HIV/AIDS STRATEGY

2016 - 2021
MERAFONG CITY LOCAL MUNICIPALITY

Contents

LIST OF ACRONYMS and abbreviations

ABC	Abstain, Be Faithful, Condomise
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retroviral Therapy
ARVs	Anti Retroviral Drugs
CBOs	Community-based Organisations
CCWs	Community Care Workers
CHBC	Community Home Based Care
DAC	District AIDS Council
DOE	Department of Education
DOF	Department of Finance
DOH	Department of Health
DOHA	Department of Home Affairs
DOJ	Department of Justice
DOL	Department of Labour
DOME	Department of Minerals and Energy
DOSD	Department of Social Development
DOT	Department of Transport
DPLG	Department of Provincial and Local Government
DSD	Department of Social Development
EPWP	Expanded Public Works Programme
FBOs	Faith–Based Organisation
GCIS	Government Communication and Information Systems
IEC	Information, Education, and Communication
HBC	Home Based Care
HCBC	Home Care Based Care
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
HTA	High Transmission Areas
LAC	Local AIDS Council
LG	Local Government
LSA	Local Service Area
M&E	Monitoring and Evaluation
MTCT	Mother-to-child transmission
NGOs	Non-Government Organisations
OI	Opportunistic Infections
OVC	Orphaned and Vulnerable Children
PEP	Post-exposure prophylaxis
PHC	Primary Health Care
PHCF	Provincial Health Consultative Forum
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
SALGA	South African Local Government Association
SANAC	South African National AIDS Council
SAPS	South Africa Police Service
STIs	Sexually Transmitted Infections
TAC	Treatment Action Campaign
TB	Tuberculosis

THP	Traditional Health Practitioner
TL	Traditional Leader
VCT	Voluntary HIV Counselling and Testing

Section A: General background

1. Introduction

South Africa is one of the countries that have high HIV prevalence in the Sub-Saharan African region of the African continent. It is estimated that almost over 5.5 million people are HIV positive and over 1.5 million children will be orphaned by 2010. Individuals are getting sick and some die due to HIV and AIDS related sicknesses. The burden of supporting and caring for the infected mainly rests upon family members and it is difficult for them to cope with the situation. Children, women, the elderly and poor communities are the ones that are mostly affected by the pandemic.

Response to the HIV pandemic requires a well co-ordinated effort that brings together government, civil society and business. Response to HIV and AIDS has to take place mainly in three broad fronts, which are:

- The prevention of new infections;
- To ensure access to treatment and literacy; and
- To care and support for the infected and affected

As part of the broad response to the impact of HIV and AIDS, efforts have to be made to mobilise communities to provide care and support to orphaned children and save them from being the victims of poverty and lack of parental guidance.

The United Nations (UN) has made a call to all governments across the world to develop and co-ordinate national responses to the HIV and AIDS. In response to this call, the South African government in partnership with civil society sectors and business has dedicated time, energy and resources to the fight against the pandemic. The South African national response is guided by a comprehensive multi-sectoral National Strategic Plan (NSP), which is reviewed after every five years.

The NSP is based on a holistic approach and it addresses issues such as:

- Poverty reduction;
- Social safety nets;
- Empowerment of women;
- Promotion of testing;
- Human and legal rights;
- Medical research; and
- Monitoring and evaluation of programmes and projects

Central to the South African response to HIV and AIDS is the intensification of a multi sectoral collaboration, which addresses and provides guide on how to:

- Address the social and economic realities that make certain segments of the society vulnerable;
- Provide tools for prevention of new infections; and
- Provide services designed to alleviate the wide-ranging impact of the pandemic

The NSP identifies the role and responsibility of different institutions that are critical in the reduction of the spread of the virus. These institutions include the three sphere of government, which have a mobilisation and co-ordination role in the fight against the pandemic.
Local government is the sphere of government that is closed to the people and it is directly affected by the impact of the disease. As part of its developmental vision, local government structures are expected to play a critical role in the co-ordination of all efforts and initiatives that seek to reverse the impact of the disease. The co-ordination role of municipalities includes:

- Ensuring that participation mechanisms are sufficiently accessible and sufficiently proactive to enable community voice of HIV and AIDS to participate in municipal affairs;
- Co-ordinating the process of engagement between partners in their response to HIV and AIDS in the municipal jurisdiction;
- Supporting the local initiatives;
- Co-ordinating community-level processes in respect of HIV and AIDS matters, including facilitating the local voices of HIV and AIDS in local governance and service delivery; and
- Ensuring that HIV and AIDS is effectively mainstreamed in the municipal IDP and other programmes;

To ensure that the above objectives are achieved the Merafong local municipality with support from the District Department of Health and The Office of the Premier, in partnership with Education and Training Unit (ETU), convened a multi-sectoral workshop involving various stakeholders and role players involved in the fight against HIV and AIDS. The main aim of the workshop was to develop a multi-sectoral local strategy in response to HIV and AIDS challenge within the district jurisdiction.

HIV and has serious impact on those who live with the virus as well as their families. The pandemic has devastating impact on all sectors of our society and has affected the fabric of the entire community.

The effects of the pandemic does not only affect the families, it also affects the availability of skills of our society and

Municipalities are charged with the responsibility of providing services that are aimed at improving people's lives. This responsibility requires municipalities to ensure that communities have access to services. HIV and AIDS pose a major challenge in the way the local municipalities plan and provide services to improve people's lives.

Local government is ideally placed to facilitate greater co-ordination at local level to ensure that the municipality, councillors, different government services, NGOs and the community work together to effectively address issues like public education care for people with AIDS and for orphans and vulnerable children.

While municipalities cannot be expected to provide all these services alone, they should play a strong role in ensuring that the needs of the community are addressed and that existing services are co-ordinated and other available services are accessed.

2. Why should Merafong local municipality address the issue of HIV and AIDS?

HIV and AIDS is one of the biggest challenges we face as a country. The rate of infection is rapidly increasing and more and more people are getting ill and dying from AIDS. Of all the people living with AIDS in the world, it is estimated that 6 out of every 10 men, 8 out of 10 women and 9 out of every 10 children live in Sub-Saharan Africa. South Africa has one of the fastest growing rates of infection in the world.

3. Background

This council identified the issue of HIV and AIDS as a priority for the municipality to deal with and held a strategic planning session with key stakeholders in the municipality area. The workshop was facilitated by the Education and Training Unit, an NGO that offers assistance to municipalities to develop a strategic plan for coping with the consequences of HIV and AIDS in their areas.

Individuals, families and communities are badly affected by the epidemic. The burden of care falls on the families and children of those who are ill. Often they have already lost a breadwinner and the meagre resources they have left are not enough to provide care for the ill person and food for the family.

Orphaned children are deprived not only of parental care, but also of financial support. Many of them leave school and have no hope of ever getting a decent education or job. The children grow up without any support or guidance from adults; this may become our biggest problem in the future.

Most of the people who are dying are between the ages of 20 and 45 – an age when most people are workers and parents. This has serious consequences for our economy and the development of the country.

AIDS can affect anyone. However, it is clear that it is spreading faster to people who live in poverty and lack access to education, basic health services, nutrition and clean water.

Young people and women are the most vulnerable. Women are often powerless to insist on safe sex and are easily infected by HIV positive partners. When people have other diseases like sexually transmitted diseases, TB or malaria they are also more likely to contract and die from AIDS.

Although AIDS has become very common, it is still surrounded by silence. People are ashamed to speak about being infected and many see it as a scandal when it happens in their families. People living with AIDS are exposed to daily prejudice born out of ignorance and fear.

We cannot tackle this epidemic unless we break the silence and remove the stigma [shame] that surrounds it. As elected representatives in communities, councillors have to provide leadership on how to deal with AIDS.

To deal with the results of the disease and the social problems it creates, we have to make sure that people living with AIDS get care and support to help them live longer and healthier lives.

We also have to make sure that those who are dying are properly looked after. For the children who are orphaned, we have to find ways of looking after them so that they do not become hopeless and turn to crime or live on the streets because of poverty.

National and Provincial government cannot fight this battle alone. They can provide health and welfare services, development programmes and information. However, municipalities, together with organisations on the ground, have to provide the type of leadership and direction that will lead to real change in people's attitudes and behaviour.

Municipalities are also ideally placed to identify the needs of people in their area and to co-ordinate a coherent response to those needs. Municipalities can engage with civil society, other government departments, as well as schools, churches and so on to make sure that everyone works together to combat the spread of AIDS and to care for those affected by the disease.

