HIV/AIDS WORKPLACE POLICY IMPLEMENTATION IN SELECTED PRIVATE SECTOR WORKPLACES IN LUSAKA PROVINCE: IMPLEMENTER'S PERSPECTIVE.

BY

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MASTER OF PUBLIC HEALTH –HEALTH POLICY AND MANAGEMENT

A DISSERTATION SUBMITTED TO DEPARTMENT OF PUBLICH HEALTH UNIVERSITY OF ZAMBIA SCHOOL OF MEDICINE IN PARTIAL FULFILMENT OF THE MASTER OF HEALTH –HEALTH POLICY AND MANAGEMENT.

JUNE 2016

CANDIDATES' DECLARATION

I, **Bridget Ennet Chatora** do hereby declare that this is my own work and that all sources of materials and publications used herein have been acknowledged .The submission is made in accordance with guidelines from the University of Zambia School of Medicine Department of Public Health. I do confirm that the dissertation has not been submitted to any other University for any academic awards.

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CERTIFICATE OF APPROVAL

The University of Zambia approves this dissertation of Bridget Rennet Chatora in partial fulfilment of the requirements for the award of Master of Public health- Health Policy and Management degree by the University of Zambia.

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ABSTRACT:

Introduction: Adult HIV prevalence in Zambia has declined from 16 % (2001-2002) to 13% (2013-2014) but still remains high. The UNAIDS call on eradicating HIV/AIDS by 2030 challenges strengthening multi–sectral response to HIV/AIDS. To understand factors affecting implementation of HIV/AIDS workplace policies, especially in the private sector, it is important to know the extent to which policies exist and experiences on implementation.

Methods: A mixed method analysis of availability and implementation of policy using the health policy initiative implementer's tool was conducted. Data from 128 member companies of the Zambia Federation of Employers was randomly collected through purposively sampled policy implementers. Categorized variables on implementation were analysed using Stata version 12.0: Fishers' exact test and logistics regression were applied to implementation factors. Concurrently, 28 in-depth interviews on purposively sampled implementers were done. Thematic analysis was used and qualitative results integrated with quantitative findings.

Results: Policies were available in 47/128 (36.72%) workplaces. The private sector accounted for 34/47 (72.34%) of all workplaces with policy. Programs were available in 56/128 (43.75%) workplaces. Both policy and programs were found in 46/47 (97.87 %) workplaces. Availability of policy was 2.7 times more likely with the increase in the size of a workplace, P Value=0.0001, ($P<0.05$). Top management support and having a specific budget for HIV programs were strongly associated with implementation. Management support was 0.253 times more likely in workplaces with policy, P value=0.013, ($P<0.05$).A specific budget for programs was 0.23 times more likely with policy ($P<0.05$). Implementation was hindered by reduced funding, lack of time, lack of sensitisation, ill-defined indicators and lack of Monitoring/Evaluation systems.

Experiences with implementation, found HIV/AIDS/Stigma and awareness were the most addressed HIV epidemic drivers in workplace programs. Commercial sex workers, GBV, Mother to Child Transmission and Males having sex with males were the least addressed. Onsite VCT and provision of MC, ART were provided through health insurance, government clinics, and subcontracted providers.

Conclusion: HIV/AIDS Workplace policies exist in the private sector at a very low proportion but policy translation into programs among workplaces with policies was very high suggesting that workplaces with policies are more likely to translate their policy into a program.

Recommendation: Structures for addressing health and safety of employees exist and should be strengthened through sensitisation to include response to HIV/AIDS towards eradicating HIV/AIDS by 2030. The extent to which workplace programs address HIV/AIDS epidemic drivers in Zambia should focus on marginalised populations, gender integration and a wellness approach.

Key Words: **HIV/AIDS, workplace, policy, programs, implementation.**

Dedication

I dedicate this research work to my late mother Mrs. Christine Mwanza Chatora and My late father Mr. Godfrey K .Chatora.

I also dedicate this work to all hard working men and women in Zambia, too numerous to mention, who keep working diligently towards the fight against HIV/AIDS.

Lastly to my children, Lisa, Laura, and Kudzai - I dream of an HIV/AIDS-free world for you!

Acknowledgements

I acknowledge the critic, mentoring guidance, and supervision of Dr. Wilbroad Mutale and my co-supervisor, Mrs. Linda Olowski.

The National HIV/AIDS STI/ TB Council staff including the chairman professor Baboo, Dr. Jabbin L. Mulwanda the Director General , Mrs. Ellen Mubanga Chanda the Public and private sector coordinator National HIV/AIDS/STI/TB Council for the guidance and support .

Zambia Federation of Employers for the resources and support to conduct the research. The Executive director Mr. Harrington Chibanda, Mr. Hilary Chilala, and Miss Akenda Simamuna. Special thanks to Mrs. Mazala Senior Programmes Manager Afya Mzuri Lusaka Zambia. I also recognise Dr. Fredrick Chitangala, Society for family health.

My gratitude to also goes to Dr liver Mweemba , Mr. Moses Simuyemba, Mr. Felix Mwenge Mr. Mumbi Chola and Dr. Hikabasa Halwiindi, thank you for your guidance during proposal development .

I am also grateful to Dr. Fabian Kabulubulu, for the initial study conceptualization and proposal development.

Finally special acknowledgments and gratitude to all member companies of Zambia Federation of Employers in Lusaka province who agreed to take part in the study.

Thank you so much.

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List of Acronym

AIDS	Acquired Immune Deficiency Syndrome
AHF	Aids health foundation
CHAMP	Community HIV/AIDS Mobilization Project
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
NAC	National AIDS Council
NASF	National AIDS Strategic Framework
SADC	Southern African Development Community
SHARE II	Support to the HIV/AIDS Response in Zambia
SWAP	Swedish Workplace HIV and AIDS Programme
W.H.O	World Health Organisation
ZBCA	Zambia Business Coalition Association
ZFE	Zambia Federation of Employers
ZARAN	Zambia AIDSlaw Research and Advocacy Network

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Key terms and definitions

HIV/AIDS Policy

An HIV/AIDS workplace policy is a written document that outlines an organisation's recognition and acknowledgment of HIV/AIDS as a workplace problem. It outlines management commitment, roles, responsibilities and position in addressing HIV/AIDS among employees. It further guides programs that the organisation is committed to undertaking in addressing HIV/AIDS (Smart and McKenna 2006). This definition and meaning will be applied for this study.

HIV/AIDS programs

These are action-oriented plans to prevent new HIV infections, provide care and support to all employees and to manage the impact of HIV/AIDS on the organisation (Bhuyan et al., 2010). The study uses this definition.

Workplace

The term workplace is defined as a location at which an employee provides work for an employer usually located in a variety of settings including offices, out–of-door facilities and in any location where work is performed, (Heath Field, 2004).This is the definition that will be used for this study.

Visibility of HIV/AIDS

Visibility of HIV/AIDS in the workplace or country was defined as having an increased number of employees or people living with HIV/AIDS or dying from HIV/AIDS (Smart and McKenna 2006)

Implementation

Implementation is defined as the carrying out, execution, or practice of a plan, a method, or any design for doing something (Laudon K, 2010 cited in Chilekwa, 2014).This study defines implementation as the process of putting a decision on HIV and AIDS workplace plans into effect by systematically executing them in order to achieve desired goals and targets (Chilekwa, 2014).

Key implementers

Borrowing from the above definition of implementation, key implementers will be defined as individuals in the workplace that have been identified and tasked with the responsibility of organising and coordinating HIV and AIDS workplace plans into effect by systematically executing them in order to achieve desired goals and targets. This will be the definition used for the study.

Stakeholders

Stakeholders are people or groups of people, who are affected by the outcome**,** negatively or positively, or those who can affect the outcomes of a proposed intervention (Freeman, 2010). In the context of a workplace, these include employees, employers, management, financiers, and shareholders (Chileshe, 2010) .

CHAPTER 1:

1.0. Introduction:

1.1. Background

Zambia is one of the sub-Saharan African countries that have been severely hit by the HIV/AIDS epidemic, the first case of which was reported in 1984 (CSO, Z.H.D.S, 2007). By 2002-2005 the prevalence rate among the economically productive age group 15-49 years stood at 16 % (CSO ZHDS, 2007) representing close to 1.2 million people of the national population of 11.3 million. Currently, Zambia's HIV prevalence rate among adults aged 15-49 stands at 13 % (CSO, 2014). Even though problems of accessing antiretroviral treatment still exist, there are now more people on treatment in Zambia. By 2011, 77.6% of people living with HIV were reported to be on treatment in Zambia (NAC, 2014).

1.1.1. Global Response

The global outlook report on HIV/AIDS reported that 33.5 million people were living with HIV/AIDS in 2013, the majority (33.1 million) of whom are adults, (WHO, 2014). There were 2.1 million new infections in 2013 alone, the majority of these (1.9 million) occurring among adults. HIV/AIDS alone is said to have been responsible for 1.5 million deaths, 1.3 million of these occurred among adults in 2013 alone. After decades of no known proven cure for HIV/AIDS, treatment and prevention interventions help to prolong a healthy and productive life (Clarke, 1994). As such there were 11.7 million people globally on antiretroviral treatment in 2013, almost 36% (34%-38%) of all people living with HIV (WHO, 2014).

Workplaces globally have been addressing HIV through adopting international and regional guidelines and resolutions (UNAIDS, 2004) for examples the Labour Organisation's Code of practice on HIV/AIDS in the world of work (ILO, 2001) as well as promoting best practices through codes such as the SADC code of good practice on HIV/AIDS and Employment (SADC , 1997).

1.1.2. Zambia Response

Different sectors in Zambia are guided by the National AIDS Strategic Framework (NASF 2011-2015) on how to address HIV/AIDS. While Workplaces in Zambia are not mandated by law to develop HIV/AIDS workplace policies, organisations with policies in place are viewed as being responsible (MOH, 2011).It is, therefore, important to understand current HIV/AIDS management practices and experiences where the adult population spends most of their time.

1.2. Statement of the Problem

According to the National strategic Framework on HIV/AIDS 2011-15, close to 500 organisations in both private and public sector in Zambia have been provided with technical support in developing HIV/AIDS workplace policies, programs and action plans (NASF, 2011-2015). However, it is not clear to what extent HIV /AIDS workplace policies and programs exist especially in the private sector. Scholarly literature on factors that facilitate or hinder implementation of HIV/AIDS workplace policies and programs especially in the private sector in Zambia is also limited.

1.3. Study Justification

The study will help to understand factors that hinder or facilitate HIV/AIDS policy and programs in the private sector and will be able to advise policymakers and stakeholders on how to respond to HIV/AIDS in the private sector workplaces. The study will also help to facilitate the process of accountability among stakeholders on the roles and responsibilities in policy translation in private sector workplaces. The study will also provide an opportunity to understand what has been working well and what has not, in the implementation of HIV/AIDS workplace policies in the private sector from the perspective of key implementers. Finally, the study will also contribute towards the limited scholarly literature on private sector responses to HIV/AIDS.

1.4. Research Question

What proportion of member companies of Zambia Federation of Employers (ZFE) in Lusaka have HIV/AIDS workplace policies and programs, and what mechanisms and resources facilitated or hindered implementation.

1.5. Study Objective

1.5.1. General objective

The objective of the study was to determine the existence and extent to which HIV/AIDS workplace policies have translated into programs in selected private sector workplaces in Lusaka.

1.5.2. Specific objectives

1. To determine the existence and proportion of HIV /AIDS workplace policies that have translated into programs in private sector workplaces in Lusaka.
2. To determine resources, mechanisms, and relationships in the workplace that promotes or hinders implementation of HIV/AIDS policy and programs.
3. To understand the experiences of implementing HIV/AIDS workplace policies from the perspective of key implementers in the workplace.

CHAPTER 2:

2.0. Literature Review

2.1. Summary

The prevalence of HIV/AIDS in Zambia has declined to 13% from 16% in 2001-2002(CSO,2014).Multi-sectral response to HIV/AIDS has seen the development and implementation of HIV/AIDS workplace policies. Past studies in Zambia have largely focused on policy evaluations on public sector response to HIV/AIDS in the workplace for example Chilekwa (2014) focused on participation of employees in workplace programs , Chileshe (2010) focused on implementation in ministry of education and Mwewa (2011) evaluated HIV/ADS mainstreaming in line ministries in Zambia. The health policy initiative tool has been used to evaluate policy implementation for example in Guatemala (Bhuyan et al., 2010) and El Salvador (Merino L, 2009) it was used to evaluate the National HIV/AIDS policy and found a number of gaps in Policy implementation. Based on 7 key dimensions of successful implementation (Bhuyan et al., 2010):Policy, context, leadership stakeholders, resources, operations and M/E (feedback) the tool provides a quantitative and qualitative approach to evaluating policy. In this study, the health policy initiative implementer's tool was adapted to evaluate HIV/AIDS workplace policy in Zambia Federation of Employers member companies, who are largely private sector.

2.2. Public sector

Public sector workplaces in Zambia are guided by the HIV and AIDS Strategy for Public Services 2010-2015 (PSMD, 2010),while the private sector is guided by the Private sector strategy for HIV and AIDS in Zambia 2006-2010 (NAC, 2009). Both these documents draw on the National strategic framework to guide public and private workplaces in the management of HIV/AIDS in the workplace. Through various implementing partners and NGOs HIV/AIDS workplace policies have been developed and implemented both in the private and public sector.

2.3. Private sector

National level recognition of HIV/AIDS as a problem necessitated the development of the National Strategic Framework on HIV/AIDS as a guide on how to respond to HIV/AIDS. The Zambia Workplace AIDS Partnership ZWAP was formed to consolidate and coordinate implementation of the National AIDS Strategic Framework (NASF) in the private sector through the guidance and support of the National AIDS Council (NAC, 2009).A number of business organisations including corporate organisations, banks and the mining sector came together to form the Zambia Business Coalition (ZBC) as an organised way of responding to the impact HIV/AIDS on businesses (ZBC, 2006). Together with Non-governmental organisations such as Oxfam, AFYA Mzuri (Smart and McKenna 2006) and others strengthened collaborations with workplaces in responding to HIV/AIDS in the workplace. The Zambia Federation of Employers' is one such partner that works to assist its members to develop and implement HIV/AIDS workplace policies. This study focused on member companies of the Zambia Federation of Employers who are largely in the private sector.

The policy to action framework shows that policy itself plays a role in its implementation (Bhuyan, 2005) in terms of the context for its formulation and development. Southern Africa workplaces were surveyed (Mahajan et al., 2007) in a study to assess policy and program implementation. It was found that most workplaces did not have input from employees or union leaders during the development of their policy. Describing it as a 'copy and paste' policy, where another company's policy is used to satisfy the requirement of having a document and only 15% of union leaders been involved in discussions during development, a further 58% did not have a copy the policy. Wide consultation on policy content allows for relevant policy content as illustrated by a study to analyse the cost benefit of having an HIV/AIDS policy in Zambia (Ilon et al., 2007). Six of seven companies examined in this study showed net-benefit in having HIV/AIDS workplace programs but also reported negative effects of such programs such as the presence of the program being perceived as threatening to employees' continued employment. The study importantly concluded that clarity of the policy objectives and inclusion in formulation among employees was needed for effective program implementation.

Another study that evaluated HIV/AIDS programs in the ministry of education in Zambia found that low management involvement in programs (Chileshe, 2010) was found to have affected employee morale to get involved in HIV/AIDS programs. Leadership gives policy governance, representation, responsibility and accountability as well as advocacy for implementation (Smart and McKenna 2006). Involvement in the formulation, as well as implementation, should, therefore, include top management and key employee representatives such as trade union leaders.

A case study to assess employee involvement in HIV/AIDS workplace programs in Chipata and Sesheke (Chilekwa, 2014) found that in spite of the widespread awareness of the existence of workplace HIV programs (83.3%) and their usefulness, very few respondents participated in the programs and very few were familiar with program objectives. It was found that 63% of respondents had never even participated in workplace programs and employee mainly got involved during World AIDS Day while remaining uninvolved throughout the year. While these studies were done in the public sector it is important to note that there is limited scholarly literature from private sector consisting mainly of reports from implementing partners.

Contextual factors that may affect implementations of HIV/AIDS workplace policies may include gender, cultural and traditional perceptions that have institutionalised workplaces as a result of the patriarchal societies that the employees come from (NAC, 2009).The impact of HIV on women has been consistently high as observed in the national health demographic surveys results (WHO, 2014).Gender being a social construct of society defines women and men's roles in society (WHO, 2010). It does not only end in the home setting but is in the workplace as well. Women's economic, vulnerability and gender-based violence against women can impact effectively implementation of HIV/AIDS workplace policies.

HIV/AIDS programs are action-oriented plans to prevent new HIV infections, provide care and support to all employees (Mwewa, 2011) and to manage the impact of HIV/AIDS on the organisation. As such programs address needs of employees living with HIV/AIDS through nutritional support, treatment, reasonable accommodation in work duties to allow for time to seek treatment and recuperation during ill health. At the same time, the workplace needs to remain productive while implementing these programs (Bhuyan et al., 2010).An evaluation study on mainstreaming of HIV/AIDS in line ministries (Mwewa, 2011), found that not all policy translates into programs. In the study program availability ranged from 41.6 to 79.7 % among workplaces with policy. Another study that assessed the availability of HIV /AIDS workplace policy in South African companies found only 41.8% (103/229) had HIV/AIDS programs (Lass 2009). HIV/AIDS programs can vary in content from basic HIV prevention strategies to comprehensive interventions of providing treatment and the extended is based on the capability of the workplace (Smart and McKenna 2006). Apart from having to cope with HIV/AIDS-related illness managers and employees alike may not know how to respond to HIV in the workplace, (Dieleman et al., 2007) the policy, therefore, guides on how to respond.

A very important role of the Ministry of health in Zambia is the provision of free antiretroviral treatments to all Zambians needing treatment (NAC, 2011). A number of partners are also available to support response to HIV/AIDS in the private sector (NAC, 2014). A study to assess the impact of HIV/AIDS on businesses in the private sector in Zambia (Baggaley et al., 1995) found that 12 companies provided HIV/AIDS educational materials to employees while 5 had an external organisation they used to refer employees for HIV information and advice. The study showed that workplaces do not necessarily need to have onsite HIV/AIDS programs but through partnerships, networks with health care providers can outsource for the services for their workplace program.

Program sustainability challenges arising as a result of over-dependence on donor resources and should be recognised and planned for (Chileshe, 2010). A survey to assess funding sources for HIV/AIDS programs in the private sector in Zambia found that 58% of workplaces were self-funded (NAC, 2009) and there were Donor preferences to fund implementing partners or stipulated conditions to contribute matching resources to programs. Small organisations have limited capacity to fund programs compared to larger workplaces (Mahajan et al., 2007) and may not know how to access available donor funds. Limitation on resources extends to infrastructure and human resources for technical competency to drive the HIV/AIDS workplace policy.

A cost-benefit analysis of workplace programs in Zambia (Ilon et al., 2007) found that, while the benefits of running programs outweighed the cost of the programs by over three times, there was a lack of monitoring and evaluation tools for the programs . An assessment of the National HIV Policy Implementation in Guatemala and El Salvador (Bhuyan et al., 2010) also found similar results and pointed out that lack of feedback on best practices to implementers hinders collaboration, sharing best practices, and building on lessons learned (Merino L, 2009) making it difficult to understand what is working in policy implementation (Gobind and Ukpere 2014). A systematic collection of a program's inputs outcome and impacts, when managed consistently, provides a basis for accountability and decision-making at program and policy level.

2.4. Summary of Literature

There was limited scholarly literature on private sector response to HIV/AIDS in the implementation of HIV/AIDS policy and programs (Mahajan et al., 2007). The studies in Zambia on HIV/AIDS workplace policy implementation have largely focused on the public sector (Mwewa, 2011) with reports and national documents being the major source of literature. Emerging issues as identified in policy implementation have been lack of leadership roles, lack of involvement of employees (Chileshe, 2010) , low policy translation into programs (Lass 2009)and lack of participation in programs (Chilekwa, 2014) lack of planning and (Mwewa, 2011) over dependency on donor support (Chileshe, 2010) as well as limited sources of funding for programs (NAC, 2014). Monitoring and Evaluation systems for policy and programs (Mwewa, 2011) have also been limited.

