HIV, AIDS, TB AND WELLNESS
EASTERN CAPE BUSINESS SECTOR
PROVINCIAL STRATEGIC PLAN 2012 - 2016

‘Healthy People - Healthy Economy
Employee wellness is everybody’s business’

SABCOHA
Empowering Business in the fight against HIV
Funding for stakeholder engagement to build consensus leading to the content contained for sectoral policy priorities has been funded by CDC and PEPFAR.
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**ABBREVIATIONS AND ACRONYMS**

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>AHI</td>
<td>Afrikaanse Handelsinstituut</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy / Treatment</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>CDC</td>
<td>US Centers for Disease Control and Prevention</td>
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<td>CSI</td>
<td>Corporate Social Investment</td>
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<td>DFID</td>
<td>UK Department for International Development</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DOTS</td>
<td>Directly Observed Treatment Short-course</td>
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<td>EAP</td>
<td>Employee Assistance Programme</td>
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<td>ECAC</td>
<td>Eastern Cape AIDS Council</td>
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<td>GVA</td>
<td>Gross Value Added</td>
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<td>HAART</td>
<td>Highly Active Antiretroviral Treatment</td>
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<td>HAST</td>
<td>HIV, AIDS, STIs and TB</td>
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<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papillomavirus</td>
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<td>HSRC</td>
<td>Human Sciences Research Council</td>
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<td>IDP</td>
<td>Integrated Development Plan</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>IPT</td>
<td>Isoniazid Prophylactic Therapy</td>
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<td>ISDRP</td>
<td>Integrated Sustainable Rural Development Programme</td>
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<td>KYE</td>
<td>Know Your Epidemic</td>
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<td>KYR</td>
<td>Know Your Response</td>
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<tr>
<td>LAC</td>
<td>Local AIDS Council</td>
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<tr>
<td>MDR-TB</td>
<td>Multi Drug Resistant (Tuberculosis)</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MEC</td>
<td>Member of Executive Council</td>
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<td>MMC</td>
<td>Medical Male Circumcision</td>
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<td>NASA</td>
<td>National AIDS Spending Assessment</td>
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<td>NDOH</td>
<td>National Department of Health</td>
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<td>NGO</td>
<td>Non-government Organisation</td>
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<td>NHI</td>
<td>National Health Insurance</td>
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<td>NIMART</td>
<td>Nurse Initiated Management of ART</td>
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<td>NSP</td>
<td>National Strategic Plan (for HIV, STIs and TB 2012-2016)</td>
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<tr>
<td>PAC</td>
<td>Provincial AIDS Council</td>
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<tr>
<td>PEPFAR</td>
<td>US President’s Emergency Plan for AIDS Relief</td>
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<td>PICT</td>
<td>Provider Initiated Counselling and Testing</td>
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<td>PLHIV</td>
<td>People Living with HIV or AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PSP</td>
<td>Provincial Strategic Plan 2012-2016</td>
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<td>PSS</td>
<td>Provincial Systems Strengthening</td>
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<td>SABCOHA</td>
<td>South African Business Coalition on HIV and AIDS</td>
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<td>ACRONYMS AND ABBREVIATIONS</td>
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<tr>
<td><strong>SANAC</strong></td>
<td>South African National AIDS Council</td>
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<td><strong>SMME</strong></td>
<td>Small, Medium and Micro Enterprises</td>
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<td><strong>SRH</strong></td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td><strong>STI</strong></td>
<td>Sexually Transmitted Infection</td>
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<td><strong>TB</strong></td>
<td>Tuberculosis</td>
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<td><strong>UNAIDS</strong></td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td><strong>USAID</strong></td>
<td>United States Agency for International Development</td>
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<tr>
<td><strong>VCT</strong></td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td><strong>WHO</strong></td>
<td>World Health Organisation</td>
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<tr>
<td><strong>XDR-TB</strong></td>
<td>Extremely Drug-resistant Tuberculosis</td>
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<tr>
<td><strong>YLL</strong></td>
<td>Years of Life Lost</td>
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GLOSSARY OF TERMS

Adherence: Drug compliance whereby the patient takes the prescribed dose of medicine at the correct time daily as advised by their doctor or other healthcare workers/providers.

Assessment: The process whereby HIV-positive patients are assessed to determine the stage of their illness and referred for appropriate medical care. Assessment involves a CD4 count, clinical staging, a physical examination and the documenting of a patient’s medical history.

Acquired Immune Deficiency Syndrome (AIDS): A disease of the human immune system that is caused by infection with HIV and characterised by a reduction in the number of CD-4 bearing helper T-cells to 20% or less of normal, thereby rendering the subject highly vulnerable to life-threatening opportunistic infections.

Activity: Actions taken or work performed through which inputs such as funds, technical assistance and other types of resources are mobilised to produce specific outputs.

Advocacy: Efforts made to get due support and recognition for a cause, policy or recommendation.

Affected Person: A person whose life is changed in any way by HIV and AIDS due to the broader impact of the epidemic.

Antiretroviral Therapy: A treatment consisting of drugs that work against the HIV infection in the body.

CD4 count: A measure of the number of T-cells per cubic millimetre of blood, and is used to analyse the immune system status of the body for diagnostic and prognostic purposes especially in cases of HIV and AIDS management.

Corporation: A company with > 1 000 employees.

Effectiveness: The extent to which an intervention has attained or is expected to attain its major relevant objectives efficiently in a sustainable fashion and with positive institutional development impact.

Epidemic: An outbreak of disease that is in excess of usual background levels.

Gender: All attributes associated with women and men, boys and girls which are socially and culturally ascribed and which vary from one society to another over time.

Gender mainstreaming: A strategy to ensure that gender analysis is used to incorporate women’s and men’s needs, constraints and potential into all development policies and strategies and into all stages of planning, implementing and evaluating of development interventions.

Gross Value Added (GVA): A measure in economics of the value of goods and services produced in an area, industry or sector of an economy. It is linked, as a measurement, to gross domestic product, as both are measures of output.

Human Immuno-deficiency Virus (HIV): A virus that weakens the body’s immune system, ultimately causing AIDS.

Infected Person: A person who is infected with HIV, the virus that causes AIDS.

Intervention: A specific activity or set of activities intended to bring about change in some aspect(s) of the status of the target population.
**Mainstreaming:** Mainstreaming implies that HIV and AIDS responses are aligned with the core mandate of the sector and not considered an “add-on” issue. Mainstreaming HIV and AIDS means all sectors determine how the spread of HIV is caused or contributed by their sector; how the epidemic is likely to affect their sector’s goals, objectives and programmes and where their sector has comparative advantage to respond to limit the spread of HIV and to mitigate the impact of the epidemic.

**Marginalised or Disadvantaged:** These two terms are used interchangeably and refer to those people in society who are deprived of opportunities for living a reasonable life and for self-respect which is regarded as normal by the community to which they belong. Thus, these concepts are defined in the context of a particular community.

**Mitigation:** Efforts made to reduce the severity or appease the expected impact or outcome.

**Mobilisation:** The act of marshalling and organising and making ready for use or action.

**Monitoring:** The routine follow-up, measuring and evaluation, both clinical and in the laboratory, of HIV-positive patients at all stages of disease to prolong health and slow the progression to AIDS-defining illnesses. This involves periodic medical examinations and CD4 and viral load testing, and enables prompt diagnosis and treatment of opportunistic infections.

**Opportunistic Infections:** Infections caused when the immune system is weakened by HIV such as TB, pneumonia.

**Outreach:** Extension of assistance or services to groups not previously reached.

**Peer Education:** Refers to activities aimed at providing information by people of a similar merit, age, social group, status or position as those that information is being passed on to.

**Peer Educator:** A person (child or adult) trained or equipped to train and support another person equal in merit, age, social group, status or position.

**PEPFAR:** The United States President’s Emergency Plan for AIDS Relief. The fund is used to assist countries of the world with saving lives of those suffering from HIV and AIDS. The programme was announced by President Bush in his 2003 State of the Union Address as a five-year $15 billion initiative to combat global HIV/AIDS. It was reauthorised in 2008 for up to $48 billion to combat global HIV/AIDS, tuberculosis and malaria over five years, transitioning from an emergency response to promoting sustainable country programmes.

**Post-Exposure Prophylaxis (PEP):** Treatment available to reduce the risk of infection in an individual immediately after exposure to HIV through sexual contact, blood transmission or needle sticks injury.

**Psychosocial Support:** Physical, economic, moral or spiritual support provided to an individual under any form of stress.


**Stages:** The clinical stages or classification developed by WHO as a guideline to monitor the progression of HIV infection or illness in resource-limited settings, it is also applicable to resourceful areas. The stages are different for adults and children. There are typically four distinct stages: primary infection, clinically asymptomatic, symptomatic and progression from HIV to AIDS. The stages are also linked to the government’s treatment classification or regimens for ART initiation.
**Stigmatisation:** Refers to the process of labelling people with the intent of treating them differently.

**Sustainability:** The continuation of benefits from a development intervention after major development assistance has been completed.

**Unit standard:** A registered statement of desired education and training outcomes and its associated assessment criteria together with administrative and other information as specified in the regulations to the South African Qualifications Authority Act, 1995.

**Viral load:** The amount of the HI virus in the blood in copies per millimetre.

**Wellbeing:** The result of the process of wellness and represents a desired end state.

**Wellness:** An active process of becoming aware of and making choices toward a healthier existence, implying that improvement is always possible. Wellness is multidimensional, covering social, occupational, spiritual, physical, intellectual, emotional, environmental, financial and medical aspects. Wellness and wellbeing are often used synonymously, the more dimensions one looks after and achieves wellness in, the greater an individual’s overall wellbeing.

**Voluntary Counselling and Testing (VCT):** A confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV and AIDS, including testing for HIV.

**Workplace:** Refers to occupational settings, stations and places where workers spend time for employment.
AIDS was 30 years old in 2011 and with over 20 years of responding to the HIV epidemic the number of people receiving antiretroviral (ARV) treatment continues to increase, with 6.65 million people globally on treatment at the end of 2010. The number of new HIV infections globally is declining as HIV programmes start to make in-roads and access to treatment expands. However, it is clear that a lot more still needs to be done, as globally more than 7 000 people are infected each day, including 1 000 children. Additionally the anticipated costs for HIV prevention, treatment, care and support is unsustainable and the effects of a global economic downturn combine to threaten progress as donors struggle to meet their commitments and provide renewed financial support.

HIV is not just a medical problem. The respect for the dignity and human rights of everyone vulnerable to and affected by HIV is an important part of the HIV response. Stigma, discrimination and gender inequality continue to undermine efforts to achieve universal access to HIV prevention, treatment, care and support.

At the High Level Meeting of the UN General Assembly in 2011 there was a call on member states to commit to The Three Zeros advocated by UNAIDS: zero new HIV infections, zero discrimination and zero AIDS-related deaths; and to redouble efforts to achieve universal access by 2015. In order to achieve these goals, focused, more efficient and sustainable responses are required along with renewed political commitment.

Furthermore, the International Labour Organisation (ILO) Recommendation 200 recognises the role of the workplace as a key entry point for facilitating access to HIV prevention, treatment, care and support services. It stresses the need for action by employers, trade and labour unions, to promote healthy workplaces. The ILO Recommendation 200 states that the key points to be considered in programmes on HIV and AIDS in the workplace should be: eliminating stigma and discrimination; protecting human rights and facilitating access to HIV prevention; treatment, care and support for workers, their families and their dependants.

South Africa’s socio-economic development faces a major obstacle in the twin HIV and TB epidemics. The health and wellness of communities is critical to the success of local businesses, the economy and the country as a whole. The HIV and TB epidemics impact on the ability of individuals to contribute productively and economically to society. HIV, AIDS and TB in the workplace can impact a business in a number of ways which include: increased absenteeism; increased staff turnover; loss of skills; declining morale and loss of tacit knowledge; which can all contribute to declining productivity and profits and also contribute to increased costs as demands for training and recruitment increase.

In South Africa new political leadership on HIV and AIDS has led to major shifts in public policy around the epidemic. The launch of the unprecedented government-led HIV Counselling and Testing (HCT) campaign, in April 2010 demonstrated the government’s renewed commitment to reduce new HIV infections. In 2010 public sector treatment protocols were amended to allow for earlier initiation of children under the age of one, pregnant women and TB co-infected patients on antiretroviral therapy (ART). In 2011 public sector treatment protocols were further amended so that all HIV positive patients with CD4 counts below 350 would be offered free ARV treatment.

The South African 20 year vision with respect to the HIV and TB epidemics has been adapted from the Three Zeros advocated by UNAIDS. The National Strategic Plan (NSP) for HIV, STIs and TB 2012-2016 was released on World AIDS day 2011 and addresses the drivers of the HIV and TB epidemics and builds on the achievements of the previous NSPs to achieve its goals. The NSP is multi-sectoral and every national and provincial government department, municipality and sector was required to develop their plan by March 2012.

One of the key NSP interventions aimed at the private sector is as follows, “all employers and labour unions, should ensure that all formal sector and informal sector employees are tested and screened annually and have equitable access to prevention, treatment and wellness services. Special attention should be given to high-risk workplaces and trades (e.g. mines and truck drivers).”

The South African Business Coalition on HIV and AIDS (SABCOHA) has as its primary purpose to mobilise and empower South African business to take effective action on ensuring wellness in the workplace which includes addressing HIV, AIDS, STIs, TB and other chronic diseases. To this end SABCOHA will coordinate efforts that ultimately mitigate the impact of HIV, AIDS, STIs, TB and ill health on sustained profitability, productivity and economic growth.

One of SABCOHA’s key strategic objectives is to strengthen co-ordination at a provincial level. The strategy to establish provincial structures to coordinate and consolidate the business sector’s response to HIV and AIDS is aimed at improving efficiency and responsiveness to local needs. Further, provincial strategies have evolved into a broader wellness approach including STIs, TB and other chronic diseases.

Strengthening provincial systems involves establishing governance mechanisms and agreeing strategic priorities for business at a provincial level. SABCOHA will support capacity development at company and industry level and facilitate business participation on multi-sectoral structures. Building on SABCOHA’s success in the Northern Cape and Western Cape, funding was secured from the US Centers for Disease Control and Prevention (CDC) for the implementation of the Provincial Systems Strengthening (PSS) programme in five additional provinces: Limpopo, North West, Free State, KwaZulu-Natal and Eastern Cape. The CDC is one of the major operating components of the United States Department of Health and Human Services and one of the key agencies through which PEPFAR (the US President’s Emergency Fund for AIDS Relief) funding is distributed.

The SABCOHA Eastern Cape Board of Governors was elected at the business sector conference held at the Premier Hotel Regent, East London in September 2011. Since their appointment, four quarterly board meetings were convened. This strategy was released for public comment and thereafter adopted by the provincial board of governors on 13th October 2012

This strategy is the outcome of substantive stakeholder engagement and research which would not have been possible without significant funding from CDC-PEPFAR. Thank you to the Border Kei and Nelson Mandela Bay business chambers in the Eastern Cape for endorsing the process and the business sector conference. SABCOHA further recognises the invaluable support of the members and secretariat of the Eastern Cape AIDS Council.

The government cannot eradicate HIV alone and a collective effort is required from all other stakeholders. The private sector, in particular, is called upon to play a much more meaningful and visible role in making resources and expertise available.

Brad Mears, Chief Executive Officer
On behalf of SABCOHA, especially the Eastern Cape Board of Governors, and the Secretariat, I am proud to present to you the Eastern Cape Business Sector Plan on HIV, AIDS, STIs, TB and Wellness 2012 – 2016. I would like to acknowledge everyone who played a part in making this strategy possible. Under the leadership of the Eastern Cape Provincial AIDS Council (ECAC), this provincial business strategy is presented to you.

The method by which this strategy has been developed is one of thorough consultation with all social partners in the Eastern Cape Province, following a district based approach. This strategy is premised on the vision contained in the NSP namely to have:

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

Secondly, this strategy is based upon the four strategic objectives of the Eastern Cape HIV, AIDS, STIs and TB Response, namely:

- Prevention of HIV, STIs and TB
- Sustaining health and wellness
- Protection of human rights
- Reducing structural vulnerability

Thirdly, this strategy includes interventions that address four of the six key drivers identified in the Eastern Cape, namely:

- Priority programme 1: Stigma and discrimination
- Priority programme 2: Inequality
- Priority programme 4: Substance abuse
- Priority programme 5: Multiple and concurrent partners

This strategy has prefaced the interventions with extensive economic data, labour statistics, and the public healthcare infrastructure available within the province. Not only is this information pertinent in defining the interventions, but it also gives a sobering sense of the
enormity of the challenges facing the Eastern Cape. The proportions of the epidemic cannot be simply interpreted by looking through the lens of the clinician. Rather HIV dynamics need to be interpreted from numerous perspectives, including the impact on the business sector in the province.

The interventions which were based upon the priority interventions identified by the business constituency have been tabulated for ease of reference. Interventions have been classified into three broad categories, namely:

- 27 company interventions
- 8 sectoral interventions
- 4 multi-sectoral interventions

The top 10 interventions that were identified as priorities are as follows:

1. Develop partnerships with government to enable provincial mobile clinics to be allocated to provide prevention, treatment and care services for the large seasonal migrant communities in the Eastern Cape agriculture sector.
2. Maximise the coverage of male and female condom dispensers in strategic points in workplaces for increased access.
3. Develop and implement a comprehensive workplace programme that addresses HIV, STIs and TB in an integrated manner and is aligned with provincial standards. The workplace programme can either be an extension of the EAP or created through the increased scope and capacity of occupational health and safety. It should ideally include HIV, STI and TB prevention and treatment services and eventually expand to cover other relevant local health conditions. It should ensure that HIV, AIDS and TB workplace policies and procedures comply with workers’ rights as they relate to stigma and discrimination.
4. Ensure that all employees are given an annual health assessment which includes: provider initiated HIV counselling and testing (PICT), screening for TB and STIs and screening for other non-communicable diseases such as hypertension, diabetes, anaemia.
5. Preventing new TB infection and disease through Isoniazid Prophylactic Therapy (IPT), infection control, early identification and treatment of TB and an improved TB cure rate.
6. Direct Corporate Social Investment (CSI) to support information and education programmes within local communities, especially schools attended by employees’ children or consider training one youth for every seven peer educators trained in a peer education programme.
7. Companies should work with trade unions to negotiate on HIV and AIDS health promotion and employee wellness workplace policies for their members. They should make sure that policies and programmes are not conflicting with unions and that efforts are not duplicated.
8. Use peer educators to discuss issues including, but not limited to: changing social norms; addressing gender-based violence; sensible alcohol use; promoting the individual; culture of acceptance and non-discrimination; address intergenerational and transactional sex; target men’s attitude to women; and promote a balanced use of traditional versus western medicine.
9. Establish internal systems aligned to accepted indicators for routine monitoring, performance measurement and external reporting.
10. Ensure visible leadership, support and participation from board members and executive management. The CEO and Chairperson need to be conversant on the issues and know the company’s position. Ownership or support of the company-based HIV, STI, TB and wellness initiatives must be at the most senior level.

I would encourage you as the reader of this document to review and understand the socio-economic conditions pertinent to your district. These are set out in the context of implementation section of this document.
As the reader of this document, how should you interpret the information contained in this strategy?

Firstly, if you are a leader from the private sector, this document sets out what your company can and should be doing in response to the epidemic. I appeal to you to adopt as many of the interventions set out in this strategy as possible. However interventions should not be formulaic. Rather, the creativity and the robustness for which the private sector is known in South Africa, needs to come to the fore, and each intervention must suit the conditions within which your company operates.

