

Volume 4: Swakopmund

Impact Assessment of HIV/AIDS on the Municipalities of Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek

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for

**the municipal authorities of
Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek,
on behalf Family Health International (FHI) and USAID/Namibia**

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Acronyms

AIDS	Acquired Immune Deficiency Syndrom
ALAN	Association of Local Authorities in Namibia
ASO	AIDS Support Organisation
ARV	Anti Retroviral
EAP	Employee Assistance Programme
EPZ	Export Processing Zone
FGD	Focus Group Discussion
FHI	Family Health International
GDP	Gross Domestic Product
GRN	Government of the Republic of Namibia
HEARD	Health Economics and HIV/AIDS Research Division
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KAP	Knowledge Attitudes and Practices
KII	Key Informant Interview
MOHSS	Ministry of Health and Social Services
MRLGH	Ministry of Regional and Local Government and Housing
NALAO	Namibia Association of Local Authorities Officers
NISER	Namibia Institute for Social and Economic Research
NEPRU	National Economic Policy Research Unit
NGO	Non Governmental Organisation
PLWA	People Living with AIDS
SADC	Southern Africa Development Community
SIAPAC	Social Impact and Policy Assessment Corporation
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAG	Story with a Gap
USAID	United States Agency for International Development

Executive Summary

Introduction

Namibia has one of the highest rates of HIV infection in the world, and the epidemic is affecting every aspect of Namibian society. The impacts of the epidemic include a reduction in the population growth rate, alterations to the demographic structure of the population, economic losses through a reduction in Gross Domestic Product (GDP), as well as changes in society at large.

Namibia has based its response on the need to involve all sectors, and it is local authorities, as the level of government closest to the people, that play a key role.

However, the ability of local authorities to respond to the epidemic is undermined because it takes place within the context of the epidemic's direct impacts *on local authorities as well*. Municipalities and councils will lose personnel to the epidemic, due to illness, death, or responding to the illness and deaths of family members. Further, HIV/AIDS increases the costs of doing business, effectively undermining efficiency and reducing turnover, with negative impacts on employment potential and the creation of revenue.

Specifically, this investigation considered the impacts on the five Namibian cities of Ongwediva, Oshakati, Swakopmund, Walvis Bay, and Windhoek. This volume presents the findings for the city of Swakopmund.

As part of their key role in responding to the epidemic, five Namibian municipalities requested support to commission assessments to determine impacts and plan their responses to the challenge. This initiative signalled one of the world's first local authority impact assessments, and the municipalities deserve credit for their foresight. Specifically, this investigation considered the impacts on the five Namibian cities of Ongwediva, Oshakati, Swakopmund, Walvis Bay, and Windhoek. This volume presents the findings for the city of Ongwediva.

HIV/AIDS

Antenatal sero-surveillance surveys are routinely used to measure adult HIV prevalence and are undertaken in Namibia by the Ministry of Health and Social Services (MOHSS). All prevalence data in this report is based on these surveys. The last such survey completed by MOHSS was in 2000, when the antenatal prevalence rate for Swakopmund was 22%. This is equivalent to the national HIV prevalence rate, and may likely result from high levels of immigration into the town by individuals seeking employment and an urban base.

The implication of this HIV prevalence rate is that over one-fifth of the adult population in Swakopmund (those aged 15 to 49+ years of age) are now likely to be infected.¹ Should the epidemic continue to follow past trends, prevalence should peak sometime between 2007/2008 at 26% and is projected to remain at that level for the foreseeable future. However, there is no reason to assume that it will indeed peak as projected, other than this is what the Namibian-accepted model says. Indeed, Namibia may follow Botswana's example and have rates of up to 50%. This suggests that there will be a need to update model findings as new data become available.

The data presented in this Assessment are based on projections derived from models of the demographic impact of HIV/AIDS on the general population. The assumptions used to develop the models are fully discussed in Annex B contained in Volume 7. It is, however, important to note that the assumptions used are based on official Ministry of Health and Social Services and Central Bureau of Statistics data, and were discussed and agreed at progress meetings held with Council officials prior to their incorporation in the model.

¹ Antenatal surveillance is routinely used to measure adult HIV prevalence. This fact is often hotly debated, with the belief often that it over-estimates prevalence. Studies elsewhere in the region indicate that, particularly earlier in the epidemic, antenatal prevalence does roughly equate with adult prevalence in the general population. As the epidemic matures, however, it may become an *underestimate* of adult prevalence, as HIV reduces fertility.

The projections indicate that slightly over 4,000 people are presently estimated to be HIV-positive, or an estimated 16% of the town's present population of 25,442 individuals. This will rise to 6,000 individuals by 2012 and slightly under 8,000 in 2021.

The data further suggest that close to 550 people in Swakopmund have died as a result of AIDS. By 2010 the figure is likely to be close to 5,000 individuals. The 4,500 AIDS deaths expected between now and 2010 are largely unavoidable, because these will result from existing HIV infections. However, it is extremely important to note that many of the projected deaths from 2010 onward could be avoided *if* future HIV infections can be reduced. By 2021, cumulative AIDS deaths are expected to exceed 12,000, *but many of these can be avoided.*

AIDS deaths can be reduced by implementing prevention programmes, including those that encourage destigmatisation, wellness and positive living for those infected and, should this become more widely available in Namibia, through treatment.

Population Growth

Despite the HIV/AIDS epidemic, the projections indicate that Swakopmund will continue to grow, but at a slower rate, growing mainly because of continued high inward migration from other areas. Current the population of the town is estimated to be about 26,000 people. By 2021, in the absence of AIDS, the population of Swakopmund would be over 60,000 people. However, the epidemic is expected to result in a population of some 49,000 people by 2021, over 18% lower than it would have been without AIDS. This will have implications for the town's planning, service delivery and revenue growth.

The socio-economic impacts of HIV/AIDS on Swakopmund are therefore likely to be severe. This is because of the number of deaths, because those who are dying are in the productive or working age groups, and because these are the workers and parents serving the community.

Economic Impacts

Retail, mining and construction are the major economic sectors of Swakopmund, with tourism also important. All will be affected, to different degrees, by the epidemic. As with all employers, the cost of labour will increase, raising the costs of services offered.

The town's retail sector relies largely on unskilled and semi-skilled labour and the costs of these personnel are unlikely to increase substantially. Further, the market for important elements of the retail sector is supported largely by tourists and will therefore suffer little from changes in demand associated with household impacts of HIV/AIDS.

The mining and construction sectors will experience the most serious impacts. Both are reliant on skilled and semi-skilled labour and staff lost to HIV/AIDS will not be as easily replaced as in the retail sector, except for unskilled labourers. The costs associated with HIV/AIDS for these sectors are likely to be larger. The impact on the sectors will, however, differ.

The effects of illness and death resulting from AIDS are also felt both by individuals and the households in which they live. Infected individuals experience lowered income as they become unable to work. Access to money becomes more difficult, and medical and other expenses increase. The situation is similar at the household level, as individual illness often results in a reduction in household income or production. The impact is then further exacerbated as productive activities and labour resources across the household are diverted towards the care of ill household members resulting in changes in the level and composition of the goods and services they demand. Retailers and producers will, therefore, be affected in different ways and as businesses are impacted, productivity declines and further jobs are lost. The economic impacts of HIV will, therefore, be felt not only by those infected but also by the entire community.

Orphans

HIV/AIDS profoundly affects families and communities, not only resulting in the loss of labour and assets, but also affects socio-cultural skills while placing almost unprecedented stress on community and extended family networks. One of the most serious consequence of the epidemic is the increase in the number of oprhans. It is estimated that there are over 700 children in Swakopmund who are currently under the age of fifteen who have lost one or both parents as a result of AIDS. This number is expected to increase to over 2,500 in the next 10 years. By 2021 the number of AIDS orphans will have increased to nearly 4,500 children. It is important to note that these figures may be an *over-estimate* of the scope of the orphan situation in Swakopmund. A study of orphans (SIAPAC, 2002) indicated that some children who are orphaned in the southern and central regions of Namibia are sent to their extended families in the north on the death of their parent(s).

Impacts on Swakopmund Municipality

These impacts will result in demands from the community for expanded or new services to be provided by local authorities and a lowered ability to pay for these services. However, municipalities are not isolated institutions and will not be immune from the impacts of the epidemic. These impacts result from the sickness and death of municipal personnel infected with HIV, and can include:

- loss of productivity;
- increased absenteeism;
- cost of sick and compassionate leave;
- increased cost of benefits; and
- increased recruitment and training costs to replace lost staff members.

The challenge is that the epidemic erodes the ability of institutions, including local authorities, to provide services, as it reduces *both* efficiency and revenues, while the personnel losses induced by HIV/AIDS affect the quality of services the municipality is able to provide.

It is important to understand that HIV-infection precedes AIDS illness and death by some eight to ten years. In other words, the AIDS mortality presently being experienced within Swakopmund Municipality results from HIV-infections acquired some six to eight years ago. The full impact of AIDS on the municipality is therefore only likely to be felt between 2008 and 2010 when the numbers of those falling ill and dying will reflect the town's current high prevalence rate. The period 2001- 2012 was therefore selected for projecting the impact of HIV/AIDS on these employees because, while current infections cannot be prevented, it was assumed that *immediate* prevention activities would be put in place to reduce those in future.

In 2001, Swakopmund Town Council employed some 366 individuals. Over the period, 2001-2012 Swakopmund is projected to lose some 110 staff across all staff grades to AIDS, provided staff numbers remain the same. AIDS deaths among Council staff are projected to continue to rise sharply from 5 deaths in 2002 to 10 in 2007. Deaths among Council employees are then projected to stabilise at between ten and eleven individuals per annum until 2012.

Swakopmund Town Council uses a grading system, with current staff occupying grades 5 to 18. The latter level is the lowest grade, occupied primarily by unskilled labourers, and the three lowest grades (those from 16 to 18) contain the most staff, some 45% of the Council's total complement. The AIDS death rate will be highest among these bands (simply because the numbers are higher), with one individual projected to die of AIDS each year during the early years of the projection, rising to four to five individuals over the period 2009 - 2012.

These levels of AIDS mortality will impact on the municipality through increased absenteeism (sick and compassionate leave), productivity losses and increased replacement and training. Each of these impacts will have an associated cost and will therefore require management and mitigation, with particular attention being paid to the financial and human resource management implications.

Human Resources Management Information System

Swakopmund Municipality is fortunate in that its human resources information management system is among the best the consultants have examined in completing similar HIV/AIDS impact assessments on the private and public sectors in Southern Africa over the past several years. This system provides management with monthly data on all personnel absences, by type, department and overall cost. It also provides data on personnel profile by age and gender. The only refinement required would be to provide cost data specific to the type of absence (i.e., sick leave, compassionate leave, casual leave, etc.).

Leave

The amount of sick leave taken by staff because of AIDS-related illnesses is one of the main costs of the epidemic to any employer. Swakopmund municipality employees are entitled to 120 days sick leave at full pay over any thirty-six month period, which can be extended by 120 days of sick leave at half pay over a thirty-six month period.

Over the period 1999-2001, the number of staff taking sick leave increased from 221 individuals taking 2,209 days off in 1991 to 254 staff who took 3,925 days of sick leave in 2001, an increase in sick days of 56% compared to a staff increase of 15%. The epidemic will increase the amount of sick leave taken by Council workers. Analysis indicates that the number of sick days taken by municipal employees *as a result of AIDS* will increase from just less than 1,000 days in 2002 to 1,500 days per year over the period 2008 - 2012. Obviously, the costs of this will be high, and programmes that encourage positive living and wellness could assist in reducing these.

Benefits

Among the benefit entitlements of employees of Swakopmund Municipality are medical aid and pension contributions. In both cases monthly contributions by the municipality can be expected to increase on a consistent basis because of the epidemic.

Membership of a medical aid plan is voluntary for employees of the municipality. Where employees are members, the municipality pays 50% of the employee's monthly contribution. In 2001 these payments amounted to N\$1.8 million. The cost of medical aid to the Council and its employees is rising as the number of those requiring AIDS medication increases.

Similarly, most employees of Swakopmund Municipality are members of the Retirement Fund for Local Authorities in Namibia.² This Fund operated as a defined benefit fund until 1992 when, due to the large number of claims, it changed to a defined contribution fund. This means that the amount paid to members' families on their premature death was effectively reduced. The current death benefit allows for a lump sum payment of 5.3 times annual salary at the death of a member, with three differing options based on the level of guarantee and investment. The impact of HIV/AIDS has already caused the funds to lower the death benefits and to increase the cost to the members. This trend will continue as more members die from the diseases associated with AIDS and death benefit claims continue to rise.

Training

Council provides training to staff subject to its policies. HIV/AIDS will increase the need for training of personnel, as employees are lost to the epidemic early in their careers. Equally, the private and other sectors, which may offer higher salary and benefit packages, may increase the rate at which they 'poach' trained staff as they lose employees. This, in turn, will increase the costs of training as it further increases staff turnover. Council training policies therefore need to include strategies for maintaining and developing skilled staff. These have to be based on the provision of more frequent but shorter-term training opportunities, within affordable cost parameters.

² Other employees -- a small minority -- are members of the Swakopmund Local Authority Retirement Fund, on which no data were made available.

Critical Functions

Some of the institutional costs associated with HIV/AIDS can be identified and, with some difficulty, quantified. Many, however, are more difficult to determine and these less obvious costs and consequences may be larger and more important. These include the loss of institutional memory, the impact on staff morale, and the inability to perform critical functions.

Those interviewed during the Assessment viewed the Town Treasurer's department as particularly vulnerable, because the head of the department is the only individual who understands all financial issues and how to make viable investments. It would thus be difficult for sub-ordinates to assume these responsibilities if the Treasurer was unavailable for long periods of time. While the Works department was not seen to be particularly vulnerable to the impacts of HIV/AIDS, the general maintenance team, which is part of this department, was seen to be a critical function as the foreman is also the driver for the team.

Costs

The main costs associated with the epidemic lie in increased absenteeism, medical aid contributions and the costs of productivity lost. Over the nine year period (2002 - 2010) the cost (at present value) will be N\$4,222,712 across all bands. The following table provides data on these increased costs by grade. The figures are discounted totals (i.e., at present value).

Table ES1: Total (Discounted) Costs Resulting from the Epidemic by Band, Swakopmund Municipality

Grade	2002	2003	2004	2005	2006	2007	2008	2009	2010
18 - 16	58,382	62,348	63,424	62,740	65,436	62,674	62,547	59,549	56,703
15 - 5	320,520	346,125	352,125	346,740	345,559	350,186	330,652	314,728	299,650
All Bands	378,901	408,595	415,550	409,480	410,995	412,860	393,199	374,277	356,353

The internal costs arising from the impact of HIV/AIDS on municipal personnel are not the sole economic impacts of the epidemic. The performance of the economy and the growth rate of the town may affect the level of demand for municipal services. There must also be concern as to the ability to pay for most services as a result of constrained household economies resulting from HIV/AIDS. It is likely that overall electricity sales will be related to the performance of the town and regional economy. Any factor, such as AIDS, depressing the growth of this economy will depress the growth in demand for electricity and revenue generated from this source.

Further, while household ability to pay for services will be constrained, household willingness to pay for these services is unknown. This can only be assessed through household level quantitative surveys, which are beyond the scope of this Impact Assessment. However, it may be that those suffering AIDS-related economic shocks would be willing to pay for services, sacrificing other items in their household budget.

The sale of land and houses is another important source of revenue for the municipality. HIV/AIDS will affect these sales in a number of ways, complicating the achievement of delivery targets and interfering with revenue flows. If land or property is purchased from the municipality with no financial ties between the buyer and the municipality existing after the sale, these impacts will be minimal. The exception would be that house and land prices and the health of the market would be affected by HIV/AIDS via the epidemic's impacts on the local and regional economy. This is likely to result in reduced sales.

The municipality presently sells serviced erven through auctions to those who can afford market prices, and to low income groups through development projects where the costs of prefinancing service provision is recouped. Sales through these projects are insured against the death of the land or house owner who, in addition, is required to name a beneficiary in the event of their death.

However, administrative costs will increase as the number of AIDS deaths rise, as changes in the financial and legal arrangements will have to be processed or repossessions take place.

Even in cases where outstanding debt is covered by an insurance policy, death will decrease the profitability of sales. This is because property sales generate revenue in two ways, firstly through the capital payment and secondly through the interest received. Insurance protects the capital, but early payment following a death means the loss of interest income for the remaining years of the loan.

A related and important issue is the impact of HIV/AIDS on revenue growth. All major sources of revenue are related to the size of the town, in terms of area and population. By 2010 the population of the town will be 12% smaller than it would have been in the absence of AIDS, and by 2021 it will be over 20% lower. This reduction in the size of the population has implications for planning of service delivery over the next ten to twenty years. This is particularly important in towns, such as Swakopmund, where investments such as electricity substations are a significant cost item.

Equally, the demand for burial space and the costs associated with its allocation, preparation and maintenance will increase as the death rate climbs and will need to be planned for. How great such an increase will be is difficult to estimate. Many residents of Swakopmund are migrants from elsewhere in Namibia. They may well opt to return to a home outside Swakopmund while ill and die outside of the town.

In addition, the epidemic demands that the Council take the lead in preventing further HIV infections not only among its staff, but also in the community it serves. These new services will require not only additional staff, but also new programmes and materials whose introduction obviously has cost implications.

Chapter 1: Introduction and Background

Introduction

The HIV epidemic is affecting every aspect of Namibian society. These impacts include, among others, a reduction in the population growth rate, alterations to the demographic structure of the population, economic losses through a reduction in Gross Domestic Product (GDP), as well as broader societal change as the nation comes to terms with its losses, and the need to care for the infected and the affected. Paralleling these national impacts are severe impacts on households and extended families. Food security is being undermined, breadwinners are dying, and household coping strategies are under unprecedented strain.

To respond to this national challenge, Namibia created the National AIDS Control Programme in 1990, which was eventually relaunched as the National AIDS Co-ordination Programme (NACOP) in 1999, underlining the need for a multi-sectoral response to the epidemic. Namibia is currently implementing the second HIV/AIDS plan (1999-2004), which outlines the responsibilities of the various sectors. Coinciding with the launching of NACOP in 1999, a National AIDS Committee was also formed. It is chaired by the Minister of Health and Social Services, and co-chaired by the Minister of Regional and Local Government and Housing. The co-chairpersonship by the Minister of Regional and Local Government and Housing is in recognition of Government's commitment to decentralisation, but is also in recognition of the fact that regional and local authorities are the ones who are closest to the people they are meant to serve.

While the need to respond to the epidemic places considerable burdens on regional and local authorities in terms of implementing effective responses to the epidemic, their ability to do so is undermined because it is taking place within the context of direct impacts *on the local authorities as well*. The local authorities will lose personnel to the epidemic, due to illness, death, or responding to the illness and deaths of family members. Further, HIV/AIDS will

increase the costs of doing business, and will effectively undermine the efficiency of the sector and reduce turnover, with negative impacts on employment potential and creation of tax revenues. Local authorities are therefore playing a central role in preventing and coping with the epidemic, while they themselves are directly affected in a variety of ways.

This volume deals specifically with the results of the assessment as they pertain to the municipality of Swakopmund. Data from the Ministry of Health and Social Services (MOHSS) surveillance survey conducted in 2000 indicates that antenatal HIV/AIDS prevalence rates for those aged 15-49 in Swakopmund was 22%. In effect, close to one-quarter of the working age adult population of the municipality may be HIV positive, and will eventually die of AIDS, resulting in productivity, skill and economic losses. These high levels of infection clearly highlight the need to better understand the implications for the town and its council.

Background to the Study

In 2000 the Chief Executive Officer of the Municipality of Windhoek initiated a process to consider the impacts of the HIV/AIDS epidemic on the municipality of that city, as well as the people it served. After discussions with counterparts in Walvis Bay and Swakopmund, the proposed investigation was broadened to include the two coastal towns as well, and was later further expanded to the two northern towns of Oshakati and Ongwediva.

Financing was sought for the impact assessments from the United States Agency for International Development (USAID), and provided via Family Health International, an international non-governmental organisation working in the HIV/AIDS arena. Technical support for the impact assessment was provided by Social Impact and Policy Analysis Corporation (SIAPAC) and was implemented by SIAPAC in conjunction with the Health Economics and HIV/AIDS Research Division (HEARD) of the University of Natal, Durban, South Africa and JTK Associates, a development consulting company located in Mbabane, Swaziland.

