

Company Policy on AIDS in Zimbabwe

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ABSTRACT

This paper examines current and potential AIDS policy, and its orientation, at the workplace in Zimbabwe, and looks at the degree of concern that commercial companies have about AIDS. All 94 companies studied expressed some concern about AIDS, but only one third had developed a specific AIDS policy, and two thirds had begun AIDS education programmes. Major concerns expressed by the companies included the recruitment of skilled labour; rising insurance, health and pension costs; loss of time and productivity; and lowered morale. Twenty two per cent of them had some form of HIV screening in place, and 41% thought pre-employment screening was justified. The paper notes current educational initiatives and makes recommendations for supportive and coordinated policy development.

Introduction

As the AIDS pandemic worsens around the world, different sectors of society are becoming increasingly aware of its potential impact and the need to be actively involved in AIDS work and AIDS campaigns. It is not merely the health services that are affected, but social welfare and security, education, and the legal profession, industry, and the economy as a whole.

Of the many sectors that need to take up the AIDS issue, the formal employment sector is particularly crucial for a number of reasons. First, many of those at risk of HIV are employed in the formal sector; therefore employers risk losing large numbers of their active workforce. Absenteeism due to ill health, caring for sick relatives, and attendance at funerals, will increase steadily. Productivity may decrease and serious losses of skilled and experienced labour are predicted. Recruitment of skilled personnel may become very much more difficult than it already is in many developing countries.

Second, some industries will be particularly affected by AIDS. The insurance industry is one example, as AIDS significantly alters actuarial projections. Other industries may also be affected if the impact of AIDS on the population is such that

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effective demand for different products and services is significantly reduced. However, one or two industries, such as rubber production, condom manufacturing, and the pharmaceutical industry, stand to benefit - and, indeed, some already are.

However, there is considerable risk that employers, as they become increasingly aware of AIDS, will try to minimise its impact by discriminating against infected employees. They may try to screen out those with HIV from employment altogether, from having access to occupational benefits, health insurance and pensions, or from travel or further training. Insofar as these measures are adopted, people with HIV or AIDS will be more and more isolated and impoverished. AIDS will be driven further underground, and the chances of developing effective awareness campaigns for prevention will be reduced. Thus discriminatory practices are not merely inhumane, but likely to incur serious long term costs by impeding prevention efforts. The World Health Organisation (WHO), which is coordinating the global response to AIDS, has consistently warned against discriminatory control measures in all spheres. The WHO, with the International Labour Organisation, drew up guidelines for supportive workplace policy in June 1988 (WHO, 1988).

An important area of study of HIV/AIDS is to find out to what extent employers are actively developing policies on HIV and AIDS, and whether discriminatory or supportive measures are being advocated. The study discussed in this paper targeted a wide cross-section of the commercial sector in Zimbabwe to identify their main areas of concern in the areas of HIV/AIDS, the needs expressed by companies, and to chronicle some of the existing policies and practices regarding AIDS. This paper, within the context of the growing AIDS epidemic in Zimbabwe, presents the main findings of the study and makes recommendations for policy guidelines which could be applied nationally to ensure that appropriate and effective responses are made to the AIDS situation. Reference is made to studies in this field in other countries, but the authors are unaware of any other systematic data on company policy and AIDS in Zimbabwe itself nor in the Southern African region.

The AIDS epidemic within Zimbabwe and the region

The global pandemic of AIDS is proving particularly devastating within those countries of Sub-Saharan Africa which are designated Pattern II by WHO. In some major Eastern, Central and Southern African cities HIV prevalence is estimated as being as high as 20-30% of young sexually active adults (WHO, 1990). In Zimbabwe, in a population of less than 10 million, 11 788 people, had been diagnosed with HIV related ill-health, and 5 994 with full AIDS, by December 1990 (ACP, 1991). Since 1988 AIDS has been reported as the leading cause of death in babies in the main hospitals in Harare, and by mid 1990 the Minister of

Health had estimated that 350 000-400 000 people in Zimbabwe had HIV infection (Stamps, 1990). Neighbouring countries, such as Zambia and Malawi, also report high levels of HIV infection and AIDS, as does most of East and Central Africa. The reported incidence of AIDS is rising extremely sharply in many countries, because of improved reporting as well as reflecting real increases in HIV infection and AIDS.