Secondly, if you are an employee, I encourage you to bring this document, and its contents to the attention of the leadership in your organisation. This document presents an opportunity for you to advocate for more support for HIV and wellness interventions in your workplace.

If you are from a Non-government Organisation (NGO) or the broader community, this document presents a framework setting out how you may partner with the business sector operating in your district.

If you are from government, this document must be read in the context of how deeper partnerships can be established between the private and public sectors. Indeed the success of this strategy is dependent upon the will and leadership of leaders from both sectors in establishing public private partnerships.

Finally, I appeal to all readers of this document to read it in the spirit of Ubuntu. If the goodwill that was so evident during the process of developing this strategy can be carried forward, then I am very confident that the objectives of this document will be achieved. As leaders, we are accountable not only to our present constituencies, but to future generations, in ensuring the success of this strategy, as well as the overarching Provincial and National Strategic Plans.

Ms Arnelle Heynes, Eastern Cape Board of Governors - Chairperson
HIV, AIDS, STI’S AND TB

The HIV, AIDS and TB epidemics are an enormous problem for South Africa and have already had a profound impact on many aspects of society. The burden of infected individuals requiring lifelong treatment and care will impact significantly on productivity and the economy.

South Africa has the largest number of HIV infections in the world with an estimated 5.7 million people living with HIV in 2009\(^2\) and the prevalence is disproportionately high for females in comparison to males.\(^3\) South Africa also has the highest TB incidence (estimated new TB cases (all forms) per 100 000 population in the world of 948 per 100 000 per year (1 in 105 people)).\(^4\) Incidence of TB has increased, in parallel to the increase in the estimated prevalence of HIV in the adult population.

There are many complex factors which influence the twin HIV and TB epidemics and their prevalence among populations. An effective response requires knowledge of the disease burden and main drivers of the HIV and TB epidemics in an area in order to tailor appropriate interventions.

HIV and AIDS

HIV prevalence varies considerably between the provinces and the underlying districts due to social, behavioural, economic and structural factors. Determinants of the epidemic in South Africa are behavioural and social, biological and structural as summarised in Table 1.

\(^2\) UNAIDS
Table 1: Key determinants and recommended action

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<th>Determinant</th>
<th>Recommended action</th>
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<tr>
<td><strong>BEHAVIOURAL AND SOCIAL DETERMINANTS</strong></td>
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<tr>
<td>Multiple sexual partners</td>
<td>Multi-level interventions that focus on sexual, social, cultural and gender norms and values.</td>
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<tr>
<td>Condom use</td>
<td>Increase consistent use, especially among key populations.</td>
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<tr>
<td>Age-disparate sexual (intergenerational)</td>
<td>Target prevention strategies at those men and women who have partners much younger/older than themselves, given that the significant age discrepancy increases HIV exposure risk compared to people who reported partners of similar age.</td>
</tr>
<tr>
<td>Alcohol and substance abuse</td>
<td>Interventions to decrease alcohol abuse and other substance abuse, including illegal substances.</td>
</tr>
<tr>
<td>Prevention knowledge and risk perception</td>
<td>Prevention strategies for people who expose themselves to the risk of HIV infection, including education and addressing perceptions of personal risk</td>
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<tr>
<td><strong>BIOLOGICAL DETERMINANTS</strong></td>
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<tr>
<td>Mother to child transmission</td>
<td>Strengthen the implementation of four prongs of the prevention of mother to child transmission (PMTCT) programme.</td>
</tr>
<tr>
<td>Medical male circumcision (MMC)</td>
<td>Continue with large scale rollout of a national medical male circumcision programme as part of a package of sexual and reproductive health services which includes gender sensitisation.</td>
</tr>
<tr>
<td>Other sexually transmitted infections</td>
<td>Prevention and early treatment of STIs.</td>
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The Eastern Cape Provincial Strategic Plan for HIV, AIDS, STIs and TB 2012 – 2016 (PSP) identifies six key social drivers which are listed in order of priority below.\(^6\)

1. Stigma and discrimination
2. Inequality
3. Overcrowding
4. Substance abuse
5. Multiple and concurrent partners
6. Orphans and vulnerable children

The key areas in the HIV response are prevention and treatment. Prevention activities need to reach both people already living with HIV and those who are at risk of HIV infection. Treatment can reduce HIV deaths and disability and allow many employed persons with HIV infection to continue working. ARV studies have shown that diagnosing HIV at a late stage of infection and delay in getting on to treatment reduces the chances of the patient responding well to treatment and are then less likely to recover to normal functioning levels.\(^7\) The emerging concept of “treatment as prevention” has been supported by various studies that show that reduced viral load of HIV positive people on ARVs reduces risk of transmission, and decreases the community viral load which in turn results in a reduction of new HIV infections.\(^8,9,10\)

South Africa’s leadership demonstrated their commitment to the HIV response with the launch of the HCT campaign in April 2010. It called upon all South Africans to know their HIV status and aimed to counsel and test 15 million South Africans for HIV by June 2011. This campaign aimed to help people to access treatment early and reduce new HIV infection by promoting healthy lifestyles in all clients who tested and knew their status. By end of 2010/11 a total of 9.7 million people had agreed to be tested. This was a three-fold increase from previous annual trends.\(^11\) The Eastern Cape’s provincial target was for 2 million people to be tested by June 2011, and by March 2012 a total of 1 274 000 people have been tested in the province.\(^12\)

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5 National Strategic Plan on HIV, STIs 25 and TB: 2012-2016
10 HPTN (2011, 12th May) ‘Initiation of antiretroviral treatment protects uninfected sexual partners from HIV infection (HPTN study 052’ Press release [PDF]
Additionally the government expanded access to ARVs and since its inception at the end of March 2011 the ARV programme had enrolled 1.4 million HIV positive people. The Eastern Cape had 264 ARV sites in March 2011 and by March 2012 this had increased to 784 sites. By March 2012, there were 179 000 people recorded to be on ARVs in the Eastern Cape. The Eastern Cape Department of Health also plans to train more nurses on Nurse Initiated Management of ART (NIMART) in order to provide coverage of two NIMART trained nurses per site. The number of nurses trained on NIMART was 1 800 in March 2012.

MMC has been shown to reduce the risk of acquiring HIV. Three recent randomised control trials in sub-Saharan Africa showed MMC reduced the risk of acquiring HIV by 60%. MMC is recommended by the World Health Organisaton (WHO) and UNAIDS in countries with a high prevalence of heterosexually transmitted HIV and low levels of male circumcision. There have been concerns about increased risky sexual behaviour as a result of MMC, however within the context of the studies done so far, MMC does not result in increased HIV risk behaviour. Additionally MMC has been shown to reduce the incidence of STIs and also Human Papillomavirus (HPV). MMC must be considered as just one element of a comprehensive HIV prevention package that includes the correct and consistent use of condoms, reductions in the number of sexual partners, delaying the onset of sexual relations, avoidance of penetrative sex, and testing and counselling to know one’s HIV serostatus.

In South Africa circumcision has been performed as part of traditional initiation, which is often done in remote areas, under unhygienic conditions and by a traditional circumciser with no medical training. The latest NSP embraces MMC and specifically includes expanding the coverage of MMC by including it as an essential part of male Sexual Reproductive Health (SRH). The NSP also targets the development of national guidelines for the safe practice of circumcision which will target circumcision practices in a traditional setting.

There is a risk that children born to mothers with HIV will acquire HIV around the time of birth or from breastfeeding. PMTCT is a strategy that aims to reduce the transmission of HIV from mother to child before, during and after birth. The PMTCT strategy includes four prongs: Prong 1: Targeted primary prevention among women of child bearing age; Prong 2: Prevention of unintended pregnancies in HIV positive women, Prong 3: Prevention of infection from HIV-positive mothers to infants; and Prong 4: Care and support for women, their children and family. The interventions to help prevent the transmission of HIV from mother to unborn child include: education and communication strategies, drugs, counselling and psychological support.

The national PMTCT programme has been in effect since 2002 and there are four areas which are key to improving PMTCT outcomes in South Africa: (1) increasing up-take of the programme, (2) upgrading the single-dose Nevirapine regimen, (3) ensuring women with low CD4 counts or AIDS are placed on highly active antiretroviral treatment (HAART) and (4) appropriately monitoring and evaluating the programme on a regular basis. There is a need for social mobilisation and communication in support of PMTCT aimed not only at women, but all members of the community.

PMTCT services are available at all Eastern Cape public health facilities as well as at private health sites; PMTCT coverage surpassed the 95% target by early 2011. Between 2007 and 2011 around 655 820 of antenatal clients tested for HIV in the province. Of these, 84 711 were found to be positive. In infants, 64 925 PCR tests were done and out of these 6 098 were found to be positive.

Sexually Transmitted Infections (STIs)

STIs which are also known as Sexually Transmitted Diseases (STDs), increase the likelihood of both transmitting and acquiring HIV. STIs can increase an individual’s susceptibility to HIV by causing inflammation and breaks in the genital tissue which allows HIV to pass easily into the body. The risk of infection by an HIV positive person can be increased by STIs as they are more likely to shed HIV in their genital secretions, which leads to a higher concentration of HIV in these secretions. Someone with HIV is also more susceptible to STIs as immuno-suppression can modify the duration, severity, and response to treatment of certain STIs, notably other viral infections such as genital herpes simplex virus infection or HPV.

However, STIs are not just biological and medical problems, but also behavioural, social, political and economic problems. Many interventions to control STIs can help reduce the spread of HIV and vice versa. This supports integration of HIV and STI services.

Tuberculosis

TB is the leading cause of death in South Africa and it is estimated that 80% of the South African population has latent TB. The risk of developing active TB is higher in certain populations. These key populations include: people living with HIV (PLHIV), children, diabetics, smokers, alcohol and substance abusers, malnourished people, migrant and refugee populations, people living in crowded conditions and people who work in poorly ventilated areas such as miners. TB is only infectious in the active cases.

There is a complex relationship between HIV and TB as compromised immunity in people living with HIV increases the risk of developing active TB and in turn TB can accelerate the course of HIV. The incidence of TB has increased in parallel to the increase in the estimated prevalence of HIV in the adult population. The co-infection rate in South Africa is one of the highest in the world with almost 75% of TB patients being HIV positive.

Integrated TB and HIV services are key to the management of co-infection of TB and HIV; as it allows early diagnosis, early initiation onto ARVs for HIV positive patients with TB, along with Isoniazid Preventive Therapy (IPT) for HIV positive people who have latent TB, which reduces the risk of developing active TB. Integrated TB and HIV services ensure co-infected people remain on treatment. TB contact tracing and screening is also a vital tool in the early detection and management of TB.

Earlier testing, faster turnaround times for diagnosis, reduction of defaulters and drug resistance surveillance are suggested actions that can aid the control of the spread of drug resistant TB in South Africa. In 2011 the Department of Health acquired GeneXpert technology which is a test with increased sensitivity for TB diagnosis that identifies any drug resistance and takes only two hours to get results. These machines have been rolled out to high burden districts and will be rolled out to every district in 2012. This will significantly reduce the lag between testing and appropriate treatment, therefore reducing the pool of infectious people, especially Multi-Drug Resistant (MDR) and Extremely Drug Resistant (XDR) TB. In the Eastern Cape the first GeneXpert machine was handed over to the OR Tambo district on World TB day 2011 and will be rolled out to a further seven hospitals (St Patricks, Uitenhage, Holly Cross, Mt Ayliff, Madzikane ka Zulu, All Saints and St Barnabas) and one machine in the Amathole NHLS centre in 2012.

Directly Observed Treatment Short-course (DOTS) is the recommended strategy for TB control and is highly efficient and cost-effective. To cure TB, at least six months of treatment is required and DOTS advocates that TB patients are directly observed and supported to take their TB medication every day until they are cured. Stigma and discrimination serve as deterrents for this strategy to be effectively used in the workplace. Interventions that reduce stigma and discrimination associated with TB and HIV have the potential to increase compliance and reduce the number of defaulters. The WHO TB cure rate target of 85% has not yet been reached in South Africa and a national target of 10% increase per year has been set in the interim.

THE DONOR CRISIS AND HEALTHCARE FINANCING IN SOUTH AFRICA

Concerns over dramatically reduced donor funding have now been realised as the global economic crisis has led to decreased donor spending for the HIV epidemic in low and middle-income countries. International HIV funding from donor governments (bilateral funders) is not as substantial as previous years after flattening in 2009 and falling by 10 percent in 2010.22

This funding crisis will have a negative impact on the global HIV and TB responses as developing countries will not be able to sustain existing prevention and treatment interventions. This could lead to an increase in new HIV and TB infections and other opportunistic diseases, increased mortality, and possible drug resistance. This has long-term cost implications with an increased number of people requiring expensive second-line drugs for both HIV and TB and will place further burden on the already strained public health system. The private sector may feel the effects particularly those relying on donor funded treatment programmes for their employees or contract workers.

Donor funds are essential for the NGOs and civil society organisations who implement many prevention and treatment programmes, which are not considered in the national health budgets. The decline in donor funding will certainly see some NGOs in the province make drastic cuts or even close down.

Total spending on public health services has nearly doubled over the past three years, from R63 billion in 2007/08 to R113 billion projected for 2011/12.23 The National AIDS Spending Assessment (NASA) estimated the combined domestic and foreign funding for the response to HIV and TB in South Africa in 2009 to be R13 billion with more than 75% of this allocated by government.24 Domestically, conditional grants for HIV and AIDS through the national health budget increased from R4.3 billion in 200825 to an estimated R7.5 billion in 2012.26

The Eastern Cape Province was allocated R46.9 billion as its equitable share of national revenue which is 15.3% of the total provincial allocations and the third highest allocation among the provinces in 2012/13.27 The Eastern Cape Department of Health budget allocation for 2012/13 was R 15.17billion.28

A recent costing of the NSP 2012-2016 revealed that at least R18.73 billion will be needed in 2012/13 and will increase to R32.25 billion by 2016. This considerable financing shortfall is beyond current national and international funding levels and additional support is required to address this financing gap. National Health Insurance (NHI) has been identified as one potential source of expanded public funding and the business sector has been identified as another key player who can support the HIV response and alleviate some funding pressures. The Department of Health (DoH) has defined this policy and approach as a “financing system that will make sure that all citizens of South Africa (and legal long-term residents) are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund.”29

Implemented successfully, the NHI has the capacity to enhance employment and socio-economic development in the long term. An assessment of the economic impact of NHI implementation suggests that, with the improved health indicators (including life expectancy and child mortality) associated with equitable access to healthcare, the potential for enhanced national productivity and industry sustainability is increased. According to the Human Sciences Research Council’s (HSRC) CEO, Olive Shisana, once NHI is in place it would help reduce health spending from 8.3% of GDP to 6.2% as the overall population would become healthier and more productive.

23 National Budget Speech 2011
The NHI is to be piloted in 10 districts in 2012 and rolled out over a period of fourteen years (2012-2026). OR Tambo has been earmarked as the Eastern Cape pilot district. Service delivery will be prioritised nationally and supported locally by district health services. Administrative structures will seek to provide support and enhance efficiency at these levels as well as to mitigate duplication of resources spent and data captured. Through the establishment of a centralised fund, and ensuring the adequacy and competency of all health service delivery mechanisms, the creation of an efficient, equitable and sustainable health system in South Africa is possible.

**HIV, AIDS AND TB - THE THREAT TO SOUTH AFRICAN BUSINESSES**

The health and wellness of communities is critical to the success of local businesses, the economy and the country as a whole. The HIV and TB epidemics impact on the ability of individuals to contribute productively and economically to society. The productivity and profitability of South African business is threatened by the labour force changes as well as changes in consumer spending and changes in the economic environment that result from HIV, AIDS and TB. There is increasing recognition that South African companies need to become involved in the response in order to survive the impact of the disease.

In countries with a high HIV prevalence the impact of HIV, AIDS and TB in the workplace is real and multifaceted as illustrated in Figure 1. Research at Boston University found that AIDS-related costs in the companies ranged from 3 to 11% of the annual salary bill in 1999-2000. HIV, AIDS and TB contribute to declining production and profits while increasing costs. The decrease in labour supply can be in terms of numbers, productivity and skill levels which impact on profitability by both increasing the cost of production and decreasing the productivity of workers. Further detail on the factors that contribute to the negative effects of the epidemic are shown in Figure 1.

**Figure 1: The impact of HIV and AIDS on business**

Gender, work and HIV

Women are more vulnerable to infection both biologically and socially. Cultural norms and economic circumstances mean as the HIV epidemic progresses, women as the primary caregivers in the community have to care for family and community members who fall ill as well as having to work or manage the household at the same time.

Many women in South Africa have limited access to secure livelihoods and socio-economic opportunities as traditionally the workplace was a male domain. Women are often dependent on their male partners from both a social and economic perspective which can mean that they have little control over their lives and choices. This places women in situations that increase their vulnerability to HIV infection.

The cultural norms applied to men in many societies also place them in situations that increase their vulnerability to HIV infection as well as facilitating HIV transmission. Multiple partners and sexual infidelity are condoned for men in many societies. Occupations that involve men spending long periods away from their families tend to encourage risky sexual behaviour which increases vulnerability to HIV among the mobile individuals, but also increases vulnerability to HIV among the sending and receiving communities.

Trade unions and HIV

Trade unions are an integral part of South African business, and have also experienced the impact of HIV and AIDS within their organisations. The loss of key staff members, workplace representatives and activists will affect how unions are able to organise and support their membership effectively. Skill levels and productivity are negatively affected as only limited training and development of the replacement staff is possible due to resource constraints.

Trade unions also have a role to play in the HIV response as leaders and co-ordinators. They should develop their own capacity and awareness to negotiate on HIV and AIDS workplace policies for their members.

Responding at the workplace

"HIV/AIDS should be recognised as a workplace issue, and be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic."

ILO Code of Practice on HIV and AIDS and the world of work

The following points elaborate on why it is necessary to deal with HIV and AIDS in the workplace:

- HIV and AIDS affect the working population and it should be recognised as a workplace issue.
- Reduction of productivity and profitability, HIV and AIDS has a huge impact on business’s bottom line and should be approached as an operational risk.
- Workplaces are accessible communities which can be the target of raising awareness, education and treatment campaigns as employees often come together and they discuss, debate, and learn from each other.
- Workplaces have structure and procedures that can be used to tackle HIV and AIDS. Workplaces already have standards that are set for working conditions and labour relations which can be refined to address HIV and AIDS. This provides an opportunity for raising awareness, education programmes, and the protection of rights.
- Leadership is crucial to the HIV and AIDS response and employers and trade unions are leaders in their communities. Countries should support and encourage HIV initiatives by communicating important messages about HIV, AIDS and TB aimed at changing social attitudes and behaviours.

POLITICAL LANDSCAPE IN THE EASTERN CAPE PROVINCE

The Eastern Cape Premier, Noxolo Kiviet has been in office since May 2009 and is a member of the ANC. In order to strengthen its leadership in response to gaps in service delivery, the Premier announced a cabinet reshuffle in November 2010 which affected 10 ministries including the MEC for Health and the MEC for Human Settlements, Safety and Liaison who chairs the ECAC. During this reshuffle, Sicelo Gqobana was appointed the new MEC for Health and Helen Sauls-August was appointed the MEC for Human Settlements, Safety and Liaison and Chair of ECAC.

The municipal elections of 2011 were held during the stakeholder engagement period with new councillors being represented on the multi-sectoral provincial and district AIDS councils. At this time the Buffalo City Metro was officially recognised.

