

The Impact of HIV and AIDS on the Small and Medium Enterprises Sector in Zimbabwe

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Acronyms and Abbreviations

AIDS	Acquired Immunity Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
CIFOZ	Construction Industry Federation of Zimbabwe
CZI	Confederation of Zimbabwean Industries
HAZ	Hospitality Association of Zimbabwe
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
ILO	International Labour Organization
MOHCW	Ministry of Health and Child Welfare
MSMED	Ministry of Small and Medium Enterprises Development
PLWHA	People living with HIV and AIDS
PSI	Population Service International
NAC	National AIDS Council
NGO	Non Governmental Organisation
SEDCO	Small Enterprises Development Corporation
STI	Sexually Transmitted Infections
STD	Sexually Transmitted Diseases
SME	Small and Medium Enterprises
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
SI	Statutory Instrument
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZBCA	Zimbabwe Business Council on AIDS
ZNCC	Zimbabwe National Chamber of Commerce
ZOU	Zimbabwe Open University

Definition of Terms

SME

From a policy perspective, the definition of SMEs is based on the number of employees, total net assets and legal structure. For one to qualify as an SME, the employment criteria and one of the other two criteria must be met. An SME is thus defined as a registered business employing less than 75 employees for the manufacturing sector and employing 50 or fewer employees in all other sectors¹. Micro-enterprises are those employing less than 5 employees and are not registered i.e. they are informal.

For the purposes of this study, an SME is defined as an enterprise employing 1 – 75 employees and has a certificate of incorporation. Although this study did not demand proof of registration, research assistants asked relevant questions to determine entrepreneurial legitimacy. The questions ranged from whether a business had a certificate of incorporation, operate with a general dealers licence or registered somehow with the local authorities.

Employer

Defined as those who responded as either Managers, CEOs or Directors.

Statutory Instrument 202, (1998)

The Statutory Instrument 202, Zimbabwe Labour Relations (HIV and AIDS) Regulations of 1998 provides for the following:

-  Education of employees on HIV and AIDS.
-  Prohibits testing for HIV and AIDS as a

precondition to the offer of employment. It states that it shall not be compulsory for any employee to undergo testing for HIV.

-  Prohibits employers to require any employee to disclose their HIV status in connection with their employment.
-  That no employer shall terminate the employment of an employee on the grounds of the employee's HIV status alone.
-  That no employee shall be prejudiced in relation to promotion, transfer, training or other development programme or in any way be discriminated against on the grounds of his HIV status alone.
-  That HIV status of an employee shall not affect his eligibility for any occupation or other benefit schemes provided for employees.
-  That any employee suffering from HIV and AIDS shall be subject to the same conditions as those applicable to any employee in terms of the Act and
-  That an employer shall provide every employee with a copy of these regulations.

The regulations make it an offence for any person who contravenes any provision of the regulations. The contravention of the regulations attracts a penalty not exceeding five thousand dollars (before currency revaluation) or imprisonment for a period not exceeding six months or both such fine and imprisonment.

¹ This definition is contained in the Government of the Republic of Zimbabwe: Small, Micro and Medium Enterprises (SMMEs) Policy and Strategic Framework: 2002-2007 of July 2002. The generic term of Small and Medium Enterprises (SMEs) has however been used throughout this document.

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- ✚ Employers Confederation of Zimbabwe
- ✚ National AIDS Council
- ✚ International Labour Organization

Globally over 40 million people are living with HIV and AIDS with Sub-Saharan Africa being the worst affected. The ILO Global Estimates on HIV and AIDS and Work² indicate that of those in the 15-49 age group and living with HIV and AIDS, 26 million of them are workers. Southern Africa remains the worst affected sub-region with most countries in the region recording prevalence rates of between 10% and 38% of the adult population of the 15-49 years age group.

Zimbabwe has been among the countries with the highest HIV prevalence rates in the sub-region. The country has however realised a significant and sustained decline in prevalence rate from 24.6% in 2004, to 20.1% in 2005 (UNAIDS). Recent findings from the Zimbabwe Demographic Health Survey indicate prevalence rates of 18.1%. The declining trends are attributed to behaviour changes within the communities. Despite this notable decline, the overall impact of the epidemic remains unacceptably high.

The HIV and AIDS pandemic continues to affect all sectors of the economy. The high burden of the pandemic is eroding the safety nets that cushion families against the devastating effects of the disease. The impact among workers is worsened by their exposure to occupational hazards, high mobility, low personal risk assessment and the fact that some

2 ILO (2004) HIV and AIDS and work: global estimates, impact and response. Geneva: ILO. Available at: www.ilo.org/aids.

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of them continue to engage in unsafe sexual practices particularly in the mining and transport sectors. The small and medium enterprises sector is by no means an exception in bearing the loss of human resource skills and productivity decline due to illness and deaths from HIV and AIDS.

The Government of Zimbabwe continues to intensify its efforts in responding to the effects of HIV and AIDS. The National AIDS Council has been set to coordinate the multi-sectoral response. A national AIDS policy and a labour code are now in place and HIV and AIDS has been declared a national emergency to facilitate resource mobilisation. A national AIDS Trust Fund was set up to provide the needed resources for implementation of programmes, although the mobilisation of adequate resources remains a major challenge.

In order to fully assess the impact of HIV and AIDS within the SME sector, the Ministry of Small and Medium Enterprises Development in partnership with the International Labour Organization (ILO) commissioned the foregoing study on the impact of HIV and AIDS on the Small and Medium Enterprises sector. The main aim of the study was to determine the knowledge levels, assess the impact and coping mechanisms including succession planning and livelihood strategies among SMEs in the context of HIV and AIDS.

Our expectation is that this report and its recommendations will galvanise all players –Government, civil society and other stakeholders to increase their responses as we intensify efforts to prevent infections and mitigate the impact of HIV and AIDS within the SMEs sector.

Sithembiso G.G. Nyoni (MP)

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Director, Sub-regional office for Southern
Africa

Globally, the number of people living with HIV and AIDS in 2005 was estimated to be 38.6 million of which 24.5 million are in Sub-Saharan Africa. Although in Zimbabwe many people continue to lose life as a result of the impact of the pandemic, coordinated efforts by government and other stakeholders have increased responses with the resultant decline in prevalence rates which have been recorded over the period 2004 to 2006.

The realisation by the Government of Zimbabwe that HIV and AIDS is destroying the social fabric and damaging the backbone of the country's economic base (the work force) has led to a multi-pronged response to the pandemic. While some research has been done on the impact of HIV and AIDS on big companies, not much in terms of comprehensive efforts had been done to consider the impact of the pandemic on the small and medium enterprise sector.

This study comes against the background that SMEs and the informal sector are employing the majority of workers in Zimbabwe and yet they are the most vulnerable to HIV and AIDS. The main objective of the study was to assess the socio-economic impact of HIV and AIDS on SMEs in Zimbabwe and recommend appropriate strategies and programmes to mitigate its effects. The survey also aimed at determining knowledge, attitudes, and practices of SMEs in the context of HIV and AIDS.

A nationwide stratified sample of 2,000 SMEs was selected with the sample size proportionate to the population size across the following sectors: manufacturing, retailing, tourism and

Executive Summary

hospitality, construction and transport. Quantitative and qualitative data collection methods were used. The quantitative method was mainly through personal face-to-face interviews with targeted owners of SMEs using a structured questionnaire. The qualitative method was mainly through

in-depth interviews with targeted owners of SMEs through an unstructured questionnaire.

Key Findings of the Study

1) Demographic Profile of Respondents

Seventy nine percent of the respondents were employers and 21% were employees. Those who responded in their capacity as Managers, CEOs or Directors were considered ‘employer’ while those who responded as non-managers were considered to be ‘employees’.

Age Range of Respondents

Ninety five percent of the respondents were in the sexually active (15-49) age group, which is also the economically productive age group (UNAIDS, 2005). Sixty one percent of the respondents however were in the 25-39 age group, twenty one percent were in the 15 to 34 age group, twelve percent in the 40 to 49 age group and six percent were above fifty years. Thus the SME sector in Zimbabwe is dominated by the 25 to 39 age group that is also more vulnerable to HIV and AIDS. According to UNAIDS (2005), this age group has an HIV AIDS prevalence rate of 20.1%.

Gender Composition of Respondents

Sixty one percent of the respondents were males while 39% were females. This is reflective of

gender imbalance in the SMEs sector where on average 37% of the employees are females. Males generally dominate most of the sectors but their dominance was greater in the construction and manufacturing sectors. Women marginally dominate the tourism and hospitality sector (52%) while there is an even gender representation in the retailing sector where 49% of employees are women. However, there is an indication that women are playing an important role in the SME sector as evidenced by the fact that 58% of the female respondents were in a position of authority, with 33% being either director/owners or CEOs.

2) Knowledge Levels, Attitudes and Perceptions of HIV and AIDS in SMEs

Knowledge Levels, Attitudes and Behaviour

Findings revealed that sixty two percent of the respondents acknowledged the fact that HIV and AIDS is a business challenge. This acknowledgment is highest in the tourism and hospitality, retail, construction and transport sectors. In spite of this high level of awareness about HIV and AIDS, risky behaviour was observed among a significant proportion of the SMEs. This behaviour is characterised by multiple sexual partners (15%) and inconsistent or non-use of condoms (46%). The gender perspective to multiple sexual partners indicated relatively high-risk behaviour on the part of male respondents than females as only 9% of women have two or more sexual partners compared to 19% of men. Married women were comparatively more faithful as only 5% had two or more sexual partners.

Condom use is a critical preventive measure in reducing the spread of HIV and AIDS. However,

some respondents indicated none or inconsistent use of condoms even with casual partners. Among the reasons and excuses given for not using condoms included that condoms: reduce sexual pleasure, are for prostitutes or for use outside marriage. Although 72% of women never use condoms because they trust their partners, the issue may be more complex than generally perceived. Condom use encompasses issues of power and sexual control and goes beyond communication between partners to the ability to negotiate and initiate the discussion on the part of women. The majority of women have little or no influence on these issues particularly when the man is the dominant partner in the relationship.

Condom usage with casual partners was higher among divorced and widowed respondents with proportions of 73% and 66% respectively. Only 60% of single and 55% of married respondents always used condoms with casual sexual partners. Use of condoms with casual partners by age group indicates that relatively more people in the 25-39 age group (56%) and the above 40 age group (57%) always use condoms than those in the 15-24 years age group.

Methods used to reduce the risk of HIV infection included abstaining from sex, use of a condom, being faithful to one sexual partner and reducing the number of sexual partners. Faithfulness to one partner seemed to be the most popular strategy (45% for males and 33% for females) of reducing risk of HIV infection. However, this is only effective if there is mutual faithfulness between partners.

Perceptions to Risk of HIV Infection

Thirty seven percent of the respondents did not perceive the risk of HIV infection compared to 63% who saw the possibility of HIV infection. A gender analysis of the results indicates that 39% of the males did not see the risk of HIV

infection whereas 61% of the males perceived some risk of HIV infection. On the other hand, 35% of the females perceived no risk of HIV infection and 65% of the females perceived the risk of HIV infection.

The majority of respondents with low perception of risk infection are those with only one sexual partner. The study revealed that 85% of men and 88% of women who perceived no risk of infection, had only one sexual partner. On the other hand, 55% of men and 34% of women with more than one sexual partner perceived some risk to infection. However, 63% of females who perceived some risk have only one partner. This may imply that women generally do not trust their partners. The difference in the perception of risk for men and for women could also be attributed to women's lack of power and ability to negotiate for safer sex and lack of mutual faithfulness. Women therefore reported a higher perception of risk. Any programme for HIV and AIDS intervention in the SME sector should target both men and women and should in turn aim to empower women to negotiate for safer sex.

3) Effects or Costs of HIV and AIDS to SMEs

Productivity Losses

The survey reveals that on average three employees per company had applied for compassionate leave to attend funerals or illness of close relatives in the 30 days before the study. A single SME lost an average of 3.6 days because of workers who attended funerals in the 30 days before the study. Only 7% of the owners did not have workers who took leave to attend funerals and illnesses in the last 12 months. SME owners lost an average of 1.2 days of production to attend funerals of employees. The average cost of time lost by an SME due to funerals or illness absenteeism was ZW\$3.8³ million in the last 12 months.

3 The figures were given before a currency valuation process, which removed three zeros. Data collection was also done at a time when inflation was hovering above 600% p.a., and on an upward trend. Also, the official inter-bank rate of exchange was 1 USD : Z\$101 000.00 (March 2006). This comment applies to all the figures given in ZW dollars.

In total, productive time lost due to absenteeism because of sickness or funeral attendance is 9.7 days in the 30 days before the survey. This is more than 40% of productive time in a month. Thus SMEs are losing a lot on production due to illness or funeral related absenteeism. Given that HIV and AIDS is the major cause of both mortality and morbidity in the country, it may also be the major cause of losses in production due to absenteeism in the last 30 days prior to the study.

SMEs however did not seem to attribute this loss in production time to HIV and AIDS. Fifty percent of the respondents thought their companies had not lost any worker due to HIV and AIDS and 19% were not sure. In addition 53% also believed that they did not lose any productive time due to HIV and AIDS related absenteeism. Given that most SMEs are run by families and employ family labour, these responses need to be taken with caution as most people generally find it difficult to openly accept and attribute the death or illness of a relative to HIV and AIDS.

Directs Costs

The average payout per company for funeral assistance to the family of the deceased worker over the past 12 months prior to the study was Z\$2.4 million. About 7% of the SMEs had estimates of costs incurred in funeral assistance of above Z\$20 million dollars and 13% of the respondents had estimated the costs between Z\$1 million dollars and Z\$20 million dollars per company.