Aims and Objectives

The **aim** of the assessment was to provide detailed insights into the internal and external impacts of the HIV/AIDS epidemic on the five municipalities of Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek, as follows:

Internal Impacts

- the impact of HIV/AIDS on the personnel within the Municipality;
- on the ability of the municipality to meet its mandated responsibilities.

External Impacts

- on the businesses within the city;
- on the health services;
- on the economic and social well-being of residents living within the Municipality;
- on the overall quality of urban life in the city.

Of equal importance, the assessment was intended to 'mainstream' HIV/AIDS into the functions of the municipalities. This was to be accomplished through the development of an HIV/AIDS strategy and action plan following review of this report by the respective local authorities.

Specific **objectives** of the assessment are as follows:

1. Project the demographic impact of HIV/AIDS illness and death on the population of local authority personnel, and indicate needed additional human resources.
2. Project the demographic impact of HIV/AIDS illness and death on the population living in the local authority areas.
3. Project the economic impacts of HIV/AIDS on households in the local authorities' areas and consider the impact this will have on affordability and payment for local authority services and the overall revenue base.
4. Project the economic impacts of HIV/AIDS on businesses in the local authorities' areas and consider the impact this will have on the viability of key business sectors.

5. Qualitatively assess the impact on 'quality of life' for the local authority areas (e.g., ability of households to meet basic livelihood needs, levels of crime, street children, etc.).
6. Consider the costs associated with HIV/AIDS prevention activities for local authority personnel. Compare this to the costs associated with *not* implementing the intervention. Outline possible programmatic interventions.
7. Outline an HIV/AIDS strategy and action plan.

Methodology

The study was divided into four phases: design; implementation; analysis and write-up; and planning/integration.

Design

Mobilisation

Start-up was delayed for several months due to various technical requirements, and work on the Assessment only began in September 2001 when all outstanding agreements were in place. Work began with a series of inception visits by the Deputy Team Leader, Mr. Mouton of SIAPAC, to all participating local authorities. The purpose of these visits was to brief local authority executives on the assessment and begin preparations for the Inception Workshop.

Inception

The Inception Workshop was held at the Safari Hotel in Windhoek on 7 and 8 November 2001. It was attended by participants from each of the participating local authorities, among them Chief Executive Officers and finance and human resource managers. The purposes of the workshop were to:

- introduce participants to the aims and objectives of the project assessing the impact of HIV/AIDS on five Namibian cities (Walvis Bay, Windhoek, Swakopmund, Oshakati and Ongwediva);

- to seek agreement on project aims and objectives with participants, following review and discussion; and
- to plan and agree to a schedule of work with representatives of each local authorities.

These objectives were met. In addition, participants recommended that an Advisory Group be appointed to guide the work of the consultants and local authorities during the Assessment, and suggested the membership of the Advisory Group. Participants also agreed on the nature and type of information and data needed for the Assessment that were to be supplied by the municipalities, and established a schedule for its provision. The Workshop minutes are included in Volume 7 of this report.

Following this workshop an Inception Report was submitted. This contained changes to the propose schedule of work because of the late start of the Assessment, and the difficulties imposed by the pending Christmas break when few officers would be available to collect the requisite information.

Concurrent with data gathering activities was the completion of a detailed literature review. A bibliography is attached to this volume.

Following the literature review, and in addition to long-term dialogue and information gathering activities, qualitative data gathering instruments were developed to conduct interviews with municipal employees. Specifically, *qualitative* discussions were held with small groups of municipal officers. The aim was to gain insights into attitudes about HIV/AIDS and recommendations on how HIV/AIDS prevention activities should proceed within the local authorities. Two qualitative approaches were employed: 1) focus group discussions; and 2) story with a gap. These were supplemented with key informant interviews with municipal managers.

At the end of this Design Phase progress meeting were held (one in Windhoek, one in Walvis Bay, one in Swakopmund, one in Oshakati and one in Ongwediva), at which time Progress Report 1 was submitted.

Implementation

Implementation consisted of three activities:

- 1) reviewing then information made available and analysing the gaps in the data;
- 2) projecting HIV/AIDS impacts; and
- 3) implementing key informant interviews, focus group discussions, and story with a gap group discussion instruments.

As soon as the relevant data became available from the local authorities on municipal personnel, these were applied to projections of municipal personnel numbers. The 1998 projections of the demographic impact of HIV/AIDS were updated by MOHSS to include 2000 seroprevalence data (using the SPECTRUM group of models), and these were used as the basis for projecting the impact of the epidemic on the five local authorities and the populations they serve.

The model required a great deal of demographic data in order to complete the projections. Data from the Central Bureau of Statistics (CBS) and the Ministry of Health and Social Services (MOHSS) were used, and the assumptions made were, to the extent possible, the same as those used in the national projections on the demographic impact of HIV/AIDS. A more detailed discussion in this regard is included in Volume 7.

The data on local authority personnel and local populations were needed in a format that was both consistent and useable. These requirements were communicated to the local authorities, and during the initial start-up meetings the consultants provided the local authorities with a format for these data and agreed to a schedule for their provision. Most of the municipalities were able to comply but, despite everyone's best efforts, a number of delays were experienced in receiving these data.

Once the data became available, projections from the model were applied to the relevant local authority populations. For example, the model allowed the projection of HIV prevalence levels and AIDS-related deaths among municipal staff by cadre. Similarly, it allowed the

investigation of the demographic impact of the epidemic among the populations these authorities served, and allowed consideration of some assumptions about these effects on demands for services and abilities to pay for these.

To supplement the quantitative data and collect information on attitudes important for an understanding of the potential impact of HIV/AIDS on the five municipalities and the people they served, two qualitative approaches were used: 1) Focus Group Discussions (FGD); and 2) Story With A Gap (SWAG). FGDs are particularly useful in collecting detailed insights into sensitive issues such as HIV/AIDS. SWAG is a variation on the FGD approach, and is a useful tool in getting participants to consider their current situation in relation to a desired state, and discussing roadblocks and needed actions to move from their current state to a desired one. For this consultancy, the two approaches were used so that respondents could consider how the local authorities might best respond to the epidemic.

At the end of the Implementation Phase further progress meetings were held (meetings were held in each of the five municipalities), at which time Progress Report 2 was submitted.

Analysis and Write-Up

As data become available the impacts of HIV/AIDS on the local authorities were modelled. This took some time, given the complexity of the projections, particularly in relation to internal migration within Namibia, and given continued data gaps. The model does not easily accommodate internal migration effects, and assistance was sought from the developer of the model in this regard. In response to requests from the Consultant, Mr. John Stover of The Futures Group kindly developed the bridging formulae needed to allow the model to incorporate internal migration.

Qualitative/participatory findings were compiled using NUD*IST, a data analysis software package designed to systematically interrogate qualitative findings, and thereafter the key findings were incorporated into the reports.

The report was then submitted for review by the municipalities and comments solicited. A final series of progress meetings was held with each of the five municipalities in order to present the findings from the draft report and facilitate receipt of comments and feedback.

Planning and Integration

Methodologies to integrate HIV/AIDS into the activities of the three local authorities, and to assist the five municipalities in prepare concise HIV/AIDS Prevention and Response Strategy and Action Plans, were developed at an advocacy workshop with the five local authorities. This was held in Walvis Bay from August 12 - 16, 2002. This planning workshop assisted the five local authorities to review and analyse the findings from the reports. Following this, participants began the process of planning for interventions intended to mitigate the impacts on the municipalities themselves, including prevention programmes intended to reduce infection rates among municipal personnel and the communities they serve.

Following the workshop the reports were finalised in draft form for final circulation, incorporating comments and changes from the local authorities. These now constitute the draft reports, and include the action plan and advocacy strategies developed at the closing workshop.

Data Limitations

Throughout the Assessment participating local authorities were extremely co-operative and helpful in making requested data available to the consulting team. However, in several instances the data required to fully assess the impact of HIV and AIDS on a particular municipality was simply not available. Where this has occurred, the impact has been assessed qualitatively. For example, in Windhoek it has not been possible to obtain detailed data on the economic base of the city by sector (i.e., manufacturing, retail, tourism, etc.). Assumptions have had to be made about their relative importance, and this has made it difficult to more precisely determine the contribution made by these industries to the municipality's revenue base and the potential impact of HIV on this.

While the data gaps vary across the five municipalities, one purpose of the strategic and action planning workshop is to assist the municipalities begin to fill these gaps and each has now included data gathering and analysis in its draft action plan.

Structure of the Overall Report

This final report is presented in seven volumes. The first volume presents integrated findings across all five cities, including a more detailed discussion of the methodology used as well as background on Namibia, the HIV/AIDS epidemic and local government in the country, while the five subsequent volumes present specific findings for each of the participating local authorities. The volumes are as follows:

This report consists of seven volumes. This Volume presents findings for the Municipality of the Town of Swakopmund.

- | | |
|-----------------|--|
| Volume 1 | Detailed study description, methodology, background information on Namibia, the epidemic in the country and on local government, as well as integrated findings arising from the Assessment of the Impact of HIV/AIDS on Five Namibia Cities |
| Volume 2 | Assessment of the Impact of HIV/AIDS on the Town of Ongwediva |
| Volume 3 | Assessment of the Impact of HIV/AIDS on the Town of Oshakati |
| Volume 4 | Assessment of the Impact of HIV/AIDS on the Town of Swakopmund |
| Volume 5 | Assessment of the Impact of HIV/AIDS on the City of Walvis Bay |
| Volume 6 | Assessment of the Impact of HIV/AIDS on the City of Windhoek |
| Volume 7: | Appendices
Terms of Reference
Projections and Modelling
Field Instruments
Minutes of Advisory Committee Meetings
Inception Workshop
Prevention and Response Strategy and Action Planning Workshop
Bibliography |

The intention is that each volume of this Assessment can be read as a stand-alone report. In order to present readable and comprehensive reports for each participating local authority, there is, however, some duplication between these volumes, in that a brief discussion of background information, the structure of the report, and an overview of the methodology used are included in volumes 2-6. However, a detailed discussion of methodology, particularly that related to the models used to present demographic projections of the impact of HIV/AIDS on each city, as well as the planning and strategy development matrices used, will be found in Volume 1 of this study.

Structure of this Volume

This volume presenting findings for the town of Swakopmund is structured as follows:

Chapter 1	Introduction, Structure of the Report, Methodology and Background to the Study
Chapter 2	Swakopmund, its community and municipal structure and functions
Chapter 3	The Impact of HIV/AIDS on the town of Swakopmund, its population and economy
Chapter 4	The Impact of HIV on the Swakopmund Town Council
Chapter 5	The Way Forward

Chapter 2: Swakopmund

Introduction

Swakopmund is situated on the west coast of the country, in the Namib Desert. It is some 300 kilometres west of the capital Windhoek and 34 kilometres north of the main Namibian port of Walvis Bay. Initially developed as a harbour by the Germans (when the British controlled Walvis Bay), Swakopmund is now the leading coastal tourism destination in Namibia.

This chapter provides information on Swakopmund, its people and municipality.

Demographic Profile

Preliminary census data for 2001 indicate that Swakopmund has a population of 25,442, living in 7,560 households with an average household size of 3.4. Based on these preliminary findings, there are some 5,500 more residents than in 1991 when there were 19,293 people living in the town.

Planning documents for the year 2000 reveal that only 26% of the town's residents are from the Erongo Region, with almost 40% being migrants from the four northern regions of Oshana, Ohangwena, Omusati and Oshikoto. At the time that the long-term plan was prepared, annual population growth was estimated at 6% per annum, based primarily on internal migration by those seeking job opportunities and an urban base.

It is, however, very likely that this rate of population growth was over-stated. The population in 2001 is now far lower than that projected on the basis of a higher annual growth figure used in the 2000 planning documents. And, while Swakopmund does attract migrants from northern Namibia, these individuals are not moving to the town at the same rate as, for example, migrants to neighbouring Walvis Bay or to the country's capital, Windhoek.

This does not detract from the fact that the majority of Swakopmund's population is largely made up of migrants as its proximity to large-scale fishing and mining industries, as well as

its tourist infrastructure encourages job seekers from elsewhere in Namibia to migrate to the town. Surveys undertaken for the long-term plan for the town indicate that close to 65% of residents moved to Swakopmund for economic reasons.

Equally, it is important to note that, as Namibia's premier coastal tourism destination, the population of the town doubles during peak holiday periods. This primarily occurs during the Christmas break and other school holidays when there is an influx of visitors from the Namibian interior to the coast.

Socio Economic Status of Residents

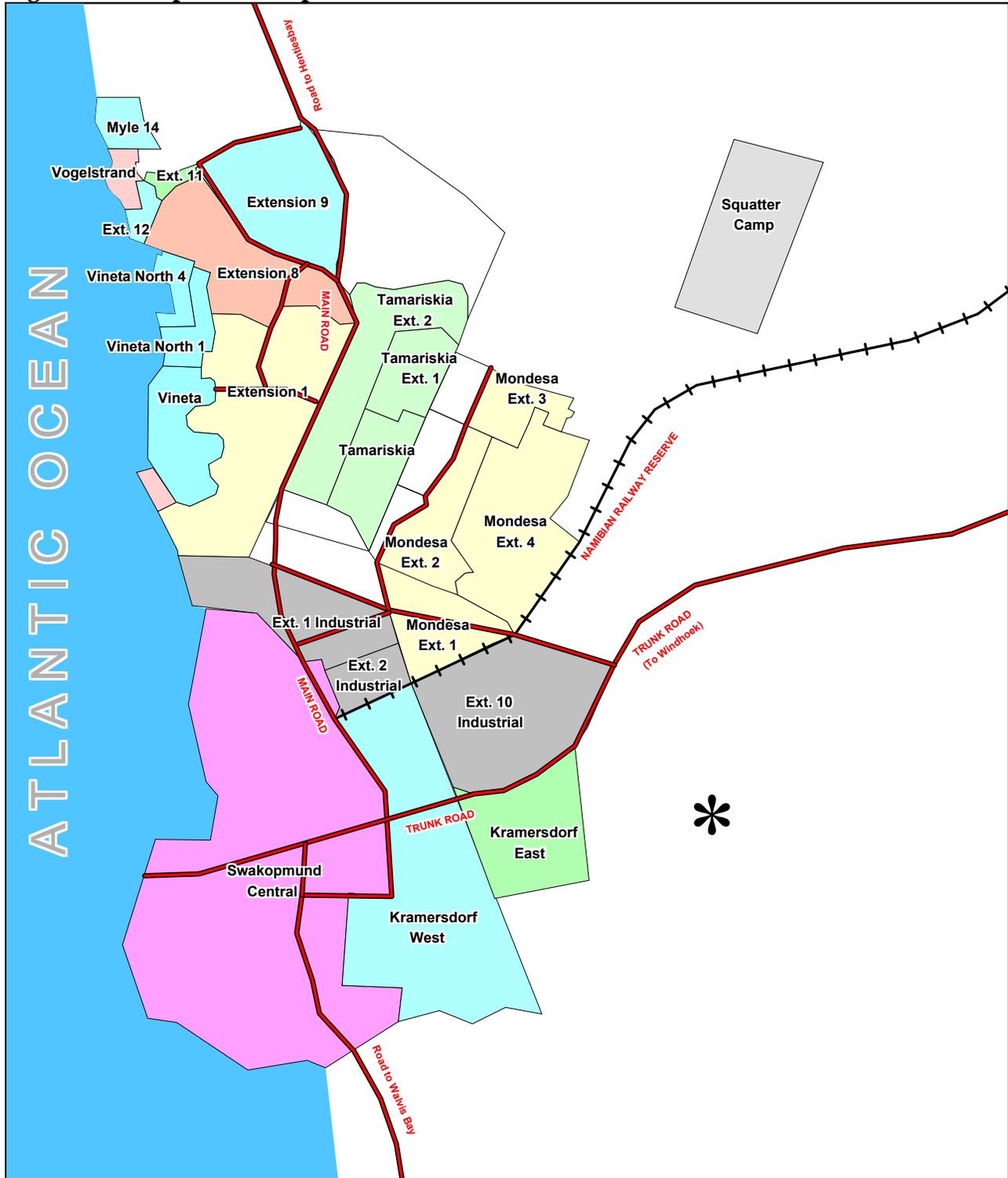
As is the case with other towns attracting internal migrants, a sample survey conducted in 2000 indicated that a larger percentage of the population than average is male (60%). The majority of Swakopmund residents (66%) derive their income from salaries and wages, and approximately 21% were not economically active. Much of Swakopmund's employment is based on tourism and is thus seasonal in nature. Underemployment is a problem, and of those in employment only 56% indicated that they held full-time jobs. Half of all households had an income below N\$1,000 in 2000, 36% earned between NS1,000 and N\$5,000, and 12% earned in excess of N\$5,000 per month.

Residential areas continue to be largely segregated because of historical circumstances, with Kramersdorf, Swakopmund Centre, and Vineta being high-income residential neighbourhoods, while Mondesa and Tamariskia are the former township areas; Rössing Mine has leased much of Tamariskia for their employees.

More recently a squatter area developed in the open plains northeast of Mondesa. This is informally known as the DRC. Mondesa and the DRC contain much of the town's population, and Mondesa in particular is often the area of first settlement for new migrants. The development of the informal squatter area and the densification of Mondesa itself are evidence of the impact of migration on housing and service delivery, as newcomers to Swakopmund move into these neighbourhoods. As a result residents here are poorer, and more likely to be unemployed. While no detailed socio-economic studies have been done in

Swakopmund, based on data from other areas (particularly, Windhoek and Walvis Bay), the majority of residents in Mondesa and the new squatter area are likely to be male, younger than the norm and have low levels of educational attainment.

Figure 2.1: Map of Swakopmund



Economy

The economy of Swakopmund is based on the tourism, mining and retail sectors. Tourism, the third largest earner of foreign exchange in Namibia, plays an important role and will continue to do so for the foreseeable future, as Swakopmund is the primary destination for 17% of all tourists entering Namibia. A large retail sector has developed, built up around the tourism industry as well the local population, particularly foreign pensioners (although they comprise only 2.5% of the town's population, they have considerable buying power). In 1997 there were 483 registered retail businesses in Swakopmund. This sector relies largely on unskilled and semiskilled labour, but is the largest source of employment in the town itself.

However, the largest single employer (both in Swakopmund and in Erongo Region as a whole) is Rössing Uranium Mine, with some 1250 employees. While the mine lies some 60 kilometres to the east of the town many of its workers live in Swakopmund and commute daily. The wages and salaries of the mine employees are thus an important source of income for the town. Income obtained from employment at the mine helps support the local retail and service industries, creating employment.

Swakopmund, as a growing town, has a healthy construction industry. This has been supported by the growth of tourism and of new neighbourhoods. The industry now employs close to 200 people regularly, but many more on a short-term basis.

The Municipality

Swakopmund is now a Part 1 municipality under the Local Authorities Act (N^o. 23 of 1992) as amended in 2000 (N^o. 24 of 2000). This Act made these municipalities the top tier of local government and decentralised many of Government's powers to these local authorities, making them the most autonomous form of local government in Namibia.