In most of Africa, HIV and AIDS affect men and women in approximately equal numbers, although typically with a different age distribution. Peak HIV infection and AIDS occurs at a younger age in women than in men (Stamps, 1990; Chin, 1990), and about a quarter of diagnosed AIDS cases occur in babies and young children. The main mode of spread of HIV is heterosexual intercourse and from mother to baby, while contaminated blood transfusion and needle stick injuries contribute relatively little to spread. Homosexual spread seems to be a minor problem. The main cofactor in transmission is the presence of other sexually transmitted diseases (STDs). In a study of 412 STD patients at a Harare clinic in 1990, 51% were reported to have HIV compared with 18% of 500 STD patients studied in 1987 (*The Herald*, 17 August 1990). HIV infection is spreading very rapidly in the young-middle-aged adult population in Zimbabwe and this has clear implications for the workforce.

Comparative research

A number of studies have been carried out on HIV and the workplace in various countries. These studies have examined workplace policy, and problems of AIDS at work due to fear, stigma, economic cost and related factors. Companies seek to employ healthy, fit employees, and pre-employment medicals are routine policy in many countries. As the impact of AIDS on companies in Africa is likely to be similar in some respects to that in, for example, the USA, it is valuable to extrapolate findings from one to the other.

A recent survey identified AIDS as one of the top three concerns of American employers (Backer, 1988). This concern is appropriate as one employer of every five who responded to the survey reported at least one worker with AIDS. By some estimates (Backer, 1988), AIDS is expected to cost employers in the USA more than US\$55 billion in 1991.

As the problem grows, employers are finding that they have to develop measures which enable them to cope with people affected in their prime working years. Workers with AIDS in America are covered by the Rehabilitation Act of 1973, and hence employers have to accommodate sick workers who are still able to work. Many USA companies have responded to the crisis by developing strategic plans and education programmes (Halcrow, 1986; Cohen, 1985). Backer

cites numerous other studies which indicate that, by 1988, approximately 21% of companies had an AIDS policy or programme in place, while 40% had some form of AIDS education. He reviews individual programmes from famous companies, such as the Wells Fargo Bank, Levi Strauss and Warner Brothers. His conclusion sums up the issue (1988:983):

"AIDS is a cost issue, a productivity issue, a human resources issue, a legal issue and it is a human issue, an issue of employer social responsibility."

Between developed countries, however, there is wide variation in AIDS policy and the extent of education within the workplace. A Canadian survey (Canadian AIDS Society, 1989) reports that only 4% of 516 companies had any AIDS policy or educational programme at that time. In developing countries there are also widely differing responses, by governments, employers and labour organisations. At one extreme is the situation in Cuba where the entire population has been screened since 1986, and infected people not only lose their employment but are kept in lifetime quarantine in a sanatorium in Havana. Full pay, benefits and care are nonetheless guaranteed, and the prevailing ethos is reported to be one of social responsibility rather than victimisation or punishment (Panos, 1990). In many developing countries labour legislation and labour organisation are weak, and employers may get away with screening and discrimination even if this is not official policy. Numerous examples of victimisation are cited in *The Third Epidemic* (Panos, 1990). These may involve people who are already ill with AIDS, or, sometimes, fit workers with HIV detected in mass screening. In severely affected countries, such as Uganda, however, it is too difficult for companies to find substitute skilled labour for mass screening to serve any useful purpose, even if it were considered ethical.

Within most of Africa and the Third World there is a critical shortage of skilled labour at all levels, and training is very expensive, frequently involving scarce foreign currency allocations for overseas training. Thus the loss of skilled labour to AIDS is particularly costly, both in terms of wasted training and replacement costs. This certainly applies to Zimbabwe. There is also sometimes a very close dependence of entire nuclear families on the place of employment, for instance in mines and agriculture. Often entire families live in compounds or housing schemes attached to the place of employment. Loss of the breadwinner means the loss of housing as well as income, and often the loss of tied schooling for children. Thus the social costs of AIDS, as increasing numbers of young adults die, will be very far reaching. This is worsened by relatively poorer access to services of all kinds, to greater underlying poverty, and inferior social security provision in general. Inadequate infrastructure and lower literacy levels make education and awareness campaigns, as well support services, less readily available in developing countries.

The main legislative instrument in Zimbabwe has been the Labour Relations Act 1985, but new structural adjustment policies will weaken the workers' position

generally. Health and safety committees have been established in a number of workplaces, within unions or under workers' committees. However, the majority of workers are not well organised, particularly on health and safety issues, and their rights are limited. Their capacity to safeguard their existing rights needs to be strengthened. The high level of unemployment, including among those with 'O' levels (ie 4 or 5 years of secondary education) contributes to worker insecurity, and makes them less likely to seek new safeguards. However, the Zimbabwe Congress of Trade Unions (ZCTU), which established a Health and Safety Department in 1990, held a policy workshop on AIDS in August 1989, and is subsequently developing policy guidelines on AIDS (Loewenson, 1991).

