



# **HIV/AIDS Guide for the Mining Sector**

## **A Resource for Developing Stakeholder Competency and Compliance in Mining Communities in Southern Africa**

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## **HIV/AIDS Guide for the Mining Sector**

A Resource for Developing Stakeholder Competency and  
Compliance in Mining Communities in Southern Africa

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# Foreword by Peter Woicke



At IFC, we recognize that economic growth is sustainable only if environmentally and socially sound. HIV/AIDS reduces prospects for development and poses a major challenge for the private sector. In the developing countries, which account for 95 percent of all HIV infections, the epidemic is as much a business issue as it is a health and humanitarian concern.

Southern Africa is particularly affected by HIV/AIDS. The disease already has a major impact on the economies in the region and especially on the mining sector, which is a key business driver.

Based on southern African experience, the **Guide** for the mining sector is a valuable tool in the fight against AIDS. It provides practical advice and management guidance that will help companies implement intervention strategies.

The **Guide** will become an integral tool of the “IFC Against AIDS” program, which we launched in 2000 as part of our commitment to sustainable development. The program helps clients understand the multiple impacts of the disease and provides guidance for corporate HIV/AIDS Action Plans. IFC’s anti-AIDS approach pays special attention to a company’s specific needs and resources, as well as existing corporate experiences and good practices.

The **Guide** will contribute to IFC’s mission, which is to promote sustainable private sector investment in developing countries.

**Peter Woicke**  
Executive Vice President  
International Finance Corporation





# Foreword by Clem Sunter



The publication of this HIV/AIDS **Guide** for the mining sector in Southern Africa is most welcome. Not only is it comprehensive in its coverage of all the issues, it is set out in such a way that it is easy to read and, more importantly, to implement in the work situation. The author, Rose Smart, is to be congratulated. Indeed, this **Guide** can be used by any company in any industry as the elements that form an effective strategy to combat the epidemic are common to all industries.

Broadly, for a company to rise to the challenge and make a comprehensive response in the war against HIV/AIDS, the framework should be as follows:

1. A clear policy should be agreed at Board level and it should be seen as a prime part of the CEO's responsibility to turn the policy into action. HIV/AIDS is such a strategic issue that it cannot be delegated to the Human Resources Department to handle as just another personnel matter. Ideally, where the company can afford it, a dedicated HIV/AIDS Co-ordinator should be appointed to oversee the programmes that convert the policy into activities on the ground. He or she should report directly to the CEO and provide the Board with regular updates on progress. The prime objective of any policy must be to create an enabling, non-discriminatory environment in which HIV/AIDS is viewed as just another medical condition – albeit a very important one – that is handled professionally, compassionately and properly.
2. This ushers in the second point which is the necessity for monitoring the programmes which are implemented in terms of the HIV/AIDS strategy. Key performance indicators on prevention, care and treatment need to be drawn up and agreed. Part of the remuneration package of the managers responsible for achieving results in this area should depend on whether the indicators show a satisfactory trend or not. In other words, HIV/AIDS should be regarded in exactly the same light as safety. After all, it is a huge part of the 'H' in any SHE (Safety, Health and the Environment) programme.
3. In addition, corporate HIV/AIDS programmes have to be evaluated at regular intervals because knowledge of what is and what is not effective is still at an early stage. This will necessitate feedback loops on whether prevention programmes are actually achieving behavioural change and whether care and treatment initiatives are really improving the quality of life of those infected with the virus and their families.

4. More specifically, the centrepiece of any workplace programme should be voluntary counselling and testing. This in turn will only happen on a wide scale if a proper wellness programme is already in place, which includes treatment of opportunistic diseases such as TB and pneumonia as well as antiretroviral therapy (when a patient's CD4 count falls below a certain threshold figure). It goes without saying that people will only come forward in large numbers to be tested if there is something in it for them in the event that they test positive. Another critical element of any prevention programme is to encourage employees to have regular check-ups for sexually transmitted infections in general as these vastly increase the chances of catching HIV and they can all be successfully treated.
5. For a company to fulfil all three legs of the triple bottom line (profits, people and the planet) in regard to HIV/AIDS, outreach programmes in the neighbouring communities of the company's operations must be added to workplace programmes. On a nation-wide scale, support should also be given to NGOs who are involved in such activities such as education for behavioural change, preventing mother to child transmission, looking after AIDS orphans and generally providing care and support for those infected and their families. Many opportunities already exist for partnerships between the public and private sectors and these partnerships should include the trade unions, NGOs and faith-based institutions as well. The war will only be won if past differences are set aside and all parties co-operate to defeat a common enemy.

So read this **Guide** and then act on it. Instead of 'ready, aim, have another workshop, aim ...', you need to fire! Begin by implementing some of the easily doable steps recommended within its pages. Get the momentum going and see where it leads. The war against HIV/AIDS within your company and its surrounding areas can be won, but it requires the Board and the CEO's commitment at the top and workplace/ community participation at grassroots level to do so.



**Clem Sunter**  
Chairman  
Anglo American Chairman's Fund



# International Finance Corporation and IFC Against AIDS

The International Finance Corporation (IFC), the private sector investment arm of the World Bank Group, promotes the economic development of its member countries. IFC is committed to providing industry with practical guidance and support in addressing key issues associated with sustainable development.



The **IFC Against AIDS** programme was created because many companies felt the need to do something about HIV/AIDS, but didn't know where to start. IFC Against AIDS provides assistance in the following areas:

- Awareness: Helping client companies to understand the impact of HIV/AIDS on their business and to assess the risks;
- Guidance on developing HIV/AIDS action plans: Providing tools and advisory services to design and implement effective responses for controlling the spread and effects of the disease; and
- Networking: Facilitating linkages with local organisations and practitioners that can offer support and technical assistance to companies implementing HIV/AIDS programmes.

The **HIV/AIDS Guide for the mining sector** is an initiative of the IFC.

The Environment and Social Development Department of the IFC and the **IFC Against AIDS** programme commissioned the testing, publication and dissemination of the **Guide** as part of a corporate effort to raise awareness and build the capacity of the private sector to effectively manage the risk of HIV/AIDS in the workplace.

The **Guide** is one of a series of tools that is being provided by the IFC to promote action and the sharing of best practice among IFC clients and the wider private sector that are engaged in the fight against HIV/AIDS.

For more information on the **IFC Against AIDS** programme contact [ifcagainstaids@ifc.org](mailto:ifcagainstaids@ifc.org) or visit their website at [www.ifc.org/ifcagainstaids](http://www.ifc.org/ifcagainstaids).

