Dihlabeng LAC HIV strategy

HIV and AIDS Strategy

2010 – 2012

Contents

INTRODUCTION

HIV and AIDS is a global challenge that is unprecedented. Its impact has changed the political, social, economic and cultural landscape of our society. Response to its multi faced challenges requires an unprecedented approach that brings together all sectors and sections of our society. Success to reduction of its spread and impact requires both leadership and commitment at all levels of society. Individual efforts cannot match the challenge posed by the HIV and AIDS pandemic.

The impact of HIV and AIDS pandemic has a potential of reversing the achievements and progress that the human kind has made over centuries. The socio-economic development of our society is adversely affected by the spread and the negative impact of this pandemic.

All corners of the world are feeling the impact of HIV and AIDS as it destroys the future of their population and eliminating the economic achievements. The HIV and AIDS pandemic have affected the African continent in high proportions with the sub - Saharan region registering the highest incidences of HIV infection and death toll. High poverty levels, conflicts and poor infrastructural developing are some of the contributors toward the spread of the pandemic.

South Africa is one of the countries with high HIV prevalence. It is estimated that over 5.5 million people are living with the HI virus and 1.5 million children will be orphaned by 2010. More people are getting sick and some are dying due to HIV and AIDS related sicknesses.

Families are faced with the burden of caring and supporting for the sick and have to cope with the pain of seeing one of them dying. The economic situation of families is severely changed since the disease usually attacks the individuals who are economically active and are the supporters and providers for the family. The elderly and children are left with nothing and they are forced to live a difficult life and survive with meagre resources and state support.

The infected and affected individuals and their families should not be left alone to engage this pandemic, communities and the society in general should be mobilised to be actively involved in the fight against the spread and impact of HIV and AIDS pandemic. Response to the disease is bigger than government alone; it needs effective co-ordination, effective leadership, commitment and broad collaboration that bring together government, civil society organisations and the private sector.

Effective response to HIV and AIDS challenge nationally is based on four main broad fronts which are:

- Prevention of new infections;
- Access to treatment and literacy;
- Care and support for the infected and affected; and
- Promotion of human rights and justice

The United Nations (UN) AIDS agencies are leading the world initiatives to ensure the reduction of new infections and provision of care and support for the infected and affected. This world body has made a call to all governments to work with civil society organisations and the private sector in developing and co-ordinating national response to HIV and AIDS pandemic.

The South African government in partnership with civil society and private sectors has dedicated time, energy and resources to the fight against the pandemic. The national response is guided by a comprehensive multi-sectoral National Strategic Plan (NSP), which is reviewed every five years.

The NSP is based on a holistic approach that 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 project

The NSP has identified two broad goals which are:

- The reduction by 50% of new infections;
- Ensuring that 80% of those who are infected have access to many services that will make them live longer and healthier lives.

To achieve the above objectives, the multi-sectoral response has to be intensified and it should address and provide guidance on how to:

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

National and provincial spheres of government are not always strategically placed to guide the implementation of programmes based on the needs and realities at local level. This weakness has in most cases resulted in implementation gap between national strategies and local responses. Municipalities are therefore better placed to bridge this gap as they are a sphere of government that is closest to people.

Municipalities are ideally placed to lead and co-ordinate effective response. Municipalities' location makes it possible for them to promote and guide policy and service development using inclusive and participatory processes. The co-ordinating role of municipalities includes:

- Ensuring that participation mechanisms are sufficiently accessible and 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 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 Integrated Development Plans (IDP) and other programmes;

To ensure an effective response to HIV and AIDS, we need to mount an offensive that brings together all sectors and sections of our society. This multi-sectoral response, should consider the political, economical, developmental gender, social, cultural and human rights aspects of the pandemic.

Our response to the pandemic has to explore and embrace new innovative strategies and plans that establish new and enhance old partnerships. The fight against HIV and AIDS has to be based on the experiences and programmes that already exist within our communities.

The Alliance of Mayors' initiative for community action on AIDS at the local level (AMICAALL) together with South African Local Government Association (SALGA) made a call to all African local government leaders to ensure that municipalities play a central role in facilitating and co-ordination of local responses.

In heeding this call, the Dihlabeng municipality and its leadership initiated the establishment of the local multi-sectoral AIDS Council to facilitate and co-ordinate all response that are mounted against the spread and mitigating impact of HIV and AIDS. To ensure an effective and well co-ordinated response, Dihlabeng municipal AIDS council convened a workshop on the **04th 05th February 2010** and it was attended by the different stakeholders to develop this local HIV and AIDS strategic plan.

