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HIV & AIDS STRATEGY

FOR THE INFORMAL ECONOMY

2017 - 2020



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& AIDS

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ZIMBABWE
Ministry of Small and Medium Enterprises
and Cooperative Development



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Table of Contents

Acronyms.....	3
Definition of terms.....	4
Foreword.....	6
Acknowledgements.....	7
Executive summary.....	8
Rationale for the strategy.....	8
Strategy development process.....	9
I Introduction.....	10
1.1 Informal economy in Zimbabwe.....	10
1.2 Context of HIV and AIDS in Zimbabwe.....	10
1.3 Situation analysis of HIV and AIDS in the informal economy in Zimbabwe.....	13
1.3.1 Commodities and services.....	13
1.3.2 Knowledge, attitudes, behaviours and practices.....	14
1.3.3 Stigmatisation.....	14
1.3.4 Mobility.....	14
1.3.5 Workplace organisation.....	15
1.3.6 Mitigation.....	15
1.3.7 Gender.....	15
1.3.8 Resource availability.....	16
1.3.9 Coordination and implementation.....	16
1.4 Rationale for the strategy.....	17
1.5 Guiding principles.....	17
1.5.1 Results based management.....	17
1.5.2 Rights based approach.....	18
1.5.3 Equity for fairness and justice.....	18
1.5.4 Evidence Based.....	18
1.5.5 Accountability.....	18
1.5.6 Country ownership, shared responsibility and global solidarity.....	18
1.5.7 Gender sensitivity and responsiveness.....	18
1.5.8 Sustainable financing.....	18
1.5.9 Good Practices for learning.....	18
1.5.10 Community involvement ownership and partnership.....	18
1.5.11 Efficiency, effectiveness and innovation.....	18
2 Strategy development process.....	19
3 Theory of change for the strategy.....	20

4	Solution pathways	22
4.1	Solution pathway 1: improve safety of working environment	22
4.2	Solution pathway 2: women empowerment	22
4.3	Solution pathway 3: increase availability of comprehensive HIV and STI information, services and commodities in informal economy localities	22
4.4	Solution pathway 4: change attitudes and behaviour towards HIV, its commodities and services	23
4.5	Solution pathway 5: reformed legal and policy framework that supports and protects informal economy	23
4.6	Solution pathway 6: capacity to mobilise informal economy for HIV programmes	23
4.7	Solution pathway 7: increase resource availability for HIV programmes in the informal economy	23
	Assumptions underpinning the theory of change	23
5.	Results Framework	24
5.1	Strategy impact	24
5.2	Strategy Outcomes	24
	5.2.1 Outcome 2	24
	5.2.2 Intermediate Outcome 1	24
5.3	The corresponding outputs and their corresponding strategies/interventions	25
5.4	Implementation Approaches	26
5.5	Supportive pillars	26
5.6	Strategy Implementation	26
6.	Strategies of the HIV and aids response in the informal economy	27
6.1	Output 1; improved skills of women, men and youths in the informal economy	27
6.2	Output 2: increased knowledge of HIV, TB, STI, cancers and SRH services and commodities	27
6.3	Output 3: increased availability of comprehensive HIV, TB, STI, cancers and SRH services and commodities in informal economy localities	28
6.4	Output 4: safe working conditions in the informal economy established	29
6.5	Output 5: increase resource allocation for the informal economy	29
6.6	Output 6 informal economy organisations have capacity to mobilise informal economy	30
6.7	Output 7: reformed legal and policy frameworks that support and protect informal economy	30
7.	Implementation approaches	31
7.1	Targeted interventions	31
7.2	Gender mainstreaming	31
7.3	Participation	31
7.4	Integration	31
7.5	Supportive pillars	31
7.6	Coordination	31
	7.6.1 Functions of the Private Sector HIV and AIDS Partnership Forum	32
	7.6.2 Provincial and District level coordination	32
	7.6.3 Innovations and operations research	32
7.7	Capacity building	33
7.8	Monitoring and evaluation	33
7.9	Strategy implementation	33
8.	Roles and Responsibilities of Stakeholders	34
	Annexures	35
	Annex 1: List of stakeholders consulted	35
	Annex 2: Problem tree	36
	Annex 3: Targeting of sectors	37

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARVS	Antiretroviral Drugs
ASRH	Adolescent Sexual and Reproductive Health
CARGS	Community ART Refill Groups
CATS	Community Adolescent Treatment Supporters
CeSHHAR	Centre for Sexual Health and HIV AIDS Research
CITC	Client Initiated Testing and Counselling
CSOs	Civil Society Organisations
DAAC	District AIDS Action Committee
DFID	Department for International Development
DHS	Demographic Health Surveys
HIV	Human Immunodeficiency Virus
HTS	HIV Testing and Counselling
IEC	Information, Education and Communication
ILO	International Labour Organisation
MOHCC	Ministry of Health and Child Care
MPSL&SW	Ministry of Public Service, Labour and Social Welfare
MSME&CD	Ministry of Small and Medium Enterprises & Cooperative Development
MWAG&CD	Ministry of Women's Affairs, Gender and Community Development
NAC	National AIDS Council
NCDs	Non Communicable Diseases
PAAC	Provincial AIDS Action Committee
PrEP	Pre-Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PSAPF	Private Sector HIV and AIDS Partnership Forum
SBCC	Social behaviour change communication
MSMEs	Micro, Small and Medium Enterprises
SRH	Sexual Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TWG	Technical Working Group
ZAPP	Zimbabwe AIDS Prevention Programme
ZIMASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZIMPHIA	Zimbabwe Population-Based HIV Impact Assessment
ZNASP III	Zimbabwe National HIV and AIDS Strategic Plan 2015-2018

Definition of Terms

Gender: refers to socially constructed women and men's roles and responsibilities. It also refers to how people are perceived and expected to think and act as women and men because of the way in which they are organized, and not because of biological differences (MOHCC: 2001).

Informal Economy:

- (a) refers to all economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements; and
- (b) does not cover illicit activities, in particular the provision of services or the production, sale, possession or use of goods forbidden by law, including the illicit production and trafficking of drugs, the illicit manufacturing of and trafficking in firearms, trafficking in persons, and money laundering, as defined in the relevant international treaties.

“economic units” in the informal economy include:

- (a) units that employ hired labour;
- (b) units that are owned by individuals working on their own account, either alone or with the help of contributing family workers; and
- (c) cooperatives and social and solidarity economy units.

It should be noted that workers and economic units in the informal economy also include:

- (a) those in the informal economy who own and operate economic units, including:
 - (i) own-account workers;
 - (ii) employers; and
 - (iii) members of cooperatives and of social and solidarity economy units;
- (b) contributing family workers, irrespective of whether they work in economic units in the formal or informal economy;
- (c) employees holding informal jobs in or for formal enterprises, or in or for economic units in the informal economy, including but not limited to those in subcontracting and in supply chains, or as paid domestic workers employed by households; and
- (d) workers in unrecognized or unregulated employment relationships.

Integration: This refers to how different kinds of HIV and AIDS services or operational programmes can be connected together to improve the health outcomes of the people served. This may include referrals from one service provider to another. It is based on the need to offer comprehensive and integrated services.

Reproductive health: Is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life

Sexual and Reproductive Health and Rights: The exercise of control over one's sexual and reproductive health linked to human rights and includes the right to:

- Reproductive health as a component of overall health, throughout life cycle, for both men and women;
- Reproductive health decision-making, including voluntary choice in marriage, family formation, determination of the number, timing and spacing of one's children, right to access information and means needed to exercise voluntary choice;
- Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; and
- Sexual and reproductive health security, including freedom from sexual violence and coercion, and the right to privacy.

Monitoring: the routine tracking of key elements of a programme or project and its intended outcomes. It usually includes information from records and surveys and can be both population and client-based.

Evaluation: is a process of assessing the effectiveness and sometimes efficiency of the project. It is a time bound exercise done to measure the extent to which the organization achieves its desired results. This is done at outcome and also impact level.

Peer education: the approach whereby educational activities are offered by trained people to members of the same age, education or social group. Activities are aimed at developing knowledge, attitudes and skills, which will enable them to be responsible for and protect their own health and prevent HIV.

PrEP: Pre-exposure prophylaxis (PrEP) is the preemptive use of drugs to prevent disease in people who have not yet been exposed to the disease-causing agent. In particular, the term is used to refer to the use of antiretroviral drugs that attack the lifecycle of the HIV virus as a strategy for the prevention of HIV and AIDS.

Youths: refers to anyone aged 15-24 years.

Young adult: refers to anyone aged 25-39 years.

Foreword

The informal economy has become a major sector in Zimbabwe. According to the 2014 Zimstat Labour Force and Child Labour Survey Report 94.5 % of 6.3 million people defined as working are in the informal economy. Seventy eight per cent of the informal economy employees were in the broad age group 20-44 years and 86% of persons in informal employment were found to be unskilled. Of the females who were in informal employment, 91% were unskilled whilst for males in informal employment, 81 % were unskilled.

The informal economy in Zimbabwe is comprised of small-scale businesses engaged in a wide range of economic activities on the margins of the formal or mainstream economy. Their operations are typically characterised by unregulated contractual agreements. Informal enterprises are operated by people of widely differing ages, social backgrounds, education levels, vocational training, and work experience who engage in very diverse production strategies and markets, and operate in differing physical, social, and political environments. Due to the nature of their jobs the sector is most vulnerable to HIV and AIDS. Health services and programmes, which are provided during normal operating hours, are out of their reach because the workers have to be by their places of work in order to earn an income. The susceptibility of the workers in the informal economy also results from lack of social protection and basic services, lack of access to formal markets ,exploitative working conditions, poverty; lack of access to education and skills training, inaccessibility to meaningful credit services and risky lifestyles. Informal enterprise operators tend to be rather youthful and therefore sexually active.

The role of the sector in driving the economy is strongly acknowledged, hence the need to safeguard it through ensuring comprehensive HIV and AIDS programmes and services with a targeted approach for women and youth. This strategy is intended to ensure comprehensive HIV and AIDS programmes and services that are tailor made to suit the specific requirements of each sector of the informal economy with interventions focusing more on behaviour change, including the uptake of HIV prevention, treatment, care and support services. The strategy which will be implemented through a coordinated mechanism is aimed at reaching out to all categories of the informal economy by the year 2020 and make the reduction of new HIV infections a historic success.

The Government of Zimbabwe appeals to all stakeholders to support the implementation of this Strategy through mobilising both financial and technical resources. National AIDS Council is committed to work together towards achieving the goals of this strategy.



Dr. Tapuwa Magure
Chief Executive Officer
National AIDS Council

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We are grateful to the various stakeholders and partners for the collective effort and technical input towards the development of the strategy. The development of the strategy led by National AIDS Council involved extensive consultations with key organisations and individuals at national, provincial, district and community levels. We are grateful to the various associations representing the informal economy especially, Zimbabwe Chamber of Informal Economy Associations (ZCIEA), Zimbabwe Cross Border Traders Association (ZCBTA), National Vendors Union of Zimbabwe (NAVUZ), Greater Harare Association of Commuter Omnibus Operators (GHACOO), Zimbabwe Chamber of SMEs (ZCSME), for their commitment and valuable input that was extremely vital to the development of this 2017-2020 HIV and AIDS Strategy for the Informal Economy. Special acknowledgement and appreciation goes to individuals working in the informal economy for their invaluable time and critical views in providing insights during the consultative processes.