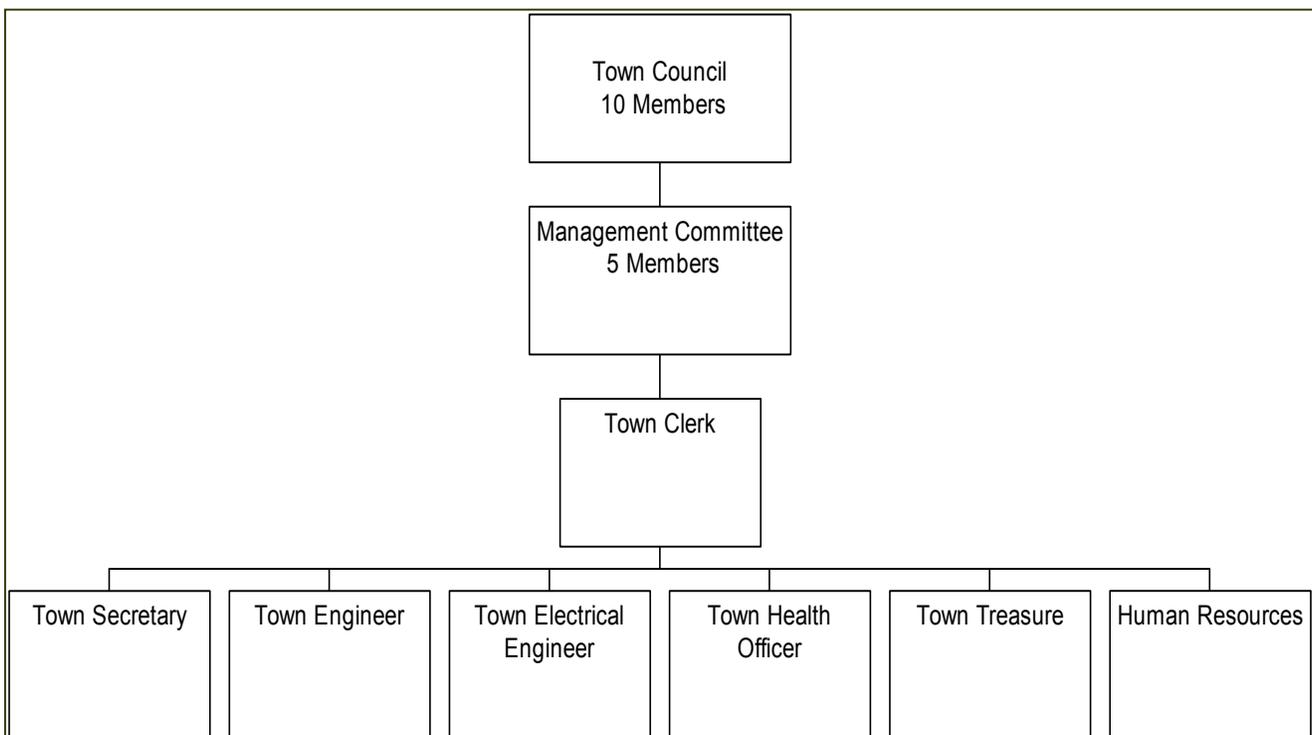
The Municipality of Swakopmund has as its objectives the provision and maintenance of safe, sufficient and affordable services for residents and visitors and the promotion of future development to the benefit of the community. In order to achieve these objectives the Municipality employed 366 individuals (November 2001) and had an operating budget of N\$91 million for the 2000/1 financial year. The Municipality's operating budget (1999 - 2001) is presented below:

Table 2.1: Swakopmund Operating Budget, 1999/00 - 2001/02

Item	1999/2000	2001/2
Total Expenses	82,285,560	91,706,620
Total Revenue	81,895,020	91,421,840
Salaries (% of expenditures)	26.6%	30.3%

The municipality provides the following services: water supply, electricity, roads, maintenance of the town, tourism promotion, sewerage, refuse removal, health services, traffic control, land, erven, parks and gardens, street lighting, housing, education and recreational services. In order to perform these services, the municipality is organised into six departments under the Town Clerk as illustrated in the following chart:

Figure 2.2: Swakopmund Organisation Chart



Key Informants indicated in interviews that the main functions of these departments are as follows:

Table 2.2: Key Departmental Functions, Swakopmund Municipality

Department	Functions
Town Engineer	Provision and maintenance of roads, sewerage and water infrastructure. Approval of building plans and identification of new erven. Responsible for all major construction projects undertaken by the Council, including town planning.
Town Electrical Engineer	Planning, installing, extending, distributing and operating all electrical distribution of power (purchased from NamPower).
Town Treasurer	Purchasing water from NamWater, oversees financial matters, prepare and present budget to council, monitor budgetary expenses. Finance capital projects and ensure good investment of council's money
Town Secretary	Secretarial services to council, safe keeping of all records, property control. Administrative issues
Health Department	Maintaining the town, environmental health within residential areas and controlling animal health. Inspections of commercial outlets. Control of various diseases. Promotion of health and well-being.
Human Resources	Integrated human resources services. Industrial relations. Training of staff, recruitment and hiring new staff. Other personnel issues

Core and Peripheral Municipal Services

Managers within the Municipality ranked the following as core and peripheral functions:

Table 2.3: Core and Peripheral Municipal Functions, Swakopmund Municipality

Core	Peripheral
Water	Recreational Facilities
Electricity	Roads
Sewerage	Parks and Gardens
Refuse Removal	Tourism
Health Services	Abattoir
Housing	

Of interest, while much of Swakopmund's economy is based on tourism, the promotion of this sector was only mentioned by one senior official and then only as a peripheral function of the Municipality. Further, the Municipality maintains tourist bungalows, which are an important source of revenue. Equally, no mention was made of the importance of the human resources department, yet in terms of managing the impact of the HIV/AIDS epidemic on the Municipality of Swakopmund this department will play a key role.

Services

The primary services provided to residents by the municipality are water, electricity, sewage and refuse removal. Water and electricity are purchased in bulk from NamWater and NamPower, respectively, with the municipality being responsible for reticulation and distribution within the urban area.

Tourism promotion and services are an important municipal function. The municipality operates a large tourism complex that contributed close to 8% of its annual revenue. In addition, other facilities and services (e.g., swimming pool, parks, etc.) are operated by the municipality for the benefit of residents and tourists alike.

All erven receive water, electricity, sanitation and refuse removal services. However, the level of service provision differs based on affordability, thus some communities (in Mondesa and the DRC) receive communal water and sanitation. In the latter area the Town Council has been developing plots and providing services in order to formalise what was an informal squatter settlement. Included in its efforts to improve housing and services, the municipality of Swakopmund is also upgrading the singles quarters within the former township of Mondesa.

The municipality has been engaged in developing these lower income areas, through housing schemes, funded by donors (e.g., KfW) or government institutions and programmes, such as the Build Together Programme or National Housing Enterprise (NHE). Within these programmes the municipality assumes responsibility for subdividing and servicing the erven, with a housing developer building the houses for sale to pre-approved lists of residents. Council prefinances the delivery of services into these areas, recovering these costs from housing sales. All such sales are insured so that in the event of the death of the buyer the amount outstanding is covered and no risk is attached.

Chapter 3: The Impact of HIV/AIDS on Swakopmund

Introduction

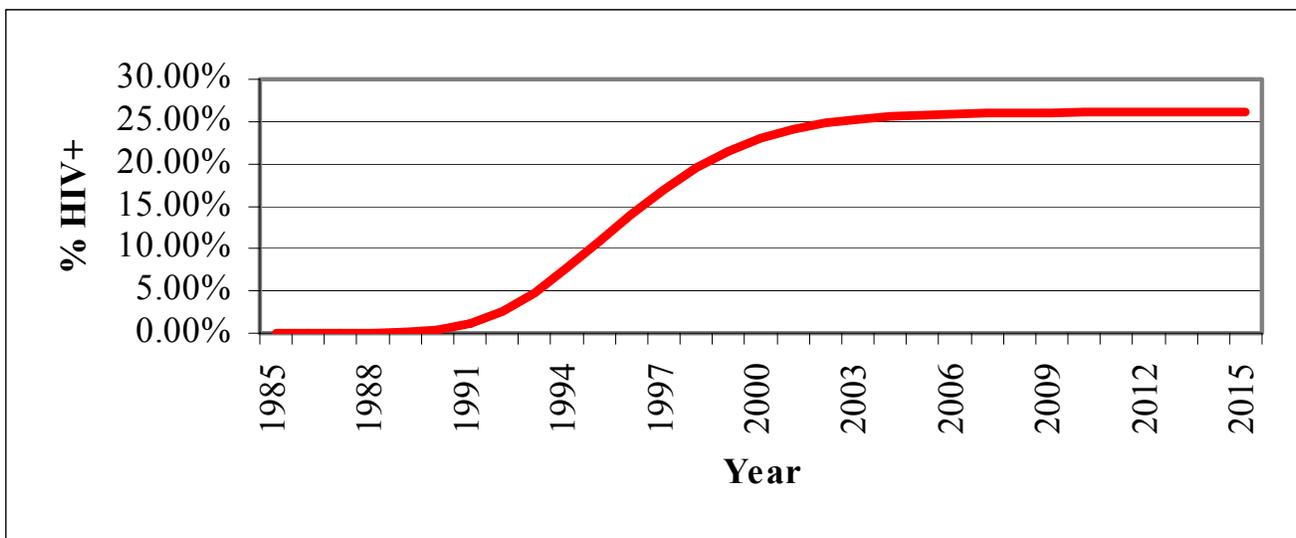
This chapter describes the situation regarding HIV/AIDS in Swakopmund, its likely impacts on the demography of the city, its economy and community, as well as the local response to the epidemic.

HIV Prevalence

Namibia undertakes antenatal sero-surveillance surveys of the HIV prevalence rate every two years. The last such survey was completed in 2000, and the antenatal prevalence rate in Swakopmund for that year was 22%. This is similar to the national adult prevalence rate of 22.3%.

HIV prevalence in Swakopmund appears to be close to its peak. If the epidemic continues to follow past trends, HIV prevalence will peak at 26% by 2004/5. We do not, however, know what will happen after the peak, as nowhere in the world has the epidemic yet run its course. For the purposes of this study it has been assumed that HIV will remain stable after this peak. This is illustrated in Figure 3.1 below.

Figure 3.1: Projected HIV Prevalence, Swakopmund (1985-2015)



This high prevalence rate implies that over twenty percent of the adult population in Swakopmund (those aged 15 to 49+ years of age) are likely to be infected. Unfortunately, Namibia's sero-surveillance data do not provide information on prevalence by socio-economic or educational status, and it is thus difficult to assess who is infected and affected by the disease.

The HIV/AIDS prevalence rate is at a relatively high level primarily because Swakopmund attracts numbers of internal migrants from northern regions of Namibia in search of employment. This results in a population with more single males in the economically active age cohorts (15 to 49 years of age) than is the average elsewhere. There is little to no socio-economic data available on migrants in Swakopmund. Studies elsewhere (i.e., Windhoek) indicate that, as a group, migrants are younger and less well educated than the average, and may engage in riskier sexual behaviours. However, while HIV/AIDS affects everyone, *regardless* of their economic well-being and status in society the disease is known to co-vary with poverty and educational status. Poverty is associated with HIV for a number of reasons primarily related to access to information and medical care. Better-educated individuals have more access to information as to the risks of unprotected sex and frequent partner change and are therefore more likely to change their behaviour. Infection with a sexually transmitted infection (STI) increases an individual's risk of being infected with HIV. Poor people tend to have higher rates of STIs because they have lesser access to quality medical care. In addition to these factors, poor people, and particularly women, may be placed at risk of HIV infection because of behaviours motivated by poverty, such as commercial or transactional sex work, and dependence on males for economic welfare. The relationship between HIV and poverty is, however, not a simple one. Many wealthier individuals are also infected. Higher income leads to greater access to resources that can lead to more sexual partners and eventual HIV infection. Infection may therefore occur across income groups, but the ability to cope with infection is more problematic for the poor.

The Demographic Impact of HIV/AIDS on Swakopmund

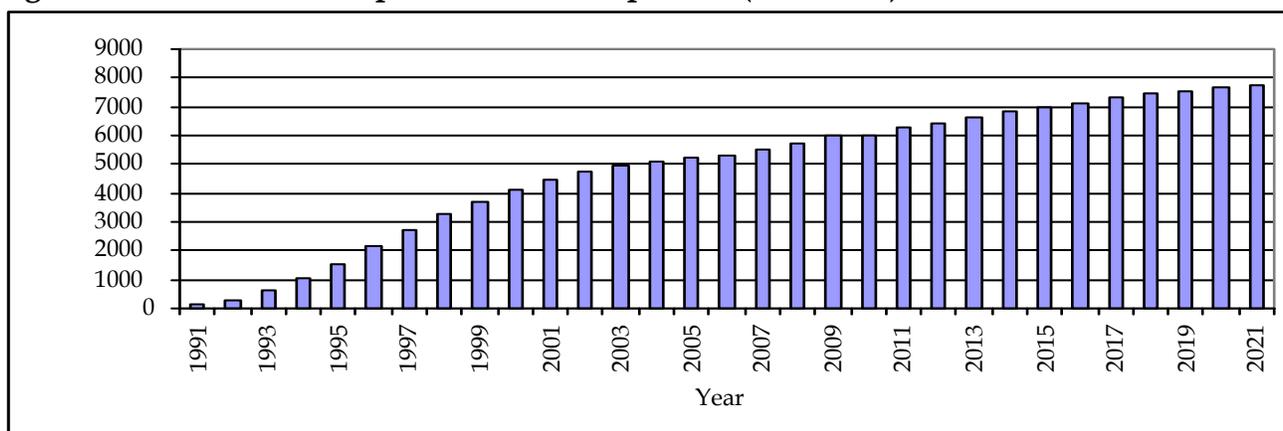
This section discusses the demographic impacts of these high rates of infection on the population of Swakopmund over the next several years. As mentioned previously, we do not know a great deal about what will happen to HIV prevalence after it peaks. Therefore, while we have a high level of confidence in the number of deaths over the next 10 years resulting from infections which have already occurred, estimates further into the future must be treated with caution.

The data presented below project the demographic impacts of HIV/AIDS for Swakopmund. They are based on projections derived from models of the demographic impact of HIV/AIDS. The SPECTRUM group of models was used for this purpose and the assumptions and methodology upon which the projections are based are discussed in Volume 7. It is important to note that these assumptions were discussed and agreed at progress meetings held with the Municipality and the Working Group prior to their incorporation in the model.

Number of HIV-Positive People

While HIV prevalence is a useful and important measure of the level of HIV in a community, it is sometimes more meaningful to convert prevalence into the number of people infected. Figure 3.2 displays the number of people infected with HIV given the present prevalence rate in the town. As can be seen there are slightly over 4,000 people who are presently estimated to be HIV- positive and this will rise to 6,000 individuals by 2012 and just under 8,000 in 2021.

Figure 3.2: Number of People HIV+, Swakopmund (1991-2021)



The figure illustrates the flow of HIV, with the number of people infected in the early stages of the epidemic increasing rapidly from 1991 until about 2002. This is because, at this stage of the epidemic, most of those who are HIV positive are newly infected and the death rate is low. There are, therefore, many new infections and few 'exits' from the population. Gradually, the rate at which people are infected slows. The reason for this decline in new infections is that a larger proportion of those vulnerable to the disease are already infected with HIV.

In practical terms, this means that at the beginning of the epidemic, when only one person in the town was infected, whomever they had sex with ran the risk of infection. In the later stages of the epidemic, an infected person may well have sex with another infected person, and as there is then no chance of a new infection, this results in a slower rate of growth in the epidemic, although the asymptomatic phase of HIV is shortened for two HIV positive sexually active partners because viral loads are increased.

However, as the rate of HIV infection declines the mortality rate increases as more of those who are HIV-positive progress to AIDS and die. At this stage of the epidemic these two factors combine and HIV prevalence stabilises. The number of HIV infected people, however, will continue to increase despite a constant prevalence rate because the city's population will grow. The prevalence rate thus remains constant although the number of infected people increases.

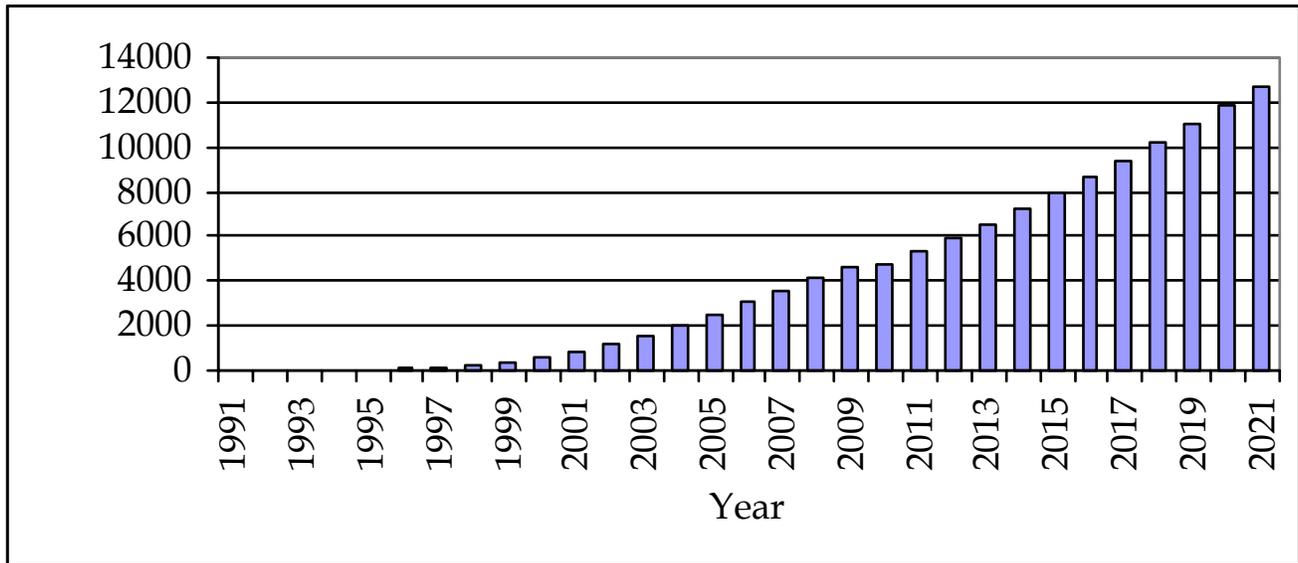
This is shown in Figure 3.2 above. The number of people infected grew rapidly from the beginning of the epidemic until 2002. The growth rate then slowed, when prevalence is projected to stabilise, but the number of people infected continues to increase as the population of the city grows.

AIDS Deaths

The HIV rate in Swakopmund means that mortality rates in the city will increase. While HIV prevalence is close to its peak, the lag between infection and death means that the AIDS

epidemic is a number of years behind. The AIDS death rate is likely to peak only eight years *after* HIV has peaked. Figure 3.3 displays number of people who have or are expected cumulatively to die of AIDS in the town.

Figure 3.3: Cumulative AIDS Deaths, Swakopmund (1991-2021)



The graph suggests that, given the level of infection to date, close to 550 people in Swakopmund have died as a result of AIDS. By 2010 the figure is likely to be closer to 5,000 individuals. The 4,500 AIDS deaths expected between now and 2010 are largely unavoidable (without access to anti retroviral treatment), because these will result from existing HIV infections. Deaths from 2010 onward could be avoided *if* future HIV infections can be reduced. By 2021, cumulative AIDS deaths are expected to exceed 12 000, but it is important to stress that *many* of these can be avoided if prevention, counselling and treatment programmes were to be rapidly scaled upwards.

Encouraging destigmatisation, wellness programmes and positive living for those infected may reduce AIDS deaths, and should this become more widely available in Namibia, through treatment (antiretroviral therapy- ART). Treatment options include the prevention of Mother to Child Transmission (MTCT) which is relatively inexpensive, and now being put in place in many countries in the Southern Africa region with high levels of infection (e.g., Botswana and

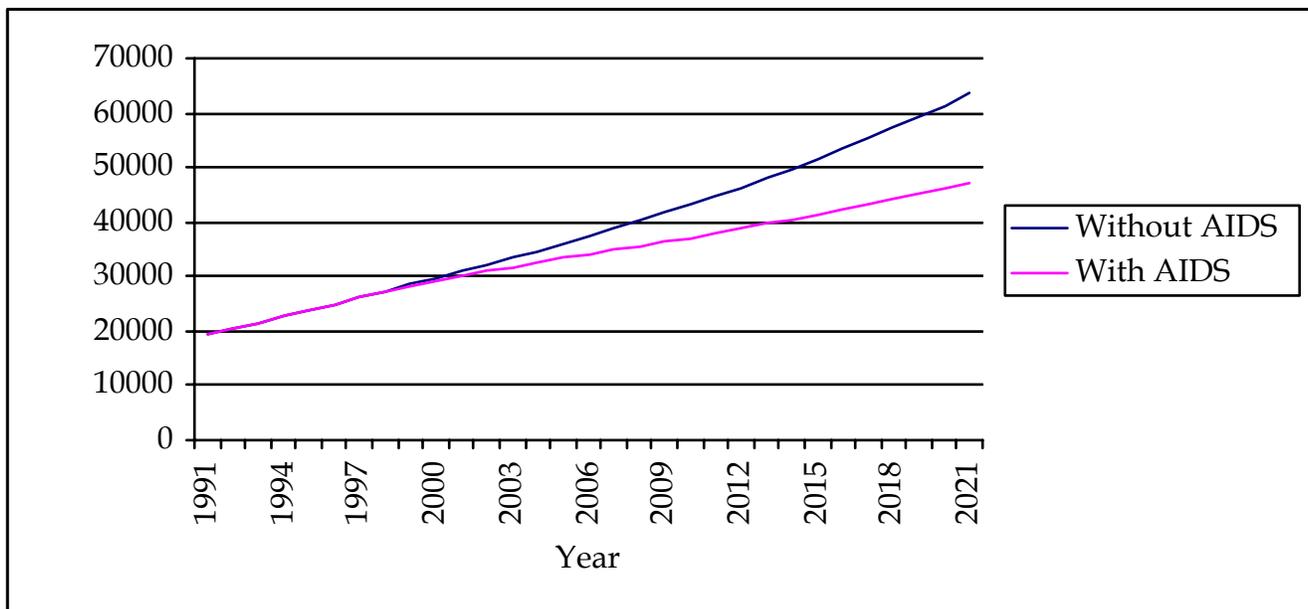
Swaziland). ART for adults, which although less expensive than previously is unlikely to become widely available in the short to medium term due both to its cost and delivery problems as this therapy requires consistent monitoring by health professionals.

