

SOCIO-ECONOMIC EFFECTS OF HIV/AIDS
ON SMALL AND MEDIUM SIZED ENTERPRISES
IN OSHAKATI, NAMIBIA

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ABSTRACT

Southern Africa has the highest HIV prevalence rates among adults in the world. Namibia has not been spared the scourge of this pandemic. In Oshakati, where this study was conducted, the HIV prevalence rate is 25.2%, the second highest in Namibia. There are not many large industries in Oshakati. The greater part of the labour force is employed in the informal sector. Small and medium sized enterprises (SMEs) provide a social safety net for the poor, the uneducated, for women and children and as such have not been spared the effects of the pandemic. In fact, they appear to be the worst hit by the pandemic.

It is against this background that an explorative and descriptive analysis of the socio-economic effects of HIV/AIDS on small and medium sized enterprises in Oshakati, Namibia, was undertaken as a foundation for developing HIV/AIDS prevention programmes.

Specific objectives of the study can be described as follows:

- To explore and describe the socio-economic effects of HIV/AIDS on small and medium-sized enterprises in Oshakati, Namibia.
- To analyse HIV prevention programmes already in place in small and medium sized enterprises in Oshakati, Namibia.
- To provide guidelines for small and medium sized enterprises that wish to develop HIV

prevention programmes.

It has been established that HIV/AIDS primarily affects women and children. SMEs in Oshakati employ almost an equal number of males and females, thereby increasing the risk of these enterprises to HIV/AIDS. The size of an organisation influences how many cases of death occur among its employees, with medium sized SMEs hit worse, followed by small and then very small SMEs. This study discovered that frequent illness, resignations and employee deaths due to HIV/AIDS increased SMEs expenditures on medical care and funerals. Almost all SMEs surveyed reported that HIV has had a negative impact on business profits. The direct causes of reduced profits were identified as increased absenteeism, frequent illness on the job, loss of customers and loss of suppliers. Other causes included a high rate of staff replacements, the need to hire temporary labour to stand in for sick staff and escalating demands for higher wages.

It goes without saying that illness, resignation and death have socio-economic effects on the livelihood of employees themselves. In the course of the study, managers of SMEs reported that the most common effects of HIV on their employees included reduced personal savings, increased drain of their income, increased expenditure on health care and a rising incidence of premature death among employees. It was also discovered through the study that stigmatisation and discrimination against employees living with HIV/AIDS still exists in some SMEs. Prejudice still exists because some employees believe they can easily become infected by colleagues living with HIV/AIDS.

One of the findings of the study is that HIV/AIDS prevention programmes are not yet established in the workplace of most SMEs in Oshakati. For those enterprises that do provide programmes, there is no evidence that they are applied consistently or in a coordinated manner. These programmes have not been formalised and are implemented haphazardly. Most SMEs have neither an HIV/AIDS policy nor a trained employee who focuses on the HIV/AIDS problem in the context of the company, as required by the MTP III. According to that regulation, SMEs are supposed to act in partnership with the community to fight the pandemic.

In conclusion, this study makes recommendations and suggestions that should help SMEs establish comprehensive HIV/AIDS prevention programmes in the workplace. Some of the recommendations include a workshop for SMEs in Oshakati to discuss the effects of HIV/AIDS on the business community and to come up with an adhoc committee to oversee the establishment and sustenance of workplace HIV prevention programs. This study further recommends SMEs to prolong life and strength of their employees by providing medical insurances, ARVs and strengthening HIV education in SMEs and the community. Partnership between large enterprises and SMEs is recommended to ensure access to resources and expertise by SMEs.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti Retroviral Therapy
ARVs	Anti Retro virals
CDC	Centre for Disease Control
CD4	Cluster Designate 4
GDP	Gross Domestic Product
HIV	Human Immune Virus
ILO	International Labour Organisation
IOE	International Organisation for Employers
JCC	Joint Consultative Committee
MoHSS	Ministry of Health and Social Services
NGOs	Non Governmental Organisations
SABCOHA	South African Business Coalition on HIV/AIDS
SMEs	Small and Medium Enterprises
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Program on HIV/AIDS
UNAM	University of Namibia
USAID	United States Agents for International Development
VCT	Voluntary Counselling and Testing

DECLARATION

I hereby declare that this study is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree from any other institution of higher education. No part of this thesis may be reproduced, stored in a retrieval system, or transmitted in any form, or by any means (e.g. electronic, mechanical, photocopying, recording, or otherwise) without the prior permission of the author, or the University of Namibia on his behalf. I grant the University of Namibia the right to reproduce this thesis in whole or in part, in any manner or format, which The University of Namibia may deem fit, for any person or institution requiring it for study and research; providing that The University of Namibia shall waive this right if the whole thesis has been or is being published in a manner satisfactory to the University.

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SYDNEY CHIKUKWA

Date.....

DEDICATION

This thesis is dedicated to my wife, Portia, for her continual encouragement, support and love and to my beautiful daughters, Lisa and Lisy. Let this accomplishment be a source of inspiration.

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Glory is to God, Ebenezer, You have taken me this far through Your strength.

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May almighty God bless you all.

CHAPTER ONE

INTRODUCTION TO AND BACKGROUND OF THE PROBLEM

1.1 INTRODUCTION

An estimated 33.2 million people worldwide were living with the HIV virus at the end of 2007. 30.8 million were adults, 15.4 million of whom were women. Of these people about 2.5 million people had been infected recently with HIV. Globally, 2.1 million people had lost their lives to AIDS by the end of 2007. Although they present a morbid picture, these figures indicate a reduction of 16 % from the 2006 estimates. This reduction is can be attributed mainly to a single country, namely India. Other significant drops in the incidence of HIV were estimated in Sub-Saharan Africa, from countries such as Zimbabwe, Angola, Kenya, Mozambique and Nigeria. In both Kenya and Zimbabwe there is growing evidence that the reduction is due in part to a reduction in the number of new infections, which in turn is partly due to the reduction of risk behaviour (UNAIDS, 2007, p. 9).

Still, Sub-Saharan Africa remains the global epicentre of the AIDS pandemic, and the region still shows no evidence that the problem is on a decline. More than two-thirds (68 %) of all HIV-infected people live in this region. The majority of these infected people (61 %) are women. It is estimated that about 1.7 million (between 1.4 and 2.4 million) people became infected with HIV in 2007, bringing to 22.5 million (20.9 to 24.3million) the total number of people living with the virus. The

scale of and current trends in the pandemic vary considerably, with southern Africa most seriously affected. This sub-region accounted for 35 % of all people living with HIV, and globally for almost one-third (32 %) of new infections and AIDS related death as of 2007. By the end of 2005, the prevalence of infected adults exceeded 15 % in eight countries (Zimbabwe, Botswana, Namibia, South Africa, Lesotho, Swaziland, Zambia and Mozambique) (UNAIDS, 2007, p.15). In the SADC region alone, Swaziland had a national HIV prevalence estimated at 33.4 %, Botswana 24.1 %, and Namibia 19.7 % (UNAIDS, 2006, p. 6). Namibia is a coastal country in southern Africa, comprising 825,214 square kilometres. It borders on Zimbabwe, Botswana, Zambia, Angola and the South Atlantic Ocean. The country has a good road network and communications infrastructure. The 2001 census indicated that 67.6 % of the population lives in communal areas and 32.4 % in commercial urban centres. The Namibian economy is heavily dependent on the extraction and processing of minerals for export. Mining accounts for 20 % of the GDP, with rich alluvial diamond deposits making Namibia a primary source of gem-quality diamonds. The mining sector employs about 3 % of the population while about half of the population depends on subsistence agriculture for their livelihood. Agriculture accounts for 11.5 % of the GDP, industry 29.8 %, and services 58.7 % (Country Facts.com, 2003, pp. 2-3). Approximately half of the Namibian population lives in the northern region, of which the majority belong to the Owambo ethnic group that is comprised of several tribes. However, because there are few large industries in the region, most of the people who hold jobs are employed by government departments or by small and medium sized enterprises (SMEs).

According to the 2001 population and housing census, Namibia had a total

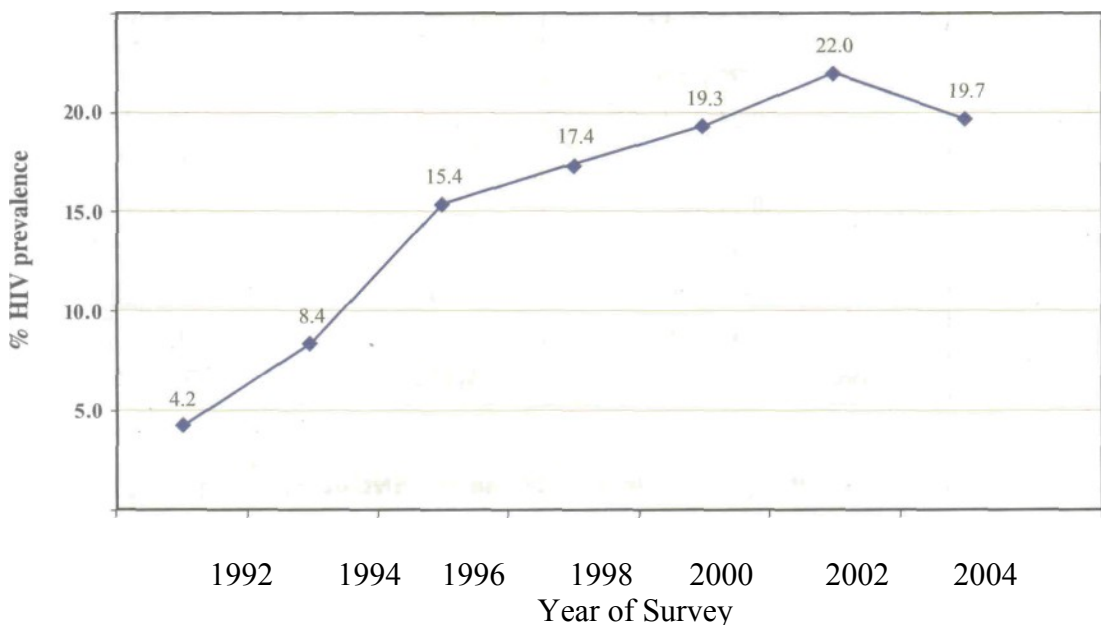
population of 1,830,330, with an annual growth rate of 2.6 % (Central Bureau of Statistics, 2001, p.1). By 2004, however, Countryfact.com (2004, p.1) estimated that the population of Namibia was 1,954,033 as of July that year. The population distribution in the country is 33 % urban and 67 % rural. At the end of the year 2000, it was estimated that 230,000 Namibians were living with HIV/AIDS. Overall, the pandemic appears to have stabilised with one in five women (20 %) who visit antenatal clinics, testing positive in 2006 (Ministry of Health and Social Services, 2007). The relatively stable trend since the mid 1990s in HIV prevalence among young, pregnant women (15-24yrs), and the rising trend of those in their 30s, suggests that prevention efforts need to be escalated (Ministry of Health and Social Services (MoHSS), 2007). During the last 10 years, the disease has become a serious public health problem. It remains one of the major obstacles to socio-economic growth because it deprives the country of scarce human and financial resources.

The 2004 National HIV sentinel survey estimated the prevalence rate among the adult population to be 19.7 %, compared to 22.0 % in the 2002 ANC survey. Pregnant women, ages 20-29 years, was a group that had a high rate of infection.

In Namibia's 13 regions, HIV prevalence ranges from 9 % in the Kunene region to 42.4 % in the Caprivi region. The highest prevalence indicated in the ANC survey was in Katima Mulilo (42.4 %), while the lowest rate was in Opuwo (8.5 %). The prevalence rate for Oshakati was 25.2 % (Ministry of Health and Social Services (MoHSS), 2005, p. 10). Statistics of the HIV pandemic in Namibia are based on ANC prevalence data. The "pre-epidemic" stage before 1992, characterized by a flat

prevalence curve was followed by the “epidemic” stage during which HIV prevalence rose quickly from 4.2 % in 1992 to 17.4 % in 1998 (see Figure 1 below). During the endemic stage, HIV remains in the population for many years; by 2002 it had reached an alarming high of 22.0 % but dropped to 19.7 % in 2004. Despite this decline, it is evident that preventative and health promotion activities that target specific age groups are urgently needed to ensure that HIV prevalence will drop and eventually stabilise at lower levels. Long-term, lower HIV prevalence levels in Namibia will depend upon the effectiveness of HIV/STD prevention education, on behavioural change, and through access to VCT and ART.

Figure 1 HIV Prevalence rate in pregnant women, biannual survey
1992 – 2004 in Namibia



Report of the 2004 National HIV Sentinel survey, Republic of Namibia Ministry of Health and Social Services, page 10.

1.2 PROBLEM STATEMENT

The ANC indicated that prevalence for Oshakati was second high of 25.2 % in 2005 (MoHSS, 2004, p. 10). The HIV/AIDS infection rate is high among the economically active population (15 to 49 years), the majority of which is employed by small and medium sized enterprises (SMEs) in Oshakati. The high incidence of HIV/AIDS is reported by all small and medium sized enterprises to have an adverse impact on their economic growth, as well as having a detrimental effect on the social well-being of their workers. The administrators and managers of these enterprises verbalised a need for prevention programmes and strategies in the workplace. Such programmes have not been established in every small and medium sized enterprise. In order to develop them, a detailed exploration and description of the socio-economic effects of HIV/AIDS on small and medium sized enterprises should be carried out. This view is supported by Gaomab (2004, p.2) who indicated that most large companies in Namibia have already implemented HIV/AIDS programmes in the workplace, while this is not the case in small and medium sized enterprises.

Based on this perceived deficiency, the researcher sought an answer to the following research question: What socio-economic effects does HIV/AIDS have on small and medium sized enterprises in Oshakati?

1.3 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study is to explore and describe the socio-economic effects of HIV/AIDS on the small and medium sized enterprises in Oshakati, Namibia, as a point of departure for SMEs to develop HIV/AIDS prevention programmes.

Specific objectives are:

- To explore and describe the socio-economic effects of HIV/AIDS on small and medium sized enterprises in Oshakati, Namibia.
- To analyse HIV prevention programmes already established in the workplace of small and medium sized enterprises in Oshakati, Namibia.
- To provide guidelines for small and medium sized enterprises that wish to develop HIV prevention programmes.

1.4 SIGNIFICANCE OF THE STUDY

Aside from contributing to building a body of information about the socio-economic effects of HIV/AIDS among SMEs in Oshakati, this study will also provide information that can be used to support policy lobbying, networking and empowerment in this sector. This study will also provide SMEs useful information about the magnitude of the socio-economic burden of HIV, which should be helpful for planning, strengthening or initiating HIV prevention programmes in the workplace. The study effectively provides a departure point for policy initiation and formulation in the area of HIV/AIDS within SMEs.

The information reproduced here is specific to SMEs in Oshakati, an important factor for providing important baseline information to “Namibianise” programmes in the workplace.

1.5 OPERATIONAL DEFINITIONS

1.5.1 Socio-economic effects

“Socio-economic effects” refers to the burden created by HIV/AIDS, and the challenges faced by small and medium sized enterprises in the fight against the disease. It also refers to responses from this sector as well as the economic and social costs resulting from the HIV/AIDS pandemic. Socio-economic effects are also measured by statistics of reduced productivity and disruption of business activities.

1.5.2 Small and medium sized enterprises

Classification of the size of an enterprise is based on the number of its employees. An enterprise of between 20 and 49 employees is regarded small, while one with 50 to 200 employees is regarded a medium sized enterprise. From this point in the study the abbreviation “SME” will be used to designate a small and medium sized enterprise.

1.6 THEORETICAL FRAMEWORK

1.6.1 Introduction

Nearly all research studies in the social and behavioural sciences, regardless of programmes, require a rationale or base for conducting research. This rationale is often called the theoretical framework (Radhakrishna, Yoder & Ewing, 2007, p. 62). Sekaran (2000) defines a theoretical framework as a conceptual model of how one makes logical sense of the relationships among several factors identified to be important. In essence, the framework attempts to integrate key pieces of information, especially variables, in a logical manner, thereby conceptualising a problem that can be tested. The theoretical framework usually frames the bigger picture of a study, identifies categories for literature review and directs research objectives. A typical theoretical framework provides a schematic description of relationships among independent, dependent, moderator, control and extraneous variables so that a reader can easily comprehend the theorised relationships (Radhakrishna et al., 2007, p. 62). The theoretical framework of study also applies to descriptive studies as this current study.

The goal of the descriptive researcher is to portray accurately the incidence, distribution, and characteristics of a group or situation. In essence, it describes “what is” part of a group or situation. In descriptive research, several variables are examined in order to describe a group or situation. Variables are not distinguished as independent, dependent, moderator or control. Descriptive research is conducted to

identify variables that can later be studied in depth. Usually, descriptive research does not involve testing a hypothesis. In this study the framework of the study will be divided into 3 components.

The framework of study will include an economic component that will examine the costs of HIV as well as production costs within SMEs. The economic component will address objective 1 of the study which is to explore the socioeconomic effects of HIV/AIDS on SMEs in Oshakati, Namibia. The economic component covered issues like effects of HIV on employees e.g. personal savings, use of income, expenditure on health and incidence of premature deaths. It also focused on effects of HIV/AIDS on SMEs including effects on labour force and business profits.

Objective 2 of the study was to analyse HIV prevention programs already established in the workplace of SMEs in Oshakati, Namibia. To address part of this objective a personnel management component will investigate the development of an HIV policy as well as make provision for care and support services. The other issues covered by the personnel management component include evaluation and monitoring of HIV policy and its review to accommodate changing information about HIV. Care and support services will focus on provision of treatment for HIV, STI and opportunistic infection within the SME worksite or employee referral to other treatment centres. This component will also focus on fair employment practices covering issues as discrimination, stigmatization, gender equality and need for recognition of social dialogue. Since these issues are addressed at personnel management level, it is the personnel management component of the framework of

study that will address objective 2 of the study.

A quality component of the framework will focus on HIV programmes in the workplace. This will address part of objective 2 of the study by focusing on issues of HIV workplace programs in place, HIV prevention education, including modes of delivery of this education. This component will also address objective 3 of the study which is to provide guidelines for SMEs that wish to develop HIV prevention programs. Knowing what is on the ground in terms of workplace programs helps to come up with guidelines as bridging gap between what is practiced and that which is not practiced. In order to adopt internationally recognisable guidelines and mould them to fit the Namibian situation it is important to have the background of HIV workplace programs and the quality component of the framework of study covers this area.

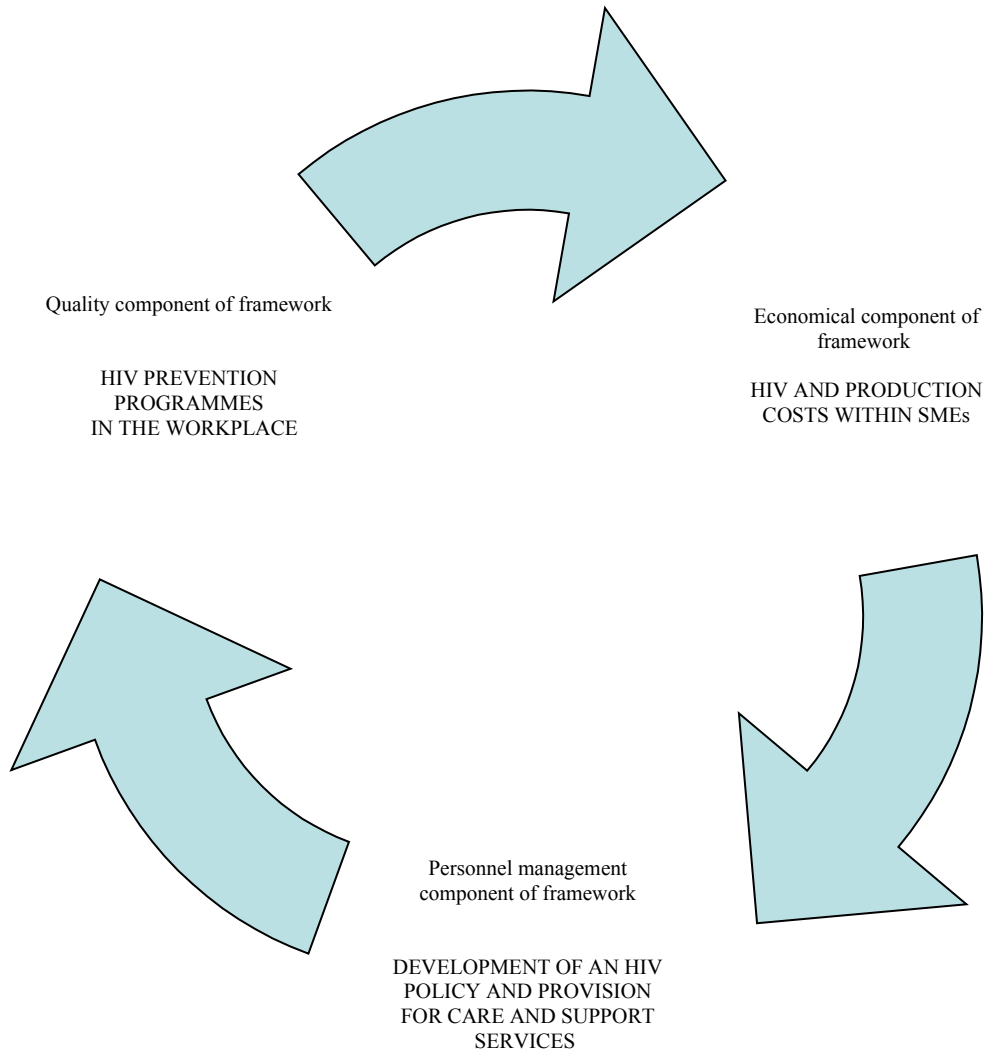


Figure 1.2 Framework for the study

Source: Sydney Chikukwa

1.7 SUMMARY

The foregoing chapter presented an overview of global, regional, and national estimates of the prevalence of HIV infection. It also introduced the purpose and the objectives of the study and stated the problem to be addressed and the significance of the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A discussion of literature will be based on the outline of the framework for the study given above. The framework will include an economic component that will look at HIV and production costs within SMEs. The personnel management component will look at development of an HIV policy as well as provision for care and support services. The quality component of the framework will focus on HIV programmes in the workplace.