Mayors and councillors should act as role models for communities and be an example to people. We should take the lead in promoting openness and ending the silence that surrounds AIDS.

We should also work closely with people living with AIDS and through our action show that we accept and care for those affected. As political leaders, we should use our influence and popularity to mobilize the community and involve volunteers in projects that provide care for people living with AIDS and orphans.

4. Important Facts to Know About HIV and AIDS

AIDS affects millions of South Africans. It is estimated that more than 5.5 million South Africans are HIV positive and about 5 000 people die every week. Infection rates differ from region to region and from province to province.

The research to measure how common HIV and AIDS infection is in South Africa is done among pregnant women who visit state health clinics. The infection rates quoted below are for those women. One can assume that many men who are partners to these women are also HIV positive. If a province has a 10% infection rate amongst pregnant women, it probably has around 5% infection rate among the population as a whole.

The infection rate amongst pregnant women is as follows: (these figures were released for 2007 by Department of Health)

- **KwaZulu Natal 39.1%**
- **Free state 31.1%**
- **Eastern Cape 28.6%**
- **Mpumalanga 32.1%**
- **Gauteng 30.8%**
- **Northern Cape 15.6%**
- **Western Cape 15.1%**
- **North West 29.0%**
- **Limpopo 20.6%**

Clear statistics of the number of AIDS orphans are not available since AIDS is not recorded as a cause of death on the death certificates of many people who die because of AIDS. Estimates are that in the middle of 2001 around 250 000 children had been orphaned because of AIDS. This will increase to about 2 million by 2010.

Life expectancy in South Africa is expected to go down from a high of around 60 years in 1994 to just over 40 years in 2005.

Most of the people who are dying from AIDS are women between the ages of 18 and 40 and men between the ages of 30 and 50. This means that the most vulnerable groups are women of child rearing and economically active age and men in their economically productive years. This has severe implications for our economy and our society as a whole.

5. The Response of African Municipalities

An alliance of mayors and municipal leaders in Africa together with the United Nations Development Programme has developed an African Mayors' Initiative for Community Action on Aids at the Local Level

(**AMICAALL**). South Africa is one of 17 countries that have adopted a declaration in Abidjan in 1997 to develop a response by municipal leaders to HIV AND AIDS.

The declaration recognizes that municipalities and councillors are the closest to the people and are responsible for addressing local problems. It states that local government; mayors and councillors have a vital role to play to do the following:

- Provide strong political leadership on the issue
- Create an openness to address issues such as stigma and discrimination
- Co-ordinate and bring together community centred multi-sectoral actions
- Create effective partnerships between government and civil society

SALGA will provide support to implement AMICAALL resolutions in South Africa.

South Africa has also established a National AIDS Council and each Province has a Provincial AIDS Council to help provide support and co-ordination of AIDS initiatives.

In many provinces, District AIDS Councils are now being set up. At a local municipal level AIDS Forums or Councils, do exist in some areas. Each municipality chooses an option that best suits them and aims to achieve the following:

- bring together the key stakeholders in civil society and local government
- ensure that there is a coherent HIV strategy in place for the area
- provide some cohesive structure to help co-ordinate the delivery of services to those most affected
- avoid duplication
- mobilise volunteers to provide care for people living with AIDS and orphans

Impact of HIV and AIDS within the municipality

The impact of HIV and AIDS pandemic in the Merafong Local Municipality manifests itself on various ways. Most local municipalities that constitute the district are experiencing an increase in the number of deaths that are HIV and AIDS related. This situation manifests itself in the increase in the demand for burial sites.

The number of people who are sick and require assistance in the form of home based care is also on the increase. This situation has resulted in a number of households not being able to pay for municipal services. Some of these families have lost the sole provider. The numbers of families that live below poverty line are increasing.

HIV and AIDS is a political and socio-economic challenge and therefore its impact is felt in a number of various ways, which include the impact on:

- Individual members of the society;
- Families
- Communities in general;
- Children;
- Economic development; and
- Provision of services;

Impact on individual members of the society

HIV and AIDS is associated with high levels of stigmatisation and discrimination. There are a number of cases where people living with the virus are ill-treated and isolated by their families and the community in general. In some parts of the local municipalities, people are isolated to an extent that they are unable to secure personal relationships. This situation has resulted in the registration of an increase in people's stress levels and depression. Due to this ill-treatment and isolation of individuals, the number of suicide cases is increasing. Cases of stigmatisation and discrimination do not affect individuals in their homes and communities but it also affects them in their workplaces.

Impact on families

The negative impact of the HIV and AIDS pandemic is not only felt by the individuals infected but it also affects their families. Some families have been destabilised and ruined. Most families have not only lost the love ones but in some instances, the sole breadwinner that kept the family alive. Due to death of the breadwinner, the property and assets are lost in the process.

The family relationships also get affected by the impact of the pandemic to an extent of isolating the infected family member. Children become victims due to lose of one or both parents and this has resulted in an increase in the number of child headed families. Families are destabilised and divided due to non-acceptance and fear of stigmatisation by the community members.

Impact on communities in general

The impact of HIV and AIDS is not only felt by the families and individuals only, it also impacts negatively in communities in general. There are certain sections of our communities who are highly infected by the virus. This situation has resulted in them being stigmatised. Communities are losing hope due to loss of leadership as a result of HIV and AIDS related sicknesses and death.

People spend most of their time having to either caring for the sick or attending funerals resulting in them not having enough time to take of their businesses.

Most municipalities in the district have notice an increase in the number of orphans and vulnerable children who are found in the streets. Some of these children are said to be involved in criminal activities. This has resulted in an increase in the demand in welfare services.

Impact on children

Children are the most vulnerable sector in our society, any social issue that affects the communities; its impact is most felt by the children. The Impact of HIV and AIDS has also highly impacted on children.

Most community workers and educators are reporting an increase in the number of child headed families. Some of these children are said to be roaming around the streets during school hours and at night in search of sustenance.

Most children who have lost both their parents are forced leave school, especially young girls, to take care of their sick or dying parent(s) or to seek work in support of their siblings and dying parents.

Children are losing out on valuable parental guidance and family values and means of livelihood. In situations where both parents are not there, the children's up-bringing gets affected and joys of childhood are missed.

Some of these children register high stress levels as a result of losing or seeing their parents dying.
Some of these children are under-performing and hardly participate in extramural activities and they drop out from school. Most of these children require emotional and psychological support

Impact on economic development and labour force

Municipalities are obligated by the constitution to create an environment for economic development. This economic development can be achieved through provision of cost effective and efficient services. This objective can be achieved through an integrated planning and effective utilisation of available resources.

The emergence and impact of HIV and AIDS has impacted negatively on municipalities' abilities effective service delivery. Municipal spending patterns have been altered to accommodate the social and health needs of the communities.

Most municipalities are reducing their economic development budgets to cater for social assistance such as indigent support and food parcels. This has serious impact in the economic development of these areas. Service delivery has been affected due to poor service payment by citizens.

Most institutions within the jurisdiction of the district municipality are registering high levels of absenteeism among staff members due to sickness, attending funerals or caring for members of the family who are sick. Municipalities and other institutions are losing specialised expertise due to sickness and death and this is costing them a lot since they have to replace and train new staff members. Some of the businesses in the jurisdiction of the Merafong local municipality are closing down.

Impact on provision of services

Government is obligated by the constitution to improve the quality of life of the citizens of South Africa. HIV and AIDS has put a strain on the ability of government and its institutions to deliver quality services to the South African citizens.

The disease is affecting both workers and the ability of the institutions to provide services. Department of Health and Social development are the ones that mostly affected by the diseases. Most of their budgets are redirected to cover the needs of the communities that are health related. Most health facilities are over-crowded and unable to cope with the demand.

The impact of HIV and AIDS on provision of services does not only affect the institutions but also affects the individual employees who either infected or affected by the pandemic. Most employees spend their time being sick or caring for loved ones who are sick. Those that are left behind at work have to ensure the pain of losing their colleagues.

Constitutional and policy framework for municipal response

The developmental agenda of the South African government mandates municipalities to be active role players in all efforts that seek to prevent the spread of HIV infections and to ensure mitigation of its impact on both the infected and affected.

Municipalities have to take responsibility for their own organisation, strategic planning, programme development and implementation, monitoring and evaluation of municipal response to the HIV and AIDS challenge.

