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Swaziland: HIV/AIDS, work and development

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«The HIV/AIDS situation continues to be not only of public health importance, but a significant socio-economic and development problem in Swaziland. The overall national adult prevalence is now estimated to be about 38.8%, which means that some 200,000 individuals in the age group of 15-49 years and form the most productive part of the labour force are now living with the virus (UNAIDS, Report on the global AIDS epidemic, 2004).»

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Deutsche Gesellschaft für
Technische Zusammenarbeit (GTZ) GmbH

Acronyms

AGOA	Africa Growth and Opportunity Act (of the United States of America)
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal clinic
CIDA	Canadian International Development Agency
CMTC	Crisis Management and Technical Committees
CRC	Constitution Review Commission
DFID	The UK Department for International Development
EU	The European Union
FLAS	Family Life Association of Swaziland
FSE	Federation of Swaziland Employers
GDP	Gross domestic product
GTZ	German Technical Cooperation (Deutsche Gesellschaft für Technische Zusammenarbeit)
HIV	Human immunodeficiency virus
ICFTU	International Confederation of Free Trade Unions
IEC	Information, education and communication
MOAC	Ministry of Agriculture and Cooperatives
MOE	Ministry of Education
PLWHA	People living with HIV/AIDS
RSSC	Royal Swazi Sugar Corporation
SAMAT	Southern Africa Multidisciplinary Advisory Team (of International Labour Organization)
SASO	Swaziland AIDS Support Organization
SFL	Swaziland Federation of Labour
SFTU	Swaziland Federation of Trade Unions
SHAPE	Swaziland HIV/AIDS Public Education
SNAP	Swaziland National AIDS Programme
STI	Sexually transmitted infection
SWANASO	Swaziland Network of AIDS Service Organizations
TASO	The AIDS Support Organisation
TB	Tuberculosis
THO	The Traditional Healers' Association
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	The United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	The United Nations Children's Fund
USAID	US Agency for International Development
WHO	World Health Organization

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Executive summary

Swaziland has a population of 1 million. Its HIV prevalence rate stood only at 5% in 1992 before rising to more than 38.8 % in 2003 (UNAIDS). It is expected to stabilize at 36% by 2010, shrinking the country's population by 25%.

The impact of the epidemic is felt at many levels: it has had a negative impact on production as about 45% of Swazis in their twenties are HIV-positive—the highest rate so far (UNAIDS 2002)¹. In fact, HIV/AIDS, more than drought conditions, could potentially worsen Swaziland's continuing food crisis². Rural areas, and especially the agricultural sector, are particularly hard hit as Swaziland's economy is largely based on agriculture. The labour pool is limited and AIDS-related mortalities are therefore leading to a decrease in productivity. Moreover, Swaziland's high unemployment rate does not translate into an available pool of labour to harvest the crops of small-scale farmers when adults are incapacitated by HIV/AIDS.

The health sector is understaffed and lacking in resources and medicines. Recently, the Ministry of Health and health-care clinics have been collaborating with traditional-medicine practitioners in order to better assist patients with AIDS-related illnesses.

Despite the recorded increases in mortality, there is little empirical or field evidence that HIV/AIDS has affected the profitability and productivity of Swazi businesses, except for illustrative evidence from small-scale studies. The response by Swazi businesses to the epidemic has focused mainly on avoidance of costs associated with the epidemic. However, such strategies have merely resulted in the burden of HIV/AIDS being passed on to households.

At the household level, there is a growing trend towards older people looking after their orphaned grandchildren or taking over the harvest. Loss of the breadwinner, poverty and increased orphaning has led to children dropping out of school and worsening food insecurity. The burden on families increases as their diminishing financial resources are used up on health care for those ill or dying as a result of HIV/AIDS.

There are few HIV/AIDS workplace programmes as many employers are reluctant to take

responsibility for the problem. However, some companies do realise the importance of retaining staff, experience, and skills and have pioneered investing in workplace programmes. New policies are needed to go beyond the workplace and benefit not only employees but also encompass communities and vulnerable groups, such as orphans and women: orphans require assistance and training so that they can continue their education; and women would benefit from education programmes to make them more in demand in the labour market.

Given the threat posed by AIDS, it is essential that a national response be mainstreamed across all major sectors, rather than being seen purely as a health issue. The workplace serves as a platform for programmes to promote awareness of HIV/AIDS-related issues and of the urgent need for prevention measures. Such programmes should include trade unions and local employers' expertise, and policies should be formulated under tripartite agreements.

1 These estimates look at the 15–49-year-old age group.

2 Recent FAO analysis. See <http://www.fao.org/>

A. Situation analysis



1. Recent economic trends and labour market situation

The Kingdom of Swaziland gained independence from Britain in 1968 under King Sobhuza II, who wielded almost absolute power, and the current king, Mswati III, has maintained that legacy. The first phase after independence (1968–73) was characterized by multi-party democratic processes within a monarchical system. In the second phase (1973 onwards), the inherited constitution was repealed in 1973 by the Royal Decree, which banned political activities and enabled the king to assume legislative, judicial and executive powers. Some changes have taken place over the years with the emergence of a new parliament and regional councils based on traditional Swazi law, resulting in a dual system of government.

Swaziland is the smallest country in Southern Africa, with an estimated population of 1 million. The country has a good road and communications infrastructure and it is possible to reach the two main cities from any part of the country within two hours. Traditionally there has been a large migrant working population working in South African mines but, in the past 20 years, the immigrant

labour force has increasingly been based on sugar, citrus and timber estates. Swaziland has a youthful population, with 46% of its inhabitants under 15 years of age.

The HIV/AIDS situation continues to be not only of public health importance, but a significant socio-economic and development problem in Swaziland³. The overall national adult prevalence is now estimated to be about 38.8%, which means that some 200,000 individuals in the age group of 15-49 years and form the most productive part of the labour force are now living with the virus (end 2003, Source 2004 Report on the Global AIDS Epidemic UNAIDS). Population growth is projected to be negative by 2004. These high prevalence rates herald a future burden of HIV-related illnesses, with serious consequences for the health-care system, which is unlikely to be able to cope with the increasing demand. The government's ability to deliver services will also be severely reduced by the dwindling workforce and the deteriorating socio-economic fabric of the country. This state of affairs necessitates an improved understanding of the driving forces of the epidemic so that appropriate policy interventions can be made.

2. Trends in HIV/AIDS prevalence

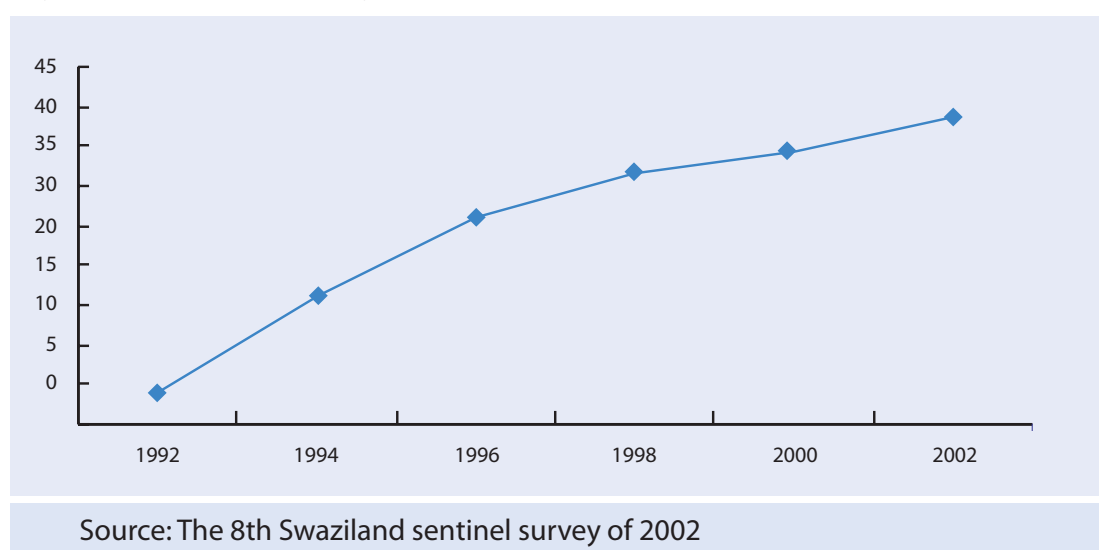
HIV/AIDS was first detected in Swaziland in 1986 and a National AIDS Control Programme was established in 1987. The 8th sentinel survey of 2002 puts the national HIV prevalence among antenatal clinic (ANC) attendees at 39% (see Figure 1), whereas UNAIDS reports a prevalence rate of 33.4% at the end of 2001. The number of estimated AIDS-related deaths in 2001 alone was 12,000 and probably the first cause of mortality in the country.