Seventeen percent of the SMEs revealed that there were no recruitment costs incurred by the businesses. Most SMEs preferred to share the work among the remaining staff rather than hire permanent or temporary staff as a coping strategy hence recruitment costs for SMEs were generally low. However, 11% incurred recruitment costs of between Z\$1-20 million. On average, recruitment costs per each SME

were ZW\$1.8 million. Of those who were able to provide some cost estimates on training induced costs due to illness or deaths, 18% said there was no training cost incurred, 32% did not know, 41% were non-committal, while 9% indicated varying costs of between Z\$25 million to over Z\$30 million.

4) Succession and Productivity Strategies

The study revealed that SMEs generally do not replace staff following extended absence of employees due to long-term illness or other AIDS related conditions. They prefer to share the workload among the remaining staff in order to maintain productivity. Sharing the job among available staff was preferred by 39% of SMEs while only 6% preferred to hire temporary staff. Other coping strategies adopted by SMEs were multi-skilling (16%), hiring temporary staff (17%), taking staff from other departments (7%) and waiting for the person to return (15%). Sharing the job among available staff was most popular in the following sectors: retail (60%), transport (61%) and manufacturing (46%). Respondents in the construction industry (66%) were in favour of multi-skilling while replacing staff was not favourable across all sectors except in the finance sector. More SMEs in the finance sector (50%) preferred to hire temporary staff as the first alternative.

The preferred coping strategies in essence depend on the remaining employees who have to take on disproportionately bigger workloads which places a strain on them and ultimately may lead to a decline in productivity in the long term. This makes SMEs more vulnerable to HIV and AIDS as the impact of absenteeism and deaths are felt for a much longer period. This is worsened by the small staff complement that most SMEs have. The unwillingness to share the control of business with people outside the family also threatens the continuity of SMEs in the event of death due to AIDS.

5) Workplace Programmes within the context of HIV and AIDS

HIV and AIDS Workplace Programmes

The high acknowledgement of HIV and AIDS as a business challenge was not converted into action by SMEs as evidenced by 67% of them who had no HIV and AIDS workplace programmes. It was also revealed that there were low levels of initiatives on the part of SMEs to provide information on HIV and AIDS as well as discuss HIV and AIDS issues at the workplace. Electronic and print media were the major sources of information about HIV and AIDS at the work place. About 40% of respondents indicated that their main source of information was radio and television while 23% respondents stated that newspapers were their main source of information on HIV and AIDS. Only 18% indicated posters and fliers at the workplace as their source of information. Lack of knowledge and resources as well as lack of appreciation of the impact of HIV and AIDS may be largely attributed to SMEs' failure to quantify the economic costs of HIV and AIDS on their business.

There was also little discussion on HIV and AIDS issues at the workplace especially among the companies with fewer employees. Sixty-eight percent of respondents had not formally discussed HIV and AIDS at the workplace. This may be attributed to the stigmatisation of HIV and AIDS and the family setting within these SMEs. Open discussion about sexual issues and opening up on one's HIV and AIDS status is taboo among close relations. For this reason, the same smaller companies underestimate the impact of HIV and AIDS on their businesses and often do not put any mitigating measures in place.

Company HIV and AIDS Policies

Only 26% of SMEs had written HIV and AIDS policies and most of those without written policies were not running any HIV and AIDS workplace programmes. The formulation of business HIV and AIDS policies by SMEs could therefore be the first step to effective HIV and AIDS workplace programmes. Eighty nine percent of employers in the SME sector however showed willingness to fund workplace programmes. These SMEs may have failed to put HIV and AIDS programmes in place because they perceive them as expensive and see no benefit of such programmes. Lack of technical know-how negatively affects the ability to implement programmes.

Way Forward

In order to mitigate the impact of HIV and AIDS in the SME sector, interventions focusing more on behaviour change are required. Information dissemination on the economic costs of HIV and AIDS, benefits of workplace programmes and encouragement of discussion of HIV and AIDS issues is also vital. SMEs should also be provided with adequate knowledge and technical assistance in the implementation of HIV and AIDS programmes at the workplace. This can be achieved in a cost effective way through collaboration with HIV and AIDS organisations, both public and NGOs. The interventions could be better facilitated if SME associations put in place sectoral policies and collect and disseminate good practices for adoption by other members.

At SME level, the impact of HIV and AIDS on business continuity can be mitigated if they adopt sound corporate governance principles. They should also make initiatives to provide information on HIV and AIDS at the workplace as well as initiating discussion on HIV and AIDS issues.

Introduction

The HIV and AIDS pandemic is considered to be the biggest threat to socio-economic development at a global level in general and Sub-Saharan Africa in particular. Globally, the number of people living with HIV and AIDS in 2005 was estimated to have been 38.6 million, of which 24.5 million were in the Sub-Saharan Africa. Half of the 6,000 new HIV infections every day in the whole world are of young people in the 15-24 age range. AIDS claimed the lives of about 2.8 million worldwide and 2 million in Sub-Saharan Africa in the year 2005. Since 1981, more than 25 million people have died of AIDS. Within Sub-Saharan Africa, the Southern Africa region with an estimate of close to 15 million living with HIV in 2005 is the most affected, accounting for 60% of prevalence in Sub-Sahara Africa. AIDS claimed over 1 million lives (46% of worldwide deaths) in Southern Africa⁴.

Zimbabwe in particular, with an estimate of over three thousand lives being claimed every week by AIDS, is one of the most affected countries. Although HIV prevalence has declined, it is still high with close to 20.1% of the population aged 15-49 estimated to be living with HIV in the country (MOHCW, 2005). HIV and AIDS has managed to reduce the life expectancy of the Zimbabwean population by almost 50% from about 65 years to just over 30 years (Khumalo *et al*, 2002). However, “the fight could be won by the right combination of leadership and comprehensive and multi-sectoral action” (UNAIDS, 2004).

With the realisation that HIV and AIDS is a problem that threatens both the social and

economic existence of the population, the Government of Zimbabwe initiated the development of a national HIV and AIDS policy through a broad consultative, consensus building process with stakeholders from all parts of the country. This resulted in the launching of a National Aids Policy in 1999, which paved the way for the establishment of the National AIDS Council (NAC) through an Act of Parliament and an AIDS levy in the same year. The NAC’s mandate is to (i) develop strategies and policies to combat HIV and AIDS, controlling and coordinating such strategies, (ii) mobilise and manage resources in support of a national response to HIV and AIDS, (iii) enhance the capacity of various sections of the community to respond to the HIV and AIDS and (iv) promote and coordinate research into HIV and AIDS and ensure the effective dissemination of the results of such research.

In 2000, the National AIDS Coordination Programme led to the development of the National HIV and AIDS Strategy Framework, a strategic plan that includes specific goals and targets. Prevention is the cornerstone of the strategic plan. However, there are also strategies for treatment and care of HIV and AIDS patients. These include the improvement of the capacity of the health care system to treat and care for the PLWHA by expanding the availability of ARVs and improving the capacity of households and communities to take care of their sick.

Various studies have shown that HIV and AIDS have a significant impact on the socio-economic situation in the country. The impact

4 UNAIDS/WHO, May 2006.

goes beyond the individuals affected and their household – it certainly spans across into the world of work – both formal and informal. The increasing costs associated with the spread of HIV and AIDS especially for the labour force has far reaching impact on businesses and the economy in general. Although studies on the macroeconomic impact of HIV and AIDS on Zimbabwe are few, there is evidence that the economic cost of HIV and AIDS in Zimbabwe is significant. Pimhidzai and Matshe (2006) estimated a loss in GDP as a result of HIV and AIDS of 13.32% of 1993 Gross Domestic Product. The loss of output, for businesses in general, is a result of reduced productivity due to illness or loss of manpower due to death as well as productivity losses due to HIV and AIDS related absenteeism. The loss of key personnel has severe consequences for the business. Firms also incur direct costs in the form of increased medical insurance contributions for staff to cover medical expenses and funeral costs.

While larger businesses can put in place mechanisms to cushion themselves against these, SMEs and informal businesses generally do not have systems and structures to mitigate the impact of HIV and AIDS hence they are more vulnerable. This is exacerbated by the ownership and control structure of SMEs whereby the owner is heavily involved in the management of all aspects of the business without clear corporate governance structures. Therefore, as a nation, Zimbabwe has a concentration of the impact of the HIV and AIDS epidemic within a sector that has the least mitigation mechanisms. Yet the SMEs sector is increasingly becoming more important now with the current, harsh macro economic environment that has led to the decimation of the formal, large employment sector. The SME sector employs the majority of the people, produces an increasingly important percentage of national GDP, employs most of the women, but it does not have the capacity and resources to respond to the epidemic.

This study sought to assess the socio-economic impact of HIV and AIDS on SMEs in Zimbabwe and recommend appropriate strategies and programmes to mitigate the effects. The study also sought to answer the question of how HIV and AIDS is affecting SMEs growth and sustainability, livelihoods of the people involved in the sector and the type and scale of responses to combat the consequences of the epidemic.

Statement of the Problem

The formal unemployment rate in Zimbabwe is arguably fast approaching the 80% mark (CSO states 9%) and this means that only about 20% of the population within the working age group is employed in the formal sector in the country. With the current macroeconomic challenges facing the country, the situation appears to be worsening as the foreign currency shortage continues, inflation surges (at 1 193% at the end of May 2006 and continuing to rise) and commercial lending rates also on the rise resulting in the decline in capacity utilisation as well as closures of large firms in the formal sector.

Estimates put the number of micro, small and medium enterprises in Zimbabwe to between 700 000 and 900 000 (Gemini study, 1998). Worldwide, the HIV and AIDS pandemic is severely affecting the economically active population group most. Thus, the impact of HIV and AIDS on the SME sector needs to be clearly understood to guide development of focused strategic interventions in the form of policies and programmes, given that the sector now employs the bulk of the work force in Zimbabwe.

The HIV and AIDS pandemic has major implications not only for the continued survival of the SME sector, but also those who derive their livelihoods from it and their dependants. The disruption of entrepreneurs and their workers in the SME sector by HIV and AIDS has far reaching effects since they make

significant contributions to Zimbabwe's economy. Although several studies have been carried out on the socio-economic impact of the pandemic on the economy, the full impact of HIV and AIDS on specifically the SME sector has really never been fully investigated, and to a greater extent, it remains unknown. Some studies have been commissioned to assess the impact of HIV and AIDS on the formal sector, and one such study was done by the Zimbabwe Business Council on AIDS (ZBCA). The study was aimed at the bigger businesses, with some listed on the Zimbabwe Stock Exchange amongst those interviewed. This particular effort therefore seeks to close the information gap by specifically focussing on the SMEs, who are important players in the Zimbabwean economy.

Objectives of the Study

The main objective of the study was to assess the socio-economic impact of HIV and AIDS on SMEs in Zimbabwe and recommend appropriate strategies and programmes to mitigate the effects. Specifically, the study sought to answer to the objectives as indicated below:

- ✚ To determine the knowledge levels, attitudes and practices of local SMEs as regards to HIV and AIDS;
- ✚ To identify the potential and nature of losses arising from and due to HIV and AIDS in the SME sector;
- ✚ To look at issues of succession planning, productivity and workplace programmes among SMEs;
- ✚ To identify livelihood strategies for the SME sector within the context of HIV and AIDS;
- ✚ Make an analysis of the impact of HIV and AIDS in a way that could help the sector understand and appreciate the scale of the epidemic on the economic bottom line on the business within the SME sector; and
- ✚ To recommend appropriate policies and programmes to the Ministry of Small to

Medium Enterprises Development and other stakeholders that mitigates the impact of the HIV and AIDS epidemic on the SMEs.

Research Questions

The above objectives will therefore be pursued along particular research questions, such as:

- ✚ The knowledge levels, attitudes and perceptions of HIV and AIDS within the world of work in particular to SMEs.
- ✚ The effects or costs of HIV and AIDS to the businesses.
- ✚ Related practices and behavioural patterns.
- ✚ The current livelihood, prevention and coping strategies for the SMEs sector within the concept of HIV and AIDS.
- ✚ Strategies for enhanced involvement of SMEs

Importance of the Study

The Gemini (1998) study estimated the number of SMEs (including micro-enterprises) in Zimbabwe to be approximately 860 000, employing around 1 600 000 persons, which was about 25% of Zimbabwe's working population. The critical role that SMEs play in the livelihoods of Zimbabweans and national economic development has been well acknowledged. Through Recommendation 189 of the International Labour Organization, member states have acknowledged the role of SMEs in their economies (ILO, 2003). Given the paucity of literature on the impact of HIV and AIDS on SMEs in Zimbabwe and the region in general, it is hoped that this study will assist in filling that gap. This study will not only involve the SMEs in proffering their own solutions, but will also bring the sector into the mainstream national response to HIV and AIDS in Zimbabwe.

The Ministry of Small and Medium Enterprises Development and other key stakeholders have taken a particularly keen interest in this study.

The Ministry would like to use the findings of the study to make appropriate interventions – policies and programmes – to be implemented in order to mitigate the impact of the epidemic on the SMEs. The study will assist the government and other stakeholders to come up with HIV and AIDS prevention and education programmes that target the SMEs to contribute the national efforts already under way.

Limitations of the Study

The major limitation of this study was non-response to some questions especially those regarding the quantification of costs of HIV and AIDS to the business enterprise. Most SMEs failed to quantify the cost of production time lost due to illness or funeral related

absenteeism. This had the effect of reducing the sample size for those questions. However, in all cases the responses were still above the minimum sample requirements. None responses were also recorded in some behavioural questions like condom use and number of sexual partners.

The figures on costs also need to be interpreted in the context of the hyperinflationary environment which characterised the period of the survey. Some of the variables required cost estimates for the last 12 months and historical figures provided could be misleading if a significant share of the costs was incurred in the earlier months. These historical figures grossly underestimate the costs incurred when interpreted in the present.