2.2 BACKGROUND OF SMEs

According to Hamwele(2005, p. 3-4), SMEs are registered with the Ministry of Trade and Industry, and some work under the umbrella of “SME Compete”, a non-governmental organisation that provides financial and technical assistance in conjunction with USAID. Most of these enterprises have less than 200 employees. Growth in this sector has increased significantly since independence. However, rates of unemployment have significantly outpaced the growth of SMEs and the growth of the national economy. About 20 % of the total labour force of 76 000 persons, is employed in the SME sector, and it contributes about 12 % of GDP. This is a strong indicator that the SME sector should become a major player in creating socio-

economic stability. The writer further states that over the past three years contribution of SMEs to GDP have risen from 8% to 12%. The net, fixed capital formation, an indicator that reflects internal economic investment, clearly shows that SMEs are extremely important. This value is apparent when a specific economic activity is analysed relative to its contribution to one of two opposing factors: to cash strapping (exportation of capital) or to local empowerment. If it belongs to the first category, it helps close the gap between the rich and the poor. SMEs were born out of the need to boost economic development, eradicate poverty and reduce unemployment and the substantial income disparity existing in independent Namibia. The country has a youthful population with an average age of 18 years. For many of these youth the SME sector is their most likely, if not their only, source of employment. SMEs are particularly hard hit by HIV and AIDS as recent investigations reveal. Since owners are usually human resource managers, marketing managers, production managers, or finance managers, the sudden loss of one such key individual can often force closure of an enterprise. Most SMEs face a number of challenges and HIV/AIDS is one of the most critical (Hamwele, 2005, p.3-4). The communal agricultural

2.3 HIV INFECTION IN AFRICA

2.3.1 Key Characteristics of HIV/AIDS

The AIDS (Acquired Immune Deficiency Syndrome) pandemic is fairly new, with

the first AIDS related deaths registered only during the mid-1980s. AIDS is caused by a virus that attacks the human body's CD4+ lymphocytes — a key element in the body's immune system. This virus is commonly known as HIV, an acronym for Human Immunodeficiency Virus. To attack a person's immune system, the virus must enter the bloodstream. Transmission can occur through sexual intercourse, from an infected mother to her infant (through the placenta during birth, or via breast milk), through the infusion of contaminated blood or blood products or through intravenous injections using infected equipment. Given the modes of transmission, it is not surprising that the occurrence of HIV/AIDS is concentrated among infants and adults between the ages 20 and 40. People who are already infected with other sexually transmitted diseases are significantly more susceptible to HIV/AIDS infection through sexual intercourse than uninfected individuals. Furthermore, females appear to be at higher risk of becoming infected via heterosexual intercourse than males. People who are infected with HIV may lead relatively healthy and productive lives for many years, because the virus has a long incubation period. During this period, the virus gradually weakens the immune system and the body becomes increasingly unable to combat infections. Symptoms of HIV infection include chronic fatigue, diarrhoea, fevers, weight loss, skin infections and swollen lymph glands. The period of time between HIV infection up to the development of AIDS generally varies between three and twelve years. The second phase (AIDS) sets in when the body is no longer able to resist more severe opportunistic infections or diseases such as tuberculosis, bacterial pneumonias, meningitis, herpes and certain types of cancer and diarrhoeal diseases. AIDS victims usually die within one to two years of the onset of a severe infection or cancer. Although life can be prolonged

with anti-retroviral treatments, as yet there is no cure for HIV/AIDS (South African Business Coalition on HIV & AIDS (SABCOHA), 2003, p. 3). Put simply, AIDS is a fatal disease caused by the Human Immunodeficiency Virus, a virus that is mostly commonly acquired through heterosexual intercourse. HIV/AIDS primarily affects adults in their economically most productive years and does not spare the privileged. HIV/AIDS is already widespread, particularly in the developing world. These characteristics suggest that HIV/AIDS could be the most devastating disease man has ever faced, not only in terms of the demographic consequences, but also in terms of the economic implications of the pandemic in countries with a history of severe epidemics.

The virus, which destroys the immune system, leaving a person vulnerable to other opportunistic infections, primarily hits people of working-age and, as a threat, far exceeds any other to the health and well-being of working people in Namibia. Reliable data on the socio-economic burden of HIV/AIDS on SMEs in this country is scarce and imprecise, although the pandemic is definitely recognized as one of the major challenges facing this sector. SMEs are particularly hard hit by HIV/AIDS because owners usually fulfil multiple roles, including human resource managers, marketing managers and production managers. The sudden death or absence of such a key person in an organisation often means that the business will be forced to close (Hamwele, 2005, p. 4).

To illustrate the effect of HIV/AIDS on businesses, a study conducted in Swaziland revealed that 73% of the surveyed companies reported having an employee living

with HIV/AIDS, while 64% reported that the business itself felt the impact of HIV/AIDS (Muwanga 2001, p. 37). In a CDC survey, it was reported that 17% of medium sized work sites and 7% of small worksites had an employee with HIV/AIDS (Muwanga, 2001, p. 37).

The terminal stages of infection, i.e. AIDS, is associated with opportunistic infections such as TB, *pneumococcal* diseases, and *Pneumocystis carinii* pneumonia, *toxoplasmosis*, *candidiasis*, and AIDS associated cancers (Morrow, Colebanders & Chin, 1989). It is during this stage of protracted morbidity that sufferers usually seek medical treatment. This advanced stage of the illness results in economical consequences to companies, households and individuals.

2.4 ECONOMIC COMPONENT

2.4.1 Effects of HIV

HIV/AIDS has an adverse socio-economic impact on all levels of the economy and especially for SMEs. Profit margins for SMEs are tight, and access to officially organised support mechanisms is extremely limited. Most businesses in this sector are individually owned, and illness or death of the proprietor is likely to lead to a closure of the business. The pandemic threatens both livelihoods and productivity in both urban and rural areas. Women and children are the most seriously affected. In the case of women, this consequence is due to the double burden they carry: taking care of sick household members while having to earn a living at the same time

(Mckay, 2003, p. 3).

HIV/AIDS infection in a company's workforce has economic implications for both the employee and the employer. For instance, projections made in South Africa in 2003 indicated that AIDS related deaths in the work force could rise to 4000 per year by the year 2005. In economic terms, this means that HIV/AIDS might cost companies between 2% and 6% of all salaries annually (Connelly & Rosen, 2003, p. 223).

Costs can be both direct and indirect. Direct costs to SMEs include costs of healthcare and other employee benefits. However, since most SMEs do not provide medical benefits to their employees, the impact of HIV/AIDS on direct cost is not as much as would be expected (Muwanga, 2001, p. 38). Nonetheless HIV/AIDS is already causing a rise in the cost of employee benefits, and the cost of risk benefits is expected to double over the next five to ten years, unless those benefits are restructured.

2.4.1.1 Direct cost of HIV

Direct and indirect costs of HIV/AIDS appear to be the same for both informal and formal sectors. Direct costs include expenditure on medical care, drugs and funerals. Indirect costs include loss of time due to illness, recruitment and training costs to replace workers, and the care of orphans. These costs are usually synergic and

enterprises ultimately lose their profits and their potential to grow.

According to significant research focusing on sub Saharan Africa, the virus generally targets the working age population, affecting people in their most productive years. The result is reduced earnings, increased demands for care, increased expenditure on health care and premature death. The amount of money in savings and disposable income declines. In the long run, consumer markets are reduced, leading to a drop in resources available for production and investment. Reduced consumer demand, resources and investment possibilities directly affect economic growth. By the year 2020, the World Bank estimates that the macroeconomic effects of HIV/AIDS may be significant enough to reduce growth of national income by up to a third in countries with adult prevalence rates over 10 % (International Organisation of Employers, 2002, p. 8).

In a conference report (Ruggles, 2001, p.1) on the economic impact of HIV, it was noted that beyond AIDS related deaths, there is some evidence that AIDS is already increasing the cost of doing business. The virus has, in effect, created a payroll tax, as companies carry direct costs for treatment of sick employees and more expensive health and insurance benefits.

In a survey of Swazi business, it was found that prolonged morbidity and mortality due to HIV/AIDS has forced companies to increase their expenditure on medical care and funerals. Illness and death also mean a loss of skilled staff and experienced labour, which in turn produces a psychological impact on the workforce. An

accumulation of these factors results in increased costs of production through recruitment and training of new staff. The overall effect on a company is reduced productivity, disruption of business operations and reduced profits (Muwanga, 2001, p. 37).

A study done in 2002 on rapidly growing SMEs concluded that HIV/AIDS appears to be having negative socio-economic effects on many of them, increasing both direct and indirect costs. It was also noted that employee attrition rate to HIV/AIDS in the sample of surveyed companies, averaged 13.0 percent per year during the two-year period preceding the study (Connelly & Rosen, 2002, p. 7).

The pandemic has a clear impact on a company's profits through the following direct costs:

- **Increased costs** – with increasing number of employees falling sick, companies have to bear the rising costs of health insurance, sick leave and funeral benefits, as well as recruitment.
- **Declining markets** – HIV/AIDS threatens economic prosperity by putting national economies at risk. Increasing impact of AIDS on business deters investment and reduced output for foreign exchange.
- **Threats to the consumer base** – overall demand for goods and services decreases and companies are forced to be less dependent on their consumer base. Households are faced with increased healthcare expenditures and risk losing their sole income earner (HIV Learning Centre, 2005, p.1).

The greatest asset of most companies, their employees, is not spared by HIV, as demonstrated by heavy losses of employees due to the virus.

2.4.1.2 Indirect cost of HIV

Indirect costs accrued by enterprises include absenteeism due to illness and funeral attendance, loss of skills, training, recruitment, reduced performance on the job and lower productivity. It is estimated that between 10 to 15% of all highly skilled employees in South Africa will have contracted HIV by the year 2010 (Muwanga, 2001, p. 11). The combined effect of morbidity followed by mortality makes absenteeism due to HIV/AIDS a significant cost (Roberts & Ran, 1996, p. 8). In one case, that of a sugar mill with 400 workers in South Africa, a study revealed that the cost of HIV/AIDS to the mill amounted to about R9543 per employee. Absenteeism accounted for 28 % of that cost. In the survey of businesses in Swaziland, it was found that 58 % of the companies reported reduced productivity, 46 % reported increased cost, and 44 % reported disruption of business operations due to HIV/AIDS. It was noted that HIV/AIDS contributed to increased absenteeism in the workplace in 56 % of the Swazi businesses surveyed (Muwanga, 2001, p. 38).

The cause of lower productivity includes factors such as absenteeism and increased recruitment and training costs to replace lost staff. Companies can, to some extent at least, shift the costs of the pandemic to the public sector. For example, when health and life insurance costs rise, some companies will be forced to reduce benefits and

people will be forced to seek care from the public sector. However, in many developing countries the public sector is dysfunctional. Consequently the social, healthcare and financial burdens often fall on households and families. But governments face the same increased mortality and morbidity among infected staff as does the private sector, reducing the public sector's ability to maintain the expertise needed to respond to the pandemic (Ruggles, 2001, p. 1).

In countries heavily affected by the pandemic, companies report declines in productivity caused by the following factors:

- **Increased absenteeism**, due to illness, caring for sick family members and preparing for and attending funerals of family and friends.
- **Staff turnover**, due to death and illness (Company operations were forced to increasingly focus on training new employees rather than on company outputs).
- **Lower morale**, resulting from illness, suffering and loss of colleagues, friends and family (Low morale disrupts continuity in the workplace and in the community).

In the face of this unprecedented challenge, businesses — like the public sector and civil society — must respond decisively. Yet, despite the scale of the threat posed by HIV/AIDS, the business community has been slow to respond. The Global Business Coalition on HIV/AIDS seeks to encourage better attitudes among managers and to invigorate corporate activities, to urge the business sector to become a recognized and valued partner in the war on AIDS (HIV Learning Centre, 2005, p. 1).

2.4.2 Effects of HIV/AIDS on the labour force

An impact of HIV/AIDS to reduce the size of the labour force would be created when both employees and potentially employable people withdraw from the labour market. This effect is not yet measurable through reliable numbers. However, it has been anticipated that the labour force will continue to grow at a slower rate than it would have in the absence of AIDS (Coulibaly, 2005, p. 5). Regarding labour turnover, the study carried out with Swazi businesses found that 33% of the companies surveyed had experienced an increased loss of skills, with large companies affected the most. Illness or death of an employee results in a loss of skills available to a company with deleterious consequences for both the quantity and quality of the products it generates. The increase in labour turnover also has an effect on quality and quantity of final product since new employees require time to acquire the skills of those they replace and to perform their duties to full capacity.

Additional costs that an employer must carry due to staff turnover include recruitment costs, overtime wages to compensate for vacant positions, and the cost of in-service training to bring new employees up to capacity function. A salary must also be paid to the new employee during the training period. It was also discovered that about 31% of the companies that were studied in Swaziland reported increases in costs for recruitment and training (Muwanga, 2002, p. 39).

Another adverse socio-economic effect of HIV is measurable in a reduction of the total number man-hours generated by a company as a consequence of increased absenteeism due to illness, caring of sick family members and attending funerals. Early retirement of workers living with HIV would also decrease the total number of man-hours, due to losses associated with turnover time for staff replacement. Children of parents living with HIV, or parents who have already died from HIV related illnesses, would be forced to enter the labour market early in order to support their parents, relatives or themselves, increasing the incidence of child labour in some countries (Coulibaly, 2005, p. 7).

The direct costs of HIV will be registered through escalating medical scheme and employee benefit costs. It was predicted in 2002 that the cost of a moderate constellation of benefits would double by the year 2005 and treble by 2010. These increases could add about 15 % to the remuneration budget of a manufacturing company by 2005 (Muwanga, 2002, p. 40).

Psychological effects on employees were reported by 38 % of companies studied in Swaziland. These effects resulted from feelings of sympathy for sick colleagues (76%), perception of lost value in life following a colleague's death (11 %) or the rejection of a sick employee (13 %). Reduced concentration and a drop in morale, coupled with shouldering extra working hours to cover for sick colleagues, adds enormous stress for an individual. Workers will consequently utilise any free time they have to get away from company premises. While HIV/AIDS has negative effects on business production and costs, the pandemic equally affects the socio-

economic livelihood of workers and their families in a negative way. Absenteeism due to funeral attendance affects both an individual's and his company's productivity. Productivity and morale are affected as staff members empathise with the loss of their colleagues and peers. In addition to human resource and operational concerns, the effect of the pandemic on the workforce has significant economic costs (O'Grady, 2004, p. 4).

The pandemic has had a destructive influence and will continue to exert this influence on the family unit, causing the deaths of parents and leaving many orphans to fend for themselves. Many households are now run by children below the age of 15 years. This devastation has many socio-economic consequences. Orphaned children drop out of school to take up full time employment in order to look after their younger brothers and sisters. Unfortunately some are driven to prostitution or to alcohol and drug abuse, circumstances that further increase their risk of contracting HIV themselves. Some of these children become burdened with unwanted pregnancies, further straining their socio-economic circumstances.

HIV/AIDS has had devastating effects on countries' economies as well as on the global economy. Since the pandemic primarily hits the age group of economically active individuals, resulting in a reduction of skills and experience in the labour force, the output of the labour force has become correspondingly less. This reduction is directly caused by illness, absenteeism and the attrition of skills and experience distributed throughout the labour force. The socio-economic dependency ratio becomes a massive social burden on countries and the world in general, as large

numbers of people are forced into early retirement due to illness (Smart, 2006, p. 2).

According to research carried out by the University of Natal (2004, p.8), the incidence of HIV has already reached very high levels and is predicted to continue rising in Southern Africa for years to come. The rise in AIDS related deaths will change the social and domestic structures of the population. Households and individuals will suffer heavy economic burdens, while private companies and institutions in other economic sectors will feel effects of varying degree. Certainly, macroeconomic effects will be experienced over the long term. Health care, welfare and education systems will be adversely affected. The university goes on to acknowledge that HIV/AIDS is the greatest threat to development in Southern Africa, with the greatest concerns for the lives and circumstances of children. Innovation and commitment to fighting the pandemic will be necessary to reduce the magnitude of its consequences on this and future generations. Psychological effects of HIV on children stem from parental illness and death, educators' illness and death and an increase in the number of deaths in a child's extended family. The challenge of caring for a growing number of orphans will become increasingly difficult and the effectiveness of traditional coping mechanisms will be eroded. A rise in poverty can lead to more risk behaviour on the part of a young population, further fuelling the spread of the pandemic. The HIV pandemic increases poverty, though the relationship between them cannot be simply explained, as more resources may increase access to sex. To avert serious effects of HIV on SMEs, it will be imperative that companies put measures in place that will improve the welfare of their employees.

The role played by the private sector is critical if efforts to fight HIV/AIDS are to be effective and sustainable. Businesses have diverse resources that can be easily and cost-effectively utilised. These include financial resources, management and marketing skills and access to workers, consumers and communities. Besides, the private sector is an ideal forum for the dissemination of information.

No business in South Africa is immune from AIDS. Many South African companies already have policies to deal with HIV/AIDS, but these are often inadequate because leadership has failed to react strategically to the pandemic. It is vital for business leaders to bear in mind that sick employees cost their employer money, but treatment costs less. If an employee continues working throughout the disease cycle and initiates treatment only in the final stages, the company will have carried both the cost of illness (e.g. lower productivity and increased absenteeism), and the price of treatment. Also, premature death results in early payments from group life, pension and medical benefits, adding further to the costs of the disease. Each potential infection that a company's prevention programme can successfully avert saves the costs that would have been incurred had that employee become infected. Studies have shown that the financial benefits that investment in prevention and treatment programmes will bring certainly exceed their costs (South African Business Coalition against HIV/AIDS (SABCOHA), 2003, p. 22).

While many businesses seem to have underestimated the future impact of HIV/AIDS on their own organisations, they are becoming increasingly aware of the costs

associated with HIV/AIDS in the form of increased absenteeism, staff turnover and recruitment and training costs, not to mention the direct costs of medical care, insurance, retirement funds and funeral costs. As more and more employees fall ill and die from AIDS, business leaders have become increasingly concerned about the overall impact the disease will have on their organizations. The fact that the majority (69%) of the survey questionnaires in this study were completed by a Chief Executive Officer, Managing Director or owner of the company, suggests that the private sector considers HIV/AIDS to be a serious threat (Muwanga, 2003, p. 23).

In a nutshell, the worrisome effects of HIV/AIDS include:

- HIV/AIDS raises the cost of doing business, reduces productivity and lowers the overall demand for goods and services.
- HIV/AIDS results in a loss of experienced personnel. As less experienced staff replaces experienced staff, productivity may be reduced.
- It raises levels of absenteeism. As HIV infection progresses to AIDS, affected workers will be off work more regularly.
- It raises recruitment and training costs.
- It increases labour turnover.
- It results in increased health care costs and disability and pension payouts.

The establishment and implementation of HIV/AIDS policies and workplace programmes will not only help reduce the spread of the pandemic, it will also reduce the disease's impact on companies. The need for a company policy arises from the

necessity to develop an organised, formalised response to the pandemic. An HIV/AIDS policy is a written document that sets out an organization's position and practices as they relate to HIV and AIDS. SABCOHA (2003, p.22) further states that a policy should not only give guidelines how a business should behave toward employees who are HIV positive, but should also provide a framework for action that can reduce the spread of HIV/AIDS and manage its impact. An HIV/AIDS policy will provide an informative point of reference concerning the rights of both employers and employees, and how these rights should be applied in practice. A good policy will also attempt to strike a balance between productivity and profitability on one hand, and a humane, fair and socially responsible response on the other. The development of a policy is only a part of a larger process. The real challenge lies in how to translate policy into practice. A policy provides an important foundation upon which workplace HIV/AIDS programmes can be built.

