AN EVALUATION OF HIV AND AIDS MAINSTREAMING IN LINE MINISTRIES

BY

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DECLARATION

I, **Alice Mwewa**, do hereby declare that this dissertation is my own original work. It has been presented in accordance with the guidelines for MPH dissertation of the University of Zambia. It has not been submitted before for any degree or examination in any other University.

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Supervisor:

I have read this dissertation and approved it for examination

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CERTIFICATE OF COMPLETION OF DISSERTATION#

I, **Alice Mwewa,** do hereby certify that this dissertation is the product of my own work and, in submitting it for my MPH programme further attest that it has not been submitted in part or in whole to another University.

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I, **Dr C. Michelo**, having submitted and read this dissertation, I am satisfied that this is the original work of the author under whose name it is being presented. I confirm that the work has been completed satisfactorily and is hereby ready for presentation to the examiners.

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ABSTRACT

Background

HIV mainstreaming is increasingly being seen as one of the strategies for an effective national response. With an estimated HIV prevalence of 14.3 percent in the 15 to 49 years age group, Zambia has adopted a multi-sectoral response to HIV and AIDS control (ZDHS 2007, NAC 2009). For line ministries, government has pioneered this initiative by encouraging them to mainstream HIV and AIDS in their respective sectors. The study aimed to evaluate HIV and AIDS Mainstreaming in Line Ministries. More specifically, the study focused on establishing the extent of HIV/AIDS mainstreaming in the Line Ministries, documenting which Ministries are utilizing the Mainstreaming guidelines and exploring barriers to HIV/AIDS mainstreaming.

Methods

This was cross-sectional evaluation study that employed a logical framework. Furthermore, the study utilized both qualitative and quantitative methods of data collection and analysis to assess the extent of HIV and AIDS mainstreaming in the government of Zambia's line ministries and to identify barriers to effective mainstreaming. The study population was comprised of staff from Line Ministries. The qualitative data was obtained from 19 individuals and was analyzed using N-Vivo. For the quantitative data, multistage sampling was used to sample a total of 516 respondents from line ministries. The data was collected by means of a structured questionnaire and was analyzed using SPSS version 18 software.

Results

The determinants of mainstreaming were found to be establishment of support groups, (OR 2.73 95% CI 1.32-5.63) for staff living with HIV, provision of condoms male/female for staff (OR 2.78 95% CI 1.29-5.97), accessibility of ARVs (OR 3.03 95% CI 1.12-8.20) by staff.

Conclusion

We conclude that mainstreaming is an important and effective strategy in mitigating the impact of HIV in line ministries. However, there are key elements that constitute a functioning mainstreaming program as revealed in the study findings.

DEDICATION

This research work is dedicated to my darling husband Gregory who believed in me even when I thought it was impossible for me to complete this work. Thank you honey, for your loving support and for taking good care of our lovely children during periods of pressure, with you by my side I can do anything. To my two beautiful daughters Sally Tamara and Temwa Mutale, my handsome son Gregory Chitambo Jnr who endured my absence during the research, thank you for being my inspiration, I love you dearly; to my parents Mr. and Mrs. Mwewa who lovingly encouraged and challenged me to finish this work, to my Father, Mr. Mwewa for providing a perfect example for me and for showing me just how to do it; to my parents in law Mr. and Mrs. Saili for your encouragment and love throughout this research. To my brothers and sisters, Elizabeth, Michael, Aaron, Ruth and Mutale for your unfailing support and love, to my brothers and sister in law, Lorraine, Clive and Patrick, to my brother and sister in marriage, Haggai and Naomi; aunt Ireen and finally to my three naughty nephews Nkwiza, Chimwemwe , Tekela and my lovely neice Tukuza, thank you all for your loving support and support.

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LIST OF ACRONYMS

AIDS	:	Acquired Immuno-deficiency Syndrome
ARVs	:	Anti-Retroviral Drugs
FPP	:	Focal Point Person
GRZ	:	Government of the Republic of Zambia
GTZ	:	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (German society for technical cooperation)
HAART	:	Highly Active Anti-retroviral Therapy
HIV	:	Human Immuno-deficiency Virus
ICASA	:	International Conference on AIDS and STIs in Africa
IEC	:	Information and Education Communication
ILO	:	International Labour Organization
MACA	:	Ministerial Coordinating Advisor
NAC	:	National HIV/AIDS/STI/TB council
NGOs	:	Non-governmental Organisaions
NGO	:	Non-government Organisation
PLWHA	:	People Living with HIV/AIDS
PSMD	:	Public Service Management Division
SADC	:	Southern African Development Countries
SANAC	:	South African National AIDS Council
SHARe	:	Support to HIV/AIDS Response in Zambia
SPSS	:	Statistical Package for Social Sciences
STI	:	Sexually Transmitted Infections
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNDP	:	United Nations Development Programme
UNZA	:	University of Zambia
USAID	:	United States Agency for International Development
VCT	:	Voluntary Counselling and Testing
WHO	:	World Health Organisation

ZANARA : Zambia National Response to AIDS

ZDHS : Zambia Demographic Health Survey

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CHAPTER ONE

INTRODUCTION

The Government of the Republic of Zambia has recognized that the HIV and AIDS pandemic has placed a major challenge on sustaining and improving the delivery of services in the Public service which is mostly comprised of line ministries (HIV/AIDS strategy, PSMD, 2010). Therefore, in its commitment to addressing the impact of HIV and AIDS on the public sector, the government has embraced the "three ones[1]" as guiding principles for the country's response.

The three ones principles were agreed upon at the International Conference on AIDS and STIs in Africa (ICASA) held in Nairobi, Kenya in 2003 (UNAIDS, 2004). At the ICASA conference, officials from the national coordinating bodies and relevant ministries of African nations, major funding mechanisms, multilateral agencies, NGOs and the private sector gathered to review principles for national level coordination of the HIV/AIDS response. They came up with three principles applicable to all stakeholders in the country level HIV/AIDS response namely, One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners, One national AIDS Coordinating authority, with a broad based multi-sector mandate, One agreed country level Monitoring and Evaluation system (UNAIDS, 2004).

In order to have a well-coordinated response, the Republic of Zambia has adopted the use of one national coordinating body, one strategic framework and one monitoring and evaluation framework. The National AIDS council, established by an Act of parliament in 2002 (NAC, 2006), has broad representation from government, the private sector and has both the authority and the budget to coordinate and support a multi-sectoral national response to AIDS.

In their implementation of the "three ones", the Government of Zambia and the

[1] "Three Ones" principles refers to One agreed HIV/AIDS Action Framework; One National AIDS Coordinating Authority, and One agreed country-level Monitoring and Evaluation System.

