The Efficacy of Health Education and Condom Distribution in Combating HIV and AIDs at Unilever Harare (2004-2005)

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Abstract
This study explores the efficacy of health education and condom distribution as corporate responses to combating HIV/ AIDS at the workplace using Uniliver Zimbabwe as case study. The study established that the HIV/AIDS epidemic destabilises labour, the psychosocial environment and organisational activities. This study reveals that the Unilever corporate health education and condom distribution programme is not meshed in socio-structural pillars and thus remains largely less effective in combating HIV/AIDS at the workplace. We therefore recommend integration of bio-medical and socio-structural approaches to increase the effectiveness of the responses to HIV/AIDS; involvement and participation; co-management of programmes between management and employees; and context based programmes. This study shows that beneficiaries should be treated as active participants to ensure success of the intervention programmes. Otherwise it remains sheer wastage of resources and energy.
Key words: health education, condom, HIV/AIDS, Uniliver, Harare, corporate response.

1. Orientation and problem statement

HIV was diagnosed first in the United States of America (USA) around 1979. According to the Zimbabwe Human Development Report (ZHDR) (2003), Zimbabwe diagnosed HIV in 1985 and from the time of diagnosis, the epidemic has had and continues to have negative impact on all levels of human existence and development. The World Health Organisation (2003) points out that HIV/AIDS have become the leading cause of death accounting for 22.6% of total deaths in 2002. Kanyenze (2002) argues that AIDS claims lives in sub Saharan Africa twenty times more than armed conflict. This scenario puts HIV/AIDS among the key threats to humanity. The reaction to the epidemic in Zimbabwe was the same as in other countries of the world. The country responded with shock, panic, denial and finally acceptance (Jackson, 2002).

Prahalad and Ramasway (2004) explain that organisations are open sub-parts of the wider society to the extent that whatever happens in society impacts on the organisation and vice versa. An organisation is an open system in that there are continuous exchanges between the organisation and society in terms of socio-cultural, political and economic factors. Increasing infections of the epidemic in society has negative effect on work organisations. Moreover, negative impact of HIV/AIDS on organisations retards their efficiency and effectiveness in providing goods and services to society.

HIV/AIDS is thus an organisational and societal issue. Organisations and societies should respond to HIV/AIDS effectively and sustainably to survive. Corporate responses to HIV/AIDS are an indispensible component for organisational survival and prosperity. According to Cohen (2001) both the developing and developed countries have for a long time recognised the link among organisational survival, organisational development and the health of personnel and people in wider society where the organisations draw their labour from. Corporate organisations in Zimbabwe have implemented responses to the epidemic in various forms, but the basic approach is biomedical in content.

The government of Zimbabwe adopted short and medium term plans based on biomedical responses to curb HIV/AIDS. However, the epidemic raged on despite the responses from the health sector such as blood screening, health education and condom distribution (Ministry of Health and Child Welfare, 2004). Kanyenze (2002) argues that the major reason for the continued increase in HIV/AIDS infection rates and the burden of AIDS can be explained in terms of the absence of a multi sectoral response strategy and failure to address the social, political and economic dimensions of the epidemic. The context of increasing HIV prevalence was also marked by negative advertisements on HIV/AIDS and failure to address stigma and discrimination.

The United Nations Joint Programme on HIV and AIDS (UNAIDS) (2005) notes that the multi dimensional nature of HIV/AIDS including the impact on all levels of society was acknowledged in the multi-sectoral approaches. All sectors were encouraged to adopt and contextualise the provisions of the national HIV/AIDS Policy to their settings. The attempt to understand and deal with the drivers of HIV/AIDS transmission

heightened. Some of the identified major drivers of HIV/AIDS were cultural beliefs and practices, poverty, political and economic instability. In the analysis cultural beliefs and practices were ranked high in the transmission of HIV/AIDS.

