HIV AND AIDS AS A THREAT TO SOUTHERN AFRICAN TOURISM

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DECLARATION

I, Lisbon Simeon Ketshabile, declare that the contents of this dissertation represent my own work, and that the dissertation has not previously been submitted for academic examination towards any qualification. Furthermore, the facts and conclusions herein are my own and not of any other individual.

Signature: _____ Date 19-09-07

ABSTRACT

The main objectives of this research were

:

- To investigate how HIV/AIDS affect Southern African tourism, with specific reference to the tour operators.
- To investigate measures taken by the Southern African tour operators and governments to combat HIV/AIDS and the chances of success.
- To make some recommendations on what can further be done to fight HIV/AIDS in the Southern African tourism sector.

T o conduct the literature study, the following methods were used:

i. Literature search particularly about Southern Africa and in general, as well as news report has been conducted.
ii. Review of HIV statistics.
iii. Use of Internet.
iv. Journals and government publications.

RESULTS:

The United Nations (2005: 22) indicates that Southern Africa is experiencing the highest rate of HIV infection in the world. The infection rate is particularly high among the young people (aged 15 – 49). This age group constitutes people who are economically active, and some of them work directly or indirectly in the tourism sector.

THETA (2003: 4) conducted a study on a number of tourism and hospitality companies in South Africa. The study results indicate that 92% of the companies surveyed do not have HIV/AIDS educational programmes for their employees, and that 91% of the surveyed companies do not provide HIV/AIDS preventive measures like condoms to their workers at workplace. The other outcome of the study is that 95% of the companies surveyed by THETA do not have voluntary

counselling and testing (VCT) programs for their employees, and 98.5% of the surveyed companies do not provide care programs for their affected workers.

In conducting the empirical survey, the following methods were followed:

This section provides an overview of the methodology that was used to conduct the survey on the impact of HIV/AIDS on a selected tourism business sector in four Southern African countries. The HIV/AIDS survey was conducted from June to August 2006 in stratified randomly sampled tourism companies/tour operators in Namibia, South Africa, Zimbabwe and Botswana. The stratified random sampling method was used to select these four Southern African countries. Eight Southern African countries were identified based on their HIV/AIDS world ranking (Annexure B). The identified countries are among the top eight countries in Southern Africa in terms of world HIV/AIDS ranking.

From each country, major tourist destinations were identified, and from these destinations, 60 tourism organisations were identified, and stratified random sampling method was used to select ten organisations from each country to make a total of 40 organisations. The reason why the sample was kept at this number was due to both time and financial constraints, and that the interviews were conducted in four different countries. The other reason is that some of the chosen countries' tourism is still in its infancy stage, and their tour operators have not experienced the economic impact of HIV/AIDS yet.

The study was conducted on the tour operators because of financial constraints and also because a number of studies have been conducted on the hospitality sector but not so much on tour operators. People interviewed include company directors, managers and some general employees at different levels of company structures. Some government officials in the tourism sector in their respective countries were also interviewed. The reason for selecting these personnel instead on interviewing the general employees was that these people are involved in management of their respective companies, therefore are expected to have better understanding of the macro economic impact of HIV/AIDS in their respective organisations than the general employees. The other reason was to ensure quality of the information. The stratified random sampling method was used

to select at least two respondents from each management level of the organisational structure in their respective departments. The survey was conducted through telephone and personal interviews.

RESULTS:

The company executives and managers who indicated that HIV/AIDS affects the day-to-day running of their businesses in Namibia is 32%, South Africa 27%, Zimbabwe 21% and Botswana 38%. Based on these results, it is clear that the daily running of a number of tourism companies in the Southern African region is affected by the HIV/AIDS pandemic.

The other indication is that 52% of the respondents strongly agreed with the statement indicating that the Southern African tourism sector experience a problem of some workers going on sick leave for a lengthy period attributed to HIV/AIDS. In addition to this, 29% of the respondents agreed with the statement but not so strongly, 11% were neutral, 6% disagreed and 2% of the respondents strongly disagreed with the statement.

CONCLUSION:

These results indicate that the Southern African tourism is loosing experienced workers due the HIV/AIDS pandemic. This study was carried in four of the Southern African countries, but looking at the results one could ascribe them to a number of other countries in the region.

HIV/AIDS impacts negatively on the Southern African Tourism Sector by killing the experienced and skilled tourism workers. Some organisations are reported to have some problems of poor quality service rendered because they operate with young inexperienced workers. A number of tourism organisations in Southern Africa experience costs resulting from continuous employment and regular interviews as a process to replace the lost employees due to HIV/AIDS.

In response to the pandemic, some organisations train their employees in different positions so that they can be able to perform different tasks so that if one person is ill or absent, they can have a replacement. This is costly because training people is expensive ad time wasting.

HIV/AIDS kills the economically active population – people who hold the skills, do the work, pay taxes, raise children, vote in the elections, and provide leadership. Some of these people work directly or indirectly in the tourism sector.

Some governments in the Southern African countries like Botswana and South Africa have policies in place to fight the pandemic, and provide AIDS drugs like antiretroviral (ARV) to the people infected by HIV/AIDS in their respective countries. However, the challenge faced by a number of Southern African countries is that some people are ignorant of the preventive measures and do not change their risky behaviour. Another criticism facing some of Southern African governments (South Africa) is that the HIV/AIDS drugs and educational campaign do not reach people living in rural areas.

The overall implication of these results is that the Southern African tourism is faced with some challenges resulting from HIV/AIDS, but with the efforts made by governments and private companies, the impact may be reduced. For example the provision for AIDS drugs like ARV prolongs the lives of people who are HIV positive, and may reduce high death rate in the region. But all these may work only if people change their risky behaviour, like using preventive measures to avoid constructing or spreading HIV/AIDS. The other implication is that a lot need to be done to educate tourism workers and the general public about HIV/AIDS.

A number of strategic recommendations are proposed in the research:

- More educational campaigns on issues surrounding the HIV/AIDS pandemic should be launched not only in urban areas but also in rural areas using the local languages.

- Southern African tourism companies and in general should include the HIV/AIDS programmes in their day-to-day business operation activities to educate and to encourage open communication among employees.

- The Southern African tourism companies and in general should conduct research in a collaborative approach to assess the impact of HIV/AIDS on their businesses.

- Where possible, the tourism companies should work with the community leaders to identify and discourage the risky behaviour that leads to the spread of HIV/AIDS.

- Tourism companies should openly talk to their employees about the HIV/AIDS pandemic on a regular basis and encourage them to go for voluntary counselling and testing, and to use the preventive measures like condoms.

- Southern African tourism companies should include HIV/AIDS programmes and treatment in their budgets for their infected and affected employees.

- Both the private and public tourism sectors should work together to enhance behavioural change among tourism employees, and to raise funds for educational programmes on issues surrounding the HIV/AIDS pandemic.

- The stakeholders from both the private and public tourism sectors should work together to draft a code of conduct that prevents risky behaviour, with which both visitors and residents of every tourist destination in Southern Africa should abide. This code of conduct must be included in the brochures, websites or in hotel menus to guide both visitors and locals on how they are expected to conduct themselves.

- Risky behaviour activities like sex tourism and commercial sex/prostitution should be discouraged in Southern African countries.

- HIV/AIDS programmes should be incorporated in both rural and urban primary schools' educational programmes to educate the young people about the pandemic. This will help the young people, as future leaders, to know the risky behaviour leading to HIV/AIDS infection.

- Southern African governments should work together to alleviate poverty in the region through identification of strong and informed leadership.

- The governments in the region should work hand-in-hand to devise strategies to fight the HIV/AIDS pandemic in a collaborative approach and to assist those countries in Southern Africa that cannot afford to purchase the HIV/AIDS treatment like ARV drugs.

- Southern African countries should establish a standing HIV/AIDS committee, which is responsible for the HIV/AIDS strategic planning, formulation, implementation and evaluation. This committee would make continuous assessments to evaluate progress of all Southern African countries in aspects of poverty alleviation activities.

DEDICATION

I would like to dedicate this dissertation to my wife, with love and sincere gratitude for the support she has given me during the study.

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ABBREVIATIONS AND ACRONYMS

AIDS: Acquired Immunodeficiency Syndrome.

ANC: Antenatal Clinics.

ART: Anti-Retroviral Treatment.

ARV: Antiretroviral.

ASSA: Actuarial Society of South Africa.

ATIC: AIDS Training and Information Centre.

BCI: Behavioural Change Interventions.

BEDIA: Botswana Export Development and Investment Authority.

BOCAIP: Botswana Christian AIDS Intervention Programme.

BOTUSA: Botswana-United States of America.

CAMPFIRE: Communal Areas Management Programmes for Indigenous Resources.

CITIES: Convention on International Trade in Endangered Species.

CSO: Central Statistics Office.

DMSAC: District Multi-Sectoral AIDS Committee.

DOH: Department of Health.

EA: Environmental Assessment.

GDP: Gross Domestic Products.

HATAB: Hospitality and Tourist Association of Botswana.

HIV: Human Immunodeficiency Virus.

HSRC: Human Science Research Council.

IEM: Integrated Environmental Management.

IDASA: Institute for Democracy in South Africa.

ILO: International Labour Organisation.

IMC: Inter-Ministerial Committee.

IPT: Isoniazid Prevention Therapy.

ITTT: Interim Tourism Task Team.

LAC: Legal Assistance Centre.

MEC: Members of the Executive Council.

NAC: National AIDS Council.

NACA: National AIDS Co-ordinating Agency.

NACOBTA: Namibia's Community-Based Tourism Association.

NACOSA: National AIDS Co-ordinating Committee of South Africa.

NAFT: National AIDS Trust Funds.

NEPAD: New Partnership for Africa's Development.

N.D.: Not Dated.

NGO: Non-governmental Organisations.

PAC: Provincial AIDS Council.

PLWA: People Living with AIDS.

PMTCT: Prevention of Mother-to-Child Transmission.

SATOUR: South African Tourism.

STD: Sexually Transmitted Diseases.

TAC: Treatment Action Campaign.

THETA: Tourism, Hospitality and Sport Education and Training Authority.

UNDP: United Nations Development Programmes.

UNICEF: United Nations International Children Funds.

US: United States.

VCT: Voluntary Counselling and Testing.

ZTA: Zimbabwean Tourism Authority.

ZTE: Zimbabwean Tourism Expo.

CONTENTS **PAGE**

CHAPTER 3

HIV AND AIDS SITUATION IN SOUTHERN AFRICA AND RESPONSE STRATEGIES

CHAPTER 4

THE IMPACT OF HIV/AIDS ON THE SOUTHERN AFRICAN TOURISM

CHAPTER 5

RESEARCH SURVEY AND RESULTS ANALYSIS

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

Annexure B: Global HIV/AIDS statistics

Annexure C: Research questionnaire

CHAPTER 1

HIV AND AIDS AS A THREAT TO SOUTHERN AFRICAN TOURISM

1. INTRODUCTION AND BACKGROUND

The United Nations Organisations (2005: 22) indicates that the Southern African Region is experiencing one of the severest HIV/AIDS pandemics on the whole African continent. According to the organization the epidemic began to spread in the Southern African region during the 1980s. In the 1990s, HIV prevalence increased dramatically. The report also indicates that since the survey of HIV prevalence among pregnant women attending antenatal clinics was conducted in the 1990s, prevalence has climbed by 25% to 45% in a number of countries within the Southern African Region. Indications are that the severity of the pandemic in urban and rural areas is quite similar, unlike in many other parts of Africa.

The United Nations International Children Fund (UNICEF) annual report on the progress of nations (2004: 18), it is increasingly evident that HIV/AIDS has a major effect in Southern Africa. There is no doubt that overall infection rates in the region are high and increasing. Some countries in the region like Botswana are reported to have an HIV infection rate of 18.284% of the entire population, and it is expected that this will increase to a peak of 30% or perhaps even higher. According to the report, infection rates among specific sub-groups of the adult population are higher, with sentinel surveys of pregnant women in the Region showing an infection rate of 40-50% in some countries within the Southern African Region. The same pattern could be true of the region's largest economy, and tourism sector, given that similar infection rates are already reported in the tourism industry of a number of Southern African countries.

HIV/AIDS affects the Southern African Region extensively, and in many different ways, given these high infection rates and the fact that, at present, HIV infection eventually results in death. Demographically, a sharp rise in the mortality rate causes life expectancy to fall, perhaps quite drastically, and a reduction in the population growth rate, could even result in negative figures. Socially, the impact is devastating, given the human cost of so much illness and so many deaths. There is an increase in poverty in some countries within the Southern

African Region, as households with AIDS patients face a reduction in income as breadwinners become sick and die, and an increase in expenditure on medical and related costs. The impact of HIV/AIDS on economic growth, per capita incomes, savings, investments and employment is significant, most obviously because of the impact on the Labour force (UNICEF, 2004: 18).

The UNICEF report further stipulates that HIV/AIDS has a negative impact on the Southern African economy, the workforce, business, and individual workers and their families. HIV/AIDS is a threat to enterprise performance. The world of work is affected by increasing costs due to Health Care, absenteeism, burial fees, recruitment, training and re-training costs. HIV/AIDS disrupts the performance of the formal and the informal sectors and small and medium enterprises. Other manifestations are low productivity, depleted human capital, challenged social security systems and threatened occupational safety and health, especially among certain groups at risk such as migrant workers and their communities and workers in the medical, tourism and transport sectors. Overall, there will be a reduction of growth and productivity if rapid measures are not taken to prevent the impact of HIV/AIDS in the Southern African Tourism Industry.

Much has been learned about the epidemic and how it should be addressed, particularly that HIV/AIDS prevention and care are complex issues requiring a multi-sectoral approach. However, the full potential of the world of work as a major venue for partnership and intervention to prevent HIV/AIDS, protect workers and reduce its impact on tourism as a business remains untapped in most Southern African countries. Therefore, the purpose of this study is to examine the social and labour implications of HIV/AIDS, as well as current practices and approaches to address the problem in Southern Africa, particularly in the Tourism Sector. Based on a preliminary assessment of impact, constraints and opportunities, this study explores the policy and programme elements of Government and Tourism Sectors' response to the tragedy.

The study will cover the HIV/AIDS in the Southern African Region and its impacts on the tourism sector. Tourism in the Southern African Region and its contribution to the Region's economy will be discussed. The concluding remarks will be made on the status of HIV/AIDS within the Southern African Region and its impacts especially on the tourism industry. The steps taken by some countries and tourism sectors will be discussed and the chances of

success will be evaluated based on policy implications and a situation analysis. Recommendations on further steps that need to be taken to fight the epidemic will be made.

2. MOTIVATION

The UNAIDS (2002: 190) indicates that the status of HIV/AIDS is high in Southern Africa. Statistically, Southern African countries have the highest percentage of HIV/AIDS prevalence among the total population in the world. Tourism contributes significantly to the economy of Southern African countries but the HIV/AIDS epidemic negatively affects the industry (United Nations International Children Funds 2004).

3. PROBLEM DESCRIPTION

The United Nations (2005: 22) indicates that Southern Africa is experiencing the highest rate of HIV infection in the world. The infection rate is particularly high among the young people (aged 15 – 49). This age group constitutes people who are economically active, and some of them work directly or indirectly in tourism sector. The Sub-Saharan Africa is the region most affected by the HIV/AIDS pandemic in the world and large number of people are dieing of AIDS in the region. People who are infected with HIV normally die within ten years of contracting the virus because there is no cure for the HIV/AIDS pandemic (Ramsey, Hazoume & Chetty, 2002: 2).

Ramsey *et al.* further indicate that the average life expectancy in the Sub-Saharan region has dropped from 62 years to 47 years due to HIV/AIDS. Some countries with the highest HIV prevalence rate in the region like Botswana, Malawi, Mozambique and Swaziland, the average life expectancy is below 40 years (Ramsey *et al.*, 2002: 3).

UNAIDS (2003: 17) indicates that the reduction in the growth of the labour force and declining productivity among some Southern African countries result in low government revenues from both individual and enterprises, including those in the tourism sector. The UNAIDS further indicates that some of the Southern African countries spend between 20% and 90% of their health budgets fighting HIV/AIDS. This indicates the negative macro-economic impacts of HIV/AIDS. Some of the Southern African countries which

have more than one-fifth of adults with HIV/AIDS, the GDP impact points is projected to be 2.6 (South Africa. Department of Economic Development & Tourism, 2004: 82).

UNAIDS (2003: 280) indicates that the most significant impact of HIV/AIDS on the general labour is on population growth. This impact has been largely felt by a number of countries in Sub-Saharan Africa. The impact of HIV/AIDS on the labour force is more serious than its impact on the general population (Lisk, 2002: 10). This labour force includes people who are working in tourism sector. For example, HIV/AIDS affects many Southern African companies including those in tourism sector through long and frequent labour absenteeism, lower labour productivity and higher employee benefits (Ellis & Terwin, 2004: 30).

The South African Tourism, Hospitality and Sport Education and Training (THETA) (2003: 4) conducted a study on a number of tourism and hospitality companies in South Africa. The study results indicates that 92% of the companies surveyed do not have HIV/AIDS educational programmes for their employee, and that 91% of the surveyed companies do not provide HIV/AIDS preventive measures like condoms to their workers at workplace. The other outcome of the study is that 95% of the companies surveyed by THETA do not have voluntary counselling and testing (VCT) programs for their employees, and 98.5% of the surveyed companies do not provide care programs for their affected workers.

THETA (2003: 7) further indicates that the major areas of concern by the tourism companies are the labour intensive, employment and training expenses, labour migration, and the employment of young inexperienced workers. These result in low productivity for the companies affected. The other way in which HIV/AIDS reduces productivity is the fact workers who are ill either go on sick leave regularly or work less efficiently than they would if they were healthy. Some employees take days off attending to funerals of family members and friends. All these affect business productivity.

4. KEY QUESTIONS

4.1 How does the high prevalence of HIV/AIDS in Southern Africa affect the region's tourism sector?

4.2 What are the Southern African tour operators and governments doing about HIV/AIDS problems and what are the chances of success?

4.3 How does HIV/AIDS affect tourism's contribution to the economies of Southern African countries?

5. OBJECTIVES

The main objectives of this research are:

- To investigate how HIV/AIDS affect Southern African tourism, with specific reference to the tour operators.
- To investigate measures taken by the Southern African tour operators and governments to combat HIV/AIDS and the chances of success.
- To make some recommendations on what can further be done to fight HIV/AIDS in the Southern African tourism sector.

6. FORMULATION OF HYPOTHESIS

Southern Africa is the region with the highest rate of HIV/AIDS in the world. The most infected group are the young people between the ages of 15 – 49. These are the people who work in different economic sectors including tourism. HIV/AIDS negatively affects the tourism sector in Southern African countries by killing skilled workers within the sector. The experienced workers are difficult to replace, and some tour operators in the region employ younger and inexperienced workers. This affects the tourism sector through the high rates of employment, which is costly and time wasting. The sector is experiencing absenteeism and low productivity among workers who are ill or their family members suffering from HIV/AIDS. This in return affects the contribution of tourism to the economies of Southern African countries. In response to the problem, a number of tourism organisations and governments in Southern Africa engage in awareness campaign to educate people about HIV/AIDS. The challenge facing most countries in Southern Africa includes lack of behavioural change by the general public. Ulness people can change their risky behaviour, the war against the spread of HIV is far from being won. The purpose of this research is to test whether this hypothesis holds the truth.

7. LITERATURE REVIEW

There are several mechanisms by which HIV/AIDS affects macro-economic performance of a country. AIDS deaths lead directly to a reduction in the number of workers available including those in the tourism industry in their most productive ages. The high death rate leads to experienced tourism workers replaced by younger, less experienced persons, which results in a reduction in productivity. Experience workers are difficult to replace, and the quality of service in the tourism sector drops because the less experienced workers do not have necessary experience (Botswana. Ministry of Wildlife & Tourism, 2003: 65).

In an attempt to achieve the aims of this study a literature review and empirical studies were conducted. The aim of a literature study was to assess what kinds of studies have already been conducted on the similar topic. This was also done to assess how much is known by other researchers on the impact of HIV/AIDS with particular reference to the Southern African tour operators and government department. The literature study was also used to identify some strategic gaps that need special attention to combat HIV/AIDS.

The aims of the empirical study was to find out how much the Southern African tour operators and government officials in the tourism sector know about the macro-economic impact of HIV/AIDS. This was also carried out to assess the level of awareness with regard to the HIV/AIDS situation in Southern Africa. The empirical study was also conducted as an assessment criteria of finding out what is being done by the Southern African tour operators and governments to curb the HIV/AIDS problems in the tourism sector and in general. This was also conducted to assess the adversity of the HIV/AIDS problems and to get some opinions on what can further be done to alleviate HIV/AIDS problems in the Southern African tourism and in general.

8. RESEARCH DESIGN/METHODOLOGY

8.1 Literature Search

i. A literature search particularly about Southern Africa and in general, as well as news report has been conducted.
ii. Review of HIV statistics.

iii. Use of Internet.

iv. Journals and government publications.

8.2 Empirical Research

The UNAIDS (2002:190) indicates that Botswana, South Africa, Namibia, and Zimbabwe are among the countries with the highest HIV/AIDS cases in Southern Africa. These countries are also the leaders in the tourism sector in Southern Africa. Based on this information, interviews were arranged with the tourism companies, especially Tour Operators within these countries. To conduct these interviews, the stratified random sampling method was used to identify the Tour Operators to be interviewed. Here, in each one of the above four (4) countries, sixty (60) Tour Operators within the major tourist destinations were identified, and from these the stratified random sampling method was used to select 10 Tour Operators based on their sizes from each country to give a total of 40. The tour operators were identified based on their registration status, sizes and period of business operation. Most of the people who were interviewed are the company CEO, MD and the managers at different levels of organisational structures. Government officials within the ministries of tourism in their respective countries were also interviewed. Where possible, the tourism stakeholders like general employees in their respective positions in their countries were also interviewed. The stratified random sampling was used to identify these individuals. Participants were selected according to their positions, gender and departments in their respective companies. Where possible, the balance was made between males and females management. The interviews were conducted through telephone and personal interviews were also carried out.

8.3 Interpretation of Findings

The findings from the interviews were interpreted and described.

8.4 Recommendations

Some necessary recommendations are made in the final report on what should further be done to alleviate the threats caused by the HIV/AIDS pandemic to the Southern African tourism sector.

9. FRAMEWORK FOR STUDY

1. Chapter one: Introduction and background
2. Chapter two: Tourism in Southern Africa and its contribution to the Southern African countries' economy.
3. Chapter three: The HIV/AIDS situation in Southern Africa and response strategies.
4. Chapter four: The impacts of HIV/AIDS on Southern African tourism.
5. Chapter five: Research design/survey and results analysis
6. Chapter six: Conclusion

CHAPTER 2

TOURISM IN SOUTHERN AFRICA AND ITS CONTRIBUTION TO THE SOUTHERN AFRICAN ECONOMY

2.1 INTRODUCTION

For the purpose of this study, the Gunn (1988: 1), widely accepted definition was used, namely that "tourism encompasses all travel with the exception of commuting". This is part of contemporarily thinking that tourism includes any activity concerned with temporary short-term movement of people to destinations outside the place where they normally live and work.

South African Tourism formally known as SATOUR (1991: 1) indicates that the environment is viewed within its broadest sense to include the natural, historical and cultural heritage as well as the lifestyles, values and traditions of all the people of not only South Africa but the entire Southern African region. These elements constitute the primary resource base for Southern African tourism and its global uniqueness is of considerable significance. The Southern African tourism sector and the environment have a strong relationship and depend on one another. Whilst the environment is the primary resource base for tourism, tourism in return provides a primary means through which an economic return can be generated from the environment.

South African Tourism further indicates that tourism is a dynamic activity that is constantly changing to cater for new and changing needs. The same can be said of the Southern African tourism sector, which is entering a particular dynamic yet complex and demanding period, especially with the prevalence of HIV/AIDS pandemic and its dramatic spread to the region. This requires flexibility to adjust to change.

Butler and Hinch (1996: 55) stipulate that the growing significance of tourism as an economic activity is reflected in the increased recognition it has been given especially in Southern Africa at both regional and national levels. There has been a rapid development of specialist educational and training facilities for academics and professionals within the Southern African countries so as to capture the economic befits of tourism. This includes widespread research activities, and the discipline could now be said to have 'come of age'. This will enhance the contribution of tourism to the Southern African economy.

This chapter covers the tourist attractions in Botswana, Namibia, South Africa and Zimbabwe. The contribution of tourism to the Southern African economy will also be discussed. The tourism policy in Botswana, South Africa, Namibia and Zimbabwe are also discussed in this chapter. Some concluding remarks have also been made at the end of the chapter. The purpose of this chapter in this study is to examine the type of tourism in Southern Africa so that the need for experienced and skilled workers can be determined. This chapter also examines the contribution of tourism to Southern African economy so that the impact of HIV/AIDS can be viewed from an economic point of view. The tourism policy framework of the Southern Africa is discussed in detail to determine the involvement of communities in tourism and also to determine the support of employment creation within the tourism sector by Southern African governments. Employment creation helps to fight poverty, which is one of the components contributing to the spread of HIV/AIDS.

2.2 TOURIST ATTRACTIONS IN BOTSWANA

Botswana's Department of Wildlife and Tourism (2001: 4) stipulates that tourism is regarded as one of the three principal pillars of the economic success of a nation that has one of the strongest economies in Africa and which boasts one of the highest per capita incomes. Botswana has a number of world–class attractions that make the country unique. The capital city of Botswana is Gaborone. One of the attractions in the city includes the Botswana National Assembly, which is located in a tranquil garden setting close to the city centre. Also close by is the National Museum and Art Gallery situated in the Independent Avenue and which houses a fine ethnographic collection and serves as the centre for ethnographic and botanical research. The modern art gallery, attached to the museum is an important window for the display, development and upliftment of Botswana arts.

The department of tourism also indicates that a variety of wildlife species can be viewed in their natural habitat in Mokolodi Nature Reserve and the Gaborone Game Reserve. These attractions are part of eco-tourism, which needs a professional guide to explain them to the tourists. Training of these professional guides is expensive and time consuming. It is further indicated by the Wildlife & Tourism Department that Batswana art has become more diverse in the wake of globalization, Local artists face an interesting challenge to introduce the uniqueness and vibrancy of their arts and crafts to a wide international audience. These attractions need more attention to be marketed worldwide, but HIV/AIDS draws more

attention and funds than the development of art, and a number of artists die of the pandemic, thus the Botswana art is deteriorating.

Botswana is renowned for its traditional crafts of which the most famous is probably the basketry practiced by the many regional groups offering individualistic design and patterns. Traditionally, such crafts as pottery and basketry were produced for utilitarian purposes and materials were generally selected from available natural resources. Designs are passed down through generations and today there is a need to preserve these skills in the face of the social dynamics of an ever-changing society. The threat posed by HIV/AIDS is a possible factor that could destroy these skills. Fortunately, there are some excellent collections of Botswana arts and crafts in both government and private collections. But these collections need an experienced person to explain them to the tourists (Botswana. Wildlife & Tourism Department, 2001: 5).

Botswana's Department of Wildlife and Tourism (2003: 10) indicates that the Okavango is one of the largest island river deltas in the world. This is a huge flood plain situated in Northern Botswana, has no natural outlets to the sea and is a vast eco-system covering 1500sq km of African wilderness. Numerous well-equipped safari camps within the swamps serve the visitors, providing for every need, making the region one of the prime safari destinations in Africa. The Okavango Marshlands are major tourist attractions in Botswana and most of the tourists who visit the country do not complete their visit without spending time in this pristine environment. For excellent holiday for the tourists to the Delta, the need for a well-trained professional and experienced tourist guide is essential.

The Department of Wildlife and Tourism in Botswana further indicates that the Okavango Delta incorporates the Moremi Game Reserve, and is a unique African Wildlife paradise and one of the finest remaining wilderness areas in the world. Safari operators provide 4x4 open game viewing vehicles and 'Mokoro' (a flat bottomed canoe) through the swamps and surrounding areas. Here professional guiding service is an important consideration. Pan, flood plains, reed banks, forests of giant acacia trees and mophane woodlands combine in an unsurpassed natural environment habitat for many wildlife species of Okavango.

A number of wildlife animals in the area include lion, elephant, leopard, giraffe, hyena, kudu, roan, antelope, zebra, lechwe, hippo and crocodile, to name just the principal species. The Okavango can only be fully appreciated by arranging to stay at one of the many lodges

situated deep within the swamps. The lodges in the swamps operate with well-trained and experienced workers. These lodges are fully equipped to cater for every need including collection and return from and to Maun by the best possible transport. Game rangers and other workers are professionals trained to provide the visitors with the most comprehensive wilderness experience possible. Training of these workers is expensive and they are almost irreplaceable due to the high level of experience required. The Okavango is arguably the finest wildlife sanctuary in Africa protected and preserved for the benefit of both tourism and the people of Botswana.

The other attraction according to the Department of Wildlife and Tourism is the Tsodilo Hills located south of Shakawe village in the western part of Botswana. These majestic quartzite hills rise 420 metres above the surrounding country and, and remarkably, are the highest point in Botswana at an elevation of 1394 metres. The hills feature over 500 individual San rock art sites, which support the spiritual and historical significance of these enigmatic hills through the ages. The Hambukushu and San people who live at the base of these hills provide guiding information to the visitors. About 150km south of Tsodilo Hills is where the range of Aha Hills is found, which is located in one of the most remote corners of Botswana against the Namibian Border.

The other fascinating attraction indicated by the Department of Wildlife and Tourism is the Chobe National Park located in the northern region of Botswana, and is an outstanding wildlife wilderness area, which is 11000sq km in size and offers enormous wildlife diversity. The Chobe and Savute Rivers attract huge concentrations of game, particularly elephant and lion in some of the highest densities in Africa, and is a source of water for the Chobe Region. In the far north, near the border town of Kasane, the Chobe River is a popular tourism centre for game viewing by either riverboat or game viewing vehicle. The well-trained and experienced tourist guides in the region provide professional guiding services. There are a number of lodges that offer excellent accommodation services to the visitor. Some few examples of the lodges in the region include Chobe Safari Lodge, Chobe Game Lodge, Kubu Lodge and Toro Lodge. The Chobe is made up of four distinct regions, namely: Savute, Serondela, Linyanti and Chobe River Frontage.

Savute is located 180km north of Maun in the western section of Chobe. The Botswana Department of Wildlife and Tourism (2001: 8) describes 5000sq km Savute as Africa's most densely populated predator area, also hosting the greatest concentration of plain antelope,

zebra and wildebeest, in Southern Africa. There are also 350 recorded bird species, and some of the most diverse landscapes in the country. Savute is renowned for its magnificent lions and the spectacular annual summer migrations of plain game.

Serondela is a popular destination for the beauty of the riverside landscapes and for the concentrations of game along Chobe River. This area offers superb sightings and photo opportunities. Serondela is probably most famous for the large number of elephants, which form one of Africa's last remaining great herds. Exciting safari experiences can be explored from the land, in special viewing vehicles or from the river in the cruise boats. Experienced guides lead the excursions.

Linyanti, north of Savute, is a nature-wooded area with beautiful river frontage of the swamps. Although fairly small, this is one of the most attractive areas in the park. The short trip of swampy river frontage is similar to the Okavango's permanent waterways with papyrus-lined lagoons, extensive reed banks and tall canopies of trees. The principal attraction to this pristine region includes the diverse wildlife of Linyanti. Many natural observing points overlooking the river provide excellent photographic opportunities. Birds-life is plentiful and the sunset is spectacular.

Most camps in the Chobe operate their own air services from Maun direct to the destinations. Accommodation is excellent in either tented or permanent camps. All offer full meals, accommodation and game viewing drives as part of the overall package. The Chobe Region offers some unusual adventure activities. For example, apart from the usual game viewing by either river craft (Mokoro) or special game-viewing vehicle, elephant back safaris and horseback rides are arranged into special designated game areas. Skilled rangers take groups to the wildlife in the most natural and undisturbed surroundings.

According to Johnson, (2001: 14), the vast Kalahari, situated across the western reaches of Botswana and occupying over half of the land area of the country, is one of the greatest ecological treasures and wilderness areas of the world. The Kalahari is protected by its sheer size and the scarcity of surface water, and has remained unspoilt by encroaching pressures of civilization. A journey into the Kalahari is a mystical experience. The vastness of the semi-desert landscape, the wildlife, the reptiles and the insects, each living a life of interdependence in this arid land, fascinates the visitors. The lure of the Kalahari lies in its remoteness, the

wilderness, the harsh, but beautiful landscape, the great sky and the silence of this pristine African eco-system.

Johnson further stipulates that there are three principal conservation regions located within the greater Kalahari region, namely: The Central Kalahari Game Reserve, the Khutse Game Reserve in the central region and the Kgalagadi Transfrontier Park in the extreme south west corner of Botswana. The reserve is remote and by its nature, even attractive to the visitors who want to escape into the desert wilderness of Botswana. The convenient mode of transport used is the four wheel drive vehicle. Game viewing is excellent, especially at the many drinking points. The entire principal desert is renowned for vast species of wildlife including lion, leopard, giraffe, wildebeest, hyena, and gemsbok, along with many small species. Bird viewing is an added attraction, particularly the many raptor species, which can be observed and easily photographed in the open country. Johnson regards the black lions of the Kalahari as the finest in Africa.

The Kgalagadi Transfrontier Park, which shares a common border with South Africa, is managed through a joint transfrontier management venture between the two countries. The Kgalagadi Transfrontier Park offers breathtaking landscapes of rolling grasslands, strangely shaped, ever shifting distinctively coloured sand dunes with a scattering of indigenous trees and shrubs. The park conserves a wide variety of desert game such as hartebeest, eland, springbok and gemsbok. Another fascinating attraction is the Khutse Game Reserve which shares a common northern boundary with the Central Kalahari Game Reserve. However, there are no fences dividing the two reserves and game species are generally common to both. This is an excellent reserve to visit as an introduction to the west conservancies of Botswana. Game viewing especially at the waterholes can be spectacular.

The Makgadikgadi and Nxai Pan National Parks are famous salt pans of the north central Botswana, and are the largest such pans in the world. These pans were formed millions of years ago when a huge lake covered the entire region. The area is remote, even by Botswana standards and herein lies the attraction. The pans are filled by seasonal rains and are the feeding and breeding grounds for huge flocks of greater flamingos, pelicans and other water-bird species.

2.2.1 TOURISM POLICY IN BOTSWANA

The government of Botswana realizes and acknowledges the contribution of tourism to the country's economy and formulates policies that create a viable environment for foreign exchange earnings and government revenues. The Botswana Government and its policies encourage foreign investment and strive to make conditions more conducive to investors. The government encourages the development of tourism in rural areas so as to create employment and raise income in rural areas in order to reduce urban drift. The Botswana Government improves the quality of national life by providing education and recreational opportunities, with the intention to project a favourable national image to the outside world. In addition, it emphasizes the need to ensure that tourist activities are carried out in an ecologically sustainable manner. The government of Botswana is keen to encourage private investment in the tourism industry. The country's tourism policy is set out to stimulate the sustainable management and utilization of country's diverse wildlife and natural beauty so that it can be preserved for future generations. Particular emphasis is placed on eco-tourism in conjunction with local communities (Botswana. Ministry of Environment, Wildlife and Tourism, 2003: 10).

2.2.2 THE CONTRIBUTION OF TOURISM TO BOTSWANA'S ECONOMY

Botswana's rich cultural and historical heritage and abundant wildlife resources provide opportunities for investment in the tourism industry. According to the Department of Tourism Research and Statistics Section in Botswana, (2004), global statistics continue to record a good growth in tourist arrival in the country. Tourist arrival in Botswana rose from 571,931 in the year 1979 to 923,132 in the year 2001. This, together with the tourism industry's multiplier effect and increased local participation, provide the potential to diversify the economy from reliance on other sectors. The government of Botswana through the Department of Tourism has established a one-stop service centre, which is The Botswana Export Development and Investment Authority (BEDIA) to expedite processing of licenses, and permits. Opportunities have been created in eco-tourism and man-made attractions.

Botswana's Department of Tourism Research and Statistics Section (2004) published the following tourism statistics in the country:

TABLE 2.1: TOURISM STATISTICS

International Tourists/year:	**2000**	**2001**	**2002**
Total tourists	1 103 796	1 048 845	1 036 558
Leisure	316 847	306 980	197 219
Business	143 304	132 012	146 437
Average nights per visitor:			
All visitors	9.8	10.3	8.2
Leisure			6.6
Business			4.2
Tourism Expenditure US$ million	313	300	309
Tourism contribution to GDP (%)	4.5	4.8	5

TABLE 2.2: TOP TEN TOURIST GENERATING COUNTRIES

Country/year	**2001**	**2002**
South Africa	478 044	407 247
Zimbabwe	319 174	401 424
Zambia	36 681	44 644
Namibia	36 681	34 814
United States of America	21 971	15 238
United Kingdom	19 283	18 077
Germany	8 875	8 640
Netherlands	6 030	5 161
Australia	5 756	5 488
France	4 358	3 679

The Department of Tourism, (2004: 10), indicates that tourists arrival in Botswana in 2001 totalled 1.4 million, a growth of 80% since 1995. The target is 10 percent growth per annum by 2020. The possible threat to this target is the HIV/AIDS pandemic. Estimates by the Department of Tourism are that tourism is contributing 4.5 percent to Botswana's gross domestic product (GDP). Based on the latest figures available, the tourism industry brings in

an annual foreign exchange worth P 500 million, the tourists spend P 1.1 billion, and government benefits by P320 million. Putting this into context, the GDP in fiscal 2001/2002 was P 32 billion: mining contributed a direct 35% and indirectly much more, manufacturing a second engine growth – 4.4 percent. As indicated in statistics above, most of the tourists visiting Botswana come from South Africa, Zimbabwe, Zambia, Namibia, the United States of America and the United Kingdom.

The employment created by tourism in Botswana is significant in both private and public sectors. For example, Tour Operators employ over 990 people who receive wages, benefits and tips amounting to over P4 443 000, (Botswana. Department of Tourism Research and Statistics, 2004). Among the people employed by the tour operators are both locals and foreigners. Hotels and associated industries employ about 362 workers both directly and indirectly to provide services and facilities to eco-tourism. Employment indicates an average of 7.7 dependants per person employed. This is a clear indication that these people employed in the tourism sector support a large number of the Botswana population.

2.3 TOURISTS ATTRACTIONS IN NAMIBIA

Tourists' attractions in Namibia are located according to 5 regions, namely, Northern Region, Western Region, Central Region, Eastern Region and Southern Region. The two main tourists attractions in the Northern Region are the internationally known Etosha National Park and the Caprivi, the water-rich north- east with its network of perennial rivers, abundant bird life, wealth of game species including elephant, hippo, red lechwe, buffalo and crocodile. The Northeast is popular with over 420 species of birds, including kingfishers, Wattled Cranes, African Fish Eagles, African Skimmers and Pygmy Geese, and rare species such as Senegal and Coppery- tailed Coucals, Rufous-bellied Tits, Black faced Bubblers, Sharp-tailed starlings and Brad-field's Hornbills.

The Western Region extends from the Kunene River the border with Angola southwards to Namibia's main harbour Walvis Bay and includes the central and northern Namib Desert with the coastal resorts of Swakopmund and Henties Bay, Terrace Bay and Torra Bay in the Skeleton Coast Park, and the arid western part of the Kunene and Erongo Region.

One of the main attractions of Namibia's coast is its outstanding angling potential, whether from the beach or off small boats, and diving for rock lobster. Popular species are kabeljou,

galjoen, back tail, steenbras, geelbek and white stump nose. The main angling season is from November to March, and these are also the hottest months in the interior. The coastal towns offer many different types of accommodation facilities.

The Central Region is where the Namibia's capital, Windhoek is situated. Windhoek offers a considerable number and wide variety of accommodation establishments ranging from large hotels to conference facilities. There are also guest farms in the surroundings of Windhoek that are popular to tourists, as they are situated in the scenic surroundings, often on private game reserves harbouring a variety of game species, thus providing the visitor with the opportunity to experience the peace and tranquillity of the bush.

The Eastern part of Namibia is known as the Omaheke Region. The town is not only the perfect stopover when travelling between Namibia, Botswana (Maun, Okavango Delta) and South Africa, but is bursting with cultural diversity and gives the tourists an insight into how the very different cultures of the Hereros, Damaras, Coloureds, Germans and Afrikaners blend together. Omaheke offers unspoilt Kalahari scenery, it is the land of the San people with an abundance of game, wide-open spaces, cattle farming, traditional villages with a lot of cultural aspects. The Omaheke Region is the biggest cattle-producing region south of the equator.

The Southern Region of Namibia's landscapes add to the uniqueness of the country's destinations. The changing colours in this pristine wilderness provide peace and tranquillity. There are signs of human activities but they only emphasise that nature dictates the course of them. Some of the famous destinations include Quiver tree forest, Giant's Playground, the Brukaros, the ghost town Kolmanskoppe, and Duwisib. Guided tours to the Rock Arch south of Luderitz and into the Namib Desert are among the activities that round off the picture of the South. The above services need the service of the experienced tourists guides, but the question one may ask is what will happen if these experienced guides die due to HIV/AIDS?.

2.3.1 TOURISM POLICY IN NAMIBIA

Namibia. The Ministry of Environment and Tourism (1994:1), indicates that the policy formulation and its implementation is an integrated process which engages continuous consultation among the affected parties. Namibia's Environmental Assessment policy is not only admired and applied within the country, but also at an international level. The policy was drafted and adopted in August 1994 by the Cabinet Resolution 16.8.94/002. The

Environmental Assessment (EA) policy was developed and refined through a prolonged process that involved cross-sectoral and multi-disciplinary consultation and negotiation. The final policy indicates a wide consensus on the need for EA in Namibia, and general agreement has been reached on how these should be implemented.

The goals and objectives of the Namibia's Environmental Assessment (EA) policy is to encourage sustainable and economic growth while protecting the environment in the long term. It aims at protecting clean air, water and soil, and a full and healthy stock of natural resources, for the benefit of the Namibia's future generations. Therefore, sector Ministries, the Private Sector, Nongovernmental Organizations (NGOs), and prospective investors and donors are encouraged to comply with this policy for all-future development projects, programmes and policies. Mr. Niko Bessinger, the Minister for Environment and Tourism indicates that the Ministry of Environment and Tourism engages in regular consultations and high involvement of all interested and affected parties during the policy implementation process (Bessinger, 1994:1).

The Government of the Republic of Namibia through the Ministry of Environment and Tourism is committed to the proper maintenance of the ecosystem, essential ecological processes and biological diversity of the country and the use of living natural resources in a responsible manner for the benefit of all Namibians, both present and future (Constitution of the Republic of Namibia – Art95 [1]). The applied concept in the country is [Namibia's Green Plan] which indicates the essential need for economic development, foreign investment, and the poverty alleviation process. Namibia depends on natural resources and certain biophysical components are exposed to environmental damage. The country is characterized by scarcity of water and the limited human and animal carrying capacity is taken into consideration during policy planning and formulation. Environmental assessments are the key guidance, among others, used to implement a sound environmental policy that strives to achieve Integrated Environmental Management (IEM) (Namibia. The Ministry of Environment and Tourism, 1994: 2).

The Government of the Republic of Namibia further stipulates that the Environmental Assessment policy emphasizes a wise use of the country's natural resources, together with the responsible management of the biophysical environment, and should be for the benefit of both current and forthcoming generations. The high level of priority is placed on maintaining ecosystems and related ecological processes, which specifically involves water supply, food

production, health, tourism and sustainable development. The high rate of commitment is placed on observing the principles of optimum sustainable yield in the exploitation of living natural resources and ecosystems, and the responsible use of non-renewable resources. The Namibian Government is engaged in active administration and legislative programmes to obtain Integrated Environmental Management through, inter alias, the execution of Environmental Assessment in line with the Environmental Assessment Policy.

Namibia's Environmental Assessment Policy stipulates that all listed policies, programmes and projects, whether implemented by the government or the private sector, must be grounded in the established EA procedures. The high level of accountability is encouraged with more emphasis on informed decision making that strives for a high level of public involvement and participation by all sectors of the Namibia community in the EA process. The proposed policies, programmes and project managers must take both environmental costs and benefits into consideration, and where suitable, the internationally accepted norms and standards must be incorporated. The concepts of sustainable development in Namibia is widely promoted to ensure that a reasonable attempt is made to minimize anticipated negative impacts and maximize the benefits of all development, and both private and government enterprise involve into a binding agreement based on the procedures and recommendations contained in the EA Report (Namibia. The Ministry of Environment and Tourism, 1994: 4).

ODINPubAFRICA (2002) indicates that valuation studies carried out on nature-based tourism in Namibia has found that such tourism is not optimally priced and that significant resources are rented at reasonable price. Fundamental efforts are therefore needed to ensure that Namibia's natural assets are priced optimally and that the funds for resource rental are captured. In facilitating this, combination methods that include user fees, indirect taxation schemes and environmental voluntary funds need to be exercised. The pricing policies drafted must at best indicate the cost of providing the environmental-based-services.

Namibia. Ministry of Environment and Tourism (n.d.) argues that the community-based tourism policy benefits local people by giving them opportunity to participate in tourism planning and developing tourism enterprises. The Namibia government through the Ministry of Environment and Tourism creates incentives to enable people to benefit from tourism on their land and to conserve wildlife and natural resources. The policy encourages established tourism businesses to work with people in communal areas, and also to work hand-in-hand with environmental conservation organizations. The fundamental principles of Namibia's

policy stipulate that people must be consulted and their ideas included in tourism planning and legislation, and the informal sector should represent community interests. Large businesses operating on communal land should maximize benefits to the local residents who often gain little from wildlife and tourism on their land.

