



Fight against AIDS: Exploring the relationships between AIDS activists, municipal health officials, and ward councillors in the Western Cape

Ismail Davids



January 2007

Contents

- 3 Introduction
- 4 Prioritising HIV/AIDS at the local level
- 5 HIV/AIDS in the Western Cape
- 7 The Treatment Action Campaign in the Western Cape
- 8 Relationships between TAC activists, municipal health officials, and ward councillors
- 12 The way forward?
- 13 Conclusion

vision

FCR believes in a future where all South Africans are able to contribute to and benefit from the democratic culture and prosperity of our country through economic activity and social action.

mission

FCR contributes to sustainable poverty alleviation interventions by facilitating good governance and municipal-community partnership processes. We do this through integrated research, community empowerment and advocacy within a sustainable livelihoods framework.

Although HIV/AIDS work is not part of FCR's direct focus, the immense socio-economic, political and moral implications of this pandemic on the nation cannot be ignored in the democracy-building process. Its impact on issues of local governance cannot be ignored. Unfortunately the implications of HIV/AIDS on local governance and vice-versa are under-researched (Kelly 2004). Though literature on partnership responses to the HIV/AIDS pandemic in general is abundant, much of it however does not focus on the local government dimension, particularly the structuring of partnership relations between municipalities and civil society groupings. This study is FCR's contribution towards developing a practice-based understanding of partnership relations between community-based TAC activists, municipal health officials, and ward councillors in four case study areas: Nyanga, Mbekweni, Wallacedene and Khayelitsha.


Introduction

“When we fail to work together, the disease (AIDS) wins”

Deputy President Phumzile Mlambo-Ngcuka speaking at a COSATU meeting, September 2006

It is now well-established that successful human development requires effective partnerships between a multitude of stakeholders within the public, private and voluntary sectors (Brinkerhoff 2000). When it comes to the AIDS epidemic facing South Africa, a sad reality is that in the noise often generated around HIV/AIDS policy and leadership at the national level, the focus on the daily struggles of ordinary people to initiate, build and sustain AIDS-related development partnerships at the local level is lost. As a development NGO, FCR is committed to supporting community-based partnerships that enhances the livelihoods of especially marginalized and vulnerable groups in society. This study therefore puts the spotlight on the nature of development partnerships between community-based AIDS activists from the Treatment Action Campaign (TAC)



and local government representatives such as ward councillors and municipal health officials in socio-economically disadvantaged areas such as Nyanga (Lower Crossroads, City of Cape Town), Mbekweni (Paarl, Drakenstein municipality), Wallacedene (Kraaifontein, City of Cape Town) and Khayelitsha (Victoria Mxenge area, City of Cape Town). Through this study FCR adds its voice to that of thousands of development activists who believe that HIV/AIDS undermines human development and that smart partnerships can play a central role in the fight against the AIDS epidemic. 


Prioritising HIV/AIDS at the local level



HIV/AIDS represents not only a health crisis, but also a development and governance crisis (Matlosa 2004; Chirambo 2006). This, of course, means that local government, as the sphere of government closest to the people, has to be involved in HIV/AIDS responses. This is especially true in South Africa where local government has an explicit development mandate. This mandate calls for a 'new' paradigm of building sustainable development partnerships between local government and local communities (Davids 2005: 5). Developmental local government embodies South Africa's attempts to overcome its legacy of racialised uneven development through an inclusive, human-centred approach to decision-making at the local level. HIV/AIDS undermines developmental local government. It undermines people's livelihoods. It destroys human capital. It reduces overall levels of citizen participation in local democratic processes. It threatens socio-economic stability, and breeds new forms of poverty and exclusion. Already, some municipalities in South Africa are faced with the following challenges:

- An increase in the number of municipal employees affected by the pandemic which in turn affects their ability to deliver essential services
- An increase in the costs to recruit, train and provide benefits for new municipal employees who are replacing deceased staff
- Declining productivity in some local economies as a result of increased absenteeism due to AIDS related illnesses
- An increase in the demand for burial space which in turn exacerbates the scarcity of land for housing development
- HIV/AIDS affected households being unable to pay for municipal services
- An increase in the number of orphans and the need for a broad-based approach to poverty reduction at the local level

- The pressing need to divert greater portions of municipal expenditure to health and social welfare expenditures

To assist municipalities in dealing with these realities, the national government has in 2000 formulated national policy guidelines for dealing with the HIV/AIDS pandemic. While these policy guidelines specify how municipalities are envisaged to play a role in dealing with the HIV/AIDS pandemic, the ability to turn these policy guidelines and prescriptions into concrete programmes and strategies remains a serious challenge (Uys 2006). What is especially lacking is local government's ability to actively engage all the relevant stakeholders, including affected communities, in the fight against the spread of HIV/AIDS. This points to weak political and administrative leadership, given that it is the task of institutional leaders to initiate and sustain strategic partnerships (Brinkerhoff 2000). The ability to forge locally-based partnerships is critical in the fight against HIV/AIDS. Research has shown that citizen participation and stakeholder involvement in locally-based, community-driven approaches to combating the effects of HIV/AIDS are important elements for sustainability and success in dealing with the HIV/AIDS pandemic at municipal level¹. It is thus no surprise that Western Cape MEC for Health, Pierre Uys, recently expressed his support for development partnerships which draws together various stakeholders in local communities with the common purpose of combating HIV/AIDS in the Western Cape province (Uys 2006). 

¹See, for example, the case of Msunduzi Municipality in Kwazulu-Natal (World Bank, Local Government Responses to HIV/AIDS: Handbook, www.worldbank.org/urban/hivadis/handbook).

HIV/AIDS in the Western Cape

The Western Cape province has a total population of more than four million people of whom the greatest number (58%) are Afrikaans-speaking. Other main languages are English (20%) and Xhosa (19.1%). Though the province has a higher Human Development Index than the national average (reflecting higher levels of per capita income, employment, literacy and life expectancy), it also has the highest Gini coefficient (reflecting gross disparities between rich and poor) (Rasool, in Abdullah 2004: 247). Despite the Western Cape's relative high levels of human development, the province has an unusually high rate of tuberculosis or TB (900 out of every 100 000 people)². This high infection rate is indicative of the gross inequality that prevails in the province, as TB is an illness often associated with conditions of abject poverty.

The Western Cape province has 30 municipalities: one metropolitan municipality (the City of Cape Town), 24 local municipalities and 5 district municipalities. Seventy two percent (72%) of the Western Cape's total population are dependent on the public health sector for their health care. The rest of the population has medical insurance and generally utilizes private health care services which are well-developed in the province (Abdullah 2004: 247). The Western Cape's public health service includes 252 fixed and 131 mobile clinics. The majority of these public health clinics, though subsidised by the provincial government, are managed by municipalities (Abdullah 2004: 246). Ninety three clinics are located within the City of Cape Town municipal area. The rest are spread through large and small towns outside of the metropolitan area of the province where higher levels of poverty and fewer livelihood opportunities compound the provision of public health services.

Although few in number, people living in small villages and on farms are reached by mobile clinics and have to make their way to the nearest towns for treatment of serious illnesses or for more specialised health interventions. Given the relative higher socio-economic status of the Western



Cape's population, HIV prevalence is lower than any other province and about half the national average. Yet, at 15.7 % the HIV epidemic is well-established and accounts for the largest burden of disease in the province (Caelters 2006b). The September 2006 HIV/AIDS statistics for the province shows that:

- the HIV prevalence amongst women aged 15 to 24 have jumped from 8.6% to 13% since 2001.
- One in every five pregnant women in the age group 25 to 29, who attend public health clinics, are HIV positive.
- Khayelitsha has the highest HIV prevalence at 33%.