The ZHDR (2003) notes that when the HIV virus first struck Zimbabwe in 1985, it found already in place a fertile socio-economic environment in form of widespread socioeconomic vulnerability which presented an ideal context for its rapid spreading. Economic and gender inequalities pose critical challenges to past and current responses to the epidemic. The gender dimensions of poverty, HIV/AIDS, in which women are disproportionately affected by all three, is an issue of major concern. For several reasons, women largely constitute the infected, affected, poorest and natural caregivers under the epidemic. The plight of women therefore requires special attention in the design, monitoring and evaluation of intervention strategies to combat the HIV/AIDS epidemic.

UNAIDS (2005) argues that the devastating impact of the epidemic, which is at its worst in the southern Africa sub-region, is benchmarked against a historical context of widespread socio-economic vulnerability of the population over many decades. Socio-economic vulnerability is defined by United Nations Fund for Women (UNIFEM) (2004) as a process in which people are subjected to economic and social re-engineering in such a manner that they are left with little or no options of pursuing sustainable socio-economic survival strategies. This scenario leads people into engaging in risky behaviour, sexually or otherwise, irrespective of their level of awareness concerning the possible negative consequences of taking such risks. The negative impact of such vulnerability continues to be strongly evident in the Zimbabwean population in particular (ZHDR, 2003).

In 2005, Zimbabwe's HIV/AIDS prevalence rate was the third highest in the world, after Botswana and Swaziland, with over 2 million people living with HIV/AIDS. Jackson (2004) reports that life expectancy in Zimbabwe was reduced to 39 years, 124 000 people were dying yearly, 4 000 new infections being realised daily and a third of these were adults of ages between 15 and 49 years, which is the productive age. These are statistics for a macro level but they have implications for the work organisations in Zimbabwe, given the intricate relationship between society and organisations.

Therefore Unilever Zimbabwe conducts business in one of the regions worst affected by the global onslaught of the HIV/AIDS pandemic, particularly on the formal labour market. In response, Unilever is taking a keen interest in combating HIV/AIDS in an attempt to promote and protect the overall health of their employees. Unilever claims to be committed to specific actions and programmes in response to the HIV/AIDS pandemic including health education and condom distribution.

According to the Unilever HIV/AIDS Checklist Assessment (2005), Unilever relies on a wide range of HIV/AIDS health education approaches based on the Information, Education and Communication (IEC) model, which includes posters; monthly magazines; HIV/AIDS information releases from Unilever South Africa, Zambia and other branches; weekly news releases and bulletins; e-mail messages; department/internal and external peer counselors; voluntary counseling and testing (VCT); access to antiretroviral drugs; and monthly seminars with other organisations such as Cottco, Standard Chartered Bank of Zimbabwe, Kingdom Bank and Zimbabwe HIV/AIDS Support Organisations (ZAPSO). Unilever distributes an average of 400 condoms monthly.

Matshalaga (1999) notes that the inherent problem in the health education and condom distribution efforts against HIV/AIDS at national and international levels is the lack of acknowledgement of the sociology and anthropology of sexuality, and the circumstances under which health education and condom distribution works or fails to work. The whole array of responses to HIV/AIDS were mainly hinged on the biomedical approach and a sustained barrage of health education and condom distribution, without a conscious engagement of sociological and anthropological issues such as gender, age, inequalities, class and socio-cultural aspects which militate against effectiveness (Kanyenze, 2002 in ZHDR 2003). It is not surprising therefore that despite the incremental approach to condom distribution and widespread electronic and print health education, infection rates continue to rise among employees and the rest of society.

