HIV & AIDS and Wellness

WESTERN CAPE BUSINESS SECTOR
PROVINCIAL STRATEGIC PLAN 2011–2015

'Taking responsibility to create a summer for all'

SOUTH AFRICAN BUSINESS COALITION ON HIV & AIDS
SABCOHA

SABCOHA

Empowering Business in the fight against HIV

HIV & AIDS AND WELLNESS

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The message of the successes in the fight to reduce the spread of HIV and AIDS in the Western Cape is reaching the whole spectrum of communities, and this success can be attributed to the integration of the forces of government and the private sector. Now it is time for us to put the strategy into action.

— Mr Theuns Botha, Western Cape Minister of Health, March 2011

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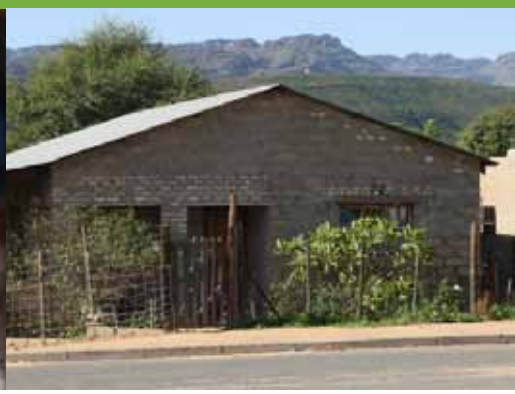

ACRONYMS

AIDS	acquired immune deficiency syndrome
ACTS	advise consent test and support
ART	antiretroviral treatment
BMI	body mass index
BWC	Business Western Cape
CDC	Centres for Disease Control and Prevention
CHAMSA	Chambers of Commerce and Industry South Africa
CHC	community health centre
CSI	corporate social investment
DoH	Department of Health
EAP	employee assistance programme
GDP	gross domestic product
HBC	home-based care
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
KAP	knowledge, attitude, perception
M&E	monitoring and evaluation
MEC	Member of Executive Committee
NACOSA	Networking HIV/AIDS Community of South Africa
NGO	non-government organisation
NSP	National Strategic Plan 2007–2011 HIV & AIDS and STIs
PAC	Provincial AIDS Council
PICT	provider initiated counselling and testing
PEPFAR	President's Emergency Plan For AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PSP	Western Cape Multi-sectoral Strategic Plan for HIV, AIDS and STIs 2007–2011
SABCOHA	South African Business Coalition on HIV and AIDS
SACTWU	South African Clothing and Textile Workers Union
SANAC	South African National AIDS Council
SANS	South African National Standard
SAQA	South African Qualifications Authority
SETA	Sector Education Training Authority
SMEs	small- and medium-sized enterprises
SMMEs	small- medium- and micro-sized enterprises
StatsSA	Statistics South Africa
STIs	sexually transmitted infections
TB	tuberculosis
Unesco	United Nations Educational, Scientific and Cultural Organisation
VCT	voluntary counselling and testing
WHO	World Health Organisation

GLOSSARY OF TERMS

ACTS protocol makes HIV screening a part of routine healthcare in a variety of clinical settings. ACTS replaces VCT with PICT as recommended by the WHO and CDC. Upon presentation, clients are offered HIV screening and thereafter serviced for the reason for their visit. This allows time for the test result to develop and clients are then counselled according to the actual as opposed to possible risk of HIV infection. This approach is integrated, streamlined and destigmatises participation.

Corporation means > 1 000 employees following on from the definition of large enterprise.

Large enterprise means > 200 but ≤ 1 000 employees following on from the definition of medium-sized enterprise.

Medium-sized enterprise means > 50 but ≤ 200 employees. The schedule to the National Small Business Act, 1996, differentiates size parameters by industry in terms of which medium in certain industries is capped at ≤ 100 employees. For the purposes of this strategy the wider definition is applied given urban rural differences.

Micro-sized enterprise means a company typically employing ≤ 5 employees as set out in the schedule to the National Small Business Act, 1996.

PEPFAR means the United States Government fund to help save the lives of those suffering from HIV and AIDS around the world. 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.

SANS 16001 means the South African National Standard on HIV and AIDS in the Workplace issued by the South African Bureau of Standards in 2007.

Small enterprise means a company typically employing > 20 and ≤ 50 employees. The schedule to the National Small Business Act, 1996, differentiates size parameters by industry in terms of which small in certain industries starts at > 10 employees. For the purposes of this strategy the narrower definition is applied given the wider application of very small enterprises.

Unit standard means 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.

Very small enterprise means a company typically employing > 5 and ≤ 20 employees. The schedule to the National Small Business Act, 1996, differentiates size parameters by industry in terms of which very small in certain industries is capped at ≤ 10 employees. For the purposes of this strategy the wider definition is applied given urban rural differences.

Wellness means 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.

Wellbeing is the result of the process of wellness and represents a desired end state.

FOREWORD

The establishment of a SABCOHA branch in the Western Cape Province coincided fortuitously with the change in government in April 2009. This change brought with it new political leadership on HIV and AIDS and major shifts in public policy around the epidemic. In April 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. The simultaneous launch of the unprecedented government-led HCT campaign demonstrated renewed commitment to reduce new infections by 50% and expand treatment to 80% of those in need.

Despite 20 years of responding to the epidemic, a turnaround is yet to be realised. Alignment and coordination across sectors and provinces is lacking, resulting in reduced effectiveness of South Africa's multi-sectoral response. SANAC, chaired by the Deputy President, and the PACs are designed to include participation from all sectors and are pivotal in strengthening coordination and cooperation in service delivery.

We have reached the final year of implementing the second NSP. The third five-year country plan is under development. In the third quarter of 2009, SANAC commissioned an independent midterm review of the current NSP. The aim was to assess achievements, lessons learnt, gaps, constraints, challenges and opportunities at provincial, sectoral and national levels, with a view to making recommendations for strengthening and improving response strategies.

Whilst there are pockets of success, we are far behind in achieving the primary aims of the NSP. A multi-sectoral communication and prevention strategy was identified as a critical need as new infections persist. Maintaining patients on treatment is equally important to expanding coverage. Strengthening health systems and decentralising and integrating services should be improved. Where monitoring and evaluation systems do exist they are fragmented and capacity is severely lacking. Institutional capacity and systems within all sectors were found to be inadequate.

SABCOHA's primary purpose is to mobilise and empower South African business to take effective action on HIV and AIDS in the workplace and beyond, and to this end will coordinate efforts that ultimately mitigate the impact of HIV and AIDS on sustained profitability and economic growth. Given a historically concentrated presence in Gauteng, SABCOHA has adopted provincial systems strengthening as one of its key strategic objectives thereby expanding its national footprint. Strengthening provincial systems involves establishing governance mechanisms and strategic priorities for business at provincial level. SABCOHA will support capacity development at company and industry level and facilitate business participation on multi-sectoral structures.

Following the successful establishment of a branch in the Northern Cape Province in March 2009, after 12 months of stakeholder consultation, SABCOHA replicated the process with funding from the Metropolitan Foundation in the Western Cape. During the first half of 2010 SABCOHA successfully redirected CDC-PEPFAR funding and expanded the provincial team to conduct similar processes in five additional provinces. By the end of 2011 SABCOHA will have seven functional provincial branches to mobilise, empower and coordinate the implementation of agreed business sector priorities.

At SABCOHA's AGM in October 2010 members adopted a change to the organisation's articles of association providing for provincial representation on the national board. Five out of the fifteen seats will be reserved and filled by representatives from provincial boards, once established. Until such time as there are official vacancies on the national board the Northern and Western Cape branches will participate in a non-voting capacity.

The SABCOHA Western Cape Board of Governors was elected at the business sector conference held in May 2010. Since appointment two quarterly board meetings were convened in 2010. This strategy was released for public comment and thereafter adopted by the provincial board of governors on 1 March 2011.

SABCOHA is a sub-recipient of South Africa's Global Fund Round 9 Award, which provides some resources for expanding existing empowerment projects and initiatives. Whilst this will benefit the Western Cape, additional resources to sustain overall coordination of this strategy over the next five years are imperative.

SABCOHA would like to make special mention of Diane Ritson, CEO of Siriti Africa, who voluntarily represented the interests of the business sector on the PAC, prior to SABCOHA initiating an in-depth consultation process. This strategy is the outcome of substantive stakeholder engagement and research which would not have been possible without significant funding of R1.05 million from the Metropolitan Foundation. SABCOHA is sincerely grateful for the support and guidance of Nathea Nicolay, then Programme Director of the Metropolitan Foundation's Health Unit, throughout the process. Thank you to the business chambers in the Western Cape – the Cape Regional Chamber; Western Cape Business Opportunities Forum; South African Chamber of Commerce and Industry; National African Federated Chamber of Commerce; and the Foundation for African Business and Consumer Services – for endorsing the process and the business sector conference. SABCOHA further recognises the invaluable support of the Western Cape MEC for Health, Mr Theuns Botha, Amanda Brinkmann, Special Advisor to the Minister of Health and Leader of Government Business: Western Cape Government, and the provincial department of health, specifically Dr Joey Cupido, Jimmy Ledwaba and their teams.

Brad Mears, Chief Executive Officer

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Executive summary

At a time of scarce resources, coordination and cooperation within and across sectors to maximise impact should be the number one priority. This strategy identifies tangible opportunities to foster this level of collaboration to achieve a 'Summer for All People' – the most favourable future scenario for South Africa – premised on improved cross-sector coordination, stronger collaborative leadership and mutual responsibility.

The Western Cape business sector provincial strategic plan is the product of extensive stakeholder consultation and research, particularly within the business sector. SABCOHA visited the metropolitan municipality and every district municipality over a six-month period during 2009 to engage stakeholders on their HIV and AIDS response strategies, service delivery, prevailing social determinants, labour market conditions and economic realities. Consideration and debate over emerging recommendations ensued at the business sector conference held in May 2010, attended by more than 170 delegates. Informed by the outcomes of the research conducted, the SABCOHA Western Cape Board of Governors further shaped and developed the 30 interventions contained herein. These interventions are structured into three categories according to the stakeholder responsible for implementation. The 30 interventions are further shortlisted into a ten-point plan of immediate priorities based on consideration of priority in terms of impact, and probability in terms of resources and will. The SABCOHA provincial board, elected at the conference, has as its primary duty the responsibility of overseeing the implementation of priorities and interventions adopted in this strategic plan.

SABCOHA will lobby companies to take responsibility for implementing the 11 company interventions. The company interventions address the need for more strategic approaches to risk management and focus on high impact initiatives that have the potential to realise a significant return on investment. SABCOHA will project manage implementation of the ten sectoral interventions. Most of the sectoral interventions are designed to support and empower companies to implement the company interventions. They also include industry

projects requiring coordination and collaboration within and across industries improving cost benefit to business. It is envisaged that government will lead and coordinate the nine multi-sectoral interventions through collaborative and participatory processes. The multi-sectoral interventions largely address shortcomings in coordination and information sharing, aim to expand service delivery by maximising scarce healthcare resources, services and outlets, and consider social determinants beyond healthcare.

A brief rationale is provided for each intervention to enhance understanding and mobilise support for implementation. Annual targets, which SABCOHA believes are measurable through Bizwell and existing internal monitoring systems, are established for the next five years.

HIV and TB constitute the largest component of the burden of disease in the Western Cape Province. Mental illness such as depression, anxiety and substance misuse, further contribute to the burden of HIV and AIDS.[1] The Western Cape is better resourced than many other provinces in that it has complementary donor funding from the Global Fund, a progressive provincial government partnership strategy and can more easily attract scarce skills. Notwithstanding, remote geographic areas and vulnerable industries remain underserviced and can benefit significantly from the interventions proposed.

Many companies have policies but few have translated these into comprehensive workplace programmes. Few companies have routine monitoring systems to effectively measure performance and inform improvements. M&E skills within the business sector are severely lacking. Uptake of workplace testing services was reportedly low. Companies are either investing in the wrong actions or not measuring programme outputs and outcomes accurately.