National AIDS Council extends its appreciation to the Ministries of Health and Child Care; Ministry of Small and Medium Enterprises and Cooperative Development; Ministry of Public Service, Labour and Social Welfare; Ministry of Women Affairs, Gender and Community Development for providing policy insight and direction. Special thanks to representatives of Employers and Labour organisations for their strategic contributions to the development of this strategy. Finally we thank the representatives of civil society organisations whose experiences helped in shaping the priority interventions identified in the informal economy strategy.

Last but not least the National AIDS Council is grateful to the International Labour Organisation (ILO) for technical review and for providing financial support towards printing of the document.

The vision to end AIDS by 2030 is possible when every sector is involved. The National AIDS Council recognizes the critical role of the Informal Economy in achieving this ambitious target, hence the development of this strategy.

Executive Summary

The Zimbabwean economy has undergone several structural changes since gaining independence in 1980. The most severe change was precipitated during the 2007- 2008 period when Gross Domestic Product is estimated to have contracted by a cumulative 50.3%, official inflation peaked at 231 million%, capacity utilisation in industry fell below 10%. By January 2009, poverty had remained widespread, infrastructure had deteriorated, the economy had become more informal and severe food and foreign currency shortages were experienced⁽¹⁾.

Adoption of a multicurrency system in February 2009 marked a shift in economic policy with a raft of policy measures introduced to counteract hyperinflation and the provision of a holistic macroeconomic framework for economic recovery⁽²⁾. The economy responded positively and GDP grew by 5.7% while year-on-year inflation was -7.7%. Industrial capacity utilisation improved from about 10% at the beginning of 2009 to between 35 and 60% by December of that year.

According to the 2014 Zimstat Labour Force and Child Labour Survey Report⁽³⁾ the informal economy has become the major sector in Zimbabwe with 94.5 % of 6.3 million people defined as working being in the informal economy. Seventy eight per cent of the informal economy employees were in the broad age group 20-44 years and 86% of persons in informal employment were found to be unskilled. Of the females who were in informal employment, 91% were unskilled whilst for males in informal employment, 81% were unskilled.

In Zimbabwe the informal economy is segmented with each sub sector possessing unique characteristics. Key informants indicated the following eight (8) groups that constitute the informal economy in Zimbabwe: Group 1 - Small scale miners; Group 2 - Cross border traders; Group 3 - Public transport workers; Group 4 - Sex Workers; Group 5 - Small scale farmers and farm workers; Group 6 - Vendors (including food vendors), and hair and beauty; Group 7 - Construction; and Group 8 – Manufacturing.

Situation Analysis of HIV and AIDS in the Informal economy in Zimbabwe

A situation analysis to identify the challenges facing the informal economy was conducted as part of the strategy development process. Several critical issues that undermine HIV and AIDS response were identified and include: access to commodities and services; knowledge, attitudes, behaviours and practices; stigmatisation; mobility; workplace organisation; mitigation; gender; resource availability; and coordination and implementation

Rationale for the Strategy

The informal economy is providing employment to the majority of people in Zimbabwe with both women and men involved as employees or employers. The informal economy has become the major sector in Zimbabwe with 94.5 % of 6.3 million people defined as working being in the informal economy. Seventy eight per cent of the informal economy employees were in the broad age group 20-44 years and 86% of persons in informal employment were found to be unskilled. Of the females who were in informal employment, 91% were unskilled whilst for males in informal employment, 81% were unskilled⁽⁴⁾. The changes in the economic landscape of the country have resulted in an increase of the contribution of the informal economy through an increase in the number of jobs and employment opportunities. However jobs in the informal economy are characterised by unregulated contractual arrangements and poor working conditions. In addition there are no social protection mechanisms in place and the informal economy is highly vulnerable to the HIV and AIDS epidemic. Although the effects of HIV and AIDS in Zimbabwe in general are known, there is very little evidence of the effects and impact in the informal economy. and thus this Strategy is critical and long overdue as part and parcel of the national response to HIV and AIDS.

¹Medium Term Plan, 2010

²Short Term Economic Recovery Plan (STERP).

³2014 Zimstat Labour Force and Child Labour Survey Report

⁴2014 Zimstat Labour Force and Child Labour Survey Report

It is also important to know how women in particular are affected as they are economically and socially marginalised and thus placed at greater risk to HIV infection. In addition HIV and AIDS is highly feminised with prevalence higher in women than men. Prevalence in females aged 15-49 years is 16.6% whilst for males in the same age group prevalence is 11.2% and for females aged 15-64 years prevalence is 16.7% and the corresponding prevalence for men in the same age group is 12.4% (ZIMPHIA, 2016).

The current HIV and AIDS policy for the micro, small and medium enterprises has provisions that are directly applicable to the informal economy.

Strategy Development Process

This strategy was developed using a participatory approach that encompassed a situational analysis, two workshops with stakeholders (consultative workshop for the draft strategy content and validation of the strategy). Informal economy stakeholders actively participated in the development process and provided useful insights that have enriched the document.

Technically, the strategy is based on primary research on HIV and AIDS in the informal economy targeting informal economy owners and employees and stakeholders working with them. A thorough review of literature on HIV and AIDS in the informal economy at the regional and international level was also undertaken. A problem tree analysis tool was used to identify key challenges affecting the informal economy with respect to HIV and AIDS. This process resulted in the development of the Theory of Change and Results Framework.

The situational analysis and literature culminated in the development of a problem tree that guided planning of results and strategies. Operational, governance, coordination issues were analysed using a SWOT analysis (strengths, weaknesses, opportunities and threats).

The theory of change for the HIV and AIDS Strategy of the Informal economy identified seven pathways of change:

- **Pathway 1:** Improve safety of working environment.
- **Pathway 2:** Women empowerment.
- **Pathway 3:** Increase availability of comprehensive HIV, TB, STI, Cancer, and SRH information, services and commodities in informal economy localities.
- **Pathway 4:** Change attitudes and behaviour towards HIV, its commodities and services.
- **Pathway 5:** Reformed legal and policy framework that supports and protects informal economy— pathway to formalisation.
- **Pathway 6:** Capacity to mobilise informal economy for HIV programmes.
- **Pathway 7:** Increase resource availability for HIV programmes in the informal economy.

1 Introduction

1.1 Informal economy in Zimbabwe

The Zimbabwean economy has undergone several structural changes since gaining independence in 1980. The most severe change was precipitated during the 2007-2008 period when Gross Domestic Product is estimated to have contracted by a cumulative 50.3%, official inflation peaked at 231 million%, capacity utilisation in industry fell below 10%. By January 2009, poverty had remained widespread, infrastructure had deteriorated, the economy had become more informal and severe food and foreign currency shortages were experienced⁽⁵⁾.

Adoption of a multicurrency system in February 2009 marked a shift in economic policy with a raft of policy measures introduced to counteract hyperinflation and the provision of a holistic macroeconomic framework for economic recovery⁽⁶⁾. The economy responded positively and GDP grew by 5.7% while year-on-year inflation was -7.7%. Industrial capacity utilisation improved from about 10% at the beginning of 2009 to between 35 and 60% by December of that year.

According to the 2014 Zimstat Labour Force and Child Labour Survey Report⁽⁷⁾ the informal economy has become the major sector in Zimbabwe with 94.5 % of 6.3 million people defined as working being in the informal economy. Seventy eight per cent of the informal economy employees were in the broad age group 20-44 years and 86% of persons in informal employment were found to be unskilled. Of the females who were in informal employment, 91% were unskilled whilst for males in informal employment, 81% were unskilled.

This development in the growing importance of the informal economy is also witnessed elsewhere in Africa with a growing and significant effect of the informal economy. Evidence points to self-employment comprising a greater share of informal employment (outside of agriculture) than wage employment at 70% of informal employment in sub-Saharan Africa and 62% in North Africa. Self-employment represents as much as 53% of informal agricultural employment in sub-Saharan Africa and 31% in North Africa⁽⁸⁾.

In Zimbabwe the informal economy is segmented with each sub sector possessing unique characteristics. Key informants indicated the following eight (8) groups that constitute the informal economy in Zimbabwe: Group 1 - Small scale miners; Group 2 - Cross border traders; Group 3 - Public transport workers; Group 4 - Sex Workers; Group 5 - Small scale farmers and farm workers; Group 6 - Vendors (including food vendors), and hair and beauty; Group 7 - Construction; and Group 8 – Manufacturing.

1.2 Context of HIV and AIDS in Zimbabwe

Zimbabwe has the fifth highest HIV prevalence in sub-Saharan Africa where 14.7% (1.2 million people) of adults aged 15-49 years in Zimbabwe were living with HIV in 2015, the majority of whom were women (700,000 women are HIV+), and there were currently around 39 000 annual deaths from AIDS, whilst there were 180 000 children living with HIV and 890 000 orphans⁽⁹⁾. New infections dropped from 79,000 in 2010 to 64,000 in 2015 with social behaviour change communication, high treatment coverage and prevention of mother to child transmission services thought to be responsible for this decline. Deaths from AIDS-related illnesses continue to reduce, falling from 61,000 in 2013 to 31,000 in 2015 whilst the number of children orphaned due to AIDS fell from 810,000 to 524,000 over the same period⁽¹⁰⁾.

⁵Medium Term Plan, 2010

⁶Short Term Economic Recovery Plan (STERP).

⁷2014 Zimstat Labour Force and Child Labour Survey Report

⁸UNAIDS, Eastern and Southern Africa HIV Epidemic Profile, 2014.

⁹UNAIDS, Eastern and Southern Africa HIV Epidemic Profile, 2014.

¹⁰AVERT (AVERTing HIV and AIDS), 2016

There has been a decline in HIV incidence rates among adults aged 15- 49 from 2.63% in 2000 to 0.92 in 2014 with annual new infections of 87,000 in 2000 to 55,000 in 2014 most possibly due to the scale up of various prevention and treatment programmes. Still, HIV prevalence remains stabilized around 14% average, predominantly affecting women showing prevalence higher at 17% than among men at 11%⁽¹¹⁾.