The strategic implementation according to the Namibia's Ministry of Environment and Tourism include the establishment of the Namibia's Community-Based Tourism Association (NACOBTA), which represents the rural community on existing tourism boards and associations. When planning for tourism, community interests is given first priority to ensure that residents or people from outside an area intending to use the land for tourism can do so only after the Ministry of Environment assessed the project feasibility, and whether the local people concerned would support the development, how it benefits the local communities, if it does not affect other local tourism enterprises, if it is in line with the regional and national tourism plans, and asses if it impacts the environment positively or negatively. Namibia's Ministry of Environment and Tourism gives maximum support to the tourism enterprises run by local residents through promotion and marketing campaigns to attract tourists, and by giving them training to equip them with the necessary skills (Namibia. Ministry of Environment and Tourism, 1994: 32).

2.3.2 THE CONTRIBUTION OF TOURISM TO NAMIBIA'S ECONOMY

The Namibia Tourism Board, (2004: 36) indicates that Namibia's economy is strongly based on minerals. Mining contributes 20% of the country's Gross Domestic Products (GDP). Namibia is the fourth largest exporter of non-fuel minerals in Africa and the world's fifth-largest producer of uranium. Namibia's four pillars of the economy are mining, fishing, tourism and agriculture. Agriculture employs the largest number of people in the country when compared to other sectors. Tourism is the fourth largest income earner in Namibia, and it employs over 10 000 people countrywide. It is an important industry because it creates benefits for the local residents. It provides higher living standards and encourages people to take care of the environment.

The Namibia Government argues that tourism depends on the environment, and it emphasises that care must be given to the environment so as to protect wildlife and other natural resources so that tourists can be continuously attracted to the country. It is also considered imperative to consider environmental protection when planning new tourism developments in Namibia.

Putting this into practice, the Namibia Ministry of Environment and Tourism has drafted the Community-based Tourism Policy. The policy gives guide-lines on the ways in which communities must benefit from the tourism industry, and how to promote social and economic development, and conservation strategies in the communal areas (Namibia. Tourism Board, 2004: 37).

Ashley *et al.* (2000: 3), state that Namibia applies the widely adopted strategy of eradicating poverty so that the country would have only a small proportion of people living in extreme poverty by 2015. Namibia did not adopt the generally applied technique in the tourism sector, national governments and donors that aim to promote private sector investment, macro-economic growth and foreign exchange earnings, without specifically taking the needs and opportunities of the poor into consideration when developing tourism. Tourism is regarded by the Namibia Government as a pro-poor economic growth that has numerous advantages involving tourists coming to that destination and providing opportunities to Namibians to sell additional goods like handicrafts and souvenirs. It also creates opportunities for Namibians to diversify their economy.

Tourism is a rapidly growing sector of Namibia's economy and a significant generator of jobs. It is the third largest source of foreign exchange after mining and fisheries. The majority of Namibia's international tourists come from within the Southern African Region, but also Namibia's unique mix of political stability, cultural diversity, and the beauty of ecological system/natural environment attract other international tourists. Tourism in Namibia creates positive impacts on resource protection and rural area development. The total of 29 communal conservancies have been developed nation-wide, resulting in enhanced land management and providing an enormous number of Namibians in rural areas with essential income (Ashley *et al.*, 2000: 8).

Ashley *et al.* (2000: 8), further indicate that most Namibians are economically involved in tourism in different ways, both formally and informally. In the formal economy, official estimates of unemployment range from 30% to 40% of the work force. Namibia is faced with constraints in shortage of skilled tourism workers, which makes it more difficult for most people to enter the formal sector. The Namibian government is actively pursuing education reform to address this problem. In 2004, the Namibia Government passed the new Labour Act, which strictly discourages discrimination at the workplace, and also establishes maximum protection for both pregnant workers and employees infected with HIV/AIDS.

2.4 TOURIST ATTRACTIONS IN SOUTH AFRICA

Namibia Colourgem Team (2006: 278) indicates that South Africa and the South African people are renowned for taking pride in their heritage and endeavour of the human spirit that continues to strive for national harmony, in conjunction with the historical memories of the past. South Africa has one of the highest daily sunshine rates in the world. Summer is from October to March but it also depends on the region and regional differences. The South African weather conditions, especial its mild winters make the country a popular year-round tourist destination.

The popular route of tourists is the Trans Kalahari route that runs from the Gauteng Province in South Africa into Botswana and connects at Buitepos, one of Namibia's border-post through to the port of Walvis Bay. This route does not only provide tourists with scenic wonders, but also with the multiplicity of wildlife and the vast open spaces. It is approximately 1400km between Windhoek and Pretoria. Gauteng means "place of gold" in Sesotho and although South Africa's smallest province, it has the country's highest population density. The capital city of South Africa is Tshwane, and is renowned for its many historical buildings and the largest number of museums in the country that makes it a great tourist destination. With regard to cultural aspects, the BaTswana people of the North West Province of South Africa speak SeTswana, English and Afrikaans. These people's culture is predominant in their daily activities, such as their beadwork, pottery and their unique music (Namibia. Colourgem Team, 2006: 280).

Namibia Colourgem Team (2006: 292), indicates that The Green Kalahari is fascinating and attractive, especially with its vivid beauty of the contrasting landscapes and scenery. Its secret attractiveness lies in its lush green vineyards that are in the fertile valleys of the great Orange River, to the vast tracks of shimmering red dunes of the Kalahari Desert. The clean red sand dunes of Kalahari provide a superb experience to the tourists. In the Green Kalahari, however, the desert shows its harsh, dry face in many striking, but beautiful ways. The area gets water from the Orange River. From its source in the Drankenberg, South Africa's largest river travels 2200km to the Atlantic Ocean at Alexander Bay. A dry, arid landscape comes to life around the banks of the river. Besides bringing water to the area, this river also shapes the character of the people of the Green Kalahari. The major attractions in the area includes the great infinitely, remote track and red dune land, which is the Kgalagadi Transfrontier Park with a boundary, unrestricted by fences, and has a large reserve in Botswana.

The fascinating attraction on the West Coast is Namaqualand. Namaqualand is a rugged mountainous plateau that overlooks a narrow sand coastal plain and the bleak beaches of the West Coast. This coastal plain is an essential source for alluvial diamond mining by boats operating from small villages like Port Nolloth. Throughout the year, Namaqualand is dry and windswept. This apparently inhospitable environment, after enough rain, produces one of the world's natural wonders. Spring explodes into wonderful colours. The area is world-famous for these marvellous displays of wild flowers and tourists from all over the world make annual pilgrimages to experience this area's beautiful appearance. The town of Springbok is the largest and the most northerly from which to visit Namaqualand (Namibia Colourgem Team, 2006: 302). Springbok offers modern amenities and a wide variety of accommodation.

The Colourgem Team (2006: 308) states that the Cape Peninsula is undoubtedly one of the world's most sought after destinations. It lies at the tip of Africa. The Peninsula prides itself on its scenic natural beauty-forests, rivers, sea, Mountains and the world's richest floral kingdom. The rainbow nation in the area represents the rich cultural history of "The Fairest Cape". The first inhabitants of the area were the Khoi and San, before the arrival of the first European settlers in 1652. Table Mountain became a sighting post and South Africa's mother city. Cape Town was the stopover for fresh fruit and vegetables on the long voyage between Europe and the Dutch West Indies.

The Cape Town City Centre provides numerous interesting attractions, such as the Castle of Good Hope, Green Market Square, the Arts Cape Theatre, the Houses of Parliament, and several museums. The cable car ride to the top of Table Mountain provides breathtaking views of the Peninsula. One of the most famous attractions of the Peninsula according to the Colourgem Team is the Victoria & Alfred Waterfront. The Victoria & Alfred Waterfront is renowned for attracting international trade and tourists. It has shops selling gem-stones, curios, souvenirs and fancy fashions, and there are plenty of restaurants and taverns, as well as cinemas and theatres. The coastline provides many beautiful bays and beaches, such as Bantry Bay and Clifton, which is famous for its four inviting beaches.

South Africa is famous for its fabulous nature reserves and national parks that attract tourists from all over the world making the country a popular tourist destination. Some of the popular national parks include the Kruger National Park which is one of the Southern Africa's greatest parks; Kwazulu Natal's Great St Lucia Wetlands Parks and the uKhahlamba Drakensberg Park are both world heritage sites; the Pilanesberg National Park located close to Gauteng and

Sun City is one of the most accessible of South Africa's Big 5 nature reserves (EcoTravel Africa, 2004: 20).

EcoTravel Africa (2004: 22), stipulates that South Africa is one of the most diverse and enchanting countries in the world. The inspiring experience to the tourists in the country includes the exotic combination of landscapes, people, history and cultural aspects. South Africa is a heady mix of third and first world cultures – along with the best and least crowded beaches in the world. What makes South Africa to be a fascinating tourist destination in the vast wildlife parks such as Kruger Park, 7 UNESCO World Heritage Sites, beautiful natural scenery, a great infrastructure and a stable post–apartheid environment. South Africa's World Heritage Sites include the Cradle of Humankind Kind Heritage Site, and is the country's most famous for archaeological attractions. It is further indicated that South African rock art sites are among the best in the world. The rock art found in the South Africa's uKhahlamba Drakensberg Park World Heritage Site is considered to be of international importance.

South Africa's Mountain ranges are popular tourist attractions in the country, with Cape Town's Table Mountain and the uKhahlamba Drakensberg Mountain Range being the most well-known and warranting a good venture for eco-tourism. The range of other attractions such as the famous Sun City can be found spread throughout the country. The Sun City Resort is a world-renowned kingdom of pleasure, with attractions, activities, and game reserves. The Sun City Resort is worldwide known as a tourism hotspot (EcoTravel Africa, 2004: 23).

EcoTravel Africa further indicates that South Africa is home to many mammals of Southern Africa. A number of wildlife safaris and tour companies operate guided tours to South Africa. Popular adventure travel activities in South Africa include: horse-riding safaris, elephant back safaris, mountain biking, birding, wildness walking trails, and science safaris.

2.4.1 TOURISM POLICY IN SOUTH AFRICA

South Africa. Department of Environmental Affairs and Tourism (1996: 6), indicates that the tourism policy formulation in South Africa is a process which is not carried out in isolation but in an integrated manner. For example, in October 1994, the Minister of Environmental Affairs and Tourism appointed the Interim Tourism Task Team (ITTT) and gave it the responsibility to draft a tourism discussion paper as a direction for a future national tourism policy. In September 1995, the ITTT drafted a Tourism Green Paper which represents the

business sector, labour movement, provincial governments, community organizations and the national government. The drafted Green Paper was distributed nation-wide for comment, and it was later forwarded to the European Union for technical assistance to the Government of South Africa and also to assist in the development of a White Paper. In order to accomplish this mission, in 1995 international tourism specialists were appointed by the European Union.

It is further indicated by the South African Department of Environmental Affairs and Tourism that the significance of the process of arriving at the White Paper for tourism is recognized in the White Paper itself. In this regard, a great deal of emphasis was placed on developing the White Paper in a way that encourages participation by all. The strategic implementation involved a continuous research process. The White Paper provides directions and a policy framework that guides development of tourism in South Africa. It is followed by an implementation strategy that contains a number of key actions in order to effectively implement the guidelines contained in the White Paper.

South Africa. Department of Environmental Affairs and Tourism (1996: 10), encourages responsible tourism practices, which is clearly stipulated by the White Paper as a policy guideline. Based on the outcome of the problem assessment, constraints and opportunities facing the country's tourism sector, the significance of global change as well as the ideas and concerns raised in the nation-wide workshops in South Africa, the concept of "Responsible Tourism" was born as the most appropriate concept for tourism development in the country. The White Paper proposes the concept of Responsible Tourism as the key guiding principle for tourism development in South Africa. Responsible tourism encourages a proactive approach by tourism industry players, which means that they must develop, market, and manage the tourism sector in a responsible manner, in order to develop a competitive advantage. Responsible tourism implies tourism industry accountability to the environment through the promotion of balanced and sustainable tourism and focus on the development of environmentally based tourism activities.

The South African Department of Environmental Affairs and Tourism indicates that responsible tourism symbolizes the responsibility of both the government and business sectors to involve the local communities that are in close proximity to the tourism activities and attractions through the development of sensible economic linkages and continuous consultation. This implies the responsibility to respect, invest and develop local cultures and protect them from over-commercialization and over exploitation. It also stipulates the role of

the local communities to become largely and actively involved in tourism, to exercise sustainable development and to ensure the safety and security of the tourists. Responsible tourism also implies the responsibility of both employers and employees in the tourism industry both to one another and to the visitors. As a hallmark of the new tourism in South Africa, responsible tourism also implies responsible government as well as the responsibility of the visitors themselves to observe the norms and practices of South Africa, particularly in respect of the physical and cultural environments.

The White Paper depicts the following important key elements of responsible tourism:

- Use of local resources in a responsible manner.
- Avoid littering and over-consumption.
- Maintain and motivate natural, economic social and cultural diversity.
- Consult the local community in planning and decision-making.
- Evaluate environmental, social and economic impacts as a prerequisite to developing tourism.
- Recognize the environment and benefits of communities in tourism.
- Monitor impacts of tourism and ensure transparency on information available.
- Encourage full responsibility, respect to the local, natural and cultural environments when marketing tourism.

Based on the above information, it is clear that responsible tourism has emerged as the most appropriate guideline because it recognises the responsibility of the government and the private sector, which is to involve the historical neglected communities in the tourism industry. Responsible tourism is a new concept that South Africa has adopted and takes to the marketplace, and it gives the country the opportunity to be a leader in the new tourism. It gives South Africa a chance to define global practice in responsible tourism and set the standard for the rest of the world to follow, rather than follow the initiatives that others have developed. Responsible tourism implies involving proactive participation and involvement by all stakeholders like the private sector, government, local communities, historically disadvantaged, consumers, non-government organisations (NGOs), the media and the general employees. It is an absolute necessity for South Africa as an emerging and a new successful international competitor to follow the concept of responsible tourism (South Africa. Department of Environmental Affairs and Tourism, 1996: 20).

The South African government is committed to the principle of responsible tourism and undertakes the appropriate actions to facilitate its implementation. For example, the government is highly involved in and actively markets and promotes the country as the premier responsible tourism destination. The South African government encourages responsible tourism by providing incentives for responsible tourism providers, through government procurement policies such as purchasing services from responsible tourism providers only.

The international organizations and agencies are also encouraged to follow the same examples of responsible tourism, and the South African government allows preferential access to national marketing funds for responsible tourism providers. The development of partnership between the tourism private sector and the local communities is highly motivated. The private sector is sensitized to the importance of involving communities in the development of responsible tourism, and both local and international media are used to recognize and promote establishments that take actions to become socially and environmentally responsible (South Africa. Department of Environmental Affairs and Tourism, 1996: 21).

The South African Department of Environmental Affairs and Tourism, (1996: 37), indicates that "A well-managed tourism industry has the potential to ameliorate, rather than to contribute to South Africa's environmental problems". The policy guidelines for environmental management applied in the country include: that sustainable and responsible tourism is promoted and encouraged, inter-alia by means of incentives to the private sector and communities, Social and environmental audits of tourism projects are encouraged to be conducted in an inexpensive rapid and participatory manner, all new tourism projects are given the mandate to conduct Integrated Environmental Management Procedures, and to ensure that tourism is integrated into land use plans in areas where tourism offers a competitive form of land use.

The South African government is committed to effectively managing and conserving the cultural resources of the country. For example, the national policy is designed in a way that encourages tourism to take note of cultural heritage resources within specific communities and environments. This implies creating benefits for all interested and affected parties within the communities and including effective protection and sustainable utilization of cultural resources (South Africa. Department of Environmental Affairs and Tourism, 1996: 38).

South Africa. Department of Environmental Affairs and Tourism (1996: 49) indicates that tourism policy formulation and implementation are a shared responsibility among national, provincial and local governments so as to formulate a sound responsible tourism concept. Labour, the private sector and communities also play a significant role in facilitating a responsible tourism concept. The South African National Government is responsible for establishing a safe and stable political and economic environment for the growth of tourism, and for the safety of both residents and tourists. The National Government actively facilitates labour market policy and creates an appropriate labour relations environment by allocating financial resources and promoting tourism as a national priority. The National Government is also responsible for planning, formulating, monitoring and updating a national tourism policy and strategies, in consultation with the relevant stake-holders. To sum up, the National Government plans, organizes leads and controls the national tourism policy formulation and implementation through co-ordination, regulation and evaluation processes.

The Provincial Governments on the other hand, facilitate, co-ordinate, regulate, monitor and develop promotion at the provincial level working hand in hand with the provincial tourism organizations. Provincial tourism organizations formulate tourism policies that are convenient to their areas, but in line with the national policy. They also play an important role as partners in the implementation of relevant national policies, strategies and objectives. The Provincial Government, through provincial tourism organizations, exercises the responsibility to market and promote their destinations. The Provincial Governments play a more vital role in tourism development activities than the National Government. These include; the involvement of local communities, safety and security of visitors, tourism superstructure development, and infrastructure development.

The Local Government plays a supporting role in the specific provincial functions of policy implementation, environmental planning and land-use, product development, marketing and promotion. Local Governments have control over land use and allocation, and also plan both urban and rural land development. These include provision and maintenance of tourist services, sites and attractions, for example, camping and caravan sites, recreational facilities like parks, historical buildings, sports facilities, theatres and museums. The Local Government markets and promotes local attractions and facilities, and enhances the local communities' participation in the tourism sector.

The private sector plays a critical role of ensuring a continuous development of tourism in South Africa. The private sector carries the risk of tourism investment and satisfying clients. The responsibilities include delivering quality tourism services that are value for money to customers. The private sector has the responsibility to enhance local communities' participation and involvement in tourism through continuous communication and consultation. By so doing, the private sector carries the responsibility to manage the tourism plants efficiently and profitably, and advertise and promote individual tourism services as well as the country – locally, regionally and internationally.

Besides providing training and retraining the workforce, the private sector is also responsible for developing and promoting socially and environmentally responsible tourism through involvement of local communities and historically neglected people in the tourism sector. The private sector is also responsible for creating potential of local communities' benefits from South African tourism development.

Labour has the responsibility to improve the quality, productivity and competitiveness of the tourism industry. Labour plays a vital role in the tourism sector, which includes providing quality services to the tourism industry, and using the available training opportunities provided by the industry to upgrade the skills of tourism workers. Labour also plays an intermediate role of negotiating on behalf of tourism workers for reasonable wages, working hours, working conditions, job security and remuneration, based on qualifications, experience and merits, and in general to ensure working conditions that are amenable to best productivity.

Communities in South Africa play a commendable role in tourism development, particularly the historical disadvantaged ones in rural areas. Communities at national, provincial and local levels play an effective role in the tourism sector and they interact with government and role players to identify potential tourism resources and attractions within their respective areas. They also have the responsibility to fully participate in all aspects of tourism, including being tourists, supporting and promoting responsible tourism and sustainable tourism development. Communities have full rights to discourage tourism development that is damaging to the local environment and their cultures, and also to participate in decision-making in respect of major tourism development planned or proposed for their areas. They also have the right to participate and promote responsible tourism in their societies.

2.4.2 THE CONTRIBUTION OF TOURISM TO SOUTH AFRICAN ECONOMY

South Africa. Department of Environmental Affairs and Tourism (1996: 2), indicates that the contribution of tourism to the South African economy has been significant through different stages and different periods. For example, in 1994 the Economist Intelligence Unit estimated that by then the value added by tourism in the South African economy was less than 2% of Gross Domestic Product (GDP). As a sign of growth and progress in terms of tourism contribution to the South African economy, Feinstein and South African Tourism Board (SATOUR) (1995), estimate that tourism contribution to GDP was in the vicinity of 4%, which is still low by world standards. The World Travel and Tourism Council estimated that tourism contributed 10.9% to GDP of the world economy in 1995. The South African Tourism (SATOUR) indicates that more than 480 000 jobs are created by tourism either directly or indirectly in South Africa. Tourism is regarded as the fourth largest earner of foreign exchange in South Africa.

The South African Tourism indicates that South Africa has a potential to develop its tourism industry, to triple its contribution to national income and to at least double its foreign exchange earnings by 2010. It is further estimated by the South African Tourism (SATOUR) that if tourism contributes 10% to the GDP of South Africa, as is the case with the United States (US), the industry would generate R40 billion annually and create 2 million jobs.

The South African Department of Environmental Affairs and Tourism further indicates that during 1995 alone, South Africa received 4.48 million international visitors. Africa continues to generate the large numbers of international tourist arrivals in South Africa (73%), and with 15% of the Europeans. North and South America, the Middle East, Australasia and the Indian Ocean Islands generate low margins of tourists, together accounting for less than 12% of total visitors. It is further estimated that there are 7.9 million domestic tourists who took a total of 17 million holidays in 1994. South Africa has a substantial potential to increase both arrival and expenditure from all the tourism markets – overseas, regional and domestic, given the fact that a large number of the historically disadvantaged communities have not traveled and that the neighbouring African Markets have good potential for further development.

Domestic tourism plays a vital role in the South African tourism industry. This market will continue to grow as the historically excluded people become actively involved in tourism as tourists themselves. International tourists also play a significant role in South African Tourism

markets. Both Overseas and African air arrival tourists spend an average of R14 000 including airfare. The South African Reserve Bank conservatively estimates that African land arrival visitors spend on average of R600 when they visit South Africa. Among the international tourism market, the business travel market, conferences, incentives and leisure segments play an important role in the South African tourism sector. The democratic elections in 1994 brought positive growth in visitor arrivals from both the regional and overseas markets.

South Africa's Department of Environmental Affairs and Tourism (1996: 14) states that tourism is an engine of growth, and is capable of dynamising and rejuvenating other sectors of the economy. Tourism employs 212 million people world-wide, and it generates $3.4 trillion in the world gross output contributing $655 billion of government tax revenues. Travel and tourism is the world's largest industry and it represents a significant opportunity for many countries including South Africa. The tourism industry is expected to grow by 50% by 2008 in South Africa, by which time the industry will be worth US$7 trillion to the world economy. The South African Department of Environmental and Tourism further indicates that the World Travel and Tourism Council estimates that travel and tourism is currently the world's largest generator of jobs. In 1994, the industry created direct and indirect employment for 212 million people, which is 10.7% of the global workforce and provided one in nine jobs. It was further estimated that between the periods 1995 and 2000 travel and tourism would add a new job every 2.5 seconds and would create 125 million new direct and indirect jobs. The tourism sector has a capability of creating new jobs within a short period of time, and this is indicated by 480 000 jobs created in South Africa since 1994.

The Department of Environmental Affairs and Tourism also indicates that tourism has the lowest ratio of investment to job creation, and more jobs are created per unit of capital invested with many tourism activities being within the reach of the small operators. Tourism creates jobs for various skills, ranging from accountants, hairdressers, tour guides and trackers. It also provides the potential for on-job training opportunities. The tourism sector creates entrepreneurial opportunities to South Africans, ranging from the informal sector like craft and fruit vendors to beach vendors, chair rentals, and others. It also creates business opportunities like; entertainment, laundry and transportation services, craft rental, arts; craft and curios sales; tour guides and walking tours of places of interest; restaurants emphasizing local cuisine; guest house; beach manicures and pedicures.

Besides business opportunities, tourism brings development to rural areas where prime attractions are located. Tourism gives rural people the opportunity to share the benefits of tourism development, and promotes more balanced and sustainable forms of tourism development. It gives South Africans an alternative to urbanization, permitting them to continue a rural family existence and enfranchising both the women and youth. Tourism helps to save the environment and encourages the protection of biodiversity on the land used for its purpose. Tourism is regard as a most effective mechanism for fostering national and international cultural exchange and understanding among people from different societies (South Africa's Department of Environmental Affairs and Tourism, 1996: 16).

The Department of Environmental Affairs and Tourism also indicates that tourism is a foreign exchange generator in South Africa. South Africa receives a total of over 4 million tourists from both regionally and overseas markets per annum, which indicates positive market opportunities for the country. Through tourism South Africa is a popular country to which visitors are drawn. Tourists do not purchase only tourism attractions like sun, sand and sea, wildlife, wine and water sports, but also purchase goods and services in the country. Tourists visiting South Africa have the opportunity to sample the local products like wine, beer, food, craft and entertainment. Besides sampling the products, tourists have leisure, time and the money to pay for the local goods and services. South Africa has the potential to influence visitor tastes and create permanent export markets, and to create continuous demand by tourists.

Tourism has a multiplier effect and its impacts are greater than the initial expenditure by visitors is South Africa. The tourism industry provides vast potential to create linkages and to dynamise other sectors of the economy like agriculture, manufacturing and services. South Africa, unlike most of her counterparts in Africa or in the developing world, has the potential to supply almost every need of the tourism industry, ranging from meat and poultry, beverages and wines, to vehicles, machinery, furniture, cut flowers, jewellery and diamonds.

The South African Department of Environmental Affairs and Tourism states that tourism in South Africa generates demand and production in other sectors of the country's economy. Different South African companies and conservation agencies are already involved in ecotourism ventures, a factor which could act as a catalyst for further development in this industry. The potential for the development of tourism in South Africa is great and promising, but the tourism industry represents vastly under-utilized opportunities.

2.5 TOURIST ATTRACTIONS IN ZIMBABWE

Themes & Hudson (1973), indicate that Zimbabwe is a Shona word that is normally taken to be a contraction of dzimba dza mabwe (house of stone). The name is probably better derived from dzimba woyo (literary venerated houses) and hence normally used for chiefs' houses or graves. Zimbabwe is renowned for many stone ruins which are presumed once to have housed chiefs, and which have also been called Zimbabwe. Just recently, the name was commonly used exclusively for the Fort Victoria ruins, previously known as Great – Zimbabwe. These ruins have become a patriotic symbol and as a result, the name Zimbabwe has been adopted and recognized as the name of the country in which they lie. The Great Zimbabwe ruins are the Sub-Saharan Africa's largest and most dramatic prehistoric site.

Caelers (1991: 79) states that Victoria Falls is one of the largest waterfalls in the world. It is situated a few kilometres from the stunted growth scrub bush of the scorched, dry Kalahari sands that stretch from the neighbouring to the banks of the Zambezi River in North – West Zimbabwe. Throughout the day and night, the solid mist rises from the chasm of the Victoria Falls to pour down on the thick canopy of tangled trees and lianas that cloak the top of the facing cliffs. The pristine forest offers tourists the opportunity to enjoy the river landscapes, the vast animal species that come to drink water, and the incredible bird life, which can be viewed from well-marked footpaths or from the comfort and safety of a boat or car. Zimbabwe's national parks management is conscious of the heritage that the country has in trust for the world, and is maintaining the falls and the rainforest virtually in their natural state.

There are timber giants of mahogany, ebony, and fig, together with their symbiotic and parasitic attendants, including rare ferns and mosses, which refresh the atmosphere in Victoria Falls. During the heavy rain season, the heavy force of the falling rain creates clouds of spray spinning high into the air, which later brings rain again. The cathedral – like gloom has drenched the forest floor and rotting underbrush, which makes the sharp African sunlight to suddenly dim when entering it. Besides bushbuck, and other small game in the area, there is also a continuous thunder of falls and the perpetual patter of falling rain, ranging in intensity from gentle drizzle to torrential downpour. During the period between February and May, the Victoria Falls produces extremely high sounds with anthem of range as the waters of the Zambezi River evaporate and rise 457 meters (1.500 feet) into the sky.

The total bank-to-bank width of the falls is more than one and half kilometres (one mile). Four islands cover 400 meters (1, 312 feet) out of a total width of 1, 708 meters (5, 604 feet). The heights of different falls are between 100 and 116 meters (327 and 380 feet). The Gorge's width at its narrowest point is 60 meters (197 feet). The volume of water that flows over the falls differs considerably. The Gorge's lowest period is between late October and early November, when it has as little as 20, 000 cubic meters (410, 400 cubic feet) of water per minute. During the heavy rain season, the flow increases swiftly and dramatically. The spectacular period for the falls viewing is between February and May, as more than 500, 000 cubic meters (10 million cubic feet) of water a minute cascade over the edge (Caelers, 1991: 81).

Caelers (1991: 81) further stipulates that the peak season for the flood is between April and May, and this period is renowned for the six falls; Devis Cataract, Main Falls, Horseshoe Falls, Rain Falls, Armchair Falls, and the Eastern Cataract. These six falls form the largest curtain of falling water in the world. Between September and November is the dry season and almost no water plunges over the Rainbow and Armchair Falls or the Eastern Cataract on the Zambian side. Moreover, the Zambezi funnels itself into the narrow Devil's Cataract on the west bank, which is already worn down more than ten meters (33 feet) below the levels of the other falls. There is a small unique nature sanctuary that overlooks the falls, which is renowned for its wildlife, birdlife, and botanical glories.

What makes Victoria Falls unique are her butterflies and yellow pansies, diadem, orange tips, and many others that fly through the forest. The most fascinating creatures in the area are the bird species like the tawny–flanked prinia with its long, slender upstanding tail, blue waxbills, fire-finches, manikins, tchagaras, black-eyed bulbuls, bateleur–eagle, haggle's robin, the exquisite paradise fly-catcher, collared and scarlet-chested sunbirds, and many other species roaming the trees, soaring above the falls, and silhouetting against the blue Zimbabwe sky. One of the most fascinating birds' species is a scarcely seen turaco, which is the remarkable Livingstone's Laurie, and is seen in a distant flight between the tree tops or over the Gorge Falls (Caelers, 1991: 81).

The other popular attractions in the Victoria Falls are the wild animal species like bushbuck, waterbuck, leopard, warthog, mongoose and baboons. In the evening, hippos come out of water to roam the open crest of the cliffs, grazing the lush grasses sustained by the regular heavy rain. The plant life creates the real glory of the forest – creepers, vines, and giant trees,

including the parasitical strangler fig that embraces and smoothers its host. The other trees found in the area include the African Mango-Steen, the unusual climbing acacia, and the potato creeper, which sends out cluster of mauve and yellow flowers remarkably similar to those that bloom on the nightshade. In this area, there is also the curious spreading cape fig, which is a large leafy tree whose fruit sprouts only from leafless branches or straight from the main trunk.

Caelers (1991: 82) also indicates that one of the most fascinating attractions within the Victoria Falls area is the Livingstone's statue overlooking the Devil's Cataract. In this area, the sound of the falls is even louder especially when descending the steps to the lower view point. The statue presents the Caledonian Society's history, and was unveiled on 6 August 1954 by Livingstone's nephew, Howard Unwin Moffat, who served as a Prime Minister of Rhodesia from 1927 to 1935. The fascinating likeness, commemorating Livingstone's life from 19 March 1815 until 1 May 18 73, was raised through the hard work of William Lowe, the then Chairman of Livingstone Memorial Committee since its introduction in 1926 until his death in 1935. The great plunge of the Devil's Cataract is seen from this point, which is seventy meters (230 – feet) high, and is thirty meters (98 feet) wide.

Victoria Falls started to develop from a remote area to be a major tourist destination in 1960s. Before this period, the area was only renowned for trading or selling curios and souvenirs. Since then, the development of hotels, international airports, and a rapidly-growing shopping centre have replaced the curio stalls. The other developments in the area are the banks, fast food restaurants, an information bureau, and the immigration office. There is also a little railway station near the Victoria Falls Hotel, which draws steam buffs from around the world. The destination board noting the 2, 651 kilometres (1, 647 miles) to Cape Town and the 1, 534 kilometres (953 miles) to Beira is a monument to the long distance that the previous steam mammoths of the track used to cover (Caelers, 1991: 84).

Caelers (1991: 84) further stipulates that modern hotels and casinos provide entertainment in the evening, and during the wonders of the falls and the scenic beauty of Zambezi are explored by visitors. Besides the falls and the rivers, there is more to see in the Victoria Falls area. For example, on the Scenic Zambezi Drive, there is a reminder of the omnipotent power of nature, a giant, 1, 500 years old baobab tree with a trunk that has a girth of sixty meters (197 feet), which is specious enough to accommodate a car. In the evening, the dancers from Craft Village demonstrate cultural dances, mime, and comedy. The building styles,

decorations, and implements represent major tribes from various countries. Part of the dance includes the Zulu war demonstrations and their circumcision rituals.

The other attractive site is the Crocodile Ranch with more than 2 000 long – shouted reptiles, ranging in length from 50cm (20 inches) to four and a half meters (15 feet). The cruises by riverboats along the wide expanses of the Zambezi River above the falls operate on a daily basis. There is abundant species of wild animals that are roaming the area, which include elephant, buffalo, and other animals that come down to the river to drink water, particularly the near national parks cottages, where hippo can be seen. Fishing for different species of fish like the combative tiger fish, succulent tilapia, giant vundu, and many others is permissible within the river bounds, and a fishing license is not a requirement (Caelers, 1991: 85).

Victoria Falls is situated at the extreme north – west of the Kalahari which is renowned for the great herds of wild animals that roam the vast semi-arid terrain bordered in the west by Botswana. The Matetsi, which is 855 meters (2, 805 feet) above sea level, is situated 47 kilometres (29 miles) from Victoria Falls along the main Bulawayo road. The attractions in Matetsi include the small settlement's grave yards containing the remains of many missionaries and early settlers. The town was named after the Matetsi, a tributary of Zambezi that joins the river halfway between Victoria Falls and Lake Kariba, after flowing through a land of stark rock outcrops covered with extensive ancient mine workings (Caelers, 1991: 85).

The Kazuma Pan National Park which is surrounded by a dense teak forest provides many prides of lion; rare antelope such as the gemsbok, tsessebe, and oribi; buffalo; and endangered animal species like rhino, the Disney–like bat–eared fox, and Cape hunting dog. This is a place where the fleet-footed cheetah, the fastest land animal in the world is found. There is also a 16 kilometres (10 miles) road leading from Matetsi to Nantwich Camp, which is one of the gateway s into Hwange National Park. The fascinating attraction in the area is the four billion tones of coal which are buried a 46 square kilometres (184 square miles) area around Hwange, and with a capability to produce two million tones a year. The Baobab Hotel is an impressive viewpoint from which to take pictures of the giant Beyer–Garratt steam locomotives making their way to the Hwange colliery yards and North West to Victoria Falls (Caelers, 1991: 88).

Hwange National Park is not only the largest national park in Zimbabwe, but also one of the world's last great elephant sanctuaries. The park covers 14, 600 square kilometres (5, 863

square miles), and is has more animals and a greater variety of animal species (107 more) than any other park in the country, and has 400 species of birds. The flora of the properly-drained northern area part of the Zambezi watershed is dominated by mopane and mixed terminalia, which is unique when compared to the rest. The Kalahari scrubland is covered with stunted growth, scattered woodlands of teak and umtshibi trees, drain into Botswana's Makgadikgadi Depression. This area is characterised by having a vast marshy depression, vleis, and fragile open grasslands on shallow soils (Caelers, 1991: 90).

Besides the fact that Hwange National Park has a great wildlife population, it is also one of the most unspoilt wildlife sanctuaries in the world where the varied geography encourages the meeting of the faunal groups. The animals that are found in the area include a growing number of rhinos, 15 000 buffalos, 3 000 zebras, 3 000 giraffes, and 16 of the 33 species of Southern African antelopes, which include 6 000 impalas, 5 000 kudus, 2 000 sables, wildebeest, hartebeest, tsessebe, roan, and gemsbok. The large numbers of animals attract predators like lions and leopards, occasional cheetahs, large numbers of spotted hyena, and sometimes a rare brown hyena. Hippos and predatory crocodiles are found in the well-maintained artificial but natural–looking water pans.

The Bulawayo Victoria Falls railway line forms the Hwange National Park's northern boundary. The experienced tour operators provide game-viewing drives. For example, a Touring Company which is based at Hwange Safari Lodge provides minibuses which are specialising in game drive viewing services to the tourists. Herds of different species of wild animals are found at the Nyamandhlovu Pan and the Guvalala Pan to be viewed coming to drink water from the ideal vantage points. The animal species roaming the area include zebra, giraffe, kudu, elephant, steenbok, impala, warthog, buffalo, wildebeest, sable, lion, black-backed jackal, hyena, and bat-eared fox (Caelers, 1991: 94).

McCrea and Pinchuck (1990: 237) indicate that one of the attractive parks in Zimbabwe is the Chimanimani national Park which is located in the Chimanimani Village. This park is renowned for its vast mountains situated in its centre. Between the park's mountain hut and the soaring peaks which are shared with Mozambique, are the location for Bundi Valley. This is covered with grass that changes from wet–season green to maize-yellow and dried brown after the rainy season. The downhill course is cracked by a series of waterfalls splashing into icy cola-coloured pools, with smooth rocks good enough to bask on. The rocks on the way up

to the Valley are most fascinating, and are completely unique compared to the granite formations throughout Zimbabwe.

The Kazuma National Park situated on the extreme North – West corner of Zimbabwe, covers an area of 31 300 hectare. It is a good area to see the scarce wild animal species like white rhino, roan antelope, wild dogs and oribi. The common species in the pan area include lion, cheetah, and vast species of antelope, buffalo and elephant. The Kazuma Pan is the only Zimbabwe's park in which gemsbok are seen on a regular basis. The other attractive national park normally associated with Victoria Falls National Park is Zambezi National Park covers 56 000 hectares. Zambezi National Park consists of 40 kilometres of Zambezi River frontage and is rich with mopane and savannas forest. This park is renowned for fishing such fish species as yellow bream and tiger fish found within the 3 fish camps; Mpala-Jena, Kandahar and Sansiba which are located along the Zambezi River (Swaney, 1992: 241).

2.5.1 TOURISM POLICY IN ZIMBABWE

Duffy (2001: 1) argues that besides the momentous events that have brought Zimbabwe to the brink of implosion, the country's wildlife conservation policies have not been unduly affected, except for the decline in tourism attributed to a questionable security system. The resource management plans in the country are made difficult by the lawlessness which include squatters, war veterans and ruling party ZANU PF militias who invade and occupy land officially reserved and designated as nature conservancies for the protection of wildlife. "A conservancy is a group of farms on which neighbouring landowners have pooled their resources for the purpose of conserving and utilising wildlife on their combined properties. The conservancy concept does not have to be restricted to the commercial farming areas, but can be extended to the communal land as well" (Namibia, 1995: 2).

Duffy further argues that a lack of precise definition or even a set of guiding principles for sustainable development in Zimbabwe contributes to the depoliticising rhetoric of wildlife conservation as a global environmental concept. Sustainable development in Zimbabwe's wildlife policy is applied on the two key areas which are the Communal Areas Management Programme for Indigenous Resources (CAMPFIRE), and the Convention on International Trade in Endangered Species (CITES). CAMPFIRE is a generally acceptable concept, and even lauded as the only applicable concept for endangered animal species in Africa (Bonner, 1993: 1). In Zimbabwe, this concept is adopted as a scheme for integrating wildlife

conservation with rural development which authorises the subsistence farmers to use the wildlife in their areas to generate money for community development by selling quotas of elephants to safari operators for trophy hunting and getting a portion of the profits for the local people's benefit.

The Officials and politicians in the National Parks Department, the Zimbabwe's Ministry of Environment and Tourism together with both the local and international NGOs are concerned with wildlife management and conservation, and are in support of the CAMPFIRE concept. This includes the support for the limited trade in ivory and other elephant parts resulting from trophy hunting and officially sanctioned culls. The other components of the policy are being strongly opposed in the country, especially those that support hunting for sporting purposes and deplore the killing of endangered animal species to promote community development. This has mixed feelings, especially among the government agencies – the Treasury, the Environment Ministry, and the District Councils who are entitled to receive and spent money derived from trophy hunting for their personal benefits (Duffy, 2001: 2).

Duffy also indicates that the politics-race and the land questions are the most divisive issues in Zimbabwe. Wildlife conservation is one of the most racially controversial concepts of public policy in Zimbabwe. This is because wildlife conservation is associated with the white community and its demand for large areas of land, which comes in direct conflict with the social and political aspirations for land allocations. For example, the setting aside of the land for wildlife management in Zimbabwe is criticised by advocates of land reform and perceived as a denial of land to the subsistence farmers, even if the land is not suitable for agricultural purposes. The CAMPFIRE concept is viewed as a form of compensation for the Zimbabwean government's failure during its 21 years in power to implement a comprehensive land reform programme.

Despite the fact that CAMPFIRE is largely and strongly supported by rural development agencies, local NGOs, donors and wildlife conservationists, its reliance upon sport hunting and the ivory trade are criticised as cruel and unethical. The lack of transparency in the financial aspects by this concept is also criticised. Zimbabwe is a country with high a level of corruption prevailing in public activities like housing, grain marketing, fuel procurement, and war veteran benefits. There is also a high level of corruption among the government officials engaging in wildlife conservation, and among members of the Army supplementing their income by poaching ivory and rhino horn (Duffy, 2002: 2).

2.5.2 THE CONTRIBUTION OF TOURISM TO ZIMBZBWE'S ECONOMY

The financial Gazette (2003: 10) indicates that the Zimbabwean Government is dedicated in its approach to tourism recovery as the essential foreign currency earner in the country, and also which used to be the country's fastest growing industry. The government is failing to stabilise the sector continuous deterioration situation. In 1999, at the beginning of the country's land reform campaign, Zimbabwe made a total of US$700 million in foreign currency earnings. Due to the prevailing political situation, in 2002 the tourism industry was depleted ten-fold, earning only US$70 million.

The aim of the land reform campaign was to resettle the landless population, and the parliamentary elections that followed in the same year was marked with the country drawing negative publicity from the international media who agree that the land reform operation is a barbaric operation. Zimbabwe became a pariah country over a short period of time, and many international investors closed down their businesses within the country. Tourism suffered dismally, and the worst was experienced when the reputable international airlines Lufthansa and Qantas pulling out, stating the decline in international tourist arrivals in the country (Financial Gazette, 2003: 1).

The hotel occupancy in Zimbabwe declined except for the locals based market during the festive season. The Zimbabwean Tourism Minister, Francis Nhema, with his effort to fend off criticism on the ministry's failure to turn around the sector, has said that domestic tourism is good for the country and must be highly promoted (The Financial Gazette, 2003: 1). Contrary to the statement, Eric Bloch, a Bulawayo-based economic consultant indicates that although domestic tourism is good for Zimbabwe by generating income; there are other aspects it does not fulfil. For example, he argues that international tourists come with much needed foreign exchange that boosts the country's foreign currency reserves. The other problem is that the domestic tourism market does not satisfy the safari side due to the fact that local tourists do no usually go on safari tours but only use hotel services. The Safari operators are suffering due to a lack of a market in Zimbabwe.

Gwenda Wawn was voted the Tourism Personality of the year in 2003 for her commitment to promoting the tourism sector. She argues that the current situation in Zimbabwe demands that the country commit resources on an international campaign to attract international tourists by creating a Zimbabwean tourism emblem and finding ways of attracting international investors

to the country. Wawn further indicates that Zimbabwe has been heavily affected by negative media reports and is in the process of coming up with a symbolic logo that will be Zimbabwean. The other problem according to Wawn is that a huge amount of funding is needed to finance the campaign in order to attract visitors from Europe, America, and the Far East, and due to the financial crisis facing the country, it is difficult for Zimbabwe to accomplish this task alone (The Financial Gazette, 2003: 2).

Wawn as cited by the Financial Gazette (2003: 2) recommends that for Zimbabwe to be successful with her recovery plan, it must follow the South African strategy of the past few years of prioritising tourism as a potential foreign currency earner which reaped overwhelming results. South Africa initiatives have grown in leaps and bounds, and are strengthened by a strong partnership between the government, international community and the local business sector. Contrary to the South African strategy, in Zimbabwe there is no close and harmonious interaction between government and the local community business. Testimony to this is the low profile Zimbabwean Tourism Expo (ZTE) which is held annually by the Zimbabwe Tourism Authority. The objective of the ZTE is to link local tourism players with international markets, but most participants feel it is not adequately organised to meet its objectives (The Financial Gazette, 2003: 2).

Zimbabwe does not have reasonable international support and it remains cut off from important balance of payments, and this in return has reduced international investment confidence. Zimbabwe is into a deep–seated economic crisis with the inflation rate of 525.8%, one of the highest in the world. In an attempt to fight this problem, Zimbabwe is sending attaches to Kuala Lumpur, the Middle East and South Africa to broaden its market on the international arena, but these efforts are failing due to the shortage of finance (Nyanhi, 2003: 3).

Nyanhi further indicates that in 2003 Jonathan Moyo, the Minister of Information and Publicity, launched a video and a song in South Africa with the intention to market the Zimbabwe's major tourist destination, the Victoria Falls. This launch in South Africa is essential because it enhances regional tourism in general, but Zimbabwe in particular needs to repair its negative image at the international level. The international tourists, according to Bloch (2003: 3), need to be assured that there is enough fuel for their trip, that the police will not stop them at the roadblocks and demand their foreign currency, and that the flights will not be cancelled unnecessary.

The Zimbabwean Tourism Authority (ZTA) discloses that tourism in the country had raised about $30 billion by June 2003 as compared to $19.7 in 2002 during the same period. This is a factor of inflation and the devaluation of the Zimbabwean dollar against the greenback rather than the increased foreign currency earnings. On the 30 September 2003, the Zimbabwe Sun Limited (ZimSun), revealed financial results that implicated the negative picture of the country. Zim Sun indicates that room occupancy dropped by 45% during the period from September 2002. This statement is in contradiction of the claims by the Zimbabwean Tourism Authority that hotel occupancy was at its peak. There are some criticisms that the figures revealed in the market are creating a bad image because some companies reveal statistics that are selective and suitable to their plans, and which are not reliable (Bloch, 2003: 3).

