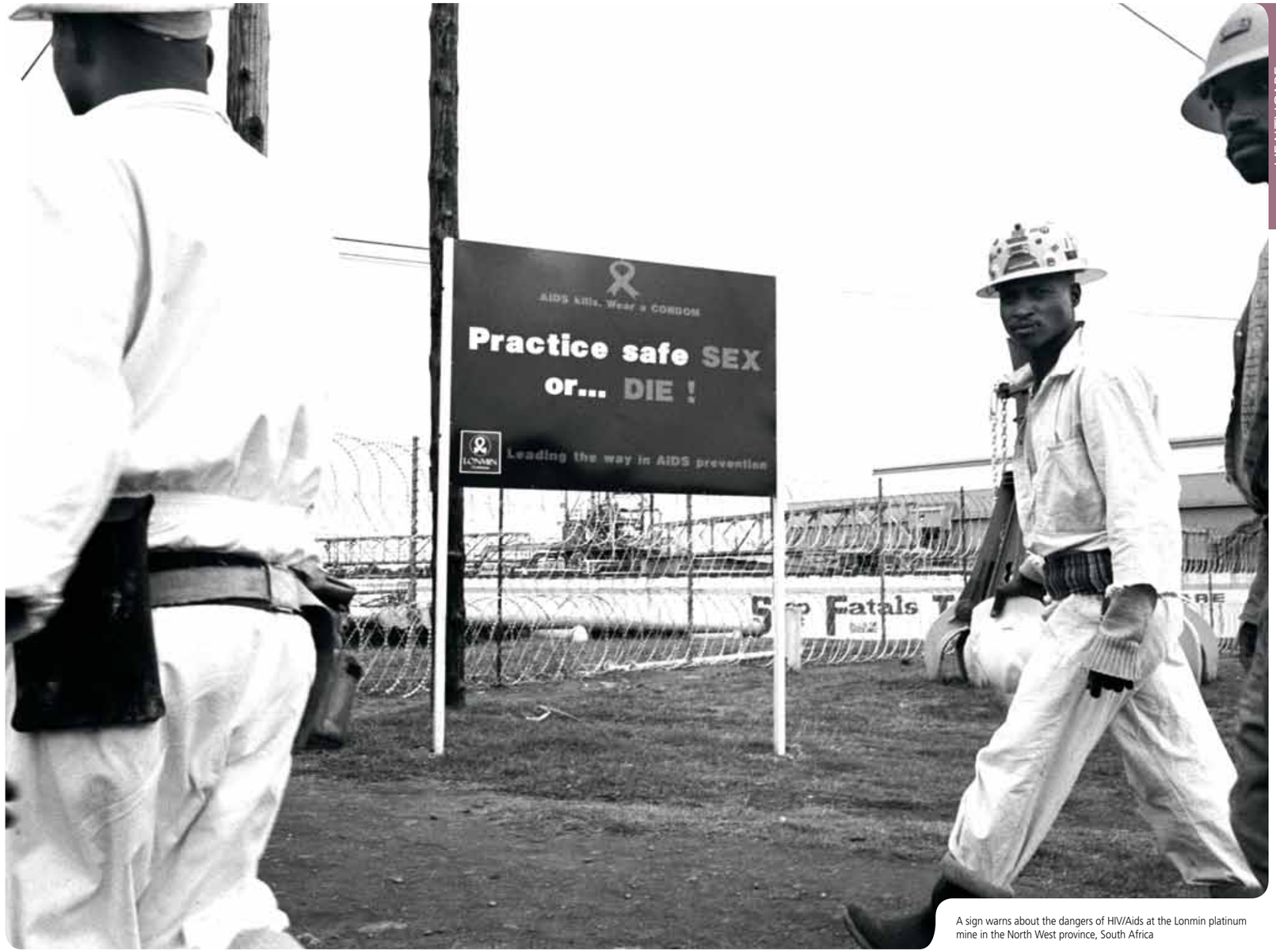
occupational hazard

Workplace ill health is a very public affair, especially where HIV/Aids and tuberculosis are concerned.

By KERRY DIMMER



A sign warns about the dangers of HIV/Aids at the Lonmin platinum mine in the North West province, South Africa

It was a court case in London in 2001 that forever changed the way mining houses looked at occupational disease. Cape Plc, an asbestos mining company, had agreed out of court to pay US$33.6 million to local asbestosis sufferers, realising the futility of fighting a case that had provoked a Law Lord's decision allowing South African workers to pursue their claims against a British-owned firm in the UK courts.

The landmark case clearly indicated to mining houses that unless they developed credible and effective healthcare systems, a storm of litigation from miners demanding health compensation could be extremely damaging for the industry.

But it would be unfair to say that the mining industry had been resting on its laurels, when many were in fact already providing adequate healthcare systems that included generous hospital and compensation packages for those suffering from illnesses such as tuberculosis (TB) and other lung diseases like pneumoconiosis.

