

Why the Private Sector should be concerned about HIV/AIDS

by

Hopolang Phororo

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About the Author

Hopolang Phororo is a researcher at the Namibian Economic Policy Research Unit (NEPRU). Prior to that she worked in Lesotho as programme officer for UNDP and was the focal point for HIV/AIDS and a member of the UNAIDS technical working group. In addition, Hopolang was a research fellow at the Institute of Southern African Studies for four years and did extensive research on the production and marketing of agricultural commodities. She represented the institute on various HIV/AIDS national committees and actively participated in AIDS awareness campaigns. She started her career with the government of Lesotho in the Ministry of Agriculture as a marketing officer. She obtained both her Bachelors of Science degree in business administration and Masters of Science degree in agricultural economics from the United States of America. Her research interests include the effects of HIV/AIDS on the economy and at the household level in the Southern Africa region and labour migratory patterns.

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1. Global and Regional Status of HIV/AIDS

HIV/AIDS is a development problem that is faced by all countries in the world. The most recent UNAIDS/WHO estimates show that in 1999 alone, 5.4 million people were newly infected with HIV. Already 18.8 million people around the world have died of AIDS and 3.8 million of them children. Of the 34.3 million people living with HIV in 1999, 33 million were adults and just under 50% (15.7 million) were women and 1.3 million were children under 15 years. Seventy one percent of the people living with HIV in 1999 were concentrated in sub-Saharan Africa. One of the key reasons for the rapid spread of the disease is its mode of transmission. HIV/AIDS is transmitted in one of three ways:

- through sexual intercourse, which can be either through heterosexual or homosexual intercourse. Most infections in the developing world are through heterosexual intercourse. STD patients are considered to be at higher risk for HIV infection because both are transmitted through unprotected sex;
- from mother to child is another mode of transmission. The child can be infected with HIV parentally, at the time of delivery or postnatally through breastfeeding;
- through blood and blood products is a very effective way of transmission, since the virus goes directly into the bloodstream. However, in many countries the risks of transmission through this mode have been minimised since the blood is screened; and
- through intravenous drug use, particularly when the equipment is contaminated the risk of infection has been high.

The countries south of the continent are the most affected by the epidemic with at least one in five people living with HIV in seven countries as noted in Table 1. However, Botswana has the highest HIV prevalence rate whereas Mozambique and Malawi reported HIV prevalence rates of less than 20%.

Table 1: HIV/AIDS Indicators in Southern Africa for 1999

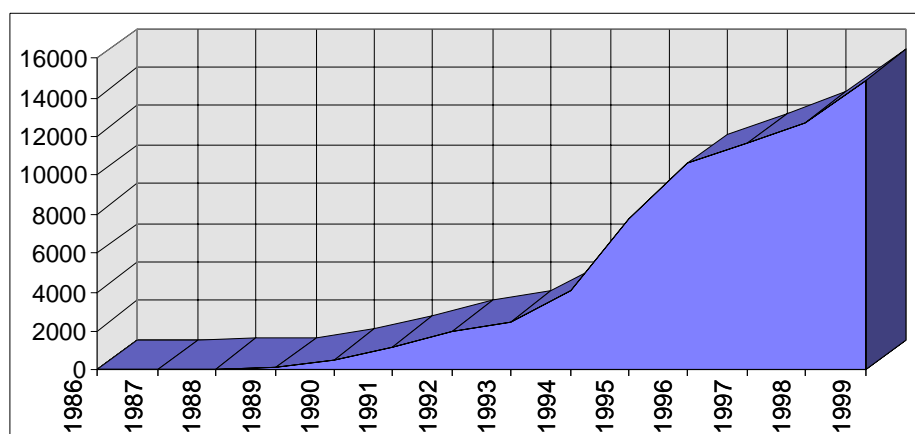
	HIV Prevalence in adults 15-49 (%)	Estimated AIDS Deaths
Botswana	35.8	24,000
Lesotho	23.6	16,000
Malawi	16.0	70,000
Mozambique	13.2	98,000
Namibia	19.5	18,000
South Africa	19.9	250,000
Swaziland	25.3	7,100
Zambia	20.0	99,000
Zimbabwe	25.1	160,000

Source: UNAIDS, 2000

One of the main reasons that has been advanced for the rapid spread of HIV/AIDS in Southern Africa is the oscillatory migration patterns. This has resulted in workers in urban areas maintaining links with their families in rural areas and moving between the two places periodically. Uneven economic development across countries and a lack of waged employment has perpetuated the situation.