ECAC, which has an exemplary record for meeting quarterly as mandated, hosted a donor coordination summit in February 2011. This summit brought together representatives from the international donor communities and the political leaders in the province in order to align available funds to the most important needs. The Premier’s leadership on HIV, AIDS and TB was visible both at the summit and at the induction of ECAC members in August 2011.

THE BUSINESS SECTOR AND SABCOHA

The 2012-2016 NSP called for every sector to develop implementation plans by March 2012. SABCOHA aims to co-ordinate a private sector implementation plan for each province in line with the NSP and the province specific PSP.

SABCOHA’s primary purpose is to mobilise and empower South African business to take effective action on ensuring wellness in the workplace which includes addressing HIV, AIDS, STIs, TB (HAST) and other chronic diseases. To this end SABCOHA will coordinate systems strengthening efforts involving the business sector that ultimately mitigate the impact of HAST and ill health on sustained profitability and economic growth.

One of SABCOHA’s key strategic objectives is to strengthen service delivery at provincial level. The strategy to establish provincial structures to coordinate and consolidate the business sector’s response to HIV and AIDS is aimed at improving efficiency and responsiveness to local needs. Further, provincial strategies have evolved into a broader wellness approach including STIs, TB and other chronic diseases.

Strengthening provincial systems involves establishing governance mechanisms and strategic priorities for business at provincial level. The development of a provincial business sector strategy that identifies business sector commitments and priorities in support of PSP’s is central to this process. SABCOHA will support capacity development at company and industry level and facilitate business participation on multi-sectoral structures.

SABCOHA is run by a CEO who reports to the National Board of Governors. The board consists of representatives from member companies and other appropriate stakeholders and individuals. SABCOHA is bound by its Articles of Association, which makes provision for a governing committee of at least five members appointed by the board. A Provincial Board of Governors was elected in each province to guide and oversee the implementation of their provincial business sector strategy.

SABCOHA has existing relationships in the Eastern Cape with, amongst others, the Automotive Industry Development Centre (AIDC), the Nelson Mandela Bay Business Chamber and the Border Kei Chamber of Business. SABCOHA has invested in relationships with both Siyakhana in Buffalo City and the AIDC in Nelson Mandela Bay and a memorandum of understanding was signed with both organisations. At a multi-sectoral level relationships with the ECAC and the PEPFAR Liaison have been furthered.
CHAPTER 2: BACKGROUND

SABCOHA has a number of existing or pilot projects operating in the Eastern Cape and these include:

**Supply Chain Development Project**

This is a comprehensive workplace programme, as well as affordable, sustainable Voluntary Counselling and Testing (VCT) and treatment offered to Small, Medium and Micro Enterprises (SMMEs) who operate within big companies’ supply chains who do not have the infrastructure or capacity to develop their own HIV/AIDS workplace programmes. The SABCOHA/Volkswagen SA/ILO Project involves seven companies who supply Volkswagen SA who are in and around Port Elizabeth and Uitenhage.

**BizAIDS**

BizAIDS engages the informal business sector by training micro-enterprise owners and employees in fundamental business skills as well as HIV risk management. Currently structured as a two-day training workshop, the project contracts experienced trainers to provide training in high risk communities. Recruitment and mobilisation occurs at a grassroots level. Training encourages participants to know their HIV status and promotes good health seeking behaviour, thereby mitigating the impact on the micro-enterprise. There are currently four trainers in the Eastern Cape. Since 2004 with funding from the United States Agency for International Development (USAID), The UK Department for International Development (DFID) and CDC, 2 630 small business owners have been trained in the BizAIDS programme in five districts in the Eastern Cape.

**Peer Educators**

SABCOHA offers support to business for peer educators in order to establish strong HIV-related education, counselling and support functions within workplace HIV and AIDS programmes. Evidence shows that peer educators are an extremely valuable resource in any workplace programme. By enhancing access to reliable information, developing skills and providing mentorship support to peer educators, this programme contributes to the effectiveness and sustainability of peer education in the workplace. Mentorship reduces the incidence of burnout amongst peer educators and strengthens effective implementation aimed at positively influencing behaviour change, facilitating referral for treatment and other services and enhancing psychosocial support. With funding from the Global Fund, SABCOHA trained 30 female peer educators in Uitenhage and KwaZakhele Township in the Nelson Mandela Bay Metro in 2011.

**Project Promote**

Project Promote is a public-private partnership between the National Department of Health (NDoH), SABCOHA and various partners including companies in the cleaning industry and institutions of higher education. The project provides support to the NDoH by extending condom distribution services to non-traditional outlets through various primary distribution sites. Historically commencing in the cleaning industry in May 2006, the project expanded in 2009 to include larger industry sites such as SASOL in Sasolburg. As part of the broader Higher Education South Africa initiative, Project Promote also expanded in 2009 to include tertiary learning institutions. Project Promote’s average monthly distribution in the Eastern Cape for 2011 was approximately 66 000 condoms per month.
CONCLUSION

The risk of HIV, AIDS and TB on productivity sustained profitability and growth should be of high concern to business and should further motivate business to support the HIV response. However, HIV fatigue coupled with the struggle for economic survival in the tough financial climate has pushed HIV, AIDS and TB down the list of priorities.

There are synergistic benefits for business to operate collectively as a sector and not individually as independent organisations. The sharing of knowledge, good practice and contemporary issues can benefit all organisations and in particular the medium and smaller businesses that do not have resources available. A coalition of businesses working together will mitigate the health risk across the whole value chain. With big business leading and the SMME sector benefiting, economic sustainability will be realised. Although the health and wellbeing of its citizens is a national priority which is in the public interest, it remains an economic necessity for business.

This business sector strategy should be seen to augment government’s national and provincial response plans.
Background

With funding from the CDC, this plan has been developed for the purpose of providing business in the Eastern Cape Province, with clear objectives in combating HAST. Beginning in 2009, SABCOHA shifted the focus of its strategic interventions, from a nationally coordinated response, to a response which was closer to where business experienced the impact of the epidemic. Through district consultations with business, SABCOHA developed this PSP from the bottom up.

This plan has been developed with the full co-operation of the business sector in the Eastern Cape Province, including members of SABCOHA, leading corporates, other small and medium companies, business associations and chambers of commerce. As part of the consultation process, SABCOHA engaged fully with the Eastern Cape PAC, as well as Eastern Cape Provincial Department of Health.

Eastern Cape strategy development

Widespread stakeholder consultation formed the critical approach adopted for the development of this strategy. The purpose of engaging in broad consultation was to ensure that this strategy reflected relevant responses to the realities of the epidemic, but also situated the responses within an economic context meaningful to business. This strategy reflects the priorities identified by business in responding to HIV, AIDS and TB in the Eastern Cape Province.

Furthermore the purpose of the consultative process was to:

- Develop and implement a sector-specific HIV, AIDS and TB plan, which encompassed identified provincial priorities, and comprehensively defined the business sectors contribution to the Eastern Cape PSP, as well as the NSP 2012 – 2016.
- Strengthen co-operation and partnerships between business, government and civil society, especially with respect to improving access to healthcare.
SABCOHA first consulted member companies in the Eastern Cape and followed with extensive desktop research to identify additional key stakeholders across all eight districts. The Eastern Cape contacts database increased to more than 391 contacts representing about 241 companies or organisations during the project period.

In excess of 57 stakeholder consultations, involving more than 76 representatives from all sectors, were conducted during this period. These one-on-one stakeholder consultations culminated in a consultative conference in September 2011.

The conference held on the 14th and 15th September at the Premier Hotel Regent, East London (Buffalo City) in the Eastern Cape, had 74 delegates representing 51 companies, government departments and civil society organisations. The conference facilitation assumed the World Cafe methodology to enable maximum expression and input. Round table conversations and storyboard development were integrated throughout the programme. Anonymous voting technology, using keypads, further facilitated consensus building and prioritisation. The conference report can be downloaded from www.sabcoha.org. This strategy is based on the outcomes of the conference and the survey findings.

The draft strategy was released for public comment in June 2012. The SABCOHA Eastern Cape Board of Governors adopted the final strategy at its meeting on 12th October 2012 noting changes informed by comments received.

Branch establishment

The proposed governance protocol was adopted by the steering committee on 6th September 2011. A call for nominations was published in the SABCOHA Eastern Cape e-newsletter, which was distributed to the provincial database in August 2011, and repeated on the first day of the conference. Nominations were received from all district and metropolitan municipalities, and included two nominations from Buffalo City Metro; three from the Nelson Mandela Bay Metro; and one each from the Cacadu, Amathole, OR Tambo and Chris Hani districts. Seats were reserved for the Joe Gqabi and Alfred Nzo districts. Conference delegates voted on the six seats for the six representative districts. Outstanding nominations will be solicited through the media.

Richard Douglas officially announced and congratulated the Eastern Cape Board of Governors after the successful completion of a transparent election process on the last day of the conference (15th September 2011). The elected board members were as follows:

**Buffalo City Metro:** Dr Clifford Panter – Mercedes Benz South Africa, Health & Safety Advisor  
**Nelson Mandela Bay Metro:** Ms Arnelle Heynes – AIDC, Workplace Programme Coordinator  
**Cacadu:** Mr Jan Muller – AHI, Business Manager South Eastern Cape Unit  
**Amathole:** Ms Nolundi Ndudane – Eskom, EAP Advisor Eastern Cape Province  
**OR Tambo:** Ms Kumbuza Gwiliza – Gwiliza Funeral Services, Managing Director  
**Chris Hani:** Mr Johan Wege – Agriculture, General Council Member  
**Joe Gqabi:** Vacant  
**Alfred Nzo:** Vacant  
**SABCOHA:** Mr Brad Mears – SABCOHA, CEO

The first board meeting was held on 22nd February 2012. The Exco was elected with Ms Arnelle Heynes and Dr Clifford Panter as Chairman and Vice-chairman respectively.
Way forward

With funding from the Global Fund to Fight AIDS, TB and Malaria, SABCOHA will be appointing a co-ordinator in the Eastern Cape Province. The Eastern Cape Board’s function will be to: oversee the implementation of the strategy; provide leadership and sound governance; and by reaching out, develop lasting relationships with all social partners in the province. A ten point plan outlining the focus for 2012-2013 was developed by the Eastern Cape Board. In determining the top priorities for the plan, board members primarily sought alignment to the Eastern Cape PSP 2012-2016 as well as taking into consideration current projects which were operational and funded.
Introduction
A strategy is a comprehensive plan of action in the pursuit of a stated purpose. In summary, this Eastern Cape Business Sector Strategic Plan identifies the vision, actions and priorities in support of the PSP, which aligns to the NSP (developed under the leadership of SANAC) and which all ultimately align with the achievements of the Millennium Development Goals for Health.

Vision and Goals
The long-term vision of the NSP (and PSP) is based on the Three Zero’s advocated by UNAIDS. This business sector strategy is guided by the relevant aspects of this vision which are:

- Zero new HIV and TB infections
- Zero preventable deaths associated with HIV and TB
- Zero discrimination associated with HIV and TB

In line with this 20-year vision, this Eastern Cape Business Sector Strategic Plan will align to the following goals drawn from the 2012-2016 Eastern Cape PSP:

- Reduce new HIV infections by at least 50% using combined prevention approaches.
- Initiate at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation.
- Reduce the number of new TB infections, as well as the number of TB deaths by 50%.
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP.
- Reduce self-reported stigma and discrimination related to HIV and TB by 50%.

The Eastern Cape PSP specifically targets priority programmes which address the key social drivers of the HIV and TB epidemics. These priority programmes are:

1. Eliminate stigma, denial and discrimination
2. Address inequality,
3. Eliminate overcrowding
4. Address substance abuse
5. Eliminate the practice of multiple and concurrent partners
6. Significantly reduce the number of orphans and vulnerable children (OVCs) in the Eastern Cape
This strategy contains options that may or may not be realised in practice. Changing political, economic, social, technological, legal and environmental external conditions as well as internal organisational realities, both within SABCOHA and companies, will affect the sector’s ability to implement. Strategy is essential for providing direction and enabling implementation. The success of this strategy is contingent upon cooperation and commitment from individual companies and business leaders.

SABCOHA seeks to mobilise, empower and coordinate the implementation of this strategy which comprises 39 interventions (initiatives, projects or programmes) structured across three categories as follows:

- 27 company interventions
- 8 sectoral interventions
- 4 multi-sectoral interventions

SABCOHA will market this strategy and approach and lobby companies to take responsibility for implementing company orientated interventions. SABCOHA undertakes to project manage sectoral interventions, the majority of which are designed to support companies to implement the company interventions. It is envisaged that government will lead and coordinate multi-sectoral interventions through collaborative and participatory processes. These multi-sectoral interventions address business sector interests over which individual companies and the business sector has little or no control. Business will promote multi-sectoral interventions in its dialogue and engagement with government.

A systematic rating of the 39 interventions by priority and probability resulted in short-listing 10 of the interventions as top priorities for immediate action as set out in the Way Forward chapter.

In evaluating the interventions, consider the following:

- “Treatment as Prevention” strategy. ART reduces an individual’s viral load thereby lowering risk of transmission and can reduce new HIV infections
- Horizontal conversations and on-going support is more effective in changing behaviour than simply providing information and education
- The biggest capacity gap in the business sector is monitoring and reporting programme outputs. This limits accountability, opportunities for improvement and sustainability

Purpose

- To consolidate and strengthen the business sector’s contribution to the goals and objectives contained in the PSP
- To develop a strategy and interventions that mitigate risk, promote sustainability of investments and create opportunities for partnership and collaboration
- To monitor performance, coordinate reporting and ensure accountability

Interventions and approach

The interventions are categorised according to the stakeholder or lead agency responsible for implementation. A rationale is provided for each intervention to contextualise the origin, motivate the benefit and/or explain the problem that the intervention aims to address. These explanations should enhance common understanding and mobilise support for implementation.

This is a 5-year strategic plan and aligns with the time frames of the current NSP and PSP. SABCOHA has invested in the development of a web-based sectoral reporting tool called Bizwell. SABCOHA plans to expand and support companies to report output data on Bizwell enabling consolidated measurement, industry comparisons and sectors reporting to government.
Each intervention is linked to the vision, goals and objectives of the current PSP. The strategic objectives of the PSP are aligned to the NSP but are slightly altered in order to reflect provincial priorities and are as follows:

1. Address social and structural drivers leading to HIV infections and measurably reduce stigma and discrimination
2. Reduce the rate of new HIV and TB infections using combination prevention methods and a multi-sectoral approach
3. Sustain health and wellness, ensuring physically and mentally healthy communities
4. Protect human rights, increase access to justice and end all unlawful discrimination and inequality.

Individual companies and all stakeholders need to take responsibility and make a contribution to capitalise on impact and desired outcomes.
## COMPANY LEVEL INTERVENTIONS