Review of Literature

HIV and AIDS is a subject that has been intensely studied and the body of knowledge continues to increase with each day. This particular study will certainly add onto that body of knowledge by focusing on the impact of HIV and AIDS on the SME sector in Zimbabwe. The literature review will focus on the economic costs and effects of HIV and AIDS as well as knowledge, attitudes and practices of SME on HIV and AIDS.

The Costs and Effects of HIV and AIDS to SMEs

The main effect of HIV and AIDS on productivity within small businesses can be measured in terms of hours worked and number of clients attended to. Clearly, absenteeism, disability and death will all have a negative impact on these indicators of productivity. In the short term, lower productivity will be a result of reduced performance and

absenteeism due to HIV and AIDS related illness. The effect is more pronounced in SMEs as most of them operate with very few key personnel. Since SMEs tend to be over-reliant on few core staff (usually family labour), skill, talent and knowledge invested in human resource is neither residual nor exchangeable, thus in the long term when an individual dies from AIDS, the enterprise incurs a great replacement cost.

However, the effects of HIV and AIDS will go beyond productivity as it leads to higher direct costs and thus lower profits. Additional costs in spiralling medical bills and funeral costs also eat into companies' profits and investment funds. Even if the business does not contribute to medical and funeral expenses, it faces higher costs because it becomes more expensive for the business to pay fixed salaries when productivity is dropping. The costs of HIV and AIDS are summarised in Table 1.

Table 1: 'Generic' Workplace Impacts of HIV and AIDS⁵

Direct costs	Indirect costs	Systemic costs
Benefits package - Health care & insurance - Disability insurance - Pension fund - Death benefit - Funeral expenses	Absenteeism - Sick leave - Compassionate leave - Attending funerals - Home-based care leave	Loss of workplace cohesion - Reduction in morale and work teams - Disruption of schedules and workplace discipline [AWOL]
Recruitment - Advertising & interviewing costs - Costs to productivity of vacant posts	Sickness - Reduced performance of individuals, due to HIV and AIDS while working	Employee attributes - Reduction in average level of skill, performance, institutional memory and experience
Training - Induction - In-service & on-the-job training costs	Management resources - Managers' time & effort responding to workplace impacts	Quality of employment - Cumulative costs reduce the quality of the workplace environment & reputation of the organisation

5 Sue Holden, Barnett and Whiteside [2002:256]

Globally, HIV and AIDS has become a major concern for companies. The World Economic Forum through the Executive Opinion Survey (2004/5) undertook a global survey to understand the extent of the response to HIV and AIDS in the workplace. This survey found that 45% of the corporates in Sub-Saharan Africa were not just concerned with the impact of HIV and AIDS on their businesses, but also in countries with high prevalence like Zimbabwe, they had some sort of policy on HIV and AIDS. However, SMEs tended to be less concerned with formal written policies. Mhloyi (2003) in a study for the Confederation of Zimbabwe Industries (CZI) revealed high prevalence of HIV and AIDS at the workplace. Management in the industry generally acknowledged that 35% of its workforce has been diagnosed as HIV positive while 60% are suspected to be so. This study was designed for the CZI membership, comprising big corporate companies and SMEs largely in the manufacturing sector, leaving a gap of establishing HIV and AIDS prevalence rate in the other sectors.

POPILO, a UN population and labour force projection, estimates that Zimbabwe may lose up to 12% of its labour force by 2020 if current HIV and AIDS trends continue unabated. Ray and Williams (1993) argue that since the formal sector in Zimbabwe is being negatively affected by the pandemic, by inference, the SME sector being the largest contributor to formal employment, is also affected. According to this study, there was an increase in the number of employees taking sick leave because of HIV and AIDS related illnesses.

Even as early as 1993, some companies were beginning to observe sharp increases in the mortality rates of their employees (Loewenson, 1998). The same study also found that lost production time due to HIV and AIDS related illnesses increased from 3-4 days per year to over 20 days for those with more serious illnesses. These periods of illness are interspaced with

periods of health and ability to work, making it difficult to predict specific periods of lost working time. Furthermore, the study found HIV to be responsible for 40% of lost working time at general industry level. In Zimbabwe, the agriculture sub-sector is estimated to be losing 10% working time a month due to HIV and AIDS-related funerals (Ncube, 1999). Over five years, agriculture output in one communal area declined by almost 50% among households affected by AIDS (Holden, 2003).

Ballard and King (2000) report findings of a survey of large and small companies in South Africa. Survey participants estimated that 11% of all employee deaths in 1998 were AIDS-related compared to 8 percent in 1997 and 7% in the previous year. Similarly, the incidence of AIDS-related compassionate leave increased from 4% in 1996 to 11% in 1998 with employees staying away from work to attend funerals of relatives or to care for ill family members, resulting in loss of man-hours, productivity and ultimately profitability.

Extended periods away from work disrupt the operations of small businesses. The extent of this disruption is extremely profound in small businesses where the absence of even one employee may mean that half the labour force is not at work. Furthermore, not only are small businesses affected by the absence of sick employees, their employment and/or earnings are also placed at risk. Small businesses generally go through three phases of development and the impact of HIV and AIDS presents a unique threat at each development stage. The highest threat is at the formative product-driven phase when the founder of the business is the most influential. Should s/he be infected, the entire work force will lose their source of income, direction and vision (ZOU/Sithole, 2003).

Price Waterhouse Coopers (1998), argue that SMEs employing women were likely to have suffered from HIV and AIDS-related losses

more than those which employed men, not necessarily from direct affliction, but through events outside the shop floor. For the period between 1994 and 1998, of the SMEs that shut down, more than 80% were owned by women. The main reason is that when an adult female member dies, generally households dissolve (Mutangadura, 2000).

Since UNICEF (2003) notes that grandmothers are now running some households due to deaths of their more able children, what remains unanswered is whether they could take over the running of small family businesses, in the event of loss of family members. This is a key question for the strategic options available in SMEs succession planning. This is closely linked to the issue of property rights. The Human Rights Watch (2003) tackles the complex property rights issues. When a male business owner dies, the women find themselves fighting the patriarchal system that makes operating an SME in Zimbabwe challenging in the event of death of the husband. The legal system is therefore an important aspect to help uphold the rights of women to property and inheritance in the SME sector, so that they garner confidence in dealing with the worst pandemic in history. The gender considerations of HIV and AIDS are important, but little effort has been made to also incorporate them in studies. Only a few studies take into account the gender aspect of HIV and AIDS in the SME sector. It is however necessary to examine this aspect closely because women are a very large part of the SME labour force.

Knowledge Levels, Attitudes and Practices of SME Operators with Respect to HIV and AIDS

In Zimbabwe, there is a relatively high level of awareness of HIV and AIDS. A 2002 survey⁶ found that 83% of women and 92% of men knew of HIV and AIDS and the majority of

young people are aware that the major mode of HIV transmission is sexual contact. The media has played a big role in raising awareness regarding the pandemic. The relatively high level of education in the country is also a contributing factor to the level of awareness. According to Mbizvo *et al.* (1997), as the level of education increases, knowledge of HIV and AIDS also increases.

In order to effectively curb the spread of HIV and AIDS in the SME sector, it is important that awareness programmes be introduced. Unless the findings of research and the high level of information dissemination are translated into practical programmes that can be implemented, there will be limited results from studies that examine the impact of HIV and AIDS on this sector. In some instances, there were revelations of unfair labour practices due to HIV and AIDS, with promotion and staff development policies entailing one form of HIV and AIDS screening. Employees showing symptoms of being sero-positive were being disadvantaged (Sithole, 2003). Mhloyi asserts that this causes limited disclosure of sero-status, thus enhancing the stigma while undermining potential support. In the same study, most business managers indicated knowledge of the impact of HIV and AIDS on productivity and a certain degree of compliance to non-discrimination laws, practising mitigation and intervention programs.

In principle, positive employees are 'fire guarded' by the Zimbabwe National AIDS policy and Statutory Instrument 202 of 1998. However, SMEs and companies address the impact of HIV and AIDS in line with their resources and at times may not implement the national policy. Part of their coping strategy is reliance on contract workers to avoid direct funeral, medical costs and employee benefits (Gemini, Techfin and SAFAIDS, study 1999:47). It is still unclear whether or not

6 NAC/MOHCW/USAID (May 2004).

there is any strict adherence to the main policy tool guiding the implementation of awareness programmes in the workplace – the Statutory Instrument 202 of 1998 contained in the National HIV and AIDS Policy (Government of Zimbabwe, 1999). Under this instrument, employers are expected to provide information on infection and transmission of HIV, prevention of HIV and AIDS, and counselling facilities for HIV and AIDS patients.

However, one limitation of this policy tool is that it is targeted mainly at large companies as opposed to SMEs. This is evidenced by the fact that education programmes are to be designed in accordance with guidelines approved by the relevant employer and employee organisations, such as trade unions. In Zimbabwe, it is mainly large companies and government agencies that have such structures, which are used mainly for negotiating salaries. The policy tool is now being used to include the SME sector as well considering its growing importance in the national economy and the increasing incidence of the pandemic within the business sector.

The National Aids Council of Zimbabwe (NAC) has come up with the Workplace

Programme (NAC 2002). The programme uses mainly the Peer Education Model. Accessories to this are leaflets, pamphlets, books, posters, stickers, handouts, condoms and videos. Yet again the design of the Workplace Programme, like the National HIV and AIDS Policy, is biased towards larger companies. However, in the recent past, companies in the SME sector have also adopted the programme.

Summary of Literature Review

Even though related literature is scarce, the little that is there suggests that SMEs are particularly vulnerable to the devastating effects of HIV and AIDS. This impact is in the form of productivity losses due to HIV and AIDS related absenteeism and losses in human resources, which undermine the continuity of SMEs. The other effect comes from increased direct costs to businesses. There is an indication of high levels of awareness of HIV and AIDS but this may not necessarily imply behaviour change. The current study is therefore expected to make an important contribution to understanding how SMEs are affected by HIV and AIDS and what strategies they can employ to mitigate its impact.

Research Methodology

Study Area

The study was conducted in Zimbabwe among SMEs operating in or near provincial capitals namely Harare, Bulawayo, Mutare, Gweru, Masvingo, Lupane, Gwanda, Bindura and Chinhoyi. The sample concentrated on urban SMEs mainly because over 60 percent of SMEs are located in the urban or peri urban areas (USAID, 1998).

Sample Size

The sample size for the study was 2,000 SMEs. The sample was considered adequate to represent the responses from the total population of SMEs. For an estimated total population size of 1 500 000 SMEs, and an error bound of the 0.05 for the proportion of SMEs affected by HIV and AIDS, the minimum sample size is 389. The target variable for the calculation of the minimum sample size is productive time lost due to HIV and AIDS. According to a study by Loewenson (1998), HIV to be responsible for 40% of lost work time at general industry level in Zimbabwe. The calculation of the minimum sample size is thus based on a proportion of 40%. The sample size of 2,000 is still more than the minimum required sample size when HIV prevalence rate (20.1%) is used as the target variable. Thus the sample size of 2,000 is adequate for a survey on Zimbabwe's SME sector.

Sample Selection

The sampling frame consisted of all registered SMEs from various organisations such as the Zimbabwe National Chamber of Commerce

(ZNCC), Confederation of Zimbabwe Industries (CZI), Hospitality Association of Zimbabwe (HAZ) and Construction Industry Federation of Zimbabwe (CIFOZ). The purposive sampling technique was used to identify the respondents. The choice of this technique was mainly due to the scatteredness of the sampling units. Using other methods mainly simple random selection would imply having a scattered sample difficult to administer and also time consuming.

The sample was done with proportionate to size with provinces having more SMEs having bigger sample representation. Further splits according to sectors were done within each province as shown below.

-  Retail [45%]
-  Manufacturing [25%]
-  Tourism and hospitality [15%]
-  Transport and communication [10%]
-  Any other [5%]

The questionnaires were targeted at the employer/owner or the CEO/MD. Where these were not available, supervisors or second in command were interviewed.

Data Collection

This study collected both quantitative and qualitative data. The main research instrument was a structured questionnaire **[attached as annex]** that had been pilot-tested before hand at the ZNCC Retreat on some 20 SME managers. This testing assisted researchers in refining the questionnaire and to set the actual interview time between 30 minutes to 1 hour.

The predominant method for data collection was the interview method, which accounted for 99% of the respondents. This method had the major advantage of allowing the interviewer to probe and gain some insights into the complex HIV and AIDS issues. The other methods, which accounted for about one percent of the responses were the 'drop and pick', e-mail and the telephone. These methods however solicited very limited responses due to fatigue and changes in contact details.

Challenges in Data Collection

There was a lot of redundant data in the lists provided by the Business Associations due to migration. In order to enhance the confidence of respondents, research assistants were provided with an official letter of introduction from the Ministry of Small and Medium Enterprises Development. Other challenges

were related to escalating costs of transport during the interviews which restricted movement of the research assistants.

Data Analysis

The data analysis was done using SPSS through detailed analysis tables that had been designed at the questionnaire design stage. This allowed for cross tabulation of results and findings on key themes such as gender, age, sectoral classification, programme issues and media strategies. Most of the analysis presented herewith was cross-tabulations to enable analysis of relationships that exist between variables. A chi-square test was further done to verify the level of significance of the association.

The qualitative data were analysed using content analysis and thematic narrative analysis. The qualitative data were used to augment the findings from the quantitative analysis.

Main Findings

Introduction

The findings are reported under the following headings:

- ✚ Demographics and situational analysis
- ✚ Knowledge, Attitudes and behaviour
- ✚ Costs of HIV and AIDS to SMEs
- ✚ Succession and livelihood strategies
- ✚ Workplace programs and practices
- ✚ HIV and AIDS policies at the workplace

As mentioned earlier, SMEs have special characteristics that make them more vulnerable to HIV and AIDS than other sectors. It is therefore, important to keep in mind SMEs' ownership and control structure in Zimbabwe for a better understanding of the economic impact of HIV and AIDS on SMEs. This has also implications on attitudes on HIV and AIDS in the sector.