Many companies that have been managing HIV and AIDS within the workplace for more than a decade, 'the veterans', are either failing to achieve the desired programme outcomes or lack evidence due to inadequate monitoring systems. On the other extreme, many medium-sized enterprises have not even begun to understand the impact of HIV and AIDS on their business, 'the beginners'. The majority of companies lie somewhere along this spectrum.

Marketing and implementation of this strategy will guide companies and industries to take responsibility and effective action. Companies will be called upon to support SABCOHA on this challenging road ahead to ensure that the requirements for effective implementation and immediate next steps are sustained over the next five years.

1 Department of Health in the Provincial Government of the Western Cape. (2008) Western Cape Burden of Disease Reduction Project Abbreviated Report 2008. Retrieved 30 October 2009 from: https://vula.uct.ac.za/access/content/group/91e9e9d8-39b6-4654-00ae-f4d74cba085f/bodabbrrep08.pdf

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Background




National and provincial political leadership changed three times in under a year, between July 2008 and May 2009. At the same time the impact of the global financial crisis began to take hold. Companies large and small, local and multinational experienced the realities brought about by lower consumer demand, a consequence of contracted credit and reduced confidence. Some South African industries were more affected than others, resulting in downsizing and cost cutting, particularly of non-production costs. As a result spending on workplace HIV and AIDS and employee wellness programmes seemed to decline. Coupled with this, companies experienced fatigue from years of implementation and many have been unsuccessful in mitigating the risk of HIV and AIDS on sustained profitability and growth. Civil society organisations, in particular, have experienced a decline in donor funding as governments internationally face increased pressure to prioritise domestic spending and are reluctant to invest in programmes that fail to achieve desired outcomes.

The Western Cape Department of Health is exceptionally fortunate in that its success in implementing its Global Fund round three programme, awarded in 2004, secured ongoing funding of around R1 billion for a second six-year period under the rolling continuation channel, starting mid-2010. This funding not only supports public health ART delivery but also educates learners within secondary schools and strengthens capacity within civil society to render palliative care and other services to communities. This augments the existing resources of the department currently employing over 28 000 people, most of whom are nursing staff, in 650 facilities and accountable for a budget of R13 billion. The Western Cape Department of Health has had an unqualified audit for the past five years and manages its finances to within 1% of budget. Two new hospitals are being built in Mitchells Plain and Khayelitsha, costing in excess of R600 million each. The provincial government is determined to provide quality healthcare for all and positive patient experiences at all facilities.

The incoming Western Cape Premier, Helen Zille, appointed the MEC for Health, Mr Theuns Botha, to chair the multi-sectoral PAC. The Western Cape Multisectoral Strategic Plan for HIV, AIDS and STIs 2007–2011 (hereinafter referred to as the PSP), developed by mid-2008, was endorsed by the current provincial cabinet in May 2010. Since May 2009 the PAC has met three times on 17 September 2009, 22 April 2010 and 9 February 2011. At a meeting of the Public Private Health Forum on 17 February 2011, MEC Botha welcomed innovative and creative proposals for public–private initiatives aimed at narrowing the quality gap between public and private healthcare.

SABCOHA adopted a district-based approach to establishing provincial branches across South Africa, a key organisational objective of systems strengthening within the business sector. This process involves several objectives informed by extensive stakeholder engagement including: strategy development, election of provincial boards of governors, strengthening multi-sectoral collaboration, developing capacity at company level and coordinating implementation, monitoring and reporting for the business sector. As part of the Western Cape process SABCOHA commissioned a survey to measure and quantify the business sector's response and investment in HIV and AIDS within the workplace and communities.

Prior to SABCOHA formally initiating the establishment of a branch in the Western Cape, Diane Ritson represented the interests of the business sector and participated in the development of the PSP through the PAC. A ten-point plan for the business sector, extracted from the PSP, was supported in principle by CHAMSA in the last quarter of 2008, subject to wider consultation through district road shows planned in collaboration with NACOSA. Unfortunately business attendance was poor, necessitating more comprehensive and widespread engagement. This strategy expands and enhances those commitments over which a degree of consensus amongst business leaders already existed. Since then CHAMSA was restructured as the BWC, which comprises business associations and chambers of commerce and industry in the Western Cape.

SABCOHA has consistently had significant membership in the Western Cape Province. There was a time when these member companies initiated opportunities to exchange information and best practice. The SABCOHA Secretariat tried to support this initiative but did not have adequate resources until the sponsorship from the Metropolitan Foundation was confirmed. Prior to receiving this sponsorship SABCOHA and Metropolitan jointly conducted a series of 'Live the Future' workshops which used the scenario planning tool to engage in dialogue and mobilise individual and organisational responsibility for shaping the future.

SABCOHA has engaged with organised labour on several occasions in an attempt to identify opportunities for strengthening collaboration in implementation. The SACTWU Worker Health Programme renders a full package of HIV services to the clothing and textile manufacturing and retail industries, including education, HCT, treatment, care and support, and HBC. This programme reaches some 15 000 members and their dependants in the Western Cape using mobile teams. These and similar programmes within the business sector should be supported and expanded. Bargaining councils also provide unique opportunities for fostering partnerships between business and labour at industry level.

Business is consistently looking for new ways to improve the efficiency and effectiveness of risk management systems without compromising quality. To this end many companies expressed support for the ACTS protocol piloted in the Western Cape in 2007. Together with the public policy changes allowing the use of lay counsellors in HCT, proper training and quality assurance are fundamental in adopting such innovative practices.

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

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Context of implementation




WESTERN CAPE PROVINCE

Geography and demographics

The Western Cape Province is located on the southernmost tip of Africa and borders the Northern Cape in the north, Eastern Cape in the east, and the Atlantic and Indian oceans to the west and east respectively. The Western Cape is the fourth largest province in terms of land size covering 129 462 square kilometres, roughly 10.6% of South Africa.[2] The province has a population density of approximately 40.8 persons per square kilometre. The City of Cape Town is the provincial capital and accommodates 66% of the Western Cape population (Table 1) resulting in higher population density ratios. Major towns in the province include Stellenbosch, Worcester, Paarl, George, Knysna, Mosselbay, Franschoek, Plettenberg Bay, Saldanha, Hermanus, Grabouw, Bellville and Beaufort West.

The Western Cape offers oceans, mountains, winelands and national parks, making it one of the world's most sought-after tourist destinations. The province is home to two Unesco World Heritage sites: Robben Island and the Cape Floral Kingdom, which stretches from the Cape Peninsula to the Eastern Cape and comprising eight protected areas including the Table Mountain National Park. The province consists of one metropolitan municipality, the City of Cape Town, and five district municipalities, namely West Coast, Cape Winelands, Overberg, Eden and Central Karoo. These six municipalities are further subdivided into 32 sub-districts.

Table 1 shows that the Western Cape Province has a population of 5 278 585, which makes up 10.4% of the South African population. The 2010 mid-year population estimates show that 52% of the provincial population is female and 48% is male. A total of 60% of the coloured

2 South Africa.info. The Western Cape Province – the land and its people. Retrieved 2 February 2011 from: http://www.southafrica.info/about/geography/western-cape.htm

population in South Africa reside in the Western Cape, which is also the largest population group in the province at 50%. The majority of the Western Cape population, around 55%, are Afrikaans speaking, followed by Xhosa at 24% and English at 19%.[3]

Table 1 Western Cape population by racial group and municipality[4]

District	African	Coloured	Indian	White	Total	%
City of Cape Town	1 219 988	1 538 310	62 354	676 446	3 497 097	66.3%
West Coast	25 705	205 416	790	54 839	286 751	5.4%
Cape Winelands	146 200	463 522	3 207	99 484	712 413	13.5%
Overberg	42 534	126 885	620	42 747	212 787	4.0%
Eden	148 775	268 108	2 407	94 017	513 307	9.7%
Central Karoo	5 357	45 225	67	5 582	56 230	1.1%
Provincial	1 588 560	2 647 465	69 446	973 115	5 278 585	100.0%

Migration data for the period 2001–2006 indicates that the Western Cape lost and gained 117 060 and 361 476 people respectively resulting in a net gain of 244 416 people. The majority of inward migration is from the Eastern Cape Province in search of housing and healthcare services.[5]

Labour market and economy

The nature of industry, labour markets and employment across the six geographic districts differ considerably. Data sources are time specific, making comparisons across districts and major industries exceptionally difficult. Rounded data may also marginally affect percentage distributions. The Western Cape makes the third largest contribution to the country's gross domestic product, at 14.5%. Many of South Africa's major insurance companies, petroleum companies and retail chains have their head offices in Cape Town. These include Chevron, Shell, Old Mutual, Sanlam, Woolworths, Avon and Justine.

Table 2 shows that the major industry contributors to the Western Cape economy are finance, manufacturing and trade, together accounting for 64% of the provincial GDP. The Western Cape is the second largest importer and exporter of the agriculture industry in South Africa. Top import products include durum wheat and wheat seeds, rice, tobacco, aquatic invertebrates and beet seeds. Top export products include citrus fruit, apples and pears, grapes, other fruit and aquatic invertebrates. The province provides ideal conditions for the harvesting of A-grade fruits, including apples, pears, grapes, olives, peaches and oranges and a large variety of vegetables. The rich fishing grounds on the west coast produce catches of snoek, lobster, abalone, calamari, octopus, oysters and mussels. In addition to exporting fresh grapes, farmers also supply wine and beverage producers. Some of the renowned brands in the province include Fruit and Veg City, Appletiser, McCain foods, Pioneer foods, Parmalat, Sea Harvest, Distell and KWV. The manufacturing sector in the Western Cape is the third largest in South Africa with the clothing and textile industry providing significant employment to women.

3 Statistics South Africa. Census 2001: Primary tables Western Cape. Retrieved 2 February 2011 from: http://www.statssa.gov.za/census01/html/WCPrimary.pdf

4 Statistics South Africa. (2008) Community Survey 2007, Basic Results: Municipalities. Created on 11 February 2011.

5 Western Cape Department of Health. (2010) Strategic Plan 2010/11–2014/15 February 2010. Retrieved 20 January 2011 from:www.capegateway.gov.za/Text/2010/3/strat_p_2010_11_final_1.pdf

Table 2 Contribution to GDP by district

Major Industry	Contribution to GDP (million)[6]	Contribution to GDP (%)
Agriculture	R9 250	3.9%
Mining	R630	0.3%
Manufacturing	R40 077	16.8%
Utilities	R3 623	1.5%
Construction	R11 457	4.8%
Trade	R34 560	14.5%
Transport	R23 996	10.1%
Finance	R78 061	32.7%
Community and social services	R12 976	5.4%
General Government	R23 802	10.0%
Total	**R238 431**	**100.0%**

Figure 1 Western Cape Province, South Africa, with the six municipal districts and major towns

6 Wesgro IQ. (2011) Western Cape Gross Domestic Product by District and Industry. Received 27 January 2011.

Table 3 shows the distribution of the 1.8 million employees by major industry division. Comparing Table 2 and 3 shows that the top three contributors to the provincial GDP are also among the top industries in terms of providing employment. Comparing contributions to GDP and employment, finance and trade illustrate different levels of labour intensiveness. Community and social services largely comprises public sector employees. In certain districts and sub-districts government is the primary employer within the local labour market.

Table 3 Working age population and percentage employed[7]

Major Industry	Employed (Thousand)[7]	Employed (%)
Agriculture	122	6.9%
Mining	3	0.2%
Manufacturing	283	16.0%
Utilities	10	0.6%
Construction	130	7.3%
Trade	379	21.4%
Transport	112	6.3%
Finance	244	13.8%
Community and social services	377	21.3%
Private households	113	6.4%
Total	**1 772**	**100.0%**

Table 4 shows that the total working age population in the Western Cape was 3 591 672 in 2007. As at the end of 2010, a minor reduction in the working age population is recorded totalling 3.403 million, of which only 68% are economically active, i.e. either employed or seeking employment. The provincial unemployment rate of 24% is substantially below the national average of 35.8%. The total number of people not economically active is 1 072 000, which includes 24 000 discouraged work seekers. Only 10% of provincial employment falls within the informal sector (non-agricultural). The majority of employment is provided by the formal (non-agricultural) sector, accounting for 76.8%. Agriculture and private households each contribute just over 6% towards provincial employment rates. Employment across racial groups is proportional.

