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HIRING PATTERNS, FIRM-LEVEL DYNAMICS AND HIV/AIDS: A CASE STUDY OF SMALL FIRMS ON THE CAPE FLATS

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Abstract

This paper explores firm-level responses to HIV/AIDS. Case studies of seven small manufacturing firms on the Cape Flats failed to record any reported HIV prevalence or any perceived increases in costs due to HIV/AIDS for any of the firms interviewed. However, an interesting picture of labour practices at the bottom end of the formal job market emerged. Small firms look after their skilled workers, but take on and dismiss unskilled workers at a high rate. Small firms do not pay medical benefits and recruit using a well-developed community network to identify good workers. These companies are thus less likely to incur significant AIDS-related costs on the production side. There is anecdotal evidence that the impact of AIDS will be on the demand side with firms perceiving that customers avoid infected workers in service provision.

Introduction

There is a growing pool of research on the impact of HIV/AIDS at the firm level (see e.g. Nattrass, 2002). Responses of firms to AIDS seem to vary a great deal. A study of a Natal sugar mill found that the cost of hiring and training workers almost doubled as a result of HIV/AIDS but health care expenditure was not prominent because of the public health system available (Morris & Cheevers, 2000). Rosen *et al* (2000) focused their study on the impact of HIV/AIDS on pension benefits, service gratuities, death benefits for HIV positive workers, costs relating to sick leave and recruitment and training of replacement workers. This study found that medical interventions that increase life expectancy reduce the aforementioned costs. Booysen and Molelekoa (2001) surveyed twenty firms in the Bloemfontein and Welkom area and found that only a quarter of these firms offer medical benefits. These benefits were mostly offered to skilled workers. Their study determined that HIV/AIDS-related costs are sensitive to skill level.

This study hoped to build on available research by assessing the impact of HIV/AIDS on small firms. It aimed to go further than other studies by

highlighting the policies and practices which firms implement in response to HIV/AIDS. In order to achieve these aims a case study was conducted, using seven small manufacturing firms on the Cape Flats. These firms are located in the Ottery and Heathfield industrial areas. Ottery and Heathfield are two suburbs south of Cape Town.

Background on Heathfield and Ottery

Figure 1: Map of Cape Town

Figure 1 represents a map of Cape Town. Heathfield and Ottery industrial areas are located between Muizenberg, the M3 and Cape Town international Airport. Both areas are within 50km of Muizenberg.

In 1996, Statistics South Africa conducted South Africa's first post-Apartheid population census. This census is known as Census '96. It provided a snap shot of South Africa's 40, 58 million people. Census 1996 was used to create a demographic breakdown of Ottery and Heathfield (see Table 1).

Table 1: Population group, Heathfield

African/Black	***Coloured***	***Indian/Asian***	***White***	***Total***
114	2 789	70	1 325	4 298
2.65%	64.89%	1.63%	30.83%	100%

Heathfield is a predominantly coloured community with 64.8% of people living in the area classified as coloured. The second largest population group in this area is white. Indians and Asians are a minority group in this area.

Table 2: Population group, Ottery

African/Black	***Coloured***	***Indian/Asian***	***White***	***Total***
245	3 910	297	1 956	6 408
3.82%	61.02%	4.63%	30.52%	100%

Ottery is very similar to Heathfield in that it is also a predominantly coloured community. A little over 30% of the individuals living in this area are white. During the Apartheid era both Ottery and Heathfield had certain areas reserved for whites. Many coloureds lived on the other side of these reserved areas. Africans and Asians were always small minority groups in both these areas.

Table 3: Gender, Heathfield

African /Black		***Coloured***		***Indian /Asian***		***White***		***Total***	
Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
48	66	1 260	1 529	30	40	592	733	1 930	2 368
2.49%	2.79%	65.28%	64.57%	1.55%	1.69%	30.67%	30.95%	100%	100%

Both Heathfield and Ottery have more females than males.

Unemployment in Heathfield and Ottery is not very high (Appendix A, Tables 1 & 2). In Heathfield, the majority of individuals in the labour force, that earn an income, earn within the range of R1001-R8000 (Appendix A, Table 4). In Ottery, the majority of individuals in the labour force, that earn an income, earn within the range R201-R6000 (Appendix A, Table 3).

Table 4: Gender, Ottery

African /Black		***Coloured***		***Indian/Asian***		***White***		***Total***	
Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
123	122	1 825	2 085	134	163	978	978	3 060	3 348
4.02%	3.64%	59.64%	62.28%	4.38%	4.87%	31.96%	29.21%	100%	100%

The Expected Impact of HIV/AIDS on the Economy

In December 2002 it was estimated that 42 million people are living with HIV/AIDS. Of this total, 29, 4 million infected individuals (70% of the world's HIV infected) live in Sub-Saharan Africa. Of the 5 million people newly infected with HIV in 2002, 3, 5 million live in Sub-Saharan Africa. 2, 4 million (77%) of the world's 3, 1 million AIDS deaths were in Sub-Saharan Africa (www.unaids.org, 2003).

Some African countries however, appear to have managed to stabilise or slow down increases in their prevalence rates. Uganda is an example of a country that implemented a very successful prevention campaign. Unfortunately most countries in Sub-Saharan Africa have not managed to duplicate Uganda's success. South Africa is an example of a country that has been slow in developing a comprehensive strategy to slow down the growth of the HIV/AIDS epidemic. This failure could hinder its economic development and the economic development of the entire Sub-Saharan region (Barks-Ruggles, 2001).

There is a belief that South Africa is capable of spearheading the African continent's economic development. In 1999 South Africa produced roughly one-third, US$131,1 billion, of Sub-Saharan Africa's (S.S.A's) total US$324 billion Gross Domestic Product (GDP). However, the ING Barings model estimates that the percentage of South Africa's contribution to total African GDP could decline by 0.4 percent per year as the result of HIV/AIDS. All macroeconomic models of the impact of AIDS on the South African economy indicate that it will slow the rate of growth (Nattrass, 2002). The impact of HIV/AIDS on the South African economy, through reducing GDP, would significantly impact Sub-Saharan Africa's total GDP (Barks-Ruggles, 2001).

The Impact that HIV/AIDS is Expected to have on the Labour Force

The section presents some of the ways in which HIV/AIDS is expected to impact the labour force.