The workshop was facilitated by Education and Training Unit (ETU) had the following objectives:

- To understand the facts about and impact of HIV and AIDS on our municipal area;
- To share best practice on responses to HIV and AIDS;
- To develop a broad local strategy to deal with prevention of more infections and care for those already affected;
- To strengthen co-ordination structure; and
- To develop a broad way forward

This strategic plan is a product of that workshop's deliberations by the different stakeholders and it has four separate but interlinked sections which are:

- Impact analysis of HIV and AIDS in Dihlabeng municipality:
  To ensure effective response to any physical or social challenge, it is important to look at the extent of the problem. In this section of the strategic plan, we are looking at the impact of the disease in Dihlabeng Municipality. This analysis is done by focussing on:

  - Impact on family and children;
  - Community and poverty;
  - Service delivery (especially health, welfare and education)
  - Local economic development

- Municipal situational analysis
  In this section of the strategic plan, we do analysis of the critical issues that have a potential in exacerbating or curbing the spread of the HIV and AIDS in the municipality. This analysis is done by looking at:
  - The municipal profile
  - Population and household breakdown
  - Income distribution
  - Age and gender profile
  - Water and sanitation
  - Education
  - Access to health services
  - State of the local economy

- Dihlabeng Local AIDS council HIV and AIDS strategy

Section four of the document is dedicated to the strategies that can be implemented in Dihlabeng municipality to ensure effective response to HIV and AIDS. Dihlabeng HIV and AIDS strategic plan is divided into three strategic areas which are:

- Education , awareness and prevention;
- Care and support for people living with HIV and AIDS; and
- Care and support for orphans and vulnerable children.

- In each of these three strategic focus areas we:
  - Define the goal that we want achieve to ensure effective local response;
  - Analyse the current situation and challenges and at the same time, we all also define the situation we would like to see in future;
  - Look at the outputs and approaches towards the implementation.
- Co-ordinating the local response

The last section of the strategic plan focuses on the structural arrangements that are needed to ensure effective response to HIV and AIDS.

MUNICIPAL SITUATION ANALYSIS

Geographic Profile:

The area of jurisdiction of the Dihlabeng Local Municipality is situated in the Thabo Mofutsanyana District Municipality region. The total estimated population in the urban areas, according to community survey 2007, is 108 449 with 31 836 households The general tendency of migration from rural to urban areas is also occurring in the area, as is the case in the rest of the Free State Province. The majority of the rural population is active within the agricultural sector. Dihlabeng Local Municipality consist of five towns namely Bethlehem, Paul Roux, Rosendal, Clarens and Fouriesburg.

VISION:

To be a municipality committed to provide effective services to its community.

MISSION:

To provide effective and efficient people centered governance that will facilitates the developmental role of local government.

STRATEGIC OBJECTIVE:

To deliver sustainable services.
To provide quality, accessible and affordable services to all Dihlabeng community.
To promote social and economic development.
To create a safe and healthy environment.
To encourage communication and community participation.

Population of the District per municipality according to Community Survey of 2007

Municipality	**Persons**		**House Holds**	
	Census 2001	**Census 2007**	**Census 2001**	**Census 2007**
Dihlabeng Local Municipality	**128 929**	**108 449**	**33 027**	**31 836**

Persons		**Households**	
2001	2007	2001	2007
128 929	108 449	33 027	31 836

Current HIV Prevalence

Around 5.7 million people in South Africa were infected with HIV/AIDS in 2008 and it is estimated that HIV kills 1000 people every day. HIV prevalence varies considerably between province, population, gender and age groups. Women bear the brunt of the HIV epidemic and account for 55% of people affected by HIV. KwaZulu Natal has the highest prevalence (25.8%) with the Western Cape with the lowest prevalence (5.3%). Communities in informal settlements who are often also the most underdeveloped, with poor access to social services including HIV/AIDS prevention, treatment, nutrition and care programs are more affected.

Legal and policy framework for municipal response

Mandate of Municipalities

The developmental agenda of the South African government mandates municipalities to be play a critical role in developing strategies and programmes that seek to improve people's lives for the better. As part of this agenda, municipalities are expected to ensure co-ordination and facilitation of initiatives that aimed at preventing the spread of the HIV and AIDS as it seeks to reverse the democratic gains made by government.

Municipalities are responsible for ensuring the prevention of new infections and spread of the disease and initiate programmes that will mitigate the impact on both the infected and affected.

Municipalities are responsibility for their own organisation, strategic planning, programme development and implementation, monitoring and evaluation of municipal response to the HIV and AIDS challenge. The municipal response to HIV and AIDS is guided by both the South African constitution and other pieces of legislation passed by the national Parliament and provincial legislatures.

Constitutional and Legislative Framework

The South African constitution is calling for the improvement of the quality of life of all citizens and freeing the potential of each person. The South African constitution also protects the rights of each every citizen and their rights. According to section 27 of Chapter 2 of the constitution deals with the Health Rights and it outlines these rights as that:

- everyone has a right to have access to:
    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,

These basic rights are expected to be enjoyed by all citizens of this country. This is the serves the foundation for the government and other stakeholders' response to HIV and AIDS challenge.

The municipal response to HIV and AIDS finds its expression in the Section 153 of the Constitution which outlines the duties and responsibilities of a developmental state. This section tasks the local government structures with the responsibility to structure and manage its administration, budgeting and planning process to give priority to the basic needs of the community and to promote its social and economic development.

The local government response to HIV and AIDS is further re-enforced by a number legislative policy frameworks. These include:

- 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;

- the municipal systems act (2000) which establishes a framework for the processes of planning, performance management, resources mobilisation and organisational change within municipalities

The HIV and AIDS pandemic represent itself in a multi dimensional nature and it therefore necessitates a multi-sectoral and integrated response based on an integrated partnership. This response should provide

the different stakeholders involved in the fight against the pandemic with ammunition to effectively engage the challenges posed by the HIV and AIDS pandemic.