The HIV epidemic is the single largest health crisis facing the Western Cape at present (see Table 1). This situation is expected to worsen until the epidemic peaks at around 2010 when HIV/AIDS will account for 25 % of all visits and admissions to health facilities in the province (Abdullah 2004: 248).

² A study however found that in one Cape Town township, HIV pushed that figure up to 1900 per 100 000 people (Caelters 2006a).


Table 1:

HIV/AIDS prevalence for the Western Cape by area, 2003-2005

AREA	2003	2004	2005
CAPE METROPOLE			
Blaauwberg	4.4	1.2	7.3
Cape Town central	11.6	13.7	11.5
Greater Athlone	10.1	16.4	17.7
Helderberg	19.1	18.8	12.8
Khayelitsha	27.2	33	32.5
Mitchell's Plain	6.3	12.9	5.1
Gugulethu/Nyanga	28.1	29.1	29.1
Oostenberg	16.1	14.8	16.2
South Peninsula	9.3	10.8	12.4
Tygerberg Eastern	7.9	12.7	15.2
Tygerberg Western	8.1	15.1	15
OVERBERG			
Bredasdorp	1.1	10	4.5
Swellendam			
Caledon/Hermanus	14.2	12.5	15.4
WINELANDS			
Ceres/Tulbagh	7.5	10.5	13.8
Worcester/Robertson	3.9	8.4	8.1
Paarl	10.1	8.9	11.4
Stellenbosch	8.5	17.8	15.5
WEST COAST			
Malmesbury	10.7	6.2	7.6
Vredenburg	10	13	8.9
Vredendal	3.9	5.8	9.9
EDEN			
Knysna/Plettenberg bay	15.6	17.4	21.1
Klein Karoo	5.4	6.5	5.3
Mossel Bay/Hessequa	13.3	12.5	8.9
George	11.6	13.3	13.8
CENTRAL KAROO			
Central Karoo	6.5	8.9	8.9

(Source: Caelers 2006b)

Public health clinics, because of their relative closeness to communities, play a crucial role in the fight against the HIV/AIDS pandemic in the province. For example, by the end of July 2006 approximately 18 900 people were getting anti-retroviral (ARV) treatment from public health clinics in the Western Cape (Caelers 2006b). Despite the importance of these clinics in the fight against AIDS, these facilities suffer severe capacity constraints which include poor management of the facilities and a shortage and neglect of medical supplies and physical infrastructure (Abdullah 2004: 247).

In order to overcome these capacity constraints, municipalities should engage in initiating and building strategic health partnerships with the private sector and specifically community-based civil society structures. These partnerships may be pragmatic relationships such as having open communication lines (e.g. clinics having an open door policy or having fortnightly discussion meetings with community-based health workers/interest groups to identify areas where support may be required), or it may be formal arrangements linking government and civil society structures through, for example, service delivery partnerships or programme monitoring and evaluation partnerships. One such civil society grouping that should be engaged at especially the local level is the TAC. The commitment of community-based TAC health activists to build public consciousness about HIV/AIDS within a framework of participatory governance is well-documented (see Friedman 2006; Friedman and Mottiar 2004). It is our view that a well-managed partnership relationship between community-based TAC activists and municipal stakeholders such as ward councillors and clinic staff has the potential to strengthen the capacity of the local state to respond more appropriately to the current HIV pandemic. 



The Treatment Action Campaign in the Western Cape




The TAC, founded on 10 December 1998 in Cape Town, actively campaigns for treatment for people living with HIV and the reduction of new HIV infections. From its inception, TAC has demanded access to anti-retroviral (ARV) therapy for children and adults with AIDS. TAC quickly emerged as a community-based response to HIV. It attracted and mobilized thousands of individuals; mostly poor, unemployed Black people with no prior involvement in socio-political issues into social activism in the form of demonstrations and community activities.

In 2004, TAC membership³ was said to be around 9000 (Friedman and Mottiar, 2004). These members operate within branches throughout South Africa's metropolitan areas, particularly Cape Town, Johannesburg and Durban. It is at branch level where TAC activists are most effective at furthering the objectives of the organisation and in giving effect to its broad aim, which is to hold government accountable to its promise to fight AIDS. At present, the Western Cape has 68 active TAC branches (Interview: Booysen 2006).

