MKHAMBATHINI MUNICIPALITY LOCAL AIDS COUNCIL

HIV AND AIDS STRATEGIC PLAN

2012 -2016

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1. INTRODUCTION

1. Introduction

"Now is not the time to lament. It is the time to act decisively, and to act together. Our message is simple. We have to stop the spread of HIV. We must reduce the rate of new infections. Prevention is our most powerful weapon against the epidemic. All South Africans should take steps to ensure that they do not become infected, that they do not infect others and that they know their status. Each individual must take responsibility for protection against HIV. To the youth, the future belongs to you. Be responsible and do not expose yourself to risks. Parents and heads of households let us be open with our children and educate them about HIV and how to prevent it." President J.G. Zuma 1 December 2009

"*The year 2011 marks 30 years of AIDS. In that time, AIDS has claimed more than 25 million lives and more than 60 million people have become infected with HIV. Still, each day, more than 7000 people are newly infected with the virus, including 1000 children. No country has escaped the devastation of this truly global epidemic. Nevertheless, HIV programmes are now bearing fruit; with global HIV incidence declining, treatment access expanding, and an unparalleled global movement mobilized to demand respect for the dignity and human rights of everyone vulnerable to, and affected by HIV. The epidemic and the response it has generated have changed our world, elevating global health inequity on the worldwide political agenda and placing people at the centre of health, development and human rights efforts. These accomplishments, while promising, are insufficient and in jeopardy. Stigma, discrimination and gender inequality continue to undermine efforts to achieve universal access to HIV prevention, treatment, care and support. An unsustainable trajectory of costs and the effects of a global economic downturn combine to threaten progress. For three decades, evidence of what works has been debated in this General Assembly, parliaments, communities, places of worship and scientific forums. We enter the fourth decade with a vast body of knowledge and an array of new tools to revolutionize prevention efforts and dramatically scale up access to treatment, care and support."* UN Secretary-General Ban Ki-moon March 2011

The Department of Cooperative Governance and Traditional Affair's Framework for an Integrated Local Government Response to HIV and AIDS states the following:

- As the number of people affected by HIV and AIDS in South Africa continues to rise, the development and governance implications of the epidemic are becoming increasingly apparent.
- HIV and AIDS can be viewed as both a challenge and an opportunity for development and governance in South Africa.
- The epidemic presents a challenge because it threatens to reverse the development gains that have been achieved since the transition to democracy in 1994 and the birth of developmental local governance in South Africa. HIV infection thrives in conditions of socio-economic vulnerability and inequity, and its impacts are most severe in communities that lack access to life-sustaining resources. In turn, HIV and AIDS impact on the sustainability of communities and their development conditions.

- From a more positive perspective, the epidemic offers opportunities to identify and address systemic social, economic, cultural and political practices and structures that hinder development, community empowerment and good governance.

In light of the aforementioned and in line with the vision of developmental local government, the Mkambathini Municipality sees itself as a key role-player in all efforts to prevent the spread of HIV and mitigate the negative impacts of AIDS on its communities. As such, the municipality presents this HIV and AIDS Strategy for 2012 – 2016 as a broad framework to work with civil society organisations and departments from the other spheres of government in an effort to reduce the infection rate and the socio-economic impact of the pandemic on its citizenry.

The overall goal of this five year strategy is to achieve by 2016:

- A 50% reduction in the new infection
- A comprehensive treatment, care and support programme for People Living with HIV and AIDS that promotes healthy lifestyles and life longevity
- A well co-ordinated programme for orphans and other vulnerable children that supports and promotes the development of these children until adulthood where they are fully functional and responsible members of society

In light of this the HIV and AIDS strategy focuses its interventions in three key areas:

- Education and Awareness – Openness and Prevention *that seeks to improve awareness, change behaviour, promote culture of acceptance, human rights and openness and a reduction in the infection rate*
- Treatment, care and support *that seeks to ensure that People Living HIV and AIDS have access to proper treatment, care and support through a continuum of care provided through public and private sector health care and community involvement.*
- Care for orphans and vulnerable children *that seeks to ensure that orphans and other vulnerable children receive adequate care and support*

In order to effect the implementation of these interventions, the strategy proposes the creation of three task teams responsible for driving the work in each of the focus areas. Each task team will comprise of municipal councillors and officials and government departments and civil society organisations the work in these focus areas.

This strategy document comprises the following section:

Section 1: this section, provides an introduction and overview of the document
Section 2: deals with the legal framework that supports the municipality's focus on HIV and AIDS
Section 3: looks at the current situation in terms of the issues that drive the pandemic, the current and potential future impact of HIV and AIDS on the municipality
Section 4: provides a problem statement, goals, core values and interventions in each of the three focus areas outlined above
Section 5: Outlines the structure, mandate and core functions of the Local AIDS Council

2. LEGAL FRAMEWORK

2.1. Legal mandate as outlined by COGTA

The Department of Cooperative Governance and Traditional Affair's Framework for an Integrated Local Government Response to HIV and AIDS outlines the mandate for municipalities to play an active and pro-active role in HIV and AIDS prevention and mitigation. The framework points out that the developmental agenda for local government is established by the Constitution of South Africa, Act No.108 of 1996 and subsequent policy and legislation pertaining to the systems and functions of local government. Below these and other provisions are discussed as per the framework.

The framework states that the Constitution outlines the developmental duties of local government, which require a municipality to structure and manage its administration, budgeting and planning processes to give priority to the basic needs of the community, and to promote its social and economic development. There is substantive evidence that the HIV and AIDS pandemic negatively impacts on the ability of governments to deliver basic services, address social needs and promote economic development.

The White Paper on Local Government (1998) outlines the vision for developmental local government and requires municipalities to ensure that all citizens received at least the minimum levels of basic services, that democracy and human rights are promoted, and that economic and sectoral development are facilitated. HIV and AIDS is a threat to service delivery, provides human rights challenges through the discrimination of People Living with HIV and AIDS and as alluded to earlier impacts negatively on economic development.

According to the framework the Municipal Systems Act (Act No 32 of 2000) establishes a clear framework for the core processes of planning, performance management, resource mobilisation and organisational change within municipalities. IDPs are intended to be the planning instrument for integration and co-ordination at the local level between the different spheres of government. The multi-dimensional nature of HIV and AIDS calls for an integrated and partnership driven response. This positions the IDP as the primary vehicle for developing and implementing local-level responses to HIV and AIDS.