Guiding documents

The municipal response to HIV and AIDS challenge is guided by three framework documents which are:

- National Strategic Plan (NSP) 2007 – 11;
- DPLG framework for local government response to HIV and AIDS; and
- SALGA Country Guide for Municipal response to HIV and AIDS.

The National Strategic Plan 2007-11

The National Strategic Plan has identified key principles that should guide the response to the pandemic by all sectors in their approach in response to pandemic. The following are some of the principles identified by the NSP:

- Supportive leadership;
- Leadership role of government;
- Greater involvement of people living with HIV;
- Effective communication;
- Effective partnership;
- Strengthening of care systems;
- Building community leadership;
- Promotion of social change;
- Challenging stigma and discrimination;
- Protecting and respecting children; and
- Tackling inequality and poverty

DPLG Framework

According to the DPLG framework, municipal response to HIV and AIDS pandemic should be guided by the existing development, governance and policy framework. It should also be informed by the developmental, governance and health agenda for South Africa.

DPLG municipal response policy guides:

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

SALGA Country Guide

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

- To promote an effective leadership response for HIV and AIDS ;
- To enhance local government input into policy development and support;

- To increase local capacity for an effective internal response;
- To increase local capacity for an effective external response;
- To promote effective partnerships; and
- To ensure monitoring, sustainability and integration.

Four Broad Response Areas:

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

HIV and AIDS Municipality Response Mapping

Response to HIV and AIDS

- HIV and AIDS is very much inter-linked with *poverty*, *social and economic inequalities* between men and women and long standing cultural behaviours and beliefs;
- HIV and AIDS require a multi-sectoral approach to address its many facets.

The success of the National Strategic Plan and its goals depends mainly on the well co-ordinated, communicated and effective partnership at local level. The NSP further makes a call to all government departments, district and local municipalities to work together with civil society organisation to ensure the development of policies, plans, setting priorities, implementation, monitoring and evaluation mechanisms that will ensure that the national goals are achieved. It then become imperative to map our response and know where currently are our service and whom we target

RESPONSE MAPPING

PROGRAMME PROJECT	**TARGET GROUP**	**LOCATION (in which ward or place)**	**HOW DO YOU MEASURE PROGRESS**	**LEAD IMPLEMENTING AGENCY**	**PARTNERS**
Prevention	All people who are sexually active.	Community at large.	More people testing negative.	DoH and DoSD	DoE, DoCS, SAPS, NGO's, FBO's etc.
Treatment	All patients with CD4 count ≤200 cells/mm3 irrespective of clinical stage **or** CD4 count ≤350 cells/mm3 in patient with TB/HIV & Pregnant woman **or** WHO stage IV irrespective of the CD4 count **or** MDR/XDR - TB	Patient around Dihlabeng Local Municipality Area.	Monthly statistics of new patient enrolling for the ARV's by Department of Health.	Department of Health & TAC	Right to care.
OVCs	All Orphans & vulnerable Children.	Orphans & vulnerable Children. DLM area.	Less Orphans & vulnerable Children in Dihlabeng area.	Child welfare.	DoSD & DDI.

IMPACT OF HIV

Family life and children

We are observing a phenomenon of HIV affecting and infecting not only the most vulnerable but even those whom because of their socio-economic status and their assets also indiscriminately get infected and affected. The most unfortunate thing that happens is amongst if not all those who work and become infected are breadwinners to extended families and this leads to Loss of family income as bread winners become too ill to work,

Poor understanding or little knowledge of the virus leads to mixed emotional responses when either one or both partners is diagnosed HIV positive because of also the stigma that is attached to HIV and in turn all of that disturbs family life and blaming and emotional abuse perpetrated towards women especially becomes the order of the day.

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

Children take a lot of emotional strain after the loss of a loved one, their primary care givers and their support base. When either one of their parents is sick they feel obliged or natural for them to take care of them even if they have to drop out of school and provide an income for the household.

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

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

Community and poverty

With more and more breadwinners becoming sick or ill, family's income become depleted and as the stigma destroys ability of families and community to care for others who are in need poverty plays another vicious cycle that limits development of our community, with more vulnerable children who are not cared and an increase in crime

Health, Welfare and Education services

Each day there is more and more people who become ill or sick demanding medical care and in most cases people just directly present themselves to hospitals bypassing primary health care centres thereby putting a lot of strain on staff in hospitals leading to depression and burnout of health care workers as number in people who need treatment increases. Affected staff becoming unproductive and rendering poor services to the public where Batho Pele principles are violated

Local Economy

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

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

The above also lead to low morale and reduced labour output and therefore reduced production. Fewer products supplied to markets when the demand is big, leads to increase in prices for goods and poor people are worse affected as buying or spending power is reduced with lose of income or loved ones who are breadwinners.

DIHLABENG MUNICIPAL HIV STRATEGY

PREVENTION, EDUCATION AND AWARENESS

Extent of the Problem analysis

A lot of people are resisting going for VCT because they engage in risk behaviour like multi partner relationship through unprotected contribute to the spread of HIV, some because of negligence or ignorance but some because they lack knowledge, few other reasons we can mention are distortions in cultural practices, myths, stereotypes and religious beliefs. Our analyses also led us to conclusion poverty is another major contributor to the spread of HIV in return HIV also exacerbate the spread and effects of poverty.