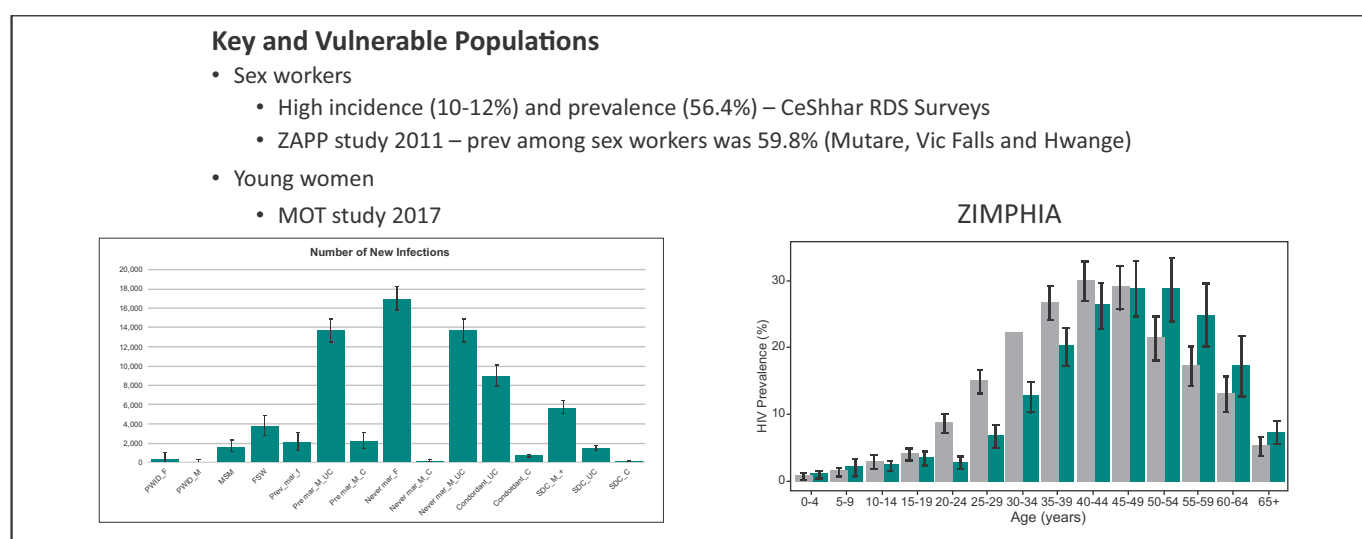
There was a 5 % decline in annual new infections among young people 15-24 between 2011 and 2014 with limited noticeable change among 25-49 year adults in the same period, but young women continue to be most vulnerable to HIV, as women and girls' risk of HIV is shaped by deep-rooted and pervasive gender inequalities including violence against women.

The populations that are considered vulnerable in the context of HIV and AIDS include women and girls, young men and women, orphans and vulnerable children and mobile populations⁽¹²⁾. Some of the key populations at high risk of HIV infection and/or not adequately reached with HIV services (most-at-risk populations) include the following⁽¹³⁾:

- Heterosexual people in stable unions or people considered to engage in low risk heterosexual sex are estimated to account for around 54.8%% of all new HIV infections.
- 11.3% of married/cohabiting couples are sero-discordant where in 6.7% the man is the HIV positive partner and in 4.5% the woman is the HIV-positive partner.
- HIV prevalence in young women is significantly higher than in their male peers, (e.g. in 20-29 year age group 20% of women have HIV infection compared to 10% of men). Young women are infected earlier with HIV, although from a lifetime perspective, men and women face a similar level of risk.
- There is no recent estimate of the proportion of new HIV infections in young people in Zimbabwe, but global data suggest that around 36% of new infections are in this group
- Sex workers and their clients together account for approximately 12% of new HIV infections. HIV prevalence in sex workers is particularly high (60%) due to the high numbers of partners, inadequate access to quality services, and a number of other factors, while incidence is estimated at 10%. At the moment though the HIV prevalence disaggregated data does not indicate the patterns in the informal economy.

Prevalence in some of the key and vulnerable populations is indicated in Figure 1 below.

Figure 1. Key and Vulnerable Populations



Source: ZIMPHIA, 2015-2016

¹¹ZIMPHIA 2015-2016

¹²Zimbabwe National AIDS Strategic Plan, 2011-2015.

¹³Zimbabwe National HIV and AIDS Strategic Plan, 2015-2020.

The HIV indicators in Zimbabwe show an improvement in the multisectoral response to the epidemic as illustrated by the latest ZIMPHIA⁽¹⁴⁾ national household survey

The current ZIMPHIA survey findings (Figure 2 below) show that the annual incidence of HIV among adults aged 15-64 in Zimbabwe is 0.45%: 0.59% among females and 0.31% among males. This corresponds to approximately 32,000 new cases of HIV annually among adults aged 15 to 64 years in Zimbabwe.

Prevalence of HIV among adults aged 15 to 64 years in Zimbabwe is 14.6%: 16.7% among females and 12.4% among males. This corresponds to approximately 1.2 million people living with HIV (PLHIV) ages 15 to 64 years in Zimbabwe.

Prevalence of viral load suppression among HIV positive adults ages 15 to 64 in Zimbabwe is 60.4%: 64.5% among females and 54.3% among males.

Figure 2. ZIMPHIA Key Findings

Zimbabwe HIV Incidence (ZIMPHIA)

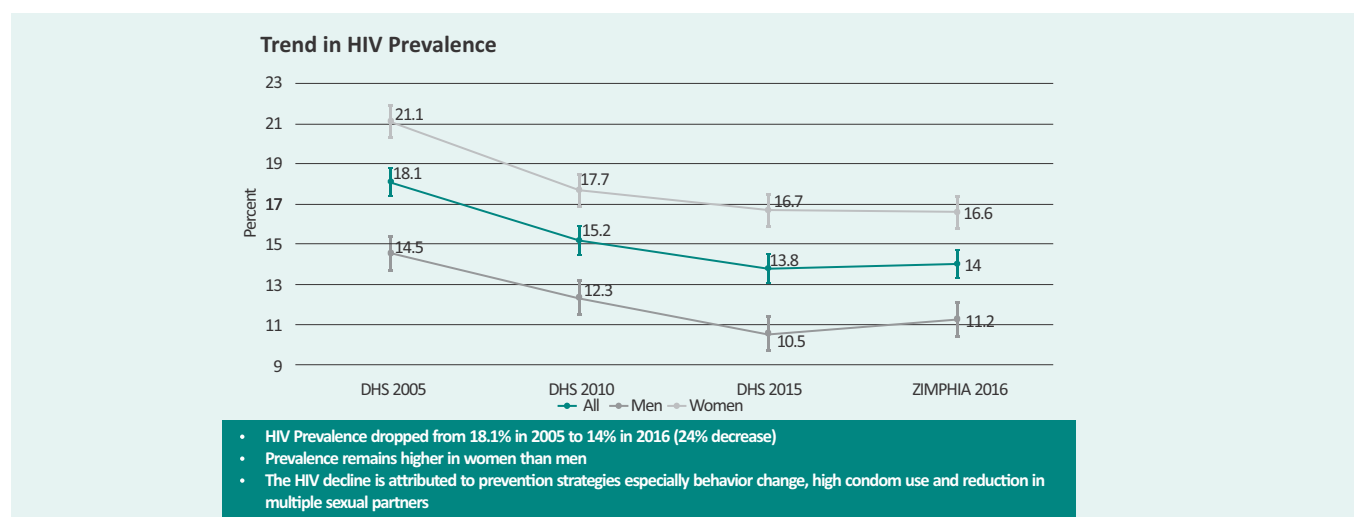
HIV Indicator	Female	95% CI	Male	95% CI	Total	95% CI
Annual Incidence (%)						
15-49 years	0.67	0.37-0.97	0.28	0.06 - 0.50	0.48	0.29-0.66
15-64 years	0.59	0.32-0.85	0.31	0.09 - 0.52	0.45	0.28-0.62
Prevalence (%)						
15-49 years	16.6	15.8-17.4	12.2	10.4 - 12.1	14.0	13.3-14.7
15-64 years	16.7	16.0-17.4	12.4	11.5 - 13.2	14.6	14.0-15.3
0-14 years	---	---	---	---	1.6	1.2-2.0
Viral load suppression (%)						
15-64 years	64.5	62.2-66.7	54.3	51.1 - 57.6	60.4	58.3-62.5

95% CI confidence interval) indicates the interval within which the true population parameter is expected to fall 95% of the time.
Viral load suppression is defined as HIV RNA < 1000 copies per ml of plasma among HIV positive adults.

Source: ZIMPHIA, 2015-2016

The trends in prevalence have been encouraging falling from a high of 18% in 2005 to 14% in 2016 as indicated in Figure 3 below.

Figure 3. Trend in HIV Prevalence



Source: ZIMPHIA, 2015-2016

¹⁴Zimbabwe Population-Based HIV Impact Assessment, 2015-2016.

1.3 Situation Analysis of HIV and AIDS in the Informal economy in Zimbabwe

A situation analysis to identify the challenges facing the informal economy was conducted as part of the strategy development process and issues undermining the HIV and AIDS response that were identified include:

- Access to commodities and services
- Knowledge, attitudes, behaviours and practices
- Stigmatisation
- Mobility
- Workplace organisation
- Mitigation
- Gender
- Resource availability
- Coordination and implementation

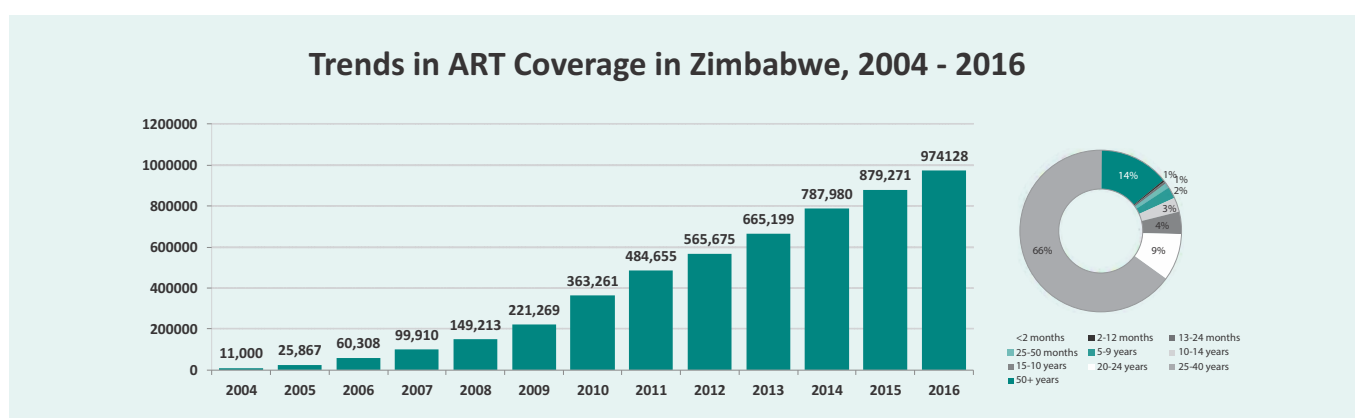
1.3.1 Commodities and services

The sector currently has limited targeted and integrated HIV, TB, STI, Cancer and SRH services. One group that is particularly affected by limited access to STI treatment is small scale miners as they are hard to reach and lack basic infrastructure for health services. Their response in these circumstances is to rely heavily on local herbs and traditional medicines (as evidenced by small scale miners in Shurugwi and vendors in Mbare) whose efficacy is not readily proven. Even in urban settings such as at Mbare Musika, vendors justified use of herbs on the grounds that they are often stigmatised and discriminated against if they visit health service providers. Where they do have access to antibiotics these are usually provided by unregistered vendors and due to lack of specialised medical knowledge they are used wilfully. This in turn predisposes the workers to the risk of resistance to antibiotics due to clients not being provided the full course and in addition medications provided may be expired and hence rendering them ineffective.

The gains that have been recorded in the fight against HIV and AIDS have resulted in acceptance that HIV has now become a manageable chronic condition due to availability of ARVs. A growing public health issue is the emergence of cancers where concern was raised that firstly there was limited access to information on cancers, the prohibitive costs of treatment which are beyond the reach of informal economy works. It was openly expressed that “*Cancer is what we now fear as it cannot be treated. It is better to have HIV than cancer because cancer is incurable*” (Mbare Centre Focus Group Discussants).