The framework also suggests that as employers, municipalities are regulated by specific labour laws that require employers to implement measures to respond to HIV and AIDS in the workplace. There are a number of important labour-related statutes though only one of them, the Employment Equity Act (Act No. 55 of 1998), makes specific reference to HIV and AIDS. However, all labour laws are general enough in scope to cover most HIV and AIDS related issues that may arise in the workplace. The Employment Equity Act, No. 55 of 1998 aims to ensure equality and non-discrimination in the workplace through anti-discrimination measures and affirmative action provisions. It also has two clauses that expressly refer to HIV and AIDS: a prohibition on unfair discrimination based on 'HIV status; and a prohibition on HIV testing without Labour Court authorisation.

The Labour Relations Act, No. 66 of 1995 aims to regulate the relationships between employees, trade unions and employers by for example, sets out when trade unions may

meet with their members at the workplace. It also regulates the resolution of disputes between employers and employees and sets out the rights of workers with regard to dismissal.

The Occupational Health and Safety Act, No. 85 of 1993 places a duty on all employers to ensure that, as far as is reasonably practicable, the working environment is safe and healthy for employees. For example, employers are required to provide safety equipment such as latex gloves to prevent the transmission of HIV during an accident involving a blood spill in the workplace.

The Compensation for Occupational Injuries Act, No. 130 of 1993 gives every employee the right to apply for compensation if injured in the course of their employment. This would include compensation for HIV infection if it can be shown that the employee was infected whilst on duty.

The Department of Public Service and Administration (DPSA) has developed guidelines on integrated human resource planning to assist departments in conducting human resource planning. The DPSA amended the Public Service Regulations in June 2002 to provide for minimum standards in managing HIV and AIDS and other life threatening diseases in the workplace. The Regulations now include a requirement for heads of departments to take reasonable steps to minimise workplace exposure. A guide that complements these regulations has also been published.

The King II Report, provides a yardstick for corporate governance management, encourages corporate governance practices that reflect a commitment to preventing occupational diseases. It specifically recommends that local government should become familiar with the implications of HIV and AIDS and actively participate in response processes.

Both common law and Section 14 of the Constitution of South Africa, Act No. 108 of 199614 states that, all persons with HIV or AIDS have a right to privacy including their HIV status. In responding to HIV and AIDS in communities and the negative impact of stigma and discrimination on the fight against the epidemic municipalities should ensure that their programmes address these issues.

The Promotion of Equity and Prevention of Unfair Discrimination Act, No 4 of
2000 prohibits unfair discrimination in the promotion of equity. Poverty and loss of means of livelihood are hallmarks of the AIDS epidemic. The Department of Social
Development affirms the legal position of Section 27 (1C) of the Constitution of South Africa14 which stipulates that “everyone has the right to have access to social security, including, if they were unable to support themselves and their dependants, appropriate social assistance” in an effort to target the economic implications of the epidemic. For municipalities this means working closely with the department in relation to a broad approach to social assistance that includes the indigent and other policies of that seek to alleviate the plight of the poor.

2.2. Other imperatives

2.2.1. AMICAALL - The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level

AMICAALL was founded in 1997 and committed mayors from African cities to:

- Aim to reduce the socio-economic impact of HIV/AIDS in our communities by implementing effective measures to reduce HIV transmission
- Promote and co-ordinate local multisectoral approaches for HIV prevention and the care of infected and affected people
- Participate in efforts to mobilise the human and financial resources necessary to implement local strategies
- Ensure the active involvement of people infected and affected by the HIV epidemic in designing and implementing local strategies
- Strengthen solidarity amongst our cities and develop an effective partnership with national and international, public and private stakeholders

2.2.1. SALGA - South African Local Government Association

As part of South Africa's contribution to meeting the commitments of AMICAALL, SALGA has issued a country guide of municipalities in South Africa.

SALGA Country guide identifies six (6) key principles that should guide municipal response to HIV and AIDS. These principles are:

- To promote an effective leadership response for HIV and AIDS
- To enhance local government input into policy development and support
- To increase local capacity for an effective internal response
- To increase local capacity for an effective external response
- To promote effective partnerships
- To ensure monitoring, sustainability and integration

In responding to the HIV and AIDS challenge municipalities can focus on four broad areas which are:

- Mitigating the impact of HIV and AIDS in our communities
- Programme co-ordination and management for effective response
- Provision of prevention, care and support to the infected and affected
- Creation of enabling environment for effective response

2.2.2. Office of the Premier – KwaZulu Natal

The Office of the Premier has offered guidelines on the purpose of Local AIDs Councils. These guidelines state that the main purpose and function of Local AIDs Councils are to:

- guide and facilitate the implementation of the National HIV and AIDS and STI Strategic Plan and other related matters
- facilitate, monitor and evaluate the protection, promotion and fulfilment of the rights of the affected and infected persons living with HIV and AIDS in the Municipality
- promote HIV and AIDS awareness in the Municipality
- promote a uniform approach and cooperation by all organs of state in the local spheres in respect of any matter relating to HIV and AIDS
- advise the Local Government on HIV and AIDS and related matters
- monitor and coordinate implementation programmes and strategies of the provincial multi-sectoral response to the epidemic
- ensure periodic review of the Local HIV and AIDS strategic plan and other related matters
- mobilize resources for the implementation of HIV and AIDS programmes and strategies at community level
- recommend appropriate research around HIV and AIDS
- report to the Provincial Council on AIDS or District AIDS Council

