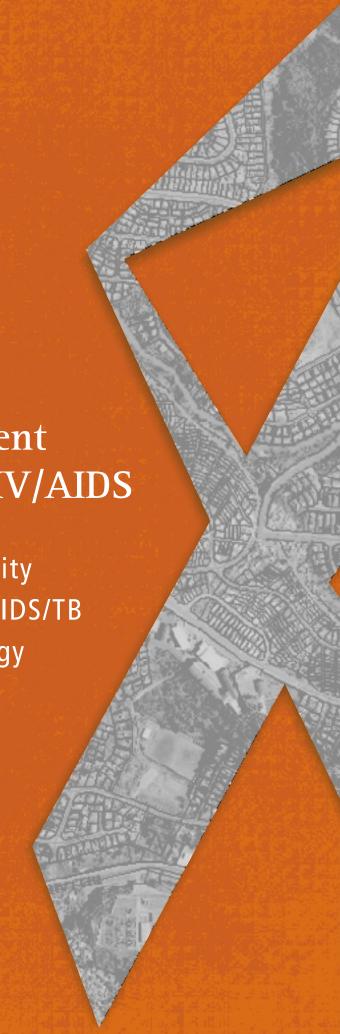


A Case Study of the City of Cape Town's HIV/AIDS/TB Multi-Sectoral Strategy





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Mainstreaming Local Government Responses to HIV and AIDS

A Case Study of the City of Cape Town's HIV/AIDS/TB Multi-Sectoral Strategy

False Bay

Table Bay

Foreword

It is widely recognised that HIV/AIDS is not only a human tragedy, but a development dilemma as well. In general, municipalities have been slow to recognise the developmental implications of HIV/AIDS. As a result, most municipal responses to date have not been sufficiently comprehensive in addressing the context of vulnerability to HIV and in providing the necessary support that will allow individuals, households, organisations and institutions to cope with the consequences of the epidemic.

In South Africa, the City of Cape Town was one of the first municipalities to invest significant capacity and resources to respond to HIV/AIDS in a multi-sectoral manner. This review, conducted six years after the City embarked on a concerted response, reveals valuable lessons from the City's experiences, both for the City of Cape Town and for other municipalities. Yet, its achievements — and there are many — notwithstanding, the City still has a long way to go for HIV/AIDS mainstreaming to be effective.

The core challenge for municipalities is to shift paradigms: from viewing HIV/AIDS as predominantly a health and behavioural concern to recognising how poverty, gender inequality, joblessness, lack of food security, inadequate shelter and lack of basic services, income inequality, despondency and lack of future prospects, amongst others, conspire to make people more vulnerable to HIV infection and less able to cope with the consequences of HIV/AIDS. A critical dimension in the response to HIV/AIDS is to ensure that human settlements are integrated, inclusive, economically viable and sustainable — which is essentially what local government's developmental mandate is about.

Mirjam van Donk DIRECTOR

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List of abbreviations

ABC Abstain, Be Faithful, Condomise
ACQuired Immune Deficiency Syndrome

ART Antiretroviral treatment

ARV Antiretroviral

CBO Community-based organisation CHC Community Health Centre **FBO** Faith-based organisation Human Immunodeficiency Virus IDP Integrated Development Plan M&E Monitoring and evaluation **MDHS** Metro District Health Services **MSAT** Multi-sectoral Action Team NGO Non-governmental organisation **NPO** Non-profit organisation

NQF National Qualifications Framework

NSP New smear positive

PMTCT Prevention of mother-to-child transmission

SACN South African Cities Network
STI Sexually Transmitted Infection

TB Tuberculosis

VCT Voluntary Counselling and Testing

1. Introduction

In recent years, policy-makers and practitioners involved in efforts to combat the HIV/AIDS¹ epidemic have increasingly advocated for integrated, multi-sectoral or mainstreamed approaches to preventing and mitigating the impacts of HIV/AIDS.² At the same time, there has been growing recognition that many of the most significant HIV/AIDS interventions are most effectively undertaken at local level, since it is at this level – of individuals, households, communities, organisations and businesses – that the effects of the disease are typically most directly experienced.³ Moreover, with the recent global trend towards decentralisation of governance, attention is increasingly turning to the role that local governments, as the structures of governance closest to citizens and the providers of key developmental services, have to play in local-level responses to the epidemic.⁴

In South Africa, a country with one of the world's highest HIV/AIDS prevalence rates⁵, most of the country's 283 municipalities have only in the last few years begun to consider their role in local level responses to HIV/AIDS. While policy and support interventions are starting to emerge from national government and other agencies to assist municipalities to mainstream HIV/AIDS, much work is still needed to develop an understanding of what mainstreaming HIV/AIDS means and how the concept can be operationalised within the local government sphere.⁶ Within this context, it is particularly important for existing mainstreaming efforts by municipalities to be documented and shared with others in order to disseminate lessons and generate best practices.⁷

This report documents the City of Cape Town's HIV/AIDS/TB Multi-Sectoral Strategy as a case study of one large urban municipality's attempt to mainstream its response to HIV/AIDS. In 2000, the City embarked on a plan to provide a comprehensive, multi-sectoral response to HIV/AIDS and TB amongst both its staff, as well as the communities it serves. During the course of the strategy's implementation over the last six years, the City has increasingly attempted to frame its multi-sectoral response in terms of 'mainstreaming.' While some important progress has been made, the experience of the City of Cape Town also reveals a range of challenges that local governments are likely to confront in their efforts to mainstream HIV/AIDS.

1.1 Objectives of the study

The brief for the research was to document and critically reflect on the City of Cape Town's efforts to mainstream HIV/AIDS since 2000. The objectives of the research were to:

- Understand the extent to which the City of Cape Town has succeeded in mainstreaming HIV/AIDS;
- Identify factors that have promoted or impeded mainstreaming efforts;
- Identify ways to strengthen HIV/AIDS mainstreaming in the City; and
- Extract lessons from the Cape Town experience that will be of benefit to other large urban municipalities in South Africa.

1.2 Methodology

The methodology for the research involved a combination of desktop reviews of literature on local government, HIV/AIDS and mainstreaming, and available documentation on the City of Cape Town's HIV/AIDS/TB response strategy, as well as interviews with a wide range of stakeholders involved in the City's HIV/AIDS strategy. Contact details for most of the key stakeholders interviewed were supplied by the City Health Department.⁸ A list of the interviews conducted is included as Appendix 1 at the end of the report. Two Multi-sectoral Action Team (MSAT) meetings and an MSAT Annual General Meeting were attended to observe the MSATs in action. At the beginning of the research, staff from Isandla Institute also had the opportunity to attend two City HIV/AIDS/TB Coordinating Committee meetings to observe the process and present an outline of the research.

A research seminar was held on 12 September 2006 to provide feedback to those who were interviewed and other interested stakeholders on the preliminary findings of the research and to obtain further input on key research questions (see list of participants in appendix 2). An interactive component of the seminar gave individuals involved in different aspects of the City's HIV/AIDS response an opportunity to discuss and share ideas about how to improve HIV/AIDS mainstreaming. The research was carried out over a period of three months, between June and September 2006.

1.3 Structure of the report

The report has been organised into the following sections:

- Section 2 provides an introduction to the case study of the City of Cape Town, including some key demographic and socio-economic background information, as well as some notable features of the context within which the city's response to HIV/AIDS was formulated and implemented.
- Section 3 provides a conceptual framework for understanding the relationship between HIV/AIDS and local
 government in terms of the impacts of HIV/AIDS and the obligations and opportunities for local government
 to play a strategic role in responding to the epidemic. This section also offers a brief introduction to the
 concept of mainstreaming HIV/AIDS, with specific reference to its application to the local government
 context.
- Section 4 gives a brief overview of the main characteristics and historical trends with regard to the HIV/AIDS
 epidemic in Cape Town.
- Section 5 then outlines the key components of the City's response to HIV/AIDS, namely the Multi-sectoral HIV/AIDS/TB Strategy.
- Section 6 follows with a review of the implementation of the internal response to HIV/AIDS in the City of Cape Town.
- Section 7 reviews progress with the implementation of the externally-focussed components of the Strategy.
- Section 8 draws key findings of the research together in a discussion of some of the challenges to, and opportunities for, mainstreaming in the City.
- Section 9 extracts key lessons about HIV/AIDS mainstreaming from the experience of the City of Cape Town.
- Section 10 concludes the report by offering some recommendations for strengthening HIV/AIDS mainstreaming and other aspects of the City's multi-sectoral response to HIV/AIDS.

2. Background to the Case Study

Cape Town is South Africa's third largest city by population size, the legislative capital of the country and its most popular international tourist destination. The municipality as it exists today came into being in December 2000, with the amalgamation of seven previously separate municipal administrations into a single unified metropolitan administrative structure.

The city has a total population of 3.2 million⁹, accounting for nearly 67% of the Western Cape province's 4.6 million total population. The city's demographic make-up is unique amongst South Africa's urban centres in that it has a relatively small black African population (35%), in relation to the Coloured (46%) and white (18%) populations. These demographics reflect the impact of apartheid era restrictions on African residency in the city. Like all South African cities, but arguably most visibly, Cape Town continues to bear the scars of Group Areas planning, with the vast majority of the city's African and Coloured population being consigned to the urban periphery. Addressing the continuing legacy of gross neglect of investment in housing, infrastructure and social services in the African and Coloured townships during apartheid is arguably the overriding challenge facing the city's government.

Table 1: Access to basic services, Cape Town (2001 Census data)		
% of households with piped water on site	84.4%	
% of households with flush toilet	87.5%	
% of households with electricity supply	88.8%	
% of households with weekly refuse removal	94.2%	

Source: City of Cape Town IDP 2006/07 2006:28.

Cape Town is characterised by some of the most severe inequalities amongst its residents of any city or town in South Africa. While the city is home to many of the country's wealthiest residents, whose quality of life rivals the best in the world, a large proportion of the city's citizens struggle to achieve even the most rudimentary standards of living. Statistics indicate that just under one fifth (19.7%) of the city's working age population are unemployed¹¹ and approximately one third (33%) of households are estimated to be earning incomes below the Household Subsistence Level of R1600.¹²

Decent housing is arguably the greatest need in the city, with an estimated backlog of over 265 000 housing units, which is growing by some 16 000 units annually, as an estimated 48 000 people from other parts of the Western Cape and other provinces stream into the city each year.¹³ The phenomenon of households splitting, which can be partly attributed to the impacts of HIV/AIDS, is likely to be further contributing to the growing housing backlog. In recent decades some of the largest informal settlements in the country have sprung up in and around the city's more established African and Coloured townships; according to the city's Integrated Development Plan (IDP) for 2006/07, almost 1 million people (nearly a third of the city's population) are estimated to be living in approximately 195 informal settlements throughout the city.¹⁴ As the IDP notes, this situation constitutes a 'social and welfare time bomb.'¹⁵ An estimated 50 000 households do not have access to adequate sanitation, while 9 000 households do not have access to a basic water supply.¹⁶ Achieving integrated housing development with sustainable access to affordable basic services, along with providing residents with access to efficient and affordable public transport, economic opportunities and community facilities, are thus burning governance challenges confronting the city.

Against this backdrop, the City has also had to confront the wide-ranging developmental consequences of HIV/AIDS, as well as the worst TB epidemic in the country. The City's Multi-Sectoral HIV/AIDS/TB Strategy was conceptualised and initiated in 2000, making Cape Town one of the first municipalities in South Africa to formulate a comprehensive policy response to HIV/AIDS.¹⁷ That the Strategy emerged at this particular time may be considered significant in at least two respects. Firstly, the local government elections that took place in December 2000 marked the end of an intense period of restructuring and transformation of the local government system and the inauguration of the final demarcation of the country's 284 new municipalities.¹⁸ It also signalled the beginning of a 'final phase' of local government transformation, in which South Africa's new local authorities were expected to take on a wide-ranging new mandate of developmental responsibilities. In this context of upheaval and change within the local government system, few municipalities at the time had the

organisational capacity – or the foresight – to recognise that the HIV/AIDS epidemic, if not already having an impact, would soon begin to have an impact on their own functioning as organisations as well as on the communities they serve. ¹⁹ Even fewer municipalities at the time grasped the obligation upon them as 'developmental local governments' ²⁰ to play an active and strategic role in driving the response to HIV/AIDS at the local level. ²¹ Because the White Paper on Local Government provided no guidance in this regard, this was perhaps hardly surprising.

A second notable feature of the timing of the emergence of the City's HIV/AIDS Strategy in 2000 was that at the time, at national level, the government's policy response to HIV/AIDS was characterised by a lack of leadership, ambivalence and inertia, as well as confusing and damaging messages about the causality between HIV and AIDS.²² Although, after much pressure from civil society and even from within its own ranks, the government released a National HIV/AIDS and STI Strategic Plan for 2000 – 2005 in 2000, it was slow to begin full implementation, especially with regard to the provision of anti-retroviral treatment (ART).²³ Without clear and decisive direction from national government, and given the highly politicised nature of the HIV/AIDS challenge confronting the country, most municipalities were slow in responding to HIV/AIDS.²⁴ Even where municipal leaders recognised the need to take proactive measures to address the increasingly visible effects of the epidemic in their municipalities, the apparently sceptical and denialist attitude towards the epidemic publicly displayed by many of the most senior ruling party leaders is likely to have had a negative influence on their approach to the epidemic.

Apart from the historical context in which the City's response to HIV/AIDS emerged, there are a number of other aspects that make it an interesting and instructive case study to document and analyse. For one, Cape Town is in several respects unique amongst other South African cities in terms of its historical, demographic and socio-economic characteristics. One of the consequences of its uniqueness is an apparent perception amongst many observers that HIV/AIDS is less of a concern for the people and the government of the city than in other municipalities in South Africa. As this report shows, however, available statistics indicate that while the prevalence rate of HIV may be lower for the overall population of the Cape Town metropolitan area than for most other large cities in South Africa, there are significant pockets within the city where rates are as high, and even significantly higher, than those in other major centres in the country. Statistics also indicate that the rate of new HIV infections has been rising at a steady rate over the last few years.

Another noteworthy feature of the City of Cape Town is that it has the highest prevalence of tuberculosis (TB) in South Africa, with some areas within the city recording amongst the highest TB prevalence rates in the world. Given the well-established relationship between HIV/AIDS and TB, this has significant implications for the spread of HIV/AIDS amongst the city's residents, as well as for the approach required in dealing with the epidemic in the city. It is precisely for this reason that the prevention and treatment of TB forms an integral component of the City's HIV/AIDS Strategy.

Finally, politically, the City of Cape Town has experienced a turbulent recent history, with political leadership of the city having see-sawed dramatically between political parties with each municipal election and party floor crossing period.²⁵ This makes it unique amongst the country's six major metropolitan municipalities, which have by and large enjoyed stable political leadership since 2000.²⁶ Internationally, most examples of effective local government responses to HIV and AIDS emphasise the importance of strong political leadership. In the case of the City of Cape Town, the question to be asked is therefore whether, and how, the political dynamics within the city have impacted on its response to the HIV/AIDS epidemic. Some observers have argued, for example, that the fact that the city had an opposition-controlled municipal council that was eager to demonstrate an alternative approach to the ruling party in national government's stand on HIV/AIDS was a significant contributing factor in the City being one of the first municipalities in the country to introduce a comprehensive HIV/AIDS Strategy in 2000.²⁷ It is also notable that Cape Town was the first municipality to begin providing anti-retroviral treatment to HIV-positive residents in 2002, when the national Department of Health had not yet started rolling out its treatment programme.²⁸

3. HIV/AIDS and Local Government

This section is intended to provide readers with a conceptual framework for understanding the impacts of HIV/AIDS on local government and the ways in which local government can respond to the epidemic. It also outlines how the concept of mainstreaming HIV/AIDS can be understood and implemented within the local government context.

3.1 Impacts and responses

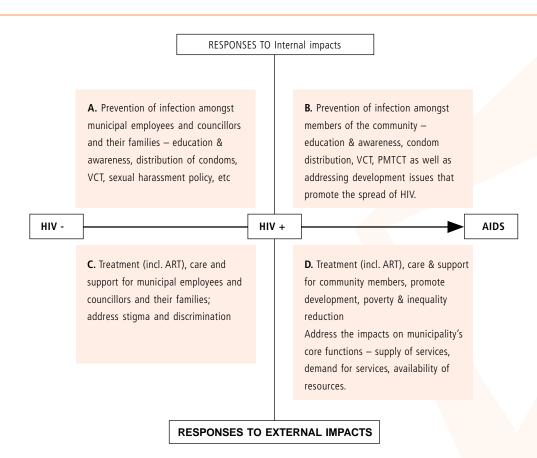
The impacts of HIV/AIDS on local governments are normally understood and analysed from two perspectives: firstly, how HIV/AIDS impacts on local governments as *organisations*, whose staff may either be infected or affected by the epidemic, with associated implications for staff absenteeism, turnover, lower productivity, reduced capacity for service delivery, and financial costs to the municipality in terms of, for example, greater spending on recruitment and training of new employees. The impacts of HIV/AIDS may also be considered in relation to political decision-making processes within the municipality, where municipal councillors may be infected or affected.²⁹

The second perspective from which the relationship between HIV/AIDS and local government is usually examined is that of the impacts of HIV/AIDS on the residents of municipalities and the resulting implications for the demand for, and supply of, services that municipalities provide. On the demand side, HIV/AIDS can be expected to result in a greater demand for municipal services and support, such as health care, poverty alleviation, and indigent concessions. In addition, the nature of services required by residents may change as a result of HIV/AIDS. For example, within the health sector, there is likely to be more demand for palliative care and support.

On the supply side, the ability of municipalities to provide services on an efficient and sustainable basis can also be affected by the impacts of HIV/AIDS on communities. For example, apart from the fact that greater demand for particular services may require a reprioritisation of budget allocations, municipal revenue generated through local rates and taxes may be negatively affected as a consequence of higher rates of unemployment and poverty within households, as well as impacts on businesses and declining local economic growth rates. The quality of services supplied by municipalities may also be negatively affected, as extra pressure is placed on staff and often limited resources. Local governments also need to procure services from companies and agencies outside of the municipality. The impacts of HIV/AIDS on vendors therefore also need to be taken into account when considering the ability of local governments to function and provide services efficiently.

As indicated in Figure 1, it is useful to understand the impacts of HIV/AIDS, and the responses required by local government, in terms of the progression of the disease from people having an HIV-negative status, through to contracting HIV, and then ultimately becoming ill or dying as a result of AIDS (the horizontal axis). The vertical axis indicates the internal impacts (within the municipality itself) and external impacts (in communities) of HIV and AIDS and the responses required at different stages of the disease. Each of the boxes, A to D, indicate the key responses required from a municipality as the disease progresses amongst individuals within the municipality as well as within the broader community within the municipality's jurisdiction.