Individuals in the workforce are naturally in the most sexually active period of their lives (Evian, 1991). In South Africa it has been estimated that AIDS-related deaths peak when individuals are at their prime productive age. AIDS-related deaths for females peak at 25-29 years, while male deaths peak at 30-35 years (Dorrington *et al*, 2001). The productive labour force, in other words, is comprised of individuals who are in the high-risk category of contracting and dying from HIV/AIDS.

The Director-General of the International Labour Organisation (ILO), Juan Somavia, reported that of the total number of people infected with HIV/AIDS, 23 million can be found in the workplace (UNAIDS epidemic update December 2001).

HIV/AIDS is expected to affect the average age of workers. A top health official has warned that some African countries could lose a quarter of their workforce to AIDS in the next 20 years (Croft, 2002). HIV/AIDS obviously affects average life expectancy. In South Africa it is estimated that if AIDS were not a factor, life expectancy would have been 66 years (Dorrington *et al*, 2001). However, because of HIV/AIDS the average life expectancy is only 47 years. On average HIV/AIDS is expected to shear 19 years off individuals' lives in South Africa (*ibid.*). This means that on average workers would die before they were even eligible to retire, which usually occurs between the ages of 55-60.

HIV positive workers eventually become AIDS-sick as their illness progresses. AIDS-sickness results in fatigue and it makes workers more susceptible to opportunistic infections. AIDS-sick workers need more sick leave and they get tired a lot quicker than HIV negative workers. Illness erodes HIV positive workers' capacity for physical and intellectual work. Once workers become AIDS-sick their disease will eventually, in the absence of anti-retroviral treatment, diminish their ability to perform their duties. Their inability to perform their duties will eventually force them to leave the relevant firm.

One of the objectives of South Africa's Employment Equity Act, 1998 (Act No.55 of 1998) is to prevent discrimination against HIV positive individuals in the workplace (Government Gazette, Dec. 2001). Labour laws protect workers from being fired simply because they are HIV positive. The Employment Equity

Act 1998 would view providing HIV negative workers with more training than their HIV positive colleagues as a form of discrimination.

Firms view training as an investment because training develops workers' existing skills. Better skilled workers are likely to be more efficient and productive. Firms would therefore want to provide HIV negative workers with more training because when workers are lost, firms lose the training that they have invested in the relevant workers. By focusing on the rights of HIV positive workers to be treated equally, labour laws thus force employers to assume that the productive lifespan of anyone that they train is shorter. Thus, the incentive to support long-term training, in the absence of anti-retroviral treatment, is reduced and all workers are likely to receive less training (Barks-Ruggles, 2001).

Even though all workers receive less training, educated workers are likely to receive more training than uneducated workers. Economic theory states that education can be positively correlated with the ability to learn. Firms that accept this theory would probably believe that educated workers could be trained at less cost (Berndt, 1991). Since training builds skill, educated workers tend to be more skilled than uneducated workers. Anderson (2002) suggests that in South Africa individuals with higher levels of education tend to get married, for the first time, at a later age. His paper suggests that getting married at a later age, coupled with naturally being very sexually active during their productive years, increases the risk of educated workers becoming HIV infected. According to this theory HIV/AIDS is expected to affect skilled and educated workers more than unskilled workers. This hypothetical theory supports the idea that firms may suffer a great loss of skill and expertise because they will lose educated, trained and skilled workers.

Anderson's theory focuses on the role that sexual activity plays in the transmission of HIV. Looking at sexual behaviour as well as malnutrition, urbanisation and unequal distribution of income provides a more comprehensive background for understanding the transmission of HIV. There is evidence that poor people are particularly at risk of contracting AIDS because malnutrition reduces the body's ability to fight it (Stillwaggon, 2000). This suggests that unemployed and poorly-paid workers are at greater risk of contracting the disease. However, if Anderson is correct then skilled workers may also be at risk (on the grounds that they are more promiscuous). On the other hand, according to the recent Human Sciences Research Council's (HSRC) national survey, people with post-school qualifications have lower HIV prevalence (Shisana & Simbayi, 2002: 54).

As stated, HIV/AIDS causes workers to become ill and debilitated. When workers are ill they stay out of work. Illness disrupts work schedules because

organisations will have to replace workers and/or rearrange workers' schedules, perhaps by having some workers work overtime, to compensate for the loss of labour. Absenteeism might even create a 'cycle of absence' where healthy workers do the work of sick workers and then, because they are over-worked, they could also become ill and be forced to stay out of work. Hence, the absence of AIDS-sick workers could result in the loss of valuable productive worker time.

Morale and productivity can be affected by the death of an HIV positive worker. When a worker dies morale is lowered because co-workers grieve the loss of a fellow worker. A co-worker's death also makes workers more aware that AIDS is a terminal disease. This could increase workers' fears of being infected by an HIV positive co-worker. Some workers may refuse to work with HIV positive workers because they fear that they could somehow contract the disease. The refusal of some workers to work with HIV positive workers could disrupt work schedules. HIV positive workers would then be assigned to working with workers who want to work with them, as opposed to working with workers who have the same level of skill or experience. Rearranging workers in this way could result in the members of a group of workers all having varying levels of skill, experience and capability. This could have a negative impact on the efficiency and productivity of the relevant group.

Methodology for Assessing the Quantitative Impact of HIV/AIDS on Firms

Aventin and Huard (2000) conducted a quantitative and a qualitative study of the impact of AIDS on three manufacturing firms in Cote d'Ivoire. Their study provides a methodology for assessing the economic impact of HIV/AIDS on firms because they identified HIV/AIDS-related costs that firms will incur.

Aventin and Huard adopted a 'two stage' methodology: involving a quantitative and qualitative assessment. The quantitative assessment looks at the 'direct' and 'indirect' costs of HIV/AIDS. These costs are then further divided into 'quantifiable' and 'difficult to quantify' costs. Quantifiable costs are: pension and provident fund contributions, service bonuses, absenteeism and sick leave, death and funeral benefits, in-firm medical services and the costs of recruiting and training replacement workers. Costs that are difficult to quantify are the impact of HIV/AIDS on worker productivity and morale. In the second stage of their assessment they supplement the quantitative data with qualitative data. For example, they look at the impact that HIV/AIDS has on socialisation (i.e. the process by which individuals gradually adopt the characteristics of the group

into which they are integrating). It is difficult for individuals to be integrated into a pool of workers that continually changes because people are ill or die (Kennedy, 2001).