2.5. Conceptual Framework

The policy to action framework defines that successful policy implementation is dependent on interacting factors in a complex environment that can facilitate or hinder implementation (Bhuyan et al., 2010). The gaps identified in literature together with the seven dimensions for successful policy implementation formed the basis for evaluation in this study. The policy to action framework was used to assess policy and program availability and factors affecting HIV/AIDS workplace policy implementation as follows (Bhuyan et al., 2010):

Policy implemention : 7 dimentions of succeful policy implementation , Figure 1:

1. **Policy:** An inclusiveness process of formulation, development and dissemination of HIV/AIDS workplace policy allows for, consultation on what needs to be addressed, negotiation on what can be feasibly provided by the employer. This process ultimately brings about a sense of ownership for policy and programs.
2. **Leadership /Advocacy**: Clearly out lined roles and responsibilities for key policy leaders to drive policy implementation. Management and union leadership involvement ensures championing and planning for resources in the overall organisational plans. Participation of employees at different level including people living with HIV/AIDS and women ensure key issues affecting different groups in the workplace are addressed**.**
3. **Stakeholders**: Multi-stakeholder involvement in implementation and ensures that services linkages to key partners for technical support guidance, resources mobilisation, and ensures the workplace is kept abreast with new trends.
4. **The context of the policy**: Social (classes of employees or levels of income) economic, gender and cultural factors contribute to the key drivers of the HIV/AIDS epidemic in Zambia. How well these are addressed in the HIV/AIDS workplace policy will affect implementation. Understanding how the private sector workplace HIV/AIDS policy is responding to these factors will provide insights to policy makers and stakeholders.

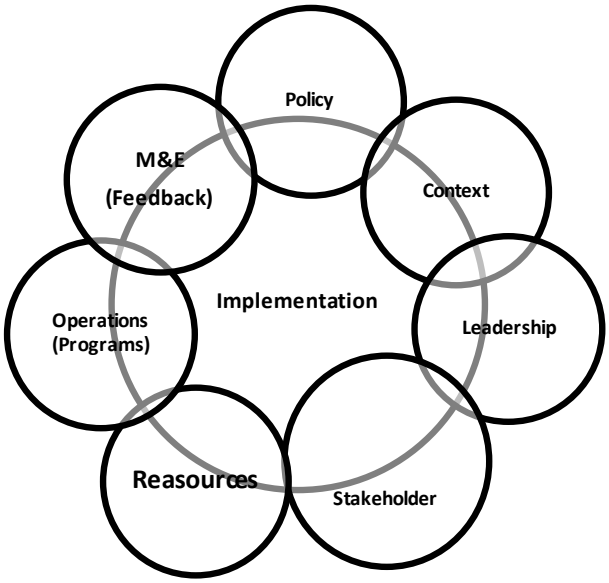

Figure 1: conceptual framework of successful HIV/AIDS workplace policy implementation adapted from health policy initiative policy implementation (Bhuyan et al., 2010)

5. Operations and Services: For the purposes of this study operation on the HIV/AIDS workplace policy will be defined by the programs that are provided for by the HIV/AIDS workplace policy as adopted by the workplace.

6. Resources: Human, time, financial, infrastructure, and resources materials will affect implantation based on quantities and quality. How much time and human resources to dedicate to HIV/AIDS programs can also affect program and policy implementation. Policy decisions are usually reflected in resources allocation for implementation (Bertozzi et al., 2008))

7. Monitoring and evaluating processes: this study will translate this as having monitoring and evaluation guidelines, processes and tools in place that assist in implementation process within the workplace. Feedback on progress and results in policy implementation to all stakeholders is important in facilitating accountability.

2.6. List of variable

Table 1 : The table below presents the list of variables to be used in the study

	HIV/AIDS workplace policy implementation
Dependant : HIV workplace pol	Policy : formulation dissemination Policy context :Social economic , cultural
Independent : HI workplace prog	1. Leadership support 2. Stake holder Involvement 3. HIV/AIDS workplace programs -Elements of pro provided -Awareness VCT, ART, Prevention and care, PM 4. Services provided- within, referred or contrac 5. Key epidemic drivers addressed –Male Circumc Condoms, Commercial Sex workers, Alcohol abuse, Gender violence. 6. Resources: Human, Financial, Equipment, suppli Information. 7. Monitoring &Evaluation-Reports, Indicators , mo overall feedback

2.7. Operational Definitions:

2.7.1. HIV/AIDS workplace Policy

An HIV/AIDS workplace policy can be summed up as a written company policy that recognizes and acknowledges that HIV/AIDS is a workplace issue; the policy outlines how the organisation will address HIV/AIDS as a workplace problem with allocation of both human and financial resources clearly outlined (Smart and McKenna 2006).

The basic guideline principles should be clearly outlined to include but not limited to the following Non-discrimination; Confidentiality ; Voluntary HIV testing services or referrals ; Safe working environment ; Awareness and sensitization on HIV/AIDS information ; Access to HIV/AIDS treatment through agreed schemes or public health service ;Compensation for occupationally acquired HIV where mechanisms exist; Employee benefits due to death and disability from HIV/AIDS ; Reasonable accommodation for employees who have been debilitated by HIV/AIDS to allow them to still continue working or leave employment ; Dismissals related to HIV/AIDS in the workplace due to endangering the lives of others by purposefully infecting other (ILO, 2004) .

1.1.1. **HIV/AIDS Workplace Programs:**

HIV/AIDS program are action-oriented plans to prevent new HIV infections, provide care and support to all employees (Bloom et al., 2006) and to manage the impact of HIV/AIDS on the organisation (Bhuyan , 2010).HIV/AIDS workplace programs need to be strengthening on the platform of adopted workplace policy (ILO, 2004). These programs can be as provided onsite services, Out-sourced or referred for access through other sources. Key contents for HIV/AIDS workplace programs (Smart and McKenna 2006) includes but not limited to: Management Sensitisation; Creation of HIV/AIDS Committees; Information and Awareness; Voluntary Counselling and Testing (VCT) ; Peer Education Training ; Healthcare (nutrition, ARVs etc.) ; Family Outreach Activities ; Community Outreach. HIV/AIDS workplace programs not only have positive returns for the workplace but also for the wider community (ILO, 2004).

CHAPTER 3:

3.0. Research Methodology

3.1. Study design

The study was a mixed method study design using quantitative and qualitative methods concurrently. The quantitative component was a cross-sectional survey conducted in 128 workplaces. The qualitative component of was a case study conducted at the same time as the quantitative aspect.

3.2. Study setting

The study took place in Lusaka and targeted member companies of the Zambia Federation of Employers (ZFE). Lusaka has a population of about 1.7 million people, with an adult HIV/AIDS prevalence rate of 20 %, which is above the national adult HIV prevalence of 13% (CSO-ZDHS, 2013-14).Close to 340,000 adults are living with HIV/AIDS in Lusaka alone (NAC, 2011).Lusaka is an urban and cosmopolitan town characterised by high rural /urban migrations among the working age group seeking employment (NAC, 2012).These key characteristics made Lusaka an ideal setup for the study.

3.3. Study population

The study targeted member companies of the Zambia Federation of Employers the majority of which are private sector organisations in Lusaka. Study participants were men and women aged 18-59 years identified as key HIV/AIDS implementers in workplaces.

3.4. Quantitative sampling procedure

Zambia Federation of Employers (ZFE) provided a sampling frame of a list of workplaces to be included in the study. Simple random sampling, without replacement, was used to select the workplaces to be contacted. Interviews were set up by contacting the workplaces with a letter from ZFE, NAC and permission from the University of Zambia. Appointments for interviews were set with key implementers with permission from the workplace.

3.4.1. **Quantitative Sample size:**

To estimate the proportion of workplaces that have translated policies into programs the following sample size calculation was used: $n = (z/D)\, 2p\,(1-p)$.

At confidence interval of 95%, CI= 0.05 and effect size of 0.05 and proportion for a new study set at P= 0.5, therefore $n = (z/D)^2 p\,(1-p)$

Where: Z=1.96, p=0.5, D=0.05

$= (1.96/0.05)^2 \times 0.5 \times 0.5$

$= 1536.64 \times 0.25$

=384.1 = 385 for a large population, however since there are only 190 member companies of Zambia Federation of Employers within Lusaka as a sampling frame , the finite population correction factor $n_0\, N / n_0 + (N-1)$ is used to calculate the required sample size n.

Where sample size $n = n_0\, N / n_0 + (N-1)$

Where: n_0 = is the calculated sample size without considering the finite population in the above proportion calculation.

N= the finite population = 190, which is the sampling frame from Zambia Federation of Employers .Therefore $n = n_0\, N / n_0 + (N-1)$

$= 385 \times 190 / 385 + (190 - 1)$

$= 73150/574 = 127.4$

= Initial sample size = 128

Though an initial response rate of 80 % among workplaces (Welch, 2012) was anticipated by contacting 154 organisations on the sampling frame, this was adjusted to 166 workplaces contacted at a response rate of 77.12% to obtain a sample size of 128.

3.5. Qualitative sampling procedure

The study purposively interviewed the same employees identified as key implementers of the HIV/AIDS workplace policy for the quantitative component .Qualitative sampling was therefore dependant on whether the interviewee wanted to give in-depth explanation for quantitative responses. Some respondents did not feel the need to explain further on the quantitative responses. As a result a total of 28 in depth interviews were conducted. Saturation point was reached when responses from respondents gave the same information and no new information or ideas were obtained during the interviews.

3.6. Data management

3.6.1. Collection Tools (Quantitative and Qualitative)

To assess implementation, adapted questions from the Policy Implementation implementer's tool Assessment Tool (Bhuyan et al., 2010) was used. The assessment tool was adapted into a questionnaire (Appendix 3) to suite the HIV/AIDS workplace policy and programs by using questions from the Workplace HIV and AIDS Manual (Smart and McKenna 2006).The tool was designed to capture quantitative data using structured questions and qualitative data using semi structured interview guided questions focused on the following key areas:

1. Policy- availability, content, formulation and dissemination.
2. Leadership- involvement and participation for policy and programs by management, unions and well as employees.
3. Partnership and Stakeholder's involvement.
4. The context of policy- Social, Economic, and Cultural factors as well gender, and HIV stigma and how they are addressed.
5. HIV/AIDS programs -elements of programs provided and how, within the workplace, through medical insurance, referred to government clinic or through another organisation or service provider.
6. Resources- human, financial, space for activities, materials and supplies including quantities and quality.

7. Monitoring and evaluating - processes, tools as well as feedback on progress and results in policy implementation in facilitating accountability.

A tape recorder was used to capture data and used to complete and verify transcribed data on the data collection tool. Document verification of availability of policy and was done during the interview.

3.6.2. **Validity and Reliability**

The study used questions from the workplace HIV and AIDS Policy Manual (Smart, 2006) and also from the health policy initiative implementers tool (Bhuyan et al., 2010). The National AIDS council private sector coordinator and Zambia Federation of Employers HIV coordinators were also consulted to validate some of the questions in the questionnaire. This was done for both the quantitative and qualitative components of the data collection tool before being pretested on 5 individuals and corrections made before being used for the study.

3.6.3. **Data collection analysis and management**

Data collection was done as an interviewer administered the questionnaire and lasted about 45 minutes for both the quantitative and qualitative data to be captured on the integrated tool, Appendix 3. Document verification of availability of policies and plans was also done and documented on the data collection tool (Appendix 3).

3.6.4. **Quantitative data analysis.**

Excel databases were used to enter quantitative data and used to checked for accuracy and consistency during cleaning before exporting the data to the statistical software Stata version 12.0 for analysis. Categorized variables on leadership, resources, programs, partnerships, monitoring and evaluation were analysed for association using Chi-Square Test - Fishers exact. Fisher exact test was used because contingency table outputs had cell counts less than 5 on cross tabulations because of scaled breakdown on responses that assessed the extent of addressing a particular variable. Logistic regression analysis was applied to categorical variables on Policy and program implementation factors.

3.6.5. **Qualitative data analysis.**

Data was collected and transcribed into the health policy initiative excel tool for qualitative data (Bhuyan et al., 2010).

Transcribed data from the excel tool was read for ideas on possible categories. Similar topics were clustered together. The researcher read and reread the generated transcripts until specific codes emerged. Codes were written next to the appropriate segment of text within the excel tool (Bhuyan et al., 2010). Related topics were then grouped together according to whether the data was from a workplace with a policy, a program, both or not. Interactions between categories were identified and checked for similarities. The codes allowed for a systematic identification of emerging, major and sub-themes (Pierson et al., 2012). Where there was a gap the cycle of reviewing data was restarted. Themes were then defined named and a written transcript of the collected data was generated. This was then integrated into the quantitative data analysis report.

3.6.6. **Data management and protection.**

Consent forms and data collection tools were kept separate and accessed only by the researcher and key stakeholders for research purposes only. Data was kept strictly confidential by the use of codes for both the company and key informants interviewed.

3.6.7. **Ethical issues**

The study involved accessing data from workplaces and which may be sensitive therefore in order to maintain the organization's possible concerns on integrity and public image.

Approval

Quantitative and qualitative data collection was conducted concurrently from October 2015 to Jan 2016 after having obtained ethical clearance from ERES Converge, and permission to proceed with the study from the University of Zambia School of Medicine department of public health. The National AIDS STI and TB Council and the Zambia Federation of Employers also provided letters of introduction to the workplace to facilitate access for the study.

Respect for participants and confidentiality

Permission to carry out the study was obtained from respective management of each workplace. To maintain confidentiality organizations that took part in the study were identified by codes and Key implementers interviewed were consented and also informed on voluntary participation. The importance of the study together with their honest answers was emphasized. Respondents were informed that it will not be possible to publically identify them or associate them with their responses after the study. The interviewer -administered questionnaire proceeded only after obtaining consent from the respondents.

CHAPTER 4:

4.0. Results

4.1. Description by Demographic Characteristics

A total of 166 workplaces were contacted to take part in the study of which 128 agreed, giving a response rate of 77.12%. Respondent's demographics collected included age, sex as well as Job title and length of stay at the organisation. Table (2) shows gender and age distribution of respondents.

Table 2: Participants Demographic Characteristics

Gender of Respondents			**Age in years of Respondents**		
	Males	**Females**		**Males**	**Females**
Frequency	83	45	Maximum Age	56	58
Percentage	64.8%	35.2 %	Minimum Age	29	25
			Average Age	42	41
Total		**128**	Overall Age range	25-58 years	
			Overall Average age	42 years	

Respondents job title and length of stay:

Human resources managers, 86/128 (67.19 %) and officers 11/128 (8.59%) were the majority of job titles represented. The least represented job titles were Chief executives, Dean of students, and Receptions at 1/128 (1.56 %) each. Table (3) illustrates respondent's job titles in the workplace.

Table 3: Distribution of Respondents by Job Title and length of stay at workplace.

	Job Title	Frequency		Job Title	Frequency
	Human resources managers	86 (67.19 %)		deputy head teachers	2 (1.56%)
	Human resources officer	11 (8.59%)		Chief executives	1 (1.56 %)
	Accountant	5 (3.91%)		Dean of students	1 (1.56 %)
	Assistant Accountant	3 (2.34%).		Receptions	1 (1.56 %)
	Manager	5 (3.91%)		Secretary	2 (1.56%)
	Health and Safety officer	4 (3.13%)		Admin officer	2 (1.56%)
	Total	**128**			

Respondent's length of stay at the workplace for both males and females ranged from a minimum of 2 months to 26 years with an average of 5years 1 month. Figure (2) illustrates respondent's length of stay in the workplace by gender.

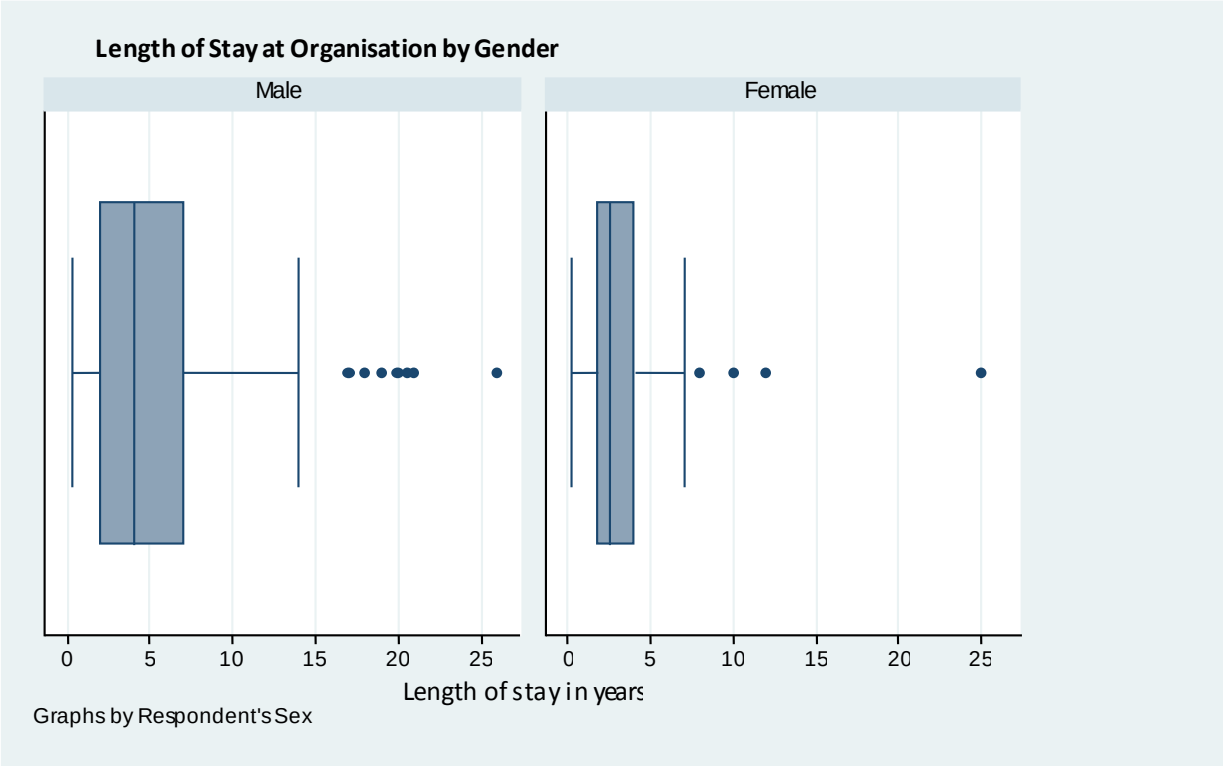

Figure 2: Box plot Distribution of Respondents length of stay at workplace by Gender

4.2. Distribution of HIV/AIDS Policies/Programs by organisation Type

Non-governmental organisations represented 8/128 (6.25%), organisations defined as Quasi were 9/128 (7.03%) and Private sector workplaces 111/128 (26.56%) of the total sample size. There were 47/128 (36.72%) workplaces with an HIV/AIDS policy. The majority, 71/128 (55.47 %) did not have a policy and the remaining 10/128 (7.81%) workplaces had a policy at the development stage. Table (4) illustrates the distribution of policy and programs by type of organisation.

Table 4: Distribution of HIV/AIDS Policy and Programs by Type of Workplace

Distribution of Workplaces by Organisation Type (N=128)			
NGO			
Retail business- private			
Insurance/Pension-Quasi			
Insurance/Pension-Private			
Computer/technology private			
Agriculture - private			
Banking/Finance private			
Telecomm/inform-Quasi			
Telecomm/inform-Private			
Transport/logistics private			
Transport/logistics-Quasi			
Hotel/hospitality			
Transport/construction			
Motor vehicle Dealer private			
Engineering private			
Manufacturing private			
Security services private			
Education/Training-Quasi			
Education/Training-private			
Other private			
Publishing/Print-private			
Distribution of Workplace Policy and Programs by Type of Organisation			
	Sample Size(N=12	**Workplaces With Policy**	**Workplaces with programs (n=56)**
	111 (86.72%)	34 (72.34%)	40 (71.43%)
	8 (6.25%)	8 (17.02 %)	8 (14.29%)
	9 (7.03 %)	9 (19.15%)	8 (14.29%)
	128	**47**	**56**

There were 56/128 (43.75%) workplaces with HIV/AIDS programs and 72 /128 (56.25 %) did not have programs at all. Among workplaces with a policy 46/47 (97.87 %) had programs and only one workplace 1/47 (2.13 %) did not have any programs. There were 10/81 (12.34%) without a policy but had HIV programs. Workplaces in the process of developing a policy had 4/10 (40%) with programs and the remaining 6/10 (60.00%) did not have.