Lack of Income or unemployment makes families more vulnerable to risk behaviour, exploitation and infection. In some cases even people who have income or better off are vulnerable by virtue of their earnings and assets they are targeted by those who have nothing for transactional sex whereby they provide basic necessities in exchange for sex.

Substances abuse like alcohol and drugs also leads to people engaging in risk behaviour whereby people fail to use condoms increasing the rate of infection in STIs, unplanned pregnancy and HIV. We have also seen a rise in a number of children who become sexually active at a tender age resulting to teenage pregnancy and we make an assumption that (need to conduct a study on effects of) genetically modified foods contributes to hormonal abnormality amongst our children.

Goal

To reduce the infection rate by 50% through ensuring that people practice safe sex; ending discrimination and stigma as well as creating public awareness; understanding and compassion before 2012.

What we need to put in place?

- Improve coordination, communication structures and systems and mobilisation of resources through effective planning within Dihlabeng
- Promote and support establishment of income generation projects
- Upscale and improve our awareness, educational and prevention programme to be extended to all areas not covered and all vulnerable groups not reached including schools and churches before end of 2010
- Encourage and support existing awareness and educational programmes/projects and motivate more people to participate
- Encourage and motivate increased uptake and usage of condoms and other educational material
- Encourage and support healthy life styles and healthy nutrition or diet through extra mural activities and food gardens
- Encourage and support more people to go for VCT also improve provision at all public care centres
- Ensure that each and every employer in Dihlabeng has a workplace policy and runs/implements an effective wellness programme

What is currently available?

Available Services		Where and who is your Target	What are the Gaps
1.	Council of Churches	Ministers Fraternal.	There is poor co-ordination, no database of services and no referral system. Some towns lack resources and other organisations does not have an access to utilize Municipality facilities e.g. Stadium, Community hall, Playground etc.
2.	Dihlabeng Development	All wards / Community.	
3.	Christian Response to HIV and AIDS	Only in BHM / Maxima Bible Church.	
4.	Department of Social Development	Identified Affected Families.	
5.	Department Health	Community of DLM area.	
6.	SAPS	Community of DLM area.	
7.	Traditional Leaders	Clients and members of the community.	
8.	Child & Family Welfare	DLM (Children & Families.)	
9.	Catholic Community Service	Community of Dihlabeng.	
10.	Love Life & goGogetters.	Youth 12 – 17 of age and adults if there is a need.	

Objectives

Objective:	How	Lead implementing agent	Partners	Resources

1	Increase and improve access, availability and uptake of VCT services.	Lobby and insist that DoH entrenches Batho Pele principles in all our public health care centres.	LAC	FBO's, NGO's, Traditional Healers etc.	DLM, DOH,
		Educate and encourage public to go for VCT.	DOH started with door to door campaign for HCT.	DoE, DOCS, SAPS, NGO's, FBO's, Love life etc.	DOH
		Identify recruit and train lay counsellors staying in close proximity to all our VCT sites.	Department of Health.	Right to care and other relevant.	DOH & SDU
2	Encourage and support healthy life styles and healthy nutrition or diet through extra mural activities and food gardens.	Educate people about importance having affordable healthy nutrition through backyard and communal food gardens growing their own food.	LAC	DoH, DOSD, DOA and other relevant stakeholders.	DLM
		Lobby the municipality and department of health and department arts sports and culture to utilise municipal facilities like community hall for extra mural activities working with, Sport unions and arts cultural bodies.	Local Aids Council	DoE, DoCS, SAPS, NGO's, FBO's, Love life, NGO's, Traditional Healers etc.	Dihlabeng Local Municipality.
3	Improve and extend education and awareness services to all areas not currently covered.	Develop a database of all educational and awareness services within Dihlabeng.	LAC	Relevant stakeholders.	
		Lobby and coordinate all service providers to extend services to places not covered and avoid duplication.	DoH	All stakeholders.	LAC
		Develop a referral, tracking and reporting tool.	DOH	Relevant stakeholders.	DOH
		Ensure that educational and awareness propaganda is culturally and generationally sensitive as well as appropriate language and methods are utilised reach out to different target groups.	LAC	All stakeholders.	LAC and other stakeholders.

		Ensure that IEC material is appropriate and relevant for groupings like conservative, illiterate, living with disability, gay and lesbian, refuges and illegal emigrants as well as schools.	Love life	Tshehetsanang Support Group & other relevant stakeholders.	LAC
		Identify recruit and train volunteers to become Peer educators for each target group.	DOH	Right to Care, Love life and goGogetters.	DOH
4	Improve provide targeted condom distribution to all high risk areas and people.	Conduct research on high risk places that drive the spread of new infection with in Dihlabeng.	DOH	All stakeholders.	DOH
		Prioritise target places and groups according to analyses of need and uptake for an appropriate allocation and provision of condoms.	DOH	Relevant stakeholders.	DOH
		Conduct a sustainable condom distribution of both male and female condoms.	DOH	Right to care	DOH
5	Effective planning, coordination and mobilisation of resources.	Ensure integration of the LAC strategy in the IDP and mainstreaming by all line departments.	DLM	LAC / DLM & DAC	DLM
		Ensure that local business is part of planning from the beginning and fundraise in actual resource items we need for implementation not money.	LAC	All Business partners.	All Business partners.
	Ensure that each and every employee in Dihlabeng has a workplace policy and runs/implements an effective wellness programmes.	The municipality to take a lead in developing a workplace policy and wellness programme through HR unit and labour union reps.	DLM	Councillors and Unions.	Dihlabeng Local Municipality
		Compile data of all employees within	LAC	Relevant	DOH, DOL &