TAC demands for greater accountability with regard to health care, its 2003 civil disobedience campaigns, and the organisation's 2006 calls for the immediate dismissal of health minister Tshabala-Msimang on grounds of incompetence have resulted in the TAC being inaccurately depicted as "anti-government" and "unpatriotic". This labelling, Robins (2006: 9) argues, stems from a belief within government that civil society should not act independently of the ruling party. Despite the negative labelling and serious disagreements about HIV/AIDS policy and leadership at the national level, the TAC has co-operative relations with a number of provincial health departments and key figures in public health decision-making. This approach, Heywood (2004: 114) states, is in line with the TAC's "...political strategy that prefers collaboration with government rather than conflict". TAC's



commitment to health partnerships with government was recently re-affirmed through its *Civil Society Statement on Partnerships to Save Lives*⁴, released on World AIDS day⁵. But what about TAC-municipal partnerships? What is the extent and nature of relationships between community-based TAC activists and local government stakeholders such as councillors and municipal health officials? How can these relationships be strengthened to benefit the fight against AIDS? 

³ Within the TAC there is no distinction between "members", "supporters", "volunteers" or "activists" (Friedman and Mottiar 2004).

⁴ www.tac.org.za. 25 January 2007.

⁵ 1 December 2006

Relationships between TAC activists, municipal health officials, and ward councillors



To learn more about the relationship between TAC activists and municipal representatives, FCR designed a survey questionnaire in collaboration with the TAC provincial organiser and the TAC branch leaders of the four case study areas. Each branch was supplied with 20 questionnaires which *active* branch members had to complete. FCR also planned to have 15 face-to-face interviews with clinic staff from the four case study areas, as well as interviews with seven out of a total of ten ward councillors representing the municipal wards in the case study areas.

TAC respondents

The TAC estimates its membership to be 763 in the four case study areas. Of this, 122 are regarded as *active* branch members with membership terms ranging from less than a year to six years (see Tables 2 & 3). In total, 53 of the estimated 122 active TAC branch members from the four branches completed the survey questionnaire, i.e. 43% (see Table 4). Most of the respondents, 33 (62%), have been members of TAC between 1-3 years, while 11 (21%) become TAC members in 2006 and 9 (17%) have been members for 4-6 years. Respondents' ages ranged from 16 to 46 years, with an average age of 27 years. A number of respondents from Khayelitsha were much younger than other branch members, with six respondents between the ages of 15-16 years.

Table 2: Membership by TAC branch

Nyanga		Mbekweni		Wallacedene		Khayelitsha		Total
Members	Active members	Members	Active members	Members	Active members	Members	Active members	
28	22	500	30	200	50	35	20	122

Table 3: Length of membership by branch

Number of years as a TAC member	Nyanga	Mbekweni	Wallacedene	Khayelitsha	Total
6	3	0	0	0	3
5	0	0	0	0	0
4	1	0	5	0	6
3	1	6	3	2	12
2	3	3	1	2	9
1	6	1	3	2	12
>1	1	0	1	9	11
	15	10	13	15	53

Table 4: Respondents by branch, including gender

Gender	Lower Crossroads	Mbekweni	Wallacedene	Khayelitsha	Total
Male	8	4	5	6	22
Female	7	6	8	9	30
Total	15 (28%)	10 (19%)	13 (24%)	15 (28%)	53

- **What were TAC members' perceptions of clinic staff?**

Overall, 83% (44) of all TAC respondents described their interactions with clinic staff as positive. In particular they described the clinic staff as friendly (60%), helpful (56%), and available (49%). However, several respondents disagreed. They described staff as rude and unavailable (21%), showing no interest (23%), lacking HIV/AIDS information (24%), and not knowing enough about TAC (23%). Some responses were contradictory, for example some respondents selected both the "friendly" and the "rude" options to describe the staff at the clinic they visited, which may highlight that not all clinic staff at the clinics interact in the same way with TAC activists. There were noticeable differences between branches with regard to the perceptions of clinic staff. The respondents at the Mbekweni and Khayelitsha branches were more positive in their descriptions and accounts of the clinic staff, while respondents at the Nyanga and Wallacedene branches were more varied in their descriptions of staff.