Cohen (2000) explains that we need to understand that perceiving HIV/AIDS solely as a medical problem (with its solutions lying only in biomedical strategies), leads to a simplistic understanding of the epidemic. This sociological and anthropological line of thinking forms the foundation of the evaluation of the health education and condom distribution programmes at Unilever. Adetunji and Meekers (2001) argue that corporate organisations in Zimbabwe have intensified corporate responses to HIV/AIDS in the form of health education and condom distribution. These corporate responses are mainly based on the IEC strategy, emphasizing on condom distribution, condom use and health education. The centrality of these corporate responses led to the formation of the Zimbabwe Business Council on AIDS (ZBCA) (2005), to encourage the corporate world to seriously educate its employees and to encourage them to use condoms. Patton (1999) explains that the corporate can use prevention, mitigation, care and support for their employees in light of the HIV/AIDS epidemic. These

responses include health education and condom distribution. The unresolved problem is why these responses are failing to deliver the desired results. Patton (1999) argues that the answer probably lies in the sociology and anthropology of sexuality and dynamics in organisation and society (for example issues of power distribution, age and gender biases).

1.1 Statement of the problem

In 2004 SAfAIDS observed that the manufacturing sector in Zimbabwe spends 13% of its revenue on funeral costs, 9% on training and replacement, 12% on sickness benefits and early retirement and an unspecified damage to the psychosocial environment despite incremental health education and condom distribution. We thus make a preliminary conclusion that HIV/AIDS is causing severe stagnation and erosion of the psycho-social workplace fabric, production, marketing and profitability capabilities and successes of business organisations. The current workplace biomedical responses to HIV/AIDS are to a greater extent ineffective, more so at a time when organisations and society need effective and sustainable responses to the epidemic to survive and fulfill their visions and missions.

1.2 Research questions

The study is guided by the following questions:

- What are the views, level of acceptance and use of health education and condom distribution at Unilever Zimbabwe?
- How do the views on health education and condom distribution affect the usefulness of the HIV/AIDS programmes at Unilever Zimbabwe?
- To what extent are the Unilever Zimbabwe health education and condom distribution programmes useful?

2. Methodology

In this study we applied a case study design based on the mixed methods approach to data gathering and analysis. The core population was all the 626 workers (27 managers, 450 full-time employees, and 149 contract workers) at Unilever Harare. We used already existing strata such as position in the organisation, age and sex to randomly select sample participants. This sampling technique was vital because it allowed us to get views on health education and condom distribution programmes from participants in same strata or in different strata based on their position or social context. Key informants like the human resources director, peer educators, company doctors and company nurses were selected purposively because of the information they possess on the research topic. We applied both primary and secondary data collection methods. Primary methods included interviews and questionnaires. Documents review was the secondary data collection method used. Formal interviews were used on the basis of an interview guide. Rapport was established first to create a friendly environment for discussions. Formal interviews were held with key informants such as the company directors, nurses and doctors. A close ending questionnaire was used on general and contract workers.

3. Analysis of results

3.1 Level of understanding of corporate responses

All participants were aware of Unilever's health education and condom distribution programmes in response to HIV/AIDS. They were also aware of the other workplace programmes such as Treatment and Care, External Interactions and Contributions (IEC) and Impact Assessment. Participants applauded Unilever for introducing these programmes to the organisation. Increased awareness and understanding were also attributed to NGOs, national and international media.

All the participants showed awareness and understanding on what is meant by corporate response(s) to HIV/AIDS. It is however important to note that although all the participants understood corporate response in terms of what Unilever offers, their knowledge of corporate responses is limited to biomedical responses. Only 5 participants directly focused on the socio-structural responses to the epidemic. Most responses show that both management and subordinates are mostly biomedically oriented. Thus failure to articulate the link between the organisation and wider society in the context of HIV/AIDS is a point of concern. These gaps in understanding corporate responses and HIV/AIDS partly explain the failure to address the major causes and drivers of HIV/AIDS at Unilever.

3.2 Provision of health education and condom distribution

Unilever's health education and condom distribution programmes are homogenous across all categories of

workers. Only those who are infected and sick declare their HIV status. These are catered for through special sub-programmes within health education. The respondents who are aware of the importance of socio-structural issues actually explained that failure to recognise the role of the socio-structural issues is militating against the success of health education and condom distribution and/or use.

