ANNEXTURE A

HIV/AIDS STRATEGY

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1. INTRODUCTION

Since the bubonic plaque and the influenza epidemic in the fourteenth century and the 1917 respectively, never in the global history has all nations and countries converged in pursuit of a common goal; to reduce enroute to ultimately eradicating Human immune-deficiency Virus and Acquired Immune Deficiency Syndrome (HIV&AIDS). The HIV&AIDS pandemic has taken the lives of millions of people like never before in the history of mankind.

When HIV&AIDS first emerged in the eighties, it was perceived purely as a health issue and the approach to mitigate it was biomedical. However the complex nature of the cause and effect, including macro and micro socio-economic impacts of this scourge, has prompted countries to earnestly and continuously revise their approaches to mitigate the spread of HIV&AIDS. HIV&AIDS have in most instances nullified many hard earned human developmental gains and in some countries further pushing poverty and unemployment to unprecedented levels.

As this pandemic continues to ravage the society, lives of skilled, semi-skilled employees are lost; this also includes the loss of institutional memory. This deprives young people an opportunity to tap onto these skills. As a result HIV&AIDS related costs increase and cause strain to households and government budget, thus exacerbating poverty and employment. Hence HIV&AIDS is counter-productive to the developmental agenda of the society.

This document therefore seeks to reflect and advance Lesedi HIV&AIDS, STIs & TB 2012-2016 Strategy, which is hoped that will form part of ongoing regional dialogue for the current political term of office. This strategy is aligned to the National Strategic Plan 2012-2016 and focuses on how local government plays a critical role in mobilising all stakeholders towards tangible output–oriented programmes. The strategy also calls for a shift in paradigm regarding HIV&AIDS, STIs & TB and local government.

2. BACKGROUND

HIV&AIDS pandemic constitutes one of the most formidable challenges to social, economic and development successes and progress, while in other parts, this scourge has undermined economies and is threatening to destabilise and profoundly affect social fabric.

According to The Joint United Nations programme on HIV&AIDS (UNAIDS), Sub Saharan Africa still bears the inordinate share of the global HIV burden and South Africa is the only country globally with the largest number of adult living with HIV. Encouraging is that there is evidence that HIV has reached plateau/maturity and the HIV-prevalence is beginning to stabilise and that more and more people are receiving antiretroviral therapy.

Since HIV&AIDS emergence in the eighties, there have been new opportunities aimed at stopping HIV-incidences and mitigating the HIV-prevalence rates. The opportunities include developing new programmes to improve, amongst others, access to and the utilisation of HIV Counselling and Testing (HCT), Prevention of Mother to Child Transmission (PMTCT) services; and the provision of ART, while addressing stigma and discrimination.

In the past decade, local municipalities' policy makers have shown the will to mitigate the spread of HIV and manage the socio-economic impacts of AIDS. The impacts of HIV&AIDS at municipality level are illustrated from two perspectives viz. a) how do HIV&AIDS impact on a municipalities as organisation i.e. currently and in the future, where staff and politicians may be infected or affected; with the resultant absenteeism, low staff morale, staff turnover, job hopping, poor quality of service, increasing costs of recruitment, retraining of new staff and loss of human capital; b) how do HIV&AIDS impact on the residents who may be infected and/or affected and the resultant burden for demand and supply of goods and services that municipalities provide, amongst others, services for health (more demand for palliative care); poverty alleviation (more grants budget); indigent assistance (more budget) and land use (graves/cemeteries).

Higher rates of unemployment and poverty may increase the chances of less revenue collection by municipalities for services provided. There is also a likelihood of low economic growth due to businesses losing expertise and valuable skills. Hence there is a critical need for municipalities to know the status of this pandemic within and outside the workplace so that they can respond appropriately and effectively.

There is global recognition that effective HIV&AIDS, STIs and Tuberculosis (TB) interventions are best employed at local government level, since it is at this level where individuals, households, families, organisations and business most feel the wrath of these pandemics. Therefore mainstreaming and programming of HIV/&AIDS, STIs and TB are best suited for this level of government.

As mandated by the vision of developmental government, local municipalities are expected to actively take a lead in all endeavours to prevent the spread of and manage the social and economic impacts of HIV&AIDS, sexually transmitted infections (STIs) and TB to their communities.

If not for legislative obligation; municipalities have very good reasons to participate in the fight against this pandemic; first as human beings, there is a moral duty to help fellow men and women and secondly municipalities should strive towards a stable and vibrant society as the impacts of HIV&AIDS increase the cost of doing business both in the world of work and government.

Therefore, municipalities should increasingly seek innovative ways and approaches to manage HIV&AIDS, at the same time utilising their core areas of expertise and embed the management of this scourge into an everyday business practices. This is premised from the fact that municipalities are doers, enablers and coordinators.

3. LESEDI BACKGROUND

3.1. Our Area

Lesedi Local Municipality is situated in the Sedibeng District Municipality of Gauteng ,South Africa. Heidelberg is the seat of the Municipality and during the first war of independence, Heidelberg served as capital of Zuid Afrikaanse Republiek, from 1880 to 1883. Lesedi can be Described as a primarily rural area, the major urban concentration located in Heidelberg and Ratanda. Heidelberg is situated along the N3 freeway (JHB – Durban) at its intersection with Provincial route R42. Lesedi comprises of the following areas: Ratanda, Shalimar Ridge, Rensburg, Heidelberg, Jordaan Park, Overkruin, Bergsig, Kaydale, Jameson Park, Driemanskap, Vischkuil / Endicott, Devon and adjacent farms. The total size of geographical area is approximately 1,489km^2 (Source: Global Insight, 2009)

Lesedi is surrounded by the following municipalities:

- Ekurhuleni (East Rand) to the North
- Gert-Sibande (Mpumalanga) to the East;
- Dipaleseng (Mpumalanga) to the South;
- Midvaal (Sedibeng)to the West

Map of Sedibeng District

3.2. *Our People*

Lesedi has a population of 76,498 as per the Global Insight 2009 distributed as follows:

		Lesedi Local Municipality
Africans	Males	32,890
	Females	31,473
Whites	Males	5,027
	Females	5,126
Coloured	Males	641
	Females	578
Asians	Males	379
	Females	385
Total		**76,498**

4. POLICY AND LEGISLATION AND HIV&AIDS, STIs & TB IN LOCAL GOVERNMENT

4.1. The Constitution

The constitution of the Republic of South Africa provides, in its preamble that "we therefore, through our freely elected representatives, adopt this Constitution as the supreme law of the Republic so as to...and establish a society based on the democratic values, social justice and fundamental human rights" and that "we believe that South Africa belongs to all who live in it, united in our diversity", (Constitution of the Republic of South Africa, 1996).

The South African constitution endorses every citizen's right to participate in the governance of the country and that its citizens' needs, including HIV&AIDS, should be responded to; and that all citizens should be encouraged to participate in the policy-making process, at the level of local government (Chapter 10 section [195] [e], Chapter 7 section [152] [a] of the Constitution of South Africa, 1996). Moreover, the constitution gives pre-eminence to the addressing of "the [felt] basic needs of the community, and to promote the social and economic development of the community" (Chapter 7 section [153] [a] of the Constitution of South Africa, 1996, The White Paper on local government, 1998). Thus, in order to fulfil its duties and accurately identify and assuage the needs of its citizens, municipal structures should be in place to manage its administration, budgeting and planning processes to give priority to the basic needs of the community (DPLG, 2007).

