

Fact Sheet on the mining industry and HIV/AIDS

Introduction

HIV/AIDS in South Africa has increased rapidly over the past decade from almost zero in 1990 to about 5.0 million people living with HIV/AIDS in 2001. Already 334 000 people were AIDS sick at the end of 2001 and this level is expected to treble to 1.4 million AIDS sick by 2009/2010. The social and economic consequences of these figures are far reaching and affect every facet of life in South Africa.

South Africa has created one of the most progressive and far-sighted policy and legislative environments for dealing with HIV/AIDS in the world. Despite this and despite the comprehensive HIV/AIDS programmes developed in the private and public sectors, the prevalence of HIV/AIDS continues to increase. This indicates that these policies and laws have not been adequately implemented and have not impacted significantly on the ground.

The Mining Industry and activities on HIV/AIDS

The mining industry has been proactive in adopting an attitude of both concerned employer as well as developing a business case against HIV/AIDS.

- 1985: First survey done in the mining industry to detect HIV amongst mineworkers.
- 1986: First group of mineworkers tested positive from Malawi; subsequent ruling by the South African government that no foreign worker may work on mines unless tested resulting in strong opposition from many sides.
- 1988: TEBA's (Employment Bureau of Africa) healthcare services developed education and awareness campaigns on STI's (sexually transmitted infections) and HIV, including videos, which were shown to all new employees.
- 1989: KAP (Knowledge, Attitudes & Practices) study that showed high level of knowledge by mineworkers about sexually transmitted infections including HIV/AIDS.
- 1989: A study on truck drivers showed that 50% of the drivers were infected with HIV whilst prevalence amongst mine workers was negligible.
- From 1990 to 1998: A randomly selected cohort of employees from one company was followed up annually for their HIV status. The sample set started with 2,292 employees; during the life of the study the cohort prevalence increased from 1% to 26%.
- From 1998 to 2000: A community study in the Carletonville area (Mothusimpilo study) organised by the Centre for Scientific and Industrial Research and the South African Institute for Medical Research showed for each of three years the prevalence of HIV increased from 28% to 30% (roughly 200 entry level employees participated).
- 1991: The Chamber of Mines signed an agreement with the National Union of Mineworkers on HIV/AIDS, which dealt with fundamental issues on pre-employment testing, confidentiality, training and benefits; included in the agreement was the commitment to a united effort to address HIV/AIDS.
- 1991: The Chamber of Mines participated in the formation of NACOSA – the National AIDS Coalition of South Africa. The Chamber contributed in the development of the National AIDS Plan that was handed to the Department of Health in 1994.
- 1993: The Chamber of Mines established a standing committee on HIV/AIDS in the Chamber to continually assess and establish best practice in the industry.
- 1994: The Chamber of Mines reviewed and customised the WHO document 'Clinical Management of HIV/AIDS' for the mining industry.
- 1995: The Chamber of Mines commissioned a survey on HIV/AIDS in Southern Africa; this was discussed at a World Bank Congress on HIV/AIDS held at Victoria Falls in 1995. 1990's onwards: Chamber of Mines members increasingly started introducing HIV/AIDS programmes which included – training of nurse counselors and peer educators, free condom distribution, awareness and education programmes, free sexually transmitted infections treatment, treatment of opportunistic infections especially TB.
- 1996: The Chamber of Mines raised the issue of HIV/AIDS at the Leon Commission
- 1998: The Chamber of Mines played a leading role in the development of the ILO Code on HIV/AIDS in the workplace.
- 1999: The Chamber of Mines supported the call for partnerships in the fight against HIV/AIDS by the then Deputy President Thabo Mbeki
- Chamber members have increasingly been involved in making their HIV/AIDS programmes available to surrounding communities and making facilities available in partnership with the state.
- 2001: The Chamber of Mines signs agreement with government and labour to establish a Tripartite HIV/AIDS Committee for the mining industry.
- 2001-2002: Chamber of Mines members begin signing specific HIV/AIDS agreements with labour unions.

- 2001-2002: Chamber of Mines members sign specific agreement with TEBA to provide home based care for terminally ill mineworkers who have agreed to return to their homes in the rural areas
- Chamber of Mine members have played a significant role in international organizations e.g., ILO, World Business Council, International funding groups.
- 2003: Agreement with government and labour to have a Summit on HIV/AIDS in the mining industry.

