

# De beers case study

[Business](#), [Company](#)



1. At the end of the 2005 De beers had a comprehensive HIV/AIDS Strategy covering all the aspects of the prevention, education, treatment and community involvement. 2. In 2005, mining amounted to 7.5% of country's GDP, but by 2006 it dropped to 2.3% 3. According to PwC 2005 was successful year for the mining industry. Global mining companies increased their investment by about 30% and profits by 60%. However, this was not the case for South Africa. According to South African Chamber of Mines, investment in country mining sector declined by almost a third in 2004 and 2005. South Africa's mineral operating profits grew by just 12% in 2005 and production fell by 6% in first half of 2006.

4. Reason for above is rooted in the volatility of the local currency, government regulations and the union's position. The value of South African Rand against USD more than doubled between Dec 2001 and Dec 2004, offsetting commodity price increase. 5. In 2005, company announced the “ shift from a supply-controlled business to a demand driven-one”. 6. South Africa is the most severely impacted region. It has largest reported infected population in the world 5.5 million. 7. Anti-retroviral drugs (ARVs) were recognised the most effective treatment for AIDS. The most commonly used combination of ARVs are Highly Active Antiretroviral Therapy (HAART) which is highly effective at fighting the spread of the virus but they are toxic and can create very difficult short and long term side effects. To be effective ARV require complete compliance with treatment from patient.

Lack of compliance may lead to other opportunistic infections and can lead to developing new drug- resistance strains of the HIV virus. 8. A survey of 771 AIDS affected households in three South African provinces reported that

more than 40% of primary caregivers took time off the work or school to care for ill HIV+ family members. HIV/AIDS reduces the quantity of skilled workers and output which leads to a reduction in a country's GDP. 9. SA has the highest prevalence rate in the world. UNAIDS estimation was as high as 18.8% 10. At the international Aids conference in 2006 in Toronto, Stephen Lewis, U. N. special envoy for AIDS in Africa attacked South African govt position on HIV/AIDS.

11. At the end of the 2006, 250K people had access to ARVs, but only 61K of them through the public health care system, which was just a small number of the estimated 850K in desperate need. 12. On December 1, 2006, South African govt released plan for five year to fight the disease. Joy Beckett noticed a new spirit of cooperation between the government and business after a meeting with them. The govt allocated 1.4 billion for HIV/AIDS programs and services. R 373 million for ARV rollout program. 13. SA has good HIV/AIDS policy but the reality is that the capacity to implement.

The public health infrastructure is challenged. Many medical doctors and nurses have left the country attracted by higher pay abroad; many of those that stayed do not have appropriate training in HIV/AIDS. 14. African black culture is generally male-dominated and the idea of male superiority is widely accepted in the society by both genders. Women are more infected than man. In this context, usage of condom and femidoms is not practised. The women are not that well educated. Although constitution provides them all rights, there are difficulties in exercising them, because of male

dominance. 15. The Debswana- experience was different because the govt was helpful – since mining contributed to almost 45% of the country's GDP.

The govt of Botswana considered HIV/AIDS as strategic perspective. 16. On the operational level, each mine was appointed with HIV/AIDS coordinators. The problem was the background of the coordinators, some were doctors and nurses while some social workers. Their background decided the nature of the activity they took at mines. So at the end, we are there was no fixed set of activity that we are able to bench mark or compare. Coordinators were fully responsible for implementing HIV/AIDS strategy. 17. The KAP studies revealed that the majority of the DBCM employees had sufficient knowledge about HIV/AIDS, but were still involved in risky behaviour. Available prevention program failed to motivate changes in behaviour.

18. Peers educators were very helpful, as they acted as mediator between the employee and manager. The company sponsored their education, but many of them left the company, to pursue their carrier in HIV/AIDS education. This created problem to maintain the optimal ratio of peer educator and employee (Optimal is 1: 50). 19. There was understanding that HIV/AIDS was a lifestyle disease requiring a systematic, broad based approach in order to achieve any significant success, but there was not many examples how to do that. 20. SPS provided a reliable baseline when above 70% participant is achieved.

Most importantly, SPSs did little to influence behaviour changes because they were anonymous and participants were not given their testing results.

21. The HIV/AIDS budgets of operations were sometimes overloaded with the

expenditure on VCT. Some 22. Some unprofitable mines did not plan VCT each year.