2.6 SUMMARY

The South African tourism sector contributes significantly to the economy of the region. Southern African tourism is based on eco-tourism, which clearly stipulates that for tourists to experience and enjoy the Southern African attractions need guidance from the experienced tourist guide. Eco-tourism refers to nature–based tourism. HIV and AIDS pose some threats to the tourism industry in Southern Africa by killing the experienced people who are supposed to provide service to the tourists for the industry to grow. Tourism contributes to the economy of Southern African countries by creating employment and contributing to the countries' Gross Domestic Products (GDP). Southern African Governments and their policies encourage foreign investment and the public to be involved in tourism business in the region. The governments also work hard to market the region globally, but the main constraint facing Southern African tourism sector is the HIV and AIDS epidemic.

Factors discussed in the above chapter include tourism in Botswana, Namibia, South Africa and Zimbabwe; tourism policy in Botswana, Namibia, South Africa and Zimbabwe. The contribution of tourism to Botswana, Namibia, South Africa and Zimbabwe's economy representing South African region has also been discussed in the chapter. The following chapter covers the HIV/AIDS situation in Southern Africa and response strategies in Botswana, South Africa, Namibia and Zimbabwe.

CHAPTER 3

HIV AND AIDS SITUATION IN SOUTHERN AFRICA AND RESPONSE STRATEGIES

3.1 INTRODUCTION

Ramsey *et al.* (2002: 2) argue that people who are HIV (Human Immunodeficiency Virus) positive but not yet developed into full blown AIDS look and feel healthy. This means that people's HIV status cannot be judged by their physical appearance. The HIV virus attacks the body system and lowers the immunity to illness and disease. HIV results in Acquired Immunodeficiency Syndrome (AIDS), which is diagnosed when a person has developed a number of opportunistic illnesses such as pneumonia, tuberculosis, diarrhoea, skin rashes and sores. They further indicate that people who are infected with HIV normally die within ten years of contracting the virus because there is still no cure for the HIV/AIDS pandemic.

The HIV virus is carried in sperm, vaginal fluids, breast milk and blood. The most frequent way of transmitting HIV/AIDS is through vaginal, anal and oral sexual intercourse with a person who is HIV positive without using a condom (unprotected sex). The Virus can also be transmitted from the HIV positive mother to the baby during pregnancy or through breast milk, and by infected blood through blood transfusion, organ transplanting, or by sharing the needles or the razors with an HIV infected person (Ramsey *et al.*, 2002: 2).

Ramsey *et al.* (2002: 3) indicate that Sub – Saharan Africa is the region most affected by the HIV/AIDS pandemic in the world and a large number of people are dying of AIDS in the region. For example, in 2001 2.3 millions Africans died of HIV/AIDS – related illness. In the same year, 3.4 million people in the region were diagnosed with HIV/AIDS, and currently, there are over 28. 1 million people in Africa diagnosed with the HIV virus. The most vulnerable people to the HIV/AIDS pandemic are young adults, specifically young women. The majority of these people are unaware that they are diagnosed with the HIV/AIDS virus. The HIV infection in Africa is commonly contracted through unprotected sex and mother-to-child transmission among the HIV positive pregnant women.

Sub – Saharan Africa is experiencing various pandemics in terms of scale and maturity. The average life expectancy in the region has dropped from 62 years to 47 years as a result of HIV/AIDS. In the countries with the highest HIV prevalence rate in the region like Botswana, Malawi, Mozambique and Swaziland, the average life expectancy is below 40 years (Ramsey et al., 2002: 3).

This chapter covers the HIV/AIDS situation in Southern Africa. HIV/AIDS policy and response strategies in Botswana, Namibia, South Africa and Zimbabwe are also discussed. Some concluding remarks are made at the end of the chapter.

3.2 HIV AND AIDS SITUATION IN SOUTHERN AFRICA

In 2001, many countries in Southern and Eastern Africa had a higher than 30% HIV prevalence rate of their adult population between the ages of 15 – 29, which means that 1 out of 3 people was HIV positive. The antenatal clinics in the cities and large towns of Swaziland indicated an HIV prevalence rates of 32.2% and in urban areas of Botswana, the indicated antenatal clinics HIV prevalence rate was 43.9%. The prevention responses in some countries in Africa are fruitful. The slowing down of the HIV prevalence in Uganda is continuing and the antenatal clinics in urban areas indicated that HIV prevalence in the country dropped from 29.5% in 1992 to 11.25% in 2000. The studies in Zimbabwe indicate that the HIV prevalence rates among the young women in urban areas have dropped (Ramsey *et al.*, 2002: 3).

In West Africa, the HIV/AIDS cases were reported much later than in the East and Southern Africa, and five West African countries show a national adult HIV prevalence rate of 5%, which means that 1 person out of 20 people is projected to be HIV positive. These five West African countries are: Burkina Faso, Cote d'Ivoire, Nigeria, Togo and Cameroon. In Senegal, the HIV/AIDS prevalence rates have been kept down by persistent political support and leadership, and by integrated prevention strategies. Some Southern African countries upgrade and expand their response strategies to fight the HIV/AIDS pandemic, and a number of these countries indicate that the high HIV prevalence rate in the region is a great challenge and to win this battle is going to be a gradual and a long process (Ramsey *et al.*, 2002: 3).

Most of the young adults in a number of African countries lack the knowledge and understanding of the HIV/AIDS pandemic. The studies conducted by UNICEF indicate that 70% of the young girls aged 15 – 19 in Somalia, over 40% in Guinea – Bissau and in Sierra

Leone had never heard of HIV/AIDS. The studies also indicate that more than 40% of young girls in Kenya and Tanzania have no clue on how the HIV/AIDS virus is transmitted. The studies carried in South Africa indicate that more than 95% of the South Africans have a clear understanding of how the HIV/AIDS pandemic is transmitted and that there is no cure for this pandemic. Knowledge and awareness is the key to effective HIV/AIDS prevention strategies. By the end of 2000, 12.1 million children in Africa had lost their mothers or both parents to HIV/AIDS pandemic. In some of the African countries with the highest HIV/AIDS prevalence rates, many babies are born with the HIV/AIDS virus and the child mortality rates are rising at an alarming rate. For example, 70% of the deaths of the children under the age of five in Zimbabwe are caused by the HIV/AIDS pandemic (Ramsey et al., 2002: 4).

Alan *et al.* (2002: 2) state that throughout all the regions and cities of Southern African countries, young people are falling ill and are dying in large numbers as a result of HIV/AIDS related causes. This creates problems for the remaining parents who take the responsibility of caring for the large numbers of orphans with little or no income at all. The question is what do ordinary people experience and understand about the HIV/AIDS pandemic?. The HIV/AIDS data in Southern Africa is limited, and little is known about how citizens respond to and cope with the pandemic. People's perceptions and experience in the Southern African region vary in important ways from what the objective data leads them to expect. HIV/AIDS is a family problem in Southern African communities. Due to the high rate of poverty and high rate of unemployment, Southern African communities are concerned with getting income, feed their families, protect themselves from crime and insecurity, and obtaining basic health care more than with being saved from HIV/AIDS.

Whiteside *et al.* (2002: 4) indicate that HIV/AIDS epidemiological data is composed of two important concepts; incidence and prevalence. Incidence is the number of people who are newly infected over a certain period of time. Prevalence is the exact population which is infected, and the prevalence rate refers to the proportion of the population that exhibits the disease at a certain period, or in simpler terms, the average over a period of time. Both incidence and prevalence concepts are used in Southern Africa as key statistics for tracking the course of the HIV/AIDS pandemic in the region. The incidence data is used to measure the spread of the HIV/AIDS pandemic and the impacts of prevention efforts.

The testing of HIV/AIDS is conducted through a blood sample, and the testing of the entire population is not feasible or justifiable, hence HIV epidemiological data is based on sample

surveys of specific sub-groups. UNAIDS (2001) indicates that HIV prevalence rates among adults (aged 15 – 49) in Botswana is 38.8% and 15% in Malawi. This report is based on seven Southern African countries. The report also stipulates that the prevalence rates are steeply rising in a number of Southern African countries, particularly Lesotho and Zimbabwe, but stabilising in other countries. This stability of HIV prevalence in some of the Southern African countries is due to increased AIDS death rates. The incidence of AIDS illness and deaths in Southern Africa continues to rise irrespective of HIV prevalence stabilisation or declines (Whiteside *et al.*, 2002: 8).

The table 3.1 below presents the HIV prevalence among adults aged 15 to 49 years in seven Southern African countries as stipulated by UNAIDS report:

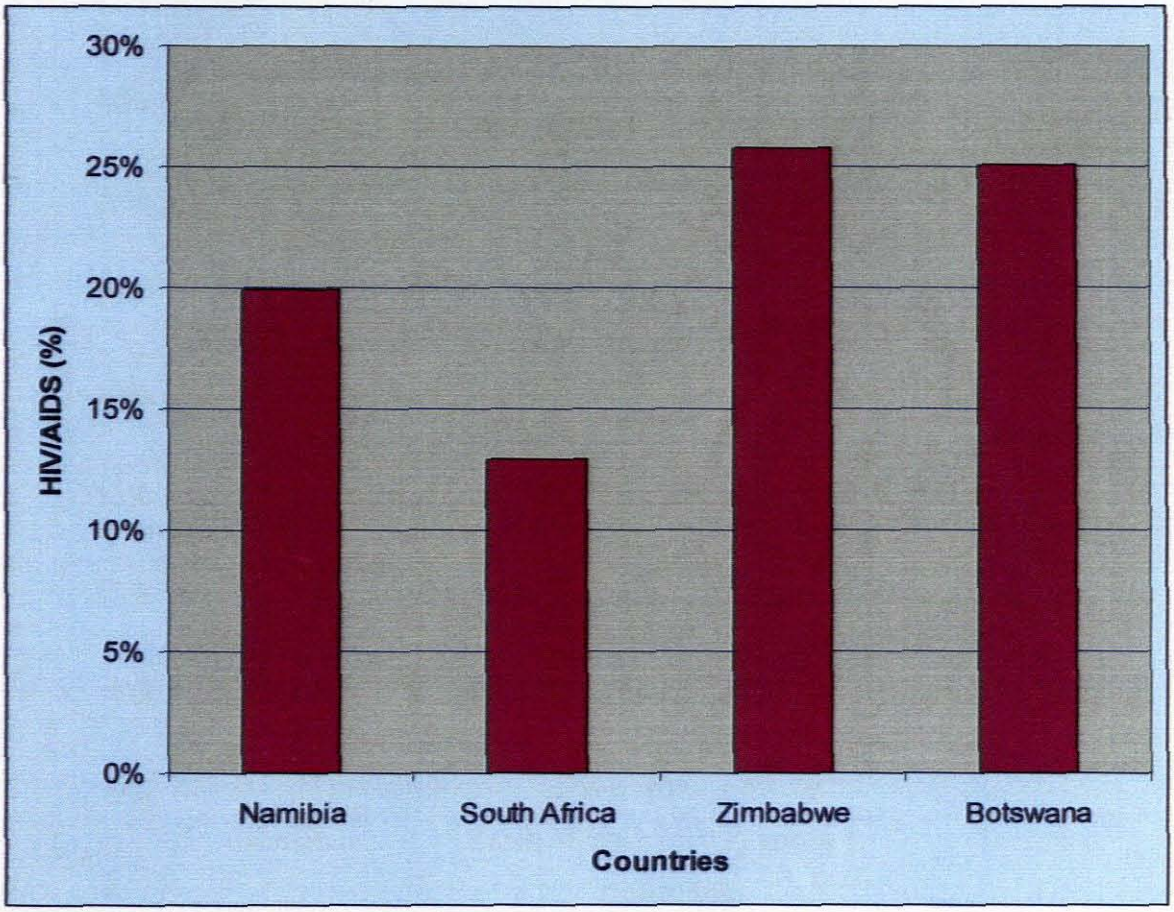
TABLE 3.1: PERCENTAGE HIV PREVALENCE PER COUNTRY IN A GIVEN PERIOD

COUNTRIES	1997	1999	2001
Lesotho	8.4	23.6	31.0
Malawi	14.9	16.0	15.0
Namibia	19.9	19.5	22.5
South Africa	12.9	19.9	20.1
Zambia	19.1	20.0	21.5
Zimbabwe	25.8	25.1	33.7
Botswana	25.1	35.8	38.8

Many countries in Southern Africa did not monitor the HIV/AIDS pandemic until recently, which results in a scarcity of data for earlier years.

The HIV prevalence in the Southern African Region as indicated by the above table (table 3.1) is further illustrated by the below graphs 1 to 3. The three graphs are composed of a randomly picked sample of four Southern African countries, which were used to represent the region in 1997, 1999 and in 2001. These graphs are used to indicate the percentage HIV/AIDS prevalence among adults aged 15–49 years for the three indicated periods. The fourth graph indicates the percentage of HIV/AIDS prevalence rates among pregnant women attending antenatal clinics in 2005 in the four Southern African countries.

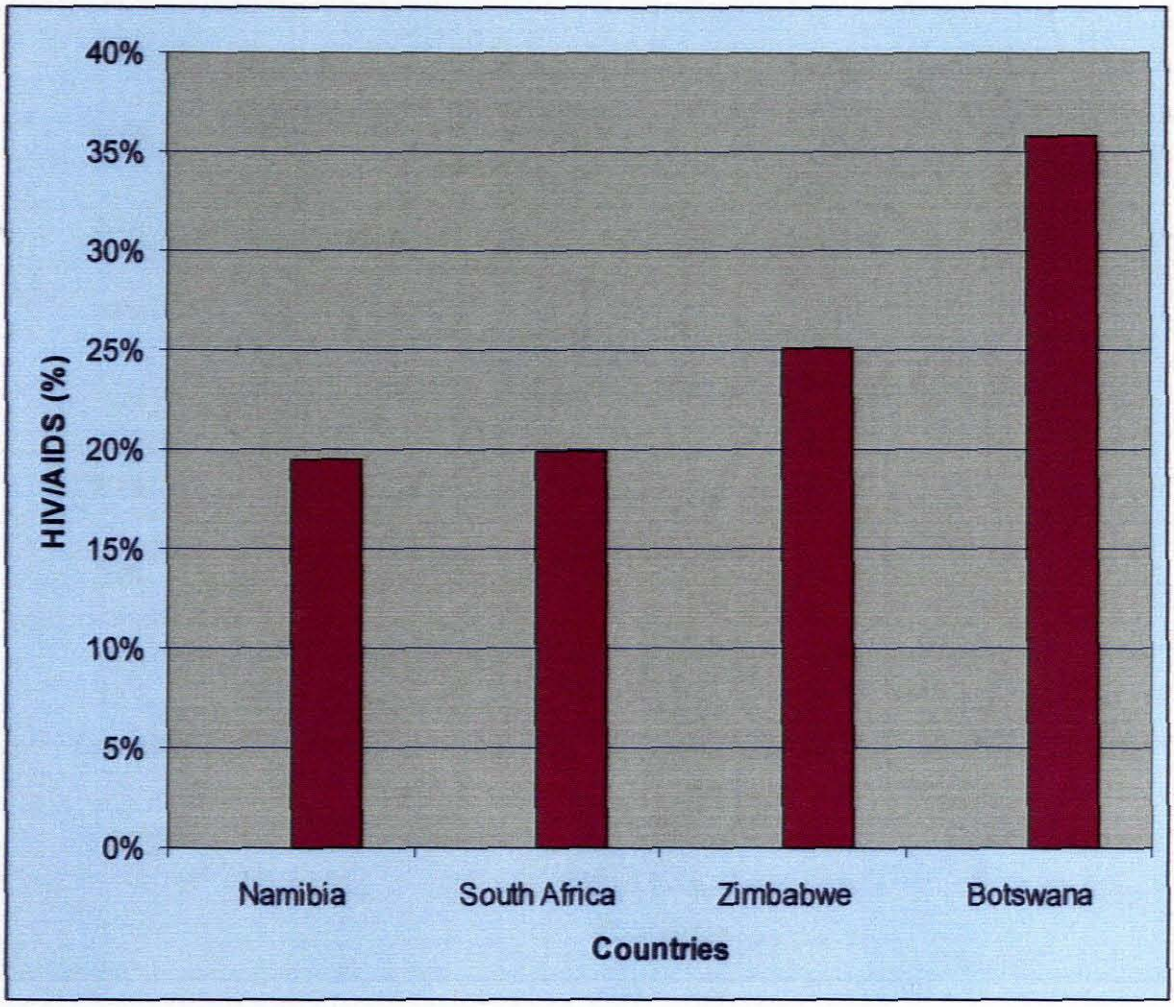
GRAPH 3.1: HIV/AIDS PREVALENCE AMONG ADULTS AGED 15-49 IN 1997



Source: UNAIDS (2006)

Graph 3.1 above indicates that in 1997 Namibia had a 19.9% HIV/AIDS prevalence among adults aged 15–49. South Africa had 12.9%, Zimbabwe 25.8%, and Botswana 25.1% for the same period.

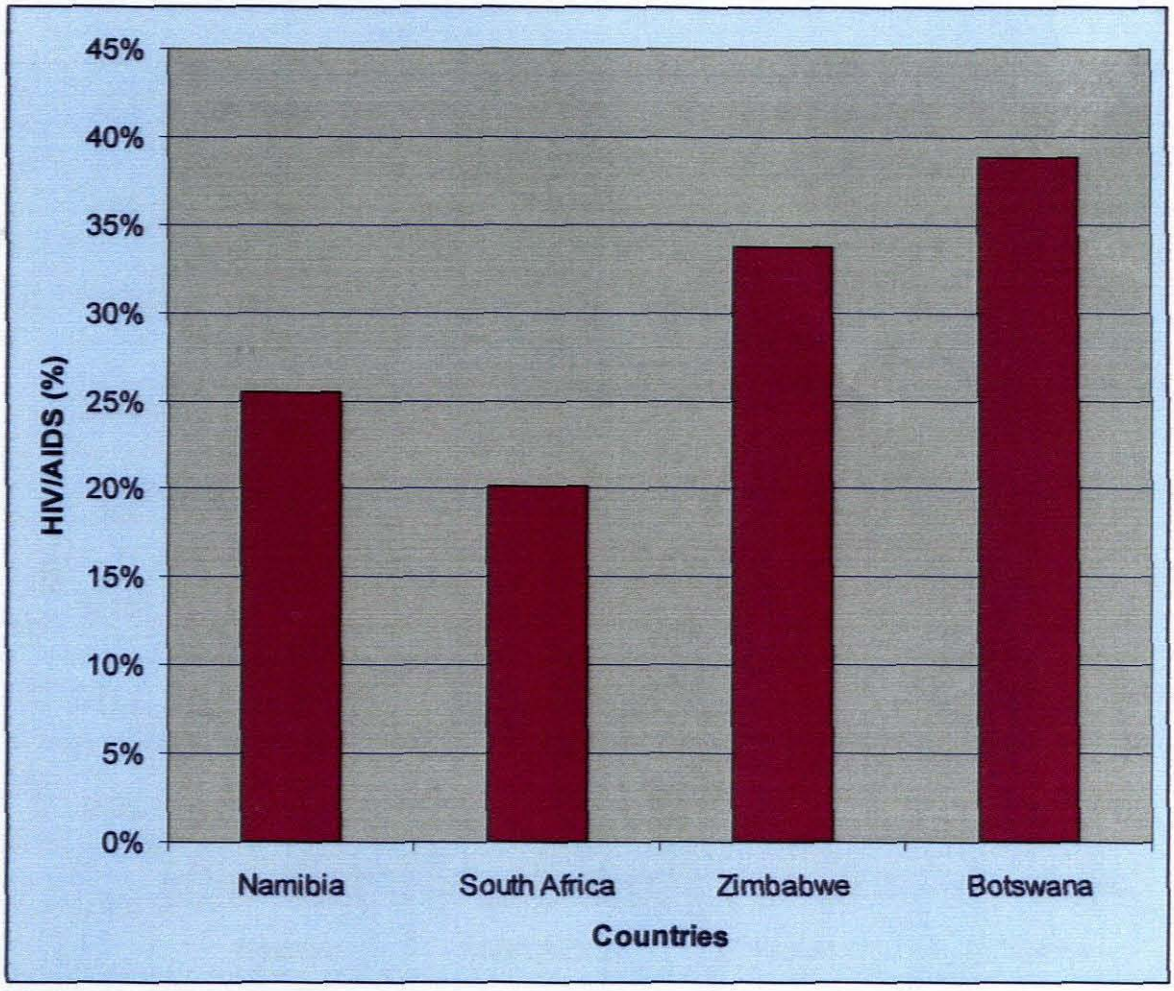
GRAPH 3.2: HIV/AIDS PREVALENCE AMONG ADULTS AGED 15-49 IN 1999



Source: UNAIDS (2006)

Graph 3.2 above indicates that Namibia had a 19.5% HIV/AIDS prevalence rate among adults aged 15–49 in 1999. This shows that there was little improvement from the 19.9% of 1997. South Africa had a 19.9% HIV/AIDS prevalence rate among adults aged 15–49 in 1999, and this indicates that the situation was becoming worse when compared to the 12.9% of 1997. The graph shows that Zimbabwe had a 25.1% HIV/AIDS prevalence rate among adults aged 15–49 years, and this indicates that there was improvement when compared to the 25.8% of 1997. Botswana had a 35.8% HIV/AIDS prevalence among the adults aged 15–49 years in 1999, and this indicates a rapid growth and a worse situation in the country when compared to the 25.1% of 1997.

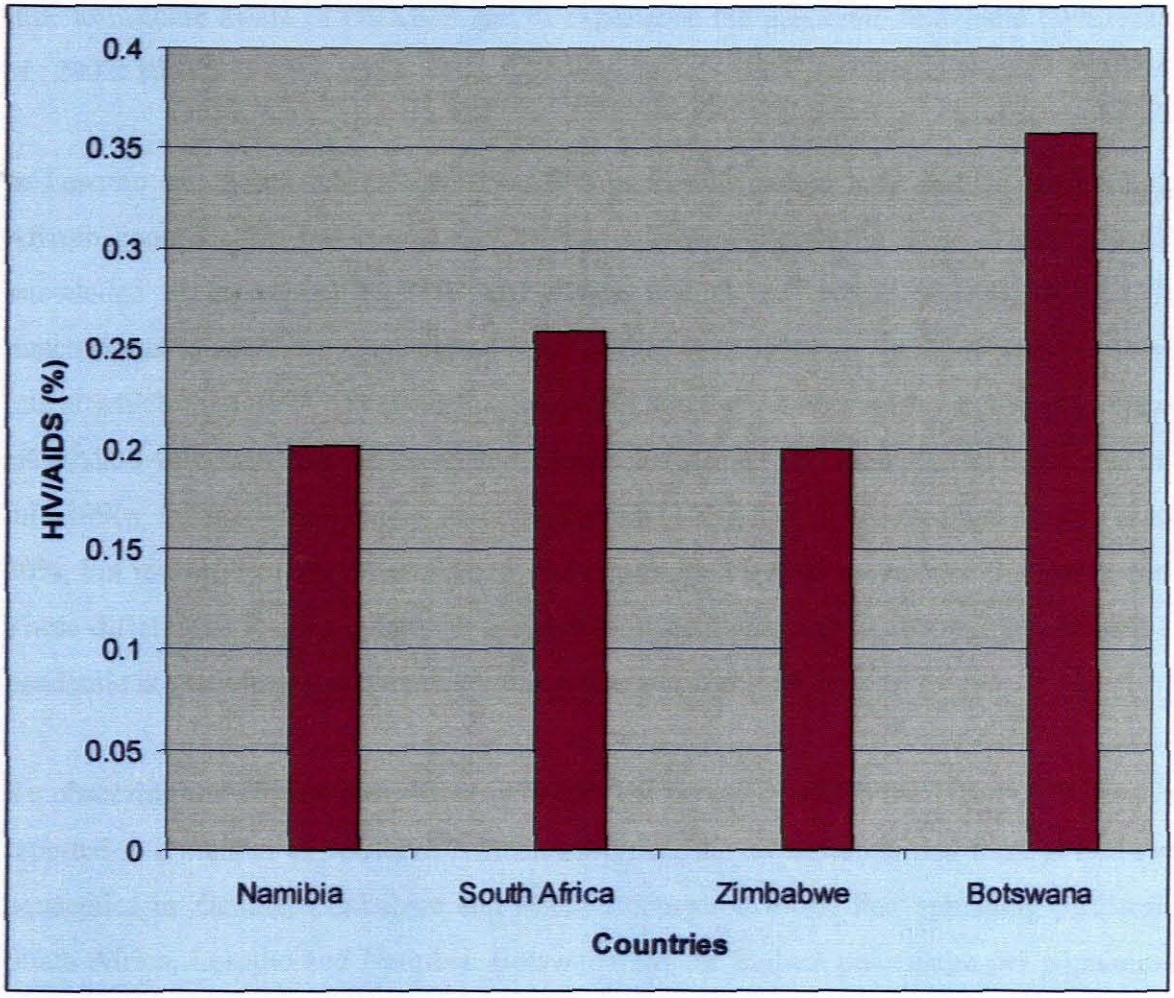
GRAPH 3.3: HIV/AIDS PREVALENCE AMONG ADULTS AGED 15-49 IN 2001



Source: UNAIDS (2006)

Graph 3.3 above shows that in 2001 the situation was becoming bad in Namibia with a 25.5% HIV/AIDS prevalence rate among adults aged 15 – 49 years, worse when compared to 1997 and 1999. South Africa had 20.1%, which indicates worse results when compared to 12.9% in 1997 and 19.9% in 1999. The graph indicates that in 2001 Zimbabwe had 33.7% HIV/AIDS among adults aged 15 – 49 years, and this shows the worst recorded when compared to 25.8% in 1997 and 25.1% in 1999. In Botswana, the graph shows that the HIV/AIDS prevalence among adults aged 15 – 49 years dramatically rose to 38.8% 2001 and this shows a worse situation in the country when compared to 25.1% in 1997 and 35.8% in 1999.

GRAPH 3.4: HIV/AIDS PREVALENCE AMONG WOMEN ATTENDING ANTE-NATAL CLINICS IN 2005



Source: UNAIDS (2006)

Graph 3.4 above indicates that 20.1% of pregnant women attending ante-natal clinics in Namibia in 2005 were HIV positive. South Africa had 25.8%, Zimbabwe 20.0%, and Botswana 35.8% in the same year.

The above graphs indicate that countries in Southern Africa are in different stages in terms of the HIV/AIDS pandemic situation. In South Africa the HIV/AIDS pandemic was first reported in the late 1980s, while in Botswana it was a few years earlier. HIV/AIDS pandemic cases in the other countries in northern part of Southern Africa were reported earlier in the 1980s. The Southern African countries indicated in the graphs have differently shaped pandemics. For example, in Zimbabwe the HIV/AIDS pandemic rose gradually through the 1980s and early 1990s, while in Botswana the pandemic begun later but rose much more

rapidly and to a higher overall level. These differences indicate the way Southern African countries experience the HIV/AIDS pandemic. In Zimbabwe, Namibia and Malawi the HIV prevalence has prevailed for a long time, and people within these countries have had a long time to become aware of HI/AIDS and to experience the pandemic first–hand (Whiteside *et al.*, 2002: 10).

In Lesotho and South Africa the HIV/AIDS pandemic started later than in most Southern African countries but has spread rapidly, and some people within these countries lack the knowledge of awareness on HIV/AIDS even though the overall prevalence rates have matched and to some extent surpassed those of the other Southern African countries. The fast rate at which the HIV/AIDS pandemic spread in Southern Africa relates to the state between HIV/AIDS infection and AIDS–related illness and death. For example, in Botswana in the mid-1990s, the ante–natal clinics reported that the HIV/AIDS prevalence had already reached 30%, but the level of illness and death was determined by the prevalence 5–8 years earlier. These differences lead to ignorance and denial in Southern Africa, the region in which HIV pandemic is spreading at a fast rate (Whiteside *et al.*, 2002: 10).

By observing the current prevalence rates and the period in which the HIV/AIDS have been reported in a number of Southern African countries, the indication is that there is less severe pandemics in Zambia, Zimbabwe and Malawi compared to the fast–spreading pandemic in South Africa, Lesotho and Namibia. Botswana has the highest percentage per population of HIV/AIDS prevalence rate when compared to the other Southern African countries. The HIV/AIDS prevalence in Zimbabwe is rising more rapidly than previously projected. In South Africa, the highest prevalence rates are among women between the ages of 20 and 29. The entire population–based surveys indicate that HIV prevalence in South Africa among men increases at an older age, in their mid-to-late thirties (Whiteside *et al.*, 2002: 11).

Whiteside *et al.* (2002: 12) further indicate that the problems with HIV data is that it is difficult to collect information about the exact number of AIDS patients or those who died from HIV/AIDS related illness. Little is known of the total number of deaths caused by HIV/AIDS in most Southern African countries due to the fact that AIDS deaths are not registered. However, South Africa has the best registration systems when compared to other Southern African countries, but the vital statistics of both births and deaths indicate only 80% of the total deaths occurring in the country, but no accurate cause of death is indicated.

HIV/AIDS is a sensitive issue and most people do not want to reveal that their family members died of the pandemic.

The young people in Southern Africa are the most vulnerable to the HIV/AIDS pandemic. In South Africa in particular, there are significant differences in terms of demographic category, with 42% of the black South Africans showing that they are affected by HIV/AIDS, 16% whites, 9% coloureds, and 3% Indians being affected by HIV/AIDS. The other indication is that 20% of the black South Africans are personally exposed to AIDS deaths, compared to 6% whites, 4% coloureds, and 2% Indians. Unlike in most countries in Southern Africa, Zambians and Malawians openly admit personal or family experience with AIDS pandemic. For example, 82% of Zambians and 65% Malawians annually attend religious gatherings out of the normal church services to discuss the HIV/AIDS pandemic, unlike in any other Southern African country (Whiteside *et al.*, 2002: 18).

UNAIDS (2005) reveals the following HIV/AIDS statistics for the top ten Southern African countries:

RANK TABLE BY: COUNTRY AND NUMBER

TABLE 3.2: PEOPLE LIVING WITH HIV/AIDS IN SOUTHERN AFRICA AS OF END OF 2005

COUNTRY	NUMBER OF PEOPLE LIVING WITH HIV
South Africa	5, 300, 000
Zimbabwe	1, 800, 000
Mozambique	1, 300, 000
Zambia	920, 000
Malawi	900, 000
Botswana	350, 000
Lesotho	320, 000
Angola	240, 000
Swaziland	220, 000
Namibia	210, 000

Source: UNAIDS (2005).

The global statistics of total people living with HIV/AIDS as indicated by UNAIDS as for end of 2005 is 40, 300, 000.

Globastat (2005) reveals the following statistics based on percentage of total population living with HIV/AIDS:

TABLE 3.3: PERCENTAGE OF TOTAL POPULATION LIVING WITH HIV/AIDS FOR GLOBAL TOP TEN COUNTRIES

COUNTRY	% OF TOTAL POPULATION LIVING WITH HIV/AIDS
Botswana	18. 284%
Zimbabwe	13. 198%
Swaziland	11. 772%
Lesotho	11. 024%
South Africa	9. 636%
Zambia	8. 905%
Namibia	8. 900%
Djibouti	8. 031%
Malawi	7. 584%
Kenya	6. 826%

Source: Globastat (2005).

Globastat (2005) indicates that HIV/AIDS negatively affects Southern Africa by reversing the socio-economic achievement the region has made over the last decade. HIV/AIDS results in an increased morbidity and mortality rates in some Southern African countries. For example, in Botswana the current infant mortality rate (IMR) under five mortality rates (U5MR) are 57 and 75 per 100 births respectively. The effect of the adult mortality rate due to HIV/AIDS is that a number of families in Southern Africa are loosing their breadwinners, thus increasing the household dependence ratio in the region.

3.2.1 HIV/AIDS POLICY AND RESPONSE STRATEGIES IN BOTSWANA

Botswana. Ministry of Health (2003: 8) states that the Botswana HIV/AIDS policy is structured on the country's Vision 2016 which stipulates that by the year 2016 Botswana will have an AIDS free generation. The stakeholders in different sectors in the country show strong commitment at the high level, and the president of Botswana is taking the lead in fighting the pandemic by providing adequate financial resources and the support of the development partners to contain the HIV/AIDS pandemic.

Botswana. The Ministry of State President National AIDS Coordinating Agency (NACA) (2003: 14) stipulates that the Botswana National AIDS Policy was developed and adopted in 1993 and later revised in 1998. This is a guideline and a framework for a National and Multi-Sectoral Response to the HIV/AIDS. As an integrated work, the Medium Term Plan 11 (MTP 11) was developed in 1994 and revised in 1997. The goals and objectives of the plan include identifying the strategic approach so that HIV response in the country can be expanded. In response to the HIV/AIDS in the country, the Botswana government has put structures in place for the implementation of the AIDS policy and MTP 11. To ensure effectiveness of the implementation of the national response and to achieve its goals and objectives, various structures are in place in the country. The examples of the structures include the National AIDS Council (NAC), Parliamentary Select Committee of Health, Ministry of Local Government and District Multi-Sectoral AIDS Committees (DMSAC).

The Botswana government is responding effectively to the HIV/AIDS epidemic and works hard to fight the disease. The country's Vision 2016 states that Botswana strives towards an AIDS–free generation by the year 2016. The government departments in different ministries show dedication in fighting the HIV/AIDS pandemic. The national policies and strategies like the Botswana HIV/AIDS Response Information Management System (BHRIMS) are in place to fight the HIV/AIDS pandemic (Botswana. Ministry of Health, 2003: 5).

The objectives of the Botswana HIV/AIDS Response Information Management System (BHRIMS) include the development of the needed infrastructure to monitor and evaluate the implementation of the National Strategic Plan. The specific objectives of the Botswana National HIV/AIDS strategy include the establishment of the Botswana HIV/AIDS Response Information Management System (BHRIMS) infrastructure, to develop national core performance indicators, to build and strengthen the human resource capacity for the

BHRIMS, to harmonize national data collection tools, to improve management and utilisation in the whole country, to develop the HIV/AIDS information management system, and to mobilise adequate resources for the implementation of the BHRIMS (United Nations Development Programme 2000: 28).

The interest and value for the monitoring and evaluation of the Botswana National HIV/AIDS Response is driven internally by the government of Botswana, based on the intensity of the national response and the need to identify the lessons to be learnt on the interventions. The Botswana government carries out a nation-wide assessment on a regular basis to identify the needs and capacities of the existing monitoring and evaluation system in the country. This assessment also helps the government to identify the strengths and weaknesses of the national response to HIV/AIDS, and the assessment's findings are used as inputs for the comprehensive national monitoring and evaluation plan. The aims of the monitoring and evaluation are: to identify the existing monitoring and evaluation infrastructure in the country, to have a clear overview of the Botswana HIV/AIDS monitoring and evaluation response, to use the findings of the baseline data to develop a comprehensive and sustainable Botswana HIV/AIDS response information management system, and to develop technical assistance and capacity building Action Plan to fight the epidemic (Botswana. Ministry of Health, 2003: 17).

The Botswana Ministry of Health further indicates that in order to achieve the above goals and objectives, Government Official within the Botswana Ministry of Health should regularly review the available literature on issues concerning HIV/AIDS, observe existing infrastructure and systems, pay regular visits to the districts within the country, and hold consultative meetings with stakeholders on a regular basis. The literature review is to be conducted to identify existing monitoring and evaluation approaches, to asses the availability of human resources, to identify opportunities, and to identify constraints that may exist. Stakeholder meetings and interviews help to examine the desires, perceptions and aspiration among the stakeholders of existing monitoring and evaluation systems in the country. The key stakeholders consulted include the National AIDS Co-ordinating Agency (NACA), Ministry of Health and Local Government, key programmes, major partnership projects, civil society organisations, and the private sector.

The stakeholders give their support to the concept of the Botswana HIV/AIDS Response Information Management System as a universal approach. The stakeholders are also committed to incorporate monitoring and evaluation system into their programmes. For

example, the Botswana Ministries of Agriculture and Education have established basic HIV/AIDS monitoring and evaluation infrastructure within their departments. These ministries have also developed guidelines to facilitate and serve as a springboard for the development of a national monitoring system. The Botswana Christian AIDS Intervention Programme (BOCAIP) and Botswana–USA (BOTUSA) have strategic plans that incorporate HIV/AIDS monitoring and evaluation systems. The Botswana Ministry of Health together with the stakeholders indicate that this is an on–going process, and the National AIDS Co-ordinating Agency (NACA) is in the process of developing a new strategic plan to guide the national HIV/AIDS response and at the same time is developing Monitoring and Evaluation Plan. The Ministries of Local Government and Agriculture integrate HIV/AIDS awareness activities into their existing Strategic Plans and Monitoring and Evaluation Systems (Botswana. Ministry of Health, 2003: 22).

The Botswana Ministry of Health also indicates that there is a wide dissemination of specific monitoring and evaluation findings in the country. Sentinel Surveillance data coordinated by National AIDS Co-ordinating Agency (NACA) in collaboration with both the Ministry of Health and the Ministry of Local Government is disseminated nation-wide to the various ministries, sectors, districts, programmes, and to the international community on an annual basis as a way of creating awareness. The aim of the government of Botswana together with the stakeholders is to develop the suitable infrastructure to monitor and evaluate the National Response based on the National Strategic Plan (2003 – 2009). The National Strategic Plan encourages the general public to go for HIV voluntary counselling and testing, and it develops and implements segmented, actionable behavioural change interventions which identify the unsafe practices that put people at risks of acquiring HIV/AIDS. The use of both male and female condoms in Botswana is encouraged by increasing the supply channels free of charge, improved access, and through sustained education for both genders (Botswana. Ministry of Health, 2003: 24).

The Botswana Government encourages the communities to identify and take action on issues contributing to the spread of HIV/AIDS in the country like alcohol abuse and unprotected sex, especially among the young people. Alcohol abuse and unprotected sex practices are the most identified factors contributing to the spread of HIV/AIDS not only in Botswana but in general. The Botswana government encourages cultural and Behavioural Change Interventions (BCI) at national and district levels to address vulnerable groups particularly in terms of sex, gender relations and alcohol abuse. The government also strives to eradicate discrimination and

stigmatisation in both private and public sectors. The Botswana Government provides HIV/AIDS treatment like Anti Retroviral Treatment (ART) and Isoniazid Prevention Therapy (IPT) free of charge to the people who are HIV positive and certified to take the treatment. Pregnant women who are also HIV positive and their families are encouraged by the government of Botswana to use the Prevention of Mother to Child Transmission (PMTCT) programme, which is provided by the government free of charge, and care is given to people living with HIV/AIDS (PLWHA) throughout the country (Botswana. Ministry of Health, 2003: 27).

3.2.2 HIV/AIDS POLICY AND RESPONSE STRATEGIES IN SOUTH AFRICA

Strode and Grant (2004: 7) argue that South Africa, like other developing countries, has experienced the HIV/AIDS epidemic for more than 20 years. The antenatal clinic survey conducted by the South African Department of Health in 2000 indicates that 25.2% of pregnant women in the country are HIV positive and 20% of adults aged 15–49 years are infected with the HIV/AIDS virus. They further argue that the South African political response to HIV/AIDS has been characterised with inconsistencies, absurdities and good practice.

The denial approach to HIV/AIDS existence was summed up in 1998 by the then deputy president Thabo Mbeki who became the centre of some controversies. For many years a number of South Africans did not take HIV/AIDS seriously and they were under the impression that the pandemic problem was just a speculation. Both the apartheid and the post apartheid governments did not initially respond to HIV/AIDS pandemic effectively. The poor response to the HIV/AIDS pandemic by the apartheid government was due to a lack of political commitment, and the post apartheid government in 1994 became more concerned with restructuring and developing new policies and programmes (Strode & Grant, 2004: 7).

The South African response to HIV/AIDS has been for a lengthy period marked with denial. Strode and Grant indicate that hundreds and thousands of South Africans loose their lives due to HIV/AIDS every year, and 1 million South Africans died in 2003 due to the pandemic, but the country lacks the political courage to fight the pandemic. The confusion around the government's HIV/AIDS policy fails programmes on various levels. For example, the Treatment Action Campaign (TAC) indicates that they cannot provide training in all of the hospitals they have aimed for in the utilisation of Nevirapine for preventing transmission of

HIV from pregnant women to their unborn babies, and some hospitals indicate that they are afraid that if they work with the TAC they may loose their government funding. The total costs for the national provincial health care in 2000 were R31.966 billion, R33.835 billion in 2001and R34.026 billion in 2002. The AIDS Budget Unit of the Institute for Democracy in Africa (IDASA) conducted a study which reveals that despite the fact that overall health care remains consistent, the actual expenses on provincial HIV/AIDS conditional grant has increased from R18 million in 2000, to R97.207 million in 2001, to R341.939 in 2002 (Strode & Grant, 2004: 9).

The South African government allocated R2.1 billion over a period of three years to fight the HIV/AIDS pandemic. The country's anti-retroviral programme is the largest public health intervention of its nature that the world has ever experienced. Strode and Grant indicate that in 2004 there were 350 000 people on the anti-retroviral (ARV) programme worldwide, and 100 000 of these people were reported to be in Brazil. The South African government's roll-out programme has 53 000 people on the ARV programme and 1.4 million people are projected to be on the programme by the end of 2007. This results in levelling of criticism at the state health sector for taking long in implementing the roll-out of the ARV programme. South African communities were quiet about HIV/AIDS during the first 15 years of which the HIV/AIDS was reported in the country. Gradually, communities are more mobilised around HIV/AIDS issues, and levels of openness are increasing and many people contribute to the fight against the HIV/AIDS pandemic by encouraging their family members to utilise the Voluntary Counselling and Testing programmes (Strode & Grant, 2004: 9).

Bern *et al.* (2006: 1) argue that the evidence does not support the South African government claims that the country's HIV/AIDS programme and policies in combating the HIV/AIDS pandemic are the best in the world. The increasing HIV/AIDS prevalence rate and the alarming death rate indicate that the struggle for fighting HIV/AIDS is far from won. The South African Minister of Health, Dr Manto Tshabalala Mosimang, as cited by Bern *et al* (2006), indicated in antenatal clinic (*ANC)* report that the United Nations stresses that poverty alleviation and HIV prevention must be given high attention in the fight against the HIV/AIDS pandemic. South Africa is facing one of the severest HIV/AIDS infection rates in the world, with 5.4 million people estimated to be living with HIV/AIDS. The World Health Organisation predicts that when compare all countries in the Sub–Saharan Africa, South Africa has the highest HIV pandemic increasing rate.

In responding to the above statement, in 2006 the South African President Mr Thabo Mbeki, as cited by Bern *et at.* (2006: 1), argued that he works in the Presidency on a daily-basis and no one indicates the alarming deaths rate due to the pandemic. Contrary to this argument, Mr Joel Netshitenze and the Reverent Frank Chikane state in a report published by the presidency that the HIV/AIDS pandemic's dreadful impact is beginning to show its significance in both morbidity and mortality. The latest predictions indicate that by July 2006, 2.2 millions South Africans would have died of HIV/AIDS. In response to this, the South African government has established a large scale of antiretroviral (ARV) treatment strategy, and the latest predictions state that 134 473 South Africans are registered on public sector ARV treatment. In addition to this figure, 80 000 patients are projected to be on ARV treatment in the private and NGO sectors (Berman *et al.*, 2006: 1).

It is significant that figures for the public sector comprise the patients who are registered to receive ARV, and do not involve those who are infected but not taking the treatment. The Actuarial Society of South Africa predicts that there are more than 500 000 adults in the country who need ARV treatment but do not get it. The health minister emphasised in the budget speech in May 2006 that infant and under-five mortality rates have dropped since 1998, but the latest indications by Statistics South Africa are that there is a 73% increase in the number of deaths in the 0-5 age group between 1997 and 2004. The death rate among the 30-35 age groups of those who have developed full blown AIDS has increased by 207% per annum. These statistics indicate that South Africa is in the grip of the HIV/AIDS pandemic. The further prediction by Statistics South Africa is that by the year 2011 more people will die of AIDS in South Africa than of all other causes of death put together.

TABLE 3.4: OVERVIEW OF HIV/AIDS IN SOUTH AFRICA

	NUMBER		**SOURCE**
Present number of HIV infections (2006)	High Low	5 500 000 5 372 474	USAIDS ASSA 2003 (2005)
Number of people on HAART (2006)	Public Private	134 473 80 000	Department of Health Department of Health
HIV infection rate (2005)	High Low	10.80% 9.80%	Human Science Research Statistics South Africa
HIV infection rate by 2025	High	18.00%	Metropolitan Life

(2006)	Low	7.00%	Metropolitan Life
Life expectancy at birth in 2025 (2006)	Worst	50 years	Metropolitan Life
	Best	59 years	Metropolitan Life
HIV + pregnant women visiting antenatal clinics (2004)	High	29.50%	Metropolitan Life
	Low	27.30%	Actuarial Society of South Africa
AIDS deaths proportional to total deaths (20050	High	57.20%	Metropolitan Life
	Low	45. 40%	Actuarial Society of South Africa
AIDS orphans currently living (2006)	High	1 200 000	UNAIDS
	Low	1 100 000	UNICEF (2004)
Child-headed households	High	719 000	HSRC (2004)
	Low	236 000	Census (2001)
Numbers of orphans (2010)	High	1 950 000	UNICEF (2002)
	Low	1 704 000	UNICEF (2002)
Workforce &AIDS (2005)		18.80%	ASSA 2003 (2005)
Shrinkage of labour force (2015)	High	25.30%	UNAIDS (2004)
	Low	23.50%	UNAIDS (2004).