It is important to state that all of the above has taken place within the context of a mining industry that provides comprehensive medical services as well as other benefits.

Vision

1. To develop and strengthen partnerships with government, labour and NGO's
2. To prevent new infections amongst the workforce.
3. To care for those infected or affected by HIV/AIDS
4. To provide outreach to the surrounding communities.
5. To base interventions on research and best practise.
6. To manage the impact of HIV and AIDS, enabling the industry to remain globally competitive for the benefit of employees, their families, shareholders and the country.

Policy

Companies in the industry developed their policies influenced by best practises on HIV/AIDS from various parts of the world, the SADC code on HIV/AIDS in the workplace, the ILO code, the Department of Health strategic document on HIV/AIDS TB and Malaria, and the NEDLAC code. This in addition to workplace agreements reached with labour unions and experience gained in everyday practise within the working environment. HIV/AIDS policies integrate the following principles –

Non discrimination:

- (1) no employee shall be dismissed on the ground of his/her HIV status;
- (2) no hiring decision based on HIV assessment
- (3) training within the workplace not influenced by HIV status
- (4) advancement or promotion not dependent on HIV status

Confidentiality and disclosure:

- (1) no employee required to disclose his/her status;
- (2) should the employee want to disclose his/her status voluntarily, it cannot be disclosed to others without the employee's written consent.

Benefits applied equally to all employee:

- (1) medical assistance is provided to an employee in accordance with the rules of the health care delivery system to which the employee is contracted.
- (2) pension funds and provident funds are applied equally to all employees.

Ill-health retirement:

- (1) When an employee is deemed medically incapacitated the employee is provided with an ill health retirement package
- (2) If however, the employee wishes, he/she can submit a dissenting opinion from a independent registered medical practitioner.

Programme Description

Companies have developed in-house models to provide workplace prevention, informed consent voluntary counselling and testing (ICVCT), care, support and treatment programmes.

Programme Evaluation

Companies have introduced review and monitoring mechanisms to evaluate the effectiveness of programmes introduced. This has been complimented by research done in-house or through contracts to independent researchers.

These mechanisms concentrate and focus on the effectiveness of the programmes in certain areas-

1. ICVCT uptake (informed consent voluntary testing and counselling)
2. Condom distribution and uptake
3. Peer educator competency and accountability
4. Where Anti-retroviral treatment has been introduced measuring uptake, adherence, side effect profiles, costs.

Increasingly companies are setting desired outcomes. Some of these outcomes are:-

Increasing VCT (voluntary testing and counselling) uptake from the current 10-15% of employees to all employees.
Encouraging all employees to attend regular peer education activities.

Financing

Every company in the mining industry has developed budgets for both workplace and community intervention programmes.

Companies spend in the region of R220-00 to R480-00 per annum per employee on workplace HIV/AIDS programmes. The budget covers issues such as awareness campaigns, formal training of employees, peer educator training, STI (sexually transmitted infections) treatment, VCT (voluntary testing and counselling) and wellness programmes and home based care. Each operation is expected to augment the budget with local community programmes – budgets are allocated separately for community partnerships – Mothusimpilo, Bambisanani, Lesedi, Powerbelt and Carletonville home based care programme to name a few.

Where companies are introducing antiretroviral treatment programmes as part of their comprehensive HIV/AIDS programmes separate budgets are allocated.

Prevention and awareness

Company internal programmes focus on awareness, education, and training, peer education, condom distribution, syndromic management of STI's (sexually transmitted infections) and community interventions.

Awareness raising events: sports days, theatre, music festivals, HIV/AIDS rallies, radio, newspaper and poster campaigns. All employees undergo induction training, which includes an HIV component; qualified instructor's train HIV/AIDS instructors/ facilitators.

Peer Educators are trained by experts through a 5-day participative, supportive and counselling course. Peer educators focus on Abstinence, Be Faithful, and Condomize (ABC) and promote the use of ICVCT (informed consent voluntary testing and counselling) and wellness services. Most companies are trying to improve the ratio of peer educators to employees (present ratio 1:65 to 1:145)

Free male condoms are provided within the workplace environment. Some companies provide female condoms.