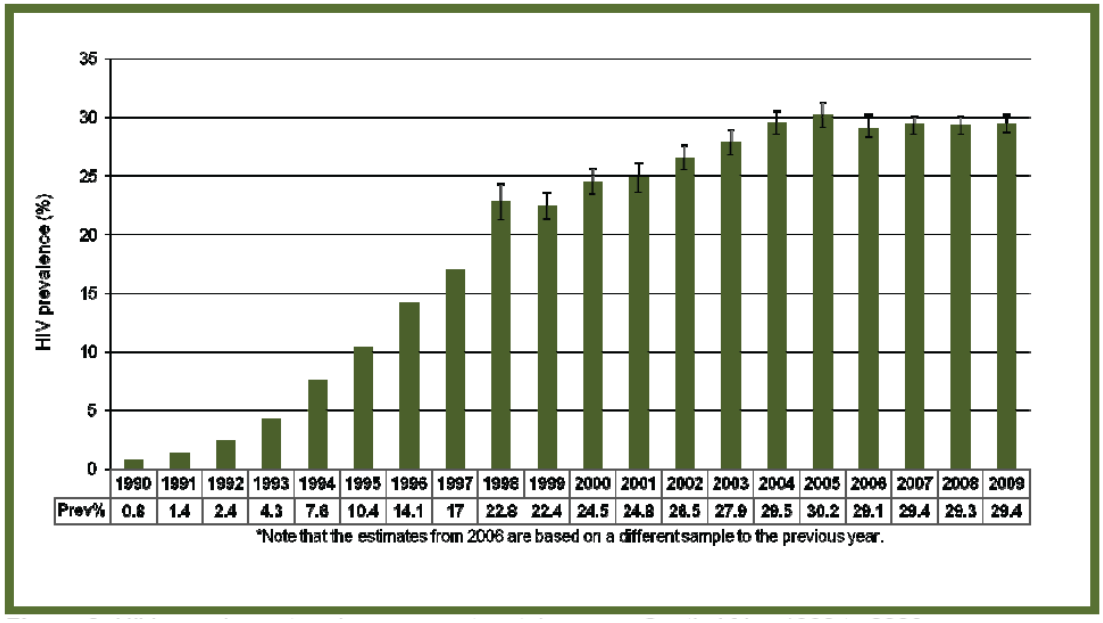
3. CURRENT SITUATION IN MKHAMBATHINI AND POSSIBLE FUTURE

3.1. Statistics

According to the Department of Health (2010):

- The 2009 the HIV prevalence in the adult population (aged 15-49) was estimated at 17.8%; or 5.63 million adults and children were with infected with HIV and AIDS. Of these, 5.3 million were adults aged 15 years and older, 3.3 million were females and 334000 were children.
- For 2009, and estimated 314 000 South Africans died of AIDS; of whom 284 000 were adults there were approximately 1.95 million AIDS orphans.
- For 2009, an estimated 1.584 million South Africans aged 15 and older were in need of Anti Retroviral Therapy; approximately 158 000 children needed Anti Retroviral Therapy and estimated 214 000 mothers were in need of PMTCT.
- The HIV prevalence is increasing among women aged 30 years and above, although the prevalence amongst 15-24 year remained static at 21.7% in 2008 and 2009, after a decrease of 0.4% in 2007**.**

The graph below presents the HIV prevalence amongst ante natal women in South Africa between 1990 and 2009. The graph illustrates that despite the stabilisation of the epidemic in the last few years to just below 30%, the prevalence rate remains high.



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Prev%	0.8	1.4	2.4	4.3	7.8	10.4	14.1	17	22.8	22.4	24.5	24.8	26.5	27.9	29.5	30.2	29.1	29.4	29.3	29.4

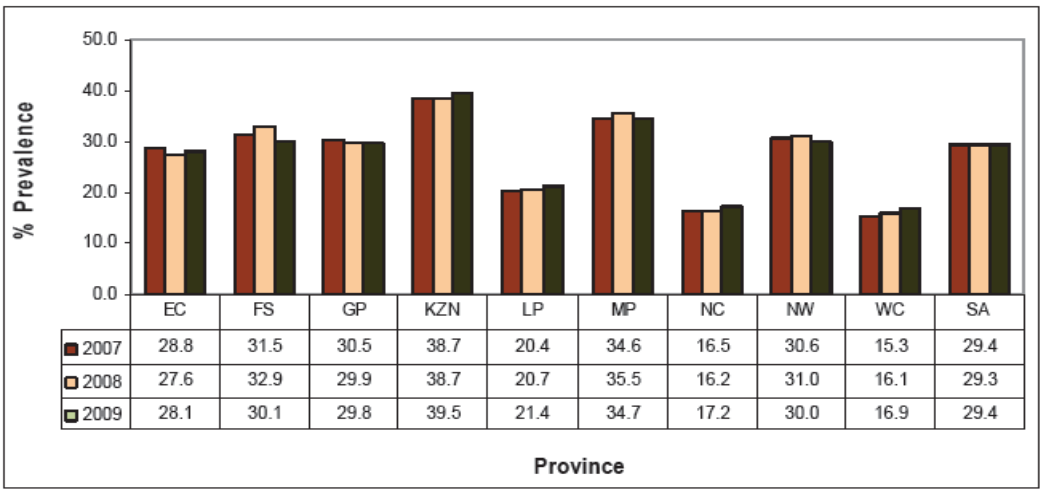
*Note that the estimates from 2006 are based on a different sample to the previous year.

Graph: HIV Prevalence Amongst Antenatal women 1990 - 2009: DOH 2010

3.1.2. Provincial HIV Prevalence

According to the Department of Health's National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa (2009) the KwaZulu Natal provincial HIV prevalence amongst 15-49 year antenatal women was 39.5% compared to the national prevalence of 29.4%.

The graph below illustrates the prevalence to HIV amongst ante natal women between 2007 and 2009. It provides a useful comparison between the different provinces.



	EC	FS	GP	KZN	LP	MP	NC	NW	WC	SA
2007	28.8	31.5	30.5	38.7	20.4	34.6	16.5	30.6	15.3	29.4
2008	27.6	32.9	29.9	38.7	20.7	35.5	16.2	31.0	16.1	29.3
2009	28.1	30.1	29.8	39.5	21.4	34.7	17.2	30.0	16.9	29.4

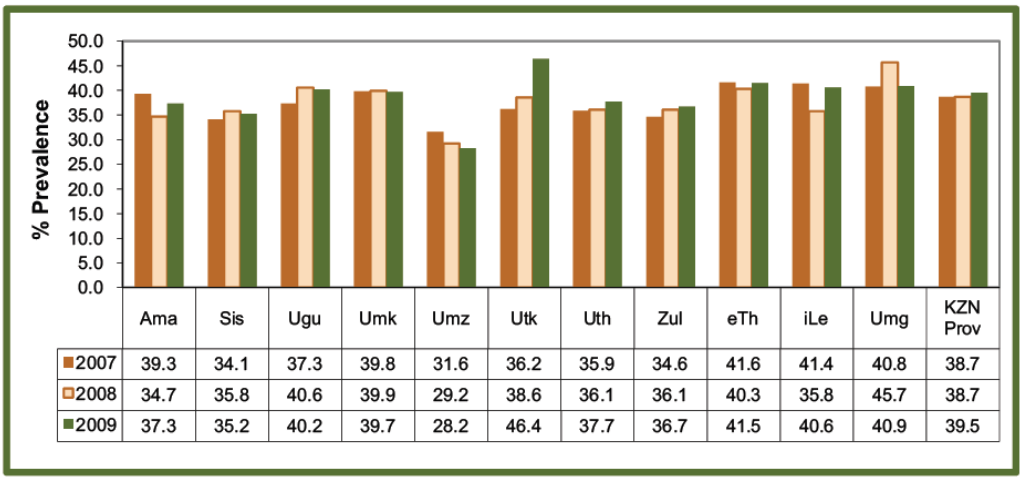
Graph: Provincial HIV prevalence amongst antenatal women: 2007 - 2009: DOH 2010

3.1.3. District HIV Prevalence

As no statistics exist for the local municipalities it is useful to reflect on the district HIV prevalence rate as it may provide an indicator of the situation within the Mkhambathini Municipality.

