Seminar Report

The Impact of HIV / AIDS at the Company Level in Botswana

Botswana Business Coalition on AIDS

Gaborone, May 1997

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SEMINAR REPORT

ON: THE IMPACT OF HIV/AIDS AT THE COMPANY LEVEL

PRESENTED BY
BOTSWANA BUSINESS COALITION ON AIDS
GABORONE, MAY 1997

Introduction

The overall aim of the Coalition is to meet the specific needs of private and parastatal companies to address HIV/AIDS as a business and work place issue and assess the growing impact of AIDS on productivity. The main objectives are:

- develop 'best practices' to cope with the impact of HIV/AIDS and provide a forum in which companies can exchange information and experience;
- establish an information centre for the business community and act as a referral service for any workplace, providing access to experts;
- empower management and act as a lobby on Government policy;
- make maximum use of existing HIV/AIDS service organisations in Botswana; and
- assess the impact of HIV/AIDS on companies.

The BBCA is currently made up of about 40 organisations upon which it draws its financial resources. The addition of each new organisation brings with it experience and expertise to draw upon.

Aim of the seminar

The purpose of the seminar was twofold. Firstly the BBCA hoped to sensitise a range of issues, concepts and current thinking in the region, on impacts, strategies and legal aspects of HIV/AIDS to a wide number of companies. This was to spark interest in the topic and to encourage companies to support the Coalition in its efforts. Secondly it hoped to open up an arena of debate and discussion between the concerned parties in order to identify needs that the Coalition should be fulfilling for its members. It was felt that both these aims were successful. The seminar was well attended by the private sector, government and NGOs (a list of participants is included at the end) illustrating a high level of interest and acknowledgment. It seemed clear that companies realise the potential extent of the problem and are interested in what can be done.

Speakers

The five presenters were carefully chosen by the BBCA as experts in their field, with plentiful experience and research in the area that they spoke about. They were:

Prof. Alan Whiteside, who is a professor in the Economic Research Unit of the University of Natal. He grew up in Swaziland, had his university education in Norwich, England

and worked as a planning officer in the Ministry of Finance in Botswana from 1980 - 1983. He has been working on HIV/AIDS issues since 1987 and holds much recognised experience in such matters. He has published widely and edits AIDS Analysis Africa.

Dr. Mbulawa Mugabe, who has an MSc and PhD in Medical Sociology from the University of London. He is a research Fellow/Lecturer and co-ordinator of the health and nutrition Unit at NIR. He has been very active in the area of HIV/AIDS research and policy development and served as the chair person of the Botswana National Steering Committee on HIV/AIDS and is the main author of the Botswana Second Medium Term Plan 1997-2000.

Dr. Rene Loewenson is an epidemiologist who works with the Organisation of African Trade Union Unity (OATUU) in Harare, Zimbabwe. She runs the OATUU Health, Safety and Environment Programme (HSEP) which has carried out work on the impact and mitigation of HIV/AIDS at the company level, both nationally and regionally.

Mr Kayira is currently the Deputy Resident Representative and Economic Adviser, UNDP. In 1994-6 he worked as chief economist, Employment Policy Unit, Ministry of Finance and Development Planning in Botswana. From 1990-94, he worked for about 4 years with the Ministry of Commerce and Industry as Director in the Department of Commerce and Consumer affairs. He previously spent 8 years with the World Bank in Washington, DC.

Mr Key Dingake obtained his LLB from the University of Botswana in 1989 after which he did a Masters degree at the University of London in Commercial and Corporate law. He is presently in his third year doctoral studies at the University of Cape Town. Key Dingake practised as a private attorney for five years and is the author of a book titled Administrative Law in Botswana.

Their presentations are shown in this report in the order that they followed at the seminar. After each presentation a summary of the key points that were raised in the discussion are listed. The seminar was officially opened by the Deputy permanent Secretary for the Ministry of health.

What will be the BBCA's role after this seminar

The Business Coalition has identified needs which arose out of the discussion in the seminar. These needs will be prioritised and follow up work carried out which will be available to members of the Coalition. This is documented in the last section of this report.

WHAT ROLE CAN COMPANIES PLAY IN PREVENTING HIV/AIDS GIVEN THE BIOMEDICAL, SEXUAL, SOCIO-CULTURAL AND ECONOMIC FACTORS ASSOCIATED WITH ITS SPREAD?

By Prof. Alan Whiteside

Introduction

Before asking what companies should do in preventing HIV it is necessary to establish if they should do anything. The paper will begin by defining key issues related to the epidemic; look at the potential impact it may have on companies; ask why companies should play a role; look at the factors driving the epidemic; and conclude by identifying key issues. It is important to begin by looking at the key terminology, concepts and a few basic statistics. The title given to me was "What role can companies play in preventing HIV/AIDS". It is necessary to distinguish between HIV and AIDS. HIV is the virus, spread mainly through sexual intercourse, that causes the body's immune system to breakdown. The breakdown of the immune system leads to the illnesses which are collectively known as AIDS (Acquired Immune Deficiency Syndrome). We are not generally concerned with the impact of HIV, because HIV infection alone has little or no impact, but with preventing its spread. We are not concerned with preventing AIDS, because once a person is HIV-positive AIDS is inevitably and, currently, incurable, (although its onset may be delayed), but with dealing with its impact.

It should also be noted that unlike other diseases, AIDS is significant because it hits people mainly in the 25 to 45 year age group and results in greatly increased illness (morbidity) and death (mortality) in this age group. The increase in mortality associated with AIDS is shown on Figure 1.

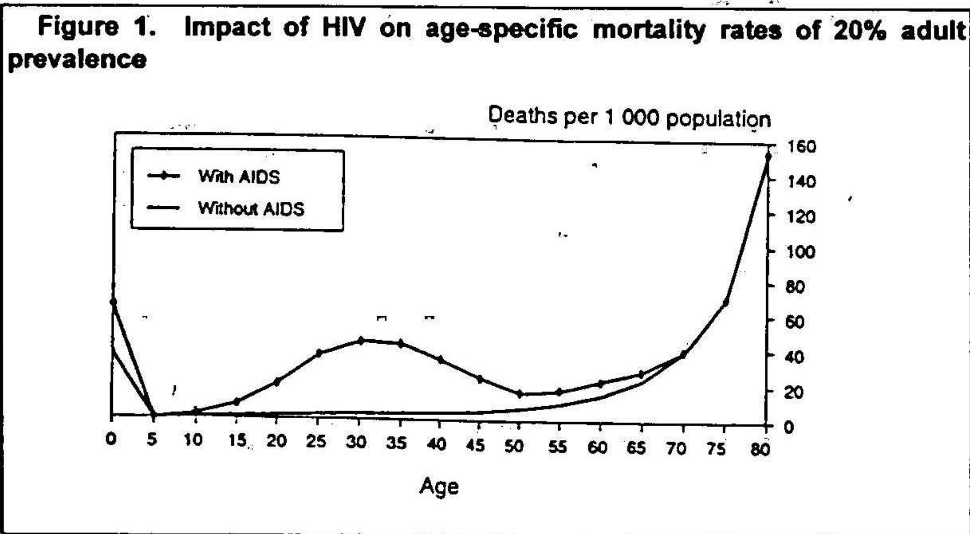
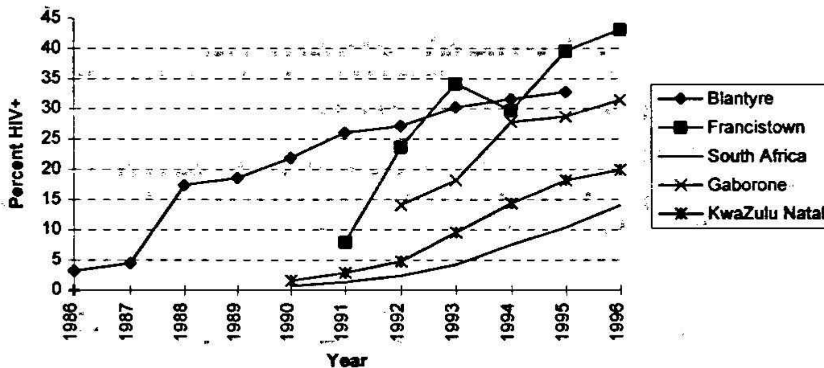


Figure 1. Impact of HIV on age-specific mortality rates of 20% adult prevalence

Source: Peter O Way and Karen A Stanecki, **"The Impact of HIV/AIDS on World Population"** US Bureau of the Census, Washington, DC, 1994.

The data from the region present a fairly bleak picture. Figure 2 shows the trend in HIV prevalence in a number of Southern African sites. A critical point is that, in Southern Africa, we are experiencing an HIV epidemic. The period between HIV infection and the onset of symptoms is probably about 7 years. This means that AIDS cases in 1997 reflect HIV infections in 1990, and most of the new 1996 HIV infections will not develop into AIDS until next century. We can use HIV data to project the increase in AIDS cases and deaths and thus plan for our response to the AIDS epidemic and its likely impact. AIDS case data are generally very poor and of limited value, in South Africa they are currently not even collected.

Figure 2: HIV Prevalence among Ante - Natal Clinic Attendees (selected countries)



Finally we need to establish two concepts which will be of value in the analysis. These are susceptibility and vulnerability. The concepts may be defined as follows:

Susceptibility: is used to describe those factors which determine the rate at which the epidemic is propagated. It may be considered in part to reflect the "riskiness" of the environment. Such factors may be physical (as in the case of the development of a new road), environmental (such as a drought which results in unusual population movements), cultural (a particular sexual practice), economic (increased mal-distribution of income) or social (the operation of labour and associated housing markets in urban areas). This concept may be operationalised at any level, being applicable at the aggregate level of an entire "society" or country or at the level of a social group such as friendship network or a household. It may also be applied at the level of meso-entities such as an organisation or manufacturing enterprise[i].

Vulnerability: describes those features of a social or economic entity make it more or less likely that excess morbidity and mortality associated with disease will have deleterious impacts upon that unit. An important component of this concept is that of medium and long term impact of death and illness on social and economic life.