4.3. Distribution of HIV/AIDS Policies/Programs by organisation size.

Availability of workplace policy and programs was analysed based on the size of workplaces. The size of the organisation was defined by the number of employees in the workplace (Lass 2009). Table (5) illustrates HIV/AIDS policy and programs distribution by size of the organisations.

Small sized (less than 100 employees)**:** The majority of small sized organisations 45/60 (75%) had no HIV workplace policy and HIV/AIDS programs were available in 14/60 (23.33%).

Table 5: Availability of HIV/AIDS Policy and Programs by Size of Organisation

Size of organisations b numbers of Employee	Sample size N= /128	Work With p (n=47)	Workplaces Developing	Workplace with Programs (n=56)
Small firms (<100)	**60 (46.88%)**	**13 (27.**	**2 (20**	**14 (25%)**
Medium firms (100–	**42 (32.81%)**	**15 (31.**	**8 (80**	**23(41.07%)**
Large firms (500-100	**17 (13.28%)**	**11 (23.**	**0 (0.0**	**11 (19.64%)**
Very large (>1000)	**9 (7.03%)**	**8 (17.0**	**0 (0.0**	**8(14.29%)**
	128	**47**	**10**	**56**

Confirmed Policy document : 42/47 workplaces ***Size increased odds of having a policy 2 .7 times**

Medium sized (between 100 and 499 employees)**:** Among these, there were 15/42 (35.00 %) with Policies and the majority, 19/42 (45.00 %) had no policy.

Large sized (between 500 and 1000 employees): Large organisations had proportionately higher number of workplaces with policies in this category at 11/17 64.71% compared to medium and small sized organisations. There were 6 /17 (35.29 %) workplaces with no policies as shown in Table (5).

Very large sized (>1000 employees): In this category there were 8/9 (88.89%) workplaces with a policy. Very large organisations had proportionately more HIV/AIDS workplace policy compared to small, medium and large organisations.

4.4. Policy factors

4.4.1. Policy; Content, Formulation and Dissemination:

Visibility of HIV/AIDS in the workplace or country was defined as having an increased number of employees or people living with HIV/AIDS or dying from HIV/AIDS (Smart and McKenna 2006).

Visibility of HIV/AIDS in the country was the common reason 24/56 (42.86%) for adopted policy/programs followed by visibility within the workplace18/56 (32.14%). There were 3/56 (5.357%) who responded due to the impact of HIV/AIDS on production and labour costs. Only one (1.79 %) had pressure from their union to respond to HIV, while 2/56 (3.57 %) did not know why their workplace had a policy/program.

4.4.2. Policy Objectives/ Goals

The extent to which workplace policy objectives and goals addressed HIV/AIDS, needs of people living with HIV/AIDS and Gender in their workplace from the perspective of the implementer are illustrated in Figure (3).

HIV/AIDS in the workplace: Most issues on HIV/AIDS were addressed in 20 /27 (42.6 %) workplaces and did not address it at all in 3/47 (6.38%). Another 7/47 (14.9%) reported that some issues were addressed but many were missing. The remaining 15/47 reported that all key issues on HIV/AIDS in the workplace were addressed.

Needs of Employees living with HIV/AIDS: Needs of employees living with HIV were not addressed by policy objectives in 2/47 (4.25%). Most key issues were addressed in 17/47 (36.00%) with a few issues still missing. There were 10/47 (21.28 %) workplaces who addressed some key issues but many still missing .All key issues were addressed by 14/47 (29.79 %) and there was no response from one respondent while the remaining 3 /47 (6.38%) did not know.

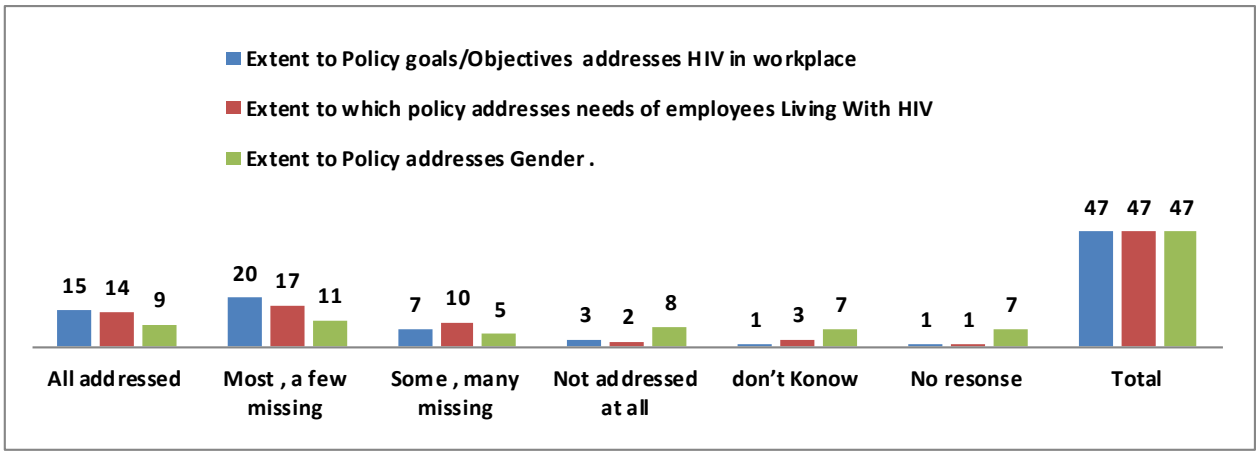

Figure 3: Extent to which Policy Goals/Objective address HIV/AIDS, PLWHIV and Gender in 47 workplaces with a Policy.

Gender integration in HIV Policy: The extent, to which policy goals and objectives addressed gender, had the majority of respondents who didn't know if it was addressed. Gender also had the majority of respondents who did not give a response to gender being addressed by their policy. Compared to extent of policy objectives addressing HIV and needs of employees living with HIV, gender was the least addressed as illustrated in figure (3).

In-depth interviews found implementers felt that their workplace policy addressed the needs of people living with HIV/AIDS by providing care, support and treatment through health schemes, as explained by some implementers.

> *The health insurance package includes a free special package specifically to cover for HIV/AIDS related issues, which they can continue even if the employee has left the organisation.* **KIHp2**

Some implementers also explained that their policy went beyond the provision of treatment through medicals schemes but also included issues relating to fair treatment of employees with HIV and gender related issues.

> *It addresses most key issues .....Because the policy focuses on fair treatment, this includes issues of gender as well* **KIHp5**

Some implementers felt that HIV had evolved over the years while their policy had not changed much to adapt to the needs of employees living longer as a result of anti-retro viral therapy. The need to have a policy that evolves with the current situation on HIV and AIDS is expressed.

> *The policy used to address the needs of the employees but now it does not really do that now, there are a lot of changes from the time when we started the policy including the needs of the employees living with HIV.* **KIHp3**

4.4.3. **Policy formulation**

Management: Extent of management and employee involvement in policy formulation is shown in Figure (4). Overall management involvement was found at 44/47 (93.61%) and lack of involvement was reported by 2/47 (4.26%) and only 1/47 (2.13 %) respondent did not respond.

In-depth interviews confirmed management's extensive involvement in the formulation as majority of respondents said their management were initiators of policy and therefore had to be involved, especially during barging of policy content.

> *We got their input and buy in during formulation but when it came to being part of the formulation workshops, they were moderately involved, however even though there is no effect on implementation but their absence is noticed and it tends to affect individual participation.* **KIHp18**

Limited involvement of management in the formulation was also found at varying stages of Policy process. Other implementers felt that management involvement was limited to certain levels of management; with others being more involved than that the rest.

> *It is not appreciated by everyone in management. Middle and lower management were more interested in the process. As a result you find that allocation of resources to the programs is usually a huge debate.* **KIHp20**

Employees Involvement in Policy formulation: Overall employee involvement in formulation was reported by 43/47 (91.48 %) and only 3/47 (6.38%) reported a lack of involvement; close to the lack of management involvement. As shown in Figure (4), extensive involvement of employees was slightly lower than that of managers while employees' moderate involvement was higher compared to that of managers.

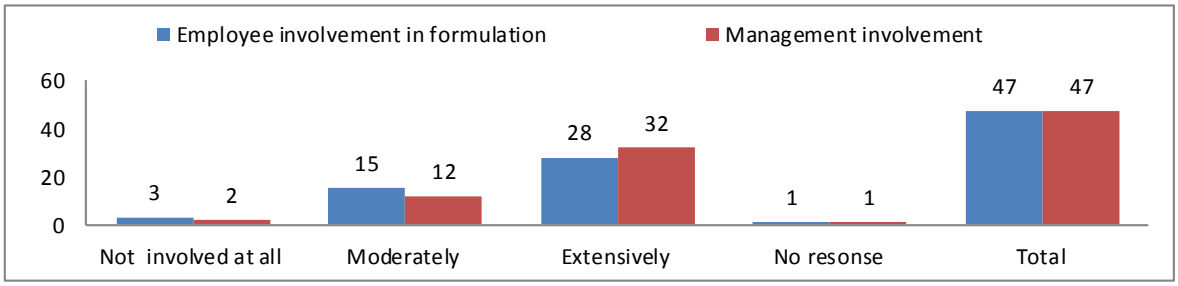

Figure 3: Extent of Management and employee involvement in Policy formulation.

In-depth interviews agree with these finding where, some workplaces did include employees in the formulation process through union representations, formulation committees and the use of policy developer experts. Other Implementers reported limited involvement of employees in formulation where management took centre stage in the formulation process as explained by one implementer,

> *Employees were moderately involved the formulation because to some extent the formulation was done at management level but with some representation*.KIHp12

There were also implementers who felt that employee involvement in policy formulation was completely absent as most of the employees were not part of the process of formulation this is explained by one implementer.

> *It was mainly a top down system with workers representatives as a union and management being involved not the employees.*KIHp6

4.4.4. **Policy Dissemination:**

Figure (5) illustrates the extent of policy dissemination among 47 workplaces with an HIV/AIDS policy.

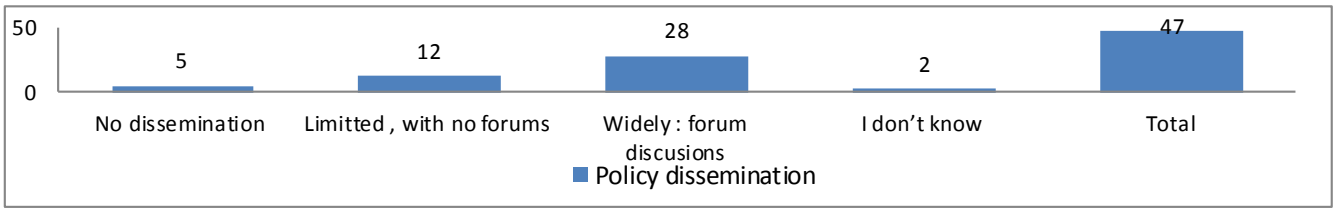

Figure 4: Extent of Policy Dissemination after formulation as reported by key implementer in workplaces with Policy.

Through in-depth interviews, the study found that workplaces used various ways to disseminate their policy .The use of emails, bulletins, meetings workshops and internal channels of communication were used as indicated by some implementers,

> *we sent through emails and then we also had trainings because of the nature of our work, we are seasonal in nature so to achieving programs related to our core business all the workers have to be fully committed as seasonal workers and these are the ones that are vulnerable so workshops were held to educate them about the policy and its content* **KIHp23**

In some workplaces policy dissemination occurred as an ongoing process through talks and workshops on HIV/AIDS prevention where employees were regularly reminded of the existence of the policy and during orientation for new employees as explained by an implementer,

> *We have observed that when new staff come in we should not just give the policy to read but also just provide orientation on the actual content of the policy, because there is too much to read at that stage, so we go through the policy with them* **KIHp**

There was also limited dissemination of HIV/AIDS workplace policy among employees and managers alike, creating a lack of ownership and clarity on policy content and provision.

> *The policy was disseminated through trade unions and supervisors but not so much these days because of employee turnover.* **KIHp4**

While dissemination of the policy at the time of formulation was reported in most workplaces, some key implementers expressed concern regarding ongoing dissemination which had reduced overtime with the coming on of new employees.

4.5. Leadership for policy and programs

Management support: Support for HIV/AIDS policy/programs from both top and lower management was almost the same 42/57 (73.68 %) and 43/57 (75.44 %) respectively. Respondents who indicated neither support nor opposition to policy and programs was however slightly higher for lower management, 13/57 (22.81%), compared to that of Top management 11/57 (19.29 %).

The in-depth interviews found that management support was interpreted in various ways including actively participating in workplace programs, by being examples or champions for key activities and in facilitating and providing approval for activities to take place, as well as allowing employee's time to attend to HIV/AIDS activities. As explained by one implementer,

> *Management is supportive because they have allowed for activities to be carried out and they allow for time off, being a part of trainings and workshops for peer educators.'* **KIHp**

Managers were perceived as supportive through the facilitation of resources for HIV/AIDS programs. Financial resources for programs sometimes required implementers to negotiate with management, when managers were willing not only to provide the financial support but also to provide a platform to negotiate the needed resources.

> *Top management is 100% supportive, despite the fact that we fight when the aspect of money for the programs comes in.* **KIHp**

Management support was fostered by having key performance indicators on HIV/AIDS programs included as part of management performance. A number of implementers indicated that their role as Human resources personnel meant that HIV/AIDS activities were part of their responsibility and therefore part their performance indicators. Some implementers felt rebuffed with negative comments about the relevance of HIV/AIDS programs. The lack of action in approving a drafted policy for over a number of years was one example of limited management support as explained by one implementer

> *Top management is supportive, but again our policy has been in draft since 2004 and it was just been sent for approval this year(2015) to head office and it's taken long, but again I wouldn't say that top management is opposed to it. It's just that they could do more to help.* **KID25**

Management Effectiveness at Policy / Program Implementation

There were 36/56 (64.28%) workplaces that rated leadership of management at policy/program implementation as effective and 20/56 (35.71%) workplaces rated their management as not being effective at all as shown in figure (6)

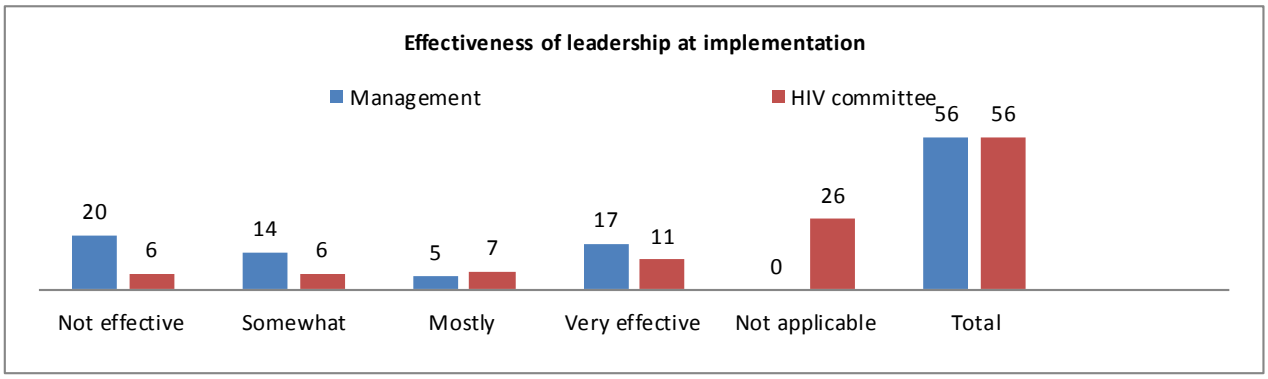

Figure 5: Leadership Effectiveness at implementation of Policy /Programs as reported by implementer in workplaces with Programs.

HIV/AIDS committees

Workplace committees were present in 30/56 (53.57 %) and the remaining 26/56 (46.43%) did not have. Figure (7) illustrated Frequency of workplace committees meetings. Fishers' exact test on Policy and HIV/AIDS committees in workplaces with programs (56/128) found that workplaces without policy were less likely to have HIV committees compared to those with policy at P value = 0.487, however this was statistically not significant (P>0.05) to suggest a difference in relationship between workplaces with a policy and those with no policy in having an HIV/AIDS committees.

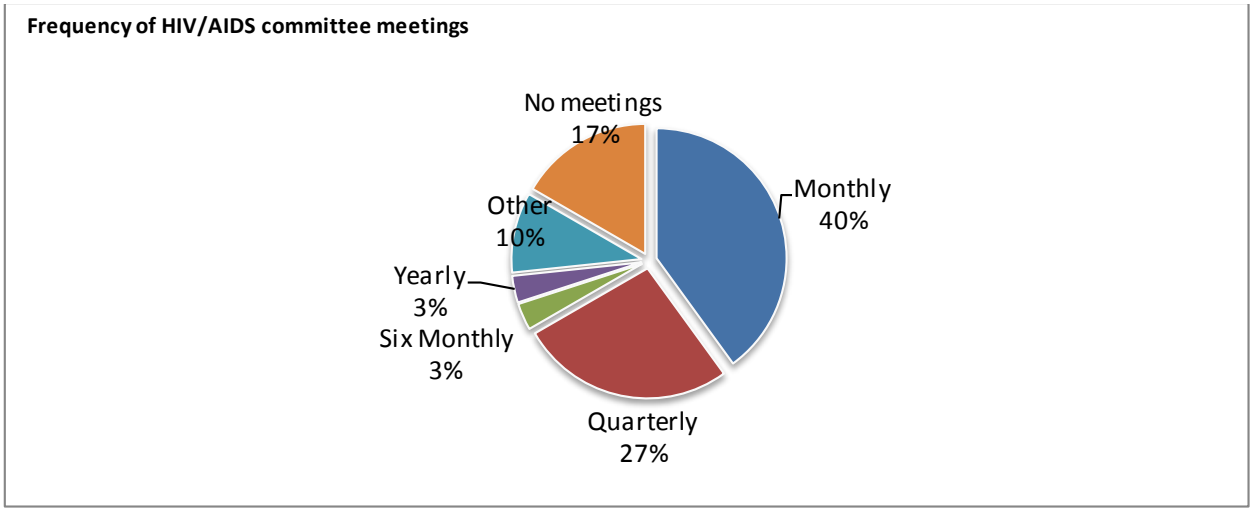

Figure 6: Frequency of workplace committee meetings as reported by key implementer in 56 workplace with HIV/ADIS workplace programs.

Through in-depth interviews effectiveness of an HIV/AIDS committee was determined to be based on levels of awareness and involvement in workplace programs by employees. Very effective committees were involved in HIV/AIDS care and support activities and also acting as a point of contact for feedback to their management with the workplace.

> *The results from the farms where we have these committees show that everyone is aware and involved and very responsive to activities meaning they (HIV/AIDS committee) are effective.* **KIHp3**

Ineffective committees were also reported mainly due to staff turnover. Employees that had originally been involved in the programs at formulation were no longer with the organisation. Others were reported ineffective based on lack of communication to employees, lack of visibility of the committee and lack of involvement in programs; this is illustrated in the comment below

> *It's (the HIV/AID workplace committee) ineffective and I don't know what happened but am supposed to be the patron of the committee, people are on duty 24/7 so maybe that's the reason for it being inactive because we are busy with work and now don't see many people who are sick in the workplace so it's like it's not an issue*[KIHp5]

No committee: Some workplaces did not have an HIV/AIDS workplace committee at all. The use of medical schemes in some workplaces has removed the need for HIV/AIDS committee. Workplaces had developed other strategic ways of ensuring programs were coordinated through the use internally trained human resources staff and peer educators, as well as the use of external organisations in managing and implementing HIV/AIDS workplace programs. This is explained in the comment below.