Population Growth

These AIDS-related deaths will decrease the population of the city in two ways. First, the deaths will directly affect the size of city's population as individual residents die. Secondly, HIV/AIDS affects young adults and this reduces the number of children born. This is because parents die before giving birth to all of the children they would have, had they remained uninfected. The population of the city is, therefore, smaller as a result of AIDS both because its citizens die and because others are never born.

It is, however, expected that Swakopmund will continue to grow, albeit at a slower rate, as a result of the high level of inward migration from other areas. The following figure presents the projected population of Swakopmund as it would have been, without AIDS and what this is now likely to be in the face of the high rates of infection and expected deaths.

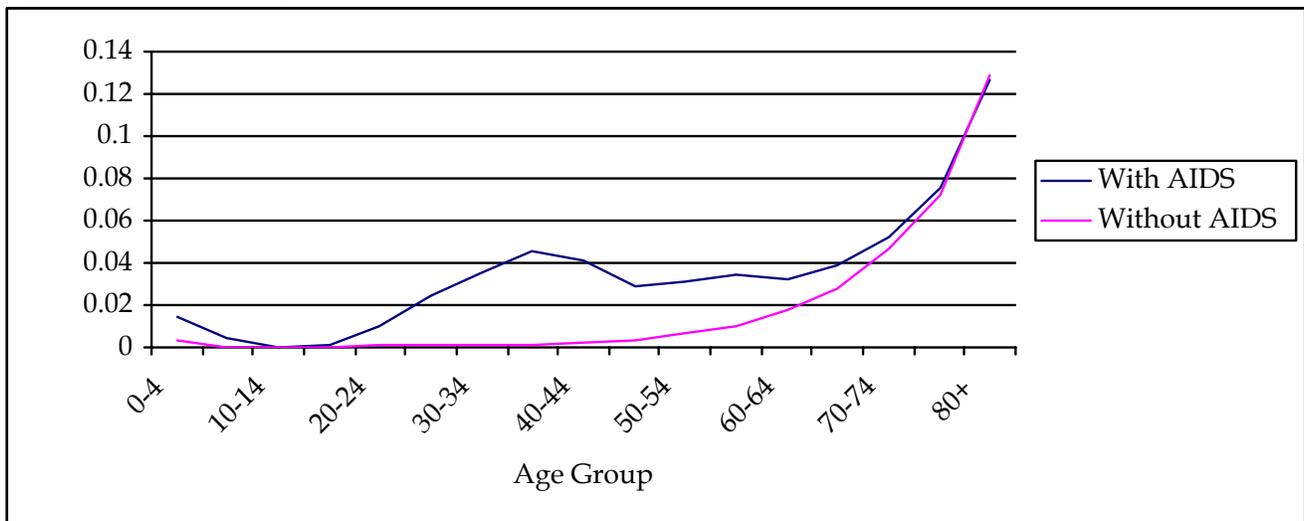
Figure 3.4: Population With and Without AIDS, Swakopmund (1991 - 2021)



Currently, the population of the city is estimated to be about 26,000 individuals. In the absence of AIDS the population would have been closer to 30,000. While the population of Swakopmund will continue to grow, Figure 3.4 shows how much larger it would have been in the absence of AIDS over the projection period. By 2021, in the absence of AIDS the population of Swakopmund would be over 60,000 people. However, the epidemic is expected to result in a population of some 49,000 people by 2021, over 18% lower than it would have been without AIDS. This will have implications for the town’s planning, service delivery and revenue growth.

The socio-economic impacts of HIV/AIDS can be severe. This is not only because of the number of deaths and the resultant reduction in the rate of population growth, but because those who are dying are in the productive, working age groups. Unlike epidemics of the past, which targeted the weak, the very young and old, HIV infects the sexually active population, and infection rates are highest in the 25-35 year old age group. It is therefore, important to note that while mortality increases so its distribution across age groups also changes. Figure 3.5 displays the mortality pattern of Swakopmund with AIDS and how it would have been without AIDS.

Figure 3.5: Mortality Rates With and Without AIDS, Swakopmund



The 'Without AIDS' line demonstrates a typical mortality pattern. Between 0 and 4 years of age mortality is relatively high as a result of child illnesses. Mortality then remains low for many years, as few people between the ages of 5 and 30 die, and subsequently increases with age.

The 'with AIDS' line shows how this pattern changes as a result of HIV. Infant and child mortality will be higher as children are infected at birth. Mortality rates between 10 and 15 will be much the same as very few young children are infected with the disease. Mortality then increases dramatically from the age of 20 peaking at between 40 and 45 years of age as a result of AIDS. What this means is that 40 year old individuals experience a mortality rate typically associated with 70 year olds.

It is this change in mortality patterns which results in the socio-economic impacts discussed below. The age groups with the greatest increases in mortality as a result of AIDS are those most responsible for economic production and social care. They are the workers of Swakopmund and the parents of children.

Economic Impact of HIV/AIDS on Swakopmund

In the previous chapter tourism, retail, mining and construction were identified as the major economic sectors of Swakopmund. All will be affected, to different degrees, by the epidemic.

As with all employers the cost of labour in the tourist industry will increase, raising the costs of services offered to tourists. Depending on the price sensitivity of tourism, this may have a negative impact on the sector. This, however, is not likely to be the case particularly with regard to international tourism. The recent decline in the value of the Namibian Dollar may have led to an increase in international arrivals. However, this gain has not been as substantial as the decrease in the value of the currency indicating that the market is not that sensitive to price. The epidemic may, however, have a greater impact on local tourists. The local tourist market may be more sensitive to price and its stability or growth will be driven by the success of the national economy, as this will affect the availability of disposable

income. Much of Swakopmund's tourist market is derived from within Namibia and the SADC region and thus may be negatively affected by the epidemic.

The town's retail sector relies largely on unskilled and semi-skilled labour and the costs of these personnel are unlikely to increase substantially. Further, the market for this sector is supported largely by tourists and wealthy local residents and will therefore suffer little from changes in demand associated with the household impacts of HIV/AIDS. However those retailers who provide for the poorer residents of the town are likely to be affected by changes in the composition of demand. While this will have a detrimental impact on some, it may well benefit others depending on the goods and services being traded.

The mining and construction sectors will experience the most serious impacts. Both, but in particular the former, are reliant on skilled and semi-skilled labour and staff lost to HIV/AIDS will not be as easily replaced as in the retail sector (except for unskilled construction labour). The impact on the sectors will, however, differ in two regards. Firstly the construction sector employs workers on a more casual basis than the mines. The mining sector offers greater benefits to its employees and is therefore liable to experience a greater increase in the cost of labour as the price of these benefits increases. It is nevertheless in a better position to structure those benefits to benefit both the employees and the industry, as this type of formal employment provides the opportunity to develop prevention activities, wellness plans and possibly introduce treatment.

Secondly, the mining and construction sectors differ in terms of their distribution of profits and costs. In the construction sector a decline in profits associated with the increasing cost of labour will affect the town more directly than a similar or larger decline in the mining sector. While Swakopmund residents own many of the local construction firms, the large mining companies are owned by outside shareholders. If profits in the construction sector are reduced, owners have less income to spend in the town, affecting the retail sector. If, however, profits decline for those mining companies with external shareholders the decreased income will not affect the town, unless the decline is such that it affects employment levels.

The economic impacts of HIV/AIDS will be felt not only at industry level, but also by households and individuals. Individuals face reduced productive capacity, often resulting in lowered income, as they become unable to work as a result of AIDS-related illnesses. At the same time as access to money becomes more difficult, the need to spend on medical and other services increases.

The situation is the same at the household level, as individual illness often results in a fall in household income or production. Further, as HIV is primarily a sexually transmitted disease it clusters in households that then tend to suffer from multiple infections. The impact on income and production is then further exacerbated as productive activities and labour resources are diverted towards the care of ill household members. Finally, the illness leads to death and the household is faced with the cost of a funeral. In order to survive these impacts households may be forced to sell assets, borrow money or rely on support from family and friends. While such strategies may dampen impacts in the short term, they tend to lead to long term difficulties. Many households in Swakopmund are very poor and will have limited ability to deal with the impacts of HIV. The social consequences of this inability to cope may in the long term be far more profound than the economic impacts.

Affected households typically change the level and composition of the goods and services they demand. Expenditures are shifted toward medical services and away from savings and other forms of consumption. Retailers and producers will, therefore, be affected in different ways, some will experience an increase in demand and others a decrease. The economic impacts of HIV will, therefore, be felt not only by those infected but also by the entire community.

The Social Impact of HIV/AIDS on the Community

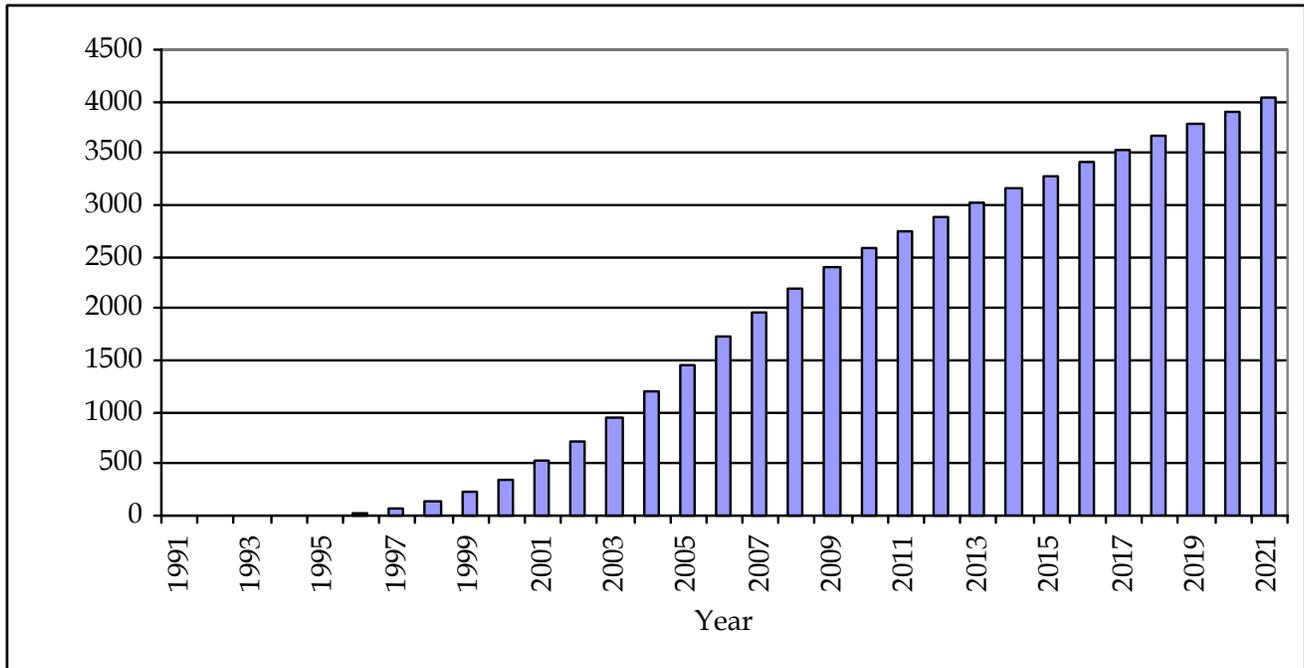
HIV/AIDS profoundly affects families and communities, resulting in the loss of labour and assets, as well as socio-cultural skills, and places almost unprecedented stress on community and extended family networks.

"Some of the most striking images of the HIV epidemic are of families, but of unfamiliar families: a grandparent surrounded by grandchildren, child-headed families, often brothers and sisters and cousins bonded together, dying adults tended by their children and communities of children without parents."
Peter Piot, Executive Director, UNAIDS

Orphans

The nature of HIV/AIDS is that it impacts communities and households over many years, and as the rate of illness and death increases, so the structure of these families and communities alters. As noted previously the age groups most affected by the increase in mortality are the worker and the parents. Losses in these age groups will leave many children in the city without parents. The following figure displays the rise in the number of children orphaned as a result of AIDS in the town:

Figure 3.6: Orphans as a Result of AIDS, Swakopmund (1991-2021)



It is already estimated that there are over 700 children in Swakopmund who are currently under the age of fifteen and have lost one or both of their parents as a result of AIDS. This number is expected to increase to over 2,500 in the next 10 years. By 2021 the number of AIDS orphans will have increased to nearly 4,500 children. The ability of local communities and neighbourhoods to absorb and care for children who have lost their parents will be strained by this rapid increase in orphans.

The impact of HIV/AIDS on children is arguably the single biggest long-term development impact. Failure to provide appropriate and adequate care for children who have lost their parents has serious implications for their development and long-term growth towards becoming productive, responsible members of any society.

The impacts of HIV/AIDS will change the demand for and type of services needed. Service providers, primarily governments and municipalities, will be expected to provide increased health and social welfare services, home-based and community care, and meet changing housing and education needs as a result of the epidemic.

At the same time as there is an increase in demand for services, which place unprecedented stress on both communities and providers, the ability to provide these services is eroded as key staff are lost. Nurses, teachers and social workers are not immune from infection and their mortality rates will also increase. The impacts of HIV/AIDS on services will have an impact on the entire community infected or not, orphaned or not.

Chapter 4: The Impact of HIV/AIDS on the Municipality

Introduction

This chapter reports on the impact of HIV/AIDS on Swakopmund Municipality. First, the ways in which HIV/AIDS affects local authorities are outlined. This is followed by a discussion on the internal impacts on the municipality itself, which are subsequently costed.

The next section of the chapter examines the external impacts of the epidemic in more detail, those affecting the Swakopmund community, the quality of life in the town, its economy and how these then affect the Council itself.

Impacts of HIV/AIDS on the Municipality of Swakopmund

HIV/AIDS results in demographic, social and economic changes in society, changes that will continue to affect both the public and private sectors in Namibia for the foreseeable future. The Municipality of Swakopmund will not be exempt from these impacts.

At the outset, what needs to be understood is that HIV infection precedes illness and AIDS death by some six to eight years, and for much of this time the disease remains invisible in those who are infected. It is only over the last several years of an individual's life as HIV progresses towards AIDS that frequent bouts of increasingly more severe illness are experienced. In other words, the AIDS mortality presently being experienced within Swakopmund Municipality results from HIV-infections acquired some six to eight years ago. The full impact of AIDS on the Municipality is only likely to be felt between 2008 and 2010 when the numbers of those falling ill and dying will reflect the currently high prevalence rate. This is what makes the immediate implementation of planning for the impact of AIDS illness and death within the municipality so important so as to prevent future infections, mitigate the impacts of the disease on the functioning of the Municipality and reduce the costs of the epidemic.

The challenge is that the epidemic erodes the ability of institutions, including local authorities, to provide services, as it reduces *both* efficiency and revenues, while the personnel losses induced by HIV/AIDS affect the quality of services provided. These impacts result from the sickness and death of municipal personnel infected with HIV, and can include:

- loss of productivity;
- increased absenteeism;
- cost of sick and compassionate leave;
- increased cost of benefits; and
- increased recruitment and training costs to replace lost staff members.

"The young people are dying, are we going to have Namibians tomorrow?" FGD Participant, Swakopmund

Studies (in West Africa) have demonstrated that HIV-positive individuals generally lose some four to six months of work time prior to the onset of AIDS, following which s/he is often absent from work, until death (Carr-Hill, Katabaro and Katahoire, 2000). The reality in Southern Africa appears to be increasingly frequent of bouts of illness and the loss of productive work time until death. There is thus a system-wide loss of experience and professionalism as the replacement and managerial stock, if available, becomes increasingly under-trained and under-experienced over time

Other losses are less easily quantified, such as those relating to the loss of experience (including institutional memory) and the effect of the illness and death of colleagues on staff morale.

Further, more managers and other skilled personnel will need to be trained within a given period of time than would otherwise have been the case. This results in increased expenditure on training (and recruitment) without an expansion in the supply of personnel overall, with less funding available for quality and service improvements. Similarly, recruitment costs increase. However, the largest costs to any system remain those from increased benefit payments and absenteeism due to illness, caring for sick family members and funeral attendance.

"The educated, skilled and experienced employees are the ones dying, and AIDS is breaking down the workforce." FGD Participant, Swakopmund.

The epidemic will also impact on revenue generation within the Municipality. Households infected or affected by HIV/AIDS will be less likely to be able to pay assessment rates and for services received. The demand for some services (e.g., water) is likely to increase over the short to medium term, but then increase at a much decreased rate over the longer-term, and with lowered ability to pay. As the numbers of these impacted households increase, the town's revenue base is eroded.

Simultaneously, AIDS affects the national economy (through the loss of skilled labour, reduced productivity as well as declining savings and investment, etc). In countries where prevalence rates are 20% or higher, such as Namibia, the GDP growth rate is expected to decline by some 1.5% to 2.6% per annum solely as a result of the disease. By 2020, GDP would thus be some 30% to 50% less than it would have been (Bonnell, 2000). While no detailed studies have been done on the macro economic impacts of HIV and AIDS in Namibia, the Government of Botswana has commissioned such a study. It concluded: "AIDS is a development of such proportions that it will inevitably have an impact on government revenues and spending, and therefore on the budget balance and government saving or borrowing. AIDS will have direct effects on some key areas of government spending, most obviously the health budget, but there will also be a range of indirect effects as the ability to raise tax revenues is affected" (BIDPA, 2000).

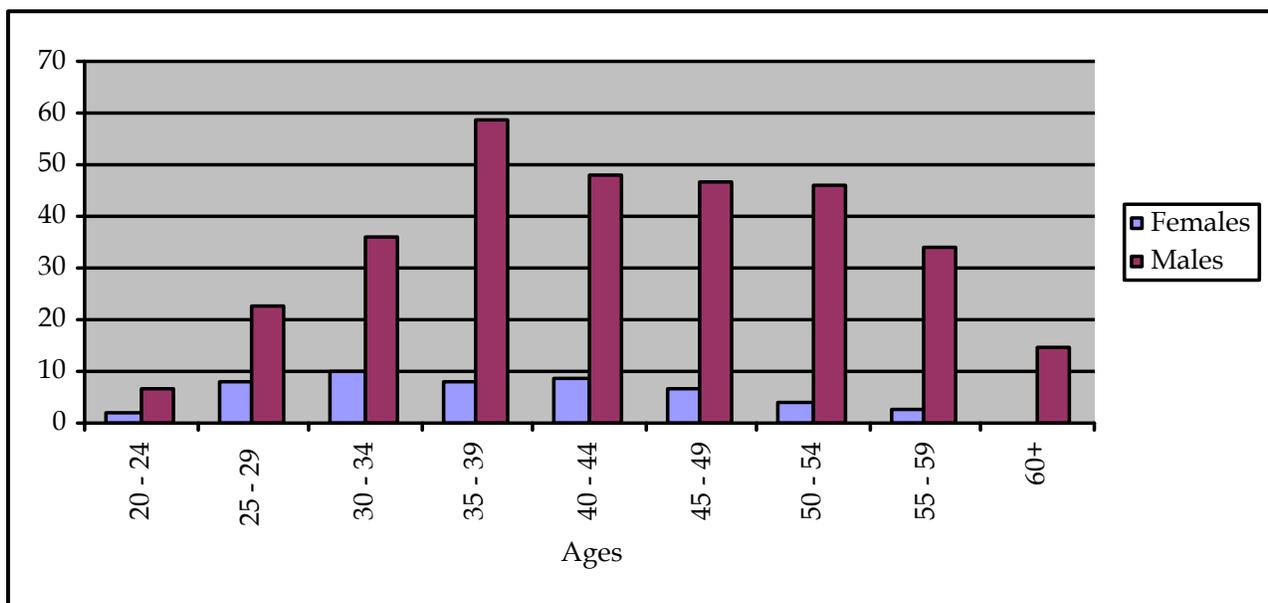
Thus at the macro level, the epidemic will reduce Government's ability to commit funds to local government, in the form of subsidies, grants and development loans, as AIDS-related demands from all sectors on available resources increase while revenues themselves decrease.