Demographics

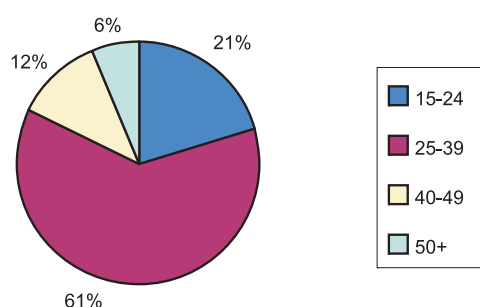
This section provides demographic characterisation of the SMEs through the respondents to the survey. The demographic characterisation of the SMEs sector is an important factor since it will enable us to understand behavioural patterns, knowledge and beliefs of SMEs looking at various demographic variables. For example, the gender distribution of respondents and their behavioural patterns, knowledge and beliefs have important implications on analysis for programme development purposes. Some of the key demographic indicators used in this study were age, gender, employer/employee statistics and sub-sectoral analysis.

Seventy nine percent of the respondents were employers and 21% were employees. The definition of employers was all those who responded as Managers, CEOs and Directors while on the other hand the definition of employees was all those who responded as non-managers. From the definitions given above, the employer category was therefore likely to be over represented by those that are classified as managers. In almost all the cases, interviewers had to gain access to workers through managers who preferred to respond to the survey themselves. The importance of the two viewpoints, of the employer and employee, was sufficient to warrant deliberate targeting of workers in the study.

Age Range of Respondents

The age range of respondents is summarised in Figure 1. The pie chart shows that 95% of respondents were in the sexually active (15-49) age group. This is also the economically productive age group (UNAIDS, 2005). However, 61% were in the 25-39 age group implying that the SME sector in Zimbabwe is dominated by the age group that is more vulnerable to HIV and AIDS. This age group

Figure 1: Age Composition of the Respondents



has a prevalence rate of 20.1% in total with females having a prevalence of 24%.

Thus, understanding the behaviour, attitudes and opinions of this age group within the SME sector will be key to combating HIV and AIDS at the workplace. Other studies carried out have revealed that mixing in sexual relations explains the higher HIV prevalence among the young women compared to their male counterparts. Young women often have two types of partners; one an older boyfriend who has accumulated assets and is able to provide money and gifts, the other slightly younger being cultivated as a potential husband. Thus young women with low rates of infection are having sex with older men with higher rates of infection

Gender of Respondents

The study revealed that overall, the gender distribution was skewed towards males who constitute 61% of the respondents against 39% for females. This further reflects the gender imbalance in the SMEs sector where on average 37.4% of the employees are females. Males generally dominate most of the sectors but their dominance is greater in the construction and manufacturing sectors. Females marginally dominate the tourism and hospitality sector (52.19% of employees are females) while an

equal distribution is in the retailing sector where 49% of employees are females and 51% are males. It is interesting to note that women are playing an important role in the SMEs sector as evidenced by the fact that 57.6% of the female respondents were in a position of authority and 33.4% of them were either director/owners or CEOs.

The composition of SMEs labour force in Zimbabwe by sector is shown in Figure 2.

The gender dimension to HIV and AIDS is always an important consideration. The UNAIDS (2005) report states that female workers are at more risk from HIV and AIDS infection as compared to men. This is due to a number of factors with poverty, cultural practices such as inheritance and economic dependency among them. Being widowed or divorced is significantly associated with higher prevalence among women. Similarly, divorced or widowed women are more likely to acquire HIV infection than married and single (never married) women. This manifestation is ascribed to several socio-economic and cultural factors that have made women more vulnerable to HIV and AIDS. In the same vain, the health model of HIV and AIDS which focuses more on biological determinants, postulates that women are at greater risk of acquiring infection in unprotected sex with an infected partner

Figure 2: Gender Composition of SMEs Labour Force by Sector

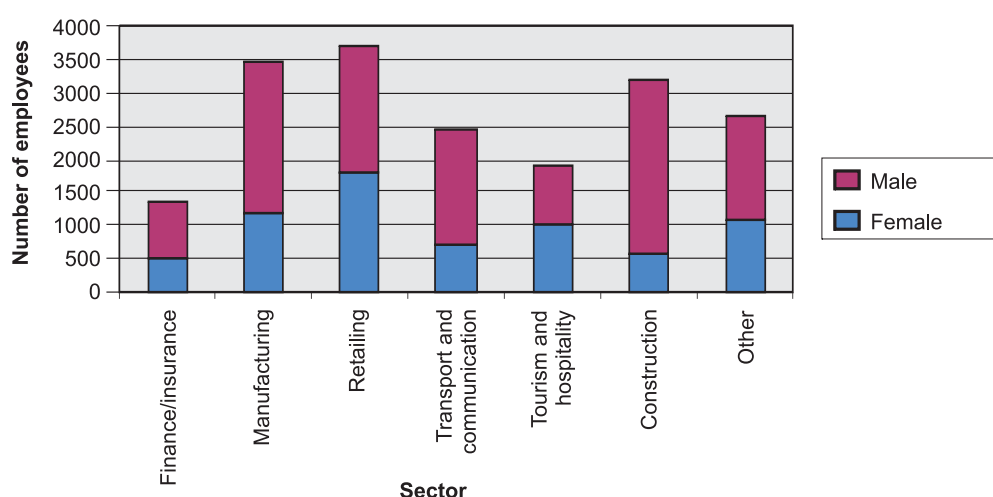


Table 2: Perceptions of Respondents to HIV and AIDS as a Business Challenge by Position

Response	Position of respondent				Total	
	Employer Number	Percent	Employee Number	Percent	Number	Percent
Yes	792	64.0	184	54.0	976	62.0
No	454	36.0	154	46.0	608	38.0
Total	1246	100.0	338	100.0	1584	100.0

than men because women have a larger exposed area and are receptive to and retain large amounts of virus in semen. It follows that major preventive strategies such as abstinence, being faithful to one partner and condom use should be encouraged in the SME sector.

Due to cultural and governance entrenched gender inequality and inequity perpetuated over the years, women have remained poor and culturally restricted. The poverty and current economic hardships lead to increased vulnerability as women are unable to negotiate safe sex. The masculine stereotype, engineered during the colonial era, and the dualisation of homes have placed married women at greater risk thereby explaining the higher prevalence among them.

Knowledge, Attitudes and Behaviour

Knowledge, attitudes and behaviour of people in the SMEs sector determine their vulnerability to HIV and AIDS. This is also important in explaining some of the observed trends in the sector. The section focuses on perceptions of SMEs as a challenge facing their businesses, behaviour of people in SMEs on HIV and AIDS related issues and their perceptions to risk of HIV infection.

Perceptions on HIV and AIDS as a Business Challenge

Overall, 81.8% of firms in the sample responded to the question on whether HIV and AIDS posed a challenge facing their company. Of those who responded, 61.6% considered HIV and AIDS as a challenge facing their

companies. Table 2 shows that most employers (64.0%) considered HIV and AIDS as a challenge to business. Of the employees interviewed, 54% also considered HIV and AIDS as a challenge to business. Thus the majority of both employers and employees believe that HIV and AIDS is an issue that negatively affects their businesses and would therefore be prepared to participate in programmes to mitigate the impact of the epidemic on the workplace.

Sectoral analysis of HIV and AIDS as a challenge facing SMEs indicated that Tourism and Hospitality is the most affected sector with a “yes” response of 86.2%. This is followed by Manufacturing (64.2%), Construction (61.6%) and Retailing (61.5%). The ZHDR, 2003 argues that workers in the construction and transport sectors are exposed to HIV and AIDS as they spend most of their time away from their spouses. As for the Tourism and Hospitality sector, the contributing factor would be attributed to the mobility of their clients. Its vulnerability lies in the high mobility of their clients, which exposes them to opportunities for sexual activities with different partners and the risk of HIV infection.

The retailing sector also faces a challenge. The fact that the owners of these outlets spend most of the time in search of cheap wares to sell exposes them to risky behaviour and HIV infection. Often the business requires extensive travelling and bargaining in search of cheaper products resulting in the establishment of sexual relationships aimed at facilitating trade. Sectoral response to HIV and AIDS as a challenge to companies is presented in Table 3.

Table 3: Responses to HIV and AIDS as a Business Challenge by Sector

Sector	Yes		No		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Finance/insurance	44	55.7	35	44.3	79	100
Manufacturing	206	64.2	115	35.8	321	100
Retailing	252	61.5	158	38.5	410	100
Transport & communication	137	56.1	107	43.9	244	100
Tourism and hospitality	131	86.2	21	13.8	152	100
Construction	90	61.6	56	38.4	146	100
Other	140	52.6	126	47.4	266	100
Total	1000	61.8	618	38.2	1618	100

Table 4: Number of Sexual Partners by Gender

Number of Sexual Partners	Gender				Total	
	Male	%	Female	%	Number	%
None	72	9.0	44	8.0	116	8.0
1 only	583	72.0	478	83.0	1061	77.0
2 or more	151	19.0	52	9.0	203	15.0
Total	806	100	574	100	1380	100

Most SMEs are labour intensive thus the impact of HIV and AIDS especially through absenteeism can be easily observed. It is therefore not surprising that SMEs in the retailing, construction and manufacturing sectors had high (above 60%) ‘yes’ response. It is further revealed that 57.9% of those who believe that HIV and AIDS is a business challenge acknowledged that a number of their employees had applied for sick leave in last 30 days. Only 25% of those who gave a “yes” response did not have workers on sick leave during the last 30 days prior to the survey.

Behaviour of Respondents

Multiple Sexual Partners

An assessment of behaviour of respondents reveals that 15% of respondents had two or more sexual partners. This is a high level of risky behaviour for any age group or category of persons. While 77% of the respondents had only one sexual partner, it was difficult to ascertain whether they would be changing partners but having one partner at a time, which is still risky behaviour. Eight percent (8%) indicated sexual inactivity. The gender

perspective to multiple sexual partners shown in Table 4 indicates relatively high-risk behaviour on the part of male respondents than females. Only 9% of women have two or more sexual partners compared to 19% for men. This difference is statistically significant with a p-value of 0.000. Thirty-five percent of the respondents did not respond to the question on multiple sexual partners.

The findings on multiple sexual partners by marital status (shown in Table 5) reflect that, relatively, unmarried men (single and divorced or separated) had more than one sexual partner. In total, 35.9% of males who responded to both the questions of marital status and number of multiple sexual partners had two or more sexual partners, 58.9% had only one sexual partner and 5.2% did not engage in sexual activities in the past 12 months. Within the married men category, 28.2% have had more than 2 sexual partners while 68.8% have been faithful to their partners. The 28.2% married men engaging in multiple sexual partners indicates that within the SME sector, one in every four married men is having an extra marital affair.

Table 5: Number of Sexual Partners Across Gender and Marital Status

Gender	Number of sex partners	Marital status of respondents				Total (%)
		Single (%)	Married (%)	Divorced/separated (%)	Widowed (%)	
Male	None	7.4	3.0	2.3	35.7	5.2
	1 only	40.7	68.8	31.8	25.0	58.9
	2 or more	51.9	28.2	65.9	39.3	35.9
	Total	100.0	100.0	100.0	100.0	100.0
Female	None	1.3	3.8	1.8	13.2	3.5
	1 only	58.9	90.5	57.9	73.7	75.9
	2 or more	39.9	5.7	40.4	13.2	20.6
	Total	100.0	100.0	100.0	100.0	100.0

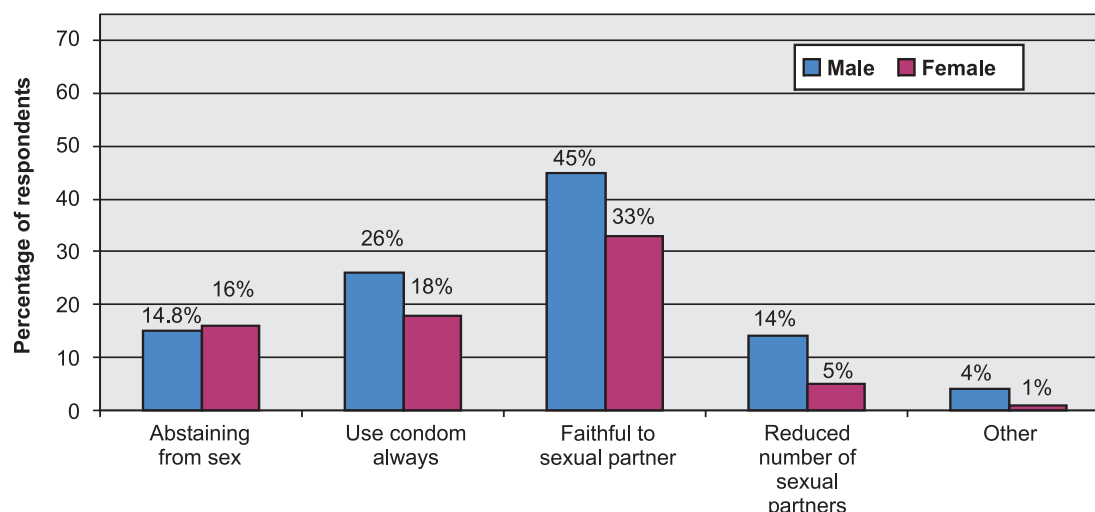
In total 20.6% of the women reported having had more than two sexual partners, 75.9% remained faithful to one sexual partner while 3.5% had not engaged in sexual activities in the past 12 months. Unlike their male counterparts, only 5.7% of the married women have had two or more sexual partners. For females, multiple sexual partnerships is higher among divorced or separated females. About 40.4% of divorced or separated female respondents had two or more sexual partners while only 1.8% of them do not have sexual partners. On the other hand, 51.9% and 65.9% of single and divorced or separated male respondents respectively, had more than one sexual partner. The combined response rate for both gender and number of sexual partners was 59.4%.