3.3 Indicators of health education and condom distribution utilisation

The main indicators utilised by management and the HIV/AIDS Committee to measure the extent to which health education and condoms are being utilised by intended beneficiaries are the number of condoms and health education materials (magazines, booklets etcetera) taken, attendance and participation in health education seminars, meetings or discussions and the feedback received from intended beneficiaries. However, concern was expressed over condom uptake because condoms are continuously found scattered on some parts of the premises. We note that attendance and participation in health education may not translate into acceptance and use of the programmes. Attendance may be done for courtesy reasons or probably out of imitation or force.

Feedback received by managers concerning the usefulness of health education and condom distribution and use is positive and encouraging. This feedback is mainly received from peer counselors during monthly meetings and reports made to the human resources manager. However, basing on the responses given there are no established mechanisms to verify through well coordinated mechanisms to ascertain the accuracy of the feedback and to improve the validity and effectiveness of that feedback for the benefit of the organisation.

All the respondents reiterated that both health education and condom distribution should continue because these programmes are sustaining the organisation in terms of effectiveness and efficiency by cushioning Unilever from the negative impacts of HIV/AIDS. Desired changes were suggested by a mere 5% of the participants who understood the socio-structural issues such as sexuality, age, religion, gender, socio-economic issues etcetera should be effected in health education and condom distribution programmes to achieve maximum usefulness to the organisation and people in them.

3.4 Capacity building for peer educators

There are 50 peer educators in various departments of the organisation (40 male and 10 female peer counsellors). Out of the 50 peer counsellors only 35 are actively participating in the activities of the organisation. This leaves the ratio between male and female peer counsellors at 30: 5. A striking issue is that there are no peer counsellors from management. According to the Unilever HIV/AIDS Checklist Assessment of April 2004, the plan was that by December 2004, more peer educators were to be trained, including managers. However, up to the end of the study there were no peer counsellors form management. Only 4 of the peer counsellors are supervisors and the rest are shop floor workers.

In terms of training received by the peer counsellors, only 3 (all male) have detailed professional training regarding peer counselling while the rest have in house training received form the other peer counsellors. Most peer counsellors are not well educated since most of the peer counsellors are shop floor workers. Most of what they know about HIV and AIDS and responses to the epidemic is mainly bio-medical and they were totally unaware of the emerging sociological and anthropological approaches to combating HIV/AIDS. This presents challenges in their delivery of health education and condom distribution because they lack the necessary HIV/AIDS competence to effectively deliver.

It is the view of the peer counselors that although their role(s) are central to HIV and AIDS workplace programmes at Unilever Zimbabwe, their contribution(s) are less effective without the support of line managers. The general response given is that line managers often view the peer education role as minor and their absence from “real” work due to counseling duties, distribution of condoms and health education materials as unnecessary. Peer counselors expressed concern over a number of issues concerning health education and condom distribution, including the following:

(a) flexibility and greater involvement i.e. peer educators want to be accepted by line and top managers and be more representatives in the HIV/AIDS Taskforce, HIV/AIDS Committee;
(b) peer counsellors want to influence formulation and planning of health education and condom distribution materials;
(c) gender equality-female peer counsellors require the organisation to train more female peer counsellors;
(d) removal of patriarchal values-female peer counsellors revealed that they are viewed negatively mostly by male workers and are often labeled as prostitutes and this was a barrier to their role(s) in health education and condom distribution;

(e) peer counsellors want periodical refresher courses and training from professional organisations to be updated on latest developments in health education, condom distribution, peer counselling and HIV/AIDS;
(f) removal of power barriers and increased management peer counsellors interaction; and
(g) managers to become peer counsellors

All peer counselors appear to have the basic knowledge in health education and condom distribution. They pointed out that health education and condom distribution should continue. They view their role(s) in health education and condom distribution as central to sustaining the organisation by reducing the negative impact of HIV/AIDS on labour, production, marketing and profit.