This paper adopts the first stage of Aventin and Huard's methodology by conducting a quantitative assessment of the impact of HIV/AIDS on seven small firms on the Cape Flats. In order to estimate direct costs, studies often have to make assumptions regarding a firm's HIV prevalence (unless of course the firm has conducted an HIV prevalence study).

This study did not test for HIV prevalence. However, the owners of the small firms interviewed appear to have close relationships with their employees. Unlike the owners of big firms, the owners of small firms are more likely to be actively and directly involved in the daily running of their firms. Small firms also have a much smaller labour force than medium and big firms. Thus, close and continual contact with their workers may allow owners of small firms to get to know their workers well. If these close relationships do exist, it is possible that owners in small firms are more likely to know whether their workers are HIV positive. However, this is more likely to be the case when small firms employ friends and family members.

Compiling the Questionnaire

Both a structured questionnaire (Appendix B) and interview style were developed to elicit narratives on HIV/AIDS-related costs that small firms may have incurred. The author conducted the personal interviews and completed the questionnaire for all firms.

In order to create an environment of trust and to build a dialogue with the respondent, a confidentiality agreement was signed (Appendix C) before conducting the interview.

There is a stigma surrounding HIV/AIDS, which can make it difficult to talk about the disease. To prevent respondents from clamming up before commencing the interview, the focus of the study was cast in broad health terms. When respondents had questions regarding the purpose of the interview they were told, as stated in the confidentiality agreement, that the study was intended for research into changes in health-related costs incurred by small firms on the Cape Flats.

Firms might prefer to keep the HIV status of their workers a secret because they do not wish to be discriminated against by customers. Employers could perceive

that customers will avoid infected workers in service provision. For example, a customer might not want an HIV positive artisan coming into their home, hurting himself and then bleeding on their floor. It would be in this firm's best interest to not disclose the HIV status of their artisans because of their perception that it could be detrimental to their business. In order to remove any possible fears of discrimination, respondents were assured that their name and the name of the firm would be kept confidential.

Attention was paid to the ordering of the questions and the way the questions were worded. The questions were as simple and direct as possible. There was always a close-ended 'yes' or 'no' question, followed by an explanation of the respondent's answer.

The ordering of the questions served to build a dialogue with the respondent. The first seven questions were general questions to provide a basic description of the firm. Sixteen questions preceded the question regarding the respondent's knowledge of the HIV status of workers. The respondents were reminded about the signed confidentiality agreement before they were asked the seventeenth question (which was about HIV status).

Questions 8-16 were intended to identify changes in HIV/AIDS-related costs (worker absenteeism, contributions by the business to health insurance and medical aid, worker fatigue, the number of new workers, workers with T.B, and productivity levels). Changes in any of these costs could provide some indication of worker's HIV status, even if the respondent did not know the HIV status of the firm's workers.

Questions 17-24 directly referred to the HIV status of workers. They aimed to determine whether the respondent was aware of the incidence of HIV among workers. They also aimed to determine:

- Whether the firm had changed in any way in response to HIV/AIDS
- The impact that HIV/AIDS had had on morale
- The respondents' concerns about HIV/AIDS and the future of the firm

A lot of consideration went into compiling the questionnaire but it is not exempt from criticism. 'Skill level' in question 7 was not clearly defined and the answers vary according to the respondent's understanding of 'skill'.

Deciding who to Interview

Initially firms were telephoned in order to arrange an interview, but this proved unsuccessful. Individuals used excuses like 'I'm too busy' or simply refused. Ultimately, interviews were conducted without pre-arrangement. Even though there were still some rejections, people were a lot more willing to be interviewed when asked in person as opposed to being asked over the telephone. Sometimes after an interview the respondent would direct the researcher to another business. If no one steered the researcher in any direction, a business was randomly chosen. This method of interviewing is known as the 'snowball sampling method'. The seven firms thus cannot be regarded as 'representative' of small firms in the area. The results of the study must thus be regarded as indicative only.

Aventin and Huard (2000) chose to study large firms with salaried company doctors. All the firms they chose had kept a register of employees that were notified to be HIV positive since at least 1993. All the small firms that were used in this study did not have a salaried doctor. However, given the fairly close relationships that existed between workers and owners in many cases, it is possible that owners would learn about HIV status through informal means. However, it should also be noted that, given the stigma which surrounds AIDS, workers may still prefer not to disclose their status – even to those close to them.