4.2. The White Paper on Local Government

The White paper invariably postulates that the "Local government's core function needs to be understood as part of the functioning of the state and its three sphere government system as a whole. It further asserts that the constitutional definition of local government's powers and functions in relation to provincial and national government, is, however, ambiguous in some respects, and requires further clarification. This situation is further complicated by the fact that most powers and functions have several components, not all of which are best performed by the same sphere of government. Hence the assumption that the governance and socio-economic aspects of HIV&AIDS, and not biomedical, are assumed to be core functions of Local Government and that of other spheres of government (White Paper on Local Government, 1998). "...it is inherent of local municipalities to support individual and community initiative and to direct community energies into projects and programmes which benefit the area as a whole".

The general themes and/or goals in the White Paper on Local Government are of change, democratic community governance, restorative justice, and ultimately the striving for a local government that "stimulates sustainable social and economic development" (White Paper on Local Government, 1998). The document puts forth four key elements to addressing these injustices, namely, maximising social development and economic growth, integrating and coordinating – with the aid of an IDP, democratising development, and leading and learning.

In the White Paper on Local Government it is posited that local government structures should endeavour to adopt inclusive approaches, including that of HIV&AIDS, so as to remove obstacles associated with impeding citizens' participation in the activities of local government. It speaks of local government

developing strategies to address communal needs ranging from subsidies for households to addressing the diverse needs of those groups designated as vulnerable, including for HIV&AIDS. Furthermore, the White Paper challenges local government to raise awareness on human rights and environmental issues.

4.3. The Municipal Systems Act, 2000

In its broadest sense the Municipal Systems Act outlines service delivery standards that should be observed by municipalities so as to realise the rise of a developmental local government (MacKay, 2004). The Municipal Systems Act (2000) espouses the development of a culture that encourages communities to participate in the affairs of a given municipality. It thus speaks to the delivery of basic municipal services and the addressing of basic communal needs, where for reference purposes; basic human needs include access to adequate housing, healthcare, food, and social security (Constitution of the Republic of South Africa, 1996).

The legislation makes explicit that communities should be consulted about their perceptions of the standards of municipal services provided by a local municipality; this would include HIV&AIDS external mainstreaming. Through meetings between ward councillors and members of the public, including organized community-based organisations, such grievances should be procured and explored, and strategies to addressing the identified needs put forth by the local municipality. However, Davids (2005) postulates that active participation by communities in creating an integrated development plan, which is one of the vehicle used to drive HIV&AIDS mainstreaming and programming, is more than a mere consultative process, it talks about capacitating the marginalized social groups who are often excluded in favour of those who possess power/wealth

4.4. The 2007 DPLG Framework for an Integrated Local Government Response to HIV&AIDS

In 2000, several municipalities accepted their mandate to be active role players in the local response to HIV&AIDS and have since adopted an array of strategies to tackle the issue (DPLG, 2007). Subsequent to study, a follow-up in 2004 revealed that municipalities had started to identify and acknowledged the epidemic as a subject that needed an appropriate response. Some of the key findings of the studies were that municipalities were not institutionally ready to embark on developmental roles; planning lacked an overview of root causes of the epidemic and instead focused on the symptoms of the disease; a lack of consultation resulted in infected and affected citizens' needs not being met; HIV&AIDS was still a sensitive issue associated with stigma and discrimination; and a lack of expertise to plan and facilitate interventions related to HIV&AIDS existed (DPLG, 2007).

Indeed, HIV&AIDS epidemic in South Africa has been depicted as one of the worst in the world, as illustrated by UNAIDS AIDS Epidemic report 2010 asserting that while the Southern Africa is the epicentre of HIV&AIDS, South Africa still lead the pack with the most number of adults infected with HIV in the whole world (UNAIDS 2010). HIV&AIDS have obvious development and social implications.

4.5. Integrated Development Plan

Integrated development planning refers to "an approach to planning that involves the entire municipality and its citizens in finding the best solutions to achieve good long-term development" ('Integrated development planning for local government', www.etu.org.za). This 'super plan' provides a given municipality with a means of devising future plans and foster sustainable, particularly communal development. Moreover, the main impetus to the development of the Integrated Development Plan (IDP) was to redress past inequalities and disparities engendered by the then apartheid government. The previous apartheid dispensation espoused policies that entrenched, for example, racially divided business and residential areas and huge disparities in the levels of services between the rich and poor areas.
Another concept integral to this evaluation is developmental local government. The shift to developmental local governance came about with the inception of the first local government election on December 5, 2000 ('Developmental local government', www.etu.org.za). Active democratic citizen participation of particularly the most vulnerable for instance, the aged, marginalized for instance, the women, and formerly disenfranchised groups for instance, Black, Coloured, Indian race groups in the planning and devising of sustainable ways to address their socio-economic and material needs; in theory, was conceived to be a defining feature of a developmental local government (The White Paper for Social Welfare, 1997).

Local government in the form of local municipalities is the political decision making structure closest to communities. It is regarded as being the best positioned and attuned to communal needs and having the political power needed to advocate on behalf of the communities it serves. Other defining features of a developmental local government include maximizing social development and economic growth, integrating and co-coordinating, democratic development and reading and learning. To ensure accountability and the shift towards a system of governance that is developmentally inclined, the following legal and policy framework has a strong bearing on the quality and relevance of HIV/AIDS programmes; and on their development and delivery.

4.6. Department of Public Service and Administration (DPSA) regulation on HIV&AIDS

This department had developed and introduced guidelines on integrated human resources planning. Subsequently the department amended the Public Service Regulation to include the management standards in managing HIV&AIDS and other diseases in the workplace. The Regulations now require head of departments to take reasonable steps to minimise exposure to HIV and other diseases infection.

4.7. The King II Report

The report encourages corporate governance that reflects a commitment to preventing occupational diseases. The report is specific in recommending that local government becoming familiar with the implications of HIV&AIDS and actively participating in responding to this scourge.

