

1  
2 | **HIV Therapy**  
3 **Review – REVISED SUBMISSION**  
4

5 **Title:**

6 | HIV/AIDS in Private Sector Companies: Cost Impacts and Responses in Southern Africa  
7

8  
9 **Summary**

10  
11 The effects of the HIV epidemic, particularly in Southern Africa, have been increasingly  
12 experienced by companies in recent years. Initially, the lag in presentation of morbidity and  
13 mortality allowed companies to ignore the epidemic. However, in the past decade, companies  
14 have been confronted with the cost impacts of seriously ill and dying employees.  
15

16 Companies in many countries in the region are strongly engaged in generating effective  
17 prevention and treatment and care responses to the epidemic. However, many small and medium  
18 companies ignore the problem, due to inadequate resources. Nonetheless, some large companies  
19 are pioneering best practices in workplace HIV/AIDS programmes in prevention and care and  
20 treatment.  
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24 **Keywords**

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26 HIV/AIDS, Private Sector, Companies, Cost Impacts, Responses, Treatment, ART, Prevention,  
27 Southern Africa, South Africa  
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## 31 Introduction

32

33 In this review we examine the impacts on, and responses of private sector companies to the  
34 HIV/AIDS epidemic in Sub-Saharan Africa particularly Southern Africa. Southern Africa has the  
35 worst HIV epidemic in Africa in terms of morbidity and mortality; it also has some of the best  
36 and most innovative responses by companies.

37

## 38 Background of HIV/AIDS in Sub-Saharan and Southern Africa

39

40 ~~The increase in mortality due to AIDS has already had a significant demographic effect.~~  
41 ~~Individuals and households face increasing risks, both directly through the risk of infection and~~  
42 ~~indirectly as social insurance mechanisms are eroded. The mortality and morbidity associated~~  
43 ~~with AIDS are different from any other type of sickness and disease. Whereas most diseases prey~~  
44 ~~largely on children or the elderly, HIV is transmitted mainly through sexual intercourse which~~  
45 ~~makes young sexually active adults the most vulnerable. The majority of PLWHAs are aged~~  
46 ~~between 19 and 45 (economic prime) and are the primary breadwinners of their families.~~

47

48 Sub-Saharan Africa is by far the worst affected region in the world by HIV/AIDS [1]. Despite  
49 having just 10% of the global population, it has 66% of People Living with HIV/AIDS  
50 (PLWHAs) and experienced 72% of AIDS deaths in 2007. It was estimated that about 5% of  
51 adults in the region were PLWHAs at the end of 2007, compared with a global prevalence rate of  
52 less than 1%. Table 1 summarises the latest available [UNAIDS](#) estimates of the numbers of  
53 PLWHAs and AIDS-related deaths in selected countries.

54

55 Southern Africa accounts for 35% of all PLWHAs and almost one third (32%) of all new HIV  
56 infections and AIDS deaths globally in 2007. [1] + South Africa has an estimated 5.7 million  
57 PLWHAs at end 2007 (~~UNAIDS 2008~~). [1] The epidemic is occurring in the most economically  
58 developed part of Africa with South Africa alone accounting for one third of Sub-Saharan Africa  
59 gross domestic product (GDP).

60

61 ~~The increase in mortality due to AIDS has already had a significant demographic effect.~~  
62 ~~Individuals and households face increasing risks, both directly through the risk of infection and~~  
63 ~~indirectly as social insurance mechanisms are eroded. The mortality and morbidity associated~~  
64 ~~with AIDS are different from any other type of sickness and disease. Whereas most diseases prey~~  
65 ~~largely on children or the elderly, HIV is transmitted mainly through sexual intercourse which~~  
66 ~~makes young sexually active adults the most vulnerable. The majority of PLWHAs are aged~~  
67 ~~between 19 and 45 (economic prime) and are the primary breadwinners of their families. [2]~~

68

69 **Table 1: ~~Key Demographic Indicators of the HIV/AIDS Epidemic-Prevalence and Deaths~~**  
70 **for Selected Developing Countries in Sub-Saharan Africa – 2007** [1]

71

Region and Country	Adults (15+)	HIV prevalence among adults (%)	All AIDS deaths
Global Total	30,800,000	0.8	2,000,000
Sub-Saharan Africa	20,300,000	5.7	1,500,000