> *We don't have an HIV/AIDS committee because we have contracted an external provider, a company that is tasked to manage the HIV programs.*

4.6. Program factors

4.6.1. Participation in HIV/AIDS workplace programs

Figure (5) illustrates the extent of participation in program activities for managers, union leaders, and employees (Females and males).

Top management: Top management participation in programs was found at 54/56 (96.42 %) with only 2 /56 (3.57) reporting no participation at all. Figure, 5 shows the extent of participation with the majority having wide participation in programs. Fishers' exact test of association at P value = 0.339, found that workplaces without policy were less likely to have management involvement in programs compared to workplaces with a policy, however, the relationship was not statically significant (P>0.05) to suggest that policy influenced management involvement.

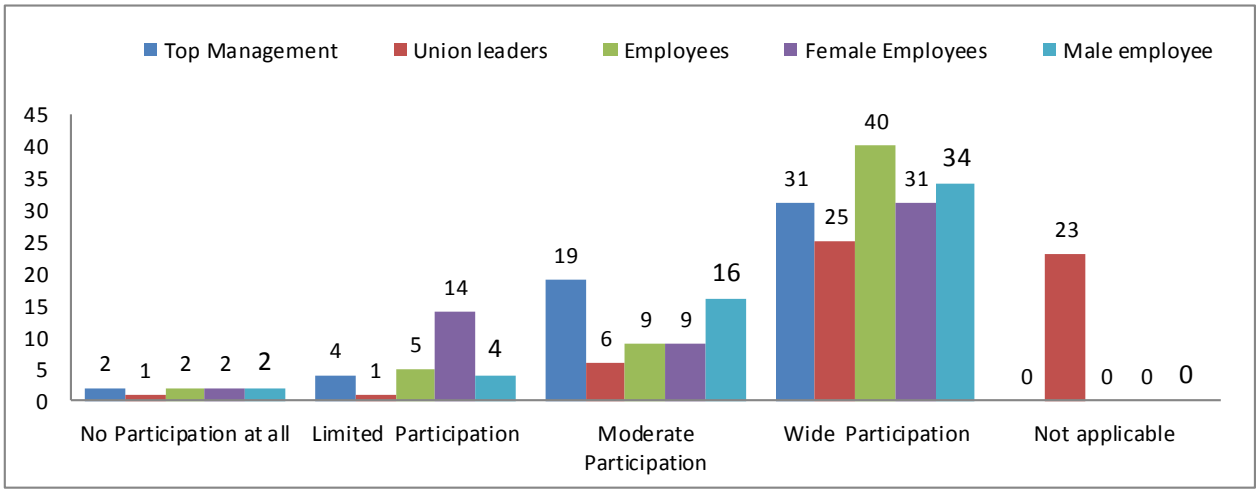

Figure 5: Extent of Participation in Workplace Programs in 56 workplaces with HIV/AIDS workplace programs as reported by key implementers of HIV/AIDS workplace programs.

Employee participation: Similar to Top management, employee participation in programs was reported by 54/56 (96.4 %) and only 2/56 (3.57%) reported no participating at all. On Extent of participation Figure (5) shows that employees had wider participating compared to Top management. Fishers exact found P value= 0.219 (positive direction), found that workplaces without policy were less likely to have employee participation however, this was not statistically significant (P>0.05) to suggest that policy influenced management involvement employee participation in HIV/AIDS programs.

Male and female participation: This was the same at 54/56 (96.42%) for both, as was a lack of participation for both males and females at 2/56 (3.57%). Figure (5) shows fewer females had wide participation compared to males and more respondents reported limited female employee participation. It also shows that Moderate participation of males was more compared to that of females. A test of independence using Fishers exact to compare male and female participation in programs found P value=0.0001, workplaces with a policy were more likely to have more female participation in programs and was statistically significant at ($P< 0.05$).

In-depth interviews found that majority of workplaces reported management participation at different levels. Some workplace had also included participation in HIV/AID programs as part of the key performance indicators for their managers as illustrated from the comment by some implementers.

> *Middle management – are involved because they are measured on it as part of the work they are doing.* **KIHp**

Female employees

In-depth interviews found limited participation of female employees was attributed to cultural factors hindering female employees from full participation. Some Implementers felt that female employees were generally shy to talk about issues relating to HIV/AIDS and sex. This is illustrated in the comment by one implementer

> *Female employees -we have wide involvement from female employees. They are always there but with a little bite of shyness in talking about HIV/AIDS and sexual matters.* **KIHp**

Employees living with HIV/AIDS

Some implementers also felt that some employees living with HIV/AIDS had limited participation in the workplace programs. Levels of participation seemed to have reduced over time with no clear indication of why this was happening.

> *Employees living with HI/AIDS -have limited involvement because of the stigma hasn't completely been dealt with; those that are sick are those who are mostly affected. Employees living with HIV-they were very interested at the start of the programs but now we don't know anymore.*

Union leaders

Union leader's participation in HIV/AIDS programs showed that they were as involved as other employees in the workplace. A few respondents felt that their union leaders were not fully involved and sighted that this could have been because union leaders were not involved at the time for policy formulation and lack of sensitisation.

> *There is limited involvement from them (union leaders) because they don't even understand issues to-do with HIV maybe because they were not fully involved in the actual policy formulation*. **KIHp**

4.7. Resource factors

Financial resources

Funding mechanisms for programs were present in 45/56 (80.35%) while 11/56 (19.64%) did not have one. Organisations with their own budget were the majority followed by donor funded workplaces and government support. Some workplaces sourced funds from their clients and insurance schemes to support their HIV programs. The number of workplaces with a specific budget for HIV/AIDS activities is illustrated in Table (6). Fishers' exact test at P value= 0.012 (negative direction) found that workplaces with a policy were more likely to have a specific budget for HIV/AIDS programs and statistically significant ($p<0.05$) to suggest that policy influenced having a specific budget for HIV programs.

Table 6: Workplaces with Specific Budget for HIV/AIDS Programs

HIV/AIDS P	Specific Budget for HIV/AIDS Programs				
	Yes	No	Don't know	No response	Totals
No	2	5	0	3	10
Yes	26	18	1	1	46
Total	28	23	1	4	56

Funding amounts for programs were sufficient in 48/56 (85.71 %) workplaces insufficiency in 5/56 (8.93 %) with 2/56 (3.57%) and 1/56 (1.79 %) who did not know and did not respond to funding sufficiency respectively. Figure (7) illustrates the further extent of sufficiency in terms of quantity and quality for finances, equipment, information and human resources.

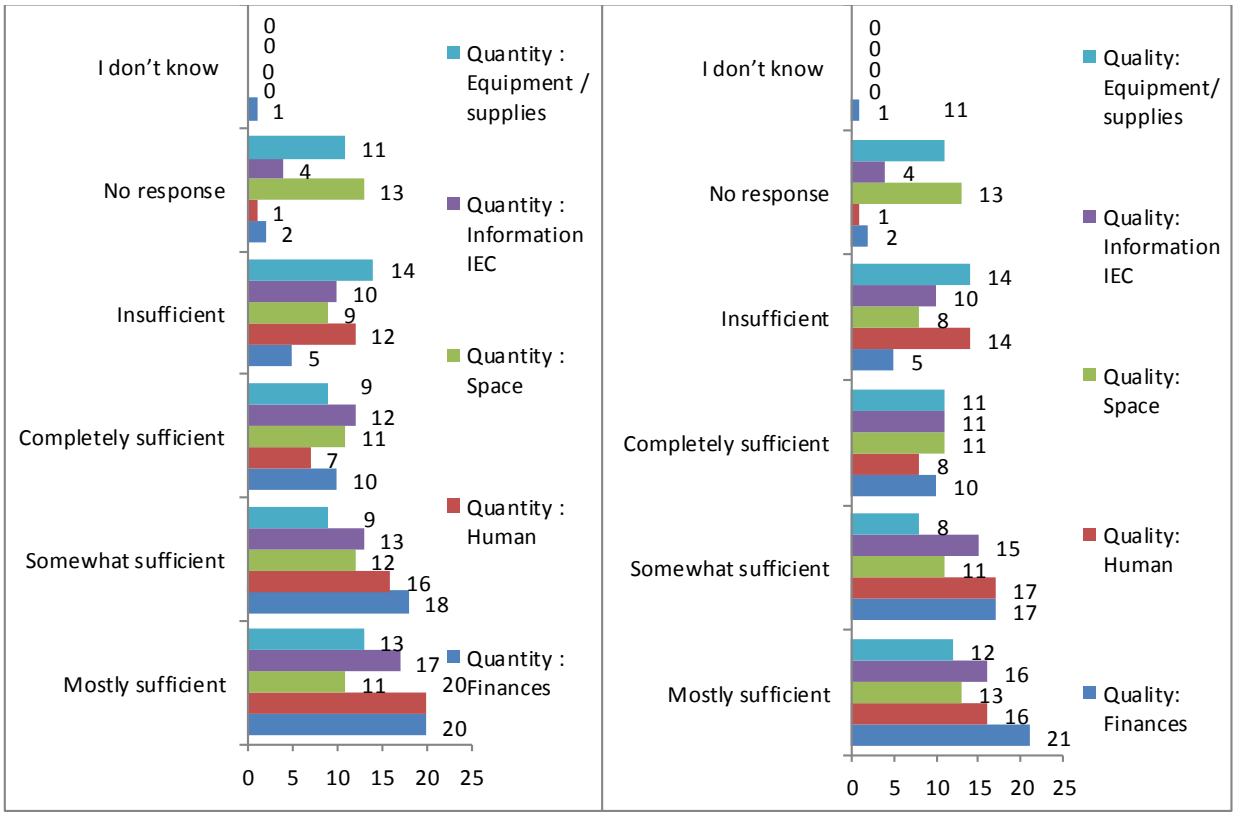

Figure 7: Quantity and Quality of available Resources for HIV/AIDS Workplace Programs as reported by key implementers of workplace programs in 56 workplaces with HIV/AIDS programs.

Barriers to accessing funding: Barriers to accessing funding for HIV/AIDS programs were reported not to exist by 32 /56 (60.71%) of implementers, while the remaining 21/56 (37.50%) had experienced barriers.

Some donors were reportedly winding up activities and therefore withdrawing support, this ultimately affected implementation of programs in the workplaces. Workplaces with specific budgets for HIV/AIDS activities reported that because of budgeting they did not have major barriers to accessing funds. Barriers included donor funding tied to specific activities in the workplace as explained by one implementer**,**

> *When Funders give the funds for specific activities rather than giving the money to be used as needs arise, it means you can only do what the funds are intended for no more than that. That restriction is sometimes difficult so you find that money is used for activities that are no longer current needs.* ***KIHp***

Competing funding needs: Competing operational activities took priority for funding for activities viewed as a core business for the workplace competing against HIV/AIDS prevention activities. Some workplaces had an allocated budget for HIV/AIDS activities which was used to take care of the organisations other needs or more pressing issues as explained by one implementer.

> *Regarding finances sometimes we have activities that are pressing to the company and they get the money that is meant for the HIV programs to finance these pressing issues KIHp8*

Delayed funding: The study also found that workplaces with funding support from other partners and donors also experienced challenges in receiving their funding for HIV/AIDS programs on time. One implementer explained this challenge as follows,

> *Yes…there is a certain percentage of our funding that comes from the government, like I said but also as a company we supplement this. What I would say is that when there are delays in issuing money for projects money for HIV/AIDS programs are also delayed.* ***KIHp***

Reduced organisational funding for programs: Some workplaces had reduced their HIV/AIDS program workplace activities as a result of the company not having met its budget and the increasingly competing operational needs versus the need to provide HIV/AIDS programs.

> *The company went into recession we have reduced the number of staff from 76 to 35, we used to have team building activities but because the company has not made profit in the past 2 years it's difficult to do so. So most activities including those related to HIV are on hold* [KIHp3].

Human Resources

Human resources were sufficient in 42/56 (75.0 %) workplaces and 14/56 (25 %) workplaces had insufficient numbers for programs. A scaled break down of human resources sufficiency is illustrated in figure (7).Fisher's exact test for association between human resources numbers (quantity) and availability of policy in workplaces with programs was significant at P-value 0.003 (negative direction), ($P<0.05$) to suggest that availability of Policy influenced Human resources for programs.

In-depth interviews found that numbers (quantity) as well as the availability of trained (quality) human resources to implement programs were affected by staff turnover as most initial providers had moved on to other organisations.

> *Most of the guys that were trained have left; sometimes peer educators may not be enough or useful to provide counselling but because we have a clinic nurse people would rather discuss confidentiality issues for HIV …peer educators would be used more for trainings* [KIDp3]

Resources Infrastructure / Space for programs

Sufficient infrastructure/space was reported by 34/56 (60.71 %) and quality of space (privacy) was sufficient in 35/56 (62.50%).Figure (7) illustrates scaled breakdown of quantity and quality of space.

In-depth interviews showed that majority of workplaces with programs had adequate space and infrastructure to carry out program activities, where this was limited implementers were able to find some space as explained below,

> *Currently, we have utilised the space that we have but we can actually have more if we define ourselves well we can have a room that is designated for wellness activities .* ***KIHp***

Equipment Supplies

Quality referred to consistency in supply for equipment and supplies as shown in Figure (7). Fisher's exact test for association of policy and quantity of equipment /supplies found P-value = 0.705 (P>0.05) which was not statistically significant to suggest a relationship of association between having a policy and sufficient quantity of equipment/ supplies for HIV programs.

In-depth interviews found insufficiencies in supplies in the provision of male and female condoms. Female condoms were unavailable in most workplaces. Insufficiencies were due to tear and wear of equipment/supplies over time, outdated VCRs and allocated vehicles for programs and training were no longer functional.

> *Male condoms were completely sufficient except for now we do not have them. Aids Health Foundation supplies other materials we secured through CHAMP - the generator TVs, which we got a long time ago also, needs replacement as most have broken down now .* ***KIHp***

While some implementers had equipment for demonstrations during trainings, it was found that materials and supplies needed to be current with the changing needs of people living with HIV/AIDS, as expressed by one implementer,

> *We do have a VCR and projector but these are outdated there is need to have some advanced technology and some of the videos we have need to talk about more than just HIV but also healthy living, after one has tested .* ***KIHp***

Resources Information

A scaled breakdown on quantity and quality of information is outlined in Figure (7). Fisher's exact test of association gave a P-value 0.010 (negative direction), ($P < 0.05$) which was statistically significant to suggest a relationship between policy and availability of information for HIV/AIDS programs.

In-depth interviews found information materials were obtained through partnerships and insufficiencies were being experienced as a result of partners ending their programs. Implementers also reported burnout with HIV/AIDS related topics. While HIV/AIDS information was important, information on health in general and its relationship to other illnesses was limited. As explained by one implementer,

> *I think that people are tired of hearing about HIV, that's why we have incorporated wellness into the programs instead of just focusing on HIV alone*.

4.8. Social-Economic factors

Table (7) shows frequency of responses on social and economic factors hindering or facilitating implementation of HIV/AIDS policy and programs in the workplace.

Table 7: Social-economic factors facilitating / hindering HIV/AIDS workplace program implementation

Factors	Facilitates	Hinders	No Response	Not .Appli	Do not Know	Totals
Religious Practices	5 (3.91%)	10 (7.81%)	41 (32.03%)	71 (55.47%)	1 (0.78%)	N= 128 (100%)
Gender norms	2 (1.56%)	10 (7.81%)	44 (34%)	71 (55.47)	1(0.78%)	128 (100%)
Cultural practices	4 (3.13%)	7 (5.47%)	45 (35.16%)	71 (55.47%)	1 (0.780 %)	128 (100%)
Social status	5 (3.91%)	9 (7.03%)	42 (32.81%)	71 (55.47%)	1 (0.780 %)	128 (100%)
Organ/Finances	27 (27.09%)	17 (13.28%)	12 (9.38%)	71 (55.47%)	1 (0.780 %)	128 (100%)
Mobility/ Migratio	2 (1.56%)	14 (10.94%)	40 (31.25%)	71 (55.47%)	1 (0.780 %)	128 (100%)
Other (time)	2 (1.56%)	7(5.47%)	47 (36.72%)	71 (55.47%)	1. (0.780 %)	128 (100%)

Religious practices

Most Implementers felt that religion and personal beliefs helped to facilitate implementation of the workplace policy. Most workplaces explained religion as being non-discriminatory including Christianity and this helped to facilitate HIV/AIDS programs as explained in the following comments,

Because we are a Christian organisation, well most of us…issues of discrimination are not a problem so it makes it easier to accept people living with HIV/AIDS.**KIHp23**

Gender and Culture

Male dominated Environment: In male-dominated environments, gender was reported as a facilitator of implementation, where employees in these workplaces had developed some comfort levels when it came to discussions on HIV/AIDS, sexually transmitted infection and condoms making it easy to discuss issues openly. As explained by an implementer.

> *Gender in a way here facilitates. Our workplace is mainly a male dominated environment since it is a factory. We have a few women, about 2 and they are not in the majority, therefore, gender is not really a big issue regarding how we address HIV or health situations.*[Kip3]

Low female involvement: Female employees had limited participation in HIV/AIDS compared to their male counterparts in programs where sex, HIV/AIDS and condoms were discussed as explained by the finding below. The expectation from male employees was usually that females should not express themselves too much when it comes to sex and HIV/AIDS discussion.

> *Especially from the female employees' side as they don't easily express their views concerning HIV in public, it's in our culture where women should not talk too much about sex or HIV/AIDS so they don't participate much*.**[KIHp8]**.

Cultural practices: Workplaces develop their own work culture among employees but also interact in communities were some traditions and cultural practices may be transferred to the workplaces. Individual employees also have different cultural and traditional backgrounds where issues relating to death are dealt with in different ways. Cultural practices such as sexual cleansing at the death of a spouse do occur and prevention programs in the workplace are hindered by some of these practices.

> *Some cultural practices in certain rural areas where our company operations do hinder our employees' activities since they work with in these areas, yeah! I would tell you openly that I have had challenges with our branches in Monze and kalomo as they call themselves, Tonga bulls! And there is an element of polygamy as a result; you find that the male employees have several partners, KIHp.*

Social status of employees

The social status of employees in workplaces differs and interactions of one social class may affect others. When employees of higher social status participated in programs it encourages participation. However, participation is limited when senior members of staff did not mingle with juniors, as explained below.

> *Social status of employees affects implementation…Both hinders and facilitates...I tell you that I have gotten much support from the general workers more than from the senior management. Senior staffs tend to shy away from these activities, unlike the lower staff* ***KIHp8*****.**

Religious practices and beliefs

Programs were found to be challenged by religious and personal beliefs when employees that are aware of their HIV status found comfort in dealing with their status through beliefs in religious healing and at times denial on the existence of HIV as explained by one implementer.

> *Because of the stigma attached to HIV/AIDS people don't want to take part in program activities they think they cannot be part of the people with HIV/AIDS. Others think they have no HIV, and have just been bewitched* ***Kip****3*

Time

The study found that a number of key implementers of HIV/AIDS programs in the workplaces where challenged with time in ensuring programs were carried out. The day to day work activities and the core business of the organisations were more pressing and there was little time to focus on programs for employees even when programs had been planned for, as explained by one implementer,

> *Time hinders implementation of HIV program in the work place. Time is a challenge in allocating activities towards the programs for HIV in the workplace; we each have deadlines and so to find common suitable time is difficult. We are here to work****Kip****4*.

Migration / Mobility

The study found that mobility was used to prevent certain sectors of employees from engaging in multiple relationships by keeping them mobile and not constantly stationed in one place this coupled with the awareness programs and making condoms available has been used by the farming sector to address HIV/AIDS. Most of the workplaces that were involved in farming and frequent traveling commented on mobility being a hindrance to programs implementation as expressed by one implementer,

> *Mobility is a hindrance in the company and is visible especially among our drivers when they are carrying out operational errands they are not only away when we have activities but also they are exposed to the possibility of multiple sexual relationships. KIHp30*

4.9. Stake holders involved in implementation

Stake holder involvement in policy development and implementation found stakeholders such as government level or coordination level stakeholders whose roles were identified mainly as guiding and mentors on how to implement and manage HIV /AIDS programs.

