HEALTHY PROFITS

Healthcare is a good investment for any company – but few can vouch for its significance as well as Anglo American's chief medical officer. **Virginia van der Vliet** finds out how Dr Brian Brink and Anglo American have spent more than 25 years supporting its southern Africa-based workforce and their families since the emergence of HIV and AIDS.

A dangerous, sexually transmitted infection that could affect more than 20 per cent of the country's adult population is an alarming prospect, especially if you are that country's biggest employer and most of your workers are male and living away from their families with money in their pockets.

Such a prospect faced Anglo American in South Africa in the mid-1980s. Although the HIV epidemic there seemed largely confined to white, gay men, in countries to the north the toll was rising fast. In the Ugandan capital, Kampala, HIV prevalence was heading towards 30 per cent among pregnant women and a number of Malawian mineworkers in South Africa had tested positive.

In response, Anglo American assembled a heavyweight in-house 'brainstrust' to examine ways of tackling HIV/AIDS, which was rapidly becoming a pandemic. The incipient team included technical services director Jack Holmes, Chairman's Fund director Michael O'Dowd, industrial relations consultant Bobby Godsell, scenario-planning expert Clem Sunter, and medical consultants Drs John Laing, Ian Potgieter and Charles Thomas. In 1986, Jenny Crisp was appointed as Anglo American's inaugural full-time HIV/AIDS education adviser, a first for any large company in South Africa.

Thinking back to those early days as a medical officer at Ernest Oppenheimer Hospital, which served the company's Free State gold mines in South Africa, Brink recalls Gavin Relly, chairman of Anglo American from 1983 to 1990, being among the first to recognise that an HIV/AIDS epidemic in southern Africa was unavoidable and that business had to

RIGHT
Mamoraka Mmutlane, then an HIV/AIDS peer educator, discusses prevention methods with staff at the Waterval Smelter, part of Anglo American's Platinum business

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respond. In 1986, the company launched two initiatives: an education and awareness programme aimed at the entire workforce; and the provision of more than $5 million in funding over the next few years to prominent researchers in Europe and the US to investigate treatment possibilities using decoy CD4 proteins inserted into red blood cells. Anglo American was also one of the first companies to publish an AIDS policy, which explicitly stated that HIV testing would not be a requirement of pre-employment medical examinations.

During 1986, Brink together with Professor Reuben Sher and Dr Lavinia Clausen, led a mining industry initiative to survey the prevalence of HIV in the entire South African mining industry workforce. Out of 18,450 South African mineworkers tested, only four were HIV-positive – 0.02 per cent! At that time, 3.8 per cent of Malawian mineworkers were HIV-positive, and only 0.34 per cent of mineworkers from Botswana. Brink can't help but reflect on how things have changed since then, and on the near-complete failure of South Africa's HIV prevention efforts over two decades.

DECADES OF CHANGE

The South African government's response was to pass legislation in October 1987 to keep infected people out and make employing them illegal. This forced the country's Chamber of Mines to stop recruiting if, like in the case of Malawi, their home governments refused to pre-test them. The legislation was quietly dropped in 1991, but it was a low point for an industry grappling with the outbreak.

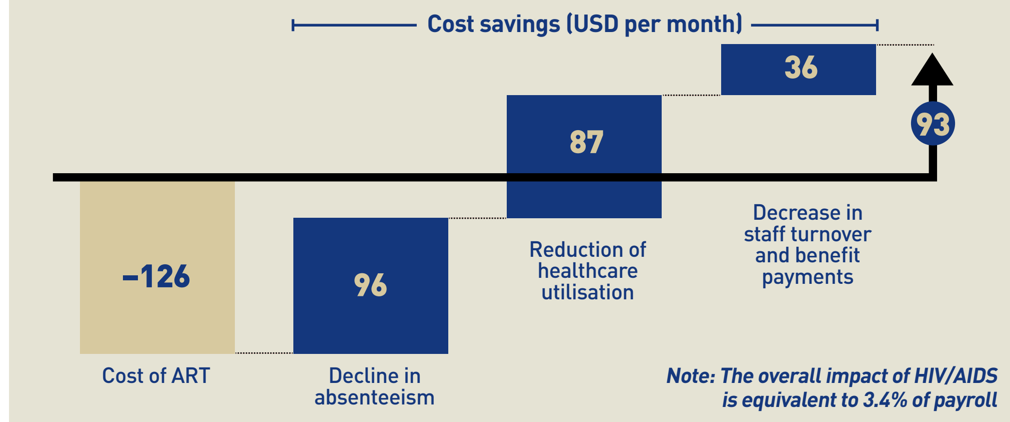
01 Residents living in Kathu, near Kumba Iron Ore's Sishen mine, hear healthcare messages about HIV/AIDS and TB

