South African Cities Network
HIV and AIDS Research Series:
Challenges and Responses for Developmental Local Governance
Foreword

HIV and AIDS has evolved from a mysterious illness often surrounded by a wide range of interpretations and responses to a developmental challenge that requires carefully crafted responses from a wide range of stakeholders. The varied interpretations and escalation of the challenge from a predominantly health issue to a developmental challenge requires extensive research to enhance the understanding of the pandemic and to develop comprehensive, integrated and sustainable responses. Such research has been initiated by the National Health Department and other government and non-government agencies. The aim of the SACN HIV and AIDS research programme with its series of research papers is to identify and address knowledge gaps that have not been covered by existing research initiatives particularly in the context of developmental local government. The research must ultimately inform integrated multi-sectoral responses developed by national, provincial and local governments. Although there is a bias towards larger towns and cities most recommendations will be relevant to smaller district and local municipalities too.

This is the first of a series of publications that will be published periodically to continuously identify and research various areas of knowledge needs relating to HIV and AIDS and possible responses from cities. This first publication is comprised of three separate but related research themes which focus on the implications of HIV and AIDS on:

- Migration patterns;
- Urban poverty;
- Spatial planning and land use management. It must be noted that this list of challenges and responses will be continuously complemented by additional research papers that will be published periodically.

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- Hector  
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Definitions

**AIDS:** AIDS is the term given to the constellation of OIs and malignancies, as well as manifestation of HIV infection itself (encephalopathy and the wasting syndrome), that occurs when the immune system is profoundly depleted.\(^1\)

**CSOs:** Civil society organisations include those organisations that designate themselves as nongovernmental (NGO), community-based (CBO), non-profit (NPO), dedicated women's, youth or political organisations and social service clubs. This category encompasses a large number of community-based AIDS initiatives, home-based care organisations, support groups and PWA associations, as well as hospices, women's and men's groups, training organisations, youth outreach groups, community centres and non-AIDS specific associations such as Black Sash, FAMSA, and mental health councils.\(^2\)

**Dependency:** The dependency ratio ordinarily measures the balance of economically productive and non-productive household members. The standard measure, total number of children and elderly over total number of working age adults, is problematic in a country with high unemployment and where social grants are available to household members who otherwise are not economically active. Other dependency ratios are the child dependency ratio that shows the proportion of children under the age of 15 divided by those between the ages of 16-64 in the household; and the female weighted dependency ratio that identifies the burden that women face as caregivers to both children and the elderly.

**HIV:** The human immunodeficiency virus (HIV) primarily infects and destroys cells in the immune system, particular CD4 (helper) T-lymphocytes, causing profound immune suppression that gradually develops over a period of years and ultimately renders the patient vulnerable to opportunistic infections (OIs) and malignancy. The rate of viral replication is directly related to the rate at which the immune system is destroyed.\(^3\)
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Acronyms

AHDSS  Agincourt Health and Demographic Surveillance System
AIDS  Acquired Immunodeficiency Syndrome
ANC  Anti-Natal Care
ART  Antiretroviral therapy
ASSA  Actuarial Society of South Africa
AU  African Union
CASE  Community Agency for Social Enquiry
CBO  Community-based organisation
CSO  Civil society organisation
DoH  National Department of Health (South Africa)
EPWP  Expanded Public Works Programme
FBO  Faith-based organisation
HIV  Human Immunodeficiency Virus
HSRC  Human Sciences Research Council
IDP  Integrated development plan
IOM  International Organisation for Migration
IRC  International Red Cross
KZN  KwaZulu-Natal
LFS  Labour Force Survey
MDG  Millennium Development Goals
MRC  Medical Research Council
NEPAD  New Economic Partnership for Africa's Development
NGO  Nongovernmental organisation
OI  Opportunistic infection
OAU  Organisation of African Unity
PEPFAR  President's Plan for Emergency AIDS Relief (USA)
PLWHA  People Living with HIV and AIDS
PMTCT  Prevention of Mother to Child Transmission
PPASA  Planned Parenthood Association of South Africa
SACBC  South African Catholic Bishops Conference
SADC  Southern Africa Development Community
SARS  South African Revenue Service
SEAHIV  South East Asia HIV and Development Programme
Stats SA  Statistics South Africa
TB  Tuberculosis
TEBA  The Employment Bureau of Africa
UNAIDS  United Nations agency for AIDS
VCT  Voluntary Counselling and Testing
WHO  World Health Organisation
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Executive Summary

This report

The Recommendations are Part 2 of a project on the links between HIV and AIDS and urban poverty. The focus is on those policies where local governments can play a role in mitigating the impacts of poverty on HIV and AIDS and HIV and AIDS on poverty.

The report has four parts:
- Policy Context
- What is the HIV and AIDS problem?
- What is the HIV and AIDS poverty problem?
- Recommendations

Policy context

The national context for local government HIV and AIDS poverty interventions is contained in the Department of Health’s HIV and AIDS/STD Strategic Plan for South Africa, 2000-2005; and Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, 2003. Both plans focus on prevention by way of condom use, abstinence, change in sexual behaviour and life skills and care and support. Neither pays much attention to poverty and neither accords a significant role to local government.

Provincial governments pay more attention to the contribution of local government, but again this is limited and more in the area of prevention and care and support than poverty. In practice provincial governments have played the predominant role in mitigating the poverty impacts of HIV through the delivery of social grants. This function is to shift to the national Social Security Agency.

Local government HIV and AIDS programmes differ in their sophistication and completeness according to the capacity of the local government and the leadership within that local government. Local government HIV and AIDS programmes again focus on prevention and care and support.

Civil society and faith-based organisations are central to the delivery of prevention and care and support activities and receive considerable support from government to this end. The participation and effective contribution of civil society organisations is an important feature of the policy context.

Prioritising prevention and care and support is a rational response to the stage reached by HIV and AIDS in South Africa. It is only in the early 2000s, with the number of AIDS-sick and AIDS-deaths increasing rapidly, that attention will shift to HIV and AIDS poverty.

An essential debate is whether poverty programmes distinguish between households whose poverty or inability to rise above poverty arises from HIV and AIDS and other households whose poverty or inability to rise above poverty arises from other causes? The qualified answer is that it is incorrect to favour individuals and households whose poverty arises from being AIDS-sick and from AIDS deaths.

This document and the exploration of the role and contribution of local government represent an exploration uncharted by policy.

What is the HIV and AIDS Problem?

The projected number of HIV-positive persons, AIDS-sick, cumulative AIDS deaths and the total number of orphans for 1990-2015 is contained in Table 1. It is apparent that the number of persons who are AIDS-sick, the number of AIDS-deaths and the total number of orphans have increased rapidly in and since the early 2000s.
<table>
<thead>
<tr>
<th>Year</th>
<th>Total HIV+</th>
<th>Total AIDS sick</th>
<th>Cumulative AIDS deaths</th>
<th>Total orphans (incl. non-AIDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>38,597</td>
<td>293</td>
<td>326</td>
<td>436,352</td>
</tr>
<tr>
<td>1995</td>
<td>943,590</td>
<td>16,135</td>
<td>20,662</td>
<td>458,431</td>
</tr>
<tr>
<td>2000</td>
<td>3,731,645</td>
<td>194,424</td>
<td>318,697</td>
<td>644,753</td>
</tr>
<tr>
<td>2005</td>
<td>5,165,797</td>
<td>589,454</td>
<td>1,542,169</td>
<td>1,297,197</td>
</tr>
<tr>
<td>2010</td>
<td>5,408,621</td>
<td>692,511</td>
<td>3,404,415</td>
<td>2,039,353</td>
</tr>
<tr>
<td>2015</td>
<td>5,407,945</td>
<td>742,261</td>
<td>5,358,501</td>
<td>2,301,277</td>
</tr>
</tbody>
</table>

The number of persons whose productivity is impaired as result of being HIV positive or having AIDS is less than half the population with HIV and AIDS. In 2004 the numbers were:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute HIV infection</td>
<td>1,476,000</td>
</tr>
<tr>
<td>Early disease</td>
<td>1,098,000</td>
</tr>
<tr>
<td>Late disease</td>
<td>1,671,000</td>
</tr>
<tr>
<td>AIDS-sick</td>
<td>534,000</td>
</tr>
</tbody>
</table>

HIV prevalence is higher the higher the proportion of the population that:
- is African
- is female
- falls within the 20-24, 25-29 and 30-34 age cohorts
- lives in cities
- lives in informal settlements in cities
- lives in high prevalence provinces.

Projections are unavailable for cities and areas of cities such as informal settlements. Projections are unavailable for households and there is little insight into the nature of household reconfiguration following the death of AIDS-sick persons, the implications for dependency and poverty among households and the ability to recover from poverty, and the demand for housing and services.

**What is the HIV and AIDS poverty problem?**

The poverty and HIV infection problem is that of poverty and gender inequality leading to behaviour that increases the risk of HIV infection.

The HIV and AIDS and poverty problem largely arises when persons are AIDS-sick. It is when a person’s ‘performance scale’ declines, late in WHO Stage 3 and during Stage 4, that a household will experience increasing expenditure, asset reduction and declining incomes.

Death concludes the medical expenses, but the cost of funerals can be about four times monthly household income and represents a major financial burden.

As AIDS deaths accumulate, the greatest poverty problem will become household reconfiguration and the increased dependency burden following the death of income-earning individuals and also of individuals who are receiving social grants.

AIDS transfers individual and familial survival onto a less resourced and often socially disadvantaged core of people. The burden of care is pushed upwards, particularly onto grandmothers; outwards, particularly onto adult female kin; and downwards, to children themselves. Few are sufficiently well resourced to take this on.

The sharply increasing number of orphans was shown in Table 1. The proportion of the orphans who are AIDS-orphans has increased/is increasing from 0.00 percent in 1990 to 0.02 percent in 1995, 23 percent in 2000, 62 percent in 2005, 78 percent in 2010 and 84 percent in 2015.
There are no reliable data regarding child-headed households, but it is clear that the numbers are still limited. The rate of increase in the number of child-headed households will be in proportion to the declining ability of the extended family and the community to take in orphans. Child support and foster care grants will slow the creation of child-headed households.

Girls, women and grandmothers bear the brunt of providing care needed by the AIDS-sick and taking in family during periods of household reconfiguration.

It appears that the elderly, especially grandmothers, play the largest role in providing care to children and their children in a context where ordinarily they would expect to be being cared for by their children. Projections for dependency amongst the elderly are contained in the report.

The death of grandparents restarts the cycles of orphanhood, but this time with even fewer options for orphans.

There are three ongoing poverty problems:
- Sexually transmitted infections increase the probability of HIV infection and low-income persons have less access to treatment.
- Inadequate nutrition compromises the immune system.
- Overcrowding, lack of ventilation, unhygienic water and sanitation, poor waste removal and the inability to heat water increases susceptibility to opportunistic infections and compromises the immune system.

A compromised immune system can increase susceptibility to HIV infection and can reduce the periods between HIV infection and the onset of “full-blown” AIDS and “full-blown” AIDS and death. Poverty and gender inequality and the ravages of HIV and AIDS diminish social capital, by which is meant (inter alia) attitudes and values that promote safe sex, and norms of reciprocity that sustain persons and households during periods of hardship.

The increase in need is coupled with increasing unemployment, ongoing urbanisation and the rapid growth of informal settlement, a housing policy that encourages the rapid growth of nuclear families, often female-headed with little or no immediate support networks, and the still multiplying ravages of HIV and AIDS. The pressure on families and communities and the challenges to community organisation represent a form of poverty which contributes both to HIV infection and difficulty mitigating the impact of AIDS-sickness and death.
Recommendations

Six overlapping areas of intervention have been identified:

**Leadership:**
- Education and prevention activities
- Build social capital
- Health
- Income support and opportunities to escape poverty
- Housing and services

**Planning**
- Assess the prevalence of HIV and AIDS in the city and the problems to which it is giving rise
- Mainstream HIV and AIDS and poverty mitigation within the IDP

**Social capital:**
- Attitudes toward vulnerable groups
- Cultural norms of reciprocity
- Protection against exploitation
- Support and work with civil society and faith-based organisations
- Resources for community organisation
- Build sustainable communities

**Health**
- Free health care for sexually transmitted diseases
- Access to antiretroviral drugs
- Nutrition programmes – food parcels, food gardens, school nutrition
- Housing and services

**Income support**
- Social grants
- Nutrition programmes - food parcels, food gardens, school nutrition
- Protection of jobs against stigma
- Free burials
- Promotion of economic development
- Free schooling and provision of school uniforms
- Subsidised housing and services

**Housing and services**
- Housing subsidy
- Free basic services
- Different forms of delivery of housing and services
- Prioritise informal settlements and run-down inner city areas
- Build sustainable communities
Chapter 1 Introduction and Background

Part of this research, which does not form part of this publication, comprised an analysis of the links between HIV and AIDS and poverty. The recommendations are Part 2 of the project. The focus is on areas where local governments can play a role in mitigating the impacts of poverty on HIV and AIDS and HIV and AIDS on poverty. The distinctions between prevention, care and support, and mitigation have to do with:

- poverty leading to behaviours that increase the risk of HIV infection;
- ill-health draining a household’s and possibly the extended family’s income and assets;
- ill-health leading to social exclusion and stigmatisation; and
- the death of the AIDS-sick individual(s) exacerbating poverty through increasing dependency during and after a period of household reconfiguration.

The recommendations summarise and take further key aspects of the Part 1 analysis and then proceed to suggest how local governments might best engage in poverty mitigation activities. The activities considered extend beyond local government actions for which they have a mandate and resources and include working within other government programmes and with civil society.

Other reports

There are a number of documents on local government responses to HIV and AIDS. Some of them are very useful and important reading. These include:


The guidance generally provided by these documents has to do with planning, mainstreaming HIV and AIDS and the need for partnerships; and their substantive concern has more to do with prevention and care and support than with post-death impact mitigation. This follows naturally from the time lag between HIV infection and death, and the fact that, in South Africa, it is only now that deaths are increasing rapidly (see Table 1). But this report holds that due to accumulating AIDS deaths the foremost poverty impacts increasingly are to be found in households after the death of the income-earning individual(s).

In their attention to prevention, some of the documents look to poverty that leads to behaviours that risk HIV infection but the documents in large part miss the impacts of the death of an income-earning individual on the individual’s family. None pay much, if any attention to the role of housing and services, such as water and sanitation, waste removal and energy, for prevention and care and impact mitigation. In South Africa these services (and roads) constitute, on average, about two thirds of municipal budgets and since they can be used proactively for prevention and care purposes, this is a significant gap.

The documents also do not provide an indication of the programmes that local governments can employ for impact mitigation purposes.

It is in this light that the specific contribution of this report is in assisting with identifying what the HIV and AIDS poverty problems are and providing recommendations on the role of local government in addressing the HIV and AIDS burden of poverty.
An essential debate

Should poverty programmes distinguish between households whose poverty or inability to rise above poverty arises from HIV and AIDS and other households whose poverty or inability to rise above poverty arises from other causes? For example, in a report on HIV and AIDS the World Bank identifies three factors that determine the household impact of a death and does not include HIV and AIDS therein.

The overall economic impact of an adult death on the surviving household members varies according to three sets of characteristics:
- those of the deceased individual, such as age, sex, income, and cause of death;
- those of the household, such as composition and assets; and
- those of the community, such as attitudes toward helping needy households and the availability of resources.