The Government, Ministry of health, the Labour office, the District AIDS Task Forces, the Zambia Institute of Human Resource Management , the International Labour Organisation , the Catholic church and the National AIDSHIV/STI /TB council.

Another group of stakeholders was also identified as being involved in the implementation of HIV/AIDS workplace policies and programs through providing technical support, funding, and expertise in the management of HIV/AIDS programs, these included:

Afya Mzuri, Community HIV/AIDS Mobilization Project (CHAMP), Zambia Business Coalition Association (ZBCA), Zambia Health Education and communications Trust (ZHECT,) and Zambia AIDSlaw Research and Advocacy Network (ZARAN) (NAC, 2009) to name a few. For coordination purposes the partners ensured that they were not going to the same organisations and to allow for coordination of activities and transparency in the implementation of workplace programmes under Zambia workplace partnership. With mutual respect among the partners because the organisations are not in competition but worked to reduce HIV /AIDS burden in Zambia.

4.10. Elements of HIV/AIDS workplaces programs

HIV/AIDS awareness: All workplaces with programs 56/56 (100%) addressed HIV/AIDS awareness in their programs. Table (7) illustrates the extent to which HIV/AIDS awareness was provided and how. Within the workplace, through Medical insurance schemes, government clinics and sub-contracting other organisations. Fisher's Exact test gave P- value = 0.807 (positive direction) was not statistically significant (P>0.50) to suggest a relationship between having a policy and provision of HIV awareness activities in workplaces with programs.

Voluntary testing and counselling for HIV (VCT): VCT was provided in 53/56 (94.0%) workplaces and 3 /56 (5.36%) did not. The majority 20/56 (35%) used onsite mechanisms. Coverage through government clinics and medical insurance schemes was equally distributed at 12/56 (21.43%) as shown in Table (7). Fishers exact test found P value = 0.614 (positive direction) was not significant (P>0.05) to suggest a relationship between policy and provision of VCT in workplaces with HIV/AIDS programs.

Provision of Male and female Condoms: Male and female condoms were provided by 38/56 (67.85%) and 26/56 (46.42%) respectively within workplaces. Female condoms were noticeably absent in twice as many workplaces 24/56 (942.8%) compared to male condoms 12/56 (21.42%).The Fishers exact test for association of Policy with the provision of female and male condoms was not significant at P-value = 0.197(positive direction) (P>0.05) and P value = 1.000 (P>0.05) respectively to suggest policy influenced provision of condoms in the workplace programs.

Table 7: How Selected Elements of HIV/AIDS Programs are provided in the Workplace Program.

	Element of HIV/AIDS Program and How it is Provided by the Workplace					
Element of Program	**Onsite**	**Govt clinic**	**Med.Insurance**	**Out Sourced**	**Not provided**	**Fishers exact**
Awareness	42 (75%)	3 (5.36%)	8(14.29)	3 (5.36%)	0 .00	0.807
VCT	20 (35%)	12(21.42%)	12(21.42%	9 (16.07%)	3 (5.37%)	0.614
Female Condoms	26 (46.42%)	1 (1.78%)		5 (8.92%)	24 (42.85%)	0.197
Male Condoms	38 (67.85%)	12(21.4%)	0.0	5(8.92%)	12 (21.42%)	1.000
ARVS	4 (7.14%)	14 (25.0 %)	24(42. %)	9 (16.07 %)	5 (8.92%)	0.271

Antiretroviral therapy (ART) to employees living with HIV/AIDS: While 5/56 (8.09) workplaces reported not providing treatment to employees living with HIV/AIDS, some 4/56(7.14%) workplaces provided access ART through their own clinics, while 14/56 (25.00%) used government clinics and 9/56 (16.07 %) used an external provider but the majority used 24/56 insurance schemes.

4.11. Key drivers of the epidemic in Zambia.

Table (8) outlines the response from key implementers on their experiences with the extent to which their HIV/AIDS workplace programs addressed selected key drivers of HIV/AIDS in Zambia.

Table 8: Implementer's Perceptive on Extent to which selected key Epidemic drivers of HIV/AIDS are addressed by workplace programs.

	Not at all	Some areas	Most areas	All areas	Do not know	Total
Stigma on HIV/AIDS	9 (16.07%)	5 (8.93%)	9 (16.07%)	33 (58.93%)	0	56
Commercial Sex Workers & HIV/AID	26 (46.43%)	10 (17.86%)	8(14.29%)	12 (21.42%)	0	56
Male circumcision	15 (26.79%)	7(12.50%)	10 (17.89%)	24 (42.86%)	0	56
PMTCT	25 (44.64%)	5(8.93%)	12 (21.43%)	13(3.21%)	1 (1.79%)	56
GBV& HIV/AIDS	23 (41.07%)	4(7.14%)	13(23.21%)	16(28.57%)	0	56
Alcohol Abuse & HIV/AIDS	18 (32.14%)	4(7.14%)	17(30.36%)	17 (30.36%)	0	56
Male having sex with males	38(67.86%)	12 (21.43%)	0	5(8.93%)	1 (1.79%)	56

Stigma/HIV/AIDS: Only 9/56 workplaces did not address stigma at all in their programs but the majority addressed all aspects 33/56 (58.93 %).Table (8) shows the extent to which it was addressed. Fishers' exact test of association between policy and addressing Stigma/HIV/AIDS at P value 0.339 (P>0.05) found that workplaces without policy were less likely to address stigma but was not statistically significant to suggest policy influenced addressing stigma.

In-depth interviews found that stigma/HIV/AIDS was being addressed in an ongoing manner as part of the talks on HIV/AIDS prevention and care. Some workplaces also included it as part of their general policy on discrimination.

It is addressed informally, not programmatically in form of banter; we have no formal approach…and some time as the HR you are forced to talk to employees whose behavior is risky. ***KIP3***

Commercial sex workers/HIV/AIDS: The majority of respondents 30/56 (53.57%) reported addressing this key driver and 26/56 (46.43%) did not address it at all. Table 8 shows a breakdown of the extent to which workplace programs addressed it. Fishers' exact test of association between policy and addressing Commercial sex workers/HIV/AIDS as a key driver at P value=1.000 and with P value>0.05, there was no difference in addressing commercial sex workers among workplaces with policy and those without.

Addressing commercial sex workers/ HIV/AIDS was a concern from the hotel and hospitality/industry, the agricultural sector and workplaces that reported frequent travel of their employees. The hotel industry employees were well informed on a strict code of conduct in interacting with commercial sex workers. Workplaces, where employees had frequent travel, expressed concern on commercial sex workers/ HIV/AIDS as a key driver and how difficult it was to address it, as it was more of a personal choice.

Especially that our employees travel a lot away from home some people may be used to having sexual relations regularly with their partners, therefore when they travel they have it with commercial sex workers so we do talk about it during sensitisation talks and during condom demonstration ***KIHp4***

Prevention of Mother to Child Transmission: MTCT was not addressed at all in 25/56 (44.64%) workplace programs and addressed by 30/56 (53.57%).Table (8) shows the extent to which it was addressed. Fisher's exact test of association between policy and addressing Prevention of Mother to Child Transmission as a key driver of the epidemic at P value= 0.747 (positive direction) was not statistically significant (P>0.05) to suggest a relationship.

Implementers reported addressing PMTCT through talks on HIV/AIDS awareness and prevention. Workplaces providing health insurance to their employees felt that prevention of mother to child transmission was adequately covered in their health insurance

> *This is covered by the medical insurance which our female employees can access during pregnancy* ***KIp2***

Gender Based Violence: This was addressed in 33/56 (58.9%) workplace as a key driver of HIV/AIDS while 25/56 (44.6 %) did not address it at all. The extent to which it was addressed varied and is shown in table (8).Fisher's exact test of association between policy and addressing Gender-based violence as a key driver of the epidemic at P value= 0.575 (positive direction) was statistically not significant (P>0.05) to suggest a relationship.

Some workplaces had integrated their GBV programs to correspond with national and international statutes on GBV response. Others included GBV in their policy on sexual harassment in the workplace. The study also found that some workplaces were partnering with Victim support unit and gender experts in addressing GBV in their programs.

> *We do observe the 16 days of activism where we get someone from Yong Women Christian Association* (YWCA*) and the police to talk to us about gender issues and gender-based violence .* ***KIHp***

Alcohol Abuse /HIV/AIDS: Alcohol abuse /HIV/AIDS was not addressed by 18/56 (32.14%) workplaces and addressed by 33/56 (59.93 %). The extent to which it was addressed is shown in Table(8).Fishers exact test of association between policy and addressing Alcohol abuse /HIV/AIDS as a key driver of the epidemic at P value= 0.958 (positive direction)) found that workplaces without were less likely to address Alcohol abuse, however, was not statistically significant (P>0.05) to suggest a relationship.

Alcohol abuse /HIV/AIDS was a concern among implementers in the majority of workplaces not only productivity in the workplace but also safety within the work environment especially with implementation of HIV/AIDS programs.

> *We discuss it a lot because of the industry we are in, we have had a few issues with alcohol abuse .Especially during those days when tujilijili were common, we were in trouble with alcohol abuse.* ***KIHp***

Alcohol abused was not addressed in isolation but with other key drivers such as gender based violence and condom utilisation and failure to use condoms properly. Strategies included the use of external facilitators such as a faith based organisation and partnerships with the drug enforcement unit and police to educate employees not only on alcohol abuse but other drugs as explained below,

> *We do this together with drugs and we invited someone from Drug Enforcement Commission DEC, this year we have already carried out this activity.* ***KIDp3***

Male Circumcision and HIV/AIDS: This was addressed by 41/56 (73.21%) workplaces, while 15/56 (26.8%) did not address it at all. Table (8) shows the extent to which it was addressed. Fishers exact test of association between policy and addressing Male circumcision/HIV/AIDS as a key driver of the epidemic at P value= 0.747 (positive direction) workplaces without policy were less likely to address Male circumcision but was not statistically significant (P>0.05) to suggest a relationship.

In-depth interviews found that MC was covered as part of HIV/AIDS awareness talks, through counselling and in male circumcision workshops where providers as experts or part of the HIV/AIDS implementation team provide talks on Male Circumcision.

> *The wellness team talks about that and we bring in a doctor to talk about the benefits of male circumcision. We do this from time to time when we have some HIV prevention talks* ***KIHp9***

Male circumcision services were referred to partners, experts defined providers and government clinic depending on agreements the workplaces had with providers. Some workplaces had also employed the use of workplace champions on Male Circumcision as a key strategy to promote male medical circumcision, as explained by one key implementer**.**

> *One of the HIV/AIDS champions in our company are circumcised, we have gone so far as to make an interview of champions who have gone through MC which we use to educate others.* ***KIHp12***

Males having Sex with Males and HIV/AIDS: Males having sex with males /HIV/AIDS as a key driver of the epidemic was not addressed at all by the majority of workplaces 38/56 (67.86%),while 12/56 (21.43%) addressed it to some extent and only 5/56 (8.9%) reported addressing all aspects. Fisher's exact test of association between policy and addressing Males having sex with males /HIV/AIDS as a key driver of the epidemic at P value= 0.547(positive direction) found that workplaces without policy were less likely to address MSM (P>0.05) but was statistically not significant.

In-depth interviews found males having sex with males as a driver of HIV/AIDS was not being addressed because homosexuality was not openly practiced and the practice was illegal in Zambia. Some implementers found Homosexuality an uncomfortable subject to address because culturally it was perceived as a taboo.

> *We have never talked about this. We know that it may be happening but due to cultural norms, it's not only a taboo but illegal it's a topic we hardly talked about. Such a person here would suffer because 90% of our employees are males and heterosexual and are married. There are no known males having sex with males here* ***Kip****3*

The study found that most key implementers were unwilling and dismissive to explain how the workplace addressed in their HIV/AIDS programs except to mention that it was against the law. As explained by one implementer.

> *We have never talked about this. We know that it may be happening but due to cultural norms, it's not only a taboo but illegal. It's a topic we hardly talked about.* ***KIDp1***

The few workplaces that addressed males having sex with males addressed it during condom promotion and as a general topic on risky sexual behaviours associated with HIV. It was also found to be discouraged and condemned when someone was thought to be at risk of engaging in homosexuality and in so doing, deterring the practice. One implementer explained it this way,

> *We do mention it* (males having sex with males) *only when we feel someone is at risk of engaging in homosexuality but because of the legalities involved, it is a difficult topic to approach.*

4.12. Monitoring and Evaluation:

4.12.1. Planning

Implementation plan for HIV workplace programs: Implementation plans for HIV programs were available in only 28/56 (50%) workplaces with programs while 28/56 (50%) did not have implementation plans.

Implementation plans were helpful with guiding budgeting and program activities. The study also found that HIV/AIDS programs did not have stand-alone implementation plans but rather integrated with the organisations operational plans and also as part of the Human resources key strategy areas. The lack of implementation plans was found among some workplace and the difficulties to implement programs without a plan is echoed,

> *We don't have an implementation plan and it is not helpful because if we forget because we are busy as a team focusing on other work areas. We tend to forget but when there is a plan in place it helps to keep active. Because I also don't have anyone visibly sick within the work place I also justify that all is well. Because we implement based on as and when the need arises some areas can be neglected so it's somewhat not helpful not having a plan in place .* ***KIHp***

4.12.2. Monitoring

External Monitoring of Implementation of programs: Only 19/56 (33.93%) workplaces reported having an external monitoring organisation for their HIV/AIDS workplace programs. The majority of workplaces 35/56 (62.5%) did not have an external monitoring organisation and 2/56 (3.57%) did not know if there was an external monitor for their programs.

Internal monitoring of Implementation of programs: In contrast, internal monitoring was higher, with 42/56 (75.00 %) workplaces having a system in place, and the remaining 14/56 (25%) did not have internal monitoring systems in place for the implementation of programs. There were 12/56 (21.4%) workplaces who had no monitoring at all. Table (9) outlines the different methods used in monitoring implementation of HIV/AIDS workplace programs.

Table 9: Methodology of Monitoring HIV/AIDS workplace programs

	Methodology used to Monitor HIV/AIDs workplace Program					
	Regular mee	Periodic report	Service statist	Other	No monitoring	Totals
(N=56)	19	20	4	1	12	56
Percentage	33.93	35.71	7.14	1.79	21.43	100

In-depth interviews found that external monitoring of workplace programs was only reported among workplaces with an HIV/AIDS policy and some workplaces in the process of developing their policy. There were no external monitoring of HIV/AIDS programs for workplaces without policy. Most of these workplaces had only internal monitoring system.

4.12.3. Key indicators for monitoring program Implementation

Key indicator used to monitor implementation included the following:

The number of people attending workshops, number of forums conducted, number of condoms distributed, number of wellness talks provided, utilization of the medical scheme, Statistics of employees on chronic care ,the number of people trained, the number of people counselled at workplace clinic and employee satisfaction surveys.

In-depth interviews found that while a number of workplaces indicated reporting on some key indicators, some implementers felt that indicators were ill-defined and needed to be well defined to facilitate ease of report and consistency in monitoring outcomes.

Feedback on HIV/AIDS Programs: The majority of respondents 38/56 (67.86%) reported that they were receiving feedback on HIV/AIDS implementation and 17/56 % had no feedback, and 1/56 (1.79%) did not know.

Overall impact of implementation: The majority 42/56 (82.14%) said they had seen positive changes as a result of programs implementation. A few 4/56 (7.14%) said they had not seen any positive changes as a result of program implementation while 6 /56 (10.71%) could not tell if any positive change had occurred.

4.13. Measures of Association

To perform an analysis of comparison of two groups (workplace with Policy and workplaces without Policy) as categorical variables, all workplaces in the process of developing their workplace policy were considered as not having an HIV/AIDS Policy and categorised as such. The Fishers exact test for a test of independence of two categorical variables.

1. **HIV/AIDS policy:** A Fisher's exact of P=value < 0.0001 with (P<0.05) was significant evidence of association between having an HIV/AIDS workplace Policy and having HIV/AIDS workplace program. Availability of Policy predicted perfectly availability of programs.
2. **Confirmed document**: The association between HIV/AIDS policy and confirmed document, when confirmed document is hypothesised to influence availability of HIV/AIDS Policy found Fishers exact test of measure independence of association gave Fisher's exact P <0.0001, (P<0.05) suggesting a strong measure of association between having a policy and confirming document. Availability of confirmed document predicted perfectly availability of programs.

3. **Organisational size;** The association between HIV/AIDS policy and Size of organisation, when Size of the organisation is hypothesised to influence the availability of HIV/AIDS Policy gave Fisher's exact P= value <0.0001 at (P=<0.05) which was statistically significant to suggest a strong measure of association between having a policy and organisation size.
4. **Organisational type:** The association between HIV/AIDS policy when Organisation type is hypothesised to influence the availability of HIV/AIDS Policy gave Fisher's exact test measure of independence of association P= value <0.009 which was statistically significant (P <0.05) suggesting a strong measure of association between having a policy and organisation type.

Size of the organisation: The odds ratio on HIV policy and size of organisation 2.7 and P Value=0.0001 and statically significant (P<0.05). The odds of having a policy for workplaces in this study were increased with increased size of the organisation by 2.7 times holding all other variables constant. Univariate analysis on Top management support, Funding mechanisms and specific budget for HIV were all statically significant as illustrated in Table (10) when all other variables are held constant.

Type of organisation on Univariate analysis at P =value 0.049 (P<0.05) was almost statistically significant with an odds ratio of 0.941 at P value =0.049, holding other variables constant. Human resources numbers were statistically not significant with odds ratio 1.52 and P value = 0.24.

Multivariate analysis: Only top management support and having a specific budget for HIV/AIDS programs were statistically significant (P<0.05) predictors of implementation in Multivariate analysis with odds ratio 0.25, P. value= 0.013, and odds ratio 0.23 P value=0.027 respectively.

Table10: Determinants of Implementation of HIV/AIDS workplace policy logistic regression Univariate and multivariate analysis.

	Univariate Analysis			Multivariate Analysis		
Predictors	**Odds ratio**	**P Value**	**95% Conf interval**	**Odds**	**P value**	**95% Conf interval**
Organisation size	2.79784	0.0001*	1.740937 -4.496375	1.503014	0.430	0.5459534 4.13781
Organisation Type	0.941037	0.049*	0.8865841-0.716145	0.8749151	0.116	0.7405965 -1.033595
Top management	0.3003007	0.003*	.1351151 -.6674348	0.2535835	0.013*	0.0861585 0.7463523
Funding mechanism	0.15	0.014*	0.0332161-0.677383	0.6877451	0.589	0.176609 -2.678195
Specific HIV Budget	0.3223221	0.008*	0.1397287-0.743523	0.2386781	0.027*	0.0670701 -0.8493683
Human resources #	1.5258808	0.240	0.7535381-3.089546	1.719384	0.142	0.8347339 3.541585

4.14. No Policy / No HIV Program

There were workplaces among ZFE member companies that did not have a workplace policy or HIV programs in place as a result there were no Implementation factors collected except for reasons for not having a policy or program in place.

Size of the organisation

The size of the organisation was one reason for not having a policy. This response was observed from workplaces that were small in terms of numbers of employees, respondents reported that employees knew each other and because they were small in terms of employee numbers it was unnecessary to have a policy in place.

> *There is no policy in the workplace. I think it's because it's a small company. But we have a medical scheme for our staff. It is that scheme that they use to seek medical attention; we don't check what illnesses they have when they go* KR4

Type of organisations

Some implementer felt that the nature of their organisation did not necessitate having a policy. Among these included schools, computer companies and publishing/ printing organisations. This is explained by one implementer who said that the nature of their work did not justify having a policy in the comment below,

> *We have no policy; our main job is supply computers and all. Moreover is an international organisation, so to do a policy is not really my job, it would have to be something done at international level.* KR8

The study also found that religious predisposition of an organisation made it difficult in some cases to discuss HIV/AIDS as it is related to sex. This made it a taboo to talk publicly about HIV/AIDS and sex, thus, they did not have an HIV/AIDS policy or program in place.