2. HIV/AIDS in Namibia

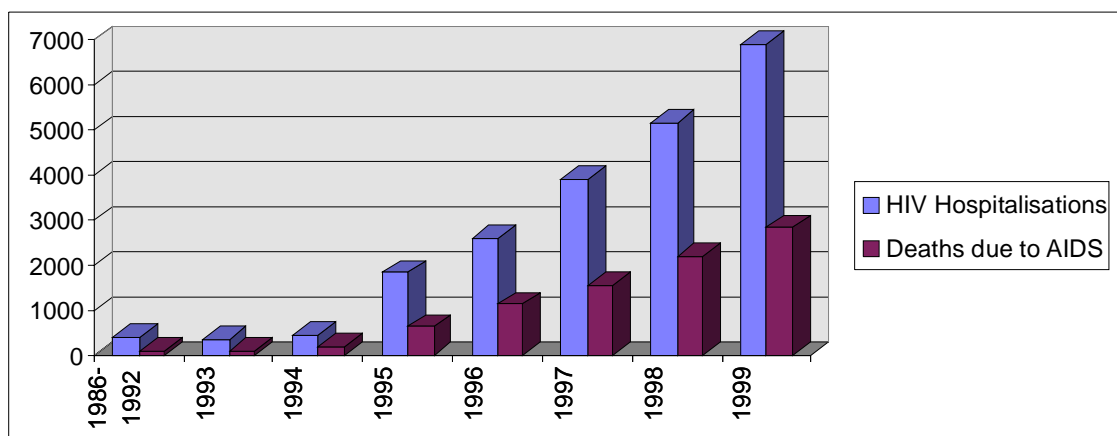
In 1986, only 4 cases of HIV/AIDS were reported and by 1996, they had climbed to 12701, resulting to 68196 cumulative infections in 1999. In 1999, a total of 14866 new HIV infections were reported and 8028 were women, accounting for 54% of all new cases (Ministry of Health and Social Services, 2000). From Figure 1, it is clear that HIV infections have risen exponentially and it is likely that the increase will continue before it levels off. Women were diagnosed at a younger age, the median age being 30 years for women and 35 years for men.

Figure 1: Positive HIV-Tests, 1986 - 1999

Source: Ministry of Health and Social Services, 2000

AIDS has by far become the main cause of deaths in hospitals, accounting for 26% of reported deaths in 1999. The cumulative number of deaths since the beginning of the epidemic has been 8679. The number of reported deaths in the age group 15-49 years continues to increase and in 1999 accounted for 47% of all deaths in hospitals (see Figure 2). However, it is believed that deaths are underreported due to some logistical constraints, reluctance by patients to be tested for HIV and underreporting of HIV/AIDS as an underlying cause of death. Figure 2 shows that HIV continues to be an increasing cause of hospitalisations, the figures rising from 355 hospitalisations in 1993 to 6878 in 1999 (Ministry of Health and Social Services, 1999).

Figure 2: Reported Number of Hospitalisations and Deaths from HIV/AIDS, 1986 - 1999