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<tr>
<th>#</th>
<th>Intervention Description</th>
<th>Rationale</th>
<th>Alignment to PSP</th>
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<td>1</td>
<td>Establish or review comprehensive and integrated company policy/ies with respect to HIV, TB and STIs. Ensure they are effectively communicating and included in the company’s core mandate. The policy/ies take into consideration gender- and rights-based dimensions of HAST including stigma and discrimination.</td>
<td>Addressing aspects of HIV, AIDS and TB in the workplace will enable employers, trade unions and government to actively contribute towards local, national and international efforts to prevent and control HIV, AIDS and TB. Policy and procedures related to company level HIV, STI and TB services should be multi-disciplinary and co-ordinate the efforts of wellness, occupational health &amp; safety, employee assistance and corporate social responsibility. The implementation of this intervention will contribute to the goal of increased multi-sectoral cooperation and effective resource utilisation for the provincial response.</td>
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<td>2</td>
<td>Ensure visible leadership, support and participation from board members and executive management. The CEO and Chairperson need to be conversant on the issues and know the company’s position. Ownership or support of the company based HIV, STI, TB and wellness initiatives must be at the most senior level.</td>
<td>Leadership is crucial to an integrated HIV, AIDS, STI, and wellness response. In many companies, senior management and board level participation in the HAST and wellness response is conspicuous by its absence. Board members and executive management are leaders in their companies and often in the broader community. They should support and encourage HIV initiatives and should be involved in communicating important messages about HAST and wellness aimed at changing social attitudes and behaviours. Support and participation of leaders in HAST and wellness activities sets a good example and encourages employees to do likewise.</td>
<td>2.1</td>
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<td>3</td>
<td>Companies should work with trade unions to negotiate on HIV and AIDS workplace policies for their members. They should make sure that policies and programmes are not conflicting with unions and that efforts are not duplicated.</td>
<td>Trade unions are an integral part of South African business, and have also experienced the impact of HAST. Trade unions also have a role to play in the HIV response as leaders, and as co-ordinators. The ILO Recommendation 200 recognises the role of the workplace as a key entry point for facilitating access to HIV prevention, treatment, care and support services. It stresses the need for action by labour unions to promote healthy workplaces.</td>
<td>3.3</td>
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<tr>
<td>4</td>
<td>Mobilise and support initiatives aimed at reducing substance abuse and promoting responsible alcohol use. For example: • Media and communication campaign which provides targeted relevant messaging in the workplace to promotes responsible alcohol use. • Social mobilisation in workplace and surrounding communities promoting responsible alcohol use • Partner with local tavern owners to provide messaging on HIV, AIDS and STI and prevention methods.</td>
<td>Alcohol use is associated with reduced perception of risk, risky behaviour (including, an increase in multiple and concurrent sexual partners, intergenerational sex and the experience of coercive or violent sex) and decreased condom use. It is also a major impediment to treatment adherence. Strategies should address male gender norms that equate alcohol use with masculinity. A 2011 report from the Medical Research Council indicates that, based on 20 studies in Africa, people who drink alcohol are 57% more likely to be HIV infected, with this likelihood increasing to 104% among those who abuse alcohol. An important effect of alcohol consumption is that it can impair adherence to ART (which may lead to increased HIV transmission).</td>
<td>Strategic enablers</td>
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<td>5</td>
<td>Use peer educators to discuss issues including but not limited to: changing social norms; addressing gender-based violence; sensible alcohol use; promoting individual; culture of acceptance and non-discrimination; address intergenerational and transactional sex; target men’s attitude to women; and promote a balanced use of traditional versus western medicine.</td>
<td>Peers tend to understand and respect each other as they share levels of expertise. Peer education uses horizontal, personal communication channels and is effective in promoting positive behaviours including: avoiding HIV infection, knowing your status, accepting others who are positive and accessing HIV treatment. Companies with high labour turnover could use occupational health practitioners, first aiders or wellness champions as change agents. The preferred ratio of change agent: employees is 1:30 but not more than 1:50. With a view to promotion of integrated wellness in the workplace, peer educators or change agents need to be trained in different spheres of health so as to add significant value and help companies remain cost effective and supportive of this social based learning approach.</td>
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<td>6</td>
<td>Develop and implement an education and behaviour change communications (BCC) programme in the company which addresses the gender dimensions of HIV, AIDS and STIs while taking into consideration the specific, and often different, needs of both men and women.</td>
<td>Addressing structural factors and the enabling environment, such as gender norms; violence against women; legal norms; women’s employment, income and livelihood; advancing education; reducing stigma and discrimination and promoting women’s leadership are critical to effective HIV, AIDS and STIs interventions for women and girls. Females are far more likely to use HIV testing services than males and messaging should also encourage men to test early.</td>
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<td>7</td>
<td>Empower women to make informed choices about reproductive health through dissemination of educational materials on rights and services.</td>
<td>Women account for nearly 60% of those living with HIV in sub-Saharan Africa. Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy and death. Sexual reproductive health services including STI counselling, diagnosis and treatment represent an important access point for women at high risk of HIV.</td>
<td>1.3</td>
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<td>8</td>
<td>Ensure that there is a policy (or components of a policy) aimed at reducing HAST stigma and unfair discrimination in the workplace.</td>
<td>HAST is still surrounded by ignorance, prejudice, discrimination and stigma. PLHIV and those belonging to groups particularly vulnerable to HIV, for e.g. those with TB often avoid, or delay, seeking needed services for fear of being “found out”, humiliated, and/or treated differently. In the workplace unfair discrimination against PLHIV has been perpetuated through practices such as pre-employment HIV testing, dismissals for being HIV positive and the denial of employee benefits. It is important to promote a non-discriminatory workplace in which people living with HIV, AIDS or TB are able to be open about their HIV status without fear of stigma or rejection.</td>
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<td>9</td>
<td>Develop a campaign that educates employees about HIV and TB, alleviates fears and misconceptions about the diseases, and promotes a non-discriminatory workplace.</td>
<td>A range of approaches, operating at multiple levels with multiple target audiences, are needed to address the causes of stigma and discrimination. Some of these approaches will work to change stigmatising attitudes; some will work to stop discriminatory behaviour. The combination of screening for other health conditions at the same time as HIV, STIs and TB, destigmatises participation within the workplace. Although each intervention on its own can contribute to the reduction of stigma, there is a significant impact if combined with other efforts across a range of activities that will together incrementally contribute to stigma reduction.</td>
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<td>10</td>
<td>Direct CSI to support information and education programmes within local community, especially schools attended by employees’ children or consider training one youth for every seven peer educators trained in a peer education programme.</td>
<td>Education has been identified as a protective factor against HIV infection. Education especially reduces the vulnerability of girls, and each year of schooling offers more protective benefits. Evidence has shown that HIV infection levels increase exponentially among school leavers who do not have employment, mentoring or further training opportunities.</td>
<td>1.7, 1.5 and 1.3</td>
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<td>11</td>
<td>Direct company CSI to key populations at risk in the broader communities through training of community champions to address these risks.</td>
<td>Key populations at risk in the community are a risk to their employees. Any risk mitigating interventions in the community will have long term benefits to the company bottom line as informed and knowledgeable community members are fundamental to reduced transmission. Champions can include people from: taverns, spaza shop sector, taxi industry, hairdressing industry and small scale farmer sector. A multi-sectoral approach encourages companies to support municipalities and local communities in order to expand service delivery.</td>
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<td>12</td>
<td>Provide information, education and awareness on PMTCT - focused on men as well as women. Where possible, companies may be able to provide ART or administer state-funded treatment for pregnant workers with HIV.</td>
<td>Transmission of the virus from an infected mother to child is one of the three main ways that HIV is transmitted. This becomes a workplace issue because pregnant workers, or the partners of workers, may be infected. The workplace therefore needs to play a role in prevention. An obvious starting point is the information and education programme, which should not only help workers understand how this type of transmission takes place, but also give support to women, and their partners, in making difficult choices about breastfeeding.</td>
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<td>13</td>
<td>Develop integrated sexual reproductive health (SRH), prevention and treatment services as part of the HCT campaign. Either at onsite clinics or through referral to appropriate nearby facilities.</td>
<td>HCT in the workplace is the entry point to prevention, treatment, care and support. Integrating SRH prevention and treatment services as part of a HCT campaign, promotes employee wellness and reduces vulnerability to HIV infection. An integrated health management model is critical in providing a holistic approach to health seeking behaviour. The PSP identifies the business sector, and agriculture as important entry points to ensure SRH services and products are available to target populations within their remit in order to improve treatment access and barriers to care. Some areas identified include: mines, airports, malls, shebeens, hotels, sex work venues/locations and clubs. Integrated models reduce the transport costs and patient time needed to access multiple services, and should save staff time.</td>
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<td>14</td>
<td>Develop and implement an information, education and communication (IEC) campaign which should address: relevant HIV, TB and STIs risk factors, prevention options, promoting health seeking behaviour and treatment adherence.</td>
<td>Effective IEC materials are an important component of a comprehensive education campaign which promote social awareness and community behaviour change and enhances the community’s knowledge on a subject. The most effective IEC materials are relevant and tap into interests of the local population. In addition, effective materials are clear, communicate specific messages, and are easily remembered.</td>
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<td>15</td>
<td>High risk industries such as those with migrant labour (mining and agriculture) and those with shift workers (security and hospitality) should develop and implement a wider social and behaviour change communication strategy which is targeted at key populations within the company. It should aim to change social norms (especially those related to gender), attitudes, promote healthy behaviours, and increase the demand and uptake of HIV and TB services.</td>
<td>Behaviour change communication is critical to changing risk behaviours (including multiple concurrent partners) that drive the HIV and TB epidemics. This encompasses the individual, community and socio-political levels and includes advocacy, media, social/community mobilisation and campaigns.</td>
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<td>16</td>
<td>Ensure that all employees are given an annual health assessment which includes: PICT, screening for TB and STI’s, screening for mental health and screening for other non-communicable diseases such as hypertension, diabetes, anaemia.</td>
<td>Annual health assessments can help to improve treatment access and reduce barriers to care. Integrated models reduce the transport costs and patient time needed to access multiple services, and should save staff time. The inclusion of screening for hypertension, diabetes, anaemia, cholesterol and BMI as well as HIV, STIs and TB reinforces health seeking behaviour, promotes employee wellness, and destigmatises participation within the workplace. HCT, TB screening and STI screening is the entry point to prevention, treatment, care and support, and is therefore the key intervention for realising national policy goals. This must be coupled with robust referral systems particularly for HIV, TB and STI’s. Ensure immediate CD4 staging for HIV positive employees. Ensure the earliest possible enrolment and universal access to appropriate treatment for HIV, STIs and TB, after screening and diagnosis.</td>
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<td>17</td>
<td>Maximise the coverage of male and female condoms dispensers in strategic points in workplace for increased access.</td>
<td>Evidence from UNAIDS and WHO shows that condoms, when used correctly and consistently, are the single, most efficient, available means to reduce the sexual transmission of HIV and other STIs. A large body of scientific evidence shows that male latex condoms have an 80 percent or greater protective effect. Condoms are a key component of comprehensive HIV prevention.</td>
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| 18 | Promote MMC in the workplace and provide special sick leave, where possible, for MMC.                                                                                                                                                                                                                                                                     | MMC has been shown to reduce the risk of acquiring HIV. Three recent randomised control trials in sub-Saharan Africa showed MMC reduced the risk of acquiring HIV by 60%.

MMC is recommended by WHO/UNAIDS in countries with a high prevalence of heterosexually transmitted HIV infection and low levels of male circumcision. Additionally MMC has been shown to reduce the incidence of STIs and also HPV. HPV when transmitted to female partners is the main cause of cervical cancer and therefore MMC has indirect benefits to the women.                                                                 | 2.1              |
| 19 | Preventing new TB infection and disease through IPT, infection control, early identification and treatment of TB and an improved TB cure rate.                                                                                                                                                                                                            | Preventing new TB infections is important as it will reduce the pool of infective people and prevent absenteeism. The association of TB with HIV and the emergence of MDR-TB and XDR-TB means it is now even more crucial to prevent TB, as the costly and longer treatment regimes needed for drug resistant strains is a burden on the already stretched treatment services. | 2.1              |

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<td>20</td>
<td>TB infection control should be considered as a component of health impact assessment for all new government and private sector projects and programmes. All high risk workplaces (mines, textiles, construction and agriculture) should consider TB infection control such as UV lights and a culture of cough hygiene in the workplace and the associated hostels.</td>
<td>TB infection control is growing in importance because of the association of TB with HIV and the emergence of MDR-TB and XDR-TB. TB is transmitted when someone with active TB coughs up TB bacilli which are then inhaled by someone else. Infection control measures such as a culture of cough hygiene and UV lights can be used in many types of high risk work environments. TB infection control requires a combination of administrative, environmental and personal respiratory interventions. This should be delivered in the broader infection control standards e.g. hand washing. This also requires each health facility to have an infection control plan and officer.</td>
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<td>21</td>
<td>Assess and understand workplace HIV and AIDS-related risk. Plan response strategies and secure resources appropriate to the nature and scale of risk, linked to objectives, targets and success criteria.</td>
<td>Many companies continue to implement ad hoc activity-based programmes that have little or no impact because they are informed by what is perceived to be popular rather than assessed risk. Inadequate situational analysis and risk assessment is being done by companies, there is an inherent awareness but it is not being quantified. Mitigation of operational risk should be on every agenda. Needs assessment is essential to understand the direction and magnitude of the response required. The management system approach recommended by SANS 16001 integrates assessment, planning, implementation, monitoring and evaluation ensuring relevance and continual improvement in response strategies.</td>
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<td>22</td>
<td>Integration of TB and HIV Treatment services to ensure:  • all TB patients who are HIV-positive are initiated on lifelong ART, irrespective of CD4 count  • all HIV positive patients with latent TB are initiated on IPT</td>
<td>The close link between TB and HIV means that treatment should be integrated. Integration allows for early diagnosis and rapid enrolment on to treatment and ensures co-infected people remain on treatment. Treatment’s focus is to reduce deaths and disability; and effective treatment for all can reduce the incidence of drug resistant TB strains which are costly and require lengthy treatment regimes.</td>
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<td>23</td>
<td>Improve proactive TB case finding – train peer educators, supervisors and managers to identify potential TB cases.</td>
<td>Active case finding allows patients to be diagnosed earlier, treated earlier which reduces both morbidity and mortality and likelihood of transmission.</td>
<td>3.1</td>
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<td>24</td>
<td>Preventing new TB infection and disease through IPT, infection control, early identification and treatment of TB and an improved TB cure rate.</td>
<td>Preventing new TB infections is important as it will reduce the pool of infectious people and prevent absenteeism. The association of TB with HIV and the emergence of MDR-TB and XDR-TB means it is now even more crucial to prevent TB, as the costly and longer treatment regimes needed for drug resistant strains is a burden on the already stretched treatment services.</td>
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<td>25</td>
<td>Workplace programme to be developed that addresses HIV, STIs and TB in an integrated manner and is aligned with national standards. The workplace programme can either be an extension of the Employee Assistance Programme (EAP) or created through the increased scope and capacity of occupational health and safety.</td>
<td>The PSP is insistent that HIV and TB diagnosis, care and treatment should not be limited to medical settings. Care and treatment should be available in a wide variety of community settings, including tertiary institutions, prisons, and NGO-funded facilities. Workplaces are also an important setting for HIV and TB diagnosis, care and treatment, or referral for care and treatment. Chronic illnesses affect productivity, profitability and the welfare of employees and their families. Good practice models exist in the private sector, and these should be explored with a view to adapting the approaches for other institutions and environments. An integrated health management model either through an EAP or as part of occupational health and safety is critical in providing a holistic approach to health seeking behaviour. Workplace programmes have resulted in many people testing and have improved the uptake of ARVs among the employed. There is also a cost benefit of comprehensive and integrated health services.</td>
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<td>26</td>
<td>Implement a comprehensive care and support programme that comprises a range of services, responding to the needs of workers with HAST for treatment, for material and psychosocial support, and for protection against discrimination and rejection. This bulk of the services should be provided in the workplace, and where certain services are not feasible; there should be partnerships with strong referral systems. Please see appendix for more detail on elements that should be included in a comprehensive care and support programme.</td>
<td>The demand for care and support is rising as the twin HIV and TB epidemics mature. Public health systems are struggling to cope and alternative delivery points need to be explored. The PSP advocates for provision of HIV and TB care and treatment in non-medical settings. The workplace is a key delivery point for many reasons, which include: HIV affects the working age population and the workplace is part of the local community and needs to mitigate socio-economic impact of HIV and TB. Care and support is a key guiding principle the ILO Code of Practice, and is one of the four key areas of action to address the HIV/AIDS pandemic in the world of work.</td>
<td>3.1</td>
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<td>27</td>
<td>Ensure that HIV, AIDS and TB workplace policies and procedures comply with workers’ rights in relation to stigma and discrimination around HIV and TB</td>
<td>The right to work is central to the ability of people with HIV and /or TB to mitigate the impact of HIV and TB on them, their families and society more broadly.</td>
<td>4.2</td>
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## SECTORAL LEVEL INTERVENTIONS

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| 1  | Mobilise and support initiatives aimed at reducing substance abuse and promoting responsible alcohol use. For example:  
  • Partner with local tavern owners to provide messaging on HIV, AIDS and STI and prevention methods. | Alcohol use is associated with reduced perception of risk, risky behaviour (including, an increase in multiple and concurrent sexual partners, intergenerational sex and the experience of coercive or violent sex) and decreased condom use. It is also a major impediment to treatment adherence. Strategies should address male gender norms that equate alcohol use with masculinity.  
  A 2011 report from the MRC indicates that, based on 20 studies in Africa, people who drink alcohol are 57% more likely to be HIV infected, with this likelihood increasing to 104% among those who abuse alcohol.  
  An important effect of alcohol consumption is that it can impair adherence to ART (which may lead to increased HIV transmission) | 1.2 |
| 2  | Expand HAST prevention and treatment services on trucking routes to include sex workers and neighbouring communities, and evaluate other feasible geographical sites. | Many transport workers are highly mobile and spend considerable time away from home. The transport sector is one of the sectors with a high HIV prevalence as workers are away from their partners and families for extended periods and have sufficient disposable income to spend on sex workers or engage in multiple sexual relationships. Basic healthcare as well as treatment for STIs (which in turn increases the risk of HIV infection) are often not available where and when transport workers need them most.  
  Sometimes condoms are very expensive or not available in locations frequented by transport workers. According to the Know your Epidemic - Know your Response (KYE/KYR) study, communities bordering national highways have higher HIV prevalence compared to those located away from trucking corridors. Sex workers from these communities often have poor health-seeking behaviour, and limited access to healthcare. Providing access to prevention and ART services for both truck drivers and the broader communities on transport routes can decrease the community viral load which will reduce the number of new HIV infections. | 1.2 |
<p>| 3  | Identify workplaces which are struggling to implement prevention and treatment services. | Building public-private cooperation is key to the new PSP and sharing resources, approaches and information will be critical to building the multi-sectoral approach. Very small enterprises employing up to 20 employees, especially in rural settings, may also be appropriate programme beneficiaries of the BizAIDS programme. | 1.7 and 2.1 |</p>
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<td>4</td>
<td>Implement a two-day donor funded training programme (SABCOHA’s BizAIDS) that combines business and life skills with HIV, AIDS, TB and wellness information and education for SMMEs. In addition ensure they are incorporated into public sector initiatives</td>
<td>Enterprises employing less than 10 employees create significant employment opportunities in South Africa but HIV, AIDS and TB could result in rapid closures if ignored. Most SMMEs have limited access to information, services and support for HIV, AIDS, TB and wellness and it is not feasible or realistic for them to implement their own workplace programmes. SMMEs have high proportion of women, narrow profit margins, are survivalist in nature, and are often in rural areas. SABCOHA's BizAIDS programme trains owners of these vulnerable industries in basic skills and risk mitigation including HIV.</td>
<td>1.7 and 2.1</td>
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<td>5</td>
<td>Coordinate and maintain a national network of peer educators to be supported through communication tools, telephonic psychosocial support and mentorship.</td>
<td>Many large companies, especially in the mining industry, have already trained peer educators or change agents. One of the fundamental obstacles to sustainability of this model is effective coordination, standardised skilling and support. The maintenance of a national peer educator database will facilitate information exchange, skills transfer and group learning thereby enhancing a return on company investments.</td>
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<td>6</td>
<td>Increase the national distribution of government condoms (particularly female condoms) by expanding to non-traditional outlets, under serviced workplaces and populations to ensure an uninterrupted supply of condoms for distribution (particularly female condoms). Condom dispensers should be placed in strategic points for increased access.</td>
<td>Condom use is the most effective method to reduce the sexual transmission of HIV especially among key populations. Condom use also serves to prevent transmission of some STIs and prevents unwanted pregnancy. Improving access to condoms is the first step in ensuring condom use.</td>
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<td>7</td>
<td>Develop proactive and innovative mechanisms to ensure adherence as well as working with service providers on rigorous systems that identify defaulters with remedial action. For example: • Promote the use of DOTS in the workplace. • Use cell phone based communication to improve treatment adherence. • Use social media - Twitter, Facebook, mxit - to improve retention and treatment adherence</td>
<td>Companies only realise a substantial return on employee health and wellness investments when employees with HIV and TB access treatment in time, and continuously, take their medication. This should result in reduced absenteeism and increased productivity. Companies should review and improve adherence support and follow up mechanisms. In order to ensure adherence the DOTS strategy ensures that TB patients are directly observed and supported to take their TB medication daily until they are cured. DOTS supporters can be health workers, employers or any responsible community member.</td>
<td>Sub-Objective 3.2</td>
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<td>8</td>
<td>Mobilise resources to provide health services for SMMEs through distribution of chronic medicines supplied by government and treatment management of chronic illnesses. Use business healthcare facilities to provide government drugs and services to families and communities. Networks of private doctors and healthcare professionals to provide government drugs and services. SME’s provide access to test their employees in the workplace, NGO’s provide services, government to provide consumables, drugs and laboratory services. Private sector supply mobile clinics resourced by DoH.</td>
<td>Many SMMEs lack adequate resources to adequately respond to HIV, STIs and TB. There is a need for effective co-ordination, innovative healthcare intervention and partnership building for these companies to participate in the response. NGO’s who provide testing and treatment, have the expertise and resources to assist SMME employees. Government in its partnership effort is ideally positioned to support this intervention through preventative testing, consumables and treatment drugs for easier access to the SMME population. Training in monitoring and reporting can be offered to NGO’s. This intervention is aimed at increased access to HIV related health services whilst contributing to job retention in the country.</td>
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## MULTI-SECTORAL LEVEL INTERVENTIONS

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| 1  | Develop and implement interventions to address multiple concurrent sexual partners in the migrant populations, for example:  
• Develop partnerships with government to enable provincial mobile clinics to be allocated to provide prevention, treatment and care services for the large seasonal migrant communities in the Eastern Cape agricultural sector. | The problem of multiple concurrent sexual partners in the Eastern Cape population is related to a range of factors. One of these factors is the migration of workers due to economic necessity. The province has a large number of workers who migrate to mines in other areas of the country seeking employment. The province also has a large number of seasonal migrants in the agricultural sector. Many existing initiatives in the agricultural sector focus on permanent employees and the mass of itinerant workers is often excluded from benefiting from these initiatives.  
Workers are away from their partners and families for extended periods and they have sufficient disposable income to spend on sex workers or to engage in multiple sexual relationships. As such there is a need for increased social cohesion and strengthening of families.  
Targeted efforts amongst high transmission populations are key in reducing transmission and increasing access to treatment. | 1.2 |
| 2  | Provide messaging about the benefits of MMC as well promoting safe circumcision practices in initiation setting in order to encourage employees and communities to accept MMC. | In the Eastern Cape circumcision has been performed as part of traditional initiation, which is often done in remote areas, under unhygienic conditions and by a traditional circumciser with no medical training. In order to expand the coverage of MMC it is important to get buy-in from traditional leaders to include MMC as part of the ritual or to train traditional circumcisers in effective and safe circumcision practices as well as providing them with the appropriate resources.  
Although circumcision is protective against HIV, a newly circumcised man must wait a few weeks to heal before having sex; otherwise there is an increased risk of HIV infection through the wound. Education to prevent risky behaviour among initiates when most at risk directly after the circumcision, is essential. | 2.1 |
<p>| 3  | Mobilise resources to provide health services for SMMEs through distribution of chronic medicines supplied by government and treatment management of chronic illnesses. Use business healthcare facilities to provide government drugs and services. Networks of private doctors and healthcare professionals to provide government drugs and services. SME’s provide access to test their employees in the workplace; NGO’s provide services, government to provide consumables, drugs and laboratory services. Private sector supply mobile clinics resourced by DoH. | Many SMMEs lack adequate resources to adequately respond to HIV, STIs and TB. There is a need for effective co-ordination, innovative healthcare intervention and partnership building for these companies to participate in the response. NGO’s who provide testing and treatment, have the expertise and resources to assist SMME employees. Government in its partnership effort is ideally positioned to support this intervention through preventative testing, consumables and treatment drugs for easier access to the SMME population. Training in monitoring and reporting can be offered to NGO’s. This intervention is aimed at increased access to HIV related health services whilst contributing to job retention in the country. | 3.3 |</p>
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<td>4</td>
<td>Improve collaboration in the dissemination and sharing of research findings and jointly identify research needs and agree priorities</td>
<td>Companies, civil society organisations, government departments, donors, academic institutions and independent research organisations conduct research and evaluations without widely disseminating and sharing findings. Under the auspices of the Provincial AIDS Council a knowledge repository should be established inviting all stakeholders to publish/post papers, reports, and presentations some of which may have been presented at conferences nationally and internationally. The repository will require proper management to ensure relevance and inform priorities including review, categorisation and archiving.</td>
<td>Strategic enablers</td>
</tr>
</tbody>
</table>
EASTERN CAPE PROVINCE

Geography and demographics

The Eastern Cape Province is situated on the south eastern South African coast and includes the former homelands of the Transkei and Ciskei. The Eastern Cape shares an international border with Lesotho and shares provincial borders with the Western Cape, Northern Cape, Free State and Kwa-Zulu Natal.