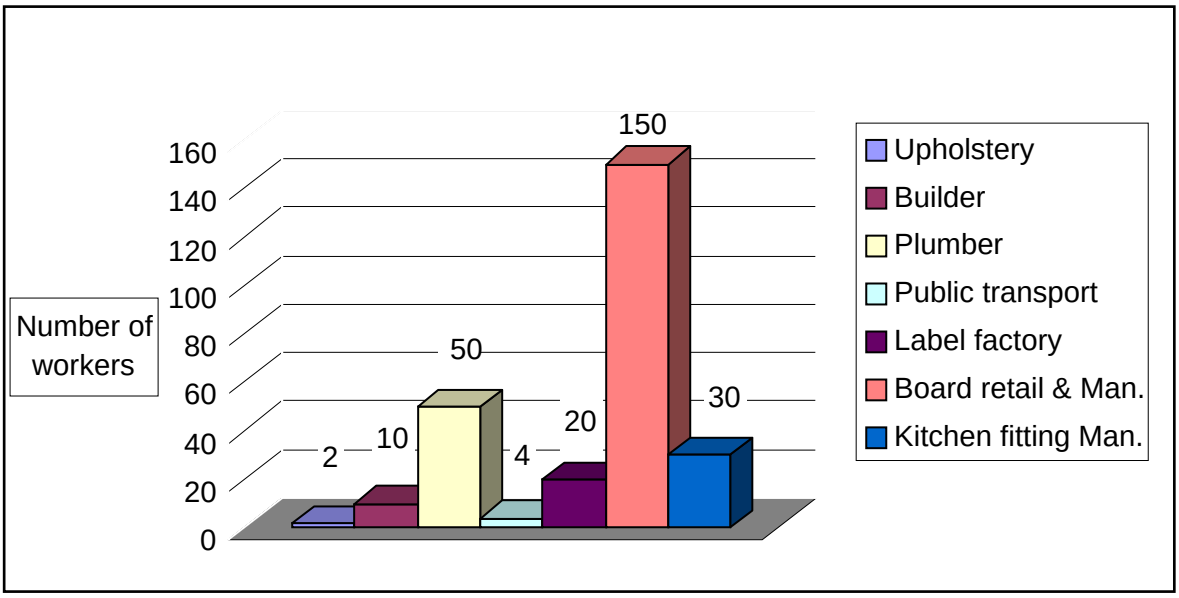
Main Findings

Instead of producing the clear-cut changes in costs that Aventin and Huard had identified, this case study produced a variety of interesting insights into the nature of labour relations and labour costs in small firms.

Background on the Businesses Interviewed

Seven firms in various lines of business were interviewed. They included: upholstering, building, plumbing, public transport, a label factory, board retail and manufacturing, and kitchen fitting manufacturing. The smallest firm employed 2 workers and the biggest firm employed 150 workers. Figure 2 provides details of the nature of the business and the number of workers in each firm.

Figure 2: The nature of the firms and the number of workers in each



Firms with only 10 or fewer workers were retained in the case study because the impact that HIV/AIDS has on a firm is not expected to be dependant on its size. If a firm has 2 workers and it loses 1 worker it would have the same impact on the firm as a firm with 50 workers losing 25 workers. The firm with 2 workers might even feel a greater impact because, unlike the firm with 25 present workers, there would be no other workers to substitute for the lost worker. Both firms would lose productive worker time and sustain costs relating to the recruitment of new workers. Therefore, this study viewed the impact of HIV/AIDS on firms with few workers as being as significant as its impact on firms with many workers.

Within the past decade, South Africa has begun to observe the impact of HIV/AIDS on its population. According to the ASSA2000 demographic model in 2002, 334 000 people were expected to have died of AIDS, i.e. 45% of total deaths for that year. All the firms interviewed had been in operation for at least 7 years. Thus, they had all been operating long enough to observe any impact that HIV/AIDS might have had on their firms. Table 5 reports the number of years that each firm has been in operation.

In order to remove any uncertainty as to whether ‘skill level’ referred to years of education, or the nature of the work that a worker performed, it was decided that skill would refer to the nature of the work. Workers that performed secretarial, administrative or management functions or were artisans, were considered skilled. For example, the builder referred to his electrician and tile layer as

skilled, while workers who mixed cement were considered unskilled. The answers to the question referring to skill are subjective but all the firms appeared to have a mixture of skilled and unskilled workers (Table 6, which summarises firms' responses to the questionnaire).

Table 5: The number of years that each business has been operating

	Number of years in business
Upholstery and repairs	13
Builder	7
Plumber	19
Public transport	20
Label factory	8
Boards retail and manufacture	15
Kitchen fittings manufacturing and retail	8

Businesses' Contribution to Medical Care and Health Benefits

None of the firms in the case study contributed towards their workers' medical aid or health insurance. Workers that could not afford their own medical aid or insurance had to rely on the state for the provision of health care. The owner, managers and administrative staff usually had medical aid and were covered by health insurance.

None of the firms assisted their workers with medical care by purchasing medicines to dispense to workers. The board retail and manufacturing firm was the only firm that sent their workers to a specific doctor if they were injured on the job. The firm only paid doctor's bills related to on-the-job injuries.

HIV/AIDS results in fatigue, and fatigued workers are more likely to injure themselves on the job. A greater number of on-the-job injuries would result in higher medical costs. If the injuries were HIV/AIDS related such higher medical costs would be an increased cost that the firm incurred because of HIV/AIDS. The respondent for this firm was the accountant. She had not noticed an increase in the amount paid to the doctor for on the job injuries. The nature of the business required a lot of manual labour. Workers were expected to carry and pack boards and business-related injuries like boards falling on someone or muscle injuries were common. The firm trained cutters on the job and if more cutters injured themselves, it could be an indication that they were inept board-cutters as opposed to being indicative of HIV/AIDS-related fatigue.

The board retail and manufacturing firm was the only firm that had noticed that their workers were increasingly fatigued. However, the increased fatigue was attributed to the fact that the firm was growing and workers had to do a lot of manual labour. The respondent also stated that workers were usually tired after a weekend. Thus in this case increased fatigue and injuries could not be linked to workers being HIV positive and AIDS sick.

Health-Related and Other Absenteeism

Two firms, the board retail and manufacturing firm and the kitchen fittings retail and manufacturing firm, experienced an increase in the number of sick days that workers were claiming. Sec 22(3) of the basic conditions on employment act 75 of 1997 states that, during the first six months of employment, workers are entitled to 1 day's sick leave for every 26 days worked. Both these firms required workers to do heavy manual labour because workers had to carry and cut wood. The respondents felt that their workers made use of their sick days in order to take a break from work. According to the respondents, the increased sick days were not illness-related. The respondents attributed the increased absenteeism to the fact that workers were more aware of their rights. Workers who stayed absent for a day would be in work again the next day.

Tuberculosis incidence can be a sign of HIV prevalence. Individuals become susceptible to diseases like tuberculosis when their immune system starts to fail. All the firms reported that none of their workers were T.B. positive. However, the plumbing firm was the only firm that regularly checked the T.B. status of their workers. This was done because they did not want unhealthy workers going into customer's homes. The plumber was the only firm that had changed and become more vigilant regarding the health of their workers.

