HIV, AIDS, TB AND WELLNESS

KWAZULU-NATAL BUSINESS SECTOR

PROVINCIAL STRATEGIC PLAN 2012 - 2016

‘Strategic Spending for Saving and Sustainability’

SABCOHA
Empowering Business in the fight against HIV
Funding for stakeholder engagement to build consensus leading to the content contained for sectoral policy priorities has been funded by CDC and PEPFAR.
You have the responsibility to start a wellness programme; and it shouldn’t be one single person’s problem. Encourage healthy lifestyles (e.g. employee credits for going to gym). There is a relationship between healthy lifestyles and employee productivity. Business should integrate HIV issues. You should be starting a healthy lifestyle programme for every company. Standard procedures or checks should be routinely carried out such as blood pressure, vision, fitness, etc.

Early detection and treatment should be used as a mechanism of prevention along with MMC programmes in partnership with the DoH; and condom distribution. High risk sectors such as the transport sector and issues such as transactional sex should be high on the agenda leading to a comprehensive health response via inter-sectoral collaboration, support and respect.

The partnership between the public and private sector is a partnership that needs to be worked on and we welcome SABCOHA and their efforts in the province.

Dr Zweli Mkhize, KwaZulu-Natal Premier, at the SABCOHA KZN Conference
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Therapy / Treatment</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>ASSA</td>
<td>Actuarial Society of South Africa</td>
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<td>CDC</td>
<td>US Centers for Disease Control and Prevention</td>
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<td>CSI</td>
<td>Corporate Social Investment</td>
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<td>DAC</td>
<td>District AIDS Council</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DOTS</td>
<td>Directly Observed Treatment Short-course</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GDPR</td>
<td>Gross Domestic product per Region</td>
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<tr>
<td>GVA</td>
<td>Gross Value Added</td>
</tr>
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<td>HAART</td>
<td>Highly Active Antiretroviral Treatment</td>
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<td>HAST</td>
<td>HIV, AIDS, STIs and TB</td>
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<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papillomavirus</td>
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<td>HSRC</td>
<td>Human Sciences Research Council</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>IPT</td>
<td>Isoniazid Prophylactic Therapy</td>
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<td>ISDRP</td>
<td>Integrated Sustainable Rural Development Programme</td>
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<td>KYE</td>
<td>Know Your Epidemic</td>
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<td>KYR</td>
<td>Know Your Response</td>
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<td>LAC</td>
<td>Local AIDS Council</td>
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<tr>
<td>MDR-TB</td>
<td>Multi Drug Resistant (Tuberculosis)</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MEC</td>
<td>Member of Executive Council</td>
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<td>MMC</td>
<td>Medical Male Circumcision</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>NGO</td>
<td>Non-government Organisation</td>
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<tr>
<td>NHI</td>
<td>National Health Insurance</td>
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<td>NSP</td>
<td>National Strategic Plan (for HIV, STIs and TB 2012-2016)</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PAAU</td>
<td>Provincial AIDS Action Unit</td>
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<td>PCA</td>
<td>Provincial Council on AIDS</td>
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<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>PEPFAR</td>
<td>US President’s Emergency Plan for AIDS Relief</td>
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<td>PICT</td>
<td>Provider Initiated Counselling and Testing</td>
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<td>PLHIV</td>
<td>People Living with HIV or AIDS</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PSP</td>
<td>Provincial Strategic Plan 2012-2016</td>
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<td>PSS</td>
<td>Provincial Systems Strengthening</td>
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<td>SABCOHA</td>
<td>South African Business Coalition on HIV and AIDS</td>
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<td>SANAC</td>
<td>South African National AIDS Council</td>
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<td>SMME</td>
<td>Small, Medium and Micro Enterprises</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WAC</td>
<td>Ward AIDS Councils</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>XDR-TB</td>
<td>Extremely Drug-resistant Tuberculosis</td>
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</table>
ABBREVIATIONS AND ACRONYMS

A person living with HIV or AIDS: Refers to a person who is infected with HIV.

Acquired Immune Deficiency Syndrome (AIDS): A disease of the human immune system that is caused by infection with HIV and characterised by a reduction in the numbers of CD4 bearing helper T-cells to 20% or less of normal, thereby rendering the subject highly vulnerable to life-threatening opportunistic infections.

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

Adult mortality rate: The probability of dying between the ages 15 and 60 or % of 15 year olds that will die before their 60th birthday.

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

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

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

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

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

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

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

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

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

Infant mortality rate: The number of children less than 12 months old who die annually per 1 000 live births.

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

Intervention: A specific activity or set of activities intended to bring about change in some aspect(s) of the status of a target population.

Mainstreaming: Mainstreaming implies that HIV and AIDS responses are aligned with the core mandate of the
sector and not considered an “add-on” issue. Mainstreaming HIV and AIDS means all sectors determine how the spread of HIV is caused or contributed to by their sector; how the epidemic is likely to affect their sectors goals, objectives and programmes and where their sector has comparative advantage to respond to limit the spread of HIV and to mitigate the impact of the epidemic.

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

**Maternal mortality rate:** The proportion of women who die whilst pregnant or within the first 42 days post-partum, per 100 000 births in a given year.

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

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

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

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

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

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

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

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

**Stigmatisation:** Refers to the process of labelling people with the intent of treating them differently.

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

**Universal infection control precautions:** A simple standard of infection control practice to be used to minimise the risk of exposure to and transmission of blood-borne pathogens.

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

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

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

At the High Level Meeting of the UN General Assembly in 2011 there was a call on member states to commit to The Three Zeros advocated by UNAIDS: zero new HIV infections; zero discrimination; and zero AIDS-related deaths; and to redouble efforts to achieve universal access by 2015. In order to achieve these goals, focused, more efficient and sustainable responses are required along with renewed political commitment. Furthermore, the International Labour Organisation (ILO) Recommendation 200 recognises the role of the workplace as a key entry point for facilitating access to HIV prevention, treatment, care and support services. It stresses the need for action by employers, trade and labour unions to promote healthy workplaces. The ILO Recommendation 200 states that the key points to be considered in programmes on HIV and AIDS in the workplace should be: eliminating stigma and discrimination; protecting human rights; and facilitating access to HIV prevention; treatment, care and support for workers, their families and their dependants.

South Africa’s socio-economic development faces a major obstacle in the twin HIV and TB epidemics. The health and wellness of communities is critical to the success of local businesses, the economy and the country as a whole. The HIV and TB epidemics impact on the ability of individuals to contribute productively and economically to society. HIV and AIDS and TB in the workplace can impact the business in a number of ways which include: increased absenteeism, increased staff turnover, loss of skills, declining morale and loss of tacit knowledge; which can all contribute to declining productivity and profits and also contribute to increased costs as demands for training and recruitment increase.¹

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

The KwaZulu-Natal 20-year vision with respect to the HIV and TB epidemics has been adapted from the Three Zeros advocated by the Joint United Nations Programme on HIV/AIDS (UNAIDS). The KwaZulu-Natal Provincial Strategic Plan (PSP) for HIV, STIs and TB 2012-2016 which is also referred to as the KwaZulu-Natal HIV, AIDS, STI and TB (HAST) Response, was released on World AIDS day 2011 and addresses the drivers of the HIV and TB epidemics and builds on the achievements of the previous PSPs to achieve its goals. It is multi-sectoral and every national and provincial government department, municipality and sector was required to develop their plan by March 2012.

One of the key PSP interventions aimed at the private sector is as follows, “all employers and labour unions, should ensure that all formal sector and informal sector employees are tested and screened annually and have equitable access to prevention, treatment and wellness services. Special attention should be given to high-risk workplaces and trades (e.g. mines and truck drivers).” Another key intervention is to implement provider initiated counselling and testing (PICT) for HIV and screening for TB in all health facilities as well as in non-health settings. The South African Business Coalition on HIV and AIDS (SABCOHA) has as its primary purpose to mobilise and empower South African business to take effective action on ensuring wellness in the workplace which includes addressing HIV, AIDS, STIs, TB and other chronic diseases. To this end SABCOHA will coordinate efforts that ultimately mitigate the impact of HIV, AIDS, STIs, TB and ill health on sustained profitability and economic growth.

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

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

The SABCOHA KwaZulu-Natal Board of Governors was elected at the business sector conference held in Durban in October 2011. Since appointment, one board meeting was convened on 20 November 2011 via teleconference and one face-to-face meeting took place on 9 February 2012. This strategy was released for public comment and thereafter adopted by the provincial board of governors on 2 October 2012.

This strategy is the outcome of substantive stakeholder engagement and research which would not have been possible without significant funding from CDC-PEPFAR. Thank you to the business chambers in KwaZulu-Natal namely; Durban Chamber of Commerce and Industry, Estcourt/Umtshezi Chamber of Commerce and Industry, iLembe Chamber of Commerce and Industry, Minara Chamber of Commerce and Industry, NAFCOC, PMB Chamber of Business, South Coast Chamber of Commerce and Industry and Zululand Chamber of Commerce and Industry for endorsing the process and the business sector conference. SABCOHA further recognises the invaluable support of the KwaZulu-Natal Provincial Council on AIDS chaired by Premier Dr Zweli Mkhize.

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

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

The method by which this strategy has been developed is one of thorough consultation with all social partners in KwaZulu-Natal Province, following a district-based approach. This strategy is premised on the province’s 20 year vision to be free of HAST infections, free of deaths associated with HIV and free of discrimination where all infected and affected people enjoy a high quality of life as outlined in the Three Zero’s Vision contained in the PSP 2012 – 2016, namely to have:

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

Secondly, this strategy is based upon the five goals of the KwaZulu-Natal HAST Response, namely:

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

This strategy has prefaced the interventions with extensive economic data, labour statistics, and the public healthcare infrastructure available within the province. Not only is this information pertinent in defining the interventions, but it also gives a sobering sense of the enormity of the challenges facing KwaZulu-Natal. The proportions of the epidemic cannot simply be interpreted by looking through the lens of the clinician. Rather HIV dynamics need to be interpreted from numerous perspectives, including the impact on the business sector in the province.
The interventions have been tabulated for ease of reference, but based upon the priority interventions identified by the business constituency. Interventions have been classified into three broad categories, namely:

- 18 Company interventions
- 5 Sectoral interventions
- 3 Multi-sectoral interventions

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

1. Mobilise and implement interventions aimed at reducing substance abuse and promoting responsible alcohol use. For example:
   - Media and communication campaign which provides targeted relevant messaging in the workplace to promote responsible alcohol use.
   - Social mobilisation in workplace and surrounding communities promoting responsible alcohol use.

2. Maxmise coverage of male and female condoms through distribution in company health facilities and installation of condom dispensers/vending machines outside strategic points in the workplace for increased access.

3. Use peer educators to discuss issues including, but not limited to: changing social norms; addressing gender-based violence; sensible alcohol use; culture of acceptance and non-discrimination; address intergenerational and transactional sex and target men’s attitude to women

4. Maximise the coverage of male and female condoms through distribution in health facilities and installation of condom dispensers outside strategic points for increased access.

5. Implement a combination of HCT and wellness screening options within the workplace. Ensure that all occupational health facilities are equipped, trained and open to administer symptom-based PICT on a continual basis. Campaign style employer-initiated HCT should be offered and is often more frequent in the early stages of a workplace programme. In later years routine counselling and testing should be practiced as part of the annual medical examinations.

6. Promote Medical Male Circumcision (MMC) in the workplace and provide special leave for MMC, where possible.

7. Develop workplace programmes that actively provide access to free and confidential STI management, actively promote STI management through referral to local public facilities and educate all employees regarding higher risk of HIV transmission with untreated STIs.

8. Develop proactive and innovative mechanisms to ensure adherence as well as working with service providers on rigorous systems that identify defaulters with remedial action. For example:
   - Promote the use of Directly Observed Treatment Short-course (DOTS) in the workplace. Use cell phone based communication to improve treatment adherence.
   - Use social media - Twitter, Facebook, MXit - to improve retention and treatment adherence

9. Provide information, education and awareness on the Prevention of Mother-to-Child Transmission (PMTCT) - focused on men as well as women. Where possible, companies may be able to provide ART or administer state-funded treatment for pregnant workers with HIV.

10. Provide TB prevention services according to national guidelines

As the reader of this document, how should you interpret the information contained in this strategy?

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

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

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

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

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

Sr Honey Allee
Chairperson of the KwaZulu-Natal Board of Governors
BACKGROUND

HIV, AIDS, STIS AND TB

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

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

KwaZulu-Natal has the highest burden of disease associated with underdevelopment and poverty in the country, which includes HIV, AIDS, STIs and TB.

HIV and AIDS

An understanding of the HIV epidemic and its key drivers is fundamental in guiding this strategy.

A Human Research Science Research Council (HRSC) study on HIV prevalence in South Africa, states that the HIV prevalence is 45.8%, which is 11.9% higher than the prevalence in the Western Cape (the province with lowest prevalence). The HIV prevalence amongst pregnant women in KwaZulu-Natal has been consistently higher than the national average over the years (Figure 1). The trend suggests some stabilisation since the mid-2000s.
It is estimated that 1,622,870 (15.8% of the total population) people are living with HIV in KwaZulu-Natal. The projections of the Actuarial Society of South Africa (ASSA) of 2011 estimates the number of people living with HIV (PLHIV) at 1,576,025. According to the South African National AIDS Council (SANAC) more than half (54%) of adult PLHIV live in KwaZulu-Natal.

The impact of HIV and AIDS at both macro and micro level are well documented. It is estimated that just over one million children have lost one or both parents to HIV related illnesses. This not only contributes to the breakdown of family structures but is also detrimental to the economic fabric of the province.

The HIV interventions proposed in the KwaZulu-Natal HAST Response are guided by the Know your Epidemic (KYE) report and other analyses which identified the key determinants of the HIV epidemic in the province. Table 1 summarises the relevant determinants of the HIV epidemic in the province and highlights actions as recommended in the National Strategic Plan (NSP) that could mitigate the impact of the epidemic.

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Figure 1: HIV Prevalence estimates from public antenatal clinic attendees: 1990 - 2010

It is estimated that 1,622,870 (15.8% of the total population) people are living with HIV in KwaZulu-Natal. The projections of the Actuarial Society of South Africa (ASSA) of 2011 estimates the number of people living with HIV (PLHIV) at 1,576,025. According to the South African National AIDS Council (SANAC) more than half (54%) of adult PLHIV live in KwaZulu-Natal.

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2 Created by authors with data sourced from National Antenatal Sentinel HIV and Syphilis Prevalence Survey in SA, 2010
### Table 1: Key determinants and recommended action

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<th>Determinant</th>
<th>Recommended action</th>
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<tr>
<td><strong>BEHAVIOURAL AND SOCIAL DETERMINANTS</strong></td>
<td></td>
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<tr>
<td>Multiple sexual partners</td>
<td>Multi-level interventions that focus on sexual, social, cultural and gender norms and values.</td>
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<tr>
<td>Condom use</td>
<td>Increase consistent use, especially among key populations.</td>
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<td>Age-disparate sexual (intergenerational) relations</td>
<td>Target prevention strategies at those men and women who have partners much younger/older than themselves, given that the significant age discrepancy increases HIV exposure risk compared to people who reported partners of similar age.</td>
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<tr>
<td>Alcohol and substance abuse</td>
<td>Interventions to decrease alcohol abuse and other substance abuse, including illegal substances.</td>
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<tr>
<td>Prevention knowledge and risk perception</td>
<td>Prevention strategies for people who expose themselves to the risk of HIV infection, including education and addressing perceptions of personal risk.</td>
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<tr>
<td><strong>BIOLOGICAL DETERMINANTS</strong></td>
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<tr>
<td>Mother to child transmission</td>
<td>Strengthen the implementation of four prongs of the PMTCT programme.</td>
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<tr>
<td>Medical male circumcision (MMC)</td>
<td>Continue with large scale rollout of a national medical male circumcision programme as part of a package of sexual and reproductive health services which includes gender sensitisation.</td>
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<tr>
<td>Other sexually transmitted infections</td>
<td>Prevention and early treatment of STIs.</td>
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<tr>
<td>Treatment as prevention</td>
<td>Initiating all eligible people living with HIV to treatment according to national guidelines to improve their health outcomes and reduce transmission.</td>
</tr>
<tr>
<td><strong>STRUCTURAL DETERMINANTS</strong></td>
<td></td>
</tr>
<tr>
<td>Mobility and migration</td>
<td>The risk of HIV infection is higher among individuals who either have personal migration experience or have sexual partners who are migrants and, therefore, appropriately targeted interventions are required.</td>
</tr>
<tr>
<td>Gender roles and norms</td>
<td>Challenge the gender roles, norms and inequities that increase women’s vulnerability to HIV and compromise men’s and women’s health; address the position of women in society, particularly their economic standing; and engage with men on changing socialisation practices.</td>
</tr>
<tr>
<td>Sexual abuse and intimate partner violence</td>
<td>Implement interventions to prevent gender-based violence, as well as intimate partner violence, and educate men about women’s rights.</td>
</tr>
</tbody>
</table>
Sexually Transmitted Infections (STIs)

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

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

Information about the rates of STI infections is not easily available and the province does not have a central repository that collects STI information and figures across the districts. The stigma around STIs is similar to that of HIV, and usually acts as a barrier to people seeking treatment and care.

The KwaZulu-Natal PSP indicates that new episodes of STIs have been declining for a considerable period of time. The total number of new episodes stood at over 440. However, despite a 100% partner notification rates, only 22% of these were treated.

Tuberculosis (TB)

TB is the leading cause of death in South Africa and it is estimated that 80% of the South African population has latent TB. According to the World Health Organisation (WHO) estimates, South Africa ranks the third highest in the world in terms of TB burden. South Africa also has the highest TB incidence (including HIV) in the world of 981 per 100 000 population per year. Approximately 1% of the South African population develops TB every year. The TB epidemic is further compounded by multi-drug resistant and extremely drug resistant TB (MDR-TB and XDR-TB). The highest prevalence of TB infection is among people in the age group 30-39 years, living in townships and informal settlements.