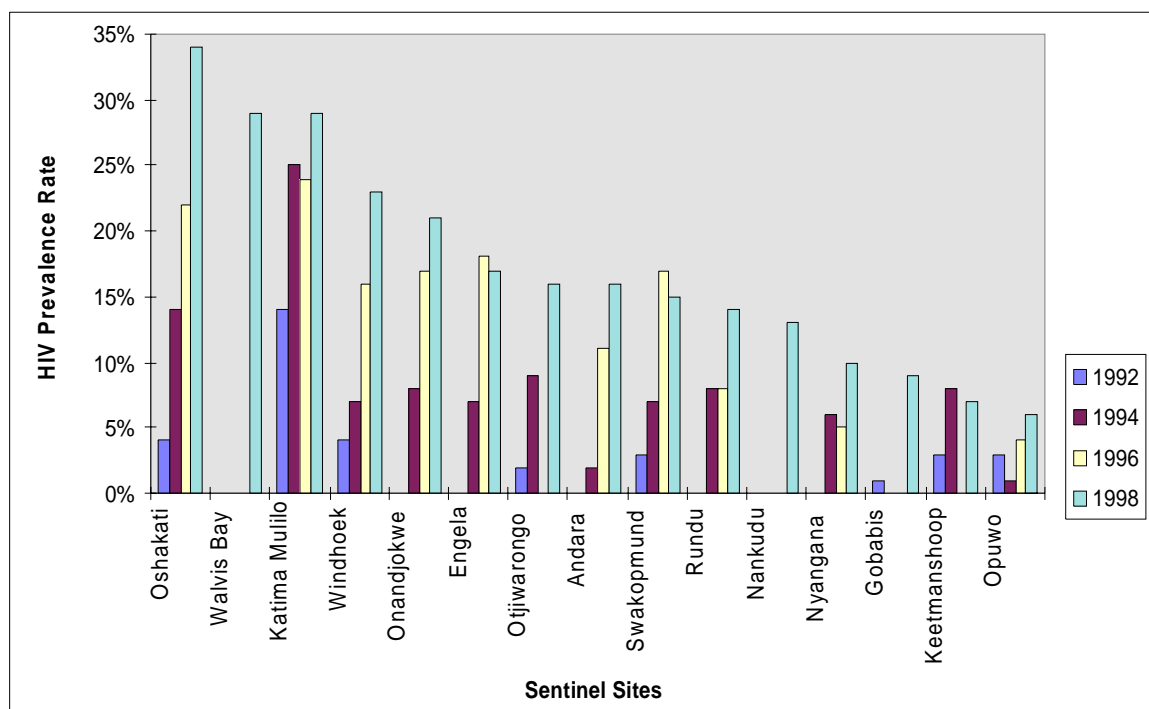


Source: Ministry of Health and Social Services, 2000

In Namibia, as in other countries, the major source of data is that on HIV prevalence. Sentinel surveys are the best sources and measure the level of HIV prevalence in a given population at a specific time. The most common surveillance data is that of antenatal clinic attenders, which can then be used to estimate the level of prevalence in the adult and national populations. The Ministry of Health and Social Services (1999) indicated that the national HIV prevalence rates in pregnant women have been rising since 1992 from 4.2% to 17.4% in 1998, particularly where consistent testing took place over the period 1992 to 1998 as noted in Figure 2.

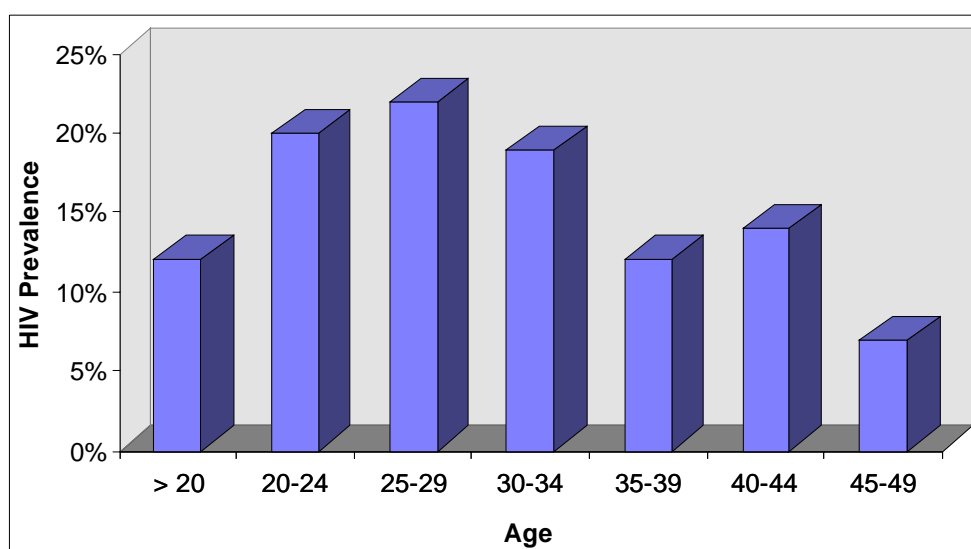
In 1992, testing was done only in eight sentinel sites and by 1998, there were 15 sites of which 5 new ones were included. Various sentinel sites, such as Katima Mulilo recorded high and increasing HIV prevalence rates for the period 1992 to 1996, but in 1998, Oshakati had a prevalence rate of 34%, which was the highest in the country. Opuwo had the lowest prevalence rate of 6% in 1998. High prevalence rates in the range of 23 - 34% were reported in 4 urban areas -- Windhoek, Walvis Bay, Katima Mulilo and Oshakati. In rural sites such as Omanjokwe, Engela and Andara, which are located close to main roads, the HIV prevalence rates were also high in 1998.