Table 4 Working age population and contribution to GDP by district

District	Working age population (15–64 years)[8]	Working age population (%)	Contribution to GDP (million)[9]	Contributition to GDP (%)
City of Cape Town	2 402 637	66.9%	R175 269	73.5%
West Coast	188 903	5.3%	R10 107	4.2%
Cape Winelands	478 945	13.3%	R27 544	11.6%
Overberg	141 649	3.9%	R6 853	2.9%
Eden	344 687	9.6%	R17 235	7.2%
Central Karoo	34 849	1.0%	R1 423	0.6%
Provincial	3 591 672	100.0%	R238 431	100.0%

Socio-economic profiles indicate that the Western Cape Province is better resourced and developed compared to other provinces. There are disparities in wealth, education level and socio-economic status, and between and within rural and urban areas.

7 Statistics South Africa. (2010) Quarterly Labour Force Survey quarter 4 Statistical Release P0211. Retrieved 9 February 2011 from: http://www.statssa.gov.za/publications/P0211/P0211February2011.pdf

8 Statistics South Africa. (2008) Community Survey 2007. Received 4 May 2010.

9 Wesgro IQ. (2011) Western Cape Gross Domestic Product by District and Industry. Received 27 January 2011.

The Western Cape Province has a strong network of tertiary institutions, including the University of Cape Town, Stellenbosch University, University of the Western Cape and Cape Peninsula University of Technology. These institutions are located in the City of Cape Town and the Cape Winelands district.

Table 5 shows that only 130 schools within the Western Cape are private out of a total number of 1 923 schools. This effectively means that 93% are public schools.

Table 5 Western Cape schools by district[10]

District	Sector	Primary	Secondary	Intermediate	Combined	Special needs education	Total
City of CT	Private	32	22	4	26	7	91
	Public	584	212	70	17	48	931
	Total	616	234	74	43	55	1 022
West Coast	Private	5	0	0	4	0	9
	Public	80	12	30	11	3	136
	Total	85	12	30	15	3	145
Cape Winelands	Private	3	0	1	6	0	10
	Public	191	46	28	11	10	286
	Total	194	46	29	17	10	296
Overberg	Private	6	0	2	5	1	14
	Public	52	14	11	6	2	85
	Total	58	14	14	11	3	100
Eden & Central Karoo	Private	1	0	0	5	0	6
	Public	154	156	29	10	5	354
	Total	155	156	29	15	5	360
Provincial	Private	47	22	7	46	8	130
	Public	1 061	440	168	55	68	1 792
	Total	1 108	462	176	101	76	1 923

The high school graduation rate is consistently around 80%, higher than in any other province. Table 6 shows the levels of education in the adult population.

Table 6 Population aged 20 years and older, by highest level of education[11]

Education levels	Western Cape Province total	Percentage distribution
No schooling	73 000	2%
Primary	514 000	15%
Secondary	1 242 000	37%
Grade 12/Std 10	972 000	29%
Higher	522 000	16%
Population over 20 years	3 323 000	100%

HIV and AIDS, and related social conditions

The five main contributors to the province's burden of disease, from highest to lowest, are major infectious diseases, injury, mental disorders, cardiovascular disease, and childhood

10 Western Cape Department of Education. (2009) Retrieved 7 October 2010 from: http://www.wced.wcape.gov.za
11 Western Cape Department of Education. (2009) Retrieved 7 October 2010 from: http://www.wced.wcape.gov.za

diseases. The single biggest risk factor for TB is concurrent HIV infection exacerbated by poverty, unemployment, overcrowding and migration. Common mental disorders such as depression, anxiety, substance misuse and childhood behavioural disorders contribute heavily to the burden of HIV and AIDS.[12]

The average life expectancy of South African females is 55.2 years and males 53.3 years. The Western Cape Province is estimated to have the highest life expectancy in the country: 66.5 years for females and 59.3 years for males.

The Western Cape was reported to have the second highest incidence of new smear-positive cases of TB in South Africa (518 in 100 000), with up to 90% of these patients falling into the economically active population group. However, the TB cure rate for the Western Cape in 2007 was 77.3%, which is just short of the national target of 78%.[13]

Table 7 shows that HIV prevalence amongst women who attend public antenatal clinics in the Western Cape Province has increased by 1.8% over a four-year period to 16.9%. However, this remains significantly below the national average of 29.4%. HIV prevalence differs considerably across districts. Specific reasons for changes year on year are not confirmed. The City of Cape Town carries the highest burden of the epidemic in terms of the actual number of HIV-infected pregnant women, constituting more than 70%.[14]

Table 7 HIV prevalence among antenatal clinic attendees in the Western Cape

District	2006 Prevalence	2007 Prevalence	2008 Prevalence	2009 Prevalence
City of Cape Town	17.0%	16.0%	17.9%	18.0%
West Coast	7.3%	10.1%	9.3%	9.5%
Cape Winelands	13.2%	12.8%	12.0%	13.2%
Overberg	13.0%	19.4%	15.9%	20.8%
Eden	11.5%	13.0%	13.0%	18.2%
Central Karoo	8.3%	23.6%	14.8%	11.8%
Provincial	15.1%	15.3%	16.1%	16.9%

When projecting the Antenatal Clinic Survey data to the entire population using actuarial modelling, prevalence rates look significantly different. Table 8 shows that the number of people estimated to be living with HIV in the Western Cape in 2010 was 318 115. This is similar to the estimate of the provincial department of health in Table 9 of 309 000.

Table 8 Western Cape HIV and AIDS demographic projections for 2010[15]

Whole population prevalence	6%
Adults (ages 20–64)	10%
People living with HIV	318 115
New HIV infections (over the year)	25 265
AIDS deaths (over the year)	16 924
Accumulated AIDS deaths	109 803
New infections per day	69
New deaths per day	46

12 Department of Health in the Provincial Government of the Western Cape. (2008) Western Cape Burden of Disease Reduction Project Abbreviated Report 2008. Retrieved 30 October 2009 from: https://vula.uct.ac.za/access/content/group/91e9e9d8-39b6-4654-00ae-f4d74cba085f/bodabbrrep08.pdf

13 Western Cape Department of Health. (2010) Strategic Plan 2010/11–2014/15 February 2010. Retrieved 20 January 2011 from: http://www.capegateway.gov.za/Text/2010/3/strat_p_2010_11_final_1.pdf

14 Department of Health South Africa. (2010) The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa 2009. Retrieved 13 December 2010 from: http://www.doh.gov.za/docs/reports/2009/antenatal/antenatal_report.pdf

15 Western Cape Department of Education. (2009) Retrieved 7 October 2010 from: http://www.wced.wcape.gov.za

Table 9 reports that 91 047 patients have been initiated on ART as at the end of December 2010 in the public sector out of an estimated HIV population of 154 499 people. According to this data 63 452 HIV-infected people may be in need of treatment. The number of these people that know their status or are receiving treatment from the private sector is unknown.

Table 9 HIV prevalence and ART uptake by district

District	Estimated HIV+ population TOTAL	Estimated HIV+ population CD4<350[16]	ART service points (Dec 2010)	On ART (Dec 2010)[17]
City of Cape Town	218 640	109 319	52	68 143
West Coast	10 430	5 215	5	2 743
Cape Winelands	33 613	16 807	13	8 914
Overberg	16 618	8 309	4	2 862
Eden	25 488	12 744	17	7 816
Central Karoo	4 211	2 105	2	569
Provincial	309 000	154 499	93	91 047

Studies conducted since 2000 show a steady increase in substance abuse in the Western Cape, most commonly alcohol, methamphetamine (commonly known as tik), mandrax, cocaine and heroin. The prevalence of lifetime alcohol use in the Western Cape ranges from 39% to 64%. Alcohol abuse is reportedly higher amongst farm dwellers in rural areas. Alcohol abuse increases risky sexual behaviour. Rates of condom usage are significantly lower when under the influence of alcohol. High rates of foetal alcohol spectrum disorders are evidence of alcohol misuse during pregnancy.[18]

Drug abuse is more prevalent amongst adolescents and youths and often used in conjunction with alcohol, contributing to school dropout rates. Tik is strongly associated with transactional sexual behaviours, mental health problems, violence, depression and anxiety.

CITY OF CAPE TOWN METROPOLITAN MUNICIPALITY

Geography and demographics

The City of Cape Town has a population larger than all the other districts in the Western Cape combined at 66.3% (Table 1). With a land size of 2 455 square kilometres, effectively 2% of the province, accommodating 3 497 097 people, the metropolitan municipality has a much higher population density ratio of 1 425 people per square kilometre. The City of Cape Town is the legislative capital of South Africa and houses several government offices including the national parliament.[19]

Three national roads start in Cape Town: the N1, which links Cape Town with Bloemfontein, Johannesburg, Pretoria and Zimbabwe; the N2, which links Cape Town with Port Elizabeth, East London and Durban; and the N7, which links Cape Town with the Northern Cape Province and Namibia.

The city is located on the shore of Table Bay and at the foot of Table Mountain; it is surrounded by Lions Head, Signal Hill and Devils Peak. The Cape Town Harbour is central to the city and is situated on one of the world's busiest trade routes. Cape Town remains one of the most

16 Western Cape Department of Health. (2010) A health profile of the Western Cape districts: The context for implementation of HIV care. Presented by Dr D Pienaar at Western Cape Business Sector Conference on HIV/AIDS and Wellness. 5 May 2010.

17 Western Cape Department of Health. (2011) Western Cape antiretroviral summary. Received 24 January 2011.

18 Harker, N., Kader, R., Myers, B., Fakier, N., Parry, C., Flisher, A., Peltzer, K., Ramlagan, S., & Davids, A. (2009). *Substance abuse trends in the Western Cape: A review of studies conducted since 2000*. Cape Town: HSRC Press.

19 City of Cape Town district municipality: Integrated development plan 2007–2011. Retrieved on 12 January 2011 from: http://www.capetown.gov.za/en.IDP/Documents/IDP_review_elephant_Jun_08_web.pdf

multicultural cities in the world, reflecting its role as a major destination for immigrants and refugees to South Africa.[20]

The City of Cape Town is divided into eight health sub-districts, namely; Eastern, Khayelitsha, Klipfontein, Mitchell's plain, Northern, Southern, Tygerberg and Western. These are then further grouped into four sub-structures.[21] The development of a district health service model was established in 2003 to better coordinate health services in the metropolitan municipality. A district health service model is a self contained segment of the national health system that services a well defined population, living within a clearly delineated administrative and geographical area and includes all institutions, individuals and interrelated elements contributing to health.[22] Each of the sub-districts has a comparative population.

By contrast, the City of Cape Town can also be demarcated into eight geographic areas, each of which has individual characteristics. There are distinct areas of great wealth and great poverty. The Atlantic Seaboard consists of suburbs such as Bantry Bay, Clifton and Llandudno, which include some of the most sought after and expensive properties in the world. Foreign property investments in these exclusive areas serve as international holiday homes to wealthy tourists. The older, more established suburbs such as Constantia and Bishopscourt, known as the Southern Suburbs, hold great historical value to Cape Town and are home to embassies, schools such as Rondebosch and Bishops, and the only vineyards and wine farms that lie within the city. In stark contrast is the Cape Flats, an expansive low lying 'flat' area to the south east of the city centre, developed during the apartheid era. This area houses much of the population of greater Cape Town and includes the two urban renewal nodes of Khayelitsha and Mitchells Plain. At least 41.4% of the City of Cape Town population speak Afrikaans followed closely by Xhosa at 29% and English being the least prevalent home language at 27.9%.