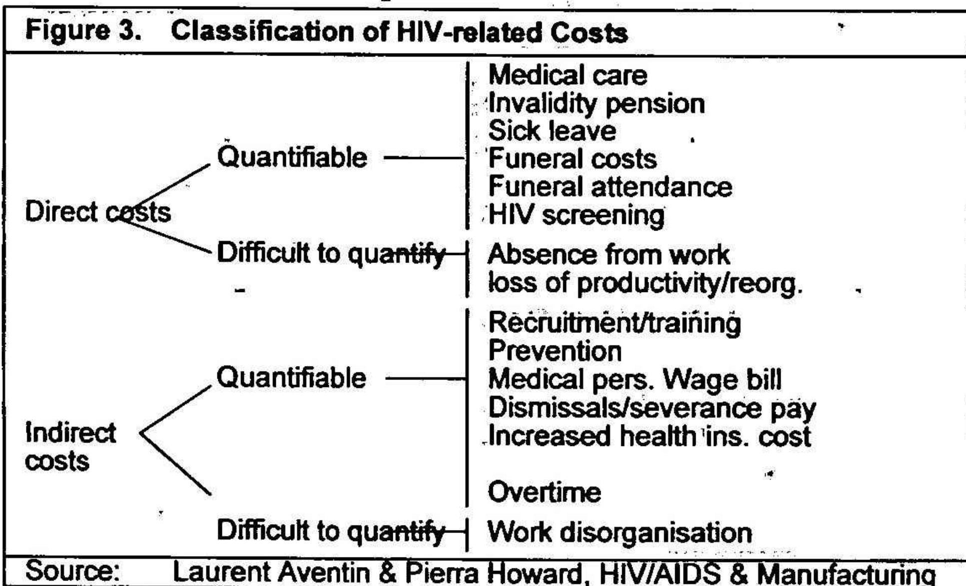
Once again, this concept may be applied at a number of levels. To offer some examples a household with only one wage earner who is aged 25 is more vulnerable than one in which there are two or more wage earners, one of whom is more than 50 years old. A farming system in a dry region where rainfall is limited to six weeks of the year is one in which any shortage of labour for key cultivation activities will result in restrictions to production for the entire season. An industrial process plant which depends upon one or two key pieces of equipment with very specialised operators who are in short supply will be more vulnerable than one in which large numbers of unskilled labour are all involved in the same or similar processes.

To summarise: individuals, communities or groups may be more or less susceptible to infection; groups, companies sectors or nations may be more or less vulnerable to the impact of increased morbidity and mortality.

Will AIDS Impact on Companies?

This is the crucial question. Will AIDS affect companies, and how will the impact be felt? This will play an important part in defining how companies will respond. It should also be mentioned that the perception of probable impact may be more important, because the actual impact is only just beginning to be felt. One way of looking at impact is set out in Figure 3 below.

Figure 3. Classification of HIV-related Costs



Source: Laurent Aventin & Pierra Howard, HIV/AIDS & Manufacturing

in Abidjan, 1995-96, AIDS Analysis Africa (Southern African Edition) 7(6) April/May 1997.

While this framework allows one to look at the impact on a company it does not tell us about the business environment and markets - a point we will return to.

What evidence is there that HIV has or will impact on these costs? In countries where the AIDS epidemic is gaining momentum there are data to suggest that both morbidity and mortality are rising. Research in Zambia showed that the mortality rate among formal sector employees rose from 0.24 per cent in 1987 to 2.1 per cent in 1993.[ii] This means that a company with 1000 employees might expect about 21 employees to die each year, and 19 of the deaths may be attributed to AIDS. However a study of two agricultural estates and one cement works rates in Zambia found lower levels of increase in mortality. Here the three firms saw mortality fluctuate from 0.88 per cent in 1992/93 to 0.72 in 1993/94 and 0.78 in 1994/95. Mortality attributable to AIDS rose from 0.48 to 0.54 to 0.56 per cent over the three years.[iii] One reason may be that these enterprise, were located in rural or peri-urban areas, where HIV prevalence rates have been slower to rise.

Morbidity data are harder to come by, but again there is some evidence to show that employees are taking more time off because of their own illness, to care for family members, and to attend funerals. In one Zambian study[iv] nurses were found to be losing 15 per cent of their working time due to their or others illness. Chilanga Cement Works in Zambia found a significant increase in hours lost due to illness and funerals, over three years the time off for illness doubled with funerals it increased 15 times[v].

What effect does this have? The World Bank looked for evidence of the effect of AIDS on 992 African firms in five sub-Saharan countries. In order for AIDS to have an impact the workforce attrition had to be large in proportion to total attrition, and these higher rates of attrition should adversely affect the costs and performance of firms.[vi] The study found both effects to be minor at this stage. The Bank looked at whether or not firms replaced labour and what, if any, difficulty they had in doing so. They found that, 37.5 per cent decided not to replace professional staff, 34 per cent skilled staff, 44 per cent operators and 51 per cent unskilled staff. These results will have been confounded by the fact that the countries are in the early stages of the AIDS, as opposed to the HIV epidemic, and in most countries, as part of the new wave of economic reform, firms have been downsizing. This process means that people who are ill or who know they are HIV-positive may opt for redundancy or early retirement, thus it takes longer for the true impact of the disease to be felt.

There have been company level studies carried out in a number of countries. This type of work will be further discussed during the course of the seminar. Nonetheless there are some lessons that can be teased out of the three, I am most familiar with the AIDSCAP work in Kenya, the Makandi Tea and coffee estate study in Malawi and Smiths' work in Zambia. In all cases the researchers tried to identify and ascribe costs of HIV and AIDS to various categories. These are shown in Table 1. The point that comes out most

forcefully from the data is that the actual cost of AIDS to employers will vary greatly depending on who is infected, what the conditions of employment are, and what benefits the company provides. For example Makandi estate operates in an area where there is ample labour and it is mostly unskilled, thus losing workers is not a major cost, but it does provide medical care on site and funeral benefits thus these are a major percentage of the cost due to AIDS. In Kenya the greatest costs were **projected** to be due to absenteeism.

Table 1 HIV/AIDS related costs, a comparison

Description of cost	*Zambia 1992/93*	*Kenya Projected 2004*	*Makandi 1995/6*
	%	%	%
Absenteeism	31.8	54.3	25.2
Expatriate employment	12.7	-	-
Medical service	14.7	12.0	37.8
Funerals	5.1	10.1	4.7
Deaths in service	15.9	-	32.3
Travel	12.5	-	-
Training/Recruitment	7.3	23.6	-
Total	100.0	100.0	100.0

When one looks at costs as a percentage of turnover or profile, the picture is different. An exhaustive study of the Makandi Tea and Coffee Estate Limited in Malawi found that 'the effects of HIV/AIDS on current levels of expenditure at Makandi are negligible. The major components of HIV/AIDS related expenditure are the estimated attributable cost of employee medical service provision and the unexpected Pension Scheme commitments resulting from the higher death in service rate.'[vii], while in Kenya a survey of five companies found that AIDS was costing US$45 per employee annually (3 per cent of company profits), and it could rise as high as $120 per employee (8 per cent of profits) by 2005.[viii] Work in three companies in Abidjan found costs varied from 0.8 to 3.2 per cent of the wage bill depending on the level of benefits but the greater part of the costs were in the period of illness[ix].

Actual expenditure, where it does occur, will be in employee benefits. For any company this will depend on exactly what is provided. Typically, in South Africa, benefits include group life insurance, pensions and medical aid. A rather sobering calculation done by Metropolitan Life on the effect of AIDS on some benefits is shown in the Table 2 below. [Personal communication from Peter Doyle, Metropolitan Life]. This may also be an important issue for those companies in Botswana who have generous employee benefits.

However, it should be noted that this can change; benefits may be reduced or contributions increased.

Table 2. Illustrated impact of AIDS on employee benefits (costs as a % of salary)			
	1995	*2000*	*2005*
Lump sum at death	1.5	3.7	6.0
Spouse's pension	4.0	7.5	10.0
Disability pension	1.5	2.3	3.0
Total	7.0	13.5	19.0

What has not been reflected in this discussion are the exogenous factors. What will the impact of the effect of AIDS in a national economy, on service provision including governments, and on the social milieu? Will the more sophisticated nature of the Southern African economies and the greater speed with which the infection has spread mean AIDS will have a more serious impact? Perhaps, but on the otherhand we have more time to respond and at least have some examples to follow from countries where the epidemic is further advanced.

Why Should Companies Play a Role in HIV/AIDS Issues?

From the previous section it will be clear that there are two distinct responses required from companies. The first, preventing the spread of HIV, and the second, planning for the impact. In most Southern African countries companies need to do both. The reasons are:

- Even though HIV levels are high there are those who are uninfected and should remain so and there are new cohorts of youth who become sexually active every year. The challenge is to keep them uninfected.
- The levels of HIV are such that an AIDS epidemic is inevitably.

The question this paper addresses is what role should companies play in preventing HIV. This section asks an even more fundamental question, why should companies play a role? "The business of business is business" is an often quoted phrase, why should companies become involved in preventing HIV or planning for AIDS. Clearly this will depend on the environment in which companies operate. Broadly speaking there are four factors/areas which determine how companies operate. There are set out in Figure 4.

Figure 4 The Operating Environment Companies and HIV/AIDS

Profitability - companies that are unprofitable go out of business.

Legality - there are a set of legal constraints including national laws, international conventions and labour agreements which govern action.

Morality - companies will have policies regarding how they treat employees and interact with the community.

Publicity - companies want good press and support for advertising

In the private sector the most important imperative is to make a profit, and the profit may be defined as receiving more money for the goods and or services than it costs to produce them. A company that consistently fails to make a profit will go out of business. This will be determined by the costs of production and the price at which it is able to sell its goods or services, Government can, of course, play a role in setting the parameters.

The second set of factors which will determine the impact of AIDS at the company level related to the legal and regulatory environment in which companies operate. These include international conventions, national laws and regulations and any local agreements between management and unions and policy. Examples of such legislation might include setting of limits or banning of screening for insurance which would either put up premiums or end life cover underwriting and legislation on termination of employment. The termination of employment issues has been problematic in some Southern African countries where employers were not allowed to retrench on medical grounds until the sick leave provisions were exhausted and a (government) medical board had been convened. Clearly this could be particularly problematic for small companies.

Thirdly, companies operate under a moral or ethical code as corporate citizens. This is determined by a range of factors in society from the market profile and perceptions to the CEO's own beliefs and values. It will play a part in how companies respond to and plan for impact and what they see as their role in prevention.

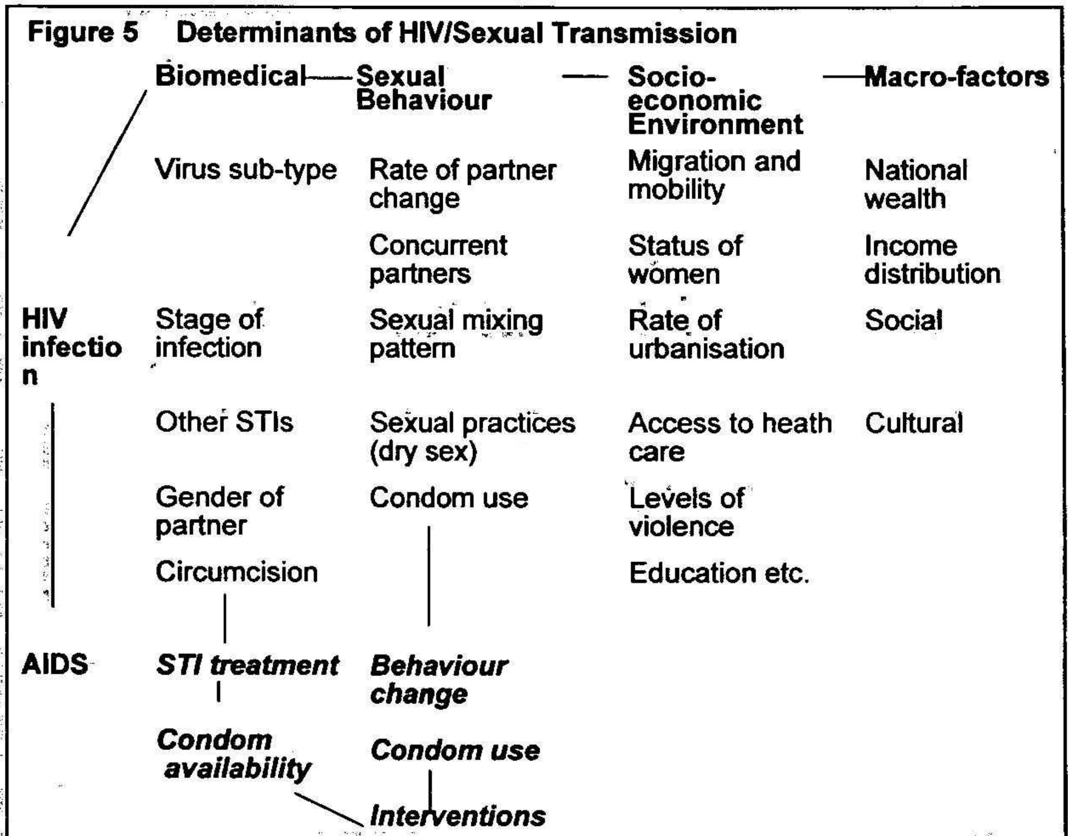
Finally companies want a good press. This may result in them doing things to achieve good publicity for example spending on education campaigns, sponsorship of certain causes. It will also mean they try to avoid adverse publicity.