Source: Marco MacFarlane (2006)

The table 4 above presents **high** and **low** predictions for the HIV/AIDS figures because most of the data is based on statistical modelling. The UNAIDS indicates in the table that 5 500 000 people in South Africans are living with the HIV/AIDS pandemic. The Actuarial Society of South Africa (2005) stipulates in the above table that the **low** HIV prevalence rate in 2006 is 5 372 474 in the country. The South African Department of Health (2006) indicates that there are 134 473 AIDS patients on ARV treatment in public clinics, and 80 000 patients are in the private clinics in the country.

The South African Human Science Research Council indicates in the above table 4 that the **high** HIV infection rate in 2005 was 10.80%, and Statistics South Africa indicates that the **low** HIV infection rate in 2005 was 9.80%. It is also indicated in the table that Metropolitan Life (2006) projected that the **high** HIV infection rate by the year 2025 would be 18.00%, and **low** projection rate would be 7.00%. Metropolitan Life further projected that the **worst** life

expectancy at birth in 2025 would be 50 years and the **best** life expectancy for the year 2025 would be 59 years.

The National HIV prevalence Survey (2004) indicates in the above table that the **high** level of HIV prevalence rate among pregnant women visiting the antenatal clinics is 29.5%. The Actuarial Society of South Africa (2004) also indicates that the **low** HIV prevalence rate among pregnant women visiting the antenatal clinics is 27.30%. Metropolitan Life (2005) states that the **high** AIDS death as a proportion of total deaths in South Africa is 57.20%, and the Actuarial Society of South Africa indicates a **low** death rate of 45.40%. The UNAIDS (2006) indicates that the **high** number of AIDS orphans Living in South Africa is 1 200 000, and the UNICEF indicates the **low** number of 1 100 000 AIDS orphans.

It is also indicated in the table by the Human Science Research Council (2004) that the **high** number of children who head households in South Africa is 719 000, and the Population Census (2001) indicates that the **low** number of children heading the households is 236 000. The UNICEF (2004) predicts that by the year 2010 the **high** number of AIDS orphans would be 1 950 000 and the **low** for the AIDS orphans in the year 2010 would be 1 704 220. The Actuarial Society of South Africa (2005) indicates that the HIV/AIDS infection among the workforce in 2005 was 18.8%. The UNAIDS projects that the **high** shrinkage of the labour force would be 25.30% by the year 2015, and the **low** shrinkage rate would be 23.50% in the year 2015.

Moodley (2006: 15) indicates that South African companies show the commitment in fighting the pandemic by investing on HIV/AIDS treatment programmes for their workers as the high costs of ignoring the epidemic begin to be experienced. Some companies loose between R1.8 billion and R2.2 billion annually due to staff absenteeism related to the HIV/AIDS pandemic. Moodley also states that Gavin George, a health economist at the health economics and HIV/AIDS research division of the University of Kwazulu–Natal indicates that education and treatment are both critically important in South Africa because some companies experience up to a 30% HIV/AIDS prevalence rate among their employees. Some of the South African companies have recently moved beyond prevention programmes to an extent of introducing and supplementing antiretroviral (ARV) treatment programmes.

George recently carried out a study to investigate different models for companies providing ARV treatment, which involves the employer funding and delivering the treatment at facilities

on site. Mining house Anglo American uses this model and in 2005 indicated that 34 000 of its 145 000 employees were HIV positive, with 9 000 in need of the treatment. George's study investigated four mining companies, one agricultural company, one financial services company and one manufacturing company. The study results indicate that the prevalence rates are high in the mining sector with Botswana's Debswana indicating a 35% prevalence rate among the employees, and Old Mutual indicating the lowest rate of 5%. A number of companies are facing the pressure of increased absenteeism and high staff turnover due to the rapid spread of HIV/AIDS in South Africa (Moodley, 2006: 15).

The Grant Thornton International Business Owners in 2006 conducted an HIV/AIDS survey of the companies with 50 to 250 employees, and the survey results indicate that some companies loose up to 23 of their employees due HIV/AIDS-related diseases within a period of two years. South Africa is estimated to be loosing up to R12 billion a year due to workers absenteeism with between R1.8 billion and R2.2 billion being directly associated with HIV/AIDS. A number of South African companies are more determined to subsidise treatment for their employees because the average annual costs of treating an employee infected with HIV/AIDS has declined significantly from R48 000 in 1998 to less than R10 000 a year. The study carried out at the Helen Joseph HIV Clinic, funded by the President's Emergency Plan for International Development indicates that the cost of successfully treating a person with HIV/AIDS is R7 285 per annum. George further argues that the advantage of ARV treatment is that it prevents the cost of not intervening from outweighing the costs of developing strategies and programmes to address the pandemic (Moodley, 2006: 15).

Caelers (2006: 3) stipulates that the available HIV/AIDS data shows that ANTI-AIDS drugs help South Africans living with the disease to live for 13 more years. The data from the United States indicates that people who started therapy in 2003 are expected to live more than 13 years longer than if they had been diagnosed in 1988. The South African HIV expert Dr Francois Venter, clinical director of the University of the Witwatersrand's reproductive health and HIV research unit, indicates that with the new drugs since 2003 survival jumps are even more possible. The US data sponsored by the National Institute of Allergy and Infectious Diseases, which is based in the United States of America and being part of the National Institute of Health (NIH) measure the survival benefits of HIV therapies and come up with the above conclusion. Caelers also indicates that the research carried by Rochelle Walensky and Kenneth Freedberg indicates that HIV therapies are effective and this is clarified by a decade

of use of anti-retroviral therapy which provided years of increased life to a number of Americans who have been diagnosed with HIV/AIDS since 1989.

The National Institute of Allergy and Infectious Diseases director, Anthony Fauci, as cited by Caelers (2006: 3), indicates that new HIV therapies transform the HIV/AIDS from a rapidly fatal disease into a medical controllable condition. He further indicates that HIV/AIDS infection is no longer the death sentence it used to be. In 2003 it was further projected by Walensky that a person starting the treatment that year could hope to live more than 13 years longer than if he/she had been diagnosed in 1988. These survival benefits are only available to people who know that they have been infected with HIV/AIDS and are certified by doctors to use the treatment. Venter indicates that most people in South Africa start the treatment when their body's ability to fight the disease (CD4 counts) is lower than the recommended measure (200) and when they are already ill (Caelers, 2006: 3).

Venter indicates that people who start taking anti-retroviral treatment when their CD4 are very low tend to have a poor prognosis. He further stipulates that the 13 years average life extension include both adherent and poorly-adherent patients, and the people with poor prognosis may dramatically bring this figure down. The patients presenting with AIDS at higher CD4 cell counts have a significant gain in years of survival. There are survival benefits that are gained globally through continued expansion of access to the HIV/AIDS treatments. Venter expressed a concern that South Africa is faced with a challenge to motivate everyone to get tested before they feel ill (Caelers, 2006: 3).

TABLE 3.5: PROFILE OF GOVERNMENT EFFORTS TO COMBAT AIDS

Expenditure	R30 million (1994) R3 billion (2006)
Condom distribution	270 million (2003) 346 million(2004)
Female condom distribution	1.3 million (2003) 2.6 million (2004)
Access to condoms	97%
Public HIV/AIDS service points	123
Public ARV distribution points	199
People on public ARV treatment	130 000
People on private ARV treatment	80 000
People accessing nutritional support	329 000

Public VCT sites	1 500 (2002/03 3 700 (2004/05)
Number of people counselled	691 000 (2003/04) 1.3 m (2004/05)
Prevention of mother-to-child facilities	2 500
Health professionals recruited	1 060
Health professionals trained on HIV	7 600
Community caregivers trained on HIV	61 000
Awareness about HIV/AIDS	92% - 98%

Source: Actuarial Society of South Africa (2004)

Table 3.5 above indicates that in 1994 the South African government spent R30 million in fighting the HIV/AIDS pandemic, and in 2006 the government budgeted R3 billion to fight the pandemic. In 2003, it is indicated in the table that 270 million condoms were distributed to the public, and in 2004 346 million condoms were distributed throughout the country. In 2003, 1.3 million female condoms were distributed nation-wide, and in 2004 the government distributed 2.6 million female condoms. This is an indication that the demand for the use of condoms was high among female South Africans. It is also indicated in the table that 97% of the people in South Africa have access to condoms, and that there are 231 public HIV/AIDS service points in the country. South Africa has 199 public antiretroviral (ARV) distribution points that are open and accessible to the population.

It is also stipulated in the table that there are 130 000 AIDS patients on public sector ARV treatment, and 80 000 AIDS patients are on private sector ARV treatment. A total of 329 people in the country have access to the nutritional support services. During the period between 2002 and 2003, 1 500 public voluntary counselling and testing (VCT) sites were established in the country, and during the period 2004/2005, the government of South Africa established a total of 3 700 voluntary counselling and testing sites. The other indication in the table is that between the period 2003 and 2004, 691 000 people in South Africa used the voluntary counselling and testing services, and in 2004/2005, 1.3 million people in the country were voluntarily counselled and tested for HIV/AIDS.

It is further indicated in the table 5 above that 2 500 prevention of mother-to-child transmission facilities have been established in the country, and there are 1 060 health professionals recruited. There are 7 600 health professionals trained specifically on HIV/AIDS programmes, and 61 000 people have been trained on HIVAIDS community care-

giving programmes. It is also stipulated in the above table that 92% to 98% of people in South Africa are aware of the HIV/AIDS pandemic and the way in which HIV virus is being transmitted.

Strode and Grant (2004: 12) argue that the national and provincial efforts to address HIV/AIDS by the apartheid government were not good enough, and it failed the national institutions and there was no national HIV/AIDS strategy. The first comprehensive national AIDS plan was established by the National AIDS Co-ordinating Committee of South Africa (NACOSA). This plan was developed outside the government concern through a full consultative process between the African National Congress (ANC) members before it became the ruling part in government. The NACOSA Plan indicates that it is imperative that South Africa's response to HIV/AIDS must be based on the principles of inter-sectoral partnerships and it is the responsibility of all the sectors. The aim of NACOSA is to mobilise and unify provincial, international and local resources.

The post-apartheid government adopted the NACOSA Plan as the national HIV/AIDS strategy in July 1999 and empowered the Directorate of HIV/AIDS and sexually transmitted diseases (STD) in the Department of Health (DOH) to ensure a comprehensive implementation process. The South Africa's National Review on HIV/AIDS response which was conducted in 1997 indicates that there is a lack of dedication by the Department of Health to an inter-departmental approach to HIV/AIDS. The institutional mechanisms to harness political commitment in place are infective, and there are some criticisms that the implementation is slow and focused narrowly on the health sector in the government other than in other sectors. The other concern is that there is a lack of co-ordination at various levels, and the conflicts between sectors are not managed and controlled (Strode & Grant, 2004: 12).

The National Review indicates that the established recommendations to resolve the institutional arrangements regarding the response to HIV/AIDS are that the political leaders should shift the accountability of fighting HIV/AIDS from the Ministry of Health to an individual person in a wider perspective, secondly, the inter-departmental and inter-sectoral responses to the HIV/AIDS pandemic need to be strengthened. The Inter-ministerial Committee (IMC) on HIV/AIDS has been established to facilitate the development of political commitment to deal with the epidemic. The South African government established the 2000 – 2005 HIV/AIDS Strategic Plan to guide the country's response to the HIV/AIDS

pandemic by both the public and private sectors. The aim of this Strategic Plan was to guide the sectors in developing their own strategic and operational plans which in return assist the nation to establish a peaceful, efficient and effective response to HIV/AIDS (Strode & Grant, 2004: 13).

The 2000–2005 HIV/AIDS Strategic Plan was established in July 1999 after reviewing the existing HIV/AIDS prevention, treatment and care strategies by the participants. The 2000–2005 HIV/AIDS Strategic Plan was established in a comprehensive approach which involved faith-based organisations, people living with AIDS (PLWA), human rights organisations, academic institutions, the civil–military alliance, the media, organised labour, organised sports, organised businesses, insurance companies, women's organisations, youth organisations, international donor organisations, health professionals and health consulting organisations, political parties and affected government departments. The consensus was reached and a committee was established and given the mandate to develop a five–year HIV/AIDS/STDs Strategic Plan. The existing goals and objectives were reviewed and the set priority areas include prevention, treatment, care and support, legal and human rights, and monitoring, research and evaluation (Strode & Grant 2004: 13).

The HIV/AIDS policy formulation process in South Africa is an integrated framework which involves a number of sectors like the traditional leaders, faith-based organisations and the private sectors to get their views and to enhance active participation. In September 1999, the Minister of Health together with the nine provincial Members of the Executive Council (MEC) for Health reviewed the policy priority areas. In October 1999 a two–day National AIDS meeting was organised by the Ministry of Health in which AIDS Co-ordinators, the National Department of Health, Directorate of HIV/AIDS/STDs, representative of the AIDS Training and Information Centre (ATIC) and representatives of various organisations discussed progress of the establishment of the five-year HIV/AIDS Strategic Plan. The goals and objectives of the plan were also established. In January 2000 the final 2000–2005 HIV/AIDS Strategic plan was established and finalised. The fundamental guiding principle for the 2000–2005 HIV/AIDS Strategic Plan is the fact that all sectors of government and other stakeholders in civic society must take part in fighting the HIV/AIDS pandemic to reduce the infection rate and HIV/AIDS impacts on both families and communities (Strode & Grant, 2004: 14).

The 2000–2005 HIV/AIDS Strategic Plan emphasises that every province must have its own Provincial AIDS Council (PAC), and this idea is supported and stressed by the cabinet. The Provincial AIDS Councils are accountable for co-ordinating the provincial multi-sectoral approach with a specific focus on districts, municipalities and communities. The responsibilities of the Provincial AIDS Councils include providing guidance and to establish a Provincial AIDS Plan which is in line with the 2000–2005 National HIV/AIDS Strategic Plan, to facilitate partnership responses among government sectors, sectors of civic society and local government departments, to evaluate the implementation of the provincial AIDS Plan and to give advices to the Provincial Cabinet on issues associated with HIV/AIDS, but in this regard the final decision on health aspects is made by the Provincial Cabinet (Strode & Grant, 2004: 16).

3.2.3 HIV/AIDS POLICY AND RESPONSE STRATEGIES IN NAMIBIA

AfroAIDSinfo (2005: 28) indicates that the Namibia government established the country's national HIVAIDS policy in August 2003. The HIV/AIDS policy formulation in Namibia is a collaborative effort by the AIDS law unit of the Legal Assistance Centre (LAC), Non-government Organisations (NGOs), and the stakeholders from the legal, social and community sectors. Namibia's Ministry of Health and Social Services spearhead the HIV/AIDS policy formulation process in the country and the LAC carries the mandate to draft it. Rianne Selle, the national co-ordinator of the government's official AIDS awareness campaign states that the first Namibia's national AIDS policy was established in 2003, but there were some HIV/AIDS national strategic plans prior to the period. In the same year, the third medium-term plan was introduced and will be used until 2009. The drafted policy aims at providing prevention and treatment, care and support for people living with HIV/AIDS, creating an enabling environment, reducing the impacts, and managing and monitoring the disease strategies.

The framework to establish a sound National HIV/AIDS policy in Namibia is a multisectoral approach. This involves partnership between government and affected stakeholders, the private sector, community-based and nongovernmental organisations, trade unions, religious groups, and people living with HIV/AIDS. The government of Namibia allocates 2% of the entire national budget to HIV/AIDS related practices, and it also encourages local authorities to allocate 2% of their annual budget for HIV/AIDS activities and also to include these activities into their key daily business operation activities. The other recommendation is that

the monthly grants allocated to AIDS orphans must be paid out along with the monthly government pensions to ensure that grants actually reach them. The monthly payments are processed through a reliable and well–established system. Pensioners who look after their own grandchildren are indicated (AfroAIDSinfo, 2005: 31).

The general public is encouraged to participate and contribute to the activities that combat HIV/AIDS in the country. For example, Helga Huses, an HIV/AIDS patient in Namibia operates a self-help project known as Family Hope Sanctuary which is based in the Katukura Township on the western outskirts of Windhoek. Helga Huses is one of the first people to receive antiretroviral (ARV) in Namibia, and publicly confirms that the treatment works and that it helped her. Her community-based organisation was established in 2004, and it is composed of 82 people, 78 women and four men. This project provides home-based care to people diagnosed with HIV/AIDS, and it also provides education facilities to people who cannot read or write. This project has 40 children from the neighbourhood between the ages of 7 and 15 who are currently studying subjects including arithmetic. Local-based organisations like butcheries, diary companies and shops in the central business district of Windhoek donate food to this project, and the UNAIDS also donates some funds to cover some of the costs of running the organisation (AfroAIDSinfo, 2005: 33).

Huses, as cited by AfroAIDSinfo (2005: 35) indicates that food is of utmost importance to people who take ARV treatment, and further emphasises that HIV/AIDS patients must not take ARV treatment on empty stomachs because it may cause stomach upsets that may result in a weak body system. She disclosed that five people in her organisation died due to poor nutrition which resulted in body weakening and eventual death. She also stresses that food security is a daily basic need which must be part of the overall strategy to fight HIV/AIDS. The Namibian ARV programme meets its target, and the UN Secretary General's report to the General Assembly on HIV/AIDS in 2005 indicated that Namibia is one of the three African countries in which over 25% of people certified to use ARV treatment actual receive it. The other two African countries are Uganda and Botswana. Dr Norman Foster indicates that Namibia begun offering ARV to the AIDS patients in August 2003 and by June 2004 there were 17, 000 patients on the treatment from both the public and private sector in the country. The projected number of Namibians in need of ARV treatment is 56, 000. The European Union provides some funds for Namibia's AIDS policy process.

United Nations. Department of Economic and Social Affairs (2004: 1) indicates that the government of Namibia is committed to combating the HIV/AIDS pandemic in the country. From 28 to 30 January 2004 the Government of Namibia in collaboration with the United Nations Department of Economic and Social Affairs held an HIV/AIDS policy formulation workshop. The aim of the workshop was to bring together government representatives, non-governmental organisations and HIV/AIDS practitioners from different countries within the Southern African Region to discuss the impact of HIV/AIDS on families within the region, and also to assess both communities and family reaction to the pandemic. The contribution towards the establishment of a strategic policy framework to assist governments to strengthen the capacity of families and family networks to cope with HIV/AIDS was also made. A participant from Eastern Europe was present as one of workshop delegations to make comparison at the level of experience across various regions.

Besides delegations from within Namibia, international delegations came from other countries including Lesotho, Mozambique, South Africa, Swaziland, Ukraine, Zambia and Zimbabwe. Issues discussed during the workshop included the impacts of HIV/AIDS on family and family networks, the generational responsibilities, and the related social interaction aspects. The strategies to reduce the HIV/AIDS impacts on various societies and families were identified, and the existing policies and programmes were reviewed to assess how they meet the needs of families affected by HIV/AIDS at various stages. The policy framework and recommendations for addressing family problems and involving intergenerational roles in HIV/AIDS policies and strategies were identified, and further capacity building imperatives and understanding gaps for evaluation activities were established (United Nations. Department of Economic & Social Affairs, 2004: 2).

The government of Namibia realises that the country is faced with the serious problem of the HIV/AIDS pandemic which also hinders progress in terms of development strategies, future planning and the country's vision of political, social and economic stability. In response to the situation, the government of Namibia is making efforts to fight HIV/AIDS as an urgent issue of its Second National Development Plan. Namibia's future national vision, Vision 2030, stipulates that the government of Namibia's main focus is on the well-being of all its citizens and residents, and to strengthen family units. The government of Namibia indicates that HIV/AIDS is not just a health matter, but a development, economic, security and human rights issue. The impacts of HIV/AIDS are diverse and overlapping, and these include the reduction of life expectancy and workforce, and loss of earnings. HIVAIDS reduces the

production capabilities for the families, and it also reduces the workforce productivity. It seriously disrupts family structures and functions by killing the parents, leaving orphans who are cared for by relatives and in most cases the grandparents (The United Nations. Department of Economic & Social Affairs, 2004: 2).

Families suffer due to stigmatisation, discrimination and economic insecurity as a result of HIV/AIDS. The most vulnerable group to the HIV/AIDS pandemic are young people, and half of the projected 6, 000 daily infected people in Namibia are the youth. This in return affects the adults because most of the people who die of AIDS are the young parents, who leave orphans with grandparents with a challenge to care for to orphaned children. Namibia's HIV/AIDS policy encourages and assists government and civil society to formulate and implement policies and programmes that support and protect families and the family network (The United Nations. Department of Economic & Social Affairs, 2004: 10).

The Namibian HIV/AIDS policy stipulates that all family members should have access to the information concerning testing, counselling and protection, and it emphasises that HIV/AIDS awareness information must be made clear to the public. Stigmatisation and discrimination against HIV positive people are discouraged, and the legislation that is discriminatory against people living with HIV/AIDS have been reviewed. The Namibian policy also stresses that all policies and programmes must support care for the children orphaned by HIV/AIDS and the legal rights and protection for these children must be clarified (The United Nations. Department of Economic & Social Affairs, 2004: 10)

3.2.4 HIV/AIDS POLICY AND RESPONSE STRATEGIES IN ZIMBABWE

USAID (2002: 1) states that Zimbabwe had a 34% of adult HIV/AIDS prevalence rate by the end of 2001, compared to an estimated 25% two years earlier. USAID further argues that Zimbabwe is one of the countries most vulnerable to the HIV/AIDS pandemic in Sub – Saharan Africa. By the end of the year 2001, 2 million adults in Zimbabwe were reported to be living with the HIV/AIDS pandemic, with women comprising 60% of the HIV/AIDS cases in the country. Zimbabwe's life expectancy is projected to drop to 35 years by 2010, compared to 66 years in 1997. The death rate in the country is expected to increase by more than 200% as a result of HIV/AIDS, compared to 1990. In the year 2000, the HIV/AIDS prevalence among women attending the antenatal clinics in the cities was 31.1%, and the median prevalence for men patients attending the Sexual Transmitted Infection (STI) clinics

in the cities was 71.1% in 1995. The median prevalence for female sex workers in the big towns and cities in 1995 was 86%.

The number of HIV/AIDS cases among women in Zimbabwe increases from the ages between 20 and 29 years, and 15% of the children under the age of 5 years in the country are reported to be living with HIV/AIDS. The government of Zimbabwe in collaboration with the US Centre for Disease Control and Prevention together with donors have established and are implementing a comprehensive prevention of Mother–To–Child Transmission (MTCT) program. In the year 2001, USAID projected that Zimbabwe had over 780, 000 AIDS orphans under the age of 15 years. Among the 15–24 years age group, HIV/AIDS prevalence for females in the country is 2.6 times more than that of males. The age and gender distribution of HIV/AIDS cases in Zimbabwe indicates that most of the HIV/AIDS transmission is from older men to young women. Zimbabwe was the first country in Southern Africa to introduce female condoms in 1997. In response to the HIV/AIDS pandemic situation in the country, the government of Zimbabwe has established the National Strategic framework on HIV/AIDS, the National AIDS Policy, the National AIDS Council (NAC), and has introduced an AIDS Levy to generate essential resources to support HIV/AIDS intervention (USAID, 2002: 2).

The establishment of the Zimbabwean National AIDS Council (NAC) was not done in isolation but is a comprehensive effort by the Ministry of Health, representatives from government departments, non-governmental organisations (NGOs), faith–based groups, the private sector, and the media. Zimbabwe's HIV/AIDS National Strategic Framework was approved by NAC in May 2000, and it aims at prevention and care for people living with HIV/AIDS in the country. A number of organisations like churches, women's groups, and NGOs take part in the fight against the HIV/AIDS pandemic in the country. In 2001, USAID donated $6.4 million to Zimbabwe's HIV/AIDS prevention and care programme, which is more than $5 million than what the organisation donated to the country in 2000. The USAID objective is to achieve behaviour change through improving accessibility to quality services, specifically in voluntary counselling and testing (VCT), communication interventions, and an improved capacity for public institutions, non-governmental organisations (NGOs), and communities to establish effective care programmes for orphans and people affected by HIV/AIDS (USAID, 2002: 2).

This strategy makes a tremendous contribution towards the HIV/AIDS awareness campaign, and studies indicate that 98% of Zimbabwe's population is aware of the HIV/AIDS pandemic.

The negative factor is that even if people are aware of the HIV/AIDS pandemic, they do not all change their risky behaviour. USAID has established the initiatives to identify sustainable, suitable Zimbabwe community programmes to help orphans and children affected by HIV/AIDS, and to initiate economic opportunities for young people affected by the pandemic. USAID also encourages a wide community-based condom distribution, selling and supply channels and use of condoms in a sustainable manner (USAID, 2002: 3).

USAID/Zimbabwe is working hard and encourages the local NGOs and faith-based organisations to give support to the establishment of an informed HIV/AIDS policy in the public sector. In the year 1999, the centre for Voluntary Counselling and Testing was established in Zimbabwe, and by the year 2001 more than 50, 000 people used it, which was more than the projected 42% expected. Most of the people who use VCT in the country are the young generation and couples. Between the year 1999 and 2000, 10 VCT clinics were developed at strategic locations across the country. USAID encourages individuals and couples to know their HIV status and use the service available and change their risky behaviour (USAID, 2002: 3).

Zimbabwe faces numerous challenges in dealing with the HIV/AIDS pandemic. For example, due to financial constraints in the country, the Health Department is failing to cope with the HIV/AIDS situation. The other challenge is that despite the HIV/AIDS awareness campaign, sustained changes in risky sexual behaviour among the public, the government is not meeting its objectives. HIV/AIDS is characterised by a stigma attached to it, and most people do not want to accept and disclose their family members who die of HIV/AIDS. The gender inequality issue in Zimbabwe results in a number of women being exposed to HIV/AIDS risky situations, which make them more vulnerable to the pandemic than men (USAID, 2002: 3).

Felicity *et al.* (2001: 1) carried out a study to asses the levels of awareness on the 1999 HIV/AIDS National Policy and on the National AIDS Council Funds by civil society and also to assess the implementation strategies. Felicity *et al.* indicated that the government of Zimbabwe established a National HIV/AIDS Policy in December 1999 with the intention of establishing guidelines for all programmes designated to fight the HIV/AIDS pandemic in the country. A number of NGOs in the country argue that Zimbabwe's policy document does not meet its objectives due to the fact that HIV/AIDS continues to spread at an alarming rate in the country. In addition to the National AIDS Trust, in 1999 the government of Zimbabwe

introduced the AIDS Levy which is managed by the National AIDS Council Board reporting directly to the Ministry of Health and Child Welfare. The centralised control of this AIDS levy and inadequate awareness among the people of Zimbabwe make access to these public funds difficult. There is limited information with regard to the level of awareness and implementation of the Public of Zimbabwe's HIV/AIDS National Policy and available National AIDS Trust Funds (NATF).

The National AIDS Council leads the implementation of the Zimbabwe's National AIDS Policy, and the National AIDS Council Board controls the funding system. The Council established the structures at the national, provincial and district levels for the development of a convenient operational atmosphere for the HIV/AIDS multi-sectoral approach. These structures suffer the criticism of not working in consultation with all civil society representatives. Policy awareness and accessibility in Zimbabwe is generally limited and varied among different NGOs.

The Zimbabwean HIV/AIDS policy contains some weak points and its dissemination and distribution strategies are inadequate. NGOs implement HIV/AIDS prevention, care, control and eradication activities irrespective of the limited awareness information by the government HIV/AIDS policy. The government of Zimbabwe considers its policy to be an important document and a milestone in combating the HIV/AIDS pandemic, but there is some criticism that little is done by the government to create awareness and to encourage the use of the policy concepts by the general public (Felicity *et al.*, 2001: 2).

There is a lack of capacity in civil societies involved in the fight against HIV/AIDS programmes, and only the traditional health associated NGOs implement the policy, although in a fragmented way. There are some individual and institutional capabilities and resources available among the non-traditional HIV/AIDS civil society development programme implementers. Suggestions are made that there is a need to increase mainstreaming and incorporation of HIV/AIDS in existing development programmes in the country. There is a lack of maximum consultation and involvement of civil society on the approach to strategic policy planning, formulation, implementation, monitoring and evaluation in the country. The civil society policy ownership is lacking, and the responsibilities and accountabilities of NGOs on policy implementation is not clearly stipulated, hence the poor participation in an on-going district policy implementation planning process (Felicity *et al.*, 2001: 2).

There is a lack of essential law enforcement in the policy implementation process. The accessibility to the National AIDS Trust Funds by a number of NGOs is minimal. This can reportedly be attributed to a number of reasons including a shortage of necessary information with regards to fund operation systems. The other reasons indicated are that most of the NGOs mainly rely on donors and do not consider the national funding to be a necessity. NGOs are not members of the District AIDS Action Committee and have little or no participation in the District Planning forum, and also in areas that are generally considered for accessing funds. The general overall administration and management of funds are aspects of concern (Felicity *et al.*, 2001: 5).

3.3 SUMMARY

This chapter indicates that Southern African Region is experiencing the severest HIV/AIDS pandemic in the whole African continent. The overall infection rates in the region are high and increasing. Some countries within the Southern African Region like Botswana are reported to have a HIV/AIDS infection rate of 18.284% of the entire population, which is high and expected to increase. HIV/AIDS poses some threats to the Southern African economy, the workforce, business, individual workers and their families. In response to the pandemic problems, Southern African countries and companies engage in collaborative policy formulation activities and encourage their citizens to utilise voluntary counselling and testing programmes. A number of countries in Southern Africa provide HIV/AIDS treatment like antiretroviral (ARV) at subsidised prices or even free of charge to both their citizens and residents who are HIV positive and certified by doctors to take treatment.

This chapter covered the HIV/AIDS situation in Southern Africa. The HIV/AIDS policy and response strategies in Botswana, South Africa, Namibia, and Zimbabwe have been discussed in the above chapter. The following chapter will deal with the impact of HIV/AIDS on Southern African tourism.

CHAPTER 4

THE IMPACT OF HIV/AIDS ON SOUTHERN AFRICAN TOURISM

4.1 INTRODUCTION

The Botswana Ministry of Health (2000:28) states that Botswana and the entire Southern African Region is confronted with many risk factors associated with the spread of HIV/AIDS, which include the migratory pattern of wage workers, alcohol abuse, deterioration of traditional family structures that used to reinforce morality, denial and ignorance. Other susceptibility factors are family and communal disruption (transfers), poverty, low status of women, high proportion of single parents and early parentage. The average age of first sexual encounters in Botswana is 17 years.

There is a migration of tourists, people from other sectors and wage-workers both from neighbouring countries and within the country itself. With this high rate of movement of both workers and tourists, there is social interaction, which includes sexual activities and unprotected sex practised. The other contributing factor to the HIV/AIDS prevalence according to the Botswana Ministry of Health (2000) is a high rate of alcohol consumption and abuse among the young people in Botswana and in a number of Southern African countries. The influence of alcohol leads to a risk of engaging in unprotected sex among the young people in Botswana, which in most cases creates high chances of spreading HIV/AIDS.

Some people are ignorant of the educational activities about AIDS, and do not take precautions like use of condoms. Due to paid jobs and demand for jobs in different areas of the country and the entire South African Region, most workers get transferred to far places and spend more time away from their family members. This factor contributes to the spread of HIV/AIDS among married people, especially if either the husband or wife engages in unprotected sex with an HIV positive person and later infects his/her partner. There is the problem of poverty in Botswana and other Southern African countries, especially in some of the rural areas, which causes people, especially young female people, to engage in sexual activities with the hope that they will get money in return. This spreads HIV/AIDS, especially if some of these people do not take preventive measures.

This chapter covers the economic impact of HIV/AIDS on Southern African tourism and in general. This includes the impact of HIV/AIDS on economic growth, on savings and on investment. Also discussed in this chapter is the impact of HIV/AIDS on the tourism workforce and productivity, which includes the loss of skilled workers, and training and recruitment costs. The impact of HIV/AIDS on poverty, which includes the impact of HIV/AIDS on the customer base and the impact of HIV/AIDS on the image of Southern African tourism are discussed. Some concluding remarks on the impact of HIV/AIDS on Southern African tourism and government responses are made.

4.2 THE ECONOMIC IMPACT

The World Travel and Tourism Council (2002: 44) states that the HIV/AIDS pandemic in South Africa is felt by most companies' managers directly in the workplace. This includes companies in the tourism sector. For example, Fedics, South Africa's largest black-owned outsourced caterer, is one of the few South African tourism companies that admits the adverse impact of the HIV/AIDS pandemic. This company has taken steps towards educating its employees on how to limit the chances of contracting the HIV virus, and how to live with the virus and to cope with difficulties associated with it.

Fedics has realised that, by effectively taking an early action to fight AIDS, it can save its employees and revenue lost through medical and treatment costs. Besides Fedics being committed to educate its employees about HIV/AIDS, it has also adopted a positive and proactive approach through an effective HIV/AIDS management strategy. The strategic approach of this company includes its HIV/AIDS policy that acknowledges the sensitivity and complexity of the HIV/AIDS pandemic, which cuts across all economic, gender and race barriers. However, the greatest challenge is to identify the secrecy and non-disclosure of HIV/AIDS due to the stigma and discrimination attached to it.

The Fedics Group encourages a non-discriminatory working environment by enhancing a code of conduct, confidentiality and disclosure around HIV testing. The approach applied by this company shows that South African tourism companies and in general cannot avoid HIV/AIDS, but they can manage its impact. This concept is the driving force behind Fedics' strategy to face the challenges posed by the HIV/AIDS pandemic. The Fedics' strategy is not just a moral concept, but a survival concept that can be applicable to a number of tourism companies in South Africa.

If necessary steps are not taken, there is no doubt that HIV/AIDS will have a serious impact on the South African economy and its people. Travel and tourism companies and stakeholders in South Africa are encouraged to adopt a proactive strategic approach in addressing the impact of HIV/AIDS (World Travel & Tourism, 2002: 33). The tourism companies are also encouraged to work together to devise strategies to combat the HIV/AIDS pandemic. This approach can save a large percentage of their employees and mitigate the impact of HIV/AIDS on their businesses.

Tourism, Hospitality and Sport Education and Training (THETA) (2003: 4) conducted a study on some South African tourism and hospitality companies which indicates that 75% of the companies surveyed do not take measures to mange HIV/AIDS in their companies. However, 2% of the managing directors of the surveyed companies take some steps in managing HIV/AIDS at workplace. It is also indicated by THETA that 93% of companies surveyed do not have HIV/AIDS policy.

THETA (2003: 5) indicates that 64% of the surveyed organisations were concerned about the impact of HIV/AIDS on their businesses, whereas 36% of the surveyed companies indicated that HIV/AIDS will not affect their businesses. The other area concern by THETA is that some tourists engage in risky behaviour like not using preventive measures and alcohol abuse when they travel than when they are at home. The international studies as indicates by THETA states that there is high sexual interaction tourists and tourism/hospitality workers. The other area which needs attention is the fact that sex tourism is perceived as spreading HIV/AIDS.

THETA (2003: 28) recommends tourism companies to use voluntary counselling and testing as a tool in fighting HIV/AIDS. Voluntary counselling and testing is imperative because it helps the workers to know their HIV status so that they can change lifestyle and make the right choices about their lives. THETA further encouraged the companies to have voluntary counselling and testing programs or to organise transport to the testing centre for workers, indicating that this will motivate workers to go for voluntary counselling and testing.

The World travel and Tourism (2002: 44) indicates that the South African President Thabo Mbeki, has promised to lead the fight against the HIV/AIDS pandemic in the country. The president is responding to the projection that one in nine people in South Africa is infected with the HIV virus. This effort by the president encourages a number of tourism companies to

act proactively in addressing the HIV/AIDS pandemic in the country. Although the significance impact of HIV/AIDS in South Africa can be quite overwhelming, there are some encouraging programmes in place within the tourism sector that give great hope in the country. One such example is the work of Fedics, a Johannesburg-based catering company. The World Travel and Tourism encourages all South African tourism companies to use Fedics' examples, and to fight HIV/AIDS head on, ask for help from other sectors and assist when and where possible to make a difference for their workers, the tourism sector and the entire South African population.

Over (2001: 51) argues that the risk of contracting HIV/AIDS and other sexually transmitted diseases (STD) by some married women in Zimbabwe is linked to domestic violence in that country. There is also a problem of gender inequality in terms of access to the labour market in tourism and other sectors. Over also argues that migration and tourism could be among the factors that contribute to the spread of HIV in Zimbabwe. This is because most of the tourism workers migrate from their homes and stay away from their families for a long time. However, migration alone is not a risk factor, but risks are determined by the way these workers conduct themselves when they are away from home, the living conditions for the migrants host destinations, and the differential HIV/AIDS levels between the destination and the place of origin.

Migration and tourism contributes to the spread of the HIV/AIDS pandemic among the tourism workers in Zimbabwe through social interaction channels with other people from other countries affected by HIV/AIDS. However, this study does not provide the statistics on correlation between tourism and migration. The spread of HIV/AIDS among the tourism workers in Zimbabwe affects the economy of the country by lowering productivity. Most companies report that their major problems are workers absenteeism and prolonged sick leave, which reduce their profits. The other argument by Over is that the negative effects of increased tourism on HIV/AIDS prevalence are justified by the positive economic benefits. Both migration and tourism are important aspects of the economy. The group most vulnerable to HIV/AIDS among the tourism workers in Zimbabwe are women (Over, 2001: 52).

Namibia's Ministry of Environment and Tourism (1994: 22) indicates that there are several mechanisms by which HIV/AIDS affects macroeconomic performance in the country and in the region at large. HIV/AIDS deaths lead directly to a reduction in the number of tourism workers available in their productive ages in the Southern African Region. The high death

rates lead to experienced tourism workers replaced by younger, less experienced persons, which results in reduction on productivity. An experienced worker is difficult to replace, and quality of service drops in a number of companies including the tourism sector.

A shortage of skilled workers leads to higher production costs and a loss of international competitiveness (Botswana. Department of Tourism 2003: 23). The market for tourism is globally focused and Botswana operates its tourism business under the World Tourism Organisation standards to compete globally. Due to the prevalence of HIV/AIDS, the Botswana Tourism sector's service quality and productivity may deteriorate if skilled workers are lost to HIV/AIDS. To compete internationally, skilled workers are essential so that quality service can be provided.

Botswana and a number of some other Southern African countries are experiencing lower government revenues and reduced private savings because of greater health care costs and loss of income for workers, which lead to slower employment creation in the formal sector, particularly capital intensive opportunities. As a result, some workers are pushed into lower paying jobs in the informal sector. According to the Botswana Ministry of Health annual report (2003: 26), the Government of Botswana spends over P10 million on HIV/AIDS drugs per annum. This affects the productivity and economy of the country because of the shift from developing and marketing tourism to the fight against HIV/AIDS.

The Department of Tourism in Botswana and some tourism companies are facing high expenditures resulting from the monitoring of high risk groups, the establishment of prevention strategies, and the provision of health care and welfare for the infected and affected tourism workers. The Botswana Ministry of Health in collaboration with some tourism sectors both private and public have established home-based care programmes for workers suffering from HIV/AIDS. This results in low productivity in the tourism sector because more money is spent on AIDS patients than on the development of tourism.

The Botswana Department of Tourism experiences increased pressure on the social security system, including life insurance and pension funds, which are important sources of capital for both government and the private sector. Tourism organisations in Botswana encourage their workers to go for voluntary HIV/AIDS testing, and also encourage those who are HIV positive to take AIDS drugs like ARV, which are provided by the government of Botswana free of charge.

The macroeconomic impact of HIV/AIDS is a sensitive issue as to about how HIV/AIDS affect savings and investment rates, and whether HIV/AIDS affects the educated and experienced tourism employees more than others. Studies in Tanzania, Cameroon, Zambia, Swaziland, Kenya, Botswana and other Sub-Saharan African countries indicate that the rate of economic growth in Southern Africa is reduced by as much as 25% over a 20 year period as a result of the HIV/AIDS pandemic (Botswana Harvard International 2003: 27). Most of the countries in the Sub-Saharan region depend on tourism for their economy, and this region is the most struck by HIV/AIDS in the world. The World Health Organisation's statistics (2004) shows that Botswana is leading the whole world with the highest percentage of population of people living with HIV and AIDS death cases. Among this population are people working in the Tourism Industry, which clearly shows that HIV/AIDS poses threats to Botswana and the entire Southern Africa Tourism sector.

4.2.1 THE IMPACT OF HIV/AIDS ON ECONOMIC GROWTH

The World Travel and Tourism (2002: 41) argues that the South African history of racial discrimination delayed the country's entry onto the world state in various economic activities including tourism. This has also limited the benefits that tourism sector would provide economically and socially. However, the future prospects of the South African tourism sector appear to be positive. There is a widespread of recognition, although somewhat more realistic and projection, of its current and potential contribution to the national economy, and more importantly, of the limiting factors that constraining its potential. Among the identified constraints prohibiting the contribution of tourism to the South African economy is the HIV/AIDS pandemic. HIV/AIDS affects South African economy by killing the economical active age groups. Among the people killed by HIV/AIDS in South Africa are the skilled tourism workers who are difficult to replace.

UNAIDS (2003: 17) indicates that the reduction in the growth of the labour force and declining productivity among some Southern African countries results in low government revenues from both individuals and enterprises. For example, Botswana government expenditure is expected to shrink by more than 20% the next twenty years due to the damage of the revenue sources in the country like tourism. At the same time, the costs of fighting the HIV/AIDS pandemic in the country are high due to the fact that more people are infected. The UNAIDS also indicates that some of the Southern African countries spend between 20% and 90% of their health budgets in fighting HIV/AIDS.

The Botswana Bureau for Economic Research (2003: 32) indicated that while the economic impact of HIV/AIDS is negative, the country's tourism sector is not witnessing the worst scenario. A research was conducted on the macroeconomic sensitivity and an analysis was made on the impact of HIV/AIDS on the economy of Botswana. According to a macro-economic analysis of the impact of HIV/AIDS on the Botswana economy up to 2015 conducted by the Bureau for Economic Research (BER), the level of the real gross domestic product (GDP) growth is projected to be 2.5% lower by 2010 and 6.7% lower by year 2015 with HIV/AIDS than without the disease.

Based on the above projections by the Bureau for Economic Research in Botswana, it is expected that if necessary measures are not taken to prevent the spread of the disease, serious problems may be encountered, since tourism contributes a significant percentage share to the economy of Botswana and the entire Southern Africa. The Tourism Sector in the country is experiencing some problems due to HIV/AIDS prevalence. The Bureau for Economic Research (2003: 33) also reveals that producer inflation is likely to be 3.4% and interest rates 3.9% higher compared to a non-AIDS scenario. The research also found that the total population of the country could also be lowered far less than in no-AIDS scenario. The population of the country is an important resource for the country since human resources contribute to the economy of the country. Without people there is no tourism because the market for the industry depends on the population within or outside the country. Among the people who are killed by HIV/AIDS, include tourism skilled workers who play a vital role in developing the Botswana Tourism Sector.

The total labour force was projected by the Bureau for Economic Research (2003: 35) to be 22% lower by the year 2015, with the overall size of the labour force remaining almost stagnant over the next few years. Overall, the population growth is expected to decline from 1.4% in the 2003 to 0% in the year 2009 and –0.5% in the year 2015. This again according to these projections shows that the tourism market is deteriorating due to the impact of HIV/AIDS. The Bureau for Economic Research (2003: 36) further indicates that the overall spending in Botswana could rise due to the continuous spreading of the HIV/AIDS pandemic and its impact on the economy of the country. If the overall spending rises, it becomes a problem for the tourism sector because people will have low disposable income to spend on tourism activities.

The Bureau for Economic Research (2003: 37) further indicates that shift in spending; resulting from rising household health expenditure does not necessarily represent a loss in Gross Domestic Product (GDP). Due to the extent that spending shifts towards less productive avenues, the longer term implications for the Botswana's economy could be negative. The Bureau also projects that HIV/AIDS could lead to declines in the average annual growth rate of 0.2% between 2003 and 2005, 0.4% between 2006 and 2010, and 0.9% between 2011 and 2015. The fall in the average real GDP growth rate could be 0.5% per year over the period.

The above information indicates that there is a shift in spending from other activities to focus more on HIVAIDS pandemic costs. This poses some problems for the Tourism Sector in Botswana and the rest of Southern Africa because smaller amount of money are spent on tourism than it would have been without AIDS. Health is a major concern by the people, therefore more concern and spending is on the fight against HIV/AIDS than to develop tourism. People are forced to spend their disposable income on HIV/AIDS to improve their health and also to take care of the infected and affected members of their families than to spend on tourism activities. This results in a decline of tourism in the region. The government of Botswana at the national level is spending a lot of money to fight the AIDS epidemic than to develop and market Botswana Tourism to the international markets. The fall in GDP growth as indicated above means that it would be more expensive to develop tourism than in no-AIDS scenario because more money is spent on fighting the epidemic.

The Botswana Ministry of Health (2002: 17), the HIV/AIDS pandemic in Botswana has become a far greater risk to human life than any other causes of deaths like road accidents. The health workers now spend more time tackling the infection than attending to industrial accidents.

Based on the above information it becomes clear that a lot need to be done. People need to be educated about the disease. The Botswana Department of Tourism Research and Statistics (2003: 31) estimated that the number of tourism employees lost to AIDS could rise from 40% to 50% of the tourism workforce in some companies in Botswana in the next 10 years. According to the Department, HIV/AIDS is already adding between 2% and 6% to salary bills.