The data show Swaziland to be on a par with other countries and provinces in the region (with the exception of Southern Mozambique). Geographically, all regions show reasonably high HIV prevalence rates: Manzini had the highest rate of 41% and Hhohho had the lowest of 36.6%. However, the HIV prevalence trend over the years appears to show some degree of stabilization in the Manzini region and a marked increase in HIV prevalence was recorded for the Shiselweni region in 2000-2002 (see Table 1).

i. Characteristics of the epidemic

The overall HIV prevalence among adolescents (aged 15-19) was 32.5% in

Figure 1. Infection among ANC population



2002 but further segregation by residence and age shows that there has been a sharp increase in the number of infections among 15-19-year-olds in urban areas, while it appears stable in rural parts. The reverse pattern is seen in the 20-24-year-old age group. The 25-29-year-old age group had the highest prevalence, followed by 20-24-year-olds. Overall prevalence in 15-24-year-olds was 41.6% and this group is used as an impact-assessment indicator for establishing infection rates among the young population and monitoring achievements towards UNGASS targets⁴ relating to HIV/AIDS.

Table 1: HIV prevalence (%) in Swaziland, by region

	1994	1996	1998	2000	2002
Hhohho	15.5	26.3	30.3	32.3	36.6
Lubombo	16.8	26.5	31.5	34.5	38.5
Manzini	15.6	27.7	34.8	41	41.2
Shiselweni	16.8	23.9	29.6	27	37.9

Source: Sentinel surveillance survey report, 2002

What makes Swaziland unique is that the high prevalence rates are uniformly distributed between urban and rural areas at 35.6% and 32.7% respectively (SNAP 2000⁵). This is due to the country's good road and communications infrastructure, that even out differences between rural and urban populations.

³ Findings of the 2002 HIV sentinel survey.

⁴ These targets were established at the United Nations General Assembly Special Session on HIV/AIDS in New York in June 2001.

⁵ SNAP: Swaziland National AIDS Programme

Despite the many efforts made in the response to the epidemic, HIV prevalence among pregnant women attending antenatal clinics continues to show increasing HIV-infection trends⁶. What is worth noting is that 67% of the HIV-infected pregnant women were less than 25 years old and about 87% of those infected were under 30 years of age. As with the adolescents mentioned above, this high level of infection among young females reflects a high rate of new infections (incidence). If these trends persist, they will have a severe impact on the socio-economic fabric of the country, since this age group represents the economically-productive and -reproductive population.

Equally high HIV prevalence rates have been recorded among married and unmarried persons—36.8% and 40% (2002) respectively. This shows that people get infected very young, even before the mean age of getting married.

ii. Factors contributing to the spread of HIV infection

Some cultural expectations and gender relations have been found to contribute to HIV transmission—in particular those that increase women's vulnerability.

In Swazi society women lack bargaining power to negotiate safe sex, and polygamy is common which greatly increases women's risk of contracting HIV. The 2002 survey found that, of those who tested positive for syphilis, 53% were HIV-positive; and among those who tested negative for syphilis, 38% were HIV-positive.

This trend has also been observed in Botswana, resulting in the infection being passed from one generation to the other. The Government of Botswana noted that, in more advanced epidemics, stopping the spread of HIV from one generation to another is one of the key interventions required. Given that prevalence rates have been found to be 4–12 times higher in young females than young males, this means stopping the spread from older men to girls.

Belief in witchcraft: This tends to delay proper treatment of the villagers who are infected with fully blown HIV/AIDS. It has been seen that when they reach the hospital it is usually too late and some of the local healers advise them to sleep with an innocent baby to get rid of HIV/AIDS (quoted from the Ministry of Labour).

Wife's inheritance: If a person dies of HIV/AIDS, it is customary that the younger brother 'marries' the widow of the dead brother in order to bring up the children. He in turn, almost never ensures whether the widow is infected with HIV, in which case his wife gets infected.

Church attitudes: Some churches are still reluctant to teach the people about HIV/AIDS. They insist that the answer to HIV/AIDS is acceptance of Christ who will empower the believer to abstain and live a holy life.

Low level of condom use: Condoms are generally available in the country but their level of use is low, due to widespread myths about them. Furthermore, in Swazi society, the youth become sexually active early in life. In a 'knowledge, attitudes and practice' baseline study conducted by Family Life Association of Swaziland and the United Nations Children's Fund (UNICEF) in 2001, 45% of young people reported being sexually active and felt that 70% of their friends were also sexually active. Most parents thought that young people engaged in early sexual activity (as evidenced by early pregnancies).

Poverty: Poverty assessment surveys carried out by the World Bank and the United Nations Development Programme (UNDP) show that 66% of Swazis live in absolute poverty. For rural areas, the percentage of people living in absolute poverty is even higher at 80%. The data show high inequalities in the distribution of income, with 10% of the population obtaining 60% of the country's income, and 90% of the population receiving only 40% of the income. This ever increasing gap is indicative of high levels of poverty in the country which are further exacerbated by the high rates of HIV⁷. Also, poor nutrition and bad general health among the people make their body's immune system less able to fight infection. Therefore, the virus is more likely to gain a hold. There is also evidence of gender discrimination in access to health care, with women not always getting the medical attention or treatment that they need.

Lack of information: A behavioural survey carried out in 2003⁸ concluded that the Swazi

6 All HIV prevalence data are from the 8th Sentinel Surveillance Survey report in Swaziland in 2002.

7 See the World Vision website: www.wv.org.za/countries/swaziland.htm

8 Alan Whiteside & Nkosinathi Ngcobo, Jane Tomlinson, & Alison Hickey (March 2003), "What is driving the HIV/AIDS epidemic in Swaziland? And what more can we do about it?" National Emergency Response Committee on HIV/AIDS and UNAIDS.

people are aware of HIV/AIDS/STIs, even though this knowledge has not translated into desirable behavioural change. As a result, there is a need for clarification about protection from HIV, update on provisions targeting young people, efforts at demystifying popular myths to avoid stigmatization among people who are inaccurately informed.

Vulnerable groups: Income inequality increases the likelihood that poor women will be forced into transactional sex as a survival strategy. Orphans and vulnerable children are more likely to be exploited and this may include sexual exploitation and abuse. In Swaziland, youth that do not find formal employment are forced into poverty and lack access to opportunities and resources, contributing to their vulnerability to HIV.

Migration: Migration has been a causal factor in the spread of HIV infection in many countries in Africa. According to a census in Swaziland (carried out by ILO/SAMAT—the Southern Africa Multidisciplinary Advisory Team of the International Labour Organization), there were 51,000 absentees—mainly men working in South Africa in the late 1990s. Census data (1997) show that the Shiselweni region has the highest levels of emigration, with over 90% of people migrating to the Manzini region. A study on subsistence agriculture farms showed close correlation between migration and HIV prevalence and AIDS deaths. It showed that the Shiselweni region had the highest number of AIDS-related deaths, followed by the Manzini region, but the Shiselweni region has the lowest prevalence of HIV (27%), and the Manzini region the highest (41%). This is because of the migration pattern within Shiselweni and the lower socio-economic status of the region. Those who migrated from the Manzini region could have acquired the infection elsewhere and only returned home to die. This study revealed that many households reported family members returning home in the terminal stages of the disease.

3. Demographic impact

This section presents an analysis of projections made by ILO on the dimension of human losses faced by Swaziland, and their consequent impact on the labour market⁹. However, these projections are rough estimates. They may provide a benchmark around which to frame national policies but should be used with caution. It must also be noted that these data make no distinction between the participation of those in the la-

bour force who are affected/infected by HIV and those who are not. This is problematic since HIV/AIDS may have significant consequences—for example, lower participation of infected workers, and increased participation of non-HIV-infected workers and relatives of those infected. The lack of data on the informal sector is also important, as this is where most people in urban areas work, and informal activities provide a livelihood for millions of inhabitants.

The 2004 Human development report clamps down Swaziland with a HDI of 0.51, an index which combines measures of life expectancy, school enrolment, literacy and income. The levels of human development indicators have considerably worsened given three years of depressed food production and rural incomes. The estimated life expectancy at birth according to recent estimates (2004) is 37,5 years¹⁰. The population growth rate is 0.55 (2004 est.) Furthermore, the current impact of the HIV/AIDS pandemic is exacting a very heavy burden on the population and the economy. The peak ages for HIV/AIDS (and resulting mortality) are 25–35 for women, and 30–40 for men. (ILO projections, see figure 5). Economically and biologically, these are the most productive years in a person's lifetime. But the potential to produce and reproduce is reduced as the epidemic sweeps away young adults who would otherwise be key contributors to household and national production.

This has resulted in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected (July 2004 est.). The following projections by the ILO show a breakdown of how and where exactly are the losses in population located.

9 UN Population Division, World Population Prospects, the 2000 Revision, New York, 2001. The estimates used for these projections are from the ILO Labour and Population Programme. Though labour force data are available for workers from the ages of 10 to 65+, this paper only addresses the active labour force of 15–49-year-olds. Labour force participation rates, from UNAIDS, are used to make labour force projections. These projections have been now updated (2004) and are available at ILO/AIDS HQ Geneva.