Cooperating Partners have been promoting HIV and AIDS Mainstreaming in the both the public and private sectors in an effort to mitigate the impact of HIV and AIDS in Zambia. Therefore, this study contributes insights towards the documentation, challenges and barriers to HIV and AIDS mainstreaming in the Line Ministries. The identification of these barriers will inform Line Ministries, Policy makers and other stakeholders on what steps to take in order to overcome the barriers in an effort to implement an effective and sustainable AIDS response in the Line Ministries.

Line ministries play an important role in the multi-sectoral response of HIV and AIDS in Zambia because most of the productive workforce in the Public Service is housed in the Line Ministries. Figures provided by payroll management and establishment control (PMEC) in late 2007 indicated that about 80% of staff in the public service were employed in line ministries indicating that most of the staff in the Public Service are hosed in line ministries (HIV and AIDS Strategy for the Public Service, 2010).

1.1 HIV Prevalence and Distribution

The HIV epidemic continues to be one of the major health and development challenges confronting humankind. Globally, there were an estimated 33 million people living with HIV, with 2.7 million new infections and 2 million deaths in 2007(Global AIDS Report, 2008). Sub-Saharan Africa remains the region most heavily affected by HIV accounting for 67% of all people living with HIV and for 75% of AIDS deaths in 2007. Southern Africa has an HIV prevalence rate ranging between 10 – 40 % of the adult population as of 2007 (Global AIDS report, 2008). Locally, results of the 2007 Zambia Demographic and Health Survey (ZDHS) reveal that HIV prevalence declined from 15.6 percent in 2001/2002 to 14.3 percent in 2007 (ZDHS, 2007). However, an HIV prevalence rate of 14.3% is still very high suggesting that infections still outstrip the number of AIDS related deaths (NAC, 2009). With a prevalence rate of 14.3 percent in the 15-49 age groups, Zambia remains one of the Sub-Saharan African countries worst affected by the HIV and AIDS pandemic.

Based on the statistics above, it can be seen that HIV continues to pose a long–term development challenge to Zambia as it reduces productivity through higher staff turnover, absenteeism and a significant loss of skills. Furthermore, the HIV/AIDS epidemic affects people at their most productive age thereby jeopardizing the objectives of Zambia's national development plans (UNDP, 2007).

1.2 Impact of HIV and AIDS on the Public Service

The public service is the biggest single employer and has been severely impacted by HIV and AIDS in most African countries (Rasingh, 2004). It is important to note that the public service workforce is mainly comprised of staff in the line ministries, therefore this paper will at times refer to the Line ministries as the public service. The majority of the departments and public servants are at national, provincial level and deal with service delivery right up to the grass roots level. It follows therefore that a very high number of the country's population are also dependants of public servants. Therefore, the impact of HIV and AIDS on the public service work force has direct implications to the wider society (NAC, 2004).

As noted above, the main burden in dealing with the impact of HIV and AIDS falls on the African public services (Rasingh, 2004). The impact of HIV and AIDS on the public sector is twofold. Internally, it affects the human resources situation within the ministries, making it difficult to maintain and develop services and significantly reducing the ability of government to fight the epidemic. At the same time, HIV has an external impact, increasing and creating needs for public services from the Zambian population. The epidemic has increased demand for services and the public sector faces challenges in responding to changing service needs, due to high levels of mortality and morbidity among staff. Because of the long-term impacts, it is therefore crucial that the HIV response is effective and targeted (UNDP, 2007).

In response to the challenges noted above, the government introduced several activities and initiatives in order to mitigate the impact of HIV and AIDS on the public Service.

The initiatives include the appointment of Focal point persons (FPPs) in each line ministry, deployment of UN volunteers in the line ministries and the encouragement of ministries to formulate HIV and AIDS workplace policies (Guidelines for the prevention and mitigation of HIV/AIDS in the public service, 2010). In addition to the initiatives noted above, the government through PSMD has recently designed and developed four tools to assist in its response to the impact of HIV and AIDS. The four tools are:-

- The HIV and AIDS Strategy for the Public Service (2010-2015)
- Implementing guidelines and framework for the strategy for the prevention and mitigation of HIV/AIDS in the Public Service
- Monitoring and Evaluation and reporting framework for HIV/AIDS programmes in the Public Service
- Advocacy and communication strategy

Added to the initiatives noted above, the government of Zambia has been implementing HIV/AIDS programs in ministries with support from partners such as the NAC, United Nations agencies, USAID, the Global fund, among other partners (National HIV/AIDS strategic Framework, 2006-2010, NAC 2006).

Furthermore, the Government of Zambia through NAC as the HIV/AIDS coordinating body and other cooperating partners such as UNDP, expects each line ministry to address the "internal and external impact of HIV and AIDS, or the way in which the epidemic affects its capabilities to provide public services" (NAC, May 2007:1). More specifically, each line ministry is expected to internally and externally mainstream HIV and AIDS. The focus of this research however was on internal mainstreaming.

2.0 LITERATURE REVIEW

The concept of mainstreaming has expanded from its "...original application in the late 1960s, when the term was coined to designate an approach to assimilating children with disabilities into regular classroom settings" (UNAIDS/GTZ, June 2003:4). Currently, the utility of the concept has extended to include gender, HIV and AIDS, human rights and sustainable development.