5. EPIDEMIOLOGY OF HIV/STIS & TUBERCULOSIS IN SEDIBENG (LESEDI AS PART)

Sedibeng has always been associated with HIV-prevalence. This perception changed from 2006, when the prevalence rate was 35%. The introduction of the District Strategy 2007-2011 in 2007 significantly contributed to the HIV-prevalence within the region to decline from 35% (2006), 33.9% (2007), 31.8% (2008) and 28.9% (2009). However, the 2010 HIV-prevalence for the district has revealed that HIV-prevalence in the region has increased to 30.9%, a significant increase of 2%. Other municipalities in Gauteng, especially West Rand, Metsweding, COJ and Tshwane, also have their HIV prevalence rates gone up, as illustrated by the graph below for five year period. This leaves Ekurhuleni being the only municipality in Gauteng to reduce their HIV-prevalence rate from from 34.0% (2009) to 33.8% (2010), decrease of 0.2%

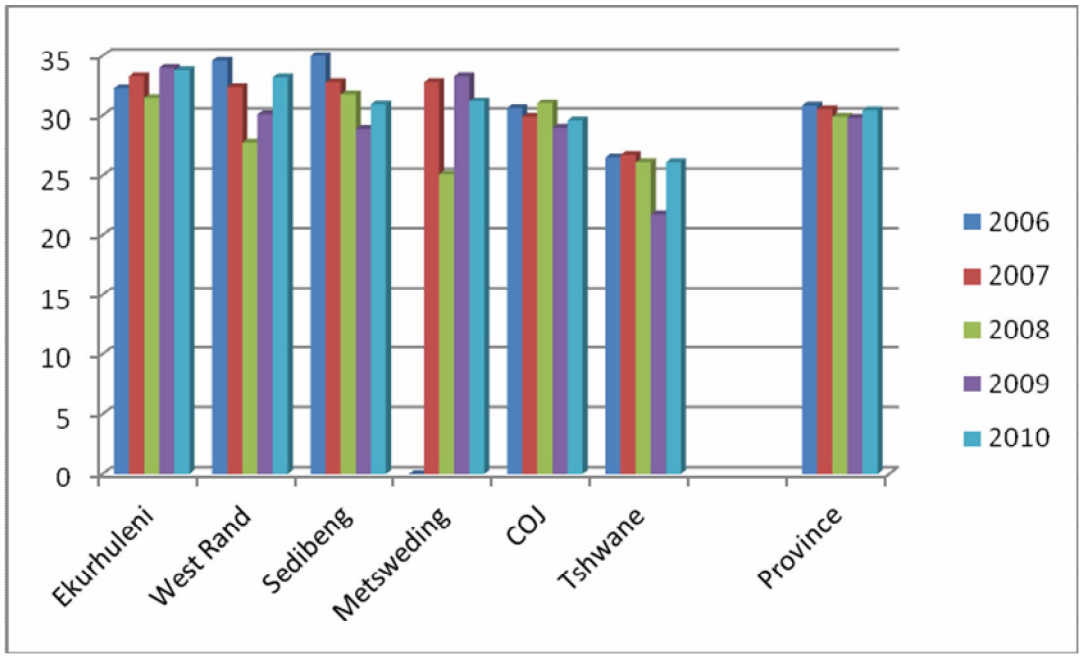
Gauteng province is ahead of other provinces in terms of programmes implementation and monitoring. There is also a body of evidence that attests that around 98% of the people of Gauteng have high level of knowledge of HIV&AIDS. However, Gauteng province did not do well in 2010 as HIV-prevalence in the province increased from 29.8% (2009) to 30.4% (2010), an increase by 0.6%.

The results for 2010 may, although to a lesser extent be attributed to the FIFA Soccer World Cup and the fact that the province, as the economic hub of the country is troubled and infiltrated migration of people into the province; who to an extent nullify good intentions and programmes employed.

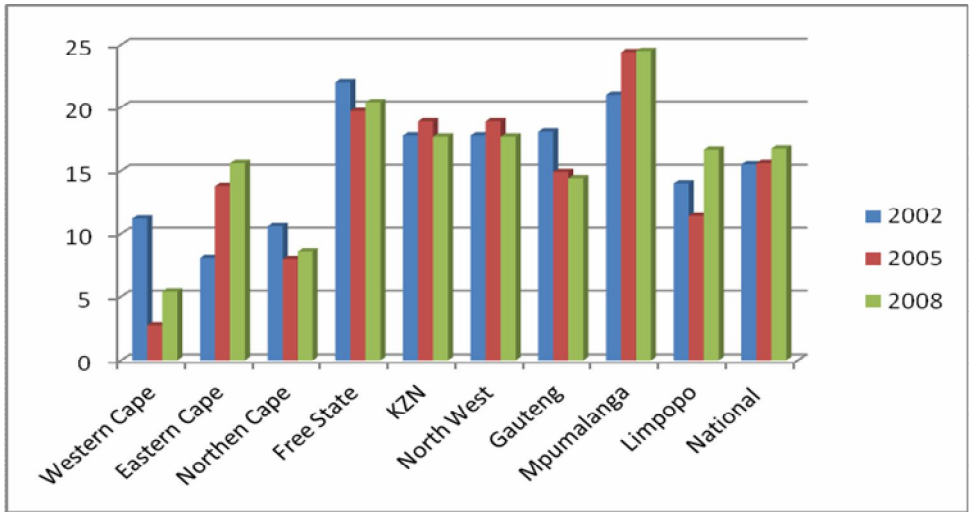
Compounding the situation is the number of untreated sexually transmitted infections, which according to numerous research evidence, predispose people to HIV infection. The province has also recorded high prevalence of sexually transmitted infections; a wakeup call for the province, Sedibeng in particular to go back to the basic of intensifying awareness campaigns against sexually transmitted infections.

The results, as extrapolated from the National HIV and syphilis prevalence Survey 2010, also calls for more concerted efforts, infiltration of every stratum of the society and mainstreaming of HIV&AIDS, STIs & TB in every walk of life in Sedibeng.

National HIV and syphilis antenatal survey (2006-2010)



HSRC population-based HIV survey



Since 2002, Human Sciences Research Council has been conducting population-based surveys. The results so far until 2008 have shown a steady statistically significant reduction of HIV-prevalence in Gauteng. The survey is comprehensive in nature in that it focuses on all individuals within society. This includes demographical perspective and socio-economic status, as opposed to national antenatal survey that surveys pregnant women that present themselves at health facilities.

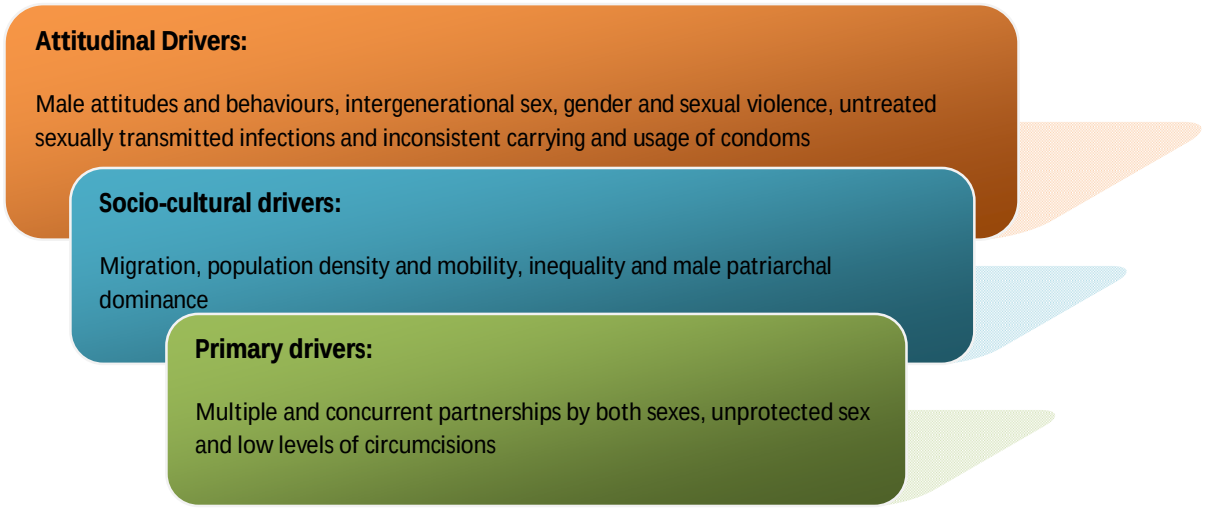
According to the HSRC survey, the province has managed to infiltrate most sectors and and the community in terms of prevention, treatment, care and support programmes. The challenge still remain with the fact that, unlike the national survey, this survey does not zoom into different districts, of which it would provide district policy-makers to understand the burden and determine relevant plan of action.