# Acronyms

AGM	Annual General Meeting
AfA	Aid for AIDS
AHR	Aurum Health Research
AIC	AIDS Information Centre (in Uganda)
AIDS	Acquired immune deficiency syndrome
AMS	HIV/AIDS Management System (from NOSA)
ARC	AIDS-related complex
ART	Antiretroviral therapy
ARV	Antiretroviral (drug)
ASO	AIDS Service Organisation
AVMIN	Anglovaal Mining Ltd.
BCC	Behaviour change communication
CASM	Community and small scale mining
CBO	Community-based organisation
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CIDA	Canadian International Development Agency
CME	Continuing medical education
COSATU	Congress of South African Trade Unions
CSM	Condom social marketing
CSI	Corporate social investment
CSIR	Council for Scientific and Industrial Research
DCSA	DaimlerChrysler South Africa
DOTS	Directly observed treatment (short course) (for TB)
DRC	Democratic Republic of the Congo
DWAF	Department of Water Affairs and Forestry (South Africa)
EAP	Employee Assistance Programme
ECD	Early childhood development
EEA	Employment Equity Act (South Africa)
GDP	Gross domestic product
GFL	Gold Fields Ltd.
GIPA	Greater involvement of people living with HIV/AIDS
GNP+	Global Network of People Living with HIV and AIDS
GRI	Global Reporting Initiative
HAART	Highly active antiretroviral therapy
HBC	Home-based care
HIV	Human immunodeficiency virus
HR	Human resources
ICFTU	International Confederation of Free Trade Unions
IEC	Information, education and communication
IFC	International Finance Corporation
IGA	Income generating activity
ILO	International Labour Organisation
JD	Job description



JSE	Johannesburg Securities Exchange
KABP	Knowledge, attitudes, behaviours and practices
KAP	Knowledge, attitudes and practices
KCM	Konkola Copper Mines
KPA	Key performance area
KYS	Know Your Status (Sishen campaign)
LSHTM	London School of Hygiene and Tropical Medicine
MDR	Multi-drug resistant TB
MIS	Management information system
MOU	Memorandum of understanding
MTCT	Mother to child transmission (of HIV)
NEDLAC	National Economic Development and Labour Council
NEPAD	New Partnership for Africa's Development
NOSA	National Occupational Safety Association
NUM	National Union of Mineworkers
OH&S	Occupational health and safety
OVC	Orphans and vulnerable children
PIA	Private Investors for Africa
PEP	Post exposure prophylaxis
PHC	Primary health care
PLWHA/PLHA	Person living with HIV/AIDS
PMTCT	Prevention of mother to child transmission (of HIV)
PPT	Periodic presumptive treatment (of STIs)
PR	Public relations
PRA	Participatory rural appraisal
PSI	Population Services International
RBM	Richards Bay Minerals
SABCOHA	The South African Business Coalition on HIV/AIDS
SADC	Southern African Development Community
SFH	Society for Family Health
SHE	Safety, health and environment
SMME	Small, medium and micro enterprise
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SWOT	Strengths, weaknesses, opportunities and threats
TB	Tuberculosis
TEBA	(previously) The Employment Bureau of Africa
TOR	Terms of reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary counselling and testing
VP	Vice-President
WEF	World Economic Forum





# Section One

## HIV/AIDS Guide for the Mining Sector: What, Why and How?

### Section One contains:

#### An introduction to the Guide;

- What is the HIV/AIDS **Guide** for the mining sector?
- Why was it developed and for whom?
- Why the focus on contractors?
- How should you use the **Guide**?
- How was the **Guide** developed?

*If we are to reach the Millennium Development Goal of halting the spread of AIDS by the year 2015, there is literally no time to lose. We have to work really very, very hard. It means helping every country understand that speaking up about AIDS is a point of honour, not a point of shame. It means explaining to everyone that stigmatising high risk groups, and imagining that everyone else is safe from infection, is both morally and factually wrong. No one should imagine that we can protect ourselves by building barriers between 'us' and 'them'. In the ruthless world of AIDS, there is no us and them.*

*Kofi Annan, UN Secretary General  
on a visit to the Ukraine*

#### An overview of the Guide;

- Contents of the **Guide**
- Format of the sub-sections or interventions

#### The mining sector and the HIV/AIDS epidemic;

- The HIV/AIDS epidemic in Southern Africa
- The HIV/AIDS epidemic and the workplace
- HIV/AIDS and the mining sector in Southern Africa

#### A framework for a "blue-chip" response to HIV/AIDS;

#### A roadmap towards a "blue-chip" response to HIV/AIDS; and

#### A template for customising the Guide for contractors and other sectors.

## Section One

# Introducing the HIV/AIDS Guide for the Mining Sector



### What is the HIV/AIDS Guide for the mining sector?

The HIV/AIDS **Guide** for the mining sector, referred to throughout as the **Guide**, is a compendium of resources – information, tools and case studies – that can be used individually or collectively by stakeholders and organisations working within mining communities in Southern Africa, to initiate or strengthen their responses to the HIV/AIDS epidemic.

### Why was it developed and for whom?

Mining communities constitute one of the most important and influential sectors in Southern Africa. They are also communities that are being severely impacted by the HIV/AIDS epidemic.

The **Guide** is intended to support the development of HIV/AIDS competencies and compliance in stakeholders and organisations operating in mining communities across Southern Africa.

The Southern African mining sector comprises a range of actors, including small scale miners, mining companies, suppliers, contractors and associated industries, national ministries, NGOs, labour unions and research institutions.

The **primary users** of the **Guide** will be emerging mining companies, trade unions, organisations providing goods or services to the large mining companies (eg contractors and service providers) and stakeholders from other related sectors (eg construction and transport). For ease of reference these diverse users are referred to throughout the **Guide** as **contractors**.

The **secondary users** of the **Guide** will be large mining companies with well-established HIV/AIDS programmes, the partners of these companies, such as the Chambers of Mines, training and research institutions, government ministries, NGOs, consultants – from geologists to jewellers – and even SMMEs and informal sector operations.



### Why the focus on Contractors?

There are multiple organisations – some small, some larger – that interface with mining companies, such as contractors, suppliers, service providers or partners. For example, in many mining companies at any point in time, there could be as many contractors on site as permanent employees of the company.

Understanding that contractors and employees interact with one another, and that the spread of HIV occurs within sexual and social networks, mining companies have identified that the lack of opportunity to involve contractors in their workplace HIV/AIDS programme, or to ensure that contracting companies have their own synergistic programmes undermines the effectiveness of their own HIV/AIDS programmes.

The **Guide** was therefore developed to assist in addressing this problem; whether it is used by the mining companies as a resource in their interactions with their contractors, or by the contractors themselves.

### How should you use the Guide?

There are no rules about how the primary and secondary users should utilise the **Guide**; rather it is intended that every user will discover their own, individual uses for it. So, the **Guide** may be used when:

- Embarking on an HIV/AIDS response;
- Tackling a particular intervention for the first time;
- Reviewing an existing HIV/AIDS response, with a view to modifying and strengthening the response; or
- Reviewing a particular intervention for similar reasons.

The **Guide** can also be used when assisting others, such as contractors, suppliers, unions and partners to establish or strengthen their HIV/AIDS responses.

Because the users and the contexts within which the **Guide** will be applied will vary considerably, adaptation of the tools and score cards will make them more relevant and useful, and users are encouraged to make whatever modifications are necessary to suit their situations and needs. A template for customising the **Guide** can be found at the end of Section One.