The uMgungundlovu District Municipality is the second most populous area in the province of KwaZulu-Natal with an estimated population that is just over one million citizens.

As indicated in the graph below, the HIV prevalence in 2009 decreased by about 4.8% as compared to 2008. This is a significant drop as compared to other district municipalities although it is still well above the national and provincial averages.



	Ama	Sis	Ugu	Umk	Umz	Utk	Uth	Zul	eTh	iLe	Umg	KZN Prov
2007	39.3	34.1	37.3	39.8	31.6	36.2	35.9	34.6	41.6	41.4	40.8	38.7
2008	34.7	35.8	40.6	39.9	29.2	38.6	36.1	36.1	40.3	35.8	45.7	38.7
2009	37.3	35.2	40.2	39.7	28.2	46.4	37.7	36.7	41.5	40.6	40.9	39.5

Graph: Prevalence per district in the province of KwaZulu-Natal 2007 - 2009: DOH 2010

Based on the above, it can be concluded that the HIV and AIDS pandemic poses a serious challenge for the Mkhambathini Municipality and its citizens.

3.2. Factors that render Mkhambathini vulnerable to a high infection rate

The municipality's proximity to major transport routes including the N3 high levels of drug and substance abuse, and other contextual factors as outlined by the Department of Health renders the municipality particularly vulnerable to a high infection rate.

Mkhambathini Municipality was formerly under the jurisdiction of the Camperdown Transitional Local Council and the iLembe and iNdlovu Regional Councils. The new Municipality was established following the local government elections in 2000, and is one of the seven municipalities falling under the uMgungundlovu District Municipality.

Mkhambathini can be divided into three distinct segments. The southern area is largely occupied by the Embo-Timuni traditional authority area, while the middle part, through which the N3 runs, contains commercial farms and Camperdown Village, the economic centre of the Municipality. The northern segment of the Municipality, in which the Mngeni River and its tributaries are to be found, is occupied by the Maphumulo and Nyavu tribal authority areas.

The Municipality is situated in the catchment's areas of the Mkhomazi and Mngeni rivers. The dominant land use in the area is agriculture.

The most notable characteristics of the Municipality are the extreme poverty of the population in the traditional authority areas, and their physical isolation from service centres and from job opportunities.

The population of Mkhambathini Municipality is estimated at 46 089 people, with the highest concentration of people in the traditional authority areas. More than 46% fall into

the 0 - 19 age group, with a further 25% in the 20 - 34 year age category. The dominance of young people in the Municipality places special demands on the provision of education and training, sports and recreational facilities, and on the expected rise in demand for jobs. The Municipality is also aware that young people are especially vulnerable to such threats as unemployment, HIV/Aids and drug abuse. Although 47% of the Municipality's population are estimated as falling within the economically active group, only 65.6% of these are in full-time employment. The situation varies according to distance from the road network and the main economic centres. In one traditional authority area, only 9% of the economically active group are employed.

The impact of a low education level (29% of Mkhambathini's population having received no formal education, and 31% only primary schooling) and the high rate of unemployment are reflected in the general poverty to be found in the Municipality. The majority of households earn less than R3 000 per annum.

Educational facilities, particularly primary schools, are unevenly distributed, and their quality and condition vary considerably. Some schools are community-built and do not meet building standards. Many rural schools lack basic facilities such as electricity and sanitation, and none have libraries. The Municipality has no facilities for skills training or tertiary education.

There are four fixed clinics in the municipal area in Maguzu (Ward 1), Injabulo (Ward 2) and Embo and Baniyena (Ward 7). Further health services in the Municipality are also provided by 2 mobile clinics covering 37 points and this has made improvements in accessibility to prevention and treatment. In addition, a new clinic is being built in Ezimwini (Ward 5) and will be ready by November 2012. Two private doctors and numerous traditional healers also practise in the area.

The Municipality has police stations at Camperdown and Mid-Illovo, which are actively involved in community policing and provide a number of services. However, the most densely populated areas of Mkhambathini lack police stations.

The only library in the Municipality is in Camperdown. Sports and recreational facilities are generally poorly developed, although Camperdown School caters for a number of different sports. Other social facilities that are not provided are old age homes and special arrangements for the disabled.

Basic infrastructure is currently provided on an unequal basis. 34% of households obtain their water from rivers and streams, making them vulnerable to cholera and other water-borne diseases. Sanitation provision is generally poor, with 23.6% having no access to sanitary facilities and 59% of households using owner-built pit latrines which often do not meet health standards. 62% of households do not have electricity, using candles and paraffin instead, while 39% do not have access to telephones. Camperdown and Umlaas Road are the only settlements in the Municipality with refuse removal services.

The Municipality's road network is of variable quality. The developed section has high-quality tarred roads and well-developed district roads, while the quality of roads in the

traditional authority areas is generally very poor. The economy of Mkhambathini is based on agriculture and manufacturing. Commercial farming, mainly large-scale sugar-cane cultivation, is dominant. Manufacturing activities, including agri-processing and light industries, cluster around Camperdown. The sugar mill in Illovo has been moved to Eston, providing another manufacturing centre in the Municipality.

According to the Department of Health these contextual factors impact on infection rate as follows:

(a) Poverty

Poverty operates through a variety of mechanisms as a risk factor for infection with HIV and AIDS. Its effect needs to be understood within a socio-epidemiological context.
It works through a myriad of interrelations, including unequal income distribution, economic inequalities between men and women which promote transactional sex, relatively poor public health education and inadequate public health system. Poverty related stressors arising from aspects of poverty in townships such as poor and dense housing, and inadequate transportation, sanitation and food, unemployment, poor education, violence, and crime, have also been shown to be associated with increased risk of HIV transmission.