6. FACTORS CONTRIBUTING TO THE SPREAD OF HIV&AIDS/STIS & TB

Over the years of scientific research, evidence have shown that factors contributing to the spread of HIV&AIDS, STIs and TB in a particular area, Lesedi included, are categorised into three layers at the least. These layers, a) attitudinal drivers (male attitudes and behaviours, intergenerational sex, gender and sexual violence, untreated sexually transmitted infections and inconsistent carrying and usage of condoms); b) socio-structural drivers (migration, population density and mobility, inequality, and cultural factors and c) primary/key drivers (multiple and concurrent partnerships by both sexes, unprotected sex and low levels of circumcision),

portray life's experiences at local community level, compounded by the socio-economic fabric of the members of the community. Below is the figure that depicts these layers;

Figure: Layers of drivers of HIV



6.1. Multiple and concurrent partnerships

Multiple and concurrent multiple partnerships has different meanings. However, the most definition agreed upon by most experts relates to" where an individual has two or more sexual relationships that overlap in/with time.' This is differentiated from serial monogamy and polygamy.

Serial monogamy relates to an individual engaging in a series of long- or short-term, exclusive sexual relationship entered into consecutively over a lifespan; and the two partners need not be married; while polygamy is a practice of having more than one spouse.

Coupled with low levels of consistent carrying and use of condoms, multiple and concurrent partnership is linked with the spread of HIV and STIs. People who engage in this practice are susceptible to infections and unwanted pregnancies, threatening to nullify all good interventions employed. The more individual sexual partners an HIV-negative a person has, the greater the chances of exposure to a person infected with HIV and sexually transmitted infections. The fact that HI viral load and thus infectivity is higher during the “acute infection” exacerbates the risk posed by multiple and concurrent partnerships.

6.2. Unprotect sexual encounters

Having unprotected sex with someone infected with HIV is very risky. Despite the fact that the persons may be infected with sexually transmitted infections, the frequency and the viral load at the time of sexual encounter play a crucial role in transmitting HIV and/or re-infection. Consistently carrying and using a condom correctly every time one engages in sex drastically reduce chances of sexually transmitted and HIV infections, including unwanted pregnancies, the latter leading to unnecessary risky practice of termination of pregnancies. This is assisted by circumcision and the reduction of multiple and concurrent partnerships.

6.3. Physical and sexual violence

South Africa has high women and children abuse, which is a major problem as it renders them vulnerable to emotional and psychological trauma, which are the vehicles to infections. Women with a history of being sexually abused are more likely to risk unsafe sex, have multiple partners, and trade sex for money. Men who are violent to their partners are also more likely to have sexually transmitted infections. These factors combine to put women who suffer sexual violence at very high risk of being infected with HIV.

6.4. Gender inequality and male dominance

Although South African culture is said to be male-dominated, according to statistics South Africa, Sedibeng has a balanced gender distribution. However, women status is still inferior and this affords them little power to negotiate sexual preferences. This is exacerbated by lack or inferior economic power women find themselves; which makes them to accede to unsafe sexual demands by working husband to avoid been financially isolated and also to protect their relationships and marriages.

Women are also expected to play the role of baby-making, home-making, satisfying the husband and nurturing children, although at times there is evidence that the husband is not faithful, increasing chances of HIV and sexually transmitted infections. Women who insist of request safer sexual practices are labelled as having too much knowledge about sex and/or being unfaithful to their husbands.

At the same time men, although the trends is steadily changing, are socialised to believe that women are inferior and should be under their control. There are also common, although wrong, perceptions that sex is part of the relationship or marriage deal; that there more sexual violence the more passion and affection and that men naturally have high sexual urges than women. Multiple and concurrent partnerships by both sexes also increase the spread of HIV and sexually transmitted infections.

6.5. Stigma and discrimination

The stigma attached to HIV seriously hinders prevention efforts, and makes HIV-positive people wary to seek care and support for fear of discrimination. People who are infected may also be reluctant to adopt behaviour that might signal their HIV-positive status to others. For example, a married HIV-positive man may not use a condom to have sex with his wife; an HIV-positive mother may continue to breastfeed her baby. Many people might not want to get tested for fear of their community finding out.

Ironically, socio-economic development and poverty relief can, in fact, sometimes drive the epidemic. This is particularly the case when development is linked to labour migration, rapid urbanisation, and cultural modernisation. Thus although poverty contributes to the spread of HIV/Aids, alleviating poverty can do likewise. For example, improved infrastructure such as new transport routes and improved access are seen as positive developmental goals. However, this often results in a larger migrant population, and facilitates the spread of Aids to previously inaccessible parts of the country.

6.6. Commercialisation of sex

The country has seen the rapid development of a relatively affluent black middle class with a desire for material goods, and a sexual culture that associates sex with gifts. Men gain social prestige by showing off material possessions and being associated with several women.

Young women are often persuaded to have sex with “sugar daddies” – older, wealthier men – in exchange for money or gifts. Some girls enter the sex industry for similar reasons. Young women infected with HIV by sugar daddies then infect younger men, who in turn infect other young women and in time become HIV-

positive older men themselves – and so the cycle continues. Older men also infect older women, usually their wives. Both younger and older women give birth to children, some of whom will be HIV-positive.

7. IMPACT OF HIV&AIDS

7.1. Impacts on government

In most countries, government is an employer and the provider of services to its citizens. However the advent of HIV&AIDS threatens government, especially local government in that expenditure increases as revenue decreases due to reduction in the economically active product age group.

7.2. Impacts on the population

HIV&AIDS knows no boundaries. As the wrath of this scourge continues, population size and distribution becomes distorted. According to global insight 2009, in the absence of data for 2012, the structure of the pyramid portrays uneven structure and composition in Sedibeng. The active productive age group and the young ones diminish, the major contributing factors being HIV-related deaths. The pyramid shows the community with the elderly, who are not employable and as such the growth and the economy suffer. Mortality rates increases and life expectancy (expected years of life form birth), becomes reduced to 48 years. Gender distribution becomes skewed as women are more vulnerable than men and their deaths rob families of the primary caregivers creating an employment gap.