3.5 Criteria for measuring effectiveness

In terms of the criteria to be used to measure the efficacy of health education and condom distribution, participants cited the importance of evaluations by the HIV/AIDS Committee. They were unaware of the specific details of the criteria except the notion that efficacy (usefulness) of health education and condom distribution should be understood in terms of the ability of the programmes to reduce and/or eliminate the negative impact of HIV and AIDS on labour, the psychosocial environment and organisational activities such as production, marketing and profit. The participants could not give alternative criteria besides that used by the HIV/AIDS Committee.

3.6 Usefulness of health education and condom distribution programmes

Responses from both management and subordinates and literature reviewed for this study reveals that corporate response(s) to HIV/AIDS are necessary if organisations are to survive the threats posed by the epidemic. Unilever Zimbabwe is not an exception in corporate responses to the epidemic. The organisation has put in place programmes in line with regulations by national and international governments and the International Labour Organisation (ILO). HIV/AIDS requires a multi-sectoral approach which should encompass the NGOs, the private and public sectors. Unilever Zimbabwe has taken a positive role for the benefit of the organisation and its workforce and for this reason alone, the organisation should be applauded because at least the organisation is doing something against HIV/AIDS.

The study reveals that health education and condom distribution programmes have been applauded by 80% of employee respondents and all management respondents. Generalising this to Unilever Zimbabwe and basing on information generated form the study alone, it can be argued that health education and condom distribution programmes are improving human lives through expanding the range of things a person can do and be even in the context of HIV/AIDS.

Unilever Zimbabwe provides health education and condoms free of charge. Lectures, booklets, internet news, government and NGO publications, branded and unbranded condoms are provided for free to everyone. This provision is necessary in the response to the epidemic because it is an option to those whose socio-cultural context allows the use of responses. Health education was cited as useful and positive views were given by the majority of the respondents. Although no one among the respondents admitted to be a beneficiary of special diet and constant diagnosis by company doctors, all the respondents pointed out that this programme is necessary. This is a conscious effort for which Unilever Zimbabwe has to be commended. The provision of special diets free of charge medication and treatment of opportunistic infections are necessary policy options being followed by the organisation. Despite the fact that private sector responses are patchy, simplistic and concerned more with information provision and blind condom distribution, the provision of special diets and medication to those who declare their HIV status are good corporate practices that receive maximum support in the organisation.

Peer education programmes have been adopted so that people can educate each other on the risks of HIV and strategies to combat the epidemic. The assumption at Unilever Zimbabwe is that health education and condom distribution will bring maximum desired effects if these programmes are headed by peer counselors. The organisation also attempts to improve the effectiveness of health education by extending peer education to spouses, children and relatives of HIV infected and workers living with AIDS where such services are required..

The current distribution points (toilets, bathrooms, corridors and locker rooms) are appropriate for them. The study also revealed that for the infected and the sick, Unilever Zimbabwe educates these categories of workers and their spouses (in the case of those who are married) on the availability of ARV drugs. Special diets are provided to people living with AIDS at work and their families. The organisation also links these individuals to internal and external peer educators and associations of people living with AIDS (PLWA) like the Chitungwiza Association of People Living with AIDS for moral support. However, this is done on request by the infected and sick.

The organisation also provides Voluntary Counselling and Testing (VCT) by third parties for all employees. For example in July 2005, eighty percent of the total workforce collected voucher through ZIMPACT, a research organisation that was conducting a study on HIV and AIDS and 60% brought their results and no one was HIV positive. Post exposure prophylaxis policy is also well integrated in which the company doctor keeps a supply of packs for any accidents that may expose employees to blood. This falls under health education. Treatment of opportunistic infections is covered by the Health Centre on a routine basis and the medical team pays special attention to opportunistic infections of employees living with AIDS.

