payments, but also to the depreciation of the lilangeni versus foreign currencies, which affected the one-third of reserves that are rand denominated. Since 1998, the stock of net official reserves in U.S. dollars has fallen by more than 30 percent, reducing the coverage relative to imports of goods and services from 3 months in 1998 to 2½ months in 2001.

70. ***In 2001, external debt increased as a percent of GDP although it declined in dollar terms.*** In dollar terms, external debt returned to its 1998 level (US$288 million) after peaking at $358 million in 2000. Both public debt, which accounts for four-fifths of external debt, and private external debt declined in 2001. Since most of the external debt (about 90 percent) is denominated in hard currencies, the depreciation of the lilangeni vis-à-vis these currencies contributed to a significant expansion in the value of the debt expressed in emalangeni. As a share of GDP, external debt in emalangeni terms increased from 23 percent in 1998 to 32 percent in 2001, and the ratio of debt service to exports of goods and nonfactor services rose from 1.5 percent to 2.3 percent. As of March 2002, about 80 percent of public external debt was owed to multilateral organizations and financial institutions—mainly the African Development Bank, which accounts for 54 percent of the debt—while Germany was the main bilateral creditor, holding 9 percent of the debt. All public debt is of long-term maturity, having been issued with repayment periods of between 10 and 40 years, and with repayment spread out between 2002 and 2040. The debt was mainly contracted on concessional terms, and the authorities estimate the average yield at about 4 percent.

Reforms in trade and exchange control regimes

71. ***Swaziland has a relatively open trade regime, with an IMF trade restrictiveness index of 4 (on a scale of 1 to 10, with 10 being the most restrictive). Tariff rates range from 3 percent to 57 percent, with a simple average rate of 6.4 percent.*** Swaziland's trade regime is mainly governed by its membership in SACU.[41] Intra-SACU trade in goods and services faces almost no remaining barriers.[42] SACU member countries, including Swaziland, completed negotiations of a new formula to share SACU duty and excise revenues among themselves. The new formula includes an element of development assistance in the sharing exercise, as it takes into account the relative economic size of the countries. Some nontariff barriers still remain, as the list of goods that require permission to be imported has not been modified since 1974. Apart from safety items such as arms and drugs, the list includes used vehicles, clothing, and textiles, mineral oils and fuels, agricultural and animal products, precious metals, and electric appliances.

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[41] Swaziland is also a member of COMESA, but—because it also belongs to SACU—has been given a derogation with regard to its intra-COMESA trade policies. The derogation expires in May 2003.

[42] The SACU agreement allows member countries to establish tariffs to protect infant industries; these tariffs would apply to imports from SACU and non-SACU countries. Swaziland has not made use of this provision.

III. The Economic Impact of HIV/AIDS in Swaziland[43]

A. Background

72. ***The spread of HIV/AIDS continued unabated over the past decade.*** With an estimated infection rate of more than 33 percent among working-age people in 2001, Swaziland was the third-most affected country in the world, after Botswana and Zimbabwe. While new HIV infection numbers started to decline in several countries throughout the region (e.g., Botswana, Namibia, and South Africa), infection rates in Swaziland rose sharply from just 4 percent of the adult population in 1992 to the current level.

73. ***Swaziland's population is severely affected by HIV/AIDS, based on available evidence on infection rates and mortality.***[44] According to data from antenatal care (ANC) attendees, infection rates in 2000 varied among the country's five regions from 27 percent to 41 percent. At the national level, HIV prevalence in 2000 was at its peak among the 20-24-year-old ANC attendees, at 42.5 percent. In 2001, an estimated 12,000 deaths (1¼ percent of the total population) were caused and 35,000 children (7 percent of all children) orphaned by AIDS (Table III.1).