10 <http://worldfacts.us/Swaziland.htm>

Figure 2. Impact of HIV/AIDS on population growth

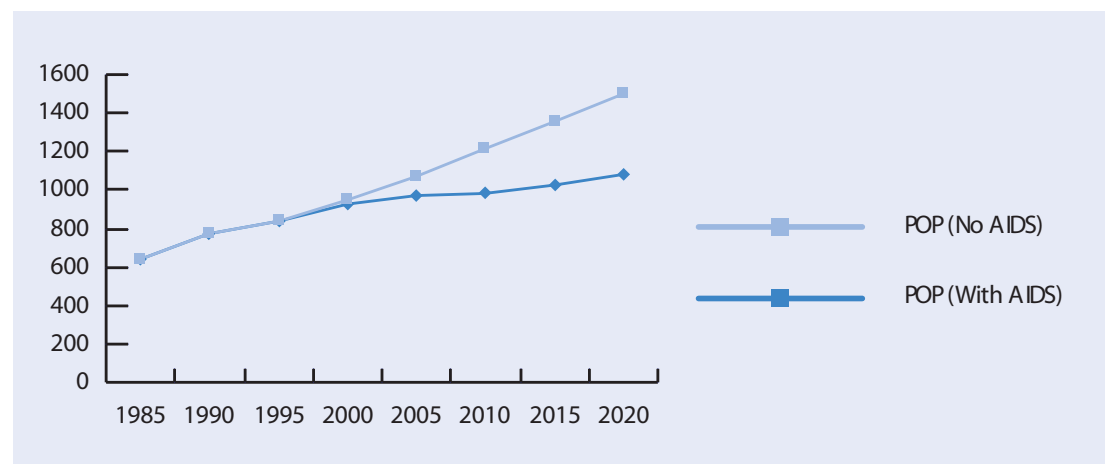


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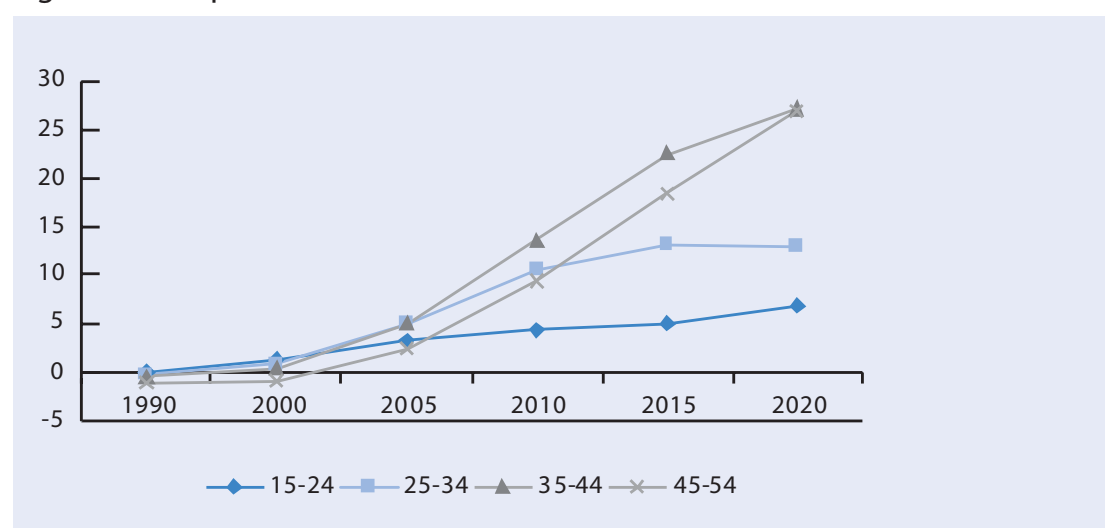


Figure 4. Gender-wise population distribution due to HIV/AIDS

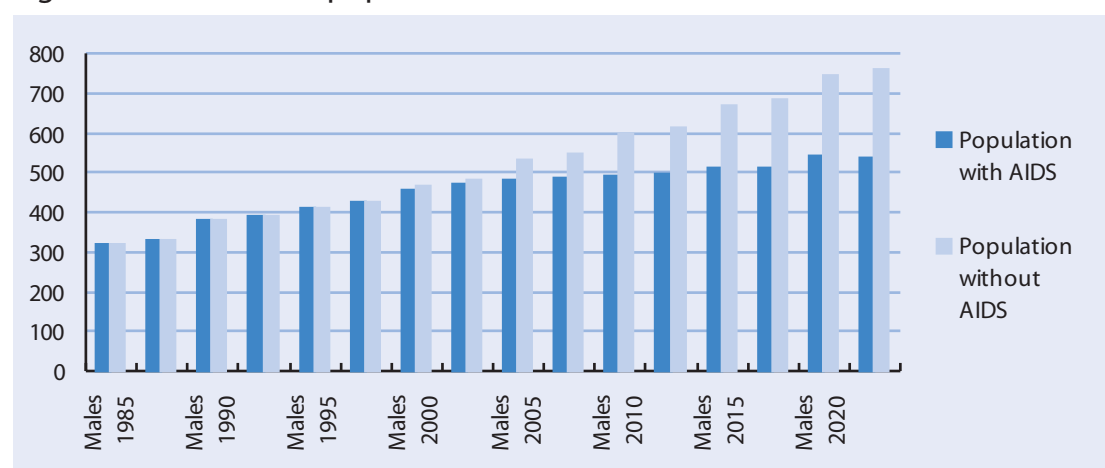
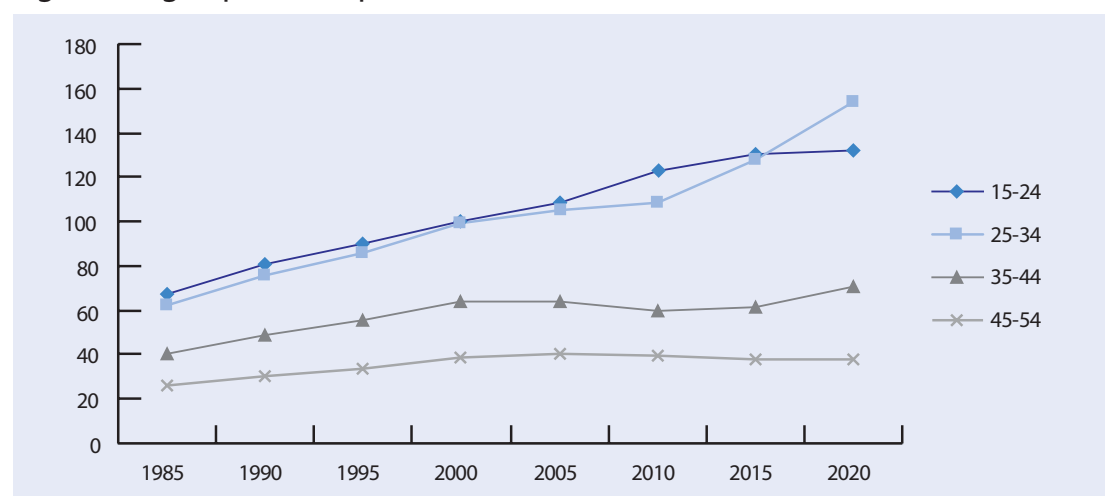


Figure 5. Age-specific impact of HIV/AIDS on the active labour force



i. Impact on the labour force

The projections in Figure 2 show that population growth over the past two decades has been seriously undermined by AIDS. Some population growth continues, but at greatly reduced levels. Figure 3 shows AIDS has a major impact on the work force; it is projected that, by 2005, the HIV/AIDS-related losses in the labour force can be calculated to be about 10%, rising to 30% by 2020. The figure is a projection for the total labour force (aged 15–49) from 1985 to 2020. Even though the labour force is still expected to grow, increased mortality due to HIV/AIDS will result in fewer persons of working age than would be the case in a no-AIDS scenario.

ii. Projected active labour force, by gender

The projections in Figure 4 show the active labour force from 1985 to 2020, but disaggregated by gender. For the year 2005, the projections show a loss of 488,000 women and 480,000 men. Even though Swaziland will lose a higher proportion of women than men from the total population, it can be seen that, within the labour force, more men will be lost. Furthermore, in the absence of AIDS, the male labour force is projected to grow much more than the female one.

iii. Projected age-specific effects on the active labour force

Figure 5 shows the percentage loss due to AIDS, by different age groups. It can be seen that the age group 25–34 is projected to have the highest loss due to HIV/AIDS. The result is a greater number of young workers in the labour force than older ones. The loss due to HIV/AIDS is also seen in the younger age groups (15–24-year-olds), but, in the later years of the projection, the 25–34-year-old age group will lose a greater percentage of its work force, and will grow at a slower rate than the other groups. In effect, the labour force will get younger due to HIV/AIDS. This effect would be even more pronounced if one added to these estimates the entry into the overall labour force the increasing number of young orphaned children under the age of 15.

The above-mentioned estimates lead to the following conclusions:

- The Swaziland labour force will grow much more slowly over the coming decades due to HIV/AIDS, with both fewer women and men in the active labour force.
- The age distribution of both the population and the labour force will continue to be drastically changed by HIV/AIDS, consisting of the very young and the old

who will have to work more because an entire generation will be lost in the middle-age groups.