		Dihlabeng and a survey of which one of them do not have workplace policy and not implementing and effective wellness programmes.		Stakeholders.	Unions
		Target employers not yet having a policy and operating a wellness programme.	LAC	Relevant Stakeholders.	DOH, DOL & Unions

TREATMENT CARE AND SUPPORT

Extent of the Problem analysis

People are afraid to test because of lack in information, being stigmatized and ignorance as a result many of them go for testing when they are already ill, with a very weak immune system and a long waiting period to access ARVs. We also have insufficient or inadequate health care services because of poor staffing or shortage of, poor management and insufficient stocking or shortage of medication, shortage of doctors and staff in primary health care clinics which consequently lead to patients jumping PHC level to hospitals and therefore staff over worked and treating patients in a poor manner, with patients refusing to go to hospitals and complaining.

Insufficient or poor emotional support systems as there are not enough lay counsellors and support groups (who are functional with sustainable programmes) leave people who are living with the HI virus not knowing what is the next step or who to talk to or thinking it's the end of the road, suicidal and scared to disclose. Accessibility to clinics is one of the big problems for people living with HIV who are on ARVs with regards to medication collection as the distance to ARV sites is long and there are no few ambulances and patient transport within Dihlabeng municipality resulting to patients particularly those who can't travel to clinics defaulting from medication

There are not enough people who volunteer (especially men) for Home Base Care services, even some of those who participate drop out of the service programme because of stipend leading to those who remain over worked and many of the terminally ill people not covered by available HBC services. The sustainability of the programme is also threatened as many of our volunteers get burnt out because of no debriefing counselling support service for HBC volunteers

There is a problematic communication gap between clinics and hospitals especially when there is a very poor referral system between hospital, clinic and HBC resulting in people who are living with HIV and at the stage of AIDS falling between the cracks with no follow up HBC services. Lack or nonexistent of nutrition is a big problem that leads to people being unable to take medication and defaulting especially when there is no income or earnings or disability grant that is paid out after a long time, unhealthy coping mechanism like alcohol abuse.

Goal

Reduce the number of people who are ill with HIV or who die from AIDS by providing medical treatment, physical care and emotional support to 80% of people who need it by 2012.

What we need to put in place?

- We need to establish a task team involving all relevant sectors and stakeholders that will coordinate all treatment care and support programmes within the municipality before end of May 2010
- Insist or lobby that Department of Health entrench Batho Pele principles and values and improve how public health care workers communicate and treat recipient of their services by end of June 2010
- Develop and implement a simple and easy to use referral system before the end of June 2010
- Facilitate and support establishment of support groups that are functional and have sustainable programme together with organisations of PLWHA, clinics and churches before the end of 2010
- Lobby and assist Department of Health to recruit and train localised lay counsellors staying in close proximity to public health care centres and ensure that they get a salary or stipend as from January 2010
- Lobby both department of Health and Public Transport for an effective transport system including patient buses assigned to specific clinics as well as public transport with convenient pickup points before June 2010
- Recruit and train more HBC volunteers especially men in each every town in Dihlabeng and conduct regular debriefing counselling sessions at least twice a year before end of 2010
- Together with department of Agriculture and Health encourage and support establishment of back yard and community food gardens as well as soup kitchens in each and every town of Dihlabeng to be coordinated and managed by locals together with CBOs, NGOs and FBOs before end of 2010

What is currently available?

Available Services		Where and who is your Target	What are the Gaps
11.	Thusanang HBC	Clarens	
12.	Hlokomela wa heno.	Clarens, Rosendal, Fouriesburg, Paul Roux and Bethlehem	
13.	Mobile clinic I & II	Clarens, Fouriesburg	
14.	Public primary health care centre (clinic)	Clarens, Rosendal	
15.	Itshepeleng HBC	Rosendal	
16.	Bambanani	Fouriesburg	
17.	Reitumetse	Fouriesburg	
18.	Ratanang	Paul Roux	
19.	DDI	Bethlehem	

20.	Khauhelo	Bethlehem	
21.	FS care in action	Bethlehem	
22.	Golden Gateway	Bethlehem	
23.	Dihlabeng Hospital	Bethlehem	
24.	Bohlokong clinic	Bethlehem	
25.	Mphohadi clinic	Bethlehem	
26.	Phekolong Hospital	Bethlehem	
27.	Bakenpark clinic	Bethlehem	
28.	Tsotello	Bethlehem	
29.	Bohlokong Hospice	Bethlehem	
30.	Catholic Community Services	OVC's Bethlehem & Rosendal	
31.	Bethlehem Clinic	Bethlehem	