Table III.1. Swaziland: HIV/AIDS Situation
(At end-2001, unless otherwise noted)

		in percent
Population	938,000	
Estimated number of people living with HIV/AIDS	170,000	
Of which		
Women	89,000	52.4
Children aged 0-14	14,000	8.2
Children aged 0-14 orphaned by AIDS	35,000	
Estimated number of AIDS-related deaths (in 2001)	12,000	

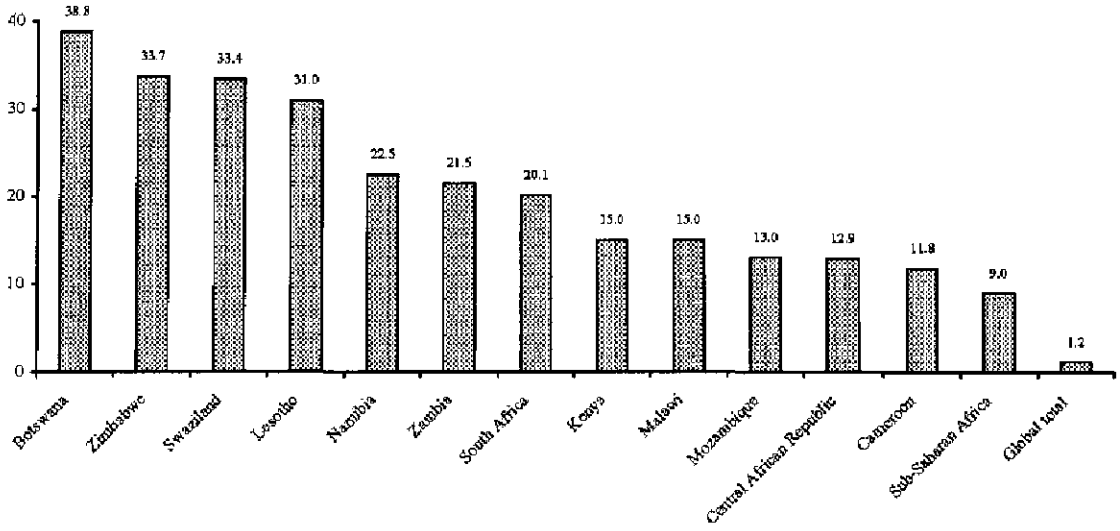
Source: UNAIDS (2002).

[43] Prepared by Gustavo Bagattini and Matthias Vocke.

[44] HIV infection rates and AIDS-related mortality for the entire population are estimated based on extrapolations from small samples. HIV tests are not mandatory in any circumstances, and the need for testing is not generally accepted in Swazi society. As a result, women attending antenatal care clinics are the only group for whom somewhat reliable statistical information on the spread of the disease is available. While women with HIV have lower fertility, which would underestimate prevalence among women, female prevalence is generally higher than male prevalence.

74. ***Swaziland is among the three countries in the world that are most affected by the spread of HIV.*** Based on estimates for the entire working-age population, Swaziland has the third-highest rate of HIV infections, both in southern Africa and worldwide—at 33.4 percent—after Botswana (38.8 percent) and Zimbabwe (33.7 percent).[45] The countries with the highest HIV infection rates are all in sub-Saharan Africa (Figure III.2).

Figure III.2. Countries with the Highest Adult HIV Infection Rates in the World, 2001
(In percent of adults aged 15-49)



Source: UNAIDS (2002).

75. ***Infection rates are particularly high among young adults, who form a large share of the economically productive population.*** Infection rates within the younger segment of this population sub-sample are also high. Furthermore, UNAIDS data for end-2001 suggest a gender divide in prevalence rates for people between 15 and 24 years of age, with infection rates for young women estimated at 31-48 percent and those for young men much lower at 12-19 percent. Reliable data on infection rates are available for attendees of antenatal care and male patients with sexually-transmitted diseases. These data show rapidly rising infection rates for antenatal care attendees at 34.2 percent in 2000, up from 3.9 percent in 1992. Prevalence rates among male patients with sexually-transmitted diseases stood at 48.9 percent in 2000.

[45] Haiti has the highest adult HIV infection rate outside Africa, recorded at 6.1 percent in 2001.