The particularly severe implications of AIDS for the workplace in SubSaharan Africa, both because of the numbers affected and because of the factors noted already, make it highly likely that many companies will try to minimise the problem by seeking to exclude infected employees from employment, training and promotion. Whilst this response is readily understandable, and to be anticipated, it can be argued that it is both unjustified and counterproductive in the long term.

Introduction to the study: background and methodology

A wide cross-section of the commercial sector in Zimbabwe was targeted in this study. All delegates to a one day national seminar on AIDS held in Harare in March 1990 were given a questionnaire to complete. One hundred and ten companies sent a total of 159 delegates to the Conference, who represented a workforce of 180 000 to 200 000 people. The sample was likely to be a good representation of private commercial companies across the nation, but with a bias towards larger companies (ie they could afford the seminar fees) and those with an existing concern about AIDS (ie they were willing to send a delegate).

Confidentiality and anonymity were guaranteed, although delegates were requested to give full company identification and some details for statistical purposes and to avoid duplication. Almost all those who responded complied with this request. The questionnaires were distributed at the start of the seminar to avoid bias in the responses from the seminar discussions. All were collected before the first presentation of the day.

The questionnaire itself was detailed and contained 56 items requiring a response (apart from company/delegate information). An open ended format was generally used, although a few closed quantitative questions were included. The aim was to explore companies' existing concerns and priorities, rather than imposing the researchers' own preconceptions. Main areas of focus included the aims of any existing AIDS policy and its content; concerns companies might have about the impact of AIDS on issues such as insurance, pensions and recruitment;

AIDS education at the workplace; policy on screening of existing or prospective employees; counselling; confidentiality; and assistance the company might value from Government, Non Government Organisations or other sources.

Results

General and demographic

There was a high response rate from both the companies (84,5% or 94 of 110) and the delegates (80,5% or 124 of 159). Delegates to the seminar held senior posts in their companies, and included chief and senior executives, middle managers (personnel officers, training and accounts managers), and a smaller number of health staff (company doctors, health officers and clinic nurses). The majority were sufficiently senior to formulate or directly influence the formulation of company policy on AIDS.

Average company size was just under 2 000 employees, with a range from under 100 to over 8 000. A few of the companies were multinationals or conglomerates. The following areas of business, commerce and industry were represented: mining; agriculture and timber; oil and chemical production; manufacturing and food processing; service industries and public service corporations; tourism; hotels and catering industries; retailers; banking, insurance and financial services. There was a wide cross-section of companies from throughout Zimbabwe.

AIDS policy and concerns

Of the 94 companies represented, 32 (33%) indicated that they already had an explicit policy on AIDS. Thirteen companies (14%) indicated that their policy was concerned with the prevention of infection and/or education (but other companies, as discussed below, have developed education strategies without recording this as company policy in their responses to this question). Four companies said that their policy was to treat AIDS in the same way as any other condition, but three indicated differential policy on AIDS and insurance. Four indicated a policy of providing counselling and support, one of no victimisation, one a policy to promote 'safe health conditions' at work, one a data gathering exercise, and another said that government must set paths for policy. More detailed subsequent questions elicited further material on these areas, indicating that more companies than those indicated here are concerned about AIDS policy.

A separate question asked specifically about the insurance and pension rights of people with AIDS. Information was given from 42 companies (45%), and of these 28 (67% of those replying) indicated that there is no discrimination, and four that infected employees are discriminated against in pension and/or insurance

policies, with four indicating that policy in this area is under review. Two responses noted that policy was up to the underwriters, and one said the multinational parent company was responsible. One respondent indicated that families would be taken care of, another that each case was assessed on merit, and another that existing employees' pension and insurance rights only would be ensured, not those of new employees.

Respondents were asked an open question on their most serious concern regarding the impact of AIDS on their company. One hundred and fifteen of 124 delegates (93%) gave detailed replies. Concern over the loss of skilled labour was the most frequently cited, by 41 (33%) respondents. Loss of manpower in general was cited by 30 (24%), absenteeism by 8 (6%), and loss of senior staff by three (2%). Four (3%) expressed concern about personnel planning, and two (2%) concern about training. In response to a closed question later on regarding time loss due to AIDS 116 (94%) respondents expressed anxiety about this.