What are the Factors Driving the Impact and the Epidemic?

The impact of the epidemic will be determined by how many infected people there are, who they are in terms of their contribution to national output and claim on resources, their age profile, how long they are ill for and how they are treated and where the

resources came from. Clearly there are various interventions that can take place to plan for and influence impact but the crucial issue for the epidemic, given the inevitable nature of the progression from HIV infection to illness and death, is to influence the number of people infected.

Here as one looks at how the epidemic develops, the crucial question is what are the factors that drive it? What determines the susceptibility of individuals and groups. This can be illustrated digramatically as is done on Figure 5.



This figure should be read from left to right. The end result of HIV infection is AIDS, a period of illness and death. However, HIV infection is not the inevitable result of sexual intercourse with an infected person. The chance of infection will depend on the gender of the uninfected person (women are more likely to be infected than men); the presence of other sexually transmitted diseases especially ulcers; whether or not the man is circumcised; the subtype of the virus (some are more virulent then others); and the stage of infection of the infected partner - early and late in infection are particularly risky periods.

In order for there to be potential exposure to the virus, sexual intercourse with an infected person has to take place. The chance of this happening, in a way that puts people at risk

of infection, will be determined by the pattern of sexual behaviour in a society. If, in a society, each person has only one sexual partner then HIV and other STIs would soon be eradicated. Issues of importance are the rate of partner change, whether there are concurrent partners, the sexual mixing patterns, sexual practices for example dry sex and the use of condoms.

However, sexual behaviour does not happen in a vacuum. It in turn is determined by the culture and socio-economic environment of a society. Issues here include migration, the mobility of the population, the status of women, rates of urbanisation, levels of violence, access to heath care, distribution of wealth and levels of education. These factors will in turn be governed by macro factors such as the wealth of the country, the distribution of income (which is perhaps more important), and the culture and social make-up of the society especially the level of social cohesion.

Interventions to date have been very limited. They have focused on biomedical and sexual behaviour. Biomedical responses have included reducing levels of sexually transmitted infection, which could cut HIV transmission by up to 50 per cent, but which have to be sustained. Condoms provide a barrier to transmission thus making them available is a biomedical intervention, ensuring they are used is a sexual behaviour intervention. Other sexual behaviour interventions are well-known, reducing the numbers of partners, delaying age of first sexual intercourse, and discouraging risky sexual practices.

What is not done in interventions is to look upstream at what determines sexual behaviour - the socio-cultural and economic environment in which people live and the national factors that determine these. It is here that interventions will be most effective. It is also here that they are most difficult to achieve.

Conclusion

An examination of the diagram of the cause of the HIV epidemic gives us an idea of the role companies can play. They can intervene in the biomedical sense - making STI treatment available, encouraging workers to seek treatment, and providing condoms. They can intervene with regard to IEC, making time available for workers to attend training, paying for workplace education programmes and perhaps supporting wider programmes that reach into the community. The degree to which the company is prepared to invest in these traditional responses will be determined by the framework in which it operates - the profitability, the legislative framework, the ethical and corporate citizenship of the company and the publicity and exposure possible. These are issues that will be explored further in other papers. It must be emphasised that HIV and AIDS is only one of the many social issue competing for corporate social spending.

What is needed is to look beyond the standard interventions and ask what more companies can do to reduce the susceptibility of their employees to HIV infection. Are there things in the work environment, in the way work is done? Examples here include

contractors operating outside urban centres with work teams. How can they reduce the chances that their workers will have many sexual partners in the area? Trucking and transport companies may feel they need to look at the susceptibility of their drivers. Actions in prevention upstream of the standard ones require a new and imaginative way of thinking. However, this is the real challenge once we have biomedical and behaviour change interventions in place.

Prevention is only half the story. We also need to look at impact. Companies need to look at the impact of AIDS and work out how they are going to respond to this. Again it may be determined by the operating environment. Issues like pre-employment screening, testing people before they gain access to employee benefits, and the responsibility of companies to chronically ill employees and their families, may need to be debated. This will have to be done in the national context, considering the issues of who bears responsibility for what, and how society may change. One thing is abundantly clear, and this is the note the paper will end on, we need information. In companies we need to know what impact HIV is having and should set up mechanisms for monitoring this. At a national level we need to know where we stand with regard to both HIV and the AIDS epidemic. This information is essential both for prevention and planning for impact. AIDS is not like a flood - immediately disastrous. It is an incremental catastrophe and the worst effects can be avoided but only with adequate information and the vision to plan for the epidemic.

Discussion

In the discussion it was raised that middle management should be included in the responsibility of HIV/AIDS and to do so, they should be sensitised to the issues surrounding HIV/AIDS including participating in education/awareness programmes. Top management do not attend education programmes and this has been a problem in the Government workplace HIV/AIDS education. It is common to find a situation in companies where management see HIV/AIDS as the 'workers problem' and divorce themselves from the issue especially where companies are foreign owned. This has been compounded in South Africa for instance, by white management verses black workers, creating an element of them and us. It is important that this misconception is re-addressed.

One area where companies could potentially become involved is financing research on vaccine development, especially since this is an area which many private sector organisations have expressed interest. Most companies have shown involvement through prevention programmes but they could get involved in research as well.

It was noted that insurance companies have omission policies for people who are HIV positive which can pose problems at company level. However insurance companies discriminate on many grounds and it was said that it becomes society's duty not to allow them to discriminate on HIV/AIDS.

WHAT IS THE IMPACT OF HIV/AIDS AT THE COMPANY LEVEL AND WHAT MAKES COMPANIES VULNERABLE TO HIV/AIDS

By Dr M Mugabe

Background

The HIV/AIDS pandemic is firmly established in Botswana. It is probably the worst emergency ever to face the country in modern history. Estimates based on the 1995 Sentinel Surveillance Survey among pregnant women revealed that approximately 13% of the general population were infected by HIV, the virus that causes AIDS. The same data suggests that HIV infection in the age group 15-49 was about 23%. The epidemic continues to grow with no sign of slowing. As past trends in the epidemic suggest an HIV infection doubling time of two years in Botswana, current HIV infection in Botswana is likely to be high than estimates based on 1995 Sentinel Surveillance Data.

Table 1: 1996 Reported HIV and AIDS Data by Age and Gender

Age	HIV Symptomatic		AIDS Cases		HIV Carries	
	F	M	F	M	F	M
0-4	112	96	79	93	7	9
5-9	8	6	5	3	1	0
10-14	1	0	0	0	2	0
15-19	101	15	19	5	22	2
20-24	335	154	129	33	82	36
25-29	326	259	167	96	63	62
30-34	237	291	119	127	70	63
35-39	152	194	93	95	33	31
40-44	75	113	59	87	11	14
45-49	45	82	22	42	12	5

50+	38	77	33	42	3	11
No Age	29	18	11	5	7	6
TOTAL	1459	1305 NG 4	736	628 NG 4	313	239 NG 3

Source: *NAP 1997*
* *NG = No Gender specified.*

Table 1 shows new reported cases of HIV signs and symptoms, carriers and AIDS cases. This data show that 2770 new cases of HIV signs and symptoms, 555 new HIV carriers and 1368 new AIDS cases were reported in Botswana during 1996. Previous data reported by the AIDS/STD Unit do not clearly distinguish between HIV carriers and HIV signs and symptoms and therefore it is difficult to make immediate comparison of the 1996 data with previous data sets. However, the 1996 data show a worsening epidemic. By the end of 1996, a cumulative AIDS cases of 4962 were reported in Botswana. As table 1 shows HIV infection and AIDS are concentrated in the age group 20-39, the most sexually active and productive section of society.

The character and impact of the HIV/AIDS epidemic in Botswana like elsewhere is pervasive and therefore demands and expanded multisectoral response. Although Botswana has extensive experience in multisectoral response to emergencies like endemic drought and more recently, the cattle lung disease in the Ngamiland (North West District), the HIV/AIDS emergency differs from the previous ones because they were more related to the rural economy. Thus, the multisectoral response was largely by government institutions, international agencies and to a less extent NGOs. The private sector remained peripheral to the drought and cattle lung disease emergencies. They therefore have to learn to participate in an expanded multi-sectoral national response.

The HIV/AIDS epidemic is an ubiquitous emergency that impacts on all segments of society. The private sectors and more specifically companies or firms are major microeconomic agents that are likely to be affected by the HIV/AIDS epidemic. Enterprises have the stock of human capital in the form of labour, skills and experience and are therefore vulnerable to the impact of the epidemic.

Loewenson (1996) has recently elaborated on the concept of vulnerability. She points out that vulnerability to HIV/AIDS reflects the extent to which AIDS will have an impact at various levels, in this particular case at the company level. Loewenson conceptually distinguishes vulnerability from susceptibility, which refers to the likelihood of a level or sector of society to experience the epidemic. Like most sectors of society the impact at company level is both economic and social. HIV/AIDS impacts at company level will be multiple: lower productivity of workers; higher absenteeism, reduced stock of trained

workers, higher job turnover, recruitment and training costs, greater outlayers for health, funeral and death benefits (African Development Bank Group 1993).

Assessing the impact of HIV/AIDS at company level in Botswana is hampered by lack of availability and access to data. There are several reasons why this situation prevails. First, the epidemic in Botswana is only now beginning to mature and become visible. Although the HIV epidemic has been silently spreading in the country for about a decade, it is only very recently that Botswana has entered the AIDS phase. Second, most companies like the rest of society have not processed and internalised the idea of a major epidemic and what consequences it may have for their operations. Third, companies have not been collecting the kind of data that would enable an assessment of HIV/AIDS impact.