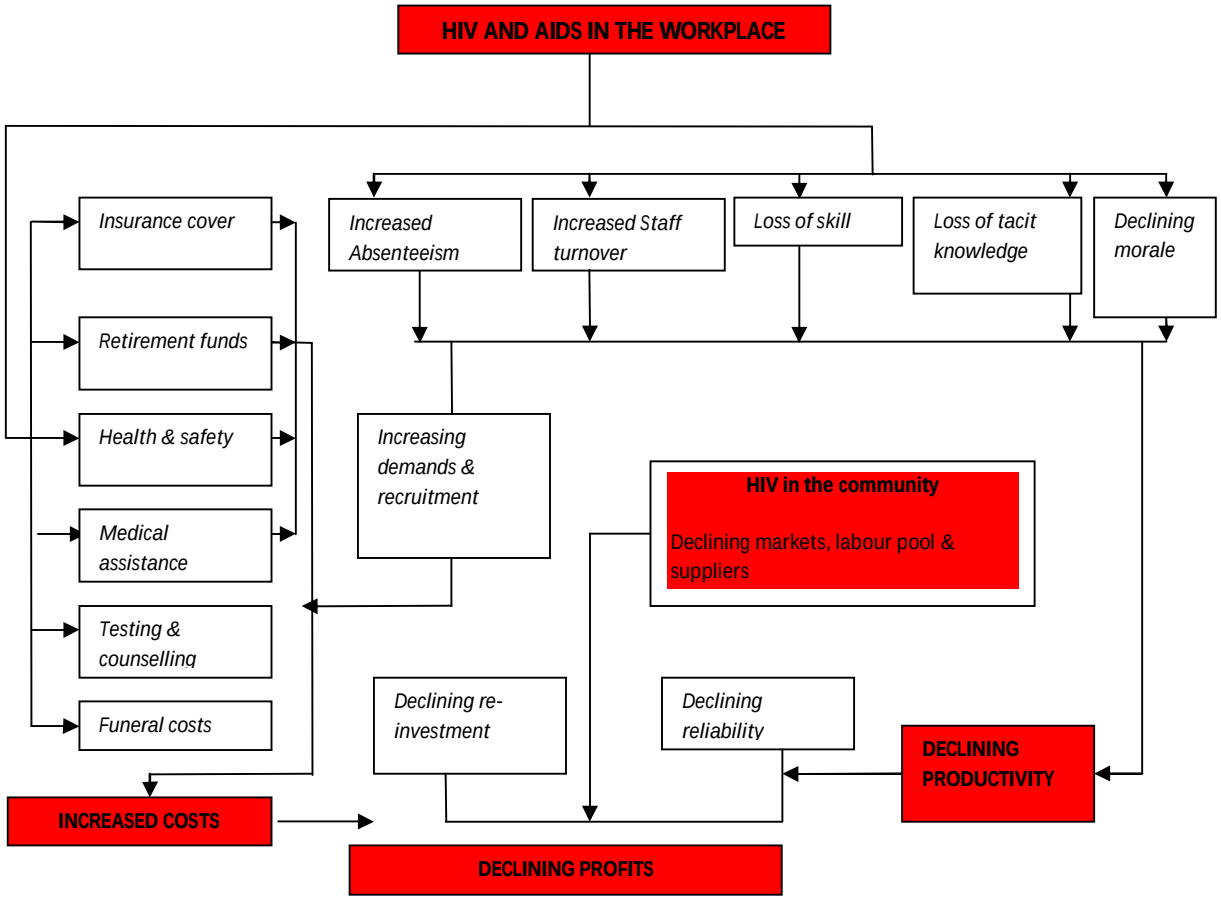
7.3. Impacts on households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses in the form of loss of income of the patient, mainly the breadwinner, household expenditures for medical expenses may increase substantially; other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person; death which results in a permanent loss of income, funeral costs and the removal of children from school, and increase in orphans, child- and elderly households.

7.4. Impacts on workplace

The impact of HIV&AIDS at the active productive age group threatens the supply of labour and increase in direct and indirect costs. Employers are hard hit by the loss of skilled and experienced employees, absenteeism and low morale. In addition, employers are burdened by costs of recruiting, training and retraining as more employees die or take early retirement. Because most companies incur the rising costs of providing health-care benefits (including the expensive AIDS drugs) and

the payment of death benefits, most lay employees off and thus increase unemployment levels within the district. This inadvertently shies away potential investors and discourages economic growth. Below is an illustration of the impact HIV&AIDS have in the world of work if nothing or very little is done at an area of generalised HIV-prevalence.



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7.5. Impacts of HIV&AIDS on the Millennium Development Goals (MDG's)

Millennium Development Goals		Impacts of HIV&AIDS
Goal 1	▪ To wipe out extreme poverty and hunger	▪ Households' capacity to improve socio-economic status ▪ Food security ▪ Orphans and vulnerable children
Goal 2	▪ To ensure primary education for all	▪ Child Labour ▪ Child-headed households, orphans and vulnerable children ▪ Loss of teachers
Goal 3	▪ To promote gender equality and empowerment of women	▪ Girls withdraw from school ▪ Women's higher vulnerability and transactional sex ▪ Poverty
Goal 4	▪ To reduce child deaths	▪ Increased need for prevention HIV transmission from mother to child (PMTCT) ▪ Paediatric/child antiretroviral therapy
Goal 5	▪ To improve maternal health	▪ Increased need for prevention HIV transmission from mother to child (PMTCT) ▪ Costs of antiretroviral Therapy
Goal 6	▪ To combat HIV&AIDS, malaria and other diseases	▪ HIV&AIDS nullify most of government endeavours to improve lives

8 HIV&AIDS/STIs & TB IN MUNICIPALITIES' CONTEXT

The South Africa's late entry in the fight against HIV&AIDS cannot justify the new HIV infection rates and the impacts AIDS has in the country. Since the re-admission to the world arena, most African Countries regard South Africa as the economic hub of Africa; however South Africa has yet to make significant progress in the fight against the AIDS epidemic. South Africa is one of the highest adult HIV prevalence at 30.2%, National HIV and Syphilis sero-prevalence survey (2010).

There is enough evidence that confirms that an increased number of economically productive age groups in the workplace opt for early retirements and others die as a result of AIDS-related illnesses. Business is beginning to feel the wrath of this ruthless monster as they experience an increase in medical aids contributions, absenteeism rates, and low staff morale. The pressure in the government departments to deliver quality services is mounting as employees' often take compassionate leaves to attend to funerals of family members, colleques and friends.

8.1. Key Performance Areas in Municipalities' Response to HIV&AIDS, STIs & TB

8.1.1. Mainstreaming

The launch of South African National AIDS Council in the nineties is aimed at bringing all stakeholders together, each playing a prominent role to mitigate HIV&AIDS. This shift in paradigm in a way demonstrated that for long HIV&AIDS had been a health problem. However the complexity of this scourge warrants that only biomedical aspect of HIV&AIDS becomes the primary focus of Health, while the socio-economic and governance aspects are shared by all sectors and departments.

Mainstreaming of HIV&AIDS has emerged as a response to the limitations of a health-led approach. It involves sectors and departments, as actors, bringing the issues surrounding this pandemic into strategic planning, all day-to-day operations, through internal, external mainstreaming programmes and programming (relationships with others).