Twenty seven respondents (22%) expressed concern about future productivity, including six (5%) who were concerned about the market for their product, and four (3%) about their company's very survival. Two of these latter are in insurance, one in hotels, and one is a diverse multinational. Those concerned about the market for their product included an alcohol supplier, a building materials supplier, a sugar refiner and a packaging company. Fifteen (12%) were concerned about economic costs to the company in general, and two about the national economy.

Insurance and pensions most worried 16 (13%) respondents, and this was particularly expressed by delegates from insurance companies themselves. Two, as noted above, had anxiety about the survival of the insurance industry. A subsequent question on the future impact of AIDS on insurance, pensions, health care and recruitment, revealed frequent anxiety in all areas. Seventy six (61%) felt that changes would be needed in insurance policy, with only three considering change unnecessary, and 35 (28%) non responses. Of those expressing the need for change, most gave general responses regarding increased costs, the need to screen people for HIV/AIDS, and the need to reduce cover or to raise premiums. Group policies were noted as particularly problematic by a few respondents.

While 83 people responded to a question on pensions, 64 (52%) of the total responses indicated concern, and 10 (8%) said there would be no problem in this area, or that discrimination was uncalled for. Two felt the situation needed review. Of those expressing concern, comments ranged from 'serious', 'drain on resources' and 'cost/premiums up', to 'funds run out'. One respondent said that the number of wives should be limited.

Ninety (73%) responses were obtained regarding health provisions. Forty three (35%) said that costs would increase, services needed expanding, including education on AIDS, and there would be additional strain on staff and material

resources because of AIDS. Only two respondents felt there was no problem. Seven (6%) respondents called for screening to exclude infected people from medical cover.

Regarding recruitment, 93 (75%) responses were obtained, of which 40 (32%) specifically expressed the need for screening of applicants, and a further 11 (9%) gave responses suggestive of this (such as 'careful scrutiny needed', 'medical certificates required'). Of the 42 other responses to this question, 40 (32%) of the total indicated anxiety about increased difficulty and cost in recruitment, one respondent was unsure whether problems would arise, and only one, a delegate from an insurance company, considered there to be no difficulty. This delegate nevertheless considered insurance, health care and pension prospects to be 'bleak' because of AIDS.

Morale was a primary concern of only 10 (8%) respondents, and stigma of a further three. However, in response to a closed question on morale, 109 (88%) said this did cause concern. Ten also expressed serious concern about the impact of AIDS on families and family life. Two were primarily concerned about a lack of belief in AIDS and one about safe health conditions, with a total of 90 respondents (73%) concerned about safety in response to a closed question on this. A lack of trust was also expressed as the major concern of one respondent.

Further concerns, expressed by one or more respondents, included attendance at funerals, family welfare, families living on company property, government legislation, loss of middle management, fear of other employees, breakdown of trust, victimisation, ignorance, and eating in canteens shared with infected people.

HIV screening

Respondents were asked detailed questions about screening policy for HIV. This included whether any screening is carried out on existing or potential employees, and on what basis; whether consent is obtained and whether individuals are informed of their test results. Where results are given, is this accompanied by counselling and if so, by whom? Confidentiality and access to results was also explored.

Only four respondents answered yes to the direct question "Does your firm do pre-employment screening for HIV or screen current employees?" Two said the purpose of pre-employment screening was to avoid employing people with HIV or AIDS, and two that it was a routine part of the medical. However, in answer to further questions, another five respondents indicated that pre-employment screening is in fact carried out for all job applicants. One gave the reason as being pension assessment. A further respondent indicated that their firm would like to screen to avoid the high costs of training people with HIV, and another that pre-employment

screening is to be introduced. One respondent commented that such screening is illegal. From the above, a total of 9 companies (10%) acknowledge pre-employment screening for HIV. Twelve (13%) acknowledge screening some existing staff, of whom two screen general workers, two on the basis of ill health, two white collar staff, two for pensions or major loans, and one senior management only. One indicated screening was offered on a voluntary basis, and one that it was linked to blood donation. A total of 21 companies (22%) acknowledge either pre-employment or some current employee HIV screening.

It is noteworthy that 42 (33%) individual delegates gave no answer to the direct question on HIV screening, a much higher refusal rate than on most questions. Further there was a high degree of inconsistency between responses to the initial direct question and later more probing questions, and also between delegates from the same company. This suggests the possibility that screening may sometimes occur without the knowledge of many management staff, let alone other employees. It could reflect the intention of companies to do screening clandestinely, knowing it is a controversial policy. People may be reluctant to apply for jobs in companies where they know HIV screening is done, thus making recruitment of skilled labour increasingly difficult.