### How was the Guide developed?

The **Guide** was developed following an assessment of current responses to HIV/AIDS by the mining sector (conducted by Golder Associates Ltd. in association with CARE Canada, in 2002), and involved periodic consultation and dialogue with IFC and specifically the IFC Against AIDS programme, and mining and social development specialists from the Corporation.

The contents of the **Guide** was then defined based on the assessment results and a review of the emerging best practices in the workplace. Many of the tools and case studies in Sections Two, Three and Four of the **Guide** are drawn from these sources.

The draft **Guide** was field tested in two phases; firstly with a range of mining sector HIV/AIDS experts and secondly with potential users. In 2004, the **Guide** was piloted in selected companies and settings – in South Africa, Botswana and Zambia – following which it was finalised and officially launched.

# Section One

## Overview of the Guide



### Contents of the Guide

The **Guide** consists of **five** sections.

**Section One** – which introduces the **Guide**, provides key background information on the mining sector and the HIV/AIDS epidemic, describes the contents of, and framework and roadmap for an optimal organisational response to the HIV/AIDS epidemic, and finally provides a template to customise the **Guide**.

**Section Two** – which covers the strategies for **managing** the HIV/AIDS epidemic within a mining sector organisation.

**Section Three** – which deals with **workplace or internal** HIV/AIDS programmes.

**Section Four** – which describes a number of **outreach or external** HIV/AIDS activities.

**Section Five** – which contains information and tools for monitoring, evaluating, and recording and reporting on an organisational HIV/AIDS response.

A number of appendices follow Section Five, providing:

- Comparative country data for the SADC region;
- Information on the mining sector in Southern Africa;
- The IFC corporate roadmap on HIV/AIDS;
- Lists of resources, references and contacts; and
- A glossary of terms.

### Format of the sub-sections or interventions

In Sections Two, Three and Four there are a number of sub-sections, each of which refers to a particular HIV/AIDS intervention, eg behavioural surveys, workplace HIV/AIDS policies, peer education, wellness programmes, partnerships etc.



Each sub-section consists of four parts. For easy reference, different icons introduce each part:



### Part 1: Briefing Note

The **briefing note** contains key background information about the intervention – such as what it is, why it is important for an organisation to include this as part of its HIV/AIDS response, what the components are of the intervention, and any issues for contractors.



**Red flags or special challenges**, where these exist, are indicated with this icon, serving to draw attention to issues and potential problems that have commonly been experienced by organisations in implementing the intervention.



### Part 2: Tool

The **tools** can be used in implementing the intervention. They take many forms; checklists, processes, menus, rules, templates, sets of questions and so on. Typically they are drawn from the literature and have been tested in various circumstances (though not necessarily in the mining sector). They can be used as they appear in the **Guide**, or adapted as required for different contexts.



### Part 3: Score Card

The **score card** is a ranking system against which to measure an organisation's status in relation to a particular intervention. In line with the National Occupational Safety Association (NOSA) HIV/AIDS Management System (AMS 16001: 2003)<sup>1</sup>, a minimal response equates to a 1 red ribbon rating, a good response earns 3 red ribbons and a “blue-chip” or best response qualifies for 5 red ribbons.

The **red ribbon** is a symbol used all over the world to show awareness and understanding regarding HIV/AIDS and to demonstrate solidarity with those who are infected and affected.

Rating	Future Actions
	Minimal Response
	Good Response
	“Blue-chip” Response

The actions included in each of the score cards are not comprehensive, but are **indicative examples** of different level responses. They are also, in the main, cumulative, i.e. an organisation should have implemented the actions against 1 red ribbon, as well as those against 3 red ribbons, in order to score 3 red ribbons, and all the actions listed, to qualify for 5 red ribbons.

The score cards are thus intended to enable users to identify and quantify (by allocating a rating to each of their interventions) their areas of strength and weakness and to record the next steps (future actions) to strengthen their responses. For example, you may rate each listed activity as follows:

- 1 = poor or below average
- 2 = average
- 3 = good

This allows for the calculation of a score for each intervention (HIV/AIDS risk and impact assessment, peer education, HIV/AIDS partnerships etc), a total for each of the 3 pillars of your HIV/AIDS response (management strategies, workplace programme and outreach programme), and a composite score for your entire HIV/AIDS response. Over time the score cards can be used as monitoring tools to track and measure progress.

Following each score card, where data does exist, the costs of interventions are indicated, to guide decision-making regarding prioritising and financing interventions.



#### Part 4: Case Study

The **case studies** describe a real life example of each intervention. These are drawn either from the literature or from the experiences of the informants during the field testing. The case studies are not necessarily best practices, but all contain valuable lessons from the field.



Finally, where good sources for **additional information** about the intervention exist, these are listed at the end of each of the sub-sections.

Examples or quotes appear throughout the text, to illustrate key points.

Remember, each of the Sections (Two to Four) and the sub-sections within these can be used individually or in combination.



#### Footnotes



<sup>1</sup> The NOSA AMS is an internationally recognised standard specification against which HIV/AIDS management systems can be assessed and certified. To access the AMS and the accompanying guideline document, go to [www.nosa.co.za](http://www.nosa.co.za)



