ZIMBABWE MAPPING & INVENTORY STUDY

Academy for Educational Development

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ACRONYMS

AED	Academy for Educational Development
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral drugs
BCC	Behavior Change Communication
CDC	U.S. Centers for Disease Control and Prevention
CSO	Central Statistics Office
CZI	Confederation of Zimbabwe Industries
DFID	Department for International Development
HIV	Human Immunodeficiency Virus
GPA	United Nations Global Program on AIDS
IEC	Information Education Communication
IHWEP	International HIV/AID Workplace Education Program
ILO	International Labor Organization
LIFE	Leadership in Fighting an Epidemic
MoHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NANGO	National Association of Nongovernmental Organizations
NECTOI	National Employment Council for the Transport Operating Industry
NGO	Nongovernmental Organization
PLWHA	People Living with HIV/AIDS
PSI	Population Services International
RA	Research Assistants
SMARTWork	Strategically Managing AIDS Responses Together Project
SMEs	Small and Medium Size Enterprises
SRR	Survey Response Rate
STI	Sexually Transmitted Infections
TAB	Tripartite Advisory Board
UNAIDS	Joint United Nation Program on AIDS
UNDP	United Nations Development Program
USAID	U.S. Agency for International Development
USDOL	U.S. Department of Labor
VCT	Voluntary Counseling and Testing
WASN	Women AIDS Support Network
WHO	World Health Organization
ZAN	Zimbabwe AIDS Network
ZBCA	Zimbabwe Business Council on AIDS
ZAPA	Zimbabwe AIDS Policy and Advocacy Project
ZAPP	Zimbabwe AIDS Prevention Project
ZAPSO	Zimbabwe AIDS Prevention Service Organization
ZCTU	Zimbabwe Congress of Trade Unions
ZNCC	Zimbabwe National Chamber of Commerce

KEY FACTS AND FIGURES

- According to UNAIDS, as of 2003, up to 46 million people in the world were living with HIV/AIDS.[1]
- Some countries will see a drop of 25% in their workforce by 2020 because of AIDS; in some countries, AIDS costs employers over 20% of their total earnings.[2]
- Zimbabwe's HIV/AIDS prevalence rate is the third highest in the world, after Botswana and Swaziland. With as many as 2.3 million people living with HIV/AIDS, the nation is one of those most severely affected by the epidemic.[3]
- One-quarter (24.9%) of all Zimbabweans between the ages of 15 and 49 are living with HIV/AIDS. These individuals are in their most sexually active years, as well as their most economically productive.[4]
- The epidemic has reduced life expectancy in Zimbabwe from 66 to 33 years of age. Each year, 200,000 Zimbabweans die from AIDS-related causes, and 2,000 new infections occur every day. Approximately 70% of hospital admissions are now HIV-related.[5]
- It is estimated that 92% of HIV cases are transmitted through unprotected heterosexual intercourse. Young women are particularly vulnerable to infection by older male sexual partners.[6]

SMARTWORK: THE WORKPLACE RESPONSE TO AIDS

SMARTWork (Strategically Managing AIDS Responses Together in the Workplace) is a project of the Academy for Educational Development (AED). SMARTWork was initiated by AED with funding from the U.S. Department of Labor and U.S. Centers for Disease Control and Prevention (CDC). With funding primarily provided by CDC for the Zimbabwe project, and DOL supporting the programs in five other countries, SMARTWork currently works in Zimbabwe, the Dominican Republic (DR), Haiti, Nigeria, Ukraine, and Vietnam.

SMARTWork forges strategic partnerships between business enterprises, labor groups, and governmental and nongovernmental organizations (NGOs) to create workplace HIV/AIDS prevention, care, and support programs. SMARTWork fosters social dialogue around workplace HIV/AIDS prevention at both the national and enterprise levels, and

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[1] Joint United Nations Programme on HIV/AIDS (UNAIDS). Report on the Global HIV/AIDS Epidemic. Geneva: UNAIDS. 2002.
[2] UNAIDS. UNAIDS Releases New Data Highlighting the Devastating Impact of AIDS in Africa. Geneva: UNAIDS. June 2002.
[3] Garbus, Lisa and Gertrude Khumalo-Sakutukwa. Country AIDS Policy Analysis Project: HIV/AIDS in Zimbabwe. San Francisco: University of California San Francisco, AIDS Policy Research Center. November 2003.
[4] UNAIDS. AIDS Epidemic Update 2003. Geneva, Switzerland. 2003.
[5] Garbus and U.S. Department of State, Bureau of African Affairs. Background Note: Zimbabwe. Washington, DC: U.S. Department of State. 2002.
[6] Garbus and Khumalo-Sakutukwa.

works to implement programs that reduce stigma and discrimination towards those living with HIV/AIDS.

SMARTWork/Zimbabwe began in-country activities in September 2002. The program offers a wide range of workplace-focused activities, including:

- Helping enterprises assess their readiness to address HIV/AIDS, and assisting them to respond effectively with appropriate HIV/AIDS policies and comprehensive programs.
- Helping enterprises assess their readiness to address HIV/AIDS, and assisting them to respond effectively with appropriate HIV/AIDS policies and comprehensive programs.
- Conducting presentations, workshops, and other trainings that build employers' and workers' capacity to undertake and sustain workplace HIV/AIDS programs.
- Providing materials and tools that aid government, business, and labor in creating and implementing effective workplace programs.

The negative impact of HIV/AIDS can no longer be seen as a challenge only for government and the health sector. An effective national response to HIV/AIDS requires a comprehensive workplace approach in which employers, labor, and government work together. Addressing HIV/AIDS in this manner will protect workers' health and safety, secure the welfare of future generations, ensure economic vitality, and protect employers' productivity and profitability. SMARTWork helps to achieve these goals and to safeguard individuals, their employers, and the broader community.

I. INTRODUCTION

Over the past two decades, many workplace-focused HIV/AIDS interventions have been undertaken in Zimbabwe. However, with the large number of organizations involved—including international and domestic NGOs, individual businesses, labor unions, and other organizations—there is not a clear sense of the range of workplace HIV/AIDS programs and policies that exist in the country. SMARTWork/Zimbabwe conducted this Mapping and Inventory Study as part of the organization's work with the CDC in Zimbabwe. The Survey is a companion to SMARTWork/Zimbabwe's document—*Zimbabwe Country Brief: A Critical Need for a Government, Business, and Labor Tripartite Response to HIV/AIDS at the Workplace*—which provides a more qualitative assessment of the situation.

The specific objectives of the study were to conduct a thorough "mapping" or "inventorying" of organizations that have, or have had, workplace HIV/AIDS prevention and education programs in both the formal and informal sectors. As part of this, the study would identify the principal activities, tools and resources being used.

Both quantitative and qualitative research methods were used to conduct the inventory, including a literature review and application of three structured questionnaires tailored to

employers, NGOs, and trade unions. The surveys collected information on the following key areas:

- Existence of workplace HIV/AIDS policies and programs at companies and other organizations. Where they exist, what are the policies?
- Knowledge and views about the *Statutory Instrument 202/98*.
- Partnering between companies and NGOs in undertaking workplace efforts.
- Participation of labor unions in HIV/AIDS programs.
- Funding sources for programs.
- Training needs of businesses and other organizations.
- Media preference for how to receive HIV/AIDS-related information.
- Willingness to participate in the SMARTWork program.

The principal investigators of the inventory study (the Inventory Team) were comprised of two AED staff and a consultant. The Inventory Team also engaged 30 Research Assistants. The fieldwork was undertaken between December 2002 and March 2003, with 2,780 questionnaires administered.