Figure 3: HIV Prevalence in Pregnant Women at Different Sentinel Sites, 1992 - 1998



Source: Ministry of Health and Social Services, 1999

In terms of the different age groups among pregnant women, the HIV prevalence rates for the 20-24 year olds was 20% and for the 25-29 year olds it was 22% in 1998. From Figure 4, it is clear that a high prevalence rate is concentrated among women in the ages 20-34 years. This is not surprising since women are more vulnerable to HIV/AIDS for a number of reasons. The efficiency of transmission of HIV from men to women is thought to be seven times greater than the other way round, which explains why women are at higher risk in heterosexual relationships (UNDP & UNAIDS, 1999). Younger women are less able to negotiate condom use because of a lack of power and experience. In addition, they have a less mature genital tract which increases the risk factor. The prevalence rate drops to 7% for women in the age group 45-49 years.

Figure 4: Age Specific HIV Prevalence in Pregnant Women, 1998

Source: Ministry of Health and Social Services, 2000

3. The Private Sector and HIV/AIDS

Since HIV is most commonly transmitted through sexual intercourse, it tends to affect those who are in their most productive and active years. An individual can be affected as a family member, a producer, a consumer and a community member. As a result, an increase in illness and death in a population will inevitably have social and economic consequences. The first impacts of HIV/AIDS will be felt at the household level and then will have a ripple effect on the community and then ultimately on the economy. Macroeconomic models developed to predict the impact of HIV/AIDS have suggested that AIDS will affect the population in two main ways:

- Declining healthiness; and
- Rising mortality rates in particular age groups.

Declining healthiness will result in reduced productivity, increased health care expenditures, reduced savings and human capital investment in terms of skill losses.

The increase in mortality rates will result in a decreased population growth rate, changed age structure toward more young and inexperienced employees. It is anticipated that a premature loss of well-trained, educated and experienced workers will arise.

4. The Private Sector and HIV/AIDS

The private sector as a vital sector in the economy will be affected by HIV/AIDS. It plays a crucial role in the provision of employment, creation of wealth and supplies

the population with food, clothing, housing and most goods and services. Research carried out in various countries reveals that many private sector companies are reluctant to deal with HIV/AIDS within their companies (UNAIDS, 2000; UNAIDS & UNDP, 1999). This is largely caused by many firms being ignorant of how they can be affected by HIV/AIDS, the high perceived costs associated with establishing a prevention programme and the feeling that employers are adults and should be responsible for their own sexual behaviour. However, Whiteside and Sunter (2000) indicate that avoiding HIV infection through prevention programmes can be very cost effective.

4.1. HIV/AIDS and the Private Sector in Namibia

In Namibia no studies have been undertaken on the impacts of HIV/AIDS at the private sector level. A few companies were contacted to establish whether they had any HIV/AIDS prevention strategies or policies in place and to what extent they had been affected by HIV/AIDS. Companies, such as Nampower and Namwater have both initiated the process of developing a HIV/AIDS policy. The former is planning to embark on a peer education programme in November. Namwater has developed a HIV/AIDS training manual for employees. The banks, namely the Commercial Bank of Namibia have an internal AIDS campaign to raise awareness of employees. Posters and flyers have been developed and in their in-house magazines, HIV/AIDS contributions featured. A peer education programme is planned before the end of the year. Standard Bank is working on a HIV/AIDS policy.

A major transportation company, UNITRANS is in the process of developing a HIV/AIDS policy. Coca Cola has recently implemented a modified and updated HIV/AIDS policy. The major mining companies, such as Rössing and Namdeb have peer education programmes, awareness campaigns and counselling services. Seaflower, one of the fishing companies is in the process of developing a HIV/AIDS policy. DHL has a HIV/AIDS policy in place. Most of these companies have experienced AIDS-related deaths but since HIV testing and reporting of results is not mandatory, the exact figures are unknown.