Figure 1 highlights the importance of the distinction between HIV and AIDS and the fact that the impacts and responses required will be determined by the stage of disease (what has been termed the 'disease dynamic'³⁰). It is therefore critical for municipalities to know the status of the epidemic in the municipality, as well as in different areas within the municipality, in order to inform the specific types of services and interventions required to respond effectively. The collection of detailed, locally specific data on HIV/AIDS is a challenge faced by many municipalities, particularly smaller municipalities with lower capacity to implement systems for data collection.³¹



Source: Adapted from Barnett and Whiteside 2002:298

Figure 1: Conceptualising HIV/AIDS and local government: Impacts and Responses

In South Africa, as is the case in the rest of sub-Saharan Africa, HIV is predominantly transmitted through sexual relations between men and women.³² Therefore, prevention efforts should be targeted at changing sexual behaviour that puts individuals at risk of HIV infection. Since HIV is mainly spread through heterosexual sexual encounters, the prevention of transmission from mother to child is also a critical element of any prevention strategy.³³ What is generally less well understood and factored into the design of HIV prevention strategies is that the socio-economic development context, as well as factors such as culture and religion, play a significant part in determining how and the extent to which HIV spreads amongst any given population. As Van Donk points out, the conventional 'ABC' approach to prevention (Abstain, Be faithful to one partner, use Condoms),

'assumes that sexual behaviour is a matter of rational individual choice. In reality, sexual behaviour itself is influenced by a range of factors, which include social, cultural, economic, political and technological factors.

These factors further determine the extent to which people can access and use methods of HIV prevention, such as condoms, mutual faithfulness and abstinence.'34

Thus, calls have been made to understand efforts aimed at preventing the spread of the disease within the broader context of development, or what has been termed the 'social ecology' of HIV/AIDS.³⁵ Accordingly, while local government HIV prevention strategies need to include interventions intended to encourage individuals to adopt safer sexual practices, they also need to address the range of 'environmental' factors that determine the context within which individuals exercise, or are unable to exercise, decisions about their sexual behaviour. Local government, by virtue of its proximity to citizens and the range of services it typically provides, is well placed to play a central role in preventing the spread of HIV and mitigating the impacts of the HIV/AIDS epidemic. Amongst the key roles that have been identified for local government are³⁶:

- Providing leadership
- Coordinating the local response to HIV/AIDS by NGOs, the private sector and other government agencies (this can be promoted through a multi-sectoral forum/network)
- Identifying local responses and resources and gaps
- Creating and coordinating local referral networks for HIV/AIDS related services
- Developing a local response plan in consultation with all stakeholders
- Facilitating the local response by identifying and removing obstacles to action and promoting participation and partnerships
- Integrating HIV/AIDS into all aspects of its work (i.e. mainstreaming) and encouraging others to do the same
- Advocacy and mobilisation, e.g. promoting awareness and openness about HIV/AIDS
- Supporting community responses through funding and/or technical assistance, or making underutilised facilities or buildings available to community AIDS service organisations
- Monitoring the epidemic and the effectiveness of local responses.

3.2 Mainstreaming

3.2.1 Key concepts

'Mainstreaming' HIV/AIDS has increasingly been promoted as the preferred approach to addressing the development implications of the epidemic by governments and other development agencies in recent years. One of the main attractions of mainstreaming is that it offers all development agencies, not only those working in the health sector, with a practical and effective approach to understanding and responding to both the direct and indirect causes and effects of HIV/AIDS.³⁷ Outside of the context of HIV/AIDS, the concept of mainstreaming has been applied to a range of other cross-cutting development concerns, such as gender inequality, poverty and disability.³⁸

In essence, mainstreaming HIV/AIDS requires organisations to analyse how HIV/AIDS impacts on themselves as organisations and on their work, currently and in the future, and to determine how they can respond in terms of their *core* work and with their comparative advantages.³⁹ The concept of mainstreaming is based on the recognition that HIV/AIDS is a problem of underdevelopment and inequitable development. Short of a vaccine or cure for HIV/AIDS being developed, the most effective long-term solution is sustained, equitable development, which requires the involvement of all development sectors.⁴⁰

A useful distinction has been made between *internal* and *external* mainstreaming. Holden⁴¹ defines *internal* mainstreaming as: 'Changing policy and practice in order to reduce the organisation's susceptibility to HIV infection and its vulnerability to the impacts of AIDS.' Mainstreaming HIV/AIDS internally entails two elements: AIDS work with staff – for example education, VCT and treatment – and changing the ways in which the organisation functions in the context of HIV/AIDS, through, for example, adapting policies and procedures.⁴²

External mainstreaming can be defined as:

'Adapting development and humanitarian programme work in order to take into account susceptibility to HIV transmission and vulnerability to the impacts of AIDS. The focus is on core programme work in the changing context created by HIV/AIDS.'43

Two concepts that are important in understanding HIV/AIDS mainstreaming are *susceptibility* and *vulnerability*. Susceptibility refers to the probability of individuals or groups of people becoming infected with HIV. Susceptibility is determined by a host of biological, behavioural and social factors. Women, for example, tend to be biologically more susceptible to HIV infection than men, while their unequal social status in most societies can significantly constrain the choices women have open to them to determine with whom they have sexual relations and the safety thereof. Other factors that put individuals or groups at higher risk of contracting HIV include access to adequate health services, infection with sexually transmitted infections (STIs), poverty, cultural norms and practices, and levels of social cohesion and conflict within society.

Vulnerability can be defined as the likelihood of HIV/AIDS having negative impacts on individuals, households, organisations or entire societies. The effects of sickness and death due to HIV/AIDS may have negative impacts such as impoverishment, the breakdown of family structures and the further marginalisation of

women. The degree to which individuals or groups are vulnerable to such negative impacts also tends to be related to a number of well-established factors, such as poverty, access to livelihood assets, access to social capital, household size and composition, and access to support from the state and other agencies (see Box 1).⁴⁴

Mainstreaming HIV/AIDS requires both susceptibility and vulnerability to be taken into account. By mainstreaming HIV/AIDS, an organisation should take measures to reduce the susceptibility of its staff and its vulnerability to the negative consequences of HIV/AIDS. In the case of local governments, they should also implement measures to reduce the susceptibility and vulnerability of the residents of the municipality through all the means at their disposal. Equally importantly, mainstreaming also means that municipalities — encompassing all their component service departments — need to be constantly vigilant that in whatever they do they do not inadvertently *increase* the susceptibility or vulnerability of communities, or of their own staff.

For the purposes of mainstreaming, the connections between HIV/AIDS and poverty and between HIV/AIDS and gender inequality are particularly important. It can be argued that mainstreaming HIV/AIDS is as much about addressing poverty and gender inequality as it is about generating awareness about and preventing the spread of the disease and addressing its health implications. In the case of poverty, it is widely recognised that the poor are disproportionately affected by HIV/AIDS, through being generally more susceptible to infection, as well as being typically least prepared and able to recover from the livelihood and other shocks to individuals and households that typically occur as a result of HIV/AIDS. By eroding livelihoods and the asset bases of poor households, HIV/AIDS plays a major role in exacerbating household poverty.

The unequal power relations that characterise the relationship between men and women in most societies are also often noted as a key factor in the fight against HIV/AIDS. Women and girls typically face a much greater susceptibility to HIV infection as a result of numerous biological and social factors. In many contexts, for example, women are unable to negotiate safe sex or stigma makes them less likely than males to seek treatment for STIs. Women and girls are also more likely to be victims of sexual violence. In addition, women and girls typically bear the brunt of the negative impacts of HIV/AIDS; for example, girls are more likely than boys to be taken out of school to care for a sick household member or to go to work to bring in an income for the household. The close link between poverty and gender also needs to be recognised, with the burden of poverty being well known to fall disproportionately on women and girls. Women and girls are also typically more likely to be forced by poverty into situations that make them more susceptible to HIV infection, such as commercial sex work or seeking 'sugar daddies.' HIV/AIDS therefore tends to have a greater negative affect on women, and exacerbates the inequalities that exist between men and women.

The importance of raising the issues of poverty and gender inequality in the context of the discussion of mainstreaming HIV/AIDS is to emphasise, as Holden⁴⁶ argues, that the fight against HIV/AIDS is essentially a fight against underdevelopment and inequality, particularly gender inequality. While prevention and medical treatment are vital in any effort to stem new infections and to prolong the lives of those living with AIDS, the long-term goal of eradicating poverty and under-development remains key to addressing the challenges posed by the epidemic. With regard to mainstreaming HIV/AIDS in local governments, besides prevention and medical care efforts, all interventions aimed at reducing poverty in all its multi-dimensional aspects as well paying particular attention to improving the status of women in society, through local government's developmental mandate, have a vital role to play in combating the epidemic.

3.2.2 Mainstreaming HIV/AIDS in practice

While there are relatively few documented case studies of HIV/AIDS mainstreaming in local government,⁴⁷ there is a growing body of case studies from other sectors — governmental and non-governmental — from which to learn about how mainstreaming can be implemented in practice and how it can be applied to the local government context.

The concepts of *internal* and *external* mainstreaming provide a starting point for understanding what local governments need to do in order to mainstream HIV/AIDS. The figure below provides a useful typology of the various kinds of interventions that organisations – in this case, municipalities – might implement as part of their responses to HIV/AIDS.

AIDS work: Interventions that are directly focussed on HIV prevention, AIDS treatment, care or support and implemented separately from the organisation's existing core work.

Integrated AIDS work: Interventions focused on prevention, treatment, care or support but which are implemented alongside, or as part of, the organisation's core work.

Internal mainstreaming: The organisation adapts its internal policies and practices to reduce the organisation's susceptibility and vulnerability to HIV/AIDS currently and in the future.

External mainstreaming: The organisation adapts its core work to take into account the changing context of HIV/AIDS susceptibility and vulnerability facing those with whom the organisation works.

Source: Adapted from Holden 2004:15 - 23.

Figure 2: A typology of organisational responses to HIV/AIDS

As is the case with the standard responses to HIV/AIDS by most organisations, the responses by most local governments are likely to fall within the top two typologies, namely AIDS work or integrated AIDS work. These responses would typically include projects or programmes, implemented directly by municipalities or supported by them, that aim to generate greater awareness about HIV/AIDS, encourage local residents to get tested for HIV, provide treatment, support and home-based care. In the case of more integrated AIDS work, such work may be incorporated into existing programmes. For example, the department responsible for revenue collection within a local government may print information about HIV/AIDS services offered by the local government on billing statements, or municipal vehicles may be adorned with HIV awareness messages. However, while such interventions may be of value in themselves in the fight against HIV/AIDS and may form part of a mainstreamed response to HIV/AIDS, mainstreaming requires municipalities to take a more fundamental look at the ways in which HIV/AIDS is likely to impact on the organisation itself and its functioning, at the present time and in the future, as well as on the residents the municipality exists to serve.

Key questions for mainstreaming

The following key questions are intended to assist leaders and managers within municipalities to think through the process of mainstreaming HIV/AIDS internally and externally:

Internal mainstreaming:

- 1. What are the impacts of HIV/AIDS on municipal staff currently (in terms of absenteeism, mortality, decrease in productivity, loss of morale, loss of skills etc.), and what are the projections for future impacts?
- 2. What can be done to reduce the risks of staff becoming infected with HIV and to support staff members and their families who are already living with HIV/AIDS?
- 3. How can the impacts of HIV/AIDS on the functioning of the municipality be minimised? (i.e. what changes to policies, procedures or systems might be needed to ensure that the municipality can continue to function effectively in the face of the HIV/AIDS epidemic?)

External mainstreaming:

- How does HIV/AIDS affect the people the municipality works with (who are the 'clients' or 'beneficiaries' of each municipal department)?
- What are the changing needs of clients as a result of HIV/AIDS?
- What can each department do, as part of its *core* business, to respond to these changing needs?
- How might the work of each department increase (or decrease) susceptibility and vulnerability of households/ communities to HIV/AIDS?
- What are the comparative advantages of each department in responding to HIV/AIDS? (i.e. reducing susceptibility and vulnerability in communities)

Sources: Adapted from Elsey and Kutengule 2003

Mainstreaming HIV/AIDS does not mean that municipalities have to fight the battle alone, or that local government approaches have to attempt to cover every aspect of a comprehensive response to HIV/AIDS. While municipalities might take the lead in driving and coordinating the local response to HIV/AIDS and in delivering certain medical and developmental services, there will be certain interventions that might be better left to other role players to implement, for example organisations within civil society, such as local NGOs or CBOs. Local government might play an active role in supporting these organisations financially or in other ways, or might refer residents to these organisations for the services they require. This is what has been termed 'complementary partnerships,' where organisations focus on their core strengths, while linking up with other organisations that complement what they can offer.⁴⁸

The institutional location of the responsibility for coordinating HIV/AIDS responses has been identified as a critical consideration with regard to mainstreaming efforts, and applies equally to local government as to other spheres of government and organisations. In many cases, the responsibility for planning and driving municipal responses to HIV/AIDS has been allocated to municipal health departments. While in itself this is not necessarily an obstacle to mainstreaming, concerns may be raised that this merely serves to further entrench notions of HIV/AIDS being purely a health concern, as well as the practical consideration of whether one line department has the institutional 'clout' to be able to direct an integrated HIV/AIDS programme across other line departments with more or less the same institutional status within the municipality. For this reason, many municipalities have opted to locate the function of HIV/AIDS coordination within the most senior administrative office in the municipality, namely the municipal/city manager's office, or the most senior political office, the Mayor's office. 49 An area of further research required is whether, and how, the various institutional options for locating the driver of HIV/AIDS mainstreaming within municipalities has an impact on the effectiveness of mainstreaming efforts. Some observers have pointed out that, from a national perspective in South Africa, the goal of mainstreaming HIV/AIDS has not been advanced as a result of a tension between, on the one hand, an acknowledgement of HIV/AIDS being not only a health issue and a stated commitment to integration and coordination of services, and on the other hand, the continuing control of the country's HIV/AIDS policies and strategies by the National Department of Health, with little apparent tolerance for divergent positions. This has been compounded by the

weakness and inaction of national coordinating structures such as the South African National AIDS Council (SANAC). As Quinlain and Willan point out, "the net effect is to restrict the scope for coordination of government actions, let alone mainstreaming1/4" 50

There is widespread consensus that political leadership and commitment are critical to success in addressing HIV/AIDS.⁵¹ In order to achieve the kind of integration and coordination required of mainstreaming, political leaders and senior officials within local governments need to understand the full spectrum of impacts of HIV/AIDS on the municipality, the municipality's mandate and obligations in response to HIV/AIDS, and how to effectively mainstream its response. While most municipal political leaders and managers would acknowledge HIV/AIDS as a cause for concern and list HIV/AIDS amongst their highest priorities, few, if any, municipalities appear to have succeeded in implementing comprehensive mainstreamed responses to HIV/AIDS.

Guiding principles for mainstreaming

Based on learning from a range of international experiences, the following seven principles have been identified for successful mainstreaming:

- 1. Approach mainstreaming as an ongoing learning process, not a one-off event
- 2. Involve employees as active participants in both internal and external mainstreaming initiatives
- 3. Involve people who are affected by HIV/AIDS since mainstreaming should respond directly to their experiences
- 4. Address gender-related issues throughout since gender and HIV/AIDS are always connected
- 5. Learn from, and link with, other agencies that are also mainstreaming HIV/AIDS and who can provide advice and assistance
- 6. Make changes as appropriate and practical, both internally and externally
- 7. Monitor progress with mainstreaming actively

Source: Holden 2004:57-59.

3.2.3 Mainstreaming HIV/AIDS and Integrated Development Planning

The Local Government: Municipal Systems Act of 2000 introduced a fundamentally new approach to planning and budgeting at local government level in South Africa, known as Integrated Development Planning (IDP). In terms of the Act, it became compulsory for all municipalities to formulate a single IDP document that would apply to the entire area under the municipality's jurisdiction and which would be the 'principal strategic planning instrument which guides and informs all planning and development, and all decisions with regard to planning, management and development, in the municipality.'52 IDP documents, which are reviewed annually, are expected to contain, amongst other elements, an assessment of the current social, economic and environmental state of the municipality, an assessment of community needs (derived by means of public participation), a prioritisation lof these needs, a development vision for the municipality, an audit of available resources, skills and capacities, strategies to achieve the development goals set out, with programmes and projects to implement these strategies, a three-year financial plan and key performance indicators and performance targets.⁵³

The IDP should be the principal planning vehicle for mainstreaming HIV/AIDS, since it is the overall plan that is supposed to guide all development that takes place within a municipal area. This should also include development interventions and services delivered by other spheres of government (e.g. provincial government departments). Integration of HIV/AIDS into municipal IDPs is also critical since all municipal budget allocations should be made directly on the basis of the contents of the IDP. In simple terms, what is not included in the IDP should not receive resources from the municipal budget.

The incorporation of HIV/AIDS responses into IDPs, let alone mainstreaming, has, however, posed a challenge for most municipalities in the country. In the majority of cases, HIV/AIDS has been addressed purely from a health perspective, with HIV/AIDS components usually only being reflected in the health component of the IDP. Often there is little understanding evident from municipal IDPs of the impacts of HIV/AIDS on the service delivery capacity of municipalities, or of the role that sector departments other than health can play in the reduction of vulnerability, prevention and mitigation of the impacts of the disease.

4. HIV/AIDS in the City of Cape Town

The importance of data on the status and characteristics of the HIV/AIDS epidemic at local level in guiding local government responses was referred to in the previous section. This section seeks to provide an overview of available information on the current and historical situation in the City of Cape Town regarding HIV/AIDS incidence, prevalence and impacts. Providing an accurate and coherent picture of the status of HIV/AIDS is usually a difficult undertaking in most South African municipalities due to a lack of easily available, localised data. In the case of Cape Town, the city has a relatively well-established and sophisticated system for collecting and analysing data on HIV and TB testing and treatment. As is the case with national data, the primary method for tracking HIV prevalence is through surveillance of women using public antenatal health facilities (both provincial and municipal health facilities). Some of the difficulties with collecting and analysing data reported by health officials were the absence of mechanisms for gathering data for specific population groups⁵⁴, the redemarcation of health sub-district boundaries, which has complicated the collation of data between municipal and provincial health facilities at sub-district level and high rates of mobility of the population of the city, which makes it more difficult to reliably map HIV prevalence in different areas.

4.1 Incidence and prevalence of HIV/AIDS

Based on antenatal surveillance data, which has been extrapolated to the general population, the average HIV prevalence rate for the City of Cape Town as a whole is currently estimated to be 16%.⁵⁵ However, as the data in table 2 below indicates, prevalence rates vary dramatically across different areas in the city. The highest rates of HIV infection in the city are found in the traditionally black African townships: Khayelitsha, the largest township in the city, has the highest prevalence rate, at almost 33%, or one out of every three adult residents; Gugulethu and Nyanga, two other major township areas, have the second highest prevalence rate, at a combined 29%. These three areas all have a significant proportion of residents who live in informal dwellings, which correlates with national survey findings that show that the locality type with the highest rate of HIV prevalence (25.8%) is urban informal settlements.⁵⁶ As might be expected, the lowest prevalence rates tend to be found in areas of the city with higher levels of socio-economic development, such as Blaauwberg and the city centre. One anomaly, however, appears to be Mitchells Plain, an area in which there is widespread poverty, which has the lowest recorded infection rate of all the areas, at 5%.⁵⁷

One of the problems with the data collected through antenatal surveillance is that it does not pick up residents who make use of private health care facilities. It may be possible, therefore, that HIV prevalence could be higher than currently estimated in some of the more developed parts of the city.