II. OVERVIEW OF HIV/AIDS IN ZIMBABWE

HIV/AIDS in Zimbabwe

The first Zimbabwean AIDS case was diagnosed in 1984 and, since then, the HIV seroprevalence rate has grown exponentially.[7] The numbers of those affected by HIV/AIDS are staggering. According to the United Nations, 24.9% of the Zimbabwe adult population aged 15-49 is HIV-positive.[8] By the end of 2001, UNAIDS estimated that 1.8 to 2.7 million Zimbabweans were living with HIV/AIDS, of whom two million were adults aged 15-49 and 60% were women.[9] UNAIDS estimates that Zimbabwe experiences 200,000 AIDS-related deaths annually, and 2,000 people are newly infected every day.[10] A half a million people have already died, and 780,000 children have lost one or both parents.[11]

As a result of AIDS, Zimbabwe's life expectancy has plunged from 66 to 33 and it is estimated that the country's population will be 61% smaller in 2050 than it would have been without the epidemic.[12] Ninety-two percent of HIV transmission is due to

[7] Central Statistical Office and Macro International. Zimbabwe Demographic and Health Survey: 1999. Harare, Zimbabwe: Central Statistical Office and Macro International. 1999.

[8] UNAIDS. AIDS Epidemiological Update 2003. The 2003 data correct previous, flawed data that indicated a prevalence rate of 33.7 percent. The lower number, according to UNAIDS, indicates a correction rather than a decline in seroprevalence.

[9] Garbus; Zimbabwe National AIDS Council (NAC). AIDS in Africa During the 90's: Zimbabwe—A review and analysis of surveys and research studies. Harare: The Zimbabwe Ministry of Health and Child Welfare, the MEAURE Project, and the CDC/Zimbabwe. 2002; UNAIDS. Report on the Global HIV/AIDS Epidemic. 2002.

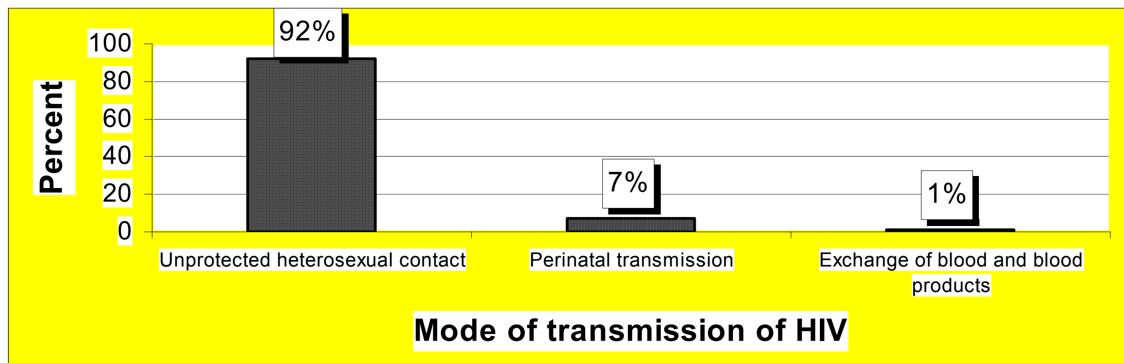
[10] Garbus, Ibid.

[11] Garbus and UNAIDS. Epidemiological Fact Sheets on HIV/AIDS: Zimbabwe. Geneva: UNAIDS. 2002.

[12] Garbus and Khumalo-Sakutukwa, op. cit.

unprotected heterosexual intercourse. Perinatal transmission accounts for seven percent of cases, and infected blood another one percent.[13] In 1990, the government began a surveillance system among pregnant women to assess unprotected heterosexual activity; the results indicate that many women have older male sexual partners, from whom they are at high risk of infection with HIV.[14]

Figure 1. Modes of Transmission of HIV in Zimbabwe



High rates of unemployment and poverty have forced people—particularly women and youth—into survival sex, thereby increasing the risk of HIV and other sexually transmitted infections (STIs).[15] As one respondent noted, "If I fail to eat because I have no money, I die in a week. If I engage in commercial sex to live, I die [from AIDS] in 20 years." A 1995 study found that 86% of Harare's sex workers were living with HIV/AIDS.[16]

Seventy percent of hospital admissions are HIV-related.[17] With HIV/AIDS-related illnesses rising to 60% of the national health budget, the government's capacity to provide basic social services is declining.[18] At the same time, Zimbabwe's health allocation dropped from 12.7% of the budget, in 2002, to 8.33% in 2003.[19] The HIV/AIDS epidemic is compounded by droughts that have affected the country since 1999 and placed half of the country at risk of starvation.[20]

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[13] NAC. AIDS in Africa during the Nineties. Garbus cites Zimbabwe General Statistics Office. Zimbabwe Demographic and Health Survey 1999. Calverton, MD: Macro International. 2000.

[14] Ministry of Health and Child Welfare. Draft: National Survey of HIV and Syphilis Prevalence Among Women Attending Antenatal Clinics in Zimbabwe: 2000. Harare, Zimbabwe: MOHCW. 2001; NAC. AIDS in Africa during the Nineties.

[15] Zimbabwe AIDS Prevention and Support Organization (ZAPSO). An Impact Assessment of the Private Sector AIDS Prevention Initiative: Workplace–Based Peer Education Program. Harare: ZAPSO. 2002; and Zimbabwe Women's Resource Center and Network. Gender and HIV/AIDS: an Analysis of Zimbabwe's National Policies and Programs on HIV/AIDS/STIs. Harare: Zimbabwe Women's Resource Center and Network. 2003.

[16] Garbus and Khumalo-Sakutukwa, op. cit.

[17] Garbus and U.S. Department of State, op. cit.

[18] Garbus and USAID. Zimbabwe: Health and Family Planning Briefing Sheet. Washington: USAID. 2002.

[19] United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Zimbabwe: AIDS-related deaths rise due to food crisis. Bulawayo: OCHA. November, 2003.

[20] Garbus cites OCHA. UN Consolidated Inter-Agency Appeal in Response to the Humanitarian Crisis in Southern Africa—Zimbabwe. New York: UN. July 2002-June 2003.

Zimbabwe's population is extremely young; 40% of the population is under age 15.[21] Because most people living with HIV/AIDS (PLWHA) are young and economically productive, the epidemic's impact on the country's economy has been devastating.[22] HIV/AIDS has reduced the country's active and productive labor force while increasing poverty. The economy faces massive challenges in maintaining sustainable productivity levels with a workforce that is often absent, placed on light duty, or unavailable due to sick, compassionate, or extended leave.[23] For example, the Food and Agriculture Organization of the United Nations (FAO) estimates that between 1985 and 2020, the country will lose 23% of its agricultural labor force because of the HIV/AIDS epidemic.[24]

Public HIV/AIDS Knowledge

Despite over two decades of experience with HIV/AIDS in Zimbabwe, misconceptions about the epidemic continue to exist. Misinformation about the virus' origin, transmission modes, and prevention and treatment methods was widespread in SMARTWork's interviews with employees. There were common misconceptions about condoms—including misguided fears about holes in condoms through which HIV can slip and/or that condoms are impregnated with HIV as a means of infecting Africans—that hampers prevention efforts.

Stigmatization against PLWHA is also rampant in Zimbabwe, in large part because illness has traditionally been viewed as punishment for negative behavior.[25] Fear of stigma and discrimination at work and in the community often discourages people from seeking counseling and testing services, and an estimated 90% of those living with HIV/AIDS do not know their serostatus.[26] In numerous SMARTWork interviews, respondents stated that they knew where to get tested, but were afraid of learning the results. Discrimination against PLWHA was noted as being widespread in both workplaces and the community. Fear and discrimination is a major hindrance to individual's learning their HIV/AIDS status, seeking care and support services, and protecting their partners from infection.

National HIV/AIDS Laws and Policies

Since the first AIDS cases were identified in 1984, the government has undertaken several responses to the epidemic. It introduced universal blood product screening, with

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[21] Garbus and Khumalo-Sakutukwa, op. cit.
[22] Zimbabwe AIDS Prevention Project (ZAPP). Peer Education Training Manual. Harare: ZAPP. 2000; and Zimbabwe National Family Planning Council. National Youth Reproductive Health Survey: 1997. Harare: Zimbabwe: Zimbabwe National Family Planning Council. 1999.
[23] NAC. AIDS in Africa during the Nineties.
[24] Garbus and Khumalo-Sakutukwa, op. cit.
[25] Garbus cites SAFAIDS/PANOS/UNAIDS. Men and HIV in Zimbabwe. 2001
[26] Garbus cites Ghosh, S. et al. Social Marketing Approaches to Voluntary Counseling and Testing (VCT) in Zimbabwe. In *XIV International Conference on AIDS*. Barcelona. 2001.

the result that infections from blood transfusions are now extremely rare (0.61%).[27] Zimbabwe created its first National HIV/AIDS Policy in 1999. The most important workplace response has been *Statutory Instrument 202 of the 1998 Labor Relations Act* (*Statutory Instrument*), which addresses HIV/AIDS in the workplace and establishes the rights and responsibilities of employers and employees. The *Statutory Instrument* is designed to ensure non-discrimination against PLWHA, and to establish the rights and responsibilities of employers and employees.