76. ***The pandemic is likely to spread further over the coming years.*** On current trends, by 2010, the number of orphans in Swaziland might triple to an estimated 120,000 (almost one-fourth of all children)[46], and life expectancy may decline further to 27 years (from 46 years in 2000).[47] Rising numbers of new infections among the working-age population suggest that the dependency ratio may continue to rise over the medium term from levels that are already high (1.0 in 2001). Depending on available treatment options, the number of AIDS-related deaths, which amounted to 1¼ percent of the total population in 2001, is likely to mirror, with a lag, the rise in infection rates. In consequence, AIDS-related mortality rates may increase dramatically, possibly to about 2 percent of the total population annually (Table III.2).

Table III.2. Swaziland: HIV Infection Rates and AIDS-Related Mortality in Southern Africa, 1990-2001
(In percent)

	HIV Infection Rates 1/						AIDS-Related Mortality Rates
	1990		1995		2001	2/	2001
Swaziland	3.9	3/	16.1	4/	33.4		1.28
Botswana	18.1	3/	32.4		38.8		1.67
Lesotho 5/	5.5	6/	31.3	4/	31.0		1.22
South Africa	0.7		10.5		20.1		0.82
Zimbabwe	12.0		37.0		33.7		1.56

Sources: UNAIDS (2002); and Swaziland Ministry of Health and Social Welfare.

1/ Based on survey results from antenatal clinic attendees.
2/ Estimated infection rate among adults aged 15-49.
3/ Data are for 1992.
4/ Data are for 1994.
5/ Infection rates are for Maseru only; they were somewhat lower in other parts of Lesotho.
6/ Data are for 1991.

77. ***Further to its demographic and social impact, HIV/AIDS threatens to significantly reduce economic growth and the standard of living over the medium term.*** In addition to its severe humanitarian and social implications, the spreading pandemic has substantial economic costs, as it constrains output growth, eliminates work skills and knowledge, shrinks the tax base, raises health-related expenditure, and increases financial imbalances in the public pension fund, all of which may in turn contribute further to the humanitarian crisis unless they are adequately addressed.

[46] Orphans in this context refers to children who have lost one or both parents.

[47] U.S. Census Bureau estimate.

78. ***The authorities reinforced their commitment to fight the disease through the establishment of the National Emergency Response Committee on HIV/AIDS (NERCHA) in 2001.*** In addition, they submitted an application to the Global HIV/AIDS Fund in September 2002, requesting funding of E 160 million (US$15 million) annually over five years. However, these efforts might still fall short of adequately addressing the likely economic burden imposed by the pandemic.

B. Macroeconomic Implications of HIV/AIDS

79. ***The economic literature on the macroeconomic impact of HIV/AIDS suggests that the disease may have fundamental implications for southern African economies.*** The pandemic could have a particularly negative effect on economies in which labor-intensive sectors dominate production. In Swaziland, the emergence of AGOA-related clothing investment in early 2000 and closures of some of the more capital-intensive businesses—such as mining operations, agro-processing, and manufacturing of consumer durables—have increased the labor intensity of the economy, making it more vulnerable to the pandemic. Some countries may be in a better position than others to avert these costs because most of their output is produced in the non-labor-intensive mining sector (e.g., Botswana, where mining output accounts for 60 percent of total output).

80. ***Swaziland's labor supply is likely to decline substantially from what it would have been without AIDS, although with a substantial lag to the HIV infection rates.*** Demographic profiles incorporating the effects of HIV/AIDS suggest that the population and labor force growth rates will decelerate and may even start to shrink later in the decade, following previous increases in the rates of HIV infections and AIDS (Table III.3).[48] Infected people have an estimated average remaining life expectancy of eight years. A declining workforce could translate into lower output growth, as long as low investment limits the capacity for a capital-labor substitution. Output growth per capita could also decrease somewhat, as declining skill levels lower total factor productivity.

Table III.3. Swaziland: Population Scenarios, 2000-50
(In thousands, unless otherwise indicated)

	2000	2015	2050
Scenario with AIDS	925	1,022	1,391
Scenario without AIDS	950	1,354	2,254
Population difference	25	332	863
(in percent)	3	25	38

Source: United Nations Population Division.