## Section One

# The Mining Sector and the HIV/AIDS Epidemic

Section One

Section Two

Section Three

Section Four

Section Five

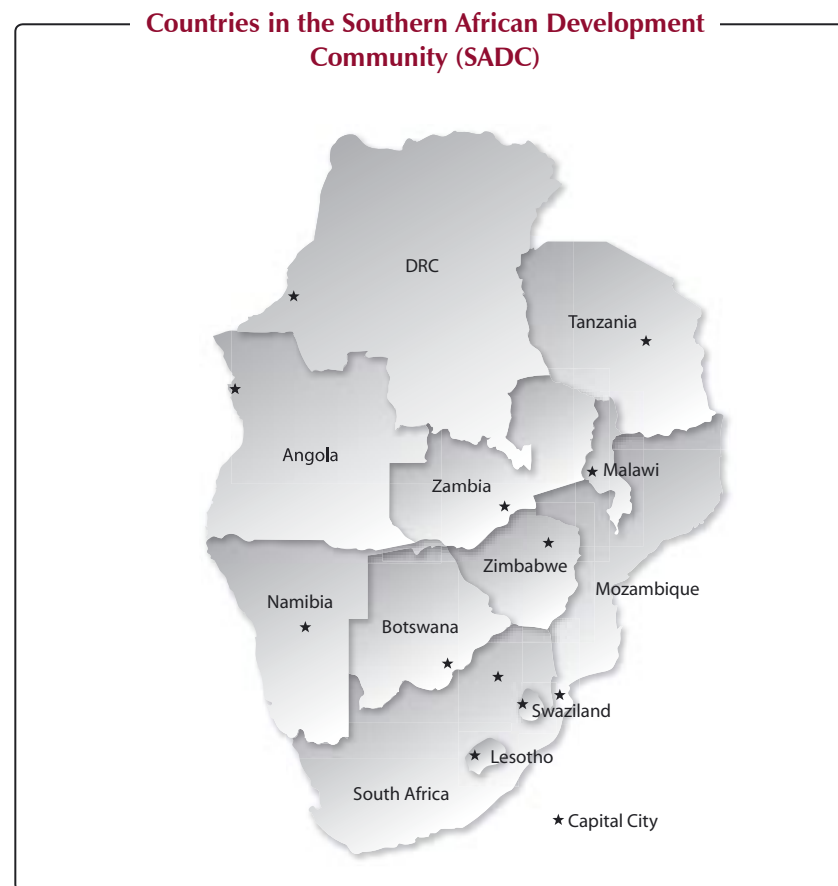
Appendices

Acknowledgements

### The HIV/AIDS Epidemic in Southern Africa

*As the world enters the third decade of the AIDS epidemic, the evidence of its impact is undeniable. Wherever the epidemic has spread unchecked, it is robbing countries of the resources and capacities on which human security and development depend. In some regions, HIV/AIDS, in combination with other crises, is driving ever-larger parts of nations towards destitution.*

**UNAIDS; AIDS epidemic update:  
December 2002**



UNAIDS estimated that, at the end of 2003, 26.6 million adults and children were living with HIV/AIDS in sub-Saharan Africa<sup>1</sup>, representing an adult prevalence rate of between 7.5% and 8.5%. Of the infected adults, more than half are women.

A summary of key HIV/AIDS data for the SADC countries follows. Additional demographic, development and economic data about these countries can be found in Appendix One.

### HIV/AIDS data for the 12 SADC countries

Country	Adults and children living with HIV/AIDS (End 2001 <sup>2</sup> )		Adults (15-49 years) HIV prevalence rate <sup>3</sup>	Total orphans as % of all children <sup>4</sup>	Orphans due to AIDS as % of total orphans and absolute number <sup>5</sup>
	Low estimate	High estimate			
<b>Angola</b>	250 000	450 000	5.5%	10.7%	14.9% 104 000
<b>Botswana</b>	260 000	390 000	38.8%	15.1%	70.5% 69 000
<b>DRC</b>	960 000	1 700 000	4.9%	9.4%	41.8% 1 366 000
<b>Lesotho</b>	230 000	480 000	31%	17%	53.5% 73 000
<b>Malawi</b>	720 000	1 100 000	15%	17.5%	49.9% 468 000
<b>Mozambique</b>	860 000	1 500 000	13%	15.5%	32.8% 418 000
<b>Namibia</b>	150 000	230 000	22.5%	12.4%	48.5% 47 000
<b>South Africa</b>	4 000 000	6 000 000	20.1%	10.3%	43.3% 662 000
<b>Swaziland</b>	130 000	200 000	33.4%	15.2%	58.8% 35 000
<b>Tanzania</b>	1 200 000	1 700 000	7.8%	12%	42.3% 815 000
<b>Zambia</b>	930 000	1 400 000	21.5%	17.6%	65.4% 572 000
<b>Zimbabwe</b>	1 800 000	2 700 000	33.7%	17.6%	76.8% 782 000



Southern Africa is home to about 30% of the global total of people living with HIV/AIDS (PLWHAs), yet this region has less than 2% of the world's population. Countries in Southern Africa have the highest HIV prevalence rates in the world, with at least one in five adults infected in a number of the SADC countries. Amongst the factors that have contributed to this are:



- Poverty associated with significant income inequalities and widespread unemployment – circumstances that have been linked to high-risk sexual behaviour and the spread of HIV;
- The low status of women, which increases their vulnerability to HIV infection;
- High prevalence of other STIs, which increases the probability of HIV transmission;
- Multiple sexual relationships;
- Low levels of condom use;
- Low levels of male circumcision;
- Cultural practices, such as early sexual debuts, dry sex and widow inheritance; and
- High mobility, settlement patterns, population dislocation in times of drought, conflict or war and worker migration.

In all of the SADC countries these factors take different forms, and the HIV/AIDS epidemic too is different, not just between countries, but within countries. For example, Botswana, Namibia and South Africa are the least poor of the SADC countries, yet they both have very high levels of HIV prevalence, which may be related to some extent to the huge income disparities in these countries. Countries supplying large numbers of migrant workers to the mines in South Africa – Lesotho and Swaziland – have very rates of HIV infection, but Mozambique, which also falls into this category has a much lower level of infection.

Countries emerging from conflict and war appear to have relatively low levels of HIV infection, though some of the data should be treated with caution as surveillance systems in these countries tend to be less robust than those in other countries.

As an example, the following extract from the UNAIDS AIDS epidemic update (December 2003) describes the situation in Angola<sup>6</sup>. Angola gives cause for concern despite the comparatively low HIV levels detected to date. After almost four decades of war, huge population movements are underway. Millions of people have been able to leave the cities and towns they had been trapped in, internal and cross-border trading movements are resuming, and an estimated 450 000 refugees are returning (many from neighbouring countries with high HIV prevalence rates). Such conditions could prime a sudden eruption of the epidemic.

In the final analysis, one similarity does emerge across all countries, namely the very high rates of orphans as a percentage of all children – over 10% in every country, bar the DRC which is close, at 9.4%. As more and more parents succumb to AIDS, this problem will continue to grow, representing arguably the greatest challenge to the future of the Region; a challenge which countries are only very recently acknowledging and attempting to address.

... companies have lost top managers, workers have lost colleagues and huge amounts of time, energy and emotion have been spent pre-occupied with issues of illness and loss. Whole families have collapsed, while companies struggling against a background of chronic poverty have taken on deeper burdens of dependency.

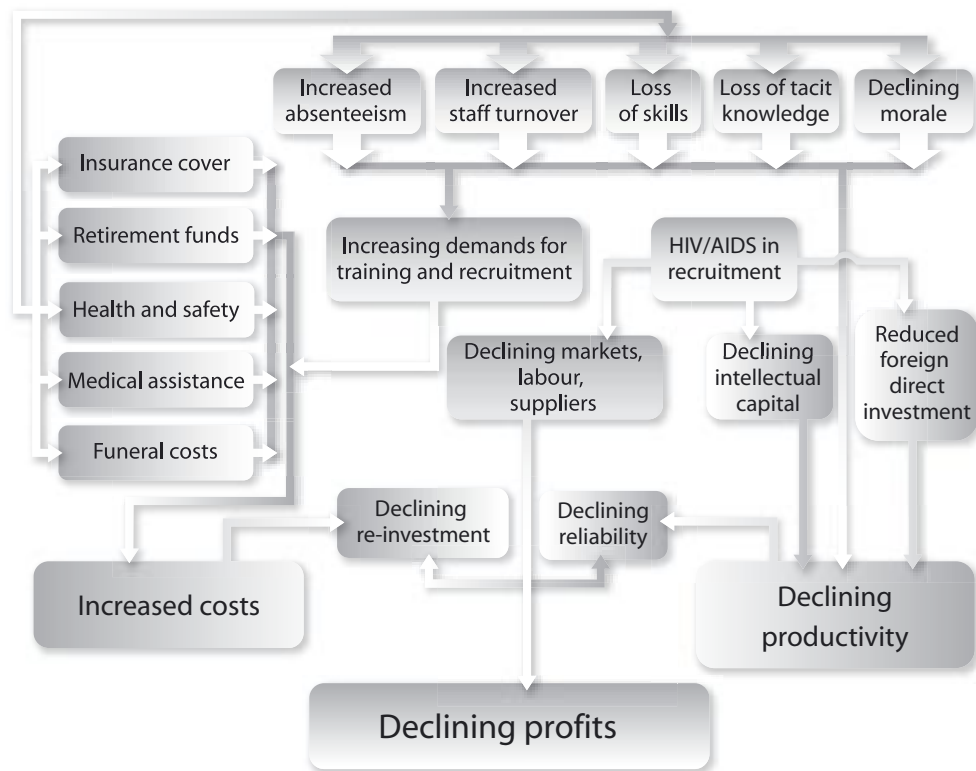
Loewenson, R (1998)