It is indicated by the Botswana's Department of Tourism that most of the tourism companies in the country are suffering from HIV/AIDS–induced absenteeism, a decline in the skilled

workforce, fall in productivity, increased sickness payments and rising employee benefits costs. The cost of standard forms of benefit like death or disability benefits or a spouse's pension is also expected to double in next five to ten years.

The costs of tourism employment are likely to rise as a result of HIV/AIDS (Botswana. Department of Tourism Research & Statistics 2004: 38). Government is the major employer in many sectors including tourism sector in Botswana. The analysis by the Department of Tourism indicates that HIV/AIDS exacerbates the shortage of tourism skilled labour, leading to an increase in the wages of skilled workers. The Botswana Department of Tourism also depicts that the employment costs of government on tourism are between 36% and 40% of the annual budget. The extent to which it would be affected depends on the proportion of the wage bill paid to skilled workers. The proportion of the tourism skilled workers according to the Department of Tourism in the overall labour force is approximately 20%. Government employs a higher proportion of skilled workers than in the labour force as a whole. The Botswana Department of Tourism indicates that 27% of tourism workers in both the government and private sectors are classified as skilled. It is also indicated that the skilled workers' salaries are on average 2.5 times higher than that of unskilled workers' salaries. With the persistence of HIV/AIDS, this is expected to rise.

HIV/AIDS-related illness and deaths of tourism workers affect employers both by increasing their costs and reducing revenues. The Department of Tourism in Botswana indicates that employers in the tourism sector spend a lot of money in areas like health care, burial, training and recruitment to replace the sick or dead employees. The process of recruitment and training is costly and time consuming. Revenues are decreased in some of the tourism organisations because of absenteeism due to illness or attendance of funerals, as well as taking care of the family members who are sick. This is a serious problem because the productive employees spend most of the time off duty attending funerals or taking care of family members who are ill of HIV/AIDS. In a number of cases some tourism organisations loose their experienced key workers, who are difficult and to a certain extent impossible to replace. Labour turnover the organisations experience leads to a less experienced and therefore less productive tourism workforce. This in return results in poor quality service rendered by the affected tourism organisations.

The Botswana Human Capital Corporation (2003: 29) in collaboration with the Department of Tourism in Botswana depict that besides the costs of general health care, tourism employers

in Botswana are most concerned about HIV/AIDS because there is no simple solution they can buy off the shelf for the pandemic of HIV/AIDS. Furthermore, Human Capital Corporation indicates that the employer is exposed to the legislation placing restrictions on the scope and funding of occupational health care in Botswana and in general. For example the company cannot impose compulsory testing for HIV. The codes of legislation are clear: obligatory testing for HIV constitutes a breach of confidence and can lead to unfair discrimination, with consequences under the Botswana Labour Relations Act. Based on the legislation, the employers are omitted from pre-testing the potential employees during employment process. This poses some problems to the organisations and employers since the chances of employing people who are HIV positive are high.

Botswana's Department of Tourism Research and Statistic Section (2003: 34) indicate that managing risks is an important consideration by most of the tourism companies in Botswana and the entire Southern Africa. A number of tourism employers are providing a funding mechanism for engaging with experienced medical people in Botswana. Individual employees are encouraged to go the doctors and testing centres to be tested for HIV and the organisations ensure that the medical aid pays, in case of private doctors consulted. The organisations encourage the employees to register with an AIDS programme, in the event of a positive diagnosis, so that the disease can be managed. Several medical Aids in Botswana are offering this service.

Namibia's Tourism Board (2004: 27) states that the relationship between HIV/AIDS and the costs and revenue of employers has rarely been examined systematically to date. Moreover, little data is available on how HIV/AIDS affects micro and small formal and informal tourism enterprises. Overall, there could be a reduction in profits if tourism companies in Namibia and in a number of Southern African countries do not take measures to prevent the impact of HIV/AIDS.

The Namibian Tourism Board also indicates that tourism employers are unlikely to be affected significantly by HIV/AIDS where those tourism employees who have to leave the tourism companies can be replaced without loss of productivity. This may happen in countries with high employment and underemployment rates. In view of the expected impact of HIV/AIDS on the composition of the available tourism workforce, there is likely to be a mismatch of human resources and tourism labour requirements in terms of qualifications,

training and experience. Other significant impacts include a loss of tourism markets where the purchasing power of the population declines.

South Africa's Department of Economic Development and Tourism (2004: 82) indicates that the most terrific impact of HIV/AIDS is in lives lost. Another impact felt mostly by those not infected is economic. Predicting the impact of the disease, especially in Southern African feeble economies, is an inappropriate practice even by the economics standards due to the fact that AIDS is more vulnerable in areas where data are least accurate. The pandemic depresses the Sub-Saharan Africa's annual growth GDP growth rate by 0.8 percentage points.

Some of the Southern African countries which have more than one-fifth of adults with HIV/AIDS, the GDP impact points is estimated to be 2.6. Besides mining and tourism, the Southern African Economy also relies on farming, and due to the fact that women have the highest incidence of AIDS, food security becomes a problem in the region because women are more involved in agriculture and households than men. HIV infection implicate that other diseases spread faster, and AIDS patients are normally weak to work effectively. The Southern African Region's food shortage in 2002 was due to the fact that many young adults were too sick to work or to travel for help (South Africa. Department of Economic Development & Tourism, 2004: 82).

Kahn (2006:1) estimates that HIV/AIDS may reduce South Africa's estimated 4.4% economic growth by between 0,38 and 0,46 percentage points by 2020. This projection is made by the Bureau for Economic Research at the University of Stellenbosch and its implication depends on the number of people infected with HIV/AIDS. This impact is not as serious as the World Bank projected in its report in 2003, that South Africa is faced with extreme economic decline if it does not deal with HIV/AIDS effectively. The UNAIDS report indicates that South Africa has 5.5 million people living with HIV/AIDS, and is the second highest in the world after India.

The UNAIDS further stipulates that South Africa has 500 000 HIV/AIDS patients in need of antiretroviral drugs and out of this number, only 204 000 get the treatment. The Bureau for Economic Research's director Prof. Ben Smit, as cited by Kahn (2006: 1) indicates that there are some significant economic benefits to be reaped from providing HIV/AIDS treatment. This study is based on three dimensions; no AIDS, AIDS with prevention interventions but no antiretroviral treatment, and AIDS with prevention interventions and a large–scale of

treatment programme that reaches 50% of those medicines by 2008. The further projection by the Actuarial Society is that the antiretroviral treatment may reduce AIDS deaths by 100 000 a year between 2008 and 2010.

HIV/AIDS would have a negative effect on economic growth under all the above discussed dimensions. Without AIDS treatment, the South African rate of gross domestic product (GDP) growth may fall from an estimated average of 4.4% over the period 2000 – 2020 to 4%. The study estimates per capita GDP of about 8% higher in real terms, as population declines outweighs negatively on the real GDP. Providing 50% AIDS coverage may bring down the pandemic's impact on economic growth by 17%, from an estimated impact of -0, 46 percentage points to -0, 38 percentage points. The effects of the pandemic would most likely be experienced after 2010 (Kahn, 2006: 3).

Kahn (2006:3) indicates that the bureau's research estimated a smaller impact on the economy than World Bank research because its researchers did not involve full employment. The semiskilled and the unskilled workers are the most vulnerable to HIV/AIDS, and they can be replaced comparatively easily from the large pool of population, which means that the economic impacts would be less felt than predicted by studies that involved full employment. In the past, most studies had often ignored the contribution made by the health services' expenditure to the GDP, and this resulted in overly optimistic projections.

4.2.2 THE IMPACT OF HIV/AIDS ON THE SAVINGS AND INVESTMENT

Lisk (2002: 11) indicates that Zimbabwe is faced with the problem of a fall in both domestic and external savings, and investments and physical capital are reduced by factors related to HIV/AIDS. This affects most of the Southern African tourism and in general because there is little or no disposable income for the people to spend on tourism. For example, studies on the macro-economic of HIV/AIDS in Malawi and South Africa reveal that the annual GDP growth rates in these two countries could drop by 1% to 2% points attributed to HIV/AIDS. This indicates that if the appropriate measures are not taken to mitigate the impact of HIV/AIDS, some countries in Southern Africa may encounter serous macro-economic instability and difficulties in future. This could have an adverse impact on investment due to loss of confidence by investors not only in tourism but in general.

Ramsey *et al.* (2002: 5) stipulate that the majority of people in Sub–Saharan Africa make their living through small–scale or home–based businesses in both the informal and formal sectors. HIV/AIDS has an enormous impact on small businesses including those in tourism sector due to the fact that some entrepreneurs either become ill with AIDS themselves or have to take care of their family members who are suffering from HIV/AIDS, and spend plenty of time away from their work, and also spending a lot of money on medical expenses. The risks of business failure and loss of living assets become much higher in these situations.

South Africa's Department of Economic Development and Tourism (2004: 82) indicates that HIV/AIDS shifts the responsibility of caring for the families to the less productive grandparents who have little or no resources. HIV/AIDS disrupts budgeting and spending plans and makes saving difficult or impossible, because a lot of money is spent on health care, traditional ceremonies and funeral expenditures than on tourism activities. For example, in Zimbabwe in 2003, the average money spent on funerals was $105. On average, the AIDS patients get too sick to work for six months before death, and the costs of care increase. One third of some 1,000 South African companies in 2003 reported that HIV/AIDS had damaged their profit, but it does not cause a run-up in wages in terms of making labour more scarce. The problems encountered include absenteeism due to sickness or attending funerals, workers moral becomes low, jobs go unfilled, and training costs increase.

HIV/AIDS is threatening direct foreign investment in Botswana, "AIDS is definitely one of the factor inhibiting foreign investment – on top of all the structural issues", said the Vice President of the Republic of Botswana, Ian Kgama (2003), in a business interview (Anon., 2003 :7). Foreign investment in Botswana is based on the tourism sector. According to the Vice President of the Republic of Botswana, some foreign investors hesitate to invest in Botswana attributed to the HIV/AIDS pandemic. The image of the Botswana Tourism is suffering due to the prevalence of HIV/AIDS. HIV is a double bind for tourism employers and their organisations. The increasing number of ill tourism workers, whose health deteriorates, pushes health care costs high and productivity down.

The Botswana Department of Tourism (2003:21) also states that some tourism organisations in Botswana face a problem of over-spending due to the workers who become too sick to work but still have a contract binding the organisation to pay them. This is a serious problem because the organisation seeks for a replacement for a sick worker, and will be paying both

the sick worker and the one replacing him. As a result, the organisation is loosing a lot of money.

The Botswana Ministry of Environment, Wildlife and Tourism (2003: 43) report states that Botswana's rich cultural and historical heritage, and abundant wildlife resources provide opportunities for investment in the tourism industry. The ministry indicates that the government of Botswana encourages the foreign investors to invest on Botswana's tourism sector. Contrary to the intention of the Botswana government, the United Nations Development Programmes report (UNDP, 2000: 22) states that the Botswana Tourism Industry is facing problems of investment changes due to return on investment losses. For example, HIV/AIDS causes a shortage of tourism skilled labour, which results in high wages and rising labour costs such as recruitment and training costs, and due to deaths of skilled workers. In response, a number of firms decide to adopt more capital-intensive production techniques, which in most cases causes the rate of investment in physical capital to arise.

The report further depicts that higher tourism labour costs cause the overall profitability of tourism investment to fall, which causes a reduction in tourism investment. The companies do not want to invest where return of investment is negative. Due to the high prevalence of HIV/AIDS in the country, investment in tourism is reduced because firms revise downwards their projections of future demand in line with lower projected Gross Domestic Product (GDP) growth rates. Investment is also strongly influenced by the degree of uncertainty or risk in an economy. Tourism contributes to the economy of Botswana, but HIV/AIDS add to the level of uncertainty in the country's economy by impacting negatively on the industry. Tourism organisations in Botswana are unsure as to whether they will be able to secure the necessary supplies of tourism skilled labour in order to maintain production, given that HIV/AIDS is anticipated to reduce tourism skilled labour supplies in future.

The changes in the level of savings impacts on investment because investment can only be made if there is sufficient amount in savings. Many African countries including Botswana are typically characterised by a shortage of domestic savings and hence a dependence upon foreign savings or capital inflows to finance investment (United Nations Development Programme 2000: 43). A reduction in the rate of domestic savings in most of Southern African countries therefore causes overall tourism investment to fall, as access to foreign savings is often highly constrained. Due to high rate of HIV/AIDS prevalence in Southern Africa, and the fact that the costs of dealing with HIV/AIDS are financed from savings, the

overall rate of savings and investment deteriorates. Indeed, reduced tourism investment due to reduced savings is the main channel through which HIV/AIDS has a negative impact on the economy of Botswana and the entire Southern African Region and tourism sector in particular.

Botswana's Department of Tourism in (2003: 43) expressed concern about the impact of HIV/AIDS on the rate of growth of tourism consumption expenditure in the country. The department indicates that the tourism growth rate is becoming lower and lower due to HIV/AIDS. HIV/AIDS causes reduction in the population growth rate and in Gross Domestic Product (GDP). The ministry of Health report (2002) states that over 70% of death cases in Botswana are caused by HIV/AIDS related diseases. Botswana is facing a problem of taking care of orphans that result from HIV/AIDS.

The impact of HIV/AIDS on demand for tourism in the country is significant since the disease is claiming a high percentage of lives. This in return affects the tourism demand because the people who die of AIDS include the market for tourism. Reduction on the population is a reduction on the tourism market, which also results in lower growth in demand. A number of people spend more money on caring for the orphans left by some family members who died of HIV/AIDS. This results in a low demand for tourism because of low disposable income available to spend on tourism. Another concern according to the Ministry of Health is that some of the orphans are HIV positive, and they need more care and expenses are accumulated. This results in a fall in tourism demand because people do not have both money and time to spend on tourism activities.

The Botswana Central Statistics Office (CSO) (2000: 28) projects that the rate of population growth over the next 25 years could fall from 2.8% a year to 0.9% a year under the AIDS scenario. Base on this prediction, it becomes clear that the demand for tourism in the country will deteriorate since the population growth is falling. The Central Statistics Office also indicates that there is a reduction in GDP growth from 4% without AIDS to 2-3% with AIDS. Based on this information, it is evident that tourism consumption growth rates will be much lower in the future as a result of AIDS as compared to the present and the past years.

4.3 THE IMPACT OF HIV/AIDS ON TOURISM WORKFORCE AND PRODUCTIVITY

UNAIDS (2003: 280) indicates that the most significant impact of HIV/AIDS on the general labour is on population growth. This impact has been greatly felt by a number of countries in Sub-Saharan Africa. Within this region, the highest rate of HIV/AIDS is in Southern Africa. The UNAIDS projects that about 36% of the adult population in Botswana, 25% in Zimbabwe and Swaziland, and 20% in South Africa and in Zambia are infected with the HIV virus. This is compared with the HIV/AIDS prevalence rate of 8.4% for Sub-Saharan Africa and 1.2% for the world as whole. The life expectancy is projected to drop from 60 years to 30 years by 2010 in the seriously affected countries, and the rate of population growth is expected to drop among most of the Southern African countries.

In countries with a higher HIV/AIDS prevalence rate, the impact is expected to be greater than in countries with lower HIV/AIDS prevalence rate. For example, the Zimbabwean population is projected to be 20% lower than without AIDS by the year 2020 (UNAIDS, 2002: 13). These projections and the available evidence on the impact of HIV/AIDS indicate that the economic and social impact of the epidemic will rise, and cause more damage, especially by killing the young people at their productive ages. This includes workers in the tourism sector.

The impact of HIV/AIDS on the general population structure is a reflection of what damage may be expected in the labour force. Most of the people who die of HIV/AIDS-related illness in Southern Africa are the adults in their productive, sexual and reproductive prime. In 1999, 80% of the newly infected people in Rwanda, Tanzania, Uganda and Zimbabwe were between the age of 20 and 49 years (Lisk, 2002: 10). For this reason, the impact of HIV/AIDS on the labour force is even more serious than its impact on the general population. For example, it is projected that by 2020 the Botswana population will be dominated by the old (above 60 years) and the young (under 15 years) people. The loss of young people in their working age, especially those who are between the age of 20 and 49 years, enormously increase the dependency ratio and also affects the work force of a number of industries including tourism.

Lisk (2002: 8) argues that commercial sex workers are more vulnerable to HIV/AIDS than any other workers, and that 80% of the commercial sex workers in most areas are HIV

positive. In generally, workers who work far away from their homes and in separation with their family members like the long distance truck drivers, train crews, sailors, mining, construction, seasonal workers in agriculture and tourism are particularly vulnerable to the HIV infection. This is because some of these people engage in commercial sex activities without taking preventive measures. This in return, results in these people being infected with the HIV virus and who later spread the virus to their spouses and to the general public who engage in sexual intercourse with them without using preventive measures.

Ellis and Terwin (2004: 30) indicate that HIV/AIDS affects many Southern African tourism companies and in general through long and frequent labour absenteeism, lower labour productivity and higher employee benefits. These factors have the largest impact on the production side of companies that have been affected by HIV/AIDS. For example, between 60% and 70% of the mining companies and about 50% of the manufactures companies in South Africa indicate that HIV/AIDS reduces their labour productivity and increases absenteeism among their employees and it leads to higher employee benefit costs. This could have a similar impact on the tourism companies. A number of companies indicate that the pandemic leads to higher labour turnover rates, lost experience and skills and higher recruitment and training costs. Most South African companies including those in the tourism sector strive to retain their skilled workers, but semi-skilled workers are often casually employed and are likely to move from one area to another to find work.

More than 16% of the South African companies indicate that HIV/AIDS disrupts the supply of goods and services to their customers. For most of the companies to meet the supply timeline and volumes and to ensure their ultimate survival, they are forced to find strategies to come to grips with the adverse implications of the pandemic. HIV/AIDS affects companies' employment decision in diverse ways. As already indicated above, lower labour productivity, prolonged absenteeism and high employee benefits and other HIV/AIDS related costs force a number of companies to invest on technology, machinery or equipment in order to shift their dependence from labour. For most of the companies within the service industry like those in tourism sector, appoint and train two employees for the same position (work shadowing) to compensate for the impacts of HIV/AIDS on labour productivity, absenteeism and mortality (Ellis & Terwin, 2004: 37).

Ellis and Terwin (2004: 44) state that 24% of small companies in South Africa indicate that HIV/AIDS increases their demand for labour, and the medium and large companies indicate

40% and 51% respectively. Most large companies experience lower labour productivity or increased absenteeism and higher labour turnover rates due to HIV/AIDS than the smaller companies. This in return affects the service quality rendered to their customers. The large companies realise that their production and service quality may be negatively affected if they do not employ more workers to compensate for the adverse impacts of HIV/AIDS.

HIV/AIDS has now become the leading cause of death in Botswana and in many African countries, with three in five deaths being attributed to HIV/AIDS (Botswana. Ministry of Health 2003: 22). The expectations of life at birth in some of the 29 African countries that are seriously affected have declined by seven years on average and by as much as twenty years in the most severe cases.

The World Heath Organisation's report (2000: 28) indicates that in South Africa, Botswana, Namibia, Zambia and Zimbabwe, the life expectancy at birth in 2000-2005 is expected to be between 20 and 29 years lower than it would have been in the absence of HIV/AIDS. The population in these countries is expected to be 20% smaller than it would have been by the year 2015. However, because of the high fertility levels, the population will still continue to grow. There is an average interval of nine to eleven years between HIV infections and full-blown AIDS.

The Botswana Tourism sector was reported to have high HIV/AIDS prevalence among the tourism workers in 2002, and the estimation in mid 2003 by the Department of Tourism was 15%, or 5% fewer than it would have been without the impact of HIV/AIDS. By the year 2015 the total percentage is expected to reach 30% or some 10% lower than it would have been without AIDS.

The impact of HIV and AIDS on Southern African Tourism productivity is obviously negative, but what is difficult to determine is the magnitude of that impact. As the disease develops workers suffer from progressively more illness, before they eventually die (United Nations Development Program 2000: 18). HIV/AIDS affects most companies' productivity because workers take time off work because they become ill, and some employees' work rate drops because of illness and depression. Some tourism organisations experience a problem of absenteeism because workers are either sick or attending funerals of family members who die of related to AIDS. Some working days are lost because some employees take time off to look

after their sick relatives and family members attributed to HIV/AIDS. Essentially, all of these effects reduce the supply of tourism labour, and increases its costs.

The other channel through which AIDS affects productivity is through the disruptive effects, which results in frequent replacement of workers. Even if tourism workers who fall sick can be replaced, their replacement does not immediately reach the same levels of productivity (Department of Tourism 2004: 25). This effect is more pronounced in Botswana and the entire Southern African Tourism Industry because on-the-job learning and experience is important. It is difficult or even impossible to replace a highly qualified and experienced worker after he dies. Due to high prevalence of HIV/AIDS epidemic in Southern Africa, the tourism sector is facing a problem of loosing some of the experienced workers. This is costly because a lot of time and money is spent in recruitment and training of new workers. As a result, some tourism companies operate with unqualified workers, which lead to low productivity and poor service rendered.

While the general channels from HIV/AIDS infection to low productivity can be described in some detail, quantifying the productivity impact is much more difficult. A lot of information is available about the general level of HIV prevalence in Southern Africa, but less information is available about prevalence rates in different sections of the tourism labour force.

Botswana's Ministry of Health (2000: 17) states that Botswana has reasonable good data on overall prevalence rate and on prevalence by age group. There is some data on prevalence rates by geographical locations, derived from testing centres in different towns, but even this does not provide reliable information on differences in urban and rural prevalence rates as many of those tested in urban centres are drawn from surrounding rural areas.

The Botswana Tourism Sector is characterised by a shortage of skilled workers, and if the skilled workers have high HIV infection rates, this shortage will be exacerbated with potentially adverse effects on economic output and growth (Botswana. Department of Tourism 2003: 13). The extent of HIV/AIDS on the tourism labour force depends on the response of firms and the government. At the same time, Botswana is characterised by extensive employment, and hence large proportion of the unskilled tourism labour force has a marginal productivity that is close to zero. HIV/AIDS infection amongst this segment of the tourism labour force is more likely to reduce the unemployment rate.

Besides a lack of information on prevalence rates in different segments of the tourism labour force, there is also uncertainty on surrounding the impact of HIV/AIDS infection on the productivity of those tourism workers who are infected. The impact depends partly on the duration of the disease. The studies conducted by Botswana Harvard International (2003) indicate that there is more detailed information on this in developed countries than in developing countries, where the incubation period could be shorter. If for example, an HIV positive person is expected to lose 250 days of work between infection and death, this would represent a productivity loss of 20% if the period from infection to death is 5 years, but only 10% of the period is 10 years (on the basis of 250 working days a year).

CLASSIFICATION OF TOURISM WORKFORCE (Botswana Ministry of Environment, Wildlife and Tourism 2003).

SKILLED	UNSKILLED
Administrators and General Managers	Clerks
Professional Tourist Guides	Receptionists
Marketing Managers	Cleaners
Technicians	Drivers
Chefs	Gardeners

4.3.1 THE LOSS OF SKILLED WORKERS

Over (2001: 53) indicates that HIV/AIDS affects the Zimbabwean tourism by disrupting the human resources available in the country. The human resources of a country are provided by the size and quality of its labour force, and HIV/AIDS affects both. HIV/AIDS affects the size and productivity of the Zimbabwean tourism labour force and in general because of mortality and morbidity. Tourism employees who die of HIV/AIDS-related illness do not only represent losses in productivity, but also losses in terms of knowledge and experience they possess.

The High morbidity among the tourism sector in Zimbabwe reduces the country's tourism labour productivity, for example, a number of companies in the tourism sector are reported to have a high rate of staff turnover, high health costs and the need to educate their employees about the pandemic and preventive measures. HIV/AIDS also poses a threat on the future

human capital in the country (Over, 2001: 53). The high death rate in Zimbabwe means that the country is faced with an increased number of AIDS orphans who are less likely to fully develop their physical and intellectual capabilities due to poverty. This in return may affect the future prospective of the country's tourism and other sectors.

Lisk (2002: 8) indicates that most of the people struck by HIV/AIDS in Namibia are between the age of 15 and 49. Some of these people within these age ranges work in the tourism sector. The impact of HIV/AIDS is significant not only on tourism workers and their families, but on general enterprises and on national economy. HIV/AIDS has become a major threat to employment objectives and to the labour market efficiency in Namibia. The loss of tourism workers and work-days linked to HIV/AIDS-related illness and the cost of taking care of the ill workers and their families all contribute to low productivity, loss of earnings, and loss of skills and experience in a number of tourism companies in the country.

HIV/AIDS changes the age and gender distribution of tourism labour force, and increases the number of women, children and elderly people who face the economic challenges. Some of the tourism companies in Namibia employ young people who do not have the experience, and other companies employ old people who are not active to work. The impact of HIV/AIDS on employment and on the labour market is a major concern for the International Labour Organisation (Lisk, 2002: 8). Another major concern by the International Labour Organisation is the discrimination against workers and people who are infected with the HIV virus at the work place.

Ramsey *et al.* (200: 5) argue that the majority of African countries have a small number of skilled workforce to manage the economy and to provide services to the public both in the government and private sectors. In a number of African countries, health, education, police and army are the government sectors most struck by HIV/AIDS pandemic. The countries with a high HIV/AIDS prevalence rate are loosing their skilled workers to HIV/AIDS. In the year 2000, 12% of educators in South Africa were projected to be HIV positive and in Botswana 4% of children had lost a school teacher to AIDS. In Zambia, death among health workers has increased 13 folds between 1980 and 1990 as a result of the HIV/AIDS pandemic. The loss of skilled workers greatly reduces the quality of basic services that the government can provide and its contribution to the rising costs of accessing infrastructure, increasing the cycle of poverty in areas affected by the AIDS pandemic. It is also difficult and expensive to replace these skilled employees who die of AIDS.

Botswana's Department of Tourism Research and Statistics (2004: 33) indicates that HIV/AIDS lowers the average age of the tourism labour force due to the impact in Botswana. Even assuming the same labour force participation rates, the median age of the labour force would be reduced by as much as two years by the year 2020, implying an increasing proportion of younger age group in the tourism labour force and other sectors in general.

Little is known of the impact of HIV/AIDS on the quality of the labour force in terms of education, training and experiences. However, it is probable that HIV/AIDS will have a severe impact on these factors, particularly in view of the effect of HIV/AIDS on the education sector, in some countries, where it is reducing the number of teachers and tourism trainers like lecturers, and leading to a rise in early school drop-out rates for students whose parents die of AIDS. This results in low number of tourism-trained people in the Southern African countries. HIV/AIDS is therefore likely to have profound effects, not only on the size, but also on the composition and quality of the tourism labour force in Botswana and the entire Southern Africa (Botswana. Department of Tourism 2004: 26).

The Department of Tourism in Botswana further indicates that a number of tourism organisations in Botswana experience the problem of loosing some of their key workers. In view of these factors, some companies have already begun to hire or train two or thee employees for the same position. This is done in fear that employees in key positions may be lost due HIV/AIDS. The government of Botswana at national level employs the same strategy by sending a large number of students to South Africa and other countries for training in tourism related courses and other courses in general. Some tourism organisations in Botswana replace their loss of key employees by importing tourism labour from South Africa and other neighbouring countries, at the risk of creating a bigger immigrant sub-population, which is often more vulnerable to HIV/AIDS infection.

HIV/AIDS has led to increased demands for spending for health and social welfare, and the costs of insurance benefits for households, companies and government have increased. According to the Botswana Ministry of Health report (2003:17), some organisations have reported a doubling of medical expenses over a five-year period; while tourism employees who fall ill have to divert their savings into their medical care. Greater claims are being made on group life insurance and health schemes.

South African tourism companies and multinationals provide anti-retroviral drugs to infected employees. Distributing these drugs safely is expensive, and the alternative is to let workers fall sick and die. South African government started providing anti-AIDS drugs like antiretroviral (ARV) to the general public in 2004 but at a few dozen public clinics. The South African government predicts that HIV/AIDS may reduce a small percentage point off the annual GDP growth. It is expensive to treat sick doctors, accountants, civil servants and the general skilled workers, but it is cheaper than waiting for a new generation because a number of them are AIDS orphans and do not have education and training skills. HIV/AIDS drugs do not cure the pandemic but lessen its impact (South Africa. Department of Economic Development and Tourism, 2004: 83).

4.3.2 TRAINING AND RECRUITMENT COSTS

Ramsey *et al.* (2002: 5) indicate that HIV/AIDS kills young working adults, and this generally affects the South African economy and productivity. They further indicate that the specific impacts on the business depends on the benefit package offered by the individual companies to their employees but it involves: absenteeism, hiring replacement workers, costs of treatment and funerals, reduced productivity, retraining of workers and providing family pensions. The study of 15 companies in Ethiopia over a five–year period indicates that 53% of all illness among workers is AIDS related. In Zimbabwe, the law was passed that funerals should only be held on weekends as the large number of funerals was intruding the economic activities.

The Botswana Tourism Sector faces some costs arising from the AIDS related mortality, and the loss of trained worker who are expensive and difficult to replace. Some of the workers in a number of organisations are experienced, and it is difficult and expensive for a number of organisations to replace an experienced person if he or she dies. Projections by the National Development Plan in collaboration with the Department of Tourism (2003) are that adult mortality (age 15-49) might increase by as much as 40 deaths per thousands adults per annum. This will lead to an increase in training costs since the skills imported would be lost. Both the Government and private sectors need to train more than the usual number of people in order to compensate for those who die either during their training, or during their period of service following the training, when the skills are being put to use. This increases the costs as excess people are trained as part of contingency plan.

The amount of extra training required depends upon the length of the training course, and the length of time for which the government or the private tourism organisation would expect to benefit from the skills provided. The aims and objectives of the Botswana Tourism Sector are to provide quality service to the clients and compete globally, which require proper training in excellent schools. For example, the Department of Tourism indicates that a first degree course lasting four years might be expected to be followed by four years of service by employee concerned. This is a total of eight years. The number of people dying of AIDS over an eight year period is compounded – and amounts to about 220 per thousands (Botswana National Development Plan 2003: 31).

The concern for the Namibian Tourism Board includes the costs of new recruitments which are projected that 15 new recruits per 1000 employees per year would be expected linked to HIV/AIDS related cases. The total costs of this extra recruitment excluding training are not expected to be sufficiently large to justify an independent estimate. The problem facing many tourism organisations in Namibia with regard to new recruits is the fact that new recruits tend to be less productive when they start to work, so there is a hidden cost in inefficiency resulting from an increased staff turnover. Operating the tourism business with inexperienced new employee results in poor service rendered by organisations and lack of competitiveness in the global market by the Namibia Tourism Sector. This could be the same case with a number of Southern African countries (Namibia. Tourism Board, 2004: 21).

The effects on the individual tourism organisation depend upon the degree of employment of skilled workers. This could be expected to have the greatest impact on the bigger tourism organisations, which are major skilled workers' employers. The other impact pointed out by the Namibian Tourism Board is the fact that there is an increase in death benefits and funeral expenses facing the tourism sector both in the government and private sectors. This results from an increased mortality rate among employees. This could however be significantly offset by savings in pension costs resulting for the earlier mortality of employees.

The Botswana National Development Plan projections (2000) indicated that pension liabilities are expected to be about 9.8% of the bill for personnel emoluments, or about 3.7% of the recruitment budget. This poses some problems to a number of tourism organisations in the country and the entire Southern African Region, especially the small organisations that are still at their infant stage. It is further indicated that the savings only apply under the present defined benefit schemes. In responding to this problem, a number of organisation including

government departments work I collaboration with insurance companies providing the annuity in the short term, and encourage employees to have life insurance.

4.4 THE IMPACT OF HIV/AIDS ON POVERTY

Lisk (2002: 14) indicates that HIV/AIDS affects the gross domestic products (GDP) of some countries in Southern Africa through its impact on tourism labour supply, savings, and through reduction in the productivity. However, HIV/AIDS does not affect only the Southern African tourism sector, but affects other sectors in general. Moreover, poverty in Southern Africa and in other parts of Africa is likely to increase as a result of the continuous spreading of the HIV virus on the continent. HIV/AIDS creates a vicious cycle by reducing economic growth, which leads to increased poverty, which in turn, results in the rapid spread of HIV/AIDS due to reduced household income and nutrition. In addition to these impacts, the HIV/AIDS pandemic results in income inequality by increasing the supply price of scarce tourism skilled labour, which results in higher wages of skilled workers when compared to the wages of unskilled labour.

Ramsey *et al.* (2002: 4) state that the impacts of the HIV/AIDS pandemic in Sub – Saharan Africa include the destruction of the development progress at various levels and throughout societies. Africa is burdened by large socioeconomic difficulties and poverty, and the HIV/AIDS pandemic threatens human welfare and social stability. HIV/AIDS is the largest obstacle to the implementation of the African Renaissance through structures like NEPAD. The poverty rate in some Southern African countries is high, and three quarter of the African continent people live on less than US$ 2 a day. The most destructive impact of HIV/AIDS in Sub – Saharan Africa is its contribution to poverty by increasing the vicious cycle of poverty already prevailing in the region, and it increases forms of social inequality.

In general, people who suffer the severest impact of HIV/AIDS are those living in poverty. The fact that HIV/AIDS kills family breadwinners and the young adults who have the potential to be breadwinners, means that most households become poorer and fragmented as children are sent away to be looked after by relatives, or they become heads of families at a young age. Supporting these children with basic needs like food, shelter and education in the face of a disintegrating traditional family network and deteriorating government services and resources is a great challenge. In Uganda, 25% of families take care of an AIDS orphan, and this stretches family resources (Ramsey *et al.* 2002: 4).

Caring for the AIDS patients is a challenging task for the families that have a small or tight financial budget. For example, Ramsey *et al.* indicate that in urban areas in Cote d'Ivoire, education investment dropped by half, food consumption dropped by 41% per capita income and health care expenses are more than four times in families that have an AIDS patient. In Rwanda, the annual per capita health care expenses for families that have an AIDS patient is US$63 compared to average families in which health care expenses is US$20 (Ramsey *et al.* 2002: 4).

Rumsey *et al.* (2002: 5) argue that almost everywhere, HIV/AIDS challenges at both family and community levels are faced by women, particularly the very young and the elderly. In Swaziland, they indicate that school enrolment dropped by 36% due to the HIV/AIDS pandemic, and the most affected gender among the pupils are the girls because they take the responsibilities of caring for AIDS patients in families. In Zambia, more than 50% of people who take care of the AIDS patients are the women, and the married women spend more than 13 hours a day with AIDS patients, and this reduces their opportunities and capabilities to raise funds for their families. Most families cannot cope with the challenges of HIV/AIDS, and they sell their valuable assets to pay for medical and funeral expenses, and this in return, deepens the cycle of poverty.

According to the United Nations Development Programme (2000: 60), the number of people living in poverty in Botswana has increased by 10% more, compared to the situation without AIDS. In a number of situations, the income of the poorest quarter of the population is expected to fall by P5.64 per person per month compared to the situation without AIDS. This in return affects the Botswana tourism industry in the sense that the disposable income is reduced and people have little amounts of money left to spend on tourism activities. There is a significant of the total income loss due to HIV/AIDS by those living in poverty, which is in the order of 1.5% to 2.0% of the total recurrent budget. The Botswana tourism sector looses its local market as a result of AIDS because it becomes expensive for most people to purchase tourism activities. Poverty alleviation measures by the Botswana government are aimed at redistributing income from those people above the poverty line to those below, especially people in rural areas. This poses some impact on the tourism sector because instead of focussing more attention on developing tourism, more attention is given to the poverty alleviation activities and programmes.

The United Nations Development programme report stipulates that HIV/AIDS is likely to cause an increase of destitute households from 4,000 to 7,000 in Botswana over the next few years, resulting from the death of income earners. This corresponds to an increase of between 20,000 – 40,000 individuals, many of whom will be orphans. AIDS is expected to create high rates of unemployment among the adults in the country. This damages the tourism sector because the local people cannot afford tourism activities if they are not employed. Botswana is currently having over 17,500 registered destitute. These people receive an allowance of 100. 00 pula per month and this costs the country over 15.4 million pula per annum. More money is spent on the destitute than in developing and marketing tourism.

Further predictions are made in the report that an additional 14,000 orphans will come from destitute households resulting from HIV/AIDS after 10 years. The total number of additional orphans caused by HIV/AIDS is certainly larger than this, since there will be many orphans within households that still have at least one income earners. According to the report, the total estimated number of orphans resulting from HIV/AIDS is 65,000, although there is considerable uncertainty over estimates taken from AIDS related projections. These estimates show that the consumption of tourism deteriorates since the age group that consume tourism is the one struck by the pandemic.

4.4.1 IMPACT OF HIV/AIDS ON TOURISM CUSTOMER BASE

Botswana's Department of Research and Statistics Section (2004: 27) indicates that Botswana's HIV/AIDS problem is forcing tour operators to restructure their businesses and expand into new markets because their local market base is dying. Tour operators targeting lower-income emerging market consumers are most at risk in the face of increasing AIDS deaths, which will cut population forecast to 1.3 million by 2010 instead of the 2 million projected by population census (2001) under a non-AIDS scenario.

The Hospitality and Tourist Association of Botswana (HATAB) have established a business strategy to deal with the pandemic. The HIV/AIDS pandemic is expected to reduce Botswana's GDP growth rates by an average of 0.5% t0 0.6% a year over the next 10 years. Other figures put the expected GDP reduction as high as 1.7% a year (HATAB 2004: 14).

HATAB, which owns a significant share of Botswana's tourism, is reducing its risk profile by extending the tourism business market from areas of high HIV/AIDS prevalence like the Sub-

Saharan region to other global market. HIV/AIDS also influences HATAB's decision to create additional income streams such as its joint venture with the Department of Wildlife, Department of Customs and the 2003 formulation of Botswana Ministry of Tourism. The Association's strategy is based on a study commissioned a few years ago. The study highlighted the HATAB specific costs effects, such as a 65% decline in operating profit for some tourism organisations stemming from payroll increases due to AIDS.

Among the projected HIV/AIDS effects by the Hospitality and Tourist Association of Botswana (HATAB) are a decrease in the customer base after 2010; a significant shift in the customer base age profile; and a 21.8% reduction in the target tourism market in Botswana by 2015. Early reaction to these projected trends will safeguard Botswana Southern African tourism value in a struggling market.

The Botswana tourism market is both local and internationally based as HATAB has indicated. With the prevalence of HIV/AIDS, the country is likely to loose a high percentage of the market especially in countries in which individuals cannot afford antiretroviral drug. This means the tourism market is deteriorating. Often these individuals are supporting families and the impact is catastrophic. Some people in foreign countries face internal cost problems such as training and health insurance. People in Botswana are the exception to the problem because the Government of Botswana through the Ministry of Health offers antiretroviral drug free of charge to the public.

Ellis and Terwin (2004: 44) state that most South African companies indicate that the HIV/AIDS pandemic has had little impact on the demand for their products and services. Most of the companies have not conducted any research to establish the impact of HIV/AIDS on their consumer base or target market. It is also indicated by many companies that HIV/AIDS does not adversely affect the decision to invest in South Africa. HIV/AIDS puts profitability under pressure, not only because of its induced cost increase, but because it reduces the size of a company's target market and therefore reduces sales when compared to a non-AIDS scenario. Some companies in Kwazulu-Natal and Gauteng indicate that HIV/AIDS imposes high threats on their profits.

4.4.2 IMPACT OF HIV/AIDS ON THE IMAGE OF SOUTHERN AFRICAN TOURISM

Lisk (2002:10) states that due a decline in economic growth and productivity, the most seriously affected Southern African tourism countries and in general will find it difficult to improve or even maintain their position in the competitive environment of the international economies, and in globalisation. For example, in 2000 Global Competitiveness, South Africa was ranked the 26th position, and this ranking was based on growth and potential for fast growth. Given the impact of HIV/AIDS not only on tourism but on other sectors in the country, it may be difficult for South African to avoid dropping from the above ranking position if the skilled and experienced workers are struck by HIV/AIDS. This economy's position is not just a status, but a future reflection of what may be expected not only in the tourism sector but in general when observing the country's technology and both skilled and unskilled workforce. Operating business with young and inexperienced workers may drop the service quality standards and result in low productivity.

The image of the Botswana Tourism Sector is affected by the prevalence of HIV/AIDS in the country. HIVAIDS claims the lives of the skilled people working in the tourism industry, resulting in poor service rendered to clients. The goals and objectives of the Department of Tourism in Botswana include competing internationally for the global market, but HIV/AIDS reduces competitiveness of the industry as the skilled and experienced people die due to the pandemic. The sector is operating with the young unskilled workers who in most cases offer low quality service to the clients (Botswana Guardian Friday 27 2004: 18).

Some tourism organisations face serious problems due to the high prevalence of HIV/AIDS in Botswana (Anon, 2004: 13). They speculate that some tourists may not feel comfortable to eat food from hotels where workers like chefs and waitress and waiters are suffering from HIV/AIDS. Botswana is reported to be one of the countries with the highest prevalence of HIV/AIDS in the world, and this damages the image of the country's tourism sector. It becomes difficult to proudly market the country globally, and most of the qualified tourism-marketing managers are struck by the pandemic. The word of mouth marketing strategy that the country relies on is damaged by the poor service rendered by the young less experienced workers who work in the sector.

4.5 SUMMARY

HIV/AIDS impacts negatively on the Southern African Tourism Sector by killing the experienced and skilled tourism workers. A number of organisations are reported to have some problems of poor quality service rendered because they operate with young inexperienced workers. Some tourism organisations in Southern Africa experience high costs resulting from continuous employment and regular interviews as a process to replace the lost employees due to HIV/AIDS. Some key employees are lost to HIV/AIDS. In response to the epidemic, some organisations train two or more people in one position so that if one dies they can have a replacement. This is costly because training more people means more expenses. The government of Botswana on the other hand, sends large numbers of students to foreign countries for training. Some Southern African countries have policies in place to fight the pandemic. Some countries in the region provide AIDS drugs like Antiretrovirals free of charge to the public.

In the past chapter, the economic impacts, impacts on the economic growth, savings and investment impacts, impacts on the labour and productivity, the impact on the skilled workers, training and recruitment costs of HIV/AIDS on Southern African tourism were discussed. The impact of HIV/AIDS on poverty, Southern African tourism image, and the impacts on the customer base were also discussed. The following chapter deals with the survey results analysis.

CHAPTER 5

RESEARCH SURVEY AND RESULTS ANALYSIS

5.1 INTRODUCTION

This section provides an overview of the methodology that was used to conduct the survey on the impact of HIV/AIDS on a selected tourism business sector in four Southern African countries. Limitations of this kind of research are also discussed. During the year 2006, the researcher designed a questionnaire to survey the impact of HIV/AIDS on Southern African tourism and to determine how countries and business have responded to the epidemic. The HIV/AIDS survey was conducted from June to August 2006 in stratified randomly sampled tourism companies in Namibia, South Africa, Zimbabwe and Botswana. The stratified random sampling method was used to select these four Southern African countries. Eight Southern African countries were identified based on their HIV/AIDS world ranking (Annexure B). The identified countries are the top eight countries in Southern Africa in terms of world HIV/AIDS ranking. The identified countries are South Africa, Zimbabwe, Mozambique, Zambia, Malawi, Democratic Republic of Congo (DRC), Botswana and Lesotho. From these countries, four countries were sampled (Botswana, South Africa, Namibia, and Zimbabwe).

From each country, major tourist destinations were identified, and from these destinations, 60 tourism organisations were identified, and the stratified random sampling method was used to select ten organisations from each country to make a total of 40 organisations. The reason why the sample was kept at this number was due to both time and financial constraints, and that the interviews were conducted in four different countries. The other reason is that some of the chosen countries' tourism is still in its infancy stage, and their tour operators have not experienced the economic impact of HIV/AIDS yet. The study was conducted on the tour operators because of financial constraints and also because a number of studies have been conducted on hospitality sector but not so much on tour operators. Tour operators contribute significantly to the economy of Southern Africa and the aim of this study was to find out if the tour operators as a sub-sector of tourism sector face similar HIV/AIDS problems as indicated by many studies in hospitality sector. The organisations were chosen based on the status of their registration. This means that only the registered organisations were selected in their respective countries. From each country, 60 questionnaires were used to gather

information. People interviewed include company directors, managers and some general employees at different levels of company structures. Some government officials in the tourism sector in their respective countries were also interviewed. The reason for selecting these personnel instead on interviewing the general employees was that these people are involved in management of their respective companies, therefore are expected to have better understanding of the macro economic impact of HIV/AIDS in their respective organisations than the general employees. The other reason was to ensure quality of the information. The stratified random sampling method was used to select at least two respondents from each management level of the organisational structure in their respective departments. The survey was conducted through telephone and personal interviews.

5.2 THE QUESTIONNAIRE

The questionnaire was designed by the researcher and evaluated in a pilot study. After the questionnaire was designed, ten copies were given to some tour operators and some government officials in the tourism sector to get their opinions and comments. The tour operators who took part in the pilot study are based in Cape Town. Among the government officials who took part in the pilot study include managers in the City of Cape Town Department of Tourism, Cape Town Route Unlimited and Department of Economic Development and Tourism. The purpose of the pilot study was to detect possible flaws in measurement procedures, to find out if all questions were clear, and to identify any non-verbal behaviour by participants and also to see if they would be comfortable with the questions contained in the questionnaire. The outcome of the pilot study indicated that the participants were comfortable with most of the questions, and some adjustments were made based on the comments that were made.