> *We have no policy on HIV and AIDs because these are very sensitive issues to discuss as Muslims; sex is not something we discuss so, and no, we do not have anything to do with HIV/ AIDS issues in the workplace.* KR6

Limited finances

The study also found workplaces that did not have finances to put in place a policy. A few had indicated that while they had consulted some experts the cost of developing an HIV/AIDS policy was not affordable for them as small workplaces.

> *We have no policy because we depend on membership fees therefore venturing into other activities would be financially strenuous on our part* KR4

Lack of sensitisation

Some workplaces did not have an HIV/AIDS policy because they did not know how to develop one and also lacked sensitisation on multi-sectral response to HIV/AIDS. They admitted that having an HIV AIDS workplace policy has not been thought about.

> *We have not just been sensitised to the need of having a policy and yet we do have a few staff that have come out to say they are positive and disclosed their status*KR1

Health scheme

Some workplaces had no HIV/AIDS workplaces policy and programs in place but had a medical scheme in place for their employees. The medical schemes did not just cater for general illnesses but also catered for HIV/AIDS related illnesses and other chronic diseases.

> *We do not have an HIVAIDS policy because our health insurance covers for HIV like any other illness I think that's enough effort in responding to HIV.* KR10

In summary Workplaces without HIV/AIDS policy and programs had some form of health care provision for their employees that catered for HIV/AIDS but also some other chronic illness. The study also found that lack of sensitisation, lack of visibility of HIV/AIDS, the cost of developing a policy, the size of organisation and type were among the reasons for not having an HIV/AIDS policy in place.

CHAPTER 5:

5.1. Discussion

The health policy initiative tool of assessing policy implementation by employing a mixed method approach (Creswell, 2013) affords the opportunity to quantify and provide insights into findings. Workplaces were able to provide reasons for the lack of policy: lack of sensitization on their role in multi- sectral response, lack of resources, availability of health insurance covering chronic care and the size of the workplace. At the same time, they showed a wellness approach to the health of employees rather than focusing on HIV/AIDS as a stand-alone program.

The study established the existence of HIV/AIDS policies in the private sector environment at 26.56% (34/128) of the total sample size, 72.34% (34/47) of all workplaces with policy and 34/111 (48.81%) in the private sector. The public sector mainstreaming of HIV/AIDS (Mwewa, 2011) in Zambia found a larger proportion of line ministries with policy at 81.81% (18/22). Public sector is mandated to respond to HIV/AIDS but this is not the case with the private sector and may account for this difference.

Another study in South Africa (Lass, 2009) used students attending summer class at Stellenbosch University as respondents and found policies at 45% (110/220). The choice of respondents could have accounted for the low results on policy status in the study which was avoided in this study by using key implementers and confirming document availability. Another survey across Southern African countries (Mahajan et al., 2007) also found a low prevalence of 36.89% (83/225). However, when focused on South African companies alone, prevalence was higher at 98.67 % (93/96).

Marched sampling on the type (sector) of the workplace was not used in this study making it difficult to conclude that type of organisation has an influence of having a policy; however the use of qualitative interviews showed that type of workplace influenced having a policy-among workplaces such as faith-based, computer technology and schools. Highly mobile workforces, hotel/ hospitality, the agricultural and construction sectors where employees are confronted with epidemic drivers regularly had policies. This agrees with the findings of fewer policies among Wholesale sector firms 25% (19/77), Retail sector,12% (18/153) and an observed higher prevalence in the construction sector 52% (57/110) and 81% (35/43) and in financing sector (Mahajan et al., 2007).

Marched sampling for proportionate representation of size of workplace was not done. However Small workplaces where the majority without policies, consistent with findings by Lass (Lass 2009) where large workplaces had 54% policy, compared to 42.5% for medium and 36.1% in small workplaces. Across Southern Africa (Mahajan et al., 2007) large firms had 85-90% (N=101) availability of policies, Medium firms had between 65–70% (N= 196) and only 15-20% (N= 691) among small workplaces. Utilisation of in-depth interviews supported the reasoning that size of a workplace plays a role in availability policy. Lack of financial resources and lack of visibility were a few reasons cited for lack of policy among small workplaces.

However, the association found that size was significantly associated with policy at P value =0.0001 ($p<0.05$) but less significant when programs were considered at p value= 0.038, Fishers exact.

Almost all workplaces that had policy 46/47, had translated their policy into programs giving 98.87% implementation, which was very high. A recent evaluation of the participation employees in programs in the ministry of education (Chilekwa, 2014) in Zambia found 100% availability of programs in workplaces (N=30). Whereas simple random sampling was used in this study, Chilekwa's study had used purposive sampling for MOE workplaces with programs, which makes it difficult to form a comparison.

Among line ministry in Zambia (Mwewa, 2011) programs ranged from 41.45%-68% comprising of various components of HIV/AIDS prevention. The study used availability of any form of HIV/AIDS prevention elements to indicate implementation. While this may be a weakness in evaluating implementation, utilisation of scales on extent to which programs addressed key drivers of the HIV epidemic provided addition strength in assessing implementation.

When implementation is assessed based on the total sample size and availability of programs , 56/128 workplaces had programs indicating only 43.75 % implementation among workplaces surveyed, which agrees more with Mwewa's study. Other studies (Lass 2009) reported programs at 41.5%.

Having a policy predicated having a program in place perfectly with odds ratio of 1, meaning having a policy in place was as good as having programs in place .Strengthened further with the findings that only 10/72 workplaces without a policy had programs compared to 46/47 workplaces with policy. This may account for the lack of differences in measures of association among workplaces with a policy and those with programs only.

Mechanisms and relationships

Policies remaining in draft form for long period's restricted access to resources thereby affecting implementation. Similar results were found of 5.7% of policies (Lass 2009) in draft or not completed in time (Mwewa, 2011). Utilisation of expert consultants or external subcontractor (Chileshe, 2010) can be used to avoid this. However, for small workplaces external providers are not always affordable and accessing them may not be a priority.

Management had more involvement in policy formulation (68 .09 %) compared to employees (57.69).These findings were high compared to Ministry of Education (Chilekwa, 2014) where management involvement was as low as 25-30% (n=64). The lack of employee participation in formulation processes was observed through qualitative interviews. The specificity of a policy to a given company's context was lost due to 'copy paste' syndrome reported in other studies (Mahajan et al., 2007) to fulfil a management or operational requirement of having a policy in place.

While policy dissemination was high, 95.74 % compared to findings in the public 53.6 % (n=480) sector in Zambia (Mwewa, 2011) there was a notable need for ongoing dissemination as observed from the quantitative interviews.

The majority of implementers were Human resources managers (43/76.79%), consistent with what is prescribed in the public sector (Mwewa, 2011). Having this as part of the performance area for assessment shows that structures do exist in the workplace where programs can be attached to responsible unites for oversight to ensure implementation, with management support. While HIV/AIDS committees were effective in most workplaces, leadership effectiveness at implementing the Policy was perceived as ineffective in some workplaces, however to effectively measure effectiveness key outcomes needed to have been defined.

Participation in programs was high (96.42 %) compared to the public sector (Chilekwa, 2014) were low management participation was reported by 50%, high participation, by 20%, and employee participation at 69% only (Chilekwa, 2014). The utilisation of scales showed that more employees widely participated (71.42%) in programs compared to top management, contrary to findings in line ministry (Mwewa, 2011) where there were no significant differences between management and general workers participation in programs.

Contrary to findings in line ministries of no difference between male and female participation in programs (Mwewa, 2011), in-depth interviews showed that there was a difference in participation and females were limited by Gender and cultural norms.

Resources

Though implementation plans were lacking in half of the workplaces with programs, their usefulness was noted qualitatively in the allocation of limited resources, providing guidance and accountability for effective management of HIV/AIDS programs.

The majority of workplaces with programs and the majority (64.29 %) were self-funded. This is close to findings of a national survey to assess funding for HIV programs in Zambia found 58% of workplaces were self-funded (NAC, 2009).Only half of the workplaces with programs had a specific budget for HIV programs and these reported minor barriers to accessing funds for programs. Delayed and competing funding needs were noted across all workplaces, however, where funding was dependent largely on donors, donor withdrawal affected continuity of programs and underscores the need to plan past post donor funding periods as was found in the ministry of education study (Chileshe, 2010) in Zambia.

The revised National strategic framework 2014-2016 challenges and suggests more strategic ways of financing programs towards eradicating HIV/AIDS by 2030 (UNAIDS, 2014). Leveraging on medical insurances schemes (NAC, 2014) for sustainability and strengthening health promotion/ prevention strategies that are less costly than treatment. While this study did not explore actual budgets allocated to programs, nor the cost benefit of having programs, but the utilisation of in-depth interviews found that workplaces that had policy also indicated having a specific budget for their programs. Which was strengthened with a Fisher's exact test P-value = 0.012 which was Significant ($P<0.05$) to suggests, strongly, that there is a difference between workplaces with a policy and those without.

Staff turnover-challenged implementation in the absence of continued training. Making use of sub guarantees was effective in Ministry of Education to mitigate the lack of capacity (Chileshe, 2010).Equipment and information insufficiencies resulted from broken down and out-dated tools with current needs of the HIV/AIDS programs and a lack of female condoms compared to male condoms. There was a burnout with HIV/AIDS-related topics and a need for more information on general health and wellness. Implementers advocated for resource centres on health rather than dedicated space for HIV/AIDS to reduce stigma among employees and improve access.

Elements of HIV/AIDS workplace programs –experiences

The Revised national strategic plan 2014-2016 ascribes to the UNAIDS challenge of eradicating HIV/AIDS by 2030 and has put in place key strategies for a multi-sectral response. While the study found the translation of policy to programs to be high at 97.87%, the extent to which some elements of HIV/AIDS prevention programs were being addressed as reported by implementers was of concern.

HIV/AIDS awareness activities are a critical a first step in accessing HIV testing services. Compared to findings in line ministries,55.2%, in Zambia (Mwewa, 2011), awareness activities were high. To eradicate HIV/AIDS by 2030 (UNAIDS, 2014) requires 90% of all people living with HIV know their HIV status by 2020.This requires concerted efforts in raising awareness at all levels.

Voluntary testing and counselling: Provision of VCT was high compared to line ministries in Zambia 48.30 % (Mwewa, 2011) and other studies (75%) (Mahajan et al., 2007). The majority also provided within the workplace. As a vital point of entry to primary prevention care and support services in the and management of HI-related illness (Sherr et al., 2007) it contributes towards the goal of eradicating HIV/AIDS. A study evaluating VCT uptake in workplaces (Corbett et al., 2006) in Zimbabwe found that there was increased uptake on site (mean site uptake of 51.1%) compared to offsite alternative (mean site uptake of 19%) explained by convenience of access, rapid testing (Matovu and Makumbi, 2007), frequent awareness campaigns, the group nature of campaigns and increased HIV awareness facilitated by pre-test counselling (Bhagwanjee et al., 2008). Some workplaces avoided barriers to VCT uptake such as stigma, fear of receiving an HIV-positive status, lack of confidentiality and discrimination, by coverage through government clinics and medical insurance schemes. Being able to refer VCT services to government clinics allows small workplaces to manage the cost of HIV/AIDS programs (Mahajan et al., 2007 (Mahajan et al., 2007) by tapping into free government services.

Provision of Male and female Condoms: The majority of workplaces (67.86 %) provided male condoms, comparable to findings in line ministries (Mwewa, 2011) where 226/309 (73.1%) respondents reported access to both male and females condoms through their workplace. Making condoms available allows for increased utilisation as found in a Tanzanian study (Matimbwi, 2013) were 97% of respondents utilised condoms from their workplace programs.

While women have a higher prevalence of HIV compared to men in Zambia (CSO, 2014) among the many factors contributing to this vulnerability is the paucity in available of female-driven HIV prevention tools as evidenced by the limited access to female condoms in this study.

Antiretroviral therapy: Provision of ART of (91.07%) was high. The sub-Saharan Africa survey found only 50% and less (Mahajan et al., 2007). Time difference between the two studies can argue that in 2007 ART was less accessible. In a more recent study in line ministries in Zambia (Mwewa, 2011), access to ARVS was reported by 40.09 % (123/301) with a strong association to mainstreaming. The Zambian government continues to be the primary provider of free treatment of HIV/AIDS (NAC, 2014) as observed in the high number of private sector workplaces reporting access through government clinics thereby minimising and diverting costs of treatment to the public sector (Rosen et al., 2007)

Utilisation of medical schemes for the provision of ART was a similar finding to other studies such as in Ministry of Education (Chileshe, 2010) in Zambia and findings across sub-Saharan countries surveyed (Mahajan et al.,2007). Apart from helping to decongest the public sector ART clinics, it enables employers to reduce overall cost and maintaining confidentiality for employees.

Selected drivers of the Epidemic

Homosexual males worldwide are 19 times more likely to be living with HIV than the normal adult male (Baral, 2007). As an epidemic driver, this was not addressed at all in 67.86% of workplaces and the primary reason given was that it was illegal Zambia.

Zambia's adult prevalence of HIV at 13% remains high and challenges targeting marginalised populations with a rights-based approach Prevention programs need to address anal sex being riskier in HIV/AIDS transmission compared to vaginal sex, condoms failure being more likely in MSM. Like other illegal practices, homosexuality and the associated risks to HIV should be addressed in all HIV/AIDS prevention programs to avoid missing hot spots towards eradicating HIV/AIDS (UNAIDS, 2014).

Partner involvement increases PMTCT service uptake compared to when the woman has no partner support (Besser 2010). Women (88.8%) are more aware than men (82.1%) about HIV transmission through breastfeeding and are more aware that this risk can be reduced during pregnancy 82.0% and 65.8% respectively (CSO, 2014) PMTCT information needs to reach more men; the workplace provides a place where men can easily be reached to increase partner involvement.

Stigma and discrimination surrounding HIV/AIDS is not only contrary to human rights but also represents a major obstacle to successful workplace programs (Skinner and Mfecane, 2004). Stigma prevents employees from accessing and taking part programs in the workplace and interferes with VCT uptake, condom uptake as well as undermines trust and confidentiality for fear of being victimised and discriminated against (Setswe, 2009).

Integration of Gender was lacking and not at all clear if it existed in some workplace policies. Violence against women has been closely linked to HIV(Murray et al., 2006) as it limits negotiation of safe sex and increases vulnerability to HIV/AIDS (Chatora, 2013).The workplace provides an environment to educate both men and women on GBV its association to HIV by partnering with the Victim support unit and gender experts in providing the legal framework on GBV linkages for support to victims.

Alcohol abuse increases risky sexual behaviour and exposure to HIV/AIDS (Weiser, 2006). Unprotected sex, having sex with a stranger and paying for sex (Magni, 2015) have all been associated with alcohol abuse and moderate alcohol drinking (Kumwenda 2009).

Monitoring and Evaluation

The National Aids strategic framework provides a reporting system for private sector workplace in the National Aids Reporting Format for M /E with standardised indicators for reporting (NAC, 2009). However, some workplaces lacked well-defined M/E systems for their HIV/workplace programs. Similar findings emerged from line ministries (Mwewa, 2011) in Zambia. While tools exist the lack of local level partnerships (Allison and Kelly 2009) and reduced coordination especially with the demise of ZWAP limits access to the tools given that a number of key implementing partners winding up their activities.

Partners have continued to provide workplaces with necessary HIV prevention messages and trainings. Mahajan's survey (2007) also acknowledged the difficulty in collecting data from workplaces, even with the utilisation of sub guarantees in the private sector, which compromises the quality of data and decision making for planning in the evaluation of program impact (Ukpere, 2014).

5.1.1. **Limitations of the study:**

The scarcity of academic literature available on HIV/AIDS activities in the private sector in Zambia meant that this study relied on reports and limited research from the public sector.

The sampling strategy used did not take into account proportionate sampling of work workplaces by size or type of workplaces. Therefore, caution in applying associations and comparisons of findings to the public sector was a limitation. However, the utilisation of mixed methods found that qualitative findings supported most of the associations made quantitatively.

A sampling frame of ZFE members companies in Lusaka was used to obtain a proportionately large number of private sector workplaces which, limits the generalisation of results to ZFE member companies.

Though permission and authorisation to collect data was obtained from both the respondent and management, some respondents without policy or those without programs tend to be defensive in explaining the lack of policy and programs in the workplace. On the converse respondents that had policies and programs also tended to give very positive responses regarding their programs. Detailed questioning on sufficiency's and extent of coverage of programs was able to show the adequacy and challenges of the programs become evident.

Utilisation of key implementers as respondents did not only introduce responder bias but the exclusion of policy-makers and partners limited the scope of the study. A broader perspective would have been more informative to understand policy implementation challenges from managers, policy makers and other stakeholder's perspective. However, responder bias was mitigated by the utilisation of mixed method and scaled responses that provided cross checking of responses.

In workplaces were key implementers were unavailable for scheduled interviews and had instead requested a proxy to be interviewed, this may have affected the quality of responses. However, in the tool provided for options when the respondent was unsure or could not provide a response.

Lastly, the study did not explore further the utilisation of health insurance services in managing HIV/AIDS and other chronic diseases from both provider's perspective and the workplace. This would have given a broader understanding of how health insurance has been used for financing HIV/AIDS and other chronic care conditions. This is a focus for further research towards sustained financing of health related workplace programs.

5.1.2. **Conclusion and Recommendations**

The majority of workplaces surveyed were from the private sector meaning that private sector workplaces in the survey had a low response to HIV/AIDS through HIV/AIDS Workplace Policy adoption but a high proportion of implementation of HIV/AIDS programs.

The study concluded that Workplace policies exist in the private sector at a very low proportion, but policy translation into programs among workplaces with policies was very high. The findings suggest that workplaces with policies are more likely to translate their policy into programs.

There is a need therefore to sensitise private sector workplaces on their role in responding to HIV/AIDS in the workplace by strengthening and having more workplaces adopt HIV/AIDS policies/programs for workplaces with a comprehensive wellness approach.

The study concluded that having adequately trained human resources and funding mechanisms in the form of specific budgets for HIV/AIDS programs facilitated implementation of programs in the workplaces.

There is a need to identify and strengthen strategic and efficient methods of integrating HIV/AIDS programs in private workplaces through health insurances and networking with key partners and government clinics.

The study concluded that Leadership and employee involvement participation in the formulation of policy and programs were high but factors such as the social status of employees, migration/mobility cultural and gender norms; affected the extent of implementation of programs by limiting the extent of participation and involvement in programs.

The study concluded that lack of planning for resources and weak uptake of existing Monitoring / Evaluation tools in the private sector hinder effective implementation and management of HIV/AIDS workplace policy.

There is a need to sensitisation and strengthen utilisation of existing National Aids Reporting system for Monitoring /Evaluating in the private sector by strengthening private sector coordination of data collection for HIV/AIDS workplace programs.

From key implementer's experiences in addressing selected key drivers of the HIV/AIDS epidemic, it is concluded that epidemic drivers such as males having sex with males, prevention of mother to child transmission and gender-based violence, are not extensively addressed in the workplace programs.

There is a need to strengthen existing policy and guidance on responding to HIV/AIDS with focused on addressing key drivers of HIV/AIDS, marginalised populations such as males having sex with males, women's vulnerability to HIV/AIDS with rights-based approach and gender integration.

The study concluded that HIV/AIDS workplaces programs provided some elements of HIV/AIDS programs, however, the extent to which programs addressed these elements needed strengthening by leveraging on already existing VMMC , VCT and ART access networks between workplaces and government clinics.

Further Scholarly research on health-related interventions in the private sector is important and necessary to under to understand impact and response to public policy on the private sector.

References

ALLISON , D. & KELLY , V. 2009. The costs and benefits of HIV workplace programmes in Zambia Technical approach paper, HLSP Institute.

BAGGALEY, R., GODFREY-FAUSSETT, P., MSISKA, R., CHILANGWA, D., CHITU, E., PORTER, J. & KELLY, M. 1995. How have Zambian businesses reacted to the HIV epidemic? *Occupational and environmental medicine,* 52**,** 565-569.