- Given that the estimated number of 35,000 orphans (UNAIDS 2001) is expected to increase to 85,900 by 2006¹¹, the labour force situation will be even more serious, with large numbers of children entering the labour force very ill-prepared in terms of their health and educational characteristics. These orphans will require additional assistance and resources in order to be integrated into society, otherwise the increasing orphan problem will have a negative impact on social and economic development.

11. Whiteside A, Wood G (1994) The Socio-Economic Impact of AIDS in Swaziland, Government of Swaziland, Mbabane.

B. Economic impact of HIV/AIDS

More than 80% of the population in Swaziland is engaged in subsistence agriculture. Recently, however, the textile industry has been expanding rapidly, largely as a result of Taiwanese investment associated with the implementation of the USA's Africa Growth and Opportunity Act (AGOA). The manufacturing sector has diversified since the mid-1980s. Mining has declined in importance in recent years, with only coal and quarry stone mines remaining active. The economy is heavily dependent on South Africa, from which it receives nine-tenths of its imports and to which it sends more than two-thirds of its exports. Customs duties from the Southern African Customs Union and worker remittances from South Africa substantially supplement domestically-earned income.

The government is trying to improve the atmosphere for foreign investment. The Swazi economy relies heavily on the export sector, which is largely based on agriculture (which accounts for 10% of GDP), agriculturally-based industries along with manufacturing (48% of GDP). Since the economy of Swaziland is dependent on scarce skilled manpower, it is predicted that the impact of HIV/AIDS will be severe.

1. Macroeconomic impact

Swaziland has a GDP per capita of US\$1,390 and is significantly poorer than

its SACU¹² neighbours, such as Botswana and Namibia. There are two forms of land holdings in the country. Fifty per cent of rural land is held in trust for the Swazi Nation by the king and is farmed on a subsistence basis by small farmers. The balance is farmed using modern methods by companies and individuals often in partnership with the government and the Swazi Nation. Some 40% of the land is title deed land, used in sugar estates and forestry plantations. The land holdings are held in trust for the king and controlled by chiefs according to traditional arrangements. More than 50% of the income is obtained from its share of SACU customs revenue.

i. Trends in Gross domestic product

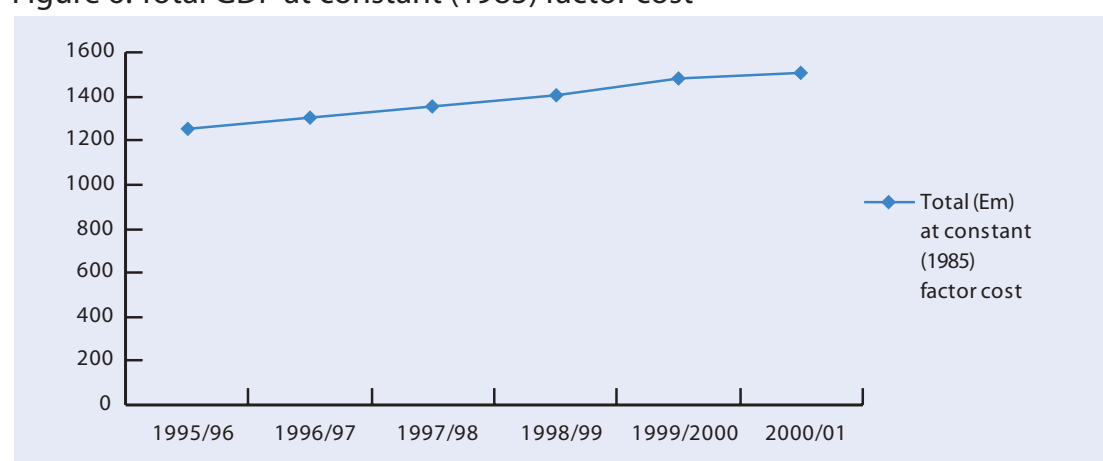
The GDP growth in the country is shown in Figure 6. Despite AIDS, the macro-indicators apparently have not changed much but these figures do not depict the changes within various folds of the economy. These changes can be understood by looking at case studies in specific sectors. GDP growth was fairly consistent until date (see figure 6). Currently, the outlook is poor as Swaziland is not an attractive prospect for foreign investment. The economic growth rate increased from 2.7% in 1998 to over 3% in 1999, after which it fell to 2.5% in 2000, before further falling to 2% in 2001.

ii. Unemployment

Formal employment is quite stagnant in Swaziland, while informal employment is increasing (and the tax base changing). HIV/AIDS is definitely having a negative impact on the employment situation. Formal-sector employment recorded only 749 additional jobs to the country's 93,962 jobs already existing in 2001, which is low even for a small economy such as Swaziland's. Unemployment stands at 40%, according to the Ministry of Economic Planning and Development¹³.

A shortage of workers leads to higher wages, which leads to increasing labour costs. The poor growth of the labour force causes capital output ratio to rise faster. The informal-sector workers are most likely to suffer from the consequences of HIV/AIDS, since they do not have health facilities or social-protection

Figure 6. Total GDP at constant (1985) factor cost



Source: Central Bank Swaziland

12 South African Customs Union—namely, Botswana, Lesotho, Namibia, South Africa and Swaziland.

13 UN Office for humanitarian affairs 'Integrated regional information network' website.

arrangements in their workplaces. This will, in turn, disrupt productivity as the frequent replacement of workers becomes increasingly difficult. Moreover, the replacements will not immediately reach the same levels of productivity, due to less experience. The effect will be more pronounced where on-the-job learning is important. There is a lack of information on prevalence rates in different segments of the labour force, and the impact of HIV infection on the productivity of infected workers. (See Table 2).

iii. Poverty

HIV/AIDS deepens poverty and increases inequalities at every level—household, community, regional and sectoral. Poverty contributes to epidemic disease, which contributes to poverty, thereby creating a vicious circle. For example, loss of labour in a farming system may result in failure to maintain infrastructures such as terracing, leading to soil erosion, and decreasing agricultural productivity. This will impoverish households and communities, reduce their ability to sustain themselves and result in poorer socialization, less formal education and, ultimately, cultural as well as material impoverishment. In 1997, the food poverty line¹⁴ included 48% of the national population (29.7% of the urban and 55% of the rural), and the total poverty line included 65.5% (45.4 % urban and 70.6% rural).

2. Impact on specific economic sectors

There is ample evidence to substantiate that AIDS-related mortality is incrementally eroding the capacity of various economic sectors and, inevitably, has dramatic repercussions. The impact of the epidemic has been studied in the private sector as well. Businesses have felt the socio-economic impact of the epidemic. The excess morbidity and mortality due to AIDS have significantly reduced productivity, increased production costs (due to high absenteeism and funeral attendance) and caused disruptions in business operations. The main causes of increase in cost for companies can be attributed to increased death benefits, medical costs, training costs and funeral costs. There has also been an increase in recruitment costs; costs due to reasonable accommodation, catering for employees' families and orphans; and extended succession plans.

i. Public sector

The public sector in Swaziland has felt the impact of HIV/AIDS, as evidenced by firm-level studies. These studies have empirical data on the actual impact of AIDS on depletion of resources. In 2001, an assessment was commissioned by the Government of Swaziland to determine the impact of HIV/

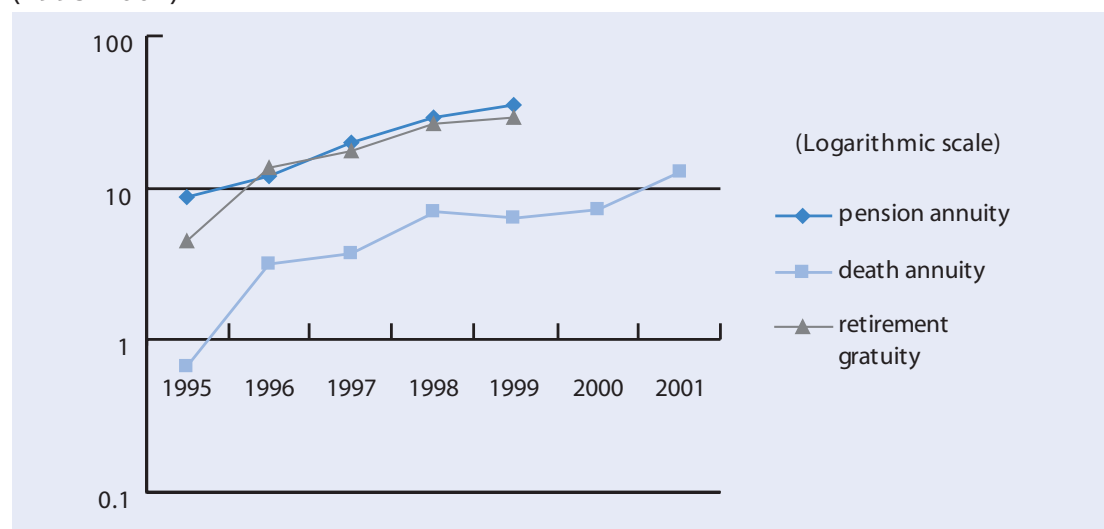
Table 2: HIV prevalence (%) in Swaziland, by sector

Year	1998	1999	2000	2001
Private sector	59 983	61 003	61 613	60 381
Public sector	31 891	32 210	32 693	33 216
Total formal employment	91 874	93 213	94 306	93 597
% change		1.46	1.17	-0.75
Informal sector	11 8244	12 6175	13 5509	14 5925

Source: Central Bank Swaziland

AIDS on the three Central Agencies of the country. These are the Ministries of Finance, Economic Planning and Development, and Public Service and Information. This study concluded that, as a result of HIV/AIDS alone, the three ministries will lose 32% of their staff to the epidemic over 20 years. Moreover, it will result in increased pension fund contributions, sick leave, compassionate leave, training and other costs. The current value base cost of the epidemic to the three central agencies is (conservatively) estimated to be (in local Lilangeni) E 10, 535,994 over the period 2002–2010. This equates to 1.5% of the annual salary budget for the three ministries¹⁵.