Objective

Outputs: What must be put in place to archive our goal (Clear and measurable objective)		**How will we Implement? Broad Approach**	**Drivers or lead implementer**	**possible partners**	**resources needed**
1.	We need to establish a task team involving all relevant sectors and stakeholders that will coordinate all treatment care and support programmes within the municipality before end of first quarter of 2010	Bring together all relevant social partners providing services to PLWHAs and sensitise them on need to form part of a coordinating structure for effective implementation	Committee of Care.	DoH, DoSD, DoE, Churches, HBCs', TAC etc.	LAC
2.	Insist or lobby that Department of Health entrench Batho Pele principles and values and improve how public health care workers communicate and treat recipient of their services by end of June 2010.	Compile a data of public health care centres where services are poor and the public is complaining. Convene a lobby session with DoH in order to bring it to their attention.			
		Empower the public on service standards they should expect and what channels to follow for			

		recourse.			
3.	Develop and implement a simple and easy to use referral system, also lobby or insist that Department of Health or Public Works and Roads to equip our public health care centres with communication infrastructure and equipment before the end of June 2010.	Conduct research on the plight or situation of OVCs			
		Convene lobby sessions to highlight the situation in our public health care centres.			
4.	Facilitate and support establishment of support groups that are functional and have sustainable programme together with organisations of PLWHA, clinics and churches before the end of 2010.	Brain storming on viability of programmes and prioritise those addressing directly plight of PLWHAs and affected families.			
5.	Lobby and assist Department of Health to recruit and train localised lay counsellors staying in close proximity to public health care centres and ensure that they get a salary or stipend as from January 2010.	Conduct research on the situation of public health care centres, community needs and gaps.	LAC	DOH	
		Convene lobby sessions with department of health department.			
6.	Lobby both departments of Health and Public Transport for an effective transport system including patient buses assigned to specific clinics as well as public transport with convenient pickup points before June 2010.	Compile information on the number of people and areas in need, as well workout pickup points for			
		Convene lobby sessions with department of health department.			
7.	Recruit and train more HBC volunteers especially men in each every town in Dihlabeng and conduct regular debriefing counselling sessions at least twice a year before end of 2010.				
8.	Together with department of Agriculture and Health encourage and support establishment of back yard and community food gardens as well as soup kitchens in each and every town of Dihlabeng to be coordinated and managed by locals together with CBOs, NGOs and FBOs before end of 2010.				

CARE AND SUPPORT FOR OVCS

Extent of the Problem analysis

We have an unconfirmed number of children who are vulnerable because in families they come from parents are either unemployed, abusing substances like alcohol and drugs or breakdown in family life because of domestic violence or death of one or both parents resulting from HIV related illnesses. What makes the situation even worse is that there are no effective coordinated efforts to assist OVCs within our municipal area. As a result of HIV and AIDS our communities are faced with a number of challenges which include:

- An increase in the number orphaned and vulnerable children in our communities;
- Many children having to leave school in their early stages of their academic lives as result of lack of parental guidance and support as well as poverty;
- Most our communities in Dihlabeng are registering an increase in the number of child headed families;
- Children involved in transactional sex as means of survival;
- Increase in the number of children of children involved in substance abuse and drugs and other criminal activities and being exposed to criminal elements;
- Children being abused by foster parents and the support they get from government not being properly utilised for their benefit.

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

Goal

To support orphans and vulnerable children by making sure they have adequate access to grants, education, nutrition and parental support to stay and complete schooling

What we need to put in place?

- Compile a data base of all OVCs, available services to them and data of service providers.
- Establish structure like child care forums and ward based AIDS councils to plan and implement programmes helping OVCs where ever they are and whatever their problems may be.
- Conduct effective outreach information sessions targeting high risk prioritised areas educating the public about the plight of OVCs and available services or help like government grants as a way of mitigating effects of HIV on children and affected families.
- Improve outreach educational programmes encouraging our communities to take active part in caring for vulnerable children
- Establish a relief bank where we mobilise and store resources for vulnerable children
- Establish a trauma centre as an emergency response but linked to other community responses as way of ensuring that children are integrated to communities they belong to
- Facilitate encourage and support big brother/sister and guardianship programmes involving all those people in the community who are affording and wanting to do something but don't know how
- Facilitate encourage and support establishment of support groups like soul buddies and peer educators.

What is currently available?

Available Services		Where and who is your Target	What are the Gaps
1.	Dihlabeng OVC Forum	OVC's	Dihlabeng OVC Data base.
2.	Child Welfare	OVC's	
3.	Golden Gateway Hospice	OVC's	
4.	DDI	OVC's	
5.	Hlokomela wa heno	OVC's	
6.	Catholic Community Service	OVC's	
7.	Care South Africa	OVC's	
8.	DOSD	OVC's	
9.	DOE	OVC's	
10.	CDW's	OVC's	
11.	Mothepuwa Public School	OVC's	
12.	Save the children UK	OVC's	
13.	Legal Aid Board	OVC's	
14.	Thabang CCF	OVC's	

What is currently available?