There is a complex relationship between HIV and TB as compromised immunity in people living with HIV increases the risk of developing active TB and TB can accelerate the course of HIV. The incidence of TB has increased in parallel to the increase in the estimated prevalence of HIV in the adult population. The co-infection rate in South Africa is one of the highest in the world with almost 75% of TB patients being HIV positive. TB case-fatality rates are between 16% and 35% among people with HIV who are not on ART compared to between 4% and 9% among people who are HIV negative. Survival of HIV positive people who have CD4 counts of less than 500 is greatly improved if ART is initiated during TB treatment compared with starting ART after TB treatment is completed.

KwaZulu-Natal has the highest number of TB infections in the country. TB is the leading cause of mortality in the province, with diagnosed TB cases increasing from 98 498 in 2005, 109 556 in 2007 to 118 162 in 2009. This represents a case load of 1 156 cases per 100 000 population, which is more than four times the epidemic threshold according to WHO.

The KwaZulu-Natal HAST Response calls for the integration of TB and HIV services, with annual testing for HIV to include screening for TB, improved contact tracing, early diagnosis and rapid enrolment on to treatment and ensuring co-infected people remain on treatment. Integrated TB and HIV services are crucial in the TB and HIV response in order to prevent, identify, and treat TB and other opportunistic infections in HIV positive patients and to improve the diagnosis, treatment, and outcomes for patients affected by both diseases.

8 KwaZulu Natal Department of Health Annual Report 2010
CHAPTER 2: BACKGROUND

KEY POPULATIONS FOR THE KWAZULU-NATAL HAST RESPONSE

A ‘key population’ is one that is most likely to be exposed to or transmit HIV and/or TB and therefore have a disproportionately high prevalence. Key populations also have significantly lower access to, or uptake of, relevant services compared to the rest of the populations. The risk of HIV and TB infection for key populations can also be driven by inadequate protection of human rights and prejudice. Therefore their engagement is critical to a successful HIV and TB response.

Despite the generalised HIV epidemic and high rates of TB infection and disease burden in South Africa, there are still certain geographic areas, as well as key populations, with higher levels of TB and HIV infection and transmission. In addition to the broad framework for addressing HIV, STIs and TB at a general population level, the PSP also identifies key populations that should be targeted for specific prevention, care, treatment and support interventions, based on risk and need.

The KwaZulu-Natal HAST Response has been designed to target the following key populations that have been identified as critical to reversing the epidemic in the province; young boys and girls (15-25 years); women; men; people with multiple and/or concurrent sexual partners; people with disabilities; sex workers; mobile casual and atypical farm workers; men who have sex with men (MSM); refugees and migrant people living with HIV; people who inject drugs and the poor.

HIV AND TB ACHIEVEMENTS AND CHALLENGES IN KWAZULU-NATAL PROVINCE

The main achievements in the HIV and TB response in the period of the previous strategic plan are as follows:

Table 2: Achievements in the KwaZulu-Natal HIV and TB response

<table>
<thead>
<tr>
<th>Achievement</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTION</strong></td>
<td></td>
</tr>
<tr>
<td>Reduction in incidence</td>
<td>The incidence of HIV is estimated to have declined from 3.8% in 2005 to 2.3% in 2008.</td>
</tr>
<tr>
<td>Reduction in Mother to Child Transmission (MTCT)</td>
<td>HIV transmission rate from mother to child declined from 22% in 2005 to 2.8% in 2010.</td>
</tr>
<tr>
<td>Increase in High Transmission Areas (HTAs) identified</td>
<td>48 High Transmission Areas (HTAs) have been established.</td>
</tr>
<tr>
<td>Post Exposure Prophylaxis (PEP)</td>
<td>100% of government and private health facilities provide continuous supply of PEP medicines.</td>
</tr>
<tr>
<td>Poverty eradication strategies started</td>
<td>The Operation Sukuma Sakhe (OSS) – the flagship poverty eradication programme in KwaZulu-Natal is addressing poverty through intensified and renewed strategies that directly focus on individuals and households at community level. The programme is critical to integration and mainstreaming of HIV and AIDS activities.</td>
</tr>
<tr>
<td>Adoption of MMC</td>
<td>Voluntary MMC has been introduced and accepted in the province. The province reported 54 670 MMC operations in the period April 2010 to June 2011 surpassing its yearly target 53 000. It is the province with the highest MMC operations in the country. It is critical that there is strong political and cultural leadership that provides advocacy for this programme.</td>
</tr>
</tbody>
</table>

Achievement | Detail
--- | ---
**TREATMENT, CARE AND SUPPORT**
Reduction of HIV deaths | The estimated number of reported deaths due to HIV and AIDS has reduced from 67,429 in 2008/09 to 54,337 in 2010/11.
Increased HCT coverage | HCT coverage has increased and achieved 95% of its target. The increase has been attributed to the 2010/11 HCT mobilisation campaign.
ART universal coverage | ART programme has achieved universal coverage with cumulative total of 459,670 people of which 45,598 are children, having been registered for ART in 2011.
HIV and TB integration | TB and HIV integration interventions have witnessed successful implementation. For example, there was an increased uptake of Isoniazid Preventive Therapy (IPT) (which reduces the risk of developing active TB in HIV positive people with latent TB). By June 2011 124,963 patients had taken IPT which was 71.5% of the target of 170,000 patients.

Management, monitoring, research and surveillance

Coordination | The province has one co-ordinating authority at provincial, district and local level, thereby achieving the “Three Ones” principle of one coordinating authority.
Functionality of AIDS Councils | The Provincial Council on AIDS is fully functional while 82% of the District AIDS Councils and 53% of Local AIDS Councils are fully functional.
Monitoring and Evaluation (M&E) framework | Stakeholders in the response have recognised the value of M&E.
Political commitment | There is strong political commitment for human rights, access to justice and in governance of the response.

Main gaps and challenges in human rights, access to justice and enabling environment:

**Table 3: Main gaps and challenges in the KwaZulu-Natal HIV and TB response**

Achievement | Detail
--- | ---
**PREVENTION**
STI services sub-optimal | The STI prevention services have not yet reached optimum effectiveness as there is still a high volume of new cases. For example, the total number of new episodes treated in 2010/11 was 440,714. Further, despite 100% partner notification, only 22% of the partners were treated.
Inadequate condom distribution | Condom distribution remains inadequate. About 18% of male and 27% of female condoms were distributed.
Low MMC coverage | The coverage of MMC remains significantly low.
Inadequate integration | Integration of services remains inadequate

**TREATMENT, CARE AND SUPPORT**
CHAPTER 2: BACKGROUND

Achievement

<table>
<thead>
<tr>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low ART follow-up</td>
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LIMITED M&E PRACTICE

<table>
<thead>
<tr>
<th>Detail</th>
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</thead>
<tbody>
<tr>
<td>Limited M&amp;E practice</td>
</tr>
<tr>
<td>Non-alignment of M&amp;E framework</td>
</tr>
<tr>
<td>Uncoordinated research</td>
</tr>
<tr>
<td>Human rights, access to justice and enabling environment</td>
</tr>
</tbody>
</table>

POlITICAl lAnDSCAPE In KwaZuLNuTAL

It is now 15 years since the province of KwaZulu-Natal embarked on a structured response to HIV and AIDS by setting up the HIV and AIDS sub-directorate in 1996. This was followed by the launch of the Cabinet Initiative and the AIDS 2000 challenge in 1998 and 1999 respectively. In 2000, the Provincial AIDS Action Unit (PAAU) was established by Cabinet to drive a province-wide response to HIV and AIDS with a vision of an “AIDS-free KwaZulu-Natal”. PAAU implemented a number of interventions that included: partnership development; capacity building; community mobilisation and support; and coordination of programmes such as home-based care, PMTCT and life skills education.

Because of the need to scale up and broaden the scope of the response, in 2004, the Cabinet resolved to dissolve PAAU and placed the coordination of all sectors and transversal issues of HIV and AIDS response with the Chief Directorate of HIV and AIDS within the Office of the Premier. The KwaZulu-Natal Provincial AIDS Council was subsequently established in November 2008 and named the Provincial Council on AIDS (PCA). The PCA is the only coordinating authority for the response at provincial level which is in line with the principle of “Three Ones”. This has cascaded down to the district and local municipal level with the establishment of district and local municipalities AIDS councils (DACs and LACs). The ongoing establishment of Ward AIDS Councils (WACs) will contribute to ensuring that coordination of the response at ward level is enhanced. The PCA is chaired by the Premier, while the DAC and the LAC are chaired by the respective Mayors. The WACs on the other hand are chaired by the respective ward councillors. In this respect, the province has achieved the principle of having one coordinating authority at the three levels and is moving towards fully achieving this at the fourth level, viz; ward level.

The KwaZulu-Natal HAST Response is aligned to the NSP; and it has a multi-sectoral approach. In line with this approach, all the KwaZulu-Natal stakeholders are expected to participate and collaborate in the implementation of the KwaZulu-Natal PSP. The plan recognises the business sector, amongst others, as being an important partner in the implementation of the plan.
THE IMPACT OF HIV, AIDS AND TB ON THE BUSINESS SECTOR

The health and wellness of communities is critical to the success of local businesses, the economy and the country as a whole. The HIV and TB epidemics impact on the ability of individuals to contribute productively and economically to society. The productivity and profitability of South African business is threatened by the labour force changes as well as changes in consumer spending and changes in the economic environment that result from HIV, AIDS and TB. There is increasing recognition that South African companies need to become involved in the response in order to survive the impact of the disease.\(^\text{12}\)

In countries with a high HIV prevalence the impact of HIV, AIDS and TB in the workplace is real and multifaceted as illustrated in Figure 2. Research at Boston University found that AIDS-related costs in companies ranged from 3 to 11% of the annual salary bill in 1999-2000.\(^\text{13}\) HIV, AIDS and TB contribute to declining production and profits while increasing costs. The decrease in labour supply can be in terms of numbers, productiveness and skill levels which impacts on profitability by both increasing the cost of production and decreasing the productivity of workers. Further details on the factors that contribute to the negative effects of the epidemic are shown in Figure 2.

**Figure 2: The impact of HIV and AIDS on business\(^\text{14}\)**

Gender, work and HIV

Women are more vulnerable to infection both biologically and socially. Cultural norms and economic circumstances mean that as the HIV epidemic progresses, women, as the primary caregivers in the community, have to care for family and community members who fall ill, as well as having to work or manage the household at the same time. Many women in South Africa have limited access to secure livelihoods and socio-economic opportunities, as traditionally the workplace was a male domain. Women are often dependent on their male partners from both a social and economic perspective which can mean that they have little control over their choices. This places women in situations that increase their vulnerability to HIV infection.


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

**Trade unions and HIV**

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

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

**Responding at the workplace**

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

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

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

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

**THE BUSINESS SECTOR AND SABCOHA IN KWAZULU-NATAL**

The KwaZulu-Natal HAST Response called for every sector to develop implementation plans by March 2012. SABCOHA aimed to co-ordinate a private sector strategic plan for the province in line with this call.

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

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

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

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

SABCOHA has existing relationships in KwaZulu-Natal with, amongst others, the Durban Automotive Cluster and the Durban Chemical Cluster. At a multi-sectoral level relationships with the KwaZulu-Natal AIDS Council, the Department of Health and the PEPFAR Liaison have been furthered. The SABCOHA Business Sector Conference, held in October 2011, was endorsed by the Durban Chamber of Commerce and Industry, The South Coast Chamber of Commerce and Industry, Zululand Chamber of Commerce and Industry, Minara Chamber of Commerce, iLembe Chamber of Commerce, Industry and Tourism and the Estcourt Umtshezi Chamber of Commerce and Industry.

SABCOHA has a number of existing or pilot projects operating in the KwaZulu-Natal and these include:
- Membership: 73 of SABCOHA’s members have operations in KwaZulu-Natal
- BizAIDS: Five active trainers and have trained more than 1,565 SMMEs from October 2010 to May 2011 across five districts
- Medium Sized Enterprise Capacity Development Programme: 87 companies currently provided with technical assistance to develop workplace programmes, mostly in the construction, automotive and chemical industries
- National Peer Educator Support Network: Five peer educator skills development training sessions were conducted in three districts (eThekwini Metro, uThungulu and uMgungundlovu) reaching 534 peer educators
- Project Promote: Ten services sites in two districts (uMgungundlovu and eThekwini Metro) with 599,000 condoms distributed during the period October 2010 to September 2011
- Bizwell: Four one-day M&E capacity building sessions were facilitated reaching 46 companies in the province

CONCLUSION
The risk of HIV and AIDS and TB on sustained profitability, productivity and growth should be a concern to business and should further motivate business to support the HIV response. However, HIV fatigue coupled with the struggle for economic survival in the tough financial climate has pushed HIV, AIDS and TB further down the list of priorities. There are synergistic benefits for business to operate collectively as a sector and not individually as independent organisations. The sharing of knowledge, good practice and contemporary issues can benefit all organisations and in particular the medium and smaller businesses that do not have resources available. A coalition of business working together will mitigate the health risk across the whole value chain. With big business leading and the Small, Medium and Micro Enterproses (SMME) sector benefiting economic sustainability will be realised. Although the health and wellbeing of its citizens is a national priority and in the public interest it remains an economic necessity for business.

This business sector strategy should be seen to augment government’s national and provincial response plans.
Background
With funding from CDC-PEPFAR this plan has been developed for the purpose of providing business in KwaZulu-Natal, with clear objectives in combating HIV, AIDS, STIs and TB. Beginning in 2009, SABCOHA shifted the focus of its strategic interventions, from a nationally co-ordinated response, to a response which was closer to where business experienced the impact of the epidemic. Through district consultations with business, SABCOHA developed this KwaZulu-Natal Strategic Plan from the bottom up.

This plan has been developed with the full co-operation of the business sector in KwaZulu-Natal, including members of SABCOHA, leading corporates, and chambers of commerce. As part of the consultation process, SABCOHA engaged fully with the KwaZulu-Natal PCA, the Premier’s Office, as well as the Provincial Department of Health.

The purpose of engaging in broad consultation was to ensure that this strategy reflected relevant responses to the realities of the epidemic, but also situated the responses within an economic context meaningful to business. This strategy reflects the priorities identified by business in responding to HIV, AIDS, STIs and TB in KwaZulu-Natal.

Strategy development
Broad stakeholder engagement formed the critical approach for the identification of priorities in this strategy. The strategy was shaped through the initial consultation with a range of companies (both members and non-members), business associations, the KwaZulu-Natal PCA, DCA’s as well as dialogues with other civil society sectors and desktop research for all districts. This process also formed the starting point of the development of SABCOHA’s contacts database for the business sector in KwaZulu-Natal. Over a period of 12 months, six districts were visited to conduct further stakeholder engagement. This process culminated with the hosting of a KwaZulu-Natal Private Sector Conference in October 2011. The purpose of the conference was to appoint a board of Governors for the province, and approve the priority areas of the Business Sector Strategy.
The conference was held in Durban on 18 and 19 October 2011, and was attended by over 150 delegates representing companies from all districts in the province. Representatives from key provincial government departments also participated and made inputs at the conference. KwaZulu-Natal Premier Dr Zweli Mkhize presented keynote inputs on the last day of the conference.

Using a World Cafe or Large Group Event methodology, the conference allowed maximum participation and input from delegates. Anonymous voting technology facilitated consensus building and the identification of priorities. Round table conversations and storyboard development were integrated into the programme throughout the conference. This strategy is based upon the outcomes of the conference, and the stakeholder consultations.

In conjunction with the KwaZulu-Natal PSP 2012-2016, this strategy provides the business sector with company level, sectoral level and multi-sectoral interventions.

The elected board members were as follows:

**Mr Marc Matthews**, Pantech – eThekwini Metropole (resigned 11 June 2012)

**Dr Danie Viljoen**, Unilever – eThekwini Metropole

**Sr Honey Allee**, IMA Wellness – eThekwini Metropole

**Ms Nomathamsanqa Cele**, Nampak – eThekwini Metropole

**Ms Nomhle Sikhosana**, Dano Textiles – eThekwini Metropole

**Ms Louise Coetzee**, Canvass and Tents – uThukela district

**Ms Ethel Zandile Myeni**, Broadreach Health Care – Ugu district

**Ms Xoliswa Makhaye**, Umgeni Water – Umgungundlovu district

**Ms Beverley McLean**, Whirlpool Corporation - iLembe district (co-opted in June 2012)

**District workshops**

Feedback from the initial stakeholder engagement process in the province showed that immediate capacity development and assistance on strategic planning around HIV interventions was required by many businesses. In response to this feedback, the district workshop series was developed which aimed to support companies to develop and implement workplace HIV, AIDS, TB and wellness programmes. District workshops are based on SANS16001 and promote a systems-based approach from assessing, planning, implementing, and monitoring to evaluating (APIME model). Outcomes from the workshops can include:

1. Understand the context and importance of assessing the risks of HIV, AIDS, TB and ill health
2. Be able to develop and implement a HIV, AIDS, TB and wellness policy in line with minimum legal requirements
3. Adopt a strategic approach to managing HIV, AIDS, TB and wellness in the workplace, ensuring accountability

During the engagement process in KwaZulu-Natal, district workshops were held in Umgungundlovu, uThungulu, eThekwini Metro, iLembe and Ugu districts. Following the adoption of the strategy, further district workshops will be planned in accordance with district needs and availability of funding.

**Way forward**

With funding from the Global Fund to Fight AIDS, TB and Malaria; SABCOHA will be appointing a co-ordinator in KwaZulu-Natal. The Board’s function will be to oversee the implementation of the strategy, provide leadership and sound governance, and by reaching out, develop lasting relationships with all social partners in the province.
INTRODUCTION

A strategy is a comprehensive plan of action in the pursuit of a stated purpose. This KwaZulu-Natal Business Sector Strategy identifies actions and priorities in support of the KwaZulu-Natal HAST Response which are in alignment to the NSP, which all ultimately align with the achievements of the Millennium Development Goals for Health and other provincial priorities.