The township of Khayelitsha, meaning 'new home', was established in 1983. Khayelitsha is Cape Town's biggest township and the second largest in South Africa with a population of approximately 407 573. It is situated about 35km from Cape Town's central business district. It is commonly known as Cape Town's poverty trap. Khayelitsha was established as a dormitory town and its residents are essentially commuters. As a result, it lacks a significant economic base apart from the retail and services sectors. Commuters make use of public transport to travel to and from the city centre.[23]

Situated 15km outside of Cape Town, along the N2 towards Paarl, is Gugulethu. This township was established in the 1960s due to the overcrowding of Langa, which was the only black residential area in Cape Town at the time. Gugulethu is known for its high crime rate with a reported 700 murders since 2005, which equates to one murder every two-and-a-half days for five consecutive years.[24]

The Cape Town metropolitan municipality has three universities, namely the University of Cape Town in Rondebosch; The University of the Western Cape situated in Bellville; and four of the five campuses of the Cape Peninsula University of Technology.

Labour market and economy

The City of Cape Town is the economic hub of the Western Cape Province. The local economy is predominantly driven by the top three contributors to GDP, that is finance, manufacturing and trade. The City of Cape Town contributes 73.5% towards the provincial GDP (Table 4). Emerging industries include construction and informal sector agriculture.

20 Municipal demarcation board. City of Cape Town. Retrieved 12 January 2011 from: www.dermarcation.org.za

21 City of Cape Town district municipality: integrated development plan 2007–2011. Retrieved on 12 January 2011 from: http://www.capetown.gov.za/en.IDP/Documents/IDP_review_elephant_Jun_08_web.pdf

22 Western Cape Department of Health. (2010) A health profile of the Western Cape districts: The context for implementation of HIV care. Presented by Dr D Pienaar at Western Cape Business Sector Conference on HIV/AIDS and Wellness. 5 May 2010.

23 Western Cape Khayelitsha Nodal Economic Development Profile. (2006) Retrieved 5 February 2011 from: www.btrust.org.za/index.php

24 Mail & Guardian. (2010) Over 700 murders in Gugulethu since 2005. Retrieved on 6 February 2011 from: http://www.mg.co.za/article/2010-11-16

Core businesses include insurance, property development, architecture, fashion design, retail, advertising, publishing, shipping and petrochemicals. The establishment of the International Convention Centre as well as the property investment industry have played a major role in growing the economy of Cape Town. Community and social services, and private households contribute to livelihoods in impoverished townships such as Khayelitsha and Gugulethu. Cape Town also houses the primary harbour and an international airport.[25] The harbour is the second busiest container port in South Africa and handles the largest amount of fresh fruit. In addition fishing has an important place in the local economy in terms of exports and ship repairs. Large Asian fishing fleets use Cape Town as a transhipment logistics and repair base.

Table 5 and Table 10 show that the highest proportion or 70% of private schools are located in the City of Cape Town and 52% of public schools.

Table 10 City of Cape Town schools by sub-structure[26]

Sub-districts	Sector	Primary	Secondary	Intermediate	Combined	Special needs education	Total
Metro Central	Private	10	14	1	0	2	27
	Public	136	60	15	15	17	243
	Total	146	74	16	15	19	270
Metro East	Private	7	3	2	6	2	20
	Public	83	43	11	0	11	148
	Total	90	46	13	6	13	168
Metro North	Private	10	2	1	12	2	27
	Public	253	59	18	1	8	339
	Total	263	61	19	13	10	366
Metro South	Private	5	3	0	8	1	17
	Public	112	50	26	1	12	201
	Total	117	53	26	9	13	218
City of Cape Town	Private	32	22	4	26	7	91
	Public	584	212	70	17	48	931
	Total	616	234	74	43	55	1 022

HIV and AIDS, and related social conditions

The City of Cape Town is experiencing a huge burden of disease with substantial variations between areas. The leading cause of death in the area is AIDS followed by homicides. The City of Cape Town with its high population has a disproportionate number of people needing HIV treatment, care and support. From Table 7, the HIV prevalence rate in the metropolitan municipality has remained fairly constant over the past few years, last reported to be 18%. It is not surprising given poverty and unemployment that Khayelitsha is reported to have a HIV prevalence rate of 32.7%.[27] It further makes sense that Khayelitsha has the highest number of patients on ART, 26% of total, as illustrated in Table 11.

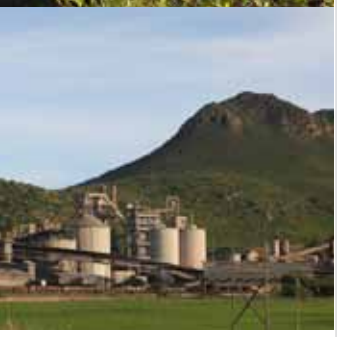
From Tables 9 and 11, a total of 64.9% of the 63 452 people that may be in need of treatment seem to be located in the City of Cape Town. The number of these people that know their status or are receiving treatment from the private sector is unknown.

25 Wesgro IQ. (2011) Western Cape Gross Domestic Product by District and Industry. Received 27 January 2011.
26 Western Cape Department of Education. (2009) Retrieved 7 October 2010 from: http://www.wced.wcape.gov.za
27 Department of Health South Africa. (2010) The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa 2009. Retrieved 13 December 2010 from: http://www.doh.gov.za/docs/reports/2009/antenatal/antenatal_report.pdf

Table 11 HIV prevalence and ART uptake in the City of Cape Town

Sub-district	Estimated HIV+ population TOTAL	Estimated HIV+ population CD4<350	ART service points (Oct 2009)	On ART (Dec 2010)
Southern	18 654	9 327	8	5 298
Western	26 201	13 100	12	10 576
Northern	26 164	13 082	4	4 949
Tygerberg	18 532	9 266	4	6 005
Klipfontein	33 423	16 712	4	6 403
Mitchells Plain	20 557	10 278	4	9 574
Khayelitsha	44 772	22 386	11	17 659
Eastern	30 337	15 168	5	7 679
City of Cape Town	218 640	109 319	52	68 143

Many households in Cape Town live in inadequate housing and depressed physical environments, including informal settlements. These areas are characterised by severe social and economic conditions, which manifest in high levels of poverty, unemployment, illiteracy, alcoholism, low health status and deviant behaviour such as crime and delinquency. Increasing crime levels have a negative impact on foreign direct investment and tourism. Substance abuse is a significant social determinant of HIV, especially among the youth.



WEST COAST DISTRICT MUNICIPALITY

Geography and demographics

This district comprises of five sub-districts and three district management areas, which are administered by the West Coast district municipality. The five sub-districts or local municipalities include Bergrivier, Cederberg, Swartland, Saldanha Bay and Matzikama.

The West Coast district municipality is 31 101 square kilometres with a total population of 286 751, 5.4% of the provincial total (Table 1). The West Coast has a predominantly coloured and Afrikaans speaking community.

The West Coast borders the Atlantic Ocean to the west, which is the source of the district's large and rich fishing sector. The eastern border is formed by a belt of sandstone mountains – the Cederberg, Gifberg, Matzikamma, Maskam, Koebee and Bokkeveld mountains. To the south is the Swartland, bordering the Cape Winelands district, with its wheat fields, vineyards, protea farms, fruit plantations, and indigenous veld flowers. Further south is the Cape Town metropolitan municipality. To the north is the Matzikama and Hardeveld, an extensive and sparsely populated area dominated by the Sandveld, known for its wild flowers and fynbos, this area borders the Northern Cape.

Saldanha Bay is South Africa's only natural harbour and is used for fishing and to export iron ore. The ore is transported to the harbour from the Northern Cape along a dedicated 800km railway line called Orex. Since the first shipment in 1976 the harbour has handled over 500 million tons of iron ore.[28]

Labour market and economy

The economy of the West Coast district is driven by manufacturing, fishing, and farming. The local economy is driven by many small suppliers and component manufacturers creating employment where otherwise there may be none. These businesses include the manufacture

28 Ports and Ships. Shipping and Harbour news out of Africa: The port of Saldanha Bay. Retrieved 5 February 2011 from: http://www.ports.co.za/saldanha-bay.php

and assembly of small parts supplied to motor manufacturers; steel processing plants; cement factories and raw materials processing.[29]

While the fishing industry provides significant employment in the district, strict quota systems have reduced the size of the industry. The West Coast is protected by a 200km commercial fishing zone. All commercial, subsistence and recreational fishing may only occur within this zone. Snoek, Cape lobster, abalone, calamari, octopus, oysters and mussels are among the delicacies produced in these waters. Inland coastal towns offer olive plantations and vineyards attracting tourists and locals alike.

The West Coast district is the fourth highest contributor to GDP in the Western Cape at 4.2% (Table 4). The establishment of further education and training colleges aims to promote skills development and the employability of local populations.

HIV and AIDS, and related social conditions

The West Coast has the lowest HIV prevalence at 9.5% (Table 7). A total of 2 743 patients had been initiated on ART as at end December 2010 (Table 9), serviced through five treatment outlets in the Citrusdal, Vredendal, Vredenberg and Oaklahoma hospitals and Piketberg Clinic.[30]

There is a high degree of illiteracy in the West Coast region which also has the least number of educational facilities, that is 145 (Table 5). It is estimated that 29% of the population older than 14 years of age are illiterate, resulting in a higher proportion of the labour force reliant on low- and semi-skilled employment in the agriculture, mining and fishing industries.[31]

Safety and security is a concern in the area, mainly due to an increase in unemployment and substance abuse. Tik is an emerging addiction amongst the youth in the West Coast district. Tik is a sexual stimulant which therefore increases the risk of HIV transmission. Substance abuse not only compromises HIV prevention but also negatively impacts on treatment adherence.

CAPE WINELANDS DISTRICT MUNICIPALITY

Geography and demographics

The Cape Winelands district consists of five local municipalities and one district management area. The local municipalities include Stellenbosch, Drakenstein, Witzenberg, Breede Valley and Breede River. The Cape Winelands is situated in close proximity to the City of Cape Town, with the towns of Stellenbosch and Paarl only 30 minutes drive to the city centre. The district covers more than 22 288 square kilometres, accommodating 13.5% of the provincial population (Table 1).

Afrikaans is widely spoken in the district, which is surrounded by mountains, farmlands and vineyards, offering hospitality and leisure destinations including wine farms, restaurants, museums and a nature reserve.

The N1 highway passes through the Cape Winelands district serving as a direct transport route between Cape Town and Johannesburg. In addition Route 62 remains the most popular tourist route as it includes all the major wine routes of Stellenbosch, Franschhoek, Paarl, Wellington, Tulbagh, Ceres, Worcester, Breedekloof, De Doorns, Robertson, McGregor, Bonnievale, Ashton and Montague.

Stellenbosch is a university town. However, its business activities have expanded significantly over the past few years.

29 Wesgro IQ. (2011) Western Cape Gross Domestic Product by District and Industry. Received 27 January 2011.

30 Western Cape Department of Health. (2011) Western Cape antiretroviral summary. Retrieved 24 January 2011.

31 West Coast district municipality. (2010) Integrated development plan: 2010–2014. Retrieved 12 January 2011 from: http://www.westcoastdm.co.za/Documents/wcdm_idp_2010_2014.pdf

Labour market and economy

There are approximately 10 528 businesses in the Cape Winelands and the district's economy is predominantly based on agriculture, manufacturing, wholesale and trade. Some of the agricultural products include table grapes, apples, pears, nectarines, plums and apricots. The Cape Winelands is a traditional supplier to this important economic sector, accounting for more than 39% of the country's area under deciduous fruit production in 2009.[32] Apples and pears are farmed mainly in the Ceres area while table grapes are grown predominantly in Paarl and the Hex River. Viticulture is dominant in Robertson, Worcester, Stellenbosch and Paarl. Fruit juice and poultry are also fast growing industries in the area. The main business hub in the district is Paarl, which has suppliers to the agricultural sector, high tourist trades and many independent wine farms.

The district has a challenge in terms of an insufficient and insecure labour market due to people being employed seasonally in agricultural and agro processing industries. The ratio of permanent to seasonal farm workers in the area is 0.69. As 85% of the agricultural sector comprises viticultural and deciduous fruit output in the district, the labour employment outlook of the region is directly linked to the performance of these crops. The Cape Winelands district is the second highest contributor to the Western Cape GDP at 11.6% (Table 4).