(b) Gender and Gender-based violence

South Africa has one of the highest rates of violence against women, with over 53 000 rapes reported to police in 2000, translating into a rape reporting rate of 123 women per 100 000 population. Sexual violence is linked with a culture of violence involving negative attitudes (e.g. deliberate intention to spread HIV) and reduced capacity to make positive decisions or to respond appropriately to HIV-prevention campaigns. More significantly, the experience of sexual assault has also been linked to risks for HIV infection. Equally interesting, two recent studies conducted among men in a township community and in an STI clinic both showed that men with a history of sexual assault were also at significantly higher risk for HIV transmission than their counterparts without such a history. In South Africa, the gender system fosters power imbalances that facilitate women's risks for sexual assault and sexually transmitted infections (STIs). South African men, like men in most societies, possess greater control and power in their sexual relationships. Women with the least power in their relationships are at the highest risk for both sexual assault and HIV infection, both stemming from the inability of women to control the actions of their sex partners.

Men who have limited resources and lack the opportunity for social advancement often resort to exerting power and control over women. Importantly, sexist beliefs and negative attitudes toward women are held by men who have not been sexually violent as well as men who have a history of sexual violence. In fact, negative attitudes toward women are so pervasive there is evidence that they are often held by women themselves.

Power and control disparities in relationships create a context for men to have multiple concurrent partners and fuel their reluctance to use condoms. Unfortunately, men's attitudes toward women impede HIV preventive actions and can culminate in the

acceptance of violence against women. Qualitative studies in South Africa consistently show that men believe they are more powerful than women and that men are expected to control women in their relationships. There is also evidence that men often hold attitudes that accept violence against women including beliefs that women should be held responsible for being raped. One in three men receiving STI clinic services endorsed the belief that women are raped because of things that they say and do and half of men believed that rape mainly happens when a woman sends a man 'sexual signals.

(c) Cultural Attitudes and Practices

There is some evidence that cultural attitudes and practices expose South Africans to HIV infections. First, gender inequalities inherent in most patriarchal cultures where women are accorded a lower status than men impact significantly on the choices that women can make in their lives especially with regards to when, with whom and how sexual intercourse takes place. Such decisions are frequently constrained by coercion and violence in the women's relationships with men. In particular, male partners either have sex with sex workers or engage in multiple relationships, and their female partners or spouses are unable to insist the use of condoms during sexual intercourse for fear of losing their main source of livelihood.

Second, there are several sex-related cultural beliefs and behavioural practices such as rites of passage to adulthood especially among male youth, rites of marriage such as premarital sex, virginity testing, fertility and virility testing, early or arranged marriages, fertility obligations, polygamy, prohibition of post-partum sex and also during breastfeeding, and rites related to death such as levirate (or spouse inheritance) and sororate (a widower or sometimes a husband of a barren woman marries his wife's sister) are also believed to spread HIV infection.

HIV infection is also believed to occur during some of the traditional health practices conducted by traditional healers when they use unsterilised sharp instruments such as knives, blades, spears, animal horns and thorns during some of the healing practices and/or recommend sex with a virgin as part of their treatment of patients.

(d) Stigma, denial, exclusion and discrimination

HIV and AIDS is perhaps one of the most stigmatised medical conditions in the world.
Stigma interferes with HIV prevention, diagnosis, and treatment and can become internalized by people living with HIV and AIDS. In the UNGASS declaration, governments committed themselves, among other things, to confront stigma, denial and eliminate discrimination by 2003. Although still prevalent, AIDS stigma appears to be declining in South Africa as shown by the findings of the 2005 national HIV and AIDS household survey, when compared to the 2002 survey.

One of the consequences of the problem of stigma, exclusion and discrimination of people living with HIV and AIDS is that it forces people who are infected to hide their condition and to continue engaging in high-risk behaviour. Another consequence is denial. Both silence and denial about HIV and AIDS are lethal because they prevent people from accurately

assessing their own personal infection risk as well as accessing the broad range of available services in this regard.

(e) Mobility and labour migration

Poverty and unemployment are linked to economic disempowerment and this affects sexual choice-making and exposure to wider sexual networks. Over and above gender vulnerability that flows from economic disempowerment, individuals who engage in work-seeking, mobile forms of work or migrant labour are at increased vulnerability to HIV as a product of higher likelihood to have multiple sexual partners, higher exposure to sex for exchange of money, amongst other risk factors. Mobile individuals include informal traders, sex workers, domestic workers, cross-border mobility, seasonal agriculture workers, migrant workers (e.g. mine-workers, construction workers, and soldiers), long-distance truck, bus and taxi drivers, travelling sales persons and business travellers.

(f) Informal settlement

Informal settlement is associated with higher levels of HIV prevalence in South Africa. There is often social fragmentation within informal settlements that may increase the likelihood of exposure to unsafe sex. In addition, there is a greater likelihood that individuals at higher risk of HIV, including work-seekers, temporary workers, and labour migrants, are resident in these areas. Informal settlements frequently lack adequate housing, sanitation and health service access, and these exacerbate overall health risks.

3.3. Possible future impact of HIV and AIDS on the municipality

The impact of HIV and AIDS pandemic in our communities has resulted in a great deal of suffering by individuals and families. The most visible impact in most areas is the increase in the number of people who are getting sick and those who dying due HIV and AIDS related sicknesses. Health care sector is not the only sector that is affected by the HIV and AIDS pandemic, all sectors inclusive of households, communities in general, education sector, private sector, labour movement as well as the state social security's services.

(a) The impact on individual, family and community

Individuals, family and community are an important part of society and without them whatever development that happens without their benefit is fruitless. The individual suffers differently to the impact of the HI virus. They suffer psychologically, physically and emotionally. At times they feel constantly sick and weak and often feel lonely and depressed. All these negative feelings and thoughts are all attributed to low self esteem, feelings of hopelessness.

Families lose each other when there is any trace of one being infected with the HI virus. The constant thought of losing an income within the household and also the loss of a member puts them into distress. At this point families become vulnerable to blaming, break-ups and discrimination against one another.

In the absence of family, community members look after the individual. When the community discriminates against those who are infected there is no hope for care and support for people living with the HIV virus. The increase of the disease within the community has a negative effect on the community such that it is felt through seeing many funeral ceremonies on a regular basis. Communities lose prominent leaders and role models. The rate of orphans is increased; the level of street children thus increases as some of them run away from foster care and abusive family environment.