This strategy contains options that may or may not be realised in practice. Changing political, economic, social, technological, legal and environmental external conditions as well as internal organisational realities, both within SABCOHA and companies will affect the sector’s ability to implement. Strategy is essential for providing direction and enabling implementation. The success of this strategy is contingent upon cooperation and commitment from individual companies and business leaders.

In line with the NSP, the KwaZulu-Natal PSP 2012-2016 aims to reduce HIV, TB and STI incidence by 50%; initiate ARV treatment for at least 80% of eligible patients and ensure that 70% of these patients remain alive and on treatment five years after initiation; reduce the number of new TB cases by 50% and reduce TB deaths by 50%; and reduce self-reported stigma and discrimination related to HIV and TB by 50%.

Every effort must be made by employers, both public and private, to ensure that HIV and TB transmission in the workplace is mitigated, and that appropriate treatment, care and support is provided to those affected. Specific strategies should ensure that prevention and treatment campaigns are inclusive in all sectors of the economy, especially the vulnerable sectors such as domestic workers and farm workers.

Addressing the dual epidemics in the workplace is an economic imperative in that it results in the reduction of absenteeism due to ill health and creates an enabling environment for employee wellbeing and productivity. Evidence has shown that enterprises that proactively implement prevention, support and treatment programmes are able to mitigate the impact of various forms of illnesses, be they acute or chronic.
The relevant strategic objectives from the PSP that were used to develop interventions for this KwaZulu-Natal Business Sector Strategic Plan are explained below:

**Priority area 1: Prevention of HIV, AIDS, STIs and TB**

**Goals**
The prevention priority area aims to achieve the following three goals:
- To reduce new HIV infection to less than 1% by 2016
- To reduce new smear positive TB infection to less than 200 per 100,000 population by 2016
- To reduce STI incidence to less than 0.5% by 2016

Focus on prevention and scaling up means that a multi-pronged approach will be adopted where biomedical, behavioural, social and structural approaches are simultaneously applied.

**Expected impact:**
By working towards achieving the above goal, KwaZulu-Natal expects to attain the following impacts:
- Reduced HIV incidence in the general population to less than 1% by 2016
- Zero HIV infection among infants born to mothers who are HIV infected by 2016
- Reduced HIV prevalence among young men and women aged 15-24 years to less than 7.5% by 2016
- Reduced new TB infections to less than 200 new smear positive TB cases per 100,000 population by 2016
- Reduced STI incidence to less than 0.5% by 2013

**Priority area 2: Sustaining health and wellness**
The primary focus of the health and wellness priority area is to provide treatment, palliative care and social support to people infected and affected by HIV and TB. The goal under this priority area is to reduce mortality, sustain wellness and improve quality of life of at least 80% of those infected and affected by 2016.

In recent years, there has been a rise in cases of drug-resistant TB in South Africa, where KwaZulu-Natal is considered the epicentre of the problem. To eliminate this problem requires deliberate and aggressive interventions in terms of finding cases, providing early and effective treatment and ensuring adherence to treatment.

The dual epidemic of HIV and TB poses enormous socio-economic difficulties on individuals, families and communities. It is common knowledge that they are a major cause of chronic illnesses and orphanhood within the province. This goal deals with the effective management of these conditions and mitigating their negative impacts.

**The key objectives for priority area 2:**
- To ensure that at least 90% of HIV infected people have access to treatment and support, remain adherent to treatment and maintain optimum health
- To ensure 90% of people infected with TB have access to services that are responsive to their needs and are of high quality
- To ensure that 80% of infected and affected people and households have access to support in order to reduce disability and improve quality of life
- To increase access to quality care and support to at least 90% of orphans and vulnerable children (OVC) by 2016
Priority area 3: Protection of human rights

Access to healthcare services is a fundamental right enshrined in the South African constitution. Ensuring access to healthcare services requires that interventions be planned and implemented in a manner that addresses the specific needs and barriers to access to health services by key populations. Furthermore, inadequate human rights protection and access to justice contribute to vulnerability to HIV, STI and TB infections. These include stigma and discrimination, gender inequality, gender violence and other forms of discrimination. This priority area deals with vulnerabilities due to factors that are influenced by human rights, policies, legal environment and social norms. It will involve:

- strengthening political and public leadership commitment in addressing the undesirable social norms
- building the capacity of service providers to deal effectively with the issues of human rights and undesirable social norms

The goal under this priority area is to reduce vulnerability to HIV, STIs and TB by creating a supportive policy, human rights and regulatory environment and promoting desirable social norms in the province by 2016.

The key objectives for priority area 3:

- To strengthen leadership at all levels of society to publicly promote the human rights and speak out against stigma, discrimination and related behaviours to create a more equal society
- To identify and address legal barriers to the implementation of interventions in order to ensure that all existing legislation and policy relating to human rights and access to justice are adhered to by 2016
- To strengthen capacity building on all relevant policy framework and legislation relating to HIV and AIDS
- To promote and support the greater involvement of PLHIV in the provincial HAST response by 2016

Priority area 5: Coordination, monitoring and evaluation

Coordination, monitoring and evaluation, and research are critical support components to successful implementation of the response. The support provided by The Office of the Premier in the form of a demonstrated political will and leadership has, for example, contributed to jump starting functionality of the coordinating structures at all levels.

The goal under this priority is to have a well coordinated provincial response to HIV and AIDS, STI and TB that is informed by an effective M&E system by 2016.

The key objectives of priority area 5:

- To strengthen coordination and management for an effective provincial response by 2016
- To strengthen monitoring and evaluation systems at all levels and ensure that at least 90% of the sectors consistently report to the coordination structures by 2016
- To strengthen the research component of the response

PURPOSE

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

The results framework forms the foundation upon which the entire KwaZulu-Natal HAST Response will be implemented over the next five years. It provides a coherent chain of results that lead towards the attainment of the provincial HAST long term vision, as illustrated in the figure below. The results framework is structured around the five priority areas for which results are expected and represents a comprehensive and coherent array of interventions designed to achieve specified objectives and goals. The description that follows provides information under each priority area on the goals, objectives and main interventions.

Figure 3: Results Framework

INTERVENTIONS AND APPROACH

The interventions are categorised according to the priority areas and strategic objectives of the KwaZulu-Natal HAST Response. 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 and it will overlap with the current and future NSP and PSP. Realignment to new national and provincial priorities may be required mid-term. 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.

SABCOHA seeks to mobilise, empower and coordinate the implementation of this strategy which comprises 26 interventions (initiatives, projects or programmes) structured across three categories as follows:

- 18 company interventions.
- 5 sectoral interventions.
- 3 multi-sectoral 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 26 interventions by priority and probability resulted in short-listing 10 of the interventions as top priorities for immediate action set out in the Way Forward. In evaluating the interventions, consider the following:

- a proper situational analysis
- looking for efficient, targeted and innovative solutions which allow us to achieve more with the resources we have
- “Treatment is Prevention” strategy. ART reduces an individual’s viral load thereby lowering risk of transmission and can reduce new HIV infections.
- 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.
## PRIORITY AREA 1: PREVENTION OF HIV, AIDS, STIS AND TB

### Objective 1: To decrease behaviours that put men and women aged 15-49 years at risk of HAST by 80% through implementation of focused programmes by 2016

<table>
<thead>
<tr>
<th>#</th>
<th>Intervention description</th>
<th>Indicator</th>
<th>Rationale</th>
<th>Lead agency</th>
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</table>
| 1 | Mobilise and implement interventions aimed at reducing substance abuse and promoting responsible alcohol use. For example:  
   • Media and communication campaign which provides targeted relevant messaging in the workplace to promote responsible alcohol use.  
   • Social mobilisation in workplace and surrounding communities promoting responsible alcohol use | # of employees, aged 25-49 years, mobilised and reached through awareness campaigns including gender-based violence information | Alcohol use is associated with reduced perception of risk, risky behaviour (including, an increase in multiple and concurrent sexual partners, intergenerational sex and the experience of coercive or violent sex) and decreased condom use. It is also a major impediment to treatment adherence. Strategies should address male gender norms that equate alcohol use with masculinity. | Company level |
| 2 | Use peer educators to discuss issues including, but not limited to: changing social norms; addressing gender-based violence; sensible alcohol use; culture of acceptance and non-discrimination; address intergenerational and transactional sex and target men’s attitude to women. | # of target population reached through outreach/group meetings, as well as one-on-one sessions broken down by gender | Peers tend to understand and respect each other as they share levels of expertise. Peer education uses horizontal, personal communication channels and is effective in promoting positive behaviours including: avoiding HIV infection, knowing your status, accepting others who are positive and accessing HIV treatment. Where companies with high labour turnover 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. With a view to the promotion of integrated wellness in the workplace, peer educators or change agents’ needs to be trained in different spheres of health so as to add significant value and help companies remain cost effective and supportive of this social based learning approach. | Company level |
| 3 | Maximise the coverage of male and female condoms through distribution in health facilities and installation of condom dispensers outside strategic points for increased access. | # of male condoms distributed  
# of female condoms distributed | Evidence from UNAIDS and WHO shows that condoms, when used correctly and consistently, are the single, most efficient, available means to reduce the sexual transmission of HIV and other sexually transmitted infections (STIs). A large body of scientific evidence shows that male latex condoms have an 80 percent or greater protective effect. Condoms are a key component of comprehensive HIV prevention. | Company level |
<p>| 4 | Increase the national distribution of government condoms by expanding to non-traditional outlets thereby improving access to high risk and under serviced workplaces and populations | # of new primary distribution sites established and reporting | | Sectoral level |</p>
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<tr>
<th>#</th>
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<tr>
<td>5</td>
<td>Expand HIV, AIDS, STIs and TB prevention and treatment services on trucking routes to include sex workers and neighbouring communities, and evaluate other feasible geographical sites.</td>
<td># of functional sites established</td>
<td>Many transport workers are highly mobile and spend considerable time away from home. The transport sector is one of the sectors with a high HIV prevalence because workers are away from their partners and families for extended periods and have sufficient disposable income to spend on sex workers or to engage in multiple sexual relationships. Basic healthcare as well as treatment for sexually transmitted diseases (which in turn increases the risk of HIV infection) are often not available where and when transport workers need them most. Sometimes condoms are very expensive or not available in locations frequented by transport workers. According to the KYE/KYR study, communities bordering national highways have higher HIV prevalence compared to those located away from trucking corridors. Sex workers from these communities often have poor health-seeking behaviour, and limited access to healthcare. Providing access to prevention and ART services for both truck drivers and the broader communities on transport routes can decrease the community viral load which will reduce the number of new HIV infections</td>
<td>Sectoral level</td>
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<tr>
<td>6</td>
<td>Implement programmes that address the specific, and often different, needs of both men and women and goals that promote gender equality and empower women.</td>
<td># of employees, mobilised and reached through awareness campaigns including gender-based violence information</td>
<td>Gender inequality and HIV, AIDS and TB are interconnected phenomena. Girls and women are particularly vulnerable to HIV infection because of their biological vulnerability and gender norms, roles and practices. Women often find themselves in positions of weakness and dependence at the workplace which easily lead to sexual harassment and abuse. South Africa is grappling with high levels of violence against women with sexual assault and intimate partner violence contributing to increased risks of HIV infection. The workplace is an important entry point to address gender inequality. In order to be effective, workplace initiatives on HIV must address gender issues including the related and underlying HIV vulnerabilities, as well as the specific needs of both women and men.</td>
<td>Company level</td>
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### Objective 2: To reduce risk of mother to child transmission of HIV to less than 1% by 2016

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<td>7</td>
<td>Provide information, education and awareness on PMTCT - focused on men as well as women. Where possible, companies may be able to provide ART or administer state-funded treatment for pregnant workers with HIV.</td>
<td># of men and females accessed through PMTCT information, education and awareness activities</td>
<td>According to the WHO the risk of mother to child transmission of HIV can be reduced to less than 2% if appropriate interventions are applied. Transmission of the virus from infected mother to child is one of the three main ways that HIV is transmitted. This becomes a workplace issue because pregnant workers, or the partners of workers, may be infected. The workplace therefore needs to play a role in prevention. An obvious starting point is the information and education programme, which should not only help workers understand how this type of transmission takes place, but also give support to women, and their partners, in making difficult choices about breast-feeding.</td>
<td>Company level</td>
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<td>8</td>
<td>Empower pregnant employees by offering testing as early as possible, during pregnancy.</td>
<td># of pregnant workers tested during first, second, and third trimesters.</td>
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<td>Company level</td>
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### Objective 3: To scale up medical male circumcision to 80% of males aged 0-49 by 2016

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<tr>
<td>9</td>
<td>Promote MMC in the workplace and provide special leave for MMC where possible.</td>
<td># of men reached by MMC promotion campaigns</td>
<td>MMC has been shown to reduce the risk of acquiring HIV. Three recent randomised control trials in sub-Saharan Africa showed MMC reduced the risk of acquiring HIV by 60%,16,17,18 MMC is recommended by WHO/UNAIDS in countries with a high prevalence of heterosexually transmitted HIV infection and low levels of male circumcision.19 Additionally MMC has been shown to reduce the incidence of STIs and also HPV. HPV when transmitted to female partners is the main cause of cervical cancer and therefore MMC has indirect benefits to the women.</td>
<td>Company level</td>
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<tr>
<td>10</td>
<td>Provide messaging about the benefits of MMC as well promoting safe circumcision practices in initiation setting in order to encourage employees and communities to accept MMC.</td>
<td># of men referred for MMC</td>
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<td>Multi-sectoral</td>
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### Objective 4: To ensure that 80% of sexually transmitted infections infected men and women receive early and appropriate treatment by 2016

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<th>Lead agency</th>
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<td>11</td>
<td>Develop workplace programmes that actively provide access to free and confidential STI management, actively promote STI management through referral to local public facilities and educate all employees regarding higher risk of HIV transmission with untreated STIs</td>
<td># employees referred for STI diagnosis and treatment</td>
<td>STIs have been shown to increase the likelihood of both transmitting and acquiring HIV. STIs are not just biological and medical problems, but also behavioural, social, political and economic problems. Many interventions to control STIs can help reduce the spread of HIV and vice versa. The stigma around STIs is similar to that of HIV, and usually act as a barrier to people seeking treatment and care. Providing education will help reduce the stigma.</td>
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<td># people served (STI diagnosis and treatment) (by age and sex)</td>
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<td></td>
<td></td>
<td># of men and women reached through STI communication and education</td>
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<td>12</td>
<td>Maximise coverage of male and female condoms through distribution in company health facilities and installation of condom dispensers/vending machines outside strategic points in the workplace for increased access</td>
<td># of male condoms distributed&lt;br&gt;# of female condoms distributed</td>
<td>Condom use is the most effective method to reduce the sexual transmission of HIV especially among key populations. Condom use also serves to prevent transmission of some STIs and prevents unwanted pregnancy.</td>
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### Objective 5: To ensure that 80% of men and women age 15-49 know their HIV status and receive STI and TB screening by 2016

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<tr>
<td>13</td>
<td>Implement a combination of HCT and wellness screening options within the workplace. Ensure that all occupational health facilities are equipped, trained and open to administer symptom based PICT on a continual basis. Campaign style employer-initiated HCT should be offered and is often more frequent in early stages of workplace programme. In later years routine counselling and testing should be practiced as part of the annual medical examinations.</td>
<td>% of men and women aged 15-49 who received an HIV test in the last 12 months and who know their results&lt;br&gt;% of men and women aged 15-49 who have been screened for TB in the last 12 months</td>
<td>Annual health assessments can help to improve treatment access and reduce barriers to care. Integrated models reduce the transport costs and patient time needed to access multiple services, and should save staff time. The inclusion of screening for hypertension, diabetes, anaemia, cholesterol and BMI as well as HIV, STIs and TB reinforces health seeking behaviour, promotes employee wellness, and destigmatises participation within the workplace. Universal access to HCT, TB, and STI screening is the entry point to prevention, treatment and care and support, and is therefore the key intervention for realising national policy goals.</td>
<td>Company level</td>
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**Objective 6: To ensure that 100% of men and women age 15-49 have access to condoms by 2016**

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| 14 | Maximise coverage of male and female condom dispensers/vending machines outside strategic points in the workplace for increased access | # of male condoms distributed  
# of female condoms distributed | Evidence from UNAIDS and WHO shows that condoms, when used correctly and consistently, are the single, most efficient, available means to reduce the sexual transmission of HIV and other STIs. A large body of scientific evidence shows that male latex condoms have an 80% or greater protective effect. Condoms are a key component of comprehensive HIV prevention. | Company level        |
| 15 | Increase the national distribution of government condoms by expanding to non-traditional outlets thereby improving access to high risk and under serviced workplaces and populations | # of new primary distribution sites  
# of service outlets  
# of condoms distributed  
% of reporting sites | Preventing new TB infections is important as it will reduce the pool of infected people and prevent absenteeism. The association of TB with HIV and the emergence of MDR-TB and extremely drug-resistant TB (XDR-TB) means it is now even more crucial to prevent TB, as the costly and longer treatment regimes needed for drug resistant strains is a burden on the already stretched treatment services. TB infection control requires a combination of administrative, environmental and personal respiratory interventions. This should be delivered in the broader infection control standards e.g. hand washing. This also requires each health facilities to have an infection control plan and officer. | Sectoral level       |

**Objective 7: To increase access to early detection, diagnosis, and early treatment of tb to 80% of exposed people by 2016.**