HIV and AIDS, and related social conditions

The Cape Winelands district antenatal prevalence rate is lower than the provincial average, 13.2% out of 16.9% (Table 7). A total of 8 914 patients are currently receiving ART (Table 9) from 13 public health facilities, namely Robertson Hospital, Brandvlei Correctional Facility, Brewelskloof Hospital, Worcester Hospital, Mbekweni Clinic, Phola Park Clinic, TC Newman Community Health Care, TC Newman Outreach – Dalevale Clinic, Wellington Clinic, Groendal Clinic, Idas Valley Clinic, Kayamandi Clinic and Ceres Hospital.[33]

From Table 9, the Cape Winelands has the highest number of HIV-infected people that may be in need of treatment out of the five district municipalities, at 12.4%. The number of these people that know their status or are receiving treatment from the private sector is unknown.

The level of education within the district is relatively low: 16% of the population have no schooling and half of the population have some primary education despite there being 296 educational facilities (Table 5). Distances and costs of transport in remote poor areas necessitate mobile or outreach healthcare services. Typically where there are vineyards and alcohol producers, alcohol abuse is one of the visible social factors requiring consideration.

The number of students enrolled at Stellenbosch University in 2010 was 27 694, of which 23 294 attended lectures at the Stellenbosch campus. This influx of students annually brings an ever-changing high-risk population in respect of HIV. Continuous education and prevention programmes are necessary to mitigate the transmission of HIV and impact of AIDS.[34]

OVERBERG DISTRICT MUNICIPALITY

Geography and demographics

The Overberg district consists of four local municipalities namely Theewaterskloof, Overstrand, Cape Agulhas and Swellendam and the Overberg district management area. The district has the second lowest population level at 4% (Table 1). The Overberg district is situated in the south of the Western Cape, borders the City of Cape Town to the west and forms the southernmost tip of Africa at Cape Agulhas, which represents the official dividing line between the Atlantic and Indian oceans. The region is surrounded by mountain ranges, a coastal plateau and forms

32 Murray, M. (2010) Key trends in the agricultural economy of the Cape Winelands District Municipality – Implications for farm workers and dwellers. June 2010. Retrieved on 5 February 2011 from: http://www.phuhlisani.com/oid%5Cdownloads%5C20100619CWDMAgricTrendsV04f%20edited.pdf

33 Western Cape Department of Health. (2011) Western Cape antiretroviral summary. Received 24 January 2011.

34 Stellenbosch University. (2011) Statistical Profile Core Statistics. Retrieved 5 February 2011 from: http://www.sun.ac.za/university/Statistieke/statseng.html

part of the Karoo landscape to the north. The natural environment is unique and includes large areas of indigenous fynbos vegetation.

Major access routes to the region are the N2 via Sir Lowry and Houw Hoek passes in the west, and Swellendam in the east. Cape Hangklip guards the coastal regional Route R44 in the west. Various mountain passes provide access from the north, including the R43, R45, R317 and R324.

Labour market and economy

The district contributes 2.9% to the provincial GDP (Table 4) the second lowest contributor. The local economy is driven predominantly by manufacturing, agriculture and tourism along the coastal towns. Crops harvested in the area include grains such as wheat, barley, oats, canola and grazing crops and deciduous fruit. Wine production occurs mainly in the Hemel-en-Aarde Valley, outside Hermanus, which yields some of the Cape's finest wines.[35]

Tourism has grown significantly in the past few years particularly during peak holiday periods and between August and November each year – the breeding season of the Southern Right whales. Many small and micro-sized enterprises can be found in the remote areas of Prince Albert and Bredasdorp. Elgin is well known for its apple orchards and is the home of Appletiser.

People in the area are dependent on seasonal work during harvest time and, as such, employment is precarious. This also extends to some businesses in the larger towns that are dependent on tourism for trade and income.

HIV and AIDS, and related social conditions

The Overberg district has the highest prevalence rate among antenatal clinic attendees in the province of 20.8%, exacerbated by factors such as mobility, migration and poverty. The district has 2 862 patients on treatment (Table 9). Patients are able to access treatment and care services at four public health facilities in the district, namely Hermanus Hospital, Swellendam Hospital, Caledon Hospital and Grabouw Community Health Care.[36]

Of the five district municipalities, the Overberg has the second highest number of HIV-infected people that may be in need of treatment out (8.6%, Table 9). The number of HIV-infected people who know their status or are receiving treatment from the private sector is unknown. Given the nature of the local labour market, however, many of these people will probably access treatment from the public sector.

A small portion of the Overberg population has some form of education, half of the district population has obtained some level of primary schooling and only a few have completed grade 12. The district has 100 educational facilities (Table 5) and one tertiary education facility. This coupled with the dependence on seasonal work in the area may lead to high numbers of young people migrating to urban areas in search of further education and job opportunities.

At least 28% of households in the Overberg district are living below the poverty line, that is earning less than R800 per month. Only 1.8% of the population falls within the high-income group with the majority (70%) classified as middle class.[37]

EDEN DISTRICT MUNICIPALITY

Geography and demographics

Eden is the largest district within the Western Cape in terms of land size with seven local municipalities, namely Bitou, Knysna, George, Hessequa, Mossel Bay, Kannaland, Oudtshoorn,

35 Wesgro IQ. (2011) Western Cape Gross Domestic Product by District and Industry. Received 27 January 2011.
36 Western Cape Department of Health. (2011) Western Cape antiretroviral summary. Received 24 January 2011.
37 Overberg district municipality. (2008) Local economic development strategy. Retrieved 12 January 2011 from: http://www.savebantamsklip.org/docs/odm_draft_led_200.pdf

and one district management area, which consists of the towns Haarlem and Uniondale. The district is home to almost 10% of the provincial population (Table 1) and borders with four other district municipalities, namely the Cacadu district in the Eastern Cape, Overberg and Cape Winelands in the west and the Central Karoo in the north.[38]

The Eden district is situated along the south-eastern coast of the Western Cape Province. It stretches for about 350km along the Indian Ocean, from the Bloukrans River in the east, to Witsand at the Breede River mouth in the west.

This region is often described as one of the most beautiful in South Africa, with the garden route as the centre of its tourism industry. The Eden district is characterised by high rainfall and dense indigenous forests.

Labour market and economy

The Eden district contributes 7.2% to the provincial GDP, making it the third largest contributor within the Western Cape (Table 4). The economic driving forces of the Eden district include agriculture, tourism, manufacturing and construction. The Garden Route is well known for its indigenous forests of yellowwood and ironwood, which sustain the areas forestry industry. Tourism in the area is seasonal and particularly high during the December period. Timeshare resorts and family holiday homes are popular. Golf is an economic driver, as the Garden Route offers golfing enthusiasts 12 golf courses within 100km. Fancourt hosts international golfing tournaments, bringing local and international visitors to George.

The manufacturing of food and beverages is clustered in small business nodes. Further east in the Karoo, sheep, cattle and ostrich husbandry, abattoirs and tanneries are key economic activities along with the farming of citrus and succulents.

Mossel Bay is home to the gas-to-liquid refinery of PetroSA following the discovery of natural offshore gas fields in 1969. The town also has a viable fishing industry and commercial harbour. Government is a significant employer in the district.

HIV and AIDS, and related social conditions

The Eden district has the second highest prevalence rate of 18.2% amongst antenatal clinic attendees (Table 7). Based on projections and actual data provided in Table 9, the 7 816 patients currently receiving ART from the public sector represent 38% of those people that may be in need of treatment. It is unknown as to how many of the remaining 62% know their HIV status or are receiving treatment from the private sector.

The district offers public health services at nine facilities; these are Plettenberg Bay CHC, George Clinic, Thembalethu CHC, Riversdale Clinic, Knysna Hospital, Knysna Stretch – Khayalethu, Knysna Stretch – Sedgefield, Mossel Bay Hospital, and Oudtshoorn Hospital.[39]

Unemployment and poverty are significant challenges within the Eden district. Low economic activity negatively affects job creation and employment opportunities, resulting in migration to other districts. In addition access to services and facilities is limited, which leads to patients not seeking HIV testing and treatment.

Furthermore it has been noted that the coastal police force faces some of the highest workloads in the province. The rate of increased drug-related crimes is high across the district, with the highest number of such crimes being reported in George, Bitou and Oudtshoorn.[40]

38 Eden district municipality. (2007) Integrated development plan 2007–2011. Retrieved 12 January 2011 from: http://www.capegateway/gov.za/idp_eden_district

39 Western Cape Department of Health. (2011) Western Cape antiretroviral summary. Received 24 January 2011.

40 Eden district municipality. (2007) Integrated development plan 2007–2011. Retrieved 12 January 2011 from: http://www.capegateway/gov.za/idp_eden_district

CENTRAL KAROO DISTRICT MUNICIPALITY

Geography and demographics

The Central Karoo district is the smallest in terms of population size (Table 1), representing a mere 1.1% of the provincial total, but largest in terms of land size, covering 38 853 square kilometres or 30% with long distances between neighbouring towns. It comprises three local municipalities, namely Beaufort West, Prince Albert, Laingsburg and one district management area, Murraysburg. Central Karoo is approximately 300km north west of Cape Town and 1 200km south west of Johannesburg along the N1. The district borders the Eastern Cape to the east and the Northern Cape to the north. The population is concentrated around the N1 highway connecting Gauteng and the Western Cape.[41]

Central Karoo is a semi-desert and forms part of the Great Karoo, which is classified as a unique arid zone. The land is rich in fossils and houses the largest variety of succulents in the world. The region has a low average annual rainfall of 260mm per year, most of its rain is received during summer, mainly between November and May, which differs from the rest of the province, which receives rain mostly during the winter months.

Apart from 2001, migration trends are outward and expected to continue until 2025. This is largely due to low economic activity and limited job opportunities.

Labour market and economy

The local economy of the Central Karoo is dependent upon agriculture, transport and trade. Beaufort West is the economic hub of the region and the connecting point for the N12 and the N1. The agricultural sector is predominantly rangeland sheep farming with the main emphasis on meat production. Small scale top quality deciduous fruit production occurs on the southern border of the district. The Karoo National Park and government departments are the biggest employers in the area. The Central Karoo district contributes the least to the provincial GDP. Emerging industries include leather manufacturing and fresh herb production – key job creation projects.

Females, Africans and the youth are more affected by unemployment, while males, whites and those in the older age groups (35–65 years) are more likely to be employed. A total of 71.1% of those employed in the Central Karoo district have incomplete secondary education levels or lower, an indication of medium to low skills in the labour market.

HIV and AIDS, and related social conditions

Central Karoo has an antenatal prevalence rate of 11.8%. Significant fluctuations in the annual survey data is evident (Table 7). No adequate explanation is provided apart from migration. A total of 569 patients have been initiated on ART (Table 9) through two public sector facilities in Beaufort West and Prince Albert.[42]

High illiteracy and low levels of education, together with limited opportunities for further education and employment, result in despondence amongst the youth and household dependency on social grants and remittance income from family members working outside the region.

Alcohol and drug abuse pose a serious threat to the overall wellbeing of communities. There are 153 illegal shebeens in the district, 86 in Beaufort West, 23 in Prince Albert and 60 in Laingsburg. An absence of parental supervision results in high levels of absenteeism from school and children turning to the streets to beg and steal.[43] Sex work along major trucking routes is a reality.

41 Central Karoo district municipality. (2007) Integrated development plan 2007–2011. Retrieved 12 January 2011 from: http://www.capegateway/gov.za/idp_central karoo_district

42 Department of Health South Africa. (2010) The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa 2009. Retrieved 13 December 2010 from: http://www.doh.gov.za/docs/reports/2009/antenatal/antenatal_report.pdf

43 Harker, N., Kader, R., Myers, B., Fakier, N., Parry, C., Flisher, A., Peltzer, K., Ramlagan, S., & Davids, A. (2009). *Substance abuse trends in the Western Cape: A review of studies conducted since 2000*. Cape Town: HSRC Press.


MR D's BARBER & HAIRSTYLE


4

Development of this plan



BACKGROUND

Following the successful establishment of SABCOHA's first provincial branch in the Northern Cape Province in March 2009, the Metropolitan Foundation expressed an interest to fund a similar project in the Western Cape. A workshop was held on 24 April 2009 to devise a project plan aimed at building on prior achievements and enhancing business sector commitments contained in the PSP. The Metropolitan Foundation confirmed their sponsorship and the project plan was finalised in May 2009. Most of the project objectives were met within 18 months. The adoption of this strategy by the elected Provincial Board of Governors represents the final deliverable. The total sponsorship amounted to R1 048 562.50.