[48] While the United Nations Population Division projects only a slowdown in population growth, the U.S. Census Bureau forecasts zero growth by 2004 and a –0.4 percent annual decline by 2010.

81. ***National saving and investment rates may decrease as a result of the pandemic.*** Public saving could decline in line with increased government spending on health and other forms of social support. Private saving may also decline, as an increasing number of households will need to finance health care costs. A World Bank study[49] indicates that the saving rate in developing countries may be negatively related to the HIV prevalence rate. The incentive to invest could decline owing to lower growth prospects, higher health-related production costs, and lower expected returns from training as workers face a greater probability of falling ill.

82. ***The potential for economic growth is seriously affected by the pandemic.*** One growth model (Haacker, 2002) estimates in Swaziland that the level of per capita output relative to a baseline scenario could be depressed by some 7 percent over the medium term and by about 2 percent over the long term, partly because total factor productivity would decline with decreasing average levels of work experience. The annual fiscal balance could deteriorate substantially as a result of sharply increasing health expenditure. Haacker estimated that the additional costs arising from AIDS-related deaths, such as a shrinking tax base and an increase in underfunding of pension funds, could be more than E 1 billion (US$95 million; cumulative estimate) during 1999-2016.

83. ***Poverty in households throughout Swaziland is likely to rise as a result of HIV/AIDS.*** Despite Swaziland's categorization as a low-middle-income country, its income distribution is highly skewed, two-thirds of the population lives on less than US$1 per day, and nearly one-third of the population is unemployed.[50] The spread of HIV/AIDS could increase poverty, as households lose their breadwinners, savings are consumed by increased medical costs and funerals, and fragile networks of support are further drained.

84. ***The pandemic could also negatively affect efforts aimed at poverty alleviation.*** With economic growth potentially slowing down as a result of HIV/AIDS, government finances might be weakened, leaving the government less able to provide social support. The main challenges for government finances could stem from a decline in non-SACU tax revenues (from both lower personal income tax revenues and corporate tax revenues), substantially higher health expenditure, the continued provision of food assistance, and the liabilities of the Public Service Pensions Fund.

C. The National Response to HIV/AIDS

85. ***The formation of NERCHA represents a new step in the fight against HIV/AIDS, which in the past was hampered by limited cooperation among various agencies.*** NERCHA's operating budget for 2002/03 (April-March) is E 32 million (¼ of 1 percent of

[49] World Bank (2000).

[50] At 0.61, Swaziland's Gini coefficient is the highest among LMI countries.

GDP).[51] The committee's moderate success in coordinating existing groups, including nongovernmental organizations (NGOs), and spending its allocation indicates that its funds may be exhausted by the end of the year. In contrast, in 2001/02, only one-fourth of the budget allocations to HIV/AIDS were actually spent, owing to coordination problems among the agencies involved.

86. ***NERCHA aims to tackle various aspects of the disease, including prevention, support, care, and impact mitigation.*** Factors exacerbating the situation include the lack of education about HIV/AIDS, behavioral practices, the health care's infrastructure and limited reach, the lack of technical experts and health care professionals, limited home-based care material, the destitution of orphans, and the prohibitive cost of adequate treatment.

87. ***Future funding of NERCHA's efforts may come from increased allocations in the national budget and from the international community.*** Budget expenditure on HIV/AIDS, which doubled in 2002/03, is expected to increase by another 50-100 percent in 2003/04. However, non-HIV/AIDS health expenditures have decreased, which may jeopardize the Ministry of Health's ability to create and maintain an appropriate infrastructure to fight and treat the disease. The authorities have submitted an application to the Global HIV/AIDS Fund requesting funding of E 160 million (US$15 million) annually over five years. The success of this and further aid requests may be dependent on the demonstration of a strong domestic commitment to fight the disease.

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[51] Out of NERCHA's budget, E 20 million was allocated from the national budget, of which E 12 million was carried over from 2001/02. NERCHA became operational in June 2002, and had spent E 10 million as of September 2002.