The questionnaire was designed to survey the impact of HIV/AIDS on Southern African tourism and to determine how countries and organisations have responded to the pandemic. The questionnaire was designed to serve both the personal and telephonic survey approach and, for the most part, the questions were qualitative in nature. Furthermore, although some of the questions surveyed the facts or intent, most questions surveyed the perceptions of the respondents. In order to optimise participation in the study, few figures were used and questions were kept simple, and most of the questions required that the respondents simply "tick" the appropriate answer. Furthermore, individual responses were not of a personal nature, and the answers do not in any way reflect on the particular persons interviewed.

In order to ensure the integrity of the results, respondents were encouraged to complete the questionnaire even if they thought that HIV/AIDS has had no impact on their organisations. Respondents were also given the option to answer that they were "neutral" whether HIV/AIDS has affected the factors in the questionnaire. The company CEO, owners and managers of tourism organisations or the company executives that know best about the impact of HIV/AIDS on their tourism business completed the questionnaire. Given the position of these individuals in their companies and the nature of the questions, most of them completed the questionnaire within a few minutes.

The personal interviews were conducted in June 2006, and the respondents were personally given the questionnaire to answer. During this period, 28 people in Namibia were personally interviewed, 37 in South Africa, 33 in Zimbabwe and 39 people were interviewed in Botswana. The telephonic interviews were conducted from mid July to August using the same questionnaire and the questions consistently. Here, 13 people in Namibia, 14 in South Africa, 10 in Zimbabwe, and 6 in Botswana were telephonically interviewed. By 15 August 2006, 180 out of targeted 240 questionnaires were completed. The 240 targeted respondents were decided based on the number of people (60) in ten organisations in each one of the four countries in which the study was conducted. Stratified random sampling was used to identify the ten organisations. Here the major tourist destinations in each one of the four countries were identified, and 60 registered tourism organisations in each country were also identified. The stratified random sampling was used to identify ten organisations from each destination. Here the organisations were first identified according to their locations in their respective destinations, and from this ten organisations were sampled. From the ten organisations in each country 60 respondents were targeted to make a total of 240. The number of respondents per organisation was not decided because organisations differ in their size and structure. To conduct the interview, the respondents from the management level in their respective organisations in each one of the four countries were identified and stratified random sampling was used to select two respondents from respective departments.

This study was aimed at the company executives and management because the nature of study was to examine the impact of HIV/AIDS in tourism business. By interviewing these dignitaries would help to capture quality data because these company executives have better understanding of the impact of HIV/AIDS in their respective businesses than most of general employee at lower levels of company structures. What transpired during the interviews was that a number of respondents did not feel comfortable to answer the questions telephonically.

The overall response rate for the survey was 75%. This indicates that a high percentage of tourism companies within the surveyed countries participated in the study.

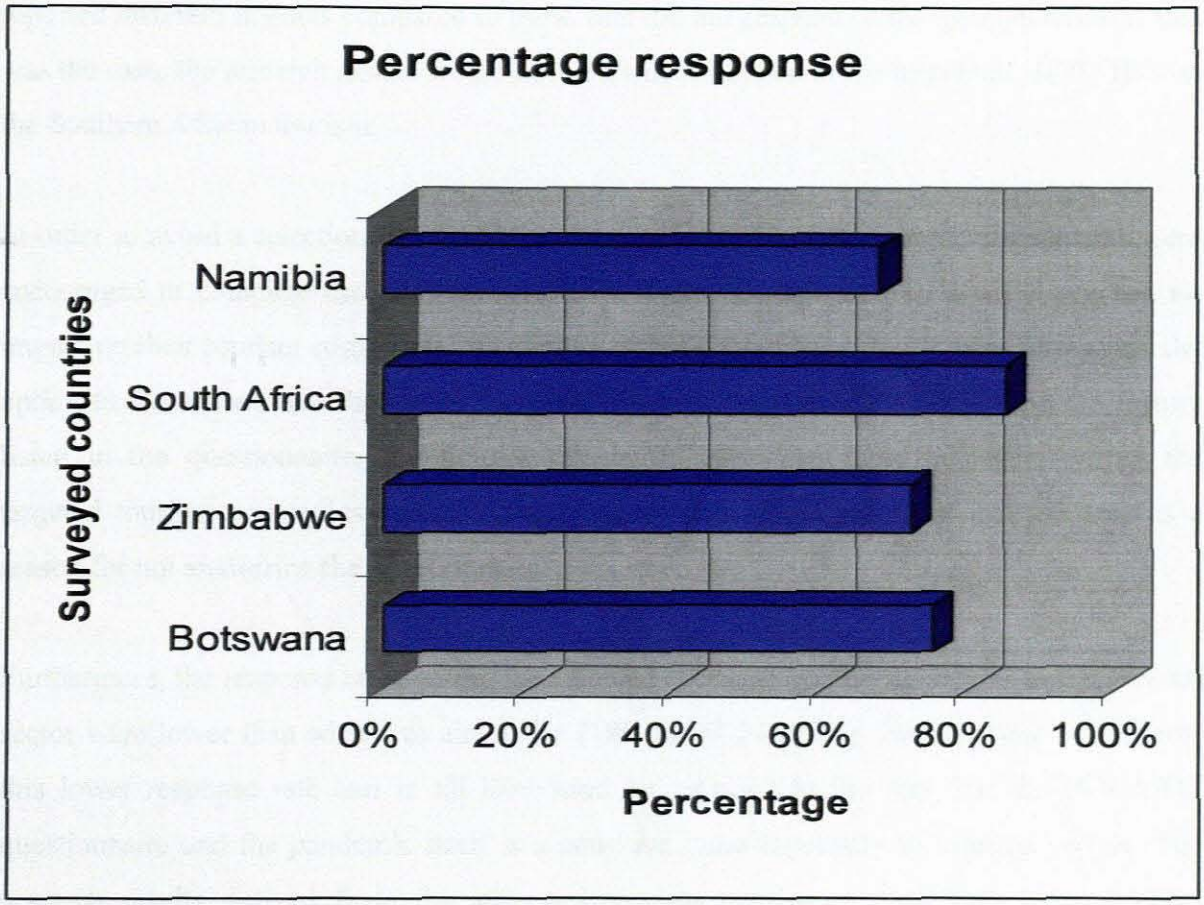
Table 5.1 below presents the actual number of people who responded to the questionnaire from the tourism sector in the four countries within the major tourist destinations.

TABLE 5.1: TOTAL NUMBER OF RESPONDENTS IN EACH COUNTRY

COUNTRY	**ACTUAL RESPONDENTS**	**INTENDED RESPONDENTS**
Namibia	41	60
South Africa	51	60
Zimbabwe	43	60
Botswana	45	60
Total	**180**	**240**
% RESPONDENTS	**75%**	**100%**

The initial respondents target number was 240, but the actual number of the respondents as presented by the table was 180 (75%). As the table demonstrates, the general response rates were fairly high in all four countries. It seems as though some companies are tired of HIV/AIDS problems. The telephonic interviews with the respondents who participated in the survey revealed that time constraints were the main reason for some people, especially the general employees not taking part in the survey. Some respondents also indicated that they were reluctant to participate because the survey will not bring solutions or changes to the damage caused by the HIV/AIDS pandemic to their businesses.

GRAPH 5.1: PERCENTAGE RESPONSE OF THE FOUR COUNTRIES



Graph 5.1 above shows that 68% of the targeted population within the tourism sector in Namibia responded to the questionnaire. The respondents' rate in South Africa was 85%, Zimbabwe 72%, and in Botswana 75% of the targeted population in the tourism sector answered the questionnaire.

5.3 RESEARCH LIMITATIONS

Before the research results are presented, it is imperative to consider the limitations of this type of research. To start with, since only 75% of the intended population in the countries that were targeted actually responded to the survey, one has to consider that there may be a selection bias in the sample. A selection bias would have occurred if the tourism companies and the actual population that participated in the survey in these four countries were significantly different from the population that decided not to respond. For example, if the population sample that responded are more concerned about the impact of HIV/AIDS, are

more likely to have conducted some research on the impact of HIV/AIDS or they are more likely to have experienced adverse impacts as a result of the pandemic, they would have reported different impacts compared to those that did not respond to the questionnaire. If this was the case, the research results would not be a true reflection of the impact of HIV/AIDS on the Southern African tourism.

In order to avoid a selection bias and to ensure the integrity of the results, respondents were encouraged to complete the questionnaire even if they thought that HIV/AIDS has had no impact on their tourism companies. As already stated above, respondents were also given the option to the answer that they were "neutral" about the impact of HIV/AIDS on the factors listed in the questionnaire. During the telephonic interview, most managers within the targeted tourism companies especially in Namibia and Zimbabwe cited lack of time as a reason for not answering the questionnaire.

Furthermore, the response rates within the selected countries and organisations in the tourism sector were lower than what was aimed for (180 out of 240/75%). Besides time constraints, this lower response rate can in all likelihood be ascribed to the fact that the HIV/AIDS questionnaire and the pandemic itself is a sensitive issue especially to infected people. The research results derived from the surveyed tourism companies within the four selected Southern African countries did not differ significantly among the respondents. These factors all support the fact that a selection bias did not occur.

The second limitation of this research that needs some consideration is the fact that a number of the questions in the survey test the perceptions of the population interviewed especially the tourism companies' executives and the government officials within tourism sector, rather than the core data like statistics. Since only a handful of tourism companies within the selected companies have conducted research to asses the impact of HIV/AIDS on their businesses, it is unlikely that many tourism companies would be able to quantify the impacts of HIV/AIDS on various aspects of their businesses.

Due to the fact that most business decisions are often influenced by the perceptions of the Directors and the Chief Executive Officers, the subjectivity of their views does not invalidate the research findings. The other limitation is that, since the survey does not cover all the Southern African countries, or even all the tourism organisations within the selected

countries, the results cannot be generalised to every individual country or company in the region.

5.4 THE SURVEY RESULTS ANALYSIS

This section of the report presents the results of the research on the impact of HIV/AIDS on Southern African tourism based on selected tourism companies and government officials within the four Southern African countries (Namibia, South Africa, Zimbabwe and Botswana). The survey was conducted during June, July and August 2006 among companies in the tourism sector in the above four Southern African countries. Some 180 respondents in 40 organisations and tourism government officials participated in the survey.

In what follows, the research questions and the participants' responses are presented and discussed in the order of appearance in the questionnaire. The results reflect the actual number and percentages of respondents that answered a question in a certain way. Questions and responses are divided into two broad categories, namely: the total number of people responded to a certain question, and the total percentage response rate to a certain answer category in all selected countries.

For the purpose of this study, the company size was measured according to the number of employees per company:

- Small company – less than 80 employees.
- Medium-size Company – 80 to 100 employees.
- Large company – more than 100 employees.

The methodology used to identify the respondents from each company was stratified random sampling. The respondents from each company were first identified according to their management positions in their respective companies. For example, people who were identified were those in senior management positions and in some cases who were in position to represent senior positions. The other variable which was considered was that both males and females from various departments (Human Resources Department, House Keeping Department) managers were given equal opportunity where possible. The reason for selecting these senior management is because they are expected to have more understanding of the

impacts of HIV/AIDS in the organisation than those counterparts at the low level of the organisational structures. Here, depending on the company size and organisational structure, at least two participants were sampled from each level of the organisational structure. The same methodology was applied to select representatives from the tourism government officials in their respective countries. The majority of the questionnaires in small companies were answered by the company Chief Executive Officers, Managing Directors or company Owners, for the big organisations most questionnaires were answered by the managers at different levels of company structures, and to a certain extent by the general employees.

To be more specific, the executives that generally completed the questionnaire include the tourism company Chief Executive Officers, Managing Directors/Owner, Financial Managers/Accountants, Food and beverage Managers, Human resources Managers and some general employees in their respective countries.

In what follows, the research questions and participants' responses with regard to the impact of HIV/AIDS on the Southern African tourism are presented and discussed.

TABLE 5.2: TOTAL NUMBER AND PERCENTAGE OF RESPONDENTS

EXECUTIVES	**NUMBER OF RESPONDENTS**	**% RESPONSE**
CEO	17	9%
General Managers	36	20%
Financial Managers	25	14%
Human resources Managers	37	21%
Food and beverage Managers	16	9%
Other employees	33	18%
Government Officials	16	9%
TOTAL	**180**	**100**

Table 5.2 above presents the total number and percentage response rate of the actual people who participated in the survey. Based on this table, the total number of people who completed the questionnaire is 180, and this figure is broken down according to the specific number and

percentage of actual participants in each category. The differences in the number of respondents are due to the fact that company structures and sizes vary significantly.

Question 1:

Are you aware that Southern Africa is the region in the world with the highest rate of HIV/AIDS infection? Yes_____ No_____

TABLE 5.3: RESPONSE RATE IN EACH COUNTRY

COUNTRY	NUMBER ANSWERED YES	PERCENTAGE ANSWERED YES	NUMBER ANSWERED NO	PERCENTAGE ANSWERED NO
Namibia	37	90%	4	10%
South Africa	46	90%	5	10%
Zimbabwe	31	72%	12	28%
Botswana	42	93%	3	7%
Total	**156**	**86%**	**24**	**14%**

Table 5.3 above presents the actual number and percentage of participants in each country who indicated that they are aware that Southern Africa is the region in the world with the highest rate of HIV/AIDS infection against those who indicated that they are not aware. To be specific, the total number of people in tourism sector who participated in the survey is 180, out of this figure, 156 indicated their awareness to the pandemic situation in the region, whereas 24 respondents indicated that they are not aware. The table shows that an average of 86% of the people who participated in the study in the four countries are aware of the pandemic situation in the region, whereas 14% average respondents indicated that they are not aware. These participants were the representatives of selected tourism sector from four countries indicated in the table.

Based on the results from each country among the surveyed population, the table presents that 90% of the respondents for both Namibia and South Africa are aware of the HIV prevalence rate in the Southern African region, whereas 10% of the participants in each one of these two countries indicated that they are not aware of the adversity of the pandemic. In Zimbabwe

72% of the surveyed population within the tourism sector indicated that they were aware that Southern Africa is the region in the world with the highest HIV/AIDS infection rate, whereas 28% of the respondents in Zimbabwe indicated that they not aware on the pandemic situation in the region. 93% of the respondents in Botswana indicated that they were aware, but 7% of the respondents indicated that they were not aware of the epidemic situation in Southern Africa. Based on the above results, the conclusion could be drawn that most of the people in Southern Africa seem to be aware of the HIV/AIDS pandemic, but much more awareness must be created not only in the tourism sector but in general.

Question 2:

(Please indicate your level of agreement with the following statements about AIDS and tourism in your country)

2.1 The AIDS problem affects your country's tourism sector:

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

TABLE 5.4: NUMBER OF RESPONDENTS FROM EACH COUNTRY

COUNTRY	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Namibia	15	10	8	5	3
South Africa	23	17	6	3	2
Zimbabwe	18	14	2	5	4
Botswana	27	7	4	5	2
Total	**83**	**48**	**20**	**18**	**11**
%	**46**	**27**	**11**	**10**	**6**

Table 5.4 above presents the actual number of respondents and the total percentage of people who indicated their level of agreement to the above statement in a given set of answers. It is indicated in the table that 83(46%) respondents out of the total number of people (180) who answered the questionnaire strongly agree that HIV/AIDS problem affects their countries' tourism sector. In addition to this figure, 48(27%) respondents within the tourism sector in the

surveyed countries agreed with the statement indicating that HIV/AIDS affects their countries' tourism sector. 20(11%) respondents indicated that they were neutral about the statement, 18 respondents disagreed with the statement, and 11(6%) respondents strongly disagreed with the statement indicating that HIV/AIDS affects their countries' tourism sector.

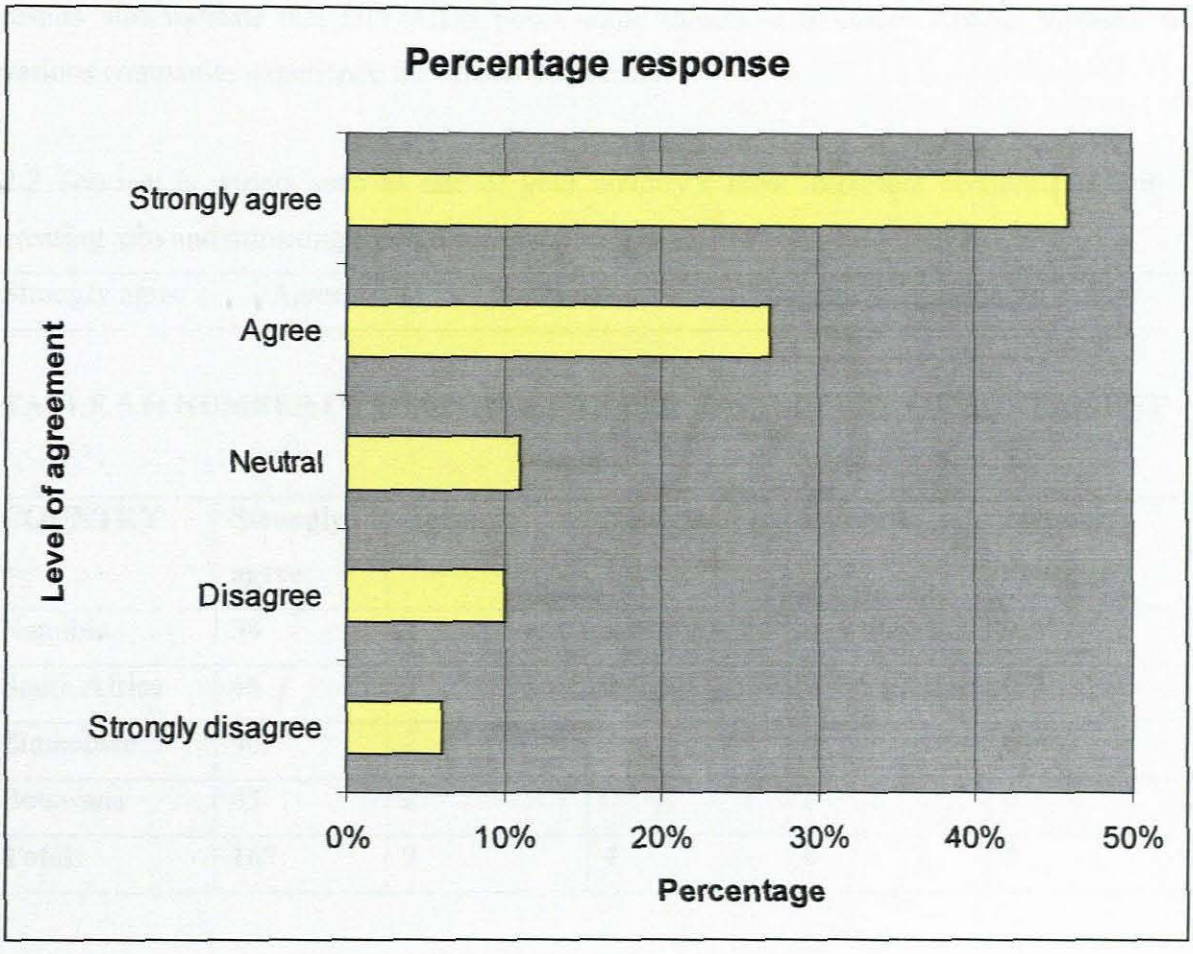
TABLE 5.5: RESPONSE RATE TO STATEMENT 2.1

COUNTRY	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Namibia	37%	24%	20%	12%	7%
South Africa	45%	35%	12%	6%	4%
Zimbabwe	42%	32%	5%	12%	9%
Botswana	60%	16%	9%	11%	4%

Table 5.5 above presents the percentage response rate to the statement 2.1 with each given level of agreement by the respondents from the four countries within the tourism sector. The results in the table indicate that 37% of the respondents in Namibia strongly agreed with the statement indicating that HIV/AIDS their countries' tourism sector, 24% just agreed with the statement, 20% were neutral, 12% disagreed, and 7% of the respondents in the country's tourism sector strongly disagreed with the statement. In South Africa, 45% of the respondents strongly agreed, 35% agreed, 12% were neutral, 6% disagreed and 4% of the respondents strongly disagreed with the statement. 42% of the respondents in Zimbabwe strongly agreed, 32% agreed, 5% were neutral, 12% disagreed and 9% strongly opposed the statement. In Botswana 60% of the respondents strongly agreed with statement, 16% agreed, 9% were neutral, 11% disagreed and 4% strongly opposed the statement 2.1.

Based on the above results (table 5.5), one may conclude that the perception of HIV/AIDS is slightly high in the Southern African tourism sector, but the situation is not perceived as bad as would be expected given the high HIV/AIDS prevalence rate in the region.

GRAPH 5.2: TOTAL RESPONSE RATE FOR THE FOUR COUNTRIES



Graph 5.2 above presents the overall percentage level of agreement to the statement indicating that HIV/AIDS is a problem to the Southern African tourism by the surveyed population in the selected countries. It indicates that 46% of the total surveyed tourism workers in Namibia, South Africa, Zimbabwe and Botswana strongly agreed that HIV/AIDS is severe in the Southern African tourism. 27% of the respondents indicated that they agree with the statement, 11% was neutral or were not sure about the statement, 10% disagreed with the statement, and 6% strongly disagreed with the statement.

One aspect also appeared during the survey was that most of the people who strongly disagreed with the statement were the tourism government officials. This conclusion was drawn from the fact that the interviews were conducted either personally or telephonically. Therefore, the respondents' positions and place of work were identified beforehand. The

majority of the respondents in the private sector indicated that they strongly agree with the statement. The conclusion drawn from these two dimensions is that the private sector in the tourism sector is more threatened by the HIV/AIDS pandemic than the public sector. The results also indicate that HIV/AIDS poses some threats to Southern African tourism, but various companies experience the effects differently.

2.2 Tourism is widely seen as one of your country's most important economic activity – creating jobs and attracting foreign income:

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

TABLE 5.6: NUMBER OF RESPONDENTS PER EACH LEVEL OF AGREEMENT

COUNTRY	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Namibia	38	2	1	0	0
South Africa	46	3	2	0	0
Zimbabwe	40	2	1	0	0
Botswana	43	2	0	0	0
Total	**167**	**9**	**4**	**0**	**0**

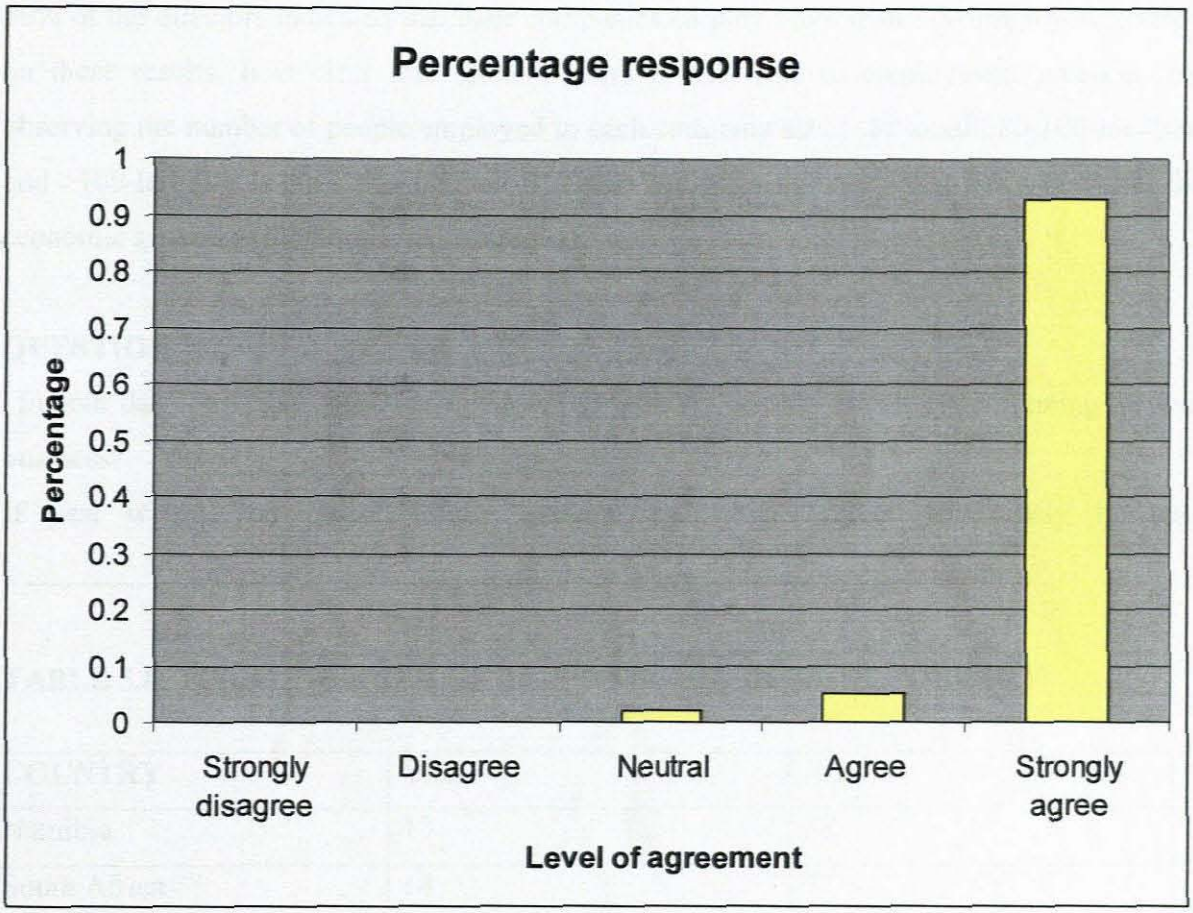
Table 5.6 above presents the actual number of respondents to each given level of agreement in the four surveyed countries. The table stipulates that 167 out of 180 respondents strongly agree that tourism is an important economic sector of their countries. In addition to this figure, 9 respondents agreed with the statement, and 4 respondents were neutral about the statement. None of the respondents either disagreed or strongly disagreed with the statement. Although the survey was carried out in only four Southern African countries, similar perceptions could possibly also be obtained from other Southern African countries. Based on these results, it is clear that tourism contribute significantly to the Southern African economy.

TABLE 5.7: PERCENTAGE RESPONSE RATE IN EACH COUNTRY TO THE STATEMENT 2.2

COUNTRY	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Namibia	93%	5%	2%	0%	0%
South Africa	90%	6%	4%	0%	0%
Zimbabwe	93%	5%	2%	0%	0%
Botswana	96%	4%	0%	0%	0%

Table 5.7 above presents the percentage response rate by the surveyed population in the four Southern African countries in which the study was conducted. The results indicate that over 90% of the population that answered the questionnaire in each country strongly affirmed that tourism is widely seen as an important economic activity of their countries. Between 4% and 6% of the respondents in these countries agreed with the statement, and 0–4% respondents were not sure or were neutral about the statement. None of the respondents disagreed with the fact that tourism is an important economic activity of their countries.

GRAPH 5.3: TOTAL RESPONSE RATE FOR THE FOUR COUNTRIES



Graph 5.3 above presents the total percentage of the level of agreement to the statement 2.2. The graph indicates that 93% of the people who answered the questionnaire within the tourism sector of the surveyed countries strongly agree to the statement indicating that tourism is an important economic activity creating jobs and attracting foreign exchange in their countries. 5% of the respondents agreed with the statement but not strongly, and 2% of the respondents were neutral about the statement. None of the respondents disagreed with the statement. This concludes that tourism plays a vital role in Southern African economy.

QUESTION 3:

How many people are working in your department/organisation?

<50	51 - 60	61 - 70	71 - 80	81 - 90	91 - 100	>100 (specify)

This question was used to assess employment creation and company size of all the surveyed organisations. In responding to this question, 30% of the company directors who answered the

survey questionnaire indicated that their companies employ less than 80 employees, 50% of the respondents indicated that their companies employ between 80 and 100 employees, and 20% of the directors indicated that their companies employ more than 100 employees. Based on these results, it is clear that tourism plays a vital role in employment creation. By observing the number of people employed in each company size (<80-small, 80-100-medium and >100-large) it is clear that tourism is a new and growing sector that has a potential for economic growth in the South African region.

QUESTION 4:

In your day – to – day activities, is the AIDS problem directly affecting the running of your business? Yes_____ No_____

If **yes,** would you please briefly explain how AIDS affect your daily business

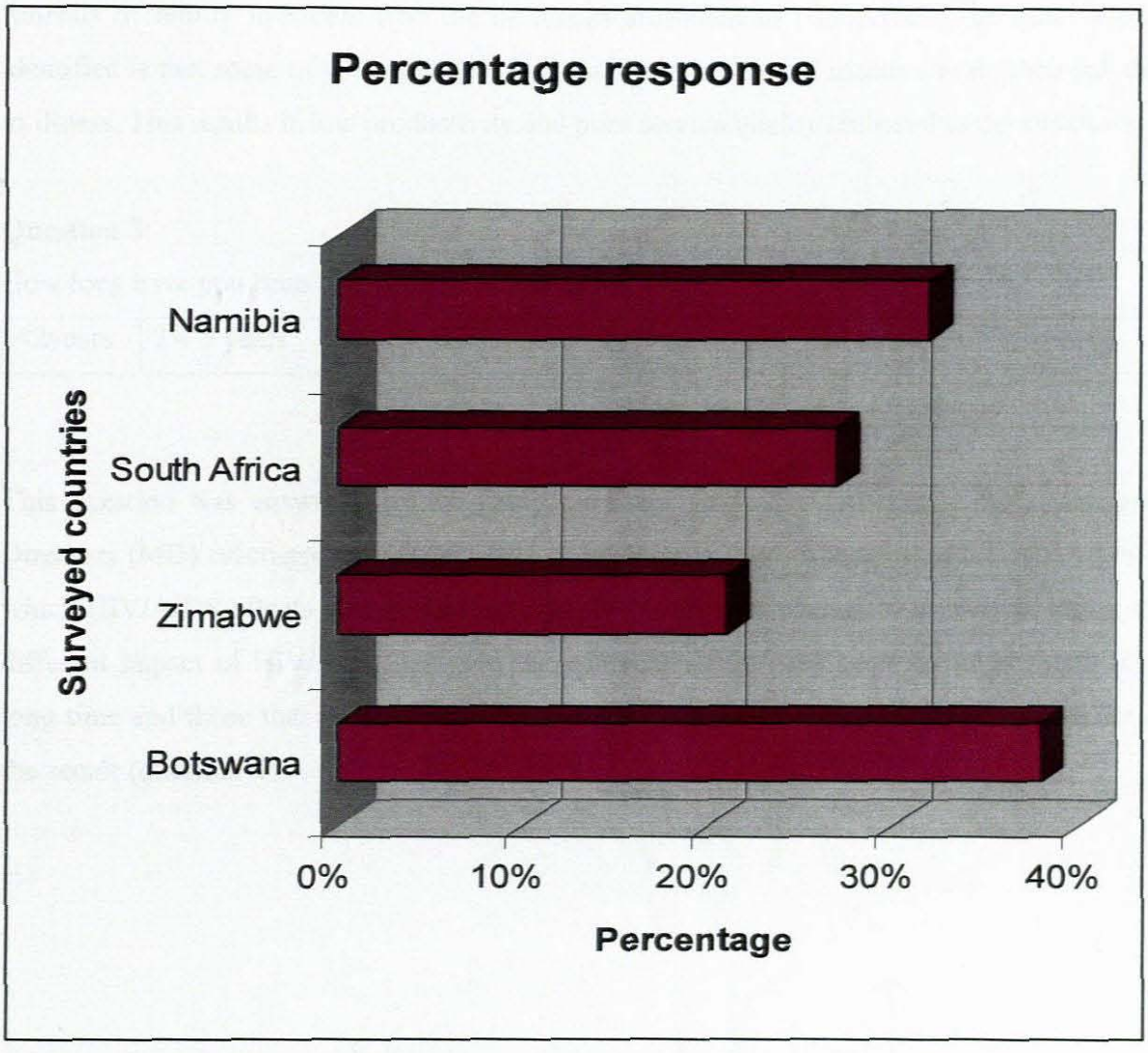
_____

TABLE 5.8: TOTAL NUMBER OF RESPONDENTS IN EACH COUNTRY

COUNTRY	YES	NO
Namibia	13	28
South Africa	14	37
Zimbabwe	9	34
Botswana	17	28

The table 5.8 above presents the actual numbers of people who responded to the questionnaire in a certain way in each one of the countries indicated in the box. The results indicate that the small companies (less than 80 employees) are not aware of the impact of the HIV/AIDS pandemic as much as the medium (80 – 100 employees) and large (over 100 employees) companies.

GRAPH 5.4: TOTAL RESPONSE RATE FOR EACH COUNTRY



Graph 5.4 above presents the response rate of the company executives and managers who indicated that HIV/AIDS affects the day-to-day running of their businesses. To be specific on each country's response rate, Namibia is 32%, South Africa 27%, Zimbabwe 21% and Botswana 38% of the respondents in 40 tourism organisations. These results are a reflection of the response rate of the surveyed tourism organisations in the four countries indicated in the graph. Based on these results, it is clear that the daily running of a number of tourism companies in the Southern African region is affected by the HIV/AIDS pandemic. However, the impact is not as bad as would be expected given the high HIV/AIDS prevalence rate in the Southern African region.

The majority of the respondents who indicated that HIV/AIDS affect their daily running of their business identified workers absenteeism as the biggest obstacle hindering progress in their businesses. They indicated that some workers regularly go on sick leave or attend funerals of family members who die of illness attributed to HIV/AIDS. The other aspect identified is that some of the employees become demoralised and inactive to do their job due to illness. This results in low productivity and poor service quality rendered to the customers.

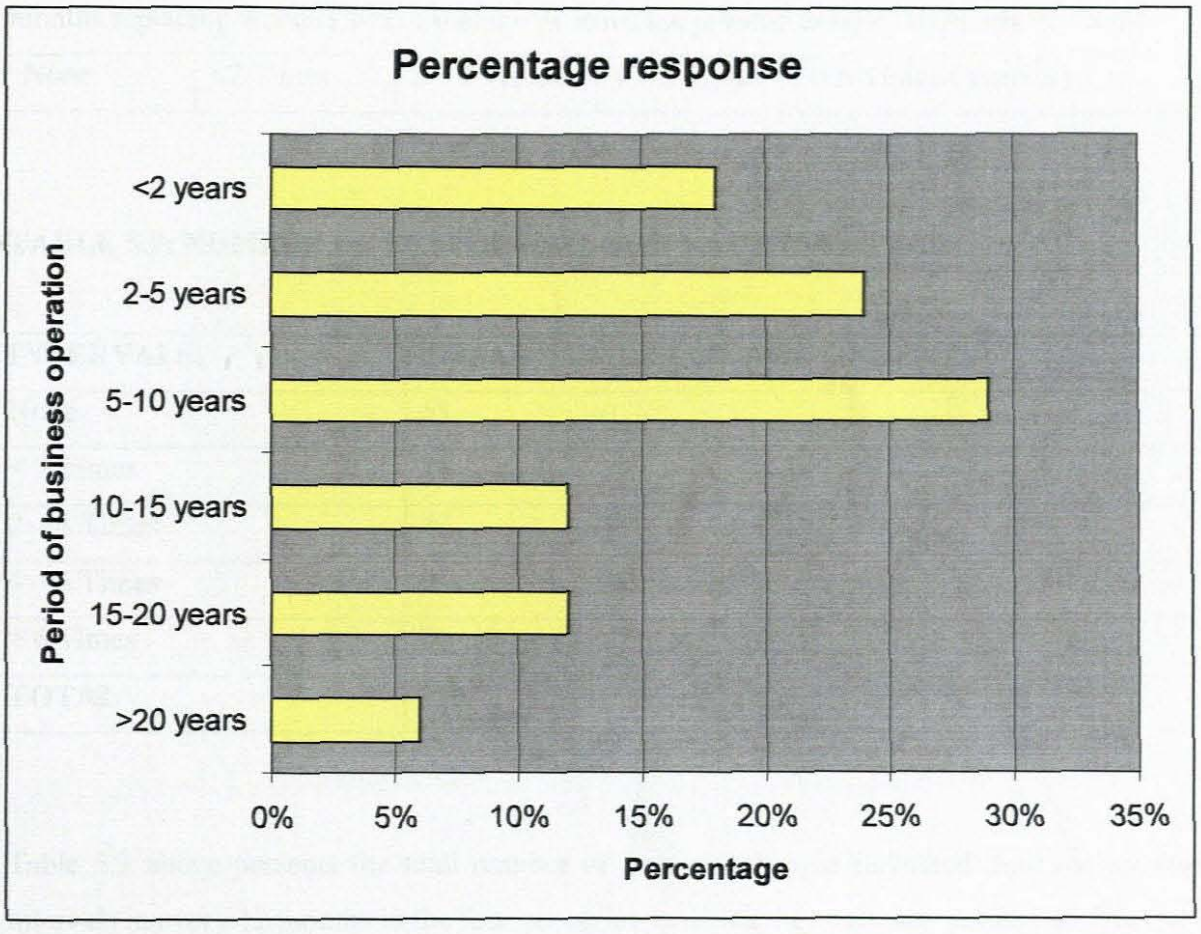
Question 5:

How long have you been operating your business?

<2years	2 – 5 years	5 -10 years	10 –15years	15 – 20 years	>20 years

This question was answered by the company Chief Executive Officers (CEO), Managing Directors (MD) or company owners. This question was used to asses the different ways in which HIV/AIDS affects companies over the given period of operation. In simpler terms, the different impact of HIV/AIDS between the companies that have been in the business for a long time and those that recently joined the sector in terms of the respondents experience in the sector (question 4).

GRAPH 5.5: RESPONSE RATE PER LENGTH OF OPERATION



Graph 5.5 above presents the overall percentage response rate to the length of tourism business operation by those company executives who participated in the survey among the four countries in which the study was conducted. The graph depicts that 18% of the executives that participated in the survey have been operating their business for less than 2 years, 24% for 2 to 5 years, 29% for 5 to 10 years, 12% for 1o to 20 years and 6% for more than 20 years.

These results indicate that the tourism sector in Southern Africa is growing. The majority of the respondents who have been in the business for more than 10 years indicated that HIV/AIDS affects their day-today running of the business (question 4) more than those who have been operating the business for less than 10 years. This is because most of these companies have broader company structures and a larger number of employees than the newly established companies.

Question 6:

How many times does your organisation conduct employment interviews in every twelve months replacing workers who either die or leave the job due to HIV/AIDS related cases?

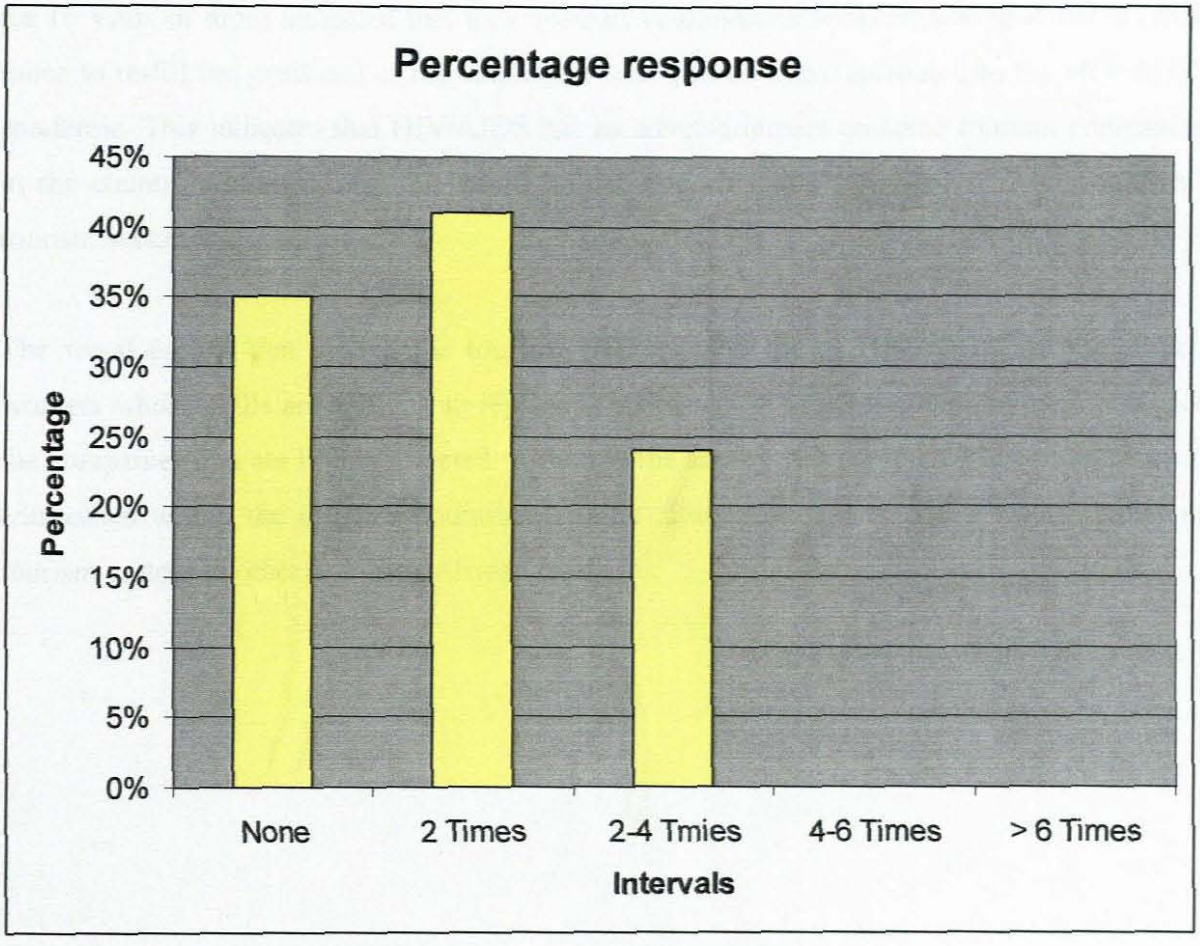
None	<2 Times	2 – 4 Times	4 – 6 Times	> 6 Times (specify)	

TABLE 5.9: NUMBER OF RESPONENTS FOR EACH INTERVAL

INTERVALS	**TOTAL NUMBER OF RESPONDENTS**
None	63
< 2 Times	74
2 – 4 Times	43
4 – 6 Times	0
> 6 Times	0
TOTAL	**180**

Table 5.9 above presents the total number of respondents who indicated their employment intervals in every 12 months in the four countries in which the study was conducted. The table shows that 63 respondents do not conduct any interviews attributed to HIV/AIDS. However, 74 respondents indicated that they conduct employment interviews less than two times, and 43 respondents indicated that they do conduct the employment interviews two to four times in 12 months linked to HIV/AIDS. None of the respondents indicated that they conduct employment interview more than four times. This shows that the impact of HIV/AIDS is felt differently by various tourism organisations. This also shows that impact of HIV/AIDS on the employment rate is not as severe as would be expected bearing in mind the HIV infection rate in Southern Africa.

GRAPH 5.6: OVERALL PERCENTAGE RESPONSE RATE



Graph 5.6 above presents the overall percentage response rate of the people who answered the questionnaire in Namibia, South Africa, Zimbabwe and Botswana. The results indicate that 35% of the respondents indicated that they do not conduct any employment interview in 12 months resulting from the HIV/AIDS pandemic. However, 41% of the respondents indicated that they conduct employment interviews at least twice in 12 months to replace employees who have died or have left the job due HIV/AIDS-related illness. Furthermore, 24% of the respondents indicated that they conduct employment interviews at least two to four times in 12 months.

Most of the respondents who indicated "None" as the response to the question were the small companies (less than 80 employees) and the newly established companies (less than two years in the business). This analysis was drawn from the response in question three which required the respondents to indicate the number of people working in their department/organisation,

and also from question five which required the respondents to indicate the duration of their businesses' operations. The respondents from the companies that have been in the business for 10 years or more indicated that they conduct employment interviews at least two to four times to re-fill the positions of the employees who passed away attributed to the HIV/AIDS pandemic. This indicates that HIV/AIDS has an adverse impact on some tourism companies in the country surveyed, and this could be the same in other Southern African countries' tourism sector.