Botswana	280,000	26.5	11,000
Kenya	1,600,000	8.6	108,000
Malawi	840,000	13.3	68,000
Mozambique	1,400,000	10.3	81,000
Namibia	180,000	14.6	5,000
Nigeria	2,400,000	3.2	17,000
South Africa	5,700,000	16.9	350,000
Tanzania	1,300,000	7.0	96,000
Uganda	810,000	7.9	77,000
Zambia	980,000	15.4	56,000
Zimbabwe	1,200,000	26.0	140,000

72

73 **Method - The Costs of HIV/AIDS to a Company**

74

75 There is a growing body of evidence from recent research [2,3] that the HIV/AIDS epidemic is  
 76 having profound and wide ranging financial impacts on businesses in South Africa. However,  
 77 this data comes from relatively few and intensive case studies and many business leaders, even in  
 78 high prevalence sectors of the economy, are often unable to point out *current* and *specific*  
 79 impacts of the epidemic on their operating costs and revenue.

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81 The individual costs of having one employee with HIV/AIDS are composed of direct or out of  
 82 pocket costs and indirect or productivity linked costs. The direct costs include increased medical  
 83 costs and the costs of recruiting and training replacement employees. The indirect costs include  
 84 the reduced productivity of the ill employee, their increased leave and absentee days, increased  
 85 supervisor's time in managing the ill employee, the costs to production until a replacement is  
 86 hired and initially lower productivity of that new employee. [2]

87

88 The organisational costs of many employees being ill with HIV/AIDS are also composed of  
 89 direct or out of pocket costs and indirect or productivity linked costs. The direct costs include  
 90 increased benefits premiums especially for health insurance, increased number of workplace  
 91 accidents and increased legal costs. The indirect costs include increased senior management  
 92 time to deal with HIV/AIDS related matters, disruption to production and loss of workforce  
 93 morale, cohesion and experience. [2]

94

95 Figure 1 summarises these costs. This way of estimating costs, (and that in Figure 2), were  
 96 developed in the late 1990's and applied in a number of studies. They remain as applicable  
 97 today.

98

99 **Figure 1: Costs of HIV/AIDS in the workforce [2]**

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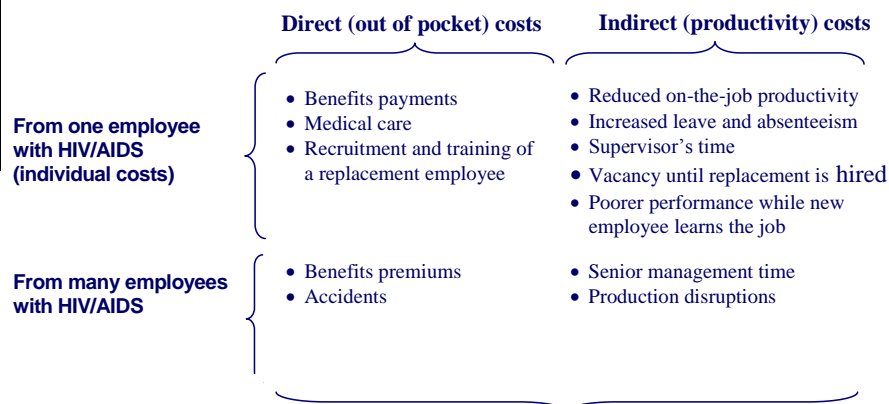
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Direct costs are out of pocket expenses for a company that will show up on the company's income statement. Indirect costs are reductions in labour productivity. Few studies exist which make some estimates of AIDS-related increases in absenteeism [4,5] and reduction in labour productivity [6]. This latter study estimated the impact of HIV/AIDS on individual labour productivity during disease progression and found that the daily difference in tea leaves picked by a Kenyan tea plucker with AIDS in the last three months of his or her life and a healthy worker was significantly less. The study not only managed to quantify what AIDS is costing the Rift Valley tea estates in lost productivity but also gave employers involved in similar labour intensive agricultural ventures, an idea of how the epidemic could affect them economically.

Hardest of all to quantify are the indirect costs resulting from multiple cases of HIV/AIDS. These impacts include: diminishing employee morale, the disruption of established work teams, the reduced efficiency of a workforce that has less experience and probably less skill, an increase in labour disputes as benefits and job security come under pressure, and the burden imposed on managers who must cope with high workforce morbidity and mortality. Most of these costs are hidden, and in some cases they will not become evident until the epidemic is further advanced.