Table 2: HIV prevalence i	n the City of (Cape Town by a	area, 2003 - 2005
Area	2003	2004	2005
Blaauwberg	4.4	1.2	7.3
Cape Town Central	11.6	13.7	11.5
Greater Athlone	10.1	16.4	17.7
Helderberg	19.1	18.8	12.8
Khayelitsha	27.2	33.0	32.5
Mitchells Plain	6.3	12.9	5.1
Gugulethu/Nyanga	28.1	29.1	29.1
Oostenberg	16.1	14.8	16.2
South Peninsula	9.3	10.8	12.4
Tygerberg Eastern	7.9	12.7	15.2
Tygerberg Western	8.1	15.1	15.0

Source: Caelers 13/09/06

An important observation about the figures in the table above is that the epidemic is at different stages of development in different areas of the city. ⁵⁸ In Khayelitsha, Gugulethu and Nyanga, where the rates of infection are highest, the epidemic appears to be mature and has been relatively stable in recent years. In other parts of the city, for example, the Tygerberg Eastern area, the epidemic appears to still be developing, with a relatively constant increase in recent years. In other areas, the prevalence rate appears to have declined steadily, such as in Helderberg where the rate has dropped from 19.1% in 2003 to 12.8% in 2005.

The differences in the characteristics of the epidemic in different parts of the city need to be taken into account in responding to the disease. The data reveals that there are effectively 'sub-epidemics' throughout the city that require different approaches in terms of the relative emphasis on vulnerability reduction, prevention, treatment and mitigating the impacts of the disease.⁵⁹

Data on HIV prevalence that is derived from antenatal surveys and extrapolated to general populations has obvious limitations in terms of how much detail it can reveal about the characteristics of the epidemic amongst different groups and sub-groups within society. In the case of Cape Town, for which data is drawn almost exclusively from antenatal sites, there is little, if any, reliable data available on HIV incidence and prevalence rates amongst different race groups, religious and ethnic groups and the local gay community.

Despite the limitations of the data available, what is very clear from what is known about HIV/AIDS in the City of Cape Town is that it constitutes a serious human and socio-economic threat. The overall estimated prevalence rate of 16% (or roughly 1 in 6 residents), only slightly below the national average, is in itself a significantly high rate, while the prevalence rates for Khayelitsha and other townships represent a potential human catastrophe if not addressed with the urgency required. It is also clear that the epidemic is growing at a significant rate. The HIV prevalence rate amongst antenatal attendees in 2000 was 8.8%. By 2004, this figure had almost doubled, to 16.9%.⁶⁰

Available evidence therefore points to a high and increasing prevalence of HIV/AIDS in Cape Town, which contradicts what appears to be a widespread perception that HIV/AIDS is not yet an issue of serious concern in the city.

4.2 Factors driving the HIV/AIDS epidemic in Cape Town

As is the case in any municipal area, in the City of Cape Town a variety of generic and locally specific factors can be identified to explain the characteristics of the HIV/AIDS epidemic. Key among these factors are the following:

- Poverty and underdevelopment: Poverty, underdevelopment and high levels of inequality and insecurity within society are well-known contributing factors to the HIV/AIDS epidemic.⁶¹ The physical environments within which people live are vital in shaping the choices that are available to them and the context within which they are able to make decisions about their sexual behaviour. According to official figures in the City's IDP, just under a third of the city's citizens live in poverty.⁶² While this average figure is in itself high, it disguises massive inequalities within the City. In Khayelitsha, for example, a township of approximately half a million residents, more than 55 per cent of the population is estimated to live below the poverty line. With poverty often comes a lack of access to even the most basic services and infrastructure required for human health. For example, in two areas of Khayelitsha, Sites B and C, it has been reported that there are an average of 105 people per toilet, or one toilet for seven households to use. Approximately 80% of residents in Khayelitsha live in informal dwellings.⁶³ Such living conditions significantly undermine people's general health status and make it especially difficult for people living with AIDS to stay healthy. Overcrowded, poorly ventilated, damp and unsanitary living conditions, as well as the dense nature of informal settlements, also substantially increase the transmission of TB.⁶⁴
- High rates of migration: There is a well-established link between the spread of HIV/AIDS and high levels of migration and urbanisation as these trends are often associated with a loss of social support and cohesion, as well as with increasing poverty as many of those who migrate to cities in search of work find few economic opportunities available to them. The City of Cape Town has been particularly affected by migration. Between 1997 and 2001 the City of Cape Town recorded the highest net migration of any of the nine major urban areas in South Africa, with 192 623 people settling in the city during this period.⁶⁵ According to the municipality's available data, between 1996 and 2001 migration accounted for 58% of population growth in the city.⁶⁶ A large proportion of these migrants add to the growing populating living in informal settlements, where conditions are most conducive to the transmission of HIV. The increasing numbers of new residents in

- the city is also likely to add extra pressure on health services that are already overburdened in many areas.
- Access to health services: While Cape Town's health infrastructure is better than in most other cities in the
 country, accessing health services remains a challenge for many of the city's poorer residents. This is due to a
 variety of factors, including the high cost of public transport, the fragmented spatial nature of the city, with
 barriers in the form of highways and railways preventing people from easily and safely getting to clinics, and
 overcrowding at some health facilities.⁶⁷
- Tuberculosis: There is strong evidence that TB is a key factor fuelling the HIV/AIDS epidemic in the city. The TB epidemic itself has reached crisis proportions in the city, which has been attributed to overcrowded and inadequate housing, under-nutrition and, increasingly, HIV/AIDS.⁶⁸ In 2005, 26 794 patients were treated for TB in Cape Town, making it the city with the highest number of TB cases anywhere in the country.⁶⁹ TB incidence (all types) in the city is currently 800/100 000 population, whereas the national figure is 500/100 000.70 In 2004, 1 138 people died of TB.71 There has been a dramatic increase in TB cases in the city over the last few years, with a reported 39% increase in caseloads between 2000 and 2004.72 While the City of Cape Town has the highest cure rate for new smear positive TB in the country (71%), it is believed that a target of 85% needs to be achieved in order to have a significant impact on the TB epidemic.⁷³ Two out of every three TB clients reporting to city clinics are also HIV-positive.⁷⁴ In some areas of the city the co-infection rate is estimated to be even higher. The areas of the city with the highest incidence of TB, namely Khayelitsha and Nyanga, also have the highest rates of HIV infection in the city. In Khayelitsha, it has been reported that 74% of TB patients are also HIV-positive. In Site B, sub-area of the township, nine out of ten TB patients were found to be HIV-positive.75 There has been an alarming increase in cases of extra-pulmonary TB (187% over the last four years), mostly in Khayelitsha and Nyanga, which has been linked to co-infection with HIV.76
- Unprotected sexual activity: The main method of HIV transmission in South Africa (and Cape Town) is
 unprotected sexual intercourse. Amongst teenagers in particular there are relatively high rates of unprotected
 sexual activity, as manifested by high rates of teen pregnancy. Social norms that result in resistance to the use
 of condoms and tolerance for multiple sexual partners also contribute to a high-risk environment.⁷⁷

Other important factors believed to be contributing to the spread of HIV/AIDS in the city include⁷⁸:

- High rates of Sexually Transmitted Infections (STIs)
- High rates of sexual violence against women and children
- Gender inequality and discrimination
- Commercial sex work
- High levels of drug and alcohol abuse
- Stigma and discrimination
- An increasing number of young women having older male partners (the so called 'sugar daddy' phenomenon)

HIV/AIDS and TB in the Western Cape

The City of Cape Town is located in the Western Cape Province, which has traditionally recorded the lowest rates of HIV prevalence out of the nine provinces in the country. The latest Department of Health National HIV Prevalence Survey, based on women attending antenatal clinics, indicates an estimated HIV prevalence rate amongst the general population of the province of 15.7% for 2005. There has been a slight recorded increase in the prevalence rate, from 15.4% in 2004, and 13.1% in 2003.¹ Over a longer period, though, a more dramatic picture is revealed. In 1994 the HIV prevalence rate for the province was approximately 1.6%; the rate of 15.4% recorded in 2004 constitutes a nearly ten-fold increase.²

Amongst all women attending antenatal clinics in the province, the highest rates of infection are amongst those between the ages of 25 and 29, with 20% (1 in 5) being HIV-positive. The prevalence of HIV amongst 15 to 24 year old women increased from 8.6% in 2001 to almost 13% in 2005. ³

As in the City of Cape Town, TB is also on the rise in the province. The number of TB cases in the Western Cape grew from 27 509 in 1997 to 47 603 in 2005.⁴ In 2005 the Western Cape had the second highest number of TB cases in South Africa, after KwaZulu-Natal, although it had the lowest TB-HIV co-infection rate amongst the provinces, at 50.4%.⁵ In 2004 it was reported that the Western Cape had the ninth highest incidence of TB in the world.⁶

Sources:

¹Department of Health 2006. ²Western Cape Department of Health 2005.

³Caelers 13/09/2006.

⁴Thom 24/03/2006.

5 Thom and Cullinan 24/03/2005.

6 Cape Argus 17/11/2004.

4.3 Impacts on mortality and socio-economic development

There are clear indications that an increasing number of people in Cape Town are dying from HIV/AIDS-related illnesses. In 2001, the recorded number of adult deaths linked to HIV/AIDS was 1 530.⁷⁹ In 2004, this figure had grown by 64%, to 2 510.⁸⁰ Since these figures reflect only those cases where the cause of death could positively be linked to HIV/AIDS, the actual number of deaths could be significantly higher. A recent population projection study predicts that the mortality rate in the city will increase from 11 per 1000 people in 2006 to 14 in 2021.⁸¹

An actuarial study commissioned by the City Health Department in 2003 predicted that by 2009, AIDS would exceed all other causes of death in the city and that the life expectancy of black Africans would drop from 55 to 40, while that of Coloured residents would fall from 65 to 55, as a result of HIV/AIDS.⁸² It is important to note, however, that the modelling for this study was done on the basis of anti-retroviral treatment not yet being widely available, and it is likely that the subsequent roll-out of the ART programme will mitigate these impacts. A more recent study conducted in 2006 predicted that the life expectancy of Africans would fall from 58 in 2001 to 52 by 2015. ⁸³

The 2006 study also suggests that the city's population growth rate is likely to slow significantly over the next fifteen years due to the impacts of HIV/AIDS as well as a decrease in migration from the Eastern Cape. According to the study, the city's population grew by approximately 700 000 between 1996 and 2006, but was expected to grow by only a further 300 000 by 2021. The growth rate was therefore expected to decline from 1.6% to 0.6%.

There appears to have been a striking increase in the number of children orphaned as a result of HIV/AIDS in the city, which represents an unfolding human tragedy and immense development challenge. In 2003 it was estimated that there were 21 000 orphans in the city; by 2004, the estimated number of orphans from AIDS was estimated to have more than doubled, to 54 000.84

Relatively little else appears to be known about the socio-economic impacts of HIV and AIDS in the City of Cape Town. No data could be located on the current or expected impacts on the local economy⁸⁵, or on the demand for health and other services. Most accounts of impacts appear to be largely anecdotal⁸⁶, suggesting an urgent need for research into the impacts across a range of social and economic sectors to guide planning and resource allocation.

4.4 Impacts on municipal staff and services

The City of Cape Town itself is one of the largest employers in the city, with a total of over 23 200 staff members. The city council has an additional 210 councillors.

From the data available from the City, it would appear that HIV/AIDS is not yet having a significant impact on municipal staff.⁸⁷ Based on the findings of the city's ongoing VCT programme, the estimated prevalence rate amongst all staff is 2.6%.⁸⁸ The total number of staff who have tested positive, as of end June 2006, is 91 (see table 3 below). However, staff involved in the City's HIV/AIDS Workplace Programme point out that the VCT initiative has only picked up those who are willing to be tested. They estimate that the true prevalence rate is probably between 6 and 8%. The infection rate amongst councillors is unknown; one of the challenges facing the HIV/AIDS Workplace programme has been to get councillors to participate in the VCT programme.

Table 3: Staff tested for HIV				
	2003/04	2004/05	2005/06	Total all years
No. of staff tested	1222	1120	1225	3567
No. tested positive	38	20	33	91
% Positive	3.1	1.8	2.7	2.6

Source: HIV/AIDS Workplace Programme: Corporate Services

In the period since November 2003 to June 2006 for which data is available, a total of 48 staff members were known to have died of causes linked to HIV/AIDS (table 4). Nine staff members enrolled in the city's treatment programme died over this period.

Table 4: Staff deaths due to HIV/AIDS				
	2003/04	2004/05	2005/06	Total all years
No. of deaths	10	19	10	39
No. of deaths in treatment programme	3	4	2	9
Total	13	23	12	48

Source: HIV/AIDS Workplace Programme: Corporate Services

The table below provides a summary of available data on staff within various departments in the municipality who have tested positive for HIV, those who are currently receiving antiretroviral treatment as part of the city's Workplace HIV/AIDS programme, and the number of service terminations and deaths recorded.

Directorate/department	Total tested	On ARVs positive	Service	Death termina
Community Development	47	10	1	2
City Health	6	2	0	1
Parks and Nature Conservation	32	6	0	1
Sports and Recreation (Social Development)	9	2	1	0
Corporate Support Services	9	1	0	0
HR Management & Support	4	0	0	0
Corporate Services	5	1	0	0
City Secretariat	1	1	0	0
Legal services	1	1	0	0
Executive Management Unit	1	0	0	1
Communications & Marketing	1	0	0	1
Operations	19	6	0	3
City Police	10	3	0	1
City Emergency Services	6	2	0	1
Human Settlement Services	3	1	0	1
Finance	9	4	0	0
Supply chain management	1	1	0	0
Revenue	8	3	0	0
Services & Infrastructure	72	20	3	4
Electricity	18	4	1	1
Water	24	5	0	1
Solid Waste	30	11	2	2
Strategy & Development	1	1	0	1
Environmental Planning	1	1	0	1
Transport, Roads and Stormwater	22	4	0	2
Other	2	0	0	0

Source: HIV/AIDS Workplace Programme: Corporate Services

Note: The reasons for service terminations include medical boarding, as well as resignations and dismissals unrelated to HIV/AIDS

As table 5 indicates, some departments appear to be more affected than others in terms of the number of staff who are HIV-positive. As might be expected, it is the departments that have more staff that have the highest number of HIV-positive members: Parks (32), Solid waste (30), Water (24) and Electricity (24). These are also departments that tend to have a higher number of staff in less skilled occupational categories (see table 6 below). It is important to note, however, that these figures represent a very small proportion of the overall workforces of these departments.

A further observation that can be made from the table is that relatively few of the staff members who are HIV-positive are currently on ART (approximately 25%). This would suggest that most HIV-positive staff are relatively healthy and do not yet need treatment. However, in the future they are likely to require treatment, which would have financial implications for the municipality's treatment programme. It is also evident that there have been very few service terminations, which may be a positive indication that HIV-positive staff are continuing to work as normal and that illness or stigma are not causing staff to leave the organisation. There also

appear to have been only a relatively small number of deaths amongst staff in the departments due to HIV/AIDS. With ART being available to staff who need it through the Workplace programme, it is unlikely that there will be a significant increase in the number of deaths in the immediate future.

Category	No. of HIV-positive staff*	Percentage of total no. of HIV-positive staff
Legislators, senior officials & managers	0	0
Professionals	1	0.5
Technicians and associated professionals	8	4.4
Clerks	22	12.3
Service & sales workers	18	10.1
Craft & related trades workers	4	2.2
Plant and machine operators & assistants	22	12.3
Elementary occupations	103	57.8
Total	178	100

^{*} For which occupational category recorded

Source: HIV/AIDS Workplace Programme: Corporate Services

The impacts of HIV/AIDS on the demand for services rendered by the municipality are not well known. In some sectors it has been clearer to see an impact than in others. For example, it appears that AIDS-related deaths have contributed to higher demand for burial space, with reports that the city's cemeteries are running out of space. The Parks and Cemeteries department has had to identify new cemeteries and other measures to create space to accommodate the demand.⁸⁹ The health sector is another sector in which the effects of HIV/AIDS are becoming increasingly apparent. One recent University of the Western Cape study on the impact of HIV/AIDS on nurses in city clinics found that HIV/AIDS has added substantially to the workload of clinic staff and has increased their levels of anxiety and stress.⁹⁰ The study reported that the challenge of HIV/AIDS was being compounded by an accelerating number of nurses leaving the public sector, decreasing productivity and a lack of adequate skills to handle patients with HIV/AIDS.

A further challenge to the city's health services is the reported phenomenon of 'treatment migration,' whereby people from other provinces, especially the Eastern Cape where health infrastructure is less developed, have been found to be moving to Cape Town specifically in order to access ART.⁹¹ Although figures on the number of people coming to the city for this reason have not been determined, this trend does appear to be placing a significant additional burden on health facilities in some areas of the city, notably as Gugulethu and Khayelitsha.

5. The City of Cape Town's HIV/AIDS/TB Multi-Sectoral Strategy

5.1 Development of the Strategy

The impetus for the City's Multi-sectoral HIV/AIDS and TB Strategy came from the City Health Department, which has driven the process from the start. The development of the strategic plan began in November 2000 with a multi-stakeholder meeting involving sixty-three representatives from a variety of sectors within the city. At this first meeting, a task team was established to develop the plan. A follow-up meeting was held in May 2001, to further develop the plan. The task team was then tasked to conduct a public participation process around the strategy through hearings at the Health and Corporate Services Portfolio Committees.

5.2 Objectives of the Strategy

The strategy is intended to be a 'broad city-wide strategic plan designed to guide the city's response to the epidemic,' that recognises that responding to HIV/AIDS cannot be confined to the health sector alone — 'all sectors need to be involved in this battle.'92 The strategy therefore aims to 'stimulate and coordinate sector action in the city,' including all departments within the municipality, as well as business, NGOs, faith-based organisations and other relevant sectors.93

The stated goals of the Strategy are to⁹⁴:

- 1. Mobilise all sectors in a developmental intervention to fight HIV/AIDS and TB;
- 2. Reduce the number of new infections (especially among the youth) through a multi-sectoral intervention strategy;
- 3. Reduce the impact of HIV and AIDS on individuals, families and communities and especially on the municipality's workforce;
- 4. Reach an 85% cure rate for new smear positive TB.

5.3 Key components

The Strategy, as contained in the original strategy document, is divided into four components: mainstreaming; mitigating the social, economic and human impacts of the epidemic; prevention, and treatment. The original strategy document notes that the format and structure of the Strategy is based on the National Department of Health's National HIV/AIDS and STI Strategic Plan for 2000 – 2005 in 2000.95

5.3.1 Mainstreaming HIV/AIDS & TB

The Strategy has sought to promote mainstreaming through two approaches. Firstly, a multi-sectoral, city-wide HIV/AIDS/TB Coordinating Committee was set up to be the primary institutional mechanism for mobilising and coordinating all sectors within and outside of the city in a multi-sectoral response to HIV/AIDS and TB. Secondly, sector departments within the city have been encouraged to formulate and implement HIV/AIDS mainstreaming plans relevant to each of their respective sectors.

In terms of the initial vision, the City HIV/AIDS/TB Coordinating Committee was to include representatives from all sector departments within the City's administration, councillors from the Health as well as other portfolio committees, staff union representatives, as well external representatives from provincial government departments and civil society organisations. The Mayoral Executive Committee member responsible for the Health portfolio is the Chair of the committee.