In executing this responsibility, Local government is guided by a number of pieces of policy and legal framework work that include the following:

Constitutional and legislative framework

The South African constitution is the cornerstone of our country's democracy. In its preamble, the constitution commits government and the people's representatives to among other things to ensure the improvement of the quality of all citizens and free the potential of each person.

Chapter 2 of the Constitution deals with the democratic values of human dignity, equality and freedom. Section 27 of this chapter focuses on the health rights, care, food and social security. According to this section, everyone has a right to have access:

a) health care services, including reproductive health care;

b) sufficient food and water; and

c) social security, including, if they unable to support themselves and their dependents,

The constitution further tasks the state with the responsibility of taking the reasonable legislative and other measures, within its available resources, to ensure progressive realisation of these rights.

Local government is a critical sphere of government that is directly linked to services delivery and has a constitutional obligation to ensure that every citizen receives reasonable treatment and care. This obligation of Local government is entrenched in Chapter 7 of the Constitution, which is outlined as, to:

a) provide democratic and accountable government for local communities;

b) ensure the provision of services to communities in a sustainable manner; and

c) promote safe and healthy environment; and encourage the involvement of communities and community organisations in the matters of local government'

A number of legislations have been developed to ensure that the vision of the constitution is realised. The constitution and these pieces of legislation provide a framework for municipal response to HIV and AIDS.

These legislations outline the need for local government to ensure that is structured and is administratively managed; its budgeting and planning processes prioritise the needs of the communities and promote social and economic development. Two most important pieces of legislations that guide the local government are:

1. the white paper on local government(1998); which outlines the vision for developmental local government and requires municipalities to ensure that all citizens receive at least minimum levels of basic services, that democracy and human rights are promoted, and that economic and sectoral development are facilitated; and
2. the municipal systems act (2000); which establishes a framework for the processes of planning, performance management, resource mobilisation and organisational change within municipalities

National Strategic Plan Guiding Principles

The country's developmental agenda mandates all sectors of our society to be involved and participate in prevention efforts that seek to reduce new infections by 50% by the year 2011.

To ensure mitigation of the impact on both the infected and affected by ensuring that we provide services to 80% of those who need care and support. These efforts are guided by a set of principles, which are:

- Supportive Leadership;
- Leadership role of government;
- Greater Involvement of People Living with HIV;
- Effective Communication;
- Effective Partnerships;
- Promoting Social Values and Cohesion;

- Tackling Inequality and poverty;
- Promoting Equality for Women and Girls;
- Protecting and Respecting Children;
- Recognising Disability;
- Challenging Stigma;
- Ensuring Equality and Non-discrimination against marginalised groups:
- Personal Responsibility:
- Building Community Leadership:
- Using scientific evidence;
- Strengthening care systems;
- Accessibility;
- Monitoring Progress:
- Financial sustainability:

Principles derived from the DPLG local government response

To create a conducive environment for local government response to HIV and AIDS at local level, the Department of Provincial and local government developed a framework for local government response. This framework outlines the legal basis for local government's involvement in the fight against the spread and impact of the disease. This framework outlines the roles and responsibilities of various stakeholders. The framework also outlines a set of principles that should guide municipal response to HIV and AIDS and these include the following:

- Legislative compliance
- Equal access;
- Equity;
- Flexibility;
- Incrementalism;
- Capacity building;
- Partnerships; and
- Human rights

Municipalities have to take responsibility for their own organisation, strategic planning, programme development and implementation and monitoring and evaluation of municipal response to the HIV and AIDS challenge. To achieve these objectives, municipalities have should ensure a well co-ordinated effort that involves all sectors of the civil society. This well co-ordinated effort should be based on the principled partnerships.

SECTION B: PRESENT SITUATION IN MERAFONG LOCAL MUNICIPALITY

The Local Context

SOCIAL AND ECONOMIC TRENDS

The Merafong Local Council estimates the 2001 population to stand at 326 273.This covers the mining town of Carletonville, Fochville, Welverdiend and the surrounding township communities of Khutsong, Kokosi and Wedela. There are informal settlements located on the periphery of the mining land where there is a population of highly mobile women who come to the mines in search of work but end up as commercial sex workers.
The above statement is supported by the table below that indicates that there are more than 90 000 adults of the population, who are single and never married.

Table: Census 2001 by municipalities, marital status and population group

	African/Black
NW405: Merafong City Local Municipality	
Married civil / religious	29 419
Married traditional / customary	30 848
Polygamous marriage	353
Living together like married partners	18 333
Never married	90 061
Widower / widow	4 024
Separated	1 263

Footnote:
Universe: All persons.
Figures greater than 0 and less than 4 are randomised to preserve confidentiality
Please refer to the extract from the report of the Census Subcommittee to the SA Stats Council on Census 2001 (p.3) when reading this table.

Merafong is just under 100 kilometers (96) from Johannesburg and about half that distance from Soweto, therefore there is a clear significant movement of people into and out of Merafong. Two mining houses Anglo-Gold and Goldfields operate the majority of the shafts, while Harmony operates two and DRD operates one shaft.
Khutsong, Wedela and Kokosi are typical South African townships with housing types reflecting the various socio economic strata of the communities. There are council houses, site and service and various informal settlement camps with some legal and others illegal. See table below.

Table: Census 2001 by Municipalities, dwelling type and population group of head of household

	African/Black	Coloured
NW405: Merafong City Local Municipality		
House or brick structure on a separate stand or yard	23 319	288
Traditional dwelling/hut/structure made of traditional materials	593	50
Flat in block of flats	995	8
Town/cluster/semi=detached house (simplex; duplex; triplex)	234	4
House/flat/room in back yard	3 119	34

Informal dwelling/shack in back yard	4 873	26
Informal dwelling/shack NOT in back yard	12 326	41
Room/flatlet not in back yard but on shared property	1 039	8

Footnote:
Universe for all households

Please refer to the extract from the report of the Census Subcommittee to the SA Stats Council on Census 2001 (p.3) when reading this table.

The demographics of these residential areas are characterized by:

- High rate of unemployment
- Large number of out of school youth
- Many commercial sex workers, estimated at 1 500
- High number of single adults

DEMOGRAPHIC TRENDS

- Economic active population decreased from75% (2001) to 73% (2007)

Table: Census 2001 by municipalities, economically active population amongst those aged 15 to 65 years, population group and gender

	African/Black		Coloured		Indian/Asian		White	
	Male	Female	Male	Female	Male	Female	Male	Female
NW405: Merafong City Local Municipality								
Employed	59 604	10 734	300	208	86	42	8 175	4 477
Unemployed	12 493	18 785	67	136	4	9	517	685
Scholar or student	4 941	5 090	31	29	9	6	1 254	1 317

Footnote:
Universe: All persons aged 15 to 65 years.
Figures greater than 0 and less than 4 are randomised to preserve confidentiality
Please refer to the extract from the report of the Census Subcommittee to the SA Stats Council on Census 2001 (p.3) when reading this table.

municipalities

- Slight increase in percentage in population dependent on others
- High and climbing HIV infection rate. 8,752 (2004); 12,200 (estimate for 2007)
- Annual AIDS related deaths - 560 (2004): 1,200 (estimate for 2007).

According to the report, the estimated infection rate was +- 40%. This report was derived from a survey done in 1999. Mine workers, sex workers and the general population of Khutsong were sampled separately. Given the substantial differences in socio economic status, and the place of origin of people living in various housing sectors, the task team saw it fit and essential to ensure a full representative sample of the area.