#### Timing of the Costs

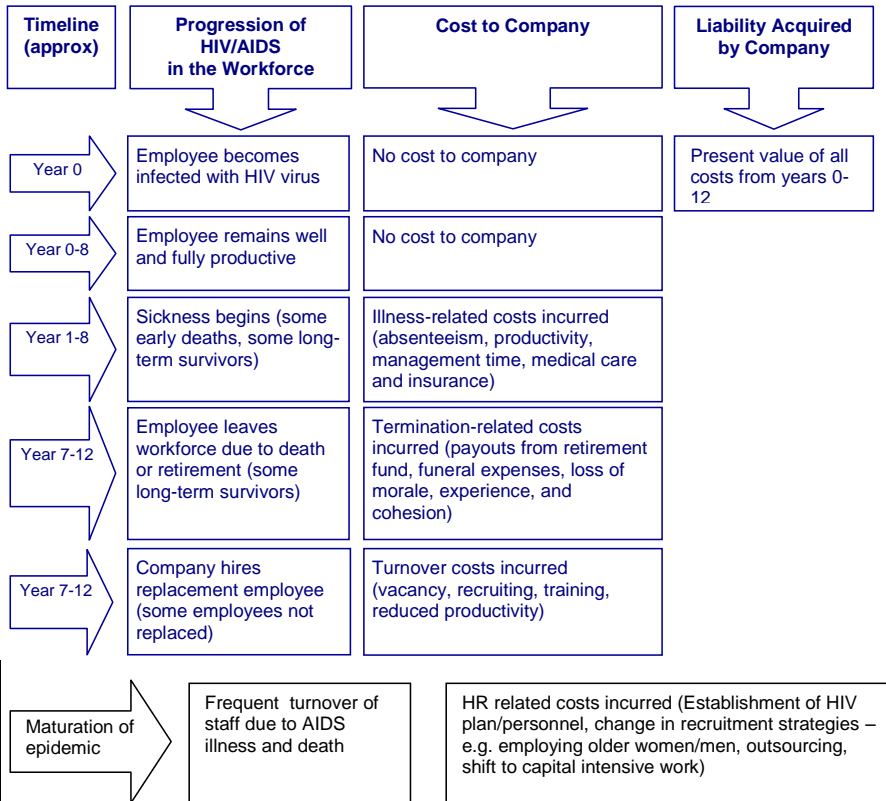
~~Figure 2 illustrates the timing of costs and liabilities which initially are very low or non-distinguishable from normal employee costs. As the employee progresses into AIDS then these costs increase, culminating in large termination related and replacement costs. As the epidemic matures so the costs for the companies increase. Those companies faced with a significant prevalence rate often respond in various ways which does have a cost implication attached to those actions.~~

The progression and intensity of opportunistic infections associated with HIV varies by asymptomatic individual. For many PLWHA these infections can appear anytime up to 6-8 years after infection. Initially the costs and liabilities associated with HIV/AIDS are very low or non-distinguishable from normal employee costs. As the employee progresses into AIDS then these costs increase, culminating in large termination related and replacement costs. As the epidemic matures so the costs for the companies increase. Those companies faced with a significant prevalence rate often respond in various ways which have a cost implication attached to those actions.

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**Figure 2: Progression of cases, costs, and liability** [2]



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### **Results - Cost Estimates**

158 | There is now a large a growing body of evidence from a decade of intensive work on estimating  
159 | the costs of HIV to companies [7-14]. However, not a lot of this work is available in the public  
160 | domain as cost impact studies are often done by private consultants and the results held by the  
161 | commissioning company. However, a recent review of these estimates found that with few  
162 | exceptions the annual labour costs of HIV morbidity and mortality rarely exceeded 3% of payroll  
163 | [8] thereby indicating why may companies ignore the effects of HIV/AIDS. The costs of an  
164 | AIDS death or retirement depends upon the skill and productivity level of the employee and  
165 | hence their salary level. In the review it was found that the average costs per AIDS related  
166 | termination as a multiple of annual compensation (wages and other benefits) varied between 0.9  
167 | and 4.7 percent [8]. One AIDS related death has a severe cost impact whilst simultaneously the  
168 | overall cost burden is relatively light.