Fourth, few companies that may have started to collect such data have not made it available in the public domain (Loewenson and Whiteside 1997). Some companies in Botswana have been quicker to realise the potential magnitude and consequences of the unfolding epidemic. This awareness at company level is evidenced by the fact that several companies have developed their own HIV/AIDS in their workplace since the early 1990s. The formation of the Botswana Business Coalition for AIDS (BBCA) is a clear expression of concern in some quarters of the business sector. In addition to lack of company level data, the national epidemiological data on the epidemic is not adequate to make a clear assessment of the impact of the epidemic at company level. For these and other reasons, assessing the impact of the epidemic in Botswana at company level invariably focuses on the probable than actual impact. The analysis is forced to relay on the broad parameters concerning the epidemic in the country and draw on probable impact emerging from better studied context elsewhere in the Southern African region, with mature epidemics or better impact data.

HIV/AIDS Impact at Company Level

It is difficult to measure impact across a spectra of companies because it will inevitably be variable. Companies vary in several respects. It is generally believed that it will not be until the next century before a full understanding of the impact of the epidemic on various sectors of society including the company level emerges (Whiteside 1997). There is a growing body of research the shows that impact of HIV/AIDS at company level will manifest itself in three main areas:

- lose of labour (quality and quantity)
- increased consumption/declining income and
- and reduced savings

HIV/AIDS related morbidity and mortality is expected to increase in the coming years in Botswana given the level of HIV prevalence in the general population and in the labour force in particular. Efrat (1997) argues that prevalence will be high in labour intensive companies. However, the impact of the AIDS, it is argued will be more severe on capital intensive companies such as mining in Botswana because of reliance on skilled and semi

skilled labour which is difficult to replace company level of productivity is expected to fall as the epidemic intensifies and the number of employees in the workplace increases.

According to Whiteside (1997) productivity will be affected if sick employees exhausted their leave entitlement but continue to hold on to their jobs as long as possible. Companies are mainly driven by profit and returns to their shareholders. Consequently, therefore, some companies may decide to ignore the social and moral imperatives and replace sick employees as part of business policy, necessity and choice. This may be the preferred option for companies that plan to downsize in the short term. This may raise weighty moral and social obligation issues. Some people that are HIV positive may opt for redundancy or early retirement. As a result, the impact of such actions may take long to be felt by companies (Whiteside 1997).

One area where AIDS will hurt companies is on expenditure related to employee benefits (group life insurance, pensions and medical Aid schemes etc). The extent to which this will happen depends on various conditions of employment and levels of benefits of different companies. Employment in Botswana not only varies from company to company, but even within companies. A large section of employees in companies has low or limited benefits.

Those companies that provide their own medical services such as the miners are expected to experience increased expenditure related to health care services. Available data shows that it is in such companies where costs are expected to rise as medical costs increase with the maturity of the epidemic.

The rise in medical costs associated with the epidemic is expected to impact on medical AID societies. The consequent response by medical AID schemes may be to increase contributions or restrict claims by introducing a minimum package or shift towards primary care. The increase in contributions may have the effected of reducing medical AID scheme membership. It is clear from this analysis that the impact of HIV/AIDS at company level will vary from one enterprise to the other. Loewenson (1995) notes that impact at company level will depend on:

- the production process, in terms of its inputs, process, output and product delivery and market.
- the employment pattern and labour value added (top management downwards)
- the benefits and health provisions
- the savings and investment resources

What Makes Companies Vulnerable to HIV/AIDS in Botswana

There are several reasons that make companies vulnerable to the epidemic in Botswana. HIV infection rates in Botswana are high in the labour force (age group 15-55). Available data show that HIV/AIDS is concentrated in the age group 20-39. Therefore, companies draw labour from the most affected section of the workforce. Even the replacement and retraining programmes are likely to be drawing from the same pool. A

related issue is that Botswana has a limited pool of skilled workforce and also experience deficiencies at the technical, professional and management levels. The epidemic is likely to further shrink the pool of skilled human resource. HIV/AIDS will increase competition for scarce skilled and experienced human resources. Consequently, Botswana may continue to rely on expatriate human resources. Reliance on expatriates may not be a viable option, especially if most of them are drawn from Sub-Saharan Africa where the epidemic is also high.

Botswana's domestic market is small. Companies that rely on this market will be affected as the epidemic intensifies. The market especially for luxury goods in expected to suffer as people shift spending to HIV/AIDS care. Financial services companies can also expect to experience declines in their services as people use up their savings and avoid long term investments in such mortgages. These changes will have a knock on effect on companies that are dependent on these activities.

Another factor that makes companies in Botswana vulnerable to HIV/AIDS is low productivity. Concern about low productivity and has been a national outcry even without factoring HIV/AIDS. HIV/AIDS related morbidity and mortality increase are expected to disrupt productivity. This will result mainly from loss of skilled and experienced personnel and absenteeism due to illness, providing care and support to family members and attending funerals. Company level of productivity is expected to fall as the epidemic intensifies and the number of employees in the workplace increases.

Conclusion

Although factors that make companies vulnerable to HIV/AIDS in Botswana can be derived from the nature and character of the epidemic, essential epidemiological data is still needed to clearly map out vulnerability profile at company level. Evidence of HIV/AIDS company level impact is not firm because of lack of such data. The initiative by the Task Force on AIDS at the Workplace to carry out work at company level is a very important step is building understanding of impact issues at company level. The problem of lack of impact data at company level will remain for sometime. This will be the case because actual impact on certain areas will take a while before it can be discernible. There are however, certain areas such as employee benefits, labour turnover, sick leave and absenteeism (lost days) where data is beginning to emerge. Monitoring these indicators is likely to assist companies to map out effective responses.

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Discussion

It was noted in the critique that companies need to separate what is certain about the epidemic, e.g. prevalence rates, data and what is uncertain, e.g. the impact, a cure and work from what they do know. HIV/AIDS presents strong moral dilemmas for management which need to be carefully assessed. However this needs to be turned around and looked at as an unusual opportunity; by companies learning to manage HIV/AIDS they will learn how to manage a variety of issues and by doing so will create stronger companies and societies than they had before.

The question of how unemployed individuals will have access to medical aid and other benefits was raised.
This paper brought up discussion on management commitment that overlapped with the previous paper and has thus already been noted.

PRESENTATION OF ON GOING INITIATIVES OF COMPANY INTERVENTIONS IN BOTSWANA

By Dr R Greener, BIDPA in National Task force on AIDS at the workplace

The presentation made use of the following slides:

1. National Task Force on AIDS at the Workplace

- Established to carry out the recommendations of a National tripartite workshop on economic and employment issues and HIV/AIDS (Nov 1996)
- Committee has representation from:
  - Employers - Botswana Business Coalition on AIDS
  - Unions - Botswana Federation of Trade Unions
  - Government - AIDS/STD Unit and Community Health Services Division
- Co-ordinated by BFTU
- Supported by OATUU and CIDA

2. Pilot Research Project - Impact of HIV/AIDS on Companies

Objectives:

- An assessment of the risk that HIV/AIDS poses for companies
- A first estimate of the past and present impact of HIV/AIDS on typical companies in Botswana
- A projection of what the future impacts might be
- Highlight possible interventions that might lessen the future impact

3. Pilot Research Project - Impact of HIV/AIDS on Companies

- 5 selected companies - 1,200 employees
- Data has been collected:
  - Qualitative - company policies and processes
  - Age and Sex of employees
  - Sickness related absenteeism
  - Labour costs
  - Company turnover
- Committee is meeting with companies in the next few days to discuss the results

4. Dissemination of Results

- The results and main conclusions will be made public in an aggregated form that does not identify the companies involved
- To BBCA members (and in BBCA newsletter)
- To BFTU
- To CHSD and companies involved in their programme
- Other (any suggestions?)
- There is evidence of a detectable impact on company turnover during the last year
- raised absenteeism in 30-40 age groups

5. Implications for Data Collection

- Useful to monitor absenteeism
- Reasons for absence
- sickness
- other
- Age/sex breakdown
- Grade/skills breakdown
- Trends over time

Discussion

The need to define what is meant by a company and the implications of difference in employee numbers was raised.

It was said that companies wanted answers to enlighten them on who has HIV/AIDS? In order to encourage this type of information people need explicit company policy that will protect an employee if he/she was to come forward with their HIV status. The confidentiality surrounding HIV/AIDS should not be breached, however a culture fostering openness should be encouraged. Dr Loewenson said that it is important for managers to internalise/personalise HIV/AIDS in order to manage companies effectively, otherwise they would be instilling denial and doubts through their company policy. Strategies are needed that are applicable to all levels of company and labour, since management are an element of labour themselves. There is no cookbook recipe!

WORKPLACE INTERVENTIONS ON HIV/AIDS

By Dr Rene Loewenson
OATUU Health, Safety and Environment Programme

This paper outlines key areas of intervention for which examples and further detail will be given in the presentation.

1. BACKGROUND: THE IMPACT OF AIDS

Noting the prior presentations to this meeting I will not repeat the detail about HIV/AIDS as a health problem, how it will impact and why workplaces should get involved in preventing and managing AIDS. However, it may be worth stating some of the key background issues that motivate and guide the interventions:

i. HIV has a long incubation period and infected persons may have many years of normal productive life, although they can infect others during this period. AIDS refers to the illness (due to TB, pneumonia, meningitis etc) that arises due to destruction of the immune system. Because people with HIV are healthy and those with AIDS have detectable medical illness, it is important to differentiate between these two states.

ii. Urban adult HIV prevalence in Southern Africa ranges from 1% to 32% (29% in Botswana in 1995), significantly higher in people with STD's and TB. The rate of new HIV infection is still increasing in most Southern African countries and will only plateau around the end of the century at around 20% of adults. With a 5-8 year incubation period, AIDS cases will only decline around 2010, and if the impact on orphans is included, the impact of AIDS will extend into the middle of the next century.

iii. HIV rates vary by occupational group, educational status, sex, and geographical region. HIV risk is higher in migrant employees and the communities they relate to, in the military and in urban areas. Mobility, for work or trade, for family reasons, in response to social and economic stress or for other reasons, is an important factor in HIV transmission.

iv. AIDS adds to an existing burden of preventable diseases in working people, including malaria, tuberculosis, respiratory infections, sexually transmitted diseases, occupational illness and injury and other trauma, and may be less prevalent than some of these health problems.

v. HIV can be stopped, and a sevenfold reduction in transmission would interrupt the epidemic. The perception of risk is a critical dimension in the transmission of HIV, and is affected by cultural practices and beliefs, other competing risks and social, economic and working environments. Prevention programmes that do not deal

with the underlying perceptions and conditions that influence uptake and use of these interventions will not succeed in significantly changing transmission.

vi. HIV/AIDS will affect production through the illness and death of productive people and through the diversion of resources from savings (and eventually investment) to care. It will also have significant social effects, ranging from demoralisation and depression as people begin dying to the loss of family social influences in orphans.

vii. Workplaces report increased mortality and longer and more frequent periods of absenteeism. These losses have variable effects, depending on the production process, but may lead to declining output due to bottlenecks and breakdowns, poor planning, reduced product quality, losses in skills and experience and infrastructural inefficiencies. Downsizing during the 'HIV phase' may leave companies with inadequate buffer resources when AIDS illness and mortality occurs.

viii. Increased health costs, funeral and other welfare costs could increase consumption and reduce savings (and investment).