2.5 QUALITY COMPONENT

2.5.1 HIV Workplace Programmes

Although the HIV/AIDS pandemic has become a major concern for SME providers, the Joint Consultative Committee (JCC), which co-ordinates SME activities in Namibia, said that HIV/AIDS programmes designed specifically for SMEs do not exist in Africa (*Namibia Economist*, 2003, p.1). A reason for this deficiency is that most of the materials on the subject have been developed for large organizations, are often costly and demand extensive resources to assemble. Because SMEs are the

engines driving economic growth, as well as the amelioration of poverty and unemployment, and the redress of socio-economic disparities, it is imperative that HIV/AIDS workplace programmes should be devised specifically for Namibian SMEs. Locally relevant programmes will enable business leaders to identify with their content. The formal workplace usually provides opportunities for practical, sustainable, and effective interventions to reduce the risk of HIV/AIDS. Unfortunately workers in this sector, the largest concentration of individuals who have “needs without voices”, lack these benefits in the workplace, because they are excluded from or under-represented in social dialogue and processes that involve institutions (Mckay, 2003, p. 2).

Freelance operators and workers without fixed wages will be reluctant to attend training sessions or HIV-related activities that eat into their work time, unless these activities are clearly useful and adapted to their circumstances. Management should keep the following factors in mind:

- If your enterprise is not a local agency, link up with community workers or organizations that have experience in the area of implementation when you initiate your programme;
- Training should not interfere with a worker’s primary concern with earning a living. Therefore, consult and find out what works best for operators — consider after-hours activities near their homes, or one-on-one training in short sessions near the workplace;
- Be considerate of household and family responsibilities. If possible, offer care

for their children while participating in training;

- Request local authorities or NGOs to use their premises for training, so that venues can be established as close as possible to the operators' places of work or homes. Some market places have stores or lock-up rooms that they might make available;
- Some operators work in insecure areas and need their sites guarded while they are away, even for short periods of training;
- Literacy levels of participants may be low. Therefore it is important to keep training and general communication simple and clear. Use training material that is visual and interactive;
- Integrate HIV training with other activities that provide perceivable benefits to operators, such as training in technical or numeracy skills.

It is especially important to ensure that activities are relevant to both women and men, and are organized in a way that is sensitive to their different needs and circumstance (International Labour Organisation (I.L.O.), 2007, p. 14).

In South Africa, the current demand from SMEs for HIV/AIDS workplace programmes is low. There are clear and consistent reasons for a lack of action by SMEs and these are constraints that will limit their ability to implement HIV/AIDS workplace programmes (Connelly & Rosen, 2003, p. 220). SME managers and owners seriously lack information on HIV/AIDS issues because they rarely receive unsolicited information from health care or HIV/AIDS service providers. They often lack human resource expertise as well (Connelly & Rosen, 2003, p. 221). Most

managers of SMEs are unwilling to pay HIV/AIDS-related expenses or for associated benefits. Because the majority of workers employed by SMEs are unskilled, managers believe that it will cost them less to replace those workers than to implement HIV/AIDS workplace programmes. This view was stated by most SME managers surveyed (Muwanga, 2001, p. 39). For instance, nearly 66% of the SMEs surveyed in South Africa incurred no direct cost due to recruitment and training. Employers' demand for, and utilisation of, HIV/AIDS programmes is also minimised through the stigma attached to the disease by their employees. There is little pressure on them to provide such a programme — few ethical expectations, little internal pressure or external pressure from trade unions or shareholders and the absence of a tradition for investing in human capital or community.

Fifteen years ago, if a call had been made for business, labour, governmental and NGO representatives to discuss a strategy to deal with HIV/AIDS collectively, the majority would not have had even a fleeting idea of what it would entail, let alone why it should be discussed. In today's world, companies have lost top managers, workers have lost colleagues, and a huge amount of time and energy has been spent on the emotionally laden issues involving illness and loss. Whole families have collapsed while companies, struggling against a background of chronic poverty, have taken on a deeper burden of dependency. HIV/AIDS causes illness, disability and death to workers and severe economic and emotional disruption of their families. It also increases the cost of doing business. Prevention of disease and the promotion of good health are not commonly regarded as business concerns. The HIV/AIDS pandemic has forced a reconsideration of this position (Smart, 2006, p. 1).

A majority of the managers of big companies are now concerned with how to protect their workforce from HIV infection and how to relate to those who are already infected (I.O.E., 2002, p13). Courses of action taken by companies largely depend on the prevalence rate among their staff, in surrounding communities and the level of knowledge and awareness about the effects of the pandemic on the part of management. In a survey conducted in South Africa, it was discovered that firms reporting the loss of any workers to AIDS had a slightly greater tendency to offer HIV/AIDS-related services than firms that did not report such losses (Connelly& Rosen, 2004, p. 8).

Most importantly, owners/managers and workers need to enter into a dialogue and decide collectively what measures should be taken. The involvement of workers' families, local suppliers, and neighbouring enterprises, as much as possible, is also of great benefit.

The following points should be covered by companies as part of basic information about HIV/AIDS:

- The meaning of the acronyms HIV and AIDS; reliable information on how HIV is transmitted and facts that dispel misinformation about its transmission.
- Facts and myths about HIV/AIDS and how to address issues of stigma and discrimination.
- Differentiation of the risks faced by women and men, and the ways that gender

inequality fuels the pandemic.

- Prevention of HIV infection, especially information about the correct use of condoms.
- Living with HIV, encompassing care and treatment, and the importance of a person knowing his or her status.

The following means can be employed to enhance the effectiveness of communication about the above mentioned topics. Develop, adapt or use existing materials to create awareness. These materials may be in the form of posters, signs, ribbons, news clips on notice boards, talks, video presentation, live theatre, radio, television, competitions (advertised through posters), sponsored events, messages inserted in pay packets, in-house magazine articles or newsletters and discussion sessions.

It may not seem effective or even possible to develop a policy for a small workplace. However, should an employer make even a small commitment to take some action to address the problem of AIDS, morale among staff will be raised and trust in management will increase. A policy does not need to be a lengthy document. It merely needs to promise workers they won't suffer discrimination because of their HIV status, and make a commitment on the part of the company to organise activities related to prevention the disease and care for workers who have become infected. Employers should be encouraged to draft a statement that draws on contributions from workers. This document should be posted where it can be seen by suppliers, customers (if relevant) and staff (I.L.O., 2007, p.15). To ensure that these

programmes for the workplace are effective, specific components need to be co-opted.

2.5.1.1 Components of an effective workplace programme

The informal sector is the hardest hit by the HIV/AIDS pandemic because of a deficit of information, resources and education. For example, though most businesses in Swaziland are willing to implement workplace prevention programmes and to commit available resources to them, lack of knowledge about how to implement a programme hinders them from taking appropriate action (Muwanga, 2001, p. 32).

Workplace prevention programmes must address the following issues (International Organisation for Employers (I.O.E.), 2002, p.16):

- Developing an HIV/AIDS policy.
- Providing HIV prevention education in the workplace is critical to long term success in the fight against HIV.
- Providing care and support in the workplace.
- Implementing fair employment practices that include non-discriminatory treatment of workers regardless of HIV status.
- Enlisting community involvement in the fight against HIV.

2.5.1.2 HIV prevention education

Education on HIV is a critical prevention tool in the fight against the continued spread of HIV. Provision for an HIV prevention education programme in the workplace should aim to help employees avoid becoming infected with HIV, at the same time teaching them to accept infected colleagues. In a supportive environment of created through education and training, staff members are less likely to discriminate against infected colleagues. A training programme provides both managers and employees a platform for the exchange of information about HIV.

Education also helps reduce anxiety and stigmatization related to the presence of HIV in the workplace because it contributes significantly to attitude and behavioural change. In developing a prevention programme, the cultural diversity of workers should be taken into consideration, as should factors such as age, gender, sexual orientation, occupation and risks predisposing employees to HIV infection.

The I.O.E. (2002, p.14) recommends that educational programmes designed to facilitate prevention of the spread of HIV should:

- Provide basic information about HIV/AIDS, about fair treatment of people living with HIV, and concerning a company's HIV policy.
- Discuss and promote HIV/STI prevention methods that include providing condoms and instruction how to use them correctly to prevent infection.
- Promote safety awareness.

- Provide clear information will address the concerns of staff members about working with people infected with the HIV virus.

The success of a programme is facilitated by a number of factors. These include the following:

- Implementing the programme during company working hours.
- Participation of top management in the programme.
- Structuring sessions of the programme so that they are presented to workers divided into small groups.
- Making participation mandatory for all workers.
- Structuring sessions to allow time for discussion of content.
- Reinforcing its value through periodic follow-up and through a pre- and a post-programme monitoring survey that assesses workers' knowledge about the subject.
- In addition, companies need to demonstrate commitment by establishing personnel management policies to address HIV.

2.6 PERSONNEL MANAGEMENT COMPONENT

2.6.1 Developing an HIV/AIDS policy

As part of developing a company policy for HIV, an official statement should be

made about the company's position and practices on the subjects of preventing transmission of HIV and how it plans to deal with HIV infection among its employees. It is important to structure this policy statement in conformity with local and national laws as well as setting standards of expected behaviour for all employees. In addition, the policy should offer guidance to employees how they can address HIV/AIDS issues and where they can go if they need assistance.

The I.O.E. (2002, p.16), advocates the following issues for drafting and maintaining a viable company policy:

- It includes worker participation in its drafting.
- It is communicated to everyone in the company in simple, clearly formulated terms.
- It must be reviewed periodically and subsequently updated in light of changing epidemiological data, dynamic therapeutic responses to the pandemic and relevant scientific information.
- It is monitored to promote successful implementation.
- It is evaluated to test whether implementation was in fact successful.

2.6.2 Care and Support Services

A policy should to make provision for certain care and support services. Care, support and treatment are fundamental elements of an effective response to HIV pandemic. To mitigate the socio-economic effects of the HIV/AIDS pandemic in the

workplace, counselling and other forms of social support for workers should be provided (I.O.E., 2002, p. 19). Voluntary testing, treatment of sexually transmitted infections (STIs) and provision of ARVs are other appropriate and effective response mechanisms.

Where health facilities are not available in the workplace, workers should be informed to which institutions they can turn for services outside the company. These often cater to the needs of workers' families. Also, implementing fair employment practices ensures that the workplace provides a non-discriminatory environment that respects the rights of all employees, and is supportive of those infected with HIV.

2.6.3 Fair Employment Practices

According to the International Labour Organization (I.L.O., 2002, p. 3) code of conduct, key principles of fair employment practices include:

- No discrimination regarding employment related to a person's HIV status.
- Continuation of employment not affected by HIV status.
- Observance of confidentiality in a healthy and safe working environment.
- Upholding gender equality in all interventions for prevention and coping.
- Provision for counselling and testing on a voluntary basis, without the use of screening for HIV as a prerequisite for employment or recruitment.
- Recognition of the need for social dialogue, prevention programmes, care and

support as fundamental to address the pandemic in the workplace.

- Willingness to make alternative working arrangements for employees with HIV/AIDS.

2.7 SUMMARY

The foregoing chapter reviewed the literature, in the context of the framework of the study, comprised of an economic component, a personnel management component and a quality component. The economic component describes the direct and indirect economic effects of HIV on SMEs, focusing on productivity, costs and the labour force. The personnel management component addresses management's policies on HIV in the workplace. How programmes can be designed is described in the quality component, emphasising the elements that would make a programme functional in the workplace.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter takes an in-depth look at both the design and methodology of the research. The main purpose of the study is to explore and describe socio-economic effects of HIV/AIDS in small and medium sized enterprises in Oshakati, Namibia, prerequisite to developing prevention programmes for HIV/AIDS in that business sector.

Specific objectives are:

- To explore and describe the socio-economic effects of HIV/AIDS in small and medium sized enterprises in Oshakati, Namibia.
- To analyse HIV prevention programmes for the workplace currently in place in small and medium sized enterprises in Oshakati, Namibia.
- To provide guidelines for small and medium sized enterprises who wish to develop HIV prevention programmes.

3.2 RESEARCH DESIGN

The research design seeks answers to the research question (Polit & Hungler, 1997,

p. 153). The design is a general plan or blueprint that describes how the research will be conducted. It focuses the kind of study proposed and its desired result. It begins with a problem, or question, and in the context of the logic of the research, determines what kind of evidence will address the research question adequately (Mouton, 2002, p. 56). A descriptive and explorative study was conducted utilising quantitative methodology.

3.2.1 Exploratory Design

An explorative research study is conducted when little information is available regarding the phenomenon under investigation (Brink, 1996, p. 209). There is limited understanding about the effects of HIV on SMEs in Namibia. Consequently, this study seeks to produce insight in-depth regarding the socio-economic impact that HIV/AIDS has on SMEs, so that effective prevention strategies can be developed and implemented.

Exploratory research begins with the phenomenon then investigates its true nature, how it manifests itself and what other factors are relevant to it (Polit & Hungler, 1997, p. 20-21). The research evaluated information perceived to be essential so that the objectives of the study could be addressed. Though studies about the effects of HIV on SMEs have produced valuable information on the phenomenon, it has not been investigated in the Namibian context, where scarce information is available.

3.2.2 Descriptive design

A descriptive design is used to investigate a phenomenon and the manner in which it manifests itself (Polit & Hungler, 1997, p. 21). The researcher sought to describe the effects of HIV on SMEs as well as evaluate the workplace programmes currently in place. Babbie and Mouton (2001, p. 80) explain that the major purpose of scientific study is to describe situations and events. The research presented here defines descriptive components for a quantitative study of the effects of HIV on SMEs and also to measure the effectiveness of workplace programmes already in place in SMEs in Oshakati, Namibia.

3.3 RESEARCH METHOD

Research methodology focuses on the research process and the tools and procedures utilised. Beginning with the tasks it must accomplish, namely data collection and sampling, it focuses on individual steps in the research process, trying to employ objective, i.e. unbiased, procedures (Mouton, 2002, p. 56). Quantitative data is information that can be numerically measured and analysed. This involves computer analysis of statistical data to test its significance. Quantitative research methodology facilitates easy comparison of data and reproduction of results (Brink, 1996, p. 120). In this study, quantitative descriptive statistical methods were used. Graphs, tables and pie charts were used to present the data and the Statistical Programme for Social Studies (SPSS) was used to analyse the data.

3.4 STUDY POPULATION

A population is any defined group that is selected as a subject for research. If a population can be defined, from oxygen molecules in the universe to supercomputers in the world, then it can be subjected to study and analysis (Melville & Goddard, 1996, p. 29). A study population includes all the members, or units, of a group that can be clearly defined in terms of its distinguishing criteria, whether they are people, objects or events (Uys & Basson, 1991, p. 86). The population of the current study is defined as all SMEs in Oshakati that employ between five and 200 people. Although the exact size of this population is unknown, the office for SMEs at the University of Namibia (Haukongo, personal communication, February 15, 2007), has estimated that there are at least 200 SMEs in that area. Of this number, 100 employ between five and nineteen people, 60 employ between 20 and 49, and the remaining 40 employ 50 to 200. For the purpose of the study, these SMEs were divided into three strata according to the size of their workforce. Enterprises with between five and 19 employees are regarded as “very small”, enterprises with 20 to 49 employees are classified as “small”, while those with 50 to 200 employees are classified as “medium sized”.

3.4.1 Inclusion Criteria

To be included in this study, an SME must be based in Oshakati and employ a workforce between 5 and 200 people. Registered as well as unregistered SMEs were included in the study. Another criterion is an operational minimum of at least one

year.

3.4.2 Exclusion Criteria

This study excluded SMEs that employed less than five and more than 200 people.

Those that had been in business for less than a year were also excluded.

3.5 SAMPLING

A sample is a group of people or elements that form part of a study population. Results from a study of the sample allow general observations to be made about the entire population (Melville & Goddard, 1996, p.30). De Vos (2002, p. 199) defines a sample as a small portion of the total set of the population; together they comprise the subject of the study. A sampling is the most feasible way of studying large populations, given resource, time and financial limitations.

Though the size of the target population has not been accurately established, as stated above it is comprised of at least 200 SMEs. A sample of 170 SMEs responded to the questionnaire distributed during the study. Some SME managers who received the questionnaire were either too busy or unwilling to respond for personal reasons.

Because a sample frame, i.e. a list of SMEs in Oshakati, was not available, all “known” businesses were approached for the purpose of the study. A sample frame is the basis for all probability sampling techniques. If an enterprise could be

identified, it was classified as “known”, and consequently as accessible. It can therefore be claimed that the total “known” population was included in this study, and a sampling from that population was not taken.

Because it is possible that some businesses exist in the target population that could not be found or identified, and were therefore excluded from the study, the probability factor cannot be calculated and the findings may not be statistically generalised. For those SMEs that participated in the study, company representatives completed research questionnaires on company premises.

3.6 DEVELOPMENT OF THE QUESTIONNAIRE

The tool used for data collection was a questionnaire developed to address the aforementioned objectives. The questionnaire contained three sections: **section 1** solicited information for compiling a company profile, **section 2** addressed the socio-economic effects of HIV/AIDS and **section 3** gathered information concerning HIV/AIDS at the workplace.

Initially, a draft questionnaire was sent to three supervisors for their comments. Before the questionnaires were finalised and distributed, the questions themselves were refined or modified based on feedback received from these supervisors. The final questionnaire was prepared after all the issues raised by them had been clarified and the questions reformulated correspondingly.

The questionnaire also accommodated the framework of the study. **Section 2**

addressed the economic component and **section 3** addressed the personnel management and quality components of the framework.

Table 3.1 Questionnaire development process

Questions	Linkage to the framework	Literature control	Comments
5, 7 and 10: Absence from work, funerals, death of workers, suppliers and customers.	Economic component	Muwanga, 2001 I.O.E., 2002	Rationale: absenteeism, death of workers, suppliers and customers affects business profits and productivity.
12 to 15: HIV Policy Other policies	Personnel management component	I.O.E., 2002	Rationale: policies on HIV and related topics are essential as personnel management tools to improve the income of their workers, thereby maximising profits.
16 to 21: HIV workplace programmes	Quality component	Namibia Economist, 2003 Muwanga, 2001	Rationale: by improving the health of workers, companies reduce absenteeism, prolong life and maximise production and profits.

3.7 VALIDITY

According to De Vos (2002), validity is the degree to which an instrument actually measures what it intends to. Different kinds of validity may be established: content validity, face validity, criterion validity and construct validity. Content validity is concerned with the adequacy of the sampling to address the content of an instrument. Face validity refers to whether the instrument appears to measure the relevant construct.

In this study face validity and content validity were determined, while criterion validity did not apply. To establish face validity, the questionnaire was submitted to three colleagues and the two supervisors for this thesis. They were asked to evaluate the questions and the thesis outline in relation to the objectives of the study (Polit & Hunger, 1997, p. 374). Confirmation from them ensured that the questions actually assessed the test characteristics identified by the researcher. The responses were then compared with a gold standard measurement of the desired characteristics being assessed (Hulley et al., 2001, p.241). To establish content validity, existing literature and policies on HIV/AIDS and SMEs were referenced.

3.8 RELIABILITY

Reliability can be defined as the accuracy or precision of an instrument. In general, reliability refers to the extent to which independent administration of the same instrument (or similar instrument) consistently yields the same results under

comparable conditions (De Vos, 2002, p. 168). In this study reliability was tested through a pilot study (inter-rater reliability) and enhanced by the researcher's thorough familiarity with the environment in which the study was conducted. Reliability improves automatically when a researcher is familiar with the research environment.

In order to ensure consistency in the measurement of attributes and to check that every notable change would be observable and not due to the measurement process, the instrument was tested for reliability. The instrument may be subjected to a test-retest technique, based on the assumption that the phenomenon to be measured remains unchanged at two times of testing and that any change is the result of random error (Dipoy & Gitlin, 1998, p. 203).

3.9 PILOT STUDY

To determine whether the research process and instrument would produce the desired data, a pilot study was carried out. By conducting a pilot study, a researcher orientates himself and identifies possible defects in the planned study (De Vos, 2002, p. 210).

The instrument was pilot tested on seven SMEs that were eligible for the survey but excluded during convenience sampling. This enabled the researcher to assess relevance and accuracy of the questionnaire in terms of information retrieval and relevance. As described above, the aspect of inter-rater reliability was established

during the pilot testing phase.

3.10 PILOT STUDY REPORT

The questionnaire was prepared and sent to supervisors for checking. The supervisors queried some issues that were unclear and gave approval for the pilot study after those issues had been addressed and the relevant content reformulated in the questionnaire.

The pilot study was carried out in Oshakati between the second and ninth of October, 2007. All seven companies that responded did not have an HIV policy in place. To minimise the time needed to complete the questionnaire, the respondents received special instructions to skip those questions not applicable to them because their company had no HIV policy.

The scale provided to answer questions 5 to 13 was confusing to the respondents because they found it difficult to quantify the magnitude of the problems using it. It was revised for the main study. In the revised questionnaire, respondents were asked whether or not they experienced particular problems in that area of the study.