Focus group discussants bemoaned the lack of access to comprehensive HIV, TB, STI, Cancer and SRH services and commodities and in addition condoms were not available at their places of work, treatment not being readily accessible although they pointed out that HIV testing services were available though infrequently. At a national level though there has been a rapid increase in ART coverage (Figure 4).

Figure 4. Trends in ART Coverage in Zimbabwe, 2004-2016



Source: ZIMPHIA, 2015-2016

The rapid increase in ART coverage has been attributed to:

- High political will and commitment
- Task shifting of HIV services i.e. HIV Testing Services to Primary Counsellors (PCs) and ART initiation to nurses
- Resilient and dedicated Human Resources for Health (HRH)
- Robust and evidence informed National Strategic Plans
- Strong partnerships with donor community i.e. Global Fund, PEPFAR, DFID etc.

1.3.2 Knowledge, Attitudes, Behaviours and Practices

Informal economy workers who were interviewed showed that they had limited evidence of knowledge, attitudes, behaviour and practices in relation to HIV and AIDS. In addition men indicated that they were reluctant to go for STI screening as they might also be tested for HIV without their knowledge. This raises the point of fear of HIV or of knowing one's status. It also brings into sharp focus other views that indicated that for workers in the sector HIV is not prioritised in many cases. This is because it is viewed as becoming invisible and those infected are living longer due to availability of ART.

Furthermore attitudes towards condom use are still negative as condoms were said to decrease sensitivity. In addition both women and men indicated that the free public sector condoms distributed (Puma brand) were not popular as they have an unpleasant smell and have a tendency of breaking easily. The female condom was universally disliked by both women and men. What was not clear from the study was whether condoms were used correctly and consistently.

Male informal economy workers indicated that they were in multiple concurrent sexual relationships and almost invariably after a short period into the relationship both parties did not see the need for a condom as they were now in a relationship and trust had developed between the parties.

Voluntary male medical circumcision (VMMC) is one of the key interventions for prevention of transmission of HIV and it provides an important entry point for combination prevention initiatives such as: HTS; early HIV care and treatment services; Sexual Reproductive Health Services (SRHS); and referrals to other programmes. The uptake of VMMC is still low. Men had misconceptions on VMMC – such as “once you are circumcised you cannot contract HIV” FGD respondents.

For female dominated enterprises if business does not go well they easily engage in sex work to supplement income.

The informal economy generally does not have structures, neither does it have fixed opening and closing time and this provides opportunities for engaging in sex work in the evenings.

1.3.3 Stigmatisation

Stigmatisation was manifested at two levels: self-induced stigmatisation and discrimination, and stigma from others which undermines peer to peer support. So deeply entrenched are some stigmatisation issues that workers opted not to access services from health facilities due to the attitudes of service providers. Workers indicated that it was for this reason that they would opt for traditional herbs or purchase commodities on the streets, notwithstanding there was no guarantee of the efficacy of these.

1.3.4 Mobility

The groups that are highly mobile include small scale miners, cross border traders, public transport workers and manufacturing and this mobility undermines adherence and continued exposure to messages to facilitate social behaviour change.

The informal mining sector is usually found in remote and hard to reach areas and this makes the provision of services and commodities extremely difficult. This remoteness thus results in exposure to HIV and AIDS whilst at the same time making it difficult to have comprehensive integrated HIV and AIDS services.

1.3.5 Workplace organisation

The Key Informants interviewed acknowledged that the majority of the informal economy is organised but highly criminalised and therefore is difficult to mobilise. In many of the informal workplace settings the lack of infrastructure contributes to the difficulty to this lack of organisation.

It must be recognised that informal economy persons recognise themselves as business people who are there to earn incomes and thus any programmes of a development nature which require them to leave their places of work to participate in HIV and AIDS programmes will have low attendance rates.

Unlike the formal economy, one of the characteristics of the informal economy is that there are no fixed or closing times. This development means that those who are so inclined have opportunities for engaging in sex work even in the evening. Anecdotal evidence shows that informal economy workers have no time for developmental programmes with the nature of their work making it difficult to access HIV messages or receive services.

Informal economy workers are too busy to access treatment from health service providers who operate in some distance from their workplace which results in the disconnect between diagnosis and treatment, as the workers have to be by their places of work in order to earn an income.

The informal economy is extremely vulnerable to HIV and AIDS because workers cannot access health facilities or social protection benefits available to workers in the formal economy, as a result they get caught up in the vicious cycle of poverty as business activities usually don't go beyond the level of survival. Small scale miners are not available during the day time as they will be underground mining. Health services and programmes which are provided during normal operating hours remain inaccessible and further expose their vulnerability to HIV and AIDS.

1.3.6 Mitigation

There are limited interventions on mitigation and in addition there are no social protection mechanisms being employed to hedge against absence from work and funeral expenses. One example where a group has taken the initiative is in Shurugwi where sex workers have started income generating activities (IGAs). However these IGAs still need further analysis into how viable they are in terms of reducing poverty and improve quality of life.

The lack of adequate social protection for decent work principles (that include social security, medical schemes, insurance cover, shorter working hours, low irregular remuneration, serious health and safety risks and gender based violence) renders workers in the informal economy to increased susceptibility to HIV.

1.3.7 Gender

There is gender segregation in enterprises - labour intensive enterprises and those that are chaotic and violent (small scale miners, public transport workers and manufacturing, small scale farmers) are dominated by men. "Softer" enterprises are dominated by women (sex workers, cross border traders, vendors of clothes and food.).

Key challenges faced by women are due to their economic dependence thus rendering them more likely to exchange transactional sex for money or favours. Women's reduced bargaining powers result in their inability to negotiate for safer sex and may expose them to gender based violence. These factors result in their increased vulnerability to HIV infection. Physiologically women are at greater risk than men of being infected by HIV during unprotected sexual intercourse because of the larger surface areas exposed to contact.

Sexual abuse and harassment is also due to factors such as failure to pay bribes, especially for women traders who sleep in open space due to lack of affordable accommodation at border posts and those in vending when negotiating to get their stuff after having been confiscated by municipal police. Vulnerability to HIV infection is increased in such circumstances as women are unable to negotiate for safer sex.

The development impacts of gender inequality are well documented. Where women generally have greater access to education, work and income, communities see positive household impacts in relation to health and mortality⁽¹⁵⁾. Societies characterised by the denial of women's rights (in terms of access to resources, decision-making, status and gender-based violence) also tend to be more prone to violent conflict⁽¹⁶⁾. Gender discrimination and gender-based violence are generally associated with lower labour productivity, poorer educational outcomes, lower child health and nutrition and higher child mortality rates. Gender inequality also strains on social and health service systems, and poorer overall economic growth from household to community and national levels⁽¹⁷⁾.

Studies have shown that greater gender equality supports greater and more sustainable development. However, the converse relationship—that economic development automatically promotes gender equality—does not hold true⁽¹⁸⁾. As such, measurement of development program processes and outcomes must pay particular attention to both how different genders are affected by development programming and how interventions are supporting women's rights and gender equality⁽¹⁹⁾.

1.3.8 Resource availability

There are opportunities to avail resources to the informal economy through various funding modalities that include resourcing from development partners. There is scope as well for self-financing HIV interventions once the legal and regulatory environment is improved and thus contribute towards the AIDS levy. However information on the collections and disbursements of the AIDS levy need scaling up as there are incorrect perceptions about how the levies are disbursed.

1.3.9 Coordination and implementation

The key informants interviewed indicated that most of the programmes are partner driven and reflect programming priorities of partners. Efforts have been made though to address this through greater efforts at coordinating levels of the MOHCC and NAC in collaboration with other key stakeholders. The informal economy bemoaned the fact that despite its importance and contribution to the economy, it does not participate in the design of HIV programmes that affect them.

The informal economy is currently not represented in any NAC coordination structures and recommended the need for their representation as a matter of urgency. The informal economy also strongly feels that their representation should be from Board level to Village level structures to ensure that their issues and concerns are addressed and their voices heard.

To ensure effective coordination and implementation, an Informal Economy Technical Working Group has been established comprising informal economy institutions that will work with NAC on the Zimbabwe HIV and AIDS Strategy for the Informal Economy. It was observed that coordination of activities for the informal economy is limited, and where there are programmes for HIV, these have been generally on an ad hoc and unplanned basis. The approaches for the informal economy are not standardised whilst those organisations that oversee the informal economy have minimal capacity to mainstream HIV.

The key informants indicated that monitoring, evaluation and reporting for HIV in the informal economy requires strengthening.

¹⁵Kabeer and Natali 2013

¹⁶Schmeidl and Piza-Lopez 2002

¹⁷Morrison and Orlando 2004; Kabeer and Natali 2013; Joint Irish Consortium on Gender Based Violence n.d

¹⁸Kabeer and Natali 2013

¹⁹UN Women 2013

1.4 Rationale for the Strategy

The informal economy is providing employment to the majority of people in Zimbabwe with both women and men involved as employees or employers. The informal economy has become the major sector in Zimbabwe with 94.5 % of 6.3 million people defined as working being in the informal economy. Seventy eight per cent of the informal economy employees were in the broad age group 20-44 years and 86% of persons in informal employment were found to be unskilled. Of the females who were in informal employment, 91 % were unskilled whilst for males in informal employment, 81 % were unskilled (²⁰).

The changes in the economic landscape of the country have resulted in an increase of the contribution of the informal economy through an increase in the number of jobs and employment opportunities. However jobs in the informal economy are characterised by unregulated contractual arrangements and poor working conditions. In addition there are no social protection mechanisms in place and the informal economy is highly vulnerable to the HIV and AIDS epidemic. Although the effects of HIV and AIDS in Zimbabwe in general are known, there is very little evidence of the effects and impact in the informal economy. and thus this Strategy is critical and long overdue as part and parcel of the national response to HIV and AIDS. It is also important to know how women in particular are affected as they are economically and socially marginalised and thus placed at greater risk to HIV infection. In addition HIV and AIDS is highly feminised with prevalence higher in women than men. Prevalence in females aged 15-49 years is 16.6% whilst for males in the same age group prevalence is 11.2% and for females aged 15-64 years prevalence is 16.7% and the corresponding prevalence for men in the same age group is 12.4% (²¹).

The current HIV and AIDS policy for the Micro, Small and Medium Enterprises (MSME) has provisions that are directly applicable to the informal economy²². The following policy objectives are relevant:

- 1) To recognise the importance of combining the efforts of entrepreneurs, managers and employees in taking action for HIV and AIDS prevention mitigation.
- 2) To promote dialogue and transparency among social and development partners in order to create an environment conducive to combating HIV and AIDS in the operational setting.
- 3) To prevent HIV infection and reduce AIDS related deaths.
- 4) To promote non-discrimination and non-stigmatisation.
- 5) To prevent screening employees for HIV on recruitment, retrenchments, promotion and training.
- 6) To maintain confidentiality pertaining to HIV and AIDS issues.
- 7) To facilitate the continued employment of HIV-infected persons as long as they are medically certified fit for appropriate employment.
- 8) To provide a healthy and safe working environment to both HIV-infected and affected employees.
- 9) To achieve gender equality and sensitivity in the workplace.
- 10) To provide a caring and supportive environment for infected workers, including their families.
- 11) To strengthen resource allocation and sustainability of MSME oriented HIV and AIDS programmes.
- 12) To monitor, evaluate and assess impact of HIV and AIDS policies and programmes.