Elderly people usually carry the heaviest burden of providing care and support to both their children of economically active age but bedridden and their grandchildren. They equally if not more suffer emotionally as The very old age grant is over stretched to cover basic necessities of children whom they are suppose to dependent on and grandchildren.

(b) The impact on Children and education sector

Children are often seen as being flexible and able to adapt to any given situation thrown at them. Little is taken into consideration that they take a lot of emotional strain after the loss of a loved one, their primary care givers and their support base. When either one of their parents is sick they feel obliged or natural for them to take care of them even if they have to drop out of school and provide an income for the household.

When they are not able to provide for the family hunger takes over and they become vulnerable because they are subjected to anything meaning selling their bodies for food to feed their siblings or ensuring there is money to get treatment for the bed ridden parent. When parents are no longer there they suffer neglect and abuse from family and community members.

Myths and distorted cultural beliefs and practices also drive vulnerability and exposure of children to abuse as some men believe that sleeping with a virgin can cure HIV thereby molesting minors.

(c) Economic development and labour force

Some of the breadwinners work in big cities. Many people who are suppose to be working the land to produce their own food are also in big cities looking for employment leaving behind a majority of school going age dependent children together with grandparents who are sent money to purchase food from wholesalers and retailers

We lose skilled people in the workforce who are breadwinners become ill after HIV infection, leading to their colleagues sharing the workload and therefore over worked with backlog as well as increased spending on recruitment and retraining of new personnel. Most employees who affected because they are friends or very close to their colleagues living or ill with HIV related infections suffer from stress as they are unable to cope with the pain of losing a friend and colleague.

The above also leads to low morale and reduced labour output and therefore reduced production. Fewer products supplied to markets when the demand is big, leads to increase

in prices for goods and poor people are worse affected as buying or spending power is reduced with lose of income or loved ones who are breadwinners.

(d) Provision of government services

As more households lose their spending and buying power, the ability to pay for government services is also affected and more people require subsidised services and social grants. As local economic development shrinks in size, so too the tax base of the municipality become smaller and implicatively left with not enough revenue to provide basic services. The municipality will not be immune from lose of skilled workforce just like any other employer and quality of output in the service delivery process gets affected.

As the infection rate increases, the entire process of representative and participatory democracy gets affected as the rest of society become less competent to respond to problems let alone voting, informing government what they want through IDP processes and attending meetings to hold public representatives accountable.

4. CORE INTERVENTIONS

This section provides the core interventions (strategies) to meet the overall objective of:

- A 50% reduction in the new infection
- A comprehensive treatment, care and support programme for People Living with HIV and AIDS that promotes healthy lifestyles and life longevity
- A well co-ordinated programme for orphans and other vulnerable children that supports and promotes the development of these children until adulthood where they are fully functional and responsible members of society

The three focus areas of the strategy are discussed separately:

- Education and Awareness – Openness and Prevention
- Treatment care and support for people living with HIV and AIDS
- Care for orphans and vulnerable children

In each of these areas the following is provided:

- Problem statement
- Broad goal
- Current services and programmes
- Core interventions

4.1. Education and Awareness – Openness and Prevention Task Team

Problem Statement

Many people engage in risky behaviour that contributes to the spread of HIV, some because of negligence or ignorance but some because they lack knowledge. Other reasons include distortions in cultural practices, religious beliefs, myths and stereotypes. The analyses also show that poverty is another major contributor to the spread of HIV. In return HIV also exacerbates the spread and effects of poverty.

Lack of income or unemployment makes families more vulnerable to risky behaviour, exploitation and infection. In some cases even people who have income are vulnerable by engaging in transactional sex whereby they provide basic necessities in exchange for sex and companionship.

Substances abuse like alcohol and drugs also leads to people engaging in risky behaviour whereby people fail to use condoms thus increasing the rate of infection in STIs, unplanned pregnancy and HIV. We have also seen a rise in a number of children who become sexually active at a tender age resulting to teenage pregnancy.

Broad Goal

To reduce the infection rate by 50% through education and awareness programmes, safe sex practices and the elimination of stigma and discriminatory practices by 2016

Current services and programmes

Who	What	Where
FET colleges	Skills development	Municipal offices
Methodist church	HIV and AIDS education	WARD 4
ABET and Masifundisane	Adult and youth education	All wards
Youth Ambassadors	HIV education, life skills and peer education	Wards 2 and 5
M2M	Promotes PMTCP programme	Ward 1
Mobile clinics	Provides health care services and education	Wards 2,3,4,5,6 and 7
Sinani	Promotes healthy living style and HIV education	WARDS 5,7 and 1
Love life	Life skills and HIV education and awareness	Wards 1 and 2
Department of Arts and Culture	Moral regeneration and HIV prevention and Reed dance	Wards 7 and 2
Community Centres	Food parcels, feeding schemes and provide OVC services	Wards 1,3,7 and 4
CRF	Facilitates disability programmes	Mkhambathini municipality
Mkhambathini Local Council	Alleviates poverty, skills development and business skills development, cultural awareness, arts and crafts and alleviates poverty through local job creation as a tourist attraction. Facilitation of HIV and AIDS strategy development	All wards
Department of Health	Planned patient transport	Wards 1 and 2

Core Interventions

Outputs: What must be put in place to archive our goal (Clear and measurable objective)	**How will we Implement? Broad Approach (Intervention)**	**Drivers and partners**
To develop an annual action plan with quarterly targets for a well co-ordinated and consistent education and awareness programme targeting every sector of the community by 2nd week of February every year for the next five years. **The action plan must include all other outputs included in Education and Awareness that are listed below**	▪ Every January task team must convene a meeting of all stakeholders to: o Develop an action plan that reaches each household in every ward at least four times a year o Every quarter the task team must meet to evaluate progress o Activities in the action plan must include: ✓ Road shows ✓ Pamphlets distribution-task team ✓ Talks (schools, churches, clinics, on pension days) etc. ✓ Door to door	**Drivers**: ▪ LAC Co-ordinator ▪ DOH **Partners**: All organisations in the municipality involved in Education and Awareness work