Questions 10 and 11 are nearly the same. In particular, question 11 is repetitive: “declining intellectual capital” and “loss of tacit knowledge” express the same idea. “Declining staff relations” in question 11 and “decreased staff morale” in question 10 are similar. Consequently, in the revised questionnaire, these two questions were

eliminated. Some important issues highlighted by the original two questions were incorporated in other questions. Since the aspects covered in original question 11 and 10 were similar, it was necessary to delete these 2 questions and incorporate only issues not covered in other questions. This had no effect on the objectives as the issues were still contained in other questions but only removed to avoid repetition.

Questions 21 and 22 address care and support services. All seven companies piloted did not have these services. However, the questions were still included in the revised questionnaire due to the relevance and importance of these services.

Some of the words used in phrasing questions were difficult to understand and were exchanged for simpler ones. However, those words for which a simple alternative could not be found were left unchanged in the questionnaire. Difficult words and phrases included “stigmatization”, “eroded financial earnings” and “high staff turnover”. However, substitutes for most of the complicated words in the questionnaire were found and were inserted in the revised tool.

In general, managers and owners of SMEs felt that completing the questionnaire required too much of their time because it was too long. Because these high level managers are critical to the ongoing operation of their organization, they consider their time too precious to use for non-business related activities. On average, the questionnaire took 20 to 30 minutes to complete. Revising the questionnaire so that the time required was reduced to half, was the best way to ensure reliable data. This was achieved by removing duplicate questions and scales provided in questions 5 to

13. However these didn't affect the purpose and objectives of the study as outlined in the paragraphs above.

Another challenge sometimes presented itself, when the researcher arrived for an appointment, only to find that the manager or owner who had agreed to participate in the study was not available or not on the premises. The appointment would have to be rescheduled, even several times in some cases. From these circumstances, it became apparent that the task of collecting data from 200 SMEs would prove difficult.

3.11 DATA COLLECTION

With help from research assistants, the researcher distributed structured questionnaires to CEOs, human resource managers or owners of SMEs. The instrument was used to collect data on the following subjects:

- Socio-economic effects of the pandemic, specifically on production costs, reduced productivity and disruption of business activity, addressing the relationship between morbidity and mortality due to HIV-related illness.
- The scope of the HIV/AIDS policy, provisions for preventative education, care and support at the workplace.
- Mitigation strategies and community involvement in the enterprise.

It was necessary to include these subjects in order to achieve the objectives of the

study. The first subject synthesized enough data to address objective 1 of the study. Issues like morbidity and mortality cover both socio and economic effects of HIV/AIDS and production costs, reduced productivity and disruption of business cover economic effects of HIV/AIDS. In order to establish and analyse HIV workplace programs within the SMEs, it was necessary to gather information on scope of the HIV/AIDS policy, provisions for preventative education, care and support at the workplace, thus the inclusion of the second subject above. To provide comprehensive guidelines on HIV/AIDS workplace programs, it was imperative to collect information on all mitigation strategies and any community involvement of SMEs and hence the inclusion of the third subject in the questionnaire.

Since the research centred on socioeconomic effects of HIV/AIDS among SMEs it was necessary to involve people in charge of SMEs to respond to the questionnaire as they were in good position to have answers to most questions. These people included owners, human resource managers and CEOs of most of these SMEs.

Data was collected between the end of October 2007 and the end of February 2008. Research assistants distributed and collected questionnaires, and clarified any queries concerning the completion of the questionnaire. The research assistants were given comprehensive training which covered the objectives, and purpose of the study. The research assistants were oriented on how to approach SMEs. Their competency was tested through group practice and after the researcher was satisfied they were then sent out to distribute and collect questionnaires.

3.12 DATA ANALYSIS

The data was presented as descriptive statistics and evaluated with quantitative, computerised statistical techniques, using SPSS. To evaluate the data, the researcher enlisted assistance from a professional statistician. The information obtained with the structured questionnaire was assembled as a database.

- The questions were coded using the SPSS programme.
- Data from the questionnaires was entered with the SPSS programme.
- Data was compared and contrasted.
- Descriptions were formulated to represent the synthesis of informational material (Langford, 2001, p. 158).

3.13 ETHICAL ISSUES

Conducting research implies the acceptance of responsibilities. A researcher is responsible to fellow researchers, to respondents, to society as a whole and, most importantly, to himself (Melville & Goddard, 1996, p. 113). A high professional standard regarding confidentiality was strictly maintained. De Vos (2002, p. 64) identifies ethical issues that are of utmost importance for the researcher. For permission to engage SMEs as participants, chief executive officers, human resource managers and owners were contacted and written consent obtained from them to include their SMEs in the study.

SMEs received detailed written information about the purpose and objectives of the

study to help them make informed decisions about whether or not to participate. Participants were assured that any information they would divulge would be treated with confidentiality and respect for privacy (Brink & Wood, 2001, p.301). Company names were not recorded on the instrument and all forms of identification that could make it possible to trace responses to a company were eliminated by use of codes.

The ethical issues that were observed during the conduct of the study are discussed below.

3.13.1 Permission

Permission to conduct the study was sought from the University of Namibia Post Graduate Committee. The written proposal was reviewed by the committee to ensure that it conformed to ethical standards of scientific research. Before individuals were recruited as participants, their written consent was obtained.

3.13.2 Participant protection

De Vos (2002, p.64) cites the view of Dane (1990, p.44) that a researcher has an ethical obligation to protect a participant against any form of harm that could result from their participation in a study. It is the obligation of the researcher to inform a potential participant about the research study beforehand, and to protect participants conscientiously and completely. It is difficult to determine whether a participant could potentially incur harm during a study and the possibility should not be

rationalised away by saying that the study might benefit them in some way.

3.13.3 Informed consent

A researcher is obliged to obtain informed consent from all participants. The researcher provided adequate information regarding the purpose and procedures of the study, about the rights of the participants. Information was also supplied to establish the credibility of the researcher. Participants were informed that they could withdraw from the study at any time. In this study, informed consent was sought when the questionnaire was administered, using a participant information leaflet (see annex 1).

3.13.4 Deception of participants

De Vos (2002, p. 66) cites the view of Loewenberg and Dolgoff (1988, p. 70) that a researcher is guilty of deception when he or she provides information to another person that is not true. He further explains that the difference between deliberate and unintentional deception should be clarified, as it is possible for a researcher to be unaware of the falsity of a piece of information imparted. Such a possibility needs to be discussed candidly with participants during or immediately after a query concerning the truth of any information is raised. To ensure participants would not be deceived the researcher provided an information leaflet with all the information about the research as well as official letter from UNAM outlining the research topic of this researcher.

3.13.5 Right to privacy and voluntary participation

In an increasingly public and transparent world, scientists need to be extremely vigilant that their actions or statements do not violate a subject's rights to privacy.

The right to privacy is expressed more concretely through the following principles.

A person has the right to:

- refuse to be interviewed;
- refuse to answer questions;
- not be interviewed at meal time;
- not be interviewed at night; and
- not be interviewed for a long duration (Mouton, 2002, p. 243)

De Vos (2002, p. 67) cites the views of Singleton, et. al. (1988 p. 454) that privacy is a participant's right to decide to whom, when, where and to what extent his attitudes, beliefs and behaviour may be revealed. Privacy is synonymous with self-determination and confidentiality. Self-determination refers to an individual's right to decide voluntarily whether or not to participate in research (Polit & Beck, 2004, p. 732). It is the responsibility of the researcher to obtain informed consent from a participant whenever information of a private nature is solicited in a study. In this study participants were given information about the objectives of the study through participants information leaflet. Their informed consent was sought after they had

read and understood the purpose and objectives of the study. The participants were assured that their responses were private and confidential.

3.13.6 Anonymity

Informants have the right to remain anonymous. That right should be respected both when it has been promised explicitly and also when no clear agreement to the contrary has been made (Mouton, 2003, p. 243). Anonymity is preserved when a person's acts or statements are revealed without a disclosure of his or her identity (Le Beau, 1998, p. 33). In this study the participants' responses were anonymous as no name of participant or company was recorded on any questionnaire.

3.13.7 Confidentiality

All participants in the study were assured that the information and opinions they shared would be treated with strictest confidentiality. They were assured that data would only be used for the stated purpose of the research and that no other person would have access to interview data. This condition is reflected by Le Beau (1998, p. 33), who states that confidentiality entails that information shared by someone is not divulged to others. No name of participant or their enterprise was recorded on any questionnaire.

3.13.8 Benefits

The benefits that the research intended to produce were thoroughly explained to the participants to encourage them to give candid and honest responses. They were also informed that the gathered data would be used to assess the effects of HIV and improve HIV prevention programmes in the workplace of SMEs.

3.14 SUMMARY

The foregoing chapter focused on research methodologies. The study population, sampling and data collection methods, reliability and validity were described. Ethical issues were also discussed, addressing permission to conduct the study, participant protection, informed consent, confidentiality, among others.

CHAPTER 4

RESULTS OF THE STUDY

4.1 INTRODUCTION

This chapter of the thesis presents the findings of the research on the socio-economic effects of HIV/AIDS on SMEs in Oshakati, Namibia.

4.1.1 Purpose and Objectives of the Study

The purpose of the study is to explore and describe the socio-economic effects caused by HIV/AIDS in small and medium sized enterprises in Oshakati, Namibia, prerequisite to developing HIV/AIDS prevention programmes. Specific objectives are:

- To explore and describe the socio-economic effects of HIV/AIDS on small and medium sized enterprises in Oshakati, Namibia.
- To analyse existing HIV prevention programmes in the workplace in small and medium sized enterprises in Oshakati, Namibia.
- To provide guidelines for small and medium sized enterprises who wish to develop HIV prevention programmes.

In the following paragraphs, the research questions and employer responses are

presented and discussed in the order they appear in the questionnaire. Questions and responses are divided into three categories, according to business profile, socio-economic effects of HIV/AIDS and responding to HIV/AIDS.

Companies were categorised according to the number of employees and Table 4.1 below present the findings.

Table 4.1 Stratification of SMEs

5-19 employees	very small enterprises
20-49 employees	small enterprises
50-200 employees	medium sized enterprises

4.2 COMPANY CHARACTERISTICS

Businesses were asked to indicate the sector under which their enterprise falls, the gender distribution of their employees as well as provide an employee skills profile.

Tables 4.1 to Table 4.3 present the data.

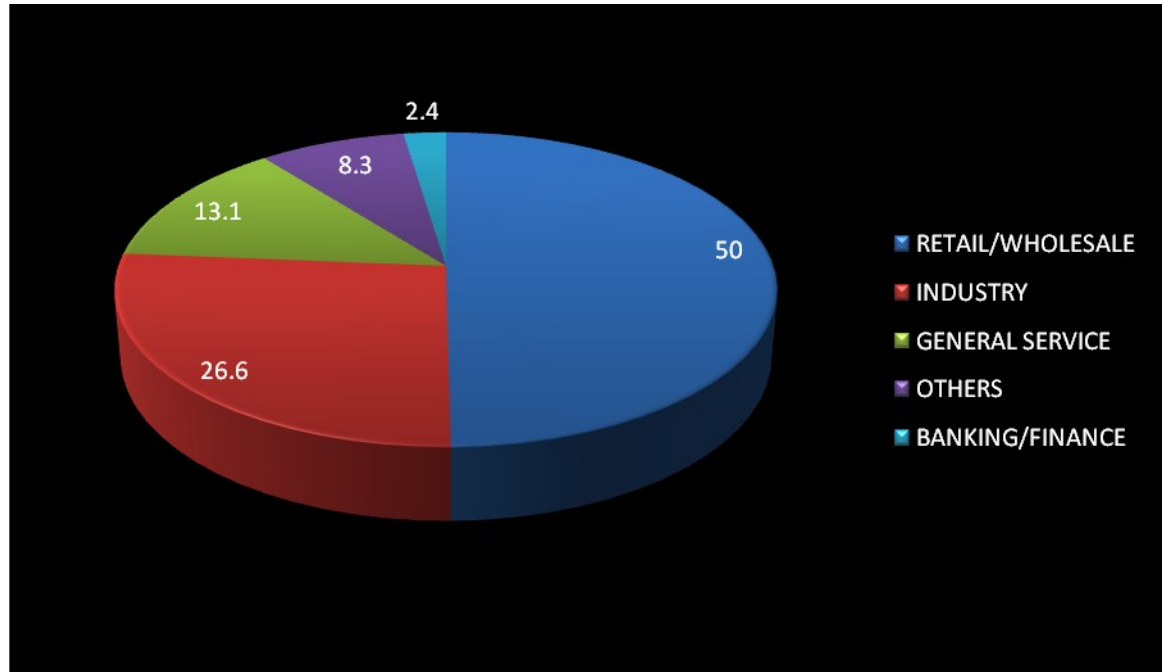
4.2.1 Size and business sector of SMEs

Participants were asked to indicate the number of employees at their worksite as well and the type of business sector in which they operate. Table 4.2 and Fig 4.1 presents the data.

Table 4.2 SMEs type and size

TYPE OF BUSINESS	Company size (number of employees at worksite)			Total (n=168)
	Very small 5-19 (n= 134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
INDUSTRY	27.6 % (37)	15.4 % (4)	25 % (2)	25.6 % (43)
RETAIL / WHOLESALE	46.3 % (62)	65.4 % (17)	62.5 % (5)	50 % (84)
FINANCIAL / BANKING	1.5 % (2)	7.7 % (2)	0	2.4 % (4)
GENERAL SERVICES	14.9 % (20)	7.7 % (2)	0	13.1 % (22)
OTHERS	9.7 % (13)	3.8 % (1)	12.5 % (1)	8.9 % (15)
TOTAL	100 % (134)	100 % (26)	100 % (8)	100 % (168)

Fig4.1: Overall Proportional (in percentages) distribution of all SMEs by sector of business



Many SMEs in the “very small” category and very few in the “medium sized” category participated in the study. Of the 168 SMEs that were surveyed, 134 were very small, 26 were small and 8 were medium sized. The three main respondents all belonged to the retail/wholesale sector. This sector constituted 46.3 % of the very small SMEs, 65.4 % of the small SMEs and 62.5 % of the medium sized SMEs. Half of the surveyed SMEs belonged to the retail and the banking and finance was the least represented (Fig 4.1)

In a survey conducted by the South Africa Business Coalition on HIV & AIDS (SABCOHA, 2003, p. 26), it was noted that out of 1006 companies that participated, 51 were large, 165 were medium sized and 790 were small. The sample size to company size ratio of that study’s sample was comparable to the current research,

which also included many very small SMEs and very few medium sized SMEs. Some of the SMEs that participated in the study are involved in businesses that cannot be easily categorised and do not belong to one of the primary sectors identified. They include companies like fitness centres and private schools.

In a study of 45 businesses conducted in Swaziland on effects of HIV in business, 40 % employed between 21 and 49 people, 25 % employed between 50 and 99 people, 18 % employed 100 to 249 people, 11 % employed 249 to 599 and 6 % employed 600 or more. Of these companies, six were from the agricultural sector, three each were from the construction and distribution sectors, seven were from manufacturing, one was from transport and 25 were from services (Muwanga, 2001, p.12). The proportional distribution of the sample to size and sector in the Swazi study was nearly the same as the sample of current study.

4.2.2 Gender distribution of employees by SME Size

The participating managers were asked to categorically state the actual number of male and female employees at their worksite. Table 4.3 presents the findings.

Table 4.3 Gender distribution of employees by SME size

Gender distribution of employees	Business size (number of employees per work site)			Total
	Very small 5-19 (n=1166)	Small 20-49 (n=740)	Medium size 50-200 (n=860)	
Total number of employees in the sector				(n=2766)
Total Females	49.1 % (572)	49.1 % (363)	29.2 % (251)	42.9 % (1186)
Total Males	50.9 % (594)	50.9 % (377)	70.8 % (609)	57.1 % (1580)

***n is the actual number of employees at work site and is used as the denominator in percent calculations. This also applies to table 4.4 below.**

Table 4.3 above indicates the gender distribution of employees by size category. The SMEs surveyed employed a total of 2766 employees, of which 42.9 % were female and 57.1 % were male. The very small and small SMEs employed almost equal numbers of males and females, approximately 49.5 % females and 50.5 % males. It was these two categories that employed the highest number of women. This ratio can be attributed to the fact that retail sales outlets prefer hiring women over males. In the medium sized SMEs, 29.2 % of the employees were female and 71.8 % were male. These figures may be due to the fact that women are actively involved in the job market as breadwinners for families and also, are either owners or important providers of labour in small family businesses.

4.2.3 Skills profile of employees by SME Size

Participants were asked to indicate the breakdown of skills of their employees. The findings are listed in Table 4.4 and Fig 4.2 below. The data is further presented to represent the overall picture within all SMEs in Fig 4.3 below.

Table 4.4 SME skill profiles by size

Business skill profile	Business size (number of employees at work site)			Total (n=2766)
	Very small 5-19 (n= 1166)	Small 20-49 (n=740)	Medium 50-200 (n=860)	
Number of skilled employees	31.9 % (372)	43.7 % (324)	26.2 % (225)	33.3 % (921)
Number of semiskilled employees	38.1 % (444)	33 % (244)	46.6 % (401)	39.4 % (1089)
Number of unskilled employees	17.2 % (200)	12.3 % (91)	27.2 % (234)	18.9 % (525)
Unsure of skill profile	12.9 % (150)	10.9 % (81)	0	8.4 % (231)
Total	100.1%	99.9%	100%	100%

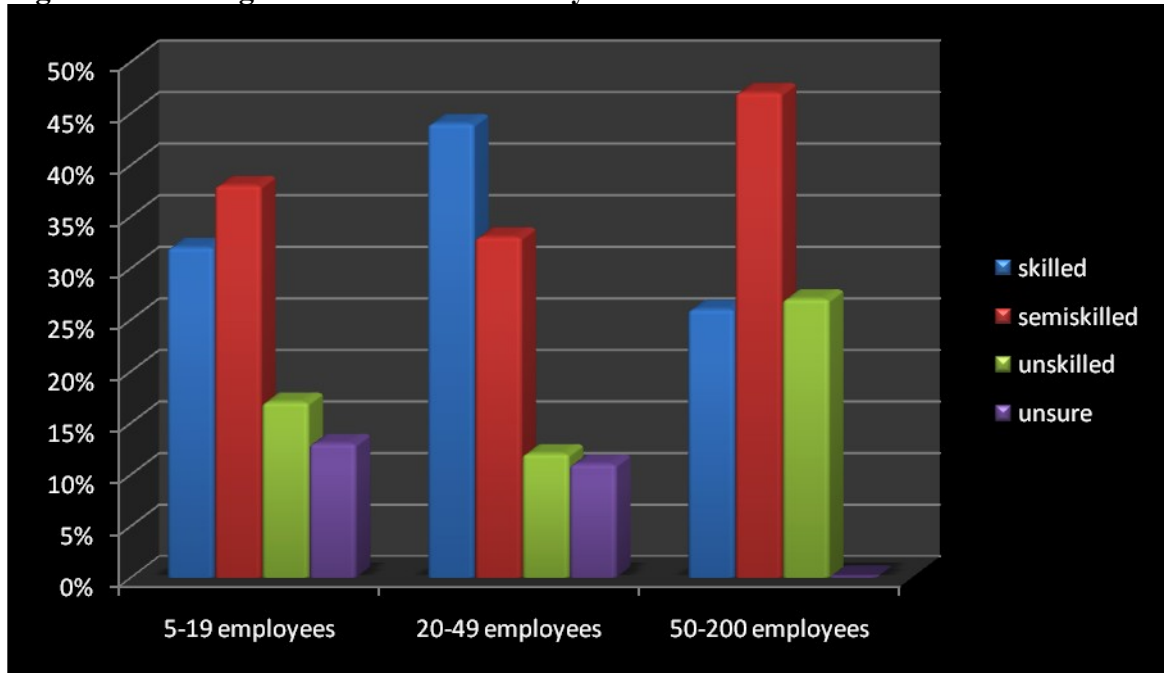
Fig 4.2: Percentage SME skill structure by size

Fig 4.3: Overall skill structure in all SMEs.