Companies, such as Shell, Perfecto Bricks, Berco Cleaning Services, Hartlief Continental Meat Products and Zimmermann Garage, currently have no HIV/AIDS prevention programmes or policies, but some are in the process of developing them. Other than having HIV/AIDS posters and distributing condoms, in most of the companies interviewed with few employees (12 - 200), no strategies are in place for HIV/AIDS policies or awareness or prevention programmes. The reason could be that deaths related to AIDS have not become an issue and that companies are unsure of what procedures need to be taken and who to contact to get assistance.

With the exception of the major mining companies, which have actively responded to the prevention of HIV/AIDS, not only for their employees but also for their families, the private sector in Namibia is realising that HIV/AIDS is a reality. Companies cannot afford to ignore the problem, because workers are increasingly becoming

infected hence they are beginning to formulate HIV/AIDS policies and to establish awareness and prevention programmes in response to the epidemic. However, any analysis indicating to what extent companies will be impacted by HIV/AIDS in terms of reduced profits or increased costs has not been undertaken.

5. Problems Associated with Examining the Impact of HIV/AIDS on the Private Sector

Throughout Africa, very few studies have been undertaken to quantify the impact of HIV/AIDS on companies. These studies were done in the early to mid 1990s, when HIV rates were increasing rapidly but with very little AIDS-related deaths. In addition these studies were mainly for internal purposes. A problem associated with these studies is that the costs of the epidemic were reported as a percentage of the wage bill or as a percentage of profits, making comparison across countries very difficult. These studies have tended to rely on national antenatal clinic prevalence data to estimate and project prevalence, in mainly male workforces. To get more accurate data would involve taking and testing the blood of employees, which requires informed consent and such tests would not necessarily give a good sample because they are expensive and complicated. However, Debswana, the diamond mining company in Botswana has administered saliva tests to its employees in order to get a clearer indication on infection rates (Whiteside and Sunter, 2000).

6. Effect of HIV/AIDS on the Private Sector

HIV/AIDS will affect the private sector in the following ways:

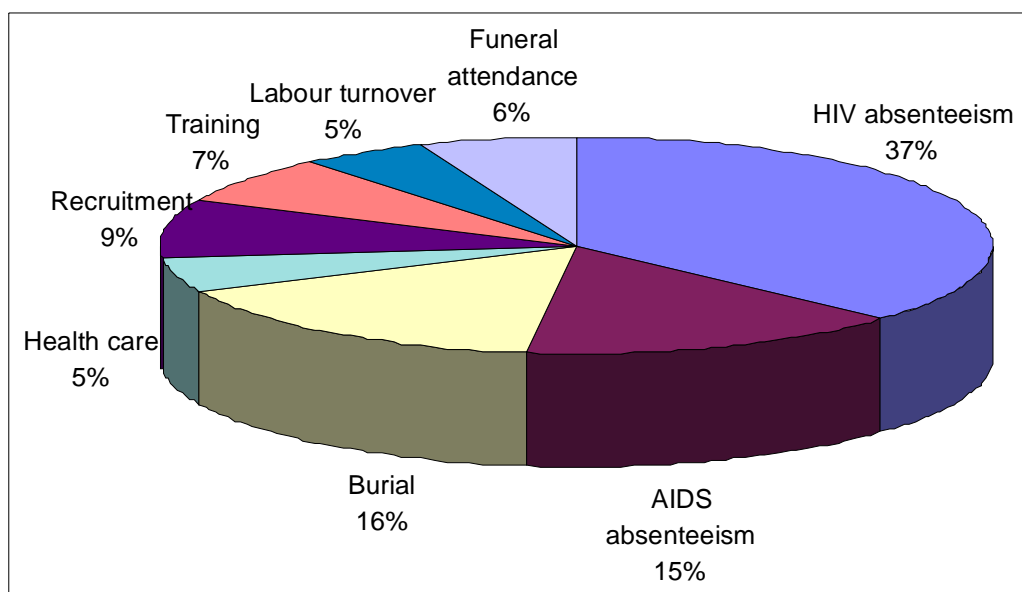
- reduced productivity,
- increased costs, and
- a loss of customers.