Data on whether consent for screening was obtained indicated that in two cases pre-employment screening was anonymous, and in 6 companies consent was obtained for pre-employment screening. In another company two delegates disagreed on whether consent was obtained. Data on back up counselling was incomplete, but in two cases of pre-employment screening with consent individuals would be advised to see their own doctor, and in one case would be counselled by clinic staff. In one case of anonymous screening, individuals are also advised to see their doctor. In seven cases the company itself would not give the test results to the individual.

Regarding screening of current staff, three companies are reported to carry out anonymous screening and 9 screening with consent. Counselling is provided, either by the company doctor or through the medical services, in 11 instances. Where screening is anonymous it is carried out for statistical purposes 'to determine health trends', as reported by one delegate from a major company in which another delegate said that screening was with consent (and others said no screening occurred).

Confidentiality of results is reported as being good, with only a private doctor, the company doctor and health staff being informed in all but a few cases. However, in four companies some of the management are informed of the results of pre-employment screening, and in four some of the management are informed of tests on current employees. It should be noted that responses to this question were incomplete.

HIV/AIDS education

A total of 57 companies (61%) indicated that they already provided AIDS education at work. Two more indicated that they are about to begin this. Most companies providing AIDS education had begun this in 1988 or 1989, but one farming estate and one insurance agency had begun AIDS education as early as 1985, and three other organisations in 1986. Several began in 1990. Interestingly, even in some companies reporting AIDS education for two years or more, delegates differ regarding its occurrence. It would appear in some cases that AIDS education might take place at the head office, the provincial office, or the worksite, but not necessarily throughout the company as a whole, or as standard policy. AIDS education was reported to be organised variously by medical staff, senior management, personnel and training managers, and public relations officers. One farming estate which started AIDS education at the end of 1986 reports having an AIDS committee.

Respondents were asked what form the AIDS education takes. Most common were talks (54, or 57%) and pamphlets (55, or 59%). Film/video was utilised by 26 (28%), and 7 (7%) mentioned drama. Only three (3%) mentioned discussion groups or seminars, and three counselling. Twenty one delegates indicated that education was being evaluated (37% of 57 companies providing education, 22% of the total companies sampled). Others reported that no evaluation was being carried out, or that they did not know how to start evaluating. Methods of evaluation included measuring condom uptake; worker feedback, either informally, through discussion, or through questionnaires; and monitoring statistics for sexually transmitted diseases (STDs). Sixteen (28% of the 57 companies) indicated that they felt education was having a positive impact on awareness, on STD reduction, on condom uptake, or on reported reduced partner change. One respondent commented that there had been complaints by sex workers that they were losing business. However, one respondent noted that whilst awareness had increased, there remained a feeling 'it doesn't apply to me', and another that 'fear of victims' had increased.

A question was included on why some companies do not have an AIDS education policy. The most commonly cited reason was that it was not an issue for discussion (27, or 22%). Twenty (16%) gave the lack of a health and safety committee as a reason, 19 (15%) said they did not know how to implement an education campaign, and 7 (6%) that they had other priorities.

Experience of AIDS

Delegates were asked if they knew of anyone within their company who had died of AIDS or had left because of AIDS. Twenty six (20%) said they did, 89 (70%) that they did not, and 13 (10%) gave no response. They were asked, further, what

reaction there had been within the company when someone died of AIDS. Five reported a reaction of fear, stigma and hostility; four reported disbelief; five a mixed reaction, surprise or a reaction that was difficult to assess; four reported little reaction at all; one reported increased awareness, and one compassion and understanding. In only four instances it was noted that few people were informed of the diagnosis.

A further question on current employees with AIDS elicited a very similar response regarding numbers and reactions. Twenty four (19%) indicated that they currently knew someone with AIDS at work, while 88 (69%) do not. Sixteen (13%) gave no response to this question. Twelve indicated that known infected employees were not much or not at all feared by colleagues, compared with 9 who were feared to a greater extent.

Assistance

Respondents were asked what assistance they would value from Government and from Non Government Organisations (NGOs). The most common request of government was for accurate statistics and information (41, 33%), followed by improved AIDS education (37, 30%). Ten sought better counselling services, and 10 improved testing facilities, including free testing services or explicit permission to allow companies to test for HIV. Seven (6%) sought clear guidelines and legislation on AIDS. There were also calls for more money, improved training, advertising and treatment. One respondent said that the government was already doing enough. One called for isolation facilities for infected people. Requests of NGOs overlapped closely with those of government, with the exception that few considered it an NGO role to provide accurate statistics on the epidemic. Rather more, 18 (15%), sought improved counselling and other support services from NGOs.