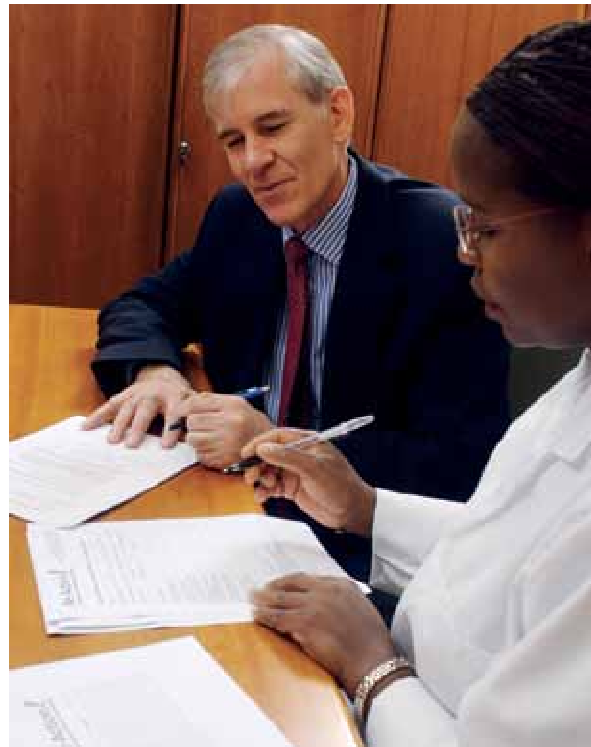
02 Brian Brink is tested during a voluntary counselling and testing session

It was a far cry indeed from the point in June 2009 when the Global Business Coalition (GBC) on HIV/AIDS, Tuberculosis and Malaria presented Anglo American's Thermal Coal with its Business Excellence Award for Best Workplace Program. This honour followed a series of awards, presented to Anglo American over a 15-year period, for its work on HIV and AIDS.

It has been a bumpy ride between the early 1980s and today. Ante-natal surveys saw South Africa's HIV prevalence rocket from less than one per cent in 1990 to more than 22 per cent in 1998. The following year, Brink and Crisp set out the problem for Anglo American's top executives: they were facing a situation where 25 to 30 per cent of the country's productive adults could sicken and die. What implications would this have for labour supply, productivity, markets, healthcare costs and communities crippled by broken families, orphans and growing despair?

EFFECTS OF ANTI-RETROVIRAL THERAPY (ART) AT AN INDIVIDUAL LEVEL – THE ANGLO AMERICAN EXPERIENCE





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"We need zero new infections each year to sustain our treatment response... We're churning in the white water rather than getting ahead of the wave."
BRIAN BRINK

The message hit home. The company was going to have to provide anti-retroviral (ARV) drugs for its workers. Nevertheless, there followed three years when Anglo American blew hot and cold on taking on such a costly and complex exercise.

Pressure for treatment was also coming from outside. At the International AIDS Conference in July 2002, activists demanding companies provide anti-retroviral therapy (ART) targeted just two: Coca-Cola and Anglo American. The latter's headquarters were feeling the heat from financial analysts who wanted to know how the company would manage the epidemic.

Other firms, too, were beginning to formulate treatment plans – even the South African government was grudgingly conceding that ARVs might have value under "certain conditions". However, there were no indications of them being made generally available in the public sector, and South Africa's then minister of health, Dr Manto Tshabalala-Msimang, continued to label them "toxic".

In an article by *Fast Company* senior editor Charles Fishman (see *Optima*, Volume 50, No. 1, March 2004), he recounts how Brink kept plugging away at the need for Anglo American to act – an endeavour in which Brink is keen to point out he had a formidable ally in Sunter, who had recently published the bestselling book *AIDS: The Challenge for South Africa*, co-authored with Alan Whiteside.