Figure 7. Trend in pension payout by the public service fund to its members (1995-2001)



Source: Government of Swaziland, Assessment of the Impact of HIV/AIDS on the Central Agencies of the Government of the Kingdom of Swaziland.

14 UN Common Country Assessment: <http://www.ecs.co.sz/cca>

15 Government of Swaziland, Assessment of the Impact of HIV/AIDS on the Central Agencies of the Government of the Kingdom of Swaziland: Executive Summary. 2002.

These ministries employ an essential part of the labour force in the country. Over 70% of Swaziland's labour force works on land and the Ministry of Agriculture and Cooperatives (MOAC) is mandated with ensuring that the land remains productive and continues to serve the population. The MOAC is faced with increased morbidity and mortality among its employees. While not all of these deaths or illnesses can be attributed to HIV/AIDS, there is a definite increase in retirements, pension payouts and expenditure on health care by government (See Figure 7).

The open-handed sick leave policy of the government has wide-ranging implications for the ministry, too. An employee can only be replaced if he has officially retired (Pension Fund 1995). This can only happen after one year, in the case of chronic conditions. In the meantime, reduced productivity and increased production costs result from other employees being paid overtime to do their sick colleague's work. Furthermore, the sick employee continues to draw his salary during this time. These factors also lead to loss of agricultural knowledge, skills and experience.

The ministry has, in the past, developed a multisectoral approach to eradicate HIV, as follows:

- a. Establishment of an HIV/AIDS focal point within the ministry, run by a full-time focal point officer
- b. Information, education and counselling (IEC) activities for their staff
- c. Control of sexually transmitted infections through condom distribution

However, these activities need to be sustained and the coverage does not extend to field workers and extension officers.

Although the trend in death annuity indicates a general increase (see Figure 7), there was a sharp increase between 1998 and 1999 and again after the year 2000. On applying trend analysis using the linear

regression model, it was found that there was an increase of E1.7 million in death annuities for each subsequent year.

The government does not provide any special medical benefits to its employees for health care within Swaziland. The employees and their dependants pay out of their own pockets for their health care. They seek care from public health services and private providers. The Public Service Pension Fund was established in 1993 to administer benefits accrued to members. Members are civil servants who contribute 5–10% of their monthly pensionable salary while the government contributes the balance of their pension package. Figure 7 shows pension payouts for all civil servants¹⁶. All available figures show a sharp increase beginning in 1996 in total payouts to members.

ii. Core industries

Agriculture

Agriculture is the largest sector in Swaziland (as in most African economies), accounting for a large portion of production and the majority of employment. The loss of a few workers during the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labour is likely to cause farmers to switch to less labour-intensive crops. In many cases, this may mean switching from export crops to food crops. Thus, the epidemic could affect the production of cash crops as well as food crops.

Due to unfavourable weather conditions that affected the agricultural output of most countries in Southern Africa, Swaziland recorded a 30% deficit in maize production¹⁷. A case study of the Mhlume Sugar Company examined the effect of HIV/AIDS on all aspects of the operation of the estate. The sugar estate provides both housing and health care for all of its employees and their families. The study concluded that AIDS will have a major impact on the estate, including effects on the production process, employee benefits, the medical costs and facilities, and the overall well-being of the estate¹⁸. The senior medical officer attributed 30% of all employee deaths over a three-year period to AIDS¹⁹. (A worker in the private sector generally has about 21 days' sick leave²⁰.)

16 Pension annuity refers to on-going payout due to members and/or dependants after the initial lump sum payout in the form of death or retirement gratuity.

17 <http://www.ilo.org/public/english/region/afpro/mdtharare/country/swaziland.htm>

18 Gilbertson I, Whiteside A (1993) AIDS and commercial agriculture, International Conference on AIDS. 1993; 9(2):918 (abstract no. PO-D28-4202).

19 Ian Gilbertson, Senior Medical Officer, Mhulume Sugar Estate, Swaziland, quoted in Toupouzis D (1998) The Implications of HIV/AIDS for Rural Development Policy and Programming: Focus on Sub-Saharan Africa. HIV and Development Programme, UNDP, June 1998.

Health care

The cost per patient per year is estimated to be E4,000 in Swaziland. Therefore, it is estimated that, by 2000, the AIDS epidemic will result in an annual health-care cost of E62.9 million and, by 2006 that cost will rise to E73.4 million²¹. The effect of HIV-related illnesses accounted for 13% of the Ministry of Health's budget in 1994 and almost double the number of outpatient visits by 1999²². Another earlier study²³ estimates that, in 1994, about 250 hospital beds would be required for adults due to AIDS and another 149 beds would be required for the paediatric AIDS cases, requiring a significant percentage of the 1,540 hospital beds in the country. The study projected that, by 1998, over half of the hospital beds in the country would be occupied by AIDS patients.

Transport and mining

In Swaziland, the country is small enough that few truck drivers are required to spend the night away from home while working. There are two groups at risk, however: those who make cross-border deliveries, and those who are in transit from other countries²⁴. Miners working in South Africa send a considerable amount of money home to Swaziland to support their families there; in 1983, 15% of rural incomes were derived from this source. As HIV-infected migrants become ill and are unable to work in the mines, they will return home and that income will be lost. High HIV prevalence will also reduce the number of new miners recruited from Swaziland to work in South Africa. Since miners have a relatively high prevalence rate, this will have a significant impact on household income²⁵.

In the transport sector, it was seen that, given the poverty in the country and the rest of the sub-region, these workers do not have to look around for sexual partners. In most cases, they are available along their truck routes. Studies have, however, revealed that condom use was high among transport workers²⁶.

The Transport Sector Project Advisory Committee was put in place in March 2002 and it was decided that representatives of major organizations and institutions running the transport industry would form a committee that would pave the way towards a sectoral response to HIV/AIDS. In collaboration with the European Union, ILO and GTZ, a strategic action plan was developed for implementation over a period of three years²⁷.

Education

In the early 1990s, the HIV prevalence rate among university students was 18.4%, and it

was predicted that most of these students would die within 10 years of their graduation. Thus, the investment society has made in their human capital will not be fully realized²⁸. It was not until the late 1990s that the real effects of the epidemic were felt within this sector. More and more teachers left classes unattended. The Ministry of Education (MoE) is not in a position to accurately state the HIV prevalence rate within the education sector among teachers, pupils and parents and can only give estimates based on projection studies, which are derived from data obtained from surveys conducted every two years by the Swaziland National AIDS Programme. The MoE commissioned an Impact Assessment of HIV/AIDS on the Education Sector. The study projected that 50,000 Swazis were dying of AIDS, while 300,000 were estimated to die of AIDS in 15 years. The number of orphans was estimated at 35,000, and was projected to increase to 120,000 in 15 years. The study further revealed that there was confusion across the population regarding basic facts about HIV and AIDS, that the Ministry could not fulfil its mandate effectively and that the cost of maintaining the current standard of education would be exorbitant.

3. Microeconomic impact

i. Enterprises

There have been a few recent empirical studies of the cost of AIDS on companies and they show that the private sector has been equally hard hit. They also show that the workplace can be an important HIV sentinel surveillance site, providing valuable epidemiological data on low-risk populations. Surveillance in the workplace also provides

20 Whiteside A, Wood G (1994) *The Socio-Economic Impact of AIDS in Swaziland*, Government of Swaziland, Mbabane.

21 Ibid.

22 Loewensen A, Whiteside A (1997) *Social and Economic Issues of HIV/AIDS in Southern Africa*, SAfAIDS Occasional Paper No. 2, SAfAIDS, Harare, Zimbabwe.

23 Whiteside A, Wood G op cit.

24 Ibid

25 Ibid.

26 Mndzebele A (July 2002) *Report of the HIV/AIDS Strategic Action Process, for the Swaziland Transport sector*. Draft final version.