The first set of characteristics determines the basic impact of the death on the surviving household members; the second and third how well the afflicted household copes. Although disentangling the three is very difficult, it is nonetheless important when attempting to assess the household impact of an adult death to consider all three sets of factors.4

The Bank argues that ‘the high cost to households from AIDS will usually be due to the large number of deaths caused by the epidemic rather than by the by the fact that they are caused by AIDS.’5 Using this logic the Bank suggests that ‘anti-poverty programmes and [HIV and AIDS] mitigation programmes be integrated.’6 Noting that most AIDS deaths occur among prime-age adults, the Bank suggests

Using prime-age adult death as a targeting criterion is likely to have several advantages. Compared with providing help to families with a death from HIV and AIDS, it is fairer since it will include families with prime-age adult deaths from other causes ...7

Similar views are expressed in South Africa.

From a broad policy perspective, I don’t think we should be disaggregating HIV-positive children from HIV-positive orphans, HIV-positive orphans from HIV-negative orphans, or for that matter orphans in general from other children living in poverty. The issues - besides that of medical treatment/support for HIV-positive children/orphans - are generally shared by the various categories of children. In the face of the AIDS pandemic then, surely we need to be a) ensuring HIV-positive people are able to access treatment b) doing everything we can to be thinking through poverty alleviation issues for all South Africans8

‘Of the 17 million children in South Africa, about 12 million are classified as living in poverty.’9 Children have a difficult life in South Africa, and not solely due to AIDS.

There is considerable merit in such views. For example, in the case of the number of deaths rather than the cause of death, the Nelson Mandela Children’s Fund suggests that extended family traditions appear to be caving in under the weight of:
- confounding numbers of AIDS orphans;
- the gradual erosion of the values that sustained it;
- urbanisation and the increasing primacy of the nuclear family;
- unemployment;
- financial hardships; and
- abject poverty10

Nonetheless, there are shortcomings in the World Bank position. For example:

Household resilience or vulnerability to illness costs depended on the severity and duration of illness, as well as household asset portfolios that influenced ability to cope, and the sustainability of coping. Evidence on TB and HIV, for which the costs of illness were highest, indicated that households struggled to cope and adopted strategies that were negative for asset portfolios, potentially leading to impoverishment.11
The World Bank is incorrect in comparing prime-age adult deaths arising from AIDS-deaths to prime-age adult deaths arising from, for example, a car crash.

Similar misgivings are expressed by the National Association of People Living with HIV and AIDS (NAPWA). NAPWA’s position includes that ‘Unemployed PLWHA [People Living with HIV and AIDS] are different from unemployed people with no chronic illness’. While accepting that ‘government has done its fair share to push back the frontiers of poverty’, ... ‘Assistance does not only mean social grants’. The Association is concerned that its members should be assisted with employment and business opportunities and provides practical suggestions in this regard. The Association also strongly urges ‘Food for all’, noting that correct nutrition increases resistance to opportunistic infections (OIs). It is not explained why unemployed PLWHA is different, but it is presumed that an environment is sought that protects workers against stigma and is tolerant of periods of ill-health. It is shown in Tables 1 and 5 that the ‘performance scale’ of most PLWHA are unaffected by their having HIV, but also that with inadequate antiretroviral therapy (ART) about 15 percent of PLWHA will experience an increasing frequency and severity of illness. Persons living in these circumstances do face particular employment problems and eventually are unable to work.

Misgivings also arise in respect of orphans. AIDS orphans are worse off. This is because...

HIV and AIDS causes serious problems for children. But singling out for assistance those children whose parents have died of AIDS stigmatizes the intended beneficiaries. The needs of individual children are not necessarily greater than those of children orphaned by other causes or vulnerable for other reasons, and the problems may begin long before their parents become ill or die from HIV and AIDS.

The significance of this debate is unclear. Government’s safety net response to poverty, notably the social grants and foster care programmes, make use of grants and other measures that in large part were not designed for circumstances arising from HIV and AIDS. Similarly, government’s programmes to help households recover from poverty, for example, job creation programmes were not designed with HIV and AIDS in mind. Nonetheless, on the whole, and accepting that there are many shortcomings, the safety net programmes and perhaps not the poverty recovery programmes, are helping to relieve poverty among very many of those whose circumstances arise from HIV and AIDS.

Can one argue for programmes that discriminate in favour of households whose poverty arises from HIV and AIDS? It seems reasonable to support food programmes, which currently are undergoing change, leading to less access to food and enterprises proposed by PLWHA, but the latter is unlikely to be an initiative that will operate at scale. However, overall, favouring persons and households whose poverty arises from HIV and AIDS is a difficult position to sustain.

Conclusions of this sort have far-reaching implications for this report. Their primary impact is to urge that local governments by and large persist with existing anti-poverty programmes. The balance of this report seeks to delineate those aspects of poverty that arise from HIV and AIDS and the role of local government in pursuing related programmes that provide a safety net and increase the possibilities for individuals and households to rise above poverty.
Chapter 2 Policy Context

The World Bank holds that an effective local government response to HIV and AIDS should be:
Consistent in what it does with National AIDS Policy and oriented to the needs of the local context.15

But what if national government policy pays little attention to the role of local governments and if the role of local government is referred to as a ‘particular uncertainty’?16 Further, what if ‘local government HIV services appear to function almost independently of the national programmes even where there is significant overlap of activities such as where local governments are setting up [voluntary counselling and testing] sites or contracting with NGOs for the provision of [home-based care].17 Of course, these comments refer to prevention, treatment and care and services, and this project has to do with poverty impacts; yet a local government official comments that in the case of ‘... strategies to alleviate poverty, food production, all other issues that go around HIV and AIDS ... on the whole, local governments have been sidelined.’18

National


Purpose of the strategic plan

This document is a broad national strategic plan designed to guide the country’s response as a whole to the epidemic. It is not a plan for the health sector specifically, but a statement of intent for the country as a whole, both within and outside government. It is recognised that no single sector, ministry, department or organisation is by itself responsible for the addressing the HIV epidemic. It is envisaged that all government departments, organisations and stakeholders will use this document as the basis to develop their own strategic and operational plans so that all our initiatives as a country as a whole can be harmonised to maximise efficiency and effectiveness.

It is allowed that local governments should participate in provincial Interdepartmental Committees.

The Operational Plan is still more sparing in reference to local government, with one reference to municipal health departments. With a view to providing the reader with information on the substance of the operational plan:

- In April 2002, after reviewing its approach to HIV and AIDS, Cabinet reiterated its commitment to the plan. Noting progress in the implementation of the plan and the impact beginning to be made with regard to the prevention campaign, Cabinet decided on a number of measures to strengthen and reinforce these efforts, including:
  - strengthening partnerships, especially via the South African National AIDS Council (SANAC);
  - continued use of nevirapine in preventing mother-to-child HIV transmission, and development of a universal rollout plan;
  - providing a protocol for a comprehensive package of care for survivors of sexual assault, including post-exposure prophylaxis with antiretroviral drugs;
  - ensuring that no one should be turned away without appropriate treatment and management of any infection or illness, irrespective of HIV status;
  - noting that antiretroviral treatment can help to improve the conditions and health of people living with AIDS if administered at certain stages in the progression of HIV and in accordance with international standards, government committed to continue its efforts to remove systemic constraints on access to these drugs; and
  - alongside poverty alleviation and nutritional interventions, to encourage investigation into alternative treatments, particularly supplements and medication for boosting the immune system.
The South African National AIDS Council is chaired by the deputy president. It has 15 national government representatives, including 12 departments; and 16 sectoral representatives, including media, NGOs, women, youth, traditional healers, celebrities and local government. There are five task teams that look at prevention; treatment, care and support; information, education and communication; research, monitoring, surveillance and evaluation; and legal issues and human rights. Poverty is not included.

- The plan is premised on the following pillars:
  - Ensuring that the great majority of South Africans who are currently not infected with HIV remain uninfected. The messages of prevention and of changing lifestyles and behaviour are therefore the critically important starting point in managing the spread of HIV and the impact of AIDS. Important in supporting these efforts in the broader context are the social programmes of government and wider society that aim to reduce poverty through improving nutrition, job creation and social support, and to improve education and to bring about moral renewal.
  - Enhancing efforts in the prophylaxis and treatment of opportunistic infections, improved nutrition and lifestyle choices.
  - Effective management of those HIV-infected individuals who have developed AIDS-defining illnesses, through appropriate treatment of AIDS-related conditions – including the possibility of using antiretroviral therapy in patients presenting with low CD4 counts to improve functional health status and to prolong life – and suitable palliative and terminal care where treatment has run its course.

Legislation pertaining to the potential role of local governments is unclear. The Constitution accords local governments responsibility for municipal health, but does not prescribe what this consists of. Local governments increasingly are providing leadership intended to destigmatise HIV and AIDS, are undertaking prevention education and communication activities and working with civil society organisations (CSOs) mostly comprising NGOs and CBOs, and faith-based organisations (FBOs) to provide home-based care. Local government primary health care clinics have been providing voluntary counselling and testing and certain clinics have been accredited to provide antiretroviral drugs and treatment. However, impending legislation will have the effect of confining local government primary health care contributions to environmental health and HIV and AIDS activities are to be channelled to provincial facilities.

The marginal role of local government can be read into Idasa’s Understanding the institutional dynamics of South Africa’s response to the HIV and AIDS pandemic, wherein local government is mentioned six times, on five occasions as being a member of the South African National AIDS Council, on one occasion as being a member of Provincial AIDS Councils, and never as actually doing something. One has to conclude that national government does not anticipate that local governments will play much of a role in addressing HIV and AIDS and, with it, poverty that arises from HIV and AIDS. This document and the exploration of the role and contribution of local government to quite some degree represent an exploration uncharted by policy.

Provincial

Following on from the 2000-2005 Strategic Plan, all provinces are to form Provincial AIDS Councils that will coordinate the provincial multi-sectoral approach with a particular focus on districts, local governments and communities.

The terms of reference for [Provincial AIDS Councils] are to:

- initiate, guide and develop a provincial AIDS Plan based on the 2000-2005 Strategic Plan;
- feed back province-specific issues to [South African National AIDS Council];
- strengthen partnership responses amongst government departments, sectors of civil society and local spheres of government;
- mobilise resources for the provincial aids plan;
- monitor the implementation of that provincial plan; and
- advise the Provincial Cabinet on matters relating to HIV and AIDS.
The Gauteng AIDS Plan 2005 - 2006 is of special interest because one of its goals is to reduce the impact of HIV and AIDS on socio-economic development and because local governments are nominally accorded a significant role. Yet, as will be seen, although their role is emphasised, local governments end up not doing all that much.

The Gauteng AIDS programme is led by the Premier and he is assisted by the Premier's Committee on AIDS, the equivalent of the Provincial AIDS Councils called for in the Strategic Plan, and the Gauteng AIDS Council. The committee comprises members of the executive Committee and heads of departments. The Council’s members are drawn from leadership of civil society across various sectors and include South African Local Government Association (Gauteng).

Each department plays specific roles in the Gauteng AIDS programme, related to its core business. All government departments are required to address AIDS both internally, through the workplace AIDS programmes, and externally according to their core business in partnership with stakeholders from the relevant sectors. This includes funding NGOs to provide services in communities. The strategy has increasingly been integrated into other cross-cutting provincial government strategies, such as youth development, care of children, gender and poverty alleviation.21

The goals of the plan are:

- reduction in new HIV infections in the general public, youth and babies;
- increased productive life for people living with HIV and AIDS;
- normal lives for children and families affected by HIV and AIDS; and
- reduced AIDS impact on socio-economic development in Gauteng.22

In practice, each of these objectives includes features that have to do with poverty, including the effects of poverty and gender ‘imbalance’ on behaviour, improved nutrition, and access to child support grants and workplace programmes. In the case of affected families and orphans, the intention is to enhance community support, support children in their homes, ensure that they obtain social grants and social services, are provided with free/subsidised housing and services, and have access to poverty alleviation programmes. The programme is notable for effectively linking AIDS goals and the province’s development strategy to 2009, and then for providing a detailed list of what the various provincial departments will do in respect of HIV and AIDS, often working with CSOs.

In the case of local governments, the provincial department of local government is charged with:

- Ensuring municipal capacity to co-ordinate the local multi-sectoral AIDS response:
  - co-ordinate the local multi-sectoral AIDS response through AIDS Councils, local multi-sectoral AIDS Units, local plans, coordination, monitoring, reports.
  - develop community capacity on prevention, care and support: educate, train, door-to-door campaigns, coordination and selective funding allocated funding for community based organisations (faith-based, youth, women, men, PLWHA and others).
  - poverty programmes: access to subsidised services for indigent families, specifically burial, water and electricity, referrals.
  - incorporate AIDS into integrated development plans (IDPs).
- Co-ordinate the Municipal AIDS response internally:
  - Workplace AIDS programme with EAP: DLG and municipalities.
  - Mainstream AIDS into municipal services.23

Poverty is included in respect of free burials, free services and referral to the social grants available. In general this seems somewhat realistic since historically provinces have seen to the delivery of social grants, but it is decidedly unambitious.

Local

Local government HIV and AIDS programmes differ in their sophistication and completeness according to the capacity of the local government and the leadership within that local govern-
ment; and, indeed, leadership within provincial government and the guidance provided to local
governments.

Msunduzi’s programme is presented by the World Bank as an example of ‘best practice’.24 Best
practice is presented in regard to the preparation of the city’s AIDS strategy, partnership and
focus. The preparation of the strategy involved considerable participation with partner organisation
that include the Children in Distress Network, Lifeline and [supposedly] more than 60
CSOs working in the area. The strategy priorities include

- community empowerment;
- education awareness;
- a referral system, supporting the rollout of treatment with Nevirapine (for HIV-infected pregnant
women);
- improving access to social grants;
- the welfare of orphans; and
- improvement in treatment and care through the clinics and community volunteers.

Poverty is not listed as a priority.

Another example is Johannesburg’s Jozi Ihlomile: A unique model of HIV and AIDS Intervention
in Johannesburg. The model is presented as unique, but most of its components are not. The model
involves the usual services, but then adds a focus on vulnerable communities. The usual services are
voluntary counselling and testing, community education, home based care services, indigent burials,
support for people living with HIV and AIDS, and vegetable gardens. While poverty is not men-
tioned, indigent burials and vegetable gardens are features of a poverty programme.

Perhaps what is unique about the model is that support is targeted to vulnerable communities rather
than to individuals and households. The model involves an ‘Adopt a Block’ programme, in terms of
which the city will train community leaders, train volunteers to adopt a block, visit each family at
least once a month with families with sick members who require home-based care at least once a
week, identify needs, provide support, education and referrals to necessary services according to iden-
tified needs, and provide HIV and AIDS education per family.

Emphasis is placed on enhancing the capacity of communities to promote behaviours that prevent
HIV infection and then are better able to provide care and support to those who are infected and
who are ill. This entails working with community leaders and establishing ‘community action groups’
for support and education of one another. The actual work undertaken by the groups will involve
dissemination of information on HIV testing, prevention of mother to child HIV transmission
(PMTCT), anti-retroviral treatment programmes, and available social services.

Of course, these are the usual information items disseminated by many groups and the sense that
something special, for example, an attempt to build social capital, is emerging in respect of the role
of communities is lost. This is apparent in the expected results: informed communities; the reduc-
tion of new HIV infections; increased family dialogues/discussions on HIV and AIDS issues, with
more informed children and the anticipation of delayed sexual relations and abstinence; improved
access to social grants; improved compliance with the taking of medication; and less stigma.

Again, poverty is not identified as a priority. The assumption appears to be that poverty is adequately
addressed in the City’s 2005 Human Development Strategy: Joburg’s Commitment to the Poor.