Objective

Outputs: What must be put in place to archive our goal (Clear and measurable objective)		How will we Implement? Broad Approach	Drivers or lead implementer	possible partners	resources needed
1.	Compile a data base of all OVCs, available services to them and data of service providers.	Develop data collection tool	Child Welfare	Relevant stakeholders with OVC forum.	Training & stationary
		Identify recruit and train partner or volunteers on	DOSD	OVC forum	Training

		how to use the tool collecting data and collating it into one database			
2.	Establish structure like child care forums and ward based AIDS councils to plan and implement programmes helping OVCs where ever they are and whatever their problems may be.	Utilise collated data base of all services and mobilise all social partners providing services, lobby them to form part of the coordinating structure in each ward	OVC forum	Relevant stakeholders.	LAC
3.	Conduct effective outreach information sessions targeting high risk prioritised areas educating the public about the plight of OVCs and available services or help like government grants as a way of mitigating effects of HIV on children and affected families.	Establish drop in centres to support children after school with nutrition, home work and parental care and guidance	Child Welfare & OVC forum	Relevant stakeholders.	Child Welfare & LAC
		Vulnerable children to get packaged services like food parcels, child grant, school nutrition, exemption from school fees and so on	OVC forum	Relevant stakeholders.	LAC & OVC forum
		Improve outreach educational programmes encouraging our communities to take active part in caring for vulnerable children	OVC forum	Relevant stakeholders.	LAC & OVC forum
4.	Establish a relief bank where we mobilise and store resources for vulnerable children	Identify property that can be utilised as a storage facility	Child Welfare have proposal	OVC forum	Funding & Donations.
		Mobilise community to donate resources like clothing, food, study aids, money including their own time to serve	LAC & OVC forum.	All stakeholders.	Storage.
5.	Establish a trauma centre as an emergency response but linked to other community responses as way of ensuring that children are integrated to communities and families they belong to	Lobby relevant institution or social partners to identify land and mobilise resources to build a centre	SAPS & DOSD	OVC forum	
		Identify and recruit professionals to donate their time as doctors, psychologists, counsellors and staff.	DOSD & DOH	Right to care.	
		Link the centre to other facilities and social partners like SAPS, churches, schools, DoSD,	DOSD & OVC forum.	Relevant stakeholders.	

		SASSA, Hospitals and clinics			
6.	Facilitate encourage and support big brother/sister and guardianship programmes involving all those people in the community who are affording and wanting to do something but don't know how?	Identify and recruit volunteers to avail themselves to serve as big brother/sister or guardian to orphans and vulnerable children but with in a protected safe and controlled environment by DoSD.	OVC forum	Child Welfare & DOSD	OVC forum
7.	Facilitate encourage and support establishment of support groups like soul buddies and peer educators.	Identify recruit and train children as peer educators.	DOH	DDI & Golden gateway hospice.	
		Work with schools and churches to establish soul buddies.	DOE & Love life.	Relevant stakeholders.	

IMPLEMENTATION PLAN:

Awareness Education and Prevention				
Three – Five Year Goal	**One year Objective 1**	**Broad Approach for:**	**Lead Implementing Agent**	**Possible Partners**
To reduce the infection rate by 50% through ensuring that people practice safe sex; ending discrimination and stigma as well as creating public awareness; understanding and compassion before 2010.		***1st Quarter:*** Launching of HCT at Thabo Mofutsanyane district on the 20 August 2010.	LAC & DoH	Right to care, Elizabeth Leaser, Care & other relevant stakeholders.
		2nd Quarter: Preparation for world Aids day 01 December 2010. Child protection week – conjunction with OVC's. Elicit drug trafficking education.	DoH & LAC OVC forum Child Welfare	All relevant stakeholders.
		3rd Quarter: HIV and AIDS and Human trafficking education – puppets.	Child welfare	
		4th Quarter:		