The project purpose was to:

1. Develop and implement a sector-specific HIV and AIDS strategic plan that encompasses identified provincial multi-sectoral priorities and, comprehensively defines the Western Cape business sector's contribution to national policy goals and objectives, simultaneously accommodating district needs.
2. Strengthen cooperation and partnerships between business, government and civil society organisations aimed at improving service delivery.

Originally a provincial conference was envisaged at the start of the project to review implementation, based on the understanding that considerable consensus already existed within the business sector regarding priority interventions. This assumption was not supported by preliminary analysis and stakeholder engagement, and the conference formed a critical part of informing the development of this strategy. Processes, activities and achievements in this regard are summarised in the three subsequent subsections.

SURVEY

SABCOHA commissioned a survey amongst companies in the Western Cape Province at the end of October 2009 to inform the development of a Western Cape business sector strategy on HIV and AIDS. The survey aimed to quantify the business sector's achievements in responding to HIV and AIDS, inform future priorities and serve as a starting point for ongoing monitoring of sectoral investments.

A monitoring and evaluation technical task team comprising volunteers was established to offer practical learning and advice in respect of the survey methodology and design. This task team met twice on 23 November 2009 and 7 April 2010.

This is the largest and most comprehensive business sector survey that SABCOHA has undertaken to date. A total of 204 companies representing 202 928 employees in the Western Cape participated in the survey. This effectively represents 17% of employees within the formal business sector in the Western Cape. High refusal rates and incomplete data created significant challenges in respect of sampling and the calculation of identified indicators. Nevertheless, the survey yielded valuable insights, identified alternative indicators and produced important lessons learnt in respect of methodology and indicator selection. The final survey report was released in August 2010. A summary of key findings are presented below.

The indicators showed that most companies surveyed have an HIV and AIDS policy (74%), however fewer have translated this policy into HIV workplace programmes (58%). Overall HIV workplace programmes are only 30% comprehensive in terms of covering all the programme elements surveyed. An important observation of the business sector's response to HIV prevention is that although 53% of the companies surveyed provide HIV testing onsite (mostly once a year), only 17% of employees have reportedly taken up employer sponsored HIV testing onsite.

A limited number of treatment, care and support indicators could be calculated due to the challenge of low levels of reporting of the requested data. The total number of employees on treatment in the business sector in South Africa is an important monitoring and evaluation statistic for the national and global coordination of the response to HIV and AIDS. It is important to note that although 65% of companies surveyed provide access to employer sponsored ART, this results in the remaining 35% of companies forcing their employees to obtain alternative funding for treatment (out of pocket, through an NGO or the public health sector).

Human rights and access to justice seem to be communicated widely within the surveyed companies, with 70% of companies having used some form of communication on human rights. Only 1.7% of employees have however disclosed their status, indicating that some level of stigma remains.

Little monitoring, reporting and evaluation of HIV workplace programmes are currently done within the surveyed companies. Few companies have an M&E framework (24%) in place and are using it to monitor outputs that can be measured, and even fewer companies have evaluated the impact of their workplace programmes through actuarial studies (19%) or research (8%). Low levels of confidence about adequate skills and capacity to monitor and report on workplace programmes were reported.

Just over 50% of companies surveyed have a preauthorised CSI budget but only 13% to 15% of total companies extend various HIV programme elements to the employee dependants. Even fewer companies extend HIV programme elements to the community.

The analysis of the suggested M&E indicators on the surveyed data shows that much remains to be done to enhance the business response to HIV. The indicators vary widely between industries and sizes of companies surveyed. In general the larger companies have a more comprehensive response to HIV and AIDS on all levels. The indicators also illustrate the gaps in the business response that could easily and cost effectively be filled with the introduction of more HIV workplace programme elements and improved monitoring and reporting frameworks. A better strategy on HIV prevention in the workplace is needed to motivate and encourage

health-seeking behaviour, knowledge of HIV status and registration for treatment. The limited business response to HIV in the communities, from which the business sector ultimately draws its workforce, remains a challenge.

STRATEGY DEVELOPMENT

Widespread stakeholder consultation formed the critical approach adopted for the development of this strategy. SABCOHA first consulted member companies in the Western Cape and conducted extensive desktop research to identify additional key stakeholders across all six districts. From a relatively small starting point, the Western Cape contacts database increased to more than 650 contacts representing about 420 companies or organisations during the project period.

All six districts were visited within the first six months, ending November 2009. A total of 100 stakeholder consultations, involving more than 150 representatives from all sectors, were conducted during this period. These one-on-one stakeholder consultations culminated in a consultative conference planned for May 2010. A steering committee was established to support conference planning. This committee met three times between February and April and provided critical leadership in shaping the conference programme and content.

More than 170 delegates attended the conference held on 4 and 5 May 2010 at Spier, in Stellenbosch. The conference facilitators used the World Cafe or Large Group Event 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. A total of 500 votes and 146 substantive comments were received in response to the 30 preliminary interventions that emerged from the one-on-one stakeholder consultations. 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 coordination of a sectoral response to the National HCT campaign caused some delays in drafting this strategy. The draft strategy was released for public comment on 8 February 2011 and tabled at the PAC meeting on 9 February 2011. The SABCOHA Western Cape Board of Governors adopted the final strategy at its meeting on 1 March 2011 noting changes informed by comments received.

BRANCH ESTABLISHMENT

The proposed governance protocol was adopted by the steering committee on 17 March 2010 and a call for nominations was published in the 5th edition of the e-newsletter distributed to the provincial database on 1 April 2010. A total of 11 nominations were received. Nominee profiles were presented at the end of the first day of the conference facilitating election. In accordance with protocol, one seat was reserved for each geographic district. As such three of the 11 nominees were automatically appointed to represent their respective districts. No nominations were received for the West Coast and Eden districts, hence these seats were reserved. Given that the maximum number of seats on the Board was ten, only five of the remaining eight nominees could be appointed. Conference delegates voted for their top five candidates using the voting keypads. The MEC for Health, Mr Theuns Botha, officially announced and congratulated the successful governors on their appointment to the SABCOHA Western Cape Board at a cocktail function on the evening of 4 May 2010.

Elected Board members were as follows:

- City of Cape Town: **Siraaj Adams** – Senior Risk Manager, Qualsa Healthcare
- City of Cape Town: **Jenny Abernethy** – Occupational Health and Wellness Manager, Woolworths

- City of Cape Town: **Diane Ritson** – Chief Executive Officer, Siriti Africa
- City of Cape Town: **Dr Sugen Naidoo** – Chairperson, Emerging Market Healthcare
- City of Cape Town: **Oscar Solomons** – General Secretary, NAFCOC Western Cape
- Central Karoo: **Mzwandile Mjadu** – Park Manager, Karoo National Park
- Cape Winelands: **Daneel van Schalkwyk** – Human Resources and Wellness Manager, Pioneer Foods
- Overberg: **Pieter Swanepoel** – Executive Director, Krombee
- West Coast – **vacant**
- Eden – **vacant**

The Board, at its first meeting held on 2 July 2010, elected Dr Sugen Naidoo and Siraaj Adams as chairman and vice-chairman respectively.

District workshops aimed at supporting companies to develop and implement workplace HIV & AIDS and wellness programmes were strategically held in the Eden and West Coast districts on 13 and 15 September 2010 respectively. At these training sessions an appeal was made for outstanding nominations to fill the vacant district seats on the provincial board. The Board accepted the nominations of Nokuzola Mkontwana – Employee Wellness Manager: PetroSA GTL Refinery for Eden, and Joshua Domorog – Skills Development Facilitator: Arcelor Mittal for West Coast. Yaaseen van der Westhuizen – Human Resources Officer: Duferco Steel Processing will serve as the alternate representative for the West Coast.

The fourth-quarter board meeting was held on 16 November 2010. At this meeting, the Board approved the schedule of quarterly meeting dates for 2011.

5

Business sector Western Cape Strategic Plan


INTRODUCTION

A strategy is a comprehensive plan of action in the pursuit of a stated purpose. In summary, this Western Cape business sector strategy identifies actions and priorities in support of the two primary aims of the NSP namely:

- to reduce the number of new HIV infections by 50%.
- to reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV.

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 the strategy. 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 30 interventions (initiatives, projects or programmes) structured across three categories as follows:

- 11 company interventions
- 10 sectoral interventions
- 9 multisectoral interventions

SABCOHA will market this strategy and approach and lobby companies to take responsibility for implementing company 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 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 30 interventions by priority and probability resulted in short-listing ten of the interventions as top priorities for immediate action set out in the 10-point priority plan on page 45.

In evaluating the interventions, consider the following:

- An alternative to fewer interventions is more targeted interventions focusing on most at-risk populations. From an economic perspective, identify and prioritise your critical path skills in relation to your operation or production process. This could inform a comprehensive starting point for continual improvement and expansion.
- Recent research narrows the divide between prevention and treatment interventions. Antiretroviral therapy reduces an individual's viral load thereby lowering risk of transmission.
- Horizontal conversations and ongoing 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 NSP. 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.

LIVE THE FUTURE SCENARIOS

In 2006, Metropolitan launched the Live the Future scenarios as a powerful tool to inspire and shape responses to HIV and AIDS. The scenario model is the flagship project of the Metropolitan Foundation. Metropolitan developed a set of scenarios to describe the impact of HIV and AIDS, and the resulting possible futures for South Africa in 2025. The scenarios were first created by using robust actuarial models and many years of data and research to support the statistics. The Metropolitan Foundation continues to run workshops using the scenarios as a tool for communities and workplaces to define their contributions to shaping the future.

Scenario matrix:

Key characteristics of each scenario:

1. **Winter of Discontent:** weak self-serving leadership; few partnerships; focus on blame, stigma and conspiracy; no behaviour change: drugs, sexual violence, gender inequality; contradictory beliefs about HIV and AIDS; high crime; AIDS response: fake cures, corrupt systems.
2. **Autumn of Limited Opportunity:** leadership driven by growth; exclusive partnerships; significant income differentials; treatment and care is available, prevention is lacking; little behaviour change; gender inequality and sexual violence; AIDS response intellectualised; limited acceptance of HIV positive people.
3. **Spring of Hope:** Idealistic broad-based but uncoordinated leadership led by communities; small duplicating partnerships; powerful pockets in civil society responding well; focus on acceptance and care; moderate behaviour change; better gender equality; AIDS response: chronic, manageable disease.
4. **Summer for all People:** Strong collaborative leadership committed to a developmental society and led by government; effective large scale public–private partnerships; focus on prevention, also provision of treatment and care; personal responsibility for health; widespread behaviour change; strong social net; integrated AIDS response.

In May 2010, over 50% of participants at the SABCOHA Western Cape conference believed that the province was currently in the Autumn of Limited Opportunity scenario. When asked to vote on where the Western Cape would be in five years time, 80% said Spring of Hope. This strategy promotes coordination, cooperation and partnership across sectors. It presents a comprehensive set of interventions as well as a shortlist, recognising that leadership, commitment and responsibility at all levels is necessary to reach a Summer for all People.

GUIDING PRINCIPLES

The principles guiding the implementation of this plan are as follows:

- **Responsibility:** *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 and wellness.

- **Participation:** at provincial, district and sub-district levels and within and across sectors.
- **Leadership:** persuade leaders to actively communicate important messages about HIV and AIDS aimed at changing social attitudes and behaviours.
- **Accountability:** transparent reporting of data promoting collective accountability.
- **Wellness:** building health, routine wellness screening and HIV testing, and earlier diagnosis and treatment.
- **Access:** expand provision of services to partners and dependants.
- **Partnership:** promote public–private partnerships in service delivery.
- **Prioritise:** focus on vulnerability within available means.
- **Quality assurance:** adherence and compliance to standards and protocols assures health and a return on investment.