### The HIV/AIDS Epidemic and the workplace

The HIV/AIDS epidemic impacts on all spheres of life. One of the most significant features is its concentration in the working age population (aged 15-49) such that those with critical social and economic roles are disproportionately affected.

HIV/AIDS hits the world of work in numerous ways, as illustrated in the diagram below.

### The impact of HIV/AIDS on enterprises<sup>7</sup>



If you are an executive in a corporation with operations in South Africa, or one of its neighbours, chances are that anywhere from 10% to 40% of your employees there are HIV positive.

Harvard Business Review  
February 2003

In badly affected countries, it cuts the supply of labour and reduces income for many workers. Increased absenteeism raises labour costs for employers, and valuable skills and experience are lost. Often, a mismatch between human resources and labour requirements is the outcome.

Stigma and discrimination negatively affects production and workplace morale<sup>8</sup>. Associated with lower productivity and profitability, tax contributions also decline, while the need for public services increases. National economies are weakened further in a period when they are struggling to become more competitive in order to weather the challenges of globalisation.



### Extract from the Harvard Business Review

AIDS is your business, by Sydney Rosen et al (February 2003)

Many corporations derive a competitive advantage from the low cost of labour in developing countries. AIDS is eroding that advantage by adding, both directly and indirectly, to wage bills. The disease not only drives up health care costs and benefits payments, it also reduces productivity for years – not weeks or months as other illnesses do. Rising absenteeism and higher employee turnover due to HIV/AIDS have forced companies to employ and train more people than usual. For instance, managers in companies in Zambia and Congo invest in training each worker to handle two or three tasks, or they hire two or three workers for every job on the expectation that at least one will die. AIDS has also forced executives to spend more time coping with lower morale in their organisations and addressing the difficult legal, social, and political issues that stem from the epidemic. For instance, companies in many developing countries face considerable pressure from governments and nongovernmental organisations to spend more on tackling AIDS and to provide jobs and additional money for victims' families.

In short, the epidemic is affecting the size, growth rate, and age and skill composition of both current and future labour forces. At the same time, HIV/AIDS is raising the cost of labour in all Southern African countries and diminishing the competitiveness of African business in the global marketplace.

Finally, the gender dimensions of the epidemic in general, and specifically in terms of the world of work must be acknowledged.

- Gender inequality – linked to patterns of social, economic and cultural inequality – makes women more vulnerable to infection. The situation is worsened further by the biological differences between men and women.
- As the epidemic spreads, women are faced with the double burden of having to work and cope with the additional responsibilities of providing care and support for family and community members who fall ill.
- Most women are still confronted with limited access to secure livelihoods and socio-economic opportunities. This increases their dependence on male partners and their vulnerability in situations where there are risks of HIV infection.
- Men, too, are subject to social and cultural pressures that increase their susceptibility to infection and their likelihood of spreading it. Multiple partners and sexual infidelity are condoned for men in many societies.
- Certain occupations tend to encourage risk-taking behaviour, especially those that involve men spending long periods away from their families. This in turn increases the risk of infection for their partners when they return home.



## HIV/AIDS and the Mining Sector in Southern Africa

### 1. Historical milestones

In countries across Southern Africa the mining sector was the first sector to respond to the HIV/AIDS epidemic.

- 1985-6:** First screening conducted in the South African gold mining industry to detect HIV among mineworkers.
- 1986:** First group of mineworkers tested positive from Malawi.
- 1988:** TEBA's healthcare services developed education and awareness campaigns on STIs and HIV/AIDS, including videos shown to all new employees.
- 1989:** Knowledge, attitudes and practices study showed a high level of knowledge by mineworkers about STIs including HIV/AIDS.
- 1989:** A study on truck drivers showed that 50% of the drivers were infected with HIV, while prevalence among mineworkers was negligible.
- 1990:** Mining companies increasingly started introducing HIV/AIDS programmes.
- 1990 - 2000:** A randomly-selected cohort of employees from one company was followed up annually for their HIV status. Prevalence of the disease in the sample increased from 1% to 26% over the life of the study.
- 1993:** The SA Chamber of Mines established a standing committee on HIV/AIDS.
- 1995:** The SA Chamber of Mines commissioned a survey on HIV/AIDS in Southern Africa.
- 1997:** The Southern African Development Community (SADC) Code on HIV/AIDS and employment was adopted.
- 1998:** The International Labour Organisation (ILO) Code on HIV/AIDS in the workplace was developed (and adopted in 2001).
- 1998:** South Africa's White Paper on Mining and Minerals outlined the need to develop an HIV/AIDS policy, the plight of migrant labour, housing and living conditions and the respective responsibilities of government and employers in addressing these issues. It also emphasised the need to protect human and labour rights in relation to education, counselling, testing and treatment.



**2000:** A SADC HIV/AIDS Strategic Framework and Programme of Action was established, which outlines plans and strategies for dealing with the epidemic for all SADC sectors. Within this strategic framework, a section relating to mining is enunciated, which includes:

- Establishing the extent of HIV/AIDS in the SADC mining sector;
- Minimising the spread of HIV/AIDS in the mining sector; and
- Providing adequate care for the infected and affected in the mining sector.

**2001:** In Zambia, the Ministry of Energy and Water Development recognised the loss of human resources, lower productivity due to illness and funeral attendance, and the costs of recruiting and retraining new staff as high HIV/AIDS mortality rates took its toll. The 2001 work plan included the training of designated HIV/AIDS focal persons and health committees, the distribution of male and female condoms, establishing counselling centres, and providing support through peer education.

**2001:** A tripartite HIV/AIDS committee for the mining industry – between government, labour and mining companies in South Africa – was established.

**2001:** Debswana introduced subsidised (90%) ART.

**2001 and 2002:** Mining companies signed specific agreements with TEBA to provide home-based care in 4 Southern African countries, for terminally-ill mineworkers who agree to return home to the rural areas.