1.5 Guiding Principles

The Guiding principles for this strategy are aligned to the following ZNASP (2015-2020) principles;

1.5.1 Results based management

There is strong desire by the Government of Zimbabwe and its partners to realize value for money in line with ZIMASSET. The HIV response will promote results, accountability and good governance at all levels.

²⁰2014 Zimstat Labour Force and Child Labour Survey Report

²¹Zimbabwe Population-Based HIV Impact Assessment, 2015-2016

²²HIV and AIDS policy for the micro, small and medium (MSMEs) in Zimbabwe (2008). Prepared by Ministry of Small and Medium Enterprises and facilitated by The International Labour Organisation (ILO) Sub-Regional Office, Harare

1.5.2 Rights based approach

In line with the Constitution of Zimbabwe, the national HIV response recognizes and upholds human rights and non-discrimination of PLHIV, Key populations, people with disabilities, youths, women, children and others who are socially excluded.

1.5.3 Equity for fairness and justice

The HIV response will ensure equitable interventions.

1.5.4 Evidence Based

The interventions for the HIV response will be evidence based and respond to community needs. Resource allocation will be determined by the value, impact and potential for scaling up initiatives.

1.5.5 Accountability

Multi-sectoral and mutual involvement, financial and programme reporting will form the basis for Extended ZNASP III accountability at all levels.

1.5.6 Country Ownership, Shared Responsibility and Global solidarity

Mutual collaboration and accountability between government, development partners, private sector civil society and communities.

1.5.7 Gender sensitivity and responsiveness

Gender mainstreaming and gender transformative approaches will inform the multi-sectoral response across all key priority result areas.

1.5.8 Sustainable financing

The Extended ZNASP III will pursue the investment approach to resource mobilization and optimize on available resources.

1.5.9 Good Practices for learning

Adoption and scale up of evidence based best practices.

1.5.10 Community involvement ownership and partnership

Communities will be empowered to take control of their resources and programmes for sustainable well-being.

1.5.11 Efficiency, effectiveness and innovation

Entrepreneurship and value for money in programming.

2 Strategy Development Process

This strategy was developed using a participatory approach that encompassed a situational analysis, key informant interviews, focus group discussions, two workshops with stakeholders (consultative workshop for the draft strategy content and validation of the strategy). Informal economy stakeholders actively participated in the development process and provided useful insights that have enriched the document.

Technically, the strategy is based on primary research on HIV and AIDS in the informal economy targeting informal economy owners, employees and stakeholders working with them. A thorough review of literature on HIV and in the informal economy at the regional and international level was undertaken. A problem tree analysis approach was used to identify key challenges affecting the informal economy with respect to HIV and AIDS (Annex 2). This process resulted in the development of the Theory of Change and Results Framework.

The situational analysis and literature review culminated in the development of a problem tree that guided planning of results and strategies. Operational, governance, coordination issues were analysed using a SWOT analysis (strengths, weaknesses, opportunities and threats).

3 Theory of Change for the Strategy

The Theory of Change for the HIV and AIDS Strategy for the Informal economy is that:

“If:

- there are safe working conditions, there is accessibility of operational areas, and informal workers have shorter periods away from work
- women are empowered
- there is time to participate in integrated HIV programmes and there are organisations working in the informal economy
- there is peer support for avoiding high risk sex
- there is availability of banking services and available capital for informal economy players
- infrastructure is available for defined working hours
- the legal framework supports and protects the informal economy

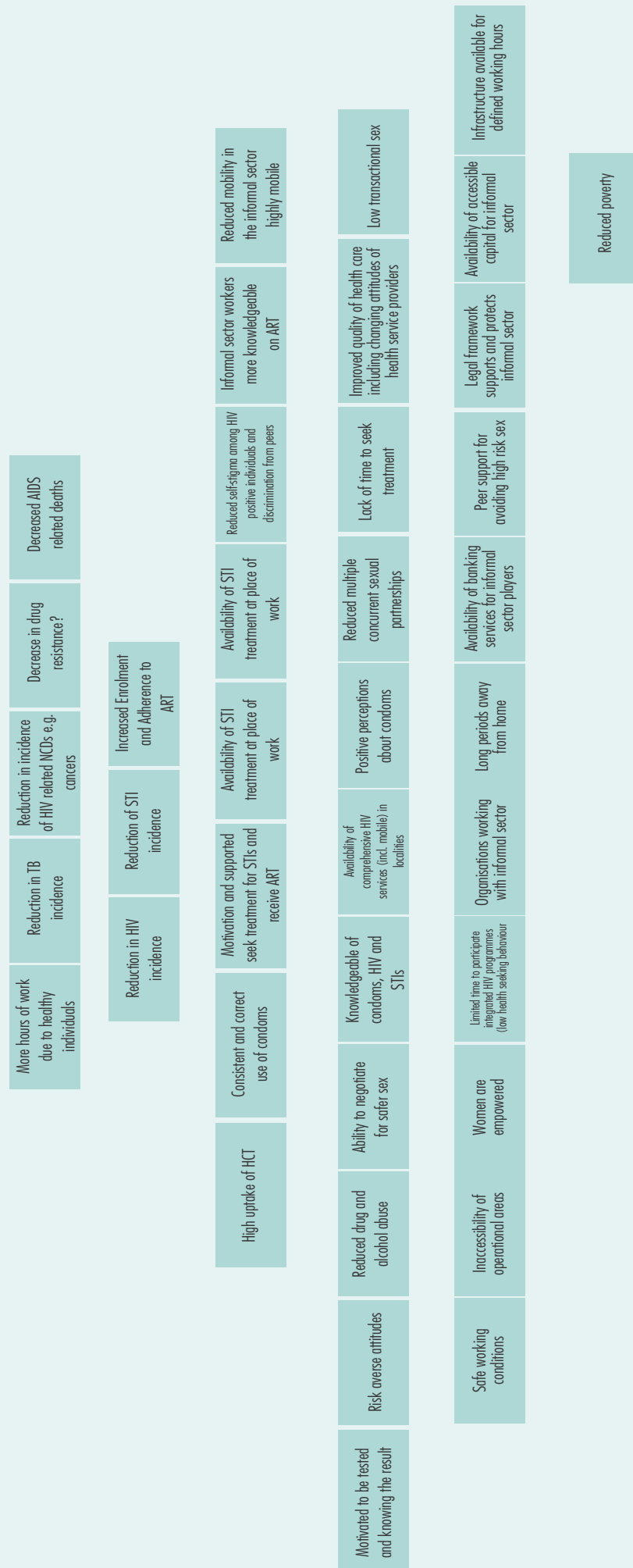
“then:

- the informal economy will have more hours of work due to healthy individuals
- there will be a reduction in the incidence of TB, HIV related NCDs, a decrease in drug resistance and decrease in AIDS related deaths

The Theory of Change identifies the major drivers of HIV and AIDS in the Informal economy as being: 1) poverty, 2) lack of access to integrated HIV services, 3) periods away from work, 4) working conditions, and 5) inadequate legal and policy environment.

As these factors are all interlinked, clearly the strategy has to be delivered in a multi-sectoral and integrated manner in order to achieve the overall strategy objectives. The Theory of Change is illustrated in Figure 5.

Figure 5. Theory of Change for the HIV and AIDS Strategy for the Informal economy



4 Solution Pathways

The Theory of Change for the HIV and AIDS Strategy of the Informal economy is defined by seven pathways of change which are interlinked and have to be attained to ensure the declared outcomes are achieved:

Pathway 1: Improve safety of working environment.

Pathway 2: Women empowerment.

Pathway 3: Increase availability of comprehensive HIV, TB, STI, Cancers, and SRH information, services and commodities in informal economy localities.

Pathway 4: Change attitudes and behaviour towards HIV, its commodities and services.

Pathway 5: Reformed legal and policy framework that supports and protects informal economy—pathway to formalisation.

Pathway 6: Capacity to mobilise informal economy for HIV programmes.

Pathway 7: Increase resource availability for HIV programmes in the informal economy.

The Theory of change was preceded by an analysis of the causes of HIV and AIDS in the informal economy. The problem tree from which the Theory of Change is derived is presented in Annex I.

4.1 Solution Pathway 1: Improve safety of working environment

The situation analysis undertaken as part of the strategy development process found that behaviours that expose the informal economy to HIV transmission are influenced by safety of the workplace. This is particularly important for risky enterprises such as small scale mining, construction and manufacturing. For such enterprises the risk of death caused by collapsed tunnels or murder (in the case of gang fights for lucrative claims or tunnels). Because of this some engage in unprotected sex with multiple sexual partners including sex workers, giving total disregard to the risk of contracting HIV. They explain their behaviour on the basis that death can come at any time due to their work environment and they live on a day-to-day basis.

4.2 Solution Pathway 2: Women empowerment

Results of studies such as ZIMPHIA and ZDHS show that HIV prevalence and incidence is higher among women, therefore women are at greater risk of contracting HIV. The vulnerability of women is underpinned by lack of economic empowerment and self-worth. In the informal economy women face capital challenges resorting to transactional sex and sex work to augment their low capital for their informal enterprises. The situation analysis highlighted how women cross border traders can engage in multiple transactional sex partnerships to avoid paying for goods and services. In other places especially those with no infrastructure for trading and designated time of closure, the potential for women to engage in sex work was said to be higher as a means to support incomes and sustain their informal enterprises. Therefore, supporting women economic empowerment and self-worth will have an effect in reducing their vulnerability to HIV.

4.3 Solution Pathway 3: Increase availability of comprehensive HIV and STI information, services and commodities in informal economy localities

Informal economy employees or employers have little time to be involved in HIV programmes or seek HIV services. Because of the lack of time, adherence to ART, HIV testing services, access to information on prevention of new HIV transmission and treatment is limited. This increases their risk to HIV drug resistance and contraction of HIV or STIs. Furthermore, HIV services and commodities are inaccessible to the informal economy localities, coupled with time limitations and long distances to services centres. These factors hinder improvement in the utilisation of integrated and comprehensive HIV services, commodities and equipment. For some informal economy enterprises such as small scale mining, public transport, the places of work do not have HIV commodities (e.g. condoms) and services (testing, and treatment). Such situations increase the risk of HIV infections and onset of AIDS that might result in death. Increasing availability of these services and commodities in informal economy workplaces will contribute to reducing their vulnerability to HIV and the onset of AIDS.

4.4 Solution Pathway 4: Change attitudes and behaviour towards HIV, its commodities and services

Stigma and discrimination from peers and health workers are a major concern with regards to ART adherence and use of condoms to prevent HIV transmission. Condom perception study and the situation analysis conducted during the development of this strategy confirmed the growing negative perceptions of the public sector condom. These perceptions were noted to be undermining efforts to reduce HIV transmission.

A condom perception study and the situation analysis conducted during the development of this strategy confirmed the growing negative perceptions about the public sector condom based on factors such as the smell and the perceived propensity of the condoms to burst. These perceptions were noted to be undermining efforts to reduce HIV transmission. There is thus a need to address the perceptions as failure to do so will result in lower uptake and thus increase risky sexual behaviours.

There is need for a change in attitudes and behaviour towards HIV, TB, STIs and SRH commodities and services within the informal economy.