The functions of the Coordinating Committee are to: 96

- Coordinate the city's overall response to HIV/AIDS, both internally and externally;
- Facilitate the development of sector plans, to monitor the implementation of plans and to hold departments
 accountable for delivery;
- Lobby and advocate for resources for the implementation of sector plans and HIV/AIDS interventions;
- Create an enabling environment for the implementation of sub-district HIV/AIDS/TB plans;
- Monitor overall implementation of plans to avoid duplication or wastage of resources;
- Create a forum through which implementation problems can be identified and resolved.

The City Health Department has played a central role in organising the Coordinating Committee. It has also driven the process to encourage other sector departments in the city to develop their plans to respond to HIV/AIDS.

5.3.2 Mitigating the socio-economic impacts of HIV/AIDS

The strategy aims to address the impacts of HIV/AIDS and TB on the well-being of communities by means of local level plans that are formulated, coordinated and implemented by Multi-Sectoral Action Teams (MSATs) in each of the health sub-districts of the city. The MSATs are intended to be flexible structures that bring together non-governmental organisations, community-based organisations and faith-based organisations engaged in HIV/AIDS prevention, care and support interventions, as well as representatives from City Health and other sector departments, the District Health Forums, local councillors, local business and provincial government departments. The objectives of the structures are to facilitate networking between all these role-players at local level in order to avoid duplication of service provision and to utilise all available resources, to mobilise local community action and volunteerism, and to identify local needs with regards to HIV/AIDS and to formulate local projects to respond.⁹⁷ In addition, the MSATs serve as a conduit for local NGOs and CBOs to access funding as well as capacity building support from the City.

5.3.3 Prevention

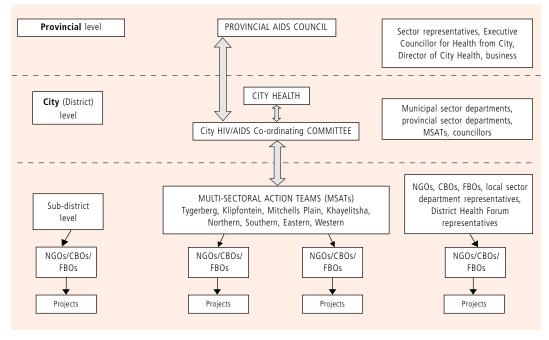
The prevention of new HIV infections is a core priority of the Strategy and is promoted via awareness raising using the ABC message (Abstain, Be faithful to one partner, and use a Condom if having multiple sexual partners or HIV-positive), as well as the distribution of condoms as widely as possible through clinics, libraries, community facilities and municipal offices. Voluntary Counselling and Testing (VCT) is made available as both a prevention strategy and an entry point to HIV care, for both residents of the city as well as City staff through the Workplace HIV/AIDS Programme. As part of the prevention strategy, the City also works in partnership with the Provincial Department of Health to implement the Prevention of Mother-to-Child Transmission (PMTCT) Programme. An important component of HIV prevention efforts is also the management of sexually transmitted infections (STIs), which have a significant impact on the spread of HIV.

5.3.4 Treatment

HIV/AIDS treatment is provided jointly by the City Health Department and the Provincial Department of Health. Currently ART is offered at twenty-five sites within the city, three of which are managed directly by the City's Health department. In addition to providing ART to residents, the City's HIV/AIDS Workplace Programme also provides free ART to municipal staff who require it but do not have medical aid cover. The Strategy document notes that the provision of treatment is both an incentive for HIV testing as well as a means of reducing mortality and orphans in the city.

5.4 Institutional set-up for implementing the strategy

Figure 3 below provides a diagrammatic representation of the various structures set up to coordinate the implementation of the Strategy and of the various stakeholders involved. The primary institutional driver of the Strategy is the City Health Department. The City HIV/AIDS Coordinating Committee acts as the main mechanism to coordinate the implementation of the strategy amongst all the stakeholders involved. The main institutional linkage from this committee, which operates at a city-wide level, to the local level is the sub-district MSATs. Projects are implemented through the member civil society organisations of the MSATs, with some support from municipal sector departments. Representation of the city at a provincial level takes place via the Provincial AIDS Council. The business sector within the City is also formally represented at the level of the Provincial AIDS Council.



Source: Adapted from City of Cape Town 2004:5.

Figure 3: Organogram of City HIV/AIDS Multi-Sectoral Strategy coordinating structures

5.5. Monitoring and evaluation

The Strategy document calls for the implementation of the Strategy to be reviewed on an annual basis, and for modifications to be made to the Strategy if necessary. 99 Ongoing monitoring of progress is conducted by the HIV/AIDS & TB Programme in the Health Directorate. Opportunities for reporting on plans and implementation by the sector departments and the MSATs are also provided at the quarterly City HIV/AIDS/TB Coordinating Committee meetings.

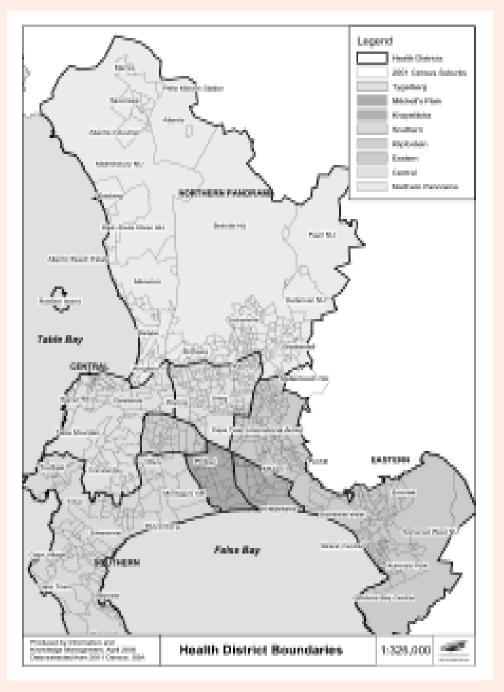
5.6 Financing the Strategy

Funding for the strategy's implementation has been secured through a combination of the City's own budget, transfers from provincial government and external grants. In the first year of the Strategy's implementation (2001/02), R10 million was allocated by the City Council to HIV/AIDS-related interventions. In the 2006/07 budget the City allocated R26.2m to HIV/AIDS and TB related interventions, of which approximately R11.5m was contributed by the Provincial Department of Health.¹⁰⁰ The city has also accessed grant funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has been used for certain components of the Strategy, such as for the MSAT coordinator positions and providing funding to community organisations.

Health sub-districts in the City of Cape Town

Following the implementation of the National Health Act (Act No. 6 of 2003), a district health system was established for the whole of the country, consisting of health districts with boundaries aligned to the boundaries of district and metropolitan municipality boundaries. Each health district is divided into sub-districts.

The City of Cape Town currently contains eight health sub-districts, namely Northern, Southern, Eastern, Western, Klipfontein, Mitchells Plain, Khayelitsha and Tygerberg. The location of these sub-districts is shown on the map below. Each sub-district contains approximately 400 000 residents.



Source: City of Cape Town 2005:159; map supplied by the Information and Knowledge Management Department, City of Cape Town

6. Review of the internal response to HIV/AIDS

This section reviews the implementation of aspects of the multi-sectoral HIV/AIDS strategy that deal with HIV/AIDS internally within the municipality. The primary internal response has taken the form of the introduction of an HIV/AIDS Workplace Policy, the implementation of which is driven by the HIV/AIDS Workplace Programme, located within the Human Resources Management and Development Department in the Corporate Services Directorate. The Health Directorate has also been closely involved in the programme, particularly in assisting with the clinical aspects of the programme.

6.1 HIV/AIDS Workplace Policy

The HIV/AIDS Workplace Policy was approved by the City Council in September 2002, with amendments to include a comprehensive treatment component being added in 2004. The policy was developed through a consultative process involving management and the two main staff unions operating in the municipality, namely SAMWU and IMATU.

The stated objectives of the policy are to 'provide a set of guidelines to address the HIV/AIDS epidemic in the world of work' and 'to manage the HIV/AIDS epidemic in the workplace by minimising the infection rate among HIV-negative employees and extending the economic lifespan of HIV-positive employees.' The policy applies to all employees and councillors.

The policy sets out the responsibilities of various stakeholders in ensuring that the policy is implemented, including the City Manager, the Corporate Human Resources Department, managers and supervisors, employees and unions. It also provides a framework for the rights of employees and how they should be treated by other employees.

The policy further outlines the approach the City will take in the event of employees being infected in the workplace, and how the City aims to prevent HIV/AIDS transmission amongst employees. Prevention interventions include making condoms freely available, educational programmes (with a specific focus on gender) and VCT. The policy also describes the eligibility of HIV-positive staff and their families to access free ART and support measures that should be available for HIV-positive staff (e.g. counselling and support groups).

Finally, the policy provides for the establishment of an HIV/AIDS Workplace Committee consisting of councillors and officials representing the city as the employer, and representatives from the two staff unions. The functions of the committee include monitoring the impact of the epidemic in the workplace, monitoring the implementation of the policy and making amendments if required, and annually reviewing the eligibility for staff to access treatment.

6.2 HIV/AIDS Workplace Programme

The City's HIV/AIDS Workplace Programme offers a comprehensive package of HIV/AIDS related services to staff, including educational programmes delivered through peer educators, VCT, comprehensive treatment, counselling and support. The programme also extends outside of the municipality by providing training to NGOs and CBOs, private companies as well as workshops in schools. The programme is implemented by a dedicated unit consisting of five staff members plus an intern psychologist, as well as peer educators and counsellors who are located throughout the City's departments.

Based purely on quantitative measurements, the Workplace Programme has achieved some impressive results in terms of educating staff about HIV/AIDS and encouraging them to get tested for HIV. Over the three year period from July 2003 to June 2006, a total of 280 peer educators and 78 peer counsellors were trained. Almost 2000 HIV/AIDS related talks and workshops were held, involving some 48 000 staff members. This indicates that a large number of staff have attended these types of events more than once. Over one million condoms have been distributed free to staff, while over 3500 staff members have taken HIV tests. While the statistics tell a story, at an individual level all these initiatives are likely to have had a significant impact on protecting more staff from the disease as well as assisting affected staff to cope.

Table 7: Key outputs of the HIV/AIDS Workplace Programme, 2003 - 2006			
	Total		
No. of peer educators trained	280		
No. of peer counsellors trained	78		
No. of talks & workshops	1991		
No. of staff reached	48 399		
% of staff attended peer education	209%		
No. of staff tested	3567 (+/- 15% of all staff)		
No. of condoms distributed	1 021 152 (+/- 57 per male staff member)		

Source: HIV/AIDS Workplace Programme: Corporate Services

The City of Cape Town was the first municipality in the country (and remains one of the few) to offer a comprehensive HIV/AIDS treatment programme for its staff, as well as for their partners and children, in cases where staff do not have private medical aid cover. In 2003 a motivation by staff in the Workplace Programme was submitted to the Human Resources Portfolio Committee, noting that in the absence of ART for staff HIV/AIDS could be expected to impact on the organisation in terms of an increase in the number of payouts from pension and provident funds, a drop in productivity amongst staff, a rise in sick and compassionate leave, and increased costs of replacing staff. The report also noted that at the time just over 5000 staff members had no medical aid cover at all, and a further 9700 had cover that would not be enough to cover the costs of treatment.

The predicted costs to the municipality of providing ART to staff who require it was R600 000 for the 2003/04 financial year (limited to 30 staff members in that year), R1.85m in 2004/05, and R2.8m in 2005/06. It was, however, pointed out that these costs were likely to be offset by a reduction in the projected increase in Group Life benefits premiums subsidised by the City, and a reduction in sick leave and other related costs. 103

Provision of ART to staff started on a pilot basis in November 2003. As of the end of June 2006, there were a total of 123 individuals (staff, partners and children) enrolled in the programme (see table 8 below). 104 Over the last three years during which the programme has been running, 39 staff members and 11 partners of staff have received ARV treatment. The figures in the table indicate that there has been a clear rise in the number of staff needing ARVs. However, it is difficult to establish over the relatively short period whether this constitutes a significant trend in terms of the development of the epidemic amongst staff or merely whether more staff members have become aware that treatment is available.

Table 8: HIV/AIDS Workplace Treatment Programme				
	2003/04	2004/05	2005/06	Total all years
No. of staff in treatment programme ¹⁰⁵	52	39	27	118
No. of partners in programme	13	8	7	28
No. of children in programme	0	1	0	1
No. of staff on ARVs	8	14	17	39
No. of partners on ARVs	3	6	2	11

Source: HIV/AIDS Workplace Programme: Corporate Services

By all accounts the workplace programme appears to be working very effectively and is achieving the desired outcomes. Some of the specific successes of the programme identified in interviews were:

- the success of the peer educator programme in mobilising hundreds of staff to become involved in the fight against HIV/AIDS and to become 'agents of change'
- the relatively high number of staff who have been tested and who know their status
- the buy-in to the programme achieved from senior and middle managers and their support for the work of peer educators
- the commitment in the municipal budget to the programme
- the number of people willing to disclose their status
- · the high quality of counselling provided to staff
- the recognition the programme has achieved from outside of the municipality¹⁰⁶
- the outreach conducted in communities
- the recognition of staff contributing to the programme

Some of the challenges facing the programme in the future include ensuring that HIV/AIDS is incorporated into the broader wellness strategy in the City, and ensuring that adequate capacity is available to manage growth in the treatment programme.

7. Review of the external response to HIV/AIDS

The implementation of the external component of the City's HIV/AIDS Multi-sectoral Strategy is reviewed in this section. The section starts by examining the implementation of the prevention and treatment components of the Strategy, followed by a review of the City HIV/AIDS/TB Coordinating Committee as the primary mechanism for mobilising action and coordinating the Multi-sectoral Strategy. The section then reviews progress with the development and implementation of HIV/AIDS sector plans, as well as the functioning and activities of the subdistrict MSATs. The section concludes by looking at the integration of HIV/AIDS within the city's IDP.

7.1 Prevention and treatment

Relative to most other municipalities in South Africa, the City of Cape Town has a well developed health system and is able to provide a comprehensive range of HIV/AIDS prevention, treatment and care services (see box 5 below).

VCT is available at all city health clinics and other facilities run by the Provincial Health department. In 2005 approximately 8% of the adult population of the City was tested for HIV.¹⁰⁷

PMTCT services are offered at ten Midwife Obstetric Units (MOUs) located in the city, with follow up being done through city clinics. This aspect of the programme appears to be achieving particularly impressive results. For example, it is reported that the provision of PMTCT has reduced mother to child HIV transmission from 30% (without intervention) to 5% in Khayelitsha.¹⁰⁸ There has also been a general reduction in infant mortality in the city, which is a likely indicator that the PMTCT programme is having the desired outcomes.¹⁰⁹

The city has also distributed a total of some 25 million condoms – the equivalent of approximately 25 per adult male per year – which is one of the highest condom distribution rates by a municipality in the country. 110 A few respondents expressed some reservations about the effectiveness of condom distribution, however, pointing out that it is not known whether the condoms are actually used, and that condom distribution needs to form part of a broader campaign focusing on generating health and responsible attitudes towards sex.

Screening for ART is currently offered at 70% of City clinics. There are currently 25 sites in the city where ART is offered. Three of these sites are run by City Health, namely the Langa, Hout Bay and Du Noon clinics; 15 sites are managed by the Metro District Health Services (MDHS); and 7 sites are based at provincial hospitals. Comprehensive HIV care is provided at approximately 80% of clinics in the city.¹¹¹

According to data supplied by the provincial Department of Health, a total of 14 188 patients were receiving ART from the various health facilities in the city as at September 2006.

Table 9: Number of ART patients, Cape Town (September 2006)		
Facility	Number of patients	
City Health clinics (3)	1509	
MDHS facilities (15)	8610	
Secondary hospitals (4)	1502	
Tertiary hospitals (3)	2567	
Total	14 188	

Source: Provincial Department of Health, HIV/AIDS Programme

A number of positive features of the prevention and treatment services provided within the city were noted by respondents, namely:

- The allocation of dedicated staff for the management of the HIV/AIDS/TB/STI programme
- The provision of a comprehensive package of HIV care
- Generally good cooperation between the City and Provincial authorities.

Some of the challenges with the provision of prevention and treatment services raised in the research were:

- Fragmentation of health services (local and provincial government/private sector)
- Discrepancies between remuneration of staff in City Health and Provincial Health (provincial government paying less)
- Scaling up the roll-out of ART and the required follow-up to match the rising demand
- The need for more non-clinic VCT sites
- Provincial Department of Health and City Health having different sub-districts (the province has 11, while the City has 8)
- Lack of standardisation of STI treatment (e.g. between government and private health services)

One of the officials interviewed from the City Health Department commented that, while the health sector has been implementing its HIV/AIDS and TB response plan and has generally been achieving its targets, this is merely a 'band aid' response to the problem. The real solution to the problem of HIV/AIDS in the city, the respondent argued, is a long-term approach to holistic community development and the reduction of poverty, which requires the commitment of all sector departments and the allocation of sufficient resources.

Health services in the City of Cape Town

Health services in the City are provided jointly by the municipality's City Health Department, the Western Cape Provincial Department of Health's Metro District Health Services (MDHS), and provincial hospitals.

The City Health Department currently operates 93 municipal clinics, 18 satellite clinics and 6 mobile clinics, which provide primary health care (PHC) as part of the district health system. In addition, the Provincial Department of Health operates 44 community health centres (CHCs) and three district hospitals within the boundaries of the city.

The services provided at municipal clinics are free and include:

- Preventative health for women and children (including family planning and immunisations)
- Treatment for sick children under the age of 13
- Treatment of TB, sexually transmitted infections (STIs)
- VCT for HIV
- Screening and referral for ART
- ART provided at selected sites
- Treatment for adults at 2 CHCs (incl. chronic diseases)
- Antenatal care at 5 clinics.
- Psychosocial support (HIV support groups, some income generation components)
- Nutritional support
- Maintenance of stable patients on ART at selected sites
- Referral to NGOs and CBOs for home-based care

VCT is offered at all municipal clinics, and most clinics can provide comprehensive AIDS care. Within the City there are 25 sites offering ART, three of which are currently operated by City Health and the rest by the provincial Department of Health. There are plans to expand the number of ART sites run by the City to eight. Prevention of mother-to-child transmission (PMTCT) services are delivered via a combination of Provincial Health Department antenatal facilities and municipal clinics. Once initial treatment is provided, municipal clinics are responsible for follow-up of mothers and babies and for providing free milk formula.

Each of the sub-districts in the city has two HIV/AIDS/TB/STI Coordinators, who are responsible for monitoring and providing support and on the spot training to health staff and for collecting and collating data from health facilities in the sub-districts with regard to all aspects of HIV/AIDS, TB and STIs.

Source: City of Cape Town 2005:158 – 159; City of Cape Town HIV/AIDS & TB Sector Plan 2006/07:3; Interview, Dr Pren Naidoo, 27/08/2006.