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<tbody>
<tr>
<td>16</td>
<td>Companywide outreach and mobilisation on TB</td>
<td># females aged 15 and above reached with TB mobilisation package</td>
<td>Preventing new TB infections is important as it will reduce the pool of infected people and prevent absenteeism. The association of TB with HIV and the emergence of MDR-TB and extremely drug-resistant TB (XDR-TB) means it is now even more crucial to prevent TB, as the costly and longer treatment regimes needed for drug resistant strains is a burden on the already stretched treatment services. TB infection control requires a combination of administrative, environmental and personal respiratory interventions. This should be delivered in the broader infection control standards e.g. hand washing. This also requires each health facilities to have an infection control plan and officer.</td>
<td>Company level</td>
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</table>
| 17 | Provide TB prevention services according to national guidelines | % of newly diagnosed HIV positive patients started on IPT  
% of HIV positive patients with latent TB receiving IPT  
% of HIV positive TB patients who are receiving ART | Preventing new TB infections is important as it will reduce the pool of infected people and prevent absenteeism. The association of TB with HIV and the emergence of MDR-TB and extremely drug-resistant TB (XDR-TB) means it is now even more crucial to prevent TB, as the costly and longer treatment regimes needed for drug resistant strains is a burden on the already stretched treatment services. TB infection control requires a combination of administrative, environmental and personal respiratory interventions. This should be delivered in the broader infection control standards e.g. hand washing. This also requires each health facilities to have an infection control plan and officer. | Company level        |
**PRIORITY AREA 2: SUSTAINING HEALTH AND WELLNESS**

**Objective 1:** To ensure that at least 90% of HIV infected people have access to treatment and support, remain adherent to treatment and maintain optimum health

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| 18 | Develop proactive and innovative mechanisms to ensure adherence as well as working with service providers on rigorous systems that identify defaulters with remedial action. For example:  
• Promote the use of DOTS in the workplace.  
• Use cellphone based communication to improve treatment adherence.  
• Use social media - Twitter, Facebook, Mxit - to improve retention and treatment adherence | % of patients with full adherence to ART  
# of patients who defaulted from treatment  
# of ART patients deregistered due to lost to follow-up  
# ART patients deregistered due to death | Companies only realise a substantial return on employee health and wellness investments when employees with HIV and TB access treatment in time, and continuously take their medication correctly. This should result in reduced absenteeism and increased productivity. Companies should review and improve adherence support and follow up mechanisms  
In order to ensure adherence the DOTS strategy ensures that TB patients are directly observed and supported to take their TB medication every day until they are cured. | Company level |
| 19 | Providing access to comprehensive ART services                                           | # of eligible adults receiving ART            | DOTS supporters can be health workers, employers or any responsible community.                                                                                                                                  | Multi-sectoral level |
| 20 | Mobilise resources to provide health services for SMMEs through distribution of chronic medicines supplied by government and treatment management of chronic illnesses. SME’s provide access to test their employees in the workplace; NGO’s provide services, government to provide consumables, drugs and laboratory services. Private sector supply mobile clinics resourced by DoH.  
Use business healthcare facilities to provide government drugs and services. Networks of private doctors and healthcare professionals to provide government drugs and services. | # of eligible adults receiving ART | Many SMMEs lack adequate resources to adequately respond to HIV, STIs and TB. There is a need for effective co-ordination, innovative healthcare intervention and partnership building for these companies to participate in the response. NGO’s who provide testing and treatment, have the expertise and resources to assist SMME employees. Government in its partnership effort is ideally positioned to support this intervention through preventative testing, consumables and treatment drugs for easier access to the SMME population.  
Training in monitoring and reporting can be offered to NGO’s. This intervention is aimed at increased access to HIV related health services whilst contributing to job retention in the country. | Multi-sectoral level |
Objective 2: To ensure that 90% of people infected with TB have access to services that are responsive to their needs and are of high quality

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<tr>
<td>21</td>
<td>Integration of HIV and TB services (or to be improved if already integrated)</td>
<td># of companies with integrated TB and HIV services within the workplace.</td>
<td>Integrated TB and HIV services are crucial in the TB and HIV response in order to prevent, identify, and treat TB and other opportunistic infections in HIV positive patients and to improve the diagnosis, treatment, and outcomes for patients affected by both diseases. Integrated services allow improved clinical care including HCT uptake, and improved care pathways for HIV positive patients with TB. Integration also provides a friendlier and more efficient service for patients through a “one-stop” service and also improves efficiency at both the facility and the health system level which ultimately result in improved patient outcomes.</td>
<td>Company level</td>
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22 Adherence to DOTS strategy guidelines and expansion of access to TB/HIV services

# of TB patients receiving DOTS

PRIORITY AREA 3: PROTECTION OF HUMAN RIGHTS

Objective 1: To strengthen leadership at all levels of society to publicly promote human rights and speak out against stigma, discrimination and related behaviours to create a more equal society.

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<tr>
<td>23</td>
<td>Ensure visible leadership, support and participation from board members and executive management. The CEO and Chairperson need to be conversant on the issues and know the company’s position. Ownership or support of the company-based HIV, STI, TB and wellness initiatives must be at the most senior level.</td>
<td>Level of participation of senior management in HIV, TB and STI activities</td>
<td>Leadership is crucial to an integrated HIV, AIDS, STI, and wellness response. In many companies, senior management and board level participation in the HIV, AIDS, STI, TB and wellness response is conspicuous by its absence. Board members and executive management are leaders in their companies and often in the broader community as well. They should support and encourage HIV initiatives and should be involved in communicating important messages about HIV, AIDS, STIs, TB and wellness aimed at changing social attitudes and behaviours. Support and participation of leaders in HIV, AIDS, STIs, TB and wellness activities sets a good example and encourages employees to do likewise.</td>
<td>Company level</td>
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<td>24</td>
<td>Establish a comprehensive and integrated company policy and procedures that cover</td>
<td># of companies with integrated policies for HIV and TB and gender and</td>
<td>One of the most effective ways of reducing and managing the impact of HIV, AIDS and TB in the workplace is through the implementation of an HIV, AIDS and TB policy and programme. Addressing aspects of HIV, AIDS and TB in the workplace will enable employers, trade unions and government to actively contribute towards local, national and international efforts to prevent and control HIV, AIDS and TB.</td>
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<td>the following where applicable: confidentiality, discrimination, routine medical</td>
<td>and rights based dimensions</td>
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<td>screening and testing for employees, respiratory infection control, treatment, sick</td>
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<td>leave, psychosocial support and job modification/alternative placement (where</td>
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<td>necessary) that is aligned to the KwaZulu-Natal HAST Response</td>
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<td>25</td>
<td>Ensure that HIV, AIDS and TB workplace policies and procedures comply/adhere to</td>
<td># of companies enforcing existing legislations</td>
<td>The right to work is central to the ability of people with HIV and/or TB to mitigate the impact of HIV and TB on them, their families and the broader community.</td>
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<td>applicable legal provisions and national/provincial plans</td>
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<td>26</td>
<td>Develop and implement interventions to address multiple and concurrent sexual</td>
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<td>The problem of multiple concurrent sexual partners in the workplace is</td>
<td>Multi-sectoral level</td>
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<td></td>
<td>partners amongst key population groups</td>
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<td>related to a range of factors. One of these factors is the migration of</td>
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<td>workers due to economic necessity. The province has a large number of</td>
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<td>workers who migrate to other areas of the country seeking employment.</td>
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<td>The province also has a large number of seasonal migrants in the</td>
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<td>agricultural sector. Many existing initiatives in the agricultural</td>
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<td>sector focus on permanent employees and the mass of itinerant workers</td>
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<td>is often excluded from benefiting from these initiatives. Workers</td>
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<td>are away from their partners and families for extended periods and they</td>
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<td>have sufficient disposable income to spend on sex workers or to engage</td>
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<td>in multiple sexual relationships. As such there is a need for increased</td>
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<td>social cohesion and strengthening of families. Targeted efforts amongst</td>
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<td>high transmission populations are key in reducing transmission and</td>
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<td>increasing access to treatment.</td>
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PRIORITY AREA 5: COORDINATION, MONITORING AND EVALUATION

Objective 1: To strengthen monitoring and evaluation systems of the multi-sectoral response and ensure that at least 90% of sectors consistently reporting to the coordination structures by 2016

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</table>
| 27 | Provision of technical assistance to companies and service providers on registration and reporting i.e. data collection, cleaning and collation | # of companies reporting data via Bizwell  
# of sectors reporting data via Bizwell | M&E is essential part of any plan and often neglected. Not only does M&E enable progress towards outcomes and goals to be tracked, but is can assess the quality and impact of a project. This provides transparency and allows accountability to be assigned within the project. Bizwell is a web-based HIS which can be used as a monitoring and reporting tool that was specially developed for SABCOHA to ensure effective capturing of HCT data in the South African business sector. It enables business to assess high risk areas in addressing disease management in the workplace. It gives intelligent and informed information on HIV and AIDS in the private sector to enable government to formulate effective strategies to address the impact of the epidemic in business. | Sectoral level     |
| 28 | Training and mentoring of principal and secondary users on the Bizwell system              | # of training sessions conducted                                           | 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 PCA a knowledge repository should be established inviting all stakeholders to publish/post papers, reports, and presentations some of which may have been presented at conferences nationally and internationally. The repository will require proper management to ensure relevance and inform priorities including review, categorisation and archiving. | Sectoral level     |
| 29 | Improve collaboration in the dissemination and sharing of research findings and jointly identify research needs and agree priorities |                                                                             |                                                                                                                                                                                                          | Multi-sectoral level |
KWAZULU-NATAL PROVINCE

Geography and demographics

KwaZulu-Natal is situated on the north eastern South African coast and shares international borders with Lesotho, Swaziland and Mozambique. It shares provincial borders with the Eastern Cape, Free State and Mpumalanga. KwaZulu-Natal was formed in 1994 with the merge of the former semi-independent homeland areas of KwaZulu into the province of Natal, which was previously a former British colony. KwaZulu-Natal is the third smallest province, covering 94,361 square kilometres and occupying 7.7% of the land area of South Africa. It has the second largest population, after Gauteng. The major roads in the province include the N2, which runs along the coast and links Durban to the Swazi border and Mpumalanga in the north, and the Eastern Cape in the south; and the N3, which runs from the coast westwards and links Durban to Gauteng and other inland areas.

The subtropical coastline which is flanked by the Indian Ocean has some of South Africa’s best-protected indigenous coastal forests and the interior of the province consists of fertile rolling hills. KwaZulu-Natal has two UNESCO World Heritage sites: iSimangaliso (formerly Greater St Lucia) Wetland Park and the UKhahlamba Drakensberg Park.

The province is divided into 10 district municipalities and one metropolitan municipality, namely Ugu, uMgungundlovu, uThukela, uMzinyathi, Amajuba, Zululand, uMkhanyakude, uThungulu, iLembe, Sisonke, and eThekwini Metropole. These 10 district municipalities are further subdivided into 50 local municipalities.

Pietermaritzburg is the provincial capital and is located in the uMgungundlovu district, where the seat of the provincial administration is situated. The eThekwini Metropole, which encompasses the City of Durban, is the largest and most cosmopolitan city in the province and is made up of several “sub-towns” and suburbs. Pinetown, The Bluff, Umhlanga, and Westville are all major suburbs that form part of the city of Durban. Other major towns in the province include: Howick, Estcourt, Hluhluwe, Richards Bay, Scottburgh, St.Lucia, and Newcastle.

The mid-year 2011 population estimates approximate the KwaZulu-Natal population to be 10,819,128 (21.4% of the South African population) with 52.3% of the province’s population being female and 47.7% male. However,

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the latest population estimates on a district level are those from 2010 (Table 4) which estimates the KwaZulu-
Natal population to be 10 645 506. It is estimated that 54% of KwaZulu-Natal’s population are living in rural areas
and that 10% of the urban population live in informal settlements.21 The 2001 Census data indicated that more
than three quarters (79.9%) of KwaZulu-Natal’s population’s first home language was isiZulu, followed by 13.4%
English, 3.5% isiXhosa and 1.5% Afrikaans.22

**Table 4: KwaZulu-Natal population by population district (2010)**

<table>
<thead>
<tr>
<th>District</th>
<th>Population total</th>
<th>Population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugu</td>
<td>745 265</td>
<td>7.0%</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>989 371</td>
<td>9.3%</td>
</tr>
<tr>
<td>uThukela</td>
<td>728 442</td>
<td>6.8%</td>
</tr>
<tr>
<td>uMzinyathi</td>
<td>539 225</td>
<td>5.1%</td>
</tr>
<tr>
<td>Amajuba</td>
<td>525 164</td>
<td>4.9%</td>
</tr>
<tr>
<td>Zululand</td>
<td>852 827</td>
<td>8.0%</td>
</tr>
<tr>
<td>uMkhanyakude</td>
<td>638 019</td>
<td>6.0%</td>
</tr>
<tr>
<td>uThungulu</td>
<td>1 025 835</td>
<td>9.6%</td>
</tr>
<tr>
<td>iLembe</td>
<td>582 617</td>
<td>5.5%</td>
</tr>
<tr>
<td>Sisonke</td>
<td>519 487</td>
<td>4.9%</td>
</tr>
<tr>
<td>eThekwini Metropole</td>
<td>3 499 254</td>
<td>32.9%</td>
</tr>
</tbody>
</table>

The estimated KwaZulu-Natal migration streams from 2006-2011 show both high out- and in-migration flows,
which are 196 933 and 198 355 respectively. A significant proportion of the out-migrants move to Gauteng and
the majority of the in-migrants come from the Eastern Cape and Gauteng provinces.24 Additionally, there is
significant rural-urban migration within the province.

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Natal, South Africa.
Labour market and economy

In 2010 KwaZulu-Natal contributed 15.8% to the country’s gross domestic product (GDP). KwaZulu-Natal inherited a legacy of underdevelopment and limited economic activity with the incorporation of the former non-independent homeland areas of KwaZulu. These areas have high levels of poverty and subsistence agriculture. The bulk of the economic activity is concentrated in three districts eThekwini, uMgungundlovu and uThungulu; contributing 53%, 12% and 8% to provincial Gross Value Add (GVA) respectively. The remaining 27% of GVA comes from the smaller towns and rural areas. The cities of eThekwini (Durban-Pinetown), Msunduzi (Pietermaritzburg) and Umhlatuze (Richards Bay, Empangeni) dominate the economic activity. However, there are smaller economic hubs around the following areas: Newcastle (steel production and coal-mining), Estcourt (meat processing), and Ladysmith and Richmond (mixed agriculture). KwaZulu-Natal also has several popular coastal holiday resorts, such as Port Shepstone, Umhlanga Rocks and Margate.

The finance, real estate and business services sector was the highest contributor to provincial GDP (Table 5) and generated a solid 11.0% of the provincial employment (Table 6). Manufacturing is another key sector in KwaZulu-Natal, contributing 16.8% to the provincial GDP, and generating 15.3% of the provincial employment. The trade sector and community and social services sector were the top two employers in the province (Table 6) and contributed significantly to GDP with 13.7% and 13.5% respectively. Further detail on the industry split of GDP and employment within the province is provided in Table 5 and Table 6. Although, relative to other high value sectors, agriculture does not contribute highly (Table 5), the highest percentage of the value added by the agricultural, forestry and fishing industry in South Africa is from KwaZulu-Natal (27.1%).

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Table 5: Contribution to KwaZulu-Natal GDP by Industry (2010)²⁶

<table>
<thead>
<tr>
<th>Major industry</th>
<th>Contribution to GDP (R million)</th>
<th>Contribution to GDP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance, real estate and business services</td>
<td>73 482</td>
<td>19.2</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>70 694</td>
<td>18.5</td>
</tr>
<tr>
<td>Wholesale, retail &amp; motor trade; catering &amp; accommodation</td>
<td>57 704</td>
<td>15.1</td>
</tr>
<tr>
<td>General government services</td>
<td>56 706</td>
<td>14.8</td>
</tr>
<tr>
<td>Transport, storage and communication</td>
<td>45 181</td>
<td>11.8</td>
</tr>
<tr>
<td>Personal services</td>
<td>27 874</td>
<td>7.3</td>
</tr>
<tr>
<td>Agriculture, forestry and fishing</td>
<td>15 883</td>
<td>4.2</td>
</tr>
<tr>
<td>Construction</td>
<td>15 198</td>
<td>4.0</td>
</tr>
<tr>
<td>Electricity, gas and water</td>
<td>11 369</td>
<td>3.0</td>
</tr>
<tr>
<td>Mining and quarrying</td>
<td>8 068</td>
<td>2.1</td>
</tr>
<tr>
<td>Total KwaZulu-Natal</td>
<td>382 159</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 6: KwaZulu-Natal employment by industry (January to March 2012)²⁷

<table>
<thead>
<tr>
<th>Major industry</th>
<th>Employed</th>
<th>Employed (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade</td>
<td>570</td>
<td>22.6%</td>
</tr>
<tr>
<td>Community and social services</td>
<td>540</td>
<td>21.4%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>386</td>
<td>15.3%</td>
</tr>
<tr>
<td>Finance</td>
<td>276</td>
<td>11.0%</td>
</tr>
<tr>
<td>Private households</td>
<td>239</td>
<td>9.5%</td>
</tr>
<tr>
<td>Construction</td>
<td>210</td>
<td>8.3%</td>
</tr>
<tr>
<td>Transport</td>
<td>180</td>
<td>7.1%</td>
</tr>
<tr>
<td>Agriculture</td>
<td>91</td>
<td>3.6%</td>
</tr>
<tr>
<td>Mining</td>
<td>18</td>
<td>0.7%</td>
</tr>
<tr>
<td>Utilities</td>
<td>9</td>
<td>0.4%</td>
</tr>
<tr>
<td>Total Employed KwaZulu-Natal</td>
<td>2 519</td>
<td>100%</td>
</tr>
</tbody>
</table>

The total working age population in KwaZulu-Natal is estimated to be 6 828 000 in Q1 2012, of which 53.6% are not economically active. The latest labour survey (Q1 2012) estimated that 2 519 000 people were employed in KwaZulu-Natal. The formal (non-agriculture) sector is the major contributor to employment in the province at 68.6%, with the informal sector contributing 18.2%. The agriculture sector and private households sector (which includes domestic workers) contribute 9.5% and 3.6% respectively towards provincial employment. Table 7 provides further detail on the KwaZulu-Natal labour force characteristics. KwaZulu-Natal had the lowest unemployment rate in the country, estimated at 20.5% in Q1 2012.