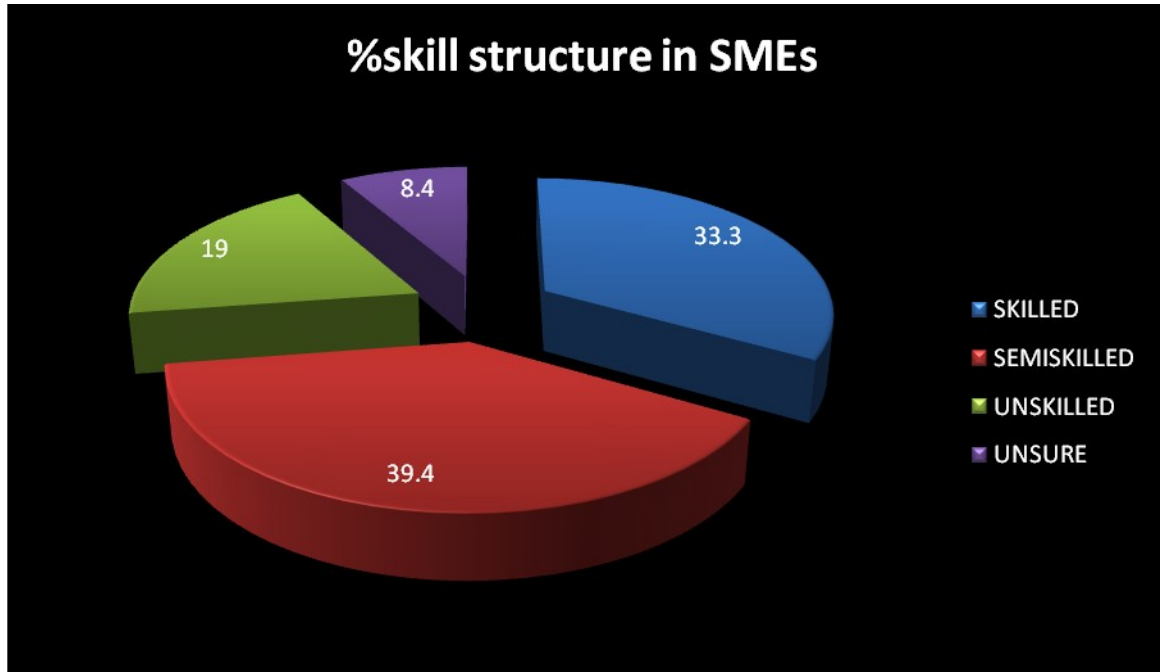


Table 4.4 and Fig 4.2 indicate the skills profile of the SMEs surveyed. The data reveals that 33.3 % of employees are skilled, 39.4 % semiskilled and 18.9 % unskilled. 8.4 % of the respondents were unsure of the skills profile of their employees. The majority of employees in the SMEs surveyed were semiskilled or unskilled. This is a typical breakdown for small and medium sized enterprises. The distribution of skills structure for the enterprises surveyed was not influenced by the size of company, as all categories showed an almost identical pattern, with the largest percentage being semiskilled employees and smallest percentage being unsure of the skills profile.

Skilled employees have certificates of competence in their respective fields issued by institutions of higher learning. Semiskilled employees have no certificate of competence but have received formal, practical training. Employees regarded as unskilled have neither certificates of competence nor received any formal training. They work as manual labourers, with ad hoc instructions or under direct supervision. Commonly, semi- and unskilled workers are particularly vulnerable to HIV/AIDS, due to a lack of education and financial resources to deal with HIV/AIDS (SABCOHA, 2003, p. 26).

In the context of HIV/AIDS, a decline in productivity or output on the part of an affected employee may vary depending on the level of skills and experience, but is generally greater with educated employees than with their unskilled co-workers. Statistics on the incidence of disease according to level of skills indicate mixed findings. A survey of blood donors in Malawi found higher infection rates among educated than among unskilled employees. In Zambia 62 % of the deaths registered among managers between 1984 and 1992 were caused by AIDS. This rate was slightly higher than for employees with mid-level positions but slightly lower than that for those with low-level position (I.L.O., 2000).

Data from Zambia confirms the absence of significant differentials based on skill levels, as between 1984 and 1992, HIV/AIDS accounted for 56 % of the deaths among all employees, 71 % among lower level employees, 57 % among middle level employees and 62 % among top level managers (Chinga'ambo, 1995, p.10).

4.3 SOCIO-ECONOMIC EFFECTS OF HIV ON SMEs IN OSHAKATI

Participants were asked if they had experienced a case of an employee with an HIV related illness, one who had died of HIV/AIDS or had resigned due to HIV in the past year. They were also asked if they had experienced cases of employees with sickness, death or resignations due to causes not related to HIV/AIDS. Because this kind of information is recorded in medical records that are not readily available due to issues of confidentiality, it was understood that responses would be based primarily on the perceptions of management. Because an element of bias is naturally associated with answering a question like this, a follow up question was posed to establish the source of the information that was provided about cases of sickness, death or resignations due to HIV.

In some instances, employees could fall sick or die due to HIV/AIDS related illness without knowledge on the part of management. People infected with the virus are often very secretive about their status due to the stigma attached to HIV. In addition, poor communication between employer companies and the institutions that treat infected people only deepen this secrecy (Muwanga, 2001, p. 15). Considering the issues that hinder or prevent the open sharing of information on the subject, the data presented here should be regarded as giving only a partial picture about the actual effects of HIV on SMEs in Oshakati.

4.3.1 HIV Related illness, resignation and death relative to SME size

Participants were asked if their company had experienced any cases of HIV related illness, resignation and/or death during the past year. Table 4.5 and Fig 4.4 presents the findings.

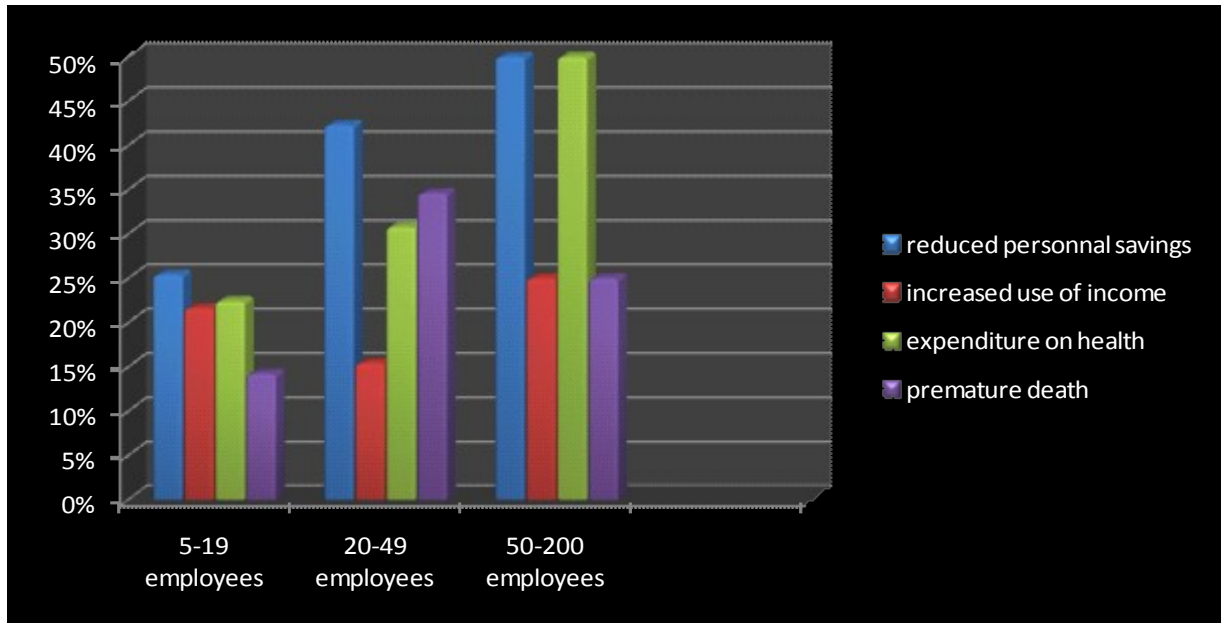
Table 4.5 SMEs that have experienced HIV related illness, resignation or death by size

SMES experienced	SME size (number of employees at work site)			Total (n=168)
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
HIV related illness	53.7 % (72)	57.7 % (15)	62.5 % (5)	54.7 % (92)
HIV related resignations	47 % (63)	50 % (13)	62.5 % (5)	48.2 % (81)
HIV related deaths	48.5 % (65)	57.7 % (15)	62.5 % (5)	50.6 % (85)

*n is the actual number of SMEs surveyed and numbers in brackets represent SMEs that experienced the particular problem, NB. Some companies experienced more than one problem at the same time e.g. 72 out of 134 (53.7%) very small SMEs experienced HIV related illness. In this study only 168 SMEs were surveyed.

This applies to all tables that are presented in this study except otherwise stated as foot notes.

Fig 4.4: Percentage of SMEs (by size) that have experienced effects of HIV effects on employees



Because of the kind of data supplied, table 4.5 and Fig 4.4 provides an indication of the socio-economic effects on SMEs as a result of illness, resignation or death due to HIV/AIDS.

Comparing SMEs on the basis of size indicates that the larger an SME is, the greater will be the extent of HIV related illness and deaths. A similar trend is seen in HIV related resignations, with very small SMEs showing a rate of 47 %, small SMEs, 50 %, and medium sized SMEs, 62.5 %. The study revealed that very small and small SMEs were affected worst by illness, while medium sized SMEs were affected to an equal degree in all the parameters measured.

A similar finding was reported by a survey conducted in South Africa in 1998 in which 16 firms were polled whether the company prevalence rate was known, and

whether HIV/AIDS had created problems for the company. Neither a major retail company nor a publishing house reported having felt any impact of HIV/AIDS to that point, while a major platinum mining company reported that four employees died every month due to AIDS. A major industrial company recorded a 31 % increase in the number of retirements due to ill-health between 1995 and 1997. Of these retirements, 17 % were due to AIDS (Galloway & Stein, 1998, p. 9).

In Swaziland AIDS related illness is currently the leading cause of death among employees in that country, contributing to over 60% of all deaths recorded. The pooled AIDS mortality rate is currently 10.54/1000 employees each year, while the crude mortality rate of Swazi employees is 16.77/1000 employees per year (Muwanga, 2004, p. 54). The current study confirms these findings that HIV/AIDS contributes to employee sickness, resignation and deaths.

In a survey of Kenyan agro-estates, it was discovered that the most important reason for employee resignations was illness and death due to AIDS (Rugalema, Weigang, & Mbwika, 1999, p. 39).

4.3.2 Sources of information on HIV/AIDS related illness, resignation and death

To seek validation for the information given on employee resignations and deaths, the source of that information was asked from the managers that participated in the study. Table 4.6 presents the findings.

Table 4.6 Sources of information on illness, resignation and death in SMEs

Source of information	SME size (number of employees at worksite)			Total (n=168)
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
Other employees	9 % (12)	15.4 % (4)	0	9.5 % (16)
Medical practitioners	7.5 % (10)	15.4 % (4)	12.5 % (1)	8.9 % (15)
Rumours	6.7 % (9)	23.1 % (6)	25 % (2)	10.1% (17)
Family and friends	2.2 % (3)	11.5 % (3)	12.5 % (1)	4.2 % (7)
Nursing personnel	3.7% (5)	19.2% (5)	12.5% (1)	6.5% (11)
Unsure/not clear	33.6 % (45)	26.9 % (7)	25 % (2)	32.1 % (54)

The study revealed that the majority of participating managers were unsure or not clear about the source of information about HIV related illness, resignation and deaths. Rumours marked the second most common source of information in small and medium sized SMEs. It can therefore be deduced that the workforce of larger

SMEs are more prone to produce rumours about the HIV status of employees, verified by 23.1 % in small SMEs and 25 % from medium sized SMEs, compared to 6 % from very small SMEs. But in general, participants were not very sure about the source of information linking HIV/AIDS to cases of illness, resignation and death. Therefore, personal perceptions could be the most important factor.

4.3.3 Effects of HIV/AIDS on employee livelihood by SME size

The managers of SMEs were also asked questions about the effects of HIV on their employees. These questions focused primarily on the factors of personal savings, use of income, expenditures for health care and premature death. Findings are presented in table 4.7.

Table 4.7 Managers' perceptions on the effects of HIV on employee livelihood by size of SME

Effect of HIV on employees	SME size (number of employee at work site)			Total (n=168)
	Very Small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
Reduced personal savings of employees	25.4 % (34)	42.3 % (11)	50 % (4)	29.2 % (49)
Increased use of income by employees	21.6 % (29)	15.4 % (4)	62.5 % (5)	22.6 % (38)
Increased expenditure on health care by employees	22.4 % (30)	30.8 % (8)	50 % (4)	25 % (42)
Incidence of premature death among employees	14.2 % (19)	34.6 % (9)	25 % (2)	17.9 % (30)

The study found that the employees of most SMEs experience HIV related effects. These effects become more pronounced with the increasing size of SMEs, very small enterprises showing the least and medium sized ones experiencing the most effects.

Very small SMEs showed reduced personal savings as the dominant effect of HIV and the incidence of premature death to be the least significant effect. However, the four polled effects were registered nearly to the same degree for very small SMEs.

Managers of small SMEs also reported reduced personal savings as the dominant HIV related effect on employees but an increased use of income by employees as the least significant effect. The effects polled were also nearly uniformly felt in this size category, though the overall magnitude of the effects was slightly higher than experienced by very small SMEs.

In the medium sized SMEs, all polled effects on employees were felt uniformly and at a higher magnitude when compared with the very small and small SMEs. The dominant effect reported was increased use of income and the least significant effect was the incidence of premature death. Overall, the employees of medium sized SMEs were the worst affected.

The inability to work and the eventual death of employees both reduce the volume of work produced by a company and consequently reduce revenue to both employees and the company. Increased expenditures on medical treatment and funeral costs represent a significant increase in expenditures of both employees and employers (Isaksen, Songstad & Spissoy, 2002, p.11). These assertions are also confirmed by the findings of the current study regarding increased expenditures in SMEs, as reported by the managers surveyed. HIV/AIDS also increased the expenditures on employee welfare by organisations in Swaziland. The costs identified were increased utilisation of healthcare, and the cost of funerals and death benefits. Companies in Swaziland spend 2.65 % of their total wage bill on HIV/AIDS related costs (Muwanga, 2004, p. 54). These findings are similar to those reported in the current study.

4.3.4 Employee behaviour towards colleagues with HIV/AIDS

Many owners of SMEs who are HIV positive decide to keep their status secret out of fear of discrimination. They also fear stigmatization by suppliers, employees, clients and the local community. Employees also suffer from the negative attitudes and behaviour of colleagues and employers, and fear they might be dismissed from employment due to their HIV status (International Labour Organisation, 2007, p.7). In addition, personal relations at work may also prove very strenuous for people living with HIV. For these reasons, the behaviour of employees towards their colleagues infected with HIV was assessed in this study. The findings are presented in table 4.8 below.

Table 4.8 Managers' perception and experience of employee behaviour towards colleagues who are suspected of or have been confirmed HIV positive

Behaviour of employees	SME size (number of employee at worksite)			Total (n=168)
	Very Small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
Stigmatize infected employees	0.8 % (1)	7.7 % (2)	12.5 % (1)	2.4 % (4)
Discriminate against infected Employees	2.2 % (3)	7.7 % (2)	25 % (2)	4.2 % (7)
Accommodate infected Employees	23.1 % (31)	42.3 % (11)	75 % (6)	28.6 % (48)
Afraid to get HIV from infected employees	0.8 % (1)	3.8 % (1)	12.5 % (1)	1.8 % (3)

The findings established that a high level of tolerance is shown toward employees

infected with HIV in the SMEs of all size categories. But especially in smaller enterprises, like institutions run by families, employees tend to accept infected colleagues more easily than is the case in medium sized enterprises. The latter employ more people of different backgrounds and diverse cultures and diverse people tend to treat one another with higher levels of intolerance. This tendency is revealed by the finding of a higher incidence of discrimination (25 %) in medium sized SMEs compared to 2.2 % in very small SMEs. Despite this difference, SMEs in all three size categories showed a high degree of accommodation of HIV infected employees and very few SMEs reported cases in which employees were afraid of infection from a colleague living with HIV. This liberal attitude confirms that basic facts about HIV transmission are understood.

In the spirit of recent efforts to increase tolerance and the growing trend in regarding the rights and dignity of persons infected or affected by HIV/AIDS, there need be no discrimination whatsoever against employees on the basis of established or assumed HIV status. Discrimination against and stigmatization of people living with HIV/AIDS inhibits efforts to prevent the spread of the disease (I.L.O., 2001, p. 3).

4.3.5 Effects of HIV/AIDS on the labour market

The labour market has not been spared by the pandemic. During the current survey, questions were posed to the managers of SMEs concerning the effects of HIV on the labour force. These questions focused primarily on staff replacement, child labour, extra hired labour and demand for higher wages. The findings are presented in Table

4.9 below.

Table 4.9 Effects of HIV on SME labour force

Effects of HIV on labour force	SME size (number of employee at work site)			Total (n=168)
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
High staff replacement	14.2 % (19)	42.3 % (11)	50 % (4)	20.2 % (34)
Increased use of child labour	18.5 % (31)	11.5 % (3)	50 % (4)	22.6 % (38)
Increased use of additional labour	14.9 % (20)	15.4 % (4)	37.5 % (3)	16.1 % (27)
Increased demand of high wages	11.9 % (16)	42.3 % (11)	37.5 % (3)	17.9 % (30)

The study revealed that the size of an SME played a significant role on the ultimate magnitude of effects of HIV/AIDS on the labour force. The effects on very small SMEs were the least significant and on medium sized SMEs the most significant. The major effects of HIV/AIDS on labour were a high rate of staff replacement and an increased dependency on child labour. When compared to very small and small SMEs, medium sized SMEs were the hardest hit by these effects because of their size.

Increased dependency on child labour and additional labour are the major effects experienced by very small SMEs. High rates of staff replacement and increased demands for higher wages were the two major effects on the labour force of small SMEs due to HIV/AIDS. For the medium sized SMEs, the effects on labour were

high but increased dependency on child labour and increased staff replacement were the most serious effects. Since small and medium sized SMEs have more employees on their worksites, they are more likely to have higher rates of death or resignation due to illness. To maintain production levels these enterprises are forced to replace employees or turn to child labour to compensate for the higher attrition. These findings correspond with the findings of a study conducted by the Uganda Railway Corporation mentioned below.

A shortage of labour due to illness and death is the most obvious effect of HIV/AIDS on industry. Enterprises always suffer from a diminished supply of labour, loss of employees and changes in the composition of the labour force. A high turnover in the work force necessitates that more resources are diverted into training and education of new staff. The Uganda Railway Corporation recorded a labour turnover rate of 15 % per year in the early 1990s (Isaksen et al., 2002, p. 26).

In a study of eight African countries that have HIV prevalence rates above 10 % of the adult population, namely Botswana, Kenya, Malawi, Namibia, South Africa, Uganda and Zimbabwe, an international labour organisation estimated that the Labour force in the year 2020 will be 10 to 22 % smaller — about 11.5 million people — than it would have been had HIV/AIDS not been a factor (I.L.O., 2000). The loss of employees, often skilled and experienced, exacerbated by increased entry of young, unskilled personnel into the labour market, is likely to decrease both the size and the quality standards of the work force (Isaksen et al., 2002, p. 27). These findings correspond to findings of the current study that showed most SMEs reported

a loss of employees.

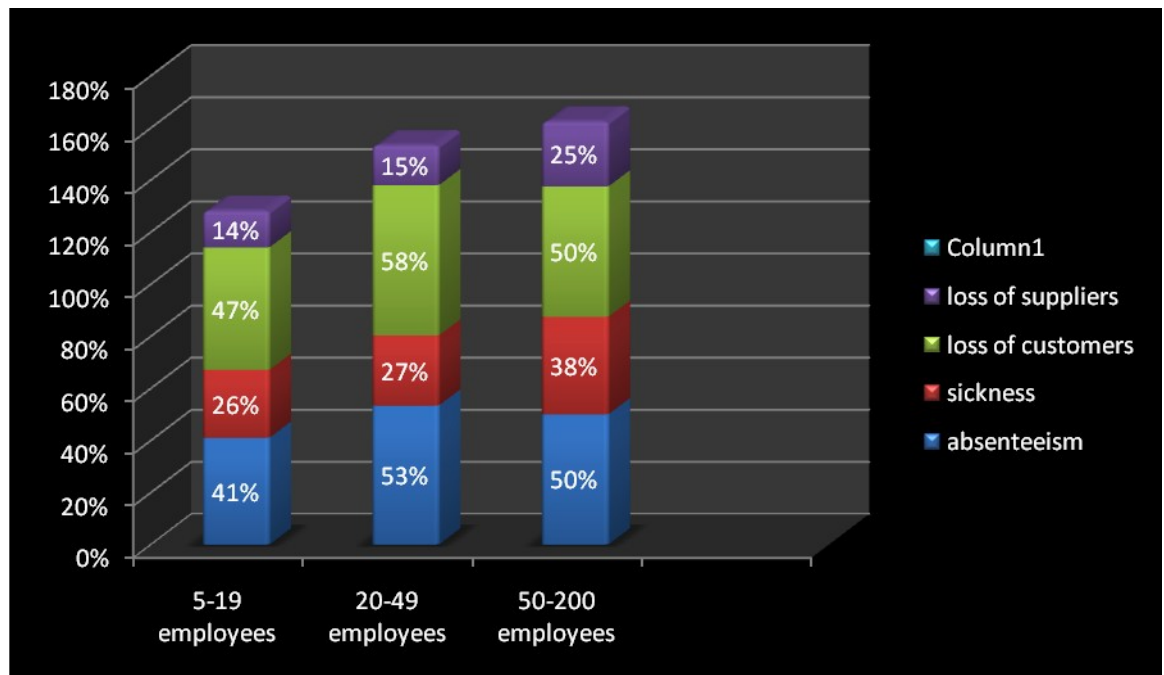
The immediate impact of HIV on skilled urban labour may be less obvious because of a greater capacity in that environment to substitute labour with capital. However, AIDS deaths cause greater long term damage to industry, since the possibility of replacing highly skilled workers with equally qualified people is lower and its cost higher. In Zambia, 78 % of 18 companies surveyed in 1993 argued that labour productivity had yet to be affected by AIDS (Cornia & Zagonari, 2002, p. 6). In contrast, most SMEs surveyed in this study reported that labour productivity has been affected by HIV/AIDS. The Zambian findings may have been influenced by the fact that the survey was conducted 15 years ago and the effects of HIV may not have been obvious, or even significant, at that time.