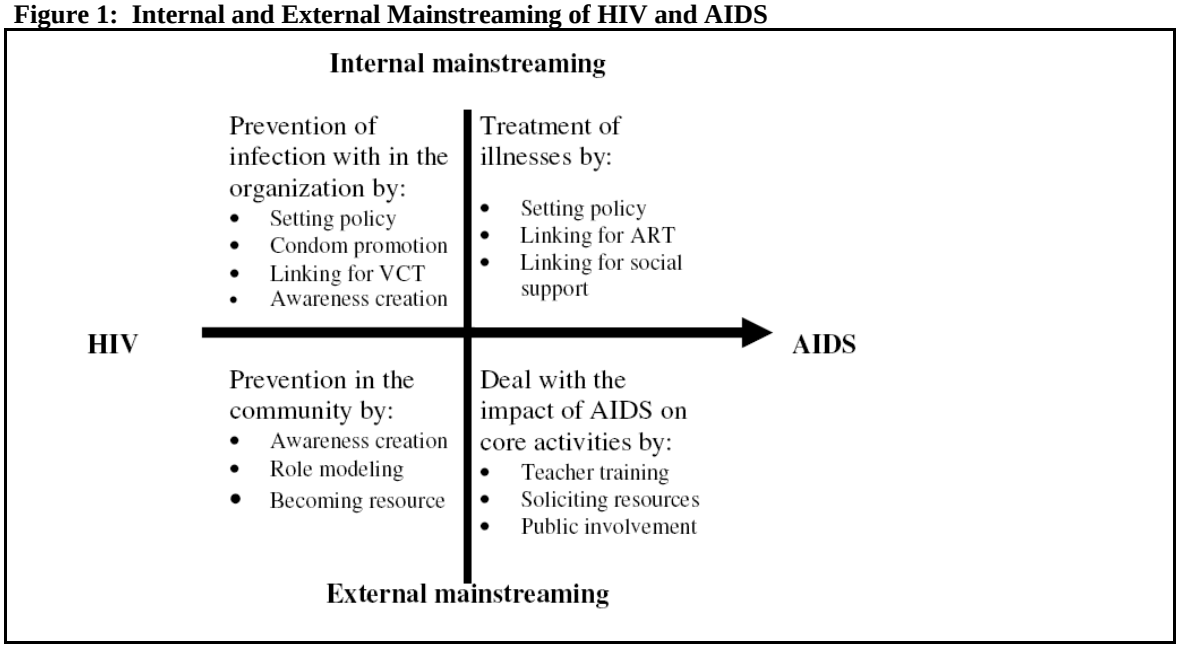
2.1 Terminology of Mainstreaming

Mainstreaming as a term implies an infusion of something new into a larger structure (programme, sector, etc.) with the intention of strengthening and protecting this structure (UNDP: UNDAF, 2007b). However, mainstreaming HIV and AIDS can be defined "…as a process that enables development actors to address the causes and effects of HIV in an effective and sustained manner, both through their usual work and within their workplace" (NAC, 2005). This can be done by addressing both the direct and indirect aspects of HIV and AIDS within the context of the normal functions of an organization or community.

More specifically, mainstreaming is essentially a process whereby a sector is analysed in terms of how HIV and AIDS can impact on that particular sector now and in the future, both internally and externally while considering how sectoral policies, decisions and actions might influence the longer-term development of the epidemic and the sector (NAC, 2007). The analysis determines how each sector should respond to the impact of HIV and AIDS, based on its core business and comparative advantage.

Mainstreaming can be either internal or external. The analysis determines how each sector should respond to the impact of HIV/AIDS, based on its core business and comparative advantage. The diagram (1) below illustrates core areas for mainstreaming HIV and AIDS.

Figure 1: Internal and External Mainstreaming of HIV and AIDS



Source: UNDP (July 2005), A Hand book for HIV/AIDS mainstreaming

The two dimensions of mainstreaming (internal and external) mainstreaming illustrated above are interlinked.

Internal mainstreaming implies that a sector identifies and responds to factors such as individual, organizational and societal factors that are likely to increase vulnerability to HIV infection for sector staff and immediate family members. Furthermore, internal mainstreaming entails that a sector recognises and therefore reverses or mitigates the likely impacts of HIV and AIDS on staff and on the organisation as a whole. Internal mainstreaming therefore is related to HIV and AIDS policies, guidelines, and activities for sector employees. Furthermore, internal mainstreaming has two elements: direct work with staff, such as awareness raising, HIV prevention, support and treatment, and modifying the ways in which the organisation functions, for example in terms of workforce planning, budgeting and assessing needs (Mainstreaming guidelines, 2010)

On the other hand, external mainstreaming requires that a sector identifies and responds to factors that are likely to increase vulnerability to HIV infection for communities or those considered clients of the sector. Moreover, external mainstreaming entails that the sector recognises and therefore reverses or mitigates the likely impacts of HIV and AIDS

on those considered clients of the sector, communities it works with and on the broader sector mandates. The focus therefore is on ensuring that those affected are included and able to benefit from programme activities. For example, an agricultural project which is adjusted to the needs of vulnerable households in HIV affected communities (Mainstreaming guidelines, 2010).

For mainstreaming to be effective, it needs to occur at all levels: global/regional, national, sector and sub-national/local.

2.2 The Importance of HIV and AIDS Mainstreaming

Mainstreaming HIV and AIDS is an essential approach for expanding multi-sectoral responses HIV/AIDS. This is because it constitutes a range of practical strategies for scaling up responses and addressing the developmental impacts of HIV and AIDS globally and regionally. Through mainstreaming, government sectors, non-governmental organizations, private sectors entities and other organizations can meet the needs of their own workplace environment, as well as apply their comparative advantage to support specific aspects of national responses (NAC, 2005).

Globally and across Africa, mainstreaming HIV/AIDS at various levels is being increasingly recognized as a fundamental component of expanding the response to the epidemic. However, the present understanding and application of mainstreaming remains somewhat limited. Mainstreaming within the context of HIV/AIDS can be seen as the product of evolution in response approaches. From the early days of the epidemic, the evolution has been, largely central level health sector led response, to a more multi-sectoral effort coordinated by national HIV/AIDS councils or commissions, with greater responsibility for implementation being evolved to individual sectors and the decentralized levels.

Mainstreaming proposes an alternative approach to the challenge of planning for HIV/AIDS within sectors, programmes and decentralized institutions. As such, it takes into account issues of comparative advantage, possible interventions and their cost

effectiveness, and consequent appropriate resource allocations, thus trying to limit duplication of efforts among sectors and agencies. Hence, a mainstreaming process leads to the identification and division of clearer areas of responsibility between partners involved in multi-sectoral at the regional, national or sub-national levels. This in turn leads to sectors implementing effective and sector specific programs thereby mitigating the impact of HIV and AIDS (NAC, 2005).

2.3 Regional Experiences on HIV and AIDS Mainstreaming

Clearly, there is a growing body of evidence of the impact HIV and AIDS. However, a review of the available literature and experiences from several countries in sub-Saharan Africa has shown that there is very little documented on what HIV/AIDS mainstreaming means in practice for different sectors (Elsey et al., 2003). Still, as demonstrated below, a consideration of regional experiences in HIV and AIDS mainstreaming provides valuable insights.

Uganda: Literature on HIV and AIDS provides substantive reference to Uganda's successes in the fight against HIV and AIDS. Unlike Zambia, the current HIV/AIDS prevalence rate for Uganda is 6.4%, which is below the Zambian HIV/AIDS prevalence rate of 14.3%. Similar to Zambia, the coordinating of HIV and AIDS activities is spearheaded by the Uganda AIDS Commission (UAC). UAC has had "…the remit for promoting a multi-sectoral response to HIV/AIDS" (Elsey and Kutengule, 2003). With regard to addressing HIV and AIDS in the public service, UAC implemented a multi-sectoral response in all 17 ministries. The most recent National Strategic Framework of HIV and AIDS activities (2000/1-2005-6) re-emphasizes the need for: Sector ministries to revise and develop strategic action plans.