Civil society25

CSOs are central to prevention and care and support activities and receive considerable support
from government to this end. CSOs and FBOs provide many other services in addition. While
it is common to refer to CSOs, it is best to begin by acknowledging the role of informal com-
munity initiatives that “are usually started by small groups of motivated individuals who are driven
by a sense of obligation to care for those in need, against a backdrop of limited or non-exis-
tent public services.”26 Informal community initiatives “begin as coping strategies within the family
and include asset/income diversification, savings schemes, help from networks and food produc-
tion among others, and then evolve into a greater reliance upon outsiders and general com-
munity resources.”27
There is a division of labour between government and CSOs and FBOs. Government departments - social development, health clinics and hospitals, child welfare - dominate in the provision of treatment; and CSOs and FBOs in care and support. AIDS responses can be classified as:

- general prevention such as condom distribution, abstinence, change in sexual behaviour, life skills;
- voluntary counselling and testing;
- prevention of mother to child transmission;
- post-exposure prophylaxis;
- care and support such as counselling, support groups, emotional care, nutrition support, orphans and vulnerable children, home-based care, household assistance and palliative care;
- treatment; and
- training human rights and legal assistance.

Generalising:

CSO/FBO contributions to AIDS are, by and large, still predominantly 'general' as opposed to 'specialised' in nature. Across the various sectors of response, activities most commonly reported by CSOs are also the ones that require the least technical expertise. Thus, in terms of prevention activity, the emphasis is on educational and outreach work on behavioural change, risk avoidance and life skills, rather than on the provision of [voluntary counselling testing, prevention of mother to child transmission and post-exposure prophylaxis]. Similar patterns can be detected elsewhere: care and support activity concentrates on emotional support, counselling, and supporting families and caregivers, rather than on more specialised functions such as palliative care; legal activities are limited primarily to referrals and support in interfacing with law enforcement structures; treatment-related activity is dominated by work on treatment literacy, as opposed to medical interventions.

Government institutions, by contrast, appear to dominate the more technical interventions and services, particularly medical ones, including provision of [voluntary counselling testing, prevention of mother to child transmission and post-exposure prophylaxis] and the treatment of [tuberculosis and sexually transmitted infections]. They are notably less involved than CSOs, however, in playing the 'face to face' care and support roles - often in people's homes - for individuals and families affected by AIDS. CSO contributions are particularly evident in areas such as support to OVC, home-based care, and nutrition support. Much of the frontline psycho-social support provision appears to be occurring through community-based, rather than governmental structures.

Initiatives that address poverty and promote job creation and support income generating projects are not mentioned. There are many CSO and FBO poverty projects in South Africa, but the connection between HIV and AIDS and poverty was not made in the study being cited.

A means of distinguishing between the various CSOs is their sources of funding. Government funds CSOs, NGOs mostly, to provide many of the services mentioned. The agendas of CSOs that are funded by government obviously align with those of government. FBOs are self-funding and their activities do not necessarily align with government. For example, their prevention message may emphasise abstinence rather than condom use. FBOs fill key niches: 'Our urgent task, together in our diversity of faiths, is to fight poverty, disease, underdevelopment and all forms of human suffering in our shared world.' Alternative sources of funding are critical for the operation of organisations such as the Treatment Action Campaign.

Despite CSOs playing such a fundamental role, key issues from a policy point of view include the sustainability of many organisations, their ability to deliver at scale, and duplication. Resource constraints - financial, human, administrative and expertise - are, of course, mentioned most frequently and in the case of volunteer home-based care workers, for example, rightly so. The emotional demands of providing care and a lack of back up too easily lead to burn out. Enhancing capacity and sustainability and coordination and direct and 'linked-up networks' provide a certain area for local government contribution.

A description of Public and Civil Society HIV and AIDS and HIV and AIDS-linked poverty programmes and a contact list of service providers on HIV and AIDS and HIV and AIDS-linked
Poverty and inequality

Urban poverty is an extremely complex phenomenon. In its Urban Poverty Series,\(^3\) The World Bank identifies the ‘dimensions of urban poverty’ - income, health, education, tenure and personal security, and empowerment, and points to 42 ‘causes or contributing factors’ and 45 ‘policy related causes’. These were described in Part 1 of the project. The Urban Poverty Series and many other similar documents are intellectually comprehensive but, in their complexity, provide limited help to practitioners regarding those features of poverty that are closely related to HIV and AIDS and on what local governments can do. Arising from interviews and many research publications, it is possible to synthesise and focus the poverty issues as follows.

Prevention

- Being able to avoid behaviour that risks HIV infection. This primarily refers to ‘survival sex’ and women’s economic dependency, physical vulnerability within relationships and risk of sexual violence like rape that prevents women’s ability to insist on safe sex.
- Being able to purchase or grow nutritious foods that enhance the immune system.
- Being able to pay for housing and services and to avoid OIs that compromise the immune system.

Support and care

- Being able to avoid behaviour that risks infecting others with HIV.
- Being able to purchase or grow nutritious foods that enhance the immune system.
- Being able to pay for housing and services and to avoid OIs that compromise the immune system.
- Sustaining household incomes that enable a continued allocation of expenditure to for example school expenses. This may take the form of protecting jobs against stigma and obtaining social grants.
- Improving access to employment and small business opportunities.

Dependency and household reconfiguration after the death of an income-earning individual or, often, the death of the mother whether or not she was earning an income. An income-earning person includes, for example, a grandparent who obtains a grant.

- Being able to avoid behaviour that risks HIV infection.
- Being able to purchase or grow nutritious foods that enhance the immune system.
- Being able to pay for housing and services and to avoid OIs that compromise the immune system.
- Sustaining household incomes that enable a continued allocation of expenditure
- Improving access to employment and small business opportunities.

Social capital

Social capital has become a very popular concept. At the same time it is defined in many different ways and there is considerable debate about the concept. From the point of view of HIV and AIDS, there are two issues: social capital as it helps to prevent behaviours that increase risk to HIV infection, and social capital as it increases the ability of communities to care for the ill and then later vulnerable persons after the death of the AIDS-sick individual. The same features of social capital serve both ends.

On one hand, these features concern individuals and households within a community that may be defined as persons living in the same area; bonds of kinship or shared historical background; persons within a social group sharing a support network, for example, members of a church. Here one is referring to:

- values concerning trust, solidarity and reciprocity\(^3\)
- social norms
On the other hand, these features concern the ability of the community or social group to organise around perceived needs and to support one another, for example, self-help and mutual assistance groups including burial societies that provide loans and help build houses for members, and stokvels that encourage collective savings. Here one is referring to:

- organisations that enhance ‘collective action and mutual responsibility’
- collective and transparent decision-making processes
- effective and accountable leadership

The contrast is with areas where there is a high level of transience - migrants, hostels, truck drivers; where there are many bars; where there is considerable hardship and the need to sell sex. To some degree the relevant feature of poverty is the nature of the urban environment.

The contrast is also with inequality. It is argued that social cohesion is diminished by inequality. Ordinarily one would think about income inequality or inequality between the races; but perhaps the most important form of inequality is gender inequality.

‘Gender inequality is a foremost obstacle to women protecting themselves from HIV infection, especially since it is often manifested as sexual violence against women and teenage girls.’

‘Sexual relations both in and outside marriage are about economic strategies as much as they are expressions of personal relationships of intimacy.’

The relevance of social capital to such issues is evident in:

‘Strong social networks and the resource flows between them can provide economic stability and opportunity to households that may deter high-risk sexual activity, particularly in a time of crisis. In addition, networks may provide avenues for the exchange of information, or shape community norms around gender relations, sexual negotiation and communication. They may provide important role modelling for health-promotive behaviour - such as using condoms or accessing clinical services, like HIV testing. Individuals within cohesive communities may have a stronger sense of self-confidence, self esteem and may be better able to take control of decision making. Finally, more cohesive communities might be more likely to take collective action around common problems including HIV and AIDS.’

Conclusion

It is apparent that poverty programmes are in place that address many of these issues, albeit not always that effectively; however there are few that are articulated as programmes that promote social capital. For example, the link made by the Department of Health between poverty and HIV and AIDS points only to local government economic development strategies.

Interventions are needed to ensure that systems and processes are developed and institutionalised that link poverty alleviation programmes and local economic development programmes with HIV and AIDS programmes. This could, for example, be linked to [local government’s] role in promoting job creation (such as promoting labour intensive operations in local industries and boosting the local economy by providing marketing and investment support to attract investors.

The foremost programmes are social grants, economic development programmes, a variety of programmes that build human capital, the Expanded Public Works Programme, subsidised housing, free basic services and food programmes.

The extent of the constraints is revealed by the limited reach of the City of Johannesburg’s 2005 Human Development Strategy: Joburg’s Commitment to the Poor. The strategy looks to household poverty, inequality and social exclusion. The measures that are proposed concern free basic services, subsidised housing, subsidised transport for some, access to clinics, facilitating access to grants, the Expanded Public Works Programme, information about employment opportunities, and so on. In the words of an interviewee in Cape Town, ‘There is no silver bullet’; or perhaps better expressed by another interviewee, ‘There is not a magic wand.’
Chapter 3 What is the HIV and AIDS Problem?

Most references to local government responses to HIV and AIDS refer to HIV and AIDS in general. This is incorrect as there are not poverty implications for most of the time that people are HIV-positive and, it is argued in this report, the most profound household poverty implications occur after the death of the AIDS-sick individual(s). The purpose of this chapter is to enable one to locate the poverty problem more clearly in the progression from infection to illness to death and to household reconfiguration. This allows a better understanding of the timing of poverty impacts and of the numbers involved.

The chapter includes sections explaining HIV and AIDS, examining the prevalence of HIV and AIDS and considering illnesses and symptoms over time.

What is HIV and AIDS?

The course of HIV infection should be read in conjunction with Figure 1.

Following initial HIV infection, an individual may experience glandular fever-like symptoms that last for a few weeks. During this time, the so-called 'window period', an individual will test negative for HIV on antibody tests. It is only after the individual has seroconverted – started to produce antibodies to the virus – typically 3 to 4 weeks after the initial infection, that these tests will yield positive results. Following the passing of these initial symptoms, the individual enters a prolonged asymptomatic phase, which typically lasts 4 to 6 years. The individual then starts to experience intermittently symptoms such as weight loss, diarrhoea and oral infections. Finally, when the individual's immune system has been severely weakened by the HIV infection, they experience a variety of opportunistic infections, such as Kaposi's sarcoma and pneumonia, which are regarded as being defining of AIDS. The term AIDS thus refers to a range of conditions that are diagnosed in the late stages of HIV infection. In the absence of treatment, the individual typically dies within 1 to 2 years of the initial AIDS-defining illness.

A number of laboratory tests have been used to determine the prognosis of people infected with HIV. The two tests that are most predictive of progression to AIDS and death are the viral load test and the CD4+ lymphocyte count. The CD4+ count is a measure of the degree of immune suppression; an uninfected individual would typically have a CD4+ count above 800 cells per mm3, while an individual experiencing AIDS would usually have a CD4+ count below 200. The viral load is a measure of the concentration of HIV in the body, and can be thought of as determining the rate of decline in the CD4+ count. Levels tend to be high at the time of seroconversion, and then fall gradually, rising again about two years after initial infection. The viral load test is important not only as a diagnostic test, but also as a measure of an individual's infectiousness; individuals with high viral loads are most likely to transmit HIV.

The CD4 count predicts the risk of OIs and is used to determine the need for prophylactic therapy and the initiation of antiretroviral therapy.
The constitutional symptoms referred to in the figure are non-specific symptoms of ill health, for example, fevers, night sweats or weight loss. These differ from symptoms that are specific to disease in certain parts of the body, such as pain in the mouth with oral thrush or shortness of breath with pneumonia.

How prevalent is HIV and AIDS?

The projections to 2015 contained in Table 1 are based on the Actuarial Society of South Africa ASSA 2002 model. The ASSA projections to 2015 require assumptions regarding:

- information and education campaigns;
- improved treatment of sexually transmitted diseases;
- voluntary counselling and testing;
- mother-to-child transmission prevention; and
- antiretroviral treatment.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total population</th>
<th>Annual growth rate</th>
<th>Total HIV+</th>
<th>Cumulative AIDS deaths</th>
<th>Total AIDS sick</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>35 538 787</td>
<td>1.8%</td>
<td>38 597</td>
<td>326</td>
<td>293</td>
</tr>
<tr>
<td>1995</td>
<td>40 153 091</td>
<td>2.7%</td>
<td>943 590</td>
<td>20 662</td>
<td>16 135</td>
</tr>
<tr>
<td>2000</td>
<td>43 966 756</td>
<td>1.4%</td>
<td>3 731 645</td>
<td>318 697</td>
<td>194 424</td>
</tr>
<tr>
<td>2005</td>
<td>46 156 343</td>
<td>0.7%</td>
<td>5 165 797</td>
<td>1 542 169</td>
<td>589 454</td>
</tr>
<tr>
<td>2010</td>
<td>47 380 126</td>
<td>0.5%</td>
<td>5 408 621</td>
<td>3 404 415</td>
<td>692 511</td>
</tr>
<tr>
<td>2015</td>
<td>48 294 565</td>
<td>0.3%</td>
<td>5 407 945</td>
<td>5 358 501</td>
<td>742 261</td>
</tr>
</tbody>
</table>

Table 1: Projected population, number of HIV positive, AIDS sick and cumulative AIDS deaths for 1990-2015, ASSA 2002 (default scenario)

Obviously the results will vary considerably according to the assumptions.

The projections show that interventions have had and are having a significant impact on the course of the epidemic. The [Prevention of Mother to Child Transmission] programme has reduced the number of babies infected and behaviour change, in particular, has seen an increase in condom use and has reduced the number of adults infected. The national ART programme can be expected to play a particularly important role in the future outcome of the epidemic. The model projects that by 2010, there are likely to be roughly 381 000 AIDS deaths per annum rather than the 495 000 that would have been expected if no ART programmes were introduced. In the default scenario, it is assumed that ultimately only about half of South Africans who need ART will be able to access it. If we
assume that only 20 percent manage to access ART, then the estimated number of AIDS deaths in 2010 increases to 450,000, but if the proportion is as high as 90% the number of AIDS deaths would be reduced to 290,000. (p. 11)

Table 1 shows

The overall expected trends for population size, the number of people infected with HIV, the number AIDS-sick, and the number of accumulated AIDS deaths ... The total population continues to increase over the period, although at a decreasing rate. From 2011, the expected annual rate of increase is 0.4 percent. The number of people infected with HIV peaks in 2013, at just more than 5.4 million, after which it starts to decrease slowly. In contrast, the number of people sick with AIDS in the middle of each year continues to rise over the period, reaching nearly 743,000 in 2015. A cumulated AIDS deaths are close to 5.4 million by the same year. By 2004, it is estimated that more than 1.2 million people have already died as a result of AIDS, just more than 5 million are infected with HIV, and over 500,000 are AIDS-sick. (p. 23)

A feature of the data is that prevalence is much higher among young women and then is higher among middle-aged men. Figure 2 shows that prevalence rises very rapidly among young women and is much higher among women than men in the 20-24 age cohort. Prevalence among women remains higher in the 25-29 age cohort, where it reaches a remarkable 29.7 percent. Using a different data source, according the Nelson Mandela/Human Sciences Research Council survey, prevalence among African women in this age cohort reaches 38.6 percent and is 29.7 percent in the 30-34 age cohort. Returning to Figure 2, HIV prevalence among men and women becomes about the same in the 30-34 age cohorts, whereas prevalence among men becomes higher than that among women.