There is no significant difference in the number of sexual partners by employment category, 28% of the employers have two or more sexual partners in comparison to 25% of the employees. Hence both employers and employees face a similar risk.

HIV Prevention Measures

Methods used to reduce the risk of HIV infection include abstaining from sex, use of a condom, being faithful to one sexual partner and reducing the number of sexual partners. As shown in Figure 3, faithfulness to one partner seems to be the most popular strategy (45% for males and 33% for females) of reducing risk of HIV infection. However, it is only effective if there is mutual faithfulness between partners. In this context, it is worrying that on average,

Figure 3: HIV Prevention Methods by Gender



only 15.4% of the respondents abstain from sex yet 41% of the respondents are not married.

Condom use

Though condom use remains key to the prevention of HIV infection in the SME sectors, its usage has always remained low especially among the high-risk people. However it was encouraging to note that the ABC method of prevention has been highlighted within the sector. Table 6 below shows condom use with casual sexual partners.

Table 6: Use of Condoms with Casual Partners

Response	Number	%
Never	171	23.3
Sometimes	164	22.3
Always	399	54.4
Total	734	100.0

Those who always use condoms constitute 54.4% of those who responded to the question on use of condoms with casual partners. This implies inconsistency or none use of condoms by the other 45.6%. There are a number of reasons mentioned for not using condoms (Figure 4). More males (9%) than female (4%) do not use the condom because they think it reduces sexual pleasure. On the other hand, more women (10%) than men (3%) say condoms are for prostitutes. The findings also reveal that condoms are less likely to be used in

marriages. A significant proportion of both men (22%) and females (14%) say condoms are for use outside marriage. This is further confirmed by the finding that only 4.3% and 4.6% of married men and women use condoms with their spouse. Almost 80% of married respondents never use condoms with their spouse.

Although 72% of women who never use condoms do so because they trust their partner, the issue may be more complex than generally perceived. Condom use encompasses issues of power and sexual control and goes beyond communication between partners to the ability to negotiate and initiate the discussion on condom use on the part of females. Most females have little or no influence on these issues particularly when the man is the dominant partner in the relationship. Table 7 shows that a higher proportion of males (56.8%) than females (50.6%) use condoms. This means that women are less likely to use condoms in a sexual encounter than males, but they need a condom they have control over.

It was however encouraging to note that condom usage with casual partners was higher especially among divorced and widowed respondents with 72.7% and 65.5% respectively, indicating a high rate use of condoms with casual partners. Only 57.2% of single and 47.2% of married respondents always use condoms with casual sexual partners. A look at the use of condoms with casual partners by

Figure 4: Reasons for Not Using Condoms by Gender

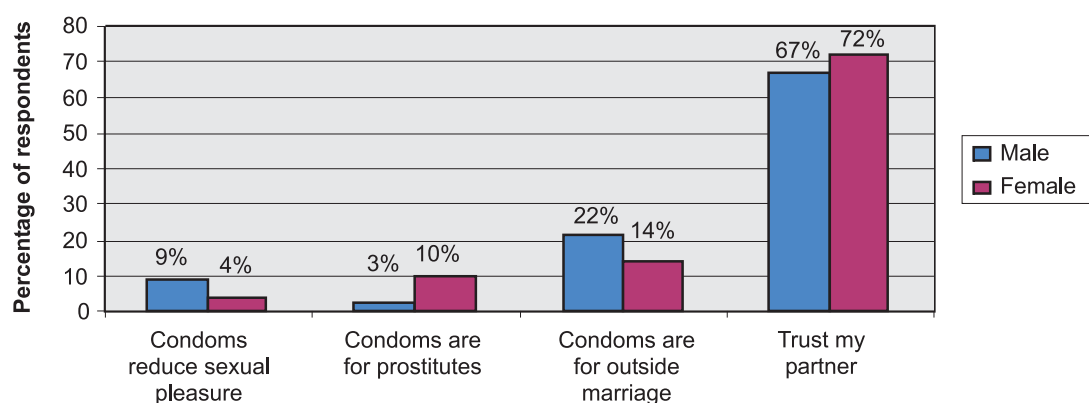


Table 7: Condom Use with Casual Partners by Demographics

Demographics		Use of Condoms			Spearman Correlation (p-value)
		Never (%)	Sometimes (%)	Always (%)	
Gender	Male	21.1	22.0	56.8	0.001
	Female	28.6	20.8	50.6	
Age range	15-24	21.8	28.7	49.4	0.000
	25-39	27.3	16.6	56.2	
	40 and above	10.4	32.8	56.8	
Marital Status	Single	20.3	22.5	57.2	0.005
	Married	29.6	23.2	47.2	
	Divorced/Separated	18.2	9.1	72.7	
	Widowed	5.2	29.3	65.5	

age group reveals that relatively more people in the 25-39 age group (56.2%) and the above 40 age group (56.8%) always use condoms than those in the 15-24 years age group (49.4%). There is therefore need to encourage condom use among the youth.

Perceptions on Risk to HIV Infection

The above discussion reveals risky behaviour by a significant proportion of people within SMEs. The issue of concern is whether they know the consequences of such behaviour. Several theories of health behaviour suggest that it is an individual's perception of risk rather than the actual risk involved that determines behaviour. Hence it is important to assess the risk perception of those at greatest actual risk. From

the results it has emerged that 37% of the respondents did not perceive themselves to be at risk of HIV infection compared to 63% who perceive some risk of HIV infection. A look at the results by gender indicates that 39% of the males do not view themselves as being at risk of HIV infection while 61% perceive themselves to be at some risk of HIV infection. On the contrary 35% of the females perceive themselves to be at “no” risk of HIV infection while 65% perceive themselves to be at “some” risk of HIV infection.

The results presented in Table 8 further reveal that the majority of respondents with low perception of risk infection are those with only one sexual partner. Among the “no risk” perception category, 84.9% and 88.1% males

Table 8: Perceptions on Risk of Infection by Number of Sexual Partners and Gender

Perceptions of risk	Number of sexual partners	Gender		Total (%)
		Male (%)	Female (%)	
No risk	None	6.0	1.3	4.1
	1 only	84.9	88.1	86.2
	2 or more	9.2	10.6	9.8
	Total	100.0	100.0	100.0
Some risk	None	0.0	2.8	1.2
	1 only	45.5	63.3	52.9
	2 or more	54.5	34.0	45.9
	Total	100.0	100.0	100.0
Don't know	None	16.9	9.4	12.8
	1 only	60.6	88.2	75.6
	2 or more	22.5	2.4	11.5
	Total	100.0	100.0	100.0

and females respectively had only one sexual partner. On the other hand, 54.5% of males and 34% of females, who have had two or more sexual partners perceived some risk to HIV infection. However, 63.3% of females who perceived some risk have had only one partner in the past 12 months. This may imply that females generally do not trust their partners.

The difference in the perception of risk, for men and women could also be attributed to women's lack of power and ability to negotiate for safer sex and lack of mutual faithfulness. Women therefore reported a higher perception of risk. Any programme for HIV and AIDS intervention in the SMEs sector should target both men and women and should in turn aim to empower women to negotiate for safer sex. In total, 48% did not respond to either the question of perception to risk nor the number of sexual partners.

The findings on perception to risk by marital status reveal that single persons generally perceive themselves to be at some risk to HIV infection. The proportion of singles who perceive some risk of infection is 67.4% while that for married respondents is 58.2%. The divorced and separated persons have a higher perception of risk 89.5%.

Among respondents who perceived no risk of infection, 9.3% had more than one sexual partner in the last 12 months. The majority (52.8%) of these were in the 15-24 age group and 41.7% in the 25-39 age groups. Fifty-four percent of the respondents who perceived some risk to HIV infection and had more than one partner were in the 25-39 age group and 23.9% in the 15-24 age group (Table 9). These figures reflect a poor attitude among youth who are not sticking to one partner.

Perceptions on risk of HIV and AIDS infection by number of sexual partners and condom usage revealed that among those who perceived no risk of infection, 55.8% always use and 38.3% never use condoms. As shown in Table 10, amongst those who never use condoms and perceive no risk of infection, 89.1% had only one sexual partner. This result shows that people believe in faithfulness to one partner as an effective way of reducing risk to infection. Of the respondents who perceive no risk of infection, 75% had only one partner. On the other hand, 58.7% of people who perceived some risk of HIV infection had more than one sexual partner.

Among those who perceived some risk of HIV infection, 25.8% sometimes use condoms and 62.1% of these had more than one sexual

Table 9: Perceptions of Risk of Infection by Number of Sexual Partners and Age Group

Perceptions of risk	Number of sex partners	Age group of respondents			Total (%)
		15-24 (%)	25-39 (%)	40 & above (%)	
No risk	None	66.7	20.0	13.3	3.9
	1 only	6.2	76.0	17.8	86.9
	2 or more	52.8	41.7	5.6	9.3
	Total	12.9	70.6	16.5	100.0
Some risk	None	0.0	57.1	42.9	1.2
	1 only	21.1	51.7	27.2	56.4
	2 or more	23.9	54.3	21.8	42.4
	Total	22.0	52.9	25.1	100.0
Don't know	None	0.0	75.0	25.0	11.8
	1 only	12.1	69.7	18.2	77.6
	2 or more	5.6	88.9	5.6	10.6
	Total	10.0	72.4	17.6	100.0

Table 10: Perceptions on Risk of Infection by Number of Sexual Partners and Use of Condoms

Perceptions of risk	Number of sex partners	Use of condoms with casual partners			Total (%)
		Never (%)	Sometimes (%)	Always (%)	
No risk	None	10.9	0.0	1.5	5.0
	1 only	89.1	14.3	71.6	75.0
	2 or more	0.0	85.7	26.9	20.0
	Total	100.0	100.0	100.0	100.0
Some risk	None	0.0	0.0	1.9	1.1
	1 only	59.4	37.9	35.4	40.2
	2 or more	40.6	62.1	62.7	58.7
	Total	100.0	100.0	100.0	100.0
Don't know	None	5.9	33.3	0.0	9.5
	1 only	94.1	20.0	64.5	61.9
	2 or more	0.0	46.7	35.5	28.6
	Total	100.0	100.0	100.0	100.0

partner. Perception of risk was higher (58.7%) among respondents with more than one sexual partner even among those who always use condoms. Sixty-two percent of those who perceived some risk of HIV infection and always used condoms had more than one sexual partner. This implies awareness on the part of respondents that promiscuity increases the risk of HIV infection.

The significance of these findings depends on the nature of the relationship between perception of risk and behaviour change. Research examining this link and refining the picture of those at most risk can contribute to further development of HIV and AIDS prevention programmes aimed at SMEs.

Considering the risky behaviour shown by a significant proportion of the respondents (15% with more than one sexual partner and 45.6% who inconsistently use condoms) in the SMEs sector, it is plausible to conclude that SMEs are vulnerable to the effects of HIV and AIDS. Therefore, it is important to assess the economic impact and quantify the costs of HIV and AIDS.

Costs of HIV and AIDS to SMEs

This section examines the costs of HIV and AIDS to SMEs by looking at the impact paths of

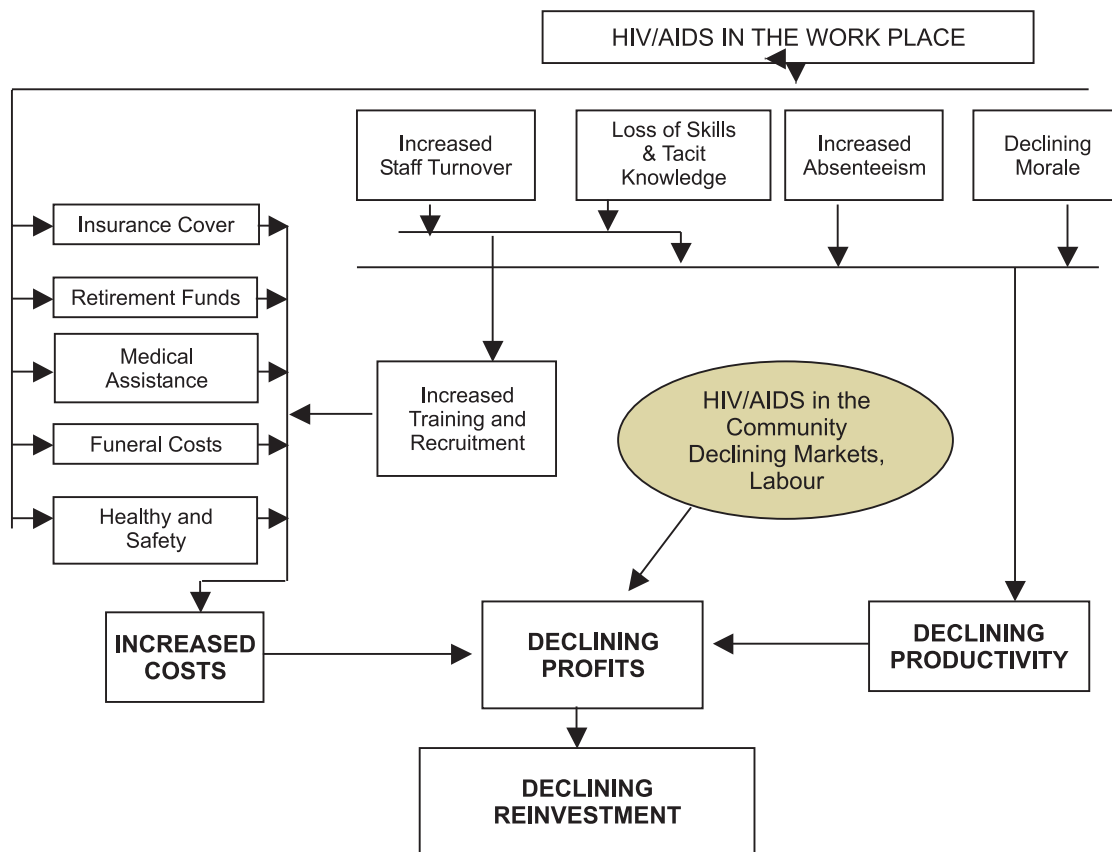
HIV and AIDS at work places. As has been alluded to, the respondents were clear that their businesses were at risk of HIV and AIDS but the challenge was in quantifying the costs. A considerable percentage of the respondents had difficulties in answering this section especially on quantifying the factors to do with absenteeism in monetary terms. The costs of HIV and AIDS on SMEs are broadly classified into indirect and direct costs. The framework below illustrates the impacts of HIV and AIDS at the workplace.