The remainder of this chapter discusses these impacts on Swakopmund Town Council.

Demographic Impacts

In 2001, Swakopmund Town Council employed some 366 individuals. The majority of these employees were males and only 51 were female (13.9%). The following figure illustrates the age and gender breakdown of Council staff. Of concern, is that many of the staff are in the age ranges most likely to become infected with HIV - 20 to 30 years of age for females, and 30 to 40 for males.

Figure 4.1: Personnel by Age and Gender, Swakopmund Municipality (2001)



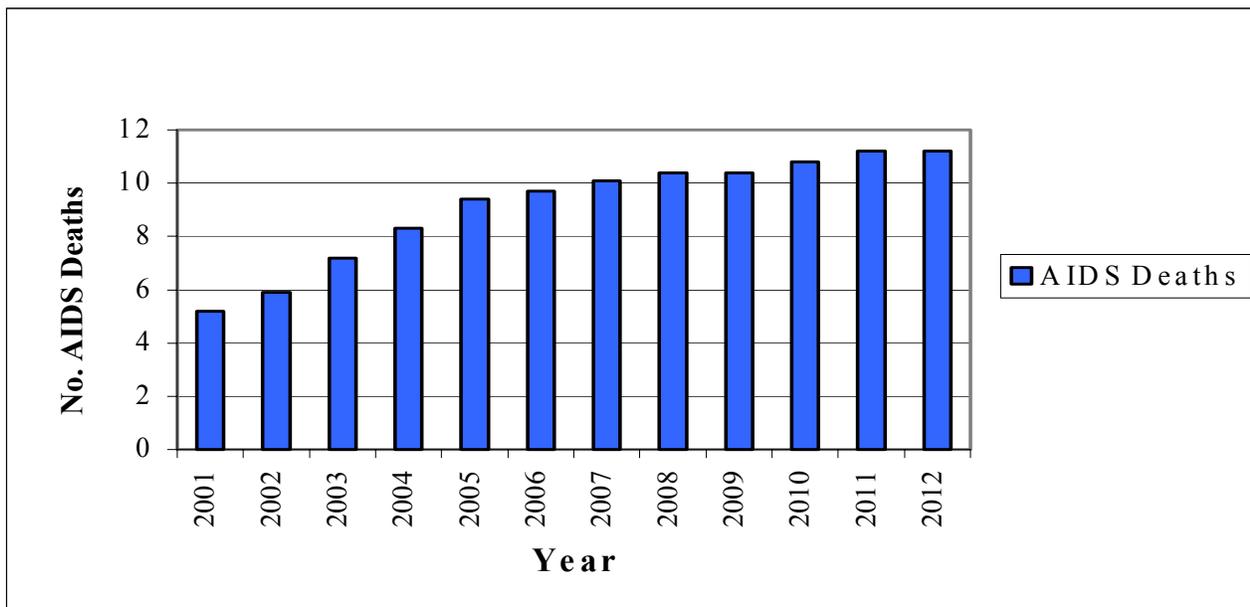
The demographic impacts of the epidemic were then projected on this sub-population using the SPECTRUM data developed for the overall population of Swakopmund. The period 2001 - 2012 was chosen for these projections, because, as was explained in the previous chapter, these reflect the current HIV prevalence rate in the town. It is assumed that the municipality will act to strengthen its efforts to prevent further infections and thus reduce the infection rate among its staff beyond 2012.

The assumption is that staff lost to the epidemic will be replaced, but that the total staff complement will remain the same as the economic impact of the epidemic over the projection period will reduce the need to increase the numbers employed by Council.

AIDS Deaths

Over the period, 2001- 2012 Swakopmund is projected to lose some 110 staff across all staff grades to AIDS, provided staff numbers remain the same. The AIDS mortality rate for the Municipality is illustrated in the following figure:

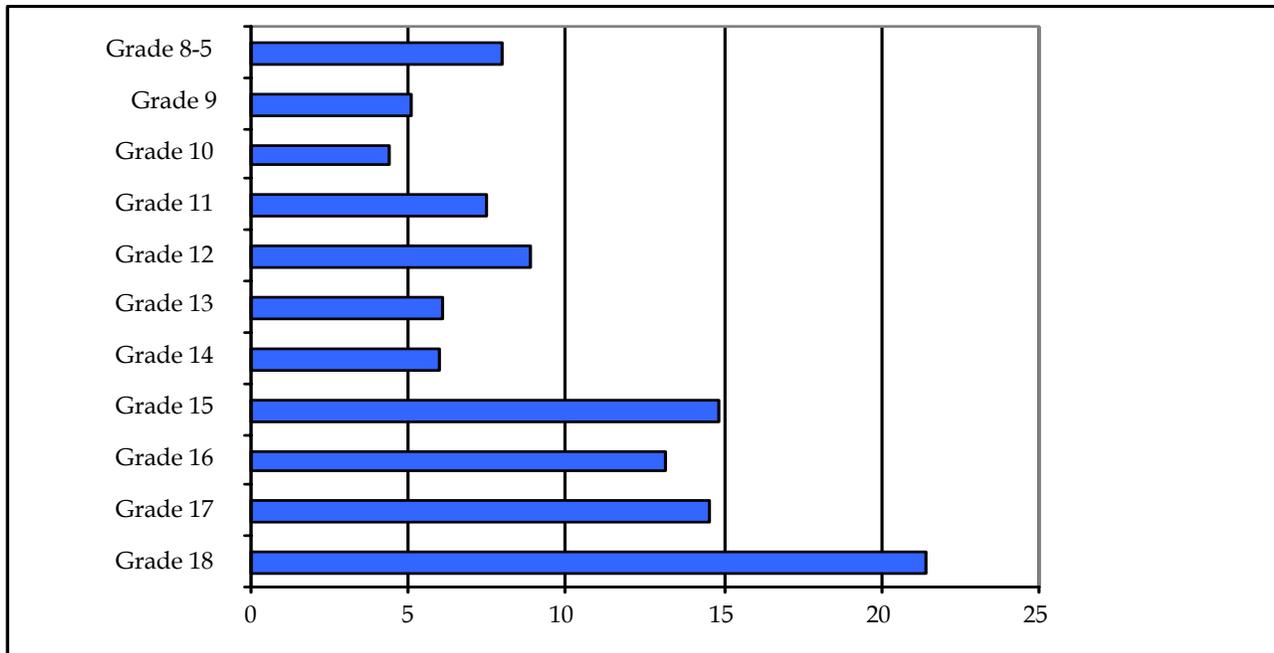
Figure 4.2: Total AIDS Mortality, Swakopmund Municipality (2001 - 2012)



As can be seen from Figure 4.2, AIDS deaths among Council staff are projected to continue to rise sharply from 5 deaths in 2002 to 10 in 2007. Deaths among Council employees are then projected to stabilise at between ten and eleven individuals per annum until 2012.

Swakopmund Town Council uses a grading system, with current staff occupying grades 5 to 18. The latter level is the lowest grade, occupied primarily by unskilled labourers, and the three lowest grades (those from 16 to 18) contain the most staff, some 45% of the Council's total complement. The AIDS death rate will be highest among these bands (simply because the numbers are higher), with one individual projected to die of AIDS each year during the early years of the projection, rising to four to five individuals over the period 2009 - 2012. The following figure illustrates all projected AIDS deaths by band over the period.

Figure 4.3: Total AIDS Mortality by Grade, Swakopmund Municipality



These levels of AIDS mortality will impact on the Council through increased absenteeism (sick and compassionate leave), productivity losses and increased replacement and training costs. These will require management and mitigation, with particular attention being paid to the financial and human resource implications, as discussed below.

Human Resources Management Information System

The initial and critical step in managing the impacts of the epidemic upon the Municipality itself is to make available data on personnel leave and absence from duty, by type (i.e., whether sick leave, casual leave for funeral attendance, etc., age and gender profile, etc. This permits managers to analyse trends and costs and indicates where the loss of critical personnel may occur allowing time for preliminary and succession planning, etc.

Swakopmund Municipality is fortunate in that its human resources information management system is among the best the consultants have examined in completing similar HIV/AIDS impact assessments on the private and public sectors across four countries in Southern Africa over the past several years. This system provides management with monthly data on all

personnel absences, by type, department and overall cost. It also provides data on personnel profile by age and gender. The only refinement required would be to provide cost data specific to the type of absence, i.e., sick leave, compassionate leave, casual leave, etc.

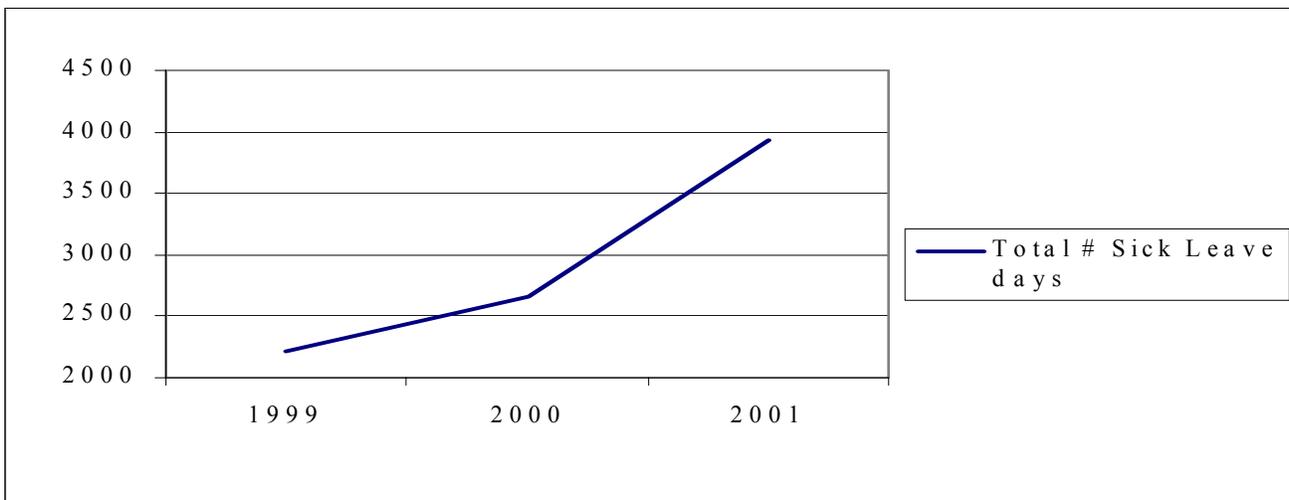
Sick Leave

The amount of sick leave taken by staff because of AIDS-related illness is one of the main costs of the epidemic to any employer. The reality of HIV/AIDS is that an employee who has AIDS becomes progressively ill, experiencing bouts of sick leave, generally over the last 12 to 18 months of their life. During this period, the individual remains on the payroll and cannot be replaced and is substituted by colleagues who act on their behalf, or by temporary appointments.

Sick leave policy is determined by the Local Authorities Act and Council employees are entitled to 120 days sick leave at full pay over any thirty-six month period, which can be extended by 120 days of sick leave at half pay over a thirty six month period.

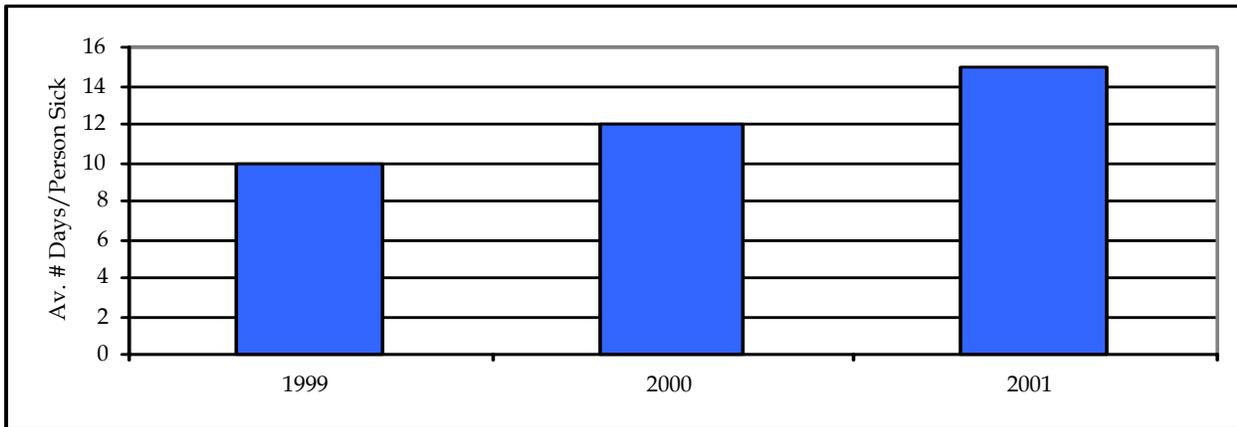
Over the period 1999 - 2001, the number of staff taking sick leave increased from 221 individuals taking 2,209 days off in 1999 to 254 staff who took 3,925 days of sick leave in 2001. The following graph illustrates this trend.

Figure 4.4: Total Sick Leave Days by Year, Swakopmund Municipality (1999-2001)



Equally, the average number of days per sick leave absence has increased over the three year period, from less than ten in 1999 to over fifteen in 2001.

Figure 4.5: Average Number Sick Leave Days per Absence, Swakopmund Municipality (1999 - 2001)

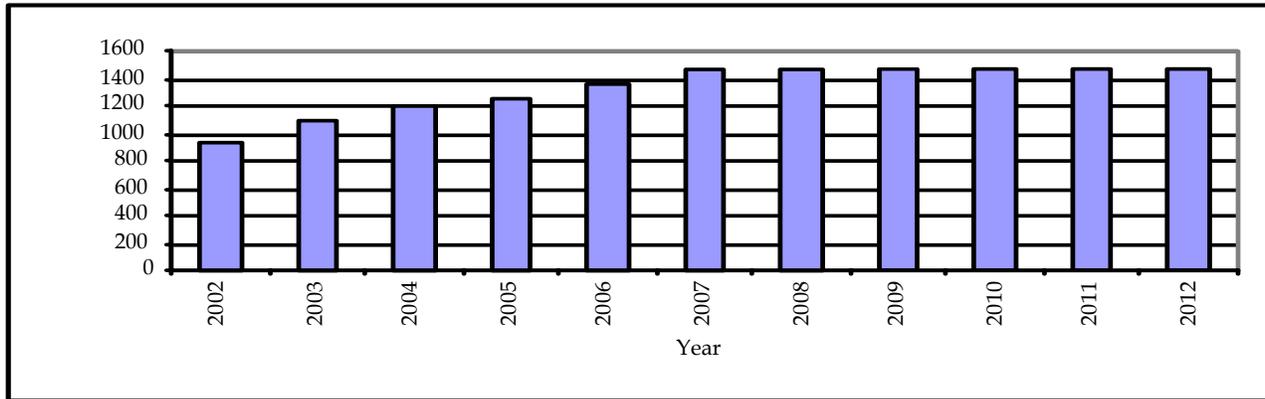


Swakopmund has in place a policy to cater for the chronically ill. This states that a staff member deemed to be chronically ill after examination by two doctors (one appointed by Council, the other by one of the two staff labour unions) can have their services terminated. While the policy, as written, is silent on benefits accruing to the individual involved, it is assumed that normal early retirement benefits will apply.

Using data made available by the municipality, sick leave for AIDS-related illness was analysed, and then projected. This analysis is based on the number of sick leave days taken by employees and recorded by the municipality. The average number of sick leave days taken has been increasing and is assumed generally to be a result of AIDS-related illness as there have been no dramatic increases in the number of employees. From the demographic projections used in this report, it was possible to estimate the level of AIDS related illness over the period which sick leave has increased. It was then calculated how many days sick leave those who were ill are likely to have taken to account for this increase in sick leave. This estimate was then used to project sick leave sick individual) to the number of estimated future deaths. Findings indicate that the number of sick leave days solely related to AIDS taken by Swakopmund municipal staff will increase from just less than 1,000 days in 2002 to

1,500 days per year over the period 2008 - 2012. Obviously, the costs of this will be high and programmes that encourage positive living and wellness could assist in reducing these.

Figure 4.6: Projected AIDS-related Sick Leave, Swakopmund Municipality (2002 - 2012)



Staff Attrition

The following table presents data on staff attrition over the past three years. It is noted that the disability retirement and death figures closely equate to the data projecting AIDS deaths among municipal staff.

Table 4.1: Staff Termination Trends, Swakopmund Municipality (1999 - 2001)

	1999	2000	2001
Retirement	8	2	7
Resignation	14	7	13
Disability Retirement	0	5	1
Death	4	6	2
Totals	26	20	23

Medical Aid

Medical Aid contributions are a benefit received by staff. These are made available through Namibia Medical Care, and employees have a choice of medical aid plan. Council pays half the monthly cost of this on behalf of employees. Certain AIDS medication costs (for opportunistic infections) are paid up to a monthly limit. The cost of medical aid to Council and to employees will rise as the number of those requiring AIDS medication increases.

The municipality paid N\$1.8 million as its contribution towards employee medical aid in 2001. These costs are expected to continue to rise in the face of the epidemic. The implications of this can be seen in the costing section below.

Training

Subject to its policies, Council provides training to staff. HIV/AIDS will increase the need for training of Municipal personnel, as employees are lost to the epidemic early in their careers. Equally, private and other sectors, offering higher salary and benefit packages, will increase the rate at which they "poach" trained municipal staff as they in turn lose employees. This is likely to be particularly true for skilled Municipal staff and those trained to degree level. This, in its turn, will increase the costs of training provided by the Municipality as it further increases staff turnover.

Municipal training policies, therefore, need to include strategies for maintaining and developing skilled staff. These have to be based on the provision of more frequent, but shorter-term training opportunities, within affordable cost parameters.

Critical Functions and Posts

Many of the costs associated with HIV/AIDS can be identified and with some difficulty quantified. Many, however, are more difficult to determine and these less obvious costs and consequences may be larger and more important. These include the loss of institutional memory, the impact on staff morale, and the inability to perform critical functions as a result.

The Assessment attempted to identify critical posts through the key informant interviews. Those interviewed were first asked to identify essential and critical functions in their departments or sections. Following this, they were asked to identify the posts critical to achieving these functions.

In most instances, officials were able to identify critical functions. The identification of the posts (i.e., individuals) fulfilling these functions became more difficult. The epidemic will increase the demand for services across many municipal departments, but particularly those responsible water, refuse removal, housing, etc. Attention will need to be paid to strengthening departments where increased service delivery will be required as a result of the epidemic.

The Town Treasurer's department was viewed vulnerable because the head of the department is the only one who understands all financial issues and how to make viable investments. It would thus be difficult for sub-ordinates to assume these responsibilities if the Treasurer was unavailable for long periods of time. While the Works department was not seen to be vulnerable to the impacts of HIV/AIDS, the general maintenance team, which is part of this department, was seen to be a critical function as the foreman is also the driver for the team.

Pension Fund

The Retirement Fund for Local Authorities in Namibia operated as a defined benefit fund until 1992, when due to the large number of claims it changed to a defined contribution fund. This means that the amount paid to member's families on their premature death was reduced.

In April 2000, the fund further reduced the level of its death benefits, as these payments had become unsustainable due to the high number of claims, which were resulting in an increase in the cost of premiums.

Prior to April 2000, the fund provided a benefit payment equal to three times annual salary as lump sum at the death of a member, plus a monthly income of 50% of base monthly salary and 10% for five minors up to the age of 25, providing they were attending an institution of higher learning. Employers pay into the fund 21.7% of the employee's base monthly salary,

of this amount 14% is used for investment, 6% goes to pay death benefits and 1.7% provides for the fund's administration. Employees contribute 10% of base monthly salary to the fund.