Figure 2 Estimated prevalence of HIV by sex and age, 2004

A critical feature of HIV and AIDS is understanding who gets ill and when, and when death is likely. Figure 2 makes the point that because HIV infection most affects young adults, due to the time lag between infection and death, it is among young and middle-aged adults that most deaths occur. This is when the dying are raising children and caring for the elderly. The death of one or more income earning household members considerably increases the dependency burden on other household members or members of the extended family who might be earning an income or be the recipient of grants. Indeed, Table 1 and the ‘Cumulative AIDS deaths’ suggest that perhaps the greater extent of poverty impacts will occur after the death of the AIDS-sick household member(s).
Where and amongst whom is HIV and AIDS most prevalent?

An idea regarding where and amongst whom HIV and AIDS is most prevalent is provided by the Nelson Mandela/Human Sciences Research Council survey.

The most important demographic predictors of HIV are: race, age, sex of respondent, locality type and province of residence.**41**

In essence, HIV prevalence is higher the higher the proportion of the population that:
- is African;
- is female;
- falls within especially the 20-24, 25-29 and 30-34 age cohorts;
- lives in cities;
- lives informal settlements in cities; and
- lives in high prevalence provinces.

The significance of provinces is apparent in Table 2. It is the cities in the Free State, Gauteng and Mpumulanga that are experiencing the highest HIV prevalence and related poverty. The question then turns to whether the SACN cities are growing rapidly and, in particular, whether this growth is due to migration. ‘Migration is a risk factor for HIV and other STIs because migrants are more likely than non-migrants to have additional partners.**42**

<table>
<thead>
<tr>
<th>Province</th>
<th>HIV positive (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>10.7</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>6.6</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>8.4</td>
</tr>
<tr>
<td>Free State</td>
<td>14.9</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>11.7</td>
</tr>
<tr>
<td>North West</td>
<td>10.3</td>
</tr>
<tr>
<td>Gauteng</td>
<td>14.7</td>
</tr>
<tr>
<td>Mpumulanga</td>
<td>14.1</td>
</tr>
<tr>
<td>Limpopo</td>
<td>9.8</td>
</tr>
</tbody>
</table>

**Table 2 HIV prevalence according to province (Source: Table 13)**

The population growth rate of the SACN cities is shown in Table 3. It is apparent that the most rapid growth is occurring among the cities in Gauteng, which, as noted, is also a province that has a high HIV prevalence. eThekwini and Cape Town lag somewhat in their growth rates and the other SACN cities are growing rather slowly.

<table>
<thead>
<tr>
<th>City</th>
<th>Growth rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buffalo City</td>
<td>0.57</td>
</tr>
<tr>
<td>Cape Town</td>
<td>2.45</td>
</tr>
<tr>
<td>Ekurhuleni</td>
<td>4.12</td>
</tr>
<tr>
<td>eThekwini</td>
<td>2.35</td>
</tr>
<tr>
<td>Johannesburg</td>
<td>4.10</td>
</tr>
<tr>
<td>Mangaung</td>
<td>1.35</td>
</tr>
<tr>
<td>Msunduzi</td>
<td>1.18</td>
</tr>
</tbody>
</table>
Table 3 Average annual population growth rate, 1996-2001

The significance of informal settlements is apparent in Table 4. HIV prevalence is about 21 percent in informal settlements. The difference with urban formal settlements, where HIV prevalence is about 12 percent, is overstated because the relevant difference between urban formal and informal areas is amongst Africans, with this data being unavailable. Following on from the points about migrants and multiple partnerships, transience is associated with multiple sex partners – ‘The rate of multiple partnerships is higher (23.5 percent) among those living in urban informal areas than among those who live in ... urban formal areas (10.2 percent).’

<table>
<thead>
<tr>
<th>Type of settlement</th>
<th>HIV positive (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban formal</td>
<td>12.1</td>
</tr>
<tr>
<td>Urban informal</td>
<td>21.3</td>
</tr>
<tr>
<td>Tribal</td>
<td>8.7</td>
</tr>
<tr>
<td>Farms</td>
<td>7.9</td>
</tr>
</tbody>
</table>

Table 4 HIV prevalence according to locality type (Source: Nelson Mandela/Human Sciences Research Council, Table 14)

An example of what the different city growth rates means is provided by a comparison between Johannesburg and Nelson Mandela. In Johannesburg, between 1996-2001 the ‘number of people in the typically migrating 15-34 age bracket grew 278 percent.’ In contrast, in Nelson Mandela, over the same period, the number of people in the 20-34 age bracket declined.

Figures 3 and 4 provide the population pyramids for Africans in ‘urban formal’ and ‘urban informal’ in Johannesburg and Nelson Mandela.
Figure 3 Johannesburg African urban formal and informal populations according to age (African population)

Comparing the urban formal and informal populations in Johannesburg, it is apparent that:

- a smaller proportion of the population in informal settlements is elderly or aged between 4-19;
- a higher proportion of the population is found in the 20-39 age cohorts; and
- there are more men than women in the high HIV-prevalence age cohorts in informal settlements in Johannesburg.

The findings are not the same in Nelson Mandela.
In the case of Nelson Mandela:
- while the distribution of the population in informal settlements is weighted toward the 25-39 age cohorts, this is not nearly as pronounced as in Johannesburg;
- the distribution of the formal urban population is weighted towards youth, whereas that of Johannesburg is weighted towards those of working age; and
- a far higher proportion of the population in the informal settlements in Nelson Mandela falls within the youth category.

The interpretation of the figures is that the working age population in the form of migrants is concentrated in cities with growing economies, which essentially comprises the three metros in Gauteng and also to a lesser extent eThekwini and Cape Town. These cities are experiencing more rapid in-migration and will have a higher HIV prevalence due to the age structure of their population and a higher proportion of migrants.

It is apparent that the burden of dealing with HIV and AIDS will fall more heavily on cities in Gauteng, and also that HIV prevalence in informal settlements is a defining problem for city managers and that this is especially so in the light of the role shelter and services play in prevention and care.

Illnesses and symptoms over time

Illnesses and symptoms change over time. Table 5 is based on the World Health Organisation, (WHO) staging system for HIV infection, which allows the evaluation of immune function based on clinical status. The moves from Stages 1 to 4 are evident in Figure 1 above. Being sure to note that Figure 1 is based on averages and also that the following statements represent rough approximations; Stage 1 concludes at the end of 12 weeks, Stage 2 concludes at the end of about seven years, Stage 3 lasts for about two years and Stage 4 concludes with death. Annexure 1 provides the WHO clinical staging system for HIV infection and disease and lists the illnesses associated with each stage and thereby why performance scale changes with the progression from Stage 1 to 4.

The illnesses included in Stages 1 to 3 are the same as those found in the general population and, to the extent that they differ among people having HIV, it will be in the frequency and severity of illness. These are AIDS-related illness and most are treatable and there are drugs available to prevent the occurrence and/or reoccurrence of some of the common OIs such as pneumocystis carinii pneumonia, tuberculosis (TB), oesophageal thrush and cryptococcal meningitis. The
exception is that no cures have been found for viruses like influenza and for chronic diarrhoea when it is caused by protozoa. For example, it is possible to treat AIDS-related illnesses in large urban centres in South Africa, with access to primary health care, prophylaxis and referral to larger hospitals. Most of the illnesses found in Stage 4, the AIDS-defining illnesses, seldom occur in the general population. Stage 4 is frequently referred to as ‘full-blown’ AIDS.

<table>
<thead>
<tr>
<th>WHO Clinical stages 1 to 4</th>
<th>Performance scale</th>
<th>Number adults (14+) infected by stage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Acute HIV infection</td>
<td>fully active and asymptomatic</td>
<td>1 476 000</td>
</tr>
<tr>
<td>2 Early disease</td>
<td>symptomatic but nearly normal activity</td>
<td>1 098 000</td>
</tr>
<tr>
<td>3 Late disease</td>
<td>bedridden &lt;50% of normal daytime</td>
<td>1 671 000</td>
</tr>
<tr>
<td>4 AIDS</td>
<td>bedridden &gt;50% of normal daytime</td>
<td>534 000**</td>
</tr>
</tbody>
</table>

Table 5 The World Health Organisation clinical staging system for HIV Infection and Disease in Adults and Adolescents (mid-2004)

In regard to children less than 14 years old, the number in Stages 1 to 3 are 211 000 and the number in Stage 4 are 33 000.

The importance of Table 5 lies in its indicating that the link between HIV and AIDS and poverty does not apply to all those who have HIV and AIDS. This is due to the nature of the illnesses associated with each stage. Stage 3 and especially Stage 4 are when the impacts on a person’s performance become pronounced. During the course of infection to death the longest stage is Stage 2, which means that for most of the period during which persons are infected with HIV there are no particular poverty impacts.

Comparing Tables 1 and 5, in 2005 11 percent of the population who are HIV-positive are AIDS-sick, but this really means persons who are chronically ill and have a CD4 count of less than 200. The proportion of the HIV-positive population who are chronically ill is larger and should count many persons in WHO Stage 3 whose CD4 count is heading towards 200.

Conclusion

When it comes to dealing with poverty, the HIV and AIDS problem can be broken down into four phases and into specific locations:

- **Prevention**: preventing HIV infection is obviously the best route to preventing poverty that arises from HIV and AIDS.

- **Care and support**: for most of the period during which persons are infected with HIV there are no particular poverty impacts. It is during the later phase of WHO Stages 3 and especially Stage 4 that poverty impacts will be felt by individuals and households.

- **Dependency and household reconfiguration**: because it is among young and middle-aged adults that most deaths occur and because this gives rise to a large dependency burden, it is probable that the greater extent of poverty impacts will occur after the death of the AIDS sick household member(s), during and after a period of household reconfiguration.

- **Ongoing**: compromised immune systems enhance susceptibility to HIV infection and, it appears, shorten the periods between HIV infection and the onset of full-blown AIDS and the onset of full-blown AIDS and death. The fourth phase is ongoing and consists of sustaining the health of a local government’s population.
Chapter 4 What is the poverty problem?

The purpose of this chapter is to frame the poverty issues the cities need to address. These have to do with prevention, care and support, assistance with funeral expenses, dependency, household reconfiguration and vulnerability, housing and services, and social capital.

But there are two initial problems. First, one has to confront the claim sometimes heard that there is, in fact, not a link between HIV and AIDS and poverty. Second, in at least one key respect, the data is hopelessly inadequate.

Confusing correlations

Johnson and Budlender of the Centre for Actuarial Research at the University of Cape Town write that

HIV risk is also influenced by socio-economic factors such as income, education and employment status.50

In contrast, reporting the results of its comprehensive HIV survey, the Nelson Mandela/Human Sciences Research Council reported that

The most important demographic predictors of HIV are race, age, sex of respondent, locality type and province of residence. Education and economic status are not significant independent predictors ...51

Employment/unemployment is also not found to be a predictor of HIV and AIDS.

And from a survey in a rural district of Sekhukhuneland in Limpopo province, there is found to be an

... absence of an association between HIV prevalence and poverty and education ...52.

The perception that there is a link between HIV risk and defining features of poverty: low income, poor education and unemployment, is not supported by statistical analysis. This is contrary to all expectations. What might explain the differences?

It is probable that there are three explanations. First, in the case of HIV and AIDS and poverty, no correlation will be identified because the majority of the HIV-positive are located in WHO Stages 1 and 2 and the ‘performance scale’ of the majority of the ill is unaffected by being HIV-positive.

Second, in the case of AIDS-deaths and poverty, obviously no correlation will be identified in a survey of people living with HIV and AIDS.

Third, in the case of poverty and HIV and AIDS prevention, ‘The trading of sexual favours out of desperation has been dubbed ‘survival sex’. Sexual culture refers not only to poverty-induced prostitution, but a context where ‘Men attract more sexual partners as they enter employment and acquire socio-economic status, and hence get infected at older ages on average’,53 and where ‘young women form sexual liaisons with older men for financial advantage’.54 In the latter instance the issue might be less one of prostitution than the “sugar daddy” phenomenon. There is also the circumstance where women are expected to prove their fertility before marriage.55 In other words, there are a series of differing and sometimes off-setting behaviours that confuse any possibility of statistical correlation.

Undoubtedly one can hold that poverty and HIV and AIDS and HIV and AIDS and poverty are intertwined.
Inadequate data

It has been argued that the foremost poverty problems arise after the death of the AIDS-sick individual. The circumstance of poverty may be short or long term. It is likely that:

- some households will fragment and only individuals will emerge, often in the form of orphans;
- some previously impoverished households will reconstitute themselves and survive as a functioning unit, but will remain dependent on grants;
- some households will reconstitute themselves and emerge from poverty; and
- some households will not be threatened by poverty.

There is no empirical basis for determining the number of households that will be impoverished and the period during which they will be impoverished. In effect, there is no empirical basis for evaluating the assertion that, due to the increasing number of AIDS-deaths, the greater poverty problem arises after the death of the AIDS-sick individual(s).

This is critical gap for local governments. Whereas social grants and medical services provided by provinces are directed to individuals, the services provided by local governments and certainly those that consume the larger portion of local government budgets, are directed to households. Taps, for example, are connected to a stand, a household is billed for water consumption and it is a household’s income that goes towards paying for service consumption above a free basic services level.

For planning purposes, it is desirable to survey household responses to, and their ability to recover from, the death of income-earning household members, including those who have grants; and to project the number of households who will live in poverty and for how long. It is acceptable that if surveys are not undertaken, planning can be undertaken on the basis of modelling and projections, even if in the form of scenarios due to data uncertainties.

Prevention

It goes without saying that the best means of preventing poverty arising from HIV and AIDS is to prevent HIV infection. The questions for local government concerns its potential contribution to alleviating poverty conditions that contribute to behaviours that the risk of HIV infection, and its creating conditions that minimise the risk of HIV infection and OIs.

The conditions of poverty that are relevant have already been described:

- low-incomes;
- gender inequality;
- inadequate nutrition;
- susceptibility to OIs as result of inadequate nutrition.

Care and support

It is when a person’s performance scale declines, late in WHO Stage 3 and during Stage 4, that a household will experience increasing expenditure, asset reduction and declining incomes. This applies even if the ill person is not earning an income, for when a household member is ill the household’s income is diverted to pay for medication and later funeral costs and persons who are employed may be fully or partly removed from jobs in order to provide care.

Referring back to Table 1, the number of AIDS-sick is projected to be about 700,000 persons in 2010. It is at this time, when the CD4 count reaches about 200 that patients are provided with antiretroviral drugs. If antiretroviral therapy is available and for so long as it is effective, a HIV-positive person can be approximated as being in Stage 2.

However, HIV-positive persons will often be sick prior to reaching a CD4 count of 200, with the possibility of losing a job before medication becomes available. Once the patient has regained
reasonable health the patient will then face the task of obtaining a job in an environment that might now be clouded with stigma. In other words, although the patient’s performance might recover, his or her income might not.

The question for local government concerns its potential contribution to supporting the income of affected households. This contribution can take various forms, for example, free basic services, ensuring that persons that are eligible for grants obtain the grants, protecting the jobs of persons who have HIV and AIDS, and food gardens.

**Assistance with funeral expenses**

Death concludes the medical expenses, but results in an expense that is even greater than the expenditure on medication, the funeral. Large funerals with many people and much food, and high priced coffins can be devastating to a household’s financial sustainability. It seems that funeral expenses can be about four times monthly household income. Local government’s can provide assistance with funeral expenses, notably in respect of burial plots. This clearly serves a need arising from HIV and AIDS, but takes the form of an indigence and serves all those who need this form of support.