The extent to which costs will be affected depends on the type of company, the skills levels and how easily the labour can be replaced and the sector it operates. It will be very costly to train replacement staff for a high skill, labour intensive industry than for a low-skill industry where replacement employees can be easily found.

Profits can be depressed due to:

Absenteeism: of employees who are infected with the virus and as it develops into AIDS, they will increasingly be in and out of work. Healthy employees can also be absent to care for sick relatives or to attend funerals. A study undertaken by Roberts and Rau across countries indicated that absenteeism (AIDS and HIV) accounted for 52% of costs. Figure 5 below shows that HIV absenteeism was greater than absenteeism from AIDS.

Figure 5: Distribution of Increased Labour Costs due to HIV/AIDS by Category



Zambia's largest cement company reported that absenteeism for funerals increased 15-fold between 1992 to 1995. As a result, the company restricted employee absenteeism for funerals to those of a spouse, parent or child (Stover and Bollinger, 1999).

Reduced morale of the workforce: as they work closer with infected colleagues.

Decreased productivity: will be one of the consequences as HIV infected employees become weaker and tire more often.

Death or retirement of employees: as a result of HIV/AIDS have to be replaced, sometimes by employees who are less experienced. Hence, training costs will increase.

Drop in the average age and experience of employees.

Increasing size of the workforce: companies in South Africa are increasing their workforces to compensate for deaths during apprenticeships and absences.

Increasing wages: particularly, in companies which rely on skilled labour.

Rising health care costs, medical aid and hospitalisation.

Balance of loans have to written off: where credit has been extended to customers, who are dying of AIDS.

Employee benefits: could be a significant area for additional AIDS costs related to employee benefits. However, this will vary from company to company depending on conditions of employment, level of staff and benefits. The benefits may include group insurance, pensions, funeral benefits and medical aid.

7. Impact on markets

The impact of HIV/AIDS depends on the demographic profile of consumers (age, sex, income level and geographical location) in specific markets. The absolute number of potential customers could decline making markets that are relatively saturated and which depend critically on population, the most vulnerable.

Where the demand for goods is far from saturated and growing strongly, many of the consumers who die or have their disposable income reduced by HIV/AIDS will be replaced by new earners and consumers. Whiteside and Sunter (2000) indicate that in South Africa, the provision of credit is a main concern for the retail sector. The risk of default on credit payments will increase in response to HIV/AIDS. Pre-loan testing for HIV will become the norm to address this issue, but it becomes more complex for long-term loans, such as mortgages because borrowers could become infected after approval of loans. Long-term lenders and insurers will have to adopt products that can reduce their exposure.

8. Models for Assessing Costs to Business

A crucial question is what can and should companies do about HIV/AIDS?

A careful quantitative assessment of additional costs incurred in maintaining a productive workforce should be undertaken. These assessments are not complicated but need a large amount of data to be collected from the company. The chronological model depicted in Table 2 is one way to assess the costs that companies will incur. The model aims to alert the business managers on all steps that are required to cope with the spread of HIV/AIDS among employees. It assists in capturing the financial implications associated with the disease.

What is clear from the studies undertaken is that HIV/AIDS will make it more expensive for a company to produce a given quantity of a product, unless costs can be reduced in other ways. If no costs can be cut, the company will either have to raise prices, market its product more aggressively or accept a drop in profits. If the increase in HIV/AIDS-related costs is large enough, the company may face the prospect of going out of business and employees losing their jobs or incomes.

For purposes of data collection and analysis, costs can be divided into three categories: direct, indirect and systemic costs. Direct costs are the easiest to collect and involve increased financial outlays. Indirect costs are more difficult to collect and include variables such as reduced workforce productivity of both infected employees and other employees who are diverted from their normal responsibilities. Systemic costs are costs that result from the cumulative impact of multiple HIV/AIDS cases. They are the most difficult to measure in the short run and for individual companies but in the long run could pose to be the most serious threat to profitability.