3.7 Weaknesses of the Unilever health and condom distribution programmes

3.7.1 Health education

The responses collected during the study reveal that health education programmes at Unilever Zimbabwe are solely based on abstinence, being faithful, condom distribution/use and discussion(s). The whole Unilever Zimbabwe HIV/AIDS policy is based on this strategy where the major concern is on dissemination as an end in itself rather than as a means to an end. Magazines, posters, internet news, lectures and condoms are provided by the organisation and external actors such as ZAPSO. Unilever Zimbabwe is content that it is doing everything to prevent HIV/AIDS through this simplistic approach. To what extent is its approach adequate in producing the desired effect? Research findings from employees reveal that the media approach adopted by the organisation is often top down (prescriptive in nature) without room for debating what health education and condom distribution mean to them.

The youth and employees not yet married are encouraged to abstain or to turn to condoms if they cannot abstain. Yet research findings reveal that the concept of abstinence remains ambiguous. The term lacks clarity. For instance does the term mean a sexless life for essential sexual beings? Abstaining sex with others but practicing masturbation? What about anal sex? Sex is defined only as virginal penetration. This is clear in the responses given by the respondents. Given the diversity among the workforce the probability that sex is defined and practiced in different ways by the actors is high. Therefore health education which does not incorporate these differences excludes some section of the intended beneficiaries. HIV and AIDS can be spread even through anal sex as long as there is blood or fluid exchange. Human beings are essentially sexual animals and therefore abstinence is difficult to attain.

The organisation does not have established mechanisms to receive and verify feedback. This poses a problem when one analyses human behaviour in relation to the programmes. Foucault (1989) explains that human beings are manipulators, innovators and rebels in the face of institutions and outside interventions. Unilever preaches abstinence just like most religious and socio-cultural groups. However, the ability of this form of education to produce the desired effect is questionable. Younger respondents said they practice sex, at times with or without condoms. Responses from management showed that health education programmes are accepted by the majority and attendance is excellent. However, this indicator may not show real sexual behaviour and perceptions towards the programmes. Lived realities are different. The organisation has no mechanisms to integrate these factors in the overall HIV/AIDS policy.

Health education on faithfulness is spread to the target population including the married and those with their spouses in the rural areas. However, responses collected through questionnaires reveal that faithfulness, just like abstinence may just be ideal. Many people may be just be faithful to the people they are n love with at that particular time. This means that employees may have sex with several partners at different time periods and claim that they are faithful. Faithfulness may have the same weaknesses as those of abstinence. The usefulness of this form of health education is debatable given that awareness and acceptance may not translate into understanding and use of the programmes. Responses show that awareness and acceptance are high. However, condoms and health education materials are found scattered in and outside company premises showing that they are not effectively utilised.

All the primary data gathering methods revealed that the majority of the employee respondents do not fully understand health education because of language barriers. For instance they are complains that lectures, meetings, internet news and magazines are mainly presented in English. This is a cause for concern in terms of the efficacy of these programmes. Understanding, not only awareness is crucial if the programmes are to produce maximum positive effects on both labour and organisational activities. Top down/prescriptive approaches were commonly cited barriers to the efficacy of health education and condom distribution. Respondents said they were not actively involved in the programme. Peer educators were accused of elite bias and imposing their agenda on the rest of the employees. There is no direct link between managers and subordinates when it comes to health education and condom distribution.

The elite bias is also present at higher levels of the machinery dealing with HIV/AIDS at the workplace: the HIV/AIDS Committee. This committee is solely composed of managers and advisers from external organisations

such as ZAPSO. It is interesting to note that there are no employee representatives in the committee. Gender inequalities are implicitly present in health education and condom distribution programmes. The ratio of male and female peer counselors is 30:5 and all the female respondents explained that few female condoms are distributed. The reasons given by management for few female peer counselors and few female condoms were that female workers were not socially ready for the job. There are no peer counselors from management and this clearly reveals that managers lack commitment to the programmes and view them as secondary issues which should be tackled by employees. Given the emphasis given to peer counseling in policing documents on health education and condom distribution and that the HIV/AIDS Committee is composed solely of managers, peer counselors should also come from management.