Sample sizes were as follows:

- Khutsong -1 500
- Mine workers - 1 000
- Women at high risk - 100

The total HIV positive prevalence according to the sample was as follows:

- Men in Khutsong - 9.3%
- Women in Khutsong - 34.4%
- Mine workers - 29.4%

EDUCATION PROFILE

- No schooling 0 11% compared to 17% in NW and 16% in RSA.
- Completed Grade 12 – 20% compared to 26% in NW and 27% in RSA.
- Higher education – 2%

Table: Census 2001 by municipality, highest level of education, population group and gender

	African/Black		Coloured		Indian/Asian		White	
	Male	Female	Male	Female	Male	Female	Male	Female
NW405: Merafong City Local Municipality								
No schooling	11 652	6 868	50	112	3	4	135	155
Grade 1/Sub A	728	450	6	5	0	0	7	5
Grade 2/Sub B	1 168	744	8	6	0	0	3	14
Grade 3/Standard 1	3 161	1 278	17	11	5	4	8	15
Grade 4/Standard 2	5 060	1 801	13	20	0	0	12	20
Grade 5/Standard 3	5 473	2 169	14	68	3	0	29	45
Grade 6/Standard 4	6 268	3 046	21	24	4	0	77	91
Grade 7/Standard 5	8 377	4 398	43	60	3	3	108	134
Grade 8/Standard 6/Form 1	7 801	4 898	52	53	0	3	586	668
Grade 9/Standard 7/Form 2	7 215	4 383	48	22	0	4	300	446
Grade 10/Standard 8/Form 3/NTC1	6 567	4 507	59	38	9	7	2 638	2 986
Grade 11/Standard 9/Form 4/NTCII	4 651	3 443	21	24	4	0	541	572
Grade 12/Standard 10/Form 5/NTCIII	9 007	6 364	85	61	40	31	4 389	4 639
Certificate with less than Grade 12	118	71	0	0	6	0	141	74
Diploma with less than Grade 12	59	47	3	0	0	0	80	57
Certificate with Grade 12	590	525	6	3	0	3	417	286
Diploma with Grade 12	648	807	10	10	14	11	702	727
Bachelors degree	141	143	3	0	4	6	251	270

Footnote:
Universe. All persons aged 20 years and older. Figures greater than 0 and less than 4 are randomised to preserve confidentiality Please refer to the extract from the report of the Census Subcommittee to the SA Stats Council on Census 2001 (p.3) when reading this table.

Income levels profile

Table: Census 2001 by municipalities, individual monthly income for the employed aged 15-65 years, population group and gender

	African/Black	
	Male	**Female**
NW405: Merafong City Local Municipality		
No income	475	314
R 1 - R 400	3 229	3 479
R 401 - R 800	5 582	2 787
R 801 - R 1600	23 996	1 971
R 1601 - R 3200	21 905	1 214
R 3201 - R 6400	3 139	724
R 6401 - R 12800	963	201

Footnote:
Universe: All employed persons aged 15 to 65 years old. Figures greater than 0 and less than 4 are randomised to preserve confidentiality Please refer to the extract from the report of the Census Subcommittee to the SA Stats Council on Census 2001 (p.3) when reading this table.

Impact of HIV and AIDS on Merafong Local Municipality

- Prominent figures have passed away due to the HIV and AIDS pandemic
- Education of the child is also affected as he/she has to take care of the sick mother or father and therefore has to leave school
- There is an increase in the number of orphans and child headed homes
- More land is now used to bury those who died of HIV and AIDS
- It also puts a burden on marriages and causes them to break-up
- There is also an increase in substance abuse like high alcohol intake and drug abuse
- HIV and AIDS puts kids and orphans in isolation other children don't want to play with HIV positive kids
- There is an increase in the level of prostitution as a result of poverty

PART C: PRESENT SERVICES AND AVAILABLE PROJECTS

Available services

1 CARLETONVILLE HOME and COMMUNITY HOME BASED CARE

1.1 Overview of CHCBC

- Started in 1998, and was initially reporting to Carletonville Aids Action Committee (CAAC).
- The mission is to provide care and support to the HIV/AIDS and other terminally ill patients and families in the communities Merafong City.
- CHCBC has a holistic and comprehensive approach to all its four programs (Support Groups, Palliative Care, Orphan Care and Poverty Alleviation/Income Generation)

1.2 Geographic boundaries covered by CHCBC services

- The CHCBC provides services in the areas of Merafong Municipality
- Areas covered are Khutsong, Carletonville Welverdiend, Wonderfontein, Rooipoort, Leeupoort (area outlying East Driefontein : Mphahlwa Village and No. 5 Informal Settlement), Blyvoor and Blybank mining areas.
- About 80% of the population of Merafong City reside in these areas.

1.3 Support group programme

- A Support Group for People Living with HIV/AIDS (PLWHAs) was started in Khutsong in the year 1999 with 15 patients.
- The Support Group has grown rapidly and currently there are 513 members registered,
- Currently a group of 18 attend sessions at the Carletonville Hospital and 30 in the informal settlements outside East Driefontein.
- Community Health Workers and WBOT

1.4 Support group activities

- Facilitated Group Sessions
- Individual needs assessments
- Individual, Group or Family Therapy/Counselling Sessions
- Home Visits
- Referrals
- Material Support
- Nutritional Support
- Social support services
- Skills Project e.g. Shoe making, bead work etc.

1.5 Palliative care

- The programme incorporates patients with chronic diseases like TB, Cancer, Stroke and AIDS.
- Areas covered
- Team players
- Patient ratios
- Average number of patients seen per month varies from month to month, depending on admissions, deaths etc.

1.6 Palliative care activities

- Daily care needs e.g. bed bathing, feeding etc
- Pain management
- Environmental hygiene.
- Family education
- Individual and family counselling
- Nutrition support
- Material support
- Referrals to other social services.

1.7 Orphan Care programme

- Initiated and implemented with technical assistance from Heartbeat Centre for Community Development in 2001.
- Orphaned and Vulnerable Children
- Child Headed Households
- Granny Headed Households
- Sponsor A Child In Need (SACIN), an initiative of Heartbeat (Terminated in 2006).
- Sakhisizwe Community Child Care Forum
- Lungisa Ikhaya project
- REPPSI Model of Psycho-social Care

1.8 Orphan care activities

- Family visits and household assessment
- Health Education
- Child Support Groups and Granny Support Groups
- Individual and Household Counselling
- Focus Groups
- Referrals to appropriate resources
- Preparation and Serving of after School meals
- Supervision of homework
- School visits by Care Givers
- Recreational activities (drama, music groups etc.)
- Monitoring of state grants applications
- After school home work assistance

1.9 Poverty alleviation/ Income generation programme

- CHCBC has been operating a bakery since the April 2002.
- The bakery produces on average 250 loaves per day.
- Supply to beneficiaries and sales
- Food gardens
- Monthly food parcels
- Skills Project (beadwork, shoe and bag making)

1.10 Other spectrum of CHCBC activities

- Quality assurance of all programs
- Training and Development
- Support and mentoring of other groups
- Care of The Carer
- Stakeholder dialogue and networking

1.11 Funders, Donors and Partners

- Department of Social Development
- Department of Health
- Nelson Mandela Children's Fund
- Anglo Gold Fund
- Goldfields (CSI)
- Ford-Fish Foundation
- US Embassy
- Executive Mayor of Merafong City
- Local AIDS Council
- TEBA Limited
- Nola Foods
- Dunns Clothing
- Churches (Khutsong and Carletonville Methodist and Roman Catholic; Our Lady of Dolour)
- Civil society
- Pick 'N PAY (Carletonville)

1.12 Overall control measures

- Legislative control
- Policies and procedures
- House rules
- Service Level agreements
- Memorandum of Understanding
- Codes of conduct

1.13 CHCBC achievements

- Mobilization of community support to CHCBC
- Initiating and sustaining Community Child Care Committees e.g. Sakhisizwe Child Care Forum
- Strengthened partnerships Accountability reporting
- Sustainability of Programme
- Model of best comprehensive approach to HIV/AIDS care
- Sourcing of donor funds
- Service area expansion
- Mentor organization for other NGO's

1.14 Challenges facing CHCBC

- Strong linkage between AIDS and poverty,
- Increasing dependency ratios from both infected and affected members of the community (including orphans)
- Growing need for more foster placements for orphans
- Inadequate food security (demand more than the supply)
- Inadequate transport
- Need to establish additional service sites,
- Recruiting male care givers

2 TRENITY HEALTH CENTRE/NEW START KHUTSONG

2.1 What is Trinity Health Centre/New Start Khutsong?

- It's a PEPFAR site appointed by Aurum Health Research Company in order to assist with the rolling out of Art programme and VCT Programme in S.A.
- It is a service provider fully registered as a Section 21 Company(NPO)
- Currently funded by Pepfar through Aurum institute.
- It is also a VCT Outreach Programme funded by Global Funding through Society For Family Health

2.2 Aims and Objectives

- To speed up the rolling out of ARTs
- To reduce stigma and fear of HIV infected persons
- To provide continued counselling and monitoring through Outreach Programmes in collaboration with Local Municipalities
- To feedback the government on the rate of mortality
- To reduce the rate of mortality
- To be more visible and relieve overcrowding and overstretching at public institutions.
- To assist with HIV Workplace programme within the Merafong Community

2.3 People eligible for this service

- Contractors/Ex-mine workers
- Communities at Large
- Small and Medium Enterprises

2.4 Funding

- Funded by PEPFAR (President Emergency Plan For AIDS Relief) being conducted by the Government of the United States of America.
- It is funded through Aurum Health Institute and Society for Family Health.