Outputs: What must be put in place to archive our goal (Clear and measurable objective)	**How will we Implement? Broad Approach (Intervention)**	**Drivers and partners**
As part of the previous output: To identify high transmission areas and develop response programmes by 2nd week of February every year for the next five years	▪ Work with ward committees to identify all truck stops, taverns, night clubs and shebeens ▪ Develop a programme to regularly supply these areas with condoms with a consistent education and awareness programme targeting these areas	**Drivers**: ▪ LAC Co-ordinator ▪ DOH **Partners**: ▪ Ward committees ▪ All organisations in the municipality involved in Education and Awareness work
To increase the supply and availability of female condoms	▪ Lobby the DOH to make more female condoms available ▪ Educate women as part of our overall education and awareness action plan on how to use the female condoms	**Drivers**: ▪ LAC Co-ordinator ▪ DOH **Partners**: All organisations in the municipality involved in Education and Awareness work
Encourage male circumcision	▪ Work with the DOH to set targets for male circumcision ▪ As part of our overall action plan encourage men to circumcise	**Drivers**: ▪ LAC Co-ordinator ▪ DOH **Partners**: All organisations in the municipality involved in Education and Awareness work

4.2. Treatment, Care and Support for People Living with HIV and AIDS Task Team

Problem Statement

The high levels of stigmatisation and discrimination has resulted in many individuals being afraid to go for testing. In addition, people are afraid to test because of lack in information, being stigmatized and ignorance. As a result many of them go for testing when they are already ill, with a very weak immune system. Many citizens seek treatment outside the municipal area as a result of stigma and discrimination.

There is a lack of emotional support systems as there are not enough lay counsellors and functional support groups with sustainable programmes. As a result there is often a lack of follow up support for patients.

There are not enough people who volunteer (especially men) for Home Base Care services.

Broad Goal

To improve access to treatment, care and support for the HIV infected people and ensure that they live a long and healthy life with communities and families playing central role by 2016 through a function referral system that effectively links all service providers

Current services and programmes

Who	What	Where
ARK	They provide transport to different service providers, assist children to obtain relevant documentation and Social grants	Ward 1
NOAH	They provide support to people living with AIDS – HBC Cook for OVCs and ensure that people access government services such social grants etc.	Ward 1
KENOSIS Lutheran church(Bishopstone)	Assist people to access social services, provide food parcels and do bereavement counselling for OVCs etc.	Ward 1
Maqongqo community care centre	Provide care and support for people living with AIDS(HBC) and OVCs.	Ward 1
Tholulwazi Christian Care Centre	Provide care and support for people living with AIDS (HBC) and OVCs.	Ward 3
Amakholw'amahle	Provide care and support for people living with AIDS(HBC)	Ward 5
Makhalima Drop in Centre	Provide care and support for people living with AIDS (HBC) and OVCs and give food parcels to the needy.	Ward 5
Abalaphi bendabuko (THO)	Traditional healing and referrals	Ward 5
Holy Apostolic church in Zion	They provide spiritual healing and Care and support to people living with AIDS(HBC)	Ward 5

Who	What	Where
Mkhambathini Independent churches Association	Provide spiritual care and support and renovate houses	Wards 2 and 3
Department of Health	Recruit, train and sustain community health workers	Wards 1 to 7(Mkhambathini)
Red Cross	Provide home base carers with KITS, train volunteers on HBC and counselling, provide food parcels, supply the sick people with walking stick, wheel chairs etc.	Ward 1 and 2
SINANI	Work with volunteers on poverty alleviation projects such as food gardening, sewing and poultry farming to assist people living with AIDS.	Wards 5 and 7

Core Interventions

Outputs: What must be put in place to archive our goal (Clear and measurable objective)	**How will we Implement? Broad Approach (Intervention)**	**Drivers and partners**
▪ To facilitate the establishment and of support groups that are linked to health centres by the end of 2011	▪ Identify existing support groups and areas where no support groups exist ▪ Work with PLWHA to establish support groups in areas where none exist ▪ Provide training on organisation development and managing organisation for support groups to ensure sustainability	**Drivers:** ▪ LAC Co-ordinator ▪ DOH and Health Centre Managers ▪ PLWHA **Partners:** ▪ Training organisations
▪ To establish clinic committees where they do not exist by June 2012 so as to support the improvement of service delivery	▪ Identify clinics that do not have clinic committees ▪ Develop a programme to establish committees in these clinics ▪ Conduct a workshop on all clinic committees on roles and responsibilities	**Drivers:** ▪ LAC co-ordinator ▪ DOH

Outputs: What must be put in place to archive our goal (Clear and measurable objective)	**How will we Implement? Broad Approach (Intervention)**	**Drivers and partners**
To ensure adherence to treatment amongst PLWHA through an ongoing education and awareness programme	▪ Develop and implement targeted educational and awareness programme with specific focus on the affected families	**Drivers:** DOH, Support Groups **Partners:** All stakeholders involved
Work towards the improvement of the health system including deployments and employment especially in the rural areas and remove barriers to access to enhance service delivery in the next three years	▪ Lobby for the employment and deployment of staff in health centres ▪ Advocate for more ARV sites ▪ Engage DOH, Public Works Department, Public Service and Administration, Roads and Transport department, Energy and Minerals to ensure improvement of services and improvement of the infrastructure	**Drivers:** DAC and LACs **Partners:** All stakeholders
Improve quality of services provided by home base care providers	▪ Recruitment and training of more HBC givers ▪ More training for existing HBC givers ▪ Improve supply of kits ▪ Improve access to office space for HBC programmes	**Drivers:** ▪ LAC Co-ordinator ▪ DOH and Health Centre Managers ▪ DOS

4.2. Care for orphans and Vulnerable Children Task Team

Problem Statement

Many children are made vulnerable because parents are either unemployed, abusing substances or there has been a breakdown in family life because of domestic violence or death of one or both parents. Further it has been seen that:

- Increasing of Orphaned children and child headed families
- Family divisions and divorces because of lack of information
- Discrimination and stigma amongst family members towards the infected
- Normal family structure is being destroyed
- Children drop out school because of discrimination and stigma attached to HIV and lack of support
- Changing of roles in the families because parents are either too sick or have died
- Children lose hope and end up with no sense of belonging
- Family leadership is eroded by the death of the parents

Broad Goal

By 2016 we would like to see empowered children living in empowered communities

- A community that is informed, aware and involved in providing holistic care for OVCs
- Children who are aware of their rights
- Children who are involved in activities that promote their all round development and helps to achieve their full potential
- Reduction in teenage pregnancy
- Programmes that are closely monitored and evaluated