**2002:** The MMSD report on mining, minerals and sustainable development in Southern Africa was published, with a strong emphasis on HIV/AIDS.

**August 2002:** August 2002: Anglo American announced its ART programme for employees.

**2003:** The first South African summit on HIV/AIDS in the mining industry was held, attended by government, labour and mining companies. Resolutions included that:

- Every workplace will have workplace HIV/AIDS policies and programmes in place by the end of 2004;
- Prevalence survey results will be shared within a national databank framework; and
- Measures will be implemented to improve the standard of housing for mineworkers.



## 2. The impact of the epidemic on the mining sector

The mining sector is a major sector in most national economies in the SADC region, not only in terms of the number of people employed but also the foreign exchange generated by mineral exports. In South Africa, experts believe that the industry hardest hit by HIV/AIDS will be mining. Studies of the sector show HIV infection rates from one-quarter to almost one-half of the country's miners. Zambia has a similar problem, where copper accounts for 75% of the country's export earnings, and 18% of the copper miners (a skilled workforce) are estimated to be HIV positive. In Botswana, where diamonds account for 80% of export earnings and half of the government's total revenue, a third of the industry's employees are estimated to be HIV positive.

Labour is an essential input in mining and the sector's use of labour leads to unique risk situations in respect of HIV transmission because:

- In many mining situations mechanisation is difficult and the industry is very labour intensive;
- Mineworkers tend to be young males – an age category most affected by HIV/AIDS. They engage in physically taxing and dangerous work for 8-12 hours a day, with infrequent breaks, limited access to food and water, and in sweltering and dusty conditions. They also live with the constant prospect of mutilating or fatal accidents;
- The use of migrant labour is common with the attendant disruption of social support mechanisms and family structures, unpleasant living conditions and limited opportunities for leisure. This, in turn, creates situations conducive to the establishment of new and/or casual sexual relationships.
- The migrant system that has serviced the mines of Southern Africa has also generated exaggerated forms of masculine identity that now abet the spread of HIV. For mineworkers, the lack of control over their life circumstances results in a risk-taking mentality which advocates high levels of sexual activity (often associated with alcohol use) as a way of dealing with dangerous and stressful lives.
- Apart from large numbers of semi-skilled workers, mines also require highly skilled and experienced professionals such as geologists and engineers. The illness or loss of these highly skilled professionals has the potential to disrupt operations significantly.

Health is another important factor, as the nature of mining requires peak physical fitness yet it is also associated with the risk of severe occupational illnesses such as pneumoconiosis, asbestosis, silicosis and tuberculosis (TB).

- Silicosis is a substantial risk factor for TB, as is HIV infection; research describes a multiplicative, rather than an additive effect of these three conditions.
- STIs are an important co-factor for HIV transmission and rates of other STIs have, in many instances, been found to be higher amongst mineworkers than in the general population. Although mines may provide STI treatment services for their workers, few provide treatment for their sexual partners and rapid re-infection is common.
- Mineworkers who become disabled as a result of advanced HIV disease are medically retired and frequently return home to remote rural areas where resources and care are limited. With their return, the flow of income to their household ceases, resulting in increased impoverishment.

For more detailed information, the MMSD<sup>9</sup> report provides a comprehensive analysis of the impact of HIV/AIDS on mining communities.



### 3. Future responses by the mining sector to the HIV/AIDS epidemic

Throughout Southern Africa, the mining sector has been at the forefront of efforts to respond to the HIV/AIDS epidemic. Nowhere is this more true than in respect of providing antiretroviral treatment (ART) to infected employees.

Trade unions, like the National Union of Mineworkers (NUM) have also played an important role in raising the profile of HIV/AIDS as an issue and in educating workers regarding HIV transmission risks, often as joint initiatives with mine management.

The MMSD report made important recommendations for future responses by the mining sector to the HIV/AIDS epidemic. These included the following:

- To urgently shift from IEC approaches (information, education and communication) to address the root causes of transmission: poverty alleviation, cultural norms around sex, and social and economic instability.
- To establish an international charter on key prevention and care strategies to be followed throughout sub-Saharan Africa.
- To shift from negative messages to ones that emphasise the need to accept HIV/AIDS and take greater responsibility for personal behaviour.
- To build capacity to deliver community-based interventions by channelling resources into CBOs and NGOs; to allow communities a greater say in the course of interventions; and to provide long-term funding.
- To monitor and analyse HIV/AIDS intervention programme outcomes to develop and improve quantitative understandings of cost-benefit relationships.
- For company stakeholders to continue to take the initiative, but in partnership so as to play a greater role in capacity building and developing best practice.
- To stimulate economic development, particularly in rural recruitment catchment areas; to subcontract services relating to HIV/AIDS care; to retrain medically boarded employees; and to encourage participation in benefit schemes.
- To employ a multi-stakeholder approach to address all aspects of the problem through a combination of measures including GIPA (the greater involvement of people living with HIV/AIDS) and the protection of individual rights.
- To establish alternative lower risk living conditions.
- That treatments must follow a logical sequence within the limits of available resources, with priority given to interventions that address problems with highest morbidity and best cost-benefit in terms of quality of life and ability to live productively.
- In order for drug costs to be affordable to those in employment, to encourage the introduction of mandatory medical benefit schemes for those in employment and to require participation in wellness schemes.
- To produce guidelines for assessing the equivalent value of the non-cash elements of HIV/AIDS interventions, eg voluntary work, etc.
- To establish and maintain resource inventories to provide stakeholders with information on available resources.
- To ensure the ability for programmes to incorporate the facility to collect quality research data and for monitoring and evaluation to be carried out in order to develop best practice.
- To build capacity by co-ordinating stakeholders, seconding staff, developing individuals and subcontracting services.



## Additional Information

The MMSD report gives an excellent summary of the history of mining in Southern Africa, available on [www.iied.org/mmsd/rrep/s\\_afr.html](http://www.iied.org/mmsd/rrep/s_afr.html).

As part of the MMSD process, research topic 2 examined the effect of HIV/AIDS on the mining sector and proposed recommendations for management of the pandemic in alignment with sustainable development in the sector. The report is available on [www.iied.org/mmsd/rrep/s\\_afr.html](http://www.iied.org/mmsd/rrep/s_afr.html).

The mining sector is also well covered in a recent document from IOM, SIDA and UNAIDS entitled *Mobile Populations and HIV/AIDS in the Southern African Region: recommendations for action* (May 2003).

UNAIDS publishes regular reports on the HIV/AIDS epidemic, which detail the status of the epidemic in all countries. These reports are available on [www.unaids.org](http://www.unaids.org).