Impact Paths of HIV and AIDS at the Workplace

From Figure 5, it can be seen that the ultimate impact of HIV and AIDS on a business is a decline in profitability subsequently leading to reduced capacity for reinvestment and in turn growth of the SME. This impact is felt through two major pathways; that of increased costs and decline in productivity.

Labour is a vital factor of production especially in SMEs who use labour intensive production methods. HIV and AIDS cause prolonged illness, which increases rates of absenteeism at work. Absenteeism maybe due to illness of the worker or that the worker has to attend to illness of a close relative (more so for women) or as a result of funeral attendance to an AIDS

Figure 5: Impact Paths of HIV and AIDS at the Workplace



related death. Just as applications for sick leave increase, so do applications for compassionate leave. For SMEs, attending a funeral of a close relative may imply suspension of operations for the entire firm if it is family owned or employs family labour. Thus a single death will have a severe impact in terms of lost production. Deaths of employees due to HIV and AIDS related illness leads to increased staff turnover and loss of tacit skills and knowledge. This not only reduces productivity, but result in increased training and recruitment costs as well. The decline in production will in turn results in reduced profitability of a business.

Businesses also incur explicit costs due to HIV and AIDS. These costs are in the form of funeral assistance to bereaved workers, retirement funds, insurance cover and increased medical assistance. Because of the thin line between family and company income, these pay outs may turn out to be quite

significant whenever a member of the family is involved. More costs are incurred in recruitment and training of replacements of deceased staff or early retirements due to HIV and AIDS related illnesses. If these direct costs are high, they reduce profitability and hinder growth of SMEs as funds could have been used for investment purposes will now be used to meet these costs. Furthermore, these costs are recurrent hence they may become a permanent feature on the companies' accounts. This impacts negatively on SMEs' long-term viability.

Quantified Indirect Costs Due to HIV and AIDS

Productivity Losses due to Absenteeism

Quantifying the number of days lost due to illness or funeral attendance is a good indicator of the impact HIV and AIDS can have on SMEs. The information was difficult for most

companies to compute. A total of 12% of the respondents stated that absenteeism had no effect on their businesses, 24% did not know what the effect was and 10% indicated some effect but the range was computed at anything between ZW\$8-25 million⁷.

Since SMEs are labour intensive and have smaller staff complements, the impact due to absenteeism by a single person is quite significant. On average the estimated number of days lost due to sick leave in the last 30 days prior to the survey was 4.9 days. Using 22 working days in a month, this translates to 22.2% loss in productive time. The average cost of absenteeism due to illness was estimated at ZW\$5 million. However, 6.90% of those who responded had costs above ZW\$20 million. It must be pointed out at this stage that the figures given were estimates.

The survey further revealed that from the 54% who responded to the question on application for compassionate leave, on average 2.5 people had applied for compassionate leave to attend funerals or illness of close relatives in the last 30 days prior to the study. A single SME lost an average 3.6 days to attending funerals in the last 30 days prior to the study. Owners lost an average of 1.2 days of production time attending funerals of employees. Among those who indicated losing time to attend funerals this average is 6.3 days (this may reflect cases where funerals were for a relative of the family owning the SME). In monetary terms, the average cost of time lost by an SME to attending funerals or illness absenteeism was calculated to be at ZW\$3.8 million in the last 12 months. The figure needs to be interpreted in light of the hyperinflationary environment that characterised the past 12 months.

In total, the productive time lost due to absenteeism either from sickness or funeral

attendance was 9.7 days in the last 30 days prior to the survey. This translates to more than 40% of productive time in a given month. This high percentage shows that the SMEs are losing a lot of productive time due to illness or funeral related absenteeism. Given that HIV and AIDS is the major cause of both mortality and morbidity in the country, it may also be the major cause of losses in production due to absenteeism in the last 30 days prior to the study. However, SMEs do not seem to attribute this loss in production time to HIV and AIDS. The majority (58%) of the respondents think their companies have not lost any productive time due to HIV and AIDS related absenteeism, while 18.5% were not sure. Since most SMEs are run by families and employ family labour, these responses may be a reflection of stigma as most people generally find it difficult to attribute the death or illness of a relative to HIV and AIDS.

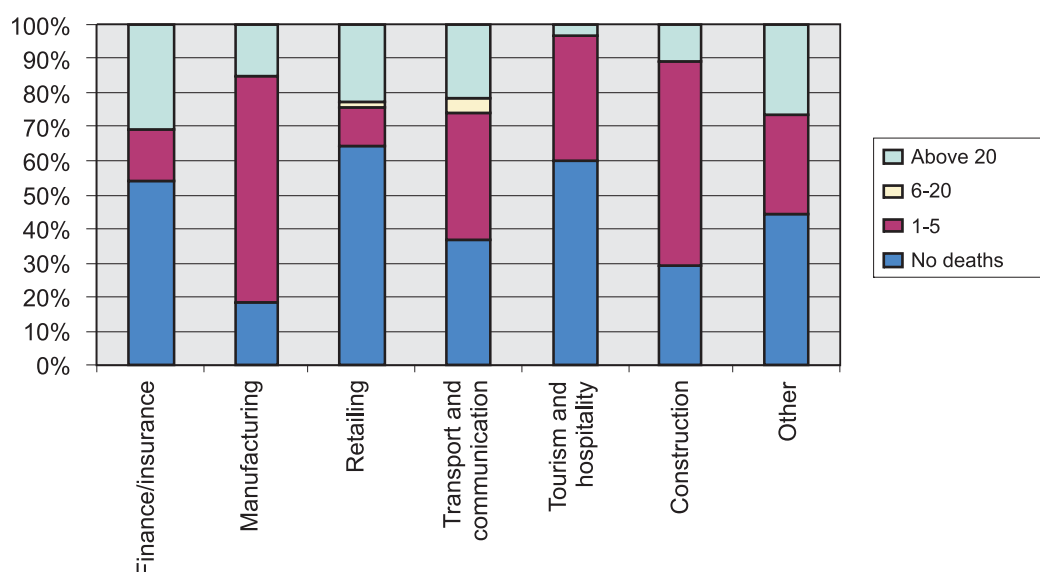
Human Resource Losses due to Deaths and Early Retirements

In the long term, HIV and AIDS related illnesses lead to death and SMEs lose valuable personnel especially those with little delegation of duties. This threatens, not just the smooth running of the business, but its continuity as well. Respondents were asked to state if any, the number of deaths that have occurred within their businesses in the past 12 months. Results showed that 19% have had a death while 16% indicated no death. Of concern was the fact that 60% of the respondents failed to answer this question. Reasons that can be given could be to do with denial. People are finding it hard to solely attribute the deaths to AIDS.

Estimates from the survey show that on average, 5 workers within an SME had died in the last 12 months. The average number of employees in each SME is 10 workers, and

7 The figures were given before a currency valuation process, which removed three zeros. Data collection was also done at a time when inflation was hovering above 600% p.a., and on an upward trend. Also, the official interbank rate of exchange was 1 USD : Z\$101 000.00

Figure 6: Distribution of Deaths by Sector



considering that the majority of SMEs (64%) employ less than 10 workers, the average death figures represent a high staff turnover and significant human resource loss for SMEs. Continuity in operations for smaller SMEs is under threat as most of those who died are either skilled (52%) or semi-skilled (32%) workers. It was also frightening to note that 64% of the last deaths recorded by SMEs are of employees in the 25-39 age group, a situation that is not healthy for business continuity.

The distribution of the deaths by the sector shows that the most affected sectors are manufacturing, transport and communication and construction. These sectors also had a higher acknowledgement of HIV and AIDS as business challenge facing their enterprises. Although SMEs acknowledge HIV/AIDS as a business challenge, they fail to accept its direct impacts (illnesses and deaths) at the workplace. SMEs generally (58%) do not attribute deaths of their employees to HIV and AIDS. As shall be discussed below, this failure to identify the impact of HIV and AIDS is partly responsible for lack of HIV and AIDS programmes at the workplace by SMEs.

Premature retirement due to illness has also the same effect (i.e. loss of personnel) as death.

However, among those who responded, 61% had no workers whose contracts were terminated. On the other hand, 19% of the respondents revealed the some workers' contracts were terminated, while another 20% did not know. Fifty five percent of SMEs in the sample failed to respond. These results indicate a significant violation of the ILO code of practice and statutory instrument 202 of 1998, with reference HIV and AIDS in the workplace. Efforts should be made to ensure strict adherence to the legal statutes and ILO code of practice in the workplace and in the SME sector.

Quantified Direct Costs Due to HIV and AIDS

Losses in productive time as discussed above are implicit costs of HIV and AIDS to SMEs. However, as highlighted above, businesses also incur direct costs due to HIV and AIDS. These costs are discussed below:

Funeral Assistance

Unlike the case of indirect costs, with direct costs, most respondents (57%) were able to give estimates on the costs involved. The results show that a considerable number of SMEs (13.1%) estimated the cost to between Z\$1

and Z\$20⁸ million while about 7% gave an estimate of above Z\$20 million. However, the average payout for funeral assistance to bereaved workers over the past 12 months prior to the study was Z\$2.4 million. Although small, this has to be interpreted in light of the hyperinflation characterising the economy. The average figure among those who paid funeral expenses is Z\$13.68 million over the past 12 months. About 22% of the SMEs did not assist with funeral costs.

Recruitment Costs and Training Costs

Some SMEs were able to quantify recruitment costs due to death and illness though 17% showed that there were no recruitment costs incurred by the companies. Most SMEs preferred to share the task among the remaining staff as a coping strategy. Very few preferred to hire permanent replacement staff, hence recruitment costs for SMEs are generally low. This will be discussed in greater detail under issues of succession and livelihood strategies.

Recruitment costs may also be low if the majority of SMEs are recruiting from the factory gates, without incurring direct recruitment costs such as advertising costs. In the transport sector for example, some temporary staff such as drivers and crew could be recruited from the gate already skilled enough to run a bus service. However, 11% incurred recruitment costs of between Z\$1-20 million. On average, recruitment costs for SMEs were estimated at ZW\$1.8 million.

Of those that were able to provide estimates on training induced costs due to illness or deaths, the figures ranged from Z\$25 million to over Z\$30 million. The figures reflect that SMEs do not face high costs of recruitment and training hence the impact of HIV and AIDS on them is through implicit productivity losses. However,

reliance on job sharing to maintain productivity and minimising costs may be counter-productive in the long term.

Succession and Livelihood Strategies

The impact of HIV and AIDS goes beyond productivity and profitability. It extends to continuity and composition of the SMEs. This depends on the coping mechanisms that SMEs employ to mitigate the impact of HIV and AIDS at the workplace. Table 11 below shows coping strategies used by SMEs to maintain productivity following extended absences of an employee due to HIV and AIDS related illness and or subsequent death.

Table 11: Priority Ranking of Business Livelihood Strategies in the SME Sector

Coping strategy	Number	%
Sharing the job among the available staff	600	39.0
Hiring temporary staff	264	17.0
Multi-skilling	256	16.0
Waiting for the person to return	239	15.0
Taking staff from other departments	115	7.0
Hiring permanent staff	85	6.0
Total	1559	100.0

Coping strategies adopted by SMEs are multi-skilling, hiring temporary staff, sharing the job among available staff, taking staff from other departments, waiting for the person to return and hiring permanent staff. The most preferred strategy to maintain productivity is sharing the job among the available staff (39%), followed by hiring of temporary staff (17%), and multi-skilling (16%). Although these are common strategies employed by SMEs, they are detrimental as the remaining staff experience job related stress and burnout. Sharing the job

8 The figures were given before a currency valuation process, which removed three zeros. Data collection was also done at a time when inflation was hovering above 600% p.a., and on an upward trend. Also, the official interbank rate of exchange was 1 USD : Z\$101 000.00

among available staff, taking staff from other departments, waiting for the individual to return and multi-skilling, which are the preferred coping strategies, depend on the remaining employees who have to take on a disproportionately bigger workload.

Sharing the job among available staff was the more preferred strategy in the retail and transport sectors with 60.1% and 60.9% of the respondents respectively. This strategy was also preferred in the manufacturing sector (45.8%). Thirty six percent of SMEs in the retail sector preferred waiting for the person to return as a coping strategy. Respondents (65.7%) in the construction industry were in favour of multi-skilling. Replacing staff was not favourable across all sectors except the finance sector from which 50% of the respondents indicated replacement of staff as a coping strategy. More SMEs in the finance sector prefer to hire temporary staff as the first strategy unlike other sectors where hiring of temporary staff was lowly ranked as a coping strategy.

The survey showed that job sharing was preferred by companies with relatively fewer employees. Sixty-seven percent of the SMEs who preferred job sharing as the first strategy had less than 10 employees while only 15.2% had more than 15 employees. It also emerged that smaller companies also preferred to wait for the person to return. Among companies that ranked waiting for the person to return as the first coping strategy, 40.89% employ less than 5 people, 39.6% employ between 5-9 people, 7.1% employ 10-14 people and 12.4% employ 15 or more people.