Table 6: Firms' responses to the questionnaire
Key: Gender: M=Men, F=Female
Race: B=Black, W=White, C=Coloured

Nature of business	***Upholstery and repairs***	***Builder***	***Plumber***	***Public transport***	***Label factory***	***Boards Retail and manufacture***	***Kitchen fittings manufacturing and retail***
Number of years in business	13	7	19	20	8	15	8
Number of employees	2	Vary/casual	50	4	20	150	30
Gender of employees	1M 1F	M	M	M	15F 5M	Mostly M	M
Race	M=B, F=C	Mixed (B&C)	Mixed (B&C)	C	Mixed (B&C&W)	Mostly B & mixed C&W	Mixed (B&C&W)
Skill level	M = trainee F=cleaner	Artisans semi-skilled	50% skilled, 50% unskilled	2 mechanics, 2 drivers	skilled	skilled, multi-skilled	multi-skilled
Health benefits provided	None	None	None	None	None	None	None
Medical care provided	None	None	None	None	None	None	None
Increased absenteeism	No	Indeterminate	No	No	No	Yes	Yes
Increased fatigue	No	No	No	No	No	Yes	No
New workers recruited	No	Indeterminate	No	No	1	Indeterminate	3
Reason for new recruitments	N/A	N/A	N/A	N/A	Business growth	Growth/casual turnover	Business growth
Employees tested positive for TB	F - 3 yrs ago	Indeterminate	No	No	No	No	No
Are you concerned about the impact HIV/AIDS will have?	Yes	Yes	Yes	No	Yes	Yes	Yes
Has your business changed?	No	No	Yes	No	No	No	No
Any workers HIV positive	No	No	No	No	No	No	No
Do you have an HIV/AIDS policy?	No	No	Yes	No	No	No	No

Multi-Skilling and On-The-Job Training

The case study highlighted the fact that these small firms have workers that are multi-skilled. Owners of small firms employ workers with multiple skills or they train workers to be multi-skilled. For example, the board retail and manufacturing firm hires anyone that can carry boards and if they perform this task adequately, they are later trained to be board cutters.

The builder said that when he has a contract he recruits a lot of casual labour by sending out a van to pick up workers waiting on street corners in informal labour exchanges. He said that workers have to be multi-skilled because 'some guys are not very reliable.' If a worker, who was on the job the day before, is absent the following day there has to be someone on site that can fill the worker's place until a replacement is found. When recruiting workers the builder tries to hire workers that can lay bricks as well as mix cement.

In the case of the board retail and manufacturing business, workers can be trained to perform different tasks. If a worker is lost, anyone can be hired and trained to perform their job. There is always a worker that can perform the lost worker's role, while a replacement is being recruited or trained. Small firms have 'key' individuals, viz. owner, managers and administrative staff that have a good working knowledge of the functioning of the business. Owners often work in their firms and are multi-skilled themselves. If a worker is ill, the owner is capable of fulfilling the absent worker's function. If any 'key' worker is absent there is always another 'key' worker that can fill the absent workers place. As a result of having a multi-skilled workforce, no single worker is indispensable.

HIV/AIDS can result in a high labour turnover, which can disrupt the running of the firm if there is no worker to replace the lost worker. However, the existence of a multi-skilled workforce makes a firm less vulnerable to the impact of high labour turnover.

A firm's vulnerability to the impact of HIV/AIDS is also influenced by its ability to train and hire replacements. The owner of the public transport firm said that he was not concerned about losing workers because 'anyone can drive a taxi and be trained to fix a van'. In this case, the owner seemed overly optimistic. A year after making this statement, this owner is having difficulty finding taxi drivers and mechanics. At the time that he made his statement he underestimated the value of the 'skills' that the nature of his business required. Being able to drive is an expensive skill because someone has to pay to write the learner's test, pay for photos, pay for lessons, pay for the driving test and perhaps even pay for a second or third test if they fail the first time. He had

thought that ‘anyone can drive a taxi’ but has since found that there are fewer available taxi drivers than thought.

Recruitment

Four out of the seven firms had recruited new workers. The label factory and the kitchen fittings manufacturing and retail firms, recruited new workers because their firms were growing. The board retail and manufacturing firm and the builder recruited new workers because of their casual labour turnover. These firms employed casual workers who sporadically came to work at the firm. In the builder’s case, workers came to work for a while when he needed them and then they left. He did not have many permanent labourers. In the case of the board retail and manufacturing firm, workers could come from the street to carry boards, and leave whenever they felt like leaving. In both these firms, workers left when they got tired of the manual labour that these jobs required. When workers got tired and left, it was easy to hire new workers to replace them. The respondent at the board retail and manufacturing firm said that almost every day unemployed individuals came to the factory to look for work. The builder stated that he did not have a problem filling his van with workers. Unemployment rates in both Heathfield and Ottery were above 5%. Ottery had a strict unemployment rate of 6.7%. The strict definition of unemployment only considers unemployed people looking for work. The broadly defined unemployment rate (includes unemployed people looking for work and unemployed that wish to work but are not looking for work) in Ottery was 7.7%. The strict unemployment rate in Heathfield was 7.6% and the broad unemployment rate was 8.5% (Appendix A).

From these firms it appeared that the high level of labour turnover was related to the nature of the work that workers had to perform and not necessarily to their HIV/AIDS status. However, it is possible that HIV-sick workers would drop out of employment relatively quickly as a result of AIDS-related fatigue.

Skilled workers were often hired out of a pool of friends, acquaintances or families. Skilled workers, especially managers, accountants and administrative staff, were almost exclusively recruited from a pool of friends and family. In the board manufacturing and retail firm, if a position in the office needed to be filled, the owner would first try to fill it by recruiting someone he knew. If he could not find someone he would ask office workers whether they knew anyone who could fill the position. Since on-the-job training could endow anyone with the skills required to perform any task, almost anyone could be hired. Thus an individual who was well acquainted with either the owner or an existing worker was usually hired. This is consistent with evidence that most recruitment of workers in South Africa is done through networks (Seekings, 2003).

The board retail and manufacturing firm permanently employed skilled workers, while unskilled workers were usually casual workers. Small firms attempt to have skilled positions occupied by individuals with whom they will have a good working relationship because, as one respondent said: ‘labour laws make it difficult to fire someone.’ Owners thus try to insure that they hire competent and capable individuals. Recommendations from workers that they know and trust about a suitable applicant give owners some assurance that the person that they hire will be competent and capable. Training is seen as an investment and firms want to secure their investment. By recruiting in this manner, firms sustain their incentive to invest in training. If firms are assured that the person they hire will be a part of the firm for some time, then there is incentive to provide training. Figure 3 is an example of the relationship that exists between the owner and skilled workers.

