS entail; it specifies the role of municipalities and provides guidance on what they can do to respond to HIV/AIDS within their existing mandates, programmes and strategies; and it defines a strategy for supporting municipalities and other role players towards these ends (DPLG, 2007a). The framework, with its accompanying implementation plan (DPLG, 2007b), is a clear attempt to locate local government's responsibility for HIV/AIDS within its mandate of maximising social development and economic growth, although it is too new to have made any impact as yet on municipalities and their responses to localised HIV/AIDS epidemics.

There is no statutory mandate that explicitly defines district or local municipality responsibilities for responding to HIV/AIDS. The mandate for local government HIV/AIDS responses might however be regarded as implicit within the more general set of mandates around: ensuring the provision of basic services; maximising social development and economic growth; promoting a healthy environment; encouraging

the involvement of communities and community organisations in local development; assessing and responding to development needs of communities; planning and co-ordinating local development; establishing sustainable and liveable settlements; bringing together coalitions and networks of local interests that co-operate to realise shared visions; responsive problem solving and a commitment to working in open partnerships with business, trade unions and community-based organisations; and directing community energies into projects and programmes that benefit the area as a whole.

In terms of the Municipal Systems Act of 2000, all municipalities must undertake planning processes to produce an integrated development plan (IDP) for a 5-year period. The IDP defines and guides all planning, budgeting, management and decision-making in a municipality. The IDP is required to be reviewed annually in consultation with communities and stakeholders and amended should this be necessary.

The IDP process holds the promise of facilitating and embedding integrated and collaborative local-level response to HIV/AIDS. In reality, however, few IDPs reflect what could be termed effective mainstreaming of HIV/AIDS into municipal functioning. More often than not, HIV/AIDS is relegated to a particular section of the IDP, without linkages to specific functions or developmental outcomes expressed in the IDP, let alone accompanying resource allocations. Also, HIV/AIDS components of IDPs (Ambert et al., 2006; Versteeg, 2006) have shown that they are often not based on adequate situation analyses of the unique context of HIV/AIDS within municipalities. There is such a rapid proliferation of HIV/AIDS responses on the part of NGOs and other local actors that IDPs tend to lose alignment with HIV/AIDS development priorities which may be addressed by non-governmental organisations' to NGOs' and provincial government agencies. There is little evidence that an integrated approach to HIV/AIDS response planning is being adopted on a wide scale, and much local government effort remains sector bound, with dominant emphasis on awareness-raising activities.

In reality, the government's own assessment has shown that only 37% of municipalities have independent capacity to prepare effective IDPs, 35% have basic institutional capacity but require continued support to prepare their plans and 28% struggle to prepare an IDP, even with support (Harrison, 2008). This sobering assessment suggests that much more support than has been forthcoming until now is needed before the promise of dealing with HIV/AIDS in the context of integrated development planning can come to fruition, and effective alignment of the different spheres of government and civil society action can occur at local level.

However, there are some strong examples of well-led, comprehensive municipal responses to HIV/AIDS, especially in the country's cities (Kelly and Marrengane, 2004), but also in some local and district municipalities (Ambert et al., 2006) where local government has played a catalytic role in the development of co-ordinated community-led responses to the epidemic.

Notable exceptions aside, municipal responses to HIV/AIDS are often limited to activities such as organising occasional HIV/AIDS awareness events, putting up billboards with HIV prevention messages and similar activities aimed at behaviour

change and personal health. Recent years have seen a growing number of municipalities adopting HIV/AIDS workplace programmes. But most of these programmes reflect an equally narrow conceptualisation of HIV/AIDS as largely a behavioural and health issue and do not fulfil the hope that local councils might support more integrated local responses (van Donk, 2008). Whilst these kinds of initiatives must have generated some value, there is certainly no strong evidence that local AIDS councils are a strong emerging force in the co-ordination and management of local AIDS responses.

One of the key implications of adopting a 'mainstream' approach to HIV/AIDS in municipal planning, service delivery and governance is that more attention needs to be paid to the human geography of HIV/AIDS – or, put differently, rediscovering 'space' in developing localised responses to HIV/AIDS. This implies recognising when there is uneven distribution of HIV within municipal boundaries, and paying attention to spatial and built environment considerations that are important in providing local responses to HIV/AIDS. It is here where municipalities can make the strongest impact on both reducing vulnerability to HIV infections and on strengthening coping capabilities and social cohesion in the face of the epidemic (Isandla, 2007). However, this remains an under-developed area of work.