- **What were TAC members' perceptions of ward councillors?**

Overall, respondents reported limited interaction and assistance from ward councillors. Of the 53 respondents, only 13 respondents, i.e. a quarter (25%) have ever had a meeting with their ward councillor on the issue of HIV/AIDS. In addition, 15 respondents said they did not know who their ward councillor was. Of the 13 respondents who had met with their councillor, five were from Mbekweni, three from Wallacedene and five from Khayelitsha. None of the respondents from Nyanga had ever met with their councillor to discuss HIV/AIDS and related issues. Most of the respondents were able to provide perceptions of their ward councillors even though most had not met with their local councillor on the issue of HIV/AIDS and few reported that their councillor had assisted their branch in any way. Generally, descriptions of ward councillors were positive, as 24 respondents (45%) said that the ward councillors were friendly, interested in helping TAC (18 or 34%) and cared about the community (12 or 50%). In addition, over a third (19 respondents or 36%) said that their ward councillor was available and they knew where to find him. However, some respondents described the councillors as rude (3 respondents), not interested in helping them (4 respondents), unavailable (7 respondents) and uninformed about HIV/AIDS in the community (11 respondents).

Clinic staff and ward councillor respondents

Out of the 15 clinic staff identified to be interviewed, only seven were available for the scheduled interviews. Also, out of an identified seven ward councillors, only two interviews could be secured. The remainder of the identified ward councillors gave different reasons for not wanting to be interviewed. Two of the ward councillors said they did not know anything about the TAC and therefore did not want to participate in the study, one refused to be interviewed telephonically after not being able to make an on-site interview and two councillors said they could not talk about anything without the approval of their political party. The difficulty in securing interviews with the councillors demonstrates a high degree of caution on the part of the local government representatives regarding speaking about TAC. This reserve should be seen within the context of TAC's activities at the time that the research was being conducted, in particular that the TAC was calling for the immediate dismissal of the national health minister⁶. As a result, many of the ANC councillors appeared not to want to go on record about their perceptions and comments regarding the TAC.

- **How did respondents describe their relationship with TAC branches?**

The following is a list of responses from the clinic staff and ward councillors in response to the above question:

Descriptions of a positive relationship:

- "We have a good relationship. We can talk openly about the topics of their talks... They are adaptable and responsive." (Wallacedene Clinic)
- "It is a very good one. We have a lot of understanding between us because we communicate well. I treat them like my colleagues." (Mbekweni Clinic)
- "Very good and professional." (Nyanga Clinic)

Description of little interaction:

- "We only deal with them if there are complaints, and they ask us for statistics and reports when there are drug reactions or deaths. They haven't asked for reports this year." (Wallacedene Community Health Centre)
- "There is no relationship really. If we needed we would help each other but we don't interact much. They are only here maybe 4 or 5 times a month. Not that there is a bad relationship."

Descriptions of no relationship or of a negative relationship:

- "There is no communication between us. They just make a noise. We invite all the community groups to meetings, but TAC don't ever pitch. I haven't seen them at all in the last two years. They don't serve us at all." (Wallacedene Community Health Centre)
- "There is no relationship." (ward councillor)

While some of the respondents have a very good relationship with the local TAC branch, it is also of interest to note the number of health representatives who have very limited interactions, or have a negative relationship with branches.

• How did respondents describe their relationship with TAC volunteers?