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 five-year strategic plan; targets have been established from 2011 until 2015. This strategy will overlap the current and future NSP. Realignment to new national priorities may be required mid-term. The targets are cumulative and informed by what SABCOHA as the sector coordinating body estimates will be reported year on year. As a result the targets may seem conservative. There is an enormous difference between outputs achieved and outputs measured and reported.

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 priority areas, goals and objectives of the current NSP, the four priority areas of which are as follows:

1. Prevention
2. Treatment, care and support
3. Monitoring, research and surveillance
4. Human rights and access to justice

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

COMPANY INTERVENTIONS

	Intervention	Rationale	NSP alignment			5-year target				
			Priority area	Goal	Objective	2011	2012	2013	2014	2015
1	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	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. The management system approach recommended by SANS 16001 integrates assessment, planning, implementation, monitoring and evaluation, ensuring relevance and continual improvement in response strategies.	1	2	2.4	50 companies	100 companies	175 companies	275 companies	400 companies
2	Establish, review and communicate an HIV & AIDS and wellness policy and related workplace procedures that express overall direction and demonstrate commitment to implementation	Policies not complemented by written procedures often lack substance and guidance for implementation. Procedures provide options and steps available to and required by employees in specific situations. Both the policy and procedures should be reviewed routinely and widely communicated to employees and targeted populations to have effect.	1	2	2.4	50 companies	100 companies	175 companies	275 companies	400 companies
3	Identify and train behaviour change agents that can influence, teach and support positive and health-seeking behaviour in others	Peer education using horizontal, personal communication channels remains effective in promoting positive behaviours including avoiding HIV infection, knowing your status, accepting others who are positive and accessing HIV treatment. Where companies with high labour turnovers are reluctant to invest in training of peer educators they 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.	1	2	2.1	500 agents	650 agents	1 000 agents	1 500 agents	2 000 agents
4	Routinely provide comprehensive wellness screening and HCT, consistent with national policy, to employees and where possible extend to spouses/partners, dependants and the broader community	HCT is the entry point to prevention, treatment and care and support, and is therefore the key intervention for realising national policy goals. Complementary screening for hypertension, diabetes, anaemia, TB, other STIs, cholesterol and BMI reinforces health-seeking behaviour, promotes employee wellness, reduces vulnerability to HIV infection and destigmatises participation within the workplace. Costs can be recovered for employees on medical schemes. Social mobilisation to motivate individual participation is a necessary element of planning and implementation.	2	5	5.1	297 210 employees (25% of formal business sector)	356 652 employees (30% of formal business sector)	416 094 employees (35% of formal business sector)	475 536 employees (40% of formal business sector)	534 978 employees (45% of formal business sector)

GOAL 1: REDUCE VULNERABILITY TO HIV INFECTION AND THE IMPACT OF AIDS

	Intervention	Rationale	NSP alignment			5-year target				
			Priority area	Goal	Objective	2011	2012	2013	2014	2015
5	Communicate a comprehensive procedure detailing public and private treatment options available to individuals testing positive, prior to HCT implementation, to enable effective referral	Companies often have complex and variable treatment options. These may include multiple medical schemes, employer-funded or community treatment programmes, public health services and/or combinations thereof. Lack of accessible information and complicated registration processes can act as barriers to treatment. A written procedure that provides a step-by-step guide for all available treatment options will enable effective referral whereby specific details on where, when and how to access treatment services is communicated, e.g. address, opening times, special requirements such as referral letter, identity document, costs, transport, etc.	2	5 & 6	5.2 & 6.1	50 companies	100 companies	175 companies	275 companies	400 companies
6	Implement systems and procedures to identify and mitigate defaulting and treatment interruption to ensure optimal adherence and health benefit	Companies only realise a substantial return on employee health and wellness investments when HIV positive employees access treatment in time and continuously take their medication correctly: right way + right time + right dose = good adherence. This should result in reduced absenteeism and increased productivity. Companies should review and improve adherence support and follow-up mechanisms.	2	6	6.2	50 companies	75 companies	100 companies	125 companies	150 companies
7	Provide onsite care and support services for employee wellness and encourage active participation in wellness support groups and other initiatives	Many companies implement EAPs offering telephonic and/ or face-to-face information, advice and counselling services to employees for a range of personal stresses and challenges often compounded by HIV. HIV can also be an underlying cause and risk. Group and peer learning through workplace support groups can be an effective complementary or alternative approach to providing care and support to employees as caregivers or those infected with HIV.	2	6	6.4	50 companies	100 companies	175 companies	275 companies	400 companies
8	Cultivate an environment of non-discrimination by challenging beliefs, perceptions and stereotypes resulting in an organisational culture conducive to disclosure	Disclosure of one's HIV positive status is a personal choice and often a lengthy process. Disclosure in an open and supportive environment can have significant health benefits. The consequences of hostility and prejudice can be equally damaging whether caused by ignorance or inhumanity. Very few disclosures take place in the workplace for fear of job loss or occupational detriment despite human and legal rights, and workplace policies denouncing discrimination.	4	17	17.3	50 companies	75 companies	100 companies	125 companies	150 companies
9	Establish internal systems aligned to accepted indicators for routine monitoring, performance measurement and external reporting	If you cannot measure do not implement. Expenditure not linked to an objective with measured outputs is wasteful. Establish indicators and targets to measure success. Develop and maintain tools and document management processes to support measurement. Tools can be paper-based or electronic using MS office software. Programmatic audit considerations should inform design. Report workplace programme output data on Bizwell, the web-based business sector M&E reporting tool developed and managed by SABCOHA. Bizwell provides useful tools and resources.	3	9	9.1	50 companies	100 companies	175 companies	275 companies	400 companies

GOAL 1: REDUCE VULNERABILITY TO HIV INFECTION AND THE IMPACT OF AIDS

	Intervention	Rationale	NSP alignment			5-year target				
			Priority area	Goal	Objective	2011	2012	2013	2014	2015
10	Increase the scope and capacity of occupational health and safety to include HIV services	In the context of occupational health and safety, HIV is managed as a risk rather than a personal health service. Occupational health services do not automatically include HCT and HIV treatment management despite the critical link between TB and HIV and the global imperative of integration. Medical skills are a scarce resource and companies should consider the cost-benefit of comprehensive and integrated services.	2	6	6.5	50 companies	75 companies	100 companies	125 companies	150 companies
11	Oblige suppliers to develop and implement workplace HIV & AIDS and wellness response strategies	Suppliers not managing employee wellness and HIV threaten sustainability of the entire value chain exposing companies to operational risk. Suppliers should be required to develop and implement workplace programmes appropriate to assessed risk. Suppliers to larger companies are often SMMEs. Larger companies can share expertise, offer technical assistance, mentor suppliers and facilitate access to funding as part of their own risk management strategy.	1	2	2.4	10 companies	20 companies	30 companies	40 companies	50 companies

SECTORAL INTERVENTIONS

	Intervention	Rationale	NSP alignment			5-year target				
			Priority area	Goal	Objective	2011	2012	2013	2014	2015
1	Implement a 2-day training programme that combines business and life skills with HIV & AIDS and wellness information and education for very small and micro-sized enterprises	Enterprises employing less than 10 employees create significant employment opportunities and are often family businesses. Other commonalities include a high proportion of women; narrow profit margins; survivalist in nature; often located in rural areas and have limited access to information, services and support. If ignored, HIV and AIDS could result in rapid closures. It is neither feasible nor realistic for these small enterprises to implement workplace programmes. As such, SABCOHA trains owners of these vulnerable enterprises in basic business skills and risk mitigation, including HIV, through a programme called BizAIDS. Very small enterprises employing up to 20 employees especially in rural settings may also be appropriate programme beneficiaries.	1	1	1.7	1 000 enterprises	2 000 enterprises	2 500 enterprises	3 000 enterprises	3 500 enterprises
2	Provide technical assistance to small and medium-sized enterprises to develop institutional capacity for the design and implementation of effective workplace programmes	SMEs seldom have the capacity to appoint specialised skills to develop and establish workplace HIV & AIDS and wellness programmes. Maintenance of programmes is fairly easy once skills, strategies and systems are established. SABCOHA has offered a capacity development programme for SMEs since 2007. Companies employing no more than 250 employees qualify. Participating companies are assisted with assessing workplace HIV and AIDS risk; training of managers, champions, steering committee members, peer educators; developing and implementing a policy and response strategies; conducting KAP surveys and M&E. This programme is complemented by 1-day district workshops.	1	2	2.4	10 enterprises	20 enterprises	30 enterprises	40 enterprises	50 enterprises
3	Coordinate and maintain a national network of peer educators to be supported through communication tools, telephonic psychosocial support and mentorship	Many companies have already trained peer educators or change agents. One of the fundamental obstacles to sustainability is effective coordination 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.	1	1	1.4	500 agents	650 agents	1 000 agents	1 500 agents	2 000 agents
4	Market the value and employability of student peer educators to prospective employers through a 'graduates of choice' programme positioning participation as aspirational	Partner with tertiary academic institutions that implement student peer education programmes to promote the employment of graduates who have been trained and are active as peer educators during their studies. These graduates are more likely to have adopted positive behaviours presenting lower risks to prospective employers. Prior training would further result in savings to prospective employers who are able to seamlessly integrate them into similar workplace interventions. In addition to greater life skills, these graduates are more likely to demonstrate community conscience.	1	2	2.1	20 graduate profiles	60 graduate profiles	140 graduate profiles	260 graduate profiles	420 graduate profiles

	Intervention	Rationale	NSP alignment			5-year target				
			Priority area	Goal	Objective	2011	2012	2013	2014	2015
5	Increase the number of serviced condom distribution outlets in public thoroughfares such as petrol forecourts and taverns	Access to condoms in high traffic public locations remains a primary objective for prevention of STIs. Each outlet requires regular servicing necessitating effective logistics management. This is best achieved through a public–private partnership similar to SABCOHA's Project Promote which successfully distributes government condoms via the contract cleaning industry. Plans to extend outlets to taverns are well advanced.	1	2	2.5	50 serviced outlets	150 serviced outlets	300 serviced outlets	350 serviced outlets	400 serviced outlets
6	Establish HCT and wellness screening services at shopping nodes targeting employees of retailers, their suppliers and consumers	SABCOHA established a community fund to support the expansion of HCT to vulnerable and high-risk populations. This initiative *inter alia* seeks to raise funds from retailers to jointly implement a testing and screening programme at targeted shopping malls, centres, complexes, etc., enhancing economies of scale. Large retailers have dispersed transient workforces comprising a high proportion of women and young people. Independent smaller retailers and small town outlets are typically underserviced.	2	5	5.1	5 shopping nodes	10 shopping nodes	15 shopping nodes	20 shopping nodes	25 shopping nodes
7	Mobilise medical schemes to partner with HCT service providers and client companies to improve HCT uptake of scheme dependants ≥ 12 years	HIV and AIDS is a prescribed minimum benefit and as such funding for HCT and treatment is covered regardless of the scheme option. The Council for Medical Schemes issued diagnosis and procedural codes for point-of-care HCT and wellness screening in April 2010 to facilitate the processing of claims in support of the national HCT campaign. Reaching and influencing scheme dependants to test is far more challenging than employees. The impact of employee testing and treatment is significantly enhanced if spouses, partners and family members receive the same services. Spouses and children covered as dependants under the principal member's scheme should be targeted through tailored social mobilisation strategies e.g. voucher schemes, family days.	2	5	5.2	38 310 Dependants (10% of estimated provincial total ≥ 12 years)	57 466 Dependants (15% of estimated provincial total ≥ 12 years)	76 621 Dependants (20% of estimated provincial total ≥ 12 years)	95 776 Dependants (25% of estimated provincial total ≥ 12 years)	114 931 Dependants (30% of estimated provincial total ≥ 12 years)
8	Unlock SETA funding to recover costs of workplace training and skills development in HIV & AIDS and wellness	The National Skills Development Strategy lll requires all SETAs to mainstream HIV and AIDS in their skills development initiatives. In order to unlock funding, training service providers need to be accredited with the Services SETA. Additionally, learning programmes need to comply with the respective registered unit standard issued by SAQA. HIV and AIDS learning outcomes fall under fundamental and general unit standards. Accreditation can be time consuming and costly for service providers but it is important for company levy claims and learners to obtain recognition or credits towards qualifications. These and other barriers should be investigated and addressed to the benefit of all stakeholders.	1	2	2.4	Establish technical task team	Ongoing	Ongoing	Ongoing	Ongoing