The *Statutory Instrument* requires employers to provide education and information relating to HIV/AIDS and other STIs; prohibits discrimination on the grounds of an employee's serostatus; prohibits HIV testing as a condition of employment or promotion; ensures the confidentiality of workers' HIV status; requires employers to provide training and information to reduce risk of infection as well as necessary personal protective devices (e.g. appropriate safety/universal precautions equipment where called for); and requires that PLWHA receive the same medical and sick benefits as other workers.

In addition, Zimbabwe has passed a number of other policies and regulations on HIV/AIDS. Zimbabwe introduced a National AIDS Levy in 1999, which is funded by a 2.4% tax on all formally employed workers' salaries. The funds, managed and distributed by the National AIDS Council, support HIV prevention efforts and provide care and support programs. Other efforts include the 1999 National AIDS Policy and National Orphans' Policy; the 2000 Strategic Framework for National HIV/AIDS Response (2000-2004); and the 2001 Prevention of Parent to Child Transmission Policy. In 2002, HIV/AIDS was declared a state of emergency in Zimbabwe, and the National HIV/AIDS Task Force convened in the same year. The government is currently drafting a *Plan for the Nationwide Provision of Antiretroviral Therapy (ART).*

In general, however, the public's awareness of these policies, programs, and funding streams remains low. Until 2000, President Mugabe rarely mentioned HIV/AIDS publicly.[28] In addition, despite the *Statutory Instrument*'s requirement that employers provide a copy of the document to workers', many are unfamiliar with the rights ensured by the law. In 2001, the Zimbabwe National Association of Nongovernmental Organizations (NANGO) and Zimbabwe AIDS Network (ZAN) released a report that assessed NGO's awareness of the country's HIV/AIDS programs and policies. It found that awareness and implementation of the National AIDS Policy is weak, and recommended clearer and more aggressive leadership of viable prevention, care, and support efforts.[29]

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[27] Garbus and Khumalo-Sakutukwa, op. cit.
[28] Ibid.
[29] Felicity Hatendi. Assessment of the Level of Implementation of the Zimbabwe National AIDS Policy and Accessibility of the National AIDS Trust Fund by Civil Society. Harare: Zimbabwe National Association of Non-Governmental Organizations and Zimbabwe AIDS Network. September 2001.

III. METHODOLOGY

The research methodology was comprised of four components:

(1) Literature review through desk research;
(2) Baseline survey;
(3) Structured and semi-structured interviews; and
(4) Trade unions consultative workshop.

A literature review was conducted to inform the design of the study instruments (key documents are listed in the bibliography). Four survey tools were developed:

- Tool 1—Questionnaire for Companies: targeted at employers in all sectors of the economy. It was designed to capture the general characteristics of the organizations and their HIV/AIDS-related education, prevention, care, and support activities; the Information, Education, and Communication (IEC) materials that they use; their policies; their perspectives on *Statutory Instrument 202/98*; and their preferred methods of receiving information.
- Tool 2—Questionnaire for Service Organizations: targeted at HIV/AIDS organizations that provide TA and other services related to HIV/AIDS and the workplace. The questionnaire was designed to capture information on the types of workplace activities that NGOs have undertaken and the materials they have designed.
- Tool 3—Questionnaire for Umbrella Organizations: a discussion guide for umbrella organizations and professional associations to learn what their and their stakeholders' views are about HIV/AIDS programs at the workplace.
- Tool 4—Questionnaire for Trade Unions: targeted at labor union representatives, and similar to Tool 1 for companies.

The Inventory Team, with the assistance of 30 Research Assistants (RAs), conducted the inventory study between December 2002 and March 2003. The work was divided into two Phases. Phase 1 covered most of Harare and was conducted by 10 RAs in December (2002) and January (2003). Phase 2 was completed by 30 RAs between February and March (2003) in 10 provinces (Bulawayo, Harare, Matabeleland North, Matabeleland South, Midlands, Masvingo, Manicaland, Mashonaland East, Mashonaland Central and Mashonaland West).

The RA's were drawn from the University of Zimbabwe and were undergraduate and post-graduate students in the fields of social work, economics, law, politics and administration, and education. SMARTWork/Zimbabwe staff held two training workshops for the research assistants. A separate workshop for trade unions was jointly organized with the Zimbabwe Congress of Trade Unions (ZCTU) on January 16, 2003. At this workshop, 20 trade union representatives completed the questionnaire.

The overall study population was drawn from a sample of private sector companies, NGOs, members of the informal sector, business and labor umbrella organizations, and public sector organizations. The samples included, for example, approximately 400

members of the Confederation of Zimbabwe Industries (CZI), 557 members of the Zimbabwe National Chamber of Commerce (ZNCC), key representatives of the 32 affiliates of the ZCTU, selected representatives of 58 rural and district councils, and 250 members of the NANGO. A total of 2,789 questionnaires were completed, yielding a Survey Response Rate (SRR) of 93% from the target sample of 3,000 questionnaires.

The Inventory Team used the number of telephone exchanges in each geographic area to estimate the concentration of commercial industry. The RAs were then allocated exchange areas to survey. They carried introductory letters, SMARTWork information materials, and copies of the 1998 *Statutory Instrument*. After completing the field data collection, the questionnaires were edited, checked, and coded. Coding was based on a dictionary created for this study. The Statistical Package for Social Scientists 10.0 (SPSS) package was used for data entry and for generating and analyzing frequencies, percentages, cross tabulations and, where appropriate, statistical tests of significance and other quantitative data.

There were a number of logistical and socio-political challenges to conducting the surveys. First, it was difficult to conduct the study at during the first period selected, because companies and organizations traditionally close for two weeks in the second half of December. Second, the severe petrol crisis (compounded by other infrastructure difficulties with electricity, telephone lines, and office supplies) substantially lengthened the time required to complete the research. Finally, in the current socio-political climate, organizations in a number of districts were suspicious of the research, responded negatively to the interviewers, and were reluctant to release documents (e.g., written HIV/AIDS policies).

IV. FINDINGS FROM EMPLOYERS AND UNIONS

Employers' Responses on HIV/AIDS Workplace Policies

Eleven percent (300) of the total number of organizations surveyed (2,789) had a HIV/AIDS policy and the remaining 89% (2,489) did not. Of the 300 organizations with policies, 3.9% (12) of them had written policies that could be documented. Interestingly, 43% (129) of the companies with policies were large, having more than 250 employees. Only 22% (66) of the organizations with policies were willing to make a copy available to the Inventory Team. The primary reason stated for unwillingness to disclose company policies was concern that the policies might not conform to national laws. Some respondents noted that HIV/AIDS is not the only disease threatening workers' health, and that a formal policy can be intimidating. Nonetheless, other companies were interested in developing policies, and had recognized that HIV/AIDS necessitated special workplace considerations and actions.

A sectoral distribution analysis of those with and without policies showed that NGOs, health-related, finance and insurance, manufacturing, and transport and communications

organizations have the great percentage of HIV/AIDS policies. The sectoral distribution of the existence of HIV/AIDS policies by type of production is shown in Table 1.