The current death benefit allows for a once off lump sum payment of 5.3 times annual salary at the death of a member, three differing options based on the level of guarantee and investment. This amount is not fixed and will be reduced if found to be too expensive.

The Retirement Fund for Local Authorities in Namibia Investment Report of 31st December 2001 reveals that the fund had investments in Namibia and South Africa, with a market value that totaled some N\$ 3.7 billion. The rate of return on these investments over the past 10 years was 16.3%.

As at the valuation date, the contribution rate required to cover the cost of risk benefits and other expenses, expressed as a percentage of pensionable salaries, was estimated as follows:

Table 4.2: Contribution Rate Required

Benefit Type	Percentage
Death Benefits	4.80
Disability Benefits	1.20
Total Risk Benefit Contribution	6.00
Expenses	1.70
Required Contribution Rate	7.70

The current contribution rate is therefore sufficient to provide for the risk benefits and the expenses. If, however, deaths increase while benefits and contributions remain constant, the required contribution for risk benefits will increase leaving less available for pensions.

In sum, the funds operate on the basis of defined contribution (as opposed to defined benefit), that is, the benefits received are determined by the amount of the contribution made by and on behalf of the employee, and the return on the investments made by the fund. This, while protecting the Fund for depletion resulting from the increased costs of AIDS mortality, does not reduce the cost of the epidemic. It merely switches these costs from the Fund to members, and the households and the communities in which they live.

The impact of HIV/AIDS has caused the funds to lower the death benefits and to increase the cost to the members. This trend will continue as more members die from the diseases associated with AIDS and the death benefits claim continues to rise.

Succession Planning

Succession planning is in place as part of the Council's Affirmative Action Policy and Programme. Succession plans are being introduced and training will be given to 'understudies' to prepare them for new posts and responsibilities. This planning will need to be widened both to include succession planning for posts identified as critical as a result of this Assessment of the Impact of HIV/AIDS and to accommodate the impact of AIDS on the municipality's affirmative action plans.

Costs

In order to estimate the cost of the epidemic to the local authority a simplified model was developed as a guide to where the major costs of the epidemic will lie. The assumptions behind these costs are discussed in Annex C to this report containing the detailed costing tables, the notes and assumptions on each of the costing sheets used. Copies of the model will be made available to each of the municipalities, so that they can be used as an ongoing planning tool. The assumptions upon which the following figures are based will need to be updated and modified, as improved data becomes available.

The main costs associated with the epidemic lie in increased absenteeism, medical aid contributions and the costs of productivity lost. Over the nine year period (2002 - 2010) the cost (at present value) will be N\$4,222,712 across all bands. The following table provides data on these increased costs by grade. The figures are discounted totals, i.e., are shown at present value.

Table 4.3: Total Increased Costs Resulting from the Epidemic by Band, Swakopmund Municipality

Grade	2002	2003	2004	2005	2006	2007	2008	2009	2010
18 - 16	58,382	62,348	63,424	62,740	65,436	62,674	62,547	59,549	56,703
15 - 5	320,520	346,125	352,125	346,740	345,559	350,186	330,652	314,728	299,650
All Bands	378,901	408,595	415,550	409,480	410,995	412,860	393,199	374,277	356,353

The following tables present the breakdowns for each band. The detailed working table, explanations and calculations are contained in Annex C to this report. It should be noted that the mortality rates and sick leave data used are taken from data contained in the two previous chapters of this report.

Table 4.4: Total Increased Costs Resulting from the Epidemic on all Bands, Swakopmund Municipality

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Deaths	6	6	8	10	11	11	11	11	12	12	12
Sick leave											
Days	880	1061	1309	1431	1461	1461	1486	1537	1608	1608	1608
Cost	173352	213080	269709	293614	296683	296683	303394	316815	335605	335605	335605
Compassionate leave cols	2196	2196	3458	3988	4190	4190	4190	4190	4720	4720	4720
Productivity	52075	67920	77171	81084	81444	81444	86602	91090	93292	93292	93292
Recruitment	1869	1869	2804	3116	3427	3427	3427	3427	3739	3739	3739
Training	3926	3926	6231	7228	7540	7540	7540	7540	8537	8537	8537
Sub total	233417	288991	359373	389029	393283	393283	405153	423062	445893	445893	445893
Benefit increase	111483	111483	111483	111483	111483	111483	111483	111483	111483	111483	111483
Compassionate leave family	16091	18649	20684	22137	22945	23219	23217	22939	22789	22674	22742
Bad debt	0	0	0	0	0	0	0	0	0	0	0
Sub total	127575	130133	132167	133620	134428	134702	134700	134422	134272	134157	134225
Total	360992	419124	491540	522650	527711	527985	539853	557485	580165	580050	580118
Discounted total	360992	399166	445841	451484	434149	413690	402847	396194	392678	373905	356142
Present value cost	4427089										

Table 4.5: Total Increased Costs Resulting from the Epidemic on Bands 18 - 16, Swakopmund Municipality

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Deaths	3	3	4	4	5	5	5	5	5	5	5
Sick leave											
Days	364	415	471	521	552	552	552	552	552	552	552
Cost	36804	41920	47546	52662	55731	55731	55731	55731	55731	55731	55731
Compassionate leave cols	606	606	808	808	1010	1010	1010	1010	1010	1010	1010
Productivity	6210	7921	8281	9991	10351	10351	10351	10351	10351	10351	10351
Recruitment	935	935	1246	1246	1558	1558	1558	1558	1558	1558	1558
Training	935	935	1246	1246	1558	1558	1558	1558	1558	1558	1558
Sub total	45490	52316	59127	65953	70207						
Benefit increases	11266	11266	11266	11266	11266	11266	11266	11266	11266	11266	11266
Compassionate leave family	1626	1885	2090	2237	2319	2346	2346	2318	2303	2291	2298
Bad debt	0	0	0	0	0	0	0	0	0	0	0
Sub total	12892	13150	13356	13503	13584	13612	13612	13584	13568	13557	13564
Total	58382	65466	72483	79456	83791	83819	83819	83791	83776	83764	83771
Discounted total	58382	62348	65744	68637	68935	65674	62547	59549	56703	53995	51428
Present value cost	673942										

Table 4.6: Total Increased Costs Resulting from the Epidemic on Bands 15 - 5, Swakopmund Municipality

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Deaths	3	3	5	6	6	6	6	6	7	7	7
Sick leave											
Days	515	646	838	909	909	909	935	985	1056	1056	1056
Cost	136547	171161	222162	240952	240952	240952	247663	261084	279874	279874	279874
Compassionate leave cols	1590	1590	2650	3180	3180	3180	3180	3180	3710	3710	3710
Productivity	45864	59999	68891	71093	71093	71093	76252	80740	82942	82942	82942
Recruitment	935	935	1558	1869	1869	1869	1869	1869	2181	2181	2181
Training	2991	2991	4985	5982	5982	5982	5982	5982	6979	6979	6979
Sub total	187927	236675	300246	323076	323076	323076	334946	352855	375686	375686	375686
Benefit increases	100218	100218	100218	100218	100218	100218	100218	100218	100218	100218	100218
Compassionate leave family	14465	16765	18593	19900	20626	20872	20871	20621	20486	20383	20444
Bad debt	0	0	0	0	0	0	0	0	0	0	0
Sub total	663	116982	118811	120118	120844	121090	121089	120839	120704	120600	120662
Total	302610	353658	419057	443194	443920	444166	456034	473694	496389	496286	496347
Discounted total	302610	336817	380097	382848	365214	348016	340300	336645	335976	319910	304714
Present value cost	3753148										

Services and Planning

Demand for housing and services lies primarily in Swakopmund's lower income neighborhoods where the majority of the town's residents live.

The demographic projections discussed in Chapter 3 indicate that the city's growth rate will be reduced by the epidemic over the next twenty years. By 2010 the population of the town will be 12% smaller than it would have been in the absence of AIDS, and by 2021 it will be over 20% lower. This reduction in the size of the population has implications for planning of service delivery over the next ten to twenty years.

However, given the backlog in housing, erven and service delivery, it is unlikely that the reduced growth rate of the city's population will permit any reduction in the planned delivery in Swakopmund's north and eastern areas over the next ten years. What this reduced growth rate does imply is a decrease in the rate at which service delivery would need to be increased over the next ten years in order to accommodate new migrants who will continue to arrive in the town.

The nature of the demand for housing will also need to accommodate changes. As the epidemic progresses in Swakopmund, there will more AIDS orphans and more households headed by children. Their housing needs and requirements are different and will need to be taken into account by planners. In this regard, useful housing models, more suitable for child-headed households, are being developed in South Africa, particularly KwaZulu Natal.

Governance

In Namibia, municipal and town council officers are democratically elected to provide service to their communities. They are thus the tier of government closest to the people they serve. The HIV/AIDS epidemic will impact on the process of local elections and the relationship between councillors and those they represent.

Firstly, councillors, as elected representatives, will be expected by their communities to lead the local response to the epidemic. This entails not only ensuring that the local authority manages and plans for service provision in the face of the impacts of HIV/AIDS, but that it actively develops and implements efforts to prevent infection and provide support to those who are infected at the grassroots level. As the impact of the epidemic deepens over the next eight to ten years, the local electorate will demand that councillors respond. If they fail to do so, voters may become increasingly dissatisfied and may vote office-holders out of office, shift their support to other candidates, or even stop voting altogether.

Secondly, councillors themselves will not be immune from the epidemic. They too will be faced with the illness and death of relatives and friends, adding to their burden as elected officials. In addition, some will themselves be infected with the virus. Already, anecdotal stories and first-hand reports from countries in the region tell of HIV infection among senior officials, and local councillors cannot assume that they or some of their colleagues will not also be infected and become ill due to HIV infection.

Thirdly, the epidemic will reduce the resources available for municipal-level service provision, by reducing the tax base or redirecting resources to AIDS-specific programmes and services. This reduction in resources, combined with the reduction in capacity at the local level, will occur at the same time that the epidemic results in increased demands for local government support and services.

Fourthly, the epidemic has the potential to impact on the electoral process itself. AIDS could make elections more difficult and more expensive to hold, by affecting some of the officials and civil society representatives who administer elections, and by complicating the process of ridding voter rolls of those who have died as a result of the epidemic. In addition, residents may be less likely to vote if they are ill or occupied with caring for an ill family member. AIDS will also cause increased illness, retirement, and death of elected officials, which will result in more frequent by-elections, further increasing costs to the municipality. In addition,

by-elections usually have much lower turnout than general elections, which means the officials elected in this way may have less support from, and connection to, individual voters and the communities that they serve.

External Impacts

The municipality is not an isolated institution. The impacts on the municipality will have implications for the wider community, just as those on the wider community will impact on the municipality.

Firstly, the economic impact of HIV/AIDS in Swakopmund may affect the Council's revenue. The revenue of the municipality is generated through the collection of rates and the sale of water and electricity, and the provision of sanitation and sewage services, which collectively account for over 70% of total revenue.

Land is sold in two ways, through auction to those who have money, particularly seaside erven, while lower income earners buy erven and construct houses through the Build Together Project. Those in low-income categories are assisted to acquire land with the municipality facilitating this process. However, loans are only available to those who apply through the Build Together Project and other sponsored programmes. Each of these loans is, however, insured against the death of the property owner.

HIV/AIDS will affect these sales in a number of ways complicating the achievement of delivery targets and interfering with revenue flows. If land or property is purchased from the municipality with no financial ties between the buyer and the municipality existing after the sale there will be little impact as a result of the epidemic. The possible exception is that house and land prices and the health of the market will be affected by HIV/AIDS via the epidemic's impact on the local and regional economy.

If, however, the municipality finances the sale of property or they administer that finance, there will be impacts. A loan agreement involving the municipality in any way means that the council will be involved if the owner dies. If the municipality administers the loan there will be an increase in the costs associated with processing and dealing with that death. In cases where any municipality finances the sale itself than there will be an increase in administrative costs, possible loss of revenue and a decline in profitability.

Administrative costs will increase as deaths increase as changes in the financial arrangements will have to be processed or repossessions conducted. For example, in the case where upon death of the house or plot owner a substitute beneficiary purchaser is identified, the agreements will have to be amended to reflect this change.

In the situation where the sale is financed by the municipality itself there is a risk that the council will lose revenue as payments stop. While the agreements include life insurance cover this will become more expensive and as deaths increase this cover will become more difficult to arrange, especially for low income groups. This may be further complicated if a household is left impoverished by the impact of AIDS or contains orphans who have no alternative accommodation.

Even if outstanding debt is covered by an insurance policy, death will decrease the profitability of sales. Sales of property generate revenue in two ways, firstly through the capital payment and secondly through the interest received. Insurance protects the capital, but early payment following a death means the loss of interest income for the remaining years of the loan.

Rates are an important source of income for the municipality. Ratepayers can be divided the private sector and households. While there will be a negative impact on the private sector, for most business owners, rates are unlikely to be a major cost component in their business operation and their ability to meet this obligation should not be affected.

However, at the household level the impact of the epidemic could affect the ability to pay rates. In addition, as the death rate increases it is likely to cluster in households and create a series of economic shocks over several years for these. These latter households will be increasingly unlikely to be able to pay for services over several months.

The sanitation, sewerage and water services are run on a policy of no profit/no loss. Therefore, while the performance of the economy and the growth rate of the city may affect the level of demand for these services, this should do little to the financial position of the municipality. This is because any change in revenue should be accompanied by a similar change in expenditure. A similar impact to that relating to rates concerning ability to pay for these services may, however, present itself.

In regard to water service, it should be noted that growth in overall demand would increase less rapidly than in the past as a result of slowed overall population growth. However, in AIDS-affected households, which are caring for the sick and dying, short-term per capita consumption of water will increase, while their ability to pay for this service will decrease.

Electricity provision is, however, different. Electricity is purchased by the council from NamPower and sold at a premium to consumers. The profit generated is used to finance other operations as well as Municipal investments. It is likely that overall electricity sales are related to the performance of the regional economy. Any factor, such as AIDS, depressing the growth of this economy will depress the growth in demand for electricity and therefore the growth in revenue of the municipality. The performance of the city's economy will, therefore, influence the revenue of the council mainly through its impact on electricity demand. Ability to pay for electricity at the household level will also become an issue.

The other major impact on revenue results from household economic impacts and ability to pay for services. Studies elsewhere in Africa (for example, in Uganda, Tanzania and South Africa) have found that the greatest impact on the household occurs just after death. After the long financial strain of recurring illness, the household is faced with the cost of burial. At

this stage households find it difficult to meet other expenses. The impact on municipal revenue resulting from household impacts will largely be determined by two factors: which expenditures the household sacrifices when these financial problems occur and the Municipal response to non-payments.

It is not possible to determine the number of households likely to be infected or affected by HIV/AIDS. However, the epidemic will not be spread evenly across all households, it will cluster, and because the disease co-varies with educational levels and poverty it will also not be spread evenly throughout all neighbourhoods.

Further household ability to pay for services will be constrained and their willingness to pay for these is unknown. This can only be assessed through household level quantitative surveys, which are beyond the scope of this assessment. However, it may be that households suffering AIDS-related economic shocks would be willing to pay for Municipal services, sacrificing other items in the household budget.

If the household has to reduce or redirect expenditure, but they choose to cut back on other products and services rather than those provided by Swakopmund Municipality, there will be no impact on revenue. If, however, households stop paying for some or all services provided by the municipality, the impact on revenue will be affected by the response of the municipality to this non-payment. If, for example, a household were unable to pay for electricity the typical response would be for the council to warn of disconnection, and then stop provision of the service. This response makes it more difficult for the household to recover from the crisis, as they are now faced with debt and reconnection charges. During the period of disconnection the municipality is making no profit. Alternatively the municipality could offer a reprieve from payments for a short period of time following a death. This would reduce the pressure on the household. Further, it should result in fewer disconnections, reducing these municipal costs. Once this period has passed the household can resume payments. In the long term this may be more financially beneficial to the household and the municipality as the profits associated with disconnection are not lost.

In practical terms an alternative policy could take the form of a two-month reprieve following the death of an account holder. Before such a policy could be adopted further investigations into the financial implications would be necessary.

The above discussion has focused on the possible impacts of the epidemic on revenue levels. A related and important issue is the impact on revenue growth. All major sources of revenue are related to the size of the city, in terms of area and population. In the demographic section of the previous chapter, the slowing in the rate of population growth was discussed. This slowing in population growth will translate into a reduction in the rate of revenue growth. However, growth in expenditures is also slowed and the net financial position of the municipality should be relatively unaffected.

There is, however, one possible set of financial impacts associated with slower growth. The staff and productive capacity of the municipality has to increase as the city grows. If the rate of increase in staff and productive capacity is based on previous population growth rates for the city than expenditures will increase faster than revenues. To prevent such an occurrence it is essential that planners include the impact of the HIV/AIDS epidemic now, as any increases in capacity, say for electricity provision, involve long term planning. This is particularly important in small towns, such as Swakopmund, where investments, such as a new sub-station are a significant cost item.

Equally, the demand for burial space and cost associated with its allocation, preparation and maintenance will increase as the death rate climbs and will need to be planned for. How great such an increase will be is difficult to estimate. Many residents of Swakopmund are migrants from elsewhere in the country. They may well opt to return home while ill and die outside of the city.

The HIV/AIDS epidemic will impact not only on the revenue of the municipality, but also on the level and pattern of expenditures. Firstly the council is a large employer and will

therefore experience the increasing cost of labour associated with the disease. The magnitude and implications of these increasing costs was discussed earlier in this chapter. Clearly, they will increase the expenditure of the municipality while no increase in revenue or provision of services is generated.

The above discussion has focused on existing revenue flows and services. The HIV/AIDS epidemic also poses new problems and the municipality will be required to respond to these. One such is likely to be changing housing demand. Within ten years there will be 2,500 orphaned children in Swakopmund. Planning for their housing needs will require the introduction of differing planning designs and standards. The introduction of these and other new services obviously have cost implications.

The Municipal Response

In completing this Assessment, concern as to the impact of HIV/AIDS on programmes and service provision was expressed by Swakopmund officers. However, mitigation of these impacts is not yet in place. This Assessment is intended to assist in addressing these.

A draft Workplace Policy is in place, largely derived from that developed by Swakopmund's neighbouring town, Walvis Bay. This Policy awaits Council approval.

Knowledge, Attitudes and Practices

Findings indicate that information needs to be provided to the Swakopmund Town Council staff. In order to raise awareness, and improve knowledge, attitudes and practices surrounding HIV and AIDS should change. The staff of Swakopmund Municipality demonstrate a lower level of knowledge of HIV/AIDS and more negative attitudes towards individuals living with HIV/AIDS than those in Walvis Bay. All but one of the thirteen mid-level participants interviewed in the Focus Group Discussions responded correctly to the general questions on HIV/AIDS, on the methods of transmission and on how HIV could not

be transmitted. Lower grade staff were less able to provide correct responses on the disease. This may be due to the fact that there have been fewer HIV/AIDS initiatives undertaken by the Swakopmund municipality.

While most participants thought that HIV/AIDS was a serious problem for the municipality and all of Namibia, several felt that certain people do not take it seriously. They showed concern about the negative impact of HIV/AIDS on service levels, quality and standards, and on the municipality pension programme.

Twice the number of participants thought that an HIV-positive mother would automatically infect a baby than those who did not. One third of the participants thought that condom use added to the transmission of HIV rather than preventing it. One man was particularly worried that the condom lubricant might contain a virus.

“I do not have a good understanding about the disease, I only came to learn about it in recent years.”
SWAG Participant

While none of the mid-level grade (8 - 11) respondents could state the difference between HIV and AIDS, all but one participant in the other groups exhibited a correct understanding of HIV versus AIDS. Only one person thought that an HIV positive person might show symptoms (hair loss was stated). All participants who responded to the question on AIDS symptoms, but one, gave a correct response. The following table illustrates some of the responses provided:

Table 4.7: Attitudes to HIV and AIDS, Swakopmund Municipality

Statement	No. of Participants	
	True	False
Question: “If a pregnant woman has the HI-virus, her child will inevitably get the HI-virus as well.”	4	2
Reasons for “false”: <ul style="list-style-type: none"> • One cleaner said, “There are stories about some medicines which can prevent children from being infected by their infected mothers.” Reasons for “true”: <ul style="list-style-type: none"> • A newly born child will be infected during the birth. • A baby is formed by the mother’s blood. 		