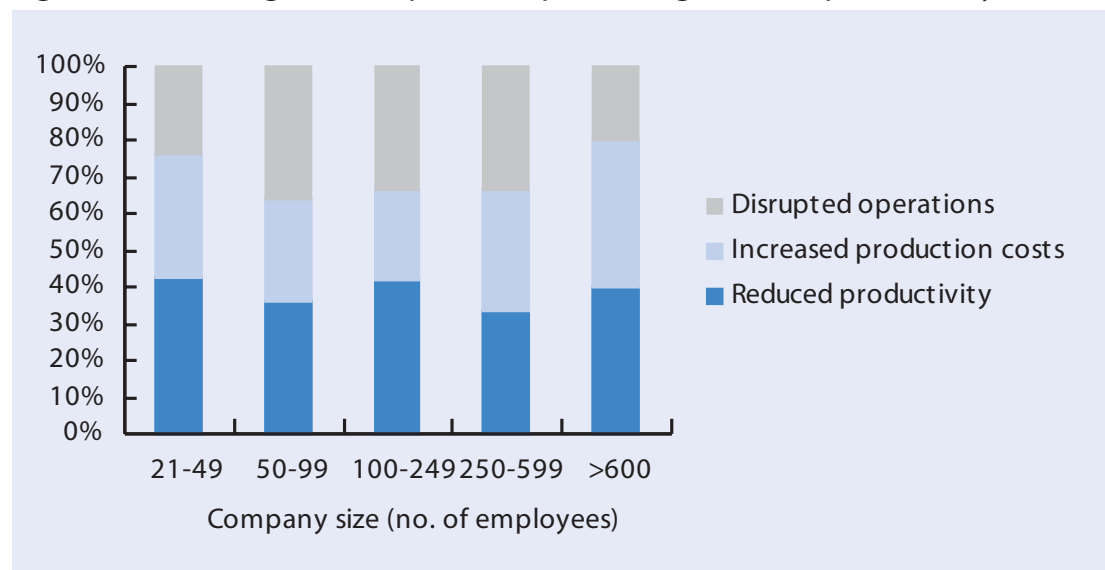
27 Ibid.

28 *Southern African Economist*, 1997. AIDS toll on regional economies, (Issue :15 April-15 May 1997).

essential data for monitoring and measuring the epidemic and for planning and managing it in an organization.

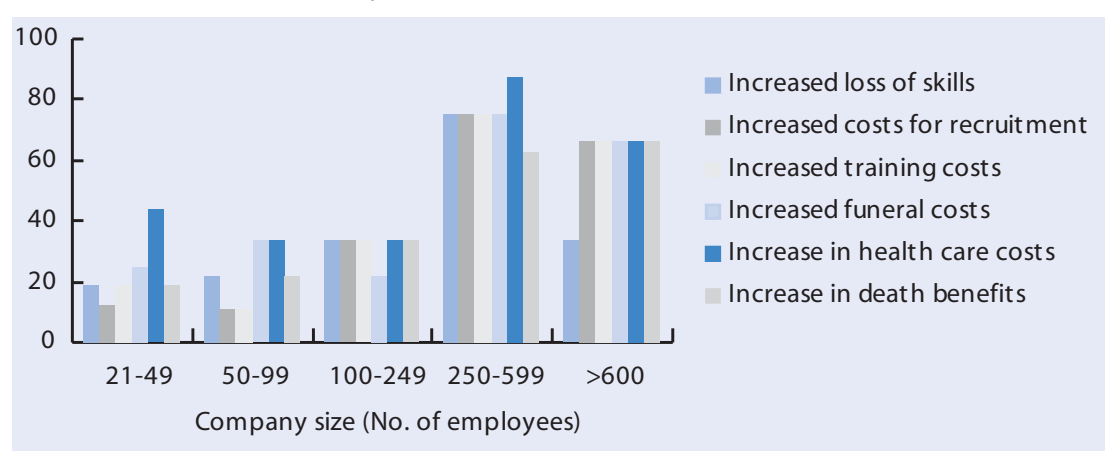
A recent study by the Royal Swazi Sugar Corporation (RSSC) of 4,183 mainly male

Figure 8. Percentage of Companies experiencing reduced productivity



workers found HIV prevalence to be 37.5%²⁹—37% among permanent employees, 43% among seasonal employees and 35% among contract employees. The highest prevalence of 43% was among agricultural employees, followed by 31% in manufacturing and 26.7% among service and administrative staff.

Figure 9. Percentage of Companies experiencing costs of funerals and death benefits due to HIV/AIDS



In the job categories, the lowest-income age group had the highest prevalence—42.6%. According to skills, 30% prevalence was seen in the higher-skilled age group and 13.4% in the highest skilled and professional age group.

Among others, a probability survey analysed the impact of HIV/AIDS on the private sector, focusing on costs imposed as a result of increased illness and deaths from HIV/AIDS³⁰. It was carried out on 45 businesses in the country affiliated to the Federation of Swaziland Employers, and stratified according to number of employees. The report also discusses the knowledge, attitudes and practices of businesses in the area of HIV/AIDS at the firm level.

A prevalence of HIV was found in most businesses in Swaziland and excess morbidity and mortality due to AIDS have significantly reduced productivity, increased production costs and caused disruptions in business operations (see Figure 10). A total of 73% of businesses reported having had an employee living with HIV/AIDS. The group most affected is the medium to large enterprises (250-599 employees) with over 87% of companies in this group having had a case of a worker living with HIV/AIDS. The study found that 33% of surveyed companies had experienced increased loss of skills, with the impact being felt more by the larger companies. The study also revealed that 31% of the companies surveyed had experienced an increase in recruitment and training costs. Again, this was felt more acutely in the larger enterprises.

The above-mentioned impacts result in an overall reduction in experience, skill, institutional memory and performance of the workforce. Unit productivity is disrupted due to increased staff turnover and companies incur increased costs in recruitment and training. The main causes of reduced productivity are increased absenteeism due to HIV/AIDS-related illnesses, workers taking time off to look after their sick relatives, funeral attendance and high labour turnover due to HIV/AIDS-related deaths of employees (see Figures 8 and 9).

The same study also found that in a private sector company, the number of employees taking extended sick leave was on the increase (see Figure 10). The company had a policy of providing 60 days' leave for employees suffering from tuberculosis. Such employees largely accounted for the increase in the number of those taking extended sick leave. The company clinic diagnosed an average of 7 new cases of tuberculosis every year—an incidence rate of 11 per 1,000 cases. Over 90% of these with TB are co-infected with HIV. The direct cost of absenteeism for a company was calculated at E 354,000 for the year 2001.

29 This study reports the results of HIV testing of 4183 (predominantly male) employees in the Lubombo region of Swaziland and a comparison with the national antenatal HIV data for the country and the region. The survey was done by Dr Clive Evian, AIDS Management and Support, an HIV consulting organization based in Johannesburg.

30 Muwanga FT (2001) Private sector response to HIV/AIDS in Swaziland – impact, response, vulnerability and barriers to implementation of workplace HIV/AIDS prevention programmes

The AIDS-specific mortality rates are still below what has been projected. Earlier projection estimated that the private sector in Southern Africa would lose up to 3% of its workforce per year to AIDS (Whiteside A and Wood G, 1993; Smart, 1999). This translates into a mortality rate of 30 per 1,000 employees. The highest from this study was 17.21 per 1,000—far lower than the estimated figures. Tuberculosis and HIV co-infection are prevalent among employees (see Figure 11). In fact, a very high degree of correlation was found between the two diseases.

ii. A business response to the epidemic

Many Swazi businesses provide a wide range of employee benefits (see Table 3). But, due to the large outlay in employee benefits, businesses are vulnerable to the economic impact of excess morbidity and mortality due to HIV/AIDS. A study by Muwanga found that only few businesses had well-defined policies to guide their HIV-prevention-and-control programmes³¹ (see Table 4 overleaf). Some big businesses also resorted to ‘outsourcing and limited benefits’ to their employees.

Figure 10. Number of employees taking sick leave for a period longer than 30 days in a private sector company

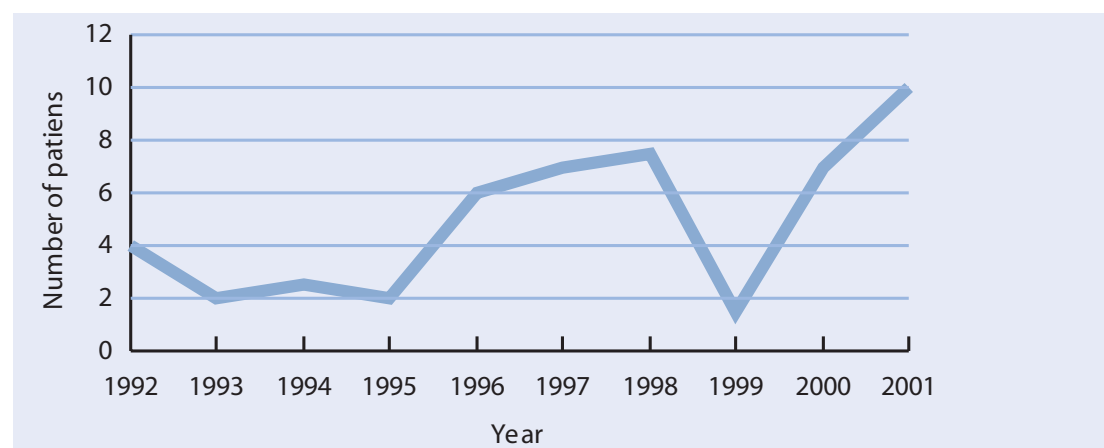


Figure 11. The association between tuberculosis and AIDS deaths in a Private sector company