Some clinic staff were positive about their relationship and interactions with the TAC volunteers. Perhaps the most satisfied of all the respondents was the clinic staff at the Mbekweni Clinic. One respondent explained that two volunteers gave talks in the waiting room at the clinic about living positively, the importance of ARVs and about what TAC was doing. Most of the respondents, however, mentioned that their interactions with TAC volunteers were very limited. A respondent working at a clinic in Khayelitsha mentioned that he mostly deals with the peer educators who ran workshops at the clinic on topics such as HIV/AIDS and treatment options and prevention. For the majority of the respondents at the clinics, their interactions with the TAC volunteers were fairly superficial in that they were aware that they presented educational talks at the clinics but did not have much direct interactions with them, and did not embark on joint ventures with them. A respondent at the Wallacedene Clinic explained that, "The TAC fieldworkers give educational talks once or twice a week on HIV, prevention and treatment. Their involvement is not very strong yet as we are not yet an ARV site... They used to be here on a more regular basis, but for some reason they have dwindled down since about a year ago". One respondent held quite negative views on the TAC based on her personal experience. She reported that, "My only interaction with TAC has been when they came to toi-toi [protest] at the gate

here, shouting in Xhosa [for my resignation]. The police were here and it was quite a riot. They were complaining about the new appointment system [that had been instituted at the clinic].... I don't know why they were against it". She went on to mention that, "They don't talk to us so they didn't understand what was behind it, and that we had good intentions for the patients. Otherwise there have been no meetings or collaborations or discussions of any kind between us".

One of the two ward councillors interviewed mentioned that there was no TAC branch in his area and that he had not had any contact with TAC branches elsewhere. The other councillor said that TAC members had approached him to ask for permission to use the community hall for meetings as the only venue that they regularly had access to was the clinic. He went on to comment that, "TAC members should not be afraid to say they are from TAC. They should act as a solid body. The few local members who have approached me did not reveal that they were part of TAC, but I know that they are members because they go to the clinic a lot to do training and they wear the TAC t-shirts".

The overall impression that emerged from the interviews was that the interactions between the TAC volunteers and the clinic staff and ward councillors were largely superficial in nature. The role of the volunteers was to share information on HIV/AIDS related topics, and their activities at the clinics have not targeted the clinic staff as such but rather the patients at the clinics. Based on the seven health representatives interviewed, not much effort has been made on the part of the TAC volunteers to build relationships with the clinic staff.

• What did respondents see as their obligations to TAC?

The clinic staff mostly saw their obligations as being directly to the patients and only indirectly to TAC. In essence they believed that they were fulfilling their obligation to TAC so long as they were seen to be responding to the needs of the patients at the clinics. This sentiment was summarised by one respondent when she stated that, "We are obliged to the patients so that they get the best treatment they need and

⁶ A week prior to the interviews being scheduled, TAC chairperson Zackie Achmat, addressed a full meeting of the Cape Town City council where he called on all councillors, especially "his ANC comrades" to support the TAC's call for health minister Tshabalala-Msimang and her director-general, Thami Mseleku, to be sacked. See Cape Times: "Put right to life before party loyalty, Achmat urges ANC ranks", 31 August 2006, pp.7

that we communicate to them to understand their treatment. TAC wants to see that this is happening, and that the patients are being treated fairly".

When this question was posed to the ward councillors who participated in the study, one replied that, "I feel no obligation to the TAC. The group has become too political, losing the picture about the reason why they exist. They no longer have the interest of the people they purport to stand for at heart".

None of the respondents made mention of the legislative imperative to dialogue and partner with civil society and that the TAC could assist them in this aspect of their work.


- **Did respondents believe that TAC could assist them in their work?**

Some of the respondents did value the role that TAC could play in enhancing citizen participation and dialogue on issues related to health care. For example, a staff member at the Mbekweni Clinic said that, "In all the time I have worked here I have involved myself with the NGOs as part of my community outreach. This clinic alone would not be able to meet people's needs without the work of the NGOs. If I ever need support here I know who I can contact". Another way in which TAC could assist that was identified by the respondents was if they could work to mobilise community members, for example, "They can mobilise audiences to come to events that the Youth Centre hosts because TAC is very good at mobilising people". Finally, it was agreed by a number of health representatives that TAC assists them with education regarding HIV/AIDS, "Their educational talks fulfill an important role which the clinic is committed to. They are very good in explaining to people the names of the medication, the side effects and the lifestyle adherence issues".