Statement	No. of Participants	
	True	False
Question: "Kissing someone who has the virus can result in infection, as it can be transmitted via saliva."	0	11
Not sure: <ul style="list-style-type: none"> • Three participants were not sure and could not say anything on this statement. 		
Question: "Condoms make the transmission of HIV more likely."	2	6
Reasons for "true": <ul style="list-style-type: none"> • "I can't trust a condom itself because I don't know where condoms are produced and I also don't know about the something inside of condoms which makes them wet. What is the purpose of this? Isn't it a virus, which we are trying to prevent?" 		
Question: "Someone who is infected with HIV will show clear symptoms, so one can tell who is HIV positive and who is not."	1	4
Reason for "true": <ul style="list-style-type: none"> • Sometimes a person with HIV will have their hair falling out. 		

Just over half of the participants in the Focus Group Discussions and SWAG mentioned that they knew of people who have died of AIDS. Others said it was difficult to know if some one had died of AIDS or was even HIV positive because of the "confidential" nature of the disease. All participants stated that AIDS is a serious problem in Namibia.

When participants were asked to state whether they "agreed" or "disagreed" with a series of eight attitudinal statements, there were unanimous answers on half of the questions, as shown below.

Table 4.8: Attitudinal Responses, Swakopmund Municipality

Statement	Agree	Disagree
Question: "I don't think that there is anyone in our local authority who has the AIDS virus."	0	5
Reasons for "disagree": <ul style="list-style-type: none"> • Some people are sick in the municipality although the respondent does not know from what. 		
Question: "There is a serious problem of 'sugar daddies' in our community."	5	0
Reasons for "agree": <ul style="list-style-type: none"> • "Most of the migrant workers are involved in this". • "It is not just men. You can also find some adult women who spend their nice time with young boys of whom some are young 		

Statement	Agree	Disagree
enough to be the woman's last born child."		
Question: "If someone is known to have the HI virus, they should be isolated."	0	6
Reasons for "disagree": <ul style="list-style-type: none"> "They are also human beings. We need to give them love and respect." "Even some of our heads of state, directors, doctors, nurses, and teachers are HIV positive." 		
Question: "Households that are taking care of an AIDS patient are avoided by other households."	1	3
Reasons for "agree": <ul style="list-style-type: none"> "People are not educated and are fearing the disease." 		
Question: "A number of people believe that they can be cleansed of the AIDS virus if they have sex with a virgin."	0	5
Question "If a woman wants to use a condom but the man does not, the man's decision should rule and they should still have sex."	1	5
Reasons for "agree": <ul style="list-style-type: none"> The husband can use a condom when he is having temporary sex. Then he does not need to use one with his wife." 		
Question: "If one is in a long-term relationship, it is really impossible to refuse sex, including sex without a condom, even if you fear that they have a sexual infection."	2	1
Reasons for "agree": <ul style="list-style-type: none"> "The wife who is in a long-term relationship can refuse only one day or may be two. But it is impossible for her to refuse without a reasonable problem, unless a divorce should be applied for." 		
Question: "If a shopkeeper has the HI virus, I would still buy products from them, including fresh produce."	3	2
Reasons for "disagree": <ul style="list-style-type: none"> "I have heard of a story in the north where a woman bought an apple and found blood in it. So I won't buy fresh produce." 		

All participants thought that the impact of AIDS on the municipality would be quite serious, leading to a drop in work level, standards and quality. Regarding the pension scheme, everyone thought that AIDS would create financial problems for the scheme especially since fewer people will be paying into the scheme and greater benefits would be paid out.

Interventions

While participants in the interviews do take AIDS seriously, they were split in their opinions on whether others thought AIDS is serious enough to warrant any interventions. All felt that

all municipality staff should be targeted for AIDS interventions equally, although one participant did mention that migrant workers might be at greater risk than the rest of the workforce.

Staff interviewed suggested the following as "ideal" prevention activities:

- An HIV/AIDS committee should be established at the workplace.
- One person from each section in the municipality should be responsible for HIV/AIDS related issues. This person should be trained to provide quality information about HIV/AIDS.
- Support groups should be established for people who are infected.
- Organisations dealing with HIV/AIDS should be invited to make presentations.
- Condoms and information pieces should be placed at the place where employees register for work every morning. Condom distribution should include demonstrations of their use.
- Videos of people suffering from AIDS should be shown.
- Drama should be used as an information dissemination tool.

In discussing the implementation of ideal interventions the staff of the Town Council believed the following issues needed attention.

Awareness Raising

Municipal management should talk about the dangers and seriousness of the disease. All monthly departmental meeting should have something on the agenda on HIV/AIDS. The Health Department should always have information on HIV/AIDS. Someone from inside the municipality should be sent for training and be responsible for awareness raising in the municipality *and* town. Awareness sessions should be held during working hours, because some people would not attend if these were held outside work time.

Political Will

Participants agreed that top management of the municipality should become more active in the fight against this killer disease. This type of process should be ongoing and not just a once-off event. Management must be serious about the epidemic if staff and ordinary people are to take the issue seriously. Participants noted that some managers and other leaders are reluctant to talk openly about AIDS.

"The issue of political will is very easy, people should stop saying that HIV/AIDS is a problem for the Department of Health, it is a problem that affects all of us." SWAG Participant, Swakopmund

Interventions to Reduce High Risk Behaviours

Participants agreed that high risk behaviour interventions are desperately needed in Swakopmund 'because many people who work here are from elsewhere, especially the north'. 'Some people, who have wives elsewhere, commit themselves to relationships in Swakopmund and condoms are not used'. 'Pamphlet and leaflets should also be distributed and people should be educated at the grass root level'. One respondent felt that high risk behaviours should be discussed in departmental meetings.

Condoms

Almost all participants stated that the Town Council should make condoms freely available, especially on Fridays and that someone should be invited to the municipality to give condom demonstrations

"People always want to have sex and there is nothing that anyone can do to stop them. The only method to reduce infections, would be to provide condoms to people." FGD, Swakopmund

Financial Support

One participant felt that finances was the key to make interventions effective and acceptable to people. Others indicated that money should be put into a trust to assist HIV/AIDS

infected people. Participants from a SWAG group indicated that it would be best if all workers came together and discussed ideal financial interventions, since they were not quite sure what it was supposed to look like. They also felt that people would not be too reluctant to contribute towards such a fund, 'because anyone can be infected'. The involvement of top management of the municipality was seen as pertinent to such an intervention.

Testing, Counselling and Treatment for HIV Positive People

'A committee should be set up at to facilitate the provision of testing, counselling and treatment of HIV/AIDS positive people. Such an intervention should encourage people to live positively, and to stop abusing drugs and alcohol but would depend on the financial ability of the local authority. Testing should be free of charge'.

One way to make such an intervention acceptable and effective would be to have a universal agreement or a policy that drugs are sold at affordable prices. Another way would be to use a special established fund to pay for these expenses. The fund should be created by the Local Authority to deal with the internal infected and affected people.

Destigmatisation

Participants who responded to this issue indicated that the municipal department of health should ensure this becomes part of the awareness campaigns to encourage and educate people about HIV/AIDS. People need to understand that they should not discriminate against HIV/AIDS positive people, because tomorrow they might be infected or affected.

"People who talk bad about HIV/AIDS positive people should put themselves in those people's shoes and think how they would feel if someone treated them in the same way "
SWAG Participant, Swakopmund

Chapter 5: The Way Forward

Introduction

This final chapter is based on the proceedings of the Strategic Response and Action Planning Workshop held in Walvis Bay from 12 - 16 August 2002, and attended by elected councillors, including mayors, management and other officials from each of the five local authorities. The purpose of the workshop was to assist each municipality develop *draft* multi-sectoral and integrated plans preventing future infections and mitigating the impact of HIV/AIDS on their city or town. The agenda, minutes of proceedings and workshop attendance list is included in Volume 7.

The process involved developing a common understanding and agreement of the impacts of HIV/AIDS on the five cities, agreeing a strategic response and, finally, participants from each local authority began developing plans to prevent and mitigate the epidemic in their own city. It should be noted that the plans developed for each local authority are drafts, and will require consolidation and expansion, prior to their submission through senior management to Council for approval.

The Planning Process

The planning process involved:

- reviewing the draft Impact Assessment reports (including ensuring their accuracy, and recommending suggested changes);
- developing a common understanding and agreement of the impacts of HIV/AIDS on the five cities;
- agreeing the elements of a strategic response
- identifying the data and information needs in order to inform this response
- developing draft plans to prevent and mitigate the impacts of the epidemic in their own city.

It should be noted that the plans developed for each local authority are *drafts*, and will require consolidation and expansion, prior to their submission through senior management to the respective Municipal or Town Council for approval.

Strategic Response

Participants agreed that an appropriate strategic response by each local authority would encompass the three areas discussed below.

Management Strategies

These are to assist the local authority identify, plan for and monitor the impacts of the epidemic on its personnel and operations.

Internal Strategies

Internal strategies are intended to enhance knowledge and understanding of HIV and AIDS among municipal employees and reduce future infections through prevention activities built on this knowledge. They are centred around the development, approval and implementation of Workplace Policies and Programmes

External Strategies

The external environment refers to the impacts of HIV/AIDS on the community served by Swakopmund Municipality. The intention of these strategies is to widen the municipal response to the epidemic through enhanced linkage with and support to existing government and non governmental organisation programmes and activities.

Based on these three strategies, the participants from Swakopmund then developed the following goal to guide and inform the town's strategic response to the epidemic:

GOAL: To reduce the social and economic development consequences of the HIV/AIDS epidemic on the operations of the municipality and its staff.

Data Needs

Detailed lists of the information and data required to plan for the epidemic's impacts and to inform prevention activities were discussed and developed at the Workshop. These included:

- data needed to inform management responses to the impact of the epidemic, for example those relating to absenteeism, personnel profiles, critical posts, etc.
- data needed to measure and monitor the epidemic's impact on the city such as that relating to its economic performance, municipal revenue, etc.
- data needed to expand the municipal prevention response both internally and externally. This included Knowledge, Attitudes and Practices studies data on other providers of prevention and support services among the wider community, for example.

Data sources for this information were discussed, and a detailed list of these is contained in the minutes of the Workshop proceedings. However, in this regard, the importance of collecting adequate data within local authorities should not be under-estimated. This is particularly pertinent in regard to the human resource management systems presently in place within each local authority. While most are able to the basic data needed to monitor the epidemic's impacts on personnel (i.e., that relating to absenteeism), with the exception of Swakopmund, none are disaggregating leave by type and none are costing these absences. These need to be monitored on a monthly basis.

Equally, no municipality is monitoring the impact and cost of AIDS related illness and death on benefit programmes and their costs. These need to be monitored annually.

Action Plans

Each municipality then developed its own plan covering the three elements of the agreed strategic response. Each strategy area has several objectives, and for each of these a detailed list of activities was developed, the person or persons responsible for the activity were

designated, the time frame established, outputs identified and budgets estimated. The detailed draft plans developed for Swakopmund are contained in Annex B to this report.

The Way Forward

Following the workshop, deadlines were set for the receipt of additional comments of the draft and will lead completion of the final report. At this stage the Assessment of the Impact of HIV/AIDS on Swakopmund is to be presented to Council for approval and action. However, the draft plans included in the final report will require further elaboration and, perhaps, amendment, by Council officers prior to their presentation to management and subsequently to Council for agreement and approval.

However, Family Health International (FHI), through whom the funds for this Assessment have been provided, has agreed that the remaining, *limited*, funds under the SIAPAC contract may be re-programmed. The intention is to support activities related to the acceptance, initiation and implementation of findings and recommendations (as contained in the plans) resulting from this Assessment by the local authorities. Requests for the use of these funds are to be made in writing to FHI through SIAPAC for approval. The types of activities suggested for the use of the remaining funds are further workshops presenting the findings from the Assessment and the draft plans to senior managers and Councils at the local level, additional data gathering exercises to supplement findings from the report or further planning exercises, etc.

Beyond these activities, additional strengths and resources are to be found within the network of local authorities in Namibia, through the national associations (NALAO and ALAN). Equally, AMICAAL can assist in developing and implementing the plans to mitigate the impacts of HIV/AIDS on each municipality. However, it is the responsibility of the appropriate representatives within each local authority to present the findings of the reports and the plans to mitigate the impacts of HV/AIDS to these national associations as well as other bodies.

Annex A: HIV/AIDS Organisations

The following AIDS Support Organisations indicate that they provide services in Swakopmund and/or in the Erongo Region.

Name of Organisation: AIDS Law Unit (LAC)

Programmes

- Litigation and legal advice,
- Lobbying and Advocacy
- Policy Formulation,
- Development of Training and Educational materials

Name of Organisation: “Aitsama Huisen” Students’ Empowerment and development trust (SEDT)

Programmes

- HIV/AIDS awareness creation,
- Provide infrastructure that would practically expose students’ to entrepreneurship,
- Facilitate exposure visits of HIV/AIDS people to schools
- Raising business awareness and host market days,
- Intensify the HIV/AIDS prevention campaign

Name of Organisation: Alliance of Mayors and Municipal leaders on HIV/AIDS in Africa (AMICAALL)

Programmes

- The programme aims to strengthen capacity to reduce the social and economic impact of HIV/AIDS on urban and peri-urban centres, with particular focus on heavily affected countries in sub-Saharan Africa by supporting the development of local government/civil society partnerships; creating capacity for scaling up multi sectoral responses; sharing knowledge and lessons about what works across countries contributing to the development of a supportive policy environment that reflects the rights of those affected and is gender sensitive; stimulating twinning and other partnerships to enhance solidarity across borders; and promoting innovative approaches to resource mobilisation for community based initiatives.

AMICAAL is the strategy adopted by the Alliance to translate its goals into concrete options in countries and communities. The overall goals of AMICAAL are to develop and implement multi-sectoral responses to the HIV/AIDS epidemic at the local level via a consultative process between Civil Society and Community leaders and achieve local capacity. It calls for a locally fed, multi-sectoral approach that complements and supports national policies.

Name of Organisation: Catholic AIDS Action (CAA)

Programmes

- Implement a modified programme for Primary schools - Stepping Stones,
- Motivate and implement youth-prevention oriented programmes such drama groups, peer-support and establish Anti AIDS Clubs in Roman Catholic affiliated parishes and schools,
- Recruit and train volunteers for spiritual support, counselling, home-visits, caring and supporting sick ones and orphaned children,
- Ensure a demonstrated commitment to HIV/AIDS awareness and prevention through periodic sermons, distribution of literature and group meetings.
- Offer support for local self-help Groups and activities,
- Soup kitchens for HIV/AIDS patients, orphans and vulnerable children,
- Initiatives in living positively and caring for ourselves in order to care for others,
- Income generating activities and limited direct (welfare) support,
- Undertake community education and outreach programmes,
- Implement annual Training of Trainers (ToT) programmes in Home Based Care and Physio-social supports,
- Host annual Conferences (both at national and regional level).

Name of Organisation: Change of lifestyle Home's Project (C. O. L. S)

Programmes

- Safe house for juvenile offenders,
- Education programme
- Health Unit (HIV/AIDS)
- 4H Project (Youth Entrepreneurial Programme)
- Youth Development Programme.

Name of Organisation: Chief Hosea Kutako Foundation AIDS Desk (CHKFAD)

Programmes

- To promote a sense of solidarity, self-discipline and practical cooperation among the youth for a genuine action,
- Promote primary health care as a first line defence against diseases with emphasis on AIDS, TB and avoidance of diet
- Organise educative meetings, seminars workshops and conferences in various communities on matters pertaining to poverty alleviation as well HIV/AIDS.

Name of Organisation: Council of Churches in Namibia (CCN)

Programmes

- Conduct faith justice and society programmes
- HIV/AIDS educational campaign,
- Conduct Violence against Women and Children Workshop,
- Operational Voluntary testing Centre, with cost involved
- Marriage counselling

Name of Organisation: ELCRN AIDS Programme

Programmes

- Home Base Care/Psycho-Social,
- Support to OVC/Counselling Services,
- Training of Trainees,
- Peer Education Training,
- Stepping Stones Programme,
- Pastors in Sexual Education and Counselling,
- Awareness Raising: Developing IEC materials etc.

Name of Organisation: Kasoyetua Youth Group of Namibia

Programmes

- House to house consultation,
- AIDS Awareness campaign and condom distribution in rural areas,
- Poem presentation and drama performance on HIV/AIDS with the intention of raising public awareness with regard to HIV/AIDS,
- Sensitisation Workshops on HIV/AIDS,
- Conduct Life Skills Educational Programmes in rural areas targeting youth aged 14-20 at secondary level.

Name of Organisation: Namibia Men Planned Parenthood Network (NAMPPAN)

Programmes

- Provide first hand information on counselling support services for men infected and affected with HIV/AIDS,
- Facilitate a comprehensive educational workshops on human rights and democracy, gender equality as partners in society and private live between men and women,
- Raise public awareness on family planning, HIV/AIDS prevention and domestic violence,

- Develop and promote user-friendly information, education and communication materials on male Reproductive Health support information and service at work place,
- Promote public debates on the role of men and women in society.

Name of Organisation: Namibia National Network for people living with HIV/AIDS
(NNNP+/LIRONGA EPARU)

Programmes

- Mitigate for the rights of PLWHA,
- Provision of information, education and communication (IEC) materials on HIV/AIDS,
- Administer Bursary Fund for PLWHA – long term object of the Network,
- Provide Counselling and Home Based Care to people living and affected by HIV/AIDS and if need be refer to suitable Counsellors,
- Offer Empowerment, self-reliance, self confidence and motivational training courses for PLWHA,
- Advocate for access to treatment, care and support for PLWHA,
- Undertake annual regional visits to selected regions in order to build the capacity of regional structures,
- Advocate to policy makers and politicians on matters of different impact to PLWHA, such the introduction of PTCT programme – (parental-to-child-transmission),
- Income generating projects to support orphans and for self-sustainable.

Name of Organisation: Namibia Planned Parenthood Association (NAPPA)

Programmes

- Condom distribution,
- Information dissemination pertaining to sexual and reproductive health,
- Educational provision on family planning,
- Development of IEC material for public use,
- Implementing a 5-year UNFPA funded project to provide SRH information and Service to youths in-and-out of school in the Ohangwena Region,
- Establishment of Youth Clubs in schools.

Name of Organisation: Namibia Students' Education Movement (NASEM)

Programmes

- Fostering of parents', students and teachers co-operation amongst various educational institutions,
- Advocate for abstinence as the best option of alternatively condom use and adherence to moral values and social ethics,

- Conduct various students' rights and obligations workshops,
- Leadership capacity building workshop for Learners and Students' Representative Council,
- Career guidance and motivational workshops for learners,
- Crisis intervention and mediation at school level,
- Participation in policy formulation with relevant stakeholders with emphasis on education and affecting the youth and the entire nation at large.

Name of Organisation: NaSoMa

Programmes

- Development of Behaviour Change Communication (CBC) materials as part of HIV/AIDS prevention approach,
- Offer training on the correct usage and consistent of both the male and female condoms,
- Build an infrastructure for implementing a Namibian managed social marketing programmes,
- Set up a countrywide distribution and sales network for male and female condoms,
- Promote and market both the male and female condoms ensuring that products are always available, affordable and easily accessible to everybody.

Name of Organisation: National Union of Namibia Workers (NUNW)

Programmes

- Collective bargaining activities,
- Dispute negotiation, resolution, mediation and prevention,
- Arbitration.

Name of Organisation: Peer Education and Counselling Project (PECP)

Programmes

- Face to face counselling,
- Helpline telephone counselling,
- Training of Community AIDS Educators and Counsellors,
- Establish Regional Community HIV/AIDS Committee select and train HIV/AIDS Community Educators,
- Condom distribution at strategic places in and around Windhoek.

Name of Organisation: Sister Namibia

Programmes

- Conduct research on the socio-cultural constructions of masculinities, feminities and sexualities as a basis for developing pilot materials for comprehensive sexuality education in Namibia,
- Advocate and lobbies for full representation and participation of women in politics and governance,
- Provide training to women in rural and marginalised urban communities on the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) and women's rights,
- Conduct discussion events on topical issues of concern to women,
- Collect and hosts regional and international materials on women and gender issues

Name of Organisation: Soli Deo Gloria HIV/AIDS Awareness Club

Programmes

- Visits to hospitals, old age homes and regional branches to offer voluntary social work promoting a culture of Christianity,
- HIV/AIDS awareness campaign through drama, musical performance and debates with focus in rural areas,
- Offer specialised musical training classes/courses,
- Facilitate Training of Trainers from selected regions.