Although only 91,000 are employed in the formal agricultural sector, over 850,000 people are dependent on small subsistence farms. KwaZulu-Natal has the highest number of people who are dependent on subsistence farming in the country, with over 40% of the 2,077,000 people in South Africa who are dependent on subsistence farming living in KwaZulu-Natal.

**Table 7: Labour force characteristics for KwaZulu-Natal (2012)**

<table>
<thead>
<tr>
<th>Major industry</th>
<th>January - March 2012 (in thousands)</th>
<th>Year on year change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 15–64 yrs</td>
<td>6,828</td>
<td>1.6%</td>
</tr>
<tr>
<td>Labour Force</td>
<td>3,168</td>
<td>3.9%</td>
</tr>
<tr>
<td>Employed</td>
<td>2,519</td>
<td>3.7%</td>
</tr>
<tr>
<td>Formal sector (non-agricultural)</td>
<td>1,729</td>
<td>3.4%</td>
</tr>
<tr>
<td>Informal sector (non-agricultural)</td>
<td>460</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Agriculture</td>
<td>91</td>
<td>-15.7%</td>
</tr>
<tr>
<td>Private households</td>
<td>239</td>
<td>27.1%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>649</td>
<td>4.7%</td>
</tr>
<tr>
<td>Not economically active</td>
<td>3,660</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Discouraged work-seekers</td>
<td>579</td>
<td>-2.2%</td>
</tr>
<tr>
<td>Other</td>
<td>3,081</td>
<td>0.1%</td>
</tr>
<tr>
<td>Rates</td>
<td>October - December 2011</td>
<td></td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>20.5%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Expanded unemployment rate *</td>
<td>39.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Labour force participation rate</td>
<td>46.4%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

*The expanded definition of unemployment includes discouraged work seekers.

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Table 8: Working age population (2007) and contribution to, Gross Domestic Product per Region (GDPR)\textsuperscript{29}

<table>
<thead>
<tr>
<th>District</th>
<th>Working age population 2007 (15-64 years)</th>
<th>Percentage of working age population (%)</th>
<th>Contribution to GDP, average 2002 - 2007 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugu</td>
<td>411 129</td>
<td>6.50%</td>
<td>3.69%</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>639 624</td>
<td>10.11%</td>
<td>8.43%</td>
</tr>
<tr>
<td>uThukela</td>
<td>397 105</td>
<td>6.28%</td>
<td>2.46%</td>
</tr>
<tr>
<td>uMzinyathi</td>
<td>268 041</td>
<td>4.24%</td>
<td>0.78%</td>
</tr>
<tr>
<td>Amajuba</td>
<td>262 968</td>
<td>4.16%</td>
<td>3.52%</td>
</tr>
<tr>
<td>Zululand</td>
<td>493 878</td>
<td>7.81%</td>
<td>1.50%</td>
</tr>
<tr>
<td>uMkhanyakude</td>
<td>334 125</td>
<td>5.28%</td>
<td>1.06%</td>
</tr>
<tr>
<td>uThungulu</td>
<td>530 592</td>
<td>8.39%</td>
<td>9.25%</td>
</tr>
<tr>
<td>iLembe</td>
<td>326 161</td>
<td>5.15%</td>
<td>3.36%</td>
</tr>
<tr>
<td>Sisonke</td>
<td>273 323</td>
<td>4.32%</td>
<td>1.09%</td>
</tr>
<tr>
<td>eThekwini Metropole</td>
<td>2 390 308</td>
<td>37.78%</td>
<td>64.85%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>6 327 254</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

HIV, AIDS, TB and related social conditions

The National HIV Prevalence, Incidence, Behaviour and Communication Survey in 2008 estimated the HIV prevalence for the KwaZulu-Natal population over two years old was 15.8%. KwaZulu-Natal also had the highest incidence of HIV, estimated at 2.3% in 2009 compared to the national average of 1.8%.\textsuperscript{30} According to SANAC in 2011 more than half (54%) of the adult PLHIV in South Africa live in KwaZulu-Natal.\textsuperscript{30}

The Antenatal Clinic Survey has been used to monitor HIV prevalence trends since 1990 and is the only indicator that has been measured accurately and consistently in South Africa. Although the Antenatal Clinic Survey only measures prevalence in first time antenatal clinic attendees, it provides a baseline for estimates and future actuarial projections of HIV infections among the whole population. The ASSA 2008 model’s projections for the number of people estimated to be living with HIV in KwaZulu-Natal and other key indicators are shown in Table 9.

The 2010 National Antenatal Clinic Survey found that KwaZulu-Natal had a HIV prevalence rate amongst women who attended public antenatal clinics of 39.5% (Figure 5) and is the highest prevalence of all the provinces. KwaZulu-Natal has consistently recorded the highest HIV prevalence since 1990. Not one of the KwaZulu-Natal districts was below the national average in 2010 and all five of the districts, which recorded prevalence rates of above 40%, were in KwaZulu-Natal (Figure 5).\textsuperscript{31}

\textsuperscript{31} Department of Health South Africa (2011) The National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa 2010
Figure 5: HIV prevalence among antenatal clinic attendees in KwaZulu-Natal by district and year. 

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>eThekweni</td>
<td>41.1%</td>
<td>41.5%</td>
<td>41.0%</td>
<td>41.6%</td>
<td>37.2%</td>
<td>35.8%</td>
<td>41.0%</td>
<td></td>
</tr>
<tr>
<td>Sisonke</td>
<td>42.3%</td>
<td>40.6%</td>
<td>35.8%</td>
<td>41.4%</td>
<td>38.9%</td>
<td>39.1%</td>
<td>39.1%</td>
<td></td>
</tr>
<tr>
<td>iLembe</td>
<td>36.9%</td>
<td>37.7%</td>
<td>36.1%</td>
<td>35.9%</td>
<td>34.6%</td>
<td>34.6%</td>
<td>34.6%</td>
<td></td>
</tr>
<tr>
<td>Uthungulu</td>
<td>41.9%</td>
<td>39.7%</td>
<td>39.9%</td>
<td>39.8%</td>
<td>36.3%</td>
<td>36.3%</td>
<td>36.3%</td>
<td></td>
</tr>
<tr>
<td>Umkanyakude</td>
<td>39.9%</td>
<td>39.9%</td>
<td>39.9%</td>
<td>39.9%</td>
<td>39.9%</td>
<td>39.9%</td>
<td>39.9%</td>
<td></td>
</tr>
<tr>
<td>Zululand</td>
<td>36.7%</td>
<td>36.7%</td>
<td>36.7%</td>
<td>36.7%</td>
<td>36.7%</td>
<td>36.7%</td>
<td>36.7%</td>
<td></td>
</tr>
<tr>
<td>Amajuba</td>
<td>39.5%</td>
<td>39.3%</td>
<td>39.3%</td>
<td>39.3%</td>
<td>46%</td>
<td>46%</td>
<td>46%</td>
<td></td>
</tr>
<tr>
<td>Umzinyathi</td>
<td>28.2%</td>
<td>29.2%</td>
<td>31.6%</td>
<td>30.9%</td>
<td>27.9%</td>
<td>36.7%</td>
<td>38.6%</td>
<td></td>
</tr>
<tr>
<td>Uthukela</td>
<td>46.7%</td>
<td>46.4%</td>
<td>38.6%</td>
<td>38.6%</td>
<td>46.4%</td>
<td>46.4%</td>
<td>46.4%</td>
<td></td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>45.7%</td>
<td>40.8%</td>
<td>42.3%</td>
<td>40.9%</td>
<td>45.7%</td>
<td>40.8%</td>
<td>40.8%</td>
<td></td>
</tr>
<tr>
<td>Ugu</td>
<td>41.1%</td>
<td>40.2%</td>
<td>40.6%</td>
<td>37.3%</td>
<td>38.9%</td>
<td>39.5%</td>
<td>39.5%</td>
<td></td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>42.3%</td>
<td>40.6%</td>
<td>40.6%</td>
<td>37.3%</td>
<td>38.9%</td>
<td>39.5%</td>
<td>39.5%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 5: HIV prevalence among antenatal clinic attendees in KwaZulu-Natal by district and year.
The district with the lowest prevalence in 2010 was uMzinyathi but this has increased from 28.2% in 2009 to 31.1% in 2010. The biggest decrease in prevalence was recorded in uThukela which dropped by almost 10% from 2009.

Table 9: KwaZulu-Natal HIV and AIDS demographic projections

<table>
<thead>
<tr>
<th>Indicator</th>
<th>KwaZulu-Natal Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
</tr>
<tr>
<td>Whole population prevalence</td>
<td>14.8%</td>
</tr>
<tr>
<td>Adults (ages 20-64)</td>
<td>25.2%</td>
</tr>
<tr>
<td>People living with HIV</td>
<td>1 550 955</td>
</tr>
<tr>
<td>New HIV infections (in the year starting 1 July)</td>
<td>44 778</td>
</tr>
<tr>
<td>AIDS deaths (in the year starting 1 July)</td>
<td>54 337</td>
</tr>
<tr>
<td>Accumulated AIDS deaths</td>
<td>766 104</td>
</tr>
</tbody>
</table>

According to the ASSA 2008 model projections the number of PLHIV in KwaZulu-Natal is 1 550 955 in 2012 (Table 9). If 30% are presumed to have CD4 counts of 350 and below, the number of patients in KwaZulu-Natal, in need of ART, is 465 287.

TB remains the leading cause of mortality in KwaZulu-Natal. The province had the highest number of TB cases in the country in 2008 with 118 162 cases (Table 10), this was almost double the figure in the next highest province and represents a caseload of 1 156 cases per 100 000 population, which is more than four times the epidemic threshold according to the WHO.

Table 10 provides a summary of TB indicators per district. KwaZulu-Natal’s TB incidence of 334.2 per 100 000 was higher than the national average and Ugu and Sisonke each had a TB incidence of over 400 cases per 100 000 in 2008. However, the biggest burden of infected individuals in 2008 was in the eThekwini Metropole, which, despite having a similar population to City of Johannesburg and City of Cape Town Metropoles, has a much higher number of TB cases. The KwaZulu-Natal TB cure rate of 55.4% was the second lowest in the country in 2007. However, the TB cure rates vary considerably at a district level from 39.1% in uMkhanyakude to 80.7% in uMzinyathi. The high rates of HIV co-infection in TB patients highlight the need for closer integration of the two programmes.

The appointment of TB Community Officers in KwaZulu-Natal has helped to trace defaulters and resulted in improved compliance and an increase in cure rates from 35% in 2004.

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Table 10: TB indicators per district

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ugu</td>
<td>9 980</td>
<td>477</td>
<td>56.6%</td>
<td>52.9%</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>12 433</td>
<td>292.6</td>
<td>58.2%</td>
<td>52.1%</td>
</tr>
<tr>
<td>uThukela</td>
<td>6 316</td>
<td>307.4</td>
<td>53.0%</td>
<td>49.9%</td>
</tr>
<tr>
<td>uMzinyathi</td>
<td>5 373</td>
<td>278.3</td>
<td>81.9%</td>
<td>80.7%</td>
</tr>
<tr>
<td>Amajuba</td>
<td>4 376</td>
<td>259.1</td>
<td>70.6%</td>
<td>68.3%</td>
</tr>
<tr>
<td>Zululand</td>
<td>7 980</td>
<td>254.8</td>
<td>60.9%</td>
<td>52.7%</td>
</tr>
<tr>
<td>uMkhanyakude</td>
<td>9 110</td>
<td>366.7</td>
<td>52.5%</td>
<td>39.1%</td>
</tr>
<tr>
<td>uThungulu</td>
<td>11 916</td>
<td>293.7</td>
<td>55.2%</td>
<td>71.1%</td>
</tr>
<tr>
<td>iLembe</td>
<td>5 614</td>
<td>331.9</td>
<td>49.2%</td>
<td>59.9%</td>
</tr>
<tr>
<td>Sisonke</td>
<td>6 340</td>
<td>452.5</td>
<td>51.1%</td>
<td>62.3%</td>
</tr>
<tr>
<td>eThekwini</td>
<td>38 624</td>
<td>357.8</td>
<td>56.8%</td>
<td>49.2%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>118 062</td>
<td>334.2</td>
<td>57.3%</td>
<td>55.4%</td>
</tr>
<tr>
<td>South Africa</td>
<td>388 782</td>
<td>287.5</td>
<td>62.5%</td>
<td>63.9%</td>
</tr>
</tbody>
</table>

Alcohol and drug abuse have long been recognised as social pathologies that need to be addressed in South Africa, especially among the youth, both in and out of school. As alcohol and drug abuse are often associated with unprotected sex they are major risk factors for HIV. Like in other parts of the country, alcohol remains the dominant substance of abuse in KwaZulu-Natal. In response to evidence of rising drug use amongst adolescents in KwaZulu-Natal an ongoing HSRC study led by Prof. Arvin Bhana is looking to develop an integrated strategy for teenage drug abuse.\footnote{http://www.hsrc.ac.za/Research_Project-812.phtml.}

The province inherited a legacy of poverty with the incorporation of the former non-independent homeland areas of KwaZulu. The former homeland areas are dominated by densely populated rural settlements and characterised by subsistence farming. These areas have a typically underdeveloped character with problems that exacerbate poverty such as: unemployment, lack of development, limited infrastructure and services.

In 2005/06 the poverty rate among individuals in KwaZulu-Natal was 58.5% which was the second highest in the country after the Eastern Cape and the incidence of poverty was much higher in the rural areas of South Africa.\footnote{Armstrong, P., Lekzewa, B. & Siebrits, K., 2008, Poverty in South Africa: A profile based on recent household surveys, Stellenbosch Economic Working Paper, 04/2008, Stellenbosch University, Department of Economics.} KwaZulu-Natal has high levels of deprivation and eight out of the 11 districts fall in the most deprived socio-economic quintiles of 1 and 2 (1 is the lowest and 5 is the highest).\footnote{Day C, Monticelli F, Barron P, Haynes R, Smith J, Sello E, editors. (2010) The District Health Barometer 2008/09. Durban: Health Systems Trust.} There are four districts which have been selected as one of the priority districts to be targeted in the Integrated Sustainable Rural Development Programme (ISRDP) which aims to improve opportunities and wellbeing for the rural poor. The ISRDP aims to increase the efficiency of the application of public funds in rural areas to create appropriate outputs in the places where they are most needed. The ISRDP facilitates health systems development in partnership with the district. The KwaZulu-Natal ISRDP districts include: Ugu, uMzinyathi, Zululand and uMkhanyakude. The development ISRDP districts should be prioritised by the provincial and local governments. The ISRDP facilitates health systems development in partnership with the district.


Education

Education is a structural driver of the HIV epidemic as it has been shown that people with higher levels of education were more likely to know about HIV prevention methods. Table 11 shows the level of education of the KwaZulu-Natal population 20 years and older. Just over 11.4% of the adult population had no schooling which is worse than the national figure of 9.4% with no schooling. Only 37% of KwaZulu-Natal’s adult population had Grade 12 or higher versus the national figure of 39.1%.

Table 11: Population aged 20 years and older, by highest level of education (2007)

<table>
<thead>
<tr>
<th>Education level</th>
<th>Population aged 20yrs and older</th>
<th>Percentage distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Schooling</td>
<td>645 475</td>
<td>11.4%</td>
</tr>
<tr>
<td>Primary</td>
<td>1 289 834</td>
<td>22.8%</td>
</tr>
<tr>
<td>Secondary</td>
<td>1 623 650</td>
<td>28.7%</td>
</tr>
<tr>
<td>Grade 12/Std 12</td>
<td>1 371 753</td>
<td>24.3%</td>
</tr>
<tr>
<td>Higher</td>
<td>592 585</td>
<td>10.5%</td>
</tr>
<tr>
<td>Other or unspecified</td>
<td>129 181</td>
<td>2.3%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>3 410 991</td>
<td>100%</td>
</tr>
</tbody>
</table>

KwaZulu-Natal has four key tertiary institutions: University of KwaZulu-Natal, (formed by the merger of the University of Natal and the University of Durban-Westville), University of Zululand, Durban University of Technology, (formed by the merge of ML Sultan Technikon and Technikon Natal) and Mangosuthu University of Technology.

Cultural and traditional context

KwaZulu-Natal has a diverse population composed of an African majority, Indians, Whites and Coloureds, this means that there is a rich mixture of culture within the province. KwaZulu-Natal is home to the Zulu traditional monarchy which is headed by King Goodwill Zwelithini kaBhekuzulu. A strong Zulu culture permeates and tradition is particularly important in the province, affecting all spheres of life for many members of the African population group. Despite his lack of direct political power, the Zulu king has considerable influence among the Zulu people and is a central figure in the HAST Response.

The African population group, which represents around 83% of KwaZulu-Natal’s population, is the worst affected by HIV, AIDS, STI and TB in the province. The King has been instrumental in curbing its spread through, for example, use of the “Reed Dance” ceremony in line with traditional culture to promote health e.g. MMC, and responsible sexual behaviour.

Administrative and governance context

The KwaZulu-Natal administration consists of three tiers of authority, namely: provincial, district and local municipal authorities. The province has one metropolitan municipality and 10 district municipalities, which are further divided into 51 local municipalities and a total of 823 wards. The South Africa Constitution vests the Executive Authority of the province in the Premier and exercises this Authority with the Members of the Executive Council (MEC). Likewise, the Executive Authority of each district and local municipality is vested in the respective Mayors.

Coordination and management of the HAST Response is a responsibility that falls under the PCA, which is chaired by the Premier. The PCA is supported by the HIV and AIDS Directorate located within the Office of the Premier which serves as its secretariat. At the district and local municipal levels DAC/LAC coordinate all HIV response activities. DACs and LACs are also expected to have secretariats. The province is in the process of setting up WACs in all 823 wards. WACs will assume the role of being the main coordinating authorities at ward level.