2.5 Staffing

- Contracted Professional Doctor
- A registered Professional Nurse.
- 1 Phlebotomist and 3 Enrolled Nurse
- Site Manager –Administers the Site, Outreach Coordinator, Referral Coordinator and Senior Counsellor.
- 13 Counsellors (Fulltime)–To counsel advise clients.
- 7 Voluntary Counsellors based at the site.
- **NB: All this people are given an extensive training by Aurum Health Institute and (SFH)New Start.**

2.6 Operational times

Open Monday to Saturday

07.00 – 16.00 Mon & Tues
07.00 – 18.00 Wednesdays & Thursdays
07.00 – 16.00 Fridays

2.7 Service rendered

ARTs

2.8 How will ARTs be administered?

- To pts who gave consent-will be started on a combination of 3 tablets.
- An examination and blood tests will be done to check the level of INFECTION in the blood.
- This treatment and tests are free.

2.9 VCT outreach programme

2.10 Counselling

- Pre and post counselling is done to pts who have tested both negative and positive.
- It is also centred around VCT Programme at the Site as well as Outreach.
- Outreach Tents, Trailer, Kombi and personnel visit neighbouring communities.

2.11 Workplace HIV programme

- The centre intends to reach out to those community members who are still productive.
- An appointment will be made for such clients by their Drs, or any referral sources for further management or initial intervention.

2.12 Administration

- A file is opened to keep records.
- Consent form is required to participate in the programme.
- VCT Records cards sent to SFH and Aurum Health.

2.13 Referral sources

- All individuals of the community
- Referrals from local clinics, Drs, home base care centers, Mothusimpilo, Khomanani etc.
- From wellness clinics at various mining companies within Merafong City.
- General practitioners with in the community

2.14 Achievements

- Very successful VCT Site and Outreach.
- 487 Patient have been treated since August 2005 to date successfully
- 38 Patient died whilst on the 1st week of contact to the center.
- 33 Children also seen and assisted, all on prophylactic treatment.
- 16 Pregnancies dealt with effectively during Antenatal periods to assist in a Negative child being born.
- 383 Patient on active HAART
- 69 Clients on Wellness Programme
- 37436 VCT done to date successfully through Aurum Institute
- OUTREACH Programme running well
- 18976 VCT done through New Start from October 2008-October 2009 Outreach Programme.

2.15 Challenges

- Late referrals from other service provides especially GP's AND Local Municipal service centers/clinics Clients are taking too long to come forward for treatment.
- 130 clients eligible to access treatment on waiting list due to lack of funding/files
- Increased rate of pregnancy post treatment intake
- Lack of further funding to increase patients accessing treatment and seen at Outreach
- Frequent patient mobility especially those from Lesotho.
- Male partners resisting treatment and testing.

- Need for a proper facility/structure/building to accommodate growing clientele
- Need to source funding for OUTREACH PROGRAMME
- Transportation
- Equipments e.g. computers

2.16 Conclusion

- Trinity Health Centre is not merely to duplicate services rendered but to speed up the roll out programme and we hope that it will be of great use to the members of the community in WESTRAND MUNICIPALITIES AND GAUTENG PROVINCE

3 DEPARTMENT OF HEALTH SERVICES

3.1 2005-2011 NSP Primary aims

- Reduce HIV infections by 50 % (ages 15-24)
- Reduce impact of HIV on families and communities expanding access to treatment ,care and support by 80% to people diagnosed with HIV

3.2 Priority areas

3.3 Prevention

- H.P and social mobilization (Mothusimpilo, KYFS, H.P etc.)
- Integration of PHC Services (F.P,ANC, STI TB are offered VCT)
- Reduction of MTCT
- Access to PEP and Psychosocial support.(Hospital).
- STIs- syndromic mx available in all facilities.
- Dual therapy(AZT & NVP) is also available for all pregnant mothers according to the national guidelines.
- PCR tests are done for all babies born from positive mothers.
- NVP given to all babies born from positive mothers
- Formula available for babies on PMTCT program
- Nutrition packs available for all patients with nutrition need.
- Psychological support given to all patients others referred to social department.

3.4 Treatment, Care and Support

- 2 ART SITES - Carletonville Hosp.
- Khutsong CCMT
- Patients on treatment- Khutsong 2080,(9paeds and adults- 1981)

3.5 Research, monitoring and surveillance

- Research – mostly from national and province- last early 2007- results not known.
- facilities- staff encouraged to do research for program improvement.
- Monitoring- statistics handed in monthly.
- Surveillance- ANC and STI prevalence.

3.6 Human and legal rights

- Confidentiality always maintained.
- Strive to accelerate access to services –
- Stigma mitigating activities – support groups at Ngos.

3.7 Challenges

- Integration of PHC Services – Strengthen
- Access to PEP- PHC level
- Improvement of PMCTC – PCR, Dual Therapy
- TB/HIV co infection – INH
- Staffing
- High defaulter rate.
- Kokosi/Wedela ARV?
- Limited space.

4 RESPONSES BY DEPARTMENT OF DEVELOPMENT AND SOCIAL SERVICES

4.1 Policy framework

- Constitution of the Republic of South Africa
- Child Care Act.1983 (as amended) Act No 74 of 1983
- Child Justice Bill 2003
- Health Act, 1977
- Health Profession Act,1974
- Labour Relation Act , 1995
- Medicine and Related Substances Control Act,2002 as amended
- Social Assistance Act
- Non – Profit Organization Act, 1997
- Public Financial Management Act
- Occupational Health and Safety Act,1993
- Policy on Sexually transmitted diseases
- Primary Health Care policy
- Policy on HIV and AIDS

4.2 Guiding principles

- Right to self-representation
- Accessibility
- Support system
- Self respect and self-sufficiency
- Access to appropriate services
- Social integration
- Enhanced inter-sectoral collaboration
- Equitable resource allocation
- Inclusion
- Batho-pele principles
- Confidentiality
- Cultural sensitivity
- Empowerment
- Family centered
- Family preservation
- Sustainability

4.3 Target group

- Children
- Youth
- Family unit
- Communities

- Older persons
- People with disabilities
- People with specific needs
- People infected and affected by HIV and AIDS

4.4 Basket of services

Orphan care

- Identification of OVC
- Referral to relevant stakeholders
- After care services which entail life skills programme to OVC.
- Caregivers assist children with homework.
- Succession planning

4.5 Care and support

- Provision of food parcels and school uniforms
- provision of protein supplements
- Basic counselling to Individuals and families e.g. bereavement counselling.
- Therapeutic group sessions with the infected and affected people.
- Home visits to the infected and affected families
- Cooked meals(Drop in centers)

4.6 Coordinating structures

- Establishment of child care forums.
- Launching of DACCA and LACCA

4.7 Advocacy programmes

- Door to door campaign
- Conducting of awareness campaigns at schools, clinics.
- Identification and establishment of support groups
- Awareness campaigns through information sharing sessions
- Commemoration of international days e.g. World AIDS Day

4.8 Social integration and empowerment

- Establishment of support groups
- Training/workshop

4.9 Support services to care givers

- Debriefing sessions
- Trainings: HCBC, Life skills, Counselling and
- EPWP Learner ship: e.g. Auxiliary Social Work & Community Health Care)

4.10 Funding of HCBCS and DROP IN centres

- Submission of a business plan(Format of the business plan provided by the Dept)
- Assessment of a business plan
- Approval of business plan
- Signing of the SLA
- Transfer of funds to the organization

4.11 Examples of the items to be included in the business plan

- Food parcels
- Protein supplements

- Cooked meals for orphaned children
- Stipends for project coordinator EPWP
- Stipends for caregivers
- Capacity building and debriefing programmes
- Community outreach
- Support group activities
- School uniform for OVC's
- Stationery
- Auditor's fee
- Transport Electricity & Rent Cleaning material
- Food gardens
- Computer & printer

4.12 Grants:

- Disability grant
- Foster care grant
- CPOS- Community place of safety
- Child support grant
- Care dependency grant.

4.13 Monitoring an evaluation

- The purpose of monitoring and evaluation is to assess compliance to the contract, both in terms of service delivery and financial management. This document provides a clear guide to clarify the role of Organizations, Service Points, Districts and the Provincial Office in terms of monitoring the delivery of services.