It has been the experience of the consultants that discussion regarding customary approaches to dealing with the dead provokes intense discussion in classes, at conferences and in meetings. There are both strong defences of custom and concern that certain funeral practices reflect not so much custom as consumption, for example, the use of limousines for the family. Church leaders and prominent community members have spoken out about the impoverishing effects of customs and approaches to death and leadership is required that will create a willingness to change aspects of funeral practices.

**Dependency, household reconfiguration and vulnerability**

**The Dependency burden**

The dependency actually created by AIDS deaths depends on whether the person who died was earning an income, whether household reconfiguration involves drawing another income-earning household member from the extended family and other options in addition. In addition to the 700 000 persons who will be AIDS-sick in 2010, there will by that time have been about 3,4 million AIDS deaths. The actual ratio of dependents to income earners and related poverty issues that is arising in South Africa as a result of AIDS deaths is unknown. The consultants are nonetheless confident that dependency is becoming a foremost poverty issue.

Thus the Nelson Mandela Children’s Fund writes that

... along with the high number of adults dying from AIDS, and reduced capacity of communities to support and care for children, is a changing family structure and care giving patterns where the burden of care falls on those who have the least capacity to provide parenting, support and care for the affected children, the elderly and the young. Hence the disturbing scenarios of grandparent-headed households and adolescent/child/sibling-headed households.56

In repetition, the question has to do with the balance between the number of households that remain sustainable after an AIDS death; the number of households that are successfully reconfigured; and the number of households that fragment, leaving behind orphans, elderly who struggle to care for family members, members of the extended family who struggle to provide assistance of some sort, and so on. This leads to a focus on orphans including child-headed households, the elderly and women.

As summarised by the Department of Social Development:

AIDS transfers individual and familial survival onto a less resourced and often socially disadvantaged core of people. The burden of care is pushed upwards, particularly onto grandmothers; outwards, particularly onto adult female kin; and downwards, to children themselves. Few are sufficiently well resourced to take this on.57
Though there is little empirical information available on long-term changes in household reconfiguration in the era of HIV and AIDS, the common generalisation is that since adult deaths tend to cluster within specific families, the death of the adults will often lead to the destruction of the family as a functioning household unit. In these circumstances, when it is possible, relatives and friends will often take in the children, although perhaps not keeping the children together. Most often the burden will fall upon grandparents, the grandmother in particular.

Generally, people tend to move to or group around someone with an income - either an employee's income or someone receiving a grant. Grandmothers are a popular choice here because unlike other relatives, e.g. siblings they tend not to have other dependants and are often willing to look after their children and grandchildren. 58

Orphans

The definition of orphans and child-headed households differs, depending on the source. The most common definition refers to children under the age of 15 whose mother and father have died. This is problematical for three reasons. First, more often than not the death of the mother alone leads to the disintegration of families and the effective creation of an orphan. Second, it is typically the mother who sees to the health and wellbeing of the children. Third, children under the age of 15 still need parenting.

The Centre for Actuarial Research at the University of Cape Town refers to maternal orphans (lost the mother or the mother and father) under the age of 18, in Table 6. It is remarkable how rapidly the number of maternal AIDS orphans is increasing and also how rapidly the percentage of orphans that are AIDS orphans is growing. In 2005 the point is being reached when the debate between policy favouring AIDS orphans over orphans generally is becoming irrelevant as such a large proportion of orphans are maternal AIDS orphans.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total orphans</th>
<th>Maternal AIDS orphans</th>
<th>% AIDS orphans</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>436 352</td>
<td>86</td>
<td>0,00</td>
</tr>
<tr>
<td>1995</td>
<td>458 431</td>
<td>7 421</td>
<td>0,02</td>
</tr>
<tr>
<td>2000</td>
<td>644 753</td>
<td>149 456</td>
<td>23</td>
</tr>
<tr>
<td>2005</td>
<td>1 297 197</td>
<td>802 334</td>
<td>62</td>
</tr>
<tr>
<td>2010</td>
<td>2 039 353</td>
<td>1 597 023</td>
<td>78</td>
</tr>
<tr>
<td>2015</td>
<td>2 301 177</td>
<td>1 937 696</td>
<td>84</td>
</tr>
</tbody>
</table>

Table 6 Orphans and maternal AIDS orphans under 18, 1990-2015, ASSA200259

A survey in the Gauteng Intersectoral AIDS Programme60 reports that 80 percent of the families said that they were willing to care for a relative with AIDS. Thus despite the popularity of foster care programmes, the number of children being cared for via the programme is quite small.61 The Nelson Mandela Children's Fund worries that it is unclear that this willingness to provide services will be sustained.

Another commonly expressed view in the literature is that despite the deep-rooted nature of extended family networks, the capacity of communities and households to cope has been undermined by the growing number of AIDS orphans... 72 percent of households caring for children in distress experienced financial hardships as a consequence of hosting a child in distress. Extended family structures cannot, therefore, be assumed to remain resilient in the face of overwhelming orphan numbers, shrinking numbers of potential caregivers and over-stretched financial and other resources. A additionally, the stigma of AIDS will certainly influence the response towards many affected children. Thus, many children are or will be left outside the traditional social safety net.62

There are no reliable data regarding child-headed households. The Nelson Mandela Children's Fund reported that in 2004 the numbers are still limited. An appraisal of home and community-based care projects undertaken by the departments of Health and Social Development found that in 2002 there were 41 076 child-headed households being cared for,63 but obviously the number will have increased since then and obviously many (most?) child-headed households will have gone un-reported and not be included in the schemes.
The number of child-headed households is linked to the ability of the extended family and community to take in the children. Without having found research that supports this hypothesis, it seems reasonable to suppose that:

- the rate of increase in the number of child-headed households will reflect the ability of the extended family to take in orphans
- foreign comparisons may not apply in South Africa insofar as the child support and foster care grants provide an incentive to, and enhances the ability of, the extended family and foster parents to take in children.

Adding to the uncertainty is the fact that many of the persons, notably the grandmothers, are old and when they die some of the children they took in will still be children. The extent to which this will be the case is unknown.

**Elderly**

In Zimbabwe, AIDS has been labelled “the grandmothers’ disease” because, ... it is the elderly who bear the burden of caring for the sick and the survivors. This is care they perform with great difficulty due to their own limited wealth, education, capital and work opportunities. Not only are these grandmothers caring for orphaned children, they are also deprived of their own financial security by the loss of their own children - the parents of the orphans now in their care — to AIDS. Without social and economic support in countries that provide little or no social security to the elderly, these grandparents invariably become destitute. The consequences for future growth are devastating with orphans entrenched in a cycle of poverty with limited potential for escape.

The elderly suffer a double burden with likely implications for their own health status and well-being: they become caregivers of the younger generations, first of their adult children and then of the AIDS orphans, and may find themselves without the income transfers from the middle generations, so that net resource flows may be from rather than to aging parents. Moreover, the physical and psychological well-being of older persons will be affected not only by the death of adult children and foregone transfers of income, goods and services, but also by the need to raise additional cash by diluting assets or deploying more hours of work to satisfy the increased burden entailed by the protracted nature of the illness. With its implied long-lasting health impairments on adult individuals, the disease jeopardises households’ ability to generate resources for the care of households’ most vulnerable members, namely, children and elderly, ... 

There are projections for dependency in the case of the elderly. The projections are based on limited data, assumptions and complex calculations and should be treated as illustrative. In addition, the fact that an elderly person lives with an adult child who has HIV does not necessarily indicate dependency if, for example, the ill-person is in WHO Stages 1 and 2.

The projections are shown in Table 7. They reflect the percent of persons aged 60, 65 and 70 who will have an adult child who is HIV-positive or has died from an AIDS-related illness. The Table points to a sharp increase in the aged who have infected offspring or offspring who have died from AIDS-related illnesses. The suggestion is that in 2010 48 percent of all 60-year old parents will be affected in this manner. Even allowing for the fact that the projections should be viewed as illustrative, it is apparent that very many among the aged will be impoverished as a result of the death of off-spring and as a result of having to provide for grandchildren and other relatives.
### Table 7
Percent of elderly age 60, 65 and 70 who, in 2010, will have an adult child infected with HIV, or dead due to AIDS

<table>
<thead>
<tr>
<th>Age</th>
<th>Infected</th>
<th>Dead</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>65</td>
<td>12%</td>
<td>1.3%</td>
</tr>
<tr>
<td>70</td>
<td>8%</td>
<td>1%</td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>65</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>70</td>
<td>13%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Then too, the death of grandparents restarts the cycles of orphanhood, but this time with even fewer options for orphans.

### Women
‘... overwhelmingly the individual response to care is driven and borne by women - the people who are most adversely directly and indirectly affected by the AIDS epidemic.’

Whether widowed or not, women in South Africa are the ones who provide the majority of care and services to children, yet it is they who are often left without shelter, property or a means of support when their partners die or they themselves become very ill. ... in a context of low marriage rates and high rates of divorce and separation ... the mother and her family are expected to look after children, ...

Woman and girls are more vulnerable than men due to gender inequality, higher unemployment levels, lower incomes, lower household incomes when the household is headed by a woman, economic dependence, exposure to violence, customs that may leave them without shelter if the partner dies, and so on. This vulnerability is especially damaging in the light of the expectation that women will care for the ill and take in members of the extended family.

### Housing and services
In a survey of home based care providers in Johannesburg, it was found that:

#### Services commonly provided by home based care providers
- Bathing
- Preparation of food
- Ensuring that patient takes medicine
- Advising family on how to care for the sick family member - ‘educating for cross infection’
- Cleaning house
- Washing clothes
- Counselling
- Assistance with obtaining grants (which is very difficult)

#### Most common housing and services problems experienced by home based care providers
- Lack of water, difficulty of obtaining water (not in RDP housing)
- Poor quality, absence, overcrowding of sanitation facilities (not in RDP housing)
- Need to use alternative heating sources, primus stove and then wood due to lack of electricity or discontinued services
- Lack of ventilation
These findings illustrate the importance of housing and services in the prevention of HIV and OIs, the care of the ill and to ease the burden and help to consolidate households during a period of household reconfiguration. Of course, poor quality housing and services are most common in informal settlements and some inner city areas. The extent of the housing backlog was reported as 1,8 million in the Department of Housing’s 2004 Breaking New Ground housing policy ‘amendments’.

**Services**

A lack of access to basic services such as electricity, potable water, refuse removal and proper sanitation are directly related to high prevalence rates of preventable diseases, such as diarrhoea, TB and other respiratory diseases.71

**Services implications for HIV and AIDS prevention**

Clean water and sanitation are relevant to the prevention of HIV infection. This is because:

... where sanitation is poor, clean water not readily accessible, the infant runs a higher risk of dying from infectious disease than from HIV transmitted by the mother during breastfeeding.72

If clean water is unavailable then a mother has to breastfeed.

Further, where poor services lead to OIs, the possible consequence is to shorten the period between HIV infection and the onset of full-blown AIDS and the onset of full-blown AIDS and death. OIs generally reduce the body’s CD4 count and undermine the ability of the immune system to fight off HIV infection and, due to the reduced CD4 count, also other infections.73

Reinforcing the point:

The hypothesis that concurrent immune stimulation accelerates HIV progression is difficult to prove definitively, since the various components that contribute to progression of disease and prognosis are difficult to distinguish. However, the clinical and laboratory evidence suggests that this is very likely. Indeed, bursts of increased replication associated with opportunistic infections and parasitic co-infections could be contributing to the HIV transmission rates observed in sub-Saharan Africa, since viral loads in plasma and genital secretions correlate with each other and with infectivity.74

**Services implications for the prevention of opportunistic infections**

Inadequate water and sanitation lead to poor personal hygiene, which is an important source of OIs. The failure to remove rubbish and flies contaminating food is another source of OIs. Energy is need to heat water for cooking food and for washing contaminated surfaces. OIs put the patient and other household members and other care givers at risk of infection. The need for these services to prevent OIs is taken to be self-evident and further details are not provided.

In the case of services, if the infected person and their households cannot wash easily and do not have access to hygienic sanitation, there is greater risk of diarrhoeal organisms and skin infections. Clean water is also necessary if mothers with HIV or AIDS are to be able to bottle feed their children.75

**Services implications for care**

Following from the example of unexplained chronic diarrhoea in Table 1, Stage 3, diarrhoea is caused by drinking water contaminated by sewage or eating food that has been in contact with contaminated water, flies or soiled hands. Domestic, personal and food hygiene are very important in preventing infection and the risk of infection is higher with inadequate access to plentiful, clean water sanitation and overcrowding. The cornerstone of management is replacement of fluids.

In addition to being needed for prevention purposes, services are needed for washing and cleaning and are central to home-based care, for example, heating water for washing the patient, cooking, washing contaminated clothing and for cleaning contaminated surfaces; and for the disposal of waste, including medical waste and ‘sharps’.
Services implications during and after the period of household reconfiguration

Household reconfiguration may involve children and the elderly moving in with relatives while their parents' children are still ill, ill persons moving in with relatives, and persons moving in with relatives after the death of the main income earner (although often the death of the mother triggers household reconfiguration, whether or not she was the main income earner). The foremost implication here is likely to be the inability of many newly or further impoverished households being unable to afford services.

Housing

Shelter implications for the prevention of opportunistic infections

With regard to the role of shelter and services in care and prevention, poor quality shelter increases the risk of viral and bacterial respiratory infections, including pneumonia. The risk of tuberculosis is particularly threatening in overcrowded conditions.76

Tuberculosis is especially important because:

HIV infection is strongest risk factor for the progression of latent (TB) to active TB. Conversely, TB is the most common life-threatening HIV-infection worldwide... 77

Shelter implications for care

Space and privacy are important for the dignity of the patient and to enable care giving.

Shelter implications during and after the period of household reconfiguration

While still functioning families and still functioning extended families that are sustained by relatives (who typically move into the dwelling unit) will warrant the continuation of pre-existing housing policies; families headed by HIV infected adults, child-headed families, expelled HIV positive family members, homeless children (not all of whom will be orphans and some proportion of whom will be HIV positive) will require shelter of some sort. This categorisation excludes children relocated to rural areas and sustained, with considerable hardship, by aged relatives. It also excludes families that have 'disappeared', a phenomenon found elsewhere in Africa and likely to occur in South Africa.78

Households consisting of a grandmother caring for her grandchildren: One of the main scenarios described in discussions was of a grandmother taking care of her grandchildren after their mother has passed away. Grandparents in this situation would also require more space than they had anticipated requiring in their old age. Often the households that grandmothers (or grandparents) head are very large because they are caring for their ill children and their children's children... accommodation is often a major problem for elderly people...79

There are many different manners in which households reconfigure themselves. Not included in the quote is the relocation of children, mostly to relatives.

Social capital

One consequence of apartheid was the disruption of families and communities. Recovery post-1994 has been impeded by increasing unemployment, ongoing urbanisation and the rapid growth of informal settlement, a housing policy that encouraged the rapid growth of nuclear families, often female-headed with little or no immediate support networks, and, of course, the still multiplying ravages of HIV and AIDS. A refrain in this report, for example, the references to the Nelson Mandela Children's Fund, has been the excessive demands being placed on families and communities. Alongside this is the invidious position of many women in circumstances where sexual violence is tolerated.