Despite this glowing picture, there are some challenges facing response measures in the public service. For instance, whereas the overall policy environment appears to permit HIV and AIDS mainstreaming into core sector activities, the "…challenge comes when sector ministries have to interpret what is meant by mainstreaming and what activities they actually need to do in order to address HIV/AIDS within their sector" (Elsey and

Kutengule, 2003). The challenging facing stakeholders in Uganda is noteworthy given that Zambia is undertaking similar initiatives and more worryingly with higher prevalence rates.

South Africa: Coordination efforts to mitigate HIV and AIDS in South Africa are spearheaded by similar agencies as in Uganda above and Zambia. The South African National AIDS Council (SANAC) advises government and advocates, monitors, mobilizes resources and undertakes research. Beyond this, SANAC also spearheads the mainstreaming of HIV and AIDS programs in the public service.

Currently there is a legal requirement for all government departments to develop workplace policies on HIV/AIDS (Elsey and Kutengule, 2003). For instance, the Department of Public Service and Administration has developed an Impact and Action Project (2000) which: "aims to ensure that the Public Service is able to sustain a quality service in spites of the progression of the AIDS pandemic. The Department of Public Service and Administration has developed a policy framework to guide departments on the minimum requirements to effectively manage HIV/AIDS in the workplace and ensure a coordinated Public Service response" (Grant et al., 2002).

However as noted by Kenyon, Heywood and Conway (2001), "…despite the existence of a well thought out plan, sufficient time, a large economy to draw on, a reasonable pool of skilled health and education workers and a sophisticated media, these policies and laws have not been adequately implemented and have not impacted significantly on the ground." Among the reasons advanced by authors to explain South Africa's limitations to address HIV and AIDS is "failure to mainstreaming HIV and AIDS in all levels of society". Currently, adult HIV/AIDS prevalence rate for South Africa is 18.1% (UNAIDS/WHO/UNICEF Epidemiological fact Sheets update, 2008). This fact also underscores the need to analyze critically Zambia's performance in mainstreaming HIV and AIDS. Granted, although Zambia's HIV prevalence rates have significantly reduced in the past few years, however rates remain very high compared to countries like Uganda and Ghana as indicated below.

Ghana: In Ghana, coordination efforts for HIV and AIDS activities are led by the Ghana AIDS Commission. The Commission has the mandate of "supporting sectors in their HIV and AIDS mainstreaming activities, the Commission is seen as a supra-ministerial and multi-sectoral body responsible for policy formation, coordination, direction, supervision and resource mobilization".

In contrast to the regional examples provided above, the prevalence rate of HIV in Ghana is significantly low. The current adult HIV/AIDS prevalence rate for Ghana is 3.1% (CIA World Factbook, 2008). Given this scenario, the focus of interventions within the different sectors, including the public service is on prevention of new infections.

Ghana further provides an interesting perspective in the mobilization of resources. Whereas ffinancial resources for the mainstreaming process are not provided from within the general sector budget, "the problem of lack of sector buy-in and potential unsustainability [*sic*] has been addressed by demanding that the sector must contribute 5% of mainstreaming budget costs. It is only when this 5% has been agreed to by sector managers that the remaining 95% can be released from the Ghana AIDS Commission" (Elsey and Kutengule, 2003).

This measure provides useful insights of how countries in the region are addressing the issue of financial constraints and securing buy-in in instances where the line ministry displays insufficient response to HIV and AIDS.

2.4 Barriers to HIV and AIDS Mainstreaming

According to Schuler (2004), there are several common barriers to HIV and AIDS mainstreaming which include limited capacity of organisations to facilitate the mainstreaming process particularly human resources, inability to identify HIV and AIDS as a strategic priority, a reluctance to take on unfunded mandates especially by government institutions and other competing development issues.

Furthermore, while the concept of mainstreaming has been with us for decades, its application to the area of HIV/AIDS is more recent and represents somewhat uncharted waters (NAC, 2005). Therefore, although many international and national organisations advocate an integrated, multi-sectoral, or mainstreamed approach, there is little clarity about what this involves and how sectors should respond in practice. Such lack of clarity has led to a number of different interpretations of the meaning of HIV/AIDS mainstreaming and a sense of confusion within government sectors as to what exactly they should be doing to mainstream HIV and AIDS (Elsey et al., 2003).

According to the paper on the impact of HIV/AIDS (UNDP 2007) on the public service, mainstreaming HIV/AIDS involves adopting HIV/AIDS related issues into the strategic, operational or programmatic planning or policies of all sector structures and institutions in the short, medium and long term as well as in day-to-day running of the organizations and sectors. However, the weaknesses in monitoring and evaluation of the implementation of these policies and the dearth in reliable data and research on the nature and impacts of these interventions have resulted in inadequate assessment of how mainstreamed HIV/AIDS is in the public and private sectors (UNDP, 2004).

2.5 Understanding Evaluation as an Approach in Research

Although its roots extend to the 17th Century, widespread systematic evaluation is a 20th century development. The concept of evaluation entails on the one hand a description of the performance of an entity being evaluated and, and on the other, some standards or criteria for judging that performance. It follows then that the central task of an evaluator is to construct a valid description of program performance in a form that permits comparison with the applicable criteria (Sriven, 1991).

Sriven (1991) and (Rossi, 2004) defines evaluation, as "…the process of determining the merit and worth and value of things and evaluations are the products of that process."

Owen and Rogers (1991) classify objects of an evaluation into the following categories: programs, plans, policies, organisations, products, and individuals. Examples of these in

the context of this research would be HIV and AIDS program under NAC, the National HIV and AIDS Policy, or individuals within the public service living positively. However, the focus of this evaluation is not on these objects of evaluation *per se*. The focus is on a component of a program. Owen and Rogers (1999) further state, "evaluators can be asked to focus on a component of a program". Such a decision permits the evaluator to focus energies and resources on a particular subject matter. Following this approach, this research focuses on mainstreaming as a component of the larger HIV and AIDS program under NAC – HIV and AIDS mainstreaming in Line Ministries.

This evaluation will have summative (e.g. extent of mainstreaming in line ministries, extent to which line ministries are utilising HIV and AIDS toolkits, and barriers to mainstreaming) as well as formative elements (e.g. suggesting a way overcome those barriers). This approach is also compatible with CIDA's evaluation guide (October 2004, p.1) which states that "evaluations are carried out to inform…about what results are being achieved…" and "...what improvements should be considered."