Yet, as much as it is desirable to create local governance systems that take greater responsibility for developing and supporting HIV/AIDS responses, there are a number of reasons to be cautious about passing on too much responsibility for dealing with the crisis of HIV/AIDS. Well-functioning systems of local government cannot be assumed to exist; and some municipalities have large service delivery backlogs and lack funds for basic services. Against this backdrop, responding to HIV/AIDS may be seen as an add-on responsibility. This is made all the less likely by the fact that the mandate for local government HIV/AIDS response is largely unfunded. But the more general goal of human settlements planning, service delivery, development strategies and governance that are informed by an explicit HIV/AIDS perspective is not unrealistic. It is not an add-on requirement to take HIV/AIDS into account as a key development concern, and this falls squarely to the responsibility of local government.

This brings us back to the importance of recognising and supporting existing community-based initiatives and the necessity of partnership building at the local level – to enhance co-ordination between various actors, to strengthen referral networks and information sharing and to emphasise the integration of various HIV/AIDS-related services.

10.4 Prospects for Responding to HIV/AIDS at the Local Level

International evidence suggests that local-level responses are key to curbing and mitigating effects of HIV/AIDS; but the way in which local responses are initiated and supported is subject to influences that may jeopardise their value. In South Africa, we have had 25 years of skirting around the need to localise HIV/AIDS

responses. Yet policy and strategies in this area remain poorly formulated and inadequately supported. There is ample anecdotal evidence of a burgeoning civil society sector, largely supported by international funding programmes but with some South African business and foundation support. There is also increasing national and provincial government support for local-level initiatives.

Local-level community activity can never be a replacement for large-scale, government-led responses to the epidemic, even though community organisations appear to be playing the leading role in certain areas of HIV/AIDS response. Community initiatives, by their very definition, are localised and lack broad 'political economic leverage' (OSAA, 2003). They cannot operate at the scale needed to address the many impacts of the epidemic across society as a whole. Their greatest strength is that they emerge from, reflect and are positioned to engage with local needs and conditions; and if national strategies can be developed to more effectively engage with CSOs, there is much to be gained.

Much attention has been paid to the co-operative relationship that emerged between government and civil society in Uganda, where the state effectively contributed to the creation of social capital in society by encouraging CSO activity, by publicly reiterating government commitment to and support of people living with HIV/AIDS and by mobilising financial support for community institutions (Jamil and Muriisa, 2004). On a much smaller scale, localised networks, such as Children in Distress Network in KwaZulu-Natal (Kelly and Marrengane, 2004), demonstrate that it is possible for civic and state entities to work together in partnership in a way that enhances overall effectiveness of their efforts.

10.4.1 What Is Needed?

We have discussed local-level responses at civil society and local government levels and have highlighted the need for strengthening localised responses to HIV/AIDS. Following is a list of key interventions that would contribute to this end.

1. *Local programmes based on more sensitive HIV surveillance and response analysis*: HIV surveillance and response analyses to date have provided very little information to help in shaping local responses. Efforts to curtail new HIV infections must begin with understanding where they are most likely to occur, and response efforts must be based on an understanding of existing services and unmet needs. There is need for higher concentration of programmes, for example, in urban informal settlements, where HIV incidence appears to be highest and ironically where there are least likely to be adequate programmes in place, or supportive municipal infrastructure.

2. *An appraisal of civil society responses*: There is need for an appraisal of civil society responses to HIV/AIDS. This should consider models of co-operation and integration of services at local level; co-ordination within the civil society sector and harmonisation with government programmes; provincial government strategies

for engaging civil society organisations; and the funding and support environment for civil society responses.

3. *A long-term agenda located at local government level*: It must be recognised that the dominant emphasis in HIV prevention on behavioural outcomes is insufficient and to some extent inappropriate, given apparent locality-determined influences on HIV infections. The realisation of integrated and sustainable human settlements with adequate access to basic services and social, economic and public infrastructure is vital if South Africa is to address the HIV/AIDS epidemic effectively in the long term. A long-term, development-oriented agenda and strategy for HIV/AIDS responses should be established for the country as a whole. The foremost opportunity for operationalising this is through municipal integrated development planning processes, and there is an opportunity to build on recent efforts to develop frameworks and guidelines for more effective municipal responses.

4. *A strategy for improved local HIV/AIDS governance*: As the epidemic in South Africa becomes progressively more complex in its infection dynamics and impacts, and local-level HIV/AIDS responses burgeon and diversify across South Africa, questions of effective HIV/AIDS governance take on ever greater importance. There is need to take stock at the provincial level of government, of strategies for engaging civil society organisations and municipalities in localising provincial implementation plans, and this should feed into a national-level strategy for attaining comprehensive and co-ordinated local responses to HIV/AIDS through complementary action on the part of national, provincial and local governments, and non-state actors.

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