A couple of respondents were unsure of how TAC could be of assistance to them:

- "Well I don't know. We are here to deliver a service and they are there for action. I suppose that we could ask them for support to be a spokesperson for our needs here."
- "No. They don't know about nursing. They can only help in terms of giving information. I don't know about whether they could help with outreach work."

- "No not really, but if they were around they could do well to keep people aware of HIV/AIDS because so many people are infected but are quiet about it since there is not much TAC awareness talks happening in the area."
- "They can't do clinical work. They can only do the education side."

Though the role of TAC in terms of mobilising, educating and raising awareness is acknowledged and valued by most of the clinic staff, the ward councillors interviewed did not see any immediate role that TAC could play in supporting them in their work. Both councillors were of the opinion that the TAC should confine its activities to keeping the community informed about HIV/AIDS. 




The way forward?



This study shows that partnership relations between TAC activists and local government representatives can be enhanced if both groupings could meet more frequently and collaborate to a greater degree. Such sentiments were reflected in the comments below:

- "We really need to meet them (TAC) so that we can understand their core function. I want to know how I can make best use of them, and in turn how I can facilitate their work. Can they help with adherence? Can we send out their fieldworkers to follow up on patients?" (Wallacedene Clinic)
- "We ought to meet regularly and communicate with each other. In terms of the incorrect information that they might be giving, that needs to be sorted out wherever they are getting their training. They must have the facts straight so that people can be clear about what they can expect from the clinic." (Mbekweni Clinic)
- "We need more interaction between TAC and the youth centre... I must get to know the TAC coordinators so as to know who to communicate with in order for the centre to find a way it can fit in with TAC's work in the community. We should also be undertaking more collaborative events."

The study also points to a need for local government representatives to develop a deeper understanding of the partnership imperatives of developmental local government, in particular the requirement for municipalities to partner with civil society organisations in the delivery of health services. Also, TAC volunteers should work harder at building and nurturing partnership relations with councillors and clinic staff and not only focus on engaging patients at clinics. It is acknowledged that there is a relatively high staff turnover at some of the clinics, and that the clinic staff and ward councillors might not have much time available to build and nurture partnership

relations. However, small efforts might go a long way in this regard. For example, based on the feedback from clinic staff and ward councillors, TAC volunteers should make a point of introducing themselves to the local government representatives, make appointments with the relevant staff or ward councillors if they wish to meet with them, invite them to meetings, and ask clinic staff permission to put up posters and distribute pamphlets inside the clinic. These small actions might prove to be very helpful in developing positive relationships with the individual clinic staff members and ward councillors. Meaningful health partnership initiatives aimed at eradicating the scourge of HIV/AIDS must be advocated, established and properly managed; and it should include community-based TAC activists, clinic staff, and ward councillors. This is an area where FCR, with its expertise in the advocacy, establishment and management of municipal-community partnerships within a sustainable livelihoods framework⁷ can play a key role as facilitator. 




⁷ The sustainable livelihoods framework (SLF) provides a picture of the key elements in describing or understanding the issues affecting livelihoods in a households, the community, region or country. This includes the concepts of people's assets or capitals (natural, human, physical, financial, social); people's vulnerabilities or susceptibilities to stresses and shocks (e.g. climatic changes, conflict or crime); the policies, institutions, processes (PIPs) and organisations which affect people (formal, informal, at different levels); the outcomes that people are looking for (which may be to increase the assets or reduce vulnerabilities); and the livelihood strategies people adopt to achieve these (which are affected by PIP environment and vulnerabilities).