Discussion

AIDS is clearly beginning to be felt as a relevant and serious issue by the commercial sector in Zimbabwe, although only 33% of companies studied had developed workplace policies on AIDS by March 1990. This figure can be assumed to over-represent company policy development at this time in the country, because of the sample used. However, many more will have developed a policy since. Primary concerns expressed were to do with recruitment, particularly of skilled labour; rising costs of insurance, health care and pensions; time loss; reduced productivity; and lowered morale. The majority had not yet knowingly experienced deaths from AIDS at work, but where people were known to have died or to be ill with AIDS, only in a minority of cases was great fear, hostility or stigma

expressed. However, in only one case was a supportive and compassionate response reported.

Screening was singled out for special attention. Although data on this was incomplete, 22% of companies appear to be screening all or some of their existing employees or job applicants, either with or without consent. Confidentiality of results varies, but generally appears good. Few companies give HIV results to the employee, but recommend that medical practitioners do this. It was noted, however, that, regarding the attitude of fellow employees to people with AIDS at work, in only four cases was it mentioned that the diagnosis was not widely known. It was not clear how fellow employees had learnt the diagnosis in the other cases. Forty one per cent of respondents considered that job applicants should be screened for HIV, or have 'careful scrutiny' for related health problems.

Education on HIV/AIDS is reported to occur in 61% of companies, the earliest campaign dating from 1985, the majority from 1988 and 1989. Talks and pamphlets were the most common educational approaches, followed by film/video. A small minority include drama, discussion groups and counselling. Evaluation of education is reported in one third of those companies with education campaigns, and in two thirds of these (16 companies) it was felt that the campaigns had a positive impact. However, evaluation methods were often informal and not comparable. Those companies not providing education on AIDS cited lack of discussion, health and safety committees, and knowledge of how to do this as the main barriers. A smaller number indicated other priorities.

Regarding assistance desired from government or NGOs, improved statistics and information, better education and awareness, and improved counselling services were most frequently mentioned. A minority wanted clear legislation and policy guidelines.

Existing workplace policy on AIDS in Zimbabwe may be summarised as *ad hoc* and limited at present. Whilst education is being increased, some companies are already adopting discriminatory measures against people with HIV or AIDS, and a majority express fears regarding the economic costs of training and employing infected people, insurance, health costs and pensions. Over 40% would like to see some screening of job applicants, which presumably could only serve to keep infected people out of employment altogether, or be used to deny them benefits such as pension, health, etc. Thus it may be anticipated that, unless clear guidelines or legislation on non discriminatory workplace policy is rapidly introduced, many more companies can be expected to adopt, in future, a screening policy to identify people with HIV.

A question to be addressed is whether the potential costs to commercial companies of losing large numbers of the workforce to AIDS, and particularly skilled and experienced personnel, justifies discriminatory measures, and whether

this is the optimal long term strategy. The WHO argues strongly against this. Discrimination has the effect of driving HIV and AIDS underground, of increasing fears about it and increasing stigma. It also punishes the sufferers and their families if infected breadwinners are out of work, and increases stress and hardships just when maximum resources are needed to cope with a life threatening condition. Thus at the individual level it is unethical and inhumane, and in many countries human rights and labour legislation would safeguard against such discrimination.

In the absence of a vaccine or proven cure, prevention of infection with HIV is crucial. Primarily this means establishing voluntary sexual behaviour change to reduce risk by using condoms in any 'risky' sexual encounter, avoiding penetrative sex, or, ideally, increasing lifetime monogamous partnerships between uninfected people. To achieve and sustain safe sex behaviour involves educating people about the risks, helping them to apply those risks to themselves, and helping them to conclude that they have more to gain personally than to lose by adopting safe sex behaviour for life. Fundamental changes in knowledge, attitude and sustained behaviour are needed, yet these are extremely difficult to achieve. Maximum openness about the epidemic, the personal experiences of people with HIV and AIDS, and a supportive general climate are more conducive to encourage people to take personal responsibility for safe sex. A fearful climate in which people with AIDS are rejected and stigmatised is more likely to make people deny the problem, not to change risk behaviour, and not to seek help if infected. It should be remembered that it is the sexual behaviour of people who already have HIV that particularly needs to change in order to limit viral spread.