Eventually, all the effort paid off, with then chief executive Tony Trahar (who headed the company from 2000 to 2007) acknowledging that Brink, whom he once described as a "relentless pest", had been right. Treatment, he decided, was "absolutely the right thing to do".

In August 2002, Anglo American announced it would be making ART available to all its workers. An article on the decision by Claire Bisseker in South Africa's *Financial Mail* quoted Brink admitting: "It is a leap of faith... I don't think the benefits will exceed the costs. There'll be a gap, but the size of the gap will be affordable."

Eight years later, Brink's July 2010 summary report on the economics of ART in Anglo American's southern African workforce vindicates that leap of faith. While the overall impact of HIV/AIDS on the company, including the cost of the ART programme, is equivalent to 3.4 per cent of payroll, without treatment the company would be in a far worse situation. The benefits of ART far outweigh the costs: at an individual level, the monthly ART cost of $126 resulted in monthly savings of $219. For Brink, the bald figures represent progress, but there have also been some disappointments.

He knows where he wants the programme to go. In an article he and Dr Jan Pienaar of the company's Thermal Coal's Highveld Hospital published in the journal *AIDS* in 2007, it is as crisply formulated as any good business strategy.

"The company currently strives to achieve an ambitious target for its HIV/AIDS programme of three zeroes (which has since been adopted by UNAIDS, the Joint United Nations Programme on HIV/AIDS): zero new infections; zero employees falling sick or dying from AIDS; and zero babies born HIV-positive in employees' families." This must be achieved with zero tolerance of discrimination, stigmatisation or breaches of human rights.

ELAINE BANISTER

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01 Sister Devagi Naidoo explains the use of the oral swab rapid HIV test to South Africa's minister of health, Dr Aaron Motsoaledi, before he volunteered to undertake a confidential HIV test at Thermal Coal's Goedehoop colliery clinic in March 2011

02 "There's still a long way to go to meet my standards." Brian Brink on Anglo American's continued efforts to control the HIV/AIDS epidemic, October 2010

PREVENTION AND TESTING

A cornerstone of the programme is voluntary counselling and HIV testing (VCT). In 2003, VCT uptake among the entire southern Africa-based Anglo American staff was less than 10 per cent; by year-end 2010, 94 per cent of employees were checking their status every year. The success of the testing programme means HIV prevalence can be accurately calculated at 16.5 per cent, and the incidence of new infections at about 1.2 per cent.

The government currently has a campaign to test 15 million South Africans by June 2015. Brink confesses to a love-hate relationship with this much-hyped initiative. He greatly admires the leadership shown by the present minister of health, Dr Aaron Motsoaledi, and the dramatic increase in the number of South Africans who now know their HIV status.

"However, if South Africa tests 15 million and 17 per cent test HIV-positive, which seems likely, that means more than 2.5 million people, of whom about a third, or 850,000, would need to go on ARVs at once," he says. "Anglo American's testing policy has had an immediate follow-through on care. I doubt that the public-health system would manage that. It's not the numbers you test, but the percentage you care for that matters."

In his report, Brink notes: "Our prevention outcomes, while better than most, are nevertheless disappointing and the HIV incidence remains unacceptably high. We need to target zero new infections each year if we want to have any hope of being able to sustain our treatment response to the existing burden of HIV disease."

There is an edge of frustration in his voice as he adds: "We're churning in the white water rather than getting ahead of the wave."

TREATMENT TAKE-UP

Closing the loop on prevention was one reason the programmes were extended to workers' dependants. This was a complex exercise given that many are scattered around southern Africa, often in remote villages with little access to healthcare. Among the female employees and worker dependants who are managed through Anglo American health services, HIV transmission to babies is virtually zero – but it's a challenge where they must rely on the creaking healthcare system in rural areas. So far it has been a somewhat disappointing exercise; only 400 dependants are currently enrolled in the HIV Wellness Programme, with 75 per cent of them on ART. This number is far below the estimates of those in need.