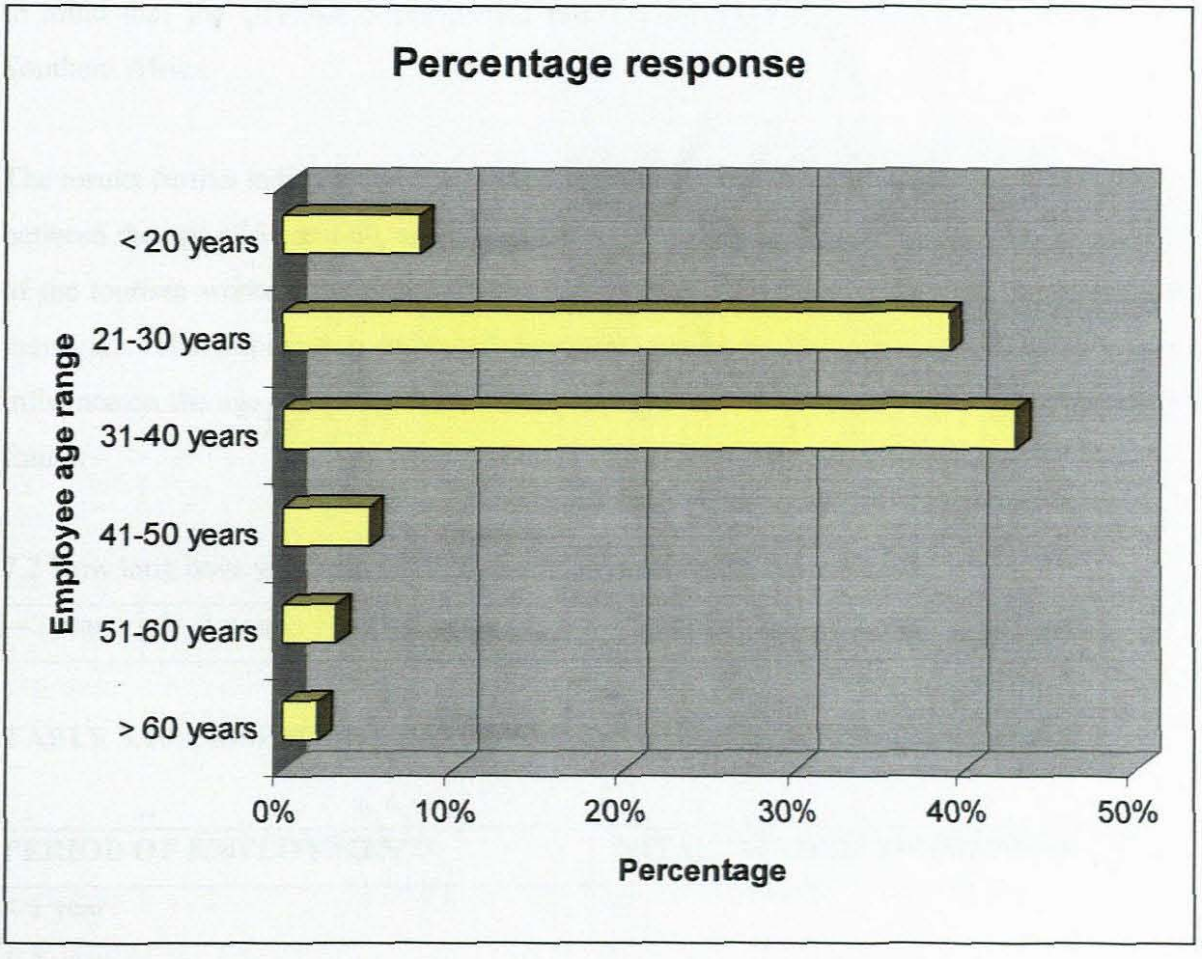
The worst part is that among the tourism workers who die of HIV/AIDS are the skilled workers whose skills are difficult to replace. This results in increasing employment costs for the companies that are highly affected. Although the survey was conducted in certain tourism companies within the selected countries, similar situation could be faced by a number of tourism sectors in other Southern African countries.

Question 7:

7.1 What is your age? **(employees only)**

< 20	21 - 30	31- 40	41 - 50	51 - 60	> 60 (specify)

GRAPH 5.7: OVERALL EMPLOYEES' RESPONSE RATE



Graph 5.7 above presents the overall employee response rate corresponding to the appropriate age category. This question was completed by employees ranging from general mangers downwards excluding the CEO, and company owners. The response rate results indicate that 8% of the respondents were under the age of 20 years. This indicates that HIV/AIDS could have an impact on the age of tourism labour force. This also indicates that some tourism companies among the countries in which the study was conducted employ young people who do not have the necessary experience. Similar situation could be faced by a number of tourism

organisations in Southern Africa. 39% of the respondents were between the age of 21 and 30 years, and 43% of the respondents indicated that they are between the age of 31 and 40 years.

Based on these results, it is clear that most of the tourism companies' employees among the countries in which the study was conducted range between the ages of 21 to 40 years. This could be the same situation in other Southern African countries. In general, this is the age group mostly struck by the HIV/AIDS pandemic. Some tourism companies may not experience the cut-throat impact of the pandemic, but the effect may be felt in future, bearing in mind that the HIV/AIDS prevalence rate among these age group is generally high in Southern Africa.

The results further indicate that 5% of the respondents were between the age of 41 and 50, 3% between the age of 51 and 60, and 2% of the respondents were over the age of 60 years. Most of the tourism workers ranging from the age of 41to 60 or more were the company general managers. The implication indicated by these results is that HIV/AIDS has a negative influence on the age of the Southern African tourism labour force, and the worst may occur in future.

7.2 How long have you been working for this organisation/department?

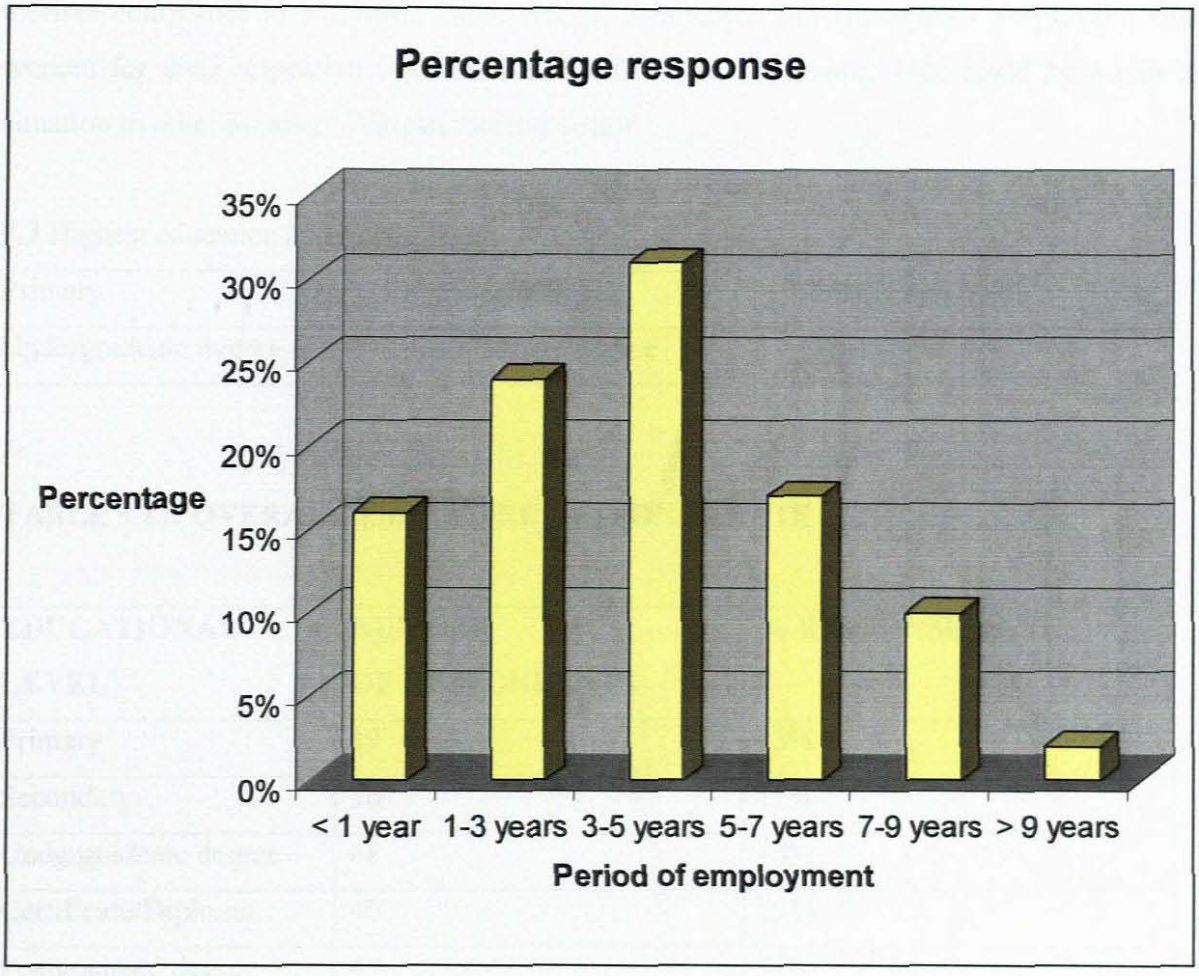
<1year	1– 3 years	3 – 5 years	5 – 7 years	7 – 9 years	> 9 years

TABLE 5.10: NUMBER OF RESPONDENTS FOR EACH AGE CATEGORY

PERIOD OF EMPLOYMENT	TOTAL NUMBER OF RESPONDENTS
< 1 year	23
1-3 years	35
3-5 years	45
5-7 years	25
7-9 years	15
> 9 years	4

Table 5.10 above presents the actual number of respondents per each period of employment category. The results indicate that most employees in the tourism sector of the countries in which the study was conducted are newly employed (1 to 5 years).

GRAPH 5.8: OVERALL PERCENTAGE EMPLOYEES' RESPONSE RATE



Graph 5.8 above presents the overall percentage response rate of the tourism workers that participated in the study in the four Southern African countries in which the survey was conducted. The participants who answered the questionnaire range from the companies' general managers, human resources managers, food and beverage managers and some other employees identified by these dignitaries in their respective departments. These results do not reflect on the company CEO, MD and tourism government officials. A total of 147 respondents in the tourism sector of the countries in which the survey was conducted answered this section of the questionnaire.

The results in graph 5.8 above indicates that 16% of the respondents worked for their organisation for less than one year, 24% between one and three years, 31% between three and five years, 17% between five and seven years, 10% between seven and nine years, and only

2% of the respondents indicated that they worked for their organisations for more than nine years. Most of the respondents who indicated that they worked for their organisations for more than seven years were the general managers. These results indicate that most of the tourism companies in Namibia, South Africa, Zimbabwe and Botswana's employees have worked for their respective organisations for five years or lower. This could be a similar situation in other Southern African tourism sector.

7.3 Highest education level completed:

Primary	Secondary	Certificate/Diploma
Undergraduate degree	Postgraduate degree	Other (Specify)

TABLE 5.11: OVERALL EMPLOYEE RESPONSE RATE

EDUCATIONAL LEVEL	**NUMBER OF RESPONDENTS**	**% RESPONSE RATE**
Primary	19	13%
Secondary	16	11%
Undergraduate degree	68	46%
Certificate/Diploma	40	27%
Postgraduate degree	4	3%
other	0	0%
TOTAL	**147**	**100%**

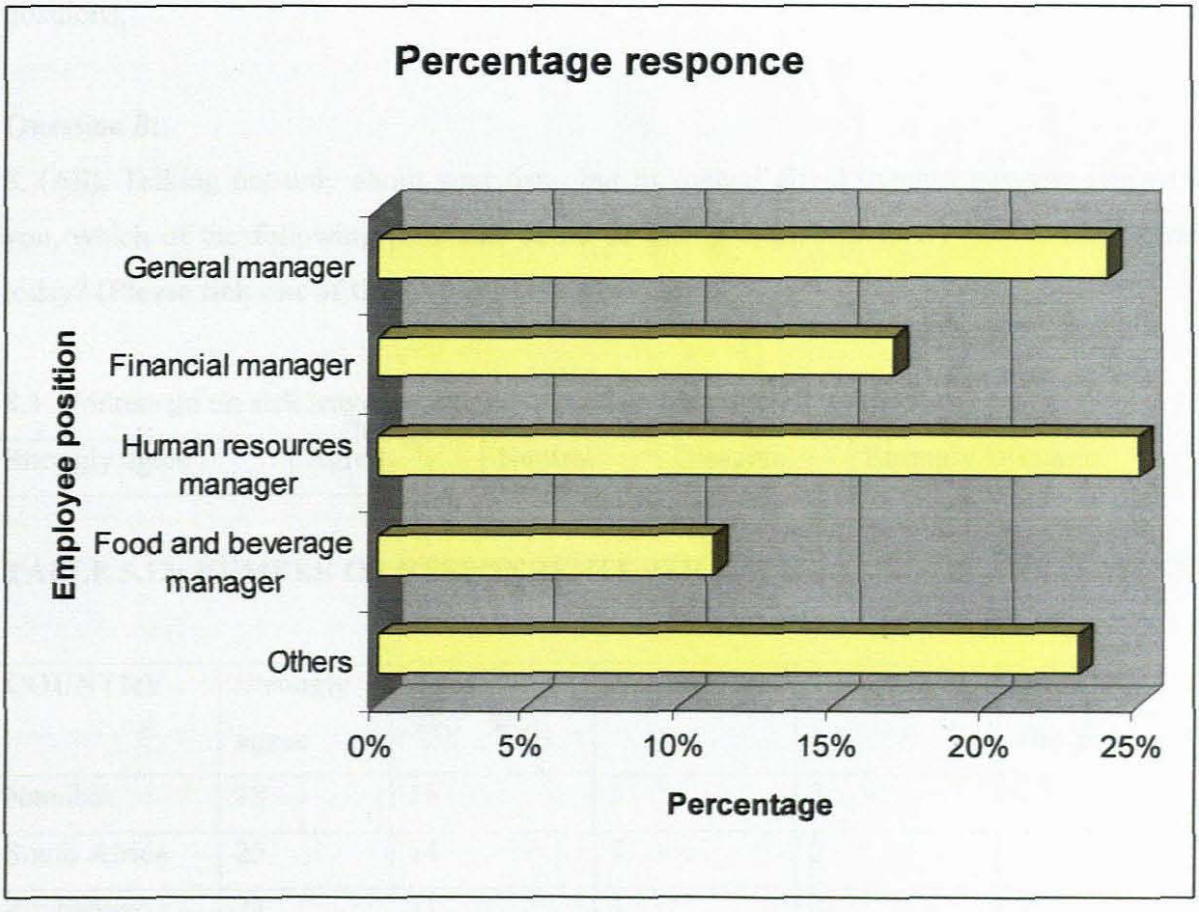
Table 5.11 above presents the overall percentage employee response rate for the selected tourism sector of the countries in which the study was conducted. This question was answered by a total of 147 tourism employees within the private sector of Namibia, South Africa, Zimbabwe and Botswana. However, the company CEO and MD were not part of the respondents. Most of the tourism employees who answered the questionnaire in these countries have either certificate/diploma or undergraduate degree in the field of their respective qualifications.

These results show that a skilled labour force play a vital role in the running of tourism business. Although this study was conducted in the above mentioned four countries, these various skills could be vital to the tourism sector of other Southern African countries which were not surveyed. Without the skills of these individuals, Southern African tourism cannot progress. HIV/AIDS poses threats to the Southern African tourism sector by killing individuals who possess these valuable skills.

7.4 Your position in the organisation:

General Manager	Food and beverage Manager	Financial Manager	Human Resources Manager	Other (specify)

GRAPH 5.9: OVERALL EMPLOYEE RESPONSE



Graph 5.9 above presents the overall percentage response rate for the tourism employees in the four Southern African countries in which the study was conducted. The graph indicates that 24 % of the respondents were the general managers, 17% were the financial managers, 25% were the human resources managers, 11% were the food and beverage managers, and 23% were the other employees who were identified by their managers in their respective departments. Examples of other employees who participated in the study include the executive chef and head chef.

Based on the results in graph 5.9 above, it is clear that these individuals possess valuable skills that are difficult to replace if they should die. The above results and positions of the respondents indicate that there is a need for tourism companies to have people who are skilled. These skills play a vital role towards the success of any tourism company in Southern Africa and in general. HIV/AIDS threatens the future prospective of the Southern African tourism by killing these individuals who are skilled to occupy the positions indicated in the graph 5.9. It is expensive to train people to acquire the skills suitable for the management positions.

Question 8:

8. **(All),** Talking not only about your firm, but in general about tourism business known to you, which of the following problems could be facing tourism industry in Southern Africa today? **(Please tick one of the five answers provided).**

8.1 Workers go on sick leave for lengthy periods – linked to HIV/AIDS:

Strongly agree	Agree	Neutral	Disagree	Strongly Disagree

TABLE 5.12: NUMBER OF RESPONDENTS PER EACH LEVEL OF AGREEMENT

COUNTRY	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Namibia	18	15	5	3	0
South Africa	25	14	7	2	3
Zimbabwe	23	11	5	4	0
Botswana	27	13	3	2	0
Total	**93**	**53**	**20**	**11**	**3**

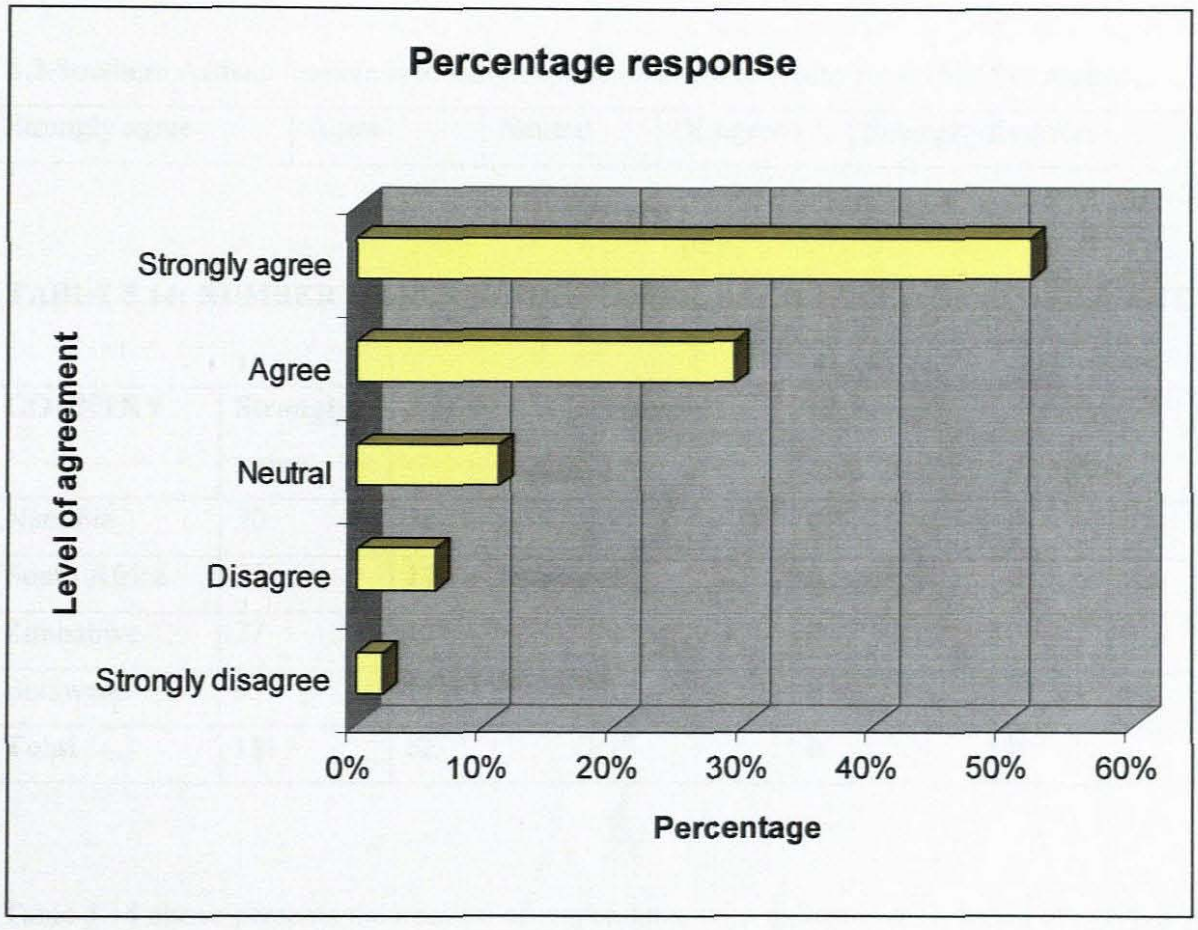
Table 5.12 above presents the actual number of people who indicated their level of agreement in each country in which the study was conducted. As already indicated in the introductory part of this survey results, a total of 180 people on the tourism sector of the countries indicated in the table answered the questionnaire and the figures indicated in the above table are a break down per each level of agreement by those individuals.

TABLE 5.13: PERCENTAGE RESPONSE RATE

COUNTRY	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Namibia	44%	37%	12%	7%	0%
South Africa	49%	27%	14%	4%	6%
Zimbabwe	53%	26%	12%	9%	0%
Botswana	60%	29%	7%	4%	0%

Table 5.13 above presents the percentage response rate of the people who answered the question in the tourism sector of the countries indicated in the table. Looking at these results for each country, percentage of respondents who strongly agreed with the statement indicating that workers go on sick leave for lengthy period in Namibia is 44%, 49% in South Africa, 53% in Zimbabwe and 60% in Botswana. 37% in Namibia, 27% in South Africa, 36% in Zimbabwe and 29% of the respondents agreed with the statement. 12% of the respondents in Namibia, 14% in South Africa, 12% in Zimbabwe and 7% in Botswana were neutral about the statement. 7% in Namibia, 4% in South Africa, 9% in Zimbabwe and 4% of the respondents in Botswana disagreed with the statement in question 8. None (0%) of the respondents in Namibia, Zimbabwe and Botswana strongly disagreed with the statement, but 6% of the respondents strongly disagreed with the statement. By observing these results, the percentage response rate for the respondents who strongly agreed and those who agreed with the statement are fairly higher than for the other levels of agreement. This indicates that most of the tourism companies in the countries in which the survey was conducted experience a problem of workers going on sick leave for a lengthy period attributed to the HIV/AIDS pandemic. Other countries in the Southern African regions could be facing a similar problem.

GRAPH 5.10: OVERALL PERCENTAGE RESPONSE RATE



Graph 5.10 above presents the overall percentage response rate of all the people in the tourism sector who participated in the survey in all four countries in which the survey was conducted. This table indicates the overall percentage response rate per each level of agreement. To be specific, 52% of the respondents strongly agreed with the statement indicating that the Southern African tourism sector experience a problem of some workers going on sick leave for a lengthy period attributed to HIV/AIDS. In addition to this, 29% of the respondents agreed with the statement but not so strongly, 11% were neutral, 6% disagreed and 2% of the respondents strongly disagreed with the statement.

Based on the entire results, it is indicated that most of the respondents affirmed the statement 8.1. This indicates that beside the four countries in which the study was conducted, the entire Southern African tourism sector could be faced with a serious problem attributed to HIV/AIDS. If employees take long sick leave, productivity and service quality become negatively affected. It is difficult for the companies to replace these employees even with

casual workers, especially if most of the people who go on sick leave for a lengthy period are the skilled workers.

8.2 Southern African tourism is loosing experienced workers who are difficult to replace:

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

TABLE 5.14: NUMBER OF RESPONDENTS PER EACH LEVEL OF AGREEMENT

COUNTRY	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Namibia	20	12	9	0	0
South Africa	31	17	3	0	0
Zimbabwe	27	12	4	0	0
Botswana	33	11	1	0	0
Total	**111**	**52**	**17**	**0**	**0**

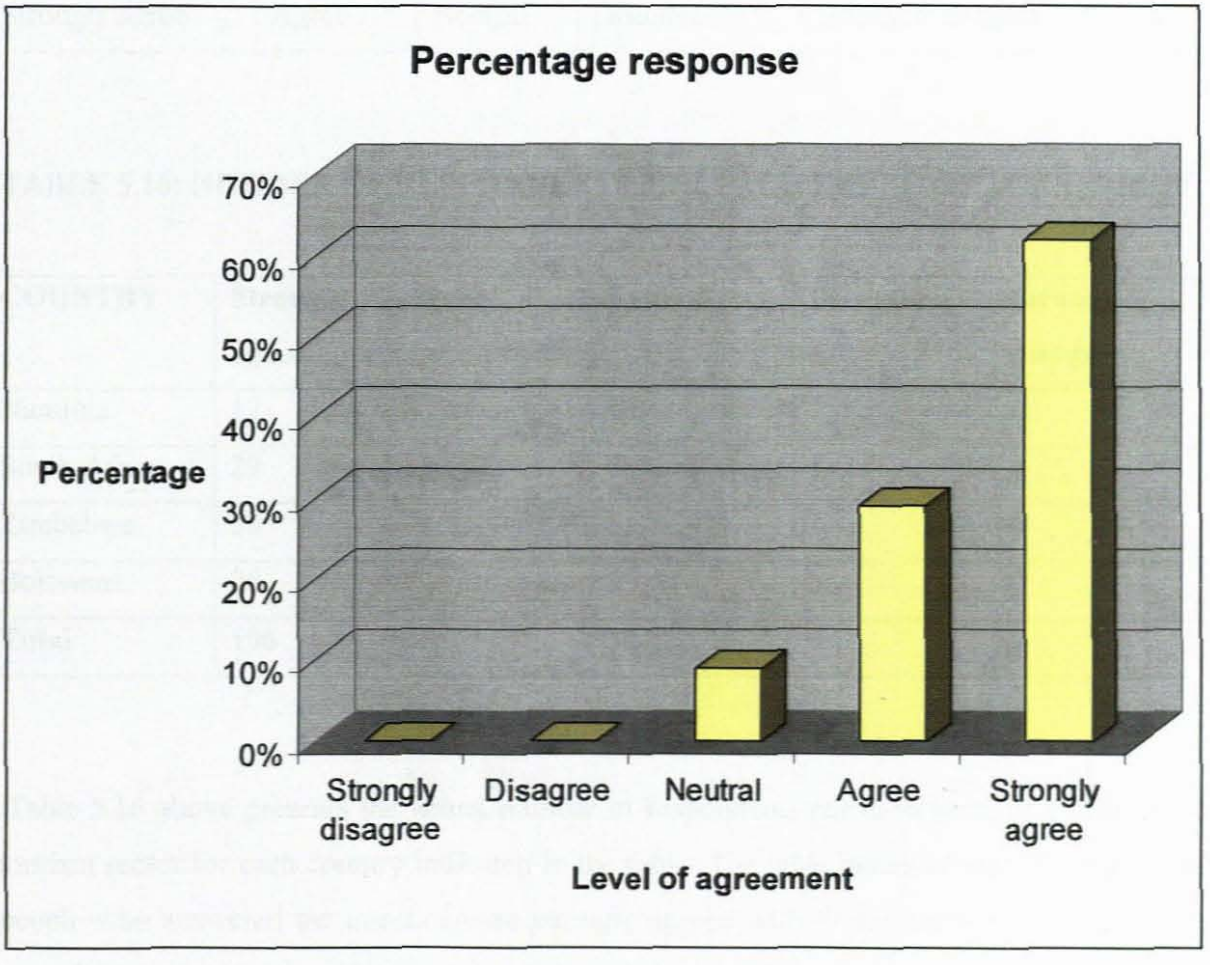
Table 5.14 above presents the number of respondents who indicated their levels of agreement from the tourism sector of the countries indicated in the table. The table indicates that 111 out of 180 of the respondents strongly agreed that Southern African tourism is loosing experienced workers who are difficult to replace. 52 out of 180 respondents agreed with the statement, 17 respondents were neutral to the statements, and none of the respondents disagreed with the statement. These results indicate that the Southern Africa could be facing a serious problem of loosing experienced workers who are difficult to replace.

TABLE 5.15: PERCENTAGE RESPONSE RATE

COUNTRY	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Namibia	49%	29%	22%	0%	0%
South Africa	61%	33%	6%	0%	0%
Zimbabwe	63%	28%	9%	0%	0%
Botswana	73%	24%	3%	0%	0%

Table 5.15 above presents the percentage response rate of the people who participated in the survey from the tourism sector of the countries indicated in the table. The percentage response rate for the respondents who indicated that Southern African tourism is loosing experienced workers as indicated in each country is 73%. Although this study was conducted in the four countries as indicated in the table, there is a possibility that the other Southern African countries could be facing similar or even a worse situation, given the high prevalence rate of the pandemic in the whole region. Training of these tourism workers is expensive, and the worst could be expected in future because more money is being spent on HIV/AIDS treatment than on training programmes. The alternative solution by the tourism companies and in general would be to train two or more people for the same position, which is expensive.

GRAPH 5.11: OVERALL PERCENTAGE RESPONSE



Graph 5.11 above presents the overall percentage response results per each level of agreement of those who participated in the study within the tourism sector of the four countries in which the survey was conducted. This table indicates that 62% of the respondents strongly agreed that Southern African tourism is loosing experienced workers who are difficult to replace attributed to HIV/AIDS. 29% of the respondents agreed with statement but not strongly, 9% of the respondents were neutral about the statement. None of the respondents opposed the statement.

These results indicate that the Southern African tourism could be loosing experienced workers due the HIV/AIDS pandemic. This study was carried in four of the Southern African countries, but looking at the results one could ascribe them to a number of other countries in the region.

8.3 The cost of operations increase because of the need to replace those absent due to illness:

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

TABLE 5.16: NUMBER OF RESPONDENTS PER EACH LEVEL OF AGREEMENT

COUNTRY	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Namibia	12	8	10	2	0
South Africa	29	13	6	3	0
Zimbabwe	30	7	5	1	0
Botswana	26	7	9	3	0
Total	**106**	**35**	**30**	**9**	**0**

Table 5.16 above presents the actual number of respondents per each level of agreement in tourism sector for each country indicated in the table. The table indicates that 106 out of 180 people who answered the questionnaire strongly agreed with Statement 8.3, 35 respondents agreed but not strongly, 30 respondents were neutral and 9 respondents disagreed but not strongly. Although people who answered the questionnaire had different views about the statement indicating that the Southern African tourism sector is facing problems of increased

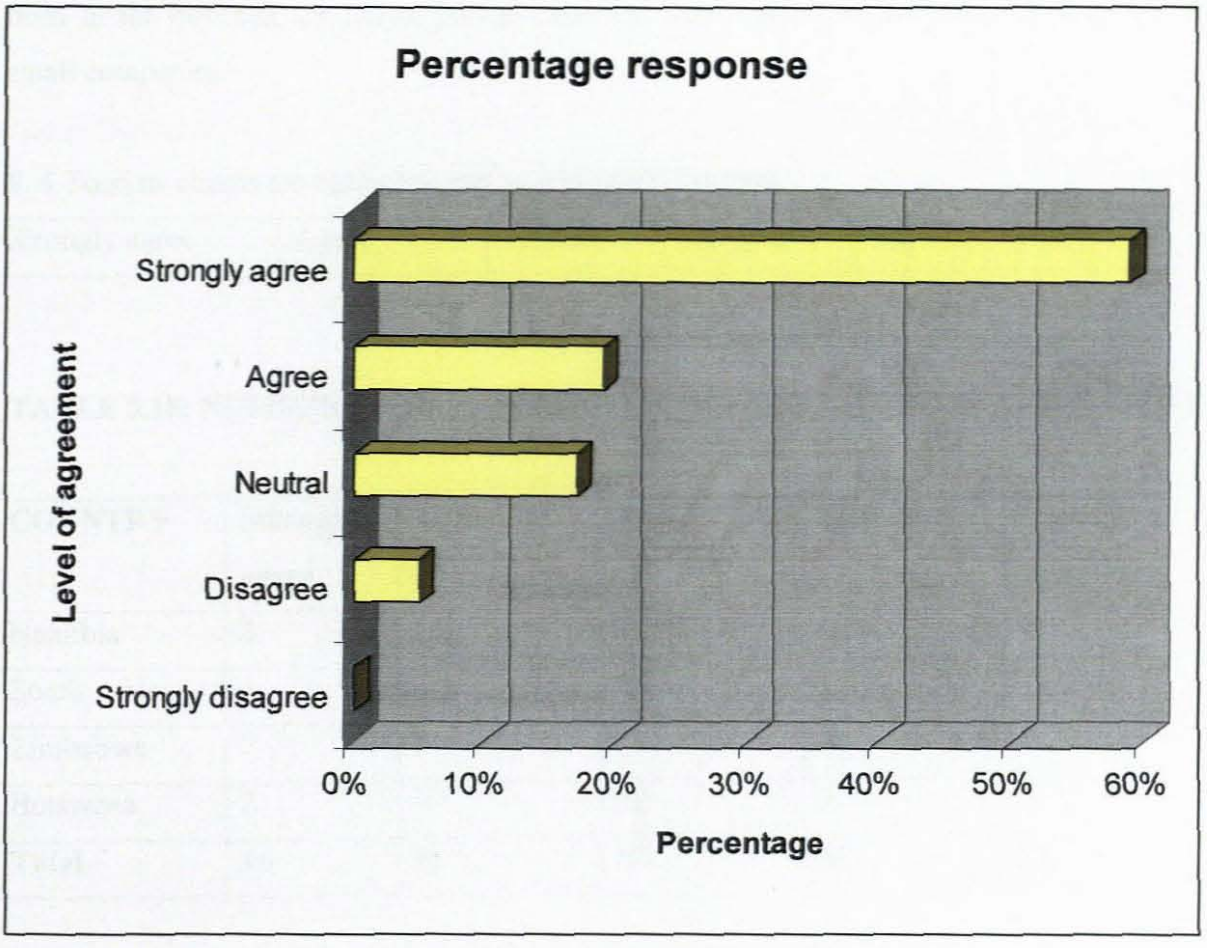
cost due the need to replace workers who are sick, the majority of the respondents confirmed that this could be a problem for a number of tourism companies.

TABLE 5.17: PERCENTAGE RESPONSE RATE

COUNTRY	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Namibia	51%	20%	24%	5%	0%
South Africa	57%	25%	12%	6%	0%
Zimbabwe	70%	16%	12%	2%	0%
Botswana	58%	15%	20%	7%	0%

Table 5.17 above presents the percentage response rate for all the respondents in each country indicated in the table correspondence to each level of agreement.

GRAPH 5.12: OVERALL PERCENTAGE RESPONSE RATE



Graph 5.12 presents the overall percentage response results of all those who participated in the survey in the four countries. The graph shows that 59% of the respondents indicated that they strongly agree that the tourism costs of operations in Southern Africa are increasing due to the HIV/AIDS pandemic. In addition to those who strongly agreed, 19% of the respondents although not strongly, agreed that the AIDS problem results in increased costs of operations in the Southern African tourism because of the need to replace workers who go on sick leave for a lengthy period. 17% of the respondents were neutral and 5% of the respondents disagreed with the statement.

Based on these results one can conclude that a number of tourism companies in Southern Africa could be experiencing tremendous operational costs attributed to the HIV/AIDS pandemic. Although the study did not cover all the countries in Southern Africa, the results support the possibility of most countries facing similar situations. The other aspect that needs to be given the utmost consideration according to the above results is that a number of

respondents who indicated either neutral or disagreed with the above statement were from the newly established small tourism companies. This indicates that larger companies that have been in the business for longer period experience the impact of HIV/AIDS more than the small companies.

8. 4 Tourists clients are being lost due to HIV/AIDS 'threats':

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

TABLE 5.18: NUMBER OF RESPONDENTS PER EACH LEVEL OF AGREEMENT

COUNTRY	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Namibia	3	5	19	10	4
South Africa	4	4	23	17	3
Zimbabwe	7	3	21	11	1
Botswana	2	9	22	7	5
Total	**16**	**21**	**85**	**45**	**13**

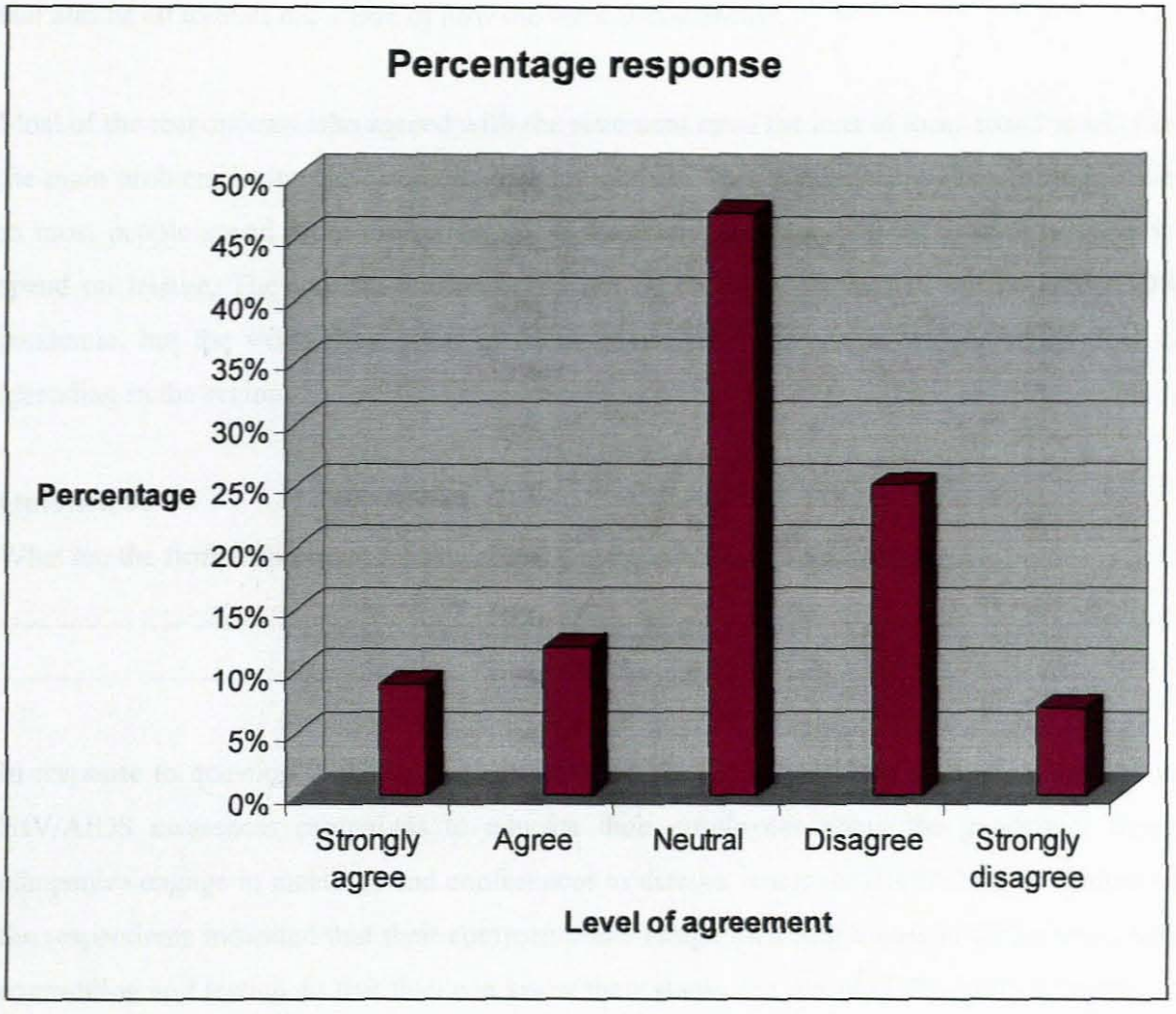
Table 5.18 above presents the total number of respondents per each level of agreement in the tourism sector of the countries indicated in the table. Figures indicated in each box corresponding to each country name are the actual number of the respondents who indicated their level of agreement in each box. Just to recap on how these numbers were calculated per each country, a total of 41 people in Namibia answered the questionnaire, South Africa 51 Zimbabwe 43 and Botswana 45. Figures indicated in each box are in accordance with these numbers of respondents per country.

TABLE 5.19: PERCENTAGE RESPONSE RATE

COUNTRY	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Namibia	7%	12%	46%	25%	10%
South Africa	8%	8%	45%	33%	6%
Zimbabwe	16%	7%	49%	26%	2%
Botswana	4%	20%	49%	16%	11%

Table 5.19 above presents the percentage response rate per each level of agreement by the respondents who answered the questionnaire from each one of the countries indicated in the table. This question was used to assess the impact of the HIV/AIDS pandemic on both local and overseas Southern African tourism market.

GRAPH 5.13: OVERALL PERCENTAGE RESPONSE



Graph 5.13 above presents the overall percentage response results for all the people who answered the questionnaire in the tourism sector of the four countries in which the survey was conducted. The graph indicates that 9% of all the respondents strongly agreed with the statement that indicates that the Southern African tourism is loosing tourists clients due to HIV/AIDS. In addition to this percentage, 12% of the total respondents agreed although not strongly with the statement. 47% of the total respondents were neutral to the statement, 25% disagreed and 7% strongly disagreed with the statement.

Although these results indicate varying level of agreement by the respondents about the statement, most of the respondents were neutral to the statement. A number of the respondents opposed the statement. This indicates that although the Southern African tourism could be loosing part of the market due to the HIV/AIDS pandemic, the situation is not that serious.

This shows that tourists are not chased away by the fact that Southern Africa is the region with the highest HIV/AIDS prevalence rate in the world. This could also be due to the fact that almost all tourists are aware of how the virus is contracted.

Most of the respondents who agreed with the statement cited the loss of local-based market as the main problem facing the Southern African tourism. This is due to low disposable income as most people spend more money on AIDS treatment and remain with little or nothing to spend on leisure. The tourism market could not be currently threatened by the HIV/AIDS pandemic, but the worst may occur in future given the high rate in which AIDS virus is spreading in the region.

Question 9:

What are the firms/departments doing about these and related problems?

_____

_____

In response to question 9 above, most respondents indicated that their companies engage in HIV/AIDS awareness campaigns to educate their employees about the pandemic. Some companies engage in meetings and conferences to discuss issues on HIV/AIDS. A number of the respondents indicated that their companies encourage their employees to go for voluntary counselling and testing so that they can know their status and use the HIV/AIDS treatment if they are infected. However, some of the respondents indicated that their companies do not do anything to fight the pandemic rather than being concerned about making profit for their businesses.

Question 10:

Do you expect the AIDS problems to become much worse in future? **(Please explain why)**

_____

_____

In response to question 10, the respondents had varying reasons, and most of them indicated that it is difficult to predict because it all depends on people's behavioural change. They stressed that if people do not change their risky behaviour, the worst HIV/AIDS situation may be expected. Some of the risky behaviour indicated by the respondents includes sex tourism, prostitution and alcohol abuse, which leads to unprotected sex. They indicated that some

people are still ignorant to the preventive measures despite the messages spread by the governments in their respective countries.

Question 11:

Do you think that the Governments in Southern Africa could do something to help address these problems? **(Please briefly explain your answer)**

_____

_____

Respondents in the four countries indicated different experience and level of commitment shown by their governments in their respective countries. In general, most respondents indicated that most governments in the region are doing a lot to educate the people and subsidise the HIV/AIDS treatment. However, a number of respondents criticised the way in which governments in some of the surveyed countries issue HIV/AIDS treatment. For example some of the respondents in South Africa indicated that the treatment campaign offered by the South African government is not accessible by all the people in need, especially people living in rural areas.

Question 12:

Do you often discuss these problems with other tour operators/organisations?**(Please briefly explain your answer)**

_____

_____

With regard to this question, the majority of the respondents indicated that they never discuss the HIV/AIDS problems with their counterparts. The reason cited by most of these respondents is that a lot of messages have already been spread by the governments, that almost everyone is aware of the HIV/AIDS pandemic, and that HIV is a sensitive issue that people would not like to talk about in most cases. However, some of the respondents indicated that they do discuss the AIDS problem with their counterparts.

Question 13:

Do you think that the Southern African tourism industry could be seriously threatened by the AIDS pandemic? **(Please briefly explain your answer)**

_____

_____

A number of the respondents indicated that with all the efforts made by the governments, Southern African tourism may not seriously be threatened by the HIV/AIDS pandemic. However, some of the respondents expressed great concern on unchanged risky behaviour by the general public in their respective countries. They stressed that if people do no change their risky behaviour the worst could happen in future. The concern was the increased rate of poverty and unemployment problems as contributing factors to the spread of HIV/AIDS.

5.5 SUMMARY

The HIV/AIDS pandemic is severe not only in Southern African tourism but in general. Some of the people working in the Southern African tourism industry are infected and affected by the pandemic. Most people are aware of the HIV/AIDS pandemic, and some messages are spread by the governments in their respective countries. Tourism plays a vital role in the Southern African economy by creating employment and attracting foreign income to a number of Southern African countries.

HIV/AIDS threatens Southern African tourism, and causes problems like workers absenteeism and prolonged sick leave. Some tourism companies in Southern Africa loose experienced workers who are difficult to replace, and this results in increased cost of operations because of the need to replace the workers who die or who become sick for a long time. However, the tourism international market-base is not seriously affected and tourists still visit the region, but the local market is slightly affected.

In the past chapter, the survey methodology, the questionnaire aims, research limitations, and the survey result were discussed. The survey results for each question in their sequential order in the questionnaire were analysed and discussed in detail. Some concluding remarks have been made on the summary base on the survey findings. In the following chapter, some concluding remarks and recommendations are made.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This section of the study summarises the main results obtained from both literature review and empirical research.

The main objectives of this research are:

- To investigate how HIV/AIDS affect Southern African tourism, with specific reference to the tour operators.
- To investigate measures taken by the Southern African tour operators and governments to combat HIV/AIDS and the chances of success.
- To make some recommendations on what can further be done to fight HIV/AIDS in the Southern African tourism sector.

6.2 LITERATURE OUTCOMES

T o conduct the study, the following methods were used:

v. Literature search particularly about Southern Africa and in general, as well as news report has been conducted.
vi. Review of HIV statistics.
vii. Use of Internet.
viii. Journals and government publications.

The United Nations (2005: 22) indicates that Southern Africa is experiencing the highest rate of HIV infection in the world. The infection rate is particularly high among the young people (aged 15 – 49). This age group constitutes people who are economically active, and some of them work directly or indirectly in tourism sector.

The UNAIDS (2005) reveals the following statistics which constitute people living with HIV/AIDS in Southern Africa as of the end of 2005.

TABLE 6.1: PEOPLE LIVING WITH HIV/AIDS IN SOUTHERN AFRICA

COUNTRY	NUMBER OF PEOPLE LIVING WITH HIV
South Africa	5, 300, 000
Zimbabwe	1, 800, 000
Mozambique	1, 300, 000
Zambia	920, 000
Malawi	900, 000
Botswana	350, 000
Lesotho	320, 000
Angola	240, 000
Swaziland	220, 000
Namibia	210, 000

By observing these results, it is evident that HIV/AIDS is severe in Southern Africa.