The City Health Department employs some 1200 staff. 112 So far it does not appear that HIV/AIDS is having a significant impact on staff. A greater concern reported by a number of respondents is the shortage of qualified health practitioners, in particular doctors and nursing staff, within the public health system. Emigration of health care workers in search of better pay and working conditions, as well as the fact that not enough new nurses are being trained to meet the demand, has resulted in a severe shortage of staff in a number of health facilities within the city. This, in conjunction with the increased demand for services caused by HIV/AIDS and TB, has placed additional stress on health services in the city. Clinics in Khayelitsha were noted to be particularly underresourced in the face of the demand for services in the township. According to some respondents, the City's health budget has also not kept pace with the increase in demand for health services, particularly with regard to the rise in new TB cases.

Similar constraints within facilities operated by the Provincial Department of Health were also reported by some respondents. The Provincial Health Department has reportedly been losing staff to the City (where pay is apparently better), to the private sector and to emigration.

From a mainstreaming perspective, these concerns are particularly important since poor quality health services or long queues at clinics could dissuade people who need treatment and assistance from seeking it. In the case of HIV and TB, delayed treatment can have particularly severe consequences for patients, and for the risks of the diseases being transmitted to others.

Some of those interviewed who have been involved directly in supervising and monitoring HIV/AIDS services expressed concerns about a perceived failure of the City to respond to the resource shortages and low levels of morale amongst health care workers in city clinics. While the resource constraints facing the City Health Department were acknowledged, senior officials within the department also noted that existing resources and staff can be used more optimally and that, based on patient numbers, some of the clinics where shortages have been reported are operating well within the established norms. One official also suggested that motivation amongst staff is even improving, as the organisational turbulence and uncertainty experienced in recent years now appears to be stabilising.

In general, the health response to HIV/AIDS and TB in the city appears to be well managed. However, the sobering reality is that the number of new infections of HIV and TB continues to climb, in some areas at an alarming rate. As a few respondents noted, based on this indicator alone, it would appear that the prevention efforts of the city are not having the desired impacts. The need for a more focussed prevention strategy was thus raised. Currently the Medical Research Council (MRC) is conducting research to develop prevention strategies focused on specific groups, which should assist in making the prevention strategy more effective.

7.2 City HIV/AIDS/TB Coordinating Committee

The City HIV/AIDS/TB Coordinating Committee was established to serve as the primary institutional mechanism for coordinating and driving the implementation of the city's Multi-Sectoral HIV/AIDS Strategy. The committee was set up in 2001 and has remained active since. Meetings of the committee take place on a quarterly basis. Until recently, monthly meetings were also held to discuss progress with the formulation of sector department plans. In mid-2006, once most of the sector departments had completed their plans, these monthly meetings were discontinued. A new format for quarterly meeting was introduced in August 2006, where feedback is given by both the MSATs and the municipal sector departments on progress with their plans and activities.

Most of the stakeholders interviewed expressed general satisfaction with the way the Coordinating Committee operates and the value it brings to their work. Some of the ways in which respondents felt the committee was playing a positive role in the City's response to HIV/AIDS include:

- Providing a point of contact between municipal staff and representatives from civil society
- Providing a forum for representatives from sector departments to interact with each other
- Serving as vital channel for communication regarding all HIV/AIDS-related plans and interventions in the city.

Some of the challenges facing the coordinating committee and some suggestions for improving the structure that were raised by respondents include:

- A lack of consistency in representation from sector departments: Designated representatives from sector
 departments have often not attended meetings regularly, or stopped attending, or the representatives have
 changed frequently. This appears to be related, at least in part, to the ongoing restructuring that has been
 taking place in the municipality in recent years. Being unable to report on any progress with implementing
 their departmental HIV/AIDS plan was also offered by one interviewee as a as reason why some sector
 representatives do not attend all meetings.
- Nominated representatives from sector departments not having decision-making authority: Many of the
 designated representatives from the sector departments are either peer educators and/or hold relatively
 junior positions, with limited influence on decision-making within their departments.
- Poor attendance by representatives from political parties: In the original plan for the committee, it was
 proposed that six councillors from the Health portfolio committee, and one councillor from each of the
 other portfolio committees would be part of the committee. However, it has been reported that very few
 councillors have participated regularly in committee meetings.
- Limited representation of provincial government sector departments: Few provincial departments have ever attended meetings.
- *No representation of the business community:* The local chamber of commerce and industry is not formally represented on the committee, although it is represented on the Provincial AIDS Council.
- Need for more two-way dialogue: Some respondents suggested that that there is a need for more space for discussion and dialogue at the meetings, particularly between the MSATs representatives and City officials.

7.3 Sector department HIV/AIDS plans

The major thrust of the external mainstreaming effort in the city has taken the form of attempts by the City Health Department, via the City HIV/AIDS Coordinating Committee, to encourage other sector departments within the City to each devise a plan for how they will respond to HIV/AIDS. Initially City Health targeted its sister departments located under the Directorate of Community Development (namely Sports and Recreation, and Open Spaces and Nature Conservation¹¹³) to develop plans. However, over time the number of departments targeted has expanded to include most of the key departments in the City. According to the Director of City Health, the real push for all sector departments to participate in mainstreaming HIV/AIDS occurred in 2004, after exposure to the South African Cities Network's research on HIV/AIDS responses in the major cities in South Africa.

Progress with developing the sector plans has been slow, having taken some two years to get to the point where nine departments have developed some kind of departmental plan. For the City Health Department, as the initiator and driving force behind the process, it appears to have been a frustrating process. Within the health department there appears to be a sound conceptualisation of mainstreaming, which it is has attempted to convey to other sector departments and political structures within the municipality through numerous presentations and documents. According to officials in the Health Department, however, it has been difficult to get other sector departments to understand how HIV/AIDS impacts on their work and how their work relates to HIV/AIDS prevention and impact mitigation, and then to put their response plans on paper. There has been a tendency by some of the sector departments to want the Health Department to tell them what to do, which, senior health officials were quick to point out, should not be their role.

Various reasons were given by stakeholders interviewed for why progress with the sector plans had been less than optimal. One of the main issues raised was a perception that there has been a lack of support for the process from high-level officials such as Directors and Executive Managers. It was noted that these officials rarely attend the City HIV/AIDS Coordinating Committee meetings and most have not followed through with the necessary action to develop the departmental plans. One respondent attributed the apparent failure of some of the senior officials within the city to prioritise HIV/AIDS to their relatively affluent socio-economic status and not being in touch with the lived reality of the City's poor.

One of the key challenges has been to find suitable sector representatives to attend Coordinating Committee meetings. In most cases, the officials within the sector departments who have been nominated to represent the departments at the meetings have been relatively junior personnel, with little influence over departmental policy or strategy formulation. In most cases it appears that the sector representatives attending the meetings are HIV/AIDS peer educators. Frequent changes in representatives attending the meetings has also been an obstacle to getting the departmental plans in place.

While it is evident that the some of the staff assigned with the responsibility of 'mainstreaming' the approach to HIV/AIDS in their sector departments are individually enthusiastic about their task, they have faced difficulties in getting more senior managers to accept the need for change. For example, one junior official explained that she was nominated by a superior to be the representative of her department to attend the City HIV/AIDS Coordinating Committee meetings. After attending a few meetings she tried to explain to her managers that the department had been requested to develop a plan to incorporate HIV/AIDS into its work. At first the managers did not see what HIV/AIDS had to do with the department's core work, but after some convincing by the official they eventually came to understand the connection. According to the official, her managers are now very supportive of the idea of HIV/AIDS mainstreaming.

Another key challenge is that even where departments have produced action plans, there is limited capacity for implementation. The staff within the departments who were assigned with the responsibility of developing the department's action plan often do not have the time to set aside to focus on implementing the plan. They also require the assistance of other staff who are tied up with their own workloads. A further challenge identified is the lack of budget allocations to implement the action plans.

At a meeting of the municipality's most senior officials on 18 October 2005, a number of decisions were taken in order to rectify some of the above deficiencies. These included a commitment by the managers to actively leading the City's mainstreaming efforts and to holding Directors accountable for departmental HIV/AIDS plans (including allocating resources in their budgets to HIV/AIDS and including AIDS issues in there performance scorecards). The meeting also decided that the Executive Management Unit should monitor the number of MAYCO speeches that include reference to HIV/AIDS, that support would be provided for the development and production of an AIDS decal to be displayed on all municipal vehicles and that officials should be involved in the MSATs.¹¹⁴ According to some officials interviewed, however, relatively few of these commitments have been implemented almost a year later.

With most of the sector department plans now having been documented, progress with implementation will be monitored regularly by means of quarterly reports to the City HIV/AIDS Coordinating Committee. The first quarterly meeting where departments will report on implementation with plans was scheduled for November 2006. The Health Directorate is responsible for collating the departmental progress reports.

7.3.1 Assessment of sector plans

Table 10 provides a summary of the status and key elements of the sector plans of the main departments and directorates within the City. Some departments have not yet formulated plans, although in some cases they have ideas about what they would like to do (e.g. Transport), or have provided *ad hoc* support to the strategy through the services they offer (e.g. Communications and Marketing). In addition to the plans submitted to the Health Department, some departments (e.g. Parks and Cemeteries, and Social Development) have also elaborated their plans in the form of a strategic plan document.

Case study: City Parks HIV/AIDS Mainstreaming Programme

The Parks and Cemeteries Department is one of the more advanced departments within the City in terms of developing and implementing a departmental HIV/AIDS response plan. The department's core responsibilities include the development and maintenance of public open spaces, centre islands, entrances to suburbs, parks, nature areas, recreation areas, sports fields, and the City's 29 cemeteries. Since June 2005 the department has been implementing an HIV/AIDS awareness programme that has seen the installation of awareness signage in a number of parks, cemeteries and buildings, and on centre islands within the city. Staff members have also decorated fifteen vehicles with HIV/AIDS awareness messages. The department has also incorporated HIV/AIDS awareness into Arbour Day events and has held its own events for World AIDS Day and Women's Day. The costs of these initiatives have been incorporated into the budgets of the four administrative districts of the department. The coordination of the department's HIV/AIDS programme is coordinated by a staff member, a proportion of whose time has been dedicated solely to the programme. Indicators related to the programme have also been included in the Director's and District Managers' performance scorecards. The department's HIV/AIDS programme was a runner up in the 2005 Annual Public Sector Innovation Awards.

The department has a workforce of approximately 2300 staff. In the last two financial years (July 2004 to June 2006) 587 staff members underwent VCT.

Source: Interview, G. Khan, Parks and Cemeteries Department, 14/08/06

The formats for the departmental plans include indicators, with baseline measurements and annual targets, which are further divided into quarterly targets. Progress on the achievement of quarterly targets is reported at the quarterly City HIV/AIDS/TB Coordinating Committee meetings.

What is apparent from reviewing the available plans is that almost all of the proposed interventions are focussed on HIV awareness and prevention. Some of the departments have clearly grasped that they can 'do their part' to promote awareness about HIV/AIDS through some relatively simple interventions as part of their day-to-day work. Examples of this include the Solid Waste Department printing HIV awareness messages on refuse bags, the installation by the Electricity Department of HIV red ribbon symbols on street lights, and the Parks and Social Development Departments placing HIV/AIDS signage in landscaped areas. Some of the departments have also included AIDS work with staff in their plans. While these kinds of interventions can no doubt contribute positively to limiting the spread of HIV amongst the city's residents and staff within the departments, they represent only one aspect of mainstreaming. Currently missing from the plans is a clear articulation of internal and external mainstreaming in relation to the potential impacts of HIV and AIDS on their organisational capacity and their core functions, as well as direct or indirect roles they can play in mitigating the socioeconomic impacts of HIV/AIDS on residents. The Economic and Human Development department perhaps comes closest to this with its plan to conduct research on the mitigation of HIV/AIDS and mainstreaming and to devise strategies related to HIV/AIDS for its various functions.

Case study: Social Development HIV/AIDS Awareness Programme

The Social Development Department is another department that has been particularly active in responding to HIV/AIDS within its area of work. The department is responsible for supporting arts and culture, providing library information services and sports and recreation facilities, and facilitating poverty alleviation, youth development, women development and gender equity, early childhood development, and assistance to people living on the street. As part of the department's HIV/AIDS awareness programme, HIV/AIDS signage has been erected at numerous facilities maintained by the department (e.g. sports centres, halls) and HIV/AIDS information has been distributed at libraries. The department has also organised HIV/AIDS awareness events or included HIV/AIDS awareness and information dissemination in events that it has organised (e.g. World AIDS Day, Family Big Walk, Youth Festival). The department has also produced a pamphlet on its HIV/AIDS programme.

In April 2006 an HIV/AIDS steering committee was established, comprising of seven nominated staff members from the various branches of the department. A staff member in the Support Services branch of the department has been assigned overall responsibility for coordinating the HIV/AIDS programme. The costs of HIV/AIDS activities are incorporated into the budgets of the different branches of the department.

Source: Social Development Department. 2006. Annual Report, July 2005 – June 2006, Interview: G. Bam & N. Davids, Social Development Department, 11/09/06

Despite the limitations of the departmental plans in terms of mainstreaming, some very creative ideas have been generated for responding to HIV/AIDS. For example, one of the departments has identified the possibility for procurement to be used to encourage businesses to take greater responsibility for HIV/AIDS amongst their staff. This could be done through incorporating certain stipulations into tender contracts, e.g. HIV/AIDS education can be included in the responsibilities of health and safety officers and contractors can be required to allow staff time off to get tested.

Department/ Directorate	Core business ¹¹⁵	Key elements of HIV/AIDS sector plan/status of plan
City Parks	Develop and maintain public open spaces, centre islands, entrances to suburbs, parks, nature areas, recreation areas, sports fields, and the City's 29 cemeteries.	Promote HIV awareness: HIV/AIDS signage in parks, cemeteries and centreis HIV/AIDS awareness events HIV/AIDS-related press releases
City Police	Provision of community policing, traffic policing, by-law enforcement and crime prevention services.	Incorporate HIV awareness into school sessions as part of Safer Cities Project: Sessions in schools
Cityscape	Provision of architectural design and urban design and project management services to all departments within the municipality.	Reduce HIV infection: Install condom dispensers at new sites HIV/AIDS education: Make educational material available at sites Contract managers informed of benefits of educating staff about HIV/AIDS HIV/AIDS education sessions conducted on site VCT: Ensure easy access to VCT for site workers

Communications and Marketing	Provision of communications, marketing services, media and corporate branding services	Plan being finalised; currently providing support to strategy in term of: Municipal publications ('Contact' staff newsletter, electronic staff newsletter, and 'City News' residents' newsletter); Internal and external municipal websites Publications and marketing materials production Assistance with press releases Design of HIV/AIDS decals for vehicles		
Economic and Human Development	Implementation and facilitation of economic activities within the municipality with a focus on increasing trade, investment, business and residency to contribute to economic growth and sustainable employment creation	Assess the economic and human impacts of HIV/AIDS: Papers on mitigating the impacts HIV/AIDS and mainstreaming written and presented to committees Development of Economic and Human Development strategies related to HIV/AIDS (e.g. urban farming, ECD, social grants, indigent services, housing): Strategies developed		
Electricity	Supply of electricity to domestic and commercial consumers, maintaining and extending electricity distribution network, and provision of public and street lighting.	No plan documented although some HIV/AIDS interventions initiated (e.g. red AIDS ribbons installed on street lights in high-burden areas)		
Finance (Revenue)	Ensuring that funds due to the city are correctly billed and collected	No plan documented; idea to insert HIV/AIDS messages with monthly accounts (approx. 1m sent out monthly)		
Health	Provision of primary health care (in partnership with the Provincial Department of Health) and environmental health, including water quality monitoring, food control, waste management monitoring, health surveillance of premises, surveillance and prevention of communicable diseases, vector control, environmental (especially air) pollution control and chemical safety.	Reduce HIV infection: Promote the ABC message and distribute condoms Promote VCT as a prevention strategy Outreach prevention interventions in communities (excl. schools) Offer HIV testing to STI clients Reduce HIV-related morbidity and mortality: Provide ART at 3 sites Establish sites for maintenance of stable clients on ART Provide comprehensive HIV care at clinics Reduce incidence of TB: Improve cure rate for new smear positive (NSP) TB Mitigate the social, economic and human impact of HIV/AIDS and TB: Fund and monitor local NGO/CBO projects through MSATs Mainstream HIV/AIDS into departmental plans: Departmental HIV/AIDS plans developed, implemented & monitored		

Human Resource Management and Development	Staff skills capacity building, management of staff productivity, learnership programme, and HIV/AIDS workplace programme.	Implementation & monitoring of workplace HIV/AIDS programme to support employee wellness: Promotion of VCT as part of HIV programmes Peer education workshops Maintain & monitor HIV/AIDS Workplace website Promote staff access to VCT HIV-positive/affected staff assessed and assisted with referral in terms of City's Workplace Programme and Treatment Policy Provide comprehensive HIV care (incl. ARVs) at workplace clinic for eligible staff
Human Settlements	Development of City's housing policy and strategy, planning and construction of new housing developments, management of existing municipal rental housing stock, management of informal settlements, and coordination of land restitution	No plan documented
Roads and stormwater	Management, provision and maintenance of metropolitan and local roads, stormwater systems, rivers and canals and structures (e.g. bridges)	Promote HIV awareness: HIV/AIDS messages and contact information on gazebos used when staff working in communities
Social Development	Providing and maintaining library services, sports and recreation facilities, promoting and developing arts and culture, and facilitating social development, with a focus on poverty alleviation, youth, children and gender development, and support for people with disabilities and people living on the street	Implement cross-cutting HIV/AIDS awareness and prevention plan: Develop departmental HIV/AIDS plan Initiate Developmental Programmes to communities: Awareness sessions with youth Library HIV/AIDS programmes Displays at libraries HIV/AIDS signage: New HIV/AIDS signage boards to be installed at facilities HIV/AIDS decals on department vehicles Street art/mural projects involving youth Peer educator/counsellor staff training: Staff trained Staff awareness workshops
Solid Waste Management	Domestic (formal and informal households) and trade refuse collection, waste minimisation, hazardous waste management, street cleaning, beach cleaning, litter collection	Promote HIV awareness: Distribution of refuse bags with HIV message Employee assistance: Appointment of HIV Peer educators at all solid waste depots

Transport	Management of air, water and rail transport needs of the City and residents, and provision and maintenance of related infrastructure	No plan documented although possible activities identified (e.g. establishing VCT sites at transport interchanges, training taxi drivers and guards on trains as peer educators and to distribute condoms.)
Water and Sanitation	Water supply and storage, treatment and purification and reticulation, and collection and treatment of sanitation effluent	No plan documented

Source: City Health Department

7.4 Multi-Sectoral Action Teams (MSATs)

The MSATs have been established as the primary vehicle for mobilising and coordinating multi-sectoral efforts to prevent and mitigate the impacts of HIV/AIDS at a localised, sub-district level within the city.

Most of the MSATs have between 20 and 30 active members (individuals and organisational representatives) who attend monthly meetings regularly, although there were usually more listed on the database of members. One MSAT was reported to have only about 10 active members, although it was pointed out that in some of the sub-districts where HIV prevalence is relatively lower there are fewer HIV/AIDS focused organisations.

Every MSAT has an executive committee of between five and ten individuals, who are elected from amongst the members. The executive committees are responsible for driving and coordinating the activities of the MSATs. In most cases this appears to be working well, although in a couple of cases it was reported that there was a lack of commitment by some members of the executive committees. All of the MSATs also have their own constitutions.