Table 2: Economic Impact of HIV/AIDS on the Workforce

Direct Costs	Indirect Costs	Systemic Costs
Benefits package	Sick leave	Loss of workplace cohesion
<ul style="list-style-type: none"> • Company-run health clinics • Medical aid/health insurance • Disability insurance • Death benefit/life insurance payout • Funeral expenses • Subsidised loans 	<ul style="list-style-type: none"> • Other leave taken by sick employees • Bereavement and funeral leave • Leave to care for dependants 	<ul style="list-style-type: none"> • Reduction in morale, motivation and concentration • Disruption of schedules and work teams or units • Breakdown of workforce discipline (slacking, unauthorised absences, theft, etc.)
Recruitment	Morbidity on the job	Workforce performance and experience
<ul style="list-style-type: none"> • Recruiting expenses (advertising, interviewing, etc.) • Cost of having positions vacant (profit the employee would have produced) 	<ul style="list-style-type: none"> • Reduced performance due to HIV/AIDS sicknesses on the job 	<ul style="list-style-type: none"> • Reduction in average level of skill, performance, institutional memory, and experience of workforce.
Training		Management resources
<ul style="list-style-type: none"> • Pre-employment education and training costs • In-service and on-the-job training costs • Salary while new employee comes to steam 		<ul style="list-style-type: none"> • Managers' time and effort for responding to workforce impacts, planning prevention and care programmes, etc. • Legal and human resource staff time for HIV-related policy development and problem solving.
HIV/AIDS programmes		
<ul style="list-style-type: none"> • Direct costs of prevention programmes (materials, staff, etc.) • Time employees spend in prevention programmes • Studies, surveys and other planning activities 		

Source: Whiteside, A and Sunter, C, 2000

In estimating the aggregate costs in all three categories, as opposed to the costs of an individual infection, three other critical pieces of information are needed:

- HIV/AIDS prevalence, morbidity and mortality must be measured through voluntary, anonymous testing or modelled;
- HIV infections tend to vary with age, sex, geographical location and by job level, a detailed demographics profile of the current and future workforce is critical to analysis; and
- Certain skills and positions are vital to a company's core processes. If such positions are vacant, the ability to provide the product or service will be heavily or completely impaired. Critical positions and skills have to be identified upfront and people filling in the posts will have to be carefully monitored for illness.

9. Responses to HIV/AIDS

Once the potential influence that HIV/AIDS will have on the firm have been identified, suitable responses will have to be put into place.

9.1. Impact on production and employees

To ensure that the production processes are not vulnerable to staff losses, strategies such as multiskilling, recruiting and training additional labour, contracting out and capital intensification will have to be adopted. Education and training programmes, provision of condom and health services are some of the activities that have been established to prevent workers from becoming infected. Companies will have to think and plan some creative strategies to prevent the spread of HIV/AIDS. As noted, several companies in Namibia have or are in the process of formulating HIV/AIDS policies. These policies should at the minimum cover prevention, care and non-discrimination. Practical management strategies, workplace principles and a workplace programme which are supported by employees should be included. The most challenging issue will be the implementation of the policies as an ongoing process, rather than on an ad-hoc basis.

9.2. Impact on costs

Costs need to be monitored and either rejected or accepted. A company may be able to reduce costs but they will have to be borne by someone and in most cases are borne by the community or the state.

9.3. Impact on markets

Increased illnesses will impact markets. It is a major issue for companies that sell most of their products and services locally. Exporters may not be affected, particularly if their markets are in developed countries.

9.4. Impact on society

The business community cannot distance itself from the society in which it operates. The same employee who works for that company is also a member of society, a household and a community. The degree to which a company is socially responsible is now a critical factor in the evaluation of the company by the public. The companies can enter into partnerships, but the role of the stakeholders needs to be clarified.

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11. List of Companies Interviewed

Telephonic interviews with Managers, Human Resource/Personnel Managers, Safety and Health Officers of Nampower, Namwater, Standard Bank, Commercial Bank of Namibia, Coca Cola, Zimmermann Garage, Shell, UNITRANS, Perfecto Bricks, Berco Cleaning Services, Hartlief Continental Meat Products and DHL. The Coordinator of the Chamber of Mines' Occupational Health Education and Awareness Programme was contacted.

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Hanns Seidel Foundation
Dr Frans Indongo St 70 –72
P.O.Box 22524
Windhoek / Namibia
Tel.: +264 61 237373
Fax: +264 61 237375
E-Mail: office@hsf.org.na
For further information visit our website:
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