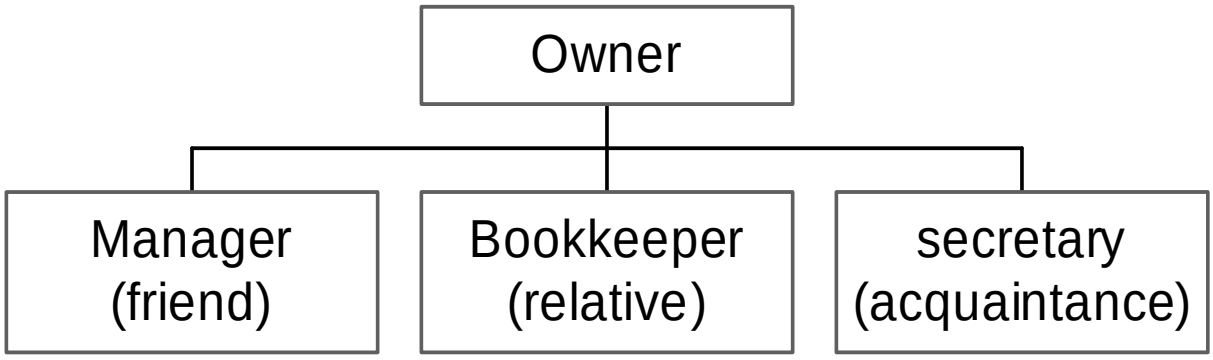


Figure 3: The relationship between the owner and skilled workers

HIV Status of Workers

Labour laws provide the protocol for dealing with HIV in the workplace. This paper presumed that the relationships between owners and workers in small firms might result in the protocol being relaxed or bypassed. However, it was determined that small firms follow the same employer employee protocol as other firms. Owners do form close relationships with their workers but there are boundaries to these relationships. The Employment Equity Act, 1998 (Act No.55 of 1998) sets a very clear boundary. It states that no employer may require an employee, or a job applicant to undertake a HIV test in order to ascertain his or her HIV status. Employers may approach the labour court to obtain authorisation for testing and employees may give informed consent for an HIV test to be undertaken. The most important aspect of the act is that everyone

with HIV or AIDS has the right to privacy. HIV positive workers may not be dismissed from their employment simply because of their HIV status. Workers are not legally required to disclose their HIV status to their employer or other workers. Employers are legally prohibited from forcing workers to disclose their HIV status.

In this study, none of the respondents had asked any worker whether he or she was HIV positive. The respondent from the board retail and manufacturing firm said that: 'Their personal life is their own business and if they want to tell me they can but I'm not going to ask'. Even in the absence of the labour law, it seemed that owners would be reluctant to determine the HIV status of their workers. The respondent from the label factory said that 'we are like a family' when she spoke about the relationships between everyone in the firm. She had not asked any of the workers about their HIV status and did not see the need to because 'we are all healthy'. This is a typical indication of the 'us versus them' syndrome, where people believe that it will never happen to one of us because it only happens to other people. This sort of behaviour is typical of heavily stigmatised diseases.

Individuals were reluctant to determine the HIV status of their colleagues, regardless of how close their relationship with the person was. The converse also appeared to be true; individuals were reluctant to disclose their HIV status, regardless of the closeness of their relationship with their colleagues. All the respondents felt that an individual's HIV status was a personal matter. Workers were free to disclose their HIV status to whomever they wanted to. In short, as a result of compliance with labour law and reluctance to ask their workers very personal questions, none of the respondents knew whether any of their workers were HIV positive.

Small Firms' Concerns

Six of the seven firms were concerned about the impact that HIV/AIDS might have on their firm. They were concerned that in the future they would lose valuable work hours and experience decreased levels of productivity if their workers were to get AIDS sick and become increasingly fatigued. The plumber was concerned about the possibility of an HIV positive worker being injured in a customer's home. The respondent was concerned that customers might not want an HIV positive stranger bleeding on their kitchen floor, thus resulting in a loss of customers. The owner of the transport firm was not concerned about the impact that HIV/AIDS would have on his firm. He felt that workers were easily replaceable. Even though half of his workforce was skilled mechanics he believed that anyone could be hired and trained. He felt that there are enough drivers and mechanics in South Africa to supply his labour needs. He said that:

‘If they get AIDS it’s their problem not my problem ’cause they won’t be able to work and I’ll get someone else.’ As noted earlier, such views amounted to ill-judged bravado on the part of this respondent.

HIV/AIDS Policy

The plumber was the only firm that had HIV/AIDS awareness posters in the office. This firm also regularly checked whether workers had TB. This was the only manner in which the firm had changed in the light of the AIDS pandemic. It was the only firm that had taken the initiative to implement a prevention programme. The other firms relied on the media to educate their workers. They felt that as adults their workers should be responsible and educate themselves. The kitchen fittings manufacturing and retail firm had had a volunteer come to the firm on his own initiative. He came during the worker’s lunch hour and gave seminars and distributed free condoms. This prevention programme was free and did not interfere with the functioning of the firm. The firms had not formulated a HIV/AIDS policy that would help them deal with HIV positive workers in the workforce.

Discussion on the Case Study’s Findings

The case study’s findings indicate that HIV/AIDS does not appear to be having an economic impact on these small businesses on the Cape Flats. The findings cannot be generalised to the whole of the Western Cape or the whole of South Africa. There might have been other firms in the Heathfield and Ottery area or in different areas on the Cape Flats that might have yielded different results. The findings of the case study can also be the result of conducting the study in the Western Cape where HIV prevalence is relatively low. This can be seen in Table 7 below, which shows the HIV prevalence[1] amongst antenatal clinic attendees by Province (Fredriksson, 2001).

[1] An antenatal survey is an internationally recommended surveillance tool to estimate HIV in populations. Whilst it has inherent limitations it is still considered the most useful tool to assess HIV prevalence in areas of high HIV prevalence. Pregnant women are sexually active, constitute an easily identifiable, accessible and stable population, and are more likely than other groups to be representative of the general population. In addition, pregnant women attend health care facilities where blood is drawn as part of routine medical services.