4.3.6 Effects of HIV/AIDS on the profits of SMEs

Table 4.10 and Fig 4.5 presents data on the effects of HIV/AIDS on profits experience by SMEs in Oshakati. These effects are brought on by factors that include increased absenteeism, frequent sickness at work, loss of customers and loss of suppliers.

Table 4.10 Effects of HIV on the profits of SMEs

Effects of HIV on business profits	SME size (number of employee at work site)			
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	Total (n=168)
Increased absenteeism	41 % (55)	53.8 % (14)	50 % (4)	43.5 % (73)
Frequent sickness at work	26.1 % (35)	26.9 % (7)	37.5 % (3)	26.8 % (45)
Loss of customers	47 % (63)	57.7 % (15)	50 % (4)	48.8 % (82)
Loss of suppliers	14.2 % (19)	15.4 % (4)	25 % (2)	14.9 % (25)

Fig4.5: Percentage of SMEs (by size) that have experienced effects of HIV on business profits

It was apparent from findings of the current study that effects of HIV/AIDS on business profit largely depended on the size of an enterprise. The effects increased

with the size of SMEs, very small SMEs reporting the least significant effects and medium sized SMEs reporting the most significant effects of HIV on business profits. Most managers of SMEs reported that HIV/AIDS negatively affected business profits, the most significant factors being increased absenteeism, loss of customers and frequent sickness at work due to HIV/AIDS. These effects become more pronounced with increased size of an enterprise, and indicated in the finding that 50% of medium sized SMEs experience almost all the effects. All categories of SMEs reported loss of suppliers as the least factor causing reduced business profits.

4.4 RESPONDING TO HIV/AIDS AT THE WORKPLACE

HIV infection is preventable. Preventing infection by all its means of transmission can be achieved through a variety of strategies that are appropriately targeted to national conditions and which are culturally sensitive. Preventing the spread of the disease can be promoted through behavioural changes, knowledge, medical treatment and the creation of a non-discriminatory environment. Institutions, organisations and businesses, are in a unique position to promote prevention efforts particularly in the area of education to bring about a change in attitudes and behaviour, making information available and through addressing socio-economic factors directly (I.L.O., 2001, p.4).

4.4.1 Existing HIV/AIDS prevention measures in SMEs in Oshakati

To assess the readiness of SMEs in Oshakati to deal with HIV in the workplace, participating managers were asked what HIV prevention measures their companies currently had in operation. The research sought to ascertain whether company HIV/AIDS policies, education for the prevention of HIV, active care and support,

equal treatment of all employees regardless of HIV status, or involvement in community HIV programmes were available through the companies surveyed. Besides researching what measures were in place, information was also gathered on how these measures were actually carried out by SMEs. The findings are documented in Table 4.11 below.

Table 4.11 HIV prevention strategies in place in SMEs by size

HIV prevention strategy in place	SME size (number of employee at work site)			Total (n=168)
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
HIV/AIDS policy for the company	6 % (8)	23.1 % (6)	37.5 % (3)	10.1 % (17)
Provision of HIV prevention education	34.3 % (46)	53.8 % (14)	50 % (4)	38.1 % (64)
Provision of care and support	20.1 % (27)	26.9 % (7)	37.5 % (3)	22 % (37)
Equal treatment of all employees regardless of HIV status	34.3 % (46)	42.3 % (11)	62.5 % (5)	36.9 % (62)
Community involvement in HIV programmes	15.7 % (21)	19.2 % (5)	37.5 % (3)	17.3 % (29)

The study revealed that the size of an enterprise influenced provision for HIV prevention strategies. Medium sized SMEs had the most strategies in place and very small SMEs had the smallest number of strategies. HIV prevention education and

equal treatment of employees irrespective of HIV status were the most common measures provided by most SMEs surveyed. Company HIV policies and company involvement in community programmes were the least common tools made available. Medium sized SMEs made most of these programmes available to their employees. The general lack of HIV prevention programmes in SMEs is confirmed by Gaomab (2004, p.2), who indicated that most large companies in Namibia have implemented HIV/AIDS programmes in the workplace, while small and medium sized enterprises have not.

4.4.2 Scope of HIV/AIDS education programmes in SMEs

Even basic information will assuage people's fears about HIV/AIDS. Awareness programmes should provide information that is relevant, accessible, and presented in language that is easily understood. Both formal and informal methods should be utilised to raise awareness about the disease. Using a combination of methods has a multiplier effect on reducing the prevalence of HIV (Muwanga, 2001, p. 51). Table 4.12 presents the current study's findings on the scope of HIV education programmes in SMEs in Oshakati. Managers were asked to supply information about the content of their education programmes.

Table 4.12 Scope of HIV education programmes in SMEs by size

Issues included in HIV prevention programs	SME size (number of employee at work site)			Total (n=168)
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
Provides information about HIV/AIDS policy	6 % (8)	23.1 % (6)	37.5 % (3)	10.1 % (17)
Discuss and promote prevention of HIV infection within the group meetings	52.2 % (70)	69.2 % (18)	50 % (4)	54.8 % (92)
Consistent and correct use of condoms	43.3 % (58)	61.5 % (16)	50 % (4)	46.4 % (78)
Occupational hazards and safety awareness	43.3 % (58)	65.4 % (17)	50 % (4)	47 % (79)
Clear answers to staff concerns about HIV	41.8 % (56)	57.7 % (15)	37.5 % (3)	44 % (74)

The study established that very few SMEs had HIV/AIDS policies in place. Therefore, only a few could provide information regarding policy. The size of an enterprise did not influence the kind of issues discussed in educational HIV prevention programmes. This evaluation is substantiated by the fact that SMEs in all three strata covered each of the surveyed issues.

Most of the managers reporting that their company had an HIV policy could not provide a copy of an actual document. This fact could be interpreted to mean that company policies were usually verbal in nature or are non-existent at all. Discussion about promotion and preventing HIV infection dominated educational programmes in all SMEs. The simplicity of this focus could improve the feasibility of setting up a company programme. These findings correlate with those from a survey conducted

by CDC in which 43 % of the work sites with more than 50 employees reported only having a policy regarding employees with a disability or life threatening illness, which would include HIV/AIDS. However, few companies had HIV/AIDS-specific policies for the workplace. About 42 % of the companies in that survey provided training to their managers regarding HIV/AIDS. However, few worksites, only 16 %, offered HIV/AIDS education. Of those that did, three quarters indicated that their programme was mandatory for at least some managers, supervisors and employees (CDC, 1997, p. 3).

4.4.3 Elements incorporated in the delivery of educational programmes by SMEs

The most valuable thing a workplace programme can do is create an atmosphere of trust and open discussion about HIV and AIDS. A conducive atmosphere is crucial to the exchange of lifesaving information and the sharing of personal experience that can promote understanding. Preventing the spread of HIV rests on two key components, that is education and practical measures to reduce risk. Education builds on the foundation of basic information and awareness. It helps people apply general principles to improve their personal situation and constructively change behaviour patterns. Education also provides people with tools they can use to assess and reduce their personal risk. It makes an important contribution to helping a person overcome fear, embarrassment and stigma.

The ILO Code recommends “interactive and participatory” educational methods because they encourage people to voice their fears, assess their risks, and develop the

understanding and skills to change their behaviour constructively. Practical measures include providing people with condoms (male and female condoms) and instructing them in their correct use, access to medical treatment for other sexually transmitted infections (STIs), and training on occupational safety and health (I.L.O., 2007, p. 16).

Table 4.13 Elements of SME educational programmes by company size

Elements of HIV educational programmes	SME size (number of employee at work site)			Total (n=168)
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
Sessions held during company time	32.8 % (44)	61.5 % (16)	37.5 % (3)	37.5 % (63)
Include top management	35.1 % (47)	34.6 % (9)	25 % (2)	34.5 % (58)
Offered in small group meetings	26.1 % (35)	23.1 % (6)	25 % (2)	25.6 % (43)
Mandatory for all staff (because offered during working hours)	39.6 % (53)	57.7 % (15)	37.5 % (3)	42.3 % (71)
Time allowed for discussion and questions	43.3 % (58)	57.7 % (15)	37.5 % (3)	45.2 % (76)
Assessed for its effectiveness before and after delivery	20.1 % (27)	19.2 % (5)	0	19 % (32)

Table 4.13 indicates to what degree important elements were present in the delivery of HIV educational programmes. The study found that HIV educational programmes conducted by most SMEs are neither mandatory for top management nor evaluated for their effectiveness. In addition, the programmes offered by most of the SMEs

surveyed are neither mandatory for employees nor delivered in a small group setting. None of the medium sized SMEs surveyed did either a pre- or post-evaluation of their programmes. Most of the managers of small SMEs reported that their programmes are offered during company time, are mandatory for all employees and allow time for discussion and questions. The effectiveness of a programme depends on participation by top management and implementation during company time (to make attendance easy) and must be monitored. Few SMEs surveyed took these elements into consideration, indicating that the programmes are neither well planned nor coordinated.

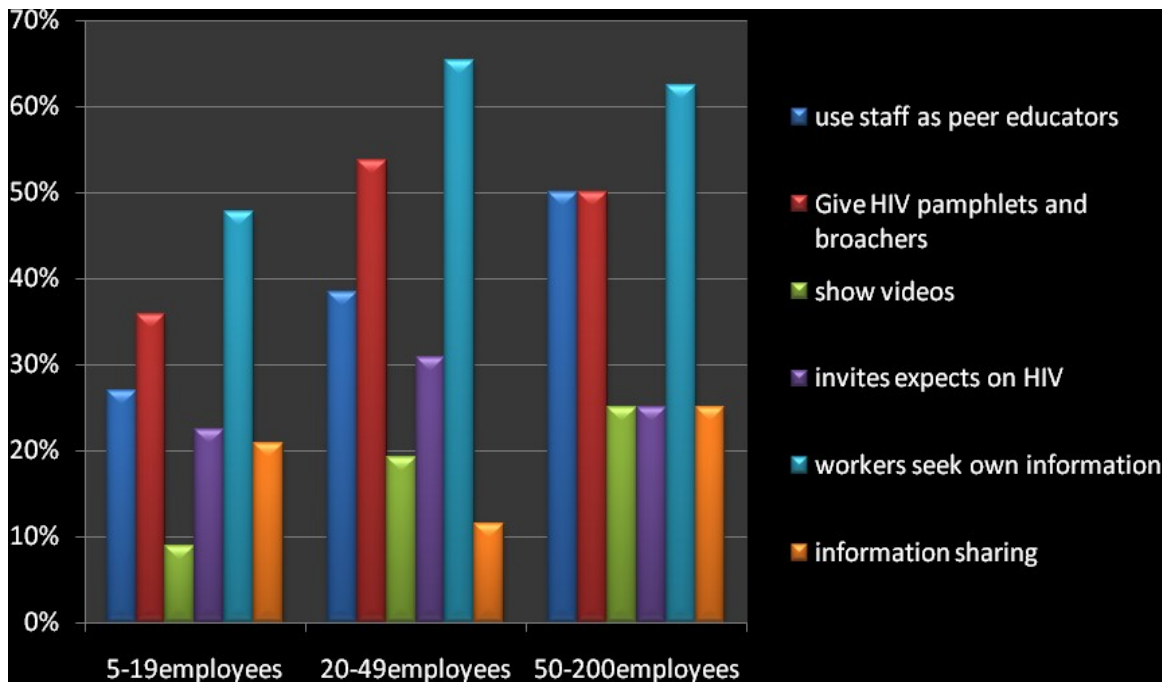
4.4.4 Modes of delivery for educational programmes

The participating managers were asked to explain the modes employed for delivering HIV educational programmes in their SMEs. Table 4.14 and Fig 4.6 below present the findings.

Table 4.14 Modes of delivering educational programmes by SMEs (by size)

Modes of delivery for educational programmes	SME size (number of employee at work site)			Total (n=168)
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
Employ staff member as peer educator	26.9 % (36)	38.5 % (10)	50 % (4)	29.8 % (50)
Distribute HIV pamphlets or Brochures	35.8 % (48)	53.8 % (14)	50 % (4)	39.3 % (66)
Screen video presentation followed by discussion	9 % (12)	19.2 % (5)	25 % (2)	11.3 % (19)
Invite experts to talk on the Subject	22.4 % (30)	30.8 % (8)	25 % (2)	23.8 % (40)
Encourage employees to research the subject on their own	47.8 % (64)	65.4 % (7)	62.5 % (5)	51.2 % (86)
Information shared with other SMEs	20.9 % (28)	11.5 % (3)	25 % (2)	19.6 % (33)

Fig 4.6: Percent SMEs (by size): modes of HIV education delivery.



Research revealed that more than half of the SMEs surveyed tell employees to research the topic on their own; a method that indicates the company assumes no active role to provide education in HIV prevention to its employees in the workplace. The majority of SMEs merely distributed HIV pamphlets and brochures on the subject. These materials are readily available at no cost from health care centres. The researcher did not request to see these brochures and therefore did not verify their contents. Very few SMEs screened video presentations, possibly because of the cost implications to organise such a presentation and because videos are probably available in local languages. A number of SMEs rely on staff members to act as peer educators because they would be credible with colleagues and because they are present in the workplace, ensuring continuity for the educational effort.

To the degree that it is practical, an information programme, course or campaign on

HIV prevention should be integrated into existing educational and human resource programmes, and should be covered in occupational safety, health and anti-discrimination strategies. Company policies that address HIV in the workplace should also form a part of general company policies. Educational strategies should be formulated by employers and employees together in consultation. It is also of great advantage if worker representatives, government representatives and other stakeholders with expertise in HIV/AIDS education, counselling and care are present at such consultations. In addition, the method of delivery should be as interactive and participatory as possible.

Consideration should be given to conducting sessions of a programme during working hours and to developing educational materials for employees for use outside the workplaces. When courses are offered, attendance should be made mandatory (I.L.O., 2001, p. 9-11).

The survey conducted with businesses in Swaziland reported that, 42 % of the companies surveyed distributed posters, 36 % made formal presentations, 33 % held participatory discussions, 33 % examined values and attitudes, 1 % had “brown-bag lunch talks”, 22 % screened video presentations, 29 % held small group discussions and 13 % organised role-play (Muwanga, 2004, p.51). These modes of presentation are similar to the ones addressed in the current study.

4.4.5 Care and support services in Oshakati SMEs

Participating managers were asked if their company provided health care or other forms of support for employees in-house. Findings are indicated in Table 4.15 below. “Care and support” includes provision for treatment of STIs and ARVs for HIV. It also encompasses psychological counselling for employees living with HIV, and financial support to help with the cost of medical treatment and nutritional requirements. Care and support services may include voluntary counselling and testing services for employees and their families. The SMEs surveyed did not offer care or support services. Thirty one percent (31.5 %) of the respondents indicated that their companies refer workers to services outside the company. Establishing such care and support internally is expensive. Management may not perceive the long term benefits of the investment and therefore are not prepared to accept the financial burden associated with it.

Table 4.15 Care and support services provided by SMEs by size

Care and support services provided	SME size (number of employees at the worksite)			Total
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
Refer workers to support outside	30.6 % (41)	38.5 % (10)	25 % (2)	31.5 % (53)

Only 30.6 % of the very small SMEs surveyed even referred employees to seek support services outside the company, while 38.5 % of small SMEs and 25 % of medium sized SMEs made such referrals.

4.4.6 Employment best practices in SMEs

The impact of HIV/AIDS in the workplace can influence a company's approach to fulfilling its employment requirements in diverse ways. Reduced productivity, increased absenteeism, costly employee benefits and other HIV/AIDS related costs may encourage some companies to invest in technology, machinery or equipment to reduce their dependence on labour. On the other hand, some companies, in an effort to maintain optimal production levels, may hire extra employees, or train two employees for the same position (known as work shadowing), to compensate for the impact of HIV/AIDS on labour productivity, absenteeism and mortality rates (South African Business Coalition on HIV & AIDS (SABCHA), 2004, p. 37).

The most immediate and effective way business can respond to the challenge of HIV/AIDS in the workplace is to protect its most valuable resource, its employees, from infection and its consequences. Becoming an agent for prevention through education, and by providing care, support and treatment, is not only good corporate citizenship, it is an absolute necessity in countries heavily affected by the virus (Nattras, Neilson, Bery, Mistry & Sievers, 2004, p.5). The role of responsible employment practice as a pillar supporting a healthy work force cannot be over emphasised in this era of HIV/AIDS.

Table 4.16 SME employment practice by size

Employment practice	SME size (number of employees at the worksite)			Total (n=168)
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	
Compliance with regulations for HIV and employment	21.6 % (29)	50 % (13)	37.5 % (3)	26.8 % (45)
Allow alternative working arrangements for PLWA	22.4 % (30)	46.2 % (12)	37.5 % (3)	26.8 % (45)
Respect confidentiality and privacy of medical information	29.9 % (40)	50 % (13)	25 % (2)	32.7 % (55)
Provide VCT to encourage workers to test so they can know their status	29.9 % (40)	53.8 % (14)	62.5 % (5)	35.1 % (59)

Table 4.16 presents SME employment practices that respond to the challenge of HIV/AIDS.

The study found that of the 168 SMEs surveyed, only 26.8 % comply with regulations on HIV and employment and have alternative working arrangements for employees living with HIV. Only 32.7 % respect confidentiality and privacy of employees, while 35.1 % provide VCT to encourage employees to establish their status through testing. Unfortunately, the SMEs that provide VCT only counsel employees or refer them to New Start centres or health care facilities for testing. Counselling, however, is not structured, a failing that can be attributed to a lack of training on the subject. The kind of counselling offered is actually simple encouragement, so that employees will visit New Start Centres where proper counselling and testing is provided by professionals.

Generally, statistics indicate that SMEs do not support employment practices that

accommodate employees living with HIV. Every company surveyed registered below 50 % on all the parameters assessed in this category. Disclosure of status is a factor that helps reduce the incidence of HIV and facilitates an individual's access to information and resources for coping with the virus. In addition, the survey discovered that very few SMEs actually respect the confidentiality of employee medical information I.L.O. (2005, p.9), or acknowledge workers' rights of privacy, employment protected gender equality, entitlement to benefits and non-discrimination.

4.4.7 Involvement in community efforts to fight HIV/AIDS

AIDS is such a serious and far-reaching problem that its very existence will define how societies develop in the future. Workers and their families cannot be regarded in isolation, for they are members of a community. Business should therefore not attempt to distance itself from the community. It needs to facilitate or establish local HIV/AIDS education and prevention activities that focus on high-risk groups and youth. In addition, the education and training sector is uniquely placed to exert an influence on the course of the pandemic by preventing the spread of the virus among young people. Youth, after all, are the source of skills and labour that will support the economy in the future. For business to remain competitive and maintain respect in the community, it needs to be responsive and safeguard its business partners against the impact of HIV/AIDS. These partners are none other than their suppliers, their service network and the community as a whole (Muwanga, 2001, p. 51).

Addressing HIV/AIDS represents a new and therefore unfamiliar challenge to company managers. Business leaders have admitted that partnerships with governments, community based organizations and unions have been critical to their response to the HIV pandemic. The inclusion of people living with HIV/AIDS, labour representatives and community members on company AIDS committees, has become common practice. These committees have contributed to policy development, planning and programme implementation (Nattrass et al., 2004, p. 6).

Company managers were asked about their involvement with HIV/AIDS activities in surrounding communities. Table 4.17 presents the findings.

Table 4.17 SME community involvement in HIV activities by size

Community HIV prevention measures	SME size (number of employees at worksite)			Total (n=168)
	Very small 5-19 (n=134)	Small 20-49 (n=26)	Medium 50-200 (n=8)	

Provide information on HIV to clients and suppliers	23.9 % (32)	26.9 % (7)	0	23.2 % (39)
Educate workers' families about HIV/AIDS	26.1 % (35)	23.1 % (6)	25 % (2)	25.6 % (43)
Involvement in community HIV programmes	15.7 % (21)	19.2 % (5)	12.5 % (1)	16.1 % (27)
Contribute resources, expertise and experience to the community	19.4 % (26)	19.2 % (5)	50 % (4)	20.8 % (35)
Plan to undertake measures in future	88.1 % (118)	88.5 % (23)	87.5 % (7)	88.1 % (148)

In this study it was found out that 88.1% of the surveyed SMEs are planning to take some kind of action to help the community fight HIV/AIDS. Community involvement among the SMEs surveyed is very low. Medium sized SMEs do not provide HIV information to their clients or suppliers, though half of them contribute resources to the community. Very small and small SMEs make insignificant contributions to the community, a fact that itself puts the community at risk. This failure will retroactively affect those SMEs because the labour pool on which they depend will be compromised in terms of both size and quality.