As mortality rises more effort is being directed towards mapping these costs in enterprises, mainly in formal sector producers (Loewenson and Mangena 1997; Jones 1996; AIDSCAP FHI 1997). The distribution of these costs are exemplified in Table 1 below, and indicate a need for mitigatory interventions to be targeted at lost work time and benefits.

TABLE 1: DISTRIBUTION OF THE IMPACT OF HIV/AIDS ON COMPANIES

Description of cost	Zambia 92/93 (%)	Kenya 94 (%)	Malawi 95/96 (%)
Absenteeism	31.8	54.3	25.2
Expatriate employment	12.7	-	-
Medical Service	14.7	12.1	37.8
Funerals	5.1	10.1	4.7
Deaths in service	15.9	-	32.3
Travel	12.5	-	-
Training	7.3	7.9	-
Recruitment		15.7	-
Total	100.0	100.0	100.0

Source: Jones C (1996)

Data from studies in the region indicate an average cost per worker ranging from USd20 - USd200. Sectors that have more skilled employment, with production processes that are significantly affected by short term labour losses, and with higher levels of benefits experience higher costs. However these may also be sectors that have greater resources and options to meet these costs. Markets may also change, as consumption needs are directed towards health demands, basic needs and caring. There is a significant gap in the understanding of the impacts on and coping mechanisms in informal and household sectors: It appears that these sectors are deeply affected by the impact of labour losses and increased consumption needs, and that these losses can lead to collapse of small businesses, increased poverty and even disruption or migration of the household as a whole. The margin of adjustment and asset base in poor households is small, and illness or time taken to care for the ill can lead to lost earnings and an increase in costs that may make it difficult to resume business (ILO 1995). Shifting the costs of ill health and mortality away from formal systems further threatens household wellbeing, and leads to long term demands on the public sector to deal with consequent household poverty.

2. OPTIONS AND RESPONSES

There is no simple cookbook solution for the impact of AIDS on employment. Each company and workplace needs to look at its production process, its inputs and markets, and factor in how a three to fourfold increase in illness and mortality could affect these aspects of production in the next 5-8 years. This illness can impact at all levels of employment, from unskilled worker to top management. Clearly, AIDS is not the only external challenge, and production and human resource policies are not structured around AIDS alone. The impact of AIDS implies relooking at these policies to see what adjustments are needed. This review, in fact, offers an opportunity to do what is essential for survival and competition under the current period of globalisation, to examine and improve the effectiveness of human resource policies and practices in production. The outline below discusses key areas for adjustment.

2.1 Prevention and health promotion

The most important intervention continues to be prevention, as most working people are NOT HIV positive. Some of the work done on prevention suggests that it is highly cost effective. From an evaluation of condom distribution versus STI treatment costs in Zimbabwe, benefits of avoiding future costs are estimated at 3.5-7.5 times greater current than HIV prevention costs (Mainor/USAID 1996). In Malawi, an estimated 10% reduction in new infections through IEC, condoms and STD control had a 3.8:1 cost: benefit ratio. Despite this the resources allocated by ALL sectors for prevention are still inadequate to meet the need, with developing countries spending US$340 million on the care of AIDS patients and only US$90 million on prevention (ILO 1995).

Allocating resources for HIV prevention needs foresight and willingness to focus on long term benefits in situations where short term problems often appear overwhelming. To

derive a cost benefit ratio they also need to be structured so they work. Prevention programmes do not mean having a few talk sessions and dramas at the shopfloor level, making condoms available, sometimes on an on off basis and hoping that the information will be absorbed. Prevention in HIV/AIDS is based on changing deeply rooted behaviour patterns, and if anyone has tried to give up smoking (causing the fatal disease lung cancer) they will know that a few messages and dustbins to throw the cigarettes away in are simply not enough.

People need to know up to date biomedical information about HIV/AIDS, its transmission, prevention and management.

At the same time these messages need to be based on an understanding of and discuss the cultural, gender, social and economic environments and perceptions of risks of the target groups. Companies influence and can make positive interventions in these areas, by promoting activities that strengthen female and family roles, reducing migrancy, improving housing, building longer term planning horizons in their employees, improving access to general health promotion and health care, enhancing literacy and so on.

FIGURE 1: FACTORS IN SUSCEPTIBILITY TO HIV

1. **BIOMEDICAL FACTORS**
   Virus type
   Viral load (disease stage)
   Gender and Age of the person
   HIV prevalence in the community from which sexual partners are drawn
   Presence of STIs (especially chancroid and genital ulcers)
   Male circumcision
   Presence of tuberculosis

2. **SEXUAL BEHAVIOUR FACTORS**
   Type of intercourse (e.g.: anal, during menses, oral etc.)
   Use of Condoms
   Use of spermicides or vaginal desiccants
   Communication on and knowledge of partners HIV status
   Extent of alcohol consumption
   Communication on sexual practices
   Number of sexual partners/rate of partner change
   Extent of concurrent partners

3. **SOCIAL AND ECONOMIC FACTORS**
   Perceived risks of HIV, knowledge and information on HIV/AIDS
   Gender relations and communication on sexual practices
   Cost, availability of and attitudes towards condom use
   Female employment, status, incomes, roles
   Income inequality
   Labour migration and mobility, trade related movements
   Polygamy and attitudes towards multiple sexual partners
   Urbanisation, education, overcrowding, poor diet
   Refugee and military movements
   Access to, cost of health (STI, TB, other) services, Social/legal norms on STI management

4. **MACRO-ECONOMIC FACTORS**
   National wealth, income distribution, employment levels
   Social and cultural norms and laws
   Budget allocations to and infrastructures for health, human resource development, housing etc,
   Rural - urban integration, trade and transport infrastructures and systems

Source: Buve et al. 1995; Loewenson/OATUU HSEP 1996

HIV/AIDS is not the only cause of ill health in workers, empirical data in companies indicating that it accounts for a half or less of lost work time. HIV prevention and AIDS management should be located a more sustained and comprehensive programme of health promotion in companies, that addresses wider, prevalent causes of ill health, such as malaria, Tb, respiratory conditions, cardiovascular disease, road traffic accidents, work related illness and so on. Where this has been effected, such as in NAMDEB in Namibia, gains have been demonstrated in both HIV/STD and general health indicators. Companies need to identify what their major health problems are, ensure that their own health services
provide competent prevention and management of these problems, including providing health promotion information to employees, or link with public health services to this end. The aim should be to detect and manage ill health as early as possible. Waiting for the appearance of serious disease and disability before responding, is not effective for prevention and management of HIV/AIDS, nor for that matter any other occupational and public health problem.

Successful HIV prevention programmes thus build educational strategies, particularly through peer education programmes, make condoms available on a sustained basis and provide early and effective treatment for sexually transmitted diseases. But they also go further. The integrate HIV/AIDS into the general management of sexually transmitted diseases, integrate this into general health promotion and management and integrate this with company and community based activities that build environments for long term behaviour change.

There are other lessons that have emerged from past practice: Programmes need to reach and be visibly backed by top management, and need to be designed jointly with workers, ensuring adequate representation of female employees. They need to monitor their performance and impact on health indicators and put this information to bipartite discussion for review. Staff managing the programmes need regular training in new public and occupational health developments, and to exchange experiences and ideas. We are all on a learning curve in managing these health issues, particularly HIV/AIDS, and information sharing is critical.

As more people become ill or die, greater focus is turned to managing HIV, promoting positive health with HIV, as well as managing the losses and costs incurred by illness and death. Rather than wait for these losses, HIV/AIDS projections can be integrated into existing practices on human resource development, savings, employee benefits and social welfare. It is not necessary to know individual's HIV status for this - the levels of adult HIV in the surrounding community are known from seroprevalence surveys of antenatal clinics and can be extrapolated to the workplace to make general projections. In an environment where HIV/AIDS is treated openly and without discrimination or stigma, people who begin to get ill may take some time before they are finally too ill to work, giving fairly long periods to work out specific replacement strategies. As AIDS is unlikely to motivate qualitative changes in employment and production policies, the key

question that arises in all spheres is "What adjustments are needed to incorporate the impact of AIDS?".

2.2 Adjustments in human resource development strategies.

As indicated earlier, increased absenteeism, increased prolonged absenteeism and three to four fold increases in labour losses demand adjustments in human resource strategies. The demographic consequences of AIDS signal that while there will be labour losses, the total supply of labour will continue to grow, signifying a continuing need for employment creation and labour intensive strategies.

Lost work time has often been managed by increasing the burden on the existing pool of workers, to make up for the production losses and fill in for the lost input. This is may lead to stress if it is not managed, particularly in areas where work pressure is high. Lost work time has been managed in some cases through work organisation strategies that provide for team work, horizontal transfers to make up for losses and through having a 'buffer' supply of labour in critical areas. In some cases provision is made for light work to be done at home, if health permits this, or for lighter duties to maintain continuity of employment in those who begin to get ill.

Lost work time signals, and often provides adequate time to respond to, what may become a more permanent labour loss.

Some companies in the region have stopped labour shedding programmes, and relooked at critical processes where labour shortages could impact widely on production, in order to enhance some labour surpluses in those areas, or at least to proactively provide for training and work organisation approaches that will facilitate replacement of lost labour. Again there is no general formula for this. Multiskilling, surplus training, in-house and out-sourced training and industry level training have been raised as possible options, but the specific application of these options will be job specific.

In an extremely competitive labour market with a narrow skills base, training has often emerged as a more viable strategy than recruitment for high skill jobs, and many companies in the region have added to existing strategies of increasing their in house training and broadening their base of skills to deal with possible losses due to AIDS. This will particularly be the case in the public sector, where salaries are not sufficiently competitive to make recruitment an option. Equally important but less well explored is the how the transfer of experience will be enhanced, and also how skills and experience will be spread in the informal sector and small enterprises that make up a large majority of workplaces in the region.

Whatever the approach, countries and companies will need to make investments in training, and build the reserves and strategies to meet increases in training demands in the next decade. This is not only or even mainly due to AIDS, but to enhance productivity, product quality and competitiveness. AIDS adds to the need for these investments, and

will certainly imply an increase in the resources needed or greater use of resource-effective strategies for training, such as in-service approaches. The cost:benefit ratios on these investments calculated for some companies indicate that in high skill (high wage) jobs, additional investments in training yield a high return in averting costs of lost time and production due to labour losses and replacement of such jobs. It makes sense to have a proactive training strategy, particularly in areas where skills losses may create significant ripple effects in production.

Managing AIDS effectively demands a proactive rather than a reactive approach to human resource development in companies. So does managing the competitive pressures of globalisation. The old personnel departments that managed hiring and firing need to be replaced by approaches that see the mobilisation and organisation of human resources as central to strategic planning for company survival and growth. Such changes are driven by information, participation and encouraging learning.

One of the components of such proactive strategies is to build bipartite understanding, interaction and agreement around critical strategies and issues. In respect of HIV/AIDS this would be provided for through enforcement of non discrimination policies on HIV/AIDS backed by top management commitment, to enhance an environment of voluntary openness about health issues, including AIDS and implemented through bipartite strategies. Such policies have been developed and agreed to at national tripartite level in Botswana, in the Botswana National Code on AIDS and Employment (Shown in Appendix 1), and comply with similar standards developed at SADC level. Companies that discuss, adopt and enforce these policies will have a form base for enhancing the openness and positive environment needed to manage some of the challenges raised by AIDS.