Table 1: Existence of HIV/AIDS Policy by Type of Production/Sector

Type of Production	Yes		No		Total	
	Number	**%**	**Number**	**%**	**Number**	**%**
Agriculture	7	6	112	94	119	4
Mining and Quarrying	5	14	32	86	37	1
Manufacturing	94	22	342	78	436	16
Electricity and Water	1	7	14	93	15	1
Construction	3	3	102	97	105	4
Finance and Insurance	30	21	116	79	146	5
Real Estate	6	15	34	85	40	2
Distribution, Hotels and Restaurants	54	4	1211	96	1265	45
Transport & Communication	42	15	235	85	277	10
Public Administration	10	22	35	78	45	2
Education	10	9	102	91	112	4
NGOs/Trusts	23	27	62	73	85	3
Health	13	33	27	67	40	1
Others	2	3	65	97	67	2
TOTAL	**300**	**11**	**2489**	**89**	**2789**	**100**

A content analysis of the documented policies revealed that none of the organizations had the entire package of recommended policy elements. Respondents were given a list of policy elements and asked to mark the elements contained in their policies. The findings are set out in Table 2. A content analysis of the policies for the 12 (3.9%)[30] organizations with written/documented HIV/AIDS-related workplace policies revealed that none of the organizations had the entire package of ILO (which are the same as SMARTWork's) recommended policy elements. Respondents were given a list of policy elements and asked to mark the elements contained in their policies. The findings are set out in Table 2. The data reflected in Table 2 is based on *multiple* responses, that is, there was likelihood of organizations in the survey responding to more than one response. As shown in Table 2, the inclusion of confidentiality of medical information in HIV/AIDS workplace policy documents had the highest response (18%), while equal staff development opportunities had the least response (12%).

[30] There were 300 companies reporting policies, but only 12 were written/documented.

Table 2: Inclusion of Policy Elements in HIV/AIDS Policies (N = 300)[31]

Policy Element	Number	%
Confidentiality of Medical Information	71	18
No HIV Testing for Recruitment	57	15
Continuation of Employment if HIV+	53	14
No Discrimination Against PLWHA	53	14
Preventing Mandatory HIV Testing	53	14
Career Progression if HIV+ or with AIDS	49	13
Equal Staff Development Opportunities	48	12
Total responses	**384**	**100**

Employers' Responses on HIV/AIDS Workplace Programs

Workplace prevention education, care, and support programs can play a critical role in reducing the transmission of HIV, stigma, and discrimination at the workplace. A comprehensive package of program components is considered most effective for the workplace (AED/SMARTWork's *Management and Labor Leaders' Guide* is a useful reference guide on how to implement a comprehensive program). Unfortunately, none of the organizations interviewed reported having a comprehensive program. Some respondents felt that it was better for an external organization or NGO to provide care and support services, since they could be objective and maintain privacy. Others noted that the large amount of stigma still associated with HIV/AIDS complicates efforts to encourage people to seek information, or to reveal their serostatus and access care.

HIV/AIDS workplace program components can be broadly divided into (1) education and prevention programs and (2) care and support programs. Regarding the first component, as Table 3 shows, only about one-half of companies had at least one element.

Table 3: Companies with at Least One HIV/AIDS Education and Prevention Program Component (N = 2 789)

Program Status	Number	%
At least one program	1289	46.2
No program at all	1500	53.8
Total	**2789**	**100.0**

Breaking down the types of activities that the 1289 organizations with programs offered, the survey found that approximately one-third of them offered formal health education sessions and/or condom distribution programs, and nearly one-quarter had peer education programs.

[31] Data in Table 2 is based on 300 organisations that responded in the survey that they had workplace HIV/AIDS policies.

Table 4: Current HIV/AIDS Education and Prevention Programs (N = 2789)[32]

Type of program	Number	%
Health Education Sessions	676	31
Condom Distribution	654	30
Peer Education	518	23
Occupational Health Service[33]	270	12
VCT	95	4
Total responses	**2213**	**100**

The survey also collected data on care and support programs that existed at the workplace. As Table 5 shows, 42.9% of companies had at least one element of an HIV/AIDS care and support program.

Table 5: Companies with at Least One HIV/AIDS Care and Support Program (N = 2789)

Program Status	Number	%
At least one program	1593	42.9
No program at all	1196	57.1
Total	**2789**	**100.0**

Table 6 presents data on the companies that had at least one HIV/AIDS care and support program component. Slightly more than one-quarter of the companies offer compassionate and/or extended leave while much fewer reported having other expected elements of HIV/AIDS care and support services.

Table 6: Current HIV/AIDS Care and Support Programs (N = 2789)[34]

Type of program	Number	%
Compassionate Leave	1040	28
Extended Leave	964	26
Medical Aid	676	18
Funeral Insurance Policies	480	13
Counseling	416	11
Nutrition	129	3
Provision of Antiretrovirals	33	1
Total responses	**3738**	**100**

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[32] This data is based on multiple responses on current HIV/AIDS Education and Prevention Programs. This is a sub-sample of 1289 companies who responded that they had at least one HIV/AIDS education and prevention program component.

[33] Occupational health services are those provided in or near the place of employment that protect workers against work-related health services and contribute to maintaining workers' best possible physical and mental health. They may also include preventive and curative medical services. See ILO. Occupational Health Services Recommendation R112, Geneva: ILO. 1959.

[34] The data reflected in Table 6 is based on multiple responses.

The sectoral distribution of STI management is shown in Table 7. Because of the strong link between the prevalence of Sexually Transmitted Infections (STIs) and HIV transmission, workplaces are encouraged to make STI diagnosis and treatment services available at low or no cost to workers and their partners. Unfortunately, only 16% (452) of organizations reported offering STI management services to their workforce.

Table 7: STI Management by Type of Production/Sector (N = 2789)

Type of Production	Yes		No		Total	
	Number	%	Number	%	Number	%
Agriculture	24	20	95	80	119	4
Mining & Quarrying	7	19	30	81	37	1
Manufacturing	92	21	344	79	436	16
Electricity and water	5	33	10	67	15	1
Construction	6	6	99	94	105	4
Finance and Insurance	25	17	121	83	146	5
Real Estate	1	2	39	98	40	1
Distribution, Hotels and Restaurant	118	9	1149	91	1267	45
Transport & Communication	56	20	221	80	277	10
Public Administration	14	31	31	69	45	2
Education	36	32	76	68	112	4
NGO/Trust	49	58	36	42	85	3
Health	12	32	26	68	38	2
Others	7	10	60	90	67	2
TOTAL	**452**	**16**	**2337**	**84**	**2789**	**100**

HIV/AIDS Related Materials Collected from the Field

SMARTWork collected HIV/AIDS materials from the field for inclusion on the projects website (www.smartwork.org). The materials frequently contained very general information about HIV/AIDS, and only three documents were targeted specifically at addressing HIV/AIDS and the workplace. In discussing these materials, respondents noted that the Ministry of Health and Child Welfare, the Ministry of Education and Culture, the National AIDS Council, and other NGOs had been active in providing posters and pamphlets on HIV/AIDS. Participants noted that pamphlets are useful because workers can take them home and read them privately. Materials must be accessible and engaging in order to be effective.

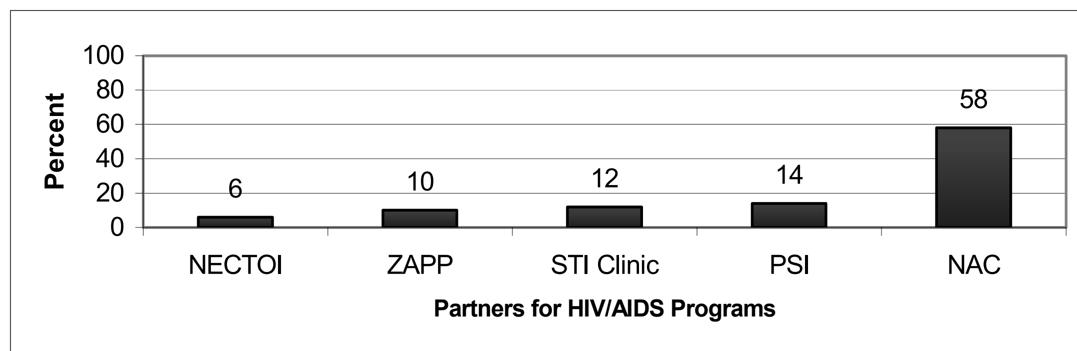
Table 8: Materials Collected from the Field

Type of Material	Number
Pamphlets	19
Booklets	17
Posters	12
Newsletters	8
Magazines	4
Reports	6
Policies	5
Fact Sheets	1
Stickers	1
Caps	1
Calendars	1
Total	**75**

Partner Organizations

Nearly one-fifth of the company respondents (19.5%) work with partner organizations to implement HIV/AIDS programs for their workplaces. The most common partner is the National AIDS Council (NAC), followed by Population Services International (PSI) and the Zimbabwe AIDS Prevention Project (ZAPP).