Despite the fact that Unilever Zimbabwe has an unspecified number of youth employees and 349 contract workers, there are no special programmes for them either within health education and condom distribution or in other HIV/AIDS workplace programmes. As observed by Matshalaga (1999) IEC programmes that lump all employees under one bracket are bound to fail because these categories of workers are affected by different socio-cultural aspects.

High risk groups were identified as sales representatives and employees living with their families in the rural areas. The response by Unilever Zimbabwe is in the form of discussions with peer counsellors and health staff. However, this appears to be a simplistic approach given the complexity of human behaviour and HIV/AIDS. The discussions with sales representatives are not systematic and they are generally poorly co-coordinated since they are done only when sales representatives come to the headquarters for sales meetings.

3.7.2 Condom distribution

Unilever Zimbabwe provides both branded and unbranded condoms free of charge to all organisational members. The problem is that there is no follow up to establish whether these condoms are used and also to investigate and understand the socio-cultural contest within which the potential and real beneficiaries operate in. This poses a barrier to the capacity of the programmes to produce maximum effectiveness, especially given the fact that condom distribution is applied uniformly in the whole organisation.

The study revealed that about 90% of the total condoms distributed are male condoms while 10% are female condoms. The reason given is that there are fewer female employees than male employees. Most female participants felt that this was discriminatory, made them more vulnerable and exposed them to sexually transmitted diseases.

Two male respondents of the Johane Marange religious sect felt that condoms are never an option against HIV/AIDS because they perpetrate sins in the eyes of God. For this group of respondents, Unilever is actually generating and strengthening immorality and the spread of HIV/AIDS. Another small group of the respondents thought condoms cause AIDS. Therefore they never use condoms. The argument from this section of respondents is that condoms are imported cheaply or donated free of charge by developed nations with the aim of spreading HIV. Condoms were also criticised for reducing virility and sexual satisfaction.

The study also reveals that socio-cultural factors are a critical barrier to the efficacy of the condom distribution programme. Most female respondents (both managers and those in subordinate positions) felt that moving around with condoms robs them of their hard-earned respect and dignity. Culturally moving around with condoms is a sign of promiscuity and for women this means prostitution. One youth employee said that his parents are totally against condoms and health education material. ‘So as long as I am living with them then condoms and health education will not effectively work for me.’ Female participants said they may be accused of prostitution by their husbands if they are found in possession of female condoms. It is clear therefore that the assumption that Information, Education and Condom distribution (IEC) programmes are useful and effective to every individual in the organisation is wrong. Thus our final conclusion is that Unilever Zimbabwe is lagging behind in incorporating complexities on board when planning and implementing health education and condom distribution.

As observed by Bolton (1995) for couples who want to have children, condoms are not an option. Also most female sexual partners are not in a position to negotiate condom use. For most of the respondents, marriage is a fertile ground for the spread of HIV/AIDS. These are critical socio-cultural issues which are impacting negatively on health education and condom distribution programmes not only at Unilever Zimbabwe, but also other organisations in the private and public sectors.

3.7.3 Gender mainstreaming

Gender mainstreaming is mentioned in all Unilever Zimbabwe HIV/AIDS policy documents. Yet in practice nothing exists. The organisation is not actively engaging women in HIV/AIDS programmes, and there are no conscious attempts to stimulate women to take positions of influence. For instance there are few female peer

counselors and nothing is done to increase this number and the number of female condoms distributed in the company. We also noted that the only influential female peer counselor is the company nurse. The rest of the female peer counselors look up to the nurse, probably because of her position in the organisation and her relationship to management. If the peer counseling role is to be of benefit to women then conscious efforts have to be made to actively orient women to the programmes by the organisation.