A feature of the struggle against apartheid was civic organisation that often was profoundly effective in mobilising communities. South Africa no longer benefits from this level civic mobilisation within communities, although there are obvious instances where there is mobilisation around specific issues, for example, the Treatment Action Campaign (TAC) and the NAPWA.
The pressure on families and communities and the challenges to community organisation represent a form of poverty that contributes both to HIV infection and difficulty mitigating the impact of AIDS-sickness and death.

**Conclusion**

In the attempt to synthesise this chapter and all that has gone before, the overlapping areas of intervention that emerge concern:

- leadership
- planning
- social capital
- health
- income support – safety net and capacity to recover from poverty
- housing and services

Support for vulnerable groups should be included within, and be explicit, in all these areas of intervention.
Chapter 5 **Recommendations**

Six overlapping areas of intervention have been identified. The potential for local governments to make a contribution varies. Some interventions fall directly within their mandate, for example, free basic services. Some interventions can only be undertaken in partnership with CSOs. Some interventions require liaising with provincial and national government and “making a case” with the relevant sphere of government. Some interventions arise from the potential for co-operation with the private sector and donors. It is probable that most interventions require some combination of the above!

This chapter is presented in terms of the six areas of intervention. The description of the areas is illustrative. In part this is because a lot of what local governments can do is contextual and depends on leadership capabilities, the NGOs and CBOs in the city's area, corporations in the city and their interests, the interests of donors, and so on.

**Leadership**

- Education and prevention activities
- Build social capital
- Health
- Maintain health
- Income support and opportunities to escape poverty
- Vulnerable groups

Leadership from mayors and councillors, and from senior management, is necessary for different reasons. Political leadership is critical to shaping policy, influencing attitudes, doing away with stigma, mobilising human resources and finances, and ensuring a sense of urgency. Leadership from senior management is critical if HIV and AIDS is to be mainstreamed in planning and given effect in practice.

Obtaining the participation of community leaders and the private sector is also essential for strategic direction, planning, the generation of resources and the implementation of many programmes. A key role is to be played by leaders representing institutions such as churches, trade unions, business associations and sports and cultural bodies.

The generation of resources is an interesting issue since it appears that often local governments will be unable to provide CSOs with financial support, but the prospect of the CSO working in an effective partnership with local government enables the CSO to obtain resources and to bring them into the municipal area. In this respect obtaining resources from donors, the private sector and various international organisations is a competitive process and a coherent, united HIV and AIDS poverty programme is highly desirable.

It is also desirable that leadership be institutionalised in a Local AIDS Council. Of course, such councils already exist in many local governments, so the issue is one of leadership participation and commitment and including poverty on their agendas.

Leadership should especially be oriented to the needs of vulnerable groups. In this respect it is important to note that while, say, foster care programmes are essential for the relief of poverty, so too are advocacy and legal aid organisations that seek to reverse gender inequality and to protect the rights and well-being of all affected by discrimination, stigma and violence. In this respect, it should be accepted that these institutions should not bear the primary responsibility for services that local government should provide and that their role includes monitoring government performance and ensuring that officials and elected political leaders are held accountable for fulfilling their mandates.
Planning

- Assess the prevalence of HIV and AIDS in the city and the problems to which it is giving rise
- Gaps in key data
- Mainstream HIV and AIDS and poverty mitigation within the IDP

This report has demonstrated that one cannot accurately write about and have policy for HIV and AIDS and poverty. Both categories are too general and the issues that arise are too differentiated. Policy has to take into account the fact that poverty gives rise to behaviour that increases the risk of HIV infection, most people who are HIV positive will not experience impaired productivity, and the biggest poverty problem arising from HIV and AIDS seems to arise after the death of AIDS-sick income earning individual(s), and an ongoing issue concerns the health of the municipal population and the ability of their immune systems to resist infection.

It has already been noted that the cities lack prevalence data, both for the cities as a whole and for areas in the city such as informal settlements, and that they especially lack data regarding household impacts and the forms of household reconfiguration. This lack of data is a serious obstacle to effective planning and implementation.

Any proposal regarding what local governments might do in respect of HIV and AIDS and poverty would be incomplete without recommending that local governments mainstream mitigating the impact of HIV and AIDS on poverty issues in their IDPs. It is understood that in the latest round of preparing IDPs, local governments have sought to mainstream HIV and AIDS, though this will certainly have been from the point of view of prevention and care and support in the form, for example, of home-based care. It has also long been the case that local governments have sought to promote economic development. As a result to call upon local governments to mainstream the impact of HIV and AIDS on poverty is rather empty unless it is clear what this entails. The following points are intended to provide some direction.

Social capital

- Attitudes towards vulnerable groups
- Cultural norms of reciprocity
- Protection against exploitation
- Support for, and work with, CSOs and FBOs
- Resources for community organisation
- Build sustainable communities

Social capital was earlier described as comprising shared attitudes, norms, values and relationships of trust; and as comprising CSOs and FBOs that organise in the interests of prevention, care and support and mitigating the impacts of poverty. The perspective of interviewees in Cape Town was that there cannot be a “big fix” approach to building social capital. Instead local governments can contribute overtime to changing attitudes and an accumulation over time of CSO and FBO capacity through often small interventions. The modesty of this approach seems both realistic and attractive.

In the Msunduzi case study mentioned earlier the World Bank claimed that 60 CSOs were working in the area on issues that were relevant to HIV and AIDS. This no doubt includes organisations for which HIV and AIDS is but one aspect of their operations, but nonetheless is difficult to believe that there are so many relevant organisations. The point, however, is that it appears that even smaller SACN cities have a greater depth and richness of CSOs and FBOs than might be anticipated. Certainly the first task facing a local government is to identify the CSOs and FBOs that it can enlist and support in its HIV and AIDS poverty mitigation programmes. This will not necessarily be an easy undertaking since it appears that not that many CSOs and FBOs are working in the area of HIV and AIDS and poverty.

The location of CSO and FBO interventions in prevention and care and support is a natural response to the phase of HIV and AIDS in South Africa. Now that HIV and AIDS has become
so prevalent and so many people are dying, it is natural as well that resources will shift into poverty mitigation. In this regard it does seem that CSOs have somewhat flexible agendas and that they will move in the direction of providing services for which there is financial support. The paucity of CSOs in mitigating the impacts of poverty can be overcome.

Health
- Free health care for example for sexually transmitted diseases
- Access to antiretroviral drugs
- Nutrition programmes - food parcels, food gardens, school nutrition
- Housing and services

Local government primary health clinics provide essential prevention services, for example in the treatment of sexually transmitted diseases, and in the provision of antiretroviral drugs (although it is anticipated that this responsibility will be shifted to provincial facilities).

There are many reports by informed observers that often persons needing treatment and needing to fulfil prescriptions cannot afford the transport costs of getting to clinics. It is unknown how pervasive this issue is, but it is certainly something that local governments should look into and something that they should address through free transport to medical facilities where necessary.

Local governments can seek to enhance the health of individuals and make a contribution to the prevention of HIV and opportunistic infections and also provide care through the delivery of housing and services and drawing on the housing subsidy, the Municipal Infrastructure Grant and the equitable share subsidy for this purpose. The role of housing and services in this respect has already been explained.

Local governments can seek to enhance the health of individuals and especially PLWHA through ensuring a nutritious diet. Until recently food parcels were provided on an emergency basis for periods of three months by provincial departments of social development. This programme is being replaced by a homestead food production programme to be operated by the Department of Agriculture, Conservation and the Environment and a nutrition and food safety programme to be operated by the Department of Health. This is in addition to ongoing school nutrition programmes.

It seems that these programmes do not envisage much of a contribution from local governments, but clearly nutrition is an issue that local governments should contribute to if they have the capacity to do so. In this regard there appears to be a role for setting aside land for food gardens, for example, in river flood plains, and in making water available. If it reaches a certain scale an exercise of this sort can also come to be viewed as job creation and small business development programme. It is interesting that the Departments of Health and Social Development report that the largest number of beneficiaries of CSO income generating projects was in the area of agriculture (accepting that the findings include rural areas).

The possibility of local gardens supporting a system of ‘food banks’ supported by FBOs and the private sector and private donations has also been mentioned.

Income support
- Social grants
- Nutrition programmes - food parcels, food gardens, school nutrition
- Protection of jobs against stigma
- Funeral expenses
- Promotion of economic development
- Free schooling and provision of school uniforms
- Subsidised housing and services

It is undoubtedly the case that the foremost need of PLWHA, affected households, and households bearing a greater dependency arising from the death of an income-earning adult is money. Local governments have it within their capacity to provide income support indirectly through free
basic services, pauper’s funerals, economic development programmes and seeking out national programmes such as the EPWP. Local governments can, many do, also support household incomes by providing information regarding social grants available and facilitating access to the grants, and also by providing information regarding free schooling.

However, the point should not be lost that providing a safety net, however necessary, risks creating dependency, and therefore that the objective of the economic development programmes should be enabling households to regroup and to escape poverty.

Housing and services

- Housing subsidy
- Free basic services
- Prioritise informal settlements and run-down inner city areas
- Protection of property rights
- sustainable communities

An additional set of interventions pertain to the ability of local governments to use housing and services proactively for prevention and care purposes. It is possible to use housing and services to:

- prevent HIV infection (marginal significance);
- prevent OIs (significant);
- lengthen the periods between HIV infection and the onset of “full-blown” AIDS and death (probably significant);
- provide care (critical); and
- reduce the disruptive influence of illness and death on household cohesion and development prospects (significant).

While housing and services can play an important part in prevention and care, the present policy and grant frameworks do not maximise this potential. It does not suffice to say that local governments should maximise the delivery of subsidised housing and the availability of services. The reason is that the needs of affected households might not be accommodated by existing policy. This is apparent in:

- the construction of backyard shacks for either the patient or other family members in order to provide space, dignity and in order to facilitate care;
- extra rooms and sanitation facilities required when a household takes in children;
- the fact that the services levels prescribed by free basic services may not be sufficient for care purposes;
- difficulties households impoverished as a result of AIDS face when confronted with services bills for consumption above the free basic service level;
- difficulties with inheritance rights and the protection of the housing needs and rights of children, women and the elderly; and
- the failure of many housing subsidy projects to contribute to the building of sustainable communities.

For example, the need for a backyard shack may be relatively short-term and a subsidy provided for the purpose of constructing a backyard shack for the care of AIDS patients is difficult to envisage. The prospect of including subsidies for the purpose of providing extra rooms for foster care purposes is more easily envisaged. Indeed, subsidies are being provided to CSOs for accommodating orphans in KwaZulu-Natal, for example, but a programme of this sort is constrained by the limited capacity of CSOs to provide services of this sort at scale.

The ability of local governments to themselves seek answers will depend on the relative balance of rich households and economic activities to low-income household needs. Cross-subsidies can be anticipated in Gauteng’s cities in a manner that is inconceivable in, say, Buffalo City and M sunduzi.

It is believed that none of the SACN cities have prepared HIV and AIDS shelter policies for prevention and care purposes and this is urgently needed.
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Annexure 1  WHO Staging System for HIV infection and disease in adults and adolescents

Clinical stage I
1. Asymptomatic
2. Persistent generalized lymphadenopathy
   Performance scale 1: asymptomatic, normal activity

Clinical stage II
3. Weight loss, <10% of body weight
4. Minor mucocutaneous manifestations (seborrheic dermatitis, prurigo, fungal nail infections, recurrent oral ulcerations, angular cheilosis)
5. Herpes zoster within the last five years
6. Recurrent upper respiratory tract infections (i.e. bacterial sinusitis)
   And/or performance scale 2: symptomatic, normal activity

Clinical stage III
7. Weight loss, >10% of body weight
8. Unexplained chronic diarrhoea, >1 month
9. Unexplained prolonged fever (intermittent or constant), >1 month
10. Oral candidiasis (thrush)
11. Oral hairy leukoplakia
12. Pulmonary tuberculosis within the past year
13. Severe bacterial infections (i.e. pneumonia, pyomyositis)
   And/or performance scale 3: bedridden <50% of the day during the last month

Clinical stage IV
14. HIV wasting syndrome, as defined by the Centers for Disease Control and Prevention
15. Pneumocystis carinii pneumonia
16. Toxoplasmosis of the brain
17. Cryptosporidiosis with diarrhoea >1 month
18. Cryptococcosis, extrapulmonary
19. Cytomegalovirus disease of an organ other than liver, spleen or lymph nodes
20. Herpes simplex virus infection, mucocutaneous >1 month, or visceral any duration
21. Progressive multifocal leukoencephalopathy
22. Any disseminated endemic mycosis (i.e. histoplasmosis, coccidioidomycosis)
23. Candidiasis of the oesophagus, trachea, bronchi or lungs
24. Atypical mycobacteriosis, disseminated
25. Non-typhoid Salmonella septicaemia
26. Extrapulmonary tuberculosis  
27. Lymphoma  
28. Kaposi’s sarcoma  
29. HIV encephalopathy, as defined by the Centers for Disease Control and Prevention.  
And/or performance scale 4: bedridden >50% of the day during the last month

Note: both definitive and presumptive diagnoses are acceptable.

a. HIV wasting syndrome: weight loss of >10% of body weight, plus either unexplained chronic diarrhoea (>1 month) or chronic weakness and unexplained prolonged fever (>1 month).

b. HIV encephalopathy: clinical findings of disabling cognitive and/or motor dysfunction interfering with activities of daily living, progressing over weeks to months, in the absence of a concurrent illness or condition other than HIV infection which could explain the findings.
Annexure 2 Public and Civil Society HIV and AIDS and HIV and AIDS-linked poverty programmes

Introduction

The purpose of this document is to identify and collate government programmes and institutions, and also those civil society institutions including NGOs, CBOs, FBOs, private sector, parastals, and donor organisations that address HIV and AIDS as well as urban poverty in circumstances where local governments can play a role in leading or facilitating the programmes.

This document intends to assist the city managers and others to identify and access developmental services that are available to role players and consumers as well as other beneficiaries of services. It must be emphasised that services and resources provided by the selected organisations have been listed without attempting to provide exhaustive descriptions of all services rendered.

Co-ordinated initiatives by government

The National Department of Social Development

The Department of Social Development is responsible for an integrated and comprehensive system of social services, facilities, programmes and social security to promote social development, social justice and the social functioning of all individuals in the country. Social Welfare services and programmes are part of a range of mechanisms to achieve social development. These include access to health, nutrition, education, housing, employment, recreation, infrastructure and other opportunities as well as services.

Each province has its own department that is responsible for social services at preventive (primary) and curative (secondary) as well as tertiary levels in partnership with NGOs, CBOs, FBOs, and the private sectors. The management and distribution of social services at provincial district and community levels fall within the provincial department’s authority.


- Creative use of auxiliary workers, volunteers and family and community care;
- Greater emphasis on anti-poverty programmes;
- Capacity-building and self-reliance to empower people to play a meaningful and productive role in the economy; and
- Commitment to continuing publicly funded non-contributory grants for the elderly and the disabled and the introduction of a new child-support benefit.

The White Paper also advocates for increased spending on welfare services and programmes based on developmental priorities. A “flagship programme”, namely, Developmental Programmes for Unemployed Women with Children under Five Years, was in 1996 used to launch developmental social welfare. The focus areas included:

- Promoting early childhood development, stimulation, care, education, health and nutrition.
- Facilitating access of poor female-headed families to employment opportunities (governmental programmes - public works, trade and industry – as well as non-governmental programmes)
- Rendering social support programmes to poor female-headed families which will be both curative and preventive (family life enrichment and parenting)
The flagship programme included support for economic activities including farming, garment-making and home-building. The participating women were to share profits and a portion was to be reinvested in the community.