The province has 16 provincial government departments which facilitate the implementation of plans in their areas of responsibility. They work collaboratively with other spheres of government and relevant agencies. All these departments are expected to integrate and mainstream HAST activities into their mandates. Coordination of these departments is done through four cabinet clusters namely, economic sector and infrastructure development; social protection, human and community development; governance and administration and justice, crime prevention and security.

Additionally, the province has a House of Traditional Leaders at provincial level, 11 local houses of traditional leaders at a district level and 265 traditional councils at local level. These structures are critical to the HAST Response.

UGU DISTRICT

Geography and demographics

The Ugu district, meaning ‘coast’ in Zulu, consists of six local municipalities namely: Vulamehlo, Umdoni, Umzumbe, UMuziwabantu, Ezingoleni and Hibiscus. This coastal district occupies the south eastern portion of KwaZulu-Natal and shares a provincial border with the Eastern Cape. The district has diverse landscapes with large areas of unspoiled sub-tropical bushland and forest, cultivated land and small rural villages, as well as bustling urban centres and major industrial complexes.

Ugu covers 5 047 square kilometres and is one of the smaller KwaZulu-Natal districts. It accommodates 7.0% of KwaZulu-Natal’s population (Table 4). The population density is very high at 141 persons per square kilometre. The population of the district is predominantly rural, with 86% of the population located in rural areas, however densities are highest in the coastal zone (Hibiscus Coast and Umdoni). IsiZulu is the home language of the majority of the population in the district (87.6%), followed by English (7.1%), isiXhosa (3.3%) and Afrikaans (1.4%).

The seat of Ugu is Port Shepstone. The main towns include: Scottburgh, Harding, Hibberdene and Margate.

The district has 112 kilometres of spectacular coastline and the golden beaches attract many tourists. The district has a wide variety of other attractions ranging from coastal forests and waterfalls, to shipwrecks and famous lighthouses. Port Edward is thought to have the smallest desert of the world, called “Red Desert” which measures only 11 hectares. The naked red soil is a striking contrast to the lush, subtropical vegetation of the surrounding areas. Other attractions in the area include: Oribi Gorge, Kwaxolo Caves, The Petrified Fossil Forest in Port Edward and the Umtamvuna Nature Reserve.

Labour market and economy\textsuperscript{41,42}

The district contributed an average of 3.69% to the provincial economy over the period 2002 - 2008 (Table 8), this was the fourth highest contribution to GDP of all 11 KwaZulu-Natal districts over the period. The district has a largely urbanised coastal zone that is responsible for the bulk of the economic activity with Hibiscus Coast producing 60% and Umdoni producing 18% of the district’s economic activity. The largely impoverished rural interior has large numbers of subsistence farmers and these municipalities each attract less than 10% of the economic activity with Ezinqoleni attracting only 2% of the economic activity. There is manufacturing centred around Port Shepstone but the interior depends mainly on large commercial sugar and banana farms. The district is focusing on the rural population with its priority service and development goals.

The sectors that were major contributors to the district’s GDP over the period 2002 - 2007 were: manufacturing (20.1%), community services (19.1%), and trade (15.7%). Transport was the fastest growing sector in terms of GDP over the period.

The sectors that played a significant role in the district’s formal employment over the period 2002 - 2007 were: agriculture (21%), community services (21%), household services (17%), trade (13%) and manufacturing (12%). However, agriculture and community services, as employers, have seen declines since 2000. Ugu had a labour participation rate of 44.8% over the period, which indicates a lower level of economic activity relative to the provincial average of 52.5%.

The agricultural sector is characterised by large commercial farming activities and subsistence farming on rural trust land which comprises mostly of livestock raising, dryland cropping and homestead gardening. The highly developed and competitive commercial farms amount to about 90% of agricultural production in the district. The district’s major commercial agricultural activities include: sugar cane, bananas and macadamias; and to a lesser extent timber, coffee, cut flowers, livestock, poultry, game farming, mangoes, and other fruit and vegetables. Ugu produces about one fifth of bananas consumed in South Africa and boasts thriving forestry plantations. The agricultural sector has seen negative growth rates and decline in employment rates over the past few years, due in part to: declining commodity prices, influx of imports, the rising costs of production and lack of broader labour force participation.

Tourism has a major impact on Ugu’s economy with nearly 43% of businesses in the commercial hubs along the coast relying solely on tourists and a further 10% relying on both tourists and local residents for custom. The coastline with its countless bays is ideal for fishing, sea kayaking, kite surfing and scuba diving. Ugu boasts some of the most beautiful and highly acclaimed Blue Flag beaches and big waves that attract surfers.

Trade and commerce is a major contributor to Ugu’s economy, and includes: wholesale and retail trade, finance and business services, personal services (which includes hairdressing and funeral services among others) and community and social services (which includes provincial and local government). Although the bulk of the trade activity is centred around the coastal areas of Hibiscus Coast and Umdoni. Trade and commerce contributes about 50% of the uMziwabantu and Umzumbe economies and about 36% of the economies in Vulamehlo and Ezinqoleni. The main commercial hubs are Port Shepstone, Shelly Beach, Margate, Port Edward, Hibberdene, Pennington, Scottburgh, Dududu, Pungashe, Ezinqoleni and Harding.

Manufacturing contributes significantly to GDP and employment in the district. The major manufacturing activities include clothing, textiles, metal products, food and beverages and wood products. There is a cement factory in the Oribi Gorge region which draws on the limestone mined nearby.

\textsuperscript{42} Ugu District Municipality Integrated Development Plan 2007/08 to 2011/12 as revised in the 2011/12 IDP review
HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 Ugu, along with eThekwini, was the district with the fourth highest HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal at 41.1% (Figure 5). This is one of the highest prevalence rates in the country. The HIV prevalence in Ugu has increased slightly by 0.9% from 2009.

Ugu reported 9,980 TB cases (all forms) in 2008 and had an incidence of 477 per 100,000 which was the highest in the province (Table 10). The cure rate of 52.9% in 2007 was a great improvement on previous years but was still below the provincial average of 55.4%. The smear conversion rate of 56.6% was just below the 57.3% achieved by the province as a whole in 2008.

The levels of education in Ugu were worse than the provincial averages in 2007, with 14.9% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 27.9% of the adult population had Grade 12 or higher compared to the provincial average of 37%.

Ugu had a deprivation index of 3.82 in 2007 which falls into the first socio-economic quintile (1 is the lowest and 5 is the highest). It ranked fifth out of the 11 KwaZulu-Natal districts in the category "the most deprived district in the province".

Ugu was selected as one of the priority districts to be targeted in the ISRDP which aims to improve opportunities and wellbeing for the rural poor. The ISRDP aims to increase the efficiency of the application of public funds in rural areas to create appropriate outputs in the places where they are most needed. The ISRDP facilitates health systems development in partnership with the district.

UMGUNGUNDLOVU DISTRICT

Geography and demographics

The uMgungundlovu district, which comes from the Zulu word meaning place of the elephant, consists of seven local municipalities namely: uMshwathi, uMngeni, Mpofana, Impendle, Msunduzi, Mkhambathini and Richmond. This inland district occupies a south central position in KwaZulu-Natal and is completely surrounded by other KwaZulu-Natal districts. The N3 national road crosses the entire length of the district. An abundant system of six major rivers and five large dams provide water.

uMgungundlovu covers 8,934 square kilometres. It accommodates 9.3% of KwaZulu-Natal’s population (Table 4). The population density is fairly high at 112 persons per square kilometre. The population is predominantly rural, with slightly more females (51.2%) than males. IsiZulu is the home language of the majority of the population in the district (79.1%), followed by English (16.2%), isiXhosa (1.5%) and Afrikaans (1.3%).

The seat of uMgungundlovu is Pietermaritzburg. The main towns include: Mooi River, Howick, Impendle, Msunduzi, New Hanover, Wartburg, Camperdown and Richmond.

Labour market and economy

The district contributed an average of 8.43% to the provincial economy over the period 2002-2008 (Table 8); this was the third highest contribution to GDP out of all 11 KwaZulu-Natal districts over the period. The KwaZulu-Natal uMgungundlovu district profile prepared, for NHI pilot in 2011, indicates that uMgungundlovu now accounts for 13.5% of KwaZulu-Natal’s Gross Geographical Product (GGP) and 14.5% of the province’s formal employment. uMgungundlovu had a labour participation rate of 60.6% over the period 2002-2006, which indicates a high economic activity level relative to the provincial average of 52.5%.

The main economic centre of the district is Msunduzi, particularly the urban centre of Pietermaritzburg, and all the other local municipalities have relatively small economies. Pietermaritzburg has a robust manufacturing sector dominated by aluminium, footwear, wood (pulp, furniture and timber products), chemicals, food and leather products. The city is surrounded by commercial agricultural activity which is also a large contributor to the district economy. Outside of the towns are the scattered manufacturing enterprises and tourist attractions. The more rural areas in most local municipalities are heavily dependent on agriculture. The community services sector is also a major contributor to the district’s economy as the establishment of Pietermaritzburg as a provincial capital has meant that there has been a migration of provincial government services from uLundi and Durban. The migration of government services to Pietermaritzburg has also seen increased contribution of trade to the local economy with the rapid growth of the retail sector and property market in the city.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 uMgungundlovu, along with iLembe, was the district with the highest HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal at 42.3% (Figure 5). This is the highest prevalence rate in the country. The HIV prevalence in uMgungundlovu has increased by 1.4% from 2009. uMgungundlovu reported 12 433 TB cases (all forms) in 2008 and had an incidence of 292.2 per 100 000 which was the fourth lowest in the province (Table 10). The cure rate of 52.1% in 2007 was just below the provincial average of 55.4%. The smear conversion rate of 58.2% was above the 57.3% achieved by the province as a whole in 2008.

In uMgungundlovu the levels of education were better than the provincial averages in 2007, with 7.8% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 41.3% of the adult population had Grade 12 or higher compared to the provincial average of 37%.

uMgungundlovu had a deprivation index of 2.38 in 2007 which falls into the third socio-economic quintile (1 is the lowest and 5 is the highest). It ranked second last out of the 11 KwaZulu-Natal districts in the category “the most deprived district in the province”.

UTHUKELA DISTRICT

Geography and demographics

The uThukela district consists of five local municipalities namely: Emnambithi/Ladysmith, Indaka, Umtshezi, Okhahlamba and Imbabazane. The district derives its name from the UThukela River which is a major river that starts in the Drakensberg Mountains and supplies water to a large portion of KwaZulu-Natal and Gauteng. This inland district occupies the central western portion of KwaZulu-Natal. It shares an international border with Lesotho and provincial border with the Free State.

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uThukela covers 11 326 square kilometres50 and is the third largest of the KwaZulu-Natal districts. It accommodates 6.8% of KwaZulu-Natal’s population (Table 4). The population density is 56 persons per square kilometre. The population is predominantly rural (75%), with slightly more females (52.4%) than males. IsiZulu is the home language of the majority of the population in the district (93.2%), followed by English (4.3%) and Afrikaans (1.3%).51

The seat of uThukela is Ladysmith. The main towns include: Bergville, Winterton, Weenen and Estcourt/Wembezi.

uThukela has some key tourist attractions which include the scenic UKhahlamba Drakensberg Park which is a UNESCO World Heritage site and the historic battlefields. The Tugela Falls, which is the world’s second tallest water fall with a drop of 948 metres, is also located in uThukela.

Labour market and economy52,53

The district contributed an average of 2.46% to the provincial economy over the period 2002 - 2008 (Table 8); this was the seventh highest contribution to GDP out of all 11 KwaZulu-Natal districts over the period. The main economic hubs in the district include: Ladysmith which is the major service and retail centre for the region and has several industrial areas including the Ithala Industrial Estate; and Estcourt/ uMtshezi which has well-established manufacturing industries including Eskort Bacon Factory, Nestle, Masonite, Narrowtex, Clover, Bunyj Toys, and Glamosa Glass.

The sectors that were major contributors to the district’s GDP over the period 2002 - 2006 were: community services (24.7%), manufacturing, (19.3%), and finance (14.0%). Finance, trade, and transport were the fastest growing sectors in terms of GDP over the period and growth in agriculture declined sharply.

The sectors that played a significant role in the district’s formal employment over the period 2002 - 2006 were: community services (28.2%), manufacturing (21.3%), household services (12.6%), trade (10.8%) and agriculture (10%). uThukela had a labour participation rate of 41.0% over the period, which indicates an economic activity level which was about 10% below the provincial average (52.5%).

Significant manufacturing sub-sectors in the district include: textile, clothing, footwear and leather industries as well as food, beverages and tobacco.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 uThukela had the second lowest HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal at 36.7% (Figure 5). Although this is still above the national prevalence rate of 30.2%, the HIV prevalence in uThukela has decreased by 9.7% from 2009.

uThukela reported 6 316 TB cases (all forms) in 2008 and had an incidence of 307.4 per 100 000 which was just below the provincial average of 334.2 per 100 000 (Table 10). The cure rate of 49.9 % in 2007 was below the provincial average of 55.4%. The smear conversion rate of 53.0 % was below the 57.3% achieved by the province as a whole in 2008.

In uThukela the levels of education were worse than the provincial averages in 2007, with 13.8% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 28.4% of the adult population had Grade 12 or higher compared to the provincial average of 37%.54

uThukela had a deprivation index of 3.72 in 2007 which falls into the second socio-economic quintile (1 is the lowest and 5 is the highest). It ranked sixth out of the 11 KwaZulu-Natal districts in the category “the most deprived district in the province”.

**UMZINYATHI DISTRICT**

**Geography and demographics**

The uMzinyathi district which means ‘home of the buffalo’ consists of four local municipalities namely: Endumeni, Nqutu, Msinga and Umvoti. This inland district occupies the central portion of KwaZulu-Natal and is completely surrounded by other KwaZulu-Natal districts. The landscape is undulating, with some steeper areas. Major rivers that flow through uMzinyathi include the Tugela River, Mooi River, Umvoti River, Blood River and Buffalo River.

uMzinyathi covers 8,589 square kilometres. It accommodates 5.1% of KwaZulu-Natal’s population (Table 4). The population density is 55 persons per square kilometre. The population is almost entirely rural with 82% of the population living in rural areas which have limited services and infrastructure. There are slightly more females (54.1%) than males. IsiZulu is the home language of the majority of the population in the district (92.9%), followed by Sesotho (2.8%) and English (2.5%).

The seat of uMzinyathi is Dundee. The main towns include: Msinga, Greyton and Kranskop. The district has 17 Tribal Authorities and in most areas, apart from Endumeni, the majority (60%) of the land is under tribal ownership such as the Ingonyama Trust in Nquthu and Msinga.

Tourism is mostly domestic although the Zulu Battlefields of Isandlwana and Rorke’s Drift attract international tourists. Other attractions include: Zulu cultural experiences, craft and birding routes, 13 private game reserves, fishing in dams and rivers, white-water rafting, horseback safaris and a host of other adventures.

**Labour market and economy**

The district contributed an average of 0.78% to the provincial economy over the period 2002 - 2008 (Table 8); this was the lowest contribution to GDP out of all 11 KwaZulu-Natal districts over the period. The main economic hubs in the district include the towns of Dundee and Greytown. The coal mining town of Dundee is the service centre and administrative heart of northern KwaZulu-Natal and it also has light to medium manufacturing industries. Greytown is a strong regional centre with substantial commercial and agricultural activity.

The sectors that were major contributors to the district’s GDP over the period 2002 - 2006 were: community services (41.6%), agriculture (20.3%), and finance (11.3%). Finance, trade, and transport were the fastest growing sectors in terms of GDP over the period and mining and electricity sectors experienced negative growth rates. The sectors that played a significant role in the district’s formal employment over the period 2002 - 2006 were: community services (36.2%), agriculture (29.9%) and household services (13.6%). uMzinyathi had a labour participation rate of 34.6% over the period, which indicates an economic activity level which was below the provincial average (52.5%).

The agricultural sector is characterised by large commercial farming activities and subsistence farming on rural land. The district’s major commercial agricultural activities include: ranching for beef, small scale sheep and mixed
farming as well as maize cultivation in the north and substantial forestry is prevalent and sugar cane and smaller scale fruit farming such as avocado and kiwi fruit cultivation in the south. Orange Grove Dairy in Dundee has one of South Africa’s largest pedigree Jersey herds and manufactures and distributes dairy products throughout the province.

uMzinyathi has mineral deposits which include coal and metal ores and Dundee and Glencoe form part of the so called Coal Rim of KwaZulu-Natal. However the substantial decline in the coal mining sector over the years has reduced the importance of the mining sector in the uMzinyathi economy. There is interest in the small scale regeneration of the coal belt for SMME development.

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

According to the Antenatal Clinic Survey, in 2010 uMzinyathi had the lowest HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal at 31.1% (Figure 5). This is still above the national prevalence rate of 30.2%. However, the HIV prevalence in uMzinyathi has increased by 2.9% from 2009.

uMzinyathi reported 5 373 TB cases (all forms) in 2008 and had an incidence of 278.3 per 100 000, which was the third lowest in the province (Table 10). The cure rate of 80.7% in 2007 was the highest in the province. The smear conversion rate of 81.9% was way above the 57.3% achieved by the province as a whole in 2008.

There is a heavy reliance on public health services for healthcare as 88% of the uMzinyathi population is uninsured. Eighty percent of the population resides in deep rural and under-developed areas. The deep rural nature of the majority of the population along with the mountainous landscape adds to the challenge of providing accessible health services in this district.

uMzinyathi was chosen as one of the 10 pilot districts for the NHI pilot in 2012 and during this pilot it will be assessed whether the health service package, the Primary Health Care teams and a strengthened referral system will improve access to quality health services, particularly in the rural and previously disadvantaged areas of the country.