The Eastern Cape is the second largest province covering 168 966 square kilometres and is roughly 13.8% of the land area of South Africa. The Eastern Cape had the third largest population of all the South African provinces in 2011. The province had a population density of approximately 42 persons per square kilometre. The 2001 Census data indicates that the majority (83.4%) of the Eastern Cape population’s first home language was isiXhosa, followed by 9.3% Afrikaans and 3.6% English.

The province was divided into six district municipalities namely: Cacadu, Amathole, Chris Hani, Ukhahlamba, OR Tambo and Alfred Nzo; and one metropolitan municipality: Nelson Mandela Bay Metro. However, many changes were made to the district and municipal structures on the 18 May 2011 for the 2011 municipal elections, key changes include:

- Buffalo River local municipality was separated from Amathole district municipality and converted into a metropolitan municipality called Buffalo City Metropolitan municipality which includes Bisho, East London and King William’s Town and the large townships of Mdantsane and Zwelitsha.
- Alfred Nzo district expanded to include Mbizana and Ntabankulu local municipalities, which were formerly part of OR Tambo district municipality
- Ukhahlamba district municipality was renamed Joe Gqabi district municipality.

Given that the latest available information at a district level is prior to this change, all information provided in this strategy, on a district level, is based on the district structure prior to the boundary adjustments of 2011, unless specified.

Bisho is the provincial capital and is 70 kilometres from East London. Port Elizabeth is the largest city and an important harbour within the Nelson Mandela Bay Metropolitan municipality. Other major towns in the province include: East London, Uitenhage, King William’s Town, Grahamstown, Mthatha, Graaff-Reinet, Cradock, Stutterheim, Aliwal North, Humansdorp, and Port St Johns.

The Eastern Cape has an untouched and pristine coastline and is home to many unique tourist attractions which include: Addo Elephant National Park, Tsitsikamma National Park, the unspoilt Wild Coast and the surfing Mecca of Jeffreys Bay. It also hosts the annual National Arts Festival in Grahamstown which draws over 50 000 people to the area every year.

There are ports at Port Elizabeth and East London and the newly built deep water Port of Ngqura in the Coega Industrial Development Zone. There are major airports in Port Elizabeth and East London which offer direct flights to the main centres and KD Matanzima airport in Mthatha also has scheduled airline services. There is also good major road and rail infrastructure.

The 2011 mid-year population estimates approximate the Eastern Cape population at 6 829 958 (13.5% of the South African population) and that 52.3% of the province’s population is female and 47.2% is male. However, the latest population estimates on a district level are those from the Eastern Cape Socio Economic Consultative Council (ECSECC) for 2009 which estimates the Eastern Cape population to be 6 728 955 (13.6% of the South African population). Table 2 provides a breakdown by population group and district.

<table>
<thead>
<tr>
<th>District</th>
<th>Black</th>
<th>Coloured</th>
<th>Indian</th>
<th>White</th>
<th>Total</th>
<th>Total%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cacadu</td>
<td>183 535</td>
<td>149 813</td>
<td>948</td>
<td>49 576</td>
<td>383 872</td>
<td>5.7%</td>
</tr>
<tr>
<td>Amathole</td>
<td>1 601 300</td>
<td>65 082</td>
<td>3 479</td>
<td>61 976</td>
<td>1 731 838</td>
<td>25.7%</td>
</tr>
<tr>
<td>Chris Hani</td>
<td>780 941</td>
<td>26 550</td>
<td>1 111</td>
<td>15 744</td>
<td>824 346</td>
<td>12.3%</td>
</tr>
<tr>
<td>Joe Gqabi</td>
<td>304 635</td>
<td>13 211</td>
<td>382</td>
<td>8 374</td>
<td>326 602</td>
<td>4.9%</td>
</tr>
<tr>
<td>OR Tambo</td>
<td>1 888 830</td>
<td>7 189</td>
<td>2 214</td>
<td>1 951</td>
<td>1 900 184</td>
<td>28.2%</td>
</tr>
<tr>
<td>Alfred Nzo</td>
<td>472 812</td>
<td>2 585</td>
<td>348</td>
<td>1 657</td>
<td>477 403</td>
<td>7.1%</td>
</tr>
<tr>
<td>Nelson Mandela Bay</td>
<td>665 345</td>
<td>245 083</td>
<td>9 468</td>
<td>164 814</td>
<td>1 084 711</td>
<td>16.1%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>5 897 398</td>
<td>509 513</td>
<td>17 950</td>
<td>304 092</td>
<td>6 728 956</td>
<td>100%</td>
</tr>
</tbody>
</table>

The estimated migration streams from 2006-2011 show that Eastern Cape’s net migration outflow of 211 600 people, is the highest in the country and that most migrants move to the Western Cape followed by significant migration to Gauteng and KwaZulu-Natal. Additionally there is significant rural-urban migration within the province.

Figure 2: Eastern Cape Province, South Africa, with districts and major towns

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44 ECSECC (2010) “STATISTICS AT YOUR FINGER TIPS” database Demographics 2009 data
Labour market and economy

In Q3 2011 the Eastern Cape contributed 7.7% to the country’s gross domestic product (GDP).\textsuperscript{46} The Eastern Cape inherited a legacy of underdevelopment and limited economic activity with the incorporation of the former homeland areas. These areas have high levels of unemployment, poverty and subsistence agriculture. The bulk of the economic activity is concentrated in the two metropolitan areas Nelson Mandela Bay and Buffalo City. However, the province is the focus of national growth and economic development efforts. Projects include the Fish River Spatial Development Initiative (SDI), the Wild Coast SDI, the West Bank Industrial Development Zone (IDZ) in East London and the Coega IDZ near Port Elizabeth which is the largest infrastructure project in post-apartheid South Africa. IDZs offer preferential rates for investors, excellent infrastructure and the formation of value chain hubs for companies within related sectors operating in the same area.

General government services, finance, real estate and business services, trade and manufacturing are all significant contributors to GDP in the province (Table 3). The manufacturing sector is dominated by the automotive industry and related industries with major centres in Nelson Mandela Bay and Buffalo City. Volkswagen South Africa, Ford and General Motors SA have plants in Port Elizabeth, and Mercedes-Benz is based in East London. Industries which support the automotive industry include plastics, batteries, automotive electronics, catalytic convertors, leather works, automotive tooling, glass, lamps, radiators, tyres and alloy wheels.

However, the global nature of the automotive industry means that the Eastern Cape is vulnerable to the fluctuations in demand for vehicles. The province has a diversification strategy and is looking to develop manufacturing industries which have a competitive advantage, increase employment and have low barriers for SMME entry. Some of the automotive support industries have diversified and also produce for other sectors, for example the plastics industry provide for the mouldings, packaging and construction industries as well as the automotive industry.

The food and beverage industry is second to the automotive industry in the manufacturing sector and is mostly clustered around the major urban areas. Almost a quarter of South Africa’s milk is produced in the province and dairy companies such as Clover, Dairybelle and Sunningdale Dairy have operations in the Eastern Cape. Port Elizabeth is home to the major beverage manufacturers: Coca-Cola, Sabco and SAB Limited’s Ibhayi brewery, and Distell have a bottling plant in the city. Cadbury’s main chocolate-manufacturing site is in Port Elizabeth and Nestlé has 11 production lines at their East London facility.

Other manufacturing industries in the Eastern Cape include agri-processing; timber and wood products; chemicals; energy and pharmaceuticals. The Eastern Cape timber and wood products industry has sawmills, pole-treatment plants, chipboard operations, a veneer plant and small manufacturing plants that produce charcoal from gum and wattle. Pharmaceuticals include Africa’s biggest manufacturer of generic drugs, Aspen Pharmacare, which has five facilities in Port Elizabeth and one in East London; Bodene, a subsidiary of Fresenius Kabi, which has a medicines plant in Port Elizabeth; and Johnson & Johnson’s finance, operations and research and development divisions which are based in East London.

Agriculture contributes very little to GDP (1.7%). However, it is an important sector in the Eastern Cape, due to the large subsistence component and the extensive agricultural capacity that could be developed in the future. The Eastern Cape has more livestock than any other province including 21% of the cattle, 28% of the sheep, and 46% of the goats in South Africa.

The main commercial agricultural activities include: deciduous fruit orchards in the Langkloof Valley; angora and sheep farming in the Karoo; pineapples, chicory and dairy products in the Alexandria-Grahamstown area; coffee and tea in Magwa; and Ostrich farms which produce 20% of South Africa’s Ostrich. There are forestry plantations in

Keiskammahoek and an olive nursery which has been developed to form a nucleus of olive production in the Eastern Cape. Subsistence and small scale farms in the former homelands focus on cattle, maize and sorghum. Spekboom, which is an indigenous tree that can store four tons of carbon per hectare, has been planted in the Eastern Cape and is providing the Eastern Cape Parks and Tourism Agency with income in a carbon-credits scheme.

There is also a fishing industry which is primarily based on squid but also has sardines, other fish and abalone. The coastline and numerous inland water bodies have aided the development of an aquaculture industry which includes prawn farming, kob hatchery, abalone farming, and marine caged fin-fish farming.

<table>
<thead>
<tr>
<th>Major Industry</th>
<th>Contribution to GDP (R million)</th>
<th>Contribution to GDP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General government services</td>
<td>42 870</td>
<td>23.2%</td>
</tr>
<tr>
<td>Finance, real estate and business services</td>
<td>38 606</td>
<td>20.9%</td>
</tr>
<tr>
<td>Trade</td>
<td>27 958</td>
<td>15.1%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>25 798</td>
<td>14.0%</td>
</tr>
<tr>
<td>Personal services</td>
<td>22 031</td>
<td>11.9%</td>
</tr>
<tr>
<td>Transport</td>
<td>14 491</td>
<td>7.8%</td>
</tr>
<tr>
<td>Construction</td>
<td>6 141</td>
<td>3.3%</td>
</tr>
<tr>
<td>Agriculture, forestry and fishing</td>
<td>3 124</td>
<td>1.7%</td>
</tr>
<tr>
<td>Electricity, gas and water</td>
<td>3 066</td>
<td>1.7%</td>
</tr>
<tr>
<td>Mining and quarrying</td>
<td>763</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Total Eastern Cape</strong></td>
<td><strong>184 848</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The Eastern Cape has one of the highest unemployment rates in the country, estimated at 27.1% in Q4 2011, and unemployment is particularly bad in the former homeland area of Transkei. The latest labour survey (Q4 2011) showed that 1 327 000 people were employed in the Eastern Cape. Table 4 shows the split of the employed by industry. A quarter of the employment in the province is within the community and social services sector which largely comprises public sector employees. Trade also contributes significantly to Eastern Cape employment at 22.8%. Manufacturing, finance, construction, private households, transport and agriculture also provide employment.

Although only 67 000 are employed in the formal agricultural sector, over 500 000 people are dependent on small subsistence farms in the former homeland areas. Around 29% of the South African population who are dependent on subsistence farming live in the Eastern Cape and this is the second highest in the country after KwaZulu-Natal (40%).

<table>
<thead>
<tr>
<th>Major Industry</th>
<th>Employed</th>
<th>Employed (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community and social services</td>
<td>339 000</td>
<td>25.5%</td>
</tr>
<tr>
<td>Trade</td>
<td>308 000</td>
<td>23.2%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>155 000</td>
<td>11.7%</td>
</tr>
<tr>
<td><strong>Total Employed Eastern Cape</strong></td>
<td><strong>1 327 000</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

CHAPTER 5: CONTEXT OF IMPLEMENTATION

<table>
<thead>
<tr>
<th>Major Industry</th>
<th>Employed</th>
<th>Employed (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>147 000</td>
<td>11.1%</td>
</tr>
<tr>
<td>Construction</td>
<td>124 000</td>
<td>9.3%</td>
</tr>
<tr>
<td>Private households</td>
<td>110 000</td>
<td>8.3%</td>
</tr>
<tr>
<td>Transport</td>
<td>75 000</td>
<td>5.7%</td>
</tr>
<tr>
<td>Agriculture</td>
<td>64 000</td>
<td>4.8%</td>
</tr>
<tr>
<td>Utilities</td>
<td>5 000</td>
<td>0.4%</td>
</tr>
<tr>
<td>Mining</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total Employed Eastern Cape</td>
<td>1 327 000</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The total working age population in the Eastern Cape is estimated to be 4 191 000 in Q4 2011, of which 57.5% are not economically active. Table 5 provides detail on the Eastern Cape labour force’s characteristics. The provincial unemployment rate of 27.1% is above the national average of 25%. The formal (non-agriculture) sector is the major contributor to employment in the province at 68.1% with the informal sector contributing 18.9%. Private households (which includes domestic workers) and agriculture contribute 8.3% and 4.8% respectively towards provincial employment.

Table 5: Labour force characteristics for the Eastern Cape (2011)

<table>
<thead>
<tr>
<th>Major Industry</th>
<th>October to December 2011</th>
<th>Year on Year Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 15–64 yrs</td>
<td>4 191 000</td>
<td>1.2%</td>
</tr>
<tr>
<td>Labour Force</td>
<td>1 821 000</td>
<td>3.3%</td>
</tr>
<tr>
<td>Employed</td>
<td>1 326 000</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Formal sector (non-agricultural)</td>
<td>903 000</td>
<td>7.0%</td>
</tr>
<tr>
<td>Informal sector (non-agricultural)</td>
<td>250 000</td>
<td>-16.1%</td>
</tr>
<tr>
<td>Agriculture</td>
<td>64 000</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Private households</td>
<td>110 000</td>
<td>-8.3%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>494 000</td>
<td>13.6%</td>
</tr>
<tr>
<td>Not economically active</td>
<td>2 370 000</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Discouraged work-seekers</td>
<td>353 000</td>
<td>-4.9%</td>
</tr>
<tr>
<td>Other</td>
<td>2018 000</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

**RATES**

<table>
<thead>
<tr>
<th>October to December 2011</th>
<th>Year on Year Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment rate</td>
<td>27.1%</td>
</tr>
<tr>
<td>Expanded unemployment rate*</td>
<td>40.9%</td>
</tr>
<tr>
<td>Labour force participation rate</td>
<td>43.6%</td>
</tr>
</tbody>
</table>

*The expanded definition of unemployment includes discouraged work seekers.

The distribution of working age population over the districts and each district’s contribution to (Gross Value Added) GVA is detailed in Table 6 below. Amathole, OR Tambo and Nelson Mandela Bay have significant proportions of the working age population in the province and Amathole and Nelson Mandela Bay also contribute significantly to the provincial GVA.

---

Table 6: Working age population (2007) and contribution to GDP by district (2009)⁴⁹

<table>
<thead>
<tr>
<th>District</th>
<th>Working age population (15-64 years)</th>
<th>Working age population (%)</th>
<th>Contribution to GVA 2009 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cacadu</td>
<td>234 087</td>
<td>6.2%</td>
<td>7.89%</td>
</tr>
<tr>
<td>Amathole</td>
<td>1 003 669</td>
<td>26.8%</td>
<td>29.85%</td>
</tr>
<tr>
<td>Chris Hani</td>
<td>424 219</td>
<td>11.3%</td>
<td>7.66%</td>
</tr>
<tr>
<td>Joe Gqabi</td>
<td>165 379</td>
<td>4.4%</td>
<td>3.66%</td>
</tr>
<tr>
<td>OR Tambo</td>
<td>947 752</td>
<td>25.3%</td>
<td>15.02%</td>
</tr>
<tr>
<td>Alfred Nzo</td>
<td>244 251</td>
<td>6.5%</td>
<td>4.50%</td>
</tr>
<tr>
<td>Nelson Mandela Bay</td>
<td>730 800</td>
<td>19.5%</td>
<td>31.43%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>3 750 157</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

HIV, AIDS, TB and related social conditions

The South African National Burden of Disease Study 2000 found that HIV and AIDS was the largest single cause of death and TB was the second largest single cause of death in the Eastern Cape. This same study found that the largest proportion of premature mortality in the province was due to HIV and AIDS at 28.2% of the total years of life lost (YLLs). TB was the third leading cause of premature mortality at 5.9% of total YLLs.⁵⁰

The 2010 National Antenatal Clinic Survey showed that Eastern Cape had a HIV prevalence amongst women who attended public antenatal clinics of 29.9% (Figure 3). Although it is just below the national average of 30.2%, this is the highest HIV prevalence recorded for Eastern Cape since the inception of the survey and an increase of almost 2% from 2009. Furthermore, the survey found that HIV prevalence trends differ considerably across districts. Cacadu and Nelson Mandela Bay Metro were the only districts to record decreases from 2009 of 3.6% and 1.7% respectively. The sample size in Cacadu was too small to draw any significant conclusions on this trend. Apart from OR Tambo and Amatole all districts were below the national average of 30.2% in 2010.⁵¹

The Antenatal Clinic Survey has been used to monitor HIV prevalence trends since 1990 and is the only indicator that has been measured accurately and consistently in South Africa. Although the Antenatal Clinic Survey only measures prevalence in first time antenatal clinic attendees, it provides a baseline for estimates and future actuarial projections of HIV infections among the whole population. Projections for the number of people estimated to be living with HIV in the Eastern Cape and other key indicators are shown in Table 7.