Name of Organisation: True Love Waits (TLW)

Programmes

- Advocate for minimal teenage pregnancies and early parenthood,
- HIV/AIDS Information dissemination to the public meetings, school visits, shebeens and at squatter areas,
- Peer education and counselling,
- Regular radio talks in at least three indigenous languages,
- Encourage young people to opt for abstinence until marriage,
- Conduct radio talks,
- House to house visits to educate the public on the transmission of HIV/AIDS as well as the prevention methods thereof.

Name of Organisation: Woman Solidarity

Programmes

- Offer talks, workshops and seminars to secondary schools students' with emphasis on violence against women,
- Telephonic and face to face counselling,
- Carry outreach programmes in a form of workshops and educational talks at schools and work place in order to raise public awareness thus ultimately reducing violence resultant HIV/ AIDS infections,
- Offers support to women who were abused, sexually, physically or emotionally,
- Crisis intervention through a third-party,
- Advocacy and lobbying, networking and research into woman abuse and rape.

Name of Organisation: Young Women Christian Association of Namibia (YWCA)

Programmes

- Offer Peer Counselling,
- Conducts HIV/ AIDS drama performance,
- Run and manage needlework classes,
- Provide counselling to teenage mothers,
- Provide Pre-and primary education,
- Conducts literacy programmes, Income generating projects (vegetable garden)

Annex B: Prevention, Response and Action Plans

SWAKOPMUND: MANAGEMENT STRATEGIES

STRATEGY AREA: Structure and Planning								
OBJECTIVE: Establish and mandate a structure to implement and monitor city's HIV/AIDS response								
INDICATOR: Improved structures and availability of resources								
No .	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Include HOD to the Committee to strengthen working group	Council	—	Sept. 02	Monthly Council Reports	—	—	—
2.	Provide resources to implement a HIV/AIDS programme in the workplace	Council	HOD, DAC, RAC and RC	Jan. 03 - June 03	Resources	Operational Budget	—	—
3.	Create a supportive and non-discriminatory working environment	Council	—	Jan. 03	Non-discriminatory working environment, especially with HIV/AIDS	—	—	—
4.	Include an agenda of management health and safety directing the issue of routinely addressing HIV/AIDS in the workplace	Coordinator	—	Monthly, starting Oct. 02	—	—	—	—
5.	Convene monthly meetings to the steering committee and forward minutes to management, health and safety meeting	Coordinator	—	Monthly	Meeting held and minutes forwarded	—	—	—
6	Submit a budget for the HIV/AIDS response in 2003/4 financial year	HOD	—	—	—	—	—	—

SWAKOPMUND: MANAGEMENT STRATEGIES

STRATEGY AREA: Baseline and Periodic Assessment

OBJECTIVE: To generate and picture of the Epidemic currently and in future

INDICATOR: Meetings convened and reports submitted indicate the improved understanding and knowledge of the epidemic in Swakopmund

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Convene a meeting to submit results of assessment report to council	Coordinator and workshop participants	—	Sept. 02	Submitted report	—	—	SIAPAC
2.	Disseminate information to staff members through meetings	Coordinator HOD and HRD	—	Oct. 02	Information disseminated at meetings	—	—	—
3.	Disseminate information/reports to external partners	Coordinator	DAC	Oct. 02	Information/reports submitted	—	—	—
4.	Submit monthly progress reports to MC/Council	Coordinator	HOD	Monthly	Report	—	—	—

SWAKOPMUND: MANAGEMENT STRATEGIES

STRATEGY AREA: Leadership (Management Strategies)

OBJECTIVE: To Demonstrate Leadership Support and Commitment to HIV/AIDS

INDICATOR:

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Train and sensitise counselors, HOD and Deputies on HIV/AIDS matters	Co-ordinator	DAC, RAC and ERC	Feb. 03	Training conducted	Training vote	Operational Budget	DAC and MOHSS
2.	Obtain commitment to and support for a Local Government response to HIV/AIDS by approving the HIV/AIDS policy	Council	—	—	Approved policy	—	—	—

SWAKOPMUND: WORKPLACE PROGRAMME

STRATEGY AREA: Workplace Policy								
OBJECTIVE: Develop, adopt and implement comprehensive programme								
INDICATOR:								
No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Establish and implement a staff member assistance programme with a HIV/AIDS prevention component (consultants)	HRD and Council	Legal partners	2003/4	Staff member assistance policy	—	—	—
2.	Employ Social Worker	Council	—	2003/4	Appointment	—	—	—

SWAKOPMUND: WORKPLACE PROGRAMME

STRATEGY AREA: Data Collection and Analysis

OBJECTIVE: Using Data for the Monitoring of HIV/AIDS Programmes

INDICATOR: Improved understanding of Data/Record Compiled and reviewed Analysis on Data Collected

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Establish HIV/AIDS Committee	Coordinator	DAC, Municipal Departments and Unions	Oct.02	Functional Committee	N/A	N/A	DAC
2.	Collection Data from Departments	HOD	HIV/AIDS Committee Supervisors	Month	Data Collected	N/A	N/A	HRD
3.	Analyse Data and Record in HRD	HRM	Coordinator, HOD and MC	Monthly	Data Analysed and Recorded	—	From Professio nal Services Vote	Specialist (Consultant s)
4.	Review Data at Committee level to Inform Response Programmes	Coordinator	HOD, MC, DAC and Committee	Nov. 03	Functional Programme	N\$50 000.00	Budget	DAC, Peer Educators and Specialist

SWAKOPMUND: WORKPLACE PROGRAMME

STRATEGY AREA: Training Programme

OBJECTIVE: To establish a cadre or appropriately trained and supported staff

INDICATOR: Trainers are trained and able to run HIV/AIDS Training

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Review existing training programs and include HIV/AIDS training package	Coordinator	Council, HR manager and training officer	2003/4	Updated Training Program	Ops Budget	—	DAC
2.	Prepare a budget sufficiently for training materials and IEC materials	Coordinator	Council MOHSS	Budget 2002/3	Training Materials	Ops Budget	—	—
3.	Identify and train staff members as peer educators (TOTs)	HOD	DAC and RAC	Oct. 02 to March 03	Peer Educator	Ops budget trainee votes	Ops Budget	Trainer

SWAKOPMUND: WORKPLACE PROGRAMME

STRATEGY AREA: Prevention Programme

OBJECTIVE: To promote and support safer sexual practice in a well informed workplace

INDICATOR: Functional prevention programme in place

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Organise mobilisation meeting	Coordinator	Council and External Speaker	Oct. 02	Meeting	—	—	—
2.	Collect and distribute HIV/AIDS materials (IEC) and condoms	Coordinator	MOHSS Reg. DAC	Oct. 02 - ongoing	Collected and distributed	—	Ops Budget	—
3.	Develop a condom promotion strategy	Committee	DAC	National AIDS Days	Strategy developed to fit in with national programme	—	Ops Budget	—
4.	Invite slogans from staff members for the production of promotional items	Committee	Staff members	Annually	Promotional items available for distribution	—	Ops Budget	External printers donors NGOs

SWAKOPMUND: WORKPLACE PROGRAMME

STRATEGY AREA: Programme for infected and affected staff

OBJECTIVE: To create an enabling environment and provide care for infected and affected staff

INDICATOR: Operational plan for infected and affected staff in place

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Organise meeting with unions to obtain assistance to conduct surveillance tests.	Council	Unions and Legal advisors	2003/4	Indicator and record of prevalence	Tons of money	Ops Budget	Professional
2.	Counseling [Training of Trainers (TOT)]	Co-ordinators and counselors	MOHSS	Ongoing	Access to Counseling	—	Ops Budget	Professional
3.	Provide positive living principle services to staff members	Co-ordinator	MOHSS, DAC and RAC	Monthly	Monthly sessions conducted	—	—	MOHSS

SWAKOPMUND: EXTERNAL PROGRAMME

STRATEGY AREA: Baseline and periodic assessment

OBJECTIVE: Collect, analyse and utilise information to inform and support HIV/AIDS response

INDICATOR: Database of organisations and resources available

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Convene a meeting with network members (DAC, RAC, HBC, etc.) for identification	Coordinator	---	Feb. 03	Meeting conducted	---	---	---
2.	Do assessment of all HIV/AIDS organisations and available resources	Coordinator	DAC and Council	Feb. 03	Assessment Done (number of organisations)	---	---	---
3.	Compile and disseminate resources and organisational database	---	---	---	---	---	---	---

SWAKOPMUND: EXTERNAL PROGRAMME

STRATEGY AREA: Participating in Local Government Fora								
OBJECTIVE: Ensure Effective net working and optional sharing of experiences								
INDICATOR:								
No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Obtain and fit into schedule of municipality of all HIV/AIDS programmes of ALAN, AMICAALL and NALAO	Council	---	Annually	---	---	---	---

SWAKOPMUND: EXTERNAL PROGRAMME

STRATEGY AREA: Participate in community HIV/AIDS response

OBJECTIVE: Join and participate and enrich community HIV/AIDS responses

INDICATOR:

No.	Activities	Responsible Person Lead unit	Other Partners	Time frame	Output	Budget	Fund- ing Source	Technical Assistance
1.	Participate in all HIV/AIDS related activities in the community	Co-ordinate	Council and DAC	Nov. 02	—	—	—	—
2.	Provide assistance in organising HIV/AIDS activities in the community	Council	Co-ordinator	Contin- uous	Availability of municipal equipment and resources	—	Operatio nal Budget	—
3.	Investigate and obtain possible external funding for HIV/AIDS programmes in the community	Council	Co-ordinator	Annually	Funds for programmes	—	—	—
4.	Provide support to people living with HIV/AIDS through projects	Council	DAC, MOHSS and Home Based Care givers	2003/4	Projects	2003/4	Ops Budget	—

Annex C: Cost Assumptions

ESTIMATING THE COST OF HIV/AIDS IN Windhoek Municipality

This simple model is divided into a number of sheets.

The first is this introduction,

The 'Total' sheet presents the total cost of HIV across all job bands/grades

The 'Result' sheets present results for each band

The 'Á&D'sheets contain the data for each band on which the costings are based

The 'Notes' sheets explain the headings in the 'Results' and 'Á&D' sheets

The 'Limitations' sheet outlines the problems with the model

This model is extremely simplified, this was necessary due to the lack of human resource data available.

It is not intended to provide an accurate estimate of cost, but rather to provide an idea of the order of magnitude

It can also be used as a planning tool to identify major costs and implications of different situations

NOTES

Deaths	Total number of employee deaths from AIDS in current year
Sick leave	
Days	Total number of days sick leave taken as a result of HIV infection in current year
Cost	Cost of sick leave: calculated as number of days*average cash salary
Compassionate leave cols	Cost of compassionate leave taken as a result of the death of colleagues
Productivity	The cost of lower productivity resulting from HIV infection
Recruitment	The cost of recruiting replacement staff for those who have died from AIDS that year
Training	The cost of training replacement staff for those who have died from AIDS that year
Sub total	
Pension fund increase	The cost of increased pension fund contributions necessary to cover increased death benefits
Compassionate leave family	Cost of compassionate leave taken as a result of the death of family members
Housing	The amount of bad debt resulting from outstanding housing loans which the life insurance has refused to cover
Sub total	
Total	
Discounted total	The present value of future costs 2002-2010

Notes

Sick leave in service	The average number of days sick leave taken, per year, up to and including the year of death for employees who die in service
Sick leave retirement	The average number of days sick leave taken, per year, up to and including the year of death for employees who die after retiring of service
Productivity loss	The proportion by which productivity is reduced as a result of HIV infection up to and including the year of death
Productivity days	The number of days work which the lost productivity is equivalent to
Productivity days cost (in service)	The cost of the work day equivalent lost for those who die in service
Productivity days cost (retirement)	The cost of the work day equivalent lost for those who die after retiring from service
Cost per day	The average cost of a lost day of work
Number of working days	Total number of working days per year per employee
Training	The average cost of training a replacement employee
Recruitment	The average cost of recruiting a replacement employee
Average outstanding debt (housing)	The average amount outstanding on an employees housing loan at the time of an AIDS related death
Proportion of life insurance refused	The proportion of life insurance pay outs, resulting from an AIDS death, which are refused on the grounds of an AIDS exclusions
In service deaths	The proportion of AIDS deaths which occur while the employee is still in service
Retirement deaths	The proportion of AIDS deaths which occur after the employee has retired from service
Premature years	The average number of years employees who die of AIDS would have remained at work
Compassionate leave family	The average (across the entire work force not just those who have lost a family member) number of days taken as compassionate leave for a family members death resulting from AIDS
Compassionate leave cols	The average (across the entire work force) number of days taken as compassionate leave for a Colleagues death resulting from AIDS
Staff growth rate	The rate at which the work force is expected to grow each year
Pension fund increase	The percentage increase in pension fund contributions, as a percentage of the salary bill, necessary to cover the cost of increased AIDS deaths
Total staff	Total staffing complement in 2002
Discount rate	The government discount rate

Limitations

The model is limited in a number of ways

Firstly, many of the complicated calculations are exogenous inputs to the model: deaths from AIDS, pension fund increases etc

Secondly, costs are not distributed throughout the year, the discounted amount assumes that they all happen at once

This is not a major concern as it makes little difference to the final result

Thirdly, the model takes little consideration of the difference in costs associated with different levels of employment and differences in age

The work force should be disaggregated by age, and job band and the model run for each.

This was not possible given the limitations of the data.

Finally, the model is limited, as is any model, in that it is only as good as the data which is entered into it.

RESULTS ALL BANDS

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Deaths	6	6	8	10	11	11	11	11	12	12	12
Sick leave											
Days	880	1061	1309	1431	1461	1461	1486	1537	1608	1608	1608
Cost	173352	213080	269709	293614	296683	296683	303394	316815	335605	335605	335605
Compassionate leave cols	2196	2196	3458	3988	4190	4190	4190	4190	4720	4720	4720
Productivity	52075	67920	77171	81084	81444	81444	86602	91090	93292	93292	93292
Recruitment	1869	1869	2804	3116	3427	3427	3427	3427	3739	3739	3739
Training	3926	3926	6231	7228	7540	7540	7540	7540	8537	8537	8537
Sub total	233417	288991	359373	389029	393283	393283	405153	423062	445893	445893	445893
Benefit increase	111483	111483	111483	111483	111483	111483	111483	111483	111483	111483	111483
Compassionate leave family	16091	18649	20684	22137	22945	23219	23217	22939	22789	22674	22742
Bad debt	0	0	0	0	0	0	0	0	0	0	0
Sub total	127575	130133	132167	133620	134428	134702	134700	134422	134272	134157	134225
Total	360992	419124	491540	522650	527711	527985	539853	557485	580165	580050	580118
Discounted total	360992	399166	445841	451484	434149	413690	402847	396194	392678	373905	356142
Present value cost	4427089										

ASSUMPTIONS AND DATA BANDS 18 - 16

	1	2	3	4	5	6	7	Death			
Sick leave in service	4	0	0	0	0	25.32337833	50.646757	101.29351			
Sick leave retirement	4	0	0	0	0	25.32337833	50.646757	0			
Productivity loss	0	0	0	0	0	0	0.1	0.1			
Productivity days	0	0	0	0	0	0	16.935324	11.870649			
Productivity days cost (in service)	0	0	0	0	0	0	1710.4678	1198.9355			
Productivity days cost (retirement)	0	0	0	0	0	0	1710.4678	0			
Cost per day	101										
Number of working days	220	Discounted	Net								
Training	500	188.4447414	311.55526								
Recruitment	500	188.4447414	311.55526								
Average outstanding debt	0										
Proportion not covered	0.1										
In service deaths	0.3										
Retirement deaths	0.7										
Premature years	20										
Compassionate leave family	2										
Compassionate leave cols	2										
Staff growth rate	0										
Benefit increase	0.003										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total staff	169	169	169	169	169	169	169	169	169	169	169
Excess mortality	0.0095264	0.011040722	0.012245	0.0131055	0.0135837	0.013745841	0.0137449	0.0135804	0.0134914	0.0134233	0.0134637
No. close family	5										
Discount rate	0.05										

Total Increased Costs Resulting from the Epidemic on Bands 18 - 16

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Deaths	3	3	4	4	5	5	5	5	5	5	5
Sick leave											
Days	364	415	471	521	552	552	552	552	552	552	552
Cost	36804	41920	47546	52662	55731	55731	55731	55731	55731	55731	55731
Compassionate leave cols	606	606	808	808	1010	1010	1010	1010	1010	1010	1010
Productivity	6210	7921	8281	9991	10351	10351	10351	10351	10351	10351	10351
Recruitment	935	935	1246	1246	1558	1558	1558	1558	1558	1558	1558
Training	935	935	1246	1246	1558	1558	1558	1558	1558	1558	1558
Sub total	45490	52316	59127	65953	70207						
Benefit increases	11266	11266	11266	11266	11266	11266	11266	11266	11266	11266	11266
Compassionate leave family	1626	1885	2090	2237	2319	2346	2346	2318	2303	2291	2298
Bad debt	0	0	0	0	0	0	0	0	0	0	0
Sub total	12892	13150	13356	13503	13584	13612	13612	13584	13568	13557	13564
Total	58382	65466	72483	79456	83791	83819	83819	83791	83776	83764	83771
Discounted total	58382	62348	65744	68637	68935	65674	62547	59549	56703	53995	51428
Present value cost	673942										

ASSUMPTIONS AND DATA FOR BANDS 15 - 5

	1	2	3	4	5	6	7	Death				
Sick leave in service	4	0	0	0	0	25.32337833	50.646757	101.29351				
Sick leave retirement	4	0	0	0	0	25.32337833	50.646757	0				
Productivity loss	0	0	0	0	0	0.1	0.1	0.1				
Productivity days	0	0	0	0	0	19.46766217	16.935324	11.870649				
Productivity days cost (in service)	0	0	0	0	0	5158.930474	4487.8609	3145.7219				
Productivity days cost (retirement)	0	0	0	0	0	5158.930474	4487.8609	0				
Cost per day	265											
Number of working days	220	Discounted	Net									
Training	1600	603.0231726	996.97683									
Recruitment	500	188.4447414	311.55526									
Average outstanding debt	0											
Proportion not covered	0.1											
In service deaths	0.7											
Retirement deaths	0.3											
Premature years	20											
Compassionate leave family	2											
Compassionate leave cols	2											
Staff growth rate	0											
Benefit increase	0.003											
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	
Total staff	573	573	573	573	573	573	573	573	573	573	573	
Excess mortality	0.0095264	0.011040722	0.012245	0.0131055	0.0135837	0.013745841	0.0137449	0.0135804	0.0134914	0.0134233	0.0134637	
No. close family	5											
Discount rate	0.05											

Total Increased Costs Resulting from the Epidemic on Bands 15 - 5

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Deaths	3	3	5	6	6	6	6	6	7	7	7
Sick leave											
Days	515	646	838	909	909	909	935	985	1056	1056	1056
Cost	136547	171161	222162	240952	240952	240952	247663	261084	279874	279874	279874
Compassionate leave cols	1590	1590	2650	3180	3180	3180	3180	3180	3710	3710	3710
Productivity	45864	59999	68891	71093	71093	71093	76252	80740	82942	82942	82942
Recruitment	935	935	1558	1869	1869	1869	1869	1869	2181	2181	2181
Training	2991	2991	4985	5982	5982	5982	5982	5982	6979	6979	6979
Sub total	187927	236675	300246	323076	323076	323076	334946	352855	375686	375686	375686
Benefit increases	100218	100218	100218	100218	100218	100218	100218	100218	100218	100218	100218
Compassionate leave family	14465	16765	18593	19900	20626	20872	20871	20621	20486	20383	20444
Bad debt	0	0	0	0	0	0	0	0	0	0	0
Sub total	663	116982	118811	120118	120844	121090	121089	120839	120704	120600	120662
Total	302610	353658	419057	443194	443920	444166	456034	473694	496389	496286	496347
Discounted total	302610	336817	380097	382848	365214	348016	340300	336645	335976	319910	304714
Present value cost	3753148										

Annex D: Bibliography

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