4.14 Organization/ Project

- The organization / project must ensure that accurate reports are submitted on time to the Service Point. Reports to be compiled according to prescribed format. The organization /facility have the responsibility to ensure the availability of the following documents;
- Separate bank account for monitoring of state funds.
- Signed service level agreement.
- Financial statements and reports.
- Minutes of management and staff meetings.
- Records and files of the general administration
- The organization / project must ensure that accurate reports are submitted on time to the Service Point. Reports to be compiled according to prescribed format. The organization /facility have the responsibility to ensure the availability of the following documents;
- Separate bank account for monitoring of state funds.
- Signed service level agreement.
- Financial statements and reports.
- Minutes of management and staff meetings.
- Records and files of the general administration

4.15 Service Point

- Guided by the service level agreement, the Service Point must ensure effective monitoring on the implementation of organization's business plan. A social worker in the employment of the state or any person designated by the Director – General may be requested to perform the following functions with regard to monitoring of facilities:
- Visit and monitor a facility for compliance with the provision of the applicable Act.
- Determine compliance to transformation imperatives.

- Monitor implementation of the organization sustainability and service plan.
- Monitor compliance with relevant legislation, policies and priorities, norms and standards and procedures
- Deal effectively with any mismanagement and maladministration within the organization
- Receive and validate reports.
- Monitoring project visibility on monthly basis.
- Provide monthly progress reports (financial and non financial) to the program supervisor
- Supervisor at the Service Point must provide quarterly report to Provincial Office through the District Office

4.16 District

- On receipt of such documents the District must do the following:
- Validate information.
- Ensure all service organizations funded by the Department are coordinated, supported and monitored.
- Ensure submission of quarterly reports by the service points.
- Submit quarterly reports to provincial office.

4.17 Province

- Monitor the progress made and the impact of services to the service recipients
- Advice the service points on the issues as picked up from the reports.
- Provide Support to the service point coordinators / organizations
- Account for the utilization of the budget spent on the organizations.
- Conduct regular site visits to funded organizations.
- Ensure submission of reports to National as per request

4.18 Challenges faced by DSD: ?

5 MOTHUSIMPILO OUTREACH PROGRAMMES

5.1 Description of the intervention

- Mothusimpilo (‘’ working together for health’’) Intervention project was launched in 1998.
- Reduce prevalence and incidence of STI s/HIV infection.
- This would be achieved by decreasing the number of sexual partners thereby reducing STIs among mine workers and sex workers.

5.2 Key interventions

- Condom promotion and distribution.
- Behaviour change though peer education model for SW and mine workers.
- Strengthening syndromic management of STIs in combination of PPT of STIs.
- PPT component focuses exclusively on self identified SWs around intervention sites and mining hostels.

5.3 Implementation

- Pre -implementation base line survey was done.(study)1998. Random, representative sample population of Merafong.
- Post -intervention survey was done in 2001.
- This allowed for comparison.

5.4 Peer Education

- Focuses on behaviour change model.
- Key messages (condom use, treatment literacy, referrals to mobiles.)
- Peer Educators recruited among self identified SW and mineworkers.
- peer educators use participatory method of education.(drama)
- PE included schools in Khutsong.
- The sessions are recorded.

5.5 Condom distribution

- Free condoms are made available at strategic points.
- This function is done by PE.
- They use tally sheets to record.
- Over one million condoms distributed annually.
- Distribution does not reflect condom use.

5.6 STI Services

- Provide training to private providers on syndromic management.
- Introduced PPT program exclusively for SW who are asymptomatic.
- Facilitated by use of three mobiles.
- Support for this service is from the mines.

5.7 Staffs complement

- 1 manager /coordinator
- Administrator
- 48 Peer educators
- Monitoring officer.
- 3 nurses
- 7 VCT Counsellors.

6 EDUCATION AND AWARENESS, PREVENTION AND OPENNESS

6.1 What is the extent of the problem?

- Lack of Cross border co-ordination of programmes and resources
- Programmes not covering entire Merafong City
- No central co-ordinating structure of programmes in Merafong City
- Lack of activities covering Northwest side of Merafong city
- Lack of networking and interaction of service providers
- Lack of comprehensive policy and programmes
- No clear indications of commitment to available strategies
- Lack of collective approach to campaigns between all service providers
- No corporation between Labour and Management on implementation of programmes
- Awareness campaigns not effective
- No focussed intervention strategy to ensure quality work and results

6.2 What is being done?

WHO	WHAT	WHERE
K.Y.F.S	Youth-STI/HIV/AIDS prevention programmes Counselling services and motivational programmes	Khutsong
Social Services	Financing orphans care projects, placement of orphans in suitable homes Counselling and community development	Merafong Council
Mothusimpilo Outreach Project	STI and HIVAIDS Education	Targets sex workers, mine workers, Youth in Schools and the community
Carletonville Home Based Care	Home Based Care and Counselling	Carletonville
N.G.Welfare	Awareness programmes, Counselling	Fochville and Carletonville
SAFV and OSR	Social work services	Rural farming areas
Boere Landbou Union	Education & Awareness programmes & Counselling for workers	Fochville
Dept of Health	Mobile clinics and VCT and PMTCT	Rural and Farming communities and Carletonville
SANCA	Counselling, awareness education and prevention	Mining houses

6.3 What are the key gaps?

- Extended municipal boundaries not properly catered for by all the programmes
- Youth programmes are not able to reach out sufficiently to the targeted group
- Availability of human and material resources to cope with the changing needs created by HIV/AIDS prevalence
- No survey indicating behavioural pattern for Wedela and Fochville
- No strategy to identify and involve other stakeholders

6.4 Priority needs

- Human, material and financial resources to be boosted
- Comprehensive, integrated and targeted approach regarding EPA
- Co-ordination, monitoring, evaluation and sustainability of all programmes within Merafong City
- Media involvement to market and promote programmes
- Rolling out of EPA programmes to the entire Merafong City
- Availability, accessibility of all services including all service providers
- Commitment by all stakeholders and role players
- Inclusive co-ordinating structure for the entire Merafong City
- Networking by all involved structures both internally and externally

7 CARE AND SUPPORT FOR PEOPLE LIVING WITH AIDS

- **7.1 What is the extent of the problem?**
- Very few people are coming forward to disclose their status, therefore it becomes difficult to identify, plan and strategize
- Most people are still denying it when tested and are found to be positive
- People are coming forward for VCT; numbers are increasing by the day.

- Married couples are not disclosing to their partners when found to have tested positive
- Attitudes towards PWAs are still negative, though there is visible improvement.

- **7.2 What is being done?**
- There are (5) five clinics in Khutsong, (2) two in Carletonville, (2) two in Kokosi, (1) one in Greens park and (1) one in Wedela, 1 mobile clinic in the farming area.
- Treatment given is (a) STI treatment (b) Counselling in all clinics (c) VCT in all clinics (d)PMTCT at all the clinics and Carletonville Hospital (e) treatment of opportunistic diseases in all clinics
- Carletonville HBC provides home based care services in Carletonville, Wedela and Khutsong, Kokosi (RUDO), Leeuwpoort and East Driefontein (Thabo Merafong)
- Dept of Health provides funding to all established HBC
- Food gardening projects training done by Department of Agriculture.
- Bread baking container funded by Department of Social Development.
- Candle making done by Support Group
- Bead making done by volunteers
- CHCBC- Khutsong wards 1,2,3,4,6,7 and Wonderfontein, Mphahlwa village, no 5 shaft

- Blybank, Carletonville, Welverdiend, Mohaleshoek and Blyvoor
- RUDO HBC –Wards 22,24,25,26
- Heartbeat HBC-22, 24, 25, 26
- Greens park HBC
- Thabo Merafong HBC –Wards 20,23
- Redirile HBC- Wards- 22,24

7.3 What are the key Gaps

- No known support groups and spiritual Counselling in Khutsong, Fochville and Wedela
- Lack of trained volunteers on HBC in some areas of Merafong City i.e. Fochville, Wedela, Kokosi and Welverdiend
- Need capacity building programmes
- Lack of finance, human and material resources
- Involvement of political leadership especially Councillors.
- Lack of Religious groupings support in HBC programmes

7.4 What are the Priority needs

- To ensure that HBC services are rendered in all other areas of Merafong City
- Establishment of PWA support groups
- Financial and material resources
- Nutritional and gardening projects
- Spiritual and emotional support group structures in the community
- Accessibility of health services to all
- Mobilisation and education of the community to support PWAs
- All service providers - donations should be channelled through LAC
- Strengthening of links between all NGOs, referral system all Religious groups to participate in all existing programmes.