3.7.4 Responsibility, involvement and participation

Responsibility, involvement and participation of all parties who have a stake in the HIV/AIDS programmes are essential if the desired effect is to be maximised for all the parties. However, responses reveal that responsibility and participation are restricted to the privileged the managers. The responsibility over health education and condom distribution programmes rest solely on management. The approach is mainly top down.

The generality of the employees are not involved or involvement and consultation are done for window dressing purposes only. Peer counselors, who are the sole link between management and subordinates, are accused of prescribing their views. Policies, plans and communication in health education and condom distribution are mainly top down. An interesting observation is that even the peer counselors who carry out the routine tasks in the health education and condom distribution do not have authority and power to influence the content of the programmes and the feedback that they provide to management is not people centered.

4. Recommendations

We therefore provide the following recommendations so that Unilever Zimbabwe addresses the effectiveness of its HIV/AIDS programmes:

- **Socio-structural issues:** The greatest weakness in health education and condom distribution programmes at Unilever is the total lack of a socio-structural approach. We therefore recommend that Unilever take into consideration socio-structural aspects such as power, class, age, gender, religion and related values as integral aspects of its HIV/AIDS programme.
- **Participation and involvement of intended beneficiaries:** It has been established that there is very little input by lower level employees who form the majority of the intended beneficiaries of health education and condom distribution programmes at Unilever Harare. This has been found to be detrimental to the success of the programmes. We therefore recommend full involvement of beneficiaries as a matter of urgency.
- **Capacity building for peer educators and counsellors:** Peer educators and counsellors are at the forefront of health education and condom distribution. They do all the routine work related to health education and condom distribution. It is necessary to train them to improve their efficiency and effectiveness in the organisation.
- **Gender equality:** Unilever Zimbabwe is composed of both female and male workers and this should be reflected in the responses and programmes against HIV and AIDS. Gender inequality is one of the commonly cited barriers to the efficacy of health education and condom distribution in both focus group discussion and questionnaires. Female employees should be encouraged to become peer counsellors and they should take an active role in these programmes and other organizational activities which affect their lives. More female condoms should be distributed. Patriarchal values and practices that militate against effectiveness of corporate responses should be eliminated.
- **Feedback:** Communication on health education and condom distribution should be based on a two-way system. Feedback is crucial to the success and future of any programme. The mechanisms of getting and verifying feedback from intended beneficiaries at Unilever Zimbabwe should be implemented. In addition to peer counselors, the HIV/AIDS Committee should foster direct feedback from the beneficiaries.
- **Disaggregating of the workforce:** Health education and condom distribution programmes should acknowledge and utilise diversity in interests, perceptions, needs and skills of their beneficiaries. There should be specific programmes for the different types of the workforce.
- **Prioritising health education and condom distribution as investments:** Line managers appear to be unconcerned with health education and condom distribution programmes because they view these programmes as a consumptive cost to the organisation. The role of these programmes in sustaining the organisation are viewed as indirect and far fetched. The human resource manager should not be the only participant in these programmes from the management strata. It is essential for the staff and line functions to be combined in health education and condom distribution. The two are sub-systems of a single organisation therefore they should work towards a common goal despite differences in conception.

6. Conclusion

HIV/AIDS is an individual, family, household, organisational, national, regional and international issue. At organisational level, HIV/AIDS decimates psycho-social aspects, production, marketing, profitability, research and development of the organisation. Corporate responses to HIV/AIDS are in various forms: health education, condom distribution, counseling, food, special diet and ARV provision. Appropriately focused corporate responses are vital in stabilising corporates that are under the threat of HIV/AIDS. Biomedical responses at organisational or national levels are inadequate on their own in addressing the wide array of causes and impact of the epidemic. Socio-structural responses should also be utilised to complement biomedical responses. Moreover, HIV/AIDS need comprehensive approaches based on multi-stakeholder responses. Stakeholder collaboration and networking are essential.

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