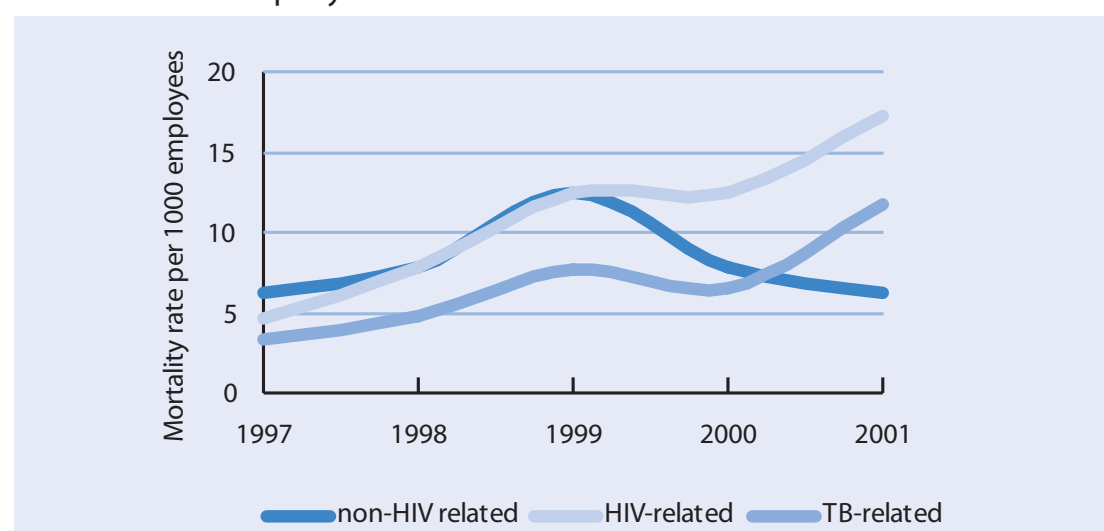


Table 3: Medical benefits provided by Companies to employees

Medical benefits	21-49	50-99	100-249	250-599	>600	Total
Free treatment onsite	1	3	3	3	2	12
Treatment at private clinic	2	3	3	3	1	12
Health insurance	3	1	3	2	3	12
Noresponsibility other than sick leave	8	2	3	2	1	16

Source: Central Bank Swaziland

However, many firms do provide in-house medical benefits to employees. Apart from those shown in the table above, benefits also include retirement schemes, death-in-service benefits, burial fees, medical care, group health insurance, disability payments and on-going family support. Health education programmes are the only elements that are widely implemented but these are limited to employees and management. Another study³² showed that the impact of AIDS on business depended on the benefit package offered by individual firms.

31 Muwanga, Fred Tusuubira (August 2001). Private Sector Response to HIV/AIDS in Swaziland-Impact, Response, Vulnerability and Barriers to Implementation of workplace HIV/AIDS prevention programmes.

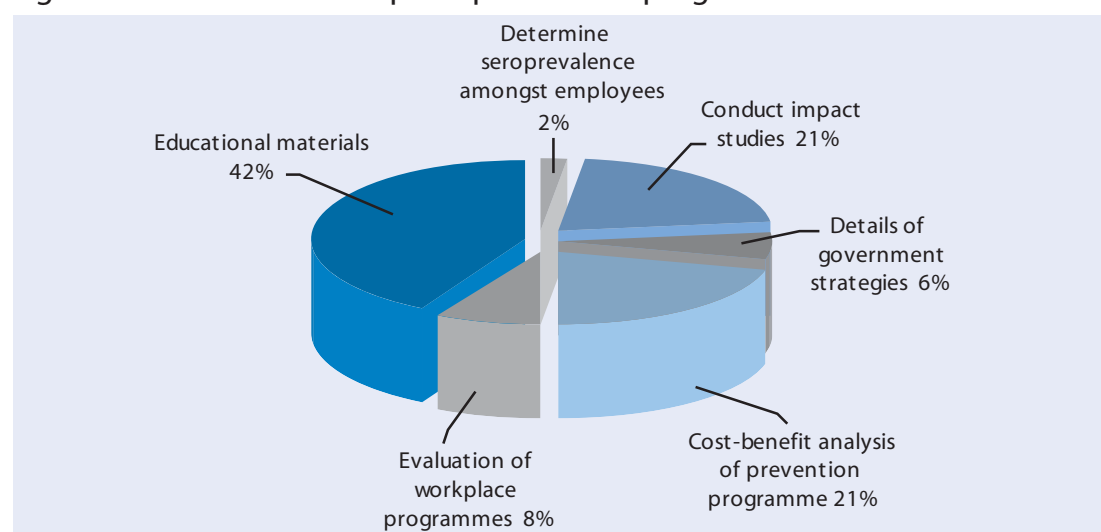
32 According to the Federation of Swaziland Employers (FSE) 2001 register, there are 440 businesses affiliated with the organization. Twenty-four companies were randomly selected for this survey. The number of workers that each business employs ranges from 2 to over 3,000. The survey included firms from diverse industrial sectors such as manufacturing, food processing, wholesale/retail, hotels, production and agro-industries.

Table 4: Companies that have workplace HIV/AIDS policies

	21-49	50-99	100-249	250-599	>600	Total
Policy on chronic diseases	1	2	4	2	2	11
Policy on chronic diseases including HIV/AIDS	1	2	3	2	2	10
Have policy on eligibility or maintenance of medical benefits	5	2	2	2	2	8
Have a specific policy on HIV/AIDS	4	1	2	1	0	13
Have policy on HIV testing	0	1	2	0	1	4
Do HIV testing of employees	0	1	0	0	0	1
Do test applicants for HIV	0	1	0	0	0	1

Source: Central Bank Swaziland

Figure 12 . Need for a Workplace prevention programme



Both these studies prove that more emphasis on workplace education is required (see figure 12 for survey conducted among companies) so that the employers and workers are aware that, to maintain commercial viability, it is economically astute to reduce operational costs incurred by HIV/AIDS. This is a potential area where ILO/AIDS can work on with the Ministry of Labour and employers and workers association. It is also vital to enable small and medium-sized companies that lack the necessary financial and human resources to run these programmes, partnerships with larger enterprises active in the fight against HIV/AIDS are recommended. Most businesses are willing to implement HIV-prevention programmes in the workplace and to commit available resources to this cause, but some lack the expertise to do so.

iii Households

AIDS-related morbidity and mortality have wide-ranging ramifications for households. These include increases in health-care costs and the diversion of labour from the farm to care for the sick person. In the event of death, there is loss of labour, loss of institutional memory, loss of income if the deceased was a breadwinner, and additional costs for the funeral. These events, in turn, have a negative impact on the amount of land cultivated, the crop yield and cropping patterns. Besides that, HIV/AIDS affects the growth of many markets for goods and services as affected households divert expenditure to meet HIV/AIDS-related costs. Non-essential goods with high elasticity of demand are likely to be more susceptible to shifts in household expenditure than staple products. Many middle-income households become poor, and market growth for goods and services targeted at upwardly-mobile households may be negatively affected.

Table 5 shows the result of a study on an agricultural household in Swaziland³³. A clear causality between the incidence of HIV and the desired output can be seen. HIV/AIDS has led to:

- a reduction in crop yield and land under cultivation,
- shifts in cropping patterns
- an increase in the number of households caring for orphans
- more children dropping out school due to lack of fees

The fact that the region receives little and erratic rainfall and has poor soils increases these households' vulnerability to the impact. Furthermore, according to the results of the study, AIDS mortality is expected to reach

33 Muwanga. Impact of HIV/AIDS on agriculture and private sector in Swaziland.

its peak in the year 2008, which means that the worst is yet to be seen. The number of orphans is expected to rise by 10,000 every year for the next six years, and more homes will be left destitute by the epidemic. Mitigation and coping strategies are at a preliminary stage and are yet to be refined. A number of commercial establishments have initiated health programmes for those with chronic illnesses and these programmes are being expanded and modified to deal with the increasing demands caused by AIDS.

Within the household, women are the most affected. A study by UNDP indicated that women's lack of access to land makes them more vulnerable to HIV/AIDS as they are forced to depend on men for it³⁴. The majority of single-parent women reside on peri-urban areas in rented accommodation. They have nowhere to leave their children when they die. With the deaths of such mothers, these children are likely to be left homeless children.

The UNDP study also found a growing number of child-headed households as a result of both parents having died from AIDS. Such homes experience extreme difficulties in trying to survive and their poverty levels are a serious cause for concern. Some get sporadic assistance from the community, but this is not enough in the medium/long term.