Table 7: Estimated HIV prevalence 1999-2001 by province among antenatal clinic attendees

Province	***1999 Prevalence %***	***2000 Prevalence %***	***2001 Prevalence %***
National	22.4	24.5	24.8
Kwazulu-Natal (KZN)	32.5	36.2	33.5
Mpumalanga (MP)	27.3	29.7	29.2
Gauteng (GP)	23.9	29.4	29.8
Free State (FS)	27.9	27.9	30.1
North West (NW)	23	22.9	25.2
East Cape (EC)	18	20.2	21.7
Limpopo (LP)	11.4	13.2	14.5
Northern Cape (NC)	10.1	11.2	15.9
Western Cape (NC)	7.1	8.7	8.6

Conclusion

By recruiting in the manner that they do and by having multi-skilled workers, the small firms in this study appear to have built up internal resistance to the impact of HIV/AIDS. Small firms keep their training and recruitment costs low. By not paying health benefits, these small firms manage to pass the potential economic cost onto the workers and the public health sector.

Given that small firms are passing on the cost of AIDS, the government should consider assisting workers in small firms. Individuals that work in small firms do not receive any health benefits from their employers. If they are unable to contribute to medical care then they have to rely on the state for access to health care. This means that if workers in small firms were to become AIDS sick they would have to rely on the public health system for assistance. Government resources would be needed to provide public health care to those who cannot afford health care. The government needs to develop and improve its public health care facilities in order to take care of HIV positive individuals. As shown by Madelaine de Villiers (2002), there is growing pressure on government hospitals, non-governmental organisations and community-based organisations as the HIV/AIDS pandemic progresses, highlighting the desperate plight of the AIDS sick poor. The health care system needs to be equal to the task of taking care of those who rely on the government as their sole health care provider.

Small firms recruit from a pool of family, friends and acquaintances. Recruiting in this manner allows employers to exclude HIV positive people from employment. This may result in HIV positive workers having difficulty finding

employment. Unemployment reduces people's access to resources and pushes these households into poverty. Unemployed individuals will migrate to friends or family that can support them. Adding an unemployed member to a household reduces average adult equivalent expenditure by R1300. Some households have no access to labour income or social grants (e.g. old age pensions or disability grants) and earn only R104 per month (Klasen & Woolard, 2000).

Poverty is linked to malnourishment and increased susceptibility to illness including HIV (Stillwaggon, 2000). Poverty can increase the likelihood of an individual becoming AIDS sick because he or she is unable to finance adequate medical expenditure and food expenditure, which will accelerate the individual becoming, AIDS sick. There is also a link between unemployment, poverty and AIDS sickness (Van der Berg, 1997). There appears to be no quick fix to solving the country's unemployment problem. However, it may be possible to address the impact of poverty, which is a by product of unemployment, through the introduction of a basic income grant (Nattrass, 2003).

Appendix A

Table 1: Employment Status in Ottery

Status	*African/Black*			*Coloured*			*Indian/Asian*			*White*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*
Employed	77	51	128	977	906	1,883	77	56	133	517	374	891
Unemployed, looking for work	7	12	19	57	67	124	6	4	10	27	37	64
Not working - not looking for work	-	2	2	8	11	19	-	1	1	9	6	15
Not working - housewife/home-maker	-	5	5	2	196	198	-	31	31	-	165	165
Not working - scholar/full-time student	10	8	18	126	127	253	4	9	13	94	71	165
Not working - pensioner/retired person	3	2	5	53	100	153	-	4	4	108	90	198
Not working - disabled person	-	-	-	11	11	22	-	1	1	4	8	12
Not working - not wishing to work	-	-	-	-	-	-	-	-	-	1	1	2
Not working - none of the above	1	-	1	8	22	30	1	2	3	21	15	36
Unspecified	-	-	-	-	-	-	-	-	-	-	-	-
NA: Aged <15	25	42	67	583	645	1,228	46	55	101	197	211	408
NA: Institution	-	-	-	-	-	-	-	-	-	-	-	-
Total	123	122	245	1,825	2,085	3,910	134	163	297	978	978	1,956

Unemployment rate (strict) based on total for all races: Unemployed looking for work/ Unemployed looking for work + employed: 19+124+10+64/ ((19+128) + (124+1883) + (10+133) + (64+891) = **6.7%**
Unemployment rate (broad) based on total for all races: (Unemployed looking for work + not working not looking for work)/ (Unemployed looking for work + employed + not working not looking for work) : 254/3289= **7.7%**

Table 2: Employment status in Heathfield

Status	African/Black			Coloured			Indian/Asian			White		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employed	23	30	53	595	607	1,202	18	18	36	322	357	679
Unemployed, looking for work	9	6	15	67	39	106	2	1	3	16	23	39
Not working - not looking for work	-	-	-	4	9	13	-	-	-	3	5	8
Not working - housewife/home-maker	-	5	5	1	196	197	-	6	6	3	63	66
Not working - scholar/full-time student	-	7	7	108	104	212	-	9	9	32	40	72
Not working - pensioner/retired person	1	2	3	171	208	379	2	-	2	55	87	142
Not working - disabled person	-	-	-	20	15	35	-	-	-	4	3	7
Not working - not wishing to work	-	-	-	-	1	1	-	1	1	-	-	-
Not working - none of the above	1	-	1	19	32	51	-	1	1	12	13	25
Unspecified	-	-	-	4	-	4	-	-	-	-	-	-
NA: Aged <15	12	14	26	250	300	550	8	4	12	108	103	211
NA: Institution	2	2	4	21	18	39	-	-	-	37	39	76
Total	48	66	114	1,260	1,529	2,789	30	40	70	592	733	1,325

Unemployment rate (strict) based on total for all races: 15+106+3+39/ ((15+53) + (1202+106) + (36+3) + (679+39)) = **7.6%**
Unemployment rate (broad) based on total for all races: 184/2154= **8.5%**