Coleman and Ford (1996) attempted to assess the range for methodologies that have been employed over the years in HIV intervention programmes. Their findings suggest that many of the early interventions were implemented with limited planning and intentions to evaluate their effectiveness. This was largely as a result of such programmes being seen as emergencies. Over time however, the need to deliver programme effectively and efficiently mounted. Types of evaluations that have been introduced include formative evaluations, impact evaluations, and process evaluations. The authors found limited evaluations that focused on behavioural measures. This limitation in the body of literature is noted within this research; however, the focus on this research is more on the process rather than the impact. Evaluating the impact and in particular behavioural changes is beyond the focus and scope of this study.

2.6 Summary of Issues Emerging from the Literature Review

The section above demonstrates fundamental issues related to mainstreaming of HIV and AIDS in the public service. The major issues include the following:

Firstly, although significant investment has been made in mainstreaming effort there are currently weaknesses in monitoring and evaluation of the implementation of these policies. Furthermore, there is a dearth in reliable data and research on the nature and impacts of these interventions, which has resulted in inadequate assessment of how mainstreamed HIV/AIDS is in the public and private sectors.

Secondly, despite the deafening push by many international and national organisations for a mainstreamed approach, there is little clarity about what this involves and how sectors should respond in practice. Such lack of clarity has lead to a number of different interpretations of the meaning of HIV/AIDS mainstreaming and a sense of confusion within government sectors as to what exactly they should be doing to mainstream HIV and AIDS.

Thirdly, the literature reviewed suggests that globally and across Africa, mainstreaming HIV/AIDS at various levels is being increasingly recognized as a fundamental component of expanding the response to the epidemic. It appears though that the mainstreaming of HIV and AIDS is still evolving.

Lastly, the HIV and AIDS mainstreaming concept is a complex and broad subject. There are two interlinked dimensions of mainstreaming; these are internal and external mainstreaming.

2.7 PROBLEM STATEMENT

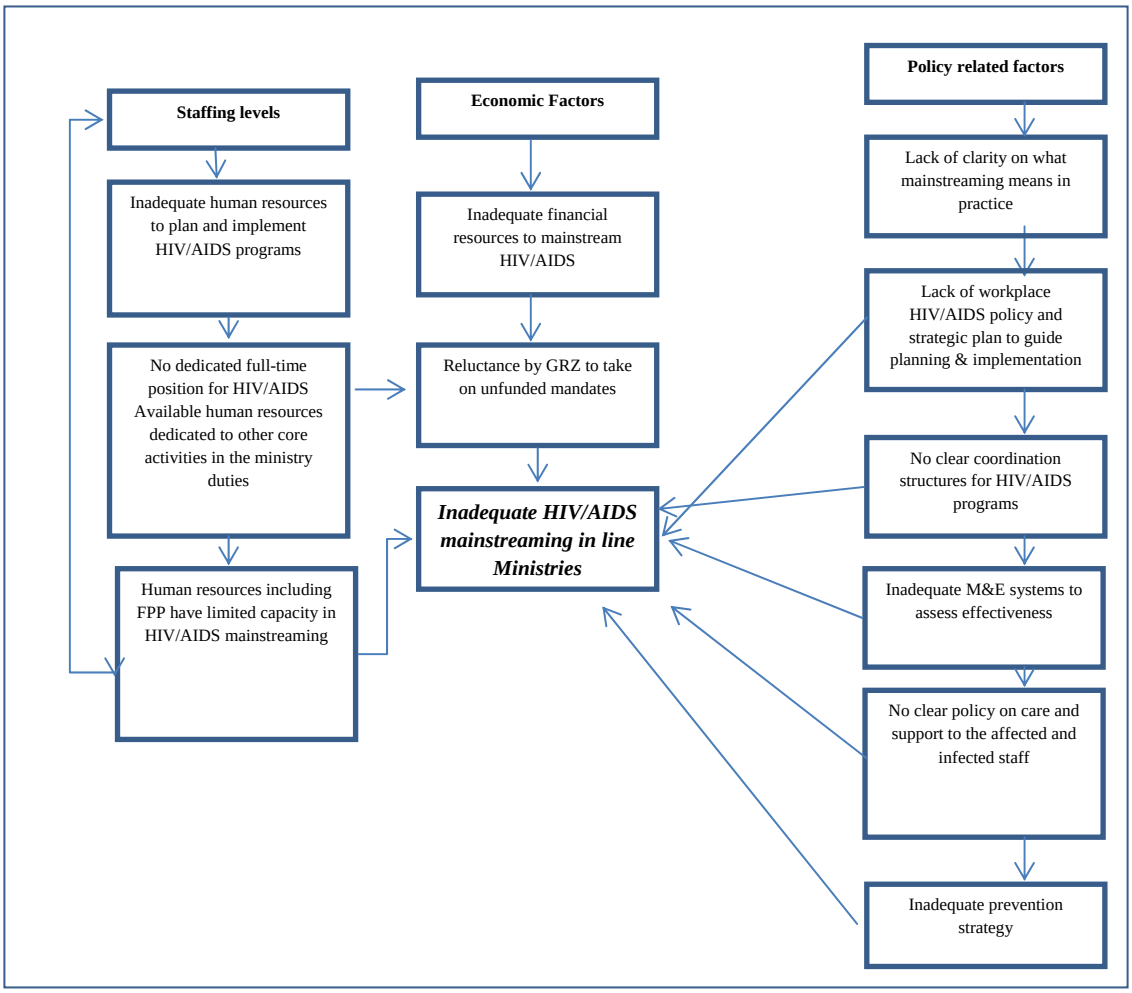
Given the challenges faced by the public service, NAC in consultation with the Public Service Management Division (PSMD) and other cooperating partners introduced HIV and AIDS mainstreaming tools for national and sub-national levels in 2006. The mainstreaming tools namely:- the NAC HIV and AIDS Mainstreaming handbook and the NAC HIV and AIDS Mainstreaming toolkit (NAC, HIV/AIDS Mainstreaming toolkit and

handbook, 2007) were designed to assist line ministries in defining their role and response to the HIV and AIDS epidemic. To this end in 2007, training and mainstreaming tools were availed to selected staff in all line ministries. However, little is known about the extent of mainstreaming in the ministries.