169  
170 However, the HIV epidemic has become a major threat to employment objectives and labour  
171 market efficiency [15]. The loss of workers and workdays due to AIDS-related illness or the  
172 demand for caring can result in a significant decline in productivity. Moreover, this leads to a  
173 loss of earnings and attrition in skilled and experienced workers. The obvious effect on the  
174 labour force is a reduction in the number of people of working age.

175  
176 AIDS deaths lead directly to a reduction in size of the labour force [9]. The deaths due to AIDS  
177 occur to workers in their most productive years. In 1999, 80% of the new infections were aged  
178 between 20 and 49. As younger, less experienced workers replace these experienced workers,  
179 labour productivity is reduced. For example, a Kenyan sugar estate estimates a 50% decrease in  
180 production, as most of the experienced workers died of AIDS related illnesses between 1993 and  
181 1997 [10]. The health cost increased tenfold and funeral costs five times. Shortages of workers  
182 lead to higher wages, which lead to higher production costs which erodes international  
183 competitiveness and exports.

184  
185 In Southern Africa the projected decrease in the labour force participation is 19% for men and  
186 18% for women. South Africa is losing an annual estimated R12 billion (US\$1.2 billion) due to  
187 absenteeism, of which approximately R2 billion (US\$200 million) can be attributed to the effects  
188 of HIV/AIDS [11]. The absenteeism rate for PLWHAs was three times higher than others.  
189 PLWHAs were absent 32 days a year on average [11].

#### 190 191 | **Company Responses**

192  
193 Company responses to HIV/AIDS among employees can be summarised under two categories:  
194 prevention and treatment and care. Individual company treatment responses have been slow  
195 until recently when treatment costs reduced substantially. As more (mainly larger) companies  
196 have recognised the problems and commenced activities to prevent transmission and treat their  
197 ill employees, a more coordinated approach has emerged in the forms of business coalitions  
198 | against HIV/AIDS [101-10444-47].

199  
200 Typically, companies have two objectives in undertaking a workplace HIV/AIDS program: (i) to  
201 limit the incidence of new infections among staff and the surrounding community and (ii) to  
202 manage the impact of existing infections on the company, staff and community. To achieve these  
203 objectives a company's programme might set goals in two areas: (i) changing behavior and  
204 increasing the use of preventative measures and (ii) improving medical care and support to  
205 PLWHAs. In some cases, companies aim to raise its corporate responsibility profile in the area  
206 of HIV/AIDS by choosing to take a leadership role in mobilising the business community,  
207 getting involved in advocacy at a regional or national level, or supporting social programmes [16-  
208 18].

209  
210 There are regional differences in the response of business to HIV/AIDS. Companies with  
211 operations only in America and Europe are less likely to have workplace programmes where  
212 health insurance covers the costs of treating HIV/AIDS. Companies with African operations are  
213 | more likely to implement workplace HIV/AIDS programmes. More than 70% of **multinational**  
214 companies surveyed with operations in Africa are now fully subsidizing access to HIV treatment

215 | for all employees.<sup>[19]</sup> Some African companies also provide confidential testing services and  
 216 | access to treatment for registered or legal dependants although most indigenous companies have  
 217 | been very slow to offer treatment to their AIDS ill employees [19].

218 |  
 219 | South African-based companies lead the way internationally in the response to HIV/AIDS.  
 220 | However, provincial variation can be found with companies in provinces. Companies in Gauteng  
 221 | province, the economic powerhouse of South Africa, (adult prevalence 21%) and KwaZulu Natal  
 222 | (28%) are more likely to have implemented programmes than lower prevalence provinces like  
 223 | the Eastern Cape (19%) and the Western Cape (8%) [1, 13].

224 |  
 225 | The South African Business Coalition on HIV/AIDS (SABCOHA) is working with a number of  
 226 | organisations including Eskom Holdings Limited, Daimler Chrysler, the International Labour  
 227 | Organisation (ILO) Project (involving Volkswagen's eight supplier companies as part of a  
 228 | broader ILO Pilot Project), and the Japan Bank for International Co-operation (JBIC), to address  
 229 | this issue. In June 2008, SABCOHA began to offer supply, or vendor chain, companies the  
 230 | opportunity to provide free VCT and treatment to their employees as part of a comprehensive  
 231 | workplace programme [44][01].