Table 3: Individual incomes in Ottery

Status	African/Black			Coloured			Indian/Asian			White		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
None	41	64	105	745	1,026	1,771	50	92	142	332	482	814
R1 - R200	1	2	3	17	27	44	-	1	1	8	14	22
R201 - R500	2	12	14	47	129	176	1	8	9	22	48	70
R501 - R1000	16	3	19	39	61	100	-	9	9	44	49	93
R1001 - R1500	10	1	11	87	73	160	5	8	13	77	53	130
R1501 - R2500	11	4	15	143	195	338	13	14	27	104	96	200
R2501 - R3500	8	5	13	145	208	353	12	5	17	84	86	170
R3501 - R4500	8	8	16	145	126	271	10	7	17	85	48	133
R4501 - R6000	8	5	13	200	120	320	14	5	19	92	30	122
R6001 - R8000	11	6	17	102	34	136	14	3	17	56	8	64
R8001 - R11000	-	2	2	50	10	60	3	-	3	20	3	23
R11001 - R16000	1	2	3	26	7	33	3	3	6	7	3	10
R16001 - R30000	1	2	3	15	3	18	-	-	-	1	-	1
R30001 or more	4	1	5	5	1	6	-	-	-	2	4	6
Unspecified	1	5	6	59	65	124	9	8	17	44	54	98
Total	123	122	245	1,825	2,085	3,910	134	163	297	978	978	1,956

Table 4: Individual incomes in Heathfield

Status	African/Black			Coloured			Indian/Asian			White		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
None	14	28	42	316	441	757	9	17	26	115	162	277
R1 - R200	-	-	-	16	20	36	-	-	-	2	21	23
R201 - R500	-	1	1	95	167	262	-	1	1	11	26	37
R501 - R1000	-	7	7	40	86	126	2	2	4	12	32	44
R1001 - R1500	6	2	8	89	128	217	-	7	7	29	40	69
R1501 - R2500	5	6	11	125	145	270	6	5	11	60	97	157
R2501 - R3500	3	4	7	107	107	214	-	2	2	56	70	126
R3501 - R4500	1	2	3	91	65	156	4	-	4	54	60	114
R4501 - R6000	2	1	3	88	37	125	2	-	2	54	57	111
R6001 - R8000	-	2	2	44	5	49	-	-	-	39	24	63
R8001 - R11000	1	1	2	16	1	17	2	-	2	23	8	31
R11001 - R16000	1	-	1	7	1	8	-	-	-	9	4	13
R16001 - R30000	2	-	2	2	-	2	-	-	-	4	-	4
R30001 or more	-	-	-	1	1	2	-	-	-	1	-	1
Unspecified	11	10	21	202	307	509	5	6	11	86	93	179
Total	46	64	110	1,239	1,511	2,750	30	40	70	555	694	1,249

Appendix B

1) What is the nature of your business?…….……
2) How long have you been in business?……..……
3) What tax bracket do you fall into? Lower, middle or higher…….……
4) How many employees do you have?……..……
5) What is the gender of your employees? ……
6) What is the race of your employees? …….……
7) What is the skill level of your employees? ……
8) Have you noticed an increase in worker absenteeism? ……..……
a) If yes, do you know the reason for this increase? …….…….
…..……..
9) Have you noticed that your workers are increasingly fatigued?……
a) If yes, do you know the reason? ……
……
10) Have you recruited any new employees recently?…….…….……..…
a) If yes, what is the reason for these recruitments?……...
……
11) Have any of your workers been treated for TB?……..
12) Do you contribute towards your employees' health insurance premium?
…….....
13) How much do you contribute towards each employee's premiums?
……
14) Have you noticed an increase in the amount you contribute?
……
a) If yes, do you know the reason for the increase?…….…….
……
15) Do you pay for medical care provided to your employees?……
a) Have you noticed an increase in these costs? (How much has it increased)
……
…….
……
…….
16) Have you noticed a change in the level of productivity of your employees?
(How have you noticed the change?)……
……
……

May I remind you again that what you tell me is confidential

17) Do you know if any of your workers are HIV positive or have AIDS?……
18) How many of your employees are HIV positive?……

19) Are workers aware that their fellow workers are HIV positive?……..…...
a) Why or why not?……
20) Has having HIV positive workers changed how workers treat each other? In what ways have workers behaviour changed? ……..
……
……
21) Does your company screen workers to see if they are HIV positive?
……
22) Do you have any HIV/AIDS awareness or prevention programs please provide details of these programs?…….
……
……
……
……
23 Are you concerned about the future impact that HIV/AIDS will have on your business? What are you concerned about?…….
……
……
……
……
24) How has your business policy and practices changed to deal with HIV/AIDS?……
……
……
……
……
25) Are you aware of any costs that HIV/AIDS has caused your company to incur?…….
……..…….
……
……

MAY I PLEASE SEE THE RECORD FOR WORKER ABSENTEEISM AND THE COSTS INCURRED FOR MEDICAL AND INSURANCE PURPOSES?

THANK YOU VERY MUCH FOR YOUR HELP AND YOUR TIME.

Appendix C

Miss Celeste Anita Coetzee is an Honours student at the University of Cape Town. She is doing research into the change in health-related costs incurred by small businesses on the Cape Flats. I have agreed to help her with her research for her honors thesis paper. Neither my name nor the name of my company will ever be used in any publication of her thesis paper.

Name:
……
Surname:
……
Company Name:
……
Telephone Number:
……
Signature:
……
Signature:
……
Date:
……

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The CSSR is an umbrella organisation comprising five units:

The Aids and Society Research Unit (ASRU) supports quantitative and qualitative research into the social and economic impact of the HIV pandemic in Southern Africa. Focus areas include: the economics of reducing mother to child transmission of HIV, the impact of HIV on firms and households; and psychological aspects of HIV infection and prevention. ASRU operates an outreach programme in Khayelitsha (the Memory Box Project) which provides training and counselling for HIV positive people

The Data First Resource Unit ('Data First') provides training and resources for research. Its main functions are: 1) to provide access to digital data resources and specialised published material; 2) to facilitate the collection, exchange and use of data sets on a collaborative basis; 3) to provide basic and advanced training in data analysis; 4) the ongoing development of a web site to disseminate data and research output.

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The Southern Africa Labour and Development Research Unit (SALDRU) was established in 1975 as part of the School of Economics and joined the CSSR in 2002. SALDRU conducted the first national household survey in 1993 (the Project for Statistics on Living Standards and Development). More recently, SALDRU ran the Langeberg Integrated Family survey (1999) and the Khayelitsha/Mitchell's Plain Survey (2000). Current projects include research on public works programmes, poverty and inequality.