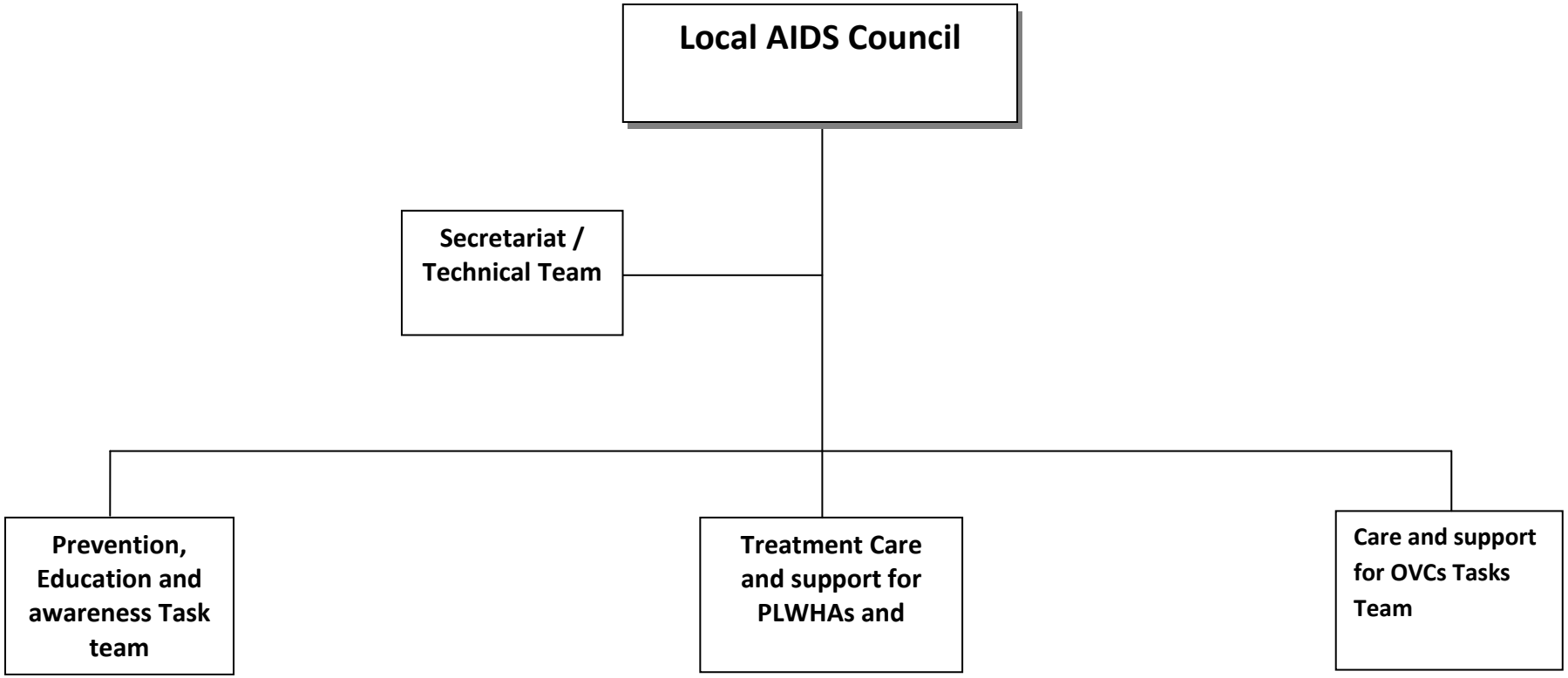
Treatment Care and Support				
Three – Five Year Goal 1	**One year Objective 1**	**Broad Approach for:**	**Lead Implementing Agent**	**Possible Partners**
Reduce the number of people who are ill with HIV or who die from AIDS by providing		***1st Quarter:***		
		2nd Quarter:		

medical treatment, physical care and emotional support to 80% of people who need it by 2012.				
		3rd Quarter:		
		4th Quarter:		

Care and Support for OVCs				
Three – Five Year Goal 1	**One year Objective 1**	**Broad Approach for:**	**Lead Implementing Agent**	**Possible Partners**
To support orphans and vulnerable children by making sure they have adequate access to grants, education, nutrition and parental support to stay and complete schooling.	Effective linkages and formalised referral protocols.	***1st Quarter:***		
		2nd Quarter: Child protection week. May 2010.	Dihlabeng OVC forum.	All stakeholders.
		3rd Quarter: Care givers wellness day - Woman's 09 August 2010.	Dihlabeng OVC forum and Child welfare (Budget).	All stakeholders
		4th Quarter: Inheritance and succession planning information day (Community awareness). 10th September 2010.	Dihlabeng OVC forum and Child welfare (Budget).	All stakeholders.

CO-ORDINATION MECHANISMS:

Diagram Illustrating the Dihlabeng LAC structure



Terms **Reference**

The Dihlabeng Local AIDS Councils has setup Subcommittees as follows:

PREVENTION SUBCOMMITTEE

1. DoHSS
2. DoE
3. Child Welfare
4. Churches and
5. Others who are strategic and relevant

TREATMENT CARE AND SUPPORT SUBCOMMITTEE

1. HBCs (once they get themselves organized)
2. DoH
3. DoSS
4. TAC
5. NAPWA
6. DALA
7. Churches and
8. Others who are strategic and relevant

CARE FOR OVCs

1. DoH
2. DoSS
3. Home Affairs
4. DoE
5. SASSA
6. DPLG
6. SAPS

9. Child Welfare
7. Golden Gateway Hospice
8. Legal Aid Board
9. Motshepuwa Public School
10. Thabang CCF
11. Save the children
12. CDW's and
13. Others who are strategic and relevant

LAC MEETING SCHEDULE:

1. At least once in every three months
2. Urgent meetings will be called when necessary

MONITORING AND EVALUATION:

WILL BE FINALIZED BY THE SECRETARIAT AFTER REVISING TARGETS AND TIME LINES, FROM THAT DEVELOP INDICATORS FOR EACH TARGET AND FORMULATE A REPORTING TOOL THAT WILL BE BASED ON THE TARGETS AND INDICATORS

COMMUNICATION STRATEGY:

For a multi-sectoral structure like an AIDS Council communication strategy requires the following:

- Broad communication approach,
- Carries our idea or key message as contained by the strategy,
- Inter-sectoral communication that is between and amongst sectors or social partners and
- Internal operational communication

An effective strategy requires broad societal involvement and effective co-ordination among all stakeholders.
For now we focus on broad approaches for communication informed by the strategy and implementation plan and we are going to deal with the detail of slogans, campaign identity, media plan, PR plan, who drives the process and who implement each step at secretariat level.

Goals	Key Message Themes.	What we intend to achieve?	Our Target group and their communication needs?	Required communication events?	Method and frequency.	Resources