232 |  
 233 | Small and micro enterprises (SMEs) are not responding as well to the threat of HIV/AIDS [20].  
 234 | In South Africa, medium and large companies employ 26% of the working population. SMEs  
 235 | provide more than 55% of total jobs, and account for 22% of GDP. Yet only about 25% of  
 236 | SMEs are estimated to have established any workplace programmes [21]. This is despite the fact  
 237 | that potentially, HIV/AIDS could have a more significant impact on SMEs - losing a worker in a  
 238 | SME can represent a significant proportion of the workforce leading to a reduction in  
 239 | productivity and high cost of retraining workers, especially skilled staff but they provide fewer  
 240 | benefits to employees. SMEs also lack dedicated Human Resource management staff and/or  
 241 | systems to assess, monitor and devise HIV/AIDS workplace programmes [21, 22].

242 | ~~The matrix~~ Table 2 below offers insight into the impact of and response to HIV/AIDS by  
 243 | companies according to company size. The impacts and responses have been ranked in order of  
 244 | importance of HIV/AIDS-related costs taken from a study [23] of South African businesses in  
 245 | 2004. Based on a number of South African studies [3, 12, 13, 24, 25, 26] and a global review [27] of  
 246 | business perceptions of the epidemic covering the opinions of 10,993 business executives in 117  
 247 | countries suggests the most common responses. There are exceptions to this norm as there are  
 248 | small and medium size companies who do provide VCT and treatment. Conversely there are  
 249 | larger corporate who do not provide the basic of prevention programmes. The construction sector  
 250 | within South Africa has been ~~eritised~~ criticised for their lack of engagement to HIV/AIDS  
 251 | impact mitigation activities.

252 | **Table 2: Impacts and Responses of Companies by Number of Employees**

Company Size	<100 employees		100-500 employees		> 500 employees	
Ordered Impact and Response	Impact	Response	Impact	Response	Impact	Response
1	Lower productivity and	HIV/AIDS policy	Lower productivity and increased	HIV/AIDS policy	Higher employee benefit costs	HIV/AIDS policy

	increased absenteeism		absenteeism			
2	Loss of experience and vital skills	Some Education and Awareness activity – usually taking the form of posters and condom distribution	Higher employee benefit costs	Some Education and Awareness activity – usually taking the form of posters and condom distribution	Intervention costs: Voluntary counselling and testing or HIV/AIDS awareness programmes	Establishment of an HIV/AIDS committee and/or coordinator
3	Higher labour Turnover rates		Loss of experience and vital skills		Lower productivity and increased absenteeism	Education and Awareness activities
4	Higher employee benefit costs		Higher labour turnover rates		Intervention costs: HIV/AIDS Treatment	VCT
5	Higher recruitment and training costs		Higher recruitment and training costs		Intervention costs: Research into the impact of HIV/AIDS	ART provision

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## 256 Prevention Activities

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### 258 Peer Education

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260 Studies [28-30] have shown peer education to be one of the most widely-used strategies for  
 261 raising awareness of HIV/AIDS. Peer education typically involves training and supporting  
 262 employees to affect change among their peers. Principles and components that affect HIV/AIDS  
 263 peer education programme quality and effectiveness include: (i) providing training for peer  
 264 educators; (ii) compensating them in some way; (iii) involving them in the design of training  
 265 curriculum and materials; and (iv) linking the education programme to other services such as  
 266 access to condoms, medical care and voluntary HIV counselling and testing.

267

### 268 Voluntary HIV Counselling and Testing (VCT)

269

270 Many people are unaware of their HIV status. From a behavior change and treatment  
 271 perspective, this knowledge is critical. VCT has proven effective in promoting prevention for  
 272 those who test negative and behavior change for those who test positive.

273

274 Although participation in workplace VCT Campaigns is often limited [24], VCT uptake is  
 275 increasing over time. When AngloAmerican started their VCT campaign in 2003 they had less  
 276 than 10% uptake. In 2005 this increased to 31% and in 2007 it reached 72% [31]. This appears to  
 277 be the trend in other companies who have ongoing VCT programmes for a number of years.  
 278 There are some 'best practice' examples of companies like Shell (Kenya) who have achieved  
 279 VCT uptake of in excess of 90% [32].