Although a number of efforts have been made to mainstream HIV and AIDS activities in line ministries as noted earlier, prior to 2006, no tools or methodologies had been developed to assist NAC and the ministries to measure progress. In 2006, a baseline survey was conducted by NAC and USAID's Support to the HIV/AIDS Response in Zambia project (SHARe) to determine the level of HIV and AIDS activities in ministries (Baseline Assessment of HIV and AIDS Mainstreaming among line Ministries, 2006). Although annual assessments were to be conducted following the 2006 baseline, systematic assessments of progress has not followed. Therefore, following this baseline it is unclear to what extent ministries are mainstreaming HIV and AIDS. Furthermore, the barriers to HIV/AIDS mainstreaming in line ministries since the introduction of the mainstreaming tools remain undocumented.

Notwithstanding the increased interest in mainstreaming, literature suggests that there is little clarity on what mainstreaming actually means in theory or practice (Elsey, Tolhurst, Theobald, 2005; Simon 2003; UNAIDS/GTZ, June 2002). Additionally, literature and experience from several countries in Sub-Saharan Africa has shown that very little is documented on what HIV/AIDS mainstreaming means in practice for different sectors (Elsey, 2003). Such conclusions provide further credence for this research as it focuses on practice, that is, the extent to which line ministries are mainstreaming HIV and AIDS in Zambia. Mainstreaming AIDS aims at producing system-wide effects, progress is likely to be gradual and not easily measurable in the short term. Hence, as most documented experiences are fairly recent, there is as yet little evidence on the outcomes and sustainability of mainstreaming processes (UNAIDS/GTZ, 2002). This study will therefore add to the body of literature on mainstreaming, documenting the barriers and providing suggestions on effective ways of overcoming barriers.

Figure 2: Problem Analysis Framework for Determinants of HIV/AIDS Mainstreaming in Line Ministries



3.0 RESEARCH QUESTIONS

In seeking to understand the above problem, the questions below will define the focus of the study.

1) What is the extent of HIV/AIDS mainstreaming in the line ministries?

2) To what extent are the line ministries utilising the HIV/AIDS mainstreaming guidelines and toolkit?

3) What are the barriers to HIV/AIDS mainstreaming in Line Ministries?

3.1 RATIONALE

Literature suggests that it is currently challenging for line Ministries to mainstream HIV and AIDS programs. Although Mainstreaming HIV and AIDS is seen as an essential approach for expanding multi-sectoral responses to HIV/AIDS, literature and experience from several countries in Sub-Saharan Africa has shown that very little is documented on what HIV/AIDS mainstreaming means in theory and practice for different sectors (Elsey, 2003).

This notwithstanding, Line Ministries play an important role in HIV/AIDS response in Zambia because most of the productive workforce in the Government is found in the Line Ministries which form the large component of the Public service (HIV and AIDS Strategy for the Public Service, 2010) . Therefore the results from this research could significantly contribute to the documentation of the levels of HIV/AIDS mainstreaming in Line Ministries and also identify the barriers to HIV/AIDS mainstreaming. The identification of these barriers will contribute to a body of knowledge that can inform Line Ministries, NAC, the national coordinating body, Policy makers and stakeholders on what steps to take in order to overcome the barriers. Finally, understanding the factors associated with HIV and AIDS mainstreaming will contribute to program and policy adjustments in line ministries in an effort to implement an effective and sustainable AIDS response in the Line Ministries.

3.2 OBJECTIVES

General Objective:

- To assess the extent of HIV/AIDS mainstreaming in line ministries and identify barriers so as to recommend ways of effective HIV/AIDS mainstreaming.

Specific Objectives

- To explore the extent of HIV/AIDS mainstreaming in the line ministries;
- To verify the extent to which ministries are using the HIV/AIDS mainstreaming guidelines
- To determine barriers to HIV/AIDS mainstreaming in line ministries and identify ways to overcome the barriers.