BARAL, S., SIFAKIS, F., CLEGHORN, F., & BEYRER, C. 2007. EElevated Risk for HIV Infection among Men Who Have Sex with Men in Low- and Middle-Income Countries 2000–2006: A Systematic Review. *PLoS Medicine, ,* 4(12), e339.

BERTOZZI, S. M., LAGA, M., BAUTISTA-ARREDONDO, S. & COUTINHO, A. 2008. Making HIV prevention programmes work. *The Lancet,* 372**,** 831-844.

BESSER , M. 2010. HIV in Pregnancy: Doing More with Less: Mothers2Mothers.

BHAGWANJEE, A., PETERSEN, I., AKINTOLA, O. & GEORGE, G. 2008. Bridging the gap between VCT and HIV/AIDS treatment uptake: Perspectives from a mining-sector workplace in South Africa. *African Journal of AIDS Research,* 7**,** 271-279.

BHUYAN , A. 2005. Commitment for Action: Assessing Leadership for Confronting the HIV/AIDS Epidemic—Lessons Learned From Pilot Studies in Bangladesh, India, Nepal, and Viet Nam. Washington,DC: Futures Group, POLICY Project.

BHUYAN , A., JORGENSEN , A. & SHARMA , S. 2010. Taking the Pulse of Policy :The Policy Implementation Assessment Tool. Washington, DC: Futures Group, Health Policy Initiative.

BLOOM, D. E., BLOOM, L. R., STEVEN, D. & WESTON, M. Business and HIV/AIDS: a healthier partnership? A global review of the business response to HIV/AIDS 2005-2006. 2006. Geneva Switzerland World Economic Forum 2006.

CHATORA, B. E. 2013. *The role of gender based violence in HIV transmission among women in Lusaka, Zambia.* Stellenbosch: Stellenbosch University.

CHILEKWA, K. C. 2014. Participation of workers in the HIV and AIDS workplace programmes public sector: A case of Chipata and Sesheke Districts.

CHILESHE, P. S. 2010. *The implementation of HIV/AIDS workplace programme in the Ministry of Education in Zambia.* Stellenbosch: University of Stellenbosch.

CORBETT, E. L., DAUYA, E., MATAMBO, R., CHEUNG, Y. B., MAKAMURE, B., BASSETT, M. T., CHANDIWANA, S., MUNYATI, S., MASON, P. R. & BUTTERWORTH, A. E. 2006. Uptake of workplace HIV counselling and testing: a cluster-randomised trial in Zimbabwe. *PLoS Med,* 3**,**e238.

CRESWELL, J. W. 2013. *Research design: Qualitative, quantitative, and mixed methods approaches*, Sage publications.

CSO, M. A. I. 2014. Zambia Demographic and Health Survey 2013-14. Rockville, Maryland, USA: Central Statistical Office,Ministry of Health, and ICF International.

DIELEMAN, M., BIEMBA, G., MPHUKA, S., SICHINGA-SICHALI, K., SISSOLAK, D., VAN DER KWAAK, A. & VAN DER WILT, G.-J. 2007. 'We are also dying like any other people, we are also people': perceptions of the impact of HIV/AIDS on health workers in two districts in Zambia. *Health Policy and Planning,* 22**,** 139-148.

FREEMAN, R. E. 2010. Strategic management: A stakeholder approach. Cambridge University Press.

GOBIND , J. & UKPERE , W. 2014. Evaluating HIV/AIDS Programme within South African Universities. *Mediterranean Journal of Social Sciences*.

ILO 2004. Workplace action on HIV/AIDS.

ILON, L., BARWISE, K., HUSKEN, S. & TEMBO, M. 2007. Cost benefit analysis of HIV workplace programmes in Zambia.

KUMWENDA , A. 2009. *The Role of Alcohol Use in HIV transmission Among Grootfotein Residents in Namibia .* Master of Philosophy HIV/AIDS Management StellenBosch Univeristy

LASS , A. 2009. *HIV/AIDS workplace policy development and implementation in a selected sample of South African organizations.* Stellenbosch : Stellenbosch University.

MAGNI, S., CHRISTOFIDES, N., JOHNSON, S., & WEINER, R. 2015. Alcohol Use and Transactional Sex among Women in South Africa: Results from a Nationally Representative Survey. *PLoS ONE, 10(12), e0145326.* .

MAHAJAN, A. P., COLVIN, M., RUDATSIKIRA, J.-B. & ETTL, D. 2007. An overview of HIV/AIDS workplace policies and programmes in southern Africa. *Aids,* 21**,** S31-S39.

MATIMBWI, T. J. 2013. *Assessment of HIV/AIDS workplace policies and programme interventions in commercial farms in Iringa region.* Muhimbili University of Health and Allied Sciences.

MATOVU, J. K. & MAKUMBI, F. E. 2007. Expanding access to voluntary HIV counselling and testing in sub-Saharan Africa: alternative approaches for improving uptake, 2001–2007. *Tropical Medicine & International Health,* 12**,** 1315-1322.

MERINO L, Q. C., CANO F, ALVARADO A , CASTILLO L. 2009. Assessments of National HIV Policy Implementation in Guatemala and El Salvador Help Identify Approaches for Overcoming Barriers to Implementation.

MURRAY, L. K., HAWORTH, A., SEMRAU, K., SINGH, M., ALDROVANDI, G. M., SINKALA, M., THEA, D. M. & BOLTON, P. A. 2006. Violence and abuse among HIV-infected women and their children in Zambia: a qualitative study. *The Journal of nervous and mental disease,* 194**,** 610.

MWEWA, A. 2011. *An Evaluation of HIV and Aids mainstreaming in line ministries.* The University of Zambia.

NAC 2009. Private Sector Strategy for HIV and AIDS in Zambia 2006-2010 Learning from the past -planing for the future .

NAC 2011. Zambia National AIDS strategic framework , 2011-2015

NAC 2014. ZAMBIA COUNTR REPORT Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access Biennial Report.

PEIRSON, L., CILISKA, D., DOBBINS, M. & MOWAT, D. 2012. Building capacity for evidence informed decision making in public health: a case study of organizational change. *BMC Public Health,* 12**,** 137.

PSMD 2010. HIV AND AIDS STRATEGY FOR THE PUBLIC SERVICES 2010-2015.

ROSEN, S., FEELEY, F., CONNELLY, P. & SIMON, J. 2007. The private sector and HIV/AIDS in Africa: taking stock of 6 years of applied research. *Aids,* 21**,** S41-S51.

SETSWE, G. K. G. 2009. *Best practice workplace HIV/AIDS programmes in South Africa: A review of case studies and lessons learned*.

SHERR, L., LOPMAN, B., KAKOWA, M., DUBE, S., CHAWIRA, G., NYAMUKAPA, C., OBERZAUCHER, N., CREMIN, I. & GREGSON, S. 2007. Voluntary counselling and testing: uptake, impact on sexual behaviour, and HIV incidence in a rural Zimbabwean cohort. *Aids,* 21**,** 851-860.

SKINNER, D. & MFECANE, S. 2004. Stigma, discrimination and the implications for people living with HIV/AIDS in South Africa: Original article. *SAHARA: Journal of Social Aspects of HIV/AIDS Research Alliance,* 1**,** p. 157-164.

SMART , R. & MCKENNA , S. 2006. WORKPLACE HIV AND AIDS POLICY MANUAL. Lusaka, ZAMBIA: Afya Mzuri.

WEISER, S. D., LEITER, K., HEISLER, M., MCFARLAND, W., KORTE, F. P., DEMONNER, S. M., … BANGSBERG, D. R. 2006. A Population-Based Study on Alcohol and High-Risk Sexual Behaviors in Botswana. *PubMed* PLoS Medicine, 3(10), e392.

WHO 2010. Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector, Geneva, Switzerland.

WHO 2014. Global Summary of the AIDS epidermic.

ZBC 2006. Zambia business coalition repot profile.

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Appendix 1

PARTICIPANTS INFORMATION SHEET

My name is Bridget Chatora. I am a student with the University of Zambia. I am going to share with you some information regarding this study.

I am conducting a study titled **Implementation of HIV/AIDS workplace policy, the implementers' perspective** in member companies of the Zambia Federation of Employers in Lusaka, Zambia. I would like to understand experiences and factors that hinder or facilitate HIV/AIDS policy implementation in the workplace. This information gathered will be used to inform policy makers and stakeholder including, Zambia Federation of Employers, National AIDS Council, as well as workplace management on what is working and what is not in policy implementation as well as to understand experiences and challenges.

I am asking you to participate in this study because of your role as a key implementer of the HIV/AIDS workplace policy in your workplace. Your experience will provide valuable insights to the study in the management of HIV/AIDS in the workplace.

In the study, you will be asked questions on the development and implementation of your organisations HIVAIDS workplace policy. The questions will focus on leadership /employee involvement, resources allocation, HIV programs, partnerships, Monitoring and Evaluation as well as availability of plans. Your suggestions and experience on how to improve policy implementation will be documented. If there are no programs, your experiences and suggestions on how the policy is managed and can be improved will be documented. You will also be asked to review your organisations HIV/AIDS Policy documents, and HIV/AIDS program and plans.

There may be some discomfort in disclosing workplace cultures that maybe perceived as hindering policy implementation. Your honest responses to these questions are very important to this study. Your responses will be treated with confidence. If you experience any discomforts and would like to discontinue, you are free to do so.

Participation in this study is voluntary and your participation will not attract any payments for taking part in the study. Information collected from you on the HIV/AIDS workplace policy in your workplace will be kept strictly confidential. Your name will not be used to identify you and the information collected. I would greatly appreciate your honest response during the interview.

If you have any questions or concerns about the research please contact:

1. Contact, principle investigator

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Appendix 2

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CONSENT TO PARTICIPATE IN RESEARCH STUDY

INFORMED DOCUMENT CONCENT

STUDY TITLE: Implementation of HIV/AIDS workplace policy, the implementers' perspective.

PRINCIPLE INVESTIGATORS: Bridget Chatora IRB NO....

INTRODUCTION

My name is Bridget Chatora; I am a student with the University of Zambia School of Medicine department of Public health. I am conducting this study in partial fulfilment of completion of my masters program in Public health policy and management. I am the investigators on this study .The study is being done in workplaces who are member companies of Zambia Federation of Employers with HIV/AIDS workplace policies in Lusaka, Zambia

PURPOSE OF THE RESEARCH:

In this study I am investigating the implementation of HIV/AIDS workplace policies in companies that have developed this policy. I will be assessing the proportion of workplaces that have translated HIV/AIDS workplace policies into programs and the factors that have hindered or facilitated the process of implementation. I would also like to understand the experiences in the implementation process from the perspective of key implementers in the workplace. The information gathered will help to understand experiences and challenges with policy implementation. This information will be used to inform policy makers including National AIDS Council, Zambia Federation of Employers and the workplace management and other stake holders on what is working and what is not in policy implementation.

WHY YOU ARE BEING ASKED TO PARTICIPATE

I am asking you to participate in this study because of your role and the experience you have in the implementation of HIV/AIDS workplace policy within your workplace. Your experience will provide valuable insights to the study in the management of HIV/AIDS in the workplace.

PROCEDURES

If you agree to participate in this study, you will be asked questions on the development and implementation of your organisations HIVAIDS workplace policy. The questions will focus on leadership /employee involvement, resources allocation, HIV programs, partnerships, monitoring and Evaluation as well as availability of plans. Your suggestions on how to improve policy implementation and your experience in the implementation process will be documented. If there are no programs your experiences on how the policy is managed will be reviewed.

During the study you will be asked to review your organisations HIV/AIDS Policy documents, and HIV/AIDS program and plans. You will be asked on the factors that have facilitated or hinder policy implementation. You will also be asked on your suggestions and experience on implementation process well as possible improvement areas.

RISKS/DISCOMFORTS TO SUBJECT OR OTHERS

If you agree to take part in the study, the information required in this study maybe your personal experience in the implementation of the policy in your workplace environment. There may be some discomfort in disclosing workplace cultures that maybe perceived as hindering policy implementation. Your honest responses to these questions are very important for future the studies and also in informing policy makers and stake holders on challenges and success in implementation process. Your responses will be treated with confidence. If you experience any discomforts and would like to discontinue, you are free to do so.

BENEFITS

If you agree to participate in this study there are no direct benefits to you but you will be contributing to the understanding of experiences and challenges in the implementation of HIV/AIDS workplace and overall management of HIV/AIDS in the workplace. The information collected will be useful to inform policy makers and stakeholder on HIV/AIDS policy implementation in the workplace.

PAYMENT:

Participation in this study is voluntary and your participation will not attract any payments for taking part in the study.

CONFIDENTAILITY

Data collected from you regarding implementation of HIV/AIDS workplace policy in your workplace will be kept strictly confidential and can only be shared with your permission and anything you say will be kept completely confidential during the interviews.

Your name will not be used to identify you and the information collected. I would greatly appreciate your honest response during the interview. You do not have to answer any question you do not want to, I will skip that question and continue with the following questions. You can chose to end participation in the study any time you want.

WHO DO I CALL IF I HAVE QUESTIONS OR PROBLEMS

If you have any questions or concerns about the research please contact:

1.Contact , principle investigator

Bridget Chatora: +260967857211
University of Zambia School of Medicine
Department of Public health
Box 50110 Lusaka Zambia
E-mail: bridgetchatora@yhoo.com

2.ERES Converge Institutional Review Board

Plot 33 Joseph Mwila Road Roads Park
P/B15 Lusaka, Zambia
+260955515633
+260955155634

3. Dr Wilbroad Mutale (supervisor)

University of Zambia School of Medicine
Department of Public health

Box 50110 Lusaka Zambia

E-mail: wmutale@gmail.com

4. Mrs Linda Olowski

University of Zambia School of Medicine
Department of public health

Box 50110 Lusaka Zambia

Kap@yahoo.com

WHAT DOES YOUR SIGNATURE AND THUMBPRINT ON THIS CONCENT MEAN

Your signature (or thumbprint/mark) on this form means:

- You have been informed about the research purpose, procedures, possible benefits and risks.
- You have been given the chance to ask questions before you sign.
- You have voluntarily agreed to be in this study

_____ _____ _____

Print name of Adult Participant Signature of Adult Participant Date

_____ _____ _____

Print name of Person Obtaining Signature of Person Obtaining Consent Date consent

Ask the participant to mark a "left thumb impression" in this box if the participant is unable to provide a signature above.

APPROVED
07 AUG 2015
ERES CONVERGE
P/BAG 125, LUSAKA.

Appendix 3:

Integrated Quantitative and Qualitative Data Collection Tool

Questions used in this tool have been adapted from the HEALTH POLICY INITATIVE TOOL: TAKING THE PULSE OF POLICY-THE POLICYIMPLEMENTATION ASSESSMENT TOOL. The questions have been adapted to suite HIV/AIDS workplace policy implementation. This tool will be used to collect quantitative and qualitative data from key workplace HIV/AIDS policy implementers in their organisations.

(Please obtain and enter all basic information about the implementer before the interview)

Basic Information about the Key Informant: Participants Study Code .....

Job Title.....

Sex: Female / Male (circle)

Length of time at Organisation.....

Name of Organisation .....

Role of Key Policy implementer (HIV/AIDS policy /programs)
.....

Address of Organisation .....

Date of interview.....

Interviewer .....

(Please obtain and enter all basic information about HIV/AIDS Workplace policy by Physical review of the Policy document)

Full Name (and number if applicable) of the policy that is the focus of the assessment:

.....

Date officially approved .....

Policy goals (summarize as stated in Policy)

1.....
2.....
3.....
4.....

Policy objectives (summarize as stated in Policy)

1.....
2.....
3.....
4.....

Policy time frame .....

Signature of interviewer certifying consent was obtained.....

Respondent agreed to interview: 1 (tick appropriately) ……

Respondent does not agreed to interview: 2 (tick appropriately)……..

Demographics on the organisation			
1	What is the size of the size of the organisation?	Less than 100 1 100-499 ` 2 500-1000 3 More than 1000 4	
2	What type of company are you working for?	Government 1 NGO/CBO 2 Corporate sector 3 Private 4 Other 5 Specify:……	
3	Why was the policy adopted?	Visibility of the disease in organisation 1 Visibility of the disease in country 2 Impact on production and skills 3 Cost of interventions 4 Pressure from trade unions 5 I don't know 6	
	Review the goals and objectives of the policy (listed above on the first page of the interview guide). Confirm with the respondent that he/she is aware of the contents of this policy and can answer questions about its implementation.		
A. Policy, Formulation, and Dissemination			

4	Referring to the goals and objectives of this policy, to what extent do you think these goals and objectives address the key issues on HIV/AIDS in the work?	Do not address important issues 1 Addresses some key issues, but many missing 2 Addresses most of the key issues, but some missing 3 Addresses all key issues 4 I do not know 5 No response 6	
	Please explain why :		
5	To what extent does the policy address the needs of the employees living with HIV/AIDS and their health status?	Does not address needs of employees living with HIV/AIDS 1 Addresses some key issues affecting employees living with HIV/AIDS 2 Addresses most of the key issues affecting employees living with HIV/AIDS 3 Addresses all key issues affecting employees living with HIV/AIDS 4 I do not know 5 No response 6	
	Please explain why :		
6	To what extent does the policy address gender issues in the workplace?	Does not address key gender issues 1 Addresses some key gender issues 2 Addresses most of the key gender issues 3 Addresses all key gender issues 4 I do not know 5 No response 6	

Please explain why :				
	*(If the policy specifies a timeframe, read out the timeframe then ask question **Q7**; otherwise skip to **Q8**)*			
7	In your opinion, are the goals and objectives achievable within the timeframe set out in the policy?	Not applicable Yes No I don't know No response	1 2 3 4 5	
	Please explain why :			
8.a	To what extent were employees in your organization involved during the process of formulating the policy?	Involved Not involved Moderate involvement Extensive involvement I do not know No response	1 2 3 4 5 6	
8.b	In your opinion how has this degree of employee involvement in policy formulation affected your policy implementation?			
	Please Explain.			
9.a	To what extent were managers in your organization involved during the process of formulating the policy?	Involved Not involved Moderate involvement Extensive involvement I do not know No response	1 2 3 4 5 6	
9.b	In your opinion how has this degree of management involvement in policy formulation affected policy implementation?			