## Footnotes



- <sup>1</sup> UNAIDS; Epidemic update (December 2003), available on [www.unaids.org](http://www.unaids.org)  
In sub-Saharan Africa at the end of 2003, between 25.0 and 28.2 million adults and children were living with HIV/AIDS; 3.0 to 3.4 million were newly infected with HIV; and between 2.2 and 2.4 million adults and children had died.
- <sup>2</sup> UNAIDS; Report on the global HIV/AIDS epidemic (July 2002)
- <sup>3</sup> UNAIDS; Report on the global HIV/AIDS epidemic (July 2002)
- <sup>4</sup> UNAIDS, UNICEF & USAID; Children on the brink 2002: A joint report on orphan estimates and program strategies (November 2002)
- <sup>5</sup> UNAIDS, UNICEF & USAID; Children on the brink 2002: A joint report on orphan estimates and program strategies (November 2002)
- <sup>6</sup> Additional information about the epidemics in Southern Africa can be found in the UNAIDS AIDS epidemic update (December 2003), available on [www.unaids.org](http://www.unaids.org)
- <sup>7</sup> Source: UNAIDS; adapted from *The business response to HIV/AIDS: impact and lessons learned* (2000)
- <sup>8</sup> HIV/AIDS-related stigma is a real or perceived negative response to a person or persons by individuals, communities or society. It is characterized by rejection, denial, discrediting, disregarding, underrating and social distance. It frequently leads to discrimination and violation of human rights.  
(Definition produced from *Stigma-AIDS 2001 discussions and Regional Consultation on Stigma and HIV/AIDS in East and Southern Africa*, 2001)
- <sup>9</sup> Available on [www.iied.org/mmsd/rrep/s\\_afr.html](http://www.iied.org/mmsd/rrep/s_afr.html)



## Section One

# A Framework for a “Blue-chip” Response to HIV/AIDS



Every organisation operating in Southern Africa is aware of HIV/AIDS and will have taken some steps to address the consequences of the epidemic in their organisation. These steps vary significantly – from ad hoc prevention activities to more considered responses, where the risks are analysed and dealt with in much the same way as other risks to an organisation’s operations.

Regardless of the approach your organisation has adopted, there will always be scope for improvement. The **Guide** is intended to support the development of improved HIV/AIDS competencies and compliance in organisations, at every level.

There are many ways to describe a comprehensive and optimal organisational response to HIV/AIDS. For the purpose of the **Guide**, a framework is used that clusters a number of interventions into one of three broad areas, namely:

- Management strategies;
- A workplace (or internal) programme, which has two main focuses; prevention, and care and support; and
- An outreach (or external) programme.

In striving for a “blue-chip” HIV/AIDS response, an organisation adopting this framework would set goals as follows:

### **Goal of the management strategies**

To manage and mitigate the impact of the epidemic through a range of governance, assessment, surveillance, planning and monitoring strategies.

### **Goal of the workplace programme**

To prevent new HIV infections and provide care and support for infected and affected employees.

### **Goal of the outreach programme**

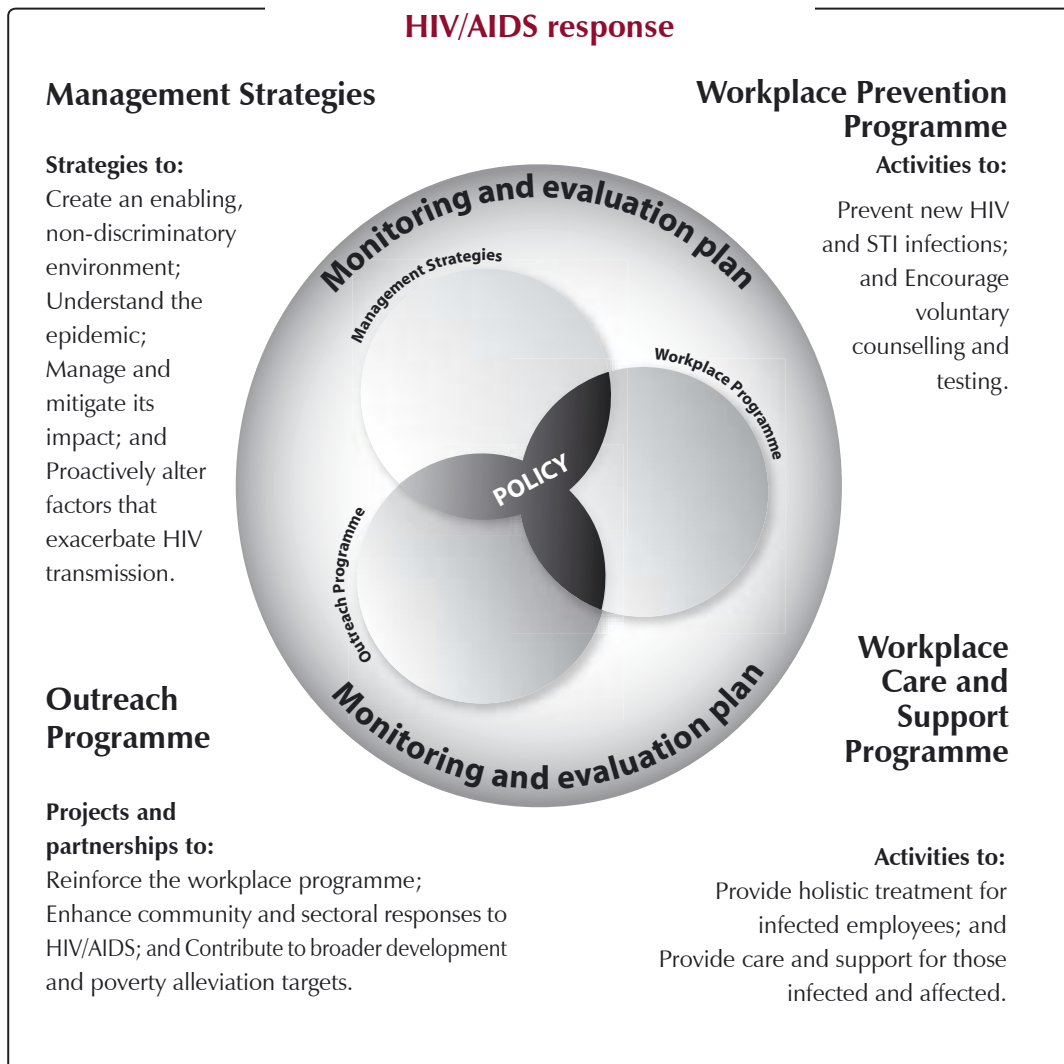
To contribute to broader community, sectoral and societal HIV/AIDS responses, in areas of comparative advantage.

It is important to stress two points:

1. That this categorisation does not mean that there is no interaction, or overlap between the three areas. In fact the opposite is true, as the following examples indicate:
  - The results of behavioural surveillance, such as KAP surveys (which appear in the **Guide** as a management strategy) are used to inform the content of workplace prevention programmes; and
  - Peer educators (part of a workplace programme in the **Guide**) frequently use their knowledge and skills in outreach activities with community groups.
2. That large and small organisations can do some, but not all of the same things, as part of their HIV/AIDS response. In many instances, however, where small organisations cannot tackle certain interventions on their own, they can achieve a great deal in partnership with larger organisations, or by finding other creative ways to achieve what large organisations may be able to achieve in more traditional ways.