Table 7: Eastern Cape HIV and AIDS demographic projections⁵²

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012</th>
<th>2014</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cacadu</td>
<td>234 087</td>
<td>6.2%</td>
<td>7.89%</td>
</tr>
<tr>
<td>Amathole</td>
<td>1 003 669</td>
<td>26.8%</td>
<td>29.85%</td>
</tr>
<tr>
<td>Chris Hani</td>
<td>424 219</td>
<td>11.3%</td>
<td>7.66%</td>
</tr>
<tr>
<td>Joe Gqabi</td>
<td>165 379</td>
<td>4.4%</td>
<td>3.66%</td>
</tr>
<tr>
<td>OR Tambo</td>
<td>947 752</td>
<td>25.3%</td>
<td>15.02%</td>
</tr>
<tr>
<td>Alfred Nzo</td>
<td>244 251</td>
<td>6.5%</td>
<td>4.50%</td>
</tr>
<tr>
<td>Nelson Mandela Bay</td>
<td>730 800</td>
<td>19.5%</td>
<td>31.43%</td>
</tr>
</tbody>
</table>


The 2012 budget speech indicated that the number of patients on ART is 179,000, according to the ASSA2008 projections there are 736,404 HIV infected people (Table 7) in 2012, assuming 30% will be in need of treatment that means that 220,921 people should be on ARVs. In the Eastern Cape the number of people that know their status or are receiving treatment from the private sector is unknown.

The HIV-911 Provincial Directory resource provides up to date information on the nearest ARV services in the district (see appendix for details). TB services are typically offered at all public health facilities in the district, including mobile clinics.

The province was reported to have 63,533 cases of all types of TB and 23,459 cases of smear positive TB which is the second worst in the country after KwaZulu-Natal. The Eastern Cape’s incidence of 331.6 cases of smear positive TB per 100,000 people is significantly higher than the national average of 287.5 per 100,000. The TB cure rate for the Eastern Cape in 2007 was 62.0%, which is below the national average of 64% and is the third second lowest in the country. The Eastern Cape’s smear conversion rate of 58.1% is the fourth worst in the country. Table 8 provides more detail on the latest TB indicators by district. The Eastern Cape averaged 7.8% for TB treatment defaulter rates from 2008 to 2010 and it is thought that one of the contributors to the defaulter rate is a lack of pre-treatment counselling.

### Table 8: TB indicators per district

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cacadu</td>
<td>6 240</td>
<td>568.5</td>
<td>60.9%</td>
<td>73.6%</td>
</tr>
<tr>
<td>Amathole</td>
<td>14 754</td>
<td>368.3</td>
<td>60.6%</td>
<td>54.8%</td>
</tr>
<tr>
<td>Chris Hani</td>
<td>6 784</td>
<td>328.4</td>
<td>77.3%</td>
<td>73.3%</td>
</tr>
<tr>
<td>Joe Gqabi</td>
<td>2 851</td>
<td>258.7</td>
<td>68.9%</td>
<td>62.6%</td>
</tr>
<tr>
<td>OR Tambo</td>
<td>14 276</td>
<td>270.6</td>
<td>51.7%</td>
<td>68.7%</td>
</tr>
<tr>
<td>Alfred Nzo</td>
<td>4 697</td>
<td>337.6</td>
<td>40.7%</td>
<td>56.5%</td>
</tr>
<tr>
<td>Nelson Mandela Bay</td>
<td>13 931</td>
<td>462.9</td>
<td>54.8%</td>
<td>56.6%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>63 533</td>
<td>331.6</td>
<td>58.1%</td>
<td>62.0%</td>
</tr>
<tr>
<td>South Africa</td>
<td>388 782</td>
<td>287.5</td>
<td>62.5%</td>
<td>63.9%</td>
</tr>
</tbody>
</table>

*smear positive cases

The district with the highest incidence is Cacadu but this district has the highest cure rate in the province.

The Eastern Cape has four main tertiary institutions: Rhodes University (Grahamstown), Fort Hare University (Alice and East London), Nelson Mandela Metropolitan University (five campuses in Port Elizabeth and one in George) and the Walter Sisulu University. The latter formed in 2005 with the merger of the University of Transkei and two technikons, the Border Technikon at Potsdam and the Eastern Cape Technikon in Butterworth and therefore has four campuses: Mthatha, Butterworth, East London and Queenstown.

Education is a structural driver of the HIV epidemic as it has been shown that people with higher levels of education were more likely to know about HIV prevention methods. Table 9 shows the level of education of the Eastern Cape population 20 years and older. Just over 10% of the adult population had no schooling which is worse than the national figure of 9.4% with no schooling. Only 28.5% of the Eastern Cape’s adult population had Grade 12 or higher versus the national figure of 39.1%.

Functional literacy in the Eastern Cape in 2010 was 69.7% compared to the national figure of 75%. Functional literacy in the metropolitan areas of Nelson Mandela Bay and Buffalo City were high at 93.3% and 88.8% respectively, however apart from Cacadu, all the other non-metropolitan areas were below the provincial average.

### Table 9: Population aged 20 years and older, by highest level of education (2007)

<table>
<thead>
<tr>
<th>Education Levels</th>
<th>Population aged 20 years and older</th>
<th>Percentage distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Schooling</td>
<td>366 590</td>
<td>10.7%</td>
</tr>
<tr>
<td>Primary</td>
<td>982 263</td>
<td>28.8%</td>
</tr>
<tr>
<td>Secondary</td>
<td>1 088 824</td>
<td>31.9%</td>
</tr>
<tr>
<td>Grade 12/Std 12</td>
<td>560 148</td>
<td>16.4%</td>
</tr>
<tr>
<td>Higher</td>
<td>320 199</td>
<td>9.4%</td>
</tr>
<tr>
<td>Other or unspecified</td>
<td>92 967</td>
<td>2.7%</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>3 410 991</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Like in other parts of the country, alcohol remains the dominant substance of abuse in the Eastern Cape. A study at three urban high schools in Mthatha found that a large number

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of students had some kind of alcohol-related problem. A recent ECAC Report on HIV and AIDS Youth Dialogues 2011/12 found that alcohol is used by more young people in the province than any other drug and that there are taverns situated near the school premises which allow easy access to alcohol. A growing problem in the province is cannabis, which is farmed in the province, especially in the former Transkei. Twenty six percent of patients admitted to specialist treatment centres had cannabis as their primary or secondary drug of choice, compared to 14% of cannabis or mandrax. In 2009, the proportion of treatment admissions with cannabis as a primary drug of abuse increased significantly.

The Eastern Cape is believed to be the poorest of South Africa’s provinces, and close to 70% of the population lives below the poverty line. The province inherited a legacy of poverty with the incorporation of the former homelands. The former homeland areas are dominated by densely populated rural settlements and characterised by subsistence farming. These areas have a typically underdeveloped character with problems that exacerbate the poverty such as: unemployment, lack of development, limited infrastructure and services.

The seven Eastern Cape districts have a range of deprivation indices which indicate the levels of social and material deprivation relative to other districts in South Africa. Cacadu and Nelson Mandela Bay are less deprived; Amathole and Joe Gqabi are more deprived and Chris Hani, OR Tambo and Alfred Nzo are the most deprived. Chris Hani, OR Tambo, Alfred Nzo and Joe Gqabi were in the top 10 most deprived districts in South Africa in 2007. Poverty rates in 2010 indicate that Chris Hani, Joe Gqabi, OR Tambo and Alfred Nzo all have poverty rates above the provincial average of 53.6% with the last three all being above 60%.

CACADU DISTRICT MUNICIPALITY

Geography and demographics

The Cacadu district consists of nine local municipalities namely: Camdeboo, Blue Crane Route, Ikwezi, Makana, Ndlambe, Sundays River Valley, Bavaians, Kouga and Kou-Kamma. This district, which covers the south western portion of the Eastern Cape Province, surrounds the Nelson Mandela Bay Metropolitan municipality. It shares provincial boundaries with the Western Cape and Northern Cape.

Cacadu is the largest of all the Eastern Cape districts; with a land area of 58 243 square kilometres. However, Cacadu has the second smallest population of the Eastern Cape districts which accounted for only 5.6% of the total Eastern Cape population in 2007. The district is mainly rural (72.8%) with a population density of 7 people per square kilometre.

The population has more females and the proportion of the population that is under 20 years old (37.6%) is much lower than the provincial average of 47.7%. Unlike other Eastern Cape district municipalities, Cacadu does not have any former homeland areas, but townships at the fringes of the towns do exist.

There is a large coloured community comprising 36% of the district’s population, 52% are African and 11% are White. IsiXhosa and Afrikaans are the most spoken home languages in Cacadu with 48.9% of the population speaking isiXhosa and 45.5% of the population speaking Afrikaans, English is the next most spoken language at 5.4%.

The seat of Cacadu is Port Elizabeth which is located outside of the district municipality in the neighbouring Nelson Mandela Bay Metropolitan municipality. The main towns include: Grahamstown, Graaff-Reinet, Alexandria, Bathurst, Boknes, Bushmans River, Port Alfred, Humansdorp, and Jeffrey’s Bay.

Despite the arid interior the district is home to many rivers. It is bordered on the west by the Bloukrans River and on the east by the Great Fish River. The Sundays and Fish Rivers, which are fed through the Fish River Transfer Scheme with water from the Orange River, help irrigate agriculture. The district is also home to well known tourist attractions such as the Tsitsikamma, Bavaians and Addo National Parks and the coastal resorts of Jeffrey’s Bay and Port Alfred. The famous National Arts Festival and Rhodes University are in Grahamstown.

60 Department of Social Development (2010) Keynote address by the Minister of Social Development, Mrs Edna Molewa, at the commemoration of the International Day against Drug Abuse and Illicit Trafficking, Mdantsane, Eastern Cape (26 Jun 2010)
Labour market and economy

Cacadu district contributed 7.9% to the provincial economy (GVA) which ranks as the fourth largest contribution of all the districts in 2009. Agriculture is an important sector as it contributed 36.4% of all the formal employment and 7.4% of all the value added in 2009. The small stock farms in the Karoo produce wool, meat and a large proportion of the world’s mohair. Other agricultural activities in the district include: cattle and dairy farms, citrus and deciduous fruit, commercial forestry and a small rock lobster fishery.

The government services sector is another significant contributor to the district’s economy providing 23.6% of the value added and 16.6% of the formal employment in 2009. The manufacturing sector which contributes 12.7% of all the value added and 6.5% of employment in the district has an agro-processing focus. Small craft cooperatives based on wool and mohair garments also provide income and employment in the district.

The monthly income of all people in Cacadu reveals that the employment profile is different to the provincial average as it is not skewed towards unskilled labour. The Community Survey 2007 found that 25.4% of the employed people in the district earned less than R401 per month compared to the provincial average of 47.8%. The percentage of people who earned more than R6 401 per month was also better than the provincial average of 6.0% and was sitting at 9.5%, indicating that there are more skilled jobs available in the district.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 Cacadu had the lowest HIV prevalence rate amongst antenatal clinic attendees in the Eastern Cape at 20.7% (Figure 3). This is the eighth lowest HIV prevalence out of all the 52 districts in the country. The HIV prevalence in Cacadu has decreased by 3.6% from 2009.

Cacadu reported 6 240 TB cases in 2008 and had an incidence of 568.5 per 100 000 which is the highest in the province (Table 8). The cure rate of 73.6% in 2007 was the highest in the province and the smear conversion rate was the third best in the province at 60.9% in 2008.

The district offers public health services at 13 hospitals, these are: Aberdeen Provincial Aided Hospital, Andries Vosloo District Hospital (Somerset East), B.J. Voster Hospital (Kareedouw), Fort England Hospital (Grahamstown), Humansdorp District Hospital, Kirkwood Care Centre Hospital, Kouga District Hospital, Midland District Hospital (Graaff Reinett), PZ Meyer Hospital (Humansdorp), S.A.W.A.S. Memorial Hospital (Jansenville), Settlers District Hospital (Grahamstown), Sundays Valley Aided Hospital (Kirkwood), Port Alfred District Hospital and Willowmore Provincial Aided Hospital.

In Cacadu the levels of education were better than the provincial averages in 2007, with 7.2% of the population over 20 years having no schooling compared to the provincial average of 10.7%, and 36.5% of the adult population had Grade 12 or higher compared to the provincial average of 28.5%. The functional literacy in Cacadu was 71.0% in 2010 which although better than the provincial average of 69.7 is worse than the national average of 75.0%.

The district’s poverty rate was 39.1% in 2010 which was less than the provincial average of 53.6%. There is outward migration to the Metro and elsewhere.

64 Eastern Cape Development Corporation: Cacadu District. Available at http://www.ecdc.co.za/cacadu_district accessed Feb-2012
CHAPTER 5: CONTEXT OF IMPLEMENTATION

AMATHOLE DISTRICT MUNICIPALITY AND BUFFALO CITY METROPOLITAN MUNICIPALITY

Geography and demographics

The Amathole district consisted of eight local municipalities namely Buffalo River, Mbhashe, Mnquma, Great Kei, Amahlathi, Ngqushwa, Nkonkobe and Nxuba. However, on 18 May 2011 the Buffalo River local municipality was separated from the Amathole district municipality and converted into a metropolitan municipality. The Buffalo City Metropolitan municipality includes Bisho, East London and King William’s Town and the large townships of Mdantsane and Zwelitsha. Given that the latest available information at a district level is prior to this change, all information provided in this strategy on a district level, is based on the district structure prior to the boundary adjustments of 2011.

Amathole covers 58,243 square kilometres and accommodates 25.5% of the Eastern Cape’s population (Table 2). The district occupies the middle portion of the Eastern Cape coastline and shares borders with three other Eastern Cape districts. The population density is 79 persons per square kilometre. The population is predominantly rural (with the exception of Buffalo City) with more females. The proportion of the population that is under 20 years old is lower than the provincial average. IsiXhosa is the home language of the majority of the population in the district (91.7%), followed by English (4.2%) and Afrikaans (3.6%).

Buffalo City is highly urbanised and has 42% of the district’s population. The former homeland areas make up two thirds of the district and much of this land is under communal tenure. These areas are densely populated, with limited services and infrastructure.

The seat of Amathole is East London in Buffalo City. The main towns include: Mdantsane, King William’s Town, Bisho, Zwelitsha, Alice, Fort Beaufort, Seymour, Bedford, Adelaida, Peddie, Hamburg, Stutterheim, Cathcart, Komga, Chintsa, Butterworth, Ngqamakhwe, Centane, Dutywa, Willowvale.

The first black South African university, Fort Hare University, is based in Alice and has a campus in East London. Tourist attractions in the district range from natural Wild Coast beaches to the forests and waterfalls of the Amatola mountains. The district is home to many of the leaders of the struggle against apartheid and is steeped in heritage and culture.

Labour market and economy

Amathole contributed 29.8% to the provincial economy (GVA), which ranks as the second largest contributor of the districts in 2009. Amathole is the district with the largest number of people who are formally employed and contributed 28.8% of all formal employment in the province. The main contributor to the district’s economy is general government which contributed 26.2% of all the value added and 26.3% of all the formal employment in 2009. Manufacturing, trade, business services, community, social and personal services are other sectors which contribute significantly to the district’s economy and formal employment.

Buffalo City contributed the majority of the district’s economic output (70.26%) and 63.47% of the formal employment in 2009. East London is the economic hub of the area. The tertiary sector is the biggest contributor to the Buffalo City economy and manufacturing is another important contributor to the economy, with a major car manufacturer recently investing in capacity. East London hosts a range of other industries which include: textiles, clothing, healthcare, pharmaceuticals, furniture, packaging, and food processing. Trade is also important in the Buffalo City economy and labour markets.

70 Eastern Cape Development Corporation: Amathole District. Available at http://www.ecdc.co.za/amathole_district accessed Feb-2012
Outside of the urban areas of Buffalo City, the district is rural and has struggled to attract viable business investment and create employment opportunities for the local residents. The communal land tenure in most of the former homeland areas means that subsistence farming, rather than commercial farming, dominates. Areas around Peddie and Butterworth have private land tenure and are commercial cattle farming areas. The coast south of East London has agricultural activity with pineapples, citrus, horticulture and livestock. Forestry is also practiced around Butterworth and the Amatole mountains. Tourism is being promoted as the sector to develop growth and employment in the region.

The monthly income of all people in Amatole reveals that the bulk of employment is similar to the provincial average and is based on unskilled labour. The Community Survey 2007 found that 44.0% of the employed people in the district earned less than R401 per month and 6.1% of employed people earned more than R6401 per month. The higher skilled income categories are probably in Buffalo City.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 Amathole has the highest HIV prevalence rate amongst antenatal clinic attendees in the Eastern Cape at 31.6% (Figure 3). The HIV prevalence in Amathole has increased by 4.4% from 2009. Amathole reported 14754 TB cases in 2008 and had an incidence of 368.3 per 100 000 which is a little higher than the provincial average of 331.6 (Table 8). The cure rate of 54.8% in 2007 was the lowest in the province and the smear conversion rate in 2008 ranked fourth best in the province at 60.6%.

In Amathole, the levels of education were better than the provincial averages in 2007, with 9.3% of the population over 20 years having no schooling compared to the provincial average of 10.7%, and 35.2% of the adult population had Grade 12 or higher compared to the provincial average of 28.5%. The functional literacy in Amathole was 71.0% in 2010 which although better than the provincial average of 69.7% is worse than the national average of 75.0%. However literacy varies considerably among the local municipalities with a high literacy rate of 88% in the Buffalo City Metropolitan municipality and low rates of 43.8% and 55.1% in Mbhashe and Great Kei local municipalities respectively.

The district’s poverty rate was 48.4% in 2010 which is below the provincial average of 53.6%, again this varies considerably among the local municipalities being lowest in Buffalo City at 36.2% and higher rates of 54.0%, 57.8% and 63.3.1% in Nkuba, Mnquma, and Great Kei respectively.

Two thirds of the district includes areas of the former homelands of the Transkei and Ciskei, which are predominately rural and densely populated with limited basic services. Piped domestic water, sanitation, school infrastructure, road infrastructure and electricity are inadequate and government faces backlogs in rectifying the situation. Poverty is widespread in the rural areas and is said to have increased over the last few years.

Additionally the dominance of the Buffalo City economy attracts migrants from the surrounding areas resulting in large informal settlements with poor and crowded housing conditions. Mdantsane which is one of the biggest townships in the country is situated between East London and King William’s Town and falls under the Buffalo City Metropolitan municipality. Despite the Mdantsane Urban Renewal Programme and having the second biggest shopping mall in the Eastern Cape, poor service delivery, unemployment, violence and crime are still commonplace in the township.

CHRIS HANI DISTRICT MUNICIPALITY

Geography and demographics

Chris Hani district consists of eight local municipalities namely: Inxuba Yethemba, Tsolwana, Inkwanca, Lukanjji, Intsika Yethu, Emalahleni, Engcobo, and Sakhisizwe. This landlocked district which is located in the central portion of the Eastern Cape Province shares a provincial boundary with the Northern Cape. The terrain ranges from arid Karroo scrubland to the moist uplands and grassland hills of the Transkei. There are four river systems in Chris Hani, namely: the Great Fish, Kei and Mbashe draining to the south and the Orange River tributaries draining to the north.

Chris Hani is the second largest of all the Eastern Cape districts; with a land area of 36 695 square kilometres. Chris Hani’s population of 798 595 accounted for 12.2% of the total Eastern Cape population in 2007. The district has population density of 24 people per square kilometre. Around 61% of the population in the Chris Hani district is rural and living in the former homeland areas of Transkei and Ciskei. The population has more females and a significant proportion (50.7%) of the population under 20 years old. There is one major urban area around Queenstown-Lukhanji. IsiXhosa is the home language of the majority of Chris Hani’s population (93.3%), followed by Afrikaans (5.4%).

The seat of Chris Hani is Queenstown other main towns include: Cradock, Middelburg, Queenstown, Hofmeyer, Tarkastad, Elliot and Cofimvaba.