4.5 Solution Pathway 5: Reformed legal and policy framework that supports and protects informal economy

Informality undermines accessibility of the informal economy to HIV programmes in contrast to the formal sector where the infrastructures in place are conducive to effective health system deliveries. The formal setting makes access to work place HIV information and service easier. It is envisaged that the process towards formalisation will contribute to effectiveness of HIV and AIDS interventions targeted at the informal economy.

4.6 Solution Pathway 6: Capacity to mobilise informal economy for HIV programmes

There are organisations that have been providing services and commodities to the informal economy although their reach has been limited due to the diversity, mobility and hard-to-reach nature of the informal economy. It is critical thus to capacitate these organisations. Improving the capacity of organisations representing informal economy enterprises will have the added advantage of improving their effectiveness in reaching the informal economy with sector specific HIV information, commodities and services in a cost effective manner.

4.7 Solution Pathway 7: Increase resource availability for HIV programmes in the informal economy

The number of organisations addressing HIV in the informal economy is limited mainly due to constraints in financial resources. Increasing resources for the informal economy will have a direct effect on increasing access to integrated and comprehensive HIV and AIDS information, services and commodities.

Assumptions underpinning the Theory of Change

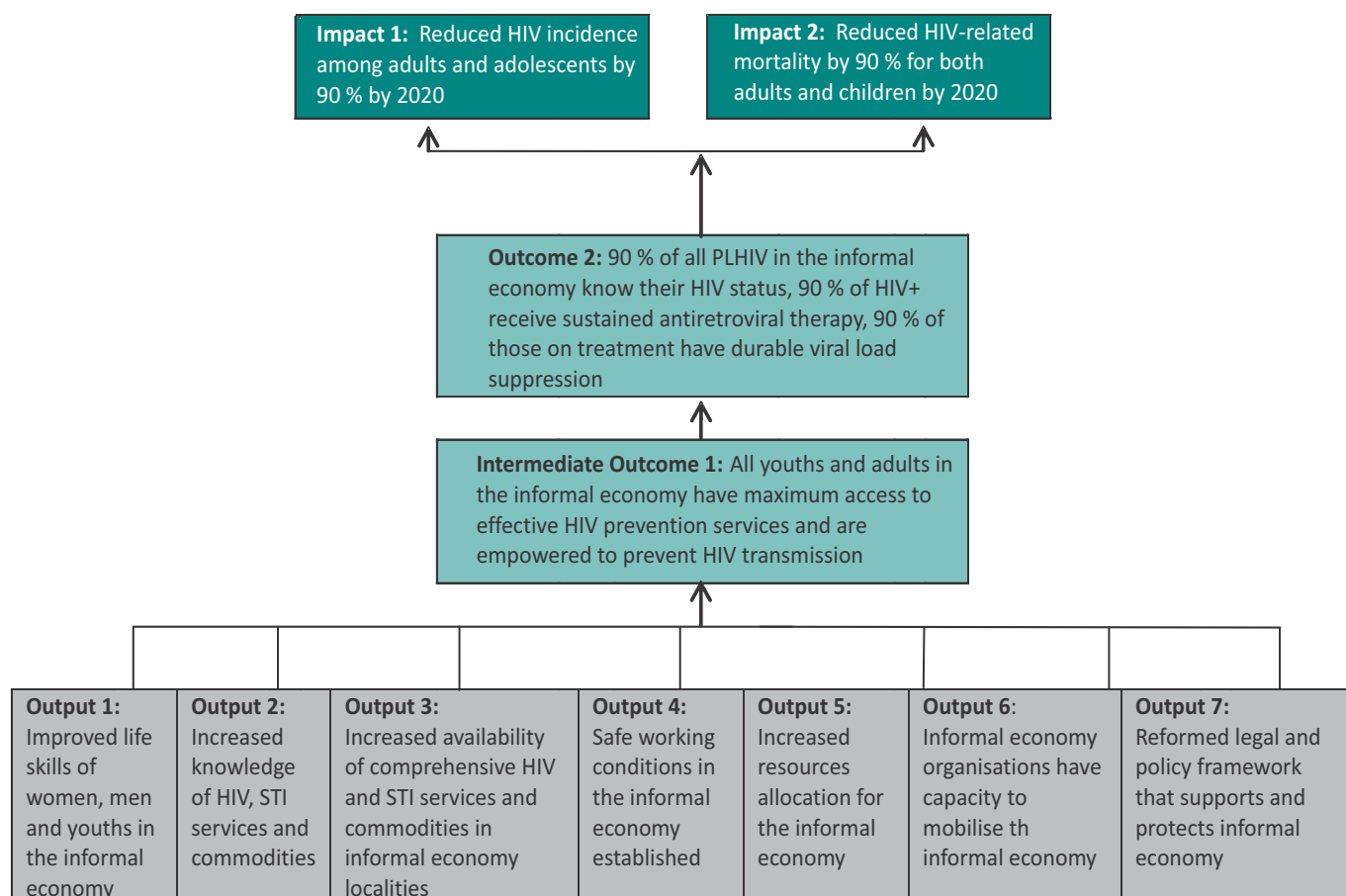
The following assumptions underpin the envisaged Theory of Change:

1. Ownership and support of the strategy by informal economy stakeholders;
2. Conducive political environment to deliver HIV programmes in remote and hard to reach areas e.g. small scale mining sites and small scale farms and farm workers.

5 Results Framework

This section presents the results framework for the strategy. It lays out the envisaged impact, outcomes and outputs. Strategies to achieve this results framework are also presented. The results framework for the strategy is presented in Figure 6

Figure 6. Results Framework



5.1 Strategy Impact

The impact statements for the strategy (derived from ZNASP III) are indicated as:

Impact 1 : Reduced HIV incidence among adults and adolescents by 90% by 2020

Impact 2: Reduced HIV-related mortality by 90% for both adults and children by 2020

5.2 Strategy Outcomes

Two outcomes will contribute to the two impact statements as follows:

5.2.1 Outcome 2

90% of all PLHIV in the informal economy know their status, 90% of HIV+ receive sustained antiretroviral therapy, and 90% of those on treatment have durable viral load suppression.

5.2.2 Intermediate Outcome 1

All youths and adults in the informal economy have maximum access to effective HIV prevention services and are empowered to prevent HIV transmission.

5.3 The corresponding outputs and their corresponding strategies/interventions are shown in Table I as follows:

The impact statements for the strategy (derived from ZNASP III) are indicated as:

Table I : Outputs and Strategies

Output 1	Strategies/Interventions
1.1 Improved life skills of women, men and youths in the informal economy	1.1.1 Develop and operationalise an integrated life skills programme
	1.1.2 Strengthen linkages between the national social behaviour change programme and informal economy HIV programmes
Output 2	Strategies/Interventions
2.1 Increased knowledge of HIV,STI, TB, SRHR and cancer services and commodities	2.1.1 Review, develop and disseminate Information, Education and Communication (IEC) material relevant to the informal economy.
	2.1.2 Develop a communication strategy for the different categories of the informal economy e.g. moonlight campaign
	2.1.3 Scale up Differentiated Models of Care e.g. Community ART Refill Groups (CARGs) to the informal economy
	2.1.4 Integrate SBCC in the informal economy
	2.1.5 Review current peer educator programs in the informal economy and develop a standardized national model
	2.1.6 Lobbying for integrated HIV services at border posts
	2.1.7 Use of social and mass media to disseminate information
Output 3	Strategies/Interventions
3.1 Increased availability of comprehensive HIV, TB, STI, SRHR services and commodities in informal economy localities.	3.1.1 Decentralization of HIV Services to the Informal economy workplaces e.g. Mobile Clinics
	3.1.2 Establish distribution decentralised points for HIV, TB, STI, SRH medicines, supplies and equipment
	3.1.3 Increase uptake of HIV, TB, STI, SRH and cancer services and commodities (PITC and CITC)
	3.1.4 Establish/strengthen condom distributors within sectors
	3.1.5 Setup after hours/flexible care and support services
	3.1.6 Establish and strengthen the capacity of the focal persons through provision of simplified IEC materials in vernacular language
	3.1.7 Support, resuscitate and strengthen outreach services targeting informal economy3.1.8 Capacitate health workers to deal with respective sectors (culture shock management on service providers).
Output 4	Strategies/Interventions
4.1 Safe Working Conditions in the Informal economy Established	4.1.1 Conduct a mapping exercise for all organisations working with the Informal economy
	4.1.2 Promotion of friendly legislative framework
	4.1.3 Advocate for the establishment of designated working place.
	4.1.4 Ensure availability of Safety and Health equipment within the Informal economy
	4.1.5 Promote the establishment of ONE STOP SHOP CENTRES (integration) in Hot Spot and Strategic areas

Output 5	Strategies/Interventions
5.1 Increase resource allocation for the informal economy	5.1.1 Establish an Informal economy Technical Working Group (TWG) to facilitate representation, collaboration, coordination as well as resource mobilisation
	5.1.2 Engage with cooperating partners to capacitate informal economy structures
	5.1.3 Forming partnerships
	5.1.4 Development of a resource mobilisation strategy
	5.1.5 Encourage informal economy through their associations clubs to establish internal funds to finance HIV and AIDS; TB Programs
Output 6	Strategies/Interventions
6.1 Informal economy organisations have capacity to mobilise the informal economy	6.1.1 Organise according to their economic activities
	6.1.2 Capacitate informal economy structures with management skills
	6.1.3 Maintain and update database
Output 7	Strategies/Interventions
7.1 Reformed Legal and Policy Framework that supports and protects the Informal economy	7.1.1 This delivery will not be directly linked with the strategy though the strategy recognises its importance. The strategy will focus on linking with other processes that are working on reforming the Legal and Policy Framework.

5.4 Implementation Approaches

The implementation approaches will be anchored on the following:

- 1) Targeted interventions
- 2) Gender mainstreaming
- 3) Participation and
- 4) Integration.

5.5 Supportive pillars

Successful implementation of this strategy will require excellence in the following four pillars of:

- 1) Coordination
- 2) Innovations and operations research
- 3) Capacity building, and
- 4) Monitoring and evaluation.

5.6 Strategy Implementation

The Strategy will be implemented over a three year period as indicated below:

Year	Activities
1	1) Standardise approaches 2) Mobilise resources for the strategy 3) Link strategy with formalisation processes
2	1) Promote integrated services 2) Bring information to informal economy on: condoms, HIV,STIs, TB, SRH and cancers 3) Decentralise integrated services
3	1) Decentralise integrated services 2) Evaluation 3) Preparation for new strategy

6 Strategies of the HIV and AIDS response in the Informal economy

The HIV and AIDS Strategy for the Informal economy mainly focuses on the prevention of new HIV infections among the informal economy populations. Those already living with HIV will be supported to reduce viral load through implementation of strategies that ensure improved access to treatment and enable them to live positively with the virus and prevent re-infections and new infections.

The following strategies are oriented towards prevention of HIV in the informal economy for realisation of expected impact results.