UNAIDS (2003: 17) indicates that the reduction in the growth of the labour force and declining productivity among some Southern African countries result in low government revenues from both individual and enterprises, including those in the tourism sector.

UNAIDS (2003: 280) indicates that the most significant impact of HIV/AIDS on the general labour is on population growth. This impact has been largely felt by a number of countries in Sub-Saharan Africa. The impact of HIV/AIDS on the labour force is more serious than its impact on the general population (Lisk, 2002: 10). HIV/AIDS affects many Southern African companies including those in tourism sector through long and frequent labour absenteeism, lower labour productivity and higher employee benefits.

THETA (2003: 4) conducted a study on a number of tourism and hospitality companies in South Africa. The study results indicate that 92% of the companies surveyed do not have HIV/AIDS educational programmes for their employees, and that 91% of the surveyed companies do not provide HIV/AIDS preventive measures like condoms to their workers at workplace. The other outcome of the study is that 95% of the companies surveyed by THETA

do not have voluntary counselling and testing (VCT) programs for their employees, and 98.5% of the surveyed companies do not provide care programs for their affected workers.

The World Travel and Tourism Council (2002: 44) states that the HIV/AIDS pandemic in South Africa is felt by most tourism companies' managers directly in the workplace.

The Southern African Tourism Sector contributes significantly to the economy of the region. Southern African tourism is based on eco-tourism, which clearly stipulates that for tourists to experience and enjoy the Southern African tourist attractions they need guidance from an experienced tourist guide. Eco-tourism refers to nature–based tourism. HIV and AIDS poses threats to the tourism sector in Southern Africa by killing the experienced people who are supposed to provide service to the tourists for the industry to grow.

Tourism contributes to the economy of Southern African countries by creating employment and contributing to the countries' Gross Domestic Products (GDP). Southern African Governments through their policies encourage foreign investment and the public to be involved in tourism business in the region. The governments also work hard to market the region globally, but the main constraint facing Southern African Tourism Sector is the HIV/AIDS pandemic.

This study indicates that Southern African Region is experiencing the severest HIV/AIDS pandemic in the whole African continent. The overall infection rates in the region are high and increasing. Some countries within the Southern African Region like Botswana are reported to have HIV/AIDS infection rate of 18.284% of the entire population, which is high and expected to increase. HIV/AIDS poses some threats to the Southern African economy, the workforce, business, individual workers and their families.

Lisk (2002: 14) indicates that HIV/AIDS affects the gross domestic products (GDP) of some countries in Southern Africa through its impact on tourism labour supply, savings, and through reduction in the tourism productivity. Moreover, poverty in Southern Africa and in other parts of Africa is likely to increase as a result of the continuous spreading of the HIV virus on the continent. HIV/AIDS creates a vicious cycle by reducing economic growth, which leads to increased poverty, which in turn, results in the rapid spread of HIV/AIDS due to reduced household income and nutrition. The poverty rate in some Southern African

countries is high, and three quarter of the African continent people live on less than US$ 2 a day.

Namibia's Ministry of Environment and Tourism (1994: 22) indicates that there are several mechanisms by which HIV/AIDS affects macroeconomic performance in the country and in the region at large. HIV/AIDS deaths lead directly to a reduction in the number of tourism workers available in their productive ages in the Southern African Region. The high death rates lead to experienced tourism workers replaced by younger, less experienced persons, which results in reduction on productivity. An experienced worker is difficult to replace, and quality of service drops in a number of companies including the tourism sector.

UNAIDS (2003: 17) indicates that the reduction in the growth of the labour force and declining productivity among some Southern African countries results in low government revenues from both individuals and enterprises.

In response to the epidemic, the Southern African countries and some companies engage in collaborative policy formulation activities and encourage their citizens to utilise voluntary counselling and testing programmes. Some countries in Southern Africa (Botswana and South Africa) provide HIV/AIDS treatment like antiretroviral (ARV) at subsidised prices or even free of charge to both their citizens and residents who are HIV positive and certified by doctors to take treatment. However, these efforts by some of the Southern countries may be hampered by some members of the public who do not change their risky behaviour.

6.3 SURVEY OUTCOMES

This section provides an overview of the methodology that was used to conduct the survey on the impact of HIV/AIDS on a selected tourism business sector in four Southern African countries. The HIV/AIDS survey was conducted from June to August 2006 in stratified randomly sampled tourism companies/tour operators in Namibia, South Africa, Zimbabwe and Botswana. The stratified random sampling method was used to select these four Southern African countries. Eight Southern African countries were identified based on their HIV/AIDS world ranking (Annexure B). The identified countries are the top eight countries in Southern Africa in terms of world HIV/AIDS ranking. The identified countries are South Africa, Zimbabwe, Mozambique, Zambia, Malawi, Democratic Republic of Congo (DRC), Botswana

and Lesotho. From these countries, four countries were sampled (Botswana, South Africa, Namibia, and Zimbabwe).

From each country, major tourist destinations were identified, and from these destinations, 60 tourism organisations were identified, and stratified random sampling method was used to select ten organisations from each country to make a total of 40 organisations. The reason why the sample was kept at this number was due to both time and financial constraints, and that the interviews were conducted in four different countries. The other reason is that some of the chosen countries' tourism is still in its infancy stage, and their tour operators have not experienced the economic impact of HIV/AIDS yet.

The study was conducted on the tour operators because of financial constraints and also because a number of studies have been conducted on the hospitality sector but not so much on tour operators. Tour operators contribute significantly to the economy of Southern Africa and the aim of this study was to find out if the tour operators as a sub-sector of tourism sector face similar HIV/AIDS problems as indicated by many studies in hospitality sector. The organisations were chosen based on the status of their registration. This means that only the registered organisations were selected in their respective countries. From each country, 60 questionnaires were used to gather information.

People interviewed include company directors, managers and some general employees at different levels of company structures. Some government officials in the tourism sector in their respective countries were also interviewed. The reason for selecting these personnel instead on interviewing the general employees was that these people are involved in management of their respective companies, therefore are expected to have better understanding of the macro economic impact of HIV/AIDS in their respective organisations than the general employees. The other reason was to ensure quality of the information. The stratified random sampling method was used to select at least two respondents from each management level of the organisational structure in their respective departments. The survey was conducted through telephone and personal interviews.

To the research, the researcher designed the questionnaires which were evaluated in a pilot study. After the questionnaire was designed, ten copies were given to some tour operators and some government officials in the tourism sector to get their opinions and comments. The tour operators who took part in the pilot study are based in Cape Town. The purpose of the pilot

study was to detect possible flaws in measurement procedures, to find out if all questions were clear, and to identify any non-verbal behaviour by participants and also to see if they would be comfortable with the questions contained in the questionnaire. The outcome of the pilot study indicated that the participants were comfortable with most of the questions, and some adjustments were made based on the comments that were made.

The questionnaire was designed to survey the impact of HIV/AIDS on Southern African tourism and to determine how countries and organisations have responded to the pandemic. The questionnaire was designed to serve both the personal and telephonic survey approach and, for the most part, the questions were qualitative in nature. Furthermore, although some of the questions surveyed the facts or intent, most questions surveyed the perceptions of the respondents. In order to optimise participation in the study, few figures were used and questions were kept simple, and most of the questions required that the respondents simply "tick" the appropriate answer.

The company CEO, owners and managers of tourism organisations or the company executives that know best about the impact of HIV/AIDS on their tourism business completed the questionnaire. Given the position of these individuals in their companies and the nature of the questions, most of them completed the questionnaire within a few minutes.

The personal interviews were conducted in June 2006, and the respondents were personally given the questionnaire to answer. During this period, 28 people in Namibia were personally interviewed, 37 in South Africa, 33 in Zimbabwe and 39 people were interviewed in Botswana. The telephonic interviews were conducted from mid July to August using the same questionnaire and the questions consistently. Here, 13 people in Namibia, 14 in South Africa, 10 in Zimbabwe, and 6 in Botswana were telephonically interviewed. By 15 August 2006, 180 out of targeted 240 questionnaires were completed. The 240 targeted respondents were decided based on the number of people (60) in ten organisations in each one of the four countries in which the study was conducted. The stratified random sampling was used to identify the ten organisations. Here the major tourist destinations in each one of the four countries were identified, and 60 registered tourism organisations in each country were also identified. The stratified random sampling was used to identify ten organisations from each destination. Here the organisations were first identified according to their locations in their respective destinations, and from this ten organisations were sampled. From the ten organisations in each country 60 respondents were targeted to make a total of 240. The

number of respondents per organisation was not decided because organisations differ in their size and structure. To conduct the interview, the respondents from the management level in their respective organisations in each one of the four countries were identified and stratified random sampling was used to select two respondents from respective departments.

This study was aimed at the company executives and management because the nature of study was to examine the impact of HIV/AIDS in tourism business. By interviewing these dignitaries would help to capture quality data because these company executives have better understanding of the impact of HIV/AIDS in their respective businesses than most of general employee at lower levels of company structures. What transpired during the interviews was that a number of respondents did not feel comfortable to answer the questions telephonically. The overall response rate for the survey was 75%. This indicates that a high percentage of tourism companies within the surveyed countries participated in the study.

To be more specific, the executives that generally completed the questionnaire include the tourism company Chief Executive Officers, Managing Directors/Owner, Financial Managers/Accountants, Food and beverage Managers, Human resources Managers and some general employees in their respective countries.

In what follows, the sample of research results and participants' responses with regard to the impact of HIV/AIDS on the Southern African tourism are presented and discussed.

Before the research results are presented, it is imperative to consider the limitations of this type of research. To start with, only 75% of the intended population in the countries that were targeted actually responded to the survey. The second limitation of this research is the fact that a number of the questions in the survey test the perceptions of the population interviewed especially the tourism companies' executives and the government officials within tourism sector, rather than the core data like statistics. The other limitation is that, since the survey does not cover all the Southern African countries, or even all the tourism organisations within the selected countries, the results cannot be generalised to every individual country or company in the region.

TABLE 6.2: TOTAL NUMBER AND PERCENTAGE OF RESPONDENTS

EXECUTIVES	NUMBER OF RESPONDENTS	% RESPONSE
CEO	17	9%
General Managers	36	20%
Financial Managers	25	14%
Human resources Managers	37	21%
Food and beverage Managers	16	9%
Other employees	33	18%
Government Officials	16	9%
TOTAL	**180**	**100**

The results in the above table indicate that most people are concerned with HIV/AIDS in their companies. This is because they do participate in AIDS survey.

1. Are you aware that Southern Africa is the region in the world with the highest rate of HIV/AIDS infection?

The first question of the survey examined the level HIV/AIDS awareness in Southern Africa among the respondents. The table below presents the results indicating how the respondents answered the question:

TABLE 6.3: RESPONSE RATE IN EACH COUNTRY

COUNTRY	NUMBER ANSWERED YES	PERCENTAGE ANSWERED YES	NUMBER ANSWERED NO	PERCENTAGE ANSWERED NO
Namibia	37	90%	4	10%
South Africa	46	90%	5	10%
Zimbabwe	31	72%	12	28%
Botswana	42	93%	3	7%
Total	**156**	**86%**	**24**	**14%**

By observing the table, 86% of the respondents indicated that they were aware of the severity of HIV/AIDS in Southern Africa and 14% of the respondents indicated that they are not aware. This indicates that although much has been done to create HIV/AIDS awareness in Southern Africa, there need to engage in more HIV/AIDS awareness campaign.

2. The AIDS problem affects your country's tourism sector:

TABLE 6.4: TOTAL RESPONSE FROM EACH COUNTRY

COUNTRY	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Namibia	15	10	8	5	3
South Africa	23	17	6	3	2
Zimbabwe	18	14	2	5	4
Botswana	27	7	4	5	2
Total	**83**	**48**	**20**	**18**	**11**
%	**46**	**27**	**11**	**10**	**6**

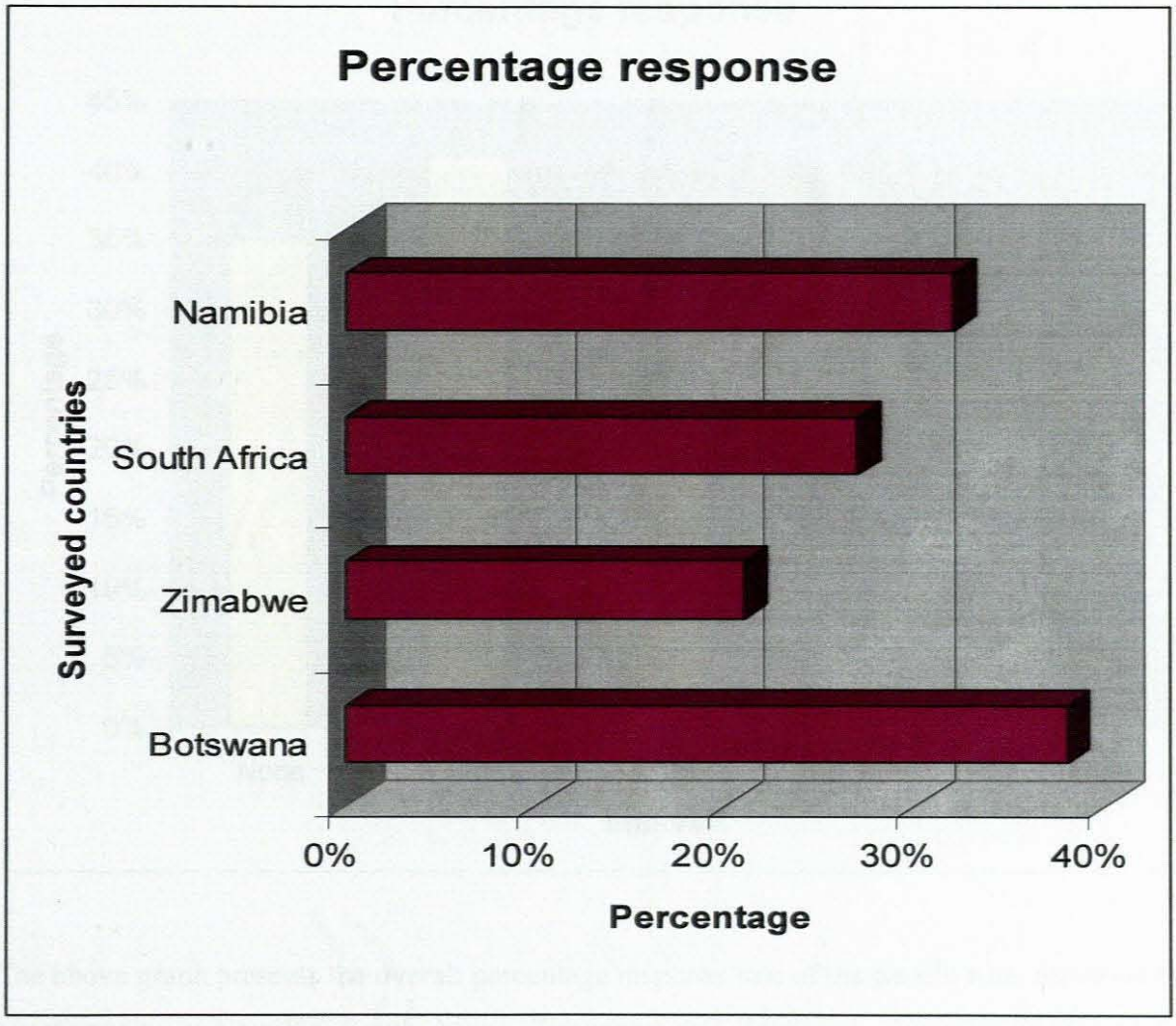
The results in question 2.1 indicate the impact of HIV/AIDS in a number of Southern African countries is experienced by a number of tourism organisations. This is because 46% of the respondents strongly agreed with the statement, and 27% also agreed.

3. Tourism is widely seen as one of your country's most important economic activity – creating jobs and attracting foreign income:

In answering question 96% of the respondents strongly agreed to the statement and 4% agreed but not strongly to the statement. These responses indicate that tourism contribute significantly to the Southern African economy.

4. In your day – to – day activities, is the AIDS problem directly affecting the running of your business?

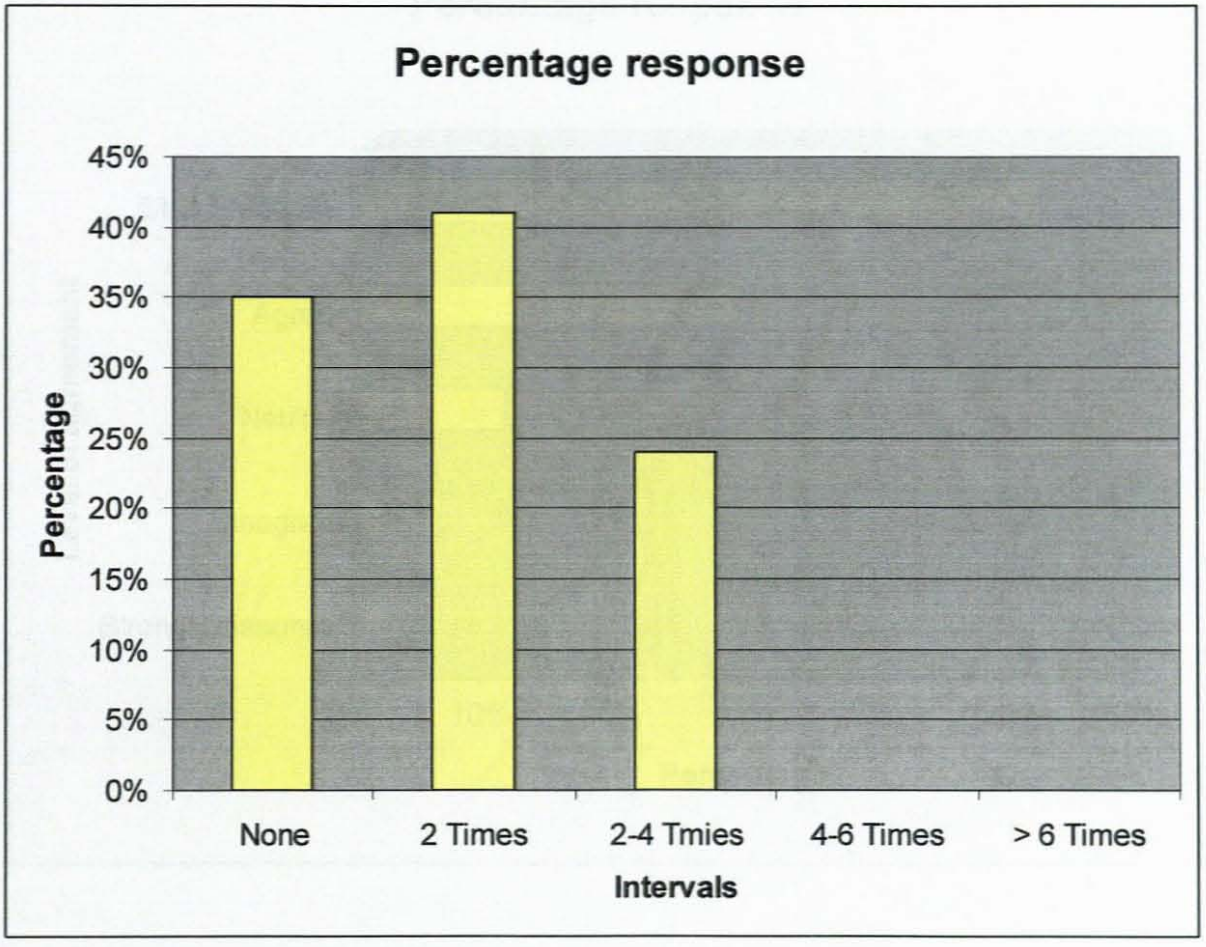
GRAPH 6.1: PERCENTAGE RESPONSE FOR EACH COUNTRY



The graph presents the response results of the company executives and managers who indicated that HIV/AIDS affects the day-to-day running of their businesses. To be specific on each country's response rate, Namibia is 32%, South Africa 27%, Zimbabwe 21% and Botswana 38% of the respondents in 40 tourism organisations. Based on these results, it is clear that the daily running of a number of tourism companies in the Southern African region is affected by the HIV/AIDS pandemic.

5. How many times does your organisation conduct employment interviews in every twelve months replacing workers who either die or leave the job due to HIV/AIDS related cases?

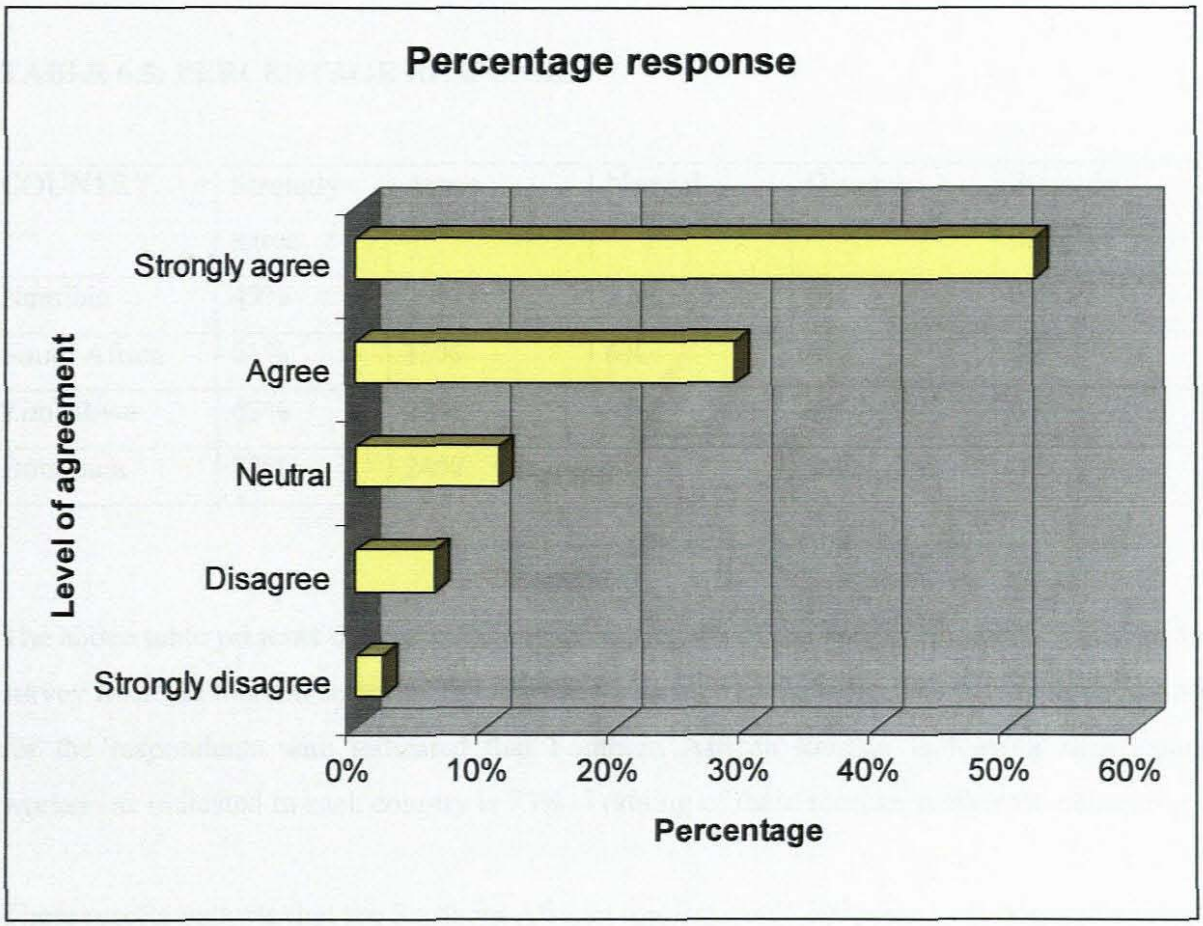
GRAPH 6.2: OVERALL PERCENTAGE RESPONSE



The above graph presents the overall percentage response rate of the people who answered the questionnaire in Namibia, South Africa, Zimbabwe and Botswana. The results indicate that 35% of the respondents indicated that they do not conduct any employment interview in 12 months resulting from the HIV/AIDS pandemic. However, 41% of the respondents indicated that they conduct employment interviews at least twice in 12 months to replace employees who have died or have left the job due HIV/AIDS-related illness. Furthermore, 24% of the respondents indicated that they conduct employment interviews at least two to four times in 12 months. These results indicate that HIV/AIDS has negative impact in tourism labour force resulting in employment costs.

5. Workers go on sick leave for lengthy periods – linked to HIV/AIDS:

GRAPH 6.3: OVERALL PERCENTAGE RESPONSE



The above graph presents the overall percentage response results of all the people in the tourism sector who participated in the survey in all four countries in which the survey was conducted. To be specific, 52% of the respondents strongly agreed with the statement indicating that the Southern African tourism sector experience a problem of some workers going on sick leave for a lengthy period attributed to HIV/AIDS. In addition to this, 29% of the respondents agreed with the statement but not so strongly, 11% were neutral, 6% disagreed and 2% of the respondents strongly disagreed with the statement.

This indicates that beside the four countries in which the study was conducted, the entire Southern African tourism sector could be faced with a serious problem attributed to HIV/AIDS. If employees take long sick leave, productivity and service quality become negatively affected. It is difficult for the companies to replace these employees even with

casual workers, especially if most of the people who go on sick leave for a lengthy period are the skilled workers.

7. Southern African tourism is loosing experienced workers who are difficult to replace:

TABLE 6.5: PERCENTAGE RESPONSE

COUNTRY	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Namibia	49%	29%	22%	0%	0%
South Africa	61%	33%	6%	0%	0%
Zimbabwe	63%	28%	9%	0%	0%
Botswana	73%	24%	3%	0%	0%

The above table presents the percentage response results of the people who participated in the survey from the tourism sector of the countries indicated in the table. The percentage response for the respondents who indicated that Southern African tourism is loosing experienced workers as indicated in each country is 73%. Training of these tourism workers is expensive.

These results indicate that the Southern African tourism could be loosing experienced workers due the HIV/AIDS pandemic. This study was carried in four of the Southern African countries, but looking at the results one could ascribe them to a number of other countries in the region.

HIV/AIDS impacts negatively on the Southern African Tourism Sector by killing the experienced and skilled tourism workers. Some organisations are reported to have some problems of poor quality service rendered because they operate with young inexperienced workers. A number of tourism organisations in Southern Africa experience costs resulting from continuous employment and regular interviews as a process to replace the lost employees due to HIV/AIDS. Some key employees are lost to HIV/AIDS.

In response to the pandemic, some organisations train their employees in different positions so that they can be able to perform different tasks so that if one person is ill or absent, they can have a replacement. This is costly because training people is expensive ad time wasting.

For example, the government of Botswana send large numbers of students to foreign countries for training not only in tourism course but in general. The government also has some policies in place to fight the pandemic. The public is offered AIDS drugs like Antiretrovirals free of charge by the government of Botswana.

The HIV/AIDS pandemic is severe not only in Southern African tourism but in general. Some of the people working in the Southern African tourism sector are infected and affected by the pandemic. Most people are aware of the HIV/AIDS pandemic, and messages are spread by the governments in their respective countries. Tourism plays a vital role in the Southern African economy by creating employment and attracting foreign income to a number of Southern African countries.

HIV/AIDS threatens Southern African tourism, and causes problems like workers absenteeism and prolonged sick leave. Some tourism companies in Southern Africa loose experienced workers who are difficult to replace, and this results in an increased cost of operations because of the need to replace the workers who die or who become sick for a long time. However, the tourism international market-base is not seriously affected and tourists still visit the region, but the local market is slightly affected.

The overall implication of these results is that the Southern African tourism is faced with some challenges resulting from HIV/AIDS, but with the efforts made by governments and private companies, the impact may be reduced. For example the provision for AIDS drugs like ARV prolongs the lives of people who are HIV positive, and may reduce high death rate in the region. But all these may work only if people change their risky behaviour, like using preventive measures to avoid constructing or spreading HIV/AIDS. The other implication is that a lot need to be done to educate tourism workers and the general public about HIV/AIDS.

This study is structured in six chapters. Chapter on is an introduction and background, chapter two covers tourism in Southern Africa and its contribution to the Southern African countries' economy, chapter three covers the HIV/AIDS situation in Southern Africa and response strategies, chapter four covers the impacts of HIV/AIDS on the Southern African tourism industry, chapter five is the research design/survey and results analysis, and chapter six is the conclusion of the whole project.

6.4 RECOMMENDATIONS

Based on the research findings, the following recommendations are proposed:

- More educational campaigns on issues surrounding the HIV/AIDS pandemic should be launched not only in urban areas but also in rural areas using the local languages.

- Southern African tourism companies and in general should include the HIV/AIDS programmes in their day-to-day business operation activities to educate and to encourage open communication among employees.
- The Southern African tourism companies and in general should conduct research in a collaborative approach to assess the impact of HIV/AIDS on their businesses.

- Where possible, the tourism companies should work with the community leaders to identify and discourage the risky behaviour that leads to the spread of HIV/AIDS.

- Tourism companies should openly talk to their employees about the HIV/AIDS pandemic on a regular basis and encourage them to go for voluntary counselling and testing, and to use the preventive measures like condoms.

- Southern African tourism companies should include HIV/AIDS programmes and treatment in their budgets for their infected and affected employees.

- Both the private and public tourism sectors should work together to enhance behavioural change among tourism employees, and to raise funds for educational programmes on issues surrounding the HIV/AIDS pandemic.

- The stakeholders from both the private and public tourism sectors should work together to draft a code of conduct that prevents risky behaviour, to which both visitors and residents of every tourists destination in Southern Africa should abide. This code of conduct must be included in the brochures, websites or in hotel menus to guide both visitors and locals on how they are expected to conduct themselves.

- Risky behaviour activities like sex tourism and commercial sex/prostitution should be discouraged in Southern African countries.

- HIV/AIDS programmes should be incorporated in both rural and urban primary schools' educational programmes to educate the young people about the pandemic. This will help the young people, as future leaders, to know the risky behaviour leading to HIV/AIDS infection.
- Southern African governments should work together to alleviate poverty in the region through identification of strong and informed leadership.

- The governments in the region should work hand-in-hand to devise strategies to fight the HIV/AIDS pandemic in a collaborative approach and to assist those countries in Southern Africa that cannot afford to purchase the HIV/AIDS treatment like ARV drugs.

- Southern African countries should establish a standing HIV/AIDS committee, which is responsible for the HIV/AIDS strategic planning, formulation, implementation and evaluation. This committee would make continuous assessments to evaluate progress of all Southern African countries in aspects of poverty alleviation activities.

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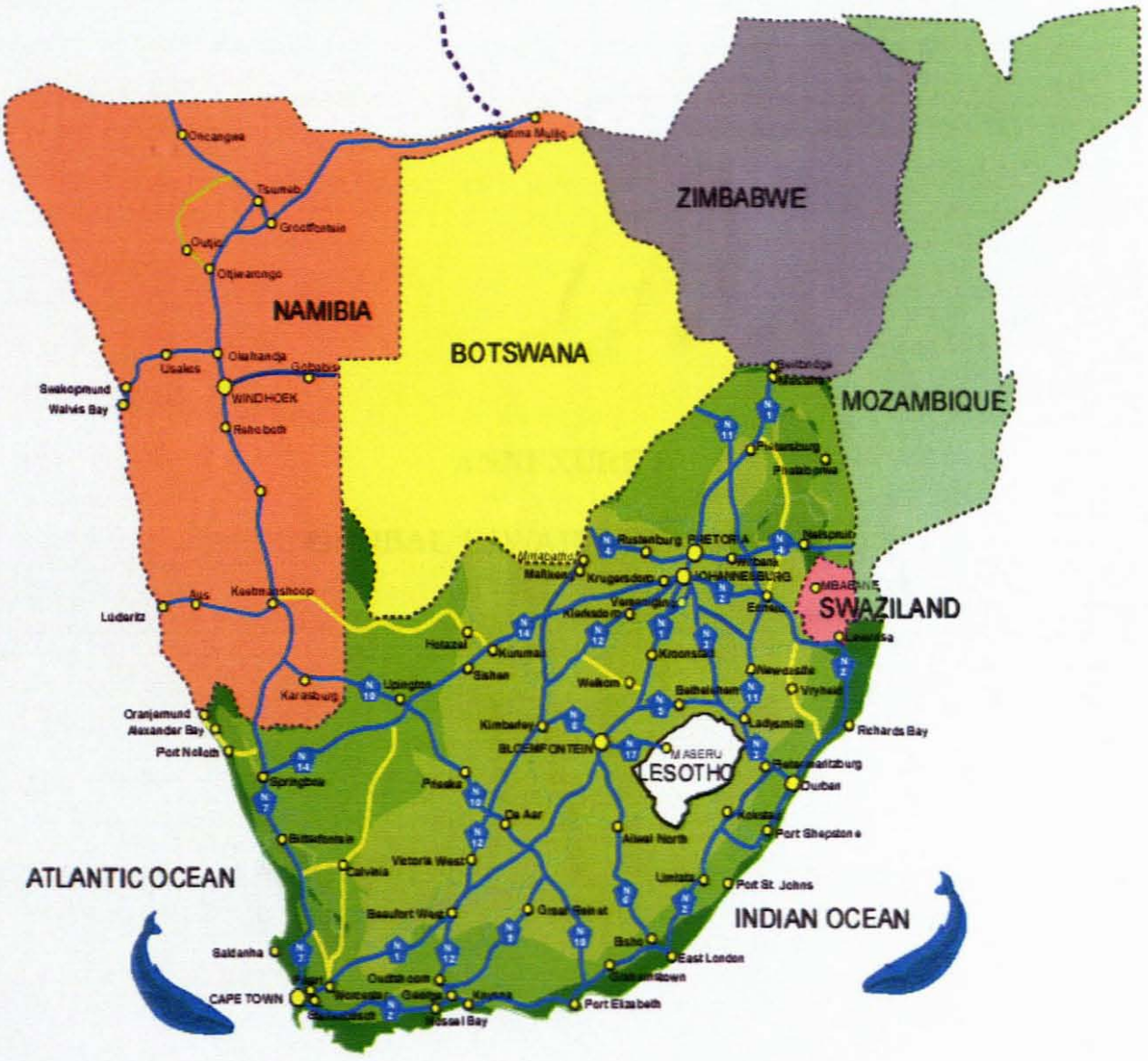
ANNEXURE A

MAP OF SOUTHERN AFRICA

MAP OF SOUTHERN AFRICA



Source: Sun Cape (2003 – 2007)

ANNEXURE B

GLOBAL HIV/AIDS STATISTICS

People living with HIV/AIDS (adults and children)
2005

Rank Table by: Country Name Number

Rank	Country Name	Number
	Global	38,600,000
98	Afghanistan	<1000
101	Albania	NA
59	Algeria	19,000
101	American Samoa	NA
101	Andorra	NA
20	Angola	320,000
101	Anguilla	NA
101	Antigua and Barbuda	NA
32	Argentina	130,000
91	Armenia	2,900
101	Aruba	NA
62	Australia	16,000
66	Austria	12,000
80	Azerbaijan	5,400
77	Bahamas	6,800
98	Bahrain	<1000
67	Bangladesh	11,000
92	Barbados	2,700
58	Belarus	20,000
64	Belgium	14,000
88	Belize	3,700
36	Benin	87,000
101	Bermuda	NA
99	Bhutan	<500
76	Bolivia	7,000
99	Bosnia and Herzegovina	<500

21	Botswana	270,000
101	Bouvet Island	NA
14	Brazil	620,000
101	British Indian Ocean Territory	NA
101	British Virgin Islands	NA
100	Brunei Darussalam	<100
99	Bulgaria	<500
30	Burkina Faso	150,000
30	Burundi	150,000
32	Cambodia	130,000
16	Cameroon	510,000
45	Canada	60,000
101	Cape Verde	NA
101	Cayman Islands	NA
23	Central African Republic	250,000
27	Chad	180,000
54	Chile	28,000
13	China	650,000
101	Christmas Island	NA
101	Cocos (Keeling Islands)	NA
29	Colombia	160,000
99	Comoros	<500
33	Congo	120,000
10	Congo (Dem. Republic of)	1,000,000
101	Cook Islands	NA
74	Costa Rica	7,400
12	Cote d'Ivoire	750,000
99	Croatia	<500
85	Cuba	4,800
99	Cyprus	<500
95	Czech Republic	1,500
78	Denmark	5,600
63	Djibouti	15,000
101	Dominica	NA
42	Dominican Republic	66,000

57	Ecuador	23,000
81	Egypt	5,300
50	El Salvador	36,000
71	Equatorial Guinea	8,900
46	Eritrea	59,000
68	Estonia	10,000
101	Ethiopia	NA
101	Faeroe Islands	NA
101	Falkland Islands (Malvinas)	NA
98	Fiji	<1000
94	Finland	1,900
32	France	130,000
101	French Guiana	NA
101	French Polynesia	NA
101	French Southern Territories and Antarctic Lands	NA
45	Gabon	60,000
58	Gambia	20,000
78	Georgia	5,600
47	Germany	49,000
20	Ghana	320,000
101	Gibraltar	NA
70	Greece	9,300
101	Greenland	NA
101	Grenada	NA
101	Guadeloupe	NA
101	Guam	NA
44	Guatemala	61,000
37	Guinea	85,000
51	Guinea-Bissau	32,000
66	Guyana	12,000
26	Haiti	190,000
101	Heard Island and McDonald Islands	NA
43	Honduras	63,000
90	Hungary	3,200
99	Iceland	<500

1	India	5,700,000
28	Indonesia	170,000
42	Iran (Islamic Republic of)	66,000
101	Iraq	NA
83	Ireland	5,000
87	Israel	4,000
30	Italy	150,000
56	Jamaica	25,000
61	Japan	17,000
101	Johnston Atoll	NA
98	Jordan	<1000
66	Kazakhstan	12,000
7	Kenya	1,300,000
101	Kiribati	NA
101	Korea (Dem. Peo. Rep. of)	NA
65	Korea (Republic of)	13,000
98	Kuwait	<1000
87	Kyrgyzstan	4,000
88	Lao People's Democratic Rep.	3,700
68	Latvia	10,000
91	Lebanon	2,900
21	Lesotho	270,000
101	Liberia	NA
101	Libyan Arab Jamahiriya	NA
101	Liechtenstein	NA
89	Lithuania	3,300
98	Luxembourg	<1000
99	Macedonia (The former Yugoslav Republic of)	<500
47	Madagascar	49,000
11	Malawi	940,000
40	Malaysia	69,000
101	Maldives	NA
32	Mali	130,000
99	Malta	<500
101	Marshall Islands	NA

101	Martinique	NA
66	Mauritania	12,000
86	Mauritius	4,100
101	Mayotte	NA
27	Mexico	180,000
101	Micronesia (Federated States of)	NA
101	Midway	NA
53	Moldova (Republic of)	29,000
101	Monaco	NA
99	Mongolia	<500
101	Montserrat	NA
59	Morocco	19,000
4	Mozambique	1,800,000
18	Myanmar	360,000
24	Namibia	230,000
101	Nauru	NA
39	Nepal	75,000
60	Netherlands	18,000
101	Netherlands Antilles	NA
101	New Caledonia	NA
96	New Zealand	1,400
75	Nicaragua	7,300
38	Niger	79,000
3	Nigeria	2,900,000
101	Niue	NA
101	Norfolk Island	NA
101	Northern Mariana Islands	NA
93	Norway	2,500
101	Oman	NA
37	Pakistan	85,000
101	Palau	NA
61	Panama	17,000
45	Papua New Guinea	60,000
65	Paraguay	13,000
35	Peru	93,000

66	Philippines	12,000
101	Pitcairn Island	NA
56	Poland	25,000
51	Portugal	32,000
101	Puerto Rico	NA
101	Qatar	NA
101	Reunion	NA
76	Romania	7,000
11	Russian Federation	940,000
26	Rwanda	190,000
101	Saint Helena	NA
101	Saint Kitts and Nevis	NA
101	Saint Lucia	NA
101	Saint Vincent and the Grenadines	NA
101	Samoa	NA
101	San Marino	NA
101	Sao Tome and Principe	NA
101	Saudi Arabia	NA
44	Senegal	61,000
68	Serbia and Montenegro	10,000
101	Seychelles	NA
48	Sierra Leone	48,000
79	Singapore	5,500
99	Slovakia	<500
99	Slovenia	<500
101	Solomon Islands	NA
49	Somalia	44,000
2	South Africa	5,500,000
31	Spain	140,000
83	Sri Lanka	5,000
19	Sudan	350,000
82	Suriname	5,200
101	Svalbard and Jan Mayen Islands	NA
25	Swaziland	220,000
73	Sweden	8,000

61	Switzerland	17,000
101	Syrian Arab Republic	NA
84	Tajikistan	4,900
6	Tanzania (United Rep. of)	1,400,000
15	Thailand	580,000
101	Timor Leste	NA
34	Togo	110,000
101	Tokelau	NA
101	Tonga	NA
55	Trinidad and Tobago	27,000
72	Tunisia	8,700
97	Turkey	<2000
99	Turkmenistan	<500
101	Turks and Caicos Island	NA
101	Tuvalu	NA
10	Uganda	1,000,000
17	Ukraine	410,000
101	United Arab Emirates	NA
41	United Kingdom	68,000
8	United States of America	1,200,000
69	Uruguay	9,600
52	Uzbekistan	31,000
101	Vanuatu	NA
34	Venezuela	110,000
22	Viet Nam	260,000
101	Virgin Islands (U.S.)	NA
101	Wake Island	NA
101	Wallis and Futuna Islands	NA
101	West Bank and Gaza	NA
101	Western Sahara	NA
101	Yemen	NA
9	Zambia	1,100,000
5	Zimbabwe	1,700,000

and the United Kingdom.

Definitions: HIV: human immunodeficiency virus, the virus that causes AIDS; AIDS: acquired immunodeficiency syndrome.

Sources: UNAIDS, 2006 Report on the Global AIDS Epidemic, May 2006, available at: http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.

ANNEXURE C

RESEARCH QUESTIONNIRE

St. Martini Gardens
4.28 Queen Victoria Road
Cape Town
8000

17 May 2006

TO WHOM IT MAY CONCERN

I am a student from Cape Peninsula University of Technology in Cape Town (South Africa). I am studying M–Tech in Tourism and Hospitality Management. I am currently working on a research dissertation to investigate the possible impact of HIV/AIDS on the Southern African tourism sector. As part of this research, I am conducting telephonic and personal interviews with a number of tour operators and government officials within the tourism sector in Southern Africa. I would like to ask you to answer the questions on the attached questionnaire if possible. The questions are fairly broad and not of a personal nature, and the answers will not in any case reflect on the particular persons interviewed or the people employed.

Your co-operation will be highly appreciated.

Yours Faithfully

Lisbon Simeon Ketshabile

QUESTIONNAIRE

HIV AND AIDS AS A THREAT TO SOUTHERN AFRICAN TOURISM

*Country*_____ *Date*_____

1. Are you aware that Southern Africa is the region in the world with the highest rate of HIV/AIDS infection? Yes_____ No_____

2. (Please indicate your level of agreement with the following statement about AIDS and tourism in your country)

2.1 The AIDS problem affects your country's tourism sector:

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

2.2 Tourism is widely seen as one of your country's most important economic activity – creating jobs and attracting foreign income:

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

3. How many people are working in your department/organisation?

<50	51 - 60	61 - 70	71 - 80	81 - 90	91 - 100	>100 (specify)

4. In your day – to – day activities, is the AIDS problem directly affecting the running of your business? Yes_____ No_____

If **Yes,** would you please briefly explain how AIDS affect your daily business_____

5. How long have you been operating your business?

<2 years	2 – 5 years	5 -10 years	10 –15years	15 – 20 years	>20 years

6. How many times do your organisation conduct employment interview in every twelve months as a result of loss of employees due to HIV/AIDS related cases?

None	<2 Times	2 – 4 Times	4 – 6 Times	> 6 Times (specify)	

7.1 What is your age? **(employees only)**

< 20	21 - 30	31- 40	41 - 50	51 - 60	> 60 (specify)

7.2 How long have you been working for this organisation/department?

<1 year	1– 3 years	3 – 5 years	5 – 7 years	7 – 9 years	> 9 years

7.3 Highest education level completed:

Primary	Secondary	Certificate/Diploma
Undergraduate degree	Postgraduate degree	Other (Specify)

7.4 Your position in the organisation:

General Manager	Human Resources Manager	Financial Manager	Food and Beverage Manager	Others

8. **(All),** Talking not only about your firm, but in general about tourism business known to you, which of the following problems could be facing tourism industry in Southern Africa today? **(Please tick one of the five answers provided).**

8.1 Workers go on sick leave for lengthy periods – linked to HIV/AIDS:

Strongly agree	Agree	Neutral	Disagree	Strongly Disagree

8.2 Southern African tourism is loosing experienced workers who are difficult to replace:

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

8.3 The cost of operations increase because of the need to replace those absent due to illness:

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

8. 4 Tourists clients are being lost due to HIV/AIDS 'threats':

Strongly agree	Agree	Neutral	Disagree	Strongly disagree

9. What are the firms/departments doing about these and related problems?

_____

_____

10. Do you expect the AIDS problems to become much worse in future? **(Please explain why)**

_____

_____

11. Do you think that the Governments in Southern Africa could do something to help address these problems? **(Please briefly explain your answer)**

_____

_____

12. Do you often discuss these problems with other tour operators/organisation? **(Please briefly explain your answer)**

_____

_____

13. Do you think that the Southern African tourism sector could be seriously threatened by the AIDS pandemic? **(Please briefly explain your answer)**

_____

_____

Thank you for your cooperation.

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