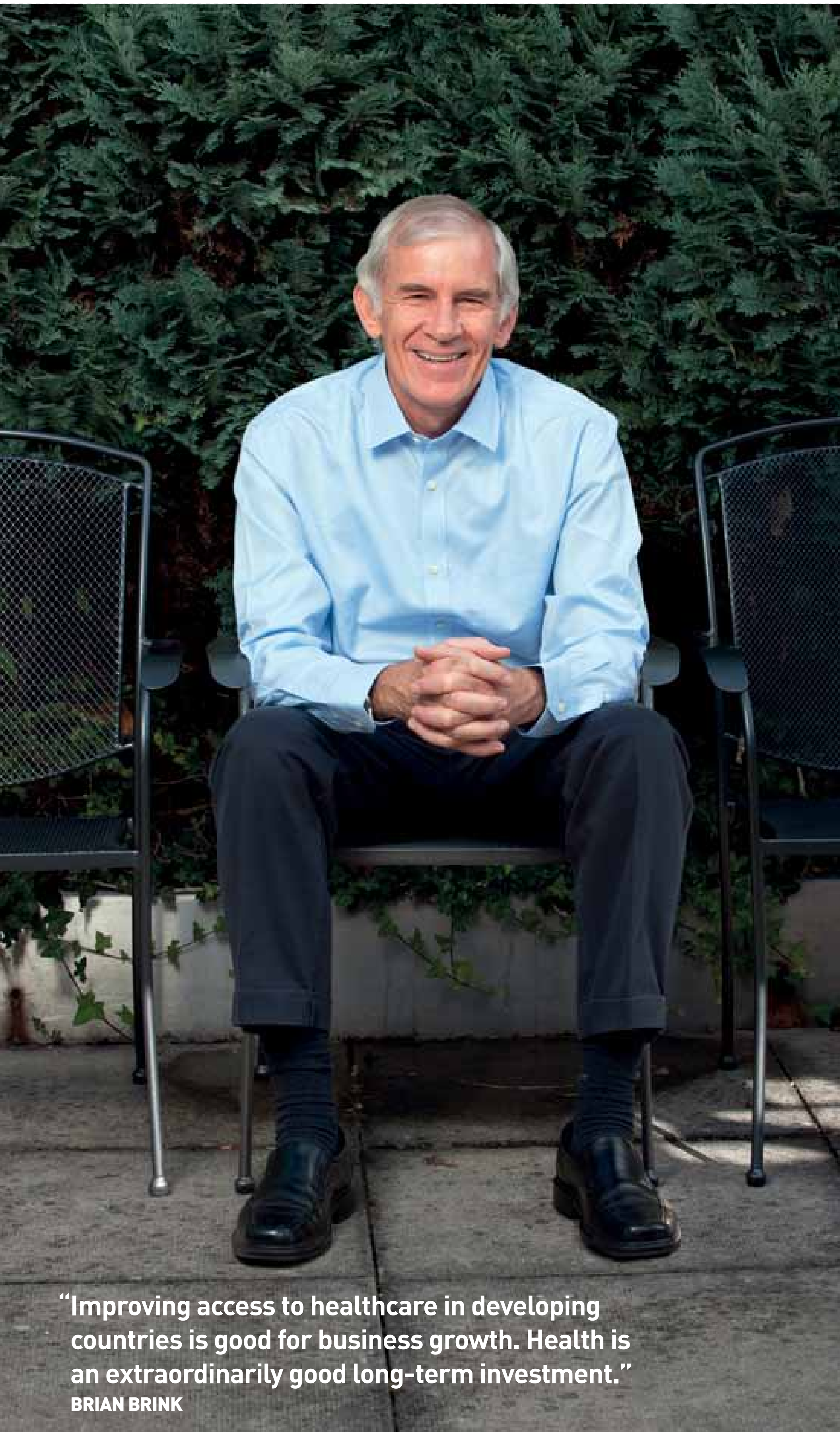
The HIV Wellness Programme is offered to all employees and dependants from the time they test HIV-positive, providing ongoing counselling and immune-system monitoring and enabling treatment to start at the optimal time.

At year-end 2010, of the approximately 12,000 employees who were HIV-positive, nearly 4,000 were on ART. The programme also tries to put all enrollees on *Isoniazid* (*INH*) drug tuberculosis (TB) prevention therapy, which has reduced AIDS mortality by 50 per cent in the programme. Another frustration is that, by the end of 2010, only 60 per cent of those believed to be HIV-positive had enrolled, though a concerted effort is being made to improve this take-up in 2011.