In Kenya, the Federation of Employers encourages corporate social responsibility. Consequently businesses reach out to their communities by donating resources to the community's response to AIDS. The social marketing of condoms, working with government and other organisation that attend to health, education and general welfare of children orphaned by AIDS, comprise part of their response (UNAIDS, 2006, p. 195). The value of responsible action proves the importance of partnership between business and the community ensuring a holistic approach in addressing HIV/AIDS issues in the workplace.

4.5 SUMMARY

The foregoing chapter presented findings on company profiles, focusing on business sector and the size of SMEs. The sectors addressed were: industry, retail/wholesale, financial/banking, general service and others that did not fit into the main sectors. Size categories were very small enterprises (5-19 employees), small enterprises (20-49 employees) and medium sized enterprises (50-200 employees). The Chapter presented findings relating to the socio-economic effects of HIV/AIDS in SMEs, concentrating on employees, company profits and labour force dynamics. SME initiatives responding to HIV at the workplace and in the community were also documented in this chapter. The major findings were that 42.8% of the employees in the surveyed SMEs were female and 57.1% were males. The majority of the surveyed SMEs employed either semiskilled or unskilled employees. HIV related illness, resignations and deaths affected bigger enterprises compared to small enterprises. Most SMEs surveyed were unsure of the sources of information on HIV related illness, resignation and deaths. Employees were also not spared by the pandemic as their income and savings were depleted due to HIV/AIDS. The study showed a high degree of tolerance towards employees infected with HIV by other employees. It was also shown that effects of HIV on labour force ranged from high staff replacement, increased use of child labour to increased demand for high wages. It was also revealed that HIV/AIDS has affected business profits through increased absenteeism, loss of customers and frequent sickness at work. Most SMEs surveyed do not have an HIV/AIDS policy and most are still to take measures to prevent HIV

infection in the community. HIV/AIDS prevention programs are not systematic and lack coordination and consistency. The following chapter presents conclusions and recommendations arising from the research.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter, research findings are summarised and conclusions are drawn in the context of the purpose and stated objectives of the study. From these conclusions, a number of recommendations are formulated and presented with acknowledgement of the limitations of the study. These limitations are highlighted and placed in context.

5.2 PURPOSE OF THE STUDY

The purpose of the study is to explore and describe the socio-economic effects caused by HIV/AIDS in small and medium sized enterprises in Oshakati, Namibia. The study is a departure point to the development of HIV/AIDS prevention programmes. The specific objectives are repeated for clarity in order to maintain focus.

5.3 SPECIFIC OBJECTIVES OF THE STUDY

Specific objectives are:

- To explore and describe the socio-economic effects of HIV/AIDS in small and

medium sized enterprises in Oshakati, Namibia.

- To analyze existing HIV prevention programmes in the workplace in small and medium sized enterprises in Oshakati, Namibia.
- To provide guidelines for small and medium sized enterprises that wish to develop HIV prevention programmes.

Below, each objective is considered individually, conclusions are drawn and recommendations submitted.

5.3.1 Objective 1

To explore and describe the socio-economic effects of HIV/AIDS in small and medium sized enterprises in Oshakati, Namibia

As HIV start to multiply in the human body, the sufferer usually experiences a gradual decrease in the number of CD4+ T cells in his blood. These cells normally protect the body from infection and other types of diseases. Some people become so ill from the symptoms of AIDS that they are unable to hold a job or complete household chores. Others may experience periods of intense, life threatening illness followed by periods of normal functioning. Opportunistic infections resulting from AIDS can be very severe, causing significant morbidity and death in people infected with the virus (Isaksen et al., 2002, p. 2).

5.3.1.1 Gender and the effects of HIV/AIDS

One of the characteristics of HIV/AIDS in Africa is the different impact it has had on men and women. Women and young girls are very vulnerable to the HIV/AIDS pandemic. It is estimated that in sub-Saharan Africa, 55 % of HIV positive adults are women (UNAIDS, 2001). Women are biologically more likely to become infected than men (Beer & Ray, 1993, p 45). This is particularly evident among young adults. However, the higher rates of HIV infection among girls are explained not only by this biological difference but also by cultural norms that define concepts of masculinity, femininity and sexuality. These cultural factors make women more susceptible as well. In many parts of Africa, girls tend to have their first sexual experiences with older men who may have been exposed to the HIV virus. On the other hand, at the onset of their sexual activity, young men generally do not have sexual relationships with people from more heavily infected age groups. Such socio-sexual factors may partially explain significant differences in rates of infection between girls and boys. Young women often engage in sexual relationships with older men for social or economic reasons. Furthermore, men may seek younger females as sexual partners in the belief that their risk of becoming infection is reduced (Isaksen et al., 2002, p.13).

The current study established the ratio of female to male employees in SMEs in Oshakati as 42.9 to 57.1 % (see table 4.3) and indicates the vulnerability of SMEs to HIV according to size.

Indicators of the effect HIV/AIDS has on SMEs were identified as mortality, absenteeism and resignations from employment. These work-related factors translate into the economic costs of HIV/AIDS carried by the enterprises.

5.3.1.2 Illness, resignation and deaths due to HIV/AIDS in SMEs in Oshakati

Table 4.5 indicates that 50.6 % of the SMEs surveyed reported at least one case of death in their workforce related to HIV/AIDS: 48.5 % of very small SMEs, 57.7 % of small SMEs and 62.5 % of medium sized SMEs reported cases of death due to HIV/AIDS. These findings correlate to those of Muwanga (2001) that reported 73 % of businesses in Swaziland experienced an employee death due to HIV/AIDS. In another study (Muwanga, 2004) that made a systematic review of the economic impact of HIV/AIDS in Swaziland, it was found that by 1998, HIV/AIDS had become the leading cause of employee deaths in Swaziland. AIDS contributed to over 60% of all employee deaths by 1999. The author further noted that the AIDS mortality rate of 10.54/1000 employees per year accounts for 63 % of all deaths in the workplace in Swaziland. It is estimated that by 2010 mortality amongst the workforce will have peaked at 30/1000 employees per year (Muwanga, 2004, p.37). In the current study, the size of an SME influenced the number of cases of death, with medium sized SMEs being hit worst. The higher rate is attributed to fact that medium sized SMEs employ a large number of people and therefore the likelihood of AIDS related deaths is higher. Compared to very small SMEs, small and medium sized SMEs tend to have some kind of statistical information on their workforce, a fact that ensures greater accuracy in their reporting and a truer reflection of the

situation at the grassroots. HIV related deaths in rates above 50 % have drastic effects on overall production levels and on costs carried by SMEs.

The number of deaths, resignations and illness due to HIV/AIDS has created an artificial shortage of skilled labour. A link exists between the skill level of an employee and his or her demand for wages. The current survey found that 17.9 % of the companies surveyed reported a high level of demand for high wages among skilled employees. Loss of skilled and experienced employees due to death, illness or resignation, coupled with the entry of young, unskilled personnel in the labour market is likely to lower both the amount and the quality of the labour force resulting in reduced profits for businesses (Isaksen, 2002, p.27). In this study, 22.6 % of the 168 SMEs surveyed reported an increased utilisation of child labour, indirectly affecting production levels which in turn adversely affect profits.

This study also discovered that frequent illness, resignation and death of employees due to HIV/AIDS have forced greater expenditure on medical care and funerals. Almost all SMEs surveyed reported that HIV has an adverse effect on their profits. Direct causes of diminished profits included increased absenteeism, frequent illness on the job, loss of customers and loss of suppliers. Other causes that were identified were high rates of staff replacement, increased use of additional labour and increased demand for higher wages. The number of businesses reporting negative effects of HIV on profits was highest in the small and medium sized categories (Table 4.9, 4.10 and Fig 4.5). Other costs that might have adversely affected the profits of these SMEs are the cost of healthcare and death benefits.

Attrition in the general population due to HIV/AIDS has also adversely affected SMEs because the number of potential customers and suppliers has also decreased. The study found that 48.8 % of SMEs surveyed reported that their profits had decreased due to a loss of customers, while 14.9 % reported the same due to loss of suppliers (Table 4.10 and Fig 4.5).

Seen from the perspective of individuals, when income is disposed on health care and medicine, the amount left for consumption of other goods decreases. This shift in economics will result in an increase in demand in some markets and a decrease in others. Markets that will suffer the most are those with high income elasticity, typically markets for luxury goods (Isaksen et al., 2002, p. 29).

As the base of potential suppliers shrinks, the demand for goods increases, pushing up the price of raw materials and services and reducing business profits. Businesses may be susceptible to the effects of an inadequate response to HIV/AIDS on the part of key suppliers. It is likely that the cost of water, electricity, telecommunication services and basic government services will prove particularly vulnerable. In these utilities and services, a break down in the continuity of supply could have downstream effects on many companies (Muwanga, 2001, p. 47).

Labour productivity is an important determinant of output and profitability. Illness compromises productivity because of the diminished ability of a sick person to perform his or her duties. Even if a person is still able to work, their level of performance is lowered through physical, psychological and physiological influences

(Muwanga, 2001, p. 38). Therefore the higher the rates of sickness, resignation and deaths due to HIV/AIDS, the higher will be the levels of absenteeism and lost productivity, translating as reduced profits to SMEs. A study of the National Railway of Zimbabwe reported that 24 % of total costs linked to HIV/AIDS were attributed to absenteeism (Bollinger, Stover, Kerkhoren, Mutangadura & Mukurazita, 1999, p. 7).

SABCOHA (2003, p. 35) found that 39 % of respondents indicated that HIV/AIDS had already reduced labour productivity or caused an increase in absenteeism among employees. Close to one in three companies surveyed indicated that HIV/AIDS has increased the cost of employee benefits and has led to higher labour turnover rates. Some 27 % of the respondents in that study reported a decrease in job experience and skills due to HIV/AIDS, while 24 % felt they had incurred recruitment and training costs due to the pandemic. These findings correlate to the findings made in this study.

5.3.1.3 High staff replacement

This study found that over 20.2 % of the SMEs surveyed reported a high increase in staff replacements, the rate increasing with the size of the SMEs. Medium sized SMEs experienced the highest staff replacement (50 %), small SMEs following with 42.3 % and the very small 14.2 % high staff replacement (Table 4.9). These findings concur with those of a survey conducted on Swazi companies that found 33 % of companies surveyed had experienced an increased loss of skills (Muwanga, 2001,

p.39). In this study, high staff replacement is attributed to illness, resignation and death of employees due to HIV/AIDS. All these negative effects were felt by more than 50 % of the companies surveyed (Table 4.5 and Fig 4.4). Illness, resignation and death lead to a loss of skills and level of job experience in SMEs, resulting in poorer quality and volume of final product. The loss may be attributed to the fact that a new employee needs time to acquire the skills need to perform a job to full capacity. Overall loss of skill and job experience within a company is not easily replaceable.

Costs are incurred by an employer through the recruitment and training of new employees. Likewise, overtime wages paid to other employees to make up for a loss in productivity due to a vacant position, is also an incurred cost. The company must also bear the cost of in-service training to bring new employees up to a level of productivity of lost employees as well as pay them salary during the period of training in which productivity is low in any case.

5.3.1.4 Absenteeism

HIV/AIDS was found to have contributed to increased absenteeism in the workplace among SMEs surveyed in Oshakati: 43.5 % of those surveyed reported that profits were negatively affected by absenteeism due HIV/AIDS related illness (Table 4.10 and Fig 4.5). An employee may absent him or herself to seek medical treatment, to take sick leave or provide care for a family member who is ill. Absence from work might even include the time spent to attend the funeral of a relative or friend. The

adverse effects of employees missing work include disrupted business operation, increased costs of production and reduced profits, all directly related to a loss of labour.

In essence, absenteeism is a cost itself, since the absent employee is also paid for the time he or she is absent. In the current study, 16.1% of SMEs survey reported employment of additional labour to cover for absent employees (Table 4.9). Even if additional labour is not hired, absenteeism will result in the necessity of regular employees having to shoulder extra work to cover for the absent colleague. For example Muwanga (2001, p. 38) reports that workers may be required to work overtime to compensate for time lost by their absent colleagues, and companies must pay a higher rate for overtime in any case. Working overtime may have the additional effect that productivity is lowered when an employee becomes overworked and exhausted.

5.3.1.5 Effects of HIV/AIDS on employees as reported by managers

Illness, resignation and death of employees have socio-economic effects on their personal livelihood. In this study it was reported by managers of SMEs that the most common effects of HIV on employees include reduced personal savings, increased demands on income, increased expenditure on health care and increased incidences of premature death (Table 4.7). Because HIV/AIDS is a chronic condition that needs constant medical attention and creates special nutritional requirements, employees frequently discover that their income gets diverted into these expensive items. As

the condition progresses, the frequency of illness increases and even more income must be used to meet these requirements. These expenditures obviously deplete a person's resources and he or she eventually is forced to draw on personal savings or insurance policies to finance treatment and care. As the terminal stage of AIDS sets in, savings are also exhausted and employees may no longer be able to afford sustained treatment. Most succumb to AIDS earlier than they would have, had they been on Anti-retroviral therapy. Premature death by an employee was reported by 17.9 % of SMEs surveyed in this study (Table 4.7).

An indirect impact of HIV on employees' livelihood comes through the inability to provide their families with basic necessities such as food, shelter, education and health care as income and savings become depleted. Compounded effects include children being withdrawn from school and/or being used as a source of labour, or family members engaging in prostitution to generate income, activities, all of which predispose the extended family to a vicious circle of HIV infection. The risk of a family falling below the poverty line is high because those infected with the virus are usually the productive members of the household. Some households may have reserves that enable them to cope with economic burdens, but others have little economic capacity and become drawn into a downward spiral that ends in dissolution (Desmond, Michael & Gow, 2000, p.3). Illness and death cause a depletion of the resources available to a family. These resources become even less when a breadwinner is unable to continue working. The more vital the role that person plays in earning a family's income, the more dramatic are the consequences to the family. Reduced income is usually paired with a significant rise in expenses (Isaksen et al.,

2002, p. 11).

The current study also discovered that 2.4 % of the SMEs surveyed reported stigmatisation of employees and 4.2 % reported discrimination against employees living with HIV. About 1.8 % of the SMEs reported that their employees feared becoming infected by fellow employees with HIV (Table 4.8). This erroneous perception shows the tenaciousness of a myth about the transmission of HIV, and is caused by an information gap in the effort to enlighten people about the virus. The fact that these percentages are small is most probably due to the structure of SMEs, which resemble family units, and bring about closeness that engenders tolerance and empathy among employees.

5.3.2 Conclusions and recommendations to address Objective 1

This study showed that:

- SMEs in Oshakati employ almost an equal number of men and women;
- SMEs in Oshakati have experienced cases of illness, resignation and death due to HIV/AIDS;
- SMEs in Oshakati increased staff replacement due to the impact of HIV/AIDS;
- SMEs in Oshakati have experienced compounded effects on productivity and profits caused by absenteeism due to HIV/AIDS;

- the livelihoods of employees of SMEs in Oshakati have been affected by HIV/AIDS.

Against this background the following recommendations are made:

5.3.2.1 Workshop for SMEs in Oshakati

SMEs in Oshakati should hold a regional workshop to discuss the effects of HIV on the business community. The Ministry of Trade and Industry could facilitate such a workshop, whose primary focus would be for representatives of SMEs to discuss the effects of morbidity and mortality caused by HIV/AIDS on their businesses and possibly to develop strategies to mitigate resulting problems. The workshop could also serve as a forum to disseminate the findings of the current study. A goal of the workshop should be to choose a substantive HIV committee comprising representatives from SMEs, non-governmental organisations (NGO) dealing with HIV in Oshakati, public health officials and community leaders.

The main objective of the committee would be to establish and sustain a structure through which the HIV pandemic could be effectively addressed as a business and workplace issue. To facilitate this objective, the committee should:

- Provide a platform for SMEs and various stakeholders to discuss and share information on effects of the pandemic and possible responses to them.

- Serve as an information and resource centre where technical support and current information can be sought by SMEs.
- Identify feasible, sustainable and audience-specific practices that could be adopted by SMEs.

5.3.2.2 Prolonging the life and strength of employees infected with HIV

To minimise absenteeism, illness, deaths and resignation of employees, SMEs could make provision for the following:

- Medical insurance that would maximise access to medical treatment and care while preserving employee income and savings.
- Distribution of ARVs to employees through a central clinic operated by a collective of SMEs.
- Dual skill or multi-skill training of employees to avert crisis caused by illness and death.
- Strengthening HIV education in SMEs and the community.

5.3.3 Objective 2

To analyze existing HIV prevention programmes in the workplace in small and medium sized enterprises in Oshakati, Namibia

5.3.3.1 Responses to HIV/AIDS by SMEs in Oshakati

This section discusses the findings of the study regarding responses implemented by SMEs in Oshakati to mitigate the effects of HIV/AIDS on their business operations. Responses include creating an HIV/AIDS policy for application in the workplace, providing HIV/AIDS prevention education programmes and SME involvement in community efforts against HIV/AIDS.

5.3.3.2 Policy on HIV/AIDS

The study revealed that the majority (90 %) of the surveyed SMEs had no policy on HIV/AIDS in place (Table 4.11). The few (10 %) that reported to have a policy on HIV/AIDS could not provide a copy of a written policy document, and it was deduced that the so-called policy was more a verbal communication about how to deal with the pandemic. Muwanga (2001, p.49), found that 22 % of businesses surveyed in Swaziland had policies on chronic illnesses that included HIV/AIDS and 18 % had a policy that specifically addressed HIV/AIDS. The current study found that size of SMEs correlated with the availability of HIV policy. A higher proportion of medium sized SMEs reported having an HIV/AIDS policy (37.5 %), followed by

small SMEs (23.1 %), while only 6 % of very small SMEs reported having a policy (Table 4.11). During the data collection stage of the study, representatives of most of the SMEs acknowledged the importance of formulating an HIV policy for the workplace. It is possible that a lack of information, capacity and/or resources could have contributed to the failure of SMEs in Oshakati to establish HIV policies.

5.3.3.3 Education programmes for HIV/AIDS prevention

Health education and training on HIV/AIDS is a way of protecting core business operations by encouraging behavioural changes that will help prevent the spread of HIV/AIDS and STDs and help people accept employees already infected with HIV. Health education and training should be offered to employees, the families of employees, labour leaders, managers and the surrounding community. It is important to train managers, supervisors and labour leaders before addressing the education of employees. It is imperative that managers, supervisors and labour leaders understand the facts about HIV/AIDS and are well versed in the company's policy on HIV/AIDS to be able to do the following:

- Answer questions from employees.
- Know where to refer employees for additional information.
- Reinforce the company's position on HIV/AIDS.
- Support and encourage the employee participation in training sessions.

- Supervise and manage company workgroups (Muwanga, 2001, p. 50).

This study found that 38.1 % of the SMEs surveyed had HIV prevention programmes (Table 4.11). The statistic was higher in small and medium sized SMEs. The scope of HIV prevention programmes, delivered in group sessions, encompassed discussion and promotion of methods of prevention of HIV infection. SME prevention programmes featured topics on the consistent and correct use of condoms, occupational hazards and safety awareness. SMEs also provide clear answers to staff concerns about HIV (Table 4.12). However less than 50 % of the surveyed SMEs:

- conducted educational programmes during company time;
- included top management in their programmes;
- conducted educational programmes in small group meetings;
- made their programme compulsory to all staff members;
- allowed time for discussions and questions; and
- assessed the programme's effectiveness through an evaluation (Table 4.13).

From the findings produced by this study, it is clear that HIV/AIDS prevention education is not yet established in most SMEs in Oshakati. For those providing it, there is no evidence of consistent or coordinated programmes. The programmes are

not formalised and are done haphazardly. Most of these SMEs do not have a designated, trained employee who focuses on the subject of HIV/AIDS on behalf of the company as required by the MTP III (2004, p. 142).

5.3.3.4 Awareness programmes

Managers indicated that various methods of providing basic HIV information are in place in less than 40 % of the SMEs surveyed. These methods ranged from the use of staff as peer educators, distribution of pamphlets and brochures on HIV, showing videos followed by discussions, inviting expert speakers, sharing information with other SMEs and encouraging employees to learn about HIV independently (Table 4.14 and Fig 4.6). These methods, though sometimes used by the SMEs that were surveyed, are not well planned or coordinated; their effectiveness is therefore not guaranteed. Employees need basic information about HIV/AIDS to answer their fears and concerns about the pandemic. Awareness programmes should be able to provide accurate, specific and readily accessible information in easily understandable language. The surveyed SMEs still lag behind in terms of well planned and coordinated HIV/AIDS prevention and awareness programmes. Programmes designed for the workplace should also include care and support for infected employees and may include distribution of ARVs and provision for treatment of STIs, and VCT.