Table 5: Effect of AIDS on agricultural production

Produce	Average household production per year		% reduction in production due to AIDS
	Non-AIDS-related deaths	AIDS-related deaths	
Maize	35.06 bags	16.05 bags	54.2%
Cattle	13.61 herds	9.58 herds	29.6%
% of land cultivated	84.2%	50%	34.2%

Source: Results of the study 'Impact of HIV/AIDS on agriculture and private sector in Swaziland'

34 UNDP, Mbabane (2002) Gender-focussed responses to HIV/AIDS.

C. Policy options

Developing a policy response to the epidemic requires a sound knowledge of the ongoing activities by the donor, and public and private sector in the area. A number of foreign donors have been mobilized against HIV/AIDS, and the government, with the help from civil society, NGOs and donors, has put in place a range of responses, interventions and strategies to combat the spread of the epidemic and to deal with its consequences. However, little change in HIV prevalence has been observed so far. Furthermore, the need to deal with the consequences of illness, death and orphaning means that additional resources are needed at a time when existing capacity is being eroded.

i National response

Swazi authorities have publicly acknowledged that HIV/AIDS has become a national calamity. In February 1999, King Mswati III called for all sectors—public, private, and NGOs—to take action. In May 1999, the Prime Minister launched the Cabinet Committee on HIV/AIDS, chaired by the Deputy Prime Minister, and the multi-sectoral Crisis Management and Technical Committees (CMTC) on HIV/AIDS. The government recognized that the crisis could not be addressed by the Ministry of Health alone and required a multi-sectoral strategy. The new committees will set policy directions and manage the mobilization of resources for all sectors, ensuring a more unified and coherent national response.

In addition, the SNAP (Swaziland National AIDS Programme) Secretariat was established in the Ministry of Health in 1989, with support from the World Health Organization (WHO). A National AIDS Task Force has also been established. The first sentinel surveillance survey was conducted in 1991 and subsequent surveys have been conducted annually, except in 1997, because of resource constraints.

The bulk of AIDS-related activities have been carried out by NGOs and AIDS service organizations, such as:

- The Family Life Association of Swaziland (FLAS), which conducts lectures on family planning, STIs, and AIDS in army barracks

in eight sites, as well as education programmes in industry, and youth counselling;

- The Swaziland AIDS Support Organization (SASO), which supports programmes benefiting PLWHA;
- The AIDS Support Organization (TASO), which provides counselling and testing services;
- The Traditional Healers' Organization (THO), which provides HIV-prevention education; and
- The NGO coalition Swaziland Network of AIDS Service Organizations (SWANASO), which coordinates the activities of NGOs working in HIV/AIDS.

ii International response

A number of activities funded by multilateral and bilateral donors have been implemented, including the following:

- UNAIDS, through the Ministry of Education, has supported the NGO -Swaziland HIV/AIDS Public Education (SHAPE) in working with secondary schools. Through their IEC activities, NGOs have been largely effective in bringing information about HIV/AIDS information to the country. However, sexual behavioural change and condom use have not accompanied that information.
- The Baphalali Swaziland Red Cross, in collaboration with the Ministry of Health, is working to improve the screening of the blood supply in the country.
- Together with the government and the Italian Cooperation, UNAIDS is also funding two pilot sites for home-based care in rural areas, involving traditional healers and community volunteers. The Salvation Army, Hospice at Home, the Catholic Church through Caritas, and the Swedish missionary Mkhuzweni Health Centre are also involved in home-based care.
- GTZ has supported many HIV/AIDS-related care activities and provided condoms and the Italian Cooperation is supporting home based care pilot projects.
- The European Union (EU) supports the SHAPE HIV-prevention project in secondary schools.
- USAID, DFID and CIDA have also been

working closely with NGOs to fight AIDS. Besides, a coordinating theme group, composed of UNAIDS with representatives from UNICEF, UNDP, UNFPA, WHO, and UNESCO, and chaired by WHO, supports the following activities:

- improving community home-based care and counselling;
 - strengthening a multisectoral response;
 - supporting the HIV and TB Prevention and Counselling Pilot Project;
 - building the capacity and coordinating the work of AIDS service organizations;
 - mobilizing young people against HIV/AIDS;
 - providing support for people living with HIV/AIDS; and
 - supporting the work of SHAPE in secondary schools.
- WHO has provided technical assistance in HIV/AIDS evaluation and programming; surveillance; a TB and HIV/AIDS programme; and development of a national HIV/AIDS policy. It has also supported the publication of health-education materials.
 - UNDP has been active in policy-level advocacy, and is providing technical assistance to the Ministry of Health and NGOs, and supporting sentinel surveillance
 - UNICEF has supported a situation analysis of orphans; provided training for primary-school teachers in HIV/AIDS education; and assisted NGOs in capacity-building.
 - UNFPA has financed study tours for NGOs and sponsored workshops on HIV, gender issues, and poverty alleviation. UNFPA is a major donor of condoms along with other donors.

iii ILO projects in the workplace

- HIV prevention in the transport sector in eight Southern African countries. This project includes Swaziland and involves the mobilization of ILO's social partners in the fight against HIV/AIDS in the transport sector, developing national policies for the prevention and the mitigation of the impact of HIV/AIDS in that sector, assisting countries in national strategic planning and developing a regional strategy based on the national strategies of the eight participating countries.
- ILO/USDOL HIV/AIDS Workplace Education Project
- ILLSA: Geared to strengthen law enforcement
- ILO/IPEC Programme on Child Labour
- HIV/AIDS and the world of work: tackling

the consequences for labour and socio-economic development: to raise awareness among ILO's constituents and other stakeholders about the labour and social implications of HIV/AIDS and to promote the ILO Code of Practice on HIV/AIDS and the world of work. Ten African countries are included in the project.

It should be noted that the Federation of Swaziland Employers (FSE), established in 1964, has had a strong influence not only in economic matters, but also in political affairs. On 12th April 1973, the independent constitution was repealed by the Royal Decree and all political parties such as Imbokodvo National Movement, and Ngwane National Liberatory Congress (NNLC) were banned. The Decree also prohibited meetings held without a written consent of the Commissioner of Police. This affected the unions as they could not meet with the rank and file membership to deliberate on issues. Many unions died a natural death as a result of this. The year 1975-77 saw a visible vacuum in collective bargaining because the only active union was the Bank Workers union.

It was decided that to bring pressure to the government to allow freedom of association and right to organize, it was important to urge them to join the ILO. After the government joined the ILO a tripartite group was represented at the GB. This resulted in Swaziland ratifying more than 30 international Conventions including convention 89 and 98 that influenced the country's legislation in Swaziland. The Swazi Federation of Labour and SFTU work together on many labour and socio-economic issues. After Swaziland revised its legal framework in 2000, it has benefited from major technical cooperation programmes geared to build capacity for CMAC (conciliators, mediators and arbitrators). Many programmes (such as those mentioned above) are in the pipeline for implementation.

D. Recommendations

The commitments outlined in this paper are signs that the country is ready to tackle the HIV/AIDS epidemic. However, the government must also commit its resources to proactive HIV/STI prevention and control. In addition to government efforts, community participation at all levels is essential for effective HIV/AIDS care, prevention, and support activities. In the presence of a coherent HIV/AIDS policy, and multisectoral involvement, Swaziland will be able to fight the HIV/AIDS epidemic.

i General

Given the threat posed by AIDS, a national response should be mainstreamed across all major sectors, rather than being considered purely as a health issue to be dealt with by the Ministry of Health.

- A multisectoral reaction should be fully incorporated into the planning process, targeting ways and means of reducing transmission and morbidity and mitigating the negative impact of AIDS. Although organizations such as UNDP and the World Bank have commissioned situation analyses in certain geographical regions, few comprehensive sectoral impact assessments have been done.
 - Human resource development efforts need to aim at replacing skills and ensuring an adequate pool of skills at any given point in time.
 - On a macroeconomic level, the generation of employment through enterprise development and investment promotion must be made a priority in order to maintain a level of investment proportional to the annual GDP growth.
 - There is a need for research that generates estimates of losses, the gender and age distributions of human capital losses, the main skill levels affected, and identification of these losses by region and sector. Studies would also need to take into account any previous efforts by the public services in these regions and their capacity to alleviate the AIDS-related labour resource problems.
 - There has been very little research done on the behavioural aspect of HIV/AIDS
- as it is a sensitive issue and the impact of education and public awareness programmes leading to changes in sexual behaviour. Such indicators will be useful in formulating preventive messages and public-awareness strategies in the future. It would also be used for identifying population groups and assessing over time the effectiveness of these programmes.
- ILO could play an important role in collaborating with the trade unions in sensitizing staff on issues related to HIV/AIDS. This would include training and enhancing the capacities of such staff in terms of tackling HIV/AIDS in the workplace, including such issues in trade union activities, and designing awareness-raising programmes.
 - As mentioned in Section B, some progressive public and private sector employers have adopted comprehensive prevention and care programmes for their staff. The role of the ILO vis-à-vis employers is to help ensure that such policies permeate all firms and not only a select group of large corporations, so that the benefits reach the grass-roots level. This should also extend to the public sector and the informal economy.
 - In creating a social safety net, it is important to develop a comprehensive 'HIV/AIDS in the Workplace' programme, for which the ILO Code of Practice on HIV/AIDS and the world of work may be used as a guide. The findings of research carried out on labour legislation provisions relating to HIV/AIDS-related discrimination can be a useful starting point.

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