Brink's report adds: "Our greatest challenge is to reduce the dropout rate from the AIDS treatment programme and to ensure good long-term adherence to ART. The first year of treatment is the most challenging; thereafter, treatment tends to stabilise."

There has been progress here, too: annual losses have dropped from more than 40 per cent in the 2004 cohort to below 20 per cent for 2010.

Brink believes Anglo American's experience raises serious questions about the government's data on the number of people on ARVs in the country. "While officially over a million South Africans have been put on the drugs, the problem is that we don't have sound data in many cases," he says. "Motsoaledi is demonstrating extraordinary leadership in reshaping



"Improving access to healthcare in developing countries is good for business growth. Health is an extraordinarily good long-term investment."
BRIAN BRINK

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CHARLES BEST

TIMELINE
BRIAN BRINK'S CAREER

1972
Is awarded an Anglo American Group vocational scholarship to support his studies at the University of the Witwatersrand Medical School

1975
Qualifies as a medical doctor – MB BCh (Witwatersrand)

1981
Joins Anglo American as a medical officer at the Ernest Oppenheimer Hospital in Welkom, becoming medical superintendent in 1986, a position he holds for seven years

1993
Relocates to Anglo American's then head office in Johannesburg, South Africa, where he is actively involved in the creation of the Southern Healthcare joint venture with United HealthCare and Southern Life

1993 to present
Acts as a trustee and/or chairman of various medical schemes. Is also elected chairman of South Africa's Board of Health Care Funders, a position he holds from 2000 to 2003

1995 to present
Is appointed as Anglo American's senior medical consultant (subsequently renamed chief medical officer) and chairs the Anglo American HIV/AIDS Policy and Strategy Committee, which is addressing the challenges that HIV/AIDS poses to business units in southern Africa

2002 to present
Serves as alternate board member and, more recently, board member, representing the global private sector on the board of the Global Fund to fight AIDS, TB and Malaria. Also serves on the board of several health and human-rights organisations, and in 2008 was appointed chair of the International Women's Health Coalition

IN NUMBERS

100,000+

Number of HIV tests carried out on Anglo American employees and contractors in 2010

94%

Percentage of southern African-based employees who participated in voluntary HIV counselling and testing in 2010

4,000

Number of HIV-positive employees who are receiving anti-retroviral drugs to manage their HIV disease

60%

Percentage of the estimated 12,000 HIV-positive employees at Anglo American's southern African business operations who are participating in HIV wellness programmes

33%

Percentage of the world's population that is currently infected with the tuberculosis (TB) bacillus – although the TB bacilli can lie dormant for years, with people only becoming sick when the immune system is weakened

1%

Percentage of TB infections among Anglo American's South Africa-based employees in 2010. This is similar to the incidence in South Africa's general population, but seven times higher than the global incidence

the country's HIV/AIDS programme, but we need more reliable statistics; for instance, on how many have dropped out of ART."

A major challenge in managing HIV/AIDS prevention is tackling the disconnection between migrant labourers working on the mines and their families, who often live hundreds of kilometres away. The migrant-labour system, which the mining industry of old was instrumental in creating, still accounts for a high percentage of the workforce in the South African mining industry.

It's an ongoing problem, adds Brink: "I am concerned by the rising incidence of TB, a disease that is inextricably linked to the incidence of HIV, and a disturbing number of cases with multi-drug-resistant and extremely drug-resistant TB." With South African rates of TB/HIV co-infection and TB incidence being the highest in the world, he believes "the escalating TB epidemic is almost more worrying than the HIV/AIDS epidemic".

Anglo American's TB-control programme is based on similar principles to its HIV/AIDS programme and is designed to ensure the disease is actively managed and properly controlled. As the TB problem demonstrates, the health of mineworkers does not stop at the mine. It is closely tied to the health problems of the communities around the mines and, for migrants, the towns and villages in South Africa and the surrounding countries they come from, and where their dependants live.

The paradox is that the closer one looks at the problem, the wider one's vision needs to be. In a recent memo looking at future interventions, Brink notes: "It is increasingly evident that a stand-alone response to HIV/AIDS will never succeed unless it is supported by a broad-based strengthening of the health system, particularly at a primary care level."

For this to work, the public and private sectors and civil society must co-ordinate their efforts for the benefit of the entire population. Health is ultimately a sustainable development issue.