5.3.4 Conclusions and recommendations to Objective 2

This study concludes that:

- The majority of SMEs in Oshakati do not have an HIV/AIDS policy in place.
- SMEs in Oshakati should make efforts to set up comprehensive HIV programmes in the workplace.
- Education programmes for HIV/AIDS prevention are neither well planned nor coordinated.
- Though SMEs promote some measures to improve awareness about HIV/AIDS, such as providing for peer education, distributing pamphlets and brochures on HIV and inviting experts to talk on HIV issues, these are not securely established or well coordinated.
- SMEs still need to form partnerships with the community to fight the HIV/AIDS pandemic.

From these findings the following measures are recommended:

5.3.4.1 An economic component of the framework: reversing socio-economic effects of HIV/AIDS in SMEs in Oshakati

To maintain productivity and profitability it is recommended that SMEs implement

measures that will reduce the effects of HIV/AIDS on business. These measures should aim to reduce HIV related illness, resignations and death as a way of minimising costs and maximising profits. These goals can be achieved through effective workplace prevention programmes integrated with daily company activities. Information and education programmes in the workplace are essential to prevent the spread of the pandemic and to foster greater tolerance for workers living with HIV/AIDS. Effective education can contribute workers' ability to protect themselves against HIV infection. It can significantly reduce anxiety and stigmatization related to HIV, minimise disruption in the workplace and bring about attitudinal and behavioural change. Programmes should be developed through consultation among stakeholders in the process: government, employers, workers and their representatives, to ensure support at all levels and the fullest participation of all concerned.

Information and education should be provided in a variety of forms, avoiding reliance exclusively on the written word and including distance learning where appropriate. Programmes should target and be tailored to the age, gender, sexual orientation, sector characteristics and behavioural risk factors of the workforce and be sensitive to its cultural context. They should be delivered by trusted and respected individuals. In India and Southern Africa, peer education has proved particularly effective because peers tend to accept and receive advice from fellow employees and members of their peer age group. Involvement of people living with HIV/AIDS in the design and implementation of programmes has also been very effective.

5.3.5 Objective 3

To provide guidelines for small and medium sized enterprises that wish to develop HIV prevention programmes

This study found that SMEs in Oshakati do not have appropriate guidelines to formulate HIV prevention programmes. This section of the study makes recommendations that should provide guidelines to develop HIV prevention programmes in the workplace. It should be emphasised that guidelines do not replace policy, and when necessary, should be altered to fit the needs and environment of each SME.

In this context the following recommendations are offered:

5.3.5.1 Quality improvement component of the framework: composition of an appropriate HIV programme for the workplace

Consideration should be given to delivering educational programmes during paid working hours and developing educational materials to be used by workers outside the workplace. When a course is offered, attendance should be obligatory.

Where practical and appropriate, programmes should:

- include activities to help individuals assess the personal risks they face (both as individuals and as members of a group) and help them reduce these risks

through decision-making, negotiation and communication skills, as well as educational, preventative and counselling programmes;

- place particular emphasis on high-risk behaviour and other risk factors such as occupational mobility that expose certain groups to increased risk of HIV infection;
- provide information about the transmission of HIV through injection and how to reduce the risk of such transmission;
- promote dialogue between government and employers' and workers' organisations from neighbouring countries and on a regional level;
- promote awareness of HIV/AIDS in vocational training programmes carried out by government and enterprises, in collaboration with workers' organizations;
- promote campaigns that target young workers and women;
- place particular emphasis on the vulnerability of women to HIV, and on prevention strategies that can reduce this vulnerability;
- emphasise that HIV cannot be contracted through casual contact, and that people who are HIV-positive do not need to be avoided or stigmatized, but should rather be supported and accommodated in the workplace;
- explain the debilitating effects of the virus and the need for everyone to empathise with colleagues living with HIV/AIDS, treating them in a non-discriminatory manner;
- provide opportunities and encourage workers to express and discuss their reactions to and emotions caused by HIV/AIDS;
- instruct workers (especially health care workers) on the use of universal

precautions and inform them about procedures they should follow in case of exposure;

- provide education about the prevention and management of STIs and tuberculosis, not only in the context of HIV infection, but also because these conditions are treatable, and their proper treatment improve workers' general health and immunity;
- promote hygiene and proper nutrition;
- promote practices of safe sex, including instruction on the use of male and female condoms;
- encourage peer education and informal educational activities; and
- be monitored, evaluated, reviewed and revised when necessary on a regular basis (I.L.O., 2001, p. 9-11).

5.3.5.2 Personnel management component of the framework: elements of a good workplace programme

A programme for HIV prevention in the workplace should:

- formulate an HIV/AIDS policy as a baseline for action;
- produce a human resource strategy to prolong the productiveness and health of employees;
- establish education programmes for HIV prevention in the workplace; and
- establish care and support services for employees and family members living

with HIV.

5.3.5.3 Partnership between SMEs and large enterprises

SMEs are often the suppliers and service providers for large enterprises. It is to the advantage of large firms to extend their expertise, resources and infrastructure to SMEs in order to help them establish effective programmes in the workplace. Large enterprises may extend education, healthcare and prevention programmes to their immediate business partners, or provide advice and information as well as training materials and finance for HIV/AIDS programmes in the workplace.

5.3.5.4 Community involvement

Employees and their families come from the general community, a fact that should engender a close relationship between SMEs and the surrounding community. The former should guard against distancing themselves from the latter. It is recommended that SMEs:

- initiate HIV/AIDS prevention and education programmes in the community, focusing on high-risk groups and youth;
- raise awareness within the community to minimise discrimination of people living with HIV;
- establish social safety nets for socio-economically disadvantaged groups; and

- provide resources, finance and manpower to fight HIV inside the community.

Finally, since SMEs often lack the financial resources needed to institute comprehensive workplace programmes, it is recommended that bonds of intra- and inter-enterprise partnership be established by the business community to fight HIV/AIDS holistically.

5.4 CONCLUSIONS

It is evident from the findings of this study that the illness, resignation and death of employees due to HIV/AIDS have a serious, negative impact on SMEs in Oshakati, compromising both their productivity and profits.

The effects of HIV/AIDS on SMEs may be summarised as follows:

- Death and illness due to HIV/AIDS result in absenteeism of employees, who leave the workplace either to seek treatment, take care of a sick family member or attend a funeral.
- Loss of skilled and experienced employees results in costs being incurred for the recruitment and training of new employees.
- SMEs compensate for the loss or absence of employees by hiring additional labour, thereby increasing production costs.

- Shortage of skilled labour may result in demand for higher wages.
- Loss of suppliers due to HIV creates shortage on demand side thereby raising the price of raw materials and services and increasing the production costs of SMEs.
- Loss of customers decreases the market base and compromises profits.
- Compounded effects include increased expenses for funerals, health care, medical aid and hospitalisation.
- HIV/AIDS has adverse socio-economic effects on the ability of employees to earn a livelihood and to maintain households, which include a loss of income, increased demand on personal savings, increased expenditure on health care and turning to children as a source of labour to generate income for supporting the family.

Managers and administrators of SMEs in Oshakati have realised that the HIV/AIDS pandemic affects their business operations adversely and have taken some steps to mitigate these effects. However, their initiatives have not been consistent or well coordinated, possibly due to a lack of resources, capacity or knowledge about establishing comprehensive programmes for the workplace.

5.5 LIMITATIONS OF THE STUDY

Some limitations were encountered during this study as described below:

Record keeping is minimal within the SMEs and more so on HIV/AIDS. Most of the information provided by CEOs, human resource managers as well as owners of SMEs depended largely on their recollection capability.

Lack of financial records made it impossible to come up with actual monetary losses due to HIV/AIDS within the SMEs.

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ANNEXURE 1: PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT

TITLE: The Socioeconomic Effect of HIV/AIDS in Small and Medium Enterprises in Oshakati, Namibia.

Introduction

You are invited to participate in this research project. This leaflet will help you make an informed decision on whether or not to participate. It is good for you to full understand why the research is being done and what it involves before you agree to participate. However should you have any unanswered questions do not hesitate to contact the researcher directly.

Purpose of the research

The purpose of this study is to explore and describe the socioeconomic effects of HIV/AIDS in SMEs in Oshakati, Namibia. It will look into the HIV prevention workplace programmes currently available and will help develop or improve HIV prevention workplace programmes. The findings of the study will be used as important baseline information for policy formulation in regard to HIV in SMEs.

What is expected?

You need to complete the research questionnaire with the research assistant.

Ethical approval of the research project

The research protocol was submitted to the post graduate committee of the University of Namibia, and was approved and authorised.

Your rights as a participant

You are at liberty to or not participate and you can stop at any time without reason.

Your withdrawal will have no effect on the outcome of the study. The implication of completing the questionnaire is that informed consent has been obtained from you. The information given by you will not be traceable and you will not be able to recall your consent.

Confidentiality

All information obtained during the study is strictly confidential. Data might be reported in scientific journals but will never include information that identifies you as a participant of this study.

** Any information needed please contact

Researcher: Mr Sydney Chikukwa 0812329780

Thank you for taking your time to go through the questionnaire

ANNEXURE 2: QUESTIONNAIRE

THE SOCIOECONOMIC EFFECTS OF HIV/AIDS IN SMALL AND MEDIUM ENTERPRISES IN OSHAKATI, NAMIBIA

SECTION 1: COMPANY PROFILE

Name of interviewer..... Date of interview.....
 Time interview started..... Time interview ended.....

1. Instructions: Use an “X” in the applicable block/space to indicate your answer or choice Indicate the type of business sector you are operating:

	Sector	Indicate with an “X”
1.1	Industry	
1.2	Retail/Wholesale	
1.3	Financial/banking	
1.4	General service	
1.5	Not applicable	

2. Indicate the number of employees currently in your business

	Range category of number of employees	Indicate with an ‘X’ next to the applicable range category
2.1	5-19	
2.2	20-49	
2.3	>50	

3. Also indicate the precise number and gender of employees currently in your business

males	females	total

4. Indicate the skill's profile of your employees

	Skill's profile	Indicate an appropriate number in this item
4.1	Skilled	
4.2	Semi- Skilled	
4.3	Unskilled	
4.4	Can not determine/unsure	
4.5	Not applicable	

SECTION 2: SOCIOECONOMIC EFFECTS OF HIV/AIDS

5. Have you experienced HIV/AIDS related illness, death or resignation within your organisation within the past year? Please indicate the exact numbers against the appropriate column.

CONDITION	HIV RELATED	NATURAL CAUSE	UNKNOWN CAUSE
5.1 Number of sick employees			
5.2 Number of employees who resigned			
5.3 Number of employees who died			
5.4 Not applicable			

6. In the table below indicate with an "X" the manner by which you are informed about a possible HIV/AIDS related death or illness in the company.

Manner of receiving information about a possible HIV/AIDS related death	Put an "X" against the appropriate way you are informed
6.1 Other employees/ Colleagues	
6.2 Medical practitioner	
6.3 Rumours	
6.4 Employees family/friends	
6.5 Nursing personnel	
6.6 Not clear/Unsure	

7. Indicate with an “X” how HIV/AIDS is affecting your employees.

HIV/AIDS issues affecting employees	Indicate with an “X” appropriate issues affecting your employees
7.1 Reduced personal savings	
7.2 Increased use of income	
7.3 Increased expenditure on health	
7.4 High incidence of premature death	
7.5 Not applicable	

8. Indicate by an “X’ the behaviour of your employees towards colleagues suspected or having HIV/AIDS.

Employee behaviour towards their colleagues with HIV/AIDS	Indicate with an “X” appropriate Behaviour affecting your employees
8.1 Stigmatize infected workers	
8.2 Discriminate against infected workers	
8.3 Accommodate infected workers	
8.4 Afraid to get HIV from infected workers	
8.5 Not applicable	

9. Indicate with an “X” how HIV/AIDS has affected your labour force.

HIV/AIDS labour force issues	Indicate with an “X” appropriate issues affecting your business
9. 1 High staff replacement due to HIV/AIDS	
9.2 Increased use of child labour	
9.3 Increased use of extra labour force	
9.4 Increased demand for higher wages	
9.5 Not applicable	

10. Indicate with an “X” how your business profits have been affected by HIV/AIDS.

HIV/AIDS issues affecting your profits	Indicate with an “X” appropriate issues affecting your business profits
10.1 Increased absenteeism	
10.2 Frequent sickness at work	

10.3 Loss of customers	
10.4 Loss of suppliers	
10.5 Not applicable	

11. Indicate as a percentage (%), how much you have spent/lost approximately on the following HIV/AIDS related issues.

Loss of revenue due to following HIV/AIDS related issues	Indicate % money lost or spent per employee per year.
11.1 Average annual salary	
11.2 Money lost to absenteeism (funeral and sickness)	
11.3 Money lost in medical treatment /medical aid	
11.4 Money lost due to underproduction	
11.5 Money lost due to retraining and recruitment	

SECTION 3: RESPONDING TO HIV/AIDS AT WORKPLACE

12. In the table below indicate the appropriate HIV/AIDS prevention measures in place within your company.

HIV prevention strategy in place.	Indicate with an "X" next to the appropriate strategy.
12.1 HIV/AIDS policy for the company	
12.2 Provision of HIV prevention education	
12.3 Provision of care and support	
12.4 Equal treatment of all employees regardless of HIV status	
12.5 Community involvement in HIV programmes	
12.6 Not applicable	

*** Please if you did not put an "X" in 12.1 above please leave question 13, 14 and 15.

13. Pertaining the development of the HIV/AIDS policy indicate the issues you took into consideration during policy development.

Issues considered	Indicate with an "X" next to the appropriate issue.
13.1 Workers participated in its development	
13.2 Policy clearly communicated to all staff	
13.3 The policy is frequently reviewed with changing issues	

13.4 Monitored for its successful implementation	
13.5 Evaluated for its effectiveness	
13.6 Not applicable	

14. Which of the following issues are addressed by your policy?

Issues addressed	Indicate with an “X” next to the appropriate issue.
14.1 Complies with the laws and culture of Namibia	
14.2 Prevents discrimination against people leaving HIV/AIDS	
14.3 Clarifies behaviour expected towards HIV positive staff	
14.4 Enshrines confidentiality and privacy	
14.5 Conforms to current polices and practices of the company	
14.6 Not applicable	

15. Indicate any other issues that are covered by your policy.

Other issues addressed	Indicate with an “X” next to the appropriate issue.
15.1 States the benefits expected by the employee	
15.2 Has work performance standards for HIV positive staff	
15.3 States educational and medical services provided	
15.4 Balance between company, management and workers needs	
15.5 Outlines both internal and external resources available.	

16. Which of the following issues are included in your HIV educational programmes?

Issues included	Indicate with an “X” next to the appropriate issue.
16.1 Provides information about the HIV policy.	
16.2 Discuss and promote prevention of HIV infection	
16.3 Emphasize consistent and correct use of condoms	
16.4 Promote occupational hazards and safety awareness	
16.5 Provide clear answers to staff concerns about PLWA and HIV	
16.6 Not applicable	

17. Pertaining the delivery of your educational programmes indicate with an “X” factors that apply to your programmes.

Factors applied during educational programs	Indicate with an “X” next
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	to the appropriate factors.
17.1 Implemented during company time	
17.2 Inclusive of top management team	
17.3 Offered in small group meetings	
17.4 Mandatory to all staff	
17.5 allows time for discussions and questions	
17.6 Has pre and post programme assessment surveys.	

18. Which of the following modes of educational delivery do you use within your organisation?

Modes of delivery	Indicate with an “X” next to the appropriate mode of delivery.
18.1 Use staff members as peer educators or trainers	
18.2 Distributes brochure and HIV pamphlets	
18.3 Shows videos followed by discussions	
18.4 Invite experts to give health education on HIV/AIDS	
18.5 Encourages workers to learn about HIV on their own	
18.6 Information sharing with other companies.	

19. Concerning care and support services indicate the ones that you provide within your company.

Care and support services	Indicate with an “X” next to the appropriate care and support services
19.1 Have VCT centre at workplace	
19.2 Provide STI and opportunist infection treatment	
19.3 Have a health care clinic on site	
19.4 Provides ART on site	
19.5 Refer workers to source support outside workplace	
19.6 None of the above	

20. Which of the following issues are covered by your employment practices?

Employment practice	Indicate with an “X” next to the appropriate employment practice.
20.1 Comply with regulations on HIV and employment	
20.2 Have alternative working arrangements for PLWA	
20.3 Respect confidentiality and privacy of medical information	
20.4 Provide VCT to encourage workers to know about their status	
20.5 None of the above	

21. Indicate appropriate HIV prevention measures you are undertaking within the community.

Community HIV prevention measures	Indicate with an “X” next to the appropriate HIV prevention measures.
21.1 Provides HIV/AIDS information to clients and suppliers	
21.2 Educate workers’ families about HIV/AIDS	
21.3 Involved in local community efforts on HIV prevention	
21.4 Contribute resources, experience, expertise to community on HIV/AIDS	
21.5 Still to do something	

ANNEXURE 3: PILOT STUDY REPORT

After the questionnaire was drafted it was sent to the supervisors for approval before finalisation. The Supervisors commented on some formulations that were not clear, and gave a green light for the pilot study after corrections were made by the researcher.

The pilot study was carried out in Oshakati between 02 October and 09 October 2007.

INCLUSION CRITERIA

Convenient sampling was used to select the companies for the pilot study and only SMEs that employed five or more people were included.

COMPANY PROFILES

The pilot study was conducted with seven companies. The smallest employed five people and the largest employed 59. The sectors included general services, retail and wholesale.

Company name	Sector	Number of employees
1. Bud well Internet Café'	general service	5
2. Furnimart	retail/wholesale	13
3. Dunn's	retail/wholesale	8
4. Big daddy	retail/wholesale	12
5. KFC	Not applicable	26
6. Shop rite	retail/wholesale	59
7. Ackerman	retail/wholesale	6

FINDINGS

1. None of the seven companies responding had a policy on HIV in place. The

questionnaire was administered to minimise time.

2. The scale used in questions special instructions, and the instruction to skip questions that did not apply to SMEs having no HIV policy, used in revised questions 5 to 13, was confusing to the respondents and made it difficult for them to quantify the magnitude of problems using the scale provided. In the proposed revised questionnaire respondents were asked whether or not they experienced specific problems.
3. Questions 10 and 11 are nearly identical. Question 11 is repetitive, for example, “declining intellectual capital” and “loss of tacit knowledge” describe the same phenomenon. The phrases, “declining staff relations” in question 11 and “decreased staff morale” in question 10 have a similar meaning. Therefore, in the revised questionnaire, these two questions were excluded. Some important issues addressed through these two questions were then incorporated in other questions.
4. Questions 21 and 22 deal with care and support services, which all seven companies in the pilot study, did not have. They were included in the revised questionnaire in order to demonstrate the need for these services.
5. Some words used in the phrasing of questions were difficult to understand and were substituted with simpler words. However, words that do not have simple synonyms were left unchanged. Some of the difficult words and phrasing included “stigmatisation eroded financial earnings, high staff turnover”. Synonyms for most of these formulations have been used in the revised tool.
6. Complaints were voiced by several managers and owners of SMEs that the questionnaire took too much time for them to complete. Most of these people are the key administrators in their organisations and they feel they have insufficient time to devote to issues not directly related to their function. On average, the questionnaire took 20 to 30 minutes to complete. Reducing this time by half would be the best option to ensure that reliable data would be supplied by respondents.

From the findings produced by the pilot study, it became apparent that collecting

data from 200 SMEs would prove difficult and it was therefore proposed to train between five and ten field workers to assist the researcher collect data. I would personally provide a daily allowance to field workers. It happened on occasion that a manager or owner was not available for a scheduled appointment and the appointment would have to be rescheduled once or even several times.

Compiled by: Sydney Chikukwa

ANNEXURE 4: LETTER FROM UNAM RESEARCH COMMITTEE

UNIVERSITY OF NAMIBIA

Private Bag 13301, 340 Mandume Ndemufayo Avenue, Pionierspark, Windhoek, Namibia



FACULTY OF MEDICAL AND HEALTH SCIENCES

**Letter of permission:
Post graduate students**

Date: 28.9.2007
Dear Student: Mr S Chikukwa

The post graduate studies committee has approved your research proposal.

Title: <u>Socioeconomic burden of HIV/AIDS among small and medium enterprises in Oshana Namibia</u>

You may now proceed with your study and data collection.

It may be required that you need to apply for additional permission to utilize your target population. If so, please submit this letter to the relevant organizations involved. It is stressed that you should not proceed with data collection and fieldwork before you have received this letter and got permission from the other institutions to conduct the study. It may also be expected that these organizations may require additional information from you.

Please contact your supervisors on a regular basis.

Faculty representative on Post graduate committee

A van Dyk
Prof A van Dyk