6.1 Output 1: Improved skills of women, men and youths in the informal economy

The main objective is to influence social behaviour change through enhancing the skills of populations in the informal economy. The strategy aims to empower youths with life and business skills to enable them to be able to negotiate for safer sex practices. The strategy equally aims to empower women and men with business skills to become economically empowered whilst also equipping them with negotiating skills to avert risky practices and including not succumbing to negative peer pressure. The strategy focuses on increasing knowledge on HIV, TB, STI, Cancers and SRHS services available. Various information dissemination strategies will be utilised to ensure messages reach the intended target which includes the most difficult to reach groups. Integrated, standardised and sector appropriated information dissemination packages will be developed to enable reaching the most high risk groups of populations in the informal economy. Special groups such as populations in artisanal mining, sex work and cross border require specific integrated information and services packaged to influence social behaviour change and avert risky perceptions. The capacity of community based structures and CSOs will be strengthened to enable provision of integrated information and services in the informal economy. The approaches will strengthen the linkages between the existing social behaviour change programmes and HIV programming in the informal economy.

Output 1	Strategies/Interventions
1.1 Improved skills of women, men and youths in the informal economy	1.1.1 Develop and operationalise an integrated life and business skills programme
	1.1.2 Strengthen linkages between the national social behaviour change programme and informal economy HIV programmes
	1.1.3 Undertake activities improving negotiation for safer sex practices, correct and consistent use of condoms
	1.1.4 Advocacy and lobbying for delayed onset of sexual debut

6.2 Output 2: Increased knowledge of HIV, TB, STI, Cancers and SRH services and commodities

The strategy aims to review and develop the integrated and comprehensive Information, Education and Communication (IEC) packages for all the intended target groups. These packages will aim at increasing knowledge of HIV, TB, STI, Cancers and SRH services and commodities. Issues on tackling gender based violence should also be included. The strategy also focuses on developing communication packages relevant to different categories of the informal economy and integrate the social behaviour change communication approaches to reach and influence social behaviour change among the populations in the informal economy.

The focus of this strategy is also on designing differentiated models of care for the various sectors of the informal economy to ensure enrolment, adherence and retention in HIV treatment. The models include literacy on ART for the populations in the informal economy. The strategy promotes a combination of peer based approaches (e.g. Community ART refill groups, support groups) and other information dissemination approaches such as social and mass media from other stakeholders and various service providers especially at border posts. The strategy reviews the existing peer educator programs and develops a standardised national model that can be adapted to suit the various categories of the informal economy.

Output 2	Strategies/Interventions
2.1 Increased knowledge of HIV, TB, STI, Cancers and RHR services and commodities	2.1.1 Review, develop and disseminate gender sensitive Information, Education and Communication (IEC) material relevant to the informal economy.
	2.1.2 Develop a communication strategy for the different categories of the informal economy e.g. moonlight campaign
	2.1.3 Scale up Differentiated Models of Care e.g. Community ART Refill Groups (CARGs) to the informal economy
	2.1.4 Integrate SBCC in the informal economy
	2.1.5 Review current peer educator programs in the informal economy and develop a standardized national model
	2.1.6 Lobbying for integrated HIV, TB, STI, Cancers and SRH services at all informal economy localities.
	1.1.7 Use of social and mass media to disseminate information

6.3 Output 3: Increased availability of comprehensive HIV, TB, STI, Cancers and SRH services and commodities in Informal economy localities

The output interventions are aimed at increasing the availability of comprehensive HIV, TB, STI, Cancers and SRH services and commodities in Informal economy localities. A capacity needs assessment will be undertaken to identify gaps in capacity to deliver comprehensive and integrated services on HIV, TB, STI, Cancers and SRH services for the informal economy population groups. A situation analysis will be conducted to assess status and availability of resources and commodities (condoms supplies, HIV testing kits, PrEP kits, and availability and accessibility of locations for testing, ART initiation, adherence and retention, cervical screening kits and STIs syndromic management and treatment services). The situation analysis will determine the patterns of services utilisation to influence prioritisation and guide estimates on supplies and distribution logistics for various categories of the informal economy while prioritising hot spots such as the artisanal mining areas and cross borders.

The focus is on: decentralising the integrated and comprehensive HIV services to the various categories of the informal economy; establishing and decentralise distribution points for integrated HIV and STIs medicines, supplies, equipment and commodities; increasing the uptake of integrated HIV and STIs services and commodities including Provider Initiated Treatment and Counselling (PITC); establishing and strengthening condom distributors within the informal economy categories; setting up flexible time (e.g. after normal working hours – moonlighting for artisanal mining sector) for provision of integrated HIV, TB, STI, Cancers and SRH services care and support services; strengthening the capacity of Focal persons in the informal economy to deliver integrated HIV support services through provision of simplified IEC materials in local languages; supporting the resuscitation and strengthening of outreach services targeting the various categories of the informal economy; and strengthening the capacity of health service providers to enable them work to with and provide services for the various categories of the informal economy.

Output 3	Strategies/Interventions
3.1 Increased availability of comprehensive HIV, TB, STI, Cancers and SRH services and commodities in informal economy localities.	3.1.1 Decentralization of HIV, TB, STI, Cancers and SRH services to the Informal economy workplaces e.g. Mobile Clinics
	3.1.2 Establish distribution decentralised points for HIV, TB, STI, Cancers and SRH services , supplies and equipment
	3.1.3 Increase uptake of HIV, TB, STI, Cancers and SRH services and commodities (PITC)
	3.1.4 Establish/strengthen condom distributors within the informal economy
	3.1.5 Setup after hours/flexible care and support services
	3.1.6 Establish and strengthen the capacity of the focal persons through provision of simplified IEC materials in vernacular languages
	3.1.7 Support, resuscitate and strengthen outreach services targeting informal economy
	3.1.8 Capacitate health workers to deal with respective sectors including community health workers especially in hard to reach localities

6.4 Output 4: Safe working conditions in the informal economy established

Output 4 calls for creation of a conducive working environment that protects population operating and working in the informal economy while ensuring their access to integrated and comprehensive HIV information, and services. This is achieved through implementation of policies and legal framework that protects the informal economy populations. Mapping of all organisations working with the informal economy is done to ensure that they operate within the required and appropriate legal and institutional framework. A review and analysis of the existing policies and laws is done so as to identify gaps in policy provisions and implementation. Advocacy and lobby sessions will be conducted for harmonisation and ensure protection and equitable access to integrated, quality and comprehensive HIV, TB, STI, Cancers and SRH services. Advocacy efforts for decriminalisation of laws that govern prostitution, informal mining, vending, etc. will be done. Advocacy and lobbying for availability of Safety and Health equipment within the

informal economy will also be a priority area of focus. Sector/category specific HIV integrated services especially for accessing condoms and other SRH services to prevent HIV infection, screening and treatment of STIs and select cancers will be implemented. Promotion and establishment of integrated ONE STOP SHOP Centres in the various sites in the informal economy will be done.

Output 4	Strategies/Interventions
4.1 Safe Working Conditions in the Informal economy established	4.1.1 Conduct a mapping exercise of all organisations working with the Informal economy
	4.1.2 Promotion of friendly legislative framework
	4.1.3 Advocate for the establishment of designated working place.
	4.1.4 Ensure availability of Safety and Health equipment within the Informal economy
	4.1.5 Promote the establishment of ONE STOP SHOP CENTRES

6.5 Output 5: Increase resource allocation for the informal economy

Output 5 focuses on mobilising and increasing resources for the informal economy to enable provision of quality, comprehensive HIV integrated services particularly for different categories of the informal economy. The output also ensures increased and improved access to quality, comprehensive

HIV, STIs, TB, SRH and cancers integrated services by the informal economy populations. The interventions will involve engaging with cooperating partners to strengthen the capacity of informal economy structures and establish partnerships for increased resource base. The strategy supports the development of a resource mobilisation strategy to enable an effective

HIV response in the informal economy. The informal economy umbrella bodies, associations and clubs are mobilised and supported to establish internal funds that support the implementation of comprehensive HIV integrated programmes. Increased resources will ensure effective and efficient delivery and implementation of the supply chain to ensure no stock outs of basic commodities such as condoms, HIV testing kits, and STIs syndromic management, select cancer and TB screening kits. The strategy will support and ensure that partnerships with the private sector and key CSOs are established to increase and expand HIV integrated service delivery points and improve availability and access to services and commodity.

Output 5	Strategies/Interventions
5.1 Increase resource allocation for the informal economy	5.1.1 Engage with cooperating partners to capacitate informal economy structures
	5.1.2 Forming partnerships
	5.1.3 Development of a resource mobilisation strategy
	5.1.4 Encourage informal economy through their associations clubs to establish internal funds to finance HIV and AIDS; TB Programs

6.6 Output 6 Informal economy organisations have capacity to mobilise informal economy

Output 6 aims to enhance the capacity of the informal economy organisations to be able to mobilise the informal economy to respond to HIV in the sector. Informal economy organised are identified and classified or categorised according to their activities for easy mobilisation and implementation of capacity building initiatives. A data base will be created to facilitate the design of the capacity strengthening programme inclusive of the monitoring and evaluation of the organisations capacitated. Capacity strengthening curriculae will include management skills that will enable informal organisations manage the HIV programmes effectively and efficiently. The database will be reviewed and upgraded periodically to ensure that relevant organisations are not omitted.

Output 6	Strategies/Interventions
6.1 Informal economy organisations have capacity to mobilise informal economy	6.1.1 Organise according to their economic activities
	6.1.2 Capacitate informal economy structures with management skills
	6.1.3 Maintain and update database

6.7 Output 7: Reformed Legal and Policy Frameworks that support and protect informal economy

This output is not directly linked with the strategy although the strategy recognises its importance. The output will focus on linking with other processes that are working on reforming the Legal and Policy Frameworks.

7 Implementation Approaches

The implementation approaches will be anchored on the following:

- 1) targeted interventions
- 2) gender mainstreaming
- 3) participation and
- 4) integration.

7.1 Targeted interventions

The informal economy is heterogeneous and each sub sector needs to be targeted specifically taking into account their unique characteristics. The targeted approaches for each sub sector are indicated in Annexure 3.

7.2 Gender mainstreaming

Gender has a feminine face and this is evidenced by gender segregation in enterprises in the informal economy and the strategy recognises that men tend to occupy the “rough” sub sectors whilst women tend to occupy the “soft” sub sectors. With this in mind interventions need to examine ways of reducing vulnerability of women and youth working in the informal economy. There have to be concerted efforts to ensure programmes initiated are gender responsive. This in turn requires that providers of services should be capacitated to ensure mainstreaming of gender into the programmes undertaken.

7.3 Participation

Programmes are partner driven and the informal economy players are not involved. Interventions will need to consider how participation of the informal economy participation can be increased.

7.4 Integration

Integration will require the leveraging of resources as currently the informal economy HIV programme is not included in the broader HIV response. There is need for deliberate linkages with programmes in HIV, and broader health system. Consideration needs to be given as to how linkages in the condom programme, STI programme, TB programme, NCDs programme, and SRH (including ASRH) can also be linked with the broader health system.

7.5 Supportive Pillars

Successful implementation of this strategy will require excellence in the following four pillars of:

- 1) coordination
- 2) innovations and operations research
- 3) capacity building, and
- 4) monitoring and evaluation.

7.6 Coordination

In order to have effective coordination current gaps than include a lack of representation of the informal economy in the formal coordination structures for HIV and AIDS in addition to limited coordination within the informal economy itself will need to be addressed.