All companies provide syndromic management of STI's (sexually transmitted infections) and some introduced the concept as early as 1982: health care practitioners are trained in syndromic management. Clinics also provide STI (sexually transmitted infections) counselling to all patients.

Neighbouring community prevention programmes developed through a portfolio of public private partnerships.

The partnerships aim to cover the communities immediately surrounding the company's operations.

The local partnerships target high-risk groups to:

- (1) target behaviour change
- (2) provide access to counselling
- (3) provide syndromic management of STI's (sexually transmitted infections)
- (4) provide periodic presumptive therapies (5) provide condom promotion and distribution.

The partnerships utilise mobile clinics with fully trained professional nurses.

Voluntary counselling and testing

ICVCT (informed consent voluntary testing and counselling) programme is available to all employees.

Some companies have developed protocols and processes for the programme with organised labour- others are in the process of doing so.

The programme adheres to WHO (World Health Organisation) Guidelines for informed consent, pre-test counselling and post-test counselling with all medical practitioners trained in the defined work-flow.

Every person, regardless of the test result receives in- depth post-test counselling.

The uptake in the VCT (voluntary testing and counselling) programme is improving as employees recognise the importance of this intervention.

Treatment , care and support

Wellness management programmes are designed to extend productive life as far as possible.

Lifestyle and skills education and counselling are provided (the importance of change in behaviour, nutrition, exercise, stopping alcohol and smoking, attending regular counselling and medical examination and the use of nutritional supplements are encouraged).

Patients undergo the mine standard annual medical exam. HIV patients are scheduled for medical review at intervals dictated by their individual disease status.

Management of opportunistic infections:

- (1) chemical prophylaxis against TB and other opportunistic diseases;
- (2) early identification and treatment of other opportunistic infections.

HIV+ employees are provided with psychosocial support

Antiretroviral therapy are presently provided to the following employees-

Employee who has been occupationally exposed: prophylactic treatment.

MTCT (mother to child transmission): therapy provided during pregnancy to HIV+ pregnant employees according to accepted protocols.

Rape victims: provide prophylactic treatment.

Some companies are beginning to provide treatment to employees living with AIDS.

Private-public partnerships support impact of ill-health retirements on rural communities.

Co-ordinated outreach programmes to people at high risk through strategic partnerships with other mining companies, government, CBOs and NGOs. The partnerships are funded on a per capita fee paid by participating companies and through additional contributions from local and international funding organisations.

The partnerships provide:

- (1) community based capacity building
- (2) home based care
- (3) support groups and income generating activities
- (4) care and support for orphans.

Employees home based care is managed and financed by individual companies except for the companies who have signed service level agreement with TEBA. These partnership agreements for home based care (January 2002) include: mines and businesses, TEBA, funding agencies, organised labour, communities, hospitals / clinics and local government.

Socio-economic impact

The HIV/AIDS epidemic confronts South Africa at a time when its economy has been averaging a 2% per annum growth rate in the past decade and with inflation averaging 6.5%.

Macro-economic simulation of the impact of HIV/AIDS on the South African economy is a complex exercise requiring multiple assumptions. Most of these models have looked at five broad economic impact channels-

A lower overall population and labor force which affects both the production potential of the economy and the expenditure side of the economy.

The direct costs, which include increased contributions to medical benefit schemes, disability cover, etc.

The indirect costs (e.g. Increased absenteeism, reduced productivity and impact on training).

An increased level of government expenditure as a result of higher demand for public health and social services.

Private households will bear the brunt of home care costs of family members living and suffering from AIDS, the cost of funerals, and the care of orphans which will reduce household savings and spending in other areas.

Independent of the above models, the industry recognises that HIV/AIDS is having the following effects on labour and therefore on the economy of the company-

- (a) Productivity is being affected by the increasing illness of the employees necessitating absenteeism and increasing sick leave;
- (b) Training and replacement of labour once the employee becomes medically incapacitated or dies replacement labour is required and productivity is reduced.
- (c) Staff morale – loss of colleagues, increased workloads, perceived and actual discrimination, uncertainty about HIV/AIDS and the fear of infection will undermine morale and productivity.

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