A further consideration is that HIV infection may not lead to illness or death for many years. The average time for full AIDS to develop is believed to be eight to ten years in the USA. Whilst this may not hold for Africa, nevertheless the likelihood is that an employee with HIV may be fit for work for many years to come. If screening is used to block infected people from employment, thousands of fit men and women will be unemployed and unemployable, all their skills, training and experience wasted. Existing labour shortages would be exacerbated and inevitably a double standard would develop whereby those with particularly valued skills would be employed regardless of HIV status. Rather than screening out people with HIV employers need to consider expanding training programmes to provide a larger pool of skilled labour.

Mass screening for HIV also has practical problems of implementation, occasional false positive and negative results, and expense. There are also ethical considerations for anonymous, or with consent, testing, and, if the latter, whether individuals are given adequate pre and post test counselling.

In the long term, maximum integration and support of infected people is the most likely strategy to reduce infection and to help infected people and their

families to cope. Discrimination should be kept to the minimum possible level to safeguard work colleagues, clients, employers, productivity, pension funds and medical and other insurance benefits. It is inevitable that changes will be needed in some pension and insurance cover based on actuarial tables that did not take AIDS morbidity and mortality into account. A format needs to be developed in these and other areas of concern that balances the needs of those with and without HIV infection, employees' rights and those of the company, and individual enterprise needs and those of the community and the nation as a whole. All sectors and organisations must share the costs of AIDS, and not try to shift costs on to vulnerable individuals or on to the state.

To achieve a balanced national and enterprise policy, it is essential that workers' organisations and committees, management and government come together to identify the issues and develop guidelines. The common interests of all should be recognised, ie maximising prevention efforts in a climate of optimal support for those already infected and their families. The WHO guidelines could form a useful basis and orientation for this. Pending clear government guidelines giving a national framework for policy, individual companies in Zimbabwe could examine these and other guidelines and policy documents by individual companies to develop their own strategies through union and management discussion. Certain companies in Zimbabwe, like David Whitehead Textiles, provide useful models.

The Minister of Health has also indicated government orientation on workplace policy, which is against screening and discrimination in all spheres of work. The AIDS Control Programme (ACP) is identifying Health Programme Facilitators in different companies and ministries. These personnel, after training, should act as coordinators of AIDS prevention initiatives. As at January 1991 (ZAN, 1991) about sixty had been identified.

Employer confederations, such as the Confederation of Zimbabwe Industry (CZI), the Employers' Confederation of Zimbabwe (EMCOZ), the Zimbabwe National Chamber of Commerce (ZNCC), the Chamber of Mines, the Zimbabwe National Farmers' Union (ZNFU), and others, need to collaborate to promote a national response to AIDS, and to standardise policies. The National AIDS Council is one obvious forum for this and the Zimbabwe AIDS Network (ZAN), primarily for NGOs, includes some representatives of employer and worker organisations.

Some organisations, such as the Institute of Personnel Management, have organised national workshops on AIDS to educate senior and middle management and to discuss policy issues. These are very valuable. Awareness then needs to be consolidated in policy formulation and programme development. The Commercial Farmers' Union (CFU) has a national AIDS representative who keeps the organisation apprised of HIV/AIDS statistics and has developed projections for

the impact of AIDS (Frazer-Mackenzie, 1990). He has also set an example by developing an extensive AIDS and STD awareness campaign on his own farm at Mutoroshanga, and distributing condoms widely.

A critical element of any workplace policy on AIDS must be effective education or awareness campaigns to promote knowledge, attitude and behaviour change. This needs to be evolved with the active participation of the target population, so that the approach is meaningful, involving, appropriate and accessible. Imaginative and varied educational approaches should be adopted, including opportunities for small group focused discussion and counselling, so that people's personal concerns may be effectively addressed. Myths, superstitions and unfounded fears should be allayed, with education aiming to empower people to take preventive action themselves, rather than provoking further fear. Education needs to be ongoing, and to be backed by appropriate support structures for infected employees and their families. Condoms should be freely supplied at work and their use explained as necessary. Some companies give out condoms in pay packets. Cadres at different levels within the workplace need to be trained as educators and counsellors, rather than relying permanently on external support. Senior management need to be convinced of the cost effectiveness of investment in well planned and coordinated educational campaigns and support services, as, in the short term at least, these will require substantial inputs of staff time and money. In the longterm this will be vastly outweighed by reducing the social and economic costs of widespread ill health and early death.