Figure 2: Company Workplace Partners for HIV/AIDS Programs (N = 2789)

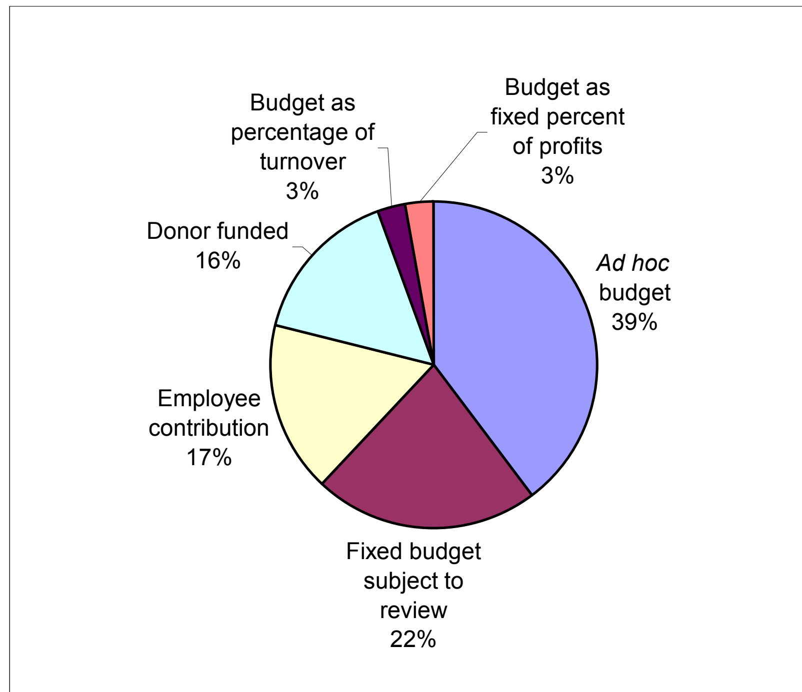


Funding and Investment in Workplace HIV/AIDS Programs

Thirty-nine percent of the organizations interviewed fund their HIV/AIDS programs through *ad hoc* budget allocations, mainly because support for such programs depends upon the companies' ability to pay, which fluctuates with their profits. Other organizations have access to donor funding through partnerships with NAC and NGOs with workplace programs. Companies also noted that they would like more information on how funds collected for the government's AIDS Levy are used, and note that the Levy

(as well as other financial incentives or rebates) could support workplace HIV/AIDS interventions. Figure 3 shows the comparisons as to how budgets for HIV/AIDS programs are determined.

Figure 3: HIV/AIDS Workplace Funding Patterns



Desired HIV/AIDS Education, Health Care, and Support Programs

Respondents were asked which programs they would like to see implemented in their workplaces. Responses to the "wish list" show that the most highly sought after program is health education (45.3%), followed by provision of anti-retroviral drugs (42%), counseling services (32.4%), and peer education programs (30.5%). Compassionate leave and extended leave received the lowest number of responses (around 14%). Interesting, these leave programs are among the most common forms of care and support offered by companies. It is not clear whether the low percentage means that these programs are not very desirable or, more likely, that they are not sought after because they are already established in many companies. Table 9 compares the percentage responses of the different items on the "wish list" of education, prevention, care, and support programs.

Table 9: "Wish" List of Education, Prevention, Care, and Support Programs (N = 2789)[35]

Program	N	%
Health Education	1262	45.3
Anti-Retroviral Drugs	1170	42.0
Counseling	903	32.4
Peer Education	850	30.5
Funeral Insurance Policy	741	26.6
Occupational Health Service	723	25.9
Extended Leave	415	14.9
Compassionate Leave	404	14.5
Total Responses	**6468**	**100**

Training Needs: Education, Prevention, Care, and Support Programs

The participants identified many training needs, including skills building on the following topics:

- Design and implementation of both policies and programs for workers as well as their dependents (especially youth)
- Prevention and control of HIV/AIDS
- Health education and identification of HIV/AIDS symptoms
- Development of IEC and BCC materials
- Facilitation of behavior change
- Home-based care to serve the needs of PLWHA who are not hospitalized
- Nutrition, especially in rural areas
- Counseling
- Increased communication with partners
- The ILO *Code of Practice* and Zimbabwe's *Statutory Instrument 202/98*.

Media Preferences

Respondents were asked which kinds of media were most appropriate for disseminating HIV/AIDS information. Radio and television are the preferred media forms, particularly for those with low literacy skills. Newspapers and music were the next most popular forms. Radios were thought to be appropriate in rural areas, where TV reception is poor. Music was deemed engaging when the lyrics are memorable. Both radio and music are appropriate outreach mechanisms for staff employed on a shop floor engaging in repetitive tasks. Table 10 summarizes these responses.

[35] Total of the multiple responses obtained on "wish" list from the 2 789 companies which participated in the survey.

Table 10: Media Preferences for Outreach on HIV/AIDS (N = 2789)[36]

Media Type	Number	%
Radio	1569	18
Television	1361	16
Newspapers	1285	14
Music	1274	14
Billboards	740	8
Films	737	8
Workshops	674	8
Posters/Pamphlets	612	7
Theatre	554	7
Total responses	**8806**	**100**

Knowledge of the 1998 Statutory Instrument 202/98

One of SMARTWork's objectives is to encourage development of policies that comply with the HIV/AIDS National Strategic Plan, using *Statutory Instrument 202/98* as the starting point. It was, therefore, important to gather baseline information on the level of knowledge about the *Statutory Instrument*, which was accomplished by asking if respondents had read the instrument or heard about it. A total of 354 respondents (12.7%) indicated that they had read the *Statutory Instrument 202/98*; 87.3% had not read it.

Respondents noted that the document was important and that every employee should receive a copy of it. Some who had not previously been familiar with the document were provided copies and indicated that they would bring it to the attention of other managers. Some companies feared that the policy would require them to retain unproductive workers, causing economic losses. Sectoral distribution on respondents who had previously read the *Statutory Instrument* is shown in Table 11.

[36] The data in Table 10 is based on multiple responses.

Table 11: Respondents Reporting Having Read Statutory Instrument 202/98, by Type of Production/Sector (N = 2789)

Types of Production	Yes		No		Total	
	Number	%	Number	%	Number	%
Agriculture	16	14	103	86	119	4
Mining and Quarrying	5	14	32	86	37	1
Manufacturing	75	17	361	83	436	16
Electricity and Water	4	27	11	73	15	1
Construction	15	14	90	86	105	4
Finance and Insurance	30	21	116	79	146	5
Real Estate	9	23	31	77	40	1
Distribution, Hotels and Restaurants	90	7	1177	93	1267	46
Transport & Communication	44	14	233	84	277	10
Public Administration	17	38	28	62	45	2
Education	17	15	95	85	112	4
NGOs/Trusts	19	22	66	78	85	3
Health	9	24	29	76	38	1
Others	4	6	63	94	67	2
TOTAL	**354**	**13**	**2435**	**87**	**2789**	**100**

Identified Needs Related to *Statutory Instrument 202/98*

The respondents offered recommendations on how the *Statutory Instrument* could be better implemented. First, widespread training and education on the document are recommended and the document should be translated into the country's national languages. Respondents also felt that simplifying the document would make it easier to discuss, describe, promote, and implement. Respondents felt that the government was an appropriate organization to provide materials and trainers for this effort.

Willingness to Participate in SMARTWork

In all, 72% of the respondents expressed willingness to participate in SMARTWork activities. Companies noted that they would be more willing to participate if the programs would have positive impacts, would not affect productivity, and be free of charge to the organization (see Table 12). Sustainability and communication over long distances were also concerns for companies surveyed.