One cannot further emphasise the reasons why the SMEs embark on these coping strategies. Perhaps by virtue of their set-up which is mostly family owned, they find it difficult to employ a non-family member in the system. Hence they design coping strategies that keep the business within the family. This inhibits growth as the scope for diversification and job specialisation is limited. Both are vital elements for expansion of

the company. Sadly the findings above indicate that most of the employees who died last are skilled or semi-skilled therefore there is limited success in coping strategies preferred by SMEs because one can only be jack of all trades but master of none.

The succession plans of SMEs were based on keeping the business in the control of the family or initial directors. However, the survey findings indicate a higher mortality in the 25-39 age group, a fact that negatively affects the continuity of business particularly when there is no separation of ownership from control. SMEs need to put in place proper corporate governance structures to ensure not only continuity but expansion of their businesses as well.

The other factor leading to bias against hiring of staff is cost minimisation. Hiring temporary staff implies double payment of salaries thus SMEs would rather share the job among the remaining staff. This practise means the remaining staff are strained which negatively affects productivity. In addition cutting costs of this nature will reduce productivity in the long term. The fact that SMEs employing more people prefer to hire staff might not be just a reflection of their ability to meet recruitment costs, but indicates a professional approach to the running of their businesses. These SMEs have greater flexibility in terms of sharing of workload but because they have already opened up to external players, they are more willing to replace staff and maintain productivity. They also have proper management and recording systems in place which makes absence of employees easily observable.

Generally, the coping strategies employed by SMEs make them more vulnerable to HIV and AIDS as the impact of absenteeism and deaths are felt for a much longer period. This is worsened by the small staff complement that most SMEs have. Furthermore, the unwillingness to share the control of business with people outside the family threatens the continuity of SMEs in the event of death due to AIDS.

Workplace Practices and Programmes

The study also sought to understand what HIV and AIDS programmes were currently being implemented and what programmes were in place for the future. With regards to what was currently happening, it was clear that most SMEs were doing little to inform their employees about HIV and AIDS within the workplace. As indicated in Table 12 below, electronic (39.8%) and print (23%) media were the major source of information about HIV and AIDS at work places.

Table 12: Sources of Information about HIV and AIDS at the Workplace

Source	Number	%
None	5	0.4
RADIO/TV at work place	558	39.8
Newspapers at work place	323	23.0
Posters/fliers at workplace	250	17.8
Other	267	19.0
Total	1403	100.0

Results show that in total about 67% of the respondents did not have any workplace programmes at all (see Table 13). One of the reasons mentioned included the fear that HIV and AIDS programmes would interfere with daily production. The misconception that HIV and AIDS is a health issue, which should be dealt with by health professionals without much role for employers was the other reason.

Table 13: Current Workplace Programmes and Practices

Programme	Number	%
None	1262	67.0
Peer education-prevention	428	23.0
HIV and AIDS treatment	59	3.0
Care and support for the affected	64	3.0
Voluntary Counselling and testing	60	3.0
Other	14	1.0
Total	1887	100.0

It was also established that employers showed a great deal of willingness to offer programmes but lacked technical skills to do so, which could be the role of external partners. Only peer education/prevention programmes (23%) recorded significant positive responses from SMEs. Those SMEs that considered HIV and AIDS as a threat and were running programmes had the following activities: peer education (23.8%), treatment (2.5%), care and support (0.3%), voluntary counselling and testing (5.3%) and other programmes (0.8%). These companies seem ready for scaling up their efforts to respond to HIV and AIDS.

Nevertheless, there are some SMEs (32%) which did not consider HIV and AIDS as a threat but were running programmes, the most common programmes being peer education (14.3%), treatment (4.7%), care and support (9.4%), VCT (1.2%) and other (2.3%). The last group does not seem to consider HIV and AIDS as a threat perhaps because they are actively doing something about it. They seem to be taking a lead in response to HIV and AIDS and therefore they need help in scaling up what they are already doing, which seems fairly comprehensive and even include such elements as ARVs.

A significant proportion (37.8%) of SMEs without programmes did not consider HIV and AIDS as a challenge facing their businesses. As mentioned above, these firms are providing themselves with false assurances. They probably do not have enough information on the impact of HIV and AIDS on their companies' productivity. This is evidenced by a significant proportion of companies with no programmes in place who were also not in a position to quantify the implicit costs of HIV and AIDS on production. For example, 90% of those who did not have HIV and AIDS programmes in place also failed to quantify the cost of time lost due to absenteeism.

These SMEs may have failed to put HIV and AIDS programmes in place because they

Table 14: HIV and AIDS Programmes and Perceptions of HIV and AIDS as a Business Challenge

Program	HIV and AIDS as a challenge facing the company				Total	
	Yes Number	%	No Number	%	Number	%
None	663	67.3	403	68.0	1066	67.5
Peer education-prevention	234	23.8	85	14.3	319	20.2
HIV and AIDS treatment	25	2.5	28	4.7	53	3.4
Care and support for the affected	3	0.3	56	9.4	59	3.7
Voluntary Counselling & testing	52	5.3	7	1.2	59	4.3
Other	8	0.8	14	2.3	22	0.6
Total	985	100	593	100	1578	100

perceived them to be expensive and saw no benefit of such programmes. Lack of knowledge negatively affects willingness to implement programmes, further confirmed by the high proportion (67.3%) of SMEs that saw HIV and AIDS as a challenge but did not have any programmes in place. In addition, companies with less than 10 employees constitute the majority (67.97%) of those with no HIV and AIDS programmes in place. On the other hand, only 10.7% of companies with more than 15 employees have no HIV and AIDS programmes in place.

This finding can be attributed to stigmatisation of HIV and AIDS since the majority of the smaller SMEs employ family labour and openly talking about sex and HIV and AIDS is taboo under such circumstances. For this reason, the same small organisations underestimate the impact of HIV and AIDS

on their companies and do not put any mitigatory measures in place. Sixty eight percent of the respondents have not formally discussed HIV and AIDS programmes at the work place. The remainder is distributed as follows: prevention (18%), counselling and testing (7%), care and support (5%), treatment and other programs (1%) each. This maybe attributed to the supposition that HIV and AIDS is too sensitive an issue to discuss especially if employees are relatives. Therefore more has to be done to stimulate formal discussion of HIV and AIDS in SMEs.

One of the prevention measures that can be taken by companies is the distribution of condoms at the work place. Results showed that only 23.8% of the SMEs distributed condoms at the work place. The argument made above about stigmatisation of HIV and AIDS could also apply here.

Table 15: SMEs that Distribute Condoms by Sector

Sector	Response				Total	
	Yes Number	%	No Number	%	Number	%
Finance/insurance	21	22.8	71	77.2	92	100.0
Manufacturing	71	18.2	320	81.8	391	100.0
Retailing	147	28.8	363	71.2	510	100.0
Transport & communication	72	28.6	180	71.4	252	100.0
Tourism and hospitality	41	23.7	132	76.3	173	100.0
Construction	27	17.8	125	82.2	152	100.0
Other	62	22.1	219	77.9	281	100.0
Total	441	23.8	1410	76.2	1851	100.0

A higher proportion of those who distributed condoms were in retailing (28.8%), transport and communication (28.6%), tourism and hospitality (23.7%) and finance and insurance (22.8%). Some of these sectors gave the highest 'yes' response to HIV and AIDS as a challenge facing their companies confirming that acceptance of the direct workplace impacts of HIV and AIDS is the first step to effective workplace interventions.

The Future...

Table 16: Respondents' Views on Important Intervention Strategies at the Workplace

Programme	Number	%
Peer education & Prevention	725	69
Counselling & Testing	119	12
Treatment	107	10
Care and Support	99	9
Total	1050	100

Peer education (45%) and other prevention (24%) and voluntary counselling and testing (12%) programmes dominated the responses on what SMEs thought were important intervention strategies in the workplace. These are programmes probably deemed easy to implement without much interference with production. At the same time, it was also noted that some respondents were now placing some importance on treatment programs, which include ARVs.

HIV and AIDS Policies at the Workplace

The response to HIV and AIDS at the work place can be taken to new heights if SMEs have HIV and AIDS policies in place. Such policies will be the foundation for wider HIV and AIDS programmes at the workplace. Sadly 74.2% of SMEs did not have written policies on HIV and AIDS. This perhaps also explains why there was a high proportion of SMEs without HIV and AIDS programmes at the workplace, because

there are so many examples around to copy from.

Willingness to Fund Workplace Programmes by Employers

The results showed that the majority of employers were willing to fund their own HIV and AIDS programmes. Of the 89% of employers who responded to the question, 84% expressed willingness to fund their own programmes whilst 8% disagreed and 8% were not sure. The relatively high percentage of SMEs who showed willingness is a good sign as it illustrates that SMEs can commit to the response to HIV and AIDS given enough knowledge and guidance.

Employees' Perceptions Towards Funding of HIV and AIDS Programmes by their Employers

Employees constituted 21% of the respondents. The majority (85%) of them thought employers should provide funding for programmes, 9% disagreed and 6% were not sure. It is difficult to understand those who disagree with the view that employers must fund HIV and AIDS programmes. It is also important to ensure that S.I.202/98 and ILO Code of Practice are widely distributed as possible.

Discrimination and Stigmatisation of HIV and AIDS at Work

Statutory Instrument 202, Zimbabwe Labour Relations (HIV and AIDS) Regulations of 1998 has eight provisions providing for education of employees on HIV and AIDS and prohibiting discrimination against HIV and AIDS victims who are already employed or when recruiting. Employees should also have access to these regulations. However, only 4.1% of employers have a copy of SI 202 and only 4% of SMEs have employees who have access to the instrument. It also emerged that only 3.7% of SMEs have employees who have access to the

ILO Code of Practice on HIV and AIDS. Employees in the SMEs sector can therefore be discriminated against without their knowledge and that of the employer that an offence is being committed. It might be for this reason that SMEs do not have policies on HIV and AIDS because they are ignorant of the fact that they are required by law to deal and accommodate HIV and AIDS victims at their workplace. Below are some of the perceptions relating to HIV and AIDS discrimination at the workplace:

Should HIV and AIDS Affected Workers Continue Working?

The study also sought the views and practices of both employers and employees on whether HIV and AIDS affected workers should be allowed to continue working. The findings revealed that 73% of employers disagreed with the view as compared to 28% who agreed. From an employee perspective, 77% of respondents disagreed and 23% agreed with the view. The bone of contention amongst the employers was the ability of the individual to continue to be productive when they are ill. There was a low percentage of employees

(23%) who would like to discontinue working when they are HIV and AIDS afflicted. If the working environment is not conducive for an ill worker, it is possible that they could opt to stay at home. The other reasons could be to do with stigma and fear. In some SMEs, meals are provided and this could be an important reason why employees would like to stay on for as long as they can still work.

Screening

The other dimension was to find out how the employers and employees felt about screening prospective employees for HIV and AIDS. Seventy percent of employers disagreed with screening while 19% were not sure and 11% agreed. Employees on the other hand had 70% disagreeing with screening, 20% not sure and 10% agreeing. The responses indicate that there is still need for HIV and AIDS education in the SMEs on the illegality of screening prospective employees for HIV and AIDS.

The above perceptions indicate that although there might be discrimination, it is relatively not widespread as most employers disagreed to HIV and AIDS discrimination at the workplace.

Discussion of Findings

Knowledge and Perceptions of HIV and AIDS at the Workplace

The study's findings revealed that the majority of SMEs perceived HIV and AIDS as a business challenge. This is evidenced by a high proportion of both employers and employees who acknowledged that HIV and AIDS was a challenge facing their businesses. This acknowledgment was higher in labour intensive sectors like construction and retailing. However, most SMEs, particularly those with fewer employees had limited ability to quantify the exact costs of HIV and AIDS at the workplace. About 60% of SMEs failed to quantify the implicit costs (i.e. value of productive time lost due to absenteeism) of HIV and AIDS at the workplace. This can be attributed to the lack of proper record keeping and management systems within small businesses that can track absenteeism and other incidences. Capacity building in this area is therefore required.

Although there was higher acknowledgment of HIV and AIDS as a business challenge, there was denial of its direct impact at the workplace. The direct impact includes sickness and deaths of staff due to HIV and AIDS related causes. Only 34% of SMEs attributed some of the deaths of their staff to HIV and AIDS. The majority were of the view that deaths and sickness of their employees were not HIV and AIDS related. Since most of these SMEs are family owned and sometimes relying on family labour, the denial of the direct impact of HIV and AIDS may be attributed to stigma. People are still unwilling to attribute deaths and illness of their close relatives to HIV and AIDS hence most SMEs could not attribute deaths or illness

of their staff to HIV and AIDS. Interventions targeting change in perception, especially the stigma, at the family level are important for increased SMEs acceptance of the direct impact of HIV and AIDS at the work place.

Behaviour and Attitudes

A significant number of respondents exhibited risky behaviour in the form of multiple sexual partners and inconsistent use of condoms. The fact that 15% of respondents had more than one sexual partner reflects that knowledge and awareness of HIV and AIDS was not always translated into safe or less risky behaviour. This behaviour was more prevalent in men than women even among married respondents. About 28% of males against 5% female married respondents had more than one sexual partner. In this case, interventions should focus more on behaviour change and identifying factors or problems encountered in enforcing behaviour change even in the face of high levels of awareness.

Some of the factors include socio-cultural beliefs of hegemonic masculinities i.e. 'what a real man is' whereby a man with more than one sexual partner is seen as the 'real man' by his peers. This most likely explains why a higher proportion of males had more than one sexual partner than females. On the other hand, dominant feminist traits like disempowerment, economic dependency and the need to supplement income contribute to some women having more than one sexual partner.