2.3Adjustments in savings and employee benefits schemes:

Adjustments will also be important in social security, savings and employee benefits schemes, to ensure that consumption needs due to AIDS do not drain household, enterprise and national savings (and thus investment resources) and at the same time to build anticipatory reserves that can meet these consumption needs. In tripartite fora on the economic and production impact of AIDS in Malawi, Botswana and Zimbabwe, the social partners agreed that community and enterprise level schemes needed to be backed by national social security mechanisms, including social health insurance, if adequate risk pooling and comprehensive coverage were to be achieved (Min of Labour, Malawi et al 1996; BFTU et al 1996, Intersectoral Committee on AIDS and Employment et al 1997). This is an important area for future development.

There has already been a response from private insurance schemes to the increased claims costs due to AIDS. This increase has motivated schemes to set thresholds for HIV testing for insured benefits, to change the benefits offered (e.g.: by removing invalidity benefits or reducing death benefit cover), or to increase the contribution rates and premiums. These changes, said to be necessary for the viability of the schemes, have raised concern

over their consequences: These include reduced coverage, contribution and savings, including of HIV-negative people who do not want to be tested. They also include increased insecurity in the survivors and dependants of those inadequately covered by schemes, with increased pressure on public and household budgets to meet their support. Changes in the insurance sector have set new barriers to employment and housing security for people who no longer qualify for insured benefits. Shortfalls in benefits have led to pressures on workers to stay in employment as long as possible, making it difficult to deal with illness, and have also led to pressures on employers to directly make up for inadequate benefits.

What can companies and employees do?

Rights to sick leave, compassionate leave and other such benefits are the same for people with HIV as for all employees, and for people ill with AIDS as for all employees with a life threatening illness. While the codes on AIDS and Employment do not establish positive or negative discrimination, improvements on these benefits may be negotiated at company level, and often are. Principles of non discrimination imply that companies should seek to ensure that their employee benefits schemes do not discriminate on grounds of HIV or AIDS, beyond what normally applied measures to deal with illness.

The changes being made in private insurance, pension, assurance and medical aid schemes and the problems that they imply require a much more active participation by contributors on the options, in terms of

- restructuring the benefits
- reviewing the contributions
- ensuring adequate returns on investments
- ensuring complementarity between schemes.

Resources will be needed to meet AIDS costs, but the options for raising these should not only be addressed by excluding the risks (excluding those with HIV) or increasing premiums. If, for example, housing security is an important buffer for household economic security after loss of the wage earner, then ill health retirement and mortgage schemes should be reviewed to see how they can provide for such security, through cash commutations or survivor pensions to pay mortgages, or through incorporating options for part rental to secure these payments. again there is no cookbook solution. Each company should look at what it is providing to ensure adequacy, efficiency and equity in the schemes. Information and education on benefits options is generally inadequate, undermining participation in the discussion of options and in planning for long term needs. AIDS adds to other pressures for contributors to ensure that they get the information and education they need to make decisions about these schemes. Companies that provide active benefits counselling and information to employees reduce conflict and confusion around benefits options and encourage long term planning in employees. This is important in enhancing the responses to the long term problems that AIDS can produce, and has been shown in preliminary data from one study to lead to attitude and behaviour changes that reduce high risk behaviour in relation to HIV/AIDS.

2.4 Interventions for corporate culture and social responsibility:

HIV will have an impact on social development, organisation and culture, with losses of key people at household and organisational level (parents in socialisation of children, elected leaders, people with experience and so on), placing increasing stress on the survivors. The demoralisation and potential to become fatalistic about death can affect all levels of society, from household to national level. Stresses in social systems such as education and health can undermine social development at all levels that may have a long term impact on society. Economic stress has in itself created pressures on households that have been reported to increase marital instability and domestic and social violence and to undermine social cohesion (Kanji and Jazdowska 1993). At the same time HIV/AIDS has opened communication between parents and children, between men and women and has stimulated debate on ethical and social issues relating to health, employment, sexuality and so on. AIDS has presented an opportunity to confront gender norms and to relook at health services towards building stronger community, preventive and integrated models of health care. While documentation of these issues is weak, they may be the area where the impact is most profound. In the long term impact on the next generation, including orphans, these effects may stretch into the middle of the next century.

There is growing concern over the need to identify and ensure a balance and equity in the costs of AIDS between the household, small and large enterprise and national level. The shedding of costs into the household sector, as appears to be currently the case, yields short term gains and long term losses in increased poverty, economic inequality and social instability.

The issue of a corporate culture of openness, non discrimination, bipartism and mutuality of interests in preventing and managing HIV/AIDS and responding to its impact has been referred to earlier in this paper. The wider social impact raises issues of social responsibility. Nelson Mandela noted in his address to the World Economic Forum in 1996 that history will judge us by our response to this epidemic. We, parents, spouses, citizens, employees, employers, companies, governments all have a role to play not only in protecting our own risks, but in responding to the wider dimensions of the social, national and even regional impact of AIDS.

What can companies do?

The formation of the Botswana Business Coalition on AIDS, and its participation in the tripartite national task force on AIDS under the Advisory Committee on AIDS at the Workplace provides an important vehicle for acting on these wider issues;

- to project a response that is informed by non discriminatory and open approaches
- to contribute a workplace thrust towards national strategies towards health promotion and HIV prevention,
- to contribute towards equity in the management of the impact of AIDS, and
- to link with and support community and local authority programmes aimed at

prevention and management of HIV/AIDS, including orphan care, improved housing, strengthening female/family roles, enhancing literacy

Our interdependency, nowhere more evident than in the spread of HIV, demands equity and a shared approach to the challenges of HIV/AIDS. Our response signals the role we define for the region's people in how economic growth will be achieved, production enhanced, jobs created and social development advanced.

Discussion

In the critique it was noted that companies must act now and not later in support of the papers argument that companies should intervene as early as possible. In doing this it is important to budget time and money to educate workers preferably by recruiting a health worker who can handle these issues professionally. This will also help detect and manage ill health. However the critiquer did mention that not knowing individuals HIV status poses a problem for the employer in terms of planning and recruitment. Training plans are crucial and HIV/AIDS will require a new approach to personnel management. This will call for more work on the part of the employer and every employer should get prepared to do so. Potential problem areas are training costs, especially for small companies as well as the expectation of employees being raised by multiskilling through remuneration. It was also mentioned that counselling around benefits options is vital.

Prevention and care need to be strongly linked at company level in order for HIV/AIDS information to be internalised. The care aspect often makes HIV/AIDS visible enough for people to accept the prevention programmes that they receive.

The emotional aspect of productivity is as important as the physical ability to work. It is therefore essential that counselling is available in the workplace environment. This will become even more crucial as more people come into contact with HIV/AIDS through their friends, family and co-workers. Counselling should not be specific to HIV/AIDS as this can breed rumour and gossip about those employees who utilise counselling services. There should be advise on benefits and general health promotion integrated into HIV/AIDS counselling. Employing a nurse as well as a councillor is ideal, if the company is large enough to warrant the expense. In house health services can save money and labour time.

WHAT ARE THE COST BENEFIT ARGUMENTS FOR COMPANIES TO INTERVENE IN THE PREVENTION AND MANAGEMENT OF HIV/AIDS?

By Mr Kayira

1. INTRODUCTION

It is now more than a decade since the government has been battling with the HIV/AIDS epidemic in Botswana. This has contributed to a substantial knowledge about the virus that was hitherto unknown. The knowledge about the virus and how it is transmitted is almost universally known in the country. Mechanisms of controlling the spread of the virus through blood transfusion in institutions have also been tightened. In spite of all these efforts the problems associated with the epidemic continue unabated. Botswana continues to experience one of the fastest growth rates of HIV spread in the region. It is now estimated that more than 200 000 people are living with HIV/AIDS. Thus, a population as big as the number of people residing in Gaborone and the surrounding villages of Tlokweng and Mogoditshane is HIV positive. An estimate of adult population of ages 15-49 indicates that close to 25 percent of this age group is HIV positive. This means that a substantial number of the workforce is affected.

Prevention of the epidemic remains pivotal to the national response. Similarly, the need to put in place instruments to mitigate the impact is critical. One of the essential elements learned this far both in Botswana and elsewhere is the need to expand players in response to the epidemic. The complexity of the epidemic and its magnitude makes it almost impossible for a single sector to effectively respond. It has also been clearly demonstrated that no sector is "immune" to this epidemic, hence the need for all sectors to play their critical roles.

This expanded response need to include the private sector, since this sector of society has unique expertise and resources that can allow business to play a key role in the national response to HIV/AIDS. An optimal response can only be achieved by combining all available resources and using all existing opportunities of influence. This challenge should be addressed by the public and private sectors in partnership, where they may fail or be less effective working alone. There is a clear role for business to play in this partnership. Much more than just providing financial support, the business community, with its marketing and organisational skills, can bring a commercial efficiency to the delivery of health promotion messages to targeted audiences.

The UN system clearly recognises the role of the private sector in both the global and national response to the challenges of HIV/AIDS. To this end, the UNAIDS, which is the UN joint programmes on HIV/AIDS has been proactive in involving the private sector in a response to the epidemic globally

2. THE COST-BENEFIT ARGUMENTS FOR BUSINESS COMMUNITY INVOLVEMENT IN HIV/AIDS

a) Workplace programmes

As noted above, HIV/AIDS is a problem that affects all sectors of the society, including the business community. Institutions, not unlike individuals, take time to respond. Similarly, institutions vary on how they understand the problem and how they respond. As a result, in Botswana and elsewhere, a varying degree of response by the business community to the epidemic has been noted. The degree of response varies from a no-response situation to a comprehensive response of the epidemic. There is an overwhelming evidence suggesting that there more benefits in being involved in HIV/AIDS activities. In many countries in the Sub-Saharan Africa, the epidemic is affecting the workforce, markets and overall business climate. Studies in Southern and Eastern Africa conducted by the African Medical and Research Foundation (AMREF) and the US organisation AIDSCAP, reach the same conclusion. These studies indicate the following impacts:

* loss of experienced personnel- particularly at the middle management and skilled worker levels;
* need for increased resources to hire and train replacements;
* increased absenteeism;
* increased labour turnover;
* decreased productivity;
* shrinkage of pool of available new hires; and
* most damagingly and pervasively, increased health care costs, including growing health staff, medical insurance, life insurance premiums and disability payments, adding to the already heavy burden of health care costs which society has to carry.

These are micro-economic impacts that have already been felt, though not to the same extent in all developing countries. There is evidence that some countries have faced or will face macro-economic impacts of this epidemic. A Kenyan business survey that found that HIV/AIDS costs companies nearly four per cent of annual profits and resulted in projections that AIDS will keep Kenya's GDP 15% smaller than it would otherwise have been by 2005. Considering that Botswana is among the countries most affected in the region, these estimates of the macroeconomic impact maybe an underestimation of the potential impacts.