Tourism is limited in the district but attractions include the Mountain Zebra Park, game farms, cultural sites and fly fishing. Farm tourism is being developed with ‘stop over’ tourism at farms and guesthouses on the N6 and N10 national routes.

Labour market and economy

The district contributed 7.7% to the provincial economy in 2009 which ranks as the third smallest of the contributions of the districts. Chris Hani’s main economic centres are Queenstown and Cradock. Lukhanji local municipality including Queenstown, accounted for 40.7% of the district’s GVA and 36.0% of formal employment in 2009.

The government sector is the biggest contributor to the district economy and district employment. Agriculture, forestry and hunting are the next most important economic activities in the area. The community, social and personal services; wholesale and retail trade; and manufacturing sectors are significant contributors to the economy at 18.5%, 13.0% and 8.6% of district GVA respectively.

The largest livestock herds in South Africa are found in Chris Hani and Queenstown is the hub for cattle trade in the district. Commercial farm ownership is still dominated by white farmers but there are commercial black cattle farmers situated around Cofimyaba and Engcobo. High value horticultural production is made possible by the many small, medium and large irrigation schemes, especially around Cradock. There is substantial subsistence agriculture in the former homeland areas and this has the potential to be developed.

Manufacturing is centred in Queenstown. Manufacturing sub-sectors include a small furniture industry, dairy processing and production of other wood products. Queenstown offers a comparative cost advantage in the provision of non-metallic mineral products, metal products, machinery, household appliances, electrical machinery and apparatus.

The monthly income of all people in Chris Hani reveals that the bulk of employment is based on unskilled labour. The Community Survey 2007 found that 54.0% of the employed people in the district earned less than R401 per month and only 3.1% of employed earned more than R6 401 per month.

**HIV, AIDS, TB and related social conditions**

According to the Antenatal Clinic Survey, in 2010 Chris Hani had a HIV prevalence rate amongst antenatal clinic attendees of 30.1% (Figure 3) which was just below the national average of 30.2%, but above the provincial average of 29.9%. Chris Hani reported 6 784 TB cases in 2008 and had an incidence of 328.4 per 100 000 which is below the provincial average of 331.6 (Table 8). The cure rate of 73.3% in 2007 was the second highest in the province and the smear conversion rate was the best in the province at 77.3% in 2008.

Chris Hani offers public health services at 16 hospitals; these are: All Saints District Hospital (Ngcobo), Cala District Hospital, Cradock District Hospital, Cofimvaba District Hospital, Dordrecht District Hospital, Elliot District Hospital (Elliot), Frontier Regional Hospital (Queenstown), Glen Grey District Hospital (Lady Frere), Hewu District Hospital (Whittlesea), Indwe District Hospital, Komani Psychiatric Hospital (Queenstown), Martje Venter District Hospital (Tarkastad), Mjanyana District Hospital (Engcobo), Molteno District Hospital, Sterkstroom District Hospital and Wilhelm Stahl District Hospital (Middelburg).

In Chris Hani the levels of education were worse than the provincial averages in 2007, with 15.1% of the population over 20 years having no schooling compared to the provincial average of 10.7%, and 25.9% of the adult population had Grade 12 or higher compared to the provincial average of 28.5%. The functional literacy in Chris Hani was 58.1% in 2010 which is far worse than the provincial average of 69.7%.

The district’s poverty rate was 58.1% in 2010, which is above the provincial average of 53.6%. Chris Hani was selected as one of the priority districts to be targeted in the Integrated Sustainable Rural Development Programme (ISRDP), which aims to improve opportunities and wellbeing for the rural poor. The ISRDP aims to increase the efficiency of the application of public funds in rural areas to create appropriate outputs in the places where they are most needed. The ISRDP facilitates health systems development in partnership with the district.

Basic services are limited and are particularly bad in former homeland areas. There are infrastructure backlogs, which include provision of piped water and sanitation, schools infrastructure and access roads. The number of tarred roads in Chris Hani is below the provincial average, which limits public transport and makes accessing health services difficult.

**JOE GQABI DISTRICT MUNICIPALITY**

**Geography and demographics**

The district was previously known as Ukhahlamba but was changed to Joe Gqabi on 18 May 2011. Joe Gqabi district is made up of four local municipalities namely: Elundini, Senqu, Maletswai and Gariep. Joe Gqabi is situated within the northern portion of the Eastern Cape and covers an area of 25 663 square kilometres, making it the third largest district in the province. Joe Gqabi shares an international border with Lesotho and provincial borders with Free State and Northern Cape. The district includes former Cape Provincial areas of the Karoo, and parts of the former Transkei in the north-east. The terrain is dominated by the Drakensberg Mountains with grasslands, but also includes a highveld and some semi-arid karoo.

Joe Gqabi is the least populated of all the Eastern Cape districts with a population of 308 363 people which is 5.6% of the Eastern Cape population. The population density is 13 persons per square kilometre which is the second lowest population density in the province. The population is predominantly rural (62.1%) with more females and a significant proportion (50.6%) of the population under 20 years old. IsiXhosa is the home language of the majority of the district’s population (72.38%), with 21.0% speaking Sesotho and 5.4% speaking Afrikaans.

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The seat of Joe Gqabi is Barkly East. Other major towns include: Aliwal North, Burgersdorp, Maclear, Lady Grey, Mount Fletcher, Mount Ayliff, Barkly East and Rhodes. The main tourist attractions in the district are: the Orange River, Gariep Dam, and the Southern Drakensburg Mountains. The Oviston Nature Reserve on the southern shoreline of the Gariep Dam offers game viewing, walking trails, fishing and bird-watching.

Labour market and economy

The district contributed 3.7% to the provincial economy (GVA) and 4.6% to formal employment in 2009, which both rank as the smallest contributions out of all the districts. Joe Gqabi’s main economic centres have historically been Barkly East and Aliwal North. However, Elundini’s labour force contributions have been growing while Senqu and Maletswai have been declining since early 2000. Elundini has also had a significant increase in its contribution to the district’s GVA which has more than doubled between 2005 and 2009, whereas Senqu and Maletswai have only managed to increase their contributions to the district’s GVA by 50% over the same period. Elundini’s increased economic contributions are in a large part due to the increase of the tertiary sector in the area, especially in the finance and insurance sub-sector. Table 10 details the contributions to GVA and labour force of the local municipalities.

Table 10: District economic and force contributions

<table>
<thead>
<tr>
<th>Local municipality</th>
<th>% of district GVA 2005</th>
<th>% of district GVA 2009</th>
<th>% of district employment 2005</th>
<th>% of district employment 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elundini</td>
<td>31.5%</td>
<td>38.2%</td>
<td>32.1%</td>
<td>39.2%</td>
</tr>
<tr>
<td>Senqu</td>
<td>29.6%</td>
<td>26.4%</td>
<td>29.5%</td>
<td>26.6%</td>
</tr>
<tr>
<td>Maletswai</td>
<td>26.8%</td>
<td>24.0%</td>
<td>22.8%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Gariep</td>
<td>12.1%</td>
<td>11.4%</td>
<td>15.5%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Total Joe Gqabi</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The tertiary sector is the biggest contributor to GVA with general government, finance and insurance, trade, and community, social and personal services contributing almost 22.7%, 17.4%, 11.5%, and 10.6% respectively to GVA in 2009.

The agricultural sector is the biggest contributor to district employment and contributed almost 30% of the jobs (both formal and informal) in 2009. However, tertiary sectors such as general government; community, social and personal services; and trade also made significant contributions of around 15% each in 2009.

The Community Survey 2007 found that 49.6% of the employed people in Joe Gqabi earned less than R401 per month and only 4.0% of employed earned more than R6 401 per month.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 Joe Gqabi had a HIV prevalence rate amongst antenatal clinic attendees of 30.2% (Figure 3) which is the same as the national average of 30.2%, but above the provincial average of 29.9%. However, Joe Gqabi recorded the biggest increase in HIV prevalence in the province, increasing by 6.7% from 2009.

Joe Gqabi reported 2 851 TB cases in 2008 and had an incidence of 528.7 per 100 000 which is the lowest in the province (Table 8). The cure rate of 62.6% in 2007 is in line with...
the provincial average and the smear conversion rate was the second best in the province at 68.9% in 2008.

Joe Gqabi offers public health services at 11 hospitals; these are: Maclear District Hospital, Tayler Bequest District Hospital (Mt. Fletcher), Aliwal North District Hospital, Burgersdorp District Hospital, Cloete Joubert District Hospital (Barkly East), Empilisweni District Hospital (Sterkspruit), Lady Grey District Hospital, St Francis Provincial, Specialised Hospital (Aliwal North), Steynsburg District Hospital and Umlamli Specialised Hospital (Sterkspruit).

In Joe Gqabi the levels of education were worse than the provincial averages in 2007, with 13.2% of the population over 20 years having no schooling compared to the provincial average of 10.7%, and 21.7% of the adult population had Grade 12 or higher compared to the provincial average of 28.5%. The functional literacy in Joe Gqabi was 56.7% in 2010 which is far worse than the provincial average of 69.7% and is the second worst district in the Eastern Cape after OR Tambo.

The densely populated areas of the former Transkei and Ciskei have high poverty levels (the poverty rate was 63.5% in 2010). Joe Gqabi had a deprivation index of 3.67 and was ranked 11th out of 52 in the most deprived district in the country in 2007. Joe Gqabi was selected as one of the priority districts to be targeted in the ISRDP which aims to improve opportunities and wellbeing for the rural poor. The ISRDP aims to increase the efficiency of the application of public funds in rural areas to create appropriate outputs in the places where they are most needed. The ISRDP facilitates health systems development in partnership with the district.

There are significant challenges in the local services infrastructure and delivery. The district has the highest number of out migrants in the province. The migrants usually go in search of employment or to take up jobs outside the district, but in Senqu and Elundini they are also migrating in order to access schools or tertiary education.

OR TAMBO DISTRICT MUNICIPALITY

Geography and demographics

OR Tambo was made up of seven local municipalities namely: Ngquza Hill, Port St Johns, Nyandeni, Mhlontlo, King Sabata Dalindyebo, Mbizana and Ntabankulu. However, on the 18 May 2011 for the 2011 municipal elections, Mbizana and Ntabankulu local municipalities were moved to Alfred Nzo district municipality. Given that the latest available information at a district level is prior to this change, all information provided in this strategy on a district level is based on the district structure prior to the boundary adjustments of 2011.

The district is situated along the Eastern side of the Eastern Cape and covers an area of 15 986 square kilometres, making it the third smallest district in the province. OR Tambo shares an international border with Lesotho and provincial borders with KwaZulu-Natal. All land in the district was part of the former Transkei homeland and contains some of the province’s last developed areas. A lot of the land is tribal trust land or unregistered state land. Land is held through PTO’s (Permission of Occupancy) which is not regarded as free hold title and this discourages investment and local economic development.

OR Tambo had a population density of 115 people per square kilometre in 2008 which is the highest population density of all the Eastern Cape districts with exception to the Metro. The 2007 Community survey estimated the population to be 1 862 224 which is highest population of the districts and 28.5% of the Eastern Cape population. The population is mostly rural (91.1%) with more females and a significant proportion (56.5%) of the population is under 20 years old. IsiXhosa is the home language of the majority of the OR Tambo’s population (98.4%).

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The seat of OR Tambo is Mthatha (formerly Umtata) which is the administrative and industrial centre of the district. The Walter Sisulu University is in Mthatha, and there is also a FET College. Other major towns include: Mqanduli, Coffee Bay, Port St Johns, Lusikisiki, Qumbu, Flag Staff and Bizana (which is now in Alfred Nzo).

The terrain has a diversity of vegetation, with sub-tropical coast, some mountainous areas, grasslands, thicket, forests and bushveld. The Pondoland Centre of Plant Endemism is one of the country’s important ecological treasures. The coastline is dominated by untouched natural vegetation and includes the bulk of the Wild Coast, which attracts tourists who want to experience the quiet unspoilt beauty of the underdeveloped coastline. There are many coastal nature reserves, proclaimed and indigenous forest reserves. Port St Johns is a developing tourism destination and new investment in facilities and a marina are planned.

The main roads include the N2 from Mthatha to Cape Town and Durban; and the R61 which runs parallel to the coast, linking many Eastern Cape towns and Kokstad in KwaZulu-Natal. The road network is generally in poor condition. In order to facilitate the export of timber from the region, the rail link between Mthatha and East London is to be upgraded and extended to Langeni.

The district has good soils and climatic conditions and is considered to have some of the richest natural resources and most fertile areas in the country. The district is also the birthplace of the prominent leaders of the liberation movement in South Africa including Nelson Rolihlahla Mandela and Oliver Reginald Tambo. The Mandela Museum in Mthatha and Qunu gives insight into the history of the struggle against apartheid and the life of the Nelson Mandela.

Labour market and economy

The district contributed 15.0% to the provincial economy (GVA) in 2009 which ranks third highest of the contributions of the districts. However the district is largely undeveloped and inherited the limited infrastructure from the former Transkei. Mathata and its surrounds in the King Sabata Dalindyabo district is the main economic and administrative centre. King Sabata Dalindyabo was the biggest employer (37.4%) and biggest contributor to GVA (41.1%) in 2009 out of all the local municipalities. King Sabata Dalindyabo’s economy and employment were dominated by tertiary level sectors with trade; general government; and community, social and personal services contributing significantly to employment and GVA in 2009. Finance and insurance has become increasingly important to King Sabata Dalindyabo’s economy with its contribution to GVA at 10.5% in 2009, an increase of almost 50% from 2005.

The tertiary sector also dominated the economy and employment at a district level with 71.6% of the GVA and 57.4% of the employment in 2009. General government contributed 20.5% to district GVA in 2009 and 12.6% to district employment. Trade; finance and insurance; business services and community, social and personal services were also significant tertiary level contributors to GVA and apart from finance and insurance they all also contributed significantly to district employment.

The agriculture, forestry and fishing sector was the one of the biggest employers in the district with 27.0% of the employment in 2009, however the contribution to GVA from this sector was small at 5.3% in 2009. The contribution of subsistence farming and the related informal economy, which dominates this region and contributes significantly to household food security, is not considered in these statistics. Forestry is the main formal agricultural activity and the majority of land is leased by the private sector but there are also community plantations. Small commercial farms concentrate on mixed farming of livestock and crops (mostly maize); however some farms have small-scale irrigation and are growing crops like cabbage and potatoes. Magwa Tea estate is a significant employer in the area.

87 Eastern Cape Development Corporation: OR Tambo District. Available at http://www.ecdc.co.za/oliver_tambo_district accessed Feb-2012
The secondary sectors, including manufacturing, have grown significantly since 2005 and in 2009 provided 23.3% of the district’s GVA and 15.5% of the employment. The manufacturing is centred in Mathata and includes food processing, wood products and furniture.

The Community Survey 2007 found that 61.5% of the employed people in the district earned less than R401 per month which is the highest proportion in the province. This indicates that the bulk of employment in OR Tambo is based on unskilled labour. Higher income levels were rare with only 3.2% of employed earning more than R6 401 per month.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 OR Tambo has a HIV prevalence rate amongst antenatal clinic attendees of 31.5% (Figure 3) which is the second highest in the province and above the national average of 30.2%. However, OR Tambo’s HIV prevalence rate increased by 1.7% from 2009. OR Tambo reported 14 276 TB cases in 2008 and had an incidence of 270.6 per 100 000 which is the second lowest incidence in the province (Table 8). The cure rate of 68.7% in 2007 was above the province average of 58.1% and the smear conversion rate was the second worst in the province at 51.7% in 2008.

OR Tambo offers public health services at 16 hospitals, namely: Bambisana District Hospital (near Lusikisiki), Bedford Orthopaedic Hospital (Umtata), Canzibe District Hospital (Ngqeleni), Greenville District Hospital (Bizia), Holy Cross District Hospital (Flagstaff), Islimela District Hospital (Port St Johns), Madwaleni District Hospital (Elliottdale), Nessie Knight District Hospital (Qumbu), St Barnabas District Hospital (Libode), St Elizabeth’s Regional Hospital (Lusikisiki), St Lucy’s District Hospital (Ku Tsolo), St Patrick’s District Hospital (Bizana), Sipetu District Hospital (Ntabankulu), Umtata Chest Hospital (Mthatha), Umtata General Regional Hospital (Mthatha), and Zithulele District Hospital (Mqanduli).

In OR Tambo the levels of education were worse than the provincial averages in 2007, with 16.7% of the population over 20 years having no schooling compared to the provincial average of 10.7%, and 20.8% of the adult population had Grade 12 or higher compared to the provincial average of 28.5%. The functional literacy in OR Tambo was 52.2% in 2010 which was the worst district in the Eastern Cape.

The district’s poverty rates were high (68.2% in 2010) and 88% of households live below the poverty level which is the worst out of all Eastern Cape districts. OR Tambo had a deprivation index of 4.47 and was ranked 3rd out of 52 in the most deprived district in the country in 2007. OR Tambo was selected as one of the priority districts to be targeted in the ISRDP which aims to improve opportunities and wellbeing for the rural poor. The ISRDP aims to increase the efficiency of the application of public funds in rural areas to create appropriate outputs in the places where they are most needed. The ISRDP facilitates health systems development in partnership with the district.

The local services infrastructure and delivery is very poor and the 2007 Community Survey found that only 35.6% of the district’s population had access to domestic water. Sanitation, electricity and road infrastructure are also inadequate. Sewage flows into the Mthatha and Tsolo rivers, and outbreaks of cholera and typhoid occur. There is high unemployment and the crime rate is growing. There is migration to the main centres which include: Mthatha, Bizana, Lusikisiki and Port St. Johns.
ALFRED NZO DISTRICT MUNICIPALITY

Geography and demographics

Alfred Nzo is situated in the northern portion of the Eastern Cape and covers an area of 6,859 square kilometres, making it the smallest district in the province after the Metropole. Alfred Nzo shares an international border with Lesotho and a provincial border with KwaZulu-Natal. One local municipality, Umzimkulu, was an island within the neighbouring KwaZulu-Natal Province and was incorporated into KwaZulu-Natal on 1 March 2006 and the Matatiele local municipality, formerly part of KwaZulu Natal, was amalgamated into the Alfred Nzo in 2005. All land in the district was part of the former impoverished Transkei homeland and contains some of the province’s last developed areas. A lot of the land is tribal trust land or unregistered state land. Land is held through PTO’s (Permission of Occupancy) which is not regarded as free hold title and this discourages investment and local economic development.

The district was made up of two local municipalities namely: Matatiele and Umzimvubu. However, on the 18 May 2011 for the 2011 municipal elections, the Mbizana and Ntabankulu local municipalities, which were formerly part of OR Tambo district municipality are now included in Alfred Nzo district municipality. Given that the latest available information at a district level is prior to this change, all information provided in this strategy on a district level is based on the district structure prior to the boundaries adjustments of 2011.

Alfred Nzo had a population density of 93 people per square kilometre in 2008, which is the second highest population density of all the Eastern Cape districts, after OR Tambo (with the exception of the Metros). The 2007 Community Survey estimated the population to be 479,395 which is 7.3% of the Eastern Cape’s population. The population is almost entirely rural (98.0%) with more females and a significant proportion of the population is under 20 years old (55.7%). IsiXhosa is the home language of the majority of OR Tambo’s population (79.3%) followed by Sesotho (18.5%).

The seat of Alfred Nzo is Mount Ayliff and the district’s economic centre, Kokstad, falls outside the provincial borders in KwaZulu-Natal. Other major towns include: Matatiele, Mount Frere and the recently added Bizana, which was previously under OR Tambo district municipality.