It is important to note that in 1994, the Department of Health and Population Development was split into two separate departments, namely, the Department of Health as well as the Department of Welfare, each with its own ministry. However, in some provinces Health and Welfare are still one department. Further, we also need to note that in South Africa, the provision of welfare services is a partnership between the private and public sectors which are financially assisted by the State. These sectors – NGOs, CBOs, FBOs, informal family and community networks, and businesses – have expertise, infrastructure and other resources which could play a significant role in mitigating the impact of HIV and AIDS and poverty.

A number of related pieces of legislation, in addition to Constitution and the White Paper, regulate the work of the Department of Social Development. Those listed under the Department of Justice will not be listed here. Social assistance in South Africa is regulated by the Social Assistance Act (Act 59 of 1992) which came into effect in March 1996. The Act regulates the payment of social grants for the aged, war veterans and disabled persons, as well as maintenance grants, foster-child grants, single-care grants and social relief.

According to the Department of Social Development’s Services Delivery Model for Developmental Social Services (Second Draft 14 December 2004) a collective responsibility for effective and efficient delivery of social services is required by various role players. Government is understood to be charged with, in addition to policy development and direct service delivery, a monitoring and evaluation role to ensure that quality services are rendered and to protect the interests and promote the well-being of clients. The range of service providers enlisted includes the three tiers/spheres of government, private sector entities as well as the civil society which includes donors, NGOs, CBOs, and FBOs. Recognising the unique contribution of various role players the Department stresses the need for service providers to ensure that services are integrated, coordinated and managed to maximise benefits for communities.

The Department of Social Development thus commits itself and ensures the provision of resources for social service delivery as well as providing strategic direction for social service delivery. In addition the department creates enabling environment for role players to effectively and efficiently ameliorate the impact of HIV and AIDS and poverty in the country.

Provincial Departments, working within the national policy framework, facilitate the establishment of social service structures among which are provincial offices, district/regional offices as well as local/service delivery points.

The department’s local/service points and municipalities both identify the needs and resources at local and community level. The former provide direct services to clients while the latter promote access to services by providing infrastructure to bring services closer to clients. The Provincial Departments and municipalities also promote the participation and mobilisation of community through door-to-door campaigns and AIDS councils.

Government has broadly and specifically adopted a pro-poor development approach. Services target groups that are the vulnerable in society that are primarily the historically disadvantaged individuals and groups. The target groups, therefore, are primarily children (under the age of 18 years), youth (14 to 28 years) and vulnerable families (single or child-headed destitute, and refugee). In brief, services are targeted for children, youth, families, older persons, and persons with disabilities.

The service clients generally enter the service system through the drop-in-centres, services offices, home visits and community visits. Recently door-to-door campaigns have been conducted to guarantee the right to and enjoyment of citizenship by all South Africans. The Department of Home Affairs is expected to provide necessary documents to everybody in South Africa—citizen, resident, refugee or visitor. The Department of Home Affairs provides documents that entitle people to access housing, education, jobs, healthcare, social grants, pensions, financial services and to elect the government of their choice.
Five broad categories of services that are rendered by the social services sector could be accessed by families and individuals through the services entry points. The services have been grouped as follows:

- Promotion and Prevention Services (HIV and AIDS related education programmes);
- Rehabilitation Services (that reduce financial and emotional demands on families and publicly funded support systems);
- Protection Services (safeguard the well being of individuals and families);
- Continuing Services (support for AIDS orphans and social grants); and
- Mental Health and Addiction Services.

**Department of Justice**

The Department is responsible for the administration of the courts, and performs these functions in conjunction with magistrates, judges and attorneys-general, who are independent. The responsibilities of the Department of Justice extend far beyond criminal justice, and include the provision of legislation, the establishment of institutions required by the Constitution – such as the Human Rights Commission and the Office of the Public Protector – and the administration of the system of civil justice.

One of the greatest challenges facing the Government since 1994 has been to create and sustain a stable society in which all are able to live in peace, safely and security. The rule of law must address violence and serious crimes, create and establish accountability for human conduct and behaviour, and ensure that human rights are respected and promoted especially with regards to the vulnerable members of society, namely, women, the aged, and children.

The Department’s Campaign on Preventing Violence Against Women was launched on 25 November 1996, International Day of No Violence Against Women. South Africa has ratified the UN Convention on the Elimination of Discrimination Against Women. South Africa has also made commitments in respect of Implementing the platform of Action which emanated from the UN’s Fourth World Conference on Women held on Beijing in 1995.

The objectives of the campaign are to:

- raise awareness and educate the community about the problem of violence against women;
- develop strategies to combat this scourge; and
- improve the community’s response to this violence when it happens.

The Department has provided for Small Claims Court. Cases involving civil claims not exceeding R3 000 are heard by a commissioner in the small claims court. The commissioner is usually a practising advocate or attorney, a legal academic or other competent person who offers his or her services free of charge.

Section 28 of the 1966 Constitution deals with the rights of children (persons under the age of 18 years), in this regard the section provides, inter alia, for the following:

- Every child shall have the right to:
  - a name and nationality as from birth;
  - parental care;
  - security, basic nutrition, and basic health and social services;
  - not be subject to neglect or abuse;
  - not be subject to exploitative labour practices, nor be required or permitted to perform work which is hazardous or harmful to his or her education, health or well-being.

In the children and maintenance courts the proceedings centre around the child. The paramount principle which the unit applies in this regard is what is in the best interest of the child.

The Prevention of Family Violence Act (Act 133 of 1993) has also assisted in making children safer in that it places an obligation on any person who suspects that a child is being ill-treated to report such suspicions as soon as possible. It also provides for victims to obtain an interdict in any magistrate’s court.
Current legislation not only takes cognisance of physical abuse, but to some extent also emotional abuse of children. A child can, for example, be removed from the care of its parents in terms of the Child Care Act (Act 174 of 1983), should the parent(s) display habits and behaviour which may seriously injure the physical, mental or social well-being of the child. This also expressly prohibits (in addition to common law rules) the abuse or abandonment of children, and makes it a criminal offence to neglect a child by not providing adequate food, clothing, shelter or medical care.

The legal Aid Board, an independent statutory body, established under the Legal Aid Act 22 of 1969, renders or makes available legal aid to indigent persons and has the power to engage legal practitioners and lay down conditions for granting legal aid.

In addition to the Board’s 12 branch offices, free legal aid is also offered by the Board’s Public Defender’s Office and legal aid clinics established in association with most universities. Legal aid is also available at all magistrate’s courts throughout the country, where officials of the Department of Justice act as agents for the South African Legal Aid Board. In these cases, legal aid is provided by lawyers in private practice and funded by the Board.

The Board has also assisted paralegal advice bureaux operated by NGOs with funding like the Legal Aid Bureau in Johannesburg, which is one of the longest-running such organisations.

The National Institute for Crime Prevention and Rehabilitation of Offenders (NICRO) is a welfare organisation aimed at preventing crime and at rehabilitating offenders. It strives to integrate offenders into the community and assist their families during their incarceration.

Department of Safety and Security

The security forces' contribution includes, inter alia, area and border protection, crime prevention and maintenance of law and order, supplying water to drought-stricken areas and purifying it, adult literacy programmes, upliftment programmes for smaller communities, primary health-care training, feeding projects, and establishing Service Corps. The Service Corps established in January 1995, is responsible for integrating ex-service members into civil society by upgrading their standard of education, as well as their vocational and life skills to enable them to find employment or to start their own enterprise.

Department of Education

The South African Schools Act 84 of 1996 provides, among others, for:

- compulsory education for learners between the ages of seven and fifteen years of age, or learners reaching the ninth grade, whichever occurs first.

Health Authorities

The Department of Health is, among others, responsible for formulating health policy and legislation as well as delivering national services which cannot be delivered cost effectively at other levels. It also ensures access to cost-effective and appropriate health commodities at all levels.

Provincial health departments are responsible, among others, for formulating and implementing provincial health policy, norms, standards and legislation. They are also responsible for the provision and/or rendering of health services and ensuring that delegated functions are performed. The services of provincial health authorities are district-based comprehensive primary health care model. The district health system, based on the primary health approach, implies the establishment of health districts in every part of the country. Two of the most important services offered by clinics are education and guidance that patients received regarding health matters.

The provincial administrations are responsible for providing ambulance services. However, in certain provinces these services are also run on an agency basis by local authorities.

The functions of local authorities are to provide personal (promotive and preventive) and non-personal (environmental) health services, which include the supply of potable water, sewage disposal and refuse removal. Public hygiene, food safety, tobacco control and other environmental health-related matters are regulated by municipal environmental health officers.
Various NGOs provide vital health services. The South African Red Cross renders emergency, health aid and home-nursing. It also operates an ambulance and air-rescue services, and comprehensive youth programmes. The South African First Aid League provides first aid at sports meetings, civil protection and training in first aid. It also provides first-aid kits. LifeLine provides 24-hours telephone counselling services to those in distress.

Hospices are centres that improve the quality of life of the terminally-ill through care, support and love. Nursing staff attend to the physical, social, emotional and psychological needs of patients and their relatives.

The Department of Health has adopted the World Health Organisation (WHO) Directly Observed Treatment Short course (DOTS), which works on a new recording and reporting system and has health workers or volunteers watching every tuberculosis (TB) patient taking their medication.

The Department has also developed a national HIV and AIDS programme which recognises that education is the most viable strategy for AIDS prevention. AIDS education guidelines for primary and secondary schools, technical colleges, nurses, social workers, health workers and other organisations have been established. Further, the Department has established a directorate to promote quality care and to support HIV-infected persons. Ten HIV-positive people were employed by the Department in 1996 to act as the "Face of AIDS" to carry the message about the disease to communities.

In May 1996, the Department first announced that it had funds available to support AIDS projects initiated by FBOs, NGOs and CBOs. Applications in this regard were invited. A total of 118 proposals were funded for 1996-97. Services rendered by these bodies ranged from community outreach, training, education, counseling, care, materials development and support.

Given the high prevalence of micronutrient deficiencies in the country, the elimination of deficiencies in vitamin A, iron and iodine is part of the Department of Health as well as those of the National Programme of Action for Children. The Primary School Nutrition Programme (PSNP) for needy primary children came into effect in 1994. Hunger, parasite infections and micronutrient deficiencies affected children’s learning capacity, school attendance and general well-being. The programme is intended to address this.

The development of a strategic plan was initiated by the Minister of Health, Dr Manto Tshabalala-Msimang in July 1999 in response to President Thabo Mbeki’s challenge to all sectors of society to become actively involved in initiatives designed to address the HIV and AIDS epidemic. The HIV and AIDS/STD strategic plan for South Africa 2000-2005 was completed and adopted during January/February 2000.

The strategic plan, the expanded national response to HIV and AIDS, was envisaged to be managed by different structures. It was envisaged that each government ministry was to have a focal person and a team whose responsibility was to plan, budget, implement and monitor HIV and AIDS interventions. It was also recommended that all other sectors including parastatals, NGOs, CBOs, FBOs, the private sector, youth and women structures were also to have dedicated HIV and AIDS focal persons.

**South African Local Government Association**

South African Local Government Association (SALGA) recognises that in order for municipalities to succeed in fulfilling their mandates they will need to work with other stakeholders that include all government departments that impact on service delivery and municipal functioning such as Water and Forestry, Housing, Finance, Health. Further, SALGA believes that municipalities should appreciate and cultivate multi-level relationships with government tiers and spheres. SALGA also lists NGOs, FBOs and the private sector as major consumers and providers of services, donors, investors and development partners. Other role players to be utilised are donor agencies, international organisations, foreign municipalities - through twinning arrangements - and communities through ward communities that participate in local government decision making. (SALGA Business Plan 2005-2007)
Local Government

It is important to remind ourselves as well as raise the awareness of all about available key municipal services. Municipal services that are provided to residents and other stakeholders include municipal public transport, ambulance services, municipal public safety, fire fighting and emergency services, libraries, water reticulation, electricity, social development as well as environmental health, sports, arts, culture and recreation.

Municipalities work in partnership with other tiers of government in the provision of social services such as housing and also recognise and address specific service needs as per Schedule 4 of the Constitution of the country. They also have a mandate to involve and consult with community in the formulation of IDPs that integrate social development issues. We have already noted that municipalities do promote access to services by providing infrastructure to bring services closer to clients.

It has been noted elsewhere in this document that municipalities do provide personal and non-personal health services which include supply of potable water, sewage disposal and refuse removal. Municipal environmental officials regulate public hygiene, food safety, tobacco control and other environmental health-related matters.

The City of Johannesburg has launched a child-headed household policy in order to keep AIDS orphans in their homes. The policy is part of a group of initiatives that provide services to indigent people such as children, the aged, and the disabled. The Policy takes the Special Case Policy of 2004, which protects indigent people, further by protecting the property rights of the child. The Special Cases Policy erases arrears and provides subsidies for basic services and sanitation.

City managers and municipalities cannot ignore the impact of HIV and AIDS on urban poverty and vice versa. Municipalities engage in strategic conversations and alliances with a range of role players drawn from government, business, and the civil society. Poverty and HIV and AIDS are two primary scourges that continue to inflict massive harm to the well being of the nation and households. Any attempt to address these twin challenges in isolation from others will not yield the desired results.

Municipalities such as Msunduzi, City of Johannesburg, Ekurhuleni, eThekwini and others have embraced forging of strategic relationships with civil society formations within their areas of jurisdiction. The result is the formation of AIDS Councils that bring business, government, and civil society together and thus pool resources and strength of participants in the fight against HIV and AIDS and urban poverty.

Local government co-ordinates poverty relief programmes, subsidise those who are unable to pay municipal rates and services, and provide infrastructure and facilities where poor households could easily access services and assistance.

Municipalities, employers and trade unions serve a useful purpose in safeguarding jobs and collaborating on employees assistance programmes. The government’s EPWP could be utilised by participants to involve vulnerable households and individuals.

The agenda or basket of measures to be taken in order to ameliorate the impact of HIV and AIDS and urban poverty has already been agreed. Structures and programmes have been established by role players and leaders. City managers may play a role, in conjunction with other role players, in mobilising resources and providing support to the chronic poor. There is sufficient goodwill for cooperation among role players. In fact churches and burial societies are willing to cooperate with municipalities in jointly finding ways and means of burying the dead in dignity. Pauper’s funerals are an affront to conscience. They could be adapted and made more accepted among the affected.

Housing and protection of family assets is another area for intervention. City managers could take many other measures to enhance the value and utility of a house. By-laws could be reviewed to allow for homes to serve as business units, early childhood development centres, and places for the care of the ill and the infirm.

One of the best measures, alongside social security payments, to address the needs of poor vulnerable households and individuals is to ensure easy access to affordable safe quality health, housing, land, recreation services and facilities within easy reach.
Municipalities have clear constitutional mandates that must be fulfilled. Civil society and role players must do all possible to hold municipalities and officials accountable for the fulfilment and promotion of the mandates.

Finally, government and municipalities have a major responsibility to provide for an enabling environment for all role players. The support for role players must be mutual and they must recognise and appreciate the unique contributions made by each one of them. Municipalities and role players must adapt to the challenges of the situation. They might have to alternate between playing the role of being leader and follower based on mutual recognition by all.

**Expanded Public Works Programme (EPWP)**

The EPWP is one of the current important initiatives that serve to address the needs of the unskilled and unemployed people who have been excluded from participating in the country's economic development. The fundamental strategies of the EPWP are to increase economic growth and address unemployment. The programme has a target of providing employment opportunities and training to at least one million targeted unemployed people in its first five years. This initiative has the potential of improving the quality of households that has the monthly income of less than R1 500 per month. Women, youth and the disabled are given a special position in the programme.