	Explain ……..		
10	In your opinion, how well was the policy disseminated to various departs within the workplace?	Not disseminated 1 Limited dissemination 2 Disseminated widely; no forums for discussion . 3 Disseminated widely; with forums for discussion 4 I do not know 5 No response 6	
	Please explain why :		

B Social, Political, and Economic Context

The questions in this section include any specific social, economic, or political issues that may affect policy implementation

From your perspective, how do social factors —within the work place or outside —facilitate or hinder you or your organization's ability to implement this policy? Please consider religious practices or beliefs, gender norms, cultural practices, ethnic affiliations, or social status, organisations finances etc

11.a	Religious practices or beliefs	Facilitate 1Hinder 2 Not applicable 3 No response 6	
	Please explain how		
11.b	Gender norms	Facilitate 1 Hinder 2 Not applicable 3 No response 4	
	Please explain how		
11.c	Cultural practices	Facilitate 1 Hinder 2 Not applicable 3	

		No response 4	
	Please explain how		
11.d	Ethnic affiliations	Facilitate 1 Hinder 2 Not applicable 3 No response 4	
	Please explain how		
11.e	Social status of employees	Facilitate 1 Hinder 2 Not applicable 3 No response 4	
	Please explain how		
11.f	Organisations finances	Facilitate 1 Hinder 2 Not applicable 3 No response 4	
	Please explain how		
11.g	Other…..specify	Facilitate 1 Hinder 2 Not applicable 3 No response 4	
	Please explain how		
12	**In your opinion, how do economic factors—at either organisation or national levels—facilitate or hinder you or your organization's ability to implement this policy? Please take into consideration domestic economic issues as well as global assistance priorities and mechanisms.**		
12.a	Unemployment	Facilitate 1 Hinder 2 Not applicable 3	

		No response 4	
	Please explain how		
12.b	Migration	Facilitate 1 Hinder 2 Not applicable 3 No response 4	
	Please explain how		
12.c	Poverty	Facilitate 1 Hinder 2 Not applicable 3 No response 4	
	Please explain how		
12.d	Other specify	Facilitate 1 Hinder 2 Not applicable 3 No response 4	
	Please explain how		
Leadership for Policy Implementation			
13	Currently, is there <u>support/opposition</u> from your organisations Management leadership for implementing this policy?		
13.a	Top management	Support 1 Opposition 2 Not applicable 3 No response 4	

	Please explain how			
13.b	Middle management	Support Opposition Not applicable No response	1 2 3 4	
	Please explain how			
13.c	Lower management	Support Opposition Not applicable No response	1 2 3 4	
14.a	In your understanding, what is the lead institution for implementing the HIV/AIDS work place policy in the country?			
	Please explain how			
14.b	How effective is this institution's leadership in implementing the policy?			
		Not effective Somewhat effective Mostly effective Very effective I do not know No response	1 2 3 4 5 6	
14.c	Does the workplace have an HIV/AIDS workplace committee?	Yes No I don't know No response	1 2 3 4	
	How effective is this workplace HIV/AIDS Committee in implementing the policy?	Not effective Somewhat effective	1 2	

		Mostly effective 3 Very effective 4 I do not know 5 No response 6	
	Please explain how		
	Does the workplace HIV/AIDS committee include some members from management?	Yes 1 No 2 I don't know 3 No response 4	
	Does the workplace HIV/AIDS committee include some members from junior level employees?	Yes 1 No 2 I don't know 3 No response 4	
	How frequent does the workplace HIV/AIDS Committee meet?	One a month 1 Once a quarter 2 Once in six month 3 Once a year 4 Other specify …….. 5 No response 6	
	Please explain		
Stakeholder Involvement in Policy Implementation			
15	Who are the stakeholders involved in implementing the HIV/AIDS work place policy in your organisation and to what extent are they involved **(***Ask about different ministries [e.g., Health, Finance, Planning, Women's Affairs], departments [e.g., reproductive health and HIV programs within the Ministry of Health], agencies, and levels within the government.)*		
15	**Stakeholders Name :**		

	Explain Extent of involvement		
	Stakeholders Name :		
	Explain Extent of involvement		
16	What, if any, other organizations could be involved in order to improve implementation of the policy in your work place? (Please identify organizations and explain why their participation would foster implementation.)		
	Organization Name :		
	Explain Extent of involvement		
	Organization Name :		
	Explain Extent of Implementation		
	Organization Name :		
	Explain Extent of Implementation		
17	To what extent are *the following groups,* whom the policy is designed to reach, involved in implementing the policy?		
17.a	Top management	None- no involvement at all 1 Limited involvement 2	

		Moderate involvement 3 Wide involvement 4 I don't know 5 Not applicable 6 No response 7	
	Please explain why :		
17.b	Middle management	None- no involvement at all 1 Limited involvement 2 Moderate involvement 3 Wide involvement 4 I don't know 5 Not applicable 6 No response 7	
	Please explain why :		
17.c	Employees	None- no involvement at all 1 Limited involvement 2 Moderate involvement 3 Wide involvement 4 I don't know 5 Not applicable 6 No response 7	
17.d	Union leaders	None- no involvement at all 1 Limited involvement 2 Moderate involvement 3 Wide involvement 4 I don't know 5 Not applicable 6 No response 7	

	Please explain why :			
17.e	Employees living with HIV/AIDS	None- no involvement at all	1	
		Limited involvement	2	
		Moderate involvement	3	
		Wide involvement	4	
		I don't know	5	
		Not applicable	6	
		No response	7	
	Please explain why :			
17.f	Female employees	None- no involvement at all	1	
		Limited involvement	2	
		Moderate involvement	3	
		Wide involvement	4	
		I don't know	5	
		Not applicable	6	
		No response	7	
	Please explain why :			
17.g	Male employees	None- no involvement at all	1	
		Limited involvement	2	
		Moderate involvement	3	
		Wide involvement	4	
		I don't know	5	
		Not applicable	6	
		No response	7	
	Please explain why :			
17.h	Other (specify)	None- no involvement at all	1	
		Limited involvement	2	

		Moderate involvement 3 Wide involvement 4 I don't know 5 Not applicable 6 No response 7	
	Please explain why :		
Implementation Planning and Resource Mobilization			
18	Does the organization have *an official implementation plan* for the HIV/AIDS work place policy?	I don't know 1 Yes 2 No 3 Not applicable 4 No response 6 No response 7	*If yes, continue with next question; if no, skip to Q21*
	Please obtain and confirm HIV/AIDS Workplace policy implementation plan by Physical review of the document *NOTE: confirm ……*		
19	Was your organization involved in the formulation of the implementation plan?	I don't know 1 Yes 2 No 3 Not applicable 4 No response 5	
	Please explain		
20	Because there is no overall written implementation plan for the HIV/AIDS policy, what is currently guiding your organization in implementing activities under the HIV/AIDS policy?		*Skip to 21, If there is a written implementation plan.*

	Please explain		
21	How helpful is this strategy or implementation plan to your organization for implementing the HIV/AIDS workplace policy?	Not helpful 1 Somewhat helpful 2 Helpful in most aspects 3 Very helpful 4 I don't know 5 Not applicable 6 No response 7	
	Please explain why		
22	Do you have any suggestions for making the implementation plan/strategy more useful for your organization?	Yes 1 No 2 Not Applicable 3 No response 4	
	Suggestion		
23	To what extent do the implementation plan/ strategy include <u>strategies</u> to address gender issues in the work place?	Does not address gender issues at all 1 Addresses some key 2 Addresses most key gender issues 3 Addresses all key gender issues 4 I don't know 5 No response 6	
	Please explain further		
24	Is there a mechanism in place to ensure funding for implementing this HIV/AIDS workplace policy?	Yes 1 No 2 I don't know 3 Not Applicable 4 No response 5	

	Please explain the available funding mechanism**.**		
25	How will funding for this policy be sustained for the duration of the policy?		
	Please explain		
26	From what sources does your organization receive funding to implement activities under the HIV/AIDS workplace policy?	*Government* 1 *Donor* 2 *Private sector* 3 *Insurance* 4 *Clients* 5 *organisation's own budget* 6 *Other (please specify* 7 No response 8	
26	Has your organization experienced problems/barriers in accessing funding for HIV/AIDS work place policy implementation (i.e. funding cycles, signatory authority, reporting requirements)	Yes 1 No 2 Don't know 3 Not Applicable 4 No response 5	
	Please explain further		
27	Does your implementation plan or strategy for HIV/AIDS program include an allocated budget for HIV/AIDS activities in the workplace?	Yes 1 No 2 Don't know 3 Not Applicable 4 No response 5	
28	What key activities would you be able to conduct with additional funding?		

	Please explain					
	Resources : Financial , Human , Infrastructure and Materials /Supplies					
29	Please rate the sufficiency (both in terms of quality and quantity) of your organization's financial human infrastructure and material (supplies) resources to fulfil the roles and responsibilities under the HIV/AIDS work place policy. *Please describe the difficulties, challenges, or consequences arising from any insufficiencies.*					
29.a	**Financial Resources**(Quantity refers to amount of funds allocated; quality refers to consistency)	***Quantity***		***Quality***		
		Insufficient	1	Insufficient	1	
		Somewhat sufficient	2	Somewhat sufficient	2	
		Mostly sufficient	3	Mostly sufficient	3	
		Completely sufficient	4	Completely sufficient	4	
		I don't know	5	I don't know	5	
		No response	6	No response	6	
	Please describe the difficulties, challenges, or consequences arising from any insufficiencies.					
29.b	**Human Resources** (Quantity refers to numbers of personnel; quality refers to trained personnel e.g. peer educators, counsellors , care and support group)	***Quantity***		***Quality***		
		Insufficient	1	Insufficient	1	
		Somewhat sufficient	2	Somewhat sufficient	2	
		Mostly sufficient	3	Mostly sufficient	3	
		Completely sufficient	4	Completely sufficient	4	
		I don't know	5	I don't know	5	
		No response	6	No response	6	
	Please describe the difficulties, challenges, or consequences arising from any insufficiencies.					
29.c	**Infrastructure/ Facilities:** (Quantity refers to dedicated space for HIV activities e.g. peer education, counsellors room, care and support space. Quality refers to privacy for providing these activities.	***Quantity***		***Quality***		
		Insufficient	1	Insufficient	1	
		Somewhat sufficient	2	Somewhat sufficient	2	
		Mostly sufficient	3	Mostly sufficient	3	
		Completely sufficient	4	Completely sufficient	4	
		I don't know	5	I don't know	5	

		No response	6	No response	6
	Please describe the difficulties, challenges, or consequences arising from any insufficiencies.				
29.d	**Equipment/ Supplies** (Quantity refers to number of equipment and supplies for EIC, Condom demonstrations tools, availability of male/female condoms ; Quality refers to consistency in supplies of the equipment and supplies)	***Quantity***		***Quality***	
		Insufficient	1	Insufficient	1
		Somewhat sufficient	2	Somewhat sufficient	2
		Mostly sufficient	3	Mostly sufficient	3
		Completely sufficient	4	Completely sufficient	4
		I don't know	5	I don't know	5
		No response	6	No response	6
	Please describe the difficulties, challenges, or consequences arising from any insufficiencies.				
29.e	**Information :** Quantity will refer to amount of Information available on HIV prevention /health gender, STIs nutrition, Referral for care and support. Quality will refer to consistent supply of this information.	***Quantity***		***Quality***	
		Insufficient	1	Insufficient	1
		Somewhat sufficient	2	Somewhat sufficient	2
		Mostly sufficient	3	Mostly sufficient	3
		Completely sufficient	4	Completely sufficient	4
		I don't know	5	I don't know	5
		No response	6	No response	6
	Please describe the difficulties, challenges, or consequences arising from any insufficiencies.				
29.f	Others…….specify				
	Please describe the difficulties, challenges, or consequences arising from any insufficiencies.				

HIV/AIDS Workplace Programme and Activities.			
30	Does your company currently have a written HIV/AIDS workplace programme?	Yes 1 No 2 Being developed 3 Unsure 4	
	If yes Please obtain and confirm HIV/AIDS program plan by Physical review of the document *NOTE: confirm:*		
31.	What elements does your HIV/AIDS workplace programme include and how are they provided: Within the work place ,Referred to Government clinic/hospital , Covered by workplace Medical insurance , Covered by other organisation or Other specify		
31.a	HIV/AIDS awareness	Within the work place 1 Referred to Government clinic/hospital 2 Covered by workplace Medical insurance 3 Covered by other organisation 4 Other specify 5 No response 6	
31.b	Anti-retroviral therapy	Within the work place 1 Referred to Government clinic/hospital 2 Covered by workplace Medical insurance 3 Covered by other organisation 4 Other specify 5 No response 6	
31.c	Female Condom provision	Within the work place 1 Referred to Government clinic/hospital 2 Covered by workplace Medical insurance 3 Covered by other organisation 4 Other specify 5 No response 6	
31.d	Male Condom provision	Within the work place 1	

		Referred to Government clinic/hospital 2 Covered by workplace Medical insurance 3 Covered by other organisation 4 Other specify 5	
31.e	Voluntary counselling and testing	Within the work place 1 Referred to Government clinic/hospital 2 Covered by workplace Medical insurance 3 Covered by other organisation 4 Other specify 5 No response 6	
31.f	Other specify	Within the work place 1 Referred to Government clinic/hospital 2 Covered by workplace Medical insurance 3 Covered by other organisation 4 Other specify 5 No response 6	
	To what extent do the workplace HIV/AIDS activities address the following issues in the workplace among employees and how? Select appropriately. Extent to which it is addressed Does not address the issues at all 1 Addresses some areas 2 Addresses most key issues 3 Addresses all key issues 4 don't know 5 No response 6	How please explain……	
	The Prevention of Mother to child transmission of HIV.	_____ Pleases explain How :	

	GenderBased Violence issues	_____	Pleases explain How :	
	Male Circumcision programs	_____	Pleases explain How :	
	Alcohol Abuse	_____	Pleases explain How :	
	HIV/AIDS stigma.	_____	Pleases explain How :	
	Males having sex with males	_____	Pleases explain How :	
	Commercial sex workers and HIV	_____	Pleases explain How :	
Monitoring and Evaluation : Feedback on Progress and Results on HIV/AIDS Policy Implementation				
32	Is there an institution(s) that is monitoring the implementation of your HIV/AIDS work place policy?	Yes No I don't know No response	1 2 3 4	If no or I don't know, move to next question.
	Name the institution :			
33	Is there an internal (with the workplace) monitoring system of implementation of your HIV/AIDS work place policy?	Yes No I don't know	1 2 3	

		No response 4	
34	What methodology is being used to monitor the implementation of your HIV/AIDS work place policy?	Regular meetings, 1 Periodic reports, 2 Site visits 3 Service statistics 4 Employee satisfaction surveys 5 No monitoring 6 Other specify 7 No response 8	*Please Select all that apply*
35	What key indicators are used to monitor the implementation of the policy?		
	Name the indicators : 1. 2. 3.		
36.a	How are key gender issues/strategies relating to the HIV/AIDS policy's implementation being assessed?		
	Explain 1. 2. 3.		
36.b	In your opinion do you think this way of assessing gender issues is effective? please explain why :		
37.a	Is your organization required to report on progress or accomplishments under this policy?	Yes 1 No 2 Don't know 3 No response 4	*If yes then ask next question , if not or don't know skip to 36*
38	What performance indicators does your organization report on		

	1 2 3 4		
38 .a	To whom		
	Explain		
38.b	How often		
	Explain		
38.c	How helpful is the overall reporting process to you and your organization/ or lack of reporting?	Not helpful 1 Somewhat 2 Mostly helpful 3 Very Helpful 4 I don t know 5 No response 6	
	Please explain why:		
39a	Are you or your organization receiving feedback on how this policy is being implemented overall?	Yes 1 No 2 Don't know 3 No response 4	**(***If no or don't know, skip to* ***Q39****)*
39b	What type of feedback information are you receiving?		
	Explain		
39 c	From whom?		

40.	f applicable, please describe any suggestions for improvement on feedback		
	Explain		
Overall Assessment			
41	Overall, how well do you think the policy is being implemented or Not.	mplemented 1 Partly implemented 2 Many parts of the policy are being 3 Implemented 4 Overall, implementation is 5 Proceeding very well 6 I don't know 7 No response 8	
	Please explain why :		
42	Are you beginning to see positive changes as a result of implementing this policy?	Yes 1 No 2 Don't know 3 No response 4	If yes ask the next question if no skip to the next.
	What are these changes Explain?		
42	In implementing this policy, have you observed any unanticipated or unintended effects?	Yes 1 No 2 Don't know 3 No response 4	
	Explain		

43	In the process of implementing the policy, which initiatives/activities at the local or national levels have been successful or serve as lessons learned	
	Please explain**.**	
44	In addition to what you have already mentioned above, do you have any additional suggestions that would improve implementation of this policy? Please describe.	
	Please explain**.**	

Thank you.

Please thank the respondent for the time, and provide your contact information for any follow-up questions or concerns.

Researchers Notes: Describe the experience and observation during interview.

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Rhodes Park, Lusaka
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+260 955 155 634
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Email: eresconverge@yahoo.co.uk

I.R.B. No. 00005948
F.W.A. No. 00011697

7th August, 2015

Ref. No. 2015-June-023

The Principal Investigator
Ms. Bridget Ennet Chatora
University of Zambia
School of Medicine
Dept. of Public Health
P.O. Box 50110,
LUSAKA.

Dear Ms. Chatora,

RE: IMPLEMTATION OF HIV AND AIDS WORKPLACE POLICY IN SELECTED WORKPLACES IN LUSAKA- THE IMPLEMENTERS PERSPECTIVE.

Reference is made to your corrections. The IRB resolved to approve this study and your participation as principal investigator for a period of one year.

Review Type	**Ordinary**	Approval No. **2015-June-023**
Approval and Expiry Date	Approval Date: 7th August, 2015	Expiry Date: 6th August, 2016
Protocol Version and Date	Version-Nil	6th August, 2016
Information Sheet, Consent Forms and Dates	• English.	6th August, 2016
Consent form ID and Date	Version-Nil	6th August, 2016
Recruitment Materials	Nil	6th August, 2016
Other Study Documents	Questionnaires.	6th August, 2016
Number of participants approved for study	128	6th August, 2016

Specific conditions will apply to this approval. As Principal Investigator it is your responsibility to ensure that the contents of this letter are adhered to. If these are not adhered to, the approval may be suspended. Should the study be suspended, study sponsors and other regulatory authorities will be informed.

Conditions of Approval

- No participant may be involved in any study procedure prior to the study approval or after the expiration date.
- All unanticipated or Serious Adverse Events (SAEs) must be reported to the IRB within 5 days.
- All protocol modifications must be IRB approved prior to implementation unless they are intended to reduce risk (but must still be reported for approval). Modifications will include any change of investigator/s or site address.
- All protocol deviations must be reported to the IRB within 5 working days.
- All recruitment materials must be approved by the IRB prior to being used.
- Principal investigators are responsible for initiating Continuing Review proceedings. Documents must be received by the IRB at least 30 days before the expiry date. This is for the purpose of facilitating the review process. Any documents received less than 30 days before expiry will be labelled "late submissions" and will incur a penalty.
- Every 6 (six) months a progress report form supplied by ERES IRB must be filled in and submitted to us.
- ERES Converge IRB does not "stamp" approval letters, consent forms or study documents unless requested for in writing. This is because the approval letter clearly indicates the documents approved by the IRB as well as other elements and conditions of approval.

Should you have any questions regarding anything indicated in this letter, please do not hesitate to get in touch with us at the above indicated address.

On behalf of ERES Converge IRB, we would like to wish you all the success as you carry out your study.

Yours faithfully,
ERES CONVERGE IRB

Dr. E. Munalula-Nkandu
BSc (Hons), MSc, MA Bioethics, PgD R/Ethics, PhD
CHAIRPERSON

NATIONAL HIV/AIDS/STI/TB COUNCIL

25th August, 2015

FINANCE BANK ZAMBIA PLC
RECEIVED
11 NOV 2015
HUMAN RESOURCE DIRECTORATE

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: INTRODUCTORY LETTER – BRIDGET CHATORA

Reference is made to the subject matter stated above.

Ms. Bridget Chatora is currently pursuing a Master of Public Health degree at the University of Zambia, School of Medicine in the department of Public Health.
In partial fulfilment of her degree, she is conducting a research on the *Implementation of HIV/AIDS Workplace Policy in selected workplaces in Lusaka – the Implementers' Perspective.* She intends to gather information on the experiences, challenges and lessons learnt in Organizations like yours which have been implementing HIV/AIDS Workplace Policy-driven programs through the Zambia Federation of Employers and National AIDS Council for over a period more than one year.

In view of the above, kindly accord her the necessary support to ensure the success of this exercise.

Dr. Jabbin L. Mulwanda
DIRECTOR GENERAL
NATIONAL HIV/AIDS/STI/TB COUNCIL

Plot 6662 Mberere Road Olympia Ext. P O Box 31941 Lusaka. Tel: +260 211 295969 Fax: +260 211 295781
Email: zfe@zamnet.zm; zfemployers@gmail.com; www.zfe.co.zm

Our Ref:

9th September 2015

To whom it may concern,

RE: Introduction of Ms. Bridget Chatora and Ms. Akende Simamuna

This letter serves to introduce, Ms Bridget Chatora, a graduate student from the University of Zambia and her research assistant, Ms. Akende Simamuna.

The above mentioned researchers are undertaking a research to evaluate and asses companies' establishment and implementation of HIV/AIDS and wellness policies in the workplace among Zambia's private sector. This research will not only provide the Federation vital information on the needs gap of member companies in this regard but will also provide vital information for the country HIV/AIDS response program under the National AIDS Council.

We therefore request that you give them full corporation and provide them the relevant information.

We thank you most sincerely for your participation now and in future.

Yours Sincerely,

Harrington Chibanda
Executive Director- Zambia Federation of Employers.

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