Conclusion



A partnership approach to HIV/AIDS is an opportunity for local government to realise its stated vision of being truly developmental. The success of partnership-based developmental local government however requires that municipalities have strong political and administrative leaders capable of putting into place effective strategies and structures to encourage and manage successful partnerships. A further requirement entails partnering with communities directly as well as with other appropriate stakeholders who are active at the grassroots and who have demonstrated their commitment to defending the interests of the most marginalised and vulnerable groups in society. TAC is such a potential partner. Since its inception in 1998, TAC have demonstrated a commitment to assert the voices of poor and

vulnerable people in policy-making processes that impacts on their livelihoods. This study has argued that a community-based partnership approach between TAC and municipalities can assist in the fight against AIDS as it has the potential to turn prevailing despair to hope, denial to acceptance, and stigma to inclusion. This study reveals that in some of the case study areas there are health-related partnerships emerging, but in other areas there is not much interaction between TAC and municipal representatives. What is perhaps encouraging is the numbers of local government representatives open to improving relationships with local TAC branches and volunteers, and who desire greater partnership collaboration. The realisation of such developmental partnerships is necessary to aid the ongoing fight against AIDS. 

**Empowering people to effectively
engage with local government towards
poverty alleviation**

Bibliography

Abdullah F (2004). *"The complexities of implementing antiretroviral treatment in the Western Cape Province of South Africa"*, in **Development Update**, 5(3), 245-264.

Brinkerhoff J (2000). *"Engaging the citizenry through partnerships"*, in **Good governance for people: policy and management**. Theron F, A van Rooyen & J van Baalen (eds.). School of Public Management and Planning, University of Stellenbosch.

Caelers D (2006a). *"Health officials to meet as TB deaths rocket"*, in **Cape Argus**: 12 September 2006, pp. 3

Caelers D (2006b). *"Aids increases among young Cape women"*, in **Cape Argus**: 13 September 2006, pp 7

Chirambo K (2006). **Democratisation in the age of HIV/AIDS: understanding the political implications**. Idasa, Pretoria

Dauids I (2005). *"Making developmental local government work"*, in **SA Reconciliation Barometer**, 3(4): 5.

Friedman S (2006). **Participatory governance and citizen action in post-apartheid South Africa**. International Institute for Labour Studies, Discussion paper (DP/164/2006), Geneva

Friedman S & S Mottiar (2004). **A moral to the tale: the Treatment Action Campaign and the politics of HIV/AIDS**. Centre for Policy Studies, Johannesburg.

Heywood M (2004). *"The price of denial"*, in **Development Update**, 5(3), 93-122.

Kelly K (2004). **Supporting local government responses to HIV/AIDS: positions, priorities, possibilities**. Centre for AIDS Development, Research and Evaluation (CADRE).

Matlosa K (2004). *"Democracy, HIV/AIDS and citizen participation: focus on the 2004 South African Election"*, in **Journal of African Elections** 3(2): 77-96

Robins S (2006). *"Aids pandemic requires decisive action: citizens must oust health minister"*, in **Cape Times**, 22 August 2006, pp. 9

Uys P (2006). *"Partnerships crucial for effective policies: Joining hands to combat HIV/AIDS"*, in **Cape Times**, 10 October 2006, pp. 11

Interview:

Booyesen, Fredalene. TAC Western Cape Provincial Organiser. 4 October 2006



Foundation for Contemporary Research

Suite 1712
17th Floor, Main Tower
Standard Bank Tower
2 Heerengracht
Foreshore
Cape Town

Tel: 021 418 4173
Fax: 021 418 4176
E-mail: info@fcr.org.za

Association incorporated under section 21
Registration number 90 06898-08
NPO registration number 011-732NPO
PBO registration number 930007396

The work of FCR
is made possible through the
support of:

FORD FOUNDATION
Strengthen democratic values, reduce poverty and injustice,
promote international cooperation and advance human achievement

**M CHARLES STEWART
MOTT FOUNDATION**

**Empowering people
to effectively
engage with
local government
towards
poverty alleviation**