8 CARE AND SUPPORT FOR OVCs

8.1 What is the extent of the problem?

- Lack of community support
- Criterion very strict for the approval of Foster parent

- Not enough volunteers
- No commitment from the Commissioner of Child Welfare
- No inclusive and updated data base on Orphans
- No follow up strategy by Social Development and other HBC on identified cases.
- Food parcels will be withdrawn from 31st November 2005

8.2 What is being done?

- Council provides subsidised office space, free water and electricity for Carletonville HBC and NGOs.
- Sixty seven child headed families receive food parcels each week and are sponsored with R100.00 each, through the Sponsor an Orphan project
- Save The Child Foundation provided three year funding for an After School Centre
- Community Child Care Forums discussing children problems in Merafong City
- IT cater for the whole of Merafong City
- After school care centres are being established and sustained in all areas of Merafong City.
- Mayor's office initiated Ubuntu project for CINDI with the theme "It takes a Village to raise a child and Motho ke Motho ka Batho bangwe".

8.3 What are the key gaps?

- Amendment of the Child care Act to accommodate every child
- Dept of Health and Dept of Social Services do not network
- Available resources do not have enough funds to expand to all other areas
- Lack of human resources particularly Social Workers
- Clear updated Data base
- Cultural barrier regarding adoption of children
- In some cases, some children are not in the child support grant system
- Lack of monitoring system for the well being of the adopted children
- Social economic status of community is very poor

8.4 What are the Priority Needs

- Needs analysis of the area
- Capacity building programmes for Foster parents, Volunteers, Social Development personnel and Health Department personnel
- Proper co-ordination of all service providers
- Regular monitoring of systems of all programmes and service providers
- Poverty alleviation programmes
- Grants must reach every deserving applicant e.g. Orphans and Foster parents
- Properly co-ordinated integrated programme for the up bringing of the child/orphan e.g. education needs and health

SECTION D: KEY RESPONSES NEEDED IN MERAFONG

There are key priority areas of intervention that can be taken to reduce the impact of HIV and AIDS on the municipality and its people.

1. Education, awareness, openness and prevention

AIDS is preventable and we can protect people who are not infected by equipping them with the knowledge that will help them change their attitude and behaviour.

It is important that education and awareness programmes conducted by various players in the municipality be co-ordinated to avoid duplication.

Education, awareness and prevention programmes can succeed only if it is conducted in an environment of openness. As long as HIV and AIDS is treated as a scandal and people living with HIV and AIDS are discriminated against, these programmes will not help change peoples attitude and behaviour.

Councillors, as the political leadership in the municipality, have to play a central role in ensuring that the disease is destigmatised.

2. Treatment and care for people living with HIV and AIDS

The existing health care facilities in the municipality barely provide the necessary medical treatment for people living with HIV and AIDS. More has to be done to provide a comprehensive treatment and support regime for sufferers.

More has to be done to initiate programmes that promote wellness and poverty alleviation amongst the HIV and AIDS infected population.

Special attention has to be paid to recruitment and training of more based carers and counsellors.

More support groups for people living with AIDS have to be launched in the municipal area.

3. Care for Orphans

As more children become infected and affected by HIV and AIDS, the need to develop and extend the services currently available will increase.

SECTION E: STRATEGY DEVELOPMENT

1 Prevention, Education and Openness and Awareness

1.1 Problem statement

- There is a lack of co-ordination in implementing effective education programmes
- Lack of enough resources to cover the whole of Merafong City
- Lack of well co-ordinated and inclusive plan/programme
- Lack of community education on available services
- Lack of inclusive and fully represented co-ordinating structure.

1.2 Long term Goal

To reduce new HIV infection by 50% by engaging:

The existence of a fully representative co-ordinating structure with a well co-ordinated comprehensive plan that will ensure that all the people of Merafong City are empowered on all issues related to HIV/AIDS eventually leading to a sustainable reduction of the infection rate.

- Ensuring that the community is well informed and educated and be able to talk openly and freely about the disease and their status
- Effective use of preventative measures to stop once and for all the spread of HIV and AIDS
- Effective coordination of all programmes and initiatives
- Training of more counsellors to provide a professional service
- Ensure that clinics are well equipped to be able to provide education for patients

1.3 Short Term objectives

- To establish an inclusive co-ordinating structure
- To establish an integrated and targeted approach regarding E.P.A.
- To introduce EPA programme to the entire Merafong City
- To improve care and management of STIs
- Ensure continuous evaluations and monitoring
-

KEY FOCUS AREAL 1: INFORMATION, EDUCATION AND CAMPAIGNING

STRATEGIC OBJECTIVE.	KEY TASK	ENABLERS	TIME FRAME
1. Strengthening the current coordinating Structure	• Update data base of all IEC stakeholders • Schedule of regular meeting	• Task team • LAC • budget	August 2019
2. To strengthen / reinforce a comprehensive integrated and targeted approach	• Development of integrated plan of activities • Programme of action • Itinerary of all activities	• Task team • HIV&AIDS TB coordinator • LAC • Budget	August 2019

	(quarterly)		
3. Extend the IEC programme to new established settlements. 4. Strengthen IEC programmes in old settlements	• Conduct an audit of IEC • Remapping re-zoning the area for im plementation	• All stake holders	August 2019
5. Train IEC organizations on the updated information	• Identify all IEC organizations • Identify training partners • Develop/identify training programmes	•	
6. Ensure continuous evaluation and monitoring of the IEC programme	• Monthly meetings • Report and statistics interpretation • Monthly reviews surveys • Quarterly report consolidation	• LAC and • IEC task team	Quarterly

1.4 COORDINATING TEAM REPRESENTATIVE

- (Trinity health)
- (NUM)
- (TAC)
- (HBC)
- (MOTHUSIMPILO)

2 Care for People Living With HIV and AIDS

2.1 Problem statement

There is a lack of Financial, human and material resources, and lack of education on how the community should access available resources and lack of accurate information of people who need CARE in Merafong City.

2.2 Long term goal

To provide care, treatment and support to not less than 80% of people living with AIDS and other terminally ill patients and their families within the Merafong City and to ensure 100% availability of facilities and material.

2.3 Short term objectives

- Ensure that HBC is rendered in all areas of Merafong City
- Establish ward based PWA support groups
- Provide accessible health services to all
- Mobilise and educate the community about HIV/AIDS to change their attitude

- To establish an inclusive co-ordinating structure.

KEY FOCUS AREA 2: CARE, TREATMENT AND SUPPORT

STRATEGIC OBJECTIVE	KEY TASKS	TIMEFRAMES
1. Ensures that HBC services are rendered to all areas of Merafong.	• linking of carers (HBC & field workers) to clinics for tracing and education/awareness • Provide HBC services in mining areas (Blyvoor, Mphahlwa, Mohaleshoek,Blok 8 and all farming communities)	9o days 12 months
2. Establish ward –based PLHIV support systems.	• Linkage between clinics existing support groups • Capacity building of support groups on sustaining operations • Develop an HIV and AIDS services/programs directory • Establish support groups [mining areas] in Greens Park	90 days 6 months 60 days 3 months
3. Provide accessible health services to all	• Lobby and advocate for ARV's to be distributed in mobile clinics	90 days
4. Mobilise & educate the community on improving their attitude towards PLHIV (Stigma)	• Integrate HIV and AIDS services to other PHC servicers. • Continuous education to families and integrate school awareness programme • Encourage disclosure of HIV status. • Involve faith based Organisation in a distigmatisation programme. • Strengthen multi Sectoral collaboration [community forum on HIV and AIDS issue] • Mainstreaming of HIV and AIDS	6 months 90 days 12 months 90 days 6 months

3 Care for Orphans and Vulnerable Children

3.1 Problem Statement

Merafong City has not been able to provide a comprehensive child care service to some orphans in area because of the criterion used to exclude some of the needy orphans who do not qualify.

3.2 Long term goal

To provide comprehensive treatment, care and support package by reaching out to not less that 80% of the people in Merafong who are in need.