This programme involves various tiers of government and departments, municipalities, state-owned entities, NGOs, and the private sectors. The work opportunities will be created by EPWP's four sectors coordinated by the Department of Public Works, in the following ways:

- **Infrastructure Sector:** Increasing the labour intensity of government-funded infrastructure project and use intensive construction methods, providing training and skills development and build cost-effective quality community assets.

- **Environment Sector:** Creating work opportunities in the public environment programmes (e.g. Working for Water, waste management, Cleaning up SA, People and Parks, etc.)

- **Social Sector:** Creating work opportunities in public social programmes (e.g. community-based health and social welfare care and early childhood development). This sector will involve the employment of people by NGOs and CBOs and co-ordinated by Department of Social Development, Health, and Education.

- **Economic Sector:** Developing small businesses and co-operatives, including utilising government expenditure on goods and services to provide work experience component of small enterprise learnership/incubation programmes.

The EPWP will result in many benefits. It will have a direct impact on HIV and AIDS through the provision of infrastructure especially to marginalised communities as well as promoting small businesses and cooperatives. Community-based health and social welfare care will through the EPWP, be provided to those in need. The impact to HIV and AIDS and HIV and AIDS-related poverty is not in doubt.
Private service partners and civil society stakeholders

NGOs, FBOs and CBOs

NGOs, FBOs and CBOs programmes that impacts on HIV and AIDS as well as poverty could be categorized into the following sectors based on their contribution to development of poor households: business, rehabilitation, prevention, community development, education, education support, environment, culture, employment and poverty alleviation, outreach to the vulnerable, policing/security, finance, health, housing, legal and para-legal, media and information, recreation, religious, safety and security, welfare, children, youth, women, older persons, and disabled persons. In fact these structures provide for the needs of a family.

In addition these programmes also provide various services to poor households and members, advice, finance/funding, facilitation/support, networking, capacity building and skills training, education and awareness raising, referral system to external agencies, counselling and guidance, lobbying and advocacy for the rights of vulnerable individuals and groups, projects evaluation, monitoring and research, social action and pressuring for change on social and economic issues, pastoral and spiritual sustenance, film/theatre, recreation, community education and campaigns, home and community-based care, hunger relief and food security, communication, radio, newspapers, and internet.

In a 2001 study Michael Aliber of the Human Science Research Council (HSRC) described the range of existing governmental and civil society initiatives which address chronic poverty. Chronic poverty was understood as when a household or individual’s condition of poverty endures over a period of time periods e.g. six months, ten years, or longer usually taken to mean that the household or individual remains beneath the poverty line for all or virtually all of this period. Alternatively, and perhaps more meaningfully, chronic poverty can be understood as a household’s or individual’s inability, or lack of opportunity, to better its circumstances over time or to sustain itself through difficult times. (Study of the Incident and Nature of Chronic Poverty and Development Policy in South Africa: An overview, May 2001).

Aliber studied a variety of anti-poverty programmes that involved government and civil society. The government’s social security or “safety net” system was by far the largest anti-poverty instrument in the country, and probably one of the more functional. The Safety net has the objective of providing a cushion to the poor against the effects of poverty. The Department of Social Development’s system of social security grants is aimed at specific groups of vulnerable people. Civil society interventions are also critically important in this regard. Developmental initiatives, promoted by the civil society, according to Aliber, involve training and capital investments in order to launch income-generating projects or to boost the SMME sector. We have already commented on this matter and we cannot over-emphasise the contribution of social activists and their assistance to poor household.

Aliber presented a summary of the main types of initiatives and programmes in the following matrix that indicate the typical activities of each of the sectors in terms of social security and development. Funding flows and numerous partnerships between sectors are common.
Government/ Private Sector NGOs and CBOs FBOs

<table>
<thead>
<tr>
<th>Social security</th>
<th>Private Sector</th>
<th>NGOs and CBOs</th>
<th>FBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Social grants (i.e. old age, disability, etc.)</td>
<td>• Occupational insurance (unemployment insurance, medical aid, etc)</td>
<td>• Community-based homecare, e.g. for orphans</td>
<td>• Soup kitchen, health services</td>
</tr>
<tr>
<td>• Subsidised health care</td>
<td>• Grants for charitable causes, e.g. child welfare</td>
<td>• Charities, child welfare organisations</td>
<td>• Shelters/missions</td>
</tr>
<tr>
<td>School feeding programmes</td>
<td>[R50 - R80 bn, of which R5 - R10 bn to low-income hh’s]</td>
<td>[R1 - R2 bn]</td>
<td>[R0.5 - R1.5 bn]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Development and Job Creation</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Poverty Alleviation Fund</td>
<td>• SMME investment and support</td>
<td>• SMME support</td>
<td>• Income generating community projects</td>
</tr>
<tr>
<td>• SMME support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Land re-distribution</td>
<td>• Income generating community projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community-Based Public Works</td>
<td>[R0.2 - R0.5 bn]</td>
<td>[&lt;R0.2 bn]</td>
<td>[&lt;R0.2 bn]</td>
</tr>
<tr>
<td>[R1 - R2 bn]</td>
<td></td>
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</tr>
</tbody>
</table>

Typical poverty-related activities of different sectors

It is critical to briefly highlight the added value that city managers may derive from working with organisations of civil society. Myths and negative perceptions about this sector abound but nothing can take from the sector its proven contribution in the fight against HIV/AIDS as well as poverty alleviation and its impact to those affected or infected. Government officials may not appreciate the development approaches adopted by civil society bodies such as TAC, Anti-Privatisation Movement, unions and others. The rights-based approach adopted by these bodies is one of the fundamental pillars of social justice and good governance. Proponents of the approach are campaigning for a basic income grant for all unemployed persons.

Civil society, represented by NGOs, CBOs, and FBOs have and continue to contribute in the transformation of society. They reach places and persons who would otherwise not be reached due to being marginalised or disadvantaged. They can also provide or promote community acceptance and ownership of programmes and initiatives to address matters related to HIV and AIDS and chronic poverty in our country.

More, importantly, civil society primarily the religious or faith-based institutions, have an inclination to establish programmes that are values-based. Caring for and sharing with the less fortunate and treating them with absolute dignity are common among them. They are, therefore, morally and spiritually prepared to serve and not receive any reward.

Civil society has the ability to organise people and resources in order to advance and protect their individual and group interests. This fact, happily, seems to be gaining currency. The contribution of civil society to the formulation of municipal Integrated Development Plans and various social campaigns are now recognised by ward Councillors and ward committees.

Corporate social investment (CSI)

Dr Bertie Lubner, O.M.S.S, Director, Plate Glass Holding, South Africa refers to corporate social investment as “philanthropy in a strategic sense” and makes a distinction with the old thinking of the philanthropy, which he defines as “giving without expectation of return”. The current thinking about philanthropy in South Africa is focused on determining where funding is going, how it is being used and what the expected returns are (South Africa at 10, World Economic Forum, Human & Rousseau, Cape Town, Pretoria).
Dr Lubner further reminds us that prior to 1994 the South African experience of global and local CSI was essentially one of investment through the NGO and CBO communities, as well as a number of important initiatives such as the Urban Foundation and the African Children’s Feeding Scheme. A number of local families and companies gave money to important causes, either through individual resolve or through the NGO sector. South Africa was then differentiated from other countries whose governments were responsible for delivering social infrastructure.

After 1994 donor money became strategically directed at enabling government structures to deliver on their responsibilities. The international donor community was quick to support capacity-building within government. The corporate donor community aimed at building capacity through public-private partnerships, while justifying its involvement to its various stakeholders.

CSI acknowledges the challenges related to building the capacity of government to deliver road, housing, water and electricity and also address job creation, poverty alleviation, health and education. New demands are, however, placed on corporates to meet the “triple bottom line” requirements and align goodwill with commercial logic and environmental sustainability. In recent years, Dr Lubner further points out, a handful of companies have begun to use “context-focused philanthropy” for the purpose of achieving both social and economic goals.

There is now a common belief among corporates that “when corporates support the right causes in the right ways - when they get “where” and “how” right - they set in motion a virtuous cycle”. Another strong view is that “government cannot be expected to develop the requisite skills as well as NGOs and the private sector can”. This view justifies public-private partnerships.

Partnerships are built on the understanding that resources are scarce both in terms of skills and finance. The purpose of public-private partnerships is to harness these scarcities and bring parties together in an optimal manner.

In terms of funding we need to note that in South Africa there are four clearly defined tiers of development funding (CSI Handbook, 6th Edition, 2003) namely:

- **Primary Level (Tier 1):** Government, foreign donor, corporate social investment, and individual
- **Secondary Level (Tier 2):** Development Bank of Southern Africa, IDT, National Development Agency (NDA), National Business Initiative (NBI), Business Trust, Umsobomvu, Private Trusts, National lottery
- **Tertiary Level (Tier 3):** NGOs & FBOs
- **End Beneficiaries (Tier 4):** Beneficiaries.

Corporates have embraced the notion of grouping themselves and working together through bodies such as NBI, to take projects to appropriate scale and to improve the capacity of government. Business Trust raised nearly R1 billion from the private sector and applied the funds on national projects in education, job creation and tourism.

Businesses are finding it easy to leverage the expertise that resides within them for example, Tiger Brands worked within its area of competence with its Unite Against Hunger campaign.

Individual initiatives do make a vast difference in the lives of the poor. Former state president Nelson Mandela has initiated at least two funds, namely, Nelson Mandela Children’s Fund (NMCF) and Nelson Mandela Foundation (NMF) to fight poverty and disregard for the needs of children as well as the impact of HIV and AIDS.

Starfish which supports in the access of 3 000 AIDS orphans was started by two young South Africans. The money they collected has set up Star Centres to care for orphans, in partnership with other existing organisations. Bill Clinton has used his political stature to raise money for AIDS by inviting pharmaceutical companies to contribute.

The Jewish Community has set up TIKKUN to look beyond their own people. The list is long. Other FBOs are doing the same for their own communities and others.

There are employees of companies who have shown a strong desire and readiness to work for non-profit organisations and volunteer their skills to communities in need.
In pursuit of “enlightened self-interest” CSI in South Africa focus on: education, job creation, health, HIV and AIDS, training and social development, arts and culture, community and rural development, the environment, sports development, safety and security, and housing.

South African grantmakers that are rated as “good” are led by Anglo American, Eskom, ABSA, Nedcor, Standard Bank, Old Mutual, Vodacom, Sasol, Transnet, SAB, MTN, Pick ’n Pay, Coca Cola, First Rand Group, De Beers, BH P Billiton, BP, Anglo Gold Ashanti, Telkom, Woolworths, FNB and Investec.

These companies are also those making the strongest contribution to job creation and HIV and AIDS. Also highly rated in this field are Metropolitan, Eskom, BMW, DaimlerChrysler, and Ford Motors.

Donors

A number of foreign donors have a long history of association with the FBO and NGO communities. In the years before 1994 they supported parallel alternative initiatives to services that were then offered by the apartheid government. They supported the capacity of the alternative anti-apartheid development and liberation movement. Post 1994 some of them have chosen to work with and through the newly-installed government. These bodies do not work exclusively in South Africa. They continue to change their focus as new global challenges emerge.

Poverty alleviation and HIV and AIDS, TB, as well as malaria prevention have remained among their priorities. Oxfam GB for instance is associated with the “Make Poverty History” campaign, lobbies around issues of fair trade and development, HIV and AIDS prevention and promotion of small enterprises - the source of new jobs and one of the keys to fighting poverty.

In association with Oxfam the South African donor landscape is occupied by bodies such as the Ford Foundation, Save the Children, Action Aid, CARE, Mott Foundation, Misereor, W K Kellogg Foundation, Open Society Foundation for South Africa, Canada Fund for Local Initiatives, Canadian International Development Agency, United States Agency for International Development, and others. Globally, with governments everywhere privatising the share of the aid flows that are funnelled through private NGOs has tripled from 4.6 percent in 1995 to 13 percent in 2004 and roughly 30 percent for emergency relief efforts. Britain provides much of its aid through NGOs as part of British foreign policy. The number of private foundations has trebled in the United States since the early 1990s (Newsweek, September 5, 2005).

The “moral economy” supports governments in a very large manner as governments source aid work to NGOs in support of charity schools and hospitals, and relief work. “Soft money” from donors, therefore, helps South African NGOs, CBOs and FBOs in their fight against the impact of HIV and AIDS and poverty both in urban and rural areas. A gap exists however broad-based community funds or foundations that tap on the good will of local institutions and individuals.
Footnotes

1 Wilson et al. (2002, p. 54)
2 Birdsall and Kelly (2005, p. 26)
3 Wilson et al. (2002, p. 48)
4 World Bank (1999, p. 209)
5 World Bank (1999, p. 211)
6 World Bank (1999, p. 232)
7 World Bank (1999, p. 234)
8 Dr Helen Meintjes, e-mail communication
10 Nelson Mandela Children's Fund (2004, slide 37)
14 Hunter and Williamson (no date, p. xi)
15 Blauuw et al. (2004, p. 110)
16 Anonymous quoted in Blauuw et al. (2004, p. 39)
18 Strode and Barrett (2004)
20 Strode and Barrett (2004, p. 15)
21 World Bank (2003, p. xi)
22 Anonymous quoted in Blauuw et al. (2004, p. 39)
24 Strode and Barrett (2004, p. 15)
26 Birdsall and Kelly (2005, p. 17)
28 Birdsall and Kelly (2005, p. 62)
29 Mkhabela (2005, p. 6)
34 Pronyk et al., (2005, no page no. provided)
35 Department of Social Development (2004, p. 23)
36 Pronyk et al., (2005, no page no. provided)
37 Nelson Mandela/Human Sciences Research Council (2002, p. 20)
42 Nelson Mandela/Human Sciences Research Council (2002, p. 56)
44 Nelson Mandela/Human Sciences Research Council (2002, p. 4)
47 Figures 3 and 4 were provided by Johan Calitz, Development Bank of Southern Africa.
50 Johnson and Budlender (2002, p. ii)
51 Nelson Mandela/Human Sciences Research Council (2002, p. 56)
52 Pronyk et al (2005, draft)
53 Johnson and Budlender (2002, p. iii)
54 Natrass (2004, p. 26)
55 Natrass (2004, p. 26)
56 Nelson Mandela Children's Fund (2001, slide 5)
57 Department of Social Development (2003, p. 14)
58 Dorrington et al., 2004, p. 28.
59 Gauteng AIDS Programme (2002/3, p. 31)
60 Dr Helen Meintjes, e-mail communication
This point was brought to my attention by Susan le Roux of the Multisectoral Aids Unit of the Gauteng Provincial Government.

Based on Merli and Palloni (2004, Table 3, p. 54)

Department of Social Development (2003, p. 15)

Bray (2003, p. 34)


Van Rensburg et al. (2002, p. 15)

Wilson et al. (2002, p. 296)

Nattrass (2004)

Wilson et al. (2002, pp. 36, 37)

Tomlinson (2004)

Tomlinson (2003, p. 1)

Wilson et al. (2002, p. 34)

Tomlinson (2001, p. 650)

CASE (2002, p. 1)

The construction of backyard shacks for this purpose is reported in Tomlinson (2004). The same report contains preliminary calculations of the water services levels needed for various forms of care and these were found to exceed 6kl per household.

http://www.who.int/docstore/hiv/scaling/anex1.html