Current services and programmes

who	what	where
Media in Education Trust	Training in behavioural change communication Provides school uniforms to OVCs	Wards 6 and 7
Makhalima Development Centre	NIP HCBC VCT Food security (gardens)	Ward 5
SINANI	Moral regeneration	Ward 1 (Maqongqo)
Save the children's fund	Capacitate ECD practitioners	All wards
Christian care centre	Children's home Medical clinic Skills development centre Early childhood development centre NGO support	Ward 4
Tholulwazi community care centre	NIP	Ward 3 (Enkanyezini)
Maqongqo community care centre	NIP	Ward 1 (Maqongqo)

Who	What	Where
Department of Social Development	NIP NGO support Isibindi Model HIV and AIDS programmes Forster care placement	Wards 3 and 1 Wards 4 and 5 all wards all wards
Department of Health	Primary health care CVT and ART NIP support	all wards
Mkhambathini Local Council	LAC Community development Referral to relevant stakeholders Needs assessment Coordination of service delivery	all wards

Core Interventions

Outputs: What must be put in place to archive our goal (Clear and measurable objective)	How will we Implement? Broad Approach (Intervention)	Drivers and partners
▪ To develop a comprehensive database of all orphaned and vulnerable children in all wards within municipality by June 2012	▪ CC givers, Ward committees, councillors and CDWs to door to door work in all wards to identify children based on a questionnaire and guidelines to identify children in need within the context of respect for the rights of the child and basic human rights of family members ▪ Inform communities before the door to door work takes places through the media ▪ LAC co-ordinator and Department of Social Development to develop questionnaire and guidelines	**Drivers:** ▪ LAC Co-ordinator ▪ Department of Social Development **Partners:** CDWs Ward Councillors CC givers

Outputs: What must be put in place to archive our goal (Clear and measurable objective)	**How will we Implement? Broad Approach (Intervention)**	**Drivers and partners**
To strengthen the existing CCCF programme in all municipal wards within 12 months	▪ Identify, recruit and more train people as care givers ▪ Institute proper coordination and monitoring systems. For example: Imbizo programme and feedback on monthly and quarterly basis from the DOS ▪ Advocacy for physical resources. For example: Food parcels, medication, shelters etc (ongoing)	**Drivers:** ▪ LAC Co-ordinator ▪ Department of Social Development **Partners:** o Ward Councillors o Ward Committees o CC givers o Organisations providing care for OVCs o SAPS o Department of Social Development o Home Affairs o Department of Education

5. Structure and Mandate of the Local AIDS Council

As part of its broad goals, Local AIDS council should ensure that all sectors:

- Collaborate in building the capacity of locally based organisations in ensuring an effective response to HIV and AIDS challenges

- Ensure positive response to HIV and AIDS in a cost-effective way with maximum impact to ensure the reduction of spread of the pandemic

- Ensure improvement of prevention programmes through information and programmes that seek to reduce the stigma and discrimination of the infected and affected

The LAC operates in three levels which are:

1. A multi-sectoral Council chaired by the Mayor

2. Three task teams which focus on three key priority areas:

    - Education, preventions and Awareness

    - Treatment, care and support for people living with HIV and AIDS

    - Care for Orphaned and Vulnerable Children (OVCs)

3. Technical Task Team / the Secretariat which comprises of:
    - Senior staff from Community and Health Services
    - Department of Health Representatives
    - Department of Social Development Representative
    - Heads of task teams

The Local AIDS Council (LACs) is expected to oversee the implementation of this plan and ensure the co-ordination of the implementation of programmes and projects that seek to reduce the impact of the pandemic as well as to eliminate duplication, competition and wasting of the scarce resources. Further, the LAC must seek to extend services were none exists.

Local AIDS Council Structure

Composition of the Local AIDS Council

- Mayor
- Portfolio Councillors allocated to each task team
- Municipal Manager
- Community and Health Services Manager

- Municipal staff to provide administrative services to the task teams
- People living with HIV and AIDS
- Business Sector
- Community Based Organisations (CBOs)
- Children organisations
- Sporting Community
- Women's Sector
- Non-Governmental Organisations NGOs
- Religious Sector
- Traditional Leaders
- Traditional Health Practitioners
- Labour Movement
- Transport industry
- Youth Sector
- Men Sector
- People with disabilities
- Government departments
- Other relevant stakeholder

Roles and responsibilities of the Local AIDS Council structures

Local AIDS Council

- Facilitate integration and co-ordination of programmes between all stake-holders and role-players
- Bring together all role-players and stakeholders
- Creation of partnerships
- Ensure the development of a local multi-sectoral strategy to respond to HIV and AIDS
- Build capacity of the local initiatives and projects
- Monitor implementation of projects and initiate new ones if they do not exist

Task Teams

(Constituted by relevant social partners involved in each area of focus)

The Local AIDS Council task teams are responsible, among other things, for:

- Building of partnerships between the stakeholders and role players
- Improving communication and co-ordination between stakeholders
- Developing cross referral systems for effective service delivery
- Facilitating the development of joint plans
- Developing a calendar of events and ensure involvement of all organisations and community
- Monitoring and evaluation of programmes and projects

Technical Task Team/Secretariat

The responsibility of the technical task team is to:

- Provide administrative support to the LAC and its sub-committees teams
- Advise the council
- Collate and compilation of reports in preparation for the local AIDS Council meetings and other relevant structures
- Minute of all council and sub-committee meetings
- Manage the correspondence including the circulation of agendas and minutes of the council and sub-committees
- Assisting task teams with logistical preparations
- Co-ordinate and prepare logistical arrangements of the LAC and its sub-structures

Mandate

The mandate of the Local AIDS Council is defined as to:

- Advocate for effective involvement of all civil society sectors in all programmes that are aimed at reduction of the spread of the disease
- Monitor the implementation of the National, Provincial and district plans by all sectors
- Create new and strengthen existing partnerships within the jurisdiction of the district and by all local municipalities
- Mobilise resources to ensure effective implementation of HIV and AIDS programmes
- Advise the municipal council on HIV and AIDS related matters

Terms of reference

- To bring together all Local HIV and AIDS stakeholders and role-players
- To allow sharing of knowledge amongst stakeholders
- To align projects, programmes and avoid duplications
- To receive reports of all sectors on responses to HIV and AIDS for the purpose of the monitoring and evaluation of the effectiveness and *impact* of all sector efforts
- To assess and evaluate projects
- To mobilise resources for Council partnership activities
- To facilitate and support the establishment of the Ward AIDS Councils fora
- To review the implementation of programmes and strategies of the multi-sectoral response to HIV and AIDS developed within the national, provincial and district framework.