The terrain is mountainous and characterised by high rainfall and grassland vegetation. Currently tourism is limited, but the southern Drakensberg’s spectacular scenery offers opportunities for development. A transfrontier park between South Africa and Lesotho is planned for the Maluti area of the southern Drakensberg. The district also has a growing international reputation as a trout fishing destination. Cultural tourism has potential for development and Alfred Nzo district is steeped in history.

Labour market and economy

The district contributed 4.5% to the provincial economy (GVA) in 2009, which ranks as the second smallest of the contributions of the districts. There is extensive subsistence farming and an informal economy which contributes significantly to household food security. However, the heavy winter snow and frosts in the mountainous regions limit the production during the winter. This district’s main economic centre, Kokstad, falls outside the provincial borders in KwaZulu-Natal. Economic activity is concentrated predominantly in the towns of Mount Frere, Mount Ayliff and Matatiele, which serve as commercial hubs for the surrounding villages.

Alfred Nzo is heavily reliant on the tertiary sectors for both employment (73.3%) and GVA (82.5%) and many households are dependent on state pensions.

The general government; community, social and personal services; and wholesale and retail trade sectors are significant contributors to the districts’ employment at 23.9%, 20.6% and 16.9% respectively. The general government; wholesale and retail trade; community, social and personal services; and finance and insurance sectors; are significant contributors to the districts’ GVA at 24.0%, 19.7%, 12.5% and 9.9% respectively.

The agriculture, forestry, and fishing sector is an important employer in the area, contributing 17.1% to the districts’ employment. Forestry is a large contributor to the formal agricultural sector with timber plantations widespread in the district and a sawmill located in Mount Ayliff. Most agriculture is at subsistence level but there is potential to develop the local economy through agriculture namely: cattle, goats, sheep, sorghum, maize, lucerne, vegetables, tropical fruit, nuts, pineapples and chicory.

The district is not strategically positioned with respect to key markets or transportation corridors therefore manufacturing is a small sector contributing less than 10% of GVA and around 5% of the employment. It is dominated by the wood products industry, with a number of firms producing builders’ joinery and planks and some furniture manufacturing in the district. Metals, metal products, machinery and equipment and other non-metal mineral products are also produced.

The Community Survey 2007 found that 58.3% of the employed people in Alfred Nzo earned less than R401 per month. This indicates that that the bulk of employment in the district is based on unskilled labour. Higher income levels were rare with only 2.3% of employed earning more than R6 401 per month which is the lowest proportion in the province.

**HIV, AIDS, TB and related social conditions**

According to the Antenatal Clinic Survey, in 2010 Alfred Nzo has a HIV prevalence rate amongst antenatal clinic attendees of 26.3% (Figure 3) which is the second lowest in the province and below both the national and provincial averages. The HIV prevalence rate in Alfred Nzo increased by 2.6% from 2009, but it is still below its peak of 29.8% in 2008.

Alfred Nzo reported 4 697 TB cases in 2008 and had an incidence of 337.6 per 100 000 which is just above the provincial average (Table 8). The cure rate of 56.5% in 2007 is one of the lowest in the province and the smear conversion rate was the worst in the province at 40.7% in 2008.

Alfred Nzo offers public health services at 4 hospitals, these are: Mary Terese / Madzikane Ka Zulu Memorial District Hospital (Mount Frere), Mount Ayliff District Hospital, and Tayler Bequest Hospital (Mount Fletcher).

In Alfred Nzo the levels of education are some of the worst in the province, below the provincial averages in 2007, with 8.0% of the population over 20 years having no schooling compared to the provincial average of 10.7%, and 21.5% of the adult population had Grade 12 or higher compared to the provincial average of 28.5%. The functional literacy in Alfred Nzo was 61.2% in 2010 which is below the provincial average of 69.7%.

Alfred Nzo has very high poverty levels with 82.3% of the population living below the poverty line and a poverty rate of 64.9% in 2010. Alfred Nzo had a deprivation index of 4.46 and was the fourth most deprived district in the country in 2008. Alfred Nzo was selected as one of the priority districts to be targeted in the ISRDP which aims to improve opportunities and wellbeing for the rural poor. The ISRDP aims increase the efficiency of the application of public funds in rural areas to create appropriate outputs in the places where they are most needed. The ISRDP facilitates health systems development in partnership with the district.  

NELSON MANDELA BAY METROPOLITAN MUNICIPALITY

Geography and demographics

The Nelson Mandela Bay Metropolitan municipality is situated inside Cacadu district municipality and covers an area of 1,959 square kilometres which encompasses the towns of Port Elizabeth, Uitenhage and Despatch. The 2007 Community Survey estimated the population to be 1,050,934 which is 16.1% of the Eastern Cape’s population. However, more recent estimates place the population at over 1.1 million. Until recently it was the only metropolitan municipality in the province and is South Africa’s fifth largest city in terms of population and the second largest in terms of area.

The population density is 580 persons per square kilometre which is the highest population density in the province. The population is almost predominantly urban and the proportion of the population that is under 20 years old (35.1%) is much lower than the provincial average of 47.7%. IsiXhosa is the home language of the majority of Nelson Mandela Bay’s population (57.3%), with 29.7% speaking Afrikaans and 12.1% speaking English. Nelson Mandela Bay has higher proportions of coloured and white populations than the rest of the province.

Port Elizabeth is the largest city in the province and is a regional centre for many companies and the first port to be established in the province. A large manufacturing sector ensures a strong financial and business services sector and the area is a popular holiday destination. The Nelson Mandela Metropolitan University is based in the city. The Coega Industrial Development Zone (IDZ) and the associated Ngqura deepwater port are situated 15km east of Port Elizabeth.

Nelson Mandela Bay is served by excellent national roads and the revamped Port Elizabeth Airport. Local tourism attractions include unspoiled beaches with Blue Flag Status and entertainment. Nelson Mandela Bay is often used as a starting point for the Garden Route. Hobie Beach is well known for triathlon and windsurfing competitions. Tourism has been further developed with the establishment of the Madiba Bay Leisure Park. Madiba Bay Leisure Park is a leisure-orientated coastal resort with a range of tourist facilities, within a wildlife conservation area that will also incorporate marine life, culture, outdoor adventure, agriculture, arts and crafts.

Labour market and economy

Port Elizabeth is the largest economic centre in the Eastern Cape. Nelson Mandela Bay was the biggest contributor to the provincial economy (GVA) in 2009 with a 31.4% of GVA. The metropole is second behind Amatole in terms of contribution to the labour force with 24.4% of the provincial employment.

The manufacturing capacity of Nelson Mandela Bay is considerable with the automotive manufacturers and related industries as well as pharmaceuticals, food and beverage, and textiles and leather. The Coega Industrial Development Zone (IDZ) has given a further boost to the manufacturing sector. The manufacturing sector contributed 20.0% to the metro’s economy and 20.2% to the Metro’s employment in 2009.

Tertiary sectors dominate the Nelson Mandela Bay economy and employment. The government sector is the next biggest contributor to the metro’s economy (17.6%) and the metro’s employment (19.1%). The business services sector; wholesale and retail trade sector; and finance and insurance sector; are significant contributors to the economy at 13.1%, 13.0% and 10.6% of the metro’s GVA respectively. The business services sector; community, social and personal services sector; and wholesale and retail trade sector

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are significant contributors to employment at 14.6%, 14.2% and 12.6% of the metro’s employment respectively.

The Community Survey 2007 found that 24.5% of the employed people in Nelson Mandela Bay earned less than R401 per month which is far below the provincial average and indicates that the employment is driven by more skilled labour. Nelson Mandela Bay also had the highest proportion of high income earners in the province with 14.6% of employed earned more than R6 401 per month.108

**HIV, AIDS, TB and related social conditions**

According to the Antenatal Clinic Survey, in 2010 Nelson Mandela Bay had a HIV prevalence rate amongst antenatal clinic attendees of 29.0% (Figure 3) which is just below both the national and provincial averages. Nelson Mandela Bay’s HIV prevalence rate decreased by 1.7% from 2009 and it is one of two districts in the province to record a decrease in the HIV prevalence rate.

Nelson Mandela Bay reported 13 931 TB cases in 2008 and had an incidence of 462.9 per 100 000 which is the second highest in the province (Table 8). The dense populations in the metropolitan area could be a reason for the higher TB burden and incidence. The TB cure rate was 56.6% in 2007 and the smear conversion rate was 54.8% in 2008, both indicators were well below the provincial averages of 62.0% and 58.1% respectively.

Nelson Mandela Bay offers public health services at 5 hospitals, these are: Dora Nginza Regional Hospital (Algoa Park), Elizabeth Donkin Specialised Hospital (Port Elizabeth), Empilweni Specialised TB Hospital (Port Elizabeth), Livingstone Regional Hospital (Port Elizabeth) and Uitenhage District Hospital.

In Nelson Mandela Bay the levels of education are varied in 2007, with 3.2% of the population over 20 years having no schooling compared to the provincial average of 10.7%, and 41.0% of the adult population had Grade 12 or higher compared to the provincial average of 28.5%.109 The functional literacy in Nelson Mandela Bay was 93.3% in 2010 which is the highest of all the Eastern Cape districts.

Nelson Mandela Bay’s poverty rate in 2010 was 33.5% which was the lowest in the Eastern Cape, but this is still high relative to national levels. Unemployment is also high relative to national levels. Basic service backlogs are mainly related to a relatively large informal housing sector, caused by inward migration from the rest of the province. The IDP estimates that 10% of the households in the metro are living on the margins in informal housing with no access to basic services.

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Mobilisation for the strategy

‘I am responsible. We are responsible. South Africa is taking responsibility.’ This emphasises both individual and collective responsibility that South Africans need to be taking in response to HIV, AIDS, TB and wellness.

Participation is a key foundation for effective implementation. Broad based and transversal participation will assist in breathing life into this strategy and making it more operational. Interventions contained herein should be a guide to implementation in workplaces and communities and public-private partnerships should be considered for effective service delivery amongst sectors.

Eastern Cape business needs to own this strategy and prioritise the implementation of appropriate interventions. SMMEs in particular need to be mobilised. This activity demands active recruitment of participants through creative and effective communication tactics, creating demand and urgency. Ongoing analysis of gaps and targeting nonparticipation will be required.

Remote locations and industry sectors presently underserviced and with poor participation records should be targeted and involved.

Participation at the sectoral level will require building relationships with and securing the commitment of business associations. Formal presentations of this strategy to key role players must be prioritised.

Multi-sectoral participation beyond the ECAC must be sought. Bringing together organisations and service providers to assess possible partnership in implementation of individual strategy interventions is required.
Accessing resources

The commitment of resources to this strategy will ultimately determine its success or failure. Additional resources to sustain overall coordination of this strategy over the next five years are imperative, especially in light of the donor funding crisis. Continued efforts to mobilise donor funding and the development of effective partnerships with the public sector will facilitate the implementation of many of the interventions advocated by this strategy. What remains is for businesses to commit resources, both human and financial, to the interventions contained herein.

Financial commitment will take the form of open and comprehensive evaluation of proposals for workplace interventions followed by the commitment of budget for the same.

Senior management support for programme development and implementation is essential. Their support can be gained by explaining that economic risks of HIV, which threaten their value chain, can be reduced through the interventions promoted in this strategy.

Senior management, as leaders with knowledge of HIV and AIDS, should also actively communicate important messages about HIV and AIDS aimed at changing social attitudes and behaviours.

Employees need to be empowered to fulfil their obligations in terms of the interventions agreed upon. Their participation must be reflected in their performance evaluation whether it be strategic negotiations, peer education, coordination, or participation in other community or provincial structures.

Sustainability

For the strategy to be considered successful it must not have an explosive start and a feeble finish. Taking cognisance of changing environmental factors over time, it is prudent for the strategy to span five years; however progress must be sustained well beyond. This is best achieved through building capacity and strengthening systems.

Joining SABCOHA, as a member, demonstrates a commitment of will and provides for ongoing coordination capacity, support and technical assistance.

Ongoing communication of developments, successes and challenges through regular newsletters and well maintained resources on the SABCOHA website will sustain momentum.

SABCOHA will continue to pursue all funding opportunities in order to sustain the projects it manages.

Taking ownership starts with committing resources and as such SABCOHA may well offer projects on a fee for service basis.

Ongoing anticipation of changes in the environment and pro-activity on the part of business will see the effective development of opportunities for greater impact.

Coordination and communication

Effective communication leveraging accurate, up-to-date, comprehensive stakeholder databases and media technology, with messaging that is succinct, relevant and useful will result in furthering the objectives of this plan.

SABCOHA will continue to circulate information regularly through its newsletters, district workshops, breakfasts and other forums.
Businesses committing to responsible reporting through Bizwell, thus providing data that can be used for tracking performance will advance accountability, improvement and multi-sectoral collaboration. Measurement is effective in promoting the required behaviour. Additionally, transparent reporting of data will promote collective accountability.

SABCOHA Eastern Cape Board of Governors chairperson is to be represented on the ECAC ensuring alignment to provincial priorities.

**Monitoring and evaluation**

Businesses are committing to responsible reporting through Bizwell, thereby providing data that can be used for tracking performance. This, in turn will advance accountability, service delivery improvement and multi-sectoral collaboration. Measurement is effective in promoting the required behaviour change. Additionally, transparent reporting of data will promote collective accountability.

The HIV and AIDS Management Standard SANS 16001:2007 is applicable to any organisation that wishes to establish, implement, maintain and improve their HIV and AIDS management system. It is based on the Assess-Plan-Implement-Monitor-Evaluate (APIME) model. M&E is an essential part of any plan, and is often neglected. Not only does M&E enable progress towards outcomes and goals, but it can assess the quality and impact of a project. This provides transparency and allows accountability to be assigned within the project. M&E takes place on a variety of levels and can monitor the resources invested, the activities implemented, services delivered as well as evaluate outcomes achieved and long-term impacts. It is important to develop SMART indicators which are: Specific; Measurable; Available (at an acceptable cost); Relevant; and Time-bound.

Bizwell is a web-based monitoring and reporting tool that was specially developed by SABCOHA to ensure effective capturing of HIV and AIDS data. Bizwell enables businesses to assess high risk areas in addressing disease management in the workplace. It gives intelligent and informed information on HIV and AIDS in the private sector to enable government to formulate effective strategies. The design also ensures that there is no duplicate reporting of data to government.

Increasing the number of responsible reporting companies registered on Bizwell will provide more accurate data on the business sector’s response and enhance the private sector’s relationship with government and the Department of Health, in particular. This will add significant value and provide opportunities for gap analysis and public-private partnerships.
Introduction

Two criteria were used to shortlist the 27 company level interventions into a 10-point plan, namely:

- **Priority**: perception of the extent to which the intervention impacts positively on the overarching aims of the NSP, in short to reduce new infections and increase the number of people on treatment. Perception of scale of the impact also influenced the rating.
- **Probability**: perception of available resources, within SABCOHA and companies, and political will i.e. the willingness of relevant stakeholders to support and implement the intervention.

The 10-point priority plan below comprises mostly of company interventions requiring responsibility and commitment of resources from companies. Refer to the tables in the previous section for the rationales, alignment to the NSP and targets for each intervention.

**The 10-point priority plan: 2012-2016**

1. Develop partnerships with government to enable provincial mobile clinics to be allocated to provide prevention, treatment and care services for the large seasonal migrant communities in the Eastern Cape agricultural sector.

2. Maximise the coverage of male and female condom dispensers in strategic points in the workplace for increased access.

3. Develop and implement a comprehensive workplace programme that addresses HIV, STIs and TB in an integrated manner and is aligned with provincial standards. The workplace programme can either be an extension of the EAP or created through the increased scope and capacity of occupational health and safety. It should ideally include HIV, STI and TB prevention and treatment services and eventually expand to cover other relevant local health conditions. It should ensure that HIV, AIDS and TB workplace policies and procedures comply with workers' rights as they relate to stigma and discrimination.
4. Ensure that all employees are given an annual health assessment which includes: provider initiated HIV counselling and testing (PICT), screening for TB and STIs and screening for other non-communicable diseases such as hypertension, diabetes, anaemia.

5. Preventing new TB infection and disease through IPT, infection control, early identification and treatment of TB and an improved TB cure rate.

6. Direct Corporate Social Investment (CSI) to support information and education programmes within local community, especially schools attended by employees’ children or consider training one youth for every seven peer educators trained in a peer education programme.

7. Companies should work with trade unions to negotiate on HIV and AIDS Health Promotion and Employee Wellness Workplace Policies for their members. They should make sure that policies and programmes are not conflicting with unions and that efforts are not duplicated.

8. Use peer educators to discuss issues including, but not limited to: changing social norms; addressing gender-based violence; sensible alcohol use; promoting individual; culture of acceptance and non-discrimination; address intergenerational and transactional sex; target men’s attitude to women; and promote a balanced use of traditional versus western medicine.

9. Establish internal systems aligned to accepted indicators for routine monitoring, performance measurement and external reporting.

10. Ensure visible leadership, support and participation from board members and executive management. The CEO and Chairperson need to be conversant on the issues and know the company’s position. Ownership or support of the company based HIV, STI, TB and wellness initiatives must be at the most senior level.

**Final thoughts**

Many ‘wellness interventions’ may result in outcomes and impacts over years and benefits are not immediately recognised. The cost-benefit of many workplace programmes has still to be determined, so in order to encourage participation recognition of successful workplace programmes for HIV, STI, TB and wellness should be given. There is an increased focus on the social needs facing South Africa and the pivotal role business can play in addressing some of these needs. Those companies who are compliant with the applicable provincial business sector HIV, STI, TB and wellness interventions should have positive brand reinforcement from customers, suppliers and employees. Suggested activities that could incentivise companies include:

- Include HIV and wellness programme in “Best Company to Work For” surveys and other business competitions.
- Lobby media coverage of workplace successes and other important HIV messaging
- Companies winning government tenders securing investments for new initiatives should all be fully compliant with the applicable provincial business sector interventions.

Additionally, in order to implement the sectoral and multi-sectoral level interventions suggested in this strategy, it is essential to have resources and a co-ordination mechanism which SABCOHA is ideally positioned to provide. Resources need to be mobilised from both the local private sector and international funders.
ACKNOWLEDGEMENTS

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SABCOHA Secretariat
Brad Mears – Chief Executive Officer for leadership support
Penny Dlamini – Strategic Partnerships Manager for stakeholder relations and drafting this strategic plan
Alex Bouche – Provincial Communications Specialist for editing, design and layout of this strategic plan
Nicola Marais – for co-ordination, research and writing this strategic plan
Richard Douglas – for stakeholder relations and initial branch set-up management
**APPENDIX 1**

**HIV-911 Provincial Directory**
HIV-911 is a database containing details on over 12 000 health and social welfare support services across South Africa. The HIV-911 database provides information on the services related to all aspects of HIV-related prevention, treatment and support to the public and to the service provider community. The information is locally relevant and is available for all provinces on a district level.

There are a variety of ways to access HIV-911’s database:

Online directory service: Go to: www.hiv911.org.za

Call centres:
1. Referral line and data collection line, call: 0860 HIV 911 / 0860 448 911 (office hours)
2. National AIDS Helpline: 0800 012 322

Mobile phone services:
1. Impilo! Health in my Hands: This service gives instant replies 24 hours a day and is free on all networks except Vodacom. Call: *130*448# and follow the menu prompts
2. Short code SMS: Send a free form text message and wait for a response. SMS: 45080

Hard copy directories:
To order a hard copy directory for each province, call 031 260 3052
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