The RAs provided feedback on those companies that seemed most interested in participating in SMARTWork programming, which were:

- Kingdom Bank, Harare
- Mazowe Flowers, Mazowe
- N. Richards and Co, Masvingo

- ZESA, branches in Marondera, Rusape, Chiredzi and Gutu
- Kenmark Construction, Harare
- Beitbridge Inn, Beitbridge
- MASHCORP, Bindura
- Kusile Rural District Council, Lupane
- City of Masvingo, Masvingo
- MARS, Bulawayo
- Mazowe Hotel, Mazowe
- Montclair Hotel and Casino, Nyanga
- Beatrice Hospital, Beatrice
- ZIMCAST, Gweru
- One Stop Shop, Bulawayo
- David Whitehead, Gweru
- Lorraine Clothing, Bulawayo
- Loben Industries, Chiredzi
- Bloo Cool Refrigeration, Chinhoyi
- Chadleigh Motors, Chinhoyi
- Batsirai Group, Mataga.

Table 12: Willingness to Participate in SMARTWork, by Type of Production/Sector (N = 2789)

Type of Production	Yes		No		Total	
	Number	%	Number	%	Number	%
Agriculture	86	72	33	28	119	4
Mining and Quarrying	19	51	18	49	37	1
Manufacturing	388	89	46	11	434	16
Electricity and water	15	100	0	0	15	1
Construction	75	71	30	29	105	4
Finance and Insurance	116	80	30	20	146	5
Real Estate	31	78	9	22	40	1
Distribution, Hotels and Restaurants	809	64	458	36	1267	45
Transport & Communication	190	69	86	31	276	10
Public Administration	37	82	8	18	45	2
Education	73	65	39	35	112	4
NGO/Trust	72	75	13	25	85	3
Health	35	92	3	8	38	1
Others	59	84	11	16	70	3
TOTAL	**2005**	**72**	**784**	**28**	2789	**100**

Responses from Trade Union Representatives

SMARTWork organized a workshop for trade unions to discuss HIV/AIDS and the workplace. Of the 32 trade unions affiliated with the ZCTU that were invited to attend, 19 did so. In attendance were the:

- Automotive and Allied Workers Union of Zimbabwe
- Commercial Workers Union of Zimbabwe
- Communication and Allied Services Workers Union of Zimbabwe
- Electronics, Communications, Radio and Television Workers Union
- Federation of Food and Allied Workers Union of Zimbabwe
- General Agricultural Plantation Workers Union
- Iron and Steel Workers' Union of Zimbabwe
- National Engineering Workers Union
- Railway Association of Enginemen
- Zimbabwe Amalgamated Railways Union
- Zimbabwe Banker and Allied Workers Union
- Zimbabwe Chemical and Plastics Allied Workers Union
- Zimbabwe Construction Workers Union
- Zimbabwe Domestic and Allied Workers Union
- Zimbabwe Education, Scientific, and Cultural Workers Union
- Zimbabwe Electricity and Energy Workers Union
- Zimbabwe Furniture Timber Allied Trade Unions
- Zimbabwe Railways Artisans Union
- Zimbabwe Textiles Workers Union.

The participants completed a questionnaire on behalf of their union (though it is possible that not all of the delegates had enough information about their organizations to answer all the questions accurately).

HIV/AIDS Policies and Collective Bargaining

Of the 19 unions present at the meeting, seven (37%) indicated that they had negotiated with businesses to include HIV/AIDS in their collective bargaining agreements, one (5%) was still in negotiations, and twelve (63%) had not included HIV/AIDS in their agreements. The eight (42%) that had—or were in the process—reported the following primary issues: confidentiality of medical information; prohibiting HIV testing in conjunction with the application process; non-discrimination policies aimed at PLWHA; and ensuring equal access to opportunities for all staff (including PLWHA). Eight (42%) of the unions that included HIV/AIDS in their negotiations had included protections for continued employment for PLWHAs and prohibition of mandatory HIV testing. Table 13 illustrates these responses.

Table 13: HIV/AIDS Policy Element Included in Collective Bargaining (N = 8)[37]

Policy Element	%
Confidentiality of Medical Information	40%
Prohibit HIV Testing during Recruitment	40%
No Discrimination against PLWHA	40%
Equal staff opportunities for all (including PLWHA)	40%
Continuation of Employment for PLWHA	35%
Prevention of Mandatory HIV Testing	35%
Career progression if living with HIV/AIDS	15%

Those unions that had not included HIV/AIDS in their collective bargaining negotiations indicated that they would like to do so. The topics they felt were most important to include were prevention of HIV testing for employment and advancement; prohibiting discrimination against PLWHA in terms of employment and advancement; and ensuring confidentiality of medical information. These responses are provided in Table 14:

Table 14: Desired Policy Elements for Collective Bargaining (N = 11)[38]

Desired Policy Element	%
Prevention of Mandatory Testing During Employment	50%
Prohibition Against HIV Testing for Recruitment	50%
Continuation of Employment for PLWHA	50%
Career progression for PLWHA	50%
Prohibition Against Discrimination Against PLWHA	45%
Equal Staff Development Opportunities	45%
Confidentiality of Medical Information	40%

Trade Union-Based Workplace Programs

Only one of the 19 unions was not operating workplace-based programs of their own. Health education was the most common of the programs implemented by the unions (80%), followed by condom distribution (40%), and peer education (40%). Fifteen percent of the unions offer voluntary counseling and testing services, and 10% operate health clinics for their members (See Table 15).

[37] Sub cluster N = 8 is the number of Unions that had negotiated (or were in the process of doing so) for the inclusion of HIV/AIDS in their collective bargaining agreements.

[38] Sub cluster N = 12, is the number of Unions that had not included HIV/AIDS in their collective bargaining negotiations.

Table 15: Trade Union-Based Workplace Programs (N = 18)[39]

HIV/AIDS Programs	%
Health Education	80
Condom Distribution	40
Peer Education	40
Voluntary Counseling and Testing (VCT)	15
Clinics Operated by Unions	10
Provision of Anti-Retroviral Drugs	0

Trade Union Knowledge of Statutory Instrument 202/98

The *Statutory Instrument* was well known to trade union representatives. Eighty-five percent of respondents (17 union representatives), reported that they knew about this document. Union representatives felt that both their members and employers need education about the *Statutory Instrument*. Without increased familiarity with the document and the protections it affords, unions will find it difficult to ensure that it is implemented appropriately. In addition, without enforcement mechanisms, it will be difficult to encourage employers to follow the protections of the law.

V. CONCLUSIONS

Workplace Policies on HIV/AIDS

Eleven percent of the 2,789 organizations that SMARTWork interviewed (300) reported that they had a workplace HIV/AIDS policy. Of the 300 organisations with policies, 288 organisations (96.1%) had policies that were not official, written policies that can be shared with workers. Only 3.9% of the organisations with policies (12 organisations) had official documents. A quarter of these 12 companies with official policies were willing to provide copies of the documents to SMARTWork.

Official policies typically lacked discussion of at least one element of comprehensive workplace protections such as anti-discrimination measures, prohibition of HIV testing, ensured confidentiality of medical records, and guaranteed continued employment for PLWHA. The most common policy elements included in the 300 companies with HIV/AIDS policies were: confidentiality of medical information (18%), continuation of employment for PLHWA (14%), implementation of anti-discrimination policies (14%), and guarantee of equal staff development opportunities (12%).

Of the 19 unions that provided information about their HIV/AIDS programs and policies, less than half have included HIV/AIDS related issues in their collective bargaining process. Forty percent of the union agreements include anti-discrimination protections for

[39] Number of Trade Unions with workplace programs (i.e. N = 18).

PLWHA, protect the confidentiality of medical information, prohibition of HIV testing of job applicants, and guarantee of equal access to staff opportunities for PLWHA. Thirty-five percent of the agreements include prohibitions of mandatory testing of employees and guarantees of continued employment for PLWHA.

Of the unions that had not included HIV/AIDS in their collective bargaining exercise, half were interested in prohibiting mandatory testing of employees and applicants and protecting PLWHA's right to employment and, to a lesser extent (45%) continued staff opportunities. Forty percent were interested in protecting the confidentiality of medical information.

Workplace HIV/AIDS Programs and Benefits

Among employers, health education and condom distribution programs are the most common workplace education and prevention programs, with 30% of employers offering them. While employers appear to be interested in implementing additional programs, they are concerned that these activities could interfere with worker productivity. Companies that have implemented HIV/AIDS programs are likely to have done so in collaboration with NGOs—approximately 200 companies and organizations report that they work with NGOs including the National AIDS Council, ZAPP, ZAPSO, PSI, and NECTOI.