The Family AIDS Caring Trust (FACT) in Mutare is developing a two hundred and fifty page manual for workplace education on AIDS. This should prove a very useful resource. David Whitehead Textiles has produced a short cartoon booklet of a personal AIDS story related to workplace issues. A drama on AIDS called "Me and My AIDS" has been developed by Meridian Theatre Company specifically for the workplace. Another drama, "Manyanya", by Batsirai Theatre Group was developed collaboratively through the Zimbabwe Association of Community Theatre (ZACT) and the AIDS Counselling Trust (ACT). Performances of the play are followed by discussion with the audience. The process of developing the play was videotaped so that this would be a resource to help others in developing an AIDS drama (ACT, 1990). The Old Mutual has run a poster competition as part of its AIDS awareness campaign. Anglo American Cooperation has modified and reprinted twenty thousand copies of a school cartoon magazine on AIDS, **ACTION Magazine**, by the Action Team, Harare. A copy has been given to each employee. Many organisations invite ACT, FACT and others to give talks, and the Family Counselling Unit runs AIDS training workshops for company personnel. Zimbabwe Red Cross promotes AIDS awareness when visiting workplaces to collect blood. These are some examples of the many initiatives already being developed in Zimbabwe.

In Brazil small clay figures of workers are being used in the construction industry for education on AIDS (AIDS Action, 1988). This follows a local tradition of using 'bonecos', as such figures are called, for story telling. In South Africa, Puppets Against AIDS tours different venues with massive puppets to convey AIDS messages in a humorous way. Prostitute collectives in Australia and Latin America have developed various AIDS education strategies including songs, dance, drama and circulating leaflets to promote condom use amongst potential clients in the workplace, beerhalls and nightclubs (Vth International Conference on AIDS, 1989). There are many different approaches to AIDS or to health education in general, depending on the knowledge, interests, education, culture and needs of employees and their families, and on the resources made available. It is up to employers to support educational initiatives from the shop floor, personnel, health and other departments, by providing time, facilities and money. They should also collaborate to develop clear policies for the enterprise internally and at a national level.

Conclusion and recommendations

AIDS throws into stark relief issues of narrow economic cost effectiveness versus employer social responsibility, and shortterm gain versus longterm investment. To curb the AIDS epidemic it is vital that integrated and supportive policies are implemented at individual enterprise and at national level, so that widespread understanding and appropriate behaviour change are fostered throughout the population, rather than increased fear, stigmatisation and isolation. A beginning has already been made. Developments that are urgently required, or need to be strengthened, include at least the following:

1. Policy development

- * collaboration by the government, employers' confederations and labour organisations to develop a national policy on AIDS and employment
- * legislation against discriminatory practices, such as anonymous testing and the routine blocking of people with HIV from employment, training or promotion
- * increased information and programme sharing between enterprises themselves, and between enterprises and ACP, AIDS organisations and other support services (such as through the National AIDS Council and Zimbabwe AIDS Network)
- * rational policies on health insurance, life assurance, pensions and other benefits to safeguard funds whilst minimising AIDS discrimination.

2. Education

- * the development of ongoing and imaginative AIDS education programmes at all levels throughout employment to promote sound knowledge, supportive attitudes, and appropriate behaviour change; where possible, such programmes should also reach families
- * training of key personnel to act as AIDS educators and supporters/counsellors within the workplace, training of peer counsellors/educators, and support for the ACP's Health Programme, Facilitators initiative
- * evaluation of education programmes.

3. Improved health, safety and support

- * improving health and safety measures to minimise risk of blood contact, particularly in personal services, but also in all first aid and company clinic facilities
- * free provision of condoms at the workplace, with support and advice on their use
- * exploration of funding mechanisms to provide maximum support for employees with AIDS and their families.

4. Expanded training

- * expanding of personnel development, technical, managerial and other training programmes to take into account increased managerial and skilled labour shortages that are projected because of AIDS.

The AIDS crisis could force companies, structural adjustment notwithstanding, to develop more comprehensive health and safety policies, become generally more socially aware and provide better welfare services within a strengthened national policy framework. The alternative is increased workplace discrimination, stigmatisation, rejection and isolation of infected persons and their families. The latter would, in the short term, be a personal disaster for thousands of people, and in the long term could be catastrophic at a national level. Nevertheless, as noted by Tony Devlin of the Anglo American Corporation (Devlin, 1990).

"If... the experience of employers over the coming years is one of increasing work absences, death in service and loss of the very skills engendered by training, then one can imagine the situation where the voice of the pre-employment testing and repeat screening lobby gain momentum".

At the same time, precisely because of the increased difficulty recruiting skilled staff, companies may find they need to have supportive HIV policies to attract skilled personnel, rather than policies that create fear. People may avoid applying for a job in a company that undertakes screening.

The time for concerted, positive action is now. In the overall national AIDS campaign the workplace has a particularly pivotal role to play.

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