In uMzinyathi the levels of education were much worse than the provincial averages in 2007, with 29.0% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 23.0% of the adult population had Grade 12 or higher compared to the provincial average of 37%.

uMzinyathi had a deprivation index of 4.57 in 2007 which falls into the first socio-economic quintile (1 is the lowest and 5 is the highest). It was the most deprived district in KwaZulu-Natal and in South Africa in 2007 and according to the Community Survey 2007, 13% of the population live on an annual income below R4,800 or less than R 400 per month.

uMzinyathi was selected as one of the priority districts to be targeted in the ISRDP which aims to improve opportunities and wellbeing for the rural poor. The ISRDP aims to increase the efficiency of the application of public funds in rural areas to create appropriate outputs in the places where they are most needed. The ISRDP facilitates health systems development in partnership with the district.

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61 KwaZulu-Natal uMzinyathi District Profile (2011) Available at: http://www.health-e.co.za/documents/7add52cb1352b210d3699762b5bb4070.pdf
AMAJUBA DISTRICT

Geography and demographics

The Amajuba district which is an isiZulu name meaning “a place of doves”, consists of three local municipalities namely: Newcastle, Emadlangeni and Dannhauser. The landscape offers grassveld, bushveld and mountain habitats. This inland district occupies the north western portion of KwaZulu-Natal and it shares provincial borders with Mpumalanga and the Free State.

Amajuba covers 6 911 square kilometres. It accommodates 4.9% of KwaZulu-Natal’s population (Table 4). The population density is 86 persons per square kilometre. The population is predominantly rural. isiZulu is the home language of the majority of the population in the district (89.4%), followed by English (4.1%) and Afrikaans (3.8%).

The seat of Amajuba is Newcastle. Other main towns include: Utrecht and Dannhauser.

Labour market and economy

The district contributed an average of 3.52% to the provincial economy over the period 2002 - 2008 (Table 8); this was the sixth highest contribution to GDP out of all 11 KwaZulu-Natal districts over the period. The main economic hub in the district is the town of Newcastle, which has a flourishing central business district, shops that service the entire region as well as large manufacturing operations. The manufacturing activities include ArcelorMittal steelworks, the massive Karbochem synthetic rubber operation, plant heavy engineering concerns, a granite tile factory, steel reinforcement, and a slagment cement factory as well as clothing and textile operations. There is a KwaZulu-Natal Clothing and Textile Cluster Business Support Centre aimed at regenerating the town’s clothing and textile industry.

The sectors that were major contributors to the district’s GDP over the period 2002 - 2006 were: manufacturing (35.1%), community services (21.8%), and finance (14.0%). The sectors that played a significant role in the district’s formal employment over the period 2002 - 2006 were: manufacturing (30.6%), community services (23.8%) and household services (12.4%). Amajuba was the third most economically active district in the province (apart from eThekwini and uMgungundlovu) during the period 2002 - 2006, with a labour participation rate of 54.6% which was above the provincial average of 52.5%.

Historically the Amajuba economy was focused on coal mining but many collieries have closed. There are opportunities for small scale mining of coal, clays or reworking coal dumps. The climate and readily available water mean that there is potential in the agricultural sector. In addition to subsistence farming, the current agricultural activities in Amajuba include: forestry, game, livestock, dairy and crops (wheat, soya, maize dried tomatoes and other vegetables). The district is the most important wool producing area in KwaZulu-Natal.

The tourism sector has potentials for economic development in the district. There are natural and historical attractions such as battlefields, cultural events, and fishing, bird watching and game reserves. The Chelmsford Nature Reserve has white rhino, wildebeest, zebra, blesbok, springbok and numerous bird species.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 Amajuba had a HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal of 39.5% (Figure 5). Although this is close to the KwaZulu-Natal prevalence rate of 39.5%, it is still far above the national prevalence rate of 30.2%. The HIV prevalence in Amajuba has increased by 2.2% from 2009.

Amajuba reported 4 376 TB cases (all forms) in 2008 and had an incidence of 259.1 per 100 000 which is the second lowest in the province (Table 10). The cure rate of 68.3 % in 2007 is well above the provincial average of 55.4%. The smear conversion rate of 70.6% was also way above the 57.3% achieved by the province as a whole in 2008.

In Amajuba the levels of education were better than the provincial averages in 2007; with 7.5% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 39.1% of the adult population had Grade 12 or higher compared to the provincial average of 37%.66

Amajuba had a deprivation index of 2.83 in 2007 which falls into the third socio-economic quintile (1 is the lowest and 5 is the highest).67 It ranked ninth out of the 11 KwaZulu-Natal districts in the category “the most deprived district in the province”.

ZULULAND DISTRICT

Geography and demographics

Zululand consists of five local municipalities namely: eDumbe, UPhongolo, Abaqulusi, Nongoma and Ulundi. The districts landscape has green hills of rich soil, waving grasslands, and abundant forests. This inland district occupies the north-west portion of KwaZulu-Natal and shares an international border with Swaziland and a provincial border with Mpumalanga.

The district is relatively remote from the major development centres in KwaZulu-Natal such as Durban, Richards Bay and Pietermaritzburg and also removed from the main growth corridors along the N3 and N2 routes. However, the coal-line corridor is an important route in the national rail network which runs through the district from Richards Bay, through Ulundi, Vryheid and Paulpietersburg and to the mining areas in Mpumalanga.

Zululand covers 14 799 square kilometres and is the largest of the KwaZulu-Natal districts.67 It accommodates 8.0% of KwaZulu-Natal’s population (Table 4). The population density is 57 persons per square kilometre. The population is predominantly rural with 60% of the population still living in traditional dwellings. IsiZulu is the home language of the majority of the population in the district (96.8%), followed by Afrikaans (1.5%).68

Most of Zululand was part of the former homeland areas of KwaZulu and has limited services and infrastructure. The seat of Zululand is Ulundi. Other main towns include: Pongola, Paulpietersburg/Dumbe, Louwsburg, Vryheid, and Nongoma. Nongoma is the Royal City of Zululand and it is the home of King Goodwill Zwelithini, the leader of the Zulu nation.

Labour market and economy

The district contributed an average of 1.5% to the provincial economy over the period 2002 - 2008 (Table 8); this was the fourth lowest contribution to GDPR out of all 11 KwaZulu-Natal districts over the period. The main economic hub in the district is the town of Vryheid which is the district’s commercial and business centre, as well as an important industrial area. The other major town of Ulundi has a narrower economic base, relying heavily on government services, commerce and informal trading, but it’s location in the centre of a densely populated and poorly serviced rural area means it has a great deal of potential for development as an economic hub with the creation of office, industrial, commercial and tourism facilities.

The sectors that were major contributors to the district’s GDP over the period 2002 - 2006 were: community services (40.2%), agriculture (16.7%) and finance (9.9%). Finance was the fastest growing sector and the mining and electricity sectors experienced negative growth over the period.

The sectors that played a significant role in the district’s formal employment over the period 2002 - 2006 were: manufacturing (30.6%), community services (23.8%) and household services (12.4%). Zululand had a labour participation rate of 36.8% over the period 2002 - 2006, which indicates an economic activity level which was way below the provincial average (52.5%).

Agriculture is one of the key contributors to the Zululand economy and ranges from commercial sugar cane and wattle farming, to livestock farming and small scale agricultural production. The district’s major agricultural produce includes: maize, groundnuts, soya beans, sunflowers, and sorghum as well as sub-tropical fruit. In some areas livestock farms are being converted to game farms and hunting lodges. There is also a large traditional medicine market where plants, bark, tubers and some wildlife products are sold at the Mona traditional market to be transported to bigger markets in Durban, Johannesburg, Malawi, Botswana, Mozambique and Swaziland. Manufacturing in Zululand includes industries such as food and beverages, clothing and textiles, leather, paper and paper products, printing and publishing, metal products, machinery and equipment. The Valpre bottled water farm is also found in Zululand.

The district has potential to develop the tourism sector as there are natural and historical attractions such as game reserves and battlefields, and activities such as fishing, and bird watching.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 Zululand had a HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal of 39.8% (Figure 5). Although this is close to the KwaZulu-Natal prevalence rate of 39.5%, it is still far above the national prevalence rate of 30.2%. Another area for concern is that the HIV prevalence in Zululand has increased by 3.1% from 2009.

Zululand reported 7 980 TB cases (all forms) in 2008 and had an incidence of 254.8 per 100 000 which was the lowest in the province (Table 10). The cure rate of 52.7% in 2007 was a little below the provincial average of 55.4%. The smear conversion rate of 60.9% however was above the 57.3% achieved by the province as a whole in 2008.

In Zululand the levels of education were much worse than the provincial averages in 2007; with 19.5% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 26.6% of the adult population had Grade 12 or higher compared to the provincial average of 37%. 

Zululand had a deprivation index of 4.18 in 2007 which falls into the first socio-economic quintile (1 is the lowest and 5 is the highest).\(^{72}\) It ranked third out of the 11 KwaZulu-Natal districts in the category “the most deprived district in the province” and was also one of the most deprived districts in South Africa.

Zululand was selected as one of the priority districts to be targeted in the ISRDP which aims to improve opportunities and wellbeing for the rural poor. The ISRDP aims to increase the efficiency of the application of public funds in rural areas to create appropriate outputs in the places where they are most needed. The ISRDP facilitates health systems development in partnership with the district.

**UMKHANYAKUDE DISTRICT**

**Geography and demographics**

The uMkhanyakude district, which was named after the famous yellow-barked fever tree, and means “seen from afar,” consists of five local municipalities namely: Umhlabuyalingana, Jozini, The Big 5 False Bay, Hlabisa and Mtubatuba. This coastal district occupies the northernmost portion of KwaZulu-Natal’s coastline and shares international borders with Mozambique and Swaziland.

uMkhanyakude covers 13,855 square kilometres and is the second largest of the KwaZulu-Natal districts.\(^{72}\) It accommodates 6.0% of KwaZulu-Natal’s population (Table 4). The population density is 43 persons per square kilometre. IsiZulu is the home language of the majority of the population in the district (97.7%).\(^{73}\)

Large areas of uMkhanyakude are located in the traditional authority areas which are under communal tenure under the jurisdiction of the Ingonyama Trust. Most of the remaining areas are under state conservation or private ownership so there are limited formal urban areas.

The seat of uMkhanyakude is Mkuze. The main towns include: Mtubatuba, Jozini, St Lucia, Manguzi, Hluhluwe and Inyala.

The district contains the Greater St Lucia Wetland Park (now known as Isimangaliso – ‘the miracle’) World Heritage Site. It is also home to the Hluhluwe-Umfolozi, Mkuze, Ndumo and Tembe game parks. The southern tip of the Lebombo Mountains and the Makhatini Flats provide a diverse and beautiful landscape. The Jozini Dam, which is one of the largest in South Africa, was designed to irrigate more than 80,000 hectares of agricultural land.

**Labour market and economy**\(^{74,75}\)

The district contributed an average of 1.06% to the provincial economy over the period 2002 - 2008 (Table 8); this was the second lowest contribution to GDPR out of all 11 KwaZulu-Natal districts over the period.

The sectors that were major contributors to the district’s GDP over the period 2002 - 2006 were: community services (approximately 41%), agriculture (approximately 26%) and trade (approximately 8%). Finance and transport were the fastest growing sectors and the agriculture, and mining sectors contracted over the period.

The sectors that played a significant role in the district’s formal employment over the period 2002 - 2006 were: community services (39.0%), agriculture (30.0%) and private households (14%). uMkhanyakude was the most economically inactive district in the province during the period 2002 - 2006, with a labour participation rate of 29.6%, which was way below the provincial average of 52.5%.

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    uMkhanyakudeDistrictMunicipality/SocioEconomicProfile.aspx
    site/municipal-structure
There was a heavy reliance on community services sectors in the economy and labour market in the district over the period, with education and health sub-sectors together contributing accounting for 62.5% of the community services’ sectors employment. Agriculture was another key contributor to the district economy and labour market and the overall contribution of this important sector to the uMkhanyakude economy and labour market has been shrinking, which is concerning. The district’s major agricultural produce includes: sugar cane, rice, coffee, cotton, fibre crops, timber, tomatoes, chillies, pineapples and various sub-tropical fruits. The district produces over 90% of South Africa’s queen pineapples. There is potential for agri-processing in the form of canning or bottling of pineapples.

Tourism is one of the key drivers uMkhanyakude economy with attractions such as the Greater St Lucia Wetland Park, Jozini Dam, Sodwana Bay and various game reserves

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 uMkhanyakude had the third highest HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal at 41.9% (Figure 5). This is one of the highest prevalence rates in the country. The HIV prevalence in uMkhanyakude has increased by 2.2% from 2009.

uMkhanyakude reported 9 110 TB cases (all forms) in 2008 and had an incidence of 366.7 per 100 000 which was the third highest in the province (Table 10). The cure rate of 39.1 % in 2007 was the worst in the province by over 10%. However, the smear conversion rate of 52.5 % in 2008 was closer to the 57.3% achieved by the province as a whole.

In uMkhanyakude the levels of education were much worse than the provincial averages in 2007; with 26.8% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 26.9.4% of the adult population had Grade 12 or higher compared to the provincial average of 37%.

uMkhanyakude had a deprivation index of 4.49 in 2007 which falls into the first socio-economic quintile (1 is the lowest and 5 is the highest). It ranked second out of the 11 KwaZulu-Natal districts in the category “the most deprived district in the province” and was also the second most deprived district in South Africa.

uMkhanyakude was selected as one of the priority districts to be targeted in the ISRDP which aims to improve opportunities and wellbeing for the rural poor. The ISRDP aims to increase the efficiency of the application of public funds in rural areas to create appropriate outputs in the places where they are most needed. The ISRDP facilitates health systems development in partnership with the district.

UTHUNGULU DISTRICT

Geography and demographics

The uThungulu district consists of six local municipalities namely: Mfolozi, uMhlathuze, Ntambanana, uMlalazi, Mthonjaneni and Nkandla. This coastal district occupies the north-eastern portion of KwaZulu-Natal’s coastline and is completely surrounded by other KwaZulu-Natal districts. uThungulu also has a number of wetlands, the most notable being Lake Cubhu and the Greater uMhlathuze Wetlands to the south of Richards Bay at Esikhawini.

uThungulu covers 8,213 square kilometres\(^{78}\) and is the fifth smallest KwaZulu-Natal district. It accommodates 9.6% of KwaZulu-Natal's population (Table 4). The population density is 108 persons per square kilometre. IsiZulu is the home language of the majority of the population in the district (93.6%), followed by English (3.5%) and Afrikaans (2.0%).\(^{79}\)

The seat of uThungulu is Richards Bay. Other notable towns include Empangeni, Eshowe, Gingindlovu, Esikhawini, Melmoth, Ngwelezane, Nseleni, Felixton and Vulindlela. Umhlatuze. The tribal areas which were part of the former KwZulu homeland are rural and are characterised by under-development and high levels of poverty.

Tourist attractions range from game reserves to cultural experiences and historical sites. Yachting and water sport enthusiasts flock to the Tuzi Gazi Waterfront which also has an upmarket office complex, shops, restaurants and walks on moorings at the small craft harbour. The KwaBulawayo Tourism Development project is aimed at uplifting the local communities in the culturally rich Umlalazi region. The district is home to King Shaka’s KwaBulawayo Military Capital, which is one of the key sites of Zulu heritage.

Labour market and economy\(^{80,81}\)

The district contributed an average of 9.3% to the provincial economy over the period 2002 - 2008 (Table 8); this was the second highest contribution to GDPR out of all 11 KwaZulu-Natal districts over the period. The main economic hubs in the district are the towns of Richards Bay and Empangeni. They both function as service centres for other parts of the district as well as having large industrial areas. The advent of the Richards Bay Industrial Development Zone near Richards Bay harbour is serving to boost economic activity.

There are other economically significant administrative nodes in the district which include: Nkandla, Melmoth, Ntambanana, Bucanana, KwaMbonambi and Eshowe.

The sectors that were major contributors to the district’s GDP over the period 2002 - 2008 were: manufacturing (40.9%), mining (12.4%) and community services (11.9%). Transport was the fastest growing sector and although agriculture still experienced growth it was not as much as other sectors and a noticeable shift from agriculture to industrialized economy can be observed over the period.

The sectors that played a significant role in the district’s formal employment over the period 2002 - 2006 were: community services (22.1%), manufacturing (19.9%) agriculture (13.8%) and trade (9.9%). uThungulu had a labour participation rate of 41.5% over the period 2002 - 2006, which indicates an economic activity level which was approximately 10% below the provincial average (52.5%).

Agriculture is one of the key contributors to the uThungulu’s labour market and the district’s major agricultural produce includes: sugar cane, citrus, sub-tropical fruits and vegetables, timber, paper and wood products. The commercial forestry sector is well developed with large private plantations owned by Mondi and Sappi.

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Subsistence agriculture and small-grower timber production is associated with the majority of the tribal areas. The mining sector is concentrated in the uMhlathuze area which is rich in mineral resources, including ilmenite, rutile, zircon and pig iron. Richards Bay Minerals is a leading producer of titanium minerals, high purity iron and zircon, found in the coastal sands of the region. Exxaro KwaZulu-Natal Sands is South Africa’s flagship empowerment mining company, involved in the mining, beneficiation and smelting of mineral sands, mainly to produce titanium slag from smelting ilmenite.

The manufacturing sector which is characterised by highly sophisticated manufacturing processes is largely concentrated on basic iron and steel, paper and printing, as well as food and beverages. There are also paper mills, forestry production, production of materials handling equipment, as well as fertilizer and special chemicals production. The single largest coal-handling facility in the world is located in the district which has been instrumental in securing the country’s position as the second-largest exporter of steam coal in the world. One of the world’s largest aluminium smelters, which produces all of South Africa’s aluminium is in Richards Bay.