Typically, educational materials include posters and brochures about HIV/AIDS. Workplace programs include:

- Health education (30.3%)
- Condom distribution (29.3%)
- Peer education (23.2%)
- Occupational health services (12.0%)
- VCT services (4.3%)
- Antiretroviral drugs (ARVs) (0.7%)

Of the respondent trade unions, most had health education programs (80%), and almost one-half offered peer education programs (40%) and condoms (40%) to their members. Fifteen percent provided VCT services, and 10% operated clinics. None provided ARVs to their members.

Twenty-eight percent of employers offer workers compassionate leave to address HIV/AIDS-related illnesses, and 26% offer extended leave, making these activities the most common forms of care and support provided for workers. (It should be noted that employers offer these benefits even though they are likely to interfere with productivity). Very few employers offer nutrition programs (3%), or anti-retroviral drugs (1%).

All of the employers were asked what kind of HIV/AIDS programming they would like to implement in their companies. The responses indicate that there is a great degree of interest in implementing programs, but that technical support and funding will be necessary. Employers note that they wish to implement the following programs:

- Health education (20%)
- Anti-retroviral drugs (18%)
- Counseling (14%)
- Peer education (13%)
- Funeral insurance policies (12%)
- Occupational health service (11%)
- Compassionate leave (6%)
- Extended leave (6%)

Financial Support for Workplace HIV/AIDS Programs

Most HIV/AIDS programming (39%) is funded on an *ad hoc* basis, making it vulnerable to being curtailed. Twenty-seven percent of companies had a fixed budget amount for HIV/AIDS programs, 17% funded activities by employees' contributions, and 16% received donor funding for their programs. Employers were interested in receiving funding from the AIDS Levy to support workplace programs.

The *Statutory Instrument 202/98*

Very few of the employer respondents had read the *Statutory Instrument* (12.7%, or 354 of 2,789 companies). Only 2.6% of them had used the document in preparing their policies. Some employers felt that the document protected workers at the employer's expense; this negative view of the policy makes it hard to encourage companies to implement the *Statutory Instrument*'s components. Unlike the employers, 85% of the trade union representatives reported that they had read the *Statutory Instrument*, and felt that it needed to be further publicized.

VI. RECOMMENDATIONS

Very few of the organizations surveyed by SMARTWork had official, written, and documentable policies on HIV/AIDS in the workplace, although about half of the unions surveyed had addressed the disease in their collective bargaining agreements. Organizations were able to describe the desired components of HIV/AIDS policies, suggesting that a beneficial first step will be to work with them on formalizing these ideas into practicable policies. Employers can work with their union organizations to implement effective policies, and address HIV/AIDS in collective bargaining agreements.

Organizations with HIV/AIDS policies can take the next step in ensuring that they have addressed all elements of an effective HIV/AIDS workplace policy. Ongoing collaboration with NGOs concerned about this issue, and with SMARTWork, presents a valuable opportunity for enacting appropriate policies for the workplace.

Few organizational representatives knew about the 1998 *Statutory Instrument 202/98* and the protections it affords. Government agencies, NGOs, and unions alike should work to publicize and educate organizations about this legislation. In so doing, employers will be encouraged to comply fully with national law, and workers will learn about the protections guaranteed to them. Respondents were also interested in exploring use of funding from the AIDS Levy to enhance workplace HIV/AIDS programs.

An effective workplace response to HIV/AIDS involves implementation of both appropriate policies and comprehensive prevention, care, and support programs to reduce transmission, stigma, and discrimination. One-third of organizations surveyed in this SMARTWork study have some type of HIV/AIDS programming for their employees, many more do not, and none of the organizations had adopted the full complement of policies and programs recommended by experts internationally. For those organizations that have adopted some prevention program components, the next step is to systematize and expand the programming to include elements that are currently missing, such as VCT or peer education. Those without current activities are encouraged to implement programs, perhaps starting with those components that they listed as desirable during the survey research. SMARTWork can assist companies in implementing cost-effective and sustainable programming that benefits worker health and enhances productivity.

APPENDIX 1: Organizations with HIV/AIDS Workplace Programs and Their Partners

The following organizations have HIV/AIDS workplace programs that they operate in partnership with an external NGO (See acronym list at the beginning of the document for the NGOs' full names).

Company	Partner	Company	Partner
Standard Chartered Bank	ZAPP	Standard Chartered Bank	PSI
TEDO	ZAPP	TM Supermarkets	PSI
Blue Ribbons	ZAPP	Trasntruck Charter	PSI
Victoria Foods	ZAPP	United Bottlers	PSI
Gold Star Sugar	ZAPP	Unifreight	PSI
Leather By Dori	ZAPP	ZIMASCO	PSI
Guardian Security	ZAPP	Zimpapers	PSI
CMED	ZAPP	Zimbabwe Phosphate Industries	ZAPSO
National Foods	ZAPP	Kingdom Financial Holdings	ZAPSO
Cairns Foods	ZAPP	Shingai Holdings	ZAPSO
Bain Farming Equipment	ZAPP	Softex	ZAPSO
Crest Zimbabwe	ZAPP	P.G. Industries	ZAPSO
Crittal Hope	ZAPP	Castrol Zimbabwe	ZAPSO
Delswa	ZAPP	BP and Shell	ZAPSO
Jetmaster	ZAPP	Lake Harvest	ZAPSO
Lion Match Company	ZAPP	Founders Building Society	ZAPSO
Suncrest Chickens	ZAPP	Zimplats	ZAPSO
Prison Training Depot	ZAPP	Ashanti Gold Fields	ZAPSO
Tobacco Processors of Zimbabwe	ZAPP	Crop Breeding Institute	ZAPSO
Hunyani Pulp and Paper	ZAPP	Granite Chemicals	ZAPSO
Quality International Hotel	ZAPP	BYCO	ZAPSO
Rainbow Tourism Group	ZAPP	Delta Distribution	ZAPSO
Ros Bryn Pottery	ZAPP	Kadoma Tissue	ZAPSO
BAT	ZAPP	National Breweries	ZAPSO
Alexander Risk Assessment	PSI	Rio Tinto	ZAPSO
Amtec Motors	PSI	Mutare Board and Paper Mills	ZAPSO
Art Corporation	PSI	CABS Building Society	ZAPSO
BAT Rothmans	PSI	Shamva Mine	ZAPSO
Cargill	PSI	Mazowe Mine	ZAPSO
Castrol	PSI	Circle Cement	ZAPSO
CIMAS	PSI	National Museums and Monuments	ZAPSO
CSC	PSI	National Waste Company	ZAPSO
Crystal Candy	PSI	Chibuku Breweries	ZAPSO
David Whitehead	PSI	Iron Duke Pyrites	ZAPSO
BP Shell	PSI	Bindura Nickel Mine	ZAPSO
Dimon Zimbabwe	PSI	Carribea Bay Hotel	ZAPSO
Eversharp	PSI	*Statutory Instrument* RDC	ZAPSO
Harare Agricultural Show	PSI	Lyons Zimbabwe	ZAPSO
Kadoma Paper Mill	PSI	Exor Petroleum	ZAPSO
Kutsaga Research Board	PSI	Micro King Finance	ZAPSO
Meikles Hotel	PSI	Fidelity Printers and Refiners	ZAPSO
Mobil Oil	PSI	Isabella Mine	ZAPSO
Stanbic	PSI	Bubi Mine	ZAPSO