Mainstreaming is a process that addresses the course and effects of HIV&AIDS, as they relate to the development and governance conditions in the society; both through their usual work and their workplace, in an effective and sustained manner. Mainstreaming means thinking differently and wearing HIV&AIDS lens.

Mainstreaming moves from the premise that HIV&AIDS are problems of underdevelopment and that a long-term solution lie in sustained, equitable and inclusive socio-economic development. This means that sectors and departments must look at their core work through the lens of HIV&AIDS and take HIV&AIDS causes and effects into account when planning, implementing, budgeting, monitoring and evaluation.

8.1.1.1. Internal Mainstreaming

The primary aim of internal mainstreaming is to ensure that the municipality can continue to operate effectively and fulfil its mandated function in the face of impacts of HIV&AIDS. This requires municipalities to implement measures to reduce the susceptibility of municipal employees to HIV infection and the vulnerability of the municipality with regard to HIV&AIDS at the workplace. The implementation and the knowledge of the burden, assists the municipality to adapt internal systems, which include succession planning.

a) Important question to ask for internal mainstreaming are:

- *What is the impact of HIV&AIDS on employees (absenteeism, low staff morale, loss of institutional memory etc?)*
- *What can the municipality do to reduce susceptibility, and support employees that are living with or/and are affected by HIV (prevention, treatment, care and support)*
- *How can the impact of HIV&AIDS on the municipality be minimised (policies, plans, systems)*

8.1.1.2. External Mainstreaming

This entails that municipality and every line department and management within the municipality adapting their core work/business to consider HIV&AIDS susceptibility and vulnerability to the communities they serve. They look at service delivery to their communities through HIV&AIDS lens.

a) Important questions to ask for external mainstreaming are

- *How do HIV&AIDS affect people (clients, customers, associates) that the department/cluster works with?*
- *What are the changing needs of these clients/customers/associates as a result of HIV&AIDS?*
- *What can be the department/cluster do, as part of the core business to respond to these needs?*
- *How might the work of the department/cluster reduce susceptibility and vulnerability of individuals, households, families, communities and associates to HIV&AIDS?*
- *What are the comparative advantages of the department/cluster in responding to HIV&AIDS?*

b) Key factors for the success of Mainstreaming HIV&AIDS

- *HIV&AIDS has to be understood as a developmental issue*
- *Commitment and active support of decision-makers*
- *Sufficient allocation of resources*
- *Knowledge, compassion and the will to do good to fellow men and women*
- *Expertise and support*
- *The willingness to learn, reflect and share experiences*

8.1.2. HIV&AIDS Programming

HIV&AIDS programming by municipalities relates to all working very closely with:

- ***Government departments:***

Department of Health and Social Development, Department of Education, Department of Correctional Services, South African Police Services, Department of Home Affairs, Department of Justice, Department of Agriculture, Department of Sports, Recreation, Arts, Culture and Heritage and Parastatals.

- ***Civil society structures:***

Faith-Based Organisations, Non Governmental Organizations, Traditional Health Practitioners, Men's Forum, Youth, Women, Children, the Elderly, People With Disabilities, People Living with HIV, Business, private sector and commercial sex workers.

The collaboration and partnership include developing, implementation, monitoring, evaluation and conducting operational research programmes that are aimed at reducing new HIV, STIs and TB infections, both internally in their departments and externally to their clients, consumers, end-users and business associates.

Programming means effective interdepartmental collaboration that aims to reduce duplication and “silo syndrome”. This approach, more often encourage effectiveness, efficiency and cost effectiveness.

8.1.3. Ward-Based approach

There has been increasing pressure for communities to participate and play a critical role in developing an “HIV-free communities and AIDS competent communities”; where everyone within the community is able to assess and make decisions about factors related to the causes and impacts of HIV&AIDS.

The process suitable to achieve competent communities is underpinned by an evolution through a spiral of community learning, action and reflection; challenging problems and making the best use of available resources. By embarking on ward-based approach, HIV&AIDS, STIs & TB programmes become fully mainstreamed at every stratum of the community i.e. individuals, households, families and the community. The focus of ward-based is based on these intertwined tasks:

- Increasing community participation
- Supporting the development of partnerships
- Identifying indigent and households that need assistance
- Assisting ward-councilors with programmes
- Encouraging existing and new networks
- Collaborating with different Ward Based Structures

The benefits of ward-based HIV&AIDS, STIs & TB programmes implementation are:

- Raising awareness of responsibility
- Community ownership of programmes

- Broadening access to services
- Improving openness and transparency
- Allows community inputs to government programmes

Therefore ward-based implementation is the fundamental and essential building block enroute to reduction of stigma and discrimination, reduction of multiple and concurrent partnerships, improved condom usage, increased utilization of HCT services, Improved TB treatment outcome etc.

8.1.4. AIDS Council

The Lesedi AIDS Council was launched on the 19 May 2010 and comprises of the Executive Mayor, Members of Mayoral Committee, Councillors, Managers, Government Departments and Civil Society Structures that have commitment in strengthening partnership against HIV/STI and TB. Quarterly Meetings are consistently held where member sectors would present their progress reports and challenges that would be discussed and tried to be resolved. The Local AIDS Council, chaired by either the Mayor or the delegated MMC, serves to coordinate and provide an oversight to the implementation of HIV&AIDS Programme.

9 LESEDI HIV&AIDS, STIs & TB 2007-2011 STRATEGY

9.1. Summary of achievements

9.1.1 Forums

- *The AIDS Council has been established and is fully functional and have since had consistent Quarterly Meetings where member sectors would present progress reports and challenges that would be discussed and tried to be resolved.*
- *IDC (Interdepartmental Collaboration Committee) is operating on a small scale locally but at a larger scale at District Level.*
  -This is the committee comprising all government departments within Sedibeng i.e. Health, Social Development, Education, SAPS, SARS, Labour, Home Affairs, Correctional Services, Local municipalities and Justice
- *The following forums are fully functional*
  Faith-Based Organisations, Non Governmental Organizations, Traditional Health Practitioners, people with disabilities, people living with HIV and men's forum

9.1.2. Programme management

9.1.2.1. Biomedical

- *Although for 2010 report the HIV-prevalence in Sedibeng has increased by 2 as alluded to earlier, there has been statistically significant reduction in HIV-prevalence over the four-year period i.e. 35% (2006); 33.9% (2007), 31.8% (2008) and 28.9% (2009).*
- *The HCT services utilisation is at 102%, surpassing the target of 312 530 which was set for Sedibeng in 2011.*
- *There has been an increase in the enrolment to Comprehensive Care, Management and Treatment (CCMT) of those clients who are eligible. By the end of 2011, 80% of clients with CD4 count less than 350 had received treatment, more than 94% of them still on the first regimen.*
- *The district has one of the lowest HIV-positive children in the province. The district has reached 4.4%, which implies that only four children born from ten HIV-positive mother (are HIV-positive (4 in 10), as compared to 9 in 10 in 2006, as sign that if used correctly and on time, combination treatment for pregnant mothers works.*
- *Improvement in diagnosis of new TB patients/client. In 206 the district diagnosed 4 648 patients, increasing to 5 244 in 2010 and reaching 4 844 in 2011. The TB cure rate was 63.7% (2006) and currently stands at 78.9% (2011), while the treatment defaulter rate decreased from 7.5% in 2007 to 5.3% in 2011.*