280  
281 *De-stigmatizing the disease*  
282

283 Discrimination in the workplace reinforces stigmatization of PLWHAs. At the same time, the  
284 workplace offers a unique opportunity to confront societal discrimination and stigma by  
285 dispelling myths and communicating that there is no need to fear PLWHAs.  
286

287 These messages can be further reinforced by workplace-based, anti-discrimination policies and  
288 programmes which demonstrate that people can live and work with HIV, often for many years.  
289 Encouraging an HIV/AIDS support group for employees, or involving PLHWAs in company  
290 awareness activities, can also be a powerful means of breaking down misconceptions, fostering  
291 understanding and acceptance, and enabling employees to freely and openly participate in  
292 company treatment programmes [33-34].  
293

294 **Treatment and Care Activities**  
295

296 In some enlightened, but still rare cases, the costs of anti-retroviral treatment (ART) for infected  
297 employees are met by the companies themselves [24, 35-38].  
298

299 There is now a discernable shift from orthodox occupational health programmes, to designing  
300 and implementing programmes aimed at treating and managing their infected employees,  
301 especially amongst larger companies. A number of factors have contributed to this situation,  
302 including:  
303

304 *Maturing epidemic:* An increasing number of infected employees are falling ill and employers  
305 are starting to experience the financial effects of the epidemic by way of rising absenteeism and  
306 increasing staff turnover rates.  
307

308 *Falling costs of treatment:* The cost of treating a PLWHA has dropped considerably. In 1998, the  
309 annual cost of treating a PLWHA stood in the region of \$US7,000 while in 2008, it was \$US250  
310 per annum. This has resulted in companies reassessing the provision of treatment to employees  
311 [39].  
312

313 *Activist pressure:* Civil society, trade unions and NGO's have lobbied governments to provide  
314 treatment to PLWHA. This coupled with a growing corporate culture of providing treatment, has  
315 resulted in more companies developing programmes to treat their infected employees.  
316

317 The majority of countries have implemented national ART programmes which vary in terms of  
318 the extent to which they provide comprehensive treatment and in terms of access, but this move  
319 has prompted companies, in particular multi-nationals to begin forging partnerships with  
320 government. These partnerships often come in the form of cross utilisation of resources.  
321 Examples of these partnerships can be found in Botswana where Debswana Diamond Mines  
322 opens its health facilities to the community whilst in Zambia, Zambian Breweries uses local  
323 clinics and hospitals to treat its staff.  
324

325 Many companies provide ART independently of public health programmes on the grounds that  
326 the costs of not intervening would soon outweigh the costs of treatment. The general rationale is  
327 that ART enables HIV infected employees to remain productive which generates indirect savings  
328 through the saving of recruitment, training and absenteeism costs. In every company, however,  
329 the projected economic returns have yet to be fully achieved due primarily to the slow take-up of  
330 ART amongst employees.

331  
332 Recent studies in companies providing ART reveal [21, 24]:

- 333 • limited participation of employees in VCT, perceived to be due to persistent fears of  
334 discrimination and stigma in workforces;
- 335 • limited numbers of individuals on ART (majority of companies with less than 1% of the  
336 employees on treatment) presenting a very high cost ratio for individual care;
- 337 • tendency of PLWHAs to seek treatment once they are very sick and incapable of  
338 working, thereby confounding intentions to maintain worker productivity by enrolling  
339 individuals in health programmes before they fall ill;
- 340 • high costs in time and resources expended to enrol employees.

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342  
343 Workplace ART programmes and the collaboration and partnerships they entail are an  
344 innovation that can complement government efforts to contain and manage HIV/AIDS  
345 epidemics. An important implication is that if company initiatives are to be effective and  
346 complement government efforts, there needs to be better co-ordination. The notion of  
347 'partnership' needs to be developed for the benefit of overall treatment efforts.

348  
349 Whilst companies struggle to get HIV infected employees on treatment [34], the benefits are  
350 evident [40] once an employee is successfully placed on a treatment programme. A study at a  
351 Kenyan tea estate has revealed that after 12 months on ART, employees worked at least twice as  
352 many days in the month than they would have in the absence of ART. This study is the first and  
353 only one of its kind and there is a real need for further research in this field.