To have a well co-ordinated programme that will ensure that all children in distress are well cared for through proper utilisation of existing and potential resources. By doing the following:

KEY FOCUS AREA 3: ORPHANED AND VULNERABLE CHILDREN

STRATEGIC OBJECTIVE	KEY TASKS	ENABLERS	TIMEFRAMES
1. Mobilise resources and support for the OVC	• Establish an educational support system • Train out of school OVCs on basic social skills • Identify potential partners • Develop indicators to measure success	• LAC • Cooperates • CBOs	To be confirmed
2. Recruit and train volunteers on foster care	• Conduct a municipal wide audit • Identify relevant partners or stakeholders • Develop a comprehensive training plan	• NGOs • LAC	
3. Rejuvenate child care committee	• Involve all community based stakeholders • Train members on how to organize committee activities	• LAC • CBOs	
4. Develop an all inclusive database of OVCs	• Combine and audit all existing municipal OVC database • Set up a geographical plan on delivering services	• LAC Task Team • NGOs • HIV and AIDS coordinator	

SECTION E: ISSUES FOR THE MUNICIPALITY

The municipalities' involvement in dealing with the consequences of HIV and AIDS has been limited. However, this workshop has provided the municipality with an opportunity to come to terms with the impact of the pandemic and what is required to reduce the infection rate and care for those who are infected and affected.

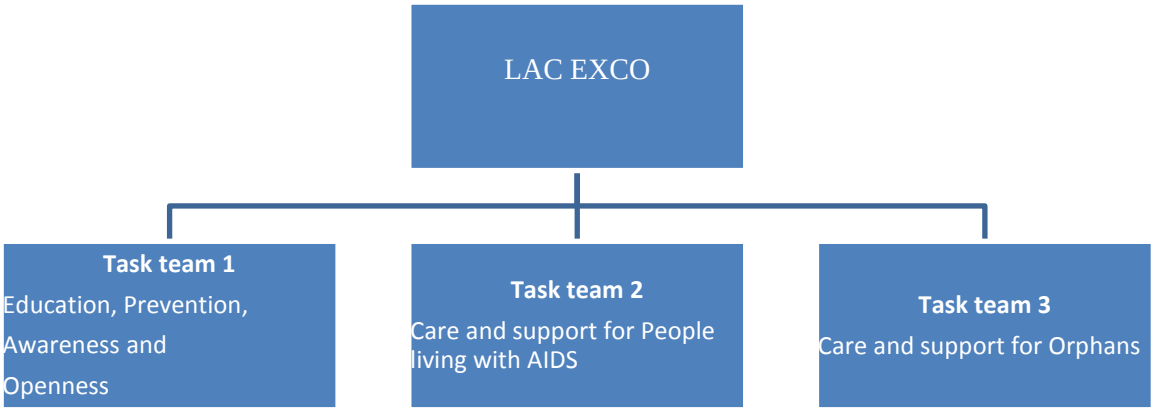
In addition to actively participating in group co-ordinating the fight against HIV and AIDS, the municipality must consider the following:

a. Read, review and make the necessary amendments before adopting this document as a HIV and AIDS working document for the municipality.

- Liaise with all stakeholders involved in HIV and AIDS programmes
- Roll out Education, awareness and prevention programmes for employees of the municipality
- Develop a referral system of available services / programmes and projects in the municipality and how to access them.

c. Encourage Councillors to play a leadership role in education, awareness and prevention programmes and encouraging the community to be accepting of people living with HIV and AIDS.

LAC RECOMMENDED STRUCTURE



Composition of the above-recommended structure

- The Mayor
- Councillor – who is heading the Health and Social development portfolio
- The Manager for Health and Social development
- The HIV and AIDS coordinator
- All the government departments
- NGOs, CBOs and FBOs
- Traditional health practitioners
- Traditional leaders
- Local business
- Task team coordinators
- Taxi and transport operators
- Youth and Women organisations
- Support groups for PLWHAs

Terms of references

TASKS FOR THE CO-ORDINATING STRUCTURE:

Co-ordinating structure/ local Aids Council	**Education, Prevention and awareness task team**	**Caring for PWA**	**Caring for Orphans**
▪ Responsible for overall co-ordination ▪ Work towards establishment of Municipal AIDS council ▪ Serve as a forum for sharing ideas ▪ Mobilise resources for the implementation programmes ▪ Ensure that there is common understanding and sharing of ideas and information between different task teams	▪ Serve as a forum to develop and share programmes among those who are involved in this area of work. ▪ Ensure that there is no duplication of programmes. ▪ Liaise with all that are involved in this area of work. ▪ Work closely with the co-ordinating structure and Local AIDS council	▪ Serve as forum for sharing ideas and programmes ▪ Co-ordinate the work of volunteer care-givers ▪ Work towards elimination of duplication ▪ Work towards establishment of a permanent haven for PWA. ▪ Work closely with co-ordinating structure/ local AIDS council ▪ Ensure recruitment and training of volunteers.	▪ Develop programmes that are aimed at improving the living conditions of orphans/OVCs. ▪ Recruitment of volunteers and ensure their training. ▪ Work towards the formation of AIDS council. ▪ Ensure that data base on orphans is up to date ▪ Work closely with coordinating structure/LAC

ANNEXURE (a)
Terms of Reference

The Constitution of the Republic of South Africa and the Municipal Structures and Systems Acts stipulates that the Local Municipality has a mandate and the responsibility to ensure that communities receive services.

1. The Strategic Framework

- Ensure a comprehensive, co-ordinated, integrated, holistic, cost-effective, and evidence-based and Local wide response to the HIV and AIDS epidemic.
- Mainstreaming HIV/AIDS-Planning and Budgeting.
- Capacity building – establishing and developing a programme of consistence capacity building for managing and implementing the local wide response.
- Resource mobilisation – ability to anticipate the need for resource, where they might be obtained and to secure them as quickly as possible
- Monitoring and evaluation.

2. Objectives of the Local AIDS Council

- To bring together all Local HIV and AIDS stakeholders.
- To allow sharing of knowledge amongst stakeholders.
- To align projects and avoid duplications.
- To access and evaluate projects
- To mobilise resources for Council partnership activities.
- To receive reports of all sectors on responses on HIV and AIDS for the purpose of the monitoring and evaluation of the effectiveness and impact of all sector efforts.
- To review the implementation of programmes and strategies of the Local multi-sectoral response to HIV and AIDS developed within the set frameworks, International, National, Provincial and District.
- To facilitate and support the establishment of the Ward AIDS Councils.

3. Structure and Composition of the Local AIDS Council

- The structure of the Council consists of the Council, Executive Committee and Secretariat.

4. General Council

The following people shall constitute the general council

NAME OF INSTITUTION	REPRESENTATIVES
Local Municipality – X3	The Mayor, HIV and AIDS Co-ordinator, Nominated Councillor
Department of Health / Hospital – X3	Hospital Manager, HIV/AIDS Co-ordinator, Health Services
Department of Social Welfare – X1	Sub-District Manager
Department of Education – X1	Sub-District Manager
Department of Agriculture – X1	Sub-District Manager
Department of Home Affairs – X1	Sub-District Manager

Department of Labour – X1	Sub-District Manager
Department of Public Works – X1	Sub-District Manager
Department of Safety and Security – X1	Sub-District Manager
Department of Local Government and Traditional Affairs	Sub-District Manager
House of Traditional Leaders – X4	Regional Authority Chairperson
Non-Governmental Organisation – X2	
Civic Based Organisation – X1	
Faith Based Organisations – X4	
Business Sector – X2	
Private Health Sector – X1	
Youth Groups – X2	
Women Groups – X2	
Traditional Healers – X2	
People Living With AIDS (PLWA) – X1	
Unions Representatives – X3	
PLWDs – X1	
Other co-opted members – X6	
Department of Housing/ Justice, Media, OVC	

5. Executive Committee

The following positions have been identified

The Executive Chairperson …….His Worship the Mayor
Deputy Chairperson (2)
The Secretariat
The Internal Secretary
Additional EXCO members (5)

6. The Business of Local AIDS Council

- The Council will decide on the number of meetings to be held per year.
- The Council will also decide on the kind of capacity building necessary

7. The Funding

- It will be the responsibility of the Merafong Local Municipality to source out funding necessary for the running of the council.

8. Term of Office

- The term of office of the Local AIDS Council will be two (2) years; provision should be made to ensure continuity there after.

9. Relationship to District AIDS Council (DAC)

- In the absence of a formal or legislative framework that can harness the relationship between the District AIDS Council and the Local AIDS Council effort will be made to forge good working and strengthen relationship in the fight against HIV and AIDS.

10. Relationship to the Ward AIDS Council (WAC)

To strengthen the working relationship with the WAC, the Local AIDS Council should strive to render the following:

- To provide leadership to the WACs and assist in mobilising the resources for WACs activities
- To ensure an ongoing communication and information dissemination to the WACs
- To promote joint undertaking of programmes, activities, campaigns, etc. With the WACs.