But with HIV/Aids reaching epidemic proportions in the mining industry, combined with the government's tardiness in providing antiretrovirals (ARVs) to sufferers, the mining houses needed to pioneer the way forward.

One of the first to react publicly, in 2002, was Anglo American Corporation. At the time it was estimated that some 29% of its workforce was HIV positive. Emotions aside, the cost implications were that it was cheaper to provide its workforce with ARVs than face the loss of skilled manpower and the probable extensive compensation litigation that would result from doing nothing.

What companies like Anglo American and De Beers, another early pioneer, realised was that in fighting HIV/Aids, they were also effectively reducing the incidents of TB, a core infection that manifests in an HIV/Aids patient, and a well-recognised miner's ailment.

HIV/Aids may be the most deadly of the diseases affecting Southern Africa's migrant labour system, but TB is a time bomb. Inhaling silica dust resulting from gold mine production can manifest as silicosis, which in turn increases the risk for developing TB.

The lethal cocktail of silicosis and TB has long been recognised in the mining fraternity and, like HIV, is easily exported throughout the region when mine workers travel back to their homes where infection permeates into their local communities.

Gavin Churchyard of the Arum Institute for Health Research is highly regarded in the industry for his HIV/Aids and TB research. He says that the mining community is a mirror of the status of diseases such as HIV/Aids in the country and, while there has been significant success in motivating testing, 'best-case practices and best examples are not yet an industry-wide phenomenon'.

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Those that are recognised leaders include the likes of the Anglo Group of Mines, Xstrata, Gold Fields and AngloGold Ashanti, all of which have developed HIV/Aids programmes that cross an entire spectrum of issues from testing through to treatment. 'These mines have been very successful in driving the uptake of HIV testing,' says Churchyard. 'In some mines there has been spectacular success in having 90% of people tested annually for the past five years. It's become the norm to be tested and know your status.'

The mining programmes that are most effective in confronting the challenge of HIV/Aids include a combination of voluntary counselling and testing with ARV therapies. It's not enough, however, to provide services such as these to employees only. When efforts are projected into local communities, along with a substantive educational programme, HIV infection rates can be brought down significantly.

Such was the case at Barrick Gold's North Mara operation in Tanzania. At the start of its programme, 10% of its workforce had HIV/Aids. Now, only 3% of the workforce show a positive status. Even more significant is that while the initial focus was HIV/Aids, the programme has expanded to include other health problems that miners face, such as other sexually transmitted diseases and reproductive health challenges.

Managing healthcare programmes is vital and can ultimately go a long way towards providing the much-needed facts and figures of the prevalence of pandemics in the industry. A number of important lessons have been

TB is prevalent among South African miners

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learnt along the way, one of which led to the creation of a blueprint of sorts by Churchyard and his colleagues. In their paper, *Evaluation of a Workplace HIV Treatment Programme in South Africa*, they outlined the management of workplace ARV programmes:

- A dedicated HIV programme manager is required for an organisation to take overall responsibility for the HIV prevention and treatment programme
- At each treatment site a dedicated HIV co-ordinator is required to administer local programmes
- The focus on counselling should be maintained inclusive of the provision of sufficient staff and the training thereof
- The integration of clinical and pharmacy services is essential
- Treatment collection points should be located close to individual workplaces
- For each centralised ARV therapy management programme, one doctor, 2.5 nurses and 2.5 counsellors should be available for every 250 patients on ARVs
- Ongoing training must be implemented to maintain a competent cadre of staff.

The Chamber of Mines could be perceived as South Africa's main lobbyist in mine-related HIV/Aids and TB awareness. Its health advisor, Thuthula Balfour-Kaipa, says that in developing healthcare programmes, the mines need to move away from anonymous testing.

'Anonymity does not empower the creation of informed programmes and the provision of appropriate wellness treatments.' She makes the point that 73% of TB patients are HIV positive. 'You cannot therefore treat them as separate diseases. HIV has an impact on TB that in turn can magnify and perpetuate the HIV epidemic. This means we need a far more robust and integrated approach.'

The most successful and sustainable programmes are those that are intertwined with everything a company does, says Brad Mears, CEO of South African Business Coalition on HIV/Aids. 'If disease management and treatment are no longer seen as exceptional items on the budget plan and are integrated as regular items, boundaries are broken down and behaviour changes. A programme's longevity is the most effective way to monitor and evaluate, to show where success is being achieved and where gaps still exist.'

But you cannot manage what you do not measure and until accurate prevalence surveys are done by governments, especially where mining is a significant contributor to economic health, only trends can be confirmed.

Churchyard has faith that the mines will continue their pioneering role in the fight against HIV/Aids and TB and in the 'ongoing study and development of new strategies for prevention and treatment'.

Research is good but ultimately the primary objective of healthcare programmes must be to prevent new infections, to ensure that a negative does not become a positive. This is possibly the biggest challenge mines have ever had to face and until there is a paradigm shift in behaviour that can only be achieved through education, HIV/Aids and TB will remain the deadliest legacy of the mines. MD

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