Fifty four percent of respondents consistently used condoms with casual sexual partners. However, there was 46% that inconsistently used condoms. Women were less likely to use

condoms than men. Contributing factors include the lack of control over the use of condoms as well as inability to negotiate for safer sex. This becomes more complex when the issue of condom use concerns sexual power and dominance as confirmed by the none-use of condoms in marriages even though a high proportion of married women perceived some risk to infection. Inconsistency in condom use was higher among the 15-24 age range. Ability to communicate on sexual issues may be an inhibiting factor for consistency in condom use in this age group.

Sixty three percent of the respondents perceived some risk of HIV infection. Fifty nine percent of those who perceived some risk of infection had more than one sexual partner. This again shows that awareness has not been translated into behaviour change. Those who were faithful to one partner generally perceived no risk of infection resulting in 67% and 72% of males and females respectively not using condoms because they are faithful to one partner. Respondents therefore believe in faithfulness to one partner as an effective way of reducing risk to infection. However, faithfulness is only effective when it is mutual therefore people should still be encouraged to use condoms consistently even if they have one sexual partner.

Costs of HIV and AIDS

HIV and AIDS at the workplace reduce profitability of SMEs due to reduction in productivity and increased direct costs. Productivity decline arises from increased absenteeism as affected workers apply for sick leave while other workers apply for compassionate leave to attend to either illness or funerals of relatives and fellow employees. Productive time lost as a result of these factors is an implicit cost of production due to HIV and AIDS. On average, SMEs had lost over 40% of productive time (for a 22 days working month) due to absenteeism arising from illness

or attending funerals (both of employees and relatives). Since HIV and AIDS is the major cause of both morbidity and mortality, a significant share of this loss may be attributed to HIV and AIDS. The loss in production was significant and poses serious implications on profitability of SMEs.

HIV and AIDS also affected operations and continuity of SMEs through loss of important skills due to deaths or early retirement. This impact is pronounced by lack of separation of ownership from control characterising most SMEs. Deaths of owners who are actively involved in the day-to-day running of the business severely affects continuity of operations. In this regard, SMEs should adopt sound corporate governance principles to minimize the impact of HIV and AIDS on business continuity. SMEs have lost an average of five employees from deaths over the past 12 months. This represents a high turnover given the SMEs' average of 10 employees per firm. Moreover, the majority of these deaths are of semi-skilled and skilled workers. This negatively affects continuity of operations and increases the need to recruit and train.

The other economic impact of HIV and AIDS arose from increased direct costs for funeral assistance, medical contributions and training and recruitment costs. About 7% of SMEs estimates funeral assistance costs of above ZW\$20 million. Among those who paid funeral assistance, the average cost was ZW\$13.5 million for the preceding year. A thin line that normally exists between family and business income for the small businesses implies that SMEs sometimes foot a higher proportion of funeral and medical bills for both staff and their close relatives. These increased costs then erode investment funds and the impact is more significant when compared to larger corporations. However, SMEs have not incurred significant recruitment and training costs, a fact attributed to the coping strategies they adopt.

Succession and Livelihood Strategies

SMEs generally prefer coping strategies that rely on the use of remaining staff in the case of prolonged absence. The most preferred strategies, particularly by SMEs employing less than 10 workers, were sharing the job among the remaining staff and multi-skilling. Although these strategies were effective in reducing recruitment costs, they are counter-productive in the long term. They result in the straining of remaining staff and increasing stress levels hence diminished ability to produce by the remaining staff. The preference of these coping strategies was also reflective of lack of proper management and recording systems in smaller companies, their reliance on family labour and unwillingness to open up to 'external' players. Hiring staff was the least preferred strategy and was only popular among SMEs employing more than 15 employees. Since there was lower replacement of staff, the impact of absenteeism was felt for a much longer period. Important interventions in this regard should focus on improving the quality of life of HIV infected workers to enhance their productivity and minimize the time they spend away from work. Such interventions include facilitating access to ARVs for the SMEs sector which should maintain their productivity in the face of high HIV prevalence at the workplace.

Workplace Practices and Programmes

There was a general lack of workplace HIV and AIDS programmes in the SME sector as 67% of them did not have HIV and AIDS programmes. This was most observed in SMEs who failed to quantify the cost of HIV and AIDS as well as those that did not acknowledge HIV and AIDS as a business challenge. The lack of programmes may therefore be a result of incapacity of the SMEs to carry out a cost benefit analysis of having HIV and AIDS programmes in place. Since the SMEs failed to

quantify the costs of HIV and AIDS, they do not realise the cost savings of having HIV and AIDS programmes in place. As a result, they generally perceive the programmes as costly to business. In addition to lack of necessary know how and skills, there is also a general misconception that HIV and AIDS is a health issue that should be dealt within the health sector. There are also some SMEs who indicated willingness to offer programmes but lack the necessary know how and technical skills.

Information dissemination aimed at educating SMEs on the benefits of HIV and AIDS programmes is required. This can be carried out in a cost effective manner through networks and partnerships of HIV and AIDS organisations (both private and public) and SMEs. Technical assistance in implementing the programmes is also important as is the development of best practices for adoption by SMEs.

Organisational HIV and AIDS policies form the basis on which HIV and AIDS programmes can be developed at the workplace. However, 74% of SMEs did not have any written policies on HIV and AIDS. The majority of those without HIV and AIDS policies also did not have any HIV and AIDS programmes running. Thus formulation of HIV and AIDS policies may be the starting point for workplace interventions. Since some SMEs lack the capacity to formulate these policies, sectoral representative associations can play a key role by formulating sectoral policies for adoption by their members.

SMEs have not been doing much in providing information about HIV and AIDS at the workplace. The primary source of information about HIV and AIDS at the workplace has been the media. There was also little discussion on HIV and AIDS issues at the workplace especially among the smaller companies. Sixty-eight percent of respondents had not formally discussed HIV and AIDS at the workplace. This

has been attributed to the stigmatisation of HIV and AIDS within the family setting that characterises SMEs. Talking openly about sexually related issues and opening up on one's status is still taboo among close relations. Interventions focusing on changing the attitudes of people on HIV and AIDS stigmatisation (more so at the family level) is vital for increased discussion of HIV and AIDS at the workplace.

Employers in the SME sector have however shown willingness to fund workplace programmes. Although this willingness has not been translated into action, it shows that it will be easy to get employers commitment in the response to HIV and AIDS in the SME sector.

Recommendations

The findings of the study reflect the existence of risky behaviour, HIV and AIDS stigma, significant costs of HIV and AIDS and lack of HIV and AIDS work place policies and intervention programmes which increases vulnerability to HIV infection in the SMEs sector. It is imperative that interventions be put in place to reduce the impact of HIV and AIDS and vulnerability of SMEs. These interventions can be implemented at the following levels:

MSMED Level Response

Facilitate Access to the Sector by Setting a SMEs Database

The Ministry should set up a national database of the SMEs in Zimbabwe, to facilitate access to this sector through a system of HIV and AIDS ‘extension officers’ whose sole responsibility is to implement IEC programmes in collaboration with other stakeholders such as development partners and the National AIDS Council.

Enforcing and Supervising Workplace Interventions

SMEs largely indicated ignorance of SI 202 of 1998. The Ministry should lead stakeholders in the process of disseminating information on the SI 202 and its provisions to SMEs. The Ministry should also facilitate, enforce and supervise any workplace interventions. A more sustainable approach would be to tie access to public funds and loans to proof of exposure and certified practices of HIV and AIDS prevention programmes.

Formulating Sector Specific Policies Sensitive to SMEs’ Unique Characteristics

The Ministry should spearhead the formulation, development, distribution and implementation of a comprehensive **manual** on HIV and AIDS specifically targeting the SMEs sector. In formulating sector-specific policies, it is acknowledging that SMEs might not have the financial resources to formulate company specific policies. SMEs must be encouraged to get involved at Provincial and District Aids Committees level so as to share information and best practice issues with other sectors, and ensure access to and integration into district/national strategy.

SMEs Participation in Policy Formulation

The process of policy formulation especially the HIV and AIDS policy for SMEs should involve SMEs to take into consideration issues of regulation and practicalities of implementation. It will also be necessary to include SME representatives in the national strategy formulation for instance at the NAC Board level, so that the sector can make contributions at that level. There is need for the SMEs to organise themselves into some structure e.g. SMEs HIV and AIDS Council so that it becomes easy for advocacy and influencing of policy.

Country Level Responses (Other Ministries, NAC and Stakeholders)

Mainstream Interventions at SMEs Level into the National Strategy

There is need to mainstream the response to HIV and AIDS at SMEs level into the national

strategy. A broad-based, multi-sectoral strategy is required to ensure that the SMEs' response is not fragmented but integrated into the country strategy. The entry point is perhaps committee of stakeholders comprising the civil society, SME associations, established companies represented by Zimbabwe Business Council on Aids (ZBCA), relevant Government ministries, and development partners, NGOs, People Living with HIV and AIDS (PLWHA) and other service providers such as PSI/ZAPSO. Once a framework has been developed, an all encompassing **SME guide or manual** with best practises, statutory instruments, and programmatic issues as contained in the ILO CODE, IEC strategy, and other critical intervention instruments could be printed and distributed and relevant training provided.

Education and Information Dissemination

The MSMED in collaboration with MOHCW and other HIV and AIDS organisations can facilitate information dissemination on the following:

-  Benefits of HIV and AIDS programmes at the workplace,
-  How HIV and AIDS programmes at the workplace can be implemented,
-  Testimonials that can be compiled and disseminated through role models in workshops,
-  Provisions of SI 202 of 1998.

Interventions on Prevention Focusing on Behaviour Change

Strategies for the response to HIV and AIDS need to focus more on behavioural change. This should be based on:

-  Addressing cultural and socio-economic factors that induce the observed risky behaviour of multiple sexual partners.
-  Raising consistency in the use of condoms.

Inheritance Property Laws

It is important to ensure the survival of the SMEs beyond their immediate families, owners and staff. One of the critical areas to be addressed includes the inheritance/property laws that should be made user friendly and gender sensitive to facilitate the natural takeover by the remaining spouse.

Curriculum within Institutions

There is need for the nation to incorporate HIV and AIDS and gender programmes within the curricula of tertiary and other training institutions. Institutions offering management courses or training to the SMEs should include HIV and AIDS in their programmes.

SME Level Responses

Adoption of Basic Management Systems and Corporate Governance

SMEs are more vulnerable to HIV and AIDS due to their ownership and control structure centred on a few individuals and lack delegation of duties. There is need to promote the adoption of basic management systems and corporate governance practices that can allow for business continuity in the event of death of owner or founder.

Creation of Linkages

Interventions in the SMEs sector can be made cost effective through linkages created in the following ways:

-  SMEs should be organised into associations and affiliated to relevant sectors to enable collaboration.
-  Facilitating/encouraging social partners to work with SMEs on HIV and AIDS.

Change of Attitudes on HIV and AIDS to Reduce Stigma

Denial of the existence of HIV and AIDS results in lack of intervention programmes at the workplace. There is therefore need for change of mindset and attitudes to ensure effectiveness and access to interventions programmes within SMEs.

VCT and Information Dissemination at the Workplace

Corporate leadership is required in SMEs to develop and implement VCT initiatives and participate in public discussions on HIV and AIDS at their workplace. SMEs should make initiatives to provide information on HIV and AIDS at the workplace.

Health Insurance

SMEs should through the relevant ministry canvass for health insurance schemes to cover themselves and their staff. And SMEs should take advantage of the existing health schemes.

International Level Responses

Sharing of Regional and International Best Practices

International organisations and NGOs can help by facilitating the compilation and dissemination of good practices on HIV and AIDS programmes within SMEs to local stakeholders for adoption and replication in local situations.

Include SMEs in Policy Framework Reviews Processes

Constant review and update of the policy framework must include the SMEs sector. The principal key indicators of a good policy framework should focus on the following: implementation and mainstreaming HIV and AIDS into national policies, prevention (innovative, local, creative and culturally sensitive), protection of human rights (avoiding racial, gender and other stigmas), treatment and caring & supporting people living with HIV and AIDS.

Capacity Building in Assessment of HIV and AIDS at the Workplace

There is need to get SMEs to understand and appreciate the impact of HIV and AIDS on their businesses' profitability levels. Capacity building in collecting and aggregating the data at SMEs level is required. As SME appreciate the impact, they would be more prepared to implement mitigation programmes.

Monitoring and Evaluation

With the help of social partners, there is need for continued research on HIV and AIDS and the SMEs sector. There is also need to quantify the amount of resources that have gone into HIV and AIDS so as to map out the provision of resources to facilitate further planning and resource allocation.

Conclusion

The majority of people engaged in the SME sector are in the sexually active group with a slight gender bias towards men. Despite high levels of awareness, risky behaviour in the form of multiple sexual partners and inconsistent use of condoms has been observed in SMEs especially among a significant proportion of unmarried people. Therefore, SMEs are vulnerable to HIV and AIDS and the majority of SMEs acknowledge that HIV and AIDS is a challenge they face.

Although the impact of HIV and AIDS through quantification of costs was difficult to assess fully due to unavailability of information from some respondents, there is enough evidence that this impact is significant mainly due to reported productivity and human resource losses as a result of absenteeism and HIV and AIDS related illness and deaths. Coping mechanisms adopted by SMEs are counter-productive in the long term as they strain the remaining staff. The impact is exacerbated by

the ownership and control structures of SMEs, the majority of which are family owned and are unwilling to accept participation by outsiders. These rely mostly on family labour and control is centred on few individuals magnifying the impact of HIV and AIDS in the event of illness and death. This setting has also contributed to the little or lack of discussion about HIV and AIDS topics at the workplace due to stigma. The general lack of workplace interventions by SMEs is also attributed to lack of knowledge on the benefits and cost effectiveness of such programs and how they are implemented.

Interventions in the SMEs sector should thus focus on behaviour change, capacity building in costs assessment and policy and programme development and knowledge about HIV and AIDS at the workplace. Needless to add that technical assistance and partnerships in the implementation of these interventions is also vital.

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