With appropriate and timely measures, these impacts could be minimised and in some cases avoided. Well developed work place programmes have had a positive impact on the risk behaviour of the workers and, consequently, on the vulnerability of institutions. Most of the programmes at the workplace include health education, provision of condoms, and counselling. In a study carried out in 17 business institutions in Africa (AIDSCAP), it was concluded that prevention interventions are both relatively inexpensive and cost-effective. Table 1 clearly demonstrates the benefits for the business community to be involved in HIV/AIDS activities. The costs of impact were calculated by factoring in the following: recruitment; health care; burial and death benefits; HIV absenteeism; funeral attendance; labour turnover; training; and post-training productivity.

Table 1
Summary of Annual Impacts Vs. Prevention Programme Costs (US $

Company Name	AIDS Impact-Total costs (1994)	AIDS Impact-Total costs (2005)	AIDS Prevention Programme - total cost (1994)^	AIDS Impact - per employee cost (1994)	AIDS prevention programme - per Employee cost (1994)
Botswana Diamond Valuing	125,941	136,985	23,124	237	44
Botswana Meat Commission	370,200	400,029	51,072	268	37
Auto Kenya, Kenya*	21,312	50,074	10,189	17	8
Kenya Transport *	61,132	147,389	28,070	28	13
Muhoroni Sugar, Kenya	58,303	117,674	21,647	49	18
Western Wood, Kenya*	40,630	102,499	31,885	25	20

* Indicates fictitious name of company; other information is accurate.
^ Lowest recurrent cost prevention programme estimates

Source: Private Sector AIDS Policy: African Work Place Profiles. Family Health International's
AIDSCAP Project (eds) Matthew Roberts & Bill Rau. (1996?)

Apart from programmes at the work place, policies that are HIV-friendly could also benefit business institutions. In Mexico, in spite of legislation stating that an HIV test could not be requested as a prerequisite for employment or used as a reason to terminate employment, some mandatory testing has continued. CONASIDA, the national AIDS council, cites the experience of one bank's use of cost-benefit analysis to support a change of practice: the private bank concluded it had spent US $ 200,000 in 1994 testing over 6,000 employees and finding only five positive per persons (US $ 40, 000 per diagnosis). On the other hand, medical care costs for those with HIV/AIDS had been US $ 7,000 per year per person. Considering that the bank had 20 HIV infected employees, it concluded that US $ 60 000 a year could have saved if routine testing stopped.

b) Beyond Workplace programmes

The success of business, however, is dependent on the health of audiences far wider than its employees. Many factors in society can impact on the business climate. Where appropriate, business should participate in public health initiatives with the public and voluntary sectors, HIV/AIDS included. Companies considering HIV/AIDS activity, sponsorship or partnership may be concerned most about the potential effects on their markets for products and services. Experience shows that detailed study of a market can result in the appropriate matching of interventions. Companies may decide to link their involvement to one brand or product, or to use the partnership to enhance their corporate image. Cause-related marketing has been used by United Distillers (USA) to associate one brand, Tanqueray Gin, with a nationwide HIV/AIDS fund raising campaign. This has resulted in enormous public support realising a total of US$ 25 million in 1996. The brand was selected for this approach following consideration of its market.

In addition to the reduction in the direct costs of HIV and AIDS described above, many of other benefits will be financial. Table 2 summarise the benefits of three types of involvement: commercial initiatives; social investment initiatives; and philanthropic initiatives.

Table 2

Summary of the Benefits of Business Involvement

HIV/AIDS Business Programmes	Their Benefits to Business
Commercial Initiatives	
Cause-related marketing in association with fund raising and public education events. Employee and customer education and protection.	Reduced health and other costs; and improved public image and sometimes increased sales.
Social Investment Initiatives	
The promotion of health education in communities close to company facilities such as mines, factories and hotels.	Healthier communities in and with which to do business.
Philanthropic Initiatives	
The donation of cash, equipment and technical assistance to NGOs fighting HIV/AIDS at the local, national and international levels.	The visibility of an expression of social responsibility, contributing to a caring company image.

3. THE NEED FOR TIMELY INTERVENTION

The timing of an HIV and AIDS intervention is critical. Research has clearly shown that there is a disproportionate advantage in starting effective HIV programmes early. The proportional costs of delaying the start of an effective HIV programme are shown in **Figure 1**. This displays on the right-hand side, the proportional costs at year thirty of the epidemic in a particular country. The difference in level of cost depend on the stage that the epidemic has reached before an effective programme is implemented. The cost of starting an effective programme rises with the stage of the epidemic. This is because there will be more sectors and programme components and a greater demand for services. The different levels of cost at thirty years probably differ from each other by factors of ten or more.

4. CONCLUSION

HIV/AIDS is clearly a problem that affect all spheres of life. To this extent, it becomes imperative that all sectors should be mobilised to participate in response to its challenges. The current explosive nature of the epidemic in Botswana is not impossible to manage. Similarly, the anticipated consequence are not inevitable. If appropriate steps are taken timely then further spread could be minimised and disastrous consequences avoided.

Evidence from countries like Thailand and Uganda have clearly shown that with a comprehensive and expanded response, the epidemic could be managed. The experiences clearly demonstrates that prevention works. Statistics in these countries indicate an increased condom use, delayed start of sexual activity, and reduced number of infections. Botswana could also be counted in future among the success stories.

The importance of the private sector in HIV response is critical. This could take many forms. In addition to the workplace programmes, the business community could also use its comparative advantages in marketing, distribution networks, to help deliver prevention messages and services. This has already happened in Thailand, where the Thai Business Coalition has played a critical role in getting the message out about prevention.

References

Private Sector AIDS Policy: African Workplace Profiles. Family Health International's AIDSCAP Project (eds) Matthew Roberts & Bill Rau. 1996?

UNAIDS, The Expanded Response to HIV/AIDS: Working in Partnership with the Private Sector (draft), 1997

UNDP, The HIV Epidemic and Development: The Unfolding of the Epidemic, 1993

Discussion

In the critique, Mr Greener replied that HIV/AIDS interventions were difficult areas for traditional cost benefit analysis because although the cost of the programme is easy to quantify, that of the benefits is more problematic as it had a qualitative aspect to it. Intervention costs are immediate, while the benefits are often reaped in the future thus making it essential that companies believe in the effectiveness of prevention programmes. It may be more useful to therefore concentrate on that aspect. This itself has its problems as benefits are related to assumptions of many kinds such as changes in the legislative environment. In order for companies to fully benefit from their intervention programmes there needs to be a united response, otherwise there is an element of 'free riders'. Not all the benefits accrue to the paying company.

It was asked if tax breaks were considered for companies who had successful education programmes. The philanthropic element of the paper can be an empty argument with the private sector as there are multiple topics to be considered.

There was debate on the question of medical aid schemes omitting HIV positive people from their market, rather than drawing on them. BOMaid replied that they were in the process of re-orientating theirs and were trying to pull company resources together to manage HIV/AIDS rather than avoid it. This initial reaction had been one of fear with no substantial evidence to back it up or throw it out. It was mentioned that one problem is when an employee undergoes ill health retirement he/she looses his/her access to medical aid at the time it is most needed. Could medical aid schemes be integrated into ill health retirement schemes?

LEGAL ASPECTS OF HIV/AIDS
AT THE WORK PLACE

By Mr K Dingake

INTRODUCTION

This paper discusses the legal implications of HIV/AIDS infected employees at the work place. The discussion focuses on three critical stages in the employment relationship. These are recruitment, conditions of employment and dismissal. The paper is not intended as an academic treatise. It is written to fulfil a practical need among parties to the employment contract: the employee and the employer. The primary focus of this paper is on Botswana Labour Law. Where theoretical concepts or historical background is provided, it is only for purposes of enhancing our understanding of the day to day practice. In this paper we seek to answer basically three questions:

(a) May a job applicant be requested to undergo HIV test?

(b) Can employees be compelled to undergo AIDS Testing?

(c) When can employment contract be validly terminated on the ground that an employee is HIV positive?

A BRIEF MEDICAL BACKGROUND

AIDS was first diagnosed in Botswana sometimes in 1985x By 1995 about 180 000 were expected to be HIV positive, out of a population of 1.3 million. Based on the above figures, it is apparent that AIDS is the most frightening catastrophe, Botswana has ever known, with the potential to cripple the economy.

It is now common cause that Human Immunodeficiency Virus (HIV) causes the Acquired Immunodeficiency Syndrome. It can be contracted through body fluids, mainly through blood or semen. It can be contracted in several ways, including through penetrative sexual intercourse, skin cut that exposes the cells; injection with infected blood or in the uterus of a pregnant womanxi AIDS is a syndrome involving opportunistic diseases. Once contracted the body defence system which fight infection are weakened. The disease is fatal. To date there is no known cure for AIDS. It must also be said, however that AIDS is not solely a health issue. It is also a Human Rights issue.

RECRUITMENT

The Common Law recognises the unfettered discretion of the employer to decide whom to employ. Under the common law a job seeker may be denied employment on any basis, no matter how unfair or capricious the grounds thereof may be.xii Similarly, under the common law , an employer could dismiss an employee for any reason or for no reason

whatsoever. All that is required for termination is the giving of the requisite contractual notice . The provision in respect of notice was not peremptory and an employer could dismiss an employee immediately as long as an employee is paid in lieu of notice. The reason for this position was the belief that every contract of employment was entered into voluntarily and consequently either party was at liberty to end it at anytime provided sufficient notice was given. Under the common law, if either party is unable to perform his/her obligations under the contract or is unable to perform for a period which is unreasonable in all the circumstances of the case, the aggrieved party is entitled to terminate the contract on the ground of non-performance.xiii As a general rule, there is no right to sick leave under the common law. Absence on account of sickness does not however constitute a valid ground for the employer to default in his/her obligations. The default could only be justifiable where the period of the absence was unreasonable vis-a-vis the employees legitimate expectation.

Most countries in Western Europe have enacted legislation to mitigate the unfettered discretion of the employer. Employers are often prohibited from discriminating on the grounds of religion, race, or sex.xiv In the United States HIV infection is characterised as a handicapping condition under the Disabilities Actxv

In terms of the above Acts an HIV positive job seeker who ordinarily qualified for a job that he/she is applying for, must not be discriminated on the basis of his/her medical condition.

In Botswana, there is no specific legislation that prevents discrimination amongst job seekers on specified grounds, such as race, ethnicity religion, sex or medical condition. Guidance on this aspect can be sought from the Constitution. In Botswana the Constitution expressly provides that no law shall discriminate on the basis of race, place of origin, political opinion, colour, creed or sex. This particular section is not very helpful to employees and employers who may be confronted with discrimination based on positive HIV status. The provision, permits an interpretation that says that discrimination based on social practice i.e. not based on the law is permissible.xvi Indeed as Radipati argues, it is feasible that Parliament may pass legislation that authorises discrimination on the basis of a medical condition (such as HIV infection) and that such enactment will not be unconstitutional as no mention is made of medical condition in the section prohibiting discrimination.

It is also worth noting that labour legislation in Botswana does not cover job seekers. The question that arises from the discussion of the above legal principles is whether it would be unlawful for an employer to insist that job seekers undergo HIV/AIDS tests. The question is made difficult by the absence of specific statute dealing with AIDS at the work place. As earlier indicated the omission or absence in the constitutional provision prohibiting discrimination on the ground of medical condition and the implied authorization of private discrimination complicates matters even further. It is the contention of this paper, however, that when confronted with the question of

discrimination on the basis of HIV status, our courts may be persuaded to rule that discrimination based on unreasonable and or arbitrary grounds is unacceptable.