9.1.2.2. Programming

- *Lesedi Municipality does have a Workplace Programme and only need to review its Policy in due course*
- *Most government departments are doing well with their internal programmes; most have trained Peer Educators*
- *Ward-based approach is functional (6 ward-based coordinators have been appointed and are on monthly stipend)*
- *Youth Development centers have contributed in youth participation in HIV&AIDS activities, including HIV testing.*
- *Most of the companies are collaborating well regarding HIV&AIDS in their workplaces.*
- *Increased financial support (burials) for indigent households*
- *Civil society structures, especially FBOs and THPs, NGO's and Men's Forum have workshoped and trained on a regular basis.*
- *Conducted community-based Knowledge, Attitudes and Practices Survey in 2011 to determine the effectiveness of the strategy and its interventions.*

9.2. Summary of Challenges

- *Lack of/or insufficient conceptual understanding of how municipalities should respond to HIV&AIDS*
- *Municipalities internal and external HIV&AIDS Mainstreaming*
- *Insufficient financial support from municipalities*
- *Consistent delay from province in transferring gazette HIV&AIDS Grants*
- *Insufficient funds to assist indigent households with burials(policy available)*

10 LESEDI HIV&AIDS, STIs & TB 2012-2016 STRATEGY

10.1 Vision

- Zero new HIV and TB infections
- Zero new infections due to vertical transmission
- Zero deaths associated with HIV and TB
- Zero discrimination associated with HIV and TB

10.2 Goals

- Reduce new HIV and STIs infections by at least 50%
- Reduce new TB infections by 50%
- Reduce stigma and discrimination associated with HIV and TB

10.3 Strategic Objectives

- To address social, economic, structural and behavioural barriers to HIV, STIs &TB prevention, treatment, care and support
- To prevent new HIV, STIs and TB infections
- To sustain health and wellness
- To protect human rights
- To monitor, evaluate and conduct research

10.4. Guiding Principles for the implementation of the Strategy

- *Access to services*
- *Equity*
- *Capacity Building*
- *Participation*
- *Partnership*