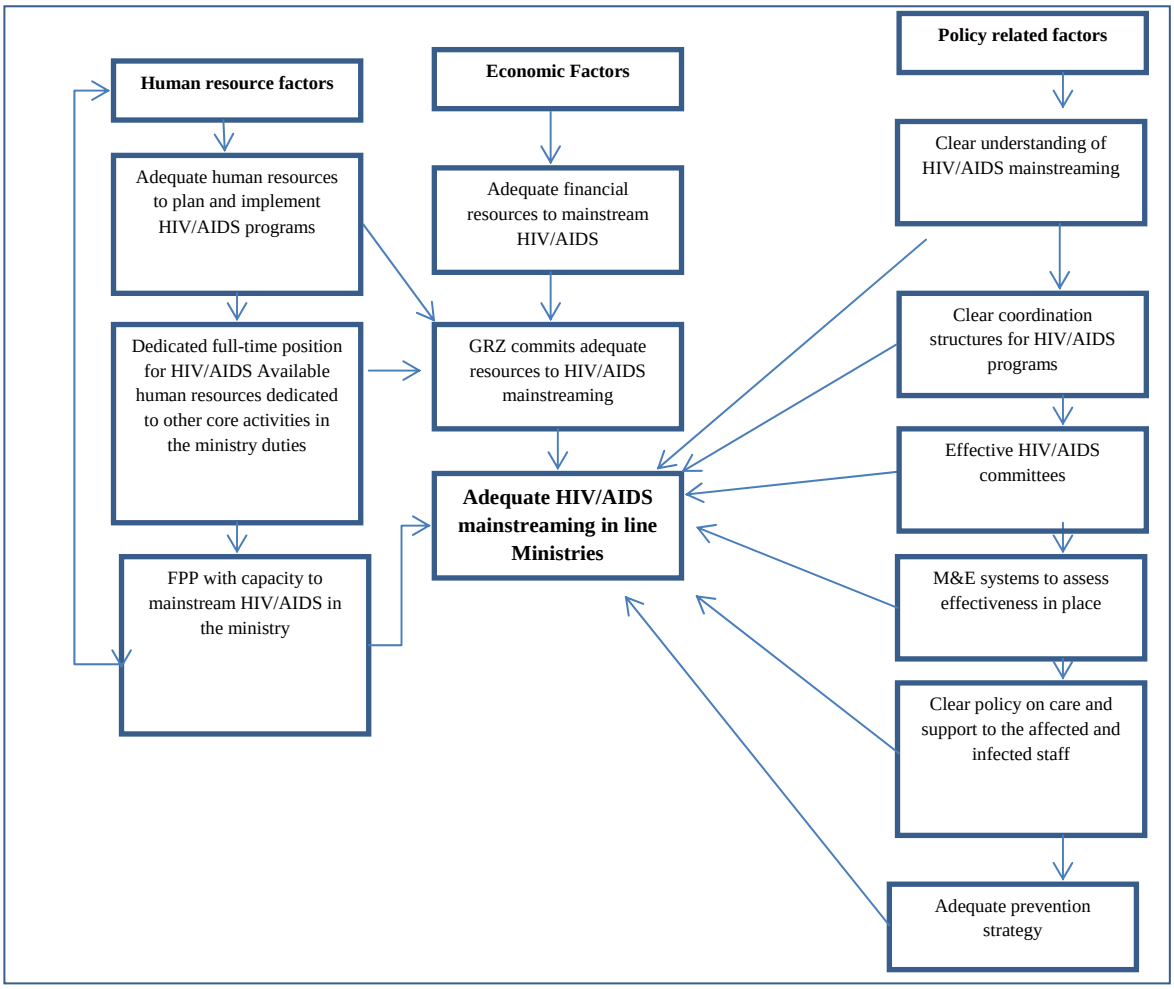
CHAPTER TWO

RESEARCH METHODOLOGY

2.1 Introduction

This section describes the research methodology of the study on the evaluation of HIV/AIDS mainstreaming in line ministries. It includes the conceptual framework on the relationship between independent and dependent variables, definitions of variables and information on the following: the research design, research setting, study population, sample sizes and sampling methods, data collection techniques, data analysis, data quality control, ethical considerations and limitations.

Figure 2.1: Conceptual Framework on Determinants of HIV/AIDS Mainstreaming in Line Ministries



The dependent and independent variables were obtained from the above conceptual framework.

The table below depicts operational definitions of the independent and independent variables including their indicators

Table 2.1: Dependent and Independent Variables for the study

Variable Type	Operational Definitions	Indicators
Dependent Variable Extent of HIV/AIDS Mainstreaming in line ministries	HIV/AIDS Mainstreaming is process that enables development actors to address the causes and effects of HIV in an effective and sustained manner, both through their usual work and within their workplace (NAC, 2005).	Proportion of ministries who have mainstreamed HIV/AIDS
Independent variables **Policy related factors** HIV/AIDS Policy	An HIV/AIDS policy is a document that outlines how a particular ministry will respond to HIV. It provides a guide for implementation	Number of ministries who have completed their HIV/AIDS policies Number of ministries who have disseminated their policies Number of ministries implementing what is outlined in the HIV/AIDS policies
Care and Support Program	A care and support program is a program aimed at providing care and support for the infected and affected. It can include HIV testing, psychosocial support, counseling, PMTCT, reproductive health, treatment and nutritional advice. (ILO code of practice)	Proportion of ministries implementing a holistic HIV/AIDS care and support program Number of staff accessing care and support programs in ministries
HIV/AIDS Prevention Strategies	These are strategies that prevent further spread of HIV. This can include behavior change communication activities, peer education, VCT, condom promotion and distribution, minimizing risky of occupational exposure to infected blood and fluids, creation of non-stigma and non-discriminatory environment (UNDP 2004)	Number of ministries implementing a holistic prevention program Number of staff accessing prevention activities in the line ministries
Coordination of HIV/AIDS Program	This refers to the management of HIV/AIDS programs. An effective HIV/AIDS workplace response needs to be well coordinated with an HIV/AIDS committee and a coordinator/fpp in place	Proportion of ministries with fpps/coordinator Number of ministries with an effective HIV/AIDS committee which meets at least once a month
Economic factors Financial resources	This refers to funds specifically budgeted/allocated to HIV/AIDS	Number of ministries with specific with GRZ budget line for HIV/AIDS Number of mainstreaming HIV/AIDS programs using GRZ money Number of ministries using donor funds to implement HIV/AIDS programs
Human Resource Factors Permanent HIV/AIDS Officer	This refers to a full time position for HIV/AIDS on the ministry establishment list	Number of ministries with permanent staff working on HIV/AIDS

2.2 Research Design

This was cross-sectional evaluation study that employed a Logical framework in evaluating the effectiveness of HIV and AIDS mainstreaming in line ministries. Effectiveness evaluation focuses on outcomes and impacts and evaluating the effectiveness of a program and usually involves estimating the impact of programs on the system and behavior change (FHI, 2001). For this study, it involved assessing the effectiveness and extent of HIV and AIDS mainstreaming in line ministries. In logical framework is an effective tool used largely for planning and monitoring but also evaluation. In this research, the tool was used to enhance a deeper understanding of key aspects of mainstreaming being employed in line ministries and related indicators for measuring success. In addition, the study utilized both qualitative and quantitative research methods. The inclusion criteria for the quantitative component were all members of staff who were randomly selected and who consented participated in the study from the ministries. In addition all those not randomly selected those who had been employed within 6 months prior to the study and those who did not consent were excluded from the study. The inclusion criteria for the qualitative component was all those who had been engaged in the management of ministerial HIV and AIDS activities for more than six months as focal point persons and consented were interviewed. All the focal point persons who did not meet the above criteria were not interviewed.

2.3 Study Setting and Study Population

Qualitative Component

The qualitative component of the study was conducted in all the 22 government line ministries, NAC and PSMD. It was achieved through in-depth interviews. Due to resource constraints and time, the study was limited to headquarters personnel for each ministry. For the same reasons, the study was undertaken within Lusaka only.

The study population comprised of key informants at management level in the line ministries, NAC and PSMD. The key informants were at management level (Senior Human Resource Management Officer, Assistant Director and Director) with specialized

knowledge on HIV and AIDS mainstreaming by virtue of them being focal point persons for HIV and AIDS in individual ministries. The key determining criteria was 'information-rich cases', which was individuals with a greater likelihood of possessing significant knowledge on the subject matter in this study. In addition, as focal persons, the key informants were in charge of overseeing the implementation of HIV and AIDS programs in the individual ministries and had undergone training in HIV and AIDS mainstreaming. Furthermore, the key informants were those who could influence policy in the ministries. The rationale for interviewing these individuals was to respond to some of the research questions related to the reasons for the current variance in HIV and AIDS mainstreaming, barriers to HIV/AIDS mainstreaming and to identify strategies that can improve the Mainstreaming of HIV and AIDS in Line Ministries.

The qualitative approach provided rich descriptive information based on the perspectives of people involved in the processes. As stated by Merriam (2002:12), the focus of qualitative inquiry was to understand the "meaning of a phenomenon from the perspectives of the participants, it is important to select a sample from which the most can be learned." The qualitative component was achieved through in-depth interviews. A semi-structured interview guide was developed and pre-tested prior to in-depth interviews with the key informants.

Quantitative Component

The study population was comprised of members of staff at various levels within ministerial headquarters. These were below management level positions and recipients or beneficiaries of the HIV/AIDS interventions. The survey was achieved through the use of a questionnaire which was administered to members of staff at various levels in the ministries. Quantitative data was obtained via the use of a questionnaire in a survey. The main language spoken in the study was English. This method in combination with the in-depth interviews not only provided useful data but also allowed for data triangulation. As noted by Golafshani (2003), triangulation can occur in several ways including the use of two or more data collection method.