COMMUNITY EXCELLENCE

Anglo American has been actively involved in community projects since the launch of the Anglo American Community HIV/AIDS Partnership Programme in 2003. It has supported youth programmes and HIV/AIDS initiatives and clinics, and has engaged in public/private partnerships. These include the building of a community health centre at Lillydale in the Bushbuckridge municipality, Mpumalanga province, and a clinic in Kathu township, Northern Cape province – both of which provide access to life-saving ARV therapy.

Currently, Anglo American is sponsoring the writing of a business plan to revitalise primary healthcare in four sub-districts of the Eastern Cape. The plan aims to establish "models of excellence for primary healthcare delivery in some of the most challenging circumstances". Brink states that Anglo American has a vested interest in seeing healthcare in the region improve: it is a 'labour-sending area' that is home to many of its workers and their dependants.

Like Anglo American's HIV/AIDS programme, the business plan will set clear outcome measures for improving the basic indicators of health, including HIV/AIDS, TB and maternal and child health, along with plans "to harness the

ANGLO PLATINUM

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01 The Swissray Expert 4000 digital X-ray machine at RPM Bleskop Hospital, Johannesburg, has greatly enhanced checking and monitoring for TB and silicosis

best of what the public, private and civil society sectors have to offer into a co-ordinated whole". The project will be government-owned and government-led. Anglo American's role will be as a facilitator in getting the plan written and implemented.

The broad-based strengthening Anglo American envisages will require better health information systems, using modern technology that will allow data accessibility even in remote areas. Anglo American's Thermal Coal business has developed such a system, the HealthSource, which is currently being piloted in two poor areas; and the Eastern Cape Department of Health has shown an interest.

"This is a great example of how some of our business skills and resources might be used in a sustainable way for the benefit of the community," says Brink. He is now on a mission to persuade businesses that are not yet convinced that what was once a leap of faith now makes hard business sense.

"Improving access to healthcare in developing countries is good for business growth," he insists. "Health is an extraordinarily good long-term investment."

For Brink, the Anglo American experience has demonstrated that the spread of HIV can be contained, and the sickness and death that AIDS threatened can be managed, so that "the epidemic does not affect the profitability and sustainability of our business. It justifies a similar response by all businesses to protect the economies of countries with a high burden of HIV/AIDS."

GETTING INDUSTRY ON BOARD

Brink currently represents the private sector on the Board of the Global Fund to Fight AIDS, TB and Malaria. As the economic recession has dug deeper into the world's pockets, funding for the Global Fund, as well as other organisations that supported HIV/AIDS programmes, has flatlined. Brink is now actively working to induce the private sector to provide broad-based support for the Fund. "Our target is that the private sector should become one of the top ten donors to the Global Fund," he says.

Anglo American recently participated in the G20 Business Summit in Seoul with this goal in mind – which had the full backing of chief executive Cynthia Carroll. At the Business Summit, which preceded the full G20 meeting, she pledged $1 million per year on behalf of Anglo American to the Global Fund for the next three years to help meet the healthcare challenges in developing economies. The company has demonstrated a clear business case for the investment and Carroll asked the assembled business leaders, from more than 100 of the top global companies, to match Anglo American's commitment. Brink admits that their initial response was disappointing. In the current economic climate, it was perhaps not the ideal time to press business for money. But he will undoubtedly keep trying.

It has been a long road from those first HIV cases among workers in the early 1980s. Does Brink feel frustrated that problems continue? He laughs and explains that the frustrating times were those early years when he could not persuade Anglo American to take action to institute treatment. He seriously considered leaving and he was investigating other options when Trahar made his about-turn. "Once treatment was possible," he says, "we never looked back."

Brink comes across as passionately committed to getting this right. But he can be Anglo American's own harshest critic: "There's still a long way to go to meet my standards," he maintains.

The edge goes out of his voice, however, when he talks of how far they have come, and recalls particular cases where the company's programme has literally pulled people back from death's door.

A doctor first of all, he has been given the resources and support by Anglo American to act on a grand scale. He has the vision to see business taking on, and helping tame, the HIV/AIDS epidemic.

As the July report concludes: "All that is required is the leadership and the will to get the job done." And, of course, Brink, the indispensable "relentless pest".