	Intervention	Rationale	NSP alignment			5-year target				
			Priority area	Goal	Objective	2011	2012	2013	2014	2015
9	Establish a database and booking agency through which participating company employees can volunteer services to community organisations	Community service organisations typically lack skills in planning, fundraising, bookkeeping, financial management, administration, human resources, organisational development, communication, marketing, etc. This compromises their ability to render specialised core services to targeted communities in a sustainable manner and increases reliance on external donor funding. Employee willingness to volunteer time and expertise should be supported by their companies through the establishment and participation of a community networking tool linking supply and demand to foster community service and *ubuntu*.	1	1	1.7	Identify existing partners, secure resources & design tool	5 participating companies	10 participating companies	15 participating companies	20 participating companies
10	Empower women to make informed choices about reproductive health in the fulfilment of their needs and risk reduction through the dissemination of education and promotional materials on rights and services	Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy and death. Whilst reproductive health should be understood broadly as the physical and psychosocial wellbeing of women, it is helpful to list related interventions as follows: sexual health education and communication; sexual violence; female mutilation; family planning; STIs; prenatal care and delivery; unsafe abortion.	2	2	2.6	Material disseminated biannually	Ongoing	Ongoing	Ongoing	Ongoing

MULTI-SECTORAL INTERVENTIONS

	Intervention	Rationale	NSP alignment			5-year target				
			Priority area	Goal	Objective	2011	2012	2013	2014	2015
1	Bring marketing and communication experts together to develop targeted and effective messaging and distribution strategies for positive behaviour change	Business employs specialised skills to position, package and sell their products and services. Advertising content distributed through multi- and new media is used to dramatically influence consumer behaviour. This intervention seeks to apply these creative techniques to HIV & AIDS and wellness inspiring health-seeking behaviour and positive living, reinforcing prevention, access to services and non-discrimination. Jointly developing content and distribution strategies will enable consistent messaging, increasing impact. The cost of distribution will need to be budgeted and sourced separately.	1	1	1.5	Concept development and commitment to participate	1 campaign	2 campaigns	3 campaigns	4 campaigns
2	Develop public private partnerships to expand access to HIV & AIDS and wellness services afterhours to populations with unmet demand	Whether paid or unpaid, once off or frequent, employees requiring time off work risk stigmatisation, creating a barrier to accessing services during working hours. This intervention involves identifying geographic areas that are underserviced or where there is a concentrated population of working men and women that would benefit from having access to health services afterhours. Consult partners and sponsors to provide funding, infrastructure (premises), material (equipment, medicines, consumables), skills (doctors, nurses, counsellors, pharmacists) and pathology services. Consider convenient access on commuter routes. Mbekweni afterhours clinic is an example of success.	2	6	6.1	Plan and resource	1 site	2 sites	3 sites	4 sites
3	Expand access to workplace clinics, where appropriate, to contractors, families and communities through public–private initiatives	Healthy communities make for healthy workforces. Operations offering healthcare services within the workplace have existing infrastructure and capacity that can be extended to communities' surrounding operations on a cost-recovery basis. Servicing families and households is not only comprehensive but produces more favourable health outcomes. These facilities will optimise scarce clinical resources and beneficiaries will save time and transport costs. Collaboration between business and government in establishing workplace community clinic services and referral is essential. Industry associations and bargaining councils may offer similar opportunities for partnership.	2	6	6.5	Consult and identify	1 site	2 sites	3 sites	4 sites
4	Increase the scope of workplace and occupational health services to include distribution of chronic medicines, supplied by government, and treatment management of chronic illnesses	These services could be provided through interventions 2 and 3 above but the difference is that this intervention focuses specifically on monitoring and managing chronic illnesses including TB, HIV, diabetes, hypertension, heart disease, asthma, etc. Workplace management will improve adherence, reduce time off work and contain public sector patient volumes. This will in turn increase productivity, save employee sick leave and open up public services for those most in need. Systems to manage logistics and accountability reporting from business to government will be required.	2	6	6.5	Identify demand and establish systems	Track company participation and patient numbers	Ongoing	Ongoing	Ongoing

	Intervention	Rationale	NSP alignment			5-year target				
			Priority area	Goal	Objective	2011	2012	2013	2014	2015
5	Extracurricular schools-based initiatives to be coordinated through an established mechanism to promote effective information sharing and optimal allocation of resources	Duplication and fragmentation of schools-based interventions results in inefficient use of resources and substantially reduces impact. A mechanism for monitoring and reporting should be identified and developed promoting information sharing, coordination and evaluation for improved outcomes including leading healthier, more fulfilling lives. Extracurricular projects and programmes are often managed by independent donor-funded organisations or service providers. Targeted beneficiaries can include learners (the future workforce) or the broader community. Related initiatives of the Western Cape Education Foundation should be supported.	1	2	2.2	10% schools participating	20% schools participating	30% schools participating	40% schools participating	50% schools participating
6	Develop a positive parenting programme and curriculum that can be used and offered by all sectors within workplaces, communities, schools, etc.	Successful behaviour change programmes differentiate between preaching and teaching. Teaching and skilling parents to lead by example and communicate openly with their children will promote positive behaviours within the entire household. Training content can be adjusted for different audiences and child age bands using a learning outcomes approach. Ideally this programme should be linked to SAQA standards and be SETA accredited.	1	2	2.3	Development	Development and piloting	Distribution and Implementation	Ongoing	Ongoing
7	Collaborate and support initiatives that provide, enable and promote food access and improved nutrition	An unhealthy diet is characterised by a high fat, low fibre, low fruit and vegetables, and high salt and sugar intake. An unhealthy diet and lifestyle significantly increases the burden of disease and mortality rate. Since HIV weakens the body's immune system, good nutrition and positive lifestyle choices can significantly contribute to improved health. Interventions that promote access to nutritional food including healthy canteens, food gardens, food parcels, food outlets, feeding schemes, and tuckshops, as well as education on nutrition and food preparation should be considered. Directly aligned to the objective of healthy diets are interventions that promote physical activity.	1	1	1.1	Profile existing business and government initiatives	Align and support initiatives	Ongoing	Ongoing	Ongoing
8	Mobilise and support initiatives aimed at reducing substance abuse and promoting responsible alcohol use	Alcohol and substance abuse are substantial determinants of mental health disorders in the Western Cape. Drug and alcohol abuse increases susceptibility to HIV infection if it leads to risky sexual behaviours. Injecting drugs and needle sharing exponentially increases risk. Alcohol also acts as an immune suppressant and binge drinking or alcoholism can speed up disease progression. Substance abuse can consign people to vicious poverty cycles further perpetuating HIV risk. Substance abuse also results in significant losses to business due to high absenteeism and low productivity.	1	2	2.8	Identify existing initiatives and gaps	Design and implement joint projects or programmes	Ongoing	Ongoing	Ongoing
9	Improve collaboration in the dissemination and sharing of research findings and jointly identify research needs and agree on priorities	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, 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.	3	11	11.1	Establish and maintain repository	Discuss Priorities	Ongoing	Ongoing	Ongoing

10-POINT PRIORITY PLAN

Two criteria were used to shortlist the 30 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.

6/11 company interventions:

1. 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.
2. Identify and train behaviour change agents that can influence, teach and support positive and health-seeking behaviour in others.
3. Routinely provide comprehensive wellness screening and HCT, consistent with national policy, to employees and where possible extend to spouses/partners, dependants and the broader community.
4. Communicate a comprehensive procedure detailing public and private treatment options available to individuals testing positive, prior to HCT implementation, to enable effective referral.
5. Establish internal systems aligned to accepted indicators for routine monitoring, performance measurement and external reporting.
6. Oblige suppliers to develop and implement workplace HIV & AIDS and wellness response strategies.

3/10 sectoral interventions:

1. Implement a 2-day training programme that combines business and life skills with HIV & AIDS and wellness information and education for very small and micro-sized enterprises.
2. Provide technical assistance to small and medium-sized enterprises to develop institutional capacity for the design and implementation of effective workplace programmes.
3. Coordinate and maintain a national network of peer educators to be supported through communication tools, telephonic psychosocial support and mentorship.

1/9 multi-sectoral interventions:

1. Develop public–private partnerships to expand access to HIV & AIDS and wellness services afterhours to populations with unmet demand.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6

Requirements for effective implementation



MOBILISATION FOR THE STRATEGY

Participation – this is a key foundation for effective implementation. Broad-based and transversal participation will breathe life into this strategy, taking the interventions off the pages and into workplaces and communities.

- Mobilising business to own this strategy and prioritise its implementation requires immediate action. SMEs 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 PAC 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. The Western Cape PAC and DoH have secured just over R1 billion from the Global Fund, which

runs concurrently with the term of this strategic plan. Much is in place to suggest that all interventions advocated by this strategy will be realised and will be effective. What remains is for businesses to commit resources to the interventions contained herein. Resource commitment will include financial and human resources.

- 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, this will be evidenced by their knowledge of HIV and AIDS, appreciating the economic risks threatening their value chain, compassion for their communities and the confidence that the interventions promoted in this strategy are realistic, achievable and the outcomes of which will have a positive impact on mitigating the HIV risk in their environment.
- Human resources – 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, 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 proactivity on the part of the business will see the exploitation 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.
- SABCOHA Western Cape Board of Governors to be represented on the PAC ensuring alignment to provincial priorities.

7

The way forward



The actions listed below require immediate attention.

MARKETING

This strategy must be marketed creatively and broadly. Its rapid uptake is a critical success factor. This can be achieved through:

- Breakfasts
- HIV conferences
- Media
- Other forums

CAPE TOWN BASED OFFICE AND COORDINATOR

Having an office and a human resource physically present in the City of Cape Town and dedicated to implementation of this strategy over five years with the prospect of extending into the future will be a demonstration of SABCOHA and the business sector's commitment to having a presence in the Western Cape. This will not be possible without growth in provincial membership and sponsorship given declining donor funding.

DEMONSTRATING BUSINESS' COMMITMENT TO HCT AND BIZWELL

Active marketing of Bizwell and increasing coverage of responsible reporting companies registered on this web-based sectoral monitoring and reporting tool will foster relationships with government and the DoH in particular. This will add significant value and extend opportunities for gap analysis and public–private partnerships. The impetus generated by the HCT campaign forms a strong platform for the expansion of the tool to record and report more broadly on HIV and AIDS workplace initiatives implemented within the business sector.

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Acknowledgements



Steering committee

- Ms Bernadette Smith – Employee Wellness Coordinator, Chevron Africa Pakistan Services Company
- Ms Diane Ritson – Chief Executive Officer, Siriti Africa
- Mr Jeremy Wiley – Immediate Past President, Cape Regional Chamber & Chief Executive Officer, De Goede Hoop Group
- Ms Louise Lackenby – Chief Operations Officer, Cape Consulting
- Ms Nathea Nicolay – Programme Director Health Unit, Metropolitan Foundation
- Mr Oscar Solomons – General Secretary, NAFCOC Western Cape
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Board of Governors

- City of Cape Town: Siraaj Adams – Senior Risk Manager, Qualsa Healthcare
- City of Cape Town: Jenny Aberbethy – Occupational Health and Wellness Manager, Woolworths
- City of Cape Town: Diane Ritson – Chief Executive Officer, Siriti Africa
- City of Cape Town: Sugen Naidoo – Chairperson, Emerging Market Healthcare
- City of Cape Town: Oscar Solomons – General Secretary, NAFCOC
- Central Karoo: Mzwandile Mjadu – Park Manager, Karoo National Park
- Cape Winelands: Daneel van Schalkwyk – Human Resources and Wellness Manager, Pioneer Foods
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- West Coast: Joshua Domorog – Skills Development Facilitator, ArcelorMittal
- Eden: Nokuzola Mkontwana – Employee Wellness Manager, PetroSA GTL Refinery

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