The coordination of the MSATs is supported by MSAT Coordinators who are assigned to each MSAT. The Coordinators were appointed by the City Health Department on two-year learnership contracts in early 2005. These positions were introduced after it was found that the HIV/AIDS/TB/STI Coordinators in the sub-districts were unable to cope with the additional burden of coordinating the MSATs. The responsibilities of the MSAT Coordinators include organising MSAT meetings, recruiting new members to the MSATs, conducting site visits of organisations that have received funding through the MSATs to implement community projects, and collecting reports from funded organisations.

The posts for the Coordinators, as well as one overall coordinator for all MSATs, are funded through a grant to the City from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Most of the Coordinators are located at sub-district health offices and most reported that they were satisfied with the level of support they have received from their colleagues at these offices.

The main point of contact between the members of the MSATs are monthly meetings, which are used mainly to plan the activities of the MSAT. Opportunities are also provided to members to share information about their work and, in some cases, for HIV/AIDS and TB information to be presented by health officials.

The activities of the MSATs have focussed mainly on raising awareness about HIV/AIDS and TB through events and campaigns typically held to coincide with World AIDS Day or TB Day, in December and March respectively. Some of the MSATs appear to have been more pro-active in organising their own awareness events than others. The MSATs also participate in and support events and campaigns of member organisations and clinics. Some of the MSATs have also supported municipal health initiatives, such as door-to-door immunisation campaigns.

City Health provides financial support to the MSATs in the form of a R15 000 annual allocation to cover their general running expenses (e.g. catering for meetings, photocopying, transport for members to attend meetings) and for awareness events. Some of the MSATs have used the allocation to cover some of the transport and cell phone expenses of the MSAT Coordinators.

A few of the MSATs have decided to start fundraising of their own in order to expand their work. Some have started to explore the possibility of registering as non-profit organisations in order to enable them to raise funds.

Table 11: NGO/CBO projects funded through the MSAT				
funding mechanism, 2006/07 financial year				
Sub-district No. projects funded				
City wide	3			
Western	9			
Eastern	7			
Khayelitsha	14			
Klipfontein	10			
Mitchells Plain	8			
Northern	2			
Southern	7			
Tygerberg	7			
Total	67			

Funding from City Health is also provided via the MSATs to support the work of individual MSAT member organisations. The process for allocating the funding is explained in box 8. Funding for this purpose was raised by the City from the Global Fund to Fight HIV, TB and Malaria. In 2005, the first year of funding, 64 projects were supported, while in 2006 funding was awarded to 67 projects. The total amount allocated to NGO/CBO projects in 2006 was R3m.

Decisions about the allocation of funds to organisations are guided by a pre-determined set of criteria. Sub-districts with higher HIV/AIDS and TB burdens are allocated more funding. The priority types of interventions for funding, according to the criteria, include the promotion of food security, community care for vulnerable children, community-based emergency accommodation or short-term placement of children, the frail and terminally ill, job creation and income generation, and life skills and youth work targeting out of school youth. 116 Funding is not provided for home-based care, which is funded by the Provincial government.

In addition to the opportunity to apply for funding, member organisations of the MSATs also have access to free capacity building training funded by the City.¹¹⁷ The topics covered by the training include funding proposal writing, project management, basic bookkeeping and report writing. Computer skills training up to NQF level 4 is also offered at no cost to MSAT members.

Almost all stakeholders directly involved in the MSATs expressed strong support for the MSAT concept and the value of these structures in strengthening community responses to HIV/AIDS and TB. Some of the reported benefits associated with the MSATs were the following:

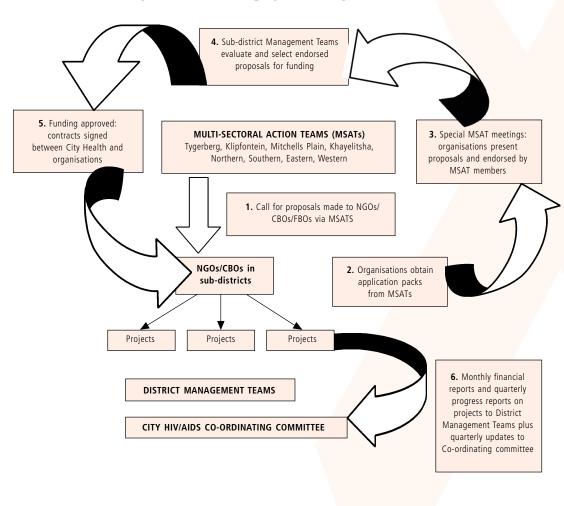
- Coordinating HIV/AIDS-related interventions and services
- Raising awareness about the services available at local level
- Ensuring that services are not unnecessarily duplicated and that limited resources within local government and civil society are used effectively
- The mobilisation of awareness about HIV/AIDS amongst communities, through events
- Access to much needed funding for community projects. Channelling funding to projects through the MSATs has been a useful way of strengthening accountability to communities and the credibility of the projects.
- The capacity building training availed to members of the MSATs. Almost all respondent reported the training to have been very useful.

A number of challenges facing the MSATs, and concerns, were also raised during interview. These are captured below:

- Non-participation of sector departments: All of the MSATs reported very low levels of participation of municipal or provincial sector departments. In most cases, it was usually only municipal health officials who attended some meetings. In a few cases, provincial education department officials also occasionally attended meetings. Some of the factors contributing to poor participation of sector departments identified were that many of the sector departments do not have staff deployed to local level, or that the administrative boundaries of the departments do not align with those of the health sub-districts. Poor or non-participation of ward councillors was also noted in most of the sub-districts. The lack of sector department commitment appears to be having a demoralising effect on other members of the MSATs. Some members expressed a perception that the MSATs are an initiative of the City but that civil society is being left to carry the burden largely alone.
- Capacity of the City to manage the process: Managing a network of structures such as the MSATs, as well as the disbursement of funding to organisations, requires a high level of commitment in terms of personnel and resources on the part of the City. Concerns were expressed by one senior official about the capacity of the City to manage and resource the strategy on a continued basis with the limited resources that are available.
- Institutional location of the responsibility for the MSATs: A point raised by one senior official was that the management and resourcing of the MSATs should not be the exclusive responsibility of the Health department, since activities of the MSATs are intended to respond to HIV/AIDS holistically and not only from a health perspective.
- Effectiveness of responses: Because of the immediate needs facing communities, the activities of the MSATs and of their member organisations in response to HIV/AIDS and TB have tended to focus on reactive, short-term interventions, without much in-depth, longer-term planning for more effective and sustained responses. With regard to the community support projects being funded via the MSATs, the point was raised by one official that, while these projects may be directly benefiting those involved, they represent a 'drop in the ocean' in the face of the overwhelming development needs in the city. The official suggested that a much larger effort, involving all departments in the city, was required to have a significant impact on poverty and underdevelopment in communities.
- Measuring impact: A point related to the above, some respondents indicated that it was difficult to gauge
 the impact of community projects funded via the MSATs. At present there is no systematic process in place
 for evaluating impacts other than site visits conducted by MSAT Coordinators and certain other health
 officials, and the reports submitted by the funded organisations. One respondent reported that they sometimes hear reports about MSAT funded projects and the impacts they are making in communities through
 Health Forum meetings.
- Commitment from some health officials: A few respondents commented that the MSATs have not received the support they require from some of the sub-district health managers and other health officials at the sub-district level. In some cases it appears these officials have not seen much value in these structures nor provided the support and resources required. In some cases it was reported that health managers saw the responsibility of managing the MSAT Coordinators as an extra burden on them.
- Uncertainty about MSAT Coordinators' positions: Some of the MSAT Coordinators voiced concerns about the uncertainty surrounding the status of their positions in terms of whether or not they are fully accredited learnerships and whether their contracts will be renewed when they expire. 118 A senior official in the City Health Department acknowledged that there had been some confusion and uncertainty amongst the coordinators but stated that the department was in the process of getting the learnerships accredited and was attempting to ensure that coordinators whose contracts could not be renewed are employed more permanently by the City.
- Support for Coordinators: While most MSAT Coordinators were generally satisfied with their working conditions and the resources at their disposal, one coordinator, located in a clinic, was struggling with access to a computer. The response from officials at City Health was that all Coordinators were shortly to be supplied with new computers.

- Use of the MSAT funding: Although according to Health Department officials the MSATs have been given
 guidelines for spending their R15 000 annual allocations, some MSAT representatives indicated that they
 were unsure about what exactly the money could be used for.
- Inconsistent attendance by MSAT members: A number of MSAT Coordinators reported the problem that
 many organisations tend to only attend meetings around the time when the call for funding proposals is put
 out. In some cases, once organisations receive funding they stop attending meetings.
- Tensions between MSATs and Health Forums: In some of the sub-districts it was reported that there had in the past been some tensions between the MSATs and the local Health Forums, apparently relating to the roles and functions of each structure and the higher allocation of funding provided for the MSATs. However, these tensions appear to have been largely resolved and in most of the sub-districts representatives from each structure attend each others' meetings.
- Lack of support from business: Some respondents noted that there have generally been very low levels of support from local businesses for the MSATs. In a few cases, MSATs had received donations of food or other services to support their activities.
- Formalisation of MSATs: A few respondents expressed concern about moves by some of the MSATs to become formal organisations by registering as non-profit organisations. The primary motivation for doing this appears to be a desire to fundraise themselves, although some respondents questioned whether this should be a function of the MSATs.

Process for funding HIV/AIDS & TB projects through the MSATs



For the last two financial years, the City of Cape Town has provided funding to NGOs, CBOs and FBOs to implement community HIV/AIDS projects through a decentralised process aligned to the MSATs at sub-district level. Funding for this purpose has been accessed by the municipality from the Global Fund.

The process to allocate funding starts with a call by the municipality to NGOs and CBOs for project proposals via each of the eight MSATs. This call is usually announced in March each year. Only organisations that participate in the MSAT are eligible to apply for funding. A standard template for project proposals is obtained through the MSAT. Each MSAT then convenes a special meeting, at which the proposals are presented and the projects are endorsed by the members of the MSAT. Only projects that are endorsed then go to through to the next round. The intention behind this requirement is to promote accountability and coordination of local level responses. Project proposals that are endorsed by the MSAT members are then forwarded to the sub-district management teams to select the final projects for funding. Representatives from the MSATs can observe the selection process, although they do not have a direct say in the selection of projects to receive funding.

Only organisations that meet minimum standards for governance and financial controls are eligible for full funding. Organisations that are not registered as non-profit organisations (NPOs) qualify for more limited funding, and must be affiliated to an umbrella organisation that can assist with building managerial and financial management capacity. Support is provided through the MSATs for such organisations to meet the required standards.

Once the projects to receive funding have been selected, contracts between the implementing organisations and the City Health Department are entered into. The deadline for signing contracts is 30 June, so that funding can be disbursed at the start of the municipality's new financial year starting on 1 July. Organisations that receive funding are required to submit monthly financial reports on financial expenditure and quarterly narrative progress reports on project implementation to the sub-district management teams. Funded organisations are also required to participate in the MSATs and report on the implementation of funds on a regular basis.

Source: City Health, Call for HIV/AIDS/TB Project Proposals Though Sub-District MSATs; City Health Directorate, Funding of HIV/AIDS and TB Non-Profit Organisations, 2006/07

7.5 HIV/AIDS in the City's IDP

As noted earlier in the report, the IDP of any municipality should be the principle planning tool which is used to ensure that mainstreaming HIV/AIDS takes place and that the necessary financial allocations to support mainstreaming are made in the municipal budget.

An assessment of the City of Cape Town's latest (2006/2007) IDP appears to suggest that HIV/AIDS is not seen as one of the municipality's main priorities. Under a section entitled 'Stakeholder expectations' at the start of the document, which lists priority needs expressed by residents through public participation processes, HIV/AIDS (or TB) is not specifically mentioned. The top five priorities raised by the number of recorded public comments at the Mayor's Listening campaign are listed as housing, job creation, crime, support for community-based projects (e.g. cooperatives) and sport and recreational facilities. Improved health services were listed only ninth.¹¹⁹ The section also contains a list of local issues prioritised by ward committees. The first five priorities on the list are parks and recreation, community facilities, roads and sidewalks, housing, and job creation. Clinics and health are listed seventh in order of priority.

In the section called 'Major challenges facing the City of Cape Town,' HIV/AIDS is mentioned under 'Social challenges,' noting there has been a steady increase in HIV prevalence in the province in recent years and that the HIV prevalence rates in some parts of the city are above the national average. The section also notes the significant rise in new TB cases in the City between 2001 and 2004, and that the City's response to the TB epidemic has been more effective in the area of treatment than in prevention.

In the section in the IDP on 'Strategic objectives and high level activities,' one of the stated strategic objectives under the 'Building strong communities' sub-section is the implementation of an integrated HIV/AIDS/ STI programme across the city. 121 The corresponding 'High level outcomes that must be achieved over the longer term' for this strategic objective refers to 'mainstreaming a multi-sectoral response that mobilises all City sectors in a developmental intervention' which includes reducing the number of HIV and TB infections and reducing the impact on individuals, families and households and the municipal workforce. Included under the heading,

'Outputs that must be achieved over the next year' is the development and implementation of eleven departmental plans 'dealing with HIV as a mainstreaming strategy.' 122

The city's HIV/AIDS and TB strategy is included as one of the Statutory Plans in section 18 of the IDP document. The IDP also includes the executive summary of the District Health Plan for the City, which describes the City's approach to dealing with HIV and AIDS.

To sum up, it would appear that there is considerable scope for HIV/AIDS to be more integrated into the City of Cape Town's IDP. Key to this is for HIV/AIDS to be reflected as a significant threat to the achievement of almost all the City's development goals. HIV/AIDS then needs to be factored into the strategies and objectives of each municipal department.

City of Cape Town Indigent Policy

Municipal indigent policies are a central mechanism through which municipalities can address poverty, and, therefore, the context of vulnerability to the impacts of HIV/AIDS. In line with national government directives to municipalities to provide free basic services to poor households, the City of Cape Town's Credit Control and Debt Management Policy provides for a package of free or subsidised basic services to residents who cannot afford to pay for them. These services (see below) have a number of direct welfare benefits for poor households, especially those in which there are people living with HIV/AIDS & TB, including poverty alleviation and the promotion of healthier living environments.

Free/subsidised municipal services:

- 6kl of water free to all households per month (200 litres per month)
- 4200 litres of free sanitation to all households per month (140 litres per day/15 toilet flushes per day)
- 50kWh of electricity per day for residential consumers (using less than 450kWh per month)
- Exemption from paying rates on the first R50 000 of the property value (i.e. property owners whose properties are valued at less than R50 000 do not pay rates)
- Rates rebates of up to 88% for retired/disabled property owners with an income less than R2600 per month
- Free refuse removal for households on properties valued at less than R50 000, subsidised refuse removal for properties up to R125 000.

Source: City of Cape Town 2006:24.

8. HIV/AIDS mainstreaming in the City of Cape Town: Challenges and opportunities

This section relates the findings of the review of the implementation of the City's HIV/AIDS Multi-sectoral Strategy to the framework for understanding mainstreaming presented in section 3, and offers some commentary on the extent to which HIV/AIDS mainstreaming has been achieved, and on what appear to have been the primary challenges, obstacles and constraints to mainstreaming, in the City of Cape Town. It also points to possible opportunities for mainstreaming to be enhanced.

8.1 Internal mainstreaming

HIV/AIDS as an issue affecting the City's staff and the functioning of the organisation appears to be well under control. There is currently a low known prevalence of HIV amongst the City's staff, and morbidity and mortality do not yet appear to be significant problems impacting on the functioning of the organisation. The City had the foresight to recognise the potential impacts of HIV/AIDS internally early and initiated a comprehensive and progressive Workplace HIV/AIDS Policy and Programme to reduce susceptibility of staff to HIV infection and to provide treatment to all staff who need it. The programme appears to have achieved a high level of buy-in from managers throughout the organisation. It is also evident that through the peer education system and other education and awareness initiatives, significant progress has been achieved towards creating a work environment that is generally supportive of staff members living with HIV/AIDS, with discrimination and stigma being minimised as far as possible.

As long as the intensive education and prevention efforts, and the treatment options offered to staff are sustained, it is unlikely that the number of staff infected with HIV will increase significantly or that HIV/AIDS will have a major impact on the municipality's functioning in future (in terms of absenteeism, mortality, morale, loss of skills etc). However, as the number of people enrolled in the City's treatment programme who need subsidised treatment grows, there will be an increasing direct financial cost to the City. These costs are likely, however, to be far less than the potential costs to the municipality of not providing treatment for staff who need it.

8.2 External mainstreaming

Mainstreaming HIV/AIDS externally appears to have posed more of a challenge to the City than mainstreaming internally. To date, progress with mainstreaming externally has been limited. There appear to be a number of reasons for this: a primary reason is the fact that mainstreaming has not been systematically or officially adopted as an approach to HIV/AIDS within the City. Mainstreaming has been promoted in an *ad hoc* manner by the Health Department, using the City HIV/AIDS Coordinating Committee as the primary conduit to other departments.

A second, related, constraint to external mainstreaming has been a lack of buy-in to the process from staff within other sector departments and, in particular, the City's most senior political leaders and management. A key explanation for this apparent lack of commitment appears to be a general perception that HIV/AIDS is not a critical development issue in the City of Cape Town. This perception may, in part, be the result of the assumption amongst decision-makers that HIV prevalence amongst staff in the municipality is low and that the situation externally is therefore the same. Clearly, as this research has shown, any perception that the population of the City has remained immune to HIV/AIDS is a myth, since available statistics indicate that one in six of the City's residents are infected with HIV, and in certain areas as many as one in three residents may be infected. As this study has also revealed, the impacts of HIV/AIDS are becoming increasingly clear in certain sectors within the City, most notably the health sector.

Another factor that might explain the lack of buy-in from senior officials is that few managers appear to understand the concept of mainstreaming or how the core work of their respective departments can play a role in the response to the epidemic. This is evident in the departmental HIV/AIDS plans that have been produced, which focus almost exclusively on AIDS work, rather than incorporating responses to HIV/AIDS into the core

business of the departments. While the Health Department has made some efforts to develop an understanding of mainstreaming amongst other departments, there has been a limit to how much staff within the Health Department have been able to do, given their existing responsibilities and workloads. This research has confirmed experience from other contexts where mainstreaming has been initiated that if sector departments are not provided with enough support to formulate plans for HIV/AIDS mainstreaming, they are likely to either do nothing, or the HIV/AIDS plans they devise will tend to focus on more conventional responses to prevention and awareness raising, rather than genuine mainstreaming. Thus, if mainstreaming is to be successfully implemented, a more systematic and intensive approach to capacity building amongst political leaders and managers within the municipality will need to be implemented.