10.5 The Approaches/Vehicles to achieving the goals and objectives

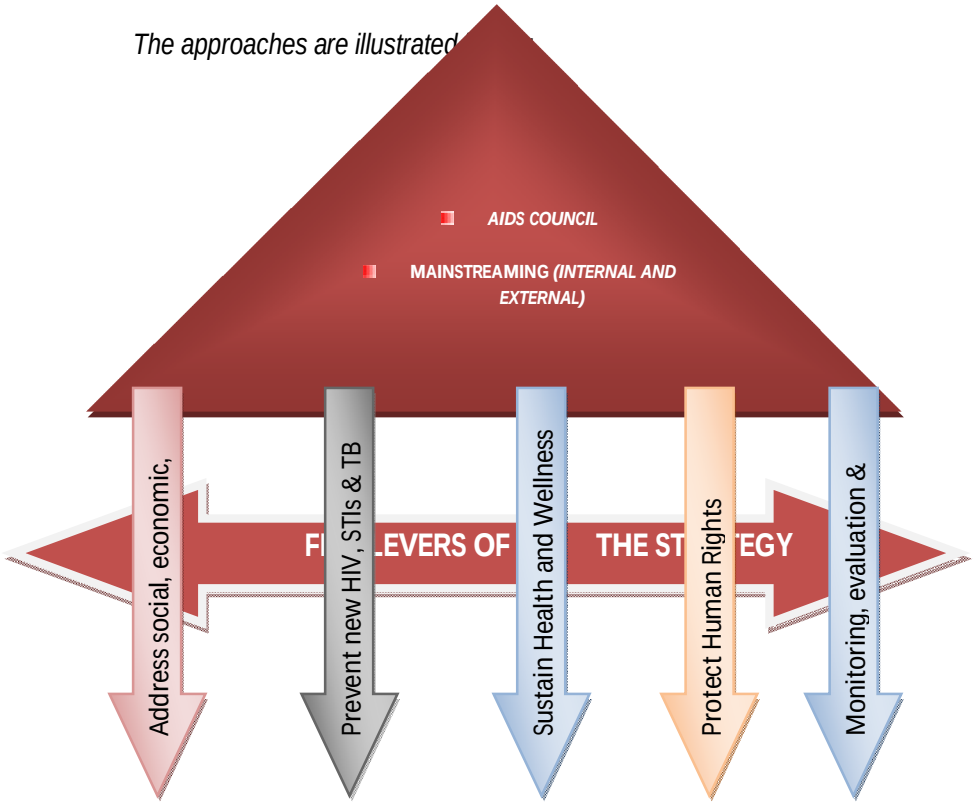
10.5.1. Mainstreaming

10.5.2. Programming

10.5.3. Ward-Based

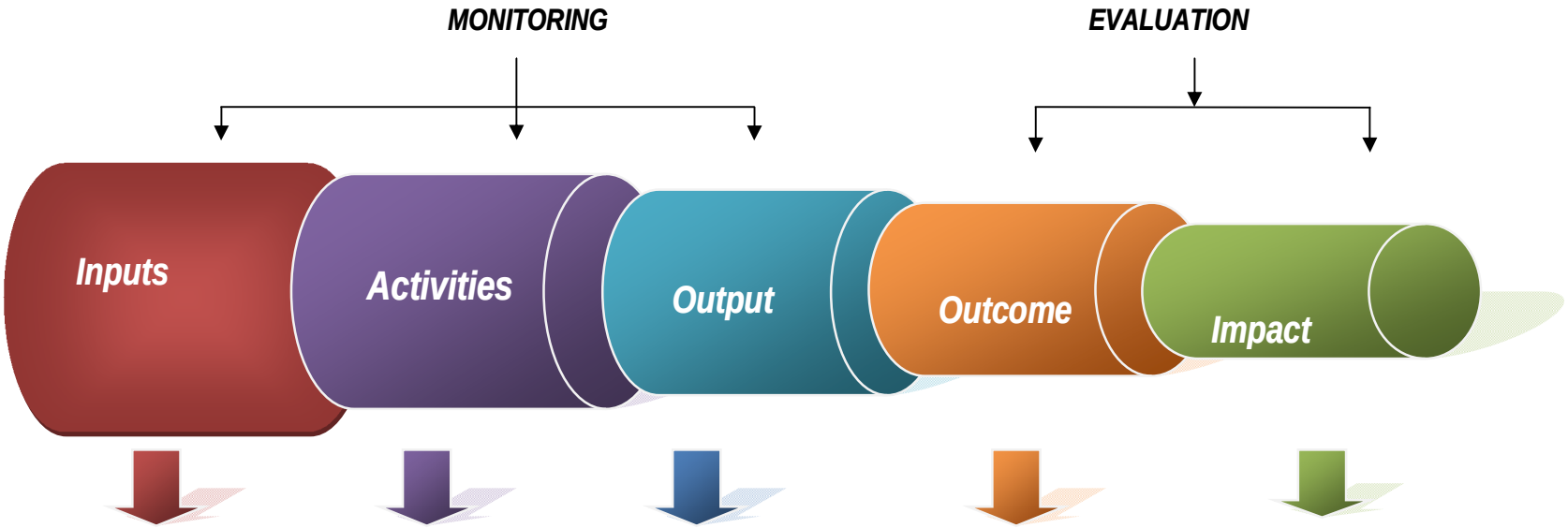
10.5.4. AIDS Council

The approaches are illustrated



WARD-BASED

11 MONITORING AND EVALUATION



INPUTS	ACTIVITIES	OUTPUT	OUTCOME	IMPACTS
Personnel *Finances* *Materials* *Facilities* *Supplies*	*Mainstreaming* *Programming* *Ward-based implementation* *AIDS Councils meetings*	*% mainstreaming* *% programming* *% ward-based* *% AIDS Council meetings*	*Employees & community empowerment* *Departments & sectors participation* *Households benefit from door to door campaigns* *Effective HIV&AIDS programme*	***Social and sexual behavioural change*** ***Reduction in new HIV, STIs & TB infections*** ***Reduction in mortality due to HIV&AIDS***

All References: Acknowledged

12 LESEDI HIV&AIDS MAINSTREAMING SECTOR PLAN (2012-2016)

4 YEAR HIV&AIDS/STIs & TB SECTOR PLAN								
4 year programme	**Project**	**Baseline**	**4 Year Target**	**Total estimated 4 year budget**	**Delivery Targets**			
					2012/2013	**2013/2014**	**2014/2015**	**2015/2016**
1. **Strategic Objective**: To mainstream HIV&AIDS/STIs & TB programmes to municipalities' employees (internal) • **Indicator 1:** Signed off District HIV&AIDS workplace policy • **Indicators 2:** Signed off District HIV&AIDS KAP survey report • **Indicator 3:** Signed off District HIV&AIDS workplace plan								
Internal mainstreaming of HIV&AIDS/STIs & TB ***(Workplace not EAP)***	Coordinate the review and adoption of HIV&AIDS workplace policy	Draft workplace policy is available	Municipality promoting, implementing and monitoring HIV&AIDS policy to employees		Coordinate the review, adoption and partial (25%), promotion and implementation of HIV&AIDS workplace policy	Promote and implement and monitor 25% of the workplace policy, cumulatively (50%)	Promote, implement and monitor 25% of the workplace policy, cumulatively (75%)	Promote, implement and monitor HIV&AIDS workplace policy on a full scale, cumulatively (100%) Progress report.
	Facilitate the process for conducting employees' HIV&AIDS	Draft survey is available	Reduce new HIV/STIs and TB infections among employees		Facilitate the process and conduct employees' HIV&AIDS/TB	Implement 25% of the findings of employees' HIV&AIDS/TB KAP survey	Implement 25% of the findings of employees' HIV&AIDS/TB KAP survey report,	Implement the remainder of the findings of KAP survey report, cumulatively

	Knowledge, Attitudes and Practice survey				Knowledge, Attitudes and Practice survey	report.	cumulatively 50%,	100% Progress report.
	Coordinate the review and adoption of HIV&AIDS Workplace Plan	Workplace plan draft plan is available	Increased employees' participation in HIV&AIDS/STIs & TB activities, especially HCT and ART programmes		Coordinate the processes towards the review, adoption, partial implementation (25%) and monitoring of HIV&AIDS Workplace Plan	Partial implements (25%) and monitor HIV&AIDS Workplace Plan, cumulatively (50%)	Partial implements (25%) and monitor HIV&AIDS Workplace Plan, cumulatively (75%)	Implements and monitor the remainder of the HIV&AIDS Workplace Plan, cumulatively (100%) Progress report.
2. **Strategic Objective**: To mainstream HIV&AIDS/STIs & TB programmes within clusters and departments (external) **Indicator:** Number of clusters implementing HIV&AIDS/STIs & TB mainstreaming to end-users and partners linked to the municipality								
External Mainstreaming of HIV&AIDS/STIs & TB ***(municipalities' departments)***	Coordinate and facilitate employees' capacity building on HIV&AIDS, STIs & TB external mainstreaming	No workshops have been conducted	Departments develop, implement and monitor HIV&AIDS plans		Facilitates the processes towards training of trainers on the concept HIV&AIDS, STIs & TB mainstreaming. Partial training of 25% of	Partial training of 25% of employees on mainstreaming, cumulatively 50% Partial (2 clusters) implementation of	Partial training of 25% of employees on mainstreaming, cumulatively 75%. Partial (2 clusters) implementation of	Partial training of 25% of employees on mainstreaming, cumulatively 100%. Implementation of mainstreaming by the remainder

					employees on mainstreaming	mainstreaming	mainstreaming, cumulatively 4 clusters	of the clusters, cumulatively 6. Progress report.
	Coordinate ward-based programme	Ward-based strategy is available	All the wards implement HIV&AIDS/STIs & TB programmes		Coordinate the appointment of 20 additional ward coordinators Implement and monitor ward-based HIV&AIDS programmes on a full scale (including the then ward-based coordinators)	Coordinate the appointment of t 10 additional ward coordinators Implement and monitor ward-based HIV&AIDS programmes on a full scale (including the then ward-based coordinators	Coordinate the appointment of 6 additional ward coordinators Implement and monitor ward-based HIV&AIDS programmes on a full scale (including the then ward-based coordinators	Implement and monitor ward-based HIV&AIDS programmes on a full scale Progress report. (including the then ward-based coordinators)

3. **Strategic Objective**: To coordinate, monitor and evaluate HIV&AIDS/STIs & TB programmes within Sedibeng Region • **Indicator 1:** Number of government departments that implement HIV&AIDS/STIs & TB programme within the region • **Indicator 2:** Number of sectors and business that implement HIV&AIDS/STIs & TB programme within the region								
HIV&AIDS, ***STIs/ & TB Programming*** ***(coordination, monitoring and evaluation outside the municipality)***	Coordinate Interdepartmental Collaboration *(all government departments within the municipality jurisdiction)*	Intergovernmental departmental committee has been established	All government departments implement HIV&AIDS programme		Facilitates the development and adoption of IDC Guiding Document (part of partnership)	Jointly plan and execute three HIV&AIDS calendar events (part of partnership)	Jointly plan and execute three HIV&AIDS calendar events (part of partnership)	Jointly plan and execute three HIV&AIDS calendar events Progress report (part of partnership)
	Coordinate AIDS Council meetings and projects	District AIDS Council is established	All stakeholders and civil society structures implement HIV&AIDS/STIs & TB programme within the region		Coordinate the processes towards the review, promotion and adoption of District AIDS Council Guideline	Facilitates the development, adoption, implementation, monitoring and evaluation of the District AIDS Council annual plan of action	Facilitates the development, adoption, implementation, monitoring and evaluation of the District AIDS Council annual plan of action	Facilitates the development, adoption, implementation, monitoring and evaluation of the District AIDS Council annual plan of action Progress report