In our view it would be unreasonable and irrational to require job seekers to undergo HIV/AIDS tests for the following reasons.

(i) Pre-employment test cannot guarantee an AIDS free work-force. An applicant may test negative for HIV, get the job, and upon getting a job he/she can be infected with AIDS.

(ii) Discriminatory testing encourages stigmatisation or ostracisation, because it promotes 'us' versus 'them' perceptions: "AIDS is not my problem, but theirs".

(iii) HIV positive job applicants may be capable of carrying out the duties required of them by the employer.

(iv) Testing prospective employees is not effective in either stopping AIDS or protecting existing employees.

It is also the argument of this paper, that notwithstanding the inadequate provisions of S 15 of the Constitution prohibiting discrimination, discrimination on the basis of medical condition, may offend against the constitutional injunction of equal protection of the law and the one protecting human dignityxvii

It follows therefore, in our view that the questions earlier posed: Whether a job seeker and or an employee can be requested to undergo AIDS test must be answered in the negative.

CONDITIONS OF UNEMPLOYMENT

Once an employee has been hired, a binding contract between the employee and the employer comes into being. The terms of this contract are not only those which have been expressed in black and white by the parties, but also those which are imposed by the law.xviii AIDS may affect conditions of employment in various ways. Employees with AIDS may be dismissed, demoted or transferred.xix As indicated above, once an employee has been hired, a binding contract comes into being and it is generally not permissible for the employer to alter the terms thereof. xx

In the case of Moyo, aforementioned, the Industrial Court ruled that an employer cannot unilaterally alter the terms and conditions of employment. An employer who desires to alter the conditions of employment must among other things demonstrate a rational commercial reason to do so.

On the basis of the reasoning in the case of **Moyo** it can be safely argued that it is not permissible for an employer to seek to alter the terms and conditions of employment of the employee because he/she is HIV positive. This is so because; medical evidence suggests that an employee who is HIV positive may be able to perform the duties expected of him by the employer. In the circumstances there would appear to be no good employment related reason or commercial rationale to do so. Neither is it possible, in our view, for an employer to request an employee to undergo HIV testing, because that may well amount to fundamental breach of the contract on the basis that such an act by the employer was destructive of mutual confidence in the relationship.xxi

Similarly any demotion and transfer on the basis that the employee is HIV positive is not permissible. It is safe to anticipate that the Industrial Court faced with the question may hold the demotion or transfer to be unfair, especially when it does not affect the capacity of the employee. Given the medical facts about the way HIV is transmitted - that there is virtually no chance of infection at the work- place it would be difficult to find justification for transferring or demoting an employee.

It is often the case that an employer may face pressure from the workforce to dismiss an HIV positive employee. Is this type of dismissal legal? There is authority for the view that labour law will not tolerate irrational, unreasonable or absurd conduct precipitated by uninformed employees.xxii The reason for this position of the law is that it is not possible for co-workers of HIV positive employees to be infected through normal contact at work.

DISMISSAL

The question that often arises is whether an employee who is HIV positive can be validly dismissed on the basis that he/she is HIV positive. In our view, a number of factors must be considered:

* *Is the capacity of the employee to adequately carry out his or her duties impaired by his or her condition?*

* *Is the employee in an occupation in which there is a high risk of infecting others?*

* *Can an employee easily be moved to another job within the business?*

* *What effect does the employees' continued employment have on the rest of the workforce (e.g. are colleagues refusing to work with him or her)?xxiii*

* *Has the employer informed his employees about AIDS and its communication, and has he provided a safe and reasonably healthy working environment?xxiv*

On the basis of the above considerations, dismissal merely on the basis that an employee is HIV positive may be considered unfair by the Industrial Court .xxv This is so because being HIV positive does not mean that the employee's ability to work is impaired. Where the Industrial Court rules that the dismissal aforesaid is unfair, an order reinstating the employee may be sought and an action for damages for the impairment of dignity may be instituted by the employee against the employer.xxvi

There is authority for the preposition that, where there is likelihood of labour unrest arising out of the continued employment of an HIV positive employee, in an occupation where there is high risk of infecting other employees, and it is not possible to transfer the concerned employee to another job in the business in which the risk of transmission of the disease is reduced, the dismissal of such employee may be considered fair.xxvii

There is also authority for the view that failure by the employee to inform the employer that he/she has contracted AIDS may be a factor in the decision whether the dismissal of the employee is unfair.*xxviii*

It is worth emphasising that where the employee has become ill because of AIDS and has become incapacitated as a result, the normal rules, governing termination of services for inability apply.xxix In our view there should in such a case, be a fair enquiry where all relevant evidence will be presented.xxx

CONCLUSION

Our discussion of legal aspects of HIV/AIDS at the work place has ought to show that the law in Botswana is in a state of flux. We have also attempted to demonstrate on the basis of medical evidence, that there is no justification for discriminating against HIV/AIDS positive employees at the workplace. In our view the only realistic and fruitful response to AIDS epidemic lies in prevention, education and non discrimination. We echo the statement associated with the chairman of the US Presidential Commission on AIDS, to the effect that 'the most significant obstacle to progress' against the AIDS epidemic is the threat of discrimination.xxxi

Employers bear enormous responsibility to avoid discrimination and other irrational and unfair conduct. They should strive to ensure that their employees have access to information and programmes on HIV/AIDS, as well as counselling facilities. It is also important that Management and Labour must jointly formulate clear policies on AIDS. In our view such policy should ensure that:-

(a) *there is no discrimination in recruitment against HIV/AIDS infected applicants.*

(b) *employees are not required to test for AIDS.*

(c) *Employees are not dismissed on the basis that they are HIV/AIDS positive.*

We also suggest that Parliament must consider passing legislation that deals specifically and comprehensively with AIDS.

Discussion

In the critique, Mr Magang asked if the law says anything about employees who are HIV positive? It was noted that the Botswana code of practise on HIV/AIDS and employment is now in being and the HIV/AIDS policy is a presidential directive which gives it certain legal status. He also asked; what is 'valid or reasonable dismissal' as law school says reasonable is what the reasonable may consider reasonable! The labour act looks at procedural fairness because medical conditions are not in the constitution. As well as this people tend to forget the concept of blackballing where something can be rejected legally if no reasons are given. On this premise, companies can silently not recruit some one if they happen to know they are HIV positive, which is unlikely. Lastly the critique mentioned that if a person was engaged in a high risk job, they should be seen to be taking precautions whether they are HIV positive or negative.

CHAIRMAN'S CONCLUDING REMARKS

- In terms of the epidemic, Botswana does have a little time on her side, as she is yet to hit the full illness phase. This makes it imperative that early survival plans are developed and that there is support and consensus on approaches at company level, with the biggest impact being labour loss.

- With no cure for AIDS, the issues must be seen from a comprehensive socio-economic perspective; instead of being seen as a health issue. This is especially true since the epidemic is incremental and not catastrophic.

- There is vital need for information dissemination by and between, Government, companies and the general public. This includes education and prevention programmes, as well as factual data, personal support systems and increased communications.

- Mangers and companies need to stay the right side of the current and future legislation. They need to stay ahead of co-worker concerns by promoting openness, maintain productive working environments, manage the spill over process bearing in mind that HIV/AIDS affect the wider family of a breadwinning employee and consider the long term effects on their markets.

- Fighting HIV/AIDS is everybodies fight; it is not for Government alone.

NEXT STEPS: CONCLUSIONS & FOLLOW UPS

From the presentations and consequent discussions, several needs of the private sector were identified. These are documented in the table below and possible areas of support by the Botswana Business Coalition on AIDS are given. The actions have been divided into three main areas; Information, Policy and strategies. The services which will arise out of this plan of action will be made available to all members of the Coalition, who are the funding pool for such work. If any company is interested in participating in this and would like to receive follow up information, they are encouraged to affiliate themselves with the BBCA.

ACTION	SUPPORT
INFORMATION:	
1. There is a need to collect and use information on health for planning.	The BBCA is involved with the national task force who's research includes this element. Co.s wanting to set up in-house monitoring systems can get support from the BBCA on request.
2. There is a need to define what resources and services are available in and beyond Botswana.	The BBCA HIV expertise index is now available (to non-members at a fee) containing organisations working in HIV/AIDS issues and their particulars. Regional information is also available on request.
3. There is a need for linking with other business coalitions to share strategies and experiences.	BBCA has established close links with the BEAD Group whose literature is available from our office. The Thailand Business Coalition is also interacting with Botswana. These links will be continually strengthened.
POLICY:	
1. There should be dissemination of National and tripartite AIDS policies.	All members should receive the Botswana code of practise on HIV/AIDS and employment. Other and regional codes are available on request.
2. Companies need support to develop policies, both at the common and in-house level.	BBCA is currently working with two companies who have contracted us to develop a company policy. This service is available to members on request. BBCA will be developing a common optimum company policy with other employers reps later this year.

3. Companies should have assistance with legal issues in terms of interpretation and employers representation.	BBCA's membership does include legal practices on who's services can be drawn. BBCA will be developing its own stand on legislation with input from the private sector.
4. There is a need to inform BOCCIM and employers reps in tripartite and government platforms on AIDS issues.	This is an on going process which has already been initiated and needs to be developed.
STRATEGIES:	
1. The Issues identified should be followed up systematically and deeply: - handling health interventions - benefits - lost work time/HRD/succession.	The national task force is currently developing interventions around these areas which will be workshoped in July. These interventions will be available to all members. However if companies specifically want to work with the BBCA on any of these issues, and have ideas on how to group discussion they should contact the co-ordinator.
2. Disseminate interventions and research findings.	This will be done in several ways: - conferences/workshops - newsletters - social clubs - reports.

APPENDIX A:

BBCA Seminar on the Impact of HIV/AIDS at the Company Level
14/5/97, BNPC Conference centre

Programme

0830-0900	Arrival of guests
0900-0905	Poem read by Billy Mosedame
0905-0915	Official opening, Mrs Gasennelwe, Deputy Permanent secretary, Ministry of Health
0915-0935	Presentation of 1st paper, Prof. Alan Whiteside, University of
Natal,	followed by a five minute critique, Derek Hudson
0935-1000	Discussion
1000-1025	Presentation of 2nd paper, Dr Mugabe, NIR, Followed by critique, Barbara Heinzen
1025-1050	Discussion
1050-1120	Tea/Coffee
1120-1140	Presentation of initiative from Botswana based research from 5 companies, Robert Greener
1140-1200	Presentation of 3rd Paper, Dr Loewenson, OATUU HSEP, followed by critique, Mr Matlhako
1200-1225	Discussion
1230-1400	Lunch, provided by Owens Corning Pipe
1400-1425	Presentation of 4th Paper, Mr Kayira, UNDP, followed by critique, Robert Greener
1425-1450	Discussion
1450-1515	Presentation of 5th Paper, Mr Dingake, UB, followed by critique, Lesang Magang
1515-1530	Tea/coffee
1530-1550	Discussion
1550-1600	Close

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