Examples of external mainstreaming

The following are examples of external HIV/AIDS mainstreaming by different municipal departments that seek to reduce susceptibility and/or vulnerability amongst individuals and households as part of their core work:

- The Housing Department introduces measures to ensure that all new housing for low-income beneficiaries is of a high standard in order to reduce negative potential health implications and maintenance costs of poor quality houses for poor households
- The Transport Department ensures that there are affordable public transport links to clinics and hospitals
- The Economic Development Department conducts a study on the impacts of HIV/AIDS on the prospects for economic growth and employment creation in the municipality and develops strategies to respond
- The Finance Department introduces a programme to ensure that all residents who qualify for indigent support are informed about how to access free basic services and other subsidies provided by the municipalities and that application procedures are user-friendly
- The Water Services Department ensures that communal taps and toilets in informal settlements are located in areas that are well-lit and safe and within easy walking distance of all dwellings
- The Property Management Department makes available unused municipal-owned land and buildings that may be used by civil society organisations for HIV/AIDS and poverty alleviation projects
- The Cemeteries Department identifies the need, and implements plans, to make more space available for burials as a result of increased mortality within the municipality due to HIV/AIDS
- The Town Planning Department designs the layout of new low-income housing developments to reduce potential safety risks for women and children and to promote greater access to clinics and other social service delivery points
- The Finance Department conducts a study on the potential impacts of HIV/AIDS on municipal revenue
- The Parks Department priorities the development of unmaintained open spaces within low-income residential areas into parks and sports fields in order to reduce safety risks, particularly for women and children, and to provide facilities for residents to participate in recreational and sporting activities that can improve their health and well-being.

Critical to the prospects for mainstreaming to be successful is the need for decision-makers within the City to understand, and be willing to respond to, the threats posed by HIV/AIDS to the achievement of the developmental goals of the City and the respective objectives and strategies of each department. This requires the predominant perception that HIV/AIDS is a 'health issue' that can be addressed purely through bio-medical and behavioural interventions to be changed. Managers within every sector department need to understand how their work can impact on the context of susceptibility and vulnerability that gives rise to the spread of the disease and to its negative socio-economic impacts.

While politicians and senior managers need to be convinced of the developmental threat posed by the HIV/AIDS epidemic, they also need to be convinced about the value and benefits of mainstreaming, since successful mainstreaming will require investment of time and resources. In this regard, mainstreaming should be presented as a mechanism for enhancing the pro-poor, pro-gender equity agenda that is contained in the vision of developmental local government, and for improving the developmental outcomes of all departments' interventions.

Mainstreaming HIV/AIDS should not be seen as taking the focus away from the priorities of the City, but rather as a way of ensuring that those priorities are constantly focussed on addressing the needs of those who are most vulnerable and marginalised, especially people living in poverty and women.

The City of Cape Town is in a stronger position than most municipalities in South Africa to successfully implement HIV/AIDS mainstreaming, with the City having significant financial resources and technical capacity at its disposal. Unlike many other municipalities, the City has also embarked on the process of mainstreaming, which constitutes a first hurdle that has already been overcome. What remains is for the City's leaders to demonstrate their commitment to HIV/AIDS by ensuring that the necessary systems and resources are put in place to enable mainstreaming to be taken further.

9. Lessons from the Cape Town experience

The following have been identified as some of the key lessons and insights about HIV/AIDS mainstreaming and implementing a multi-sectoral HIV/AIDS strategy that arise from the case study of the City of Cape Town:

- Political buy-in is imperative: The experience of Cape Town confirms one of the central lessons from international practice; that mainstreaming requires political backing at the highest levels within the organisation to ensure that it is prioritised and implemented. Without the most senior political leaders and managers within the municipality understanding the need for mainstreaming and what resources and support it entails, it is very difficult for any department to single-handedly ensure that mainstreaming is implemented in the municipality.
- Mainstreaming is not just about each department doing their part to create awareness: Although raising
 awareness and spreading messages about prevention are vital in the response to HIV/AIDS, mainstreaming
 requires departments to take a much more fundamental approach to HIV/AIDS and how they can respond
 through their core work and taking into account their comparative advantages.
- Sectors need training and support to mainstream HIV/AIDS: Related to the previous lesson, it is vital that sector departments within a municipality receive sufficient training and follow-up support in order to develop a clear understanding of what mainstreaming is and how to apply it to their core area of work. Providing this support whether by an internal or external agent needs to be included in the municipality's plans and budgets. Individual lobbying of senior officials within departments may also be required to obtain their buy-in.
- Mainstreaming is a process: There are no quick fixes to achieving mainstreaming and it should not be
 expected to happen overnight. Mainstreaming is a process that takes time and effort by all stakeholders
 within the municipality. Without an understanding of what is required to mainstream HIV/AIDS by each
 department/unit within the organisation, and a genuine commitment to the process, the mainstreaming
 process is likely to be very slow or to not deliver the results needed. Mainstreaming also does not have to
 involve all departments all at once. As was the case in the City of Cape Town, it might be useful to start with
 a few departments and bring other departments into the process as capacity within the municipality is built.
- HIV/AIDS should not be treated in isolation to other health and development issues: The case study of the City of Cape Town's response to HIV/AIDS serves as a reminder that HIV/AIDS and the solutions to the challenges posed by the epidemic cannot be isolated from other health and development issues, such as poverty and gender inequality. A very positive aspect of the City's Strategy is its twin focus on both HIV/AIDS and TB as both being critical health concerns in themselves, as well as mutually reinforcing. What the Cape Town case also demonstrates is how other development challenges are fundamentally interrelated with efforts to address the HIV/AIDS and TB epidemics. The devastating levels of poverty and, in particular, the lack of adequate housing for the poor in the City, is severely undermining efforts to combat the two epidemics.
- The institutional location of the driver of mainstreaming needs to be carefully considered: While it is critical for mainstreaming to have a 'champion,' careful thought needs to be given to which department/unit would be best placed to lead the municipality's mainstreaming effort. In the case of the City of Cape Town, the Health Department emerged as the institutional driver of mainstreaming, which has certain advantages and disadvantages. However, it is clear that it can be very difficult for one department to successfully lead the mainstreaming initiative without the backing, and the designated authority, from the highest political and administrative structures in the organisation. It can also be very difficult for a department, with its own programmatic priorities and capacity constraints, to dedicate the required staff and other resources to coordinate and monitor mainstreaming, particularly if it has not been specifically assigned this responsibility and been allocated sufficient resources.
- Coordinating a multi-sectoral response requires capacity and resources: The Cape Town case study demonstrates how local government is especially well placed to initiate and coordinate a multi-sectoral response to HIV/AIDS at the local level. However, performing this role requires significant capacity and financial and other administrative resources, which can be underestimated when embarking on a multi-sectoral strategy.

- It is useful to have a city-wide structure and decentralised structures to coordinate the response: Cape
 Town's model of having a City HIV/AIDS/TB Coordinating Committee at the city-wide level to oversee the
 implementation of the city's HIV/AIDS and TB Strategy, with structures also at sub-district level (i.e. the
 MSATs), appears to have been a useful and practical approach to managing a multi-sectoral response to
 HIV/AIDS at the scale of a large city. In smaller municipalities it may only be necessary to have a city-wide
 structure but in large urban centres the two-tiered model may be more appropriate to ensure that all
 communities and organisations can be covered. In the case of Cape Town, the health sub-districts were used
 to demarcate the areas covered by each of the MSATs. Other municipalities may choose to use other types of
 demarcations for decentralised structures, such as wards or sub-councils.
- Communities can be mobilised to fight HIV/AIDS but they need support: The system of sub-district MSATs established by the City of Cape Town has proved to be an effective approach to mobilising and building the capacity of communities at grassroots level to respond to HIV/AIDS. It may therefore be useful to replicate the MSAT concept in other municipalities, particularly large cities. However, a key lesson from Cape Town's experience is that these structures, which are based on volunteer support and commitment from within communities, require support and resources from the municipality, which needs to be factored in when deciding to implement this approach. It is also very important to ensure that the contribution of community volunteers is recognised and rewarded appropriately, in order to keep volunteers motivated and committed.

10. Recommendations

The recommendations that follow are offered as suggestions for strengthening HIV/AIDS mainstreaming in the City of Cape Town, as well as aspects of the City's multi-sectoral response to HIV/AIDS more generally. While many of the recommendations will apply specifically to the City and its particular HIV/AIDS strategy, it is hoped that some of the ideas presented might be useful for other cities dealing with similar challenges in their efforts to respond to HIV/AIDS.

- The challenge of HIV/AIDS needs to be prioritised at the highest levels in the municipality: The commitment to the mainstreaming effort in the City needs to be visible amongst the municipality's most senior politicians and officials, and needs to be backed up by the allocation of resources to support a concerted effort at mainstreaming throughout the organisation. It is crucial for the mainstreaming effort to succeed that the politicians and officials at the highest levels are informed about what mainstreaming is, why it is important and what resources will be required to implement it. This could be done through direct lobbying or presentations to the Mayor and his/her executive committee, as well as the most senior management committee in the municipality.
- Dedicated resources should be allocated to mainstreaming: The successful implementation and coordination
 of mainstreaming will require the city to allocate financial and human resources to provide for the range of
 inputs and support required, such as dedicated staff to drive the process, training, meetings, administrative
 resources etc.
- Sector departments involved in the mainstreaming effort need support and guidance: A need was clearly expressed by representatives from sector departments for further training and support to assist them to understand the concept of mainstreaming and how they can apply it in practice within their sectors. While it is important to acknowledge the efforts made by officials within the Health Directorate, the limited capacity of staff, whose primary work is not to drive HIV/AIDS mainstreaming, was also raised as a concern. It is therefore recommended that the necessary investment be made in building internal capacity to support sector departments, or the assistance of external agencies be sought. This will involve training on HIV/AIDS mainstreaming for staff in sector departments as well as providing guidelines for how they should develop mainstreaming plans.
- Formalise HIV/AIDS focal points within sector departments: Experience in other contexts where mainstreaming has been attempted has shown that it is useful for sector departments to have 'focal points,' who are individuals tasked with the responsibility of leading the mainstreaming effort within their sectors. Currently in the City, most sector departments have nominated individuals to represent the department on the City HIV/AIDS & TB Coordinating Committee. It is recommended that these individuals, or other staff members within each department, are formally designated as HIV/AIDS focal points, and that the responsibility for supporting the mainstreaming process be incorporated into their job descriptions. International experience suggests that for focal points to be effective they need to understand mainstreaming and their role clearly, have the time and resources to do their work, have the support of management, have some level of influence within their departments, and have the motivation and skills required. Once focal points in all relevant departments have been established, it might also be useful to create a working group within the structure of the City HIV/AIDS Coordinating Committee where the focal points can meet regularly and share experiences, ideas and review progress with the implementation of departmental plans.
- HIV/AIDS mainstreaming should be included in senior managers' performance agreements: This is something that has been attempted in the City but, due to a variety of factors, has not been achieved to date. While it is critical that managers responsible for the various line functions within local governments themselves understand and are committed to HIV/AIDS mainstreaming, experience has shown that one of the best ways of ensuring that mainstreaming takes place is for HIV/AIDS mainstreaming related targets to be incorporated into managers' performance scorecards. With defined responsibilities for mainstreaming, against which their performance can be assessed (and on which performance bonuses might be based) senior managers are more likely to take mainstreaming seriously.

- Consideration should be given to relocating the main institutional driver of mainstreaming in the municipality: Currently the Health Directorate plays the lead role in attempting to implement HIV/AIDS mainstreaming in the city. While there are advantages of this arrangement, the limitations of this approach have also been pointed to in this report. Once there is the necessary buy-in to the mainstreaming agenda amongst leadership at the highest levels in the municipality, it is recommended that there be a serious internal discussion about the pros and cons of the current institutional mechanisms for promoting mainstreaming and whether alternative arrangements might serve the mainstreaming cause more effectively. For example, certain other local governments have established HIV/AIDS units within the City Manager's or Mayor's offices, with dedicated staff and resources allocated for the specific purpose of facilitating the implementation of mainstreaming and other activities related to the municipality's response to HIV/AIDS. Locating the institutional driver of mainstreaming outside of the health function also assists to alter dominant perceptions that HIV/AIDS is a 'health issue.' Of course, in thinking through the different institutional options, the City of Cape Town will need to consider issues of capacity and the availability of resources, as well as the possible risks that may be associated with altering the status quo.
- HIV/AIDS mainstreaming needs to be integrated into the IDP: Mainstreaming HIV/AIDS within the municipality is unlikely to be given the attention it requires unless it is reflected as a priority in the municipality's IDP. Entrenching HIV/AIDS mainstreaming in the IDP will require the implications of HIV/AIDS as a strategic development and governance issue affecting the municipality to be clearly articulated, along with a clear explanation of the municipality's strategic response, and how the strategy will be managed and coordinated, with clear roles and responsibilities assigned. It is also important that linkages between poverty reduction, gender inequality and HIV/AIDS be explained, and that opportunities for interventions that support these linkages be created wherever possible. The HIV/AIDS mainstreaming action plans of each of the sector departments will also need to be integrated into the document, and provision made within the annual municipal budget to enable these plans to be implemented. Finally, the indicators and targets associated with the sectoral mainstreaming action plans need to be fully integrated into the performance management system of the municipality.
- Conduct a participatory strategic planning exercise: The City's current HIV/AIDS and TB Multi-sectoral Strategy has been in place since 2000. With almost six years of accumulated experience with implementation, it is recommended that the City convene a city-wide participatory workshop involving all key stakeholders to revisit the original Strategy document and to review progress, challenges encountered, the changing context of HIV/AIDS in the city, and how mainstreaming can be more effectively facilitated amongst all stakeholders. The outcome of this workshop would be a renewed strategy and way forward. Such an exercise may also help to reinvigorate and inspire those involved in the battle against the disease locally, as well as raise the profile of HIV/AIDS as an issue in the City.
- Consolidate the understanding of the epidemic in the city: While the City of Cape Town, in contrast to many other municipalities, has a relatively sophisticated and effective system for collecting data on HIV prevalence, there is a need to make sense of all the information that is available and to fill in gaps where knowledge about HIV/AIDS within particular sub-groups or geographical areas is limited. There is also a relative scarcity of information available about the current and projected future impacts of the epidemic on various sectors. The City of Cape Town is fortunate to have at its disposal a wealth of medical and other research expertise located in various institutions that can be drawn upon to assist with generating the required knowledge about the epidemic. This knowledge is vital to understanding how best the City, as well as other role-players, can invest resources in preventing the spread of the epidemic and responding to its socio-economic consequences. It is also important that this information be packaged in ways that are accessible to stakeholders within the municipality (e.g. councillors, officials driving sectoral mainstreaming programmes) as well as external stakeholders amongst civil society and the private sector. The City's website could be one channel through which to disseminate this information.

- Prevention strategies need to be more focussed and targeted: One of the current weaknesses of the Strategy that was identified in the study is that prevention efforts are not having the intended impact in terms of reducing the number of new HIV infections. In fact, HIV incidence across the city has a whole has been steadily increasing over the past five years. This arguably points to a need for the current prevention strategy to be revised and refocused, with specific strategies to target different groups at particular risk of infection. At the same time, however, it is important that targeted prevention strategies are informed by a recognition of the socio-economic context in which the city's residents live and interact to ensure that such strategies do not disempower and/or stigmatise 'high-risk' groups.
- Address critical constraints in the health system: Despite the generally above average standard of health services available in the City of Cape Town, almost all respondents in direct contact with health facilities in the city agreed that there are chronic staff shortages and budgetary constraints that have made working conditions less than ideal for staff and have lead to a deterioration of the quality of patient care provided at a number of facilities. Since health services are at the frontline of the response to HIV/AIDS, it is vital that solutions be implemented to address these challenges. This will require political will at the highest levels within the city as well as the province, and a coordinated effort between the two spheres of government, to ensure that the required budgetary allocations are made and systems are improved where necessary.
- Develop a strategy to support orphans and other vulnerable children: With current estimates suggesting that there are 54 000 orphans in the City of Cape Town due to HIV/AIDS, and that the figure is set to increase in the next few years, there is an urgent need to develop strategies to address the specific needs of this most vulnerable group affected by HIV/AIDS. A strategy to support orphans and vulnerable children should entail an assessment of the numbers of children, their locations, their living arrangements (e.g. child-headed households, children living on the street) and what types of support they require. The City Multi-sectoral HIV/AIDS Coordinating Committee is well-placed to oversee the development and implementation of such a strategy, since it incorporates (or should incorporate) most of the key local and provincial government and civil society role-players whose services would be required to provide comprehensive support to orphans and vulnerable children (e.g. Housing, Education, Social Development).
- Develop a comprehensive M&E system: While monitoring of different components of the Strategy is taking place in various forms, there is a need to consolidate the elements of M&E into a comprehensive system that can be used to assess the impacts of the Strategy as a whole. This would require the development of key indicators against which the overall impact of the strategy can be measured (e.g. the incidence of HIV and TB, the number of children born HIV-positive, the infant mortality rate etc.).
- Ensure that people living with HIV/AIDS participate directly in all processes: Since they are the primary target group that is supposed to be supported through the Strategy, opportunities need to be created for ongoing participation by people living with (and directly affected by) HIV/AIDS.

The following recommendations deal specifically with the MSATs:

- Increase resources for coordination: The MSAT system is a central component of the City's HIV/AIDS Strategy and has demonstrated its potential to make a valuable contribution to the response to HIV/AIDS in the city over the last three years. However, the full potential of the MSATs could be further realised through the allocation of increased human and financial resources to assist with coordinating and supporting these structures. For example, the MSAT Coordinator positions could be made more secure and additional staff could be allocated to managing the programme (i.e. supervising and supporting the coordinators, managing funding disbursed through the MSATs, liaising with sector departments, monitoring and evaluating MSAT activities and projects, providing opportunities for learning between MSATs, documenting best practices and disseminating lessons).
- Resolve the concerns of the MSAT Coordinator positions: It is clear from the study that the MSAT Coordinators are vital to the functioning and sustainability of the MSATs. Most of the current Coordinators appear to have established good relationships with the MSAT members and have developed useful capacity for HIV/AIDS networking. However, the current concerns a number of MSAT Coordinators expressed with regard to the status of their learnerships, the future of their positions, support with transport and communication

- expenses, and administrative resources appear to be having a demotivating effect on some Coordinators. It is recommended that these concerns be addressed as a matter of urgency and that consideration be given to making the positions of coordinators more secure.
- Acknowledge the contribution of community volunteers: The vital role of the volunteers who participate in
 and manage the MSATs should be acknowledged and rewarded appropriately in order to sustain their
 commitment. For example, members of the management committees of the MSATs could be reimbursed for
 the direct costs they often personally incur as a result of their work for the MSATs (e.g. transport and
 telephone costs). Another idea is to have an annual function for the MSAT members at which awards can be
 made to recognise the achievements of the MSATs and honour individuals' contributions.
- Reinstate MSAT operational plans: These plans are intended to be based on needs analyses in each subdistrict and are supposed to guide all the activities of each MSAT and assist in identifying gaps and priority needs for funding of projects. However, in most cases these plans are no longer being implemented. It is therefore recommended that the operational plans be reinvigorated as the basis for local level responses to HIV/AIDS and TB.
- Strengthen linkages with sector departments: The generally low levels of participation of municipal sector departments, as well as provincial government departments, was identified as a key challenge facing the MSATs. Communication to and commitment from these departments appear to be the main contributing factors to this problem. It is recommended that all sector departments and relevant provincial departments (e.g. Health, Social Welfare and Population Development, Education) are provided with a list of contact details for all of the MSATs and dates for monthly meetings. It would be also important for each sector department and provincial government department to identify staff located in each health sub-district or nearest equivalent administrative structure and for their contact details to be provided to each MSAT Coordinator.
- Explore ways to streamline the funding and reporting process for MSAT members: It is clear that the city funding channelled to AIDS service organisations via the MSATs is fulfilling a vital support role. However, concerns have been expressed that the current application and reporting requirements associated with this funding place a significant burden on both the City as well as the recipient organisations, especially those with less capacity. In the case of some of the recipients, the amount of paperwork involved in accessing and reporting on the funding appears to be quite disproportionate to the size of the grants disbursed. It is therefore recommended that the City explore ways of making it easier for recipients to report on funding while still maintaining a minimum required level of accountability. One of the challenges the city faces is the onerous demands placed on it to account for public funds by national legislation, in particular the Municipal Finance Management Act. One course of action might be to lobby and advocate for changes in legislation to enable municipalities to provide assistance to civil society organisations more easily. 125
- Strengthen M&E of MSAT-funded projects: The current monitoring of projects that are funded via the MSATs is practical and geared towards the legal obligations the municipality has to comply with, as well as its available capacity. However, although projects are required to submit quarterly narrative reports on progress with implementation of the projects, no evaluations on the projects are conducted to assess their impacts. While conducting comprehensive evaluations of the large number of projects funded may not be financially viable or practical, it is recommended that some kind of evaluation of a sample of projects be conducted in order to establish the impact they are making (versus the resources invested), what capacity building needs they have, and to identify innovative practices that could be shared with other projects. Positive findings from the evaluation could also be used to secure ongoing political commitment within the municipality to providing funding for community-based HIV/AIDS projects.
- Establish sub-district HIV/AIDS referral networks: One of the functions the MSATs are ideally placed to
 provide is a referral network for HIV/AIDS and other related services within each of the health sub-districts.
 Over time each network would aim to cover the entire spectrum of services, including education, VCT,
 PMTCT, ART, comprehensive HIV/AIDS treatment, support and wellness programmes, income generation,
 home-based care, hospice care, death and burial services, bereavement support and care for orphaned and
 vulnerable children. Establishing sub-district HIV/AIDS referral networks will require each MSAT to compile a

database of all relevant organisations, institutions and government (local and provincial) departments in the sub-district providing services and assistance relating to HIV/AIDS prevention, treatment, care and support. The sub-district databases would need to be supplemented by a city-wide database of institutions and organisations that provide services on a wider scale than individual sub-districts. Sources of funding for organisations could also be included in this database. The intention would then be that the MSATs would provide a 'one-stop' information service point for residents. The responsibility for building and maintaining the MSAT databases could be given to the MSAT Coordinators, or it could be delegated to one of the MSAT member organisations. In the latter case, these organisations may require some form of financial assistance in order to take on this responsibility.