### 354 355 **Conclusions and Future Perspective**

356  
357 At the end of 2008 the global economy appeared to be spiraling into recession. The switch from  
358 boom to bust happened in a few short months. In July 2008, oil prices reached an all time high of  
359 \$147 per barrel ~~and~~; most commodity prices were rising rapidly ~~and it seemed that there was~~  
360 ~~little to worry about in global economic terms~~. In January 2009 oil had fallen to less than \$34 per  
361 barrel [41] and most other commodities had fallen dramatically. In November 2008, the IMF  
362 warned that prospects for global growth had deteriorated and the evidence since then is that the  
363 contraction has continued. The IMF predicted that world output would expand by 2.2% in 2009,  
364 down by some 0.75% of GDP compared to their October forecast. In emerging markets, growth  
365 would 'slow appreciably'[42].

366  
367 The consequences of a global recession will be far reaching. Slower growth means fewer jobs  
368 and redundancies. Pressure on the private sector profits will lead to a greater focus on core  
369 business which means that if HIV interventions and AIDS treatment are not seen as crucial then  
370 there may be cut backs. There will also be an impact on international foreign aid. Data show that

371 after the 1991 banking crisis in Scandinavia foreign aid flows from Finland, Norway and Sweden  
372 fell and took between 7 and 10 years to recover. Many philanthropic bodies have their resources  
373 invested in the world's stock markets and they may face constraints as returns fall. The point of  
374 this is simply to note that the world has changed and it is crucial that those working in the field  
375 of HIV/AIDS recognise this.

376  
377 However, the impact of HIV/AIDS on companies is very real. Companies in many countries are  
378 now strongly engaged in generating effective prevention and treatment and care responses to the  
379 epidemic. However, this does vary by company size, with many small and medium companies  
380 continuing to ignore the problem, due to inadequate resources. Whilst some large companies are  
381 pioneering best practices in workplace HIV/AIDS programmes in prevention and care and  
382 treatment.

383  
384 Expectantly, those companies whose profitability is more adversely affected have more  
385 motivation to respond; also companies that are more profitable have the financial capacity to  
386 respond. Secondly, those companies who experience more pressure through union and public  
387 opinion are more likely to respond [43].

388  
389 To ensure that the economies within the countries in Southern Africa remain buoyant, there is a  
390 need for companies and government to work together in an effort to manage HIV/AIDS. This  
391 means maximising treatment efforts throughout the economy through the fostering of  
392 partnerships. Whilst managing the health of PLWHAs remains important, it does not hide the  
393 fact that this exercise acts only to mop up an ever increasing flow of new infections. The ultimate  
394 objective remains to halt new infections and this can only be done through successful prevention  
395 and treatment programmes championed by companies.

396  
397 There is much work remaining to be done in companies to adequately address the impacts of this  
398 large epidemic.

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## **Executive Summary**

### **Scale of the Epidemic**

- The unprecedented scale of the HIV epidemic, particularly in Southern Africa, has meant that companies have been confronted by many sick and dying employees.

### **Cost Impacts on Companies**

- The cost impacts have been increasingly experienced by companies in recent years. The lag in presentation of morbidity and mortality allowed companies to initially ignore the epidemic.
- The impact of HIV/AIDS on companies is now very real.

### **Company Responses**

- Companies in many countries are now strongly engaged in generating effective prevention and treatment and care responses to the epidemic.
- However, this does vary by company size, with many small and medium companies continuing to ignore the problem, due to inadequate resources.
- Some large companies are pioneering best practices in workplace HIV/AIDS programmes in prevention and care and treatment.

### **Conclusions**

- Companies until the last decade ignored the increasing level of morbidity and mortality.
- Evidence on private sector responses shows wide range of responses

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- Data on private sector responses is limited, as such, there is little comprehensive data on the costs of HIV on private sector in southern Africa. Lack of information is the reason for many companies continuing to ignore the epidemic. However, there are companies which have recognized the threat and in developing workplace programmes; have become leaders and exemplars of 'best practice'
- The HIV response in the private sector is evolving – early interventions that focused on education are now incorporated into broader programmes (VCT and provision of ART, supply chain etc)
- There is much work remaining to be done in companies to adequately address the impacts of this large epidemic.

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