Richards Bay harbour is one of the largest deep-water ports on the African continent. It has the highest volume of bulk cargo of all African ports, handling in excess of 75-million tons of cargo annually, which is double the capacity of Durban. The port has been a key driver in the large-scale industrialisation in the area due to its world-class bulk-handling facilities which has enabled trade links with international economies.

Tourism is already a major income-earner with potential for further development and there is a growing domestic and international demand for Zulu crafts and cultural items.

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

According to the Antenatal Clinic Survey, in 2010 uThungulu had the third lowest HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal at 36.9% (Figure 5). Although this is below the provincial average of 39.5% it is still above the national prevalence rate of 30.2%. The HIV prevalence in uThungulu has decreased slightly by 0.8% from 2009.

uThungulu reported 11 916 TB cases (all forms) in 2008 and had an incidence of 293.7 per 100 000 which was the fifth lowest in the province but still above the national average of 287.5 per 100 000 (Table 10). The cure rate of 71.1 % in 2007 was the second highest in the province and way above the provincial average of 55.4%. The smear conversion rate of 55.2 % in 2008 however, was not as good the 57.3% achieved by the province as a whole in 2008.

In uThungulu the levels of education were worse than the provincial averages in 2007, with 17.4% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 33.2% of the adult population had Grade 12 or higher compared to the provincial average of 37%.

uThungulu had a deprivation index of 3.46 in 2007 which falls into the second socio-economic quintile (1 is the lowest and 5 is the highest). It ranked eighth out of the 11 KwaZulu-Natal districts in the category “the most deprived district in the province”.

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ILEMBE DISTRICT

Geography and demographics

The iLembe district consists of four local municipalities namely: Mandeni, KwaDukuza, Ndwedwe and Maphumulo. This coastal district occupies the central portion of KwaZulu-Natal’s coastline and is completely surrounded by other KwaZulu-Natal districts. The district is bisected by the N2 national highway running from Durban up through Richards Bay to Swaziland and Mozambique.

iLembe covers 3,269 square kilometres and is the smallest of the KwaZulu-Natal districts apart from the metropole. It accommodates 5.5% of KwaZulu-Natal’s population (Table 4). The population density is 192 persons per square kilometre. The population is predominantly rural. IsiZulu is the home language of the majority of the population in the district (86.4%), followed by English (8.6%).

KwaDukuza/Stanger, Mandeni, the Dolphin Coast and Nkwazi are the main urban areas in the district. There are informal settlements with limited facilities or infrastructural services on the periphery of the developed areas and within the towns. The rural areas have a lack of basic services and infrastructure and there are continued service delivery backlogs. The provision of basic infrastructure and services in the rural and traditional areas is hampered by topographical constraints.

The seat of iLembe is KwaDukuza. The main towns include: Stanger, Ballito, Mandeni and Nkwazi.

Labour market and economy

The district contributed an average of 3.36% to the provincial economy over the period 2002 - 2008 (Table 8); this was the middle KwaZulu-Natal district in terms of contribution to GDP over the period. The Compensation/Ballito area north of the new King Shaka International Airport has been identified as the new economic hub of the district with the Imbonini development which offers high quality mini factories and stand alone factory warehouses. Isithebe Industrial Estate continues to be an effective manufacturing hub, offering cost-effective production space to prospective investors.

The sectors that were major contributors to the district’s GDP over the period 2002 - 2006 were: manufacturing (35.1%), agriculture (17.1%) and community services (16.6%). Transport, finance, and trade were the fastest growing sectors while growth in the mining sector was minimal. Agriculture experienced a sharp decline over the period.

The sectors that played a significant role in the district’s formal employment over the period 2002 - 2006 were: agriculture (33%), community services (22%) and manufacturing (20%). iLembe had a labour participation rate of 48.9% over the period 2002-2006, which indicates an economic activity level which was just below the provincial average (52.5%).

The manufacturing sector comprises of a number of well established industries which includes heavy industries such as sugar and paper mills and a variety of light industries. Products include wood, other wood products, food, beverages, clothing, textiles and tobacco products.

Agriculture is one of the key contributors to the iLembe economy and labour market and it ranges from the commercial agriculture concentrated along the coastal strip east of the N2 to subsistence agriculture which dominates in the rural hinterland and inland areas. The district’s major agricultural activities include: sugar cane farming, forestry, fruit and vegetable farming, tunnel farming, and fresh cut flowers.

iLembe is at the heart of South Africa’s logistics platform and the newly developed King Shaka International Airport and Dube Trade Port is pivotal to the district’s future success.

The bulk of the tourism infrastructure is located in KwaDukuza — Dolphin Coast. However the tourism sector is consistently growing and offers cultural, heritage, beach and nature based tourism. iLembe district municipality is referred to as the ‘Jewel of the Zulu Kingdom’ because of its wealth of cultural resources. There is international and local interest in King Shaka and Zulu culture and history which is driving the cultural, heritage aspects of tourism.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 iLembe, along with uMgungundlovu, were the district with the highest HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal at 42.3% (Figure 5). This is the highest prevalence rate in the country. The HIV prevalence in iLembe has increased by 1.7% from 2009.

iLembe reported 5 614 TB cases (all forms) in 2008 and had an incidence of 331.9 per 100 000 which was very close to the provincial average of 334.2 per 100 000 (Table 10). The cure rate of 59.9 % in 2007 was above the provincial average of 55.4% but was below the national average of 63.9%. The smear conversion rate of 49.2 % was below the 57.3% achieved by the province as a whole in 2008.

In iLembe the levels of education were worse than provincial averages in 2007, with 17.8% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 27.8% of the adult population had Grade 12 or higher compared to the provincial average of 37%.88

iLembe had a deprivation index of 3.63 in 2007 which falls into the second socio-economic quintile (1 is the lowest and 5 is the highest).89 It ranked seventh out of the 11 KwaZulu-Natal districts in the category “the most deprived district in the province”.

SISONKE DISTRICT

Geography and demographics

The Sisonke district consists of five local municipalities namely: Ingwe, Kwa Sani, Greater Kokstad, Ubuhlebezwe and Umzimkhulu. The landscape ranges from the rolling green hills of Ixopo to the mountains in the southern Drakensburg. This inland district occupies the south west portion of KwaZulu-Natal and shares an international border with Lesotho and a provincial border with the Eastern Cape.

Sisonke covers 11 126 square kilometres.89 It accommodates 4.9% of KwaZulu-Natal’s population (Table 4). The population density is the lowest in the province at 28 persons per square kilometre. The population is predominantly rural. IsiZulu is the home language of the majority of the population in the district (57.1%), followed by isiXhosa (36.1%) and English (2.4%).89

The seat of Sisonke is Ixopo. Other main towns include: Underberg and Kokstad.

The district includes the southernmost part of the Ukhahlamba Drakensberg National Park, a UNESCO World Heritage Site.

Labour market and economy

The district contributed an average of 1.09% to the provincial economy over the period 2002 - 2008 (Table 8); this was the third lowest contributor to GDP out of all 11 KwaZulu-Natal districts over the period. The main economic hub in the district is the town of Kokstad which serves as the service centre and commercial hub for most of the western part of the district as well as the northern districts of the Eastern Cape.

The sectors that were major contributors to the district’s GDP over the period 2002 - 2006 were: agriculture, (33.5%), community services (33.3%) and trade (12.8%). Finance, construction, and trade were the fastest growing sectors and the agricultural sector contracted sharply over the period.

The sectors that played a significant role in the district’s formal employment over the period 2002 - 2006 were: agriculture (38%), community services (30.9%) and household services (15%). Sisonke had a labour participation rate of 36.4% during the period 2002 - 2006, which indicates an economic activity level which was far below the provincial average (52.5%).

Agriculture was one of the key contributors to Sisonke’s economy and labour markets and has many commercial farms and forestry plantations. However a larger part of this sector’s employment was in agriculture and the hunting industry than in the forestry and logging subsector. The district’s major agricultural produce includes: a variety of crops and vegetables, livestock and sugar cane as well as wood harvested for the paper industry. Dairy is a vibrant industry and the district produces 10% of the milk consumed in South Africa which includes 35% of Clover Milk.

Tourism, with the related trade sector activities in hotel and restaurants and retail, is also a significant sector in Sisonke’s economy. The unspoilt natural environment has high eco-tourism and adventure tourism potential. Activities such as horse riding, mountain biking, hiking, river rafting, abseiling and canoeing are available. Some of the natural attractions include San rock art sites, pristine berg pools and streams, caves and hilltops with splendid views. The Sani2C, one of South Africa’s top multi stage mountain bike rides, starts from Underberg and goes through Sisonke district ending in Scottburgh.

HIV, AIDS, TB and related social conditions

According to the Antenatal Clinic Survey, in 2010 Sisonke had a HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal of 37.2% (Figure 5). Although this is below the provincial average of 39.5% it is still above the national prevalence rate of 30.2%. The HIV prevalence in Sisonke has increased by 2.0% from 2009.

Sisonke reported 6 340 TB cases (all forms) in 2008 and had an incidence of 452.5 per 100 000 which was the second highest in the province (Table 10). The cure rate of 62.3% in 2007 was above the provincial average of 55.4%. The smear conversion rate of 51.1% was below the 57.3% achieved by the province as a whole in 2008.

In Sisonke the levels of education varied with only 10.9% of the population over 20 years with no schooling which is slightly better than the provincial average of 11.4%. However, only 21.6% of the adult population had Grade 12 or higher compared to the provincial average of 37%. The levels of education varied with only 10.9% of the population over 20 years with no schooling which is slightly better than the provincial average of 11.4%. However, only 21.6% of the adult population had Grade 12 or higher compared to the provincial average of 37%.

Sisonke had a deprivation index of 4.12 in 2007 which falls into the first socio-economic quintile (1 is the lowest and 5 is the highest). It ranked fourth out of the 11 KwaZulu-Natal districts in the category “the most deprived district in the province”.

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ETHEKWINI METROPOLE

Geography and demographics

The eThekwini metropolitan municipality occupies a south central position on KwaZulu-Natal's coastline in an area that stretches from Umkomaas in the south, including some tribal area in Umbumbulu, to Tongaat in the north, moving inland to Ndwedwe, and ends at Cato Ridge in the west.

eThekwini covers 2,297 square kilometres of which 36% is rural and a further 29% is peri-urban.\(^95\) It is the smallest of the KwaZulu-Natal districts. It accommodates 32.9% of KwaZulu-Natal's population (Table 4). The population density is 1,399 persons per square kilometre which is the highest in the province, but is typical of a metropolitan area. IsiZulu is the home language of the majority of the population in the district (63.0%), followed by English (30.0%) and isiXhosa (3.4%).\(^96\)

eThekwini is a metropolitan municipality that includes many major towns or settlements which include Durban, Chatsworth, Inanda, Kwa-Mashu, Mpumalanga, Ntuzuma, Phoenix, Pinetown Umlazi and Umhlanga.

Durban is known as the playground of the Zulu Kingdom and attracted close to 10 million tourists in the 2010/11 financial year. The sun-drenched beaches, wide range of water sports and other activities feed into an enormous hospitality industry.

Labour market and economy\(^97,98\)

The district contributed an average of 64.85% to the provincial economy over the period 2002 - 2008 (Table 8); this was the highest contribution to GDP out of all 11 KwaZulu-Natal districts over the period. The sectors that were major contributors to the district's GDP over the period 2002 - 2006 were: manufacturing (approximately 15%), finance (approximately 21%), community service (approximately 17%), trade (approximately 24%) and transport (approximately 15%). Finance, transport and trade were the fastest growing sectors and the electricity, agriculture, and community services sectors experienced limited growth over the period.

The sectors that played a significant role in the district's formal employment over the period 2002 - 2006 were: manufacturing (25.6%), community services (20.6%), trade (15.2%), finance (14.3%) and household services (10.7%). eThekwini had a labour participation rate of 66.8% during the period 2002 - 2006, which indicates an economic activity level which was above the provincial average (52.5%).

The manufacturing sector is key to the local economy and includes the following industries: automotive, chemical and rubber products, industrial chemicals, clothing and textiles, metals and engineering, food, beverage, tobacco products, wood and wood products and electrical machinery and apparatus. There are also two of the four major crude-oil processing refineries in the country - Sapref and Petronas which process 180,000 and 135,000 barrels per day respectively.

Durban port is key to the transport and logistics sector in the city and operates 24 hours a day 365 days a year. The port is strategically placed on the world shipping routes and is one of the busiest and the biggest in terms of container capacity on the African continent. With its 57 berths docking over 4,000 commercial vessels, the port handles 31.4 million tons of cargo worth more than R50 billion each year.\(^99\)

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Durban is the leading domestic tourist destination in South Africa. Attractions include: beaches, shopping, uShaka Marine World, many fine hotels, nightspots, ethnic attractions, traditional villages, craft markets, sparkling dams and big-game parks, such as, Mitchell Park where a 100 year old Admiral tortoise is kept. Durban is also a prime conference and important business tourism destination.

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

According to the Antenatal Clinic Survey, in 2010 eThekwini, along with Ugu, was the district with the fourth highest HIV prevalence rate amongst antenatal clinic attendees in KwaZulu-Natal at 41.1% (Figure 5). This is one of the highest prevalence rates in the country. The HIV prevalence in eThekwini has decreased by 0.4% from 2009. eThekwini reported 38,624 TB cases (all forms) in 2008 which is the highest burden of cases of any district in KwaZulu-Natal. The Metropole had an incidence of 357.8 per 100,000 which was the fourth highest in the province (Table 10). The cure rate of 49.2% in 2007 was below the provincial average of 55.4%. The smear conversion rate of 56.8% was just below the 57.3% achieved by the province as a whole in 2008.

In eThekwini the levels of education were better than the provincial averages in 2007, with only 4.3% of the population over 20 years with no schooling compared to the provincial average of 11.4%, and 47.1% of the adult population had Grade 12 or higher compared to the provincial average of 37%.


REQUIREMENTS FOR EFFECTIVE IMPLEMENTATION

Mobilisation for the strategy

‘I am responsible. We are responsible. South Africa is taking responsibility.’ This slogan emphasises both individual and collective responsibility that South Africans need to be taking in response to HIV and AIDS, TB and wellness. Active participation is a key foundation for effective implementation. Broad based participation will breathe life into this strategy. Interventions should be taken off the pages of this strategy and implemented within workplaces and communities. Public-private partnerships should be strongly considered to improve service delivery.

KwaZulu-Natal business needs to own this strategy through the elected board of governors and prioritise the implementation of appropriate interventions. SMME’s in particular need to be mobilised. This activity demands active recruitment of participants through creative and effective communication, creating demand and urgency. Remote locations and industry sectors presently underserviced and with poor participation records should be engaged and involved. Senior management, as leaders with knowledge of HIV and AIDS, TB and wellness, should also actively communicate important messages about HIV and AIDS, TB and wellness aimed at changing social attitudes and behaviours.

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. Ongoing analysis of gaps and addressing nonparticipation will be required.

Multi-sectoral participation beyond the KwaZulu-Natal Provincial Council on AIDS must be sought. True partnerships delivering better access to healthcare will occur at the district level. Businesses are encouraged to find out who the district healthcare officials in their area are, and reach out to them. Bringing together organisations and service providers to assess the possibility of partnering in the implementation of multi-sectoral level strategy interventions is required.
Accessing resources

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

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

Sustainability

For the strategy to be considered successful it must not have an explosive start and a feeble finish. Taking cognisance of continuously changing environmental factors it is prudent for the strategy to span 5 years. However progress into a broader wellness domain must be advocated both during this strategy, and beyond.

Joining SABCOHA, as a member, demonstrates a commitment of will and provides for ongoing coordination capacity, support and technical assistance. Constant 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. Ownership starts with committing resources and as such SABCOHA may well offer projects on a fee for service basis, to support the objectives of this strategy.

Coordination and communication

Effective communication providing accurate, up-to-date, comprehensive information, using current media technology is critical. SABCOHA will continue to circulate information regularly through its newsletters, website, district workshops, breakfasts and other fora.

Monitoring and evaluation

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

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

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

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

Two criteria were used to shortlist the 25 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 previous section for the rationales, alignment to the PSP and targets for each intervention.

1. Mobilise and implement interventions aimed at reducing substance abuse and promoting responsible alcohol use. For example:
   - Media and communication campaign which provides targeted relevant messaging in the workplace to promote responsible alcohol use.
   - Social mobilisation in workplace and surrounding communities promoting responsible alcohol use.
2. Maximise coverage of male and female condoms through distribution in company health facilities and installation of condom dispensers/vending machines outside strategic points in the workplace for increased access.
3. Use peer educators to discuss issues including, but not limited to: changing social norms; addressing gender-based violence; sensible alcohol use; culture of acceptance and non-discrimination; address intergenerational and transactional sex and target men’s attitude to women.
4. Maximise the coverage of male and female condoms through distribution in health facilities and installation of condom dispensers outside strategic points for increased access.
5. Implement a combination of HCT and wellness screening options within the workplace. Ensure that all occupational health facilities are equipped, trained and open to administer symptom-based provider initiated HCT on a continual basis. Campaign style employer-initiated HCT should be offered and is often more frequent in the early stages of a workplace programme. In later years routine counselling and testing should be practiced as part of the annual medical examinations.
6. Promote MMC in the workplace and provide special leave for MMC, where possible.
7. Develop workplace programmes that actively provide access to free and confidential STI management, actively promote STI management through referral to local public facilities and educate all employees regarding higher risk of HIV transmission with untreated STIs.
8. Develop proactive and innovative mechanisms to ensure adherence as well as working with service providers on rigorous systems that identify defaulters with remedial action. For example:
   • Promote the use DOTS in the workplace. Use cell phone based communication to improve treatment adherence.
   • Use social media - Twitter, Facebook, MXit - to improve retention and treatment adherence
9. Provide information, education and awareness on PMTCT - focused on men as well as women. Where possible, companies may be able to provide ART or administer state-funded treatment for pregnant workers with HIV.
10. Provide TB prevention services according to national guidelines.
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APPENDIX 1

HIV-911 Provincial Directory

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

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

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

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

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

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