• Promote learning and sharing: While there is currently some exchange of experiences between the MSATs through the City HIV/AIDS Coordinating Committee meetings and the MSAT Coordinators' monthly meetings, it might be useful for the MSAT members (e.g. the management committees) to have opportunities to meet each other and share their experiences. This could be done through learning exchanges between individual MSATs, or occasional events where practices and lessons can be presented. It would also be useful to share information about the projects of individual MSAT member organisations through site visits or presentations. A further possibility is to produce a regular MSAT newsletter (e.g. quarterly), which could be used to disseminate news and innovative practices from the MSATs and projects.

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Appendix 1: List of interviews

Dr Ivan Toms Executive Director: Health

Ms Esther Carolissen Coordinator: HIV/AIDS Workplace Programme
Mr Herman van der Watt Manager: Employee Wellness Programme
Ms Lokiwe Mtwazi Executive Director: Community Development
Dr Pren Naidoo AIDS/STI/TB Programme Manager (City Health)

Cllr Martin Fienies MAYCO Member for Health

Ms Nomzamo Sishuba-Mbane MSAT Coordinator: Western sub-district
Ms Nyameka Mbula MSAT Coordinator: Klipfontein sub-district
Mr Chuma Sandile MSAT Coordinator: Northern sub-district
Mr Clifford Martinus Chairperson: MSAT Western sub-district

Mr Desmond Dickson

Ms Beulah Newhoudt-Arendse
Mr Vuyani Kota Former
Ms Zukiswa Mkutyukelwa
Ms Emmarentia Van Breda

Western sub-district HIV/AIDS/TB/STI Coordinator
Former MSAT Coordinator: Southern sub-district
MSAT Coordinator: Khayelitsha sub-district
Northern sub-district HIV/AIDS/TB/STI Coordinator

Ms Jacque Pondo Chairperson: MSAT Northern sub-district

Ms Jacqui Ross Southern sub-district HIV/AIDS/TB/STI Coordinator

Pastor Adriaan Blom Chairperson: MSAT Southern sub-district

Ms Jeanette Masala City Health HIV/AIDS/TB office

Ms Gasiena Khan City Parks

Mr. Alubraan Davids

Director, Social Development Department

Social Davelopment Department

Ms Nuhraan Davids Social Development Department Mr Dino Appollis Water & Sanitation Department

Mr Charles Cooper Communications and Marketing Department

Ms Desiree Epstein Operations: Special Projects

Ms Bronwin Sabor MSAT Coordinator: Tygerberg sub-district
Ms Rochelle Rudolph MSAT Coordinator: Mitchells Plain sub-district
Ms Wendy Windvogel MSAT Coordinator: Eastern sub-district

Ms Juanita Arendse Assistant Director: HIV/ AIDS, Provincial Department of Health

Ms Mariette Williams WC-NACOSA

Appendix 2: List of participants at research feedback seminar, 12 September 2006

Ms Esther Carolissen Coordinator: HIV/AIDS Workplace Programme

Ms Evelyn Custer City Health: Tygerberg sub-district
Ms Nuhraan Davids` Social Development Department

Mr Clint Dixon Executive Assistant, MAYCO Health member

Ms Desiree Epstein Operations: Special Projects
Mr John Frans Transport Department

Mr Roger Fritz RED1, EAP & HIV/AIDS Coordinator
Rev David Galetta Chairperson: MSAT Klipfontein sub-district

Ms Gasiena Khan City Parks

Cllr Cathlene Labuschagne Health Portfolio Committee

Mr Pat Lenox Director: Economic and Human Development Department

Mr Clifford Martinus Chairperson: MSAT Western
Ms Jeanette Masala City Health HIV/AIDS/TB office
Ms Bongile Maxambele Sensible Drinking Project

Ms Nyameka Mbula MSAT Coordinator: Klipfontein sub-district

Ms Nomaphelo Mohlala Ubabalo Christian Development and Support Programme
Ms Sibongile Nohiya Mitchells Plain sub-district HIV/AIDS/TB/STI Coordinator
Ms Neshaan Peton Klipfontein sub-district HIV/AIDS/TB/STI Coordinator

Ms Nomzamo Sishuba-Mbane MSAT Coordinator: Western sub-district

Ms Aspi Siyolo Khayelitsha sub-district HIV/AIDS/TB/STI Coordinator

Mr Mzwandile Sokupa Human Settlements Department

Mr Desmond Toerien IMATU

Mr Herman van der Watt Manager: Employee Wellness Programme

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Ms Wendy Windvogel MSAT Coordinator: Eastern sub-district
Mr Simbongile Ntshangase Human Settlements Department
Ms Venetia Paulse Social Development Department

Dr P Naidoo City Health: HIV/AIDS/TB Programme Manager

Ms Mariette Williams WC-NACOSA

Appendix 3: Useful resources on HIV/AIDS mainstreaming

The following are recommended as useful texts for those interested in learning more about mainstreaming HIV/ AIDS:

ACORD. 2005. Generic Training Guide on HIV and AIDS Mainstreaming. Kampala, ACORD.

AMICAALL, The World Bank, UNAIDS, UNDP. 2005. *The AMICAALL Toolkit: Local Governance and HIV/AIDS. Geneva,* AMICAALL.

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Endnotes

- In most instances throughout this report the abbreviation, 'HIV/AIDS,' has been used. However, it is noted that in some reports the preferred reference is to 'HIV and AIDS," in recognition of the differential nature and impacts of infection with HIV versus its development into AIDS, with its associated illnesses. In some places where there has been a need to emphasise this distinction in the report, the term 'HIV and AIDS' has been used.
- Elsey and Kutengule 2003; UNDP, UNAIDS and The World Bank 2005:10.
- The World Bank, UNDP, UN Habitat, Cities Alliance, and AMICAALL 2003:vii; Kelly 2003:4.
- The World Bank et al 2003:vii.
- The most recent Department of Health National HIV Prevalence Survey for South Africa in 2005 estimated that almost 19% of the country's population, or 5.5 million people, are currently living with HIV (Department of Health 2006:17.
- The National Department of Provincial and Local Government is in the process of finalising a Framework for Development and Governance Responses to HIV and AIDS, along with a support programme to assist municipalities to develop and implement local responses to HIV/AIDS. Some work to support HIV/AIDS mainstreaming amongst municipalities is also being done by various other agencies, such as the South African Cities Network, the Consolidated Municipal Transformation Programme and the Centre for Municipal Research and Advice.
- The lack of available documented best practices around local government responses to HIV/AIDS is noted by Kelly 2003:3.
- Restructuring within the City's administration in mid-2006 resulted in the City Health Department becoming the Health Directorate. Throughout this report 8 references to both terms are used.
- City of Cape Town 2006:34.
- Morris 08/06/2006.
- This figure is based on a narrow definition of employment. 11
- 12 City of Cape Town. 2006:179.
- City of Cape Town 2006:27 & 29. 13
- In June 2005, the City's Mayoral Committee approved a new Human Settlement Plan for the municipality to address the growing housing backlog. The plan aims to deliver 20 000 housing opportunities over the next ten years, from a current delivery rate of approximately 8 000 housing opportunities per annum (City of Cape Town 2005:149).
- City of Cape Town 2006:27. 15
- 16 City of Cape Town 2006:176.
- A 'comprehensive' response can be defined as one that involves a package of interventions, including prevention, treatment, care and support and impact 17 mitigation.
- In 2006, one district municipality was dissolved, reducing the total number of municipalities in the country to 283.
- AfroAIDSinfo. Local Government Responses, accessed at http://www.afroaidsinfo.org/public/Policy/localresponses/aboutgovernment.htm. Retrieved July 23, 2006.
- 20 The 1998 White Paper on Local Government defined the vision of 'developmental local government as local government 'committed to working with citizens groups and communities to create sustainable human settlements which provide for a decent quality of life and meet the social, economic and material needs of communities in a holistic way.' (Republic of South Africa 1998:no page).
- These issues appear to have remained key stumbling blocks since 2000. A study by the South African Cities Network on city responses to HIV/AIDS in 2004 noted 21 that the two key barriers to city's establishing effective HIV/AIDS responses were capacity constraints amongst staff and a lack of strategic planning around the impacts of HIV/AIDS and its long-term consequences. (Kelly 2004:7)
- 22 Barnett and Whiteside 2002:297-298; Quinlan and Willan 2005:229 – 230 & 236; Cameron 2005:103 – 122.
- 23 Ouinlan and Willan 2005:229 - 230.
- The government's response to the epidemic continues to be highly controversial. There remains much criticism from civil society of the National Department of Health's slow roll-out of the ARV programme and of the Health Minister's apparent reluctance to acknowledge the severity of the AIDS crisis in South Africa and the need for treatment roll-out to be stepped up significantly.
- The Democratic Alliance (DA) won control of the City from the African National Congress (ANC) in the December 2000 local government elections. Two years later, following the October 2002 floor crossing period, the ANC won back control of the City Council. In the March 2005 municipal elections, a DA-led coalition again gained political control of the City.
- All of the other five metropolitan municipal councils in South Africa have been led by the ruling ANC since the 2000 municipal elections with little significant 26 opposition. Cape Town is the only metropolitan municipality where there has been opposition strong enough to challenge the ANC. Currently, following the March 2006 local government elections, the City is under the control of a Democratic Alliance-led coalition government.
- According to one senior official interviewed, at the time the DA-led council was looking to allocate significant resources (approximately R10m) specifically for addressing HIV/AIDS in the City. The immediate impetus for developing the Multi-sectoral HIV/AIDS and TB Strategy was therefore to provide a means of allocating these resources
- ART only started to be available at public sector health facilities in the country in April 2004. 28
- This is an area of research that is yet to be fully explored. For an example of a study that has been done on the topic, see Manning 2003. For an analysis of the impacts of HIV/AIDS on local government electoral processes in South Africa, see Strand, Matlosa, Strode and Chirambo 2005.
- Barnett and Whiteside 2002:298. 30
- 31 Kelly 2003:5.
- Van Donk 2002:1. 32
- Van Donk 2002:1. 33
- Van Donk 2002:1. 34 Van Donk 2006:156.
- 36
 - Smart 2001; AfroAIDSinfo. Local Government Responses, accessed at http://www.afroaidsinfo.org/public/Policy/localresponses/aboutgovernment.htm. Retrieved July 23, 2006. Annan and Kouassi 2005:11
- 37
- Annan and Kouassi 2005:11. 38
- Elsey and Kutengule 2003:12. 39
- Holden 2004:5 &13. 40
- 41 Holden 2004:x.
- 42 Holden 2004:x.
- 43 Holden 2004:x
- 44 Holden 2004:6-9
- 45 Holden 2004:10-11; Van Donk 2006:166.
- Holden 2004:13. 46
- As Holden (2004:52) points out, the lack of documented good mainstreaming practice is not unique to the local government sector. Most development agencies 47 have not been implementing mainstreaming for long enough for a body of good practice to have e<mark>merged.</mark>
- 48 Holden 2004:13 "Local Government responses," accessed at http://www.afroaidsinfo.org/pblic/Policy/localrespones/aboutgovernment.htm. Retrieved July 23, 2006.
- 49 Quinlain and Willan 2005:237. 50
- Kelly 2003:4. 51
- 52 Republic of South Africa 2000:44.
- Republic of South Africa 1998:no page
- It was noted by some respondents that very little is known about HIV infection amongst the white population in the City, since the majority of whites make use of 54 private health care services and are consequently not tracked through the public health system. This figure was given during interviews with senior officials within City Health.
- 55
- Nelson Mandela Foundation/HSRC 2005:40.
- 57 The prevalence data in table 2 shows other apparent anomalies. For example, the data for the Blaauwberg and Mitchells Plain sub-districts show dramatic year-onyear fluctuations, which are inconsistent with the more steady annual variations in the data recorded for other sub-districts.
- 58 Caelers 13/09/06.

- 59 Caelers 13/09/06.
- 60 Naidoo 2006
- Barnett and Whiteside 2002:33 34. 61
- City of Cape Town 2006:19. 62
 - Thom 28/02/2006.
- City of Cape Town 2006:22.
- 65 City of Cape Town 2006:18.
- City of Cape Town 2006:18. 66
- City of Cape Town 2006:169. 67
- 68 Thom 20/03/2002.
- Thom 28/02/2006.
- 70 City Health 2006:1.
- 71 Naidoo 2006.
- 72 Naidoo 2006.
- Naidoo 2006. 73
- 74 City of Cape Town 2005:159.
- 75 Thom 28/02/2006.
- 76 Thom 24/03/2005
- City of Cape Town 2006:169. 77
- City of Cape Town 2006:169. 78
- Schroeder 03/03/2003. 79
- 80 Naidoo 2006.
- Morris 2006: 08/06/2006. 81
- 82 Smetherham 2003:08/04/2003.
- 83 Morris 2006:08/06/2006
- Smetherham 2003:08/04/2003; Naidoo 2006. 84
- The City has on occasion used the fact that it has a relatively lower HIV prevalence rate than other cities in the country as a draw card for investment. For 85 example, in one publication publicising its response to HIV/AIDS, it is noted that the City 'still has the lowest HIV infection rate of all SA cities,' which gives it 'a competitive advantage for business.' (Leadership in HIV/AIDS 2004)
- Almost all the stakeholders interviewed in the course of the study expressed a view that HIV/AIDS was a major problem in the city. However, few respondents 86 were able to quote statistics or point to specific concrete examples of the social or economic impacts of the epidemic
- According to figures provided by the Human Resource Development and Management Department, there are a total of 23 252 staff in the City, of which 17 488 87 are male (75.2%) and 5 765 are female (24.8%).
- This figure is based on statistics compiled by the HIV/AIDS Workplace Programme over three financial years, from July 2003 to June 2006.
- Peters 2005:10/04/2005.
- 90 Goligoski 2005:08/04/2005.
- Morrison,09/06/2005. 91
- City of Cape Town 2004:1. 92
- City of Cape Town 2004:1. 93
- City of Cape Town 2004:1. 94
- City of Cape Town 2004:1 95
- City of Cape Town 2004:5; City of Cape Town 2006:2.
- 97 Naidoo 2006.
- City of Cape Town 2006:3. 98
- City of Cape Town 2004:4. 99
- Phillip 05/04/2006.
- City of Cape Town HIV/AIDS Workplace Policy.
- Van der Watt 2003:2. 102
- 103 Van der Watt 2003:3-4.
- 104 This figure does not correlate to the totals in the table due to a total of 24 members having either died (9) or terminated their service with the municipality (15).

 105 The apparent decline in the number of staff enrolled in the treatment programme each year can be explained by the fact that some staff who test HIV-positive
- are referred to external programmes because they do not qualify for the City's internal treatment programme. Some staff whose medical aids have sufficient benefits are referred to private health care providers, while others are referred to local state clinics or hospitals for treatment.
- 106 The HIV/AIDS Workplace Programme of the City of Cape Town has been widely praised as a model for other municipalities to replicate. The programme has received a number of awards, including from the South African Cities Network and the CPSI Public Sector Innovations Awards.
- 107 Naidoo 2006.
- 108 Naidoo 2006.
- 109 Interview with Dr Ivan Toms, 19/07/2006
- 110 Naidoo 2006.
- 111 City of Cape Town 2006:118.
- 112 City of Cape Town 2005:157.
- 113 As a consequence of internal restructuring within the municipality, these departments have subsequently been renamed the Social Development Department and the Parks and Cemeteries Departments.
- 114 Naidoo 2006.
- 115 Information obtained from City of Cape Town Annual Report 2004/05.
- 116 City Health Directorate 2006.2.
- 117 Over the last two years the City Health Department has allocated over R600 000 to capacity building training for MSAT members. The organisation funded to
- provide the training WC-NACOSA has also been funded to provide ongoing mentorship to eight developing organisations from amongst the MSAT members.

 The two-year contracts of most of the co-ordinators are set to terminate at the beginning of 2007. At the time of conducting the research, one of the co-ordinator posts was vacant after the co-ordinator resigned to assume a full-time position within the municipality. While this was viewed as an example of the programme having empowered one of the co-ordinators, a legitimate concern is that the investment in building the capacity of the individual has been lost to the MSATs and the health sector more generally.
- 119 City of Cape Town 2006:12.
- 120 City of Cape Town 2006:22.
- 121 City of Cape Town 2006:74.
- 122 Gender 'mainstreaming' is treated similarly under the same set of strategic objectives, where ten departments are also required 'to develop and implement gender plans as a mainstreaming strategy.
- 123 Holden 2004:54.
- 124 AfroAlDSinfo. Local Government Responses, accessed at http://www.afroaidsinfo.org/public/Policy/localresponses/aboutgovernment.htm. Retrieved July 23,
- 125 One respondent made a suggestion that the amount of funding below which some of the more onerous reporting requirements apply be increased to make it easier to make grants to community-based organisations.