This framework, upon which the **Guide** is based, can be depicted graphically as follows:

### Framework for a comprehensive HIV/AIDS response





## Section One

# Roadmap Towards a “Blue-chip” Response to HIV/AIDS

### List of possible priorities for an HIV/AIDS response:

- Organisational HIV/AIDS audit
- Workplace HIV/AIDS policy
- Co-ordinator and workplace HIV/AIDS structure
- HIV/AIDS leadership and management commitment
- HIV/AIDS legal compliance
- Behavioural surveillance – the KAP survey
- Biological HIV surveillance
- HIV/AIDS risk and impact assessment
- Managing the human resource implications of the HIV/AIDS epidemic
- HIV/AIDS corporate social investment
- Prevention through behaviour change communication
- Peer education
- Condom promotion and distribution
- STI management
- Safe working environment
- Voluntary counselling and testing
- Prevention of mother to child transmission (of HIV)
- Wellness programme
- The greater involvement of people living with HIV/AIDS
- HIV/AIDS partnerships and collaborative relationships
- HIV/AIDS networks
- Community entry strategies for HIV/AIDS interventions
- Community outreach projects

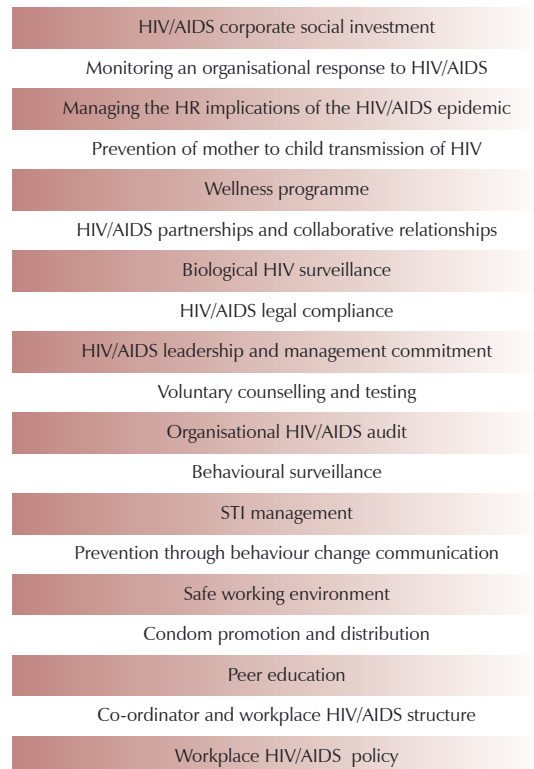
The roadmap, below, is a visual representation of the important elements of an HIV/AIDS response, and a way of positioning an organisation at a point along the road towards a “blue-chip” response to HIV/AIDS, based on the interventions in the **Guide**.

Create your own roadmap, with a selection and sequence of interventions that reflects the priorities that you have set for your HIV/AIDS response. Remember, there is more than one way to reach your destination.

 **Blue-chip Response**

 **Good Response**

 **Minimal Response**



## Section One

# Template for Customising the Guide

The **Guide** will always be more useful if it has been adapted to suit the context of each organisation. These organisations may be in sectors other than mining, eg transport, construction, agribusiness etc, or they may be operating in Regions other than Southern Africa.

The following template identifies those areas where adaptations are most likely to be required.

### Section One:

#### HIV/AIDS Guide for the Mining Sector: What, Why and How?

What is the HIV/AIDS <b>Guide</b> for the mining sector?	Change focus from the mining sector to your sector
Why was it developed and for whom?	Add the rationale for why your sector requires priority attention
Overview of the <b>Guide</b> : format of the sub-sections or interventions	Amend the score card to reflect a rating system with which you are familiar  Replace the red ribbons with symbols that apply to your sector and/or geographical area
The mining sector and the HIV/AIDS epidemic <ul style="list-style-type: none"><li>• The HIV/AIDS epidemic in Southern Africa</li><li>• HIV/AIDS and the mining sector in Southern Africa</li></ul>	Replace this information with background information about: <ul style="list-style-type: none"><li>• The HIV/AIDS epidemic in your Region</li><li>• The interactions between your sector and the HIV/AIDS epidemic</li></ul>
Framework for a “blue-chip” response to HIV/AIDS	Change the “blue chip” concept to something that relates to your sector
Roadmap towards a “blue-chip” response to HIV/AIDS	



## Section Two: Management Strategies

- Organisational HIV/AIDS audit
- Workplace HIV/AIDS policy
- Co-ordinator and workplace HIV/AIDS structure
- HIV/AIDS leadership and management commitment
- HIV/AIDS legal compliance
- Behavioural surveillance – the KAP survey
- Biological HIV surveillance
- HIV/AIDS risk and impact assessment
- Managing the human resource implications of the HIV/AIDS epidemic
- HIV/AIDS corporate social investment

In all the management strategies:

- Delete examples, in boxes, that do not relate to your sector, and replace with ones that are more relevant
- Review the “Red flags and special challenges” and add/amend/delete to more closely reflect the reality in your sector
- Change the score cards to the format you have decided upon and have described in Section One
- Under “Costs”, add any cost-related information for your sector
- Replace the case studies with case studies from your sector
- Delete non relevant information from the “Additional information” box and add sources of information from your sector and/or Region

## Section Three: Workplace HIV/AIDS Programme

- Prevention through behaviour change communication
- Peer education
- Condom promotion and distribution
- STI management
- Safe working environment
- Voluntary counselling and testing
- Prevention of mother to child transmission (of HIV)
- Wellness programme

Conduct the same review as for the management strategies, ensuring that the information is grounded in the reality of your sector, eg the extent to which health services – for STI management, PMTCT and wellness programmes – are available to employees

The provision of antiretroviral therapy to infected employees is becoming increasingly more commonly available in many sectors. When amending the **Guide**, make sure that this section most accurately reflects the current situation in your sector





#### Section Four: External or Outreach Response

- The greater involvement of people living with HIV/AIDS
- HIV/AIDS partnerships and collaborative relationships
- HIV/AIDS networks
- Community entry strategies for HIV/AIDS interventions
- Community outreach projects

Conduct the same review as for the management strategies and workplace programme, ensuring that the information is grounded in the reality of your sector, eg the particular features of your sector will dictate how the sector interacts with the communities in which it operates

#### Section Five: Measuring and Monitoring an HIV/AIDS Response

Monitoring, evaluating, and recording and reporting an organisation's response to HIV/AIDS

Add/amend/delete information so that this section is relevant to your sector. For example, you may operate in areas where other systems than the NOSA standards and certification are used. If your system has any HIV/AIDS-related standards, these should be documented here.

#### Appendices

**Appendix One:**  
Comparative country data

Remove and replace (if required) with information that is relevant to your Region

**Appendix Two:**  
Fact sheet on the mining sector in Southern Africa

Remove and replace with information that is relevant to your sector

**Appendix Four:**  
Resources, references and contacts

Add/amend/delete with information relevant to your Region and sector

**Appendix Five:**  
Glossary

Add/amend/delete to reflect terminology used in your Region and sector