An Informal Economy Technical Working Group (TWG) will be formed to operationalise the Zimbabwe HIV and AIDS Strategy for the informal sector. This TWG will also feed into other groupings that represent labour, employers, civil society and the interests of specific sectors. The coordination mechanism needs to build on existing networks in an effort to enhance the overall response to HIV and AIDS. The Zimbabwe Private Sector HIV and AIDS Partnership Forum (PSAPF) was constituted to strengthen the coordination of the private sector response and guide the implementation of a common

strategy and the informal economy will be represented at the PSAPF. The PSAPF is a national forum, composed of all social partners, private sector organisations and other key stakeholders working the field of HIV and AIDS in the World of Work.

The informal economy will also be represented in the decentralised coordinating structures that include the Provincial AIDS Action Committees, District AIDS Action Committees, and Wards AIDS Action Committees. Civil society organisations and private sector are coordinated through umbrella networks such as Zimbabwe AIDS Network and Zimbabwe Business Council on HIV and AIDS among others. Coordination of key populations has to date been minimal due to the unclear legal framework surrounding groups such as commercial sex workers and prisoners.

7.6.1 Functions of the Private Sector HIV and AIDS Partnership Forum

Functions of the PSAPF are as follows:

- To create a national platform for further discussion and debate on practical issues in response to the epidemic as a business and workplace issue
- Increase access to national and international resources, information and education related to HIV and AIDS.
- The forum will create a mechanism for documenting, monitoring and evaluating the private sector response to HIV and AIDS.
- The forum will create the opportunity for key stakeholders to share experiences and good practices within the world of work.

7.6.2 Provincial and District level coordination

Provincial AIDS Action Committees are tasked with facilitation, coordination, promotion, monitoring and implementation of HIV and AIDS activities at Provincial and District levels. District AIDS Action Committees (DAACs) in 67 administrative districts provide responsive stewardship at the provincial and district levels respectively. Both PAACs and DAACs comprise of fifteen (15) members each.

7.6.3 Innovations and Operations Research

Innovations in reaching the informal economy will be undertaken through developing programmes that result in increased uptake of services. Findings from innovative approaches will be documented as part of the process of scaling up activities nationwide across the informal economy. Programmes conducted should be followed up and operations research will need to be undertaken periodically to test the effectiveness of programmes.

Research will need to identify activities that are of value (low cost - high return interventions) and feasible for scale up and these interventions need to be assessed for their cost effectiveness. There is increasing need for high quality operations research that can address questions of efficiency and effectiveness of these efforts and provide data for decision making. One area requiring attention is that of the underserved key population groups in the country since leaving them out of focus will severely hamper all efforts that have gone into work on HIV and AIDS.

The operations research undertaken will be employed as an effective tool for advocating for policy change and operations research findings should help inform resource allocation and policy decisions. Achieving viable programmes that integrate HIV services, including prevention efforts, into broader public health systems requires operations research that is focused on optimizing sustainable and scalable systems.

7.7 Capacity Building

Organisations that oversee the informal economy have no capacity to mainstream HIV but will need to be capacitated to ensure they are able to fulfil this role including line ministries such as the Ministry of Small and Medium Enterprises & Cooperative Development (MSME&CD), Ministry of Women's Affairs, Gender and Community Development

(MGWA&CD). Closely aligned to capacity building is the need to ensure the availability of sufficient funds for implementing training.

7.8 Monitoring and Evaluation

The informal economy has to date not been specifically targeted with monitoring and evaluation having been undertaken thus far. Implementation of the HIV and AIDS Strategy for the Informal economy will require monitoring and evaluation and the results will be incorporated into the overall national monitoring and evaluation system.

7.9 Strategy Implementation

The Strategy will be implemented over a three year period as indicated below:

Year	Activities
1	1) Standardise approaches 2) Mobilise resources for the strategy 3) Link strategy with formalisation processes
2	1) Promote integrated services 2) Bring information to informal economy on HIV, TB, STI, Cancers and SRH services and condoms. 3) Decentralise integrated services
3	1) Decentralise integrated services 2) Evaluation 3) Preparation for new strategy

8 Roles and Responsibilities of Stakeholders

The key stakeholders for the HIV and AIDS Strategy are listed below including their roles and responsibilities.

Stakeholder	Roles and Responsibilities
National AIDS Council	- Oversee, facilitate and coordinate strategic planning and implementation of a comprehensive response initiative on HIV and AIDS - Spearhead advocacy and social and resource mobilisation towards scaling up and an accelerated fight against HIV and AIDS - To monitor and evaluate the national multisectoral efforts on HIV and AIDS in order to enhance their impact
Ministry of Small and Medium Enterprises & Cooperative Development	- Play an oversight role - Linking the informal economy with other stakeholders. - Pushing for enactment of legal frameworks in the informal economy.
Ministry of Women's Affairs, Gender and Community Development	- Gender mainstreaming - Community mobilization
Ministry of Health and Child Care	- Information dissemination - Coordination of activities - Provision of treatment, care and support services - Policy formulation
Ministry of Public Services, Labour and Social Welfare	Legislative role and ensuring social protection enhancement
Ministry of Local Government, Public Works and National Housing	To improve service delivery in the areas of: - Improvement of institutional management systems - Development of turnaround Strategies for all local authorities. - Recapitalization of local authorities for the replacement of obsolete heavy equipment
Business member organisations	- Participate in the Private Sector HIV and AIDS Partnership Forum - Provide technical support
UN Agencies	Coming up with conventions and recommendations and also oversight responsibility
HIV and AIDS Support Organisations	Compliment the roles played by the Informal economy
Standards Association of Zimbabwe	Development and maintenance of standards
Informal economy organisations	- Link informal economy members together and thus gain representation in the policy making and rule-setting bodies affecting their work and lives. - Spearhead coordination and implementation of HIV and AIDS activities - Bring about increased visibility of informal economy workers - Undertake research and publicise official statistics on the informal economy - Spearhead recognition of the informal economy as contributors to the overall economy and thus also become legitimate beneficiaries of economic and social policies

Annex 1: List of Stakeholders Consulted

National AIDS Council
Ministry of Small and Medium Enterprises & Cooperative Development
Ministry of Health and Child Care
Ministry of Public Service, Labour and Social Welfare
Ministry of Women Affairs, Gender and Cooperative Development
Ministry of Local Government, Public Works and National Housing
Employers Confederation of Zimbabwe
Greater Harare Association of Commuter Omnibus Operators
Informal traders
International Labour Organisation
Manufacturers
National Mine Workers Union of Zimbabwe
National Vendors Union of Zimbabwe
Small scale miners
UNAIDS
World Education International
Zimbabwe AIDS Support Organisation
Zimbabwe Chamber of Informal Economy Associations
Zimbabwe Chamber of SMEs
Zimbabwe Congress of Trade Unions
Zimbabwe Cross Borders Traders Association
Zimbabwe Federation of Trade Unions
ZNNP+

Annex 2: Problem Tree

Less hours of work due to illness	High TB incidence	High incidence of NCDs e.g. cancers	Increase in drug resistance	Increased AIDS related deaths
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High HIV incidence	High STI incidence	Enrolment and adherence to ART is weak
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Low uptake of HTS	Inconsistence and incorrect use of condoms	Lack of motivation and time to seek treatment for STIs and receive Art	Unavailability of STI treatment at place of work	self-stigma and individual discrimination
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Drug and alcohol abuse	Failure to negotiate for safer sex	Lack of information on condoms, HIV and STIs	limited access to comprehensive HIV services (including mobile services)	Negative perceptions about condoms	multiple concurrent sexual partnerships	Lack of time to seek treatment	Poor health care including negative attitudes from health service providers	High transactional sex
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Unsafe working conditions	Inaccessibility of operational areas	Low women empowerment	Limited time to participate in integrated HIV programmes (low health seeking behaviour)	Few organisations working with the informal sector	Long periods away from home	Availability of cash at hand	Peer pressure for high risk sex	No legal framework that protects vendors	Low capital for enterprises	Long hours of work due to unavailability of infrastructure for the informal sector	Poverty
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Inadequate resources available for HIV programming in the informal economy

Annex 3: Targeting of Sectors

Sector	Characteristics	What we can do to reach them
Small scale mining	Inaccessible , i.e. areas and people, Illegal, Organized structures, High mobility, Violent in nature, Drug abuse, High illiteracy, Hazardous and unsafe working environments, High liquidity, Attitude problems (less responsible), No social protection, Prone to HIV and STIs due to potential earnings, Long absence from home, Poor hygiene, Male dominated, Long working hours	Use existing structures and capacitate them, Decentralization HIV and STIs services, like ART and VCT, Decentralization of condom distribution, Identification of focal persons and peer educators and capacitate them, Use of moonlight services / flexible working hours
Cross border traders	- Ever mobile, - Limited lines of credit, - Seek cheap services e.g. using long distant trucks to smuggle goods - Border jumping - Multiple sexual partner relationships - Second homes in their countries of trade - Cheating - Abusive language,	- Make use of their associations - Initiate Income lending and Savings (ISALs) - Strengthen HIV Services at entry points - Differentiated Models of Care.
Public transport workers	- Inaccessible due to plying of different routes to meet targets Drug abuse - High liquidity and high demand due to cash generation of the industry - Negative attitude due to lack of information - Peer pressure - No social protection - Long working hours which result in spousal separation - Abusive language - Mob psychology - Stiff competition due to cash generating potential, Competition from unlicensed operators.	- Use of existing structures and capacitate them - Visit them at ranks where they relax during less off peak hours and give them information, Information dissemination through fliers, through Vehicle Inspection Department and Zimbabwe Traffic Safety Board where they go for training and refresher courses
Sex Workers	- Some operate in groups, some as individuals, and some as brothels - Some are violent and some are thieves, Some are under age - Mobile - Some operate at night	- Unorganised hence approach them through their representatives - Set up mobile clinics closer to where they operate with flexible times - Distribute Information materials and condoms
Small scale farmers and farm workers	- Seasonal income - Work extra hard - Most of them lack irrigation - Hire trucks to transport their goods - Their commodity prices are determined by middle men and are, exposed to abuse,	- Make use of existing structures e.g. WADCO and VIDCO - Make use of their associations. - Use of mass media
Vendors (including clothing and food vendors) and hair and beauty	- Accessible (designated places) - Inaccessible (no designated places) - Work up to odd hours (those in undesignated places) - Subject to victimisation and harassment - Work in hazardous places(no water, sanitation and hygiene facilities) - Over populated - Intense competition - Violent - Some abuse and sell illegal substances	- Approach them through their organisations (those belonging to associations), Set up information centres and mobile clinics with flexible times where they operate and at hot spots

Sector	Characteristics	What we can do to reach them
Construction	- Ever busy - Male dominated - Hazardous working conditions - Long working hours - Poor living working conditions Tiresome work - Mobile and live away from families - Average income earners Engage in extramarital relationships.	- Outreach services, mass media, incorporate HIV programmes in SHEQM (Safety, Health, Environment and Quality Management), collaboration with relevant line Ministries e.g. MOHCC, Ministry of Transport and Infrastructural Development, CSOs etc.
Manufacturing	- Some are mobilised whilst others are not mobilised operating at individual places/levels (can be reached through vending) - Accessible - Have predictable working hours Prone to partisan influence - Work in hazardous conditions - No medical check-ups - High level of cash movement - Not covered by social protection system	- Engage them through their association and in their operational places



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