Company	Partner	Company	Partner
International Labor Organization	ZAPSO	Dustan Transport	NECTOI
DFID	ZAPSO	Whelson Transport	NECTOI
Air Zimbabwe	ZAPSO	Abercrombie & Kent	NECTOI
Windmill	ZAPSO	United Touring Company	NECTOI
Exide Batteries	ZAPSO	Clan Transport	NECTOI
Zimbabwe Revenue Authority	ZAPSO	Glens Corporation	NECTOI
Lancashire Steel	ZAPSO	Bass Plant & Hire	NECTOI
African Development Bank	ZAPSO	DD Transport	NECTOI
ZUPCO	NECTOI	Cargo Carriers	NECTOI
Power Coach Express	NECTOI	Rixi Taxi Cooperative	NECTOI
Mattan Trucking	NECTOI	Preston Transport	NECTOI
Munezwa	NECTOI	GDC Haulage	NECTOI
Mutsvanzva	NECTOI	Longhaul International	NECTOI
Zvinoira Bus Service	NECTOI	Commercial Transport	NECTOI
Mbizi Motorways	NECTOI	Stuttafords Removals	NECTOI
Kukura Kurerwa	NECTOI	Carlisle Enterprises	NECTOI
Mucheche Investments	NECTOI	Waste Away P/L	NECTOI
Kumukira Bus Service	NECTOI	Rod Cole Transport	NECTOI
Kumukira Express	NECTOI	Terry Bettin	NECTOI
Shiriyekutanga Bus Service	NECTOI	Mariller Estates	NECTOI
RTO Rutendo	NECTOI	Trek Express	NECTOI
K and S Bus Service	NECTOI	Farquar Transport	NECTOI
Gwatidzo Motorways	NECTOI	Mendelson Motors	NECTOI
Modcraft Transport	NECTOI	Russel Noach	NECTOI
Kutakura P/L	NECTOI	Ajay Motorways	NECTOI
Manyanga Investments	NECTOI	ELT Bus Service	NECTOI
Tenda Transport	NECTOI	Joubert Transport	NECTOI
Masara Transport	NECTOI	Colbro Transport	NECTOI
Chawasarisa Transport	NECTOI	Western Transport	NECTOI
Msabaeka Bus Service	NECTOI	Matabeleland Carriers	NECTOI
Kuwirirana Bus Service	NECTOI	Sibube Buses	NECTOI
Tauya Coach Services	NECTOI	Sky York Taxis	NECTOI
B & C Bus Company	NECTOI	Dokotela Buses	NECTOI
Vazungu Express	NECTOI	Permason Transport	NECTOI
Musasiwa Bus Service	NECTOI	R & R Transport	NECTOI
RPK Bus Service	NECTOI	RMS Transport	NECTOI
Marongwee Bus Service	NECTOI	SLES Trading	NECTOI
African Genesis	NECTOI	Shamrock Transport	NECTOI
George Elcombe	NECTOI	Senator Transport	NECTOI
Unifreight Swift	NECTOI	Forklift Transport	NECTOI

APPENDIX 2: HIV/AIDS Materials Provided by Respondents

Respondent organizations generously made available materials that they use in their outreach and education efforts (see the acronym list at the beginning of the document for the organizations' full names).

Title of Material Provided	Organization Providing Document
A Step-by-Step Guide to Starting Business	SYB
Adventure Unlimited	SCRIPTURE UNION
AIDS and Me	THE RED CROSS
AIDS in Our Community	UNAIDS
AIDS is for Real	CIMAS
An Investigation into the Knowledge, Attitudes and Practices on HIV/AIDS of Residents of Mines	BETSERANAI HBC AND ORPHAN CARE CENTRE
Annual Report	NANGO
Are Women Part of the Question?	GENDER FORUM NEWS IN ZIMBABWE
A-to-Z About Testing	TCE
Because We Know How Important it is for You to Know	ZAPSO
Boys, Young Men and HIV/AIDS	SAFAIDS
Breastfeeding and HIV Transmission	SAFAIDS
Brochure	INDIGENOUS COMMERCIAL FARMERS UNION
Business Service for Women	WIBZ
Deciding to Stay HIV-Negative	TCE
Deciding to Stay HIV-Negative	TCE
Doing it Naked	CORRIDORS OF HOPE
Draft HIV/AIDS Policy	N. RICHARDS
Driven to the Streets Due to a lack of Care or Poverty	ZNCFWC
Fact Sheet: Men and HIV/AIDS	SAFAIDS
Five Golden Rules	CORRIDORS OF HOPE
Health and Safety Policy	QUTON SEED COMPANY
Help Them Live Positively	CIMAS
HIV/AIDS and the Workplace	NACP
HIV/AIDS Policy	KINGDOM
HIV/AIDS: What is VCT?	SAFAIDS
Hupenyu Unukosha	ZAPP
Imibuzo le Mpendulo Mayelana Ngomkhuhlane we HIV/AIDS	ZAPSO
Imibuzo Mayelane Ngokuhlolwa Kwamaccikwane e HIV	ZAPSO
Impilo Kule HIV Iomkhuhlane we AIDS	NACP
Improve Your Business	IYB
Impumela Yokuhlolwa Kwegazi Lakho Itshoni Ngekusasa Yakho	NEW START
In Case of Emergency, Open this Packet	FHI AIDSCAP
Indaba Yami	MAC
Information Series 4: Taking Control	TCE
Information Series 5: Youth and Sexual Life	TCE
Insights and Foresights	UNICEF
Lamuhla I AIDS Ingakimi –Kusasa Ingakwakho	MASO
Living Through AIDS	NACP

Title of Material Provided	Organization Providing Document
Make a New Start Today	NEW START
Making Sex Safer	AMERICAN COLLEGE HEALTH ASSOCIATION
Manlike Kindome	AIDS HELPLINE
Men and AIDS	UNAIDS
Men and HIV	SAFAIDS
Men: You Make a Difference	NACP
Misleading Ideas and Beliefs About STDS	NACP
Mobilization for Microbicides	THE ROCKEFELLER FOUNDATION
Nahu Dzevahurume Maererano Nechirwere Che HIV/AIDS	ZAPSO
NANGO News	NANGO
Nango Workshop on NGO Responses to HIV/AIDS	QUALITY INTENATIONAL HOTEL
National AIDS Policy	NACP/MOH
National HIV/AIDS Policy Document	NACP
National Policy on HIV/AIDS for the Republic of Zimbabwe	BETSERANAI/HSC AND ORPHAN CARE CENTRE
Nhau Dzemadzimai Maererano Nechirwere Che HIV/AIDS	ZAPSO
Nutrition Guide	NEW START
On Guard	NSSA
Prevention of Parent-to-Child HIV Transmission	NACP
PROFAM Matters	PROFAM
Programs and Activities	ZIMBABWE RED CROSS
Protector Plus	PSI
Regional HIV/AIDS Resource	SAFAIDS
Report	NANGO
Report for NANGO/ZAN	FELICITY LYDIA SEKAI HATENDI
Research Project Report	S.B. MOYO- BETSERANAI CHBC
Research Report	NANGO
Responding to Stigma and Discrimination	SAFAIDS
RIFA Conservation Education Camp	NISSSAN ZIMBABWE
SAFAIDS News	SAFAIDS
SAFAIDS News (Issues 2 and 4)	SAFAIDS
Say Yes to Condoms	CORRIDORS OF HOPE
School Drop Out: Where Are You Going to Land?	ZNFPC
Sexual Health Exchange	SAFAIDS
Storm Telling for CABA Baseline Survey	BETSERANAI COMMUNITY BASED ORGANISATION
Talking Abstinence	ZNFPC
Telling Your Partner About Herpes	AMERICAN SOCIAL HEALTH ASSOCIATION
The Voice	UNIFREIGHT
The Wellness Way	KRAMES COMMUNICATIONS
To Know is to Care	JOHNSON AND JOHNSON
Unprotected Casual Sex	NECTOI
WASN News	WASN
We are Equal	CIMAS
What Smart Guys are Wearing (Calendar and Sticker)	PSI
What to Expect from Counseling and Testing	NACP/PSI
What to Expect from Counseling and Testing	NEW START
What You Need to Know About Nevirapine	WASN

Title of Material Provided	Organization Providing Document
Women and AIDS	WANKIE COLLITERY HOSPITAL
Women and AIDS	WASN
Women's' Matters on HIV/AIDS	ZAPSO
Worth the Wait	STEP
Your National Society	THE RED CROSS
Zinofanira Kuzikanwa Pamusoro Pe HIV/AIDS	ZAPSO
Ziva Utano Hwako Uronge Ramangwana Rako	BETSERANAI COMMUNITY-BASED PROGRAMME
ZNCWC Newsletter	ZNCWC

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