2.4 Sample Size and Sampling Procedures

Qualitative Method

As earlier mentioned, there are 22 line ministries in Zambia, each of these has an HIV/AIDS Focal point person who is in charge of coordinating HIV and AIDS activities in the Ministry. Out of the 22 Ministries, at least 21 focal point persons 1 individual from NAC and 1 individual from PSMD were interviewed.

Quantitative Method

Multi-stage sampling was used for the survey. The three stages are presented below:

Stage 1:

In the first instance, all the twenty-two line ministries in Zambia were included in the study. However, the study was limited to ministerial headquarters given the time and resource constraints.

Stage 2:

The population size for the twenty -two Ministries at headquarters only was 2,498. In order to calculate the sample size, Epi Info was used. Expected frequency of factor under study of 50% was used since the study has not been done before in the government ministries using a precision of 5%, which brings the worst acceptable result to 45%. A sample size of 333 was obtained at 95% confidence level. The sample contribution of each Ministry was determined by calculating the ratios according to the population in each Ministry (probability Proportional to Size).

Stage 3

Each Ministry was treated as a cluster. Therefore, in order to account for the design effect of cluster sample size calculation, the n which is 333 was multiplied by 1.5 which brought the sample size to **500**.

As indicated above the total population in the line ministries at headquarters during the time of the study was is 2,498. The sample contribution for each ministry was determined by calculating the ratio according to the population in each line ministry

(Probability Proportional to Size). This is illustrated in the table below.

Table 2.4 : Sample Size

	Study Unit	Population (GRZ Establishment)	Actual Filled Positions	Sample contribution according to Size of Ministry (PPS)
1.	Ministry of Education	492	327	327/2498 x 500 = **66**
2.	Ministry of Foreign Affairs	160	89	89/2498 x 500 = **18**
3.	Ministry of Information and Broadcasting Services	166	77	77/2498 x 500 = **15**
4.	Ministry of Commerce, Trade and Industry	149	90	90/2498 x 500 =**18**
5.	Ministry of Sport Youth and Child Development	147	97	97/2498 x 500 = **19**
6.	Ministry of Science, Technology and Vocational Training	150	82	82/2498 x 500= **16**
7.	Ministry of Home Affairs	75	48	48/2498 x 500 = **10**
8.	Ministry of Tourism, Environment and Natural Resources	160	87	87/2498 x 500 = **17**
9.	Ministry of Works and Supply	96	71	71/2498 x 500 = **14**
10.	Ministry of Health	200	103	103/2498 x 500 =**21**
11.	Ministry of Local Government and Housing	202	121	121/2498 x 500 = **24**
12	Ministry of Labour and Social Security	174	106	106/2498 x 500 = **26**
13	Ministry of Lands	285	199	199/2498 x 500 =**40**
14	Ministry of Finance and National Planning	465	316	316/2498 x 500 =**63**
15	Ministry of Gender and Development	19	19	19/2498 x 500 =**4**
16	Ministry of Justice	111	84	84/2498 x 500 =**17**
17	Ministry of Mines and	54	39	39/2498 x 500 =**9**

	Minerals			
18	Ministry of Agriculture and Cooperatives	286	119	119/2498 x 500 =**24**
19	Ministry of Energy and Water Development	207	112	112/2498 x 500 =**22**
20	Ministry of Communications and Transport	342	216	216/2498 x 500 =**43**
21	Ministry of Community Development and Social Services	160	96	96/2498 x 500 = **19**
22	Ministry of Defence*			
	Total	**4100**	**2498**	**500**

Data sources: Ministry Human Resources Departments, 2009; HR Officers
*Data not provided for security reasons.

Stage 4:

Furthermore, simple random sampling was used to identify individual respondents in each ministry. Therefore, respondents were randomly chosen from the staff list or sampling frame.

2.5 Data Collection Techniques

Primary data

Quantitative and qualitative methods of data collection were used. A Semi structured interview guide was used for key informants while scheduled structured questionnaires were used to collect quantitative data.

Secondary data

Secondary data was collected from review of policy documents, reports from various actors in the HIV and AIDS sector was reviewed for triangulation. Most HIV and AIDS policies in line ministries were completed and launched in the last 4 years. Therefore, for the purposes of this study, reviewing of key documents covered primarily the period during and after implementation of the policies, 2006-09. Information that was collected primarily focused on the functioning of HIV and AIDS programmes in the line Ministries. More broadly, literature from other countries on management of HIV and AIDS in the Public service was considered. Additionally, another way that secondary

data was obtained was by reviewing Journal articles data. Internet searches (Google and other specialised websites) provided additional methods for collecting secondary data.

2.6 Data Analysis

For the quantitative data, questionnaires were collected, checked for accuracy and completeness on a daily basis, thereafter the data was coded and entered into the computer using SPSS for Windows version 18. The Pearson Chi square test was used to determine association and relationships within the data. A result showing a p value of 0.05 or less at 95% confidence interval was considered significant. In addition, Logistic regression analysis was used to determine independent factors associated with HIV and AIDS Mainstreaming in the line Ministries.

For the qualitative data, N-Vivo was used to analyze the data. Typed transcripts were assigned to N-Vivo and coded. All transcripts were read through to tease out emerging themes and allowed for generation of new codes for data sorting. After generating code-based outputs from N-Vivo, a further systematic analysis was done, making use of content analytic summary tables. These assisted in presenting coded data from different respondents to allow for effective comparison and holistic analysis of the data.

2.7 Data Quality Control

The semi-structured interview guide and the structured questionnaire were pre-tested. To ensure quality control of data questionnaires were collected, checked for accuracy and completeness on a daily basis.

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2.8 Ethical considerations

Approval to undertake the study was sought from UNZA REC. Permission was obtained from the Permanent Secretaries in the Line ministries. Confidentiality was ensured. Informed consent was obtained from participants of the research.

In order ensure anonymity, the researcher disguised identities of all participants using codes. All respondents were informed about the study being undertaken in fulfilment of

academic requirements.

CHAPTER THREE

ANALYSIS AND PRESENTATION OF DATA

Data collected is presented below in four key sections consistent with the main areas of focus in this research. Section one, provides a brief synopsis of the socio-demographic factors of participants in this research. Section two, covers the status of mainstreaming and barriers of mainstreaming in line ministries. Lastly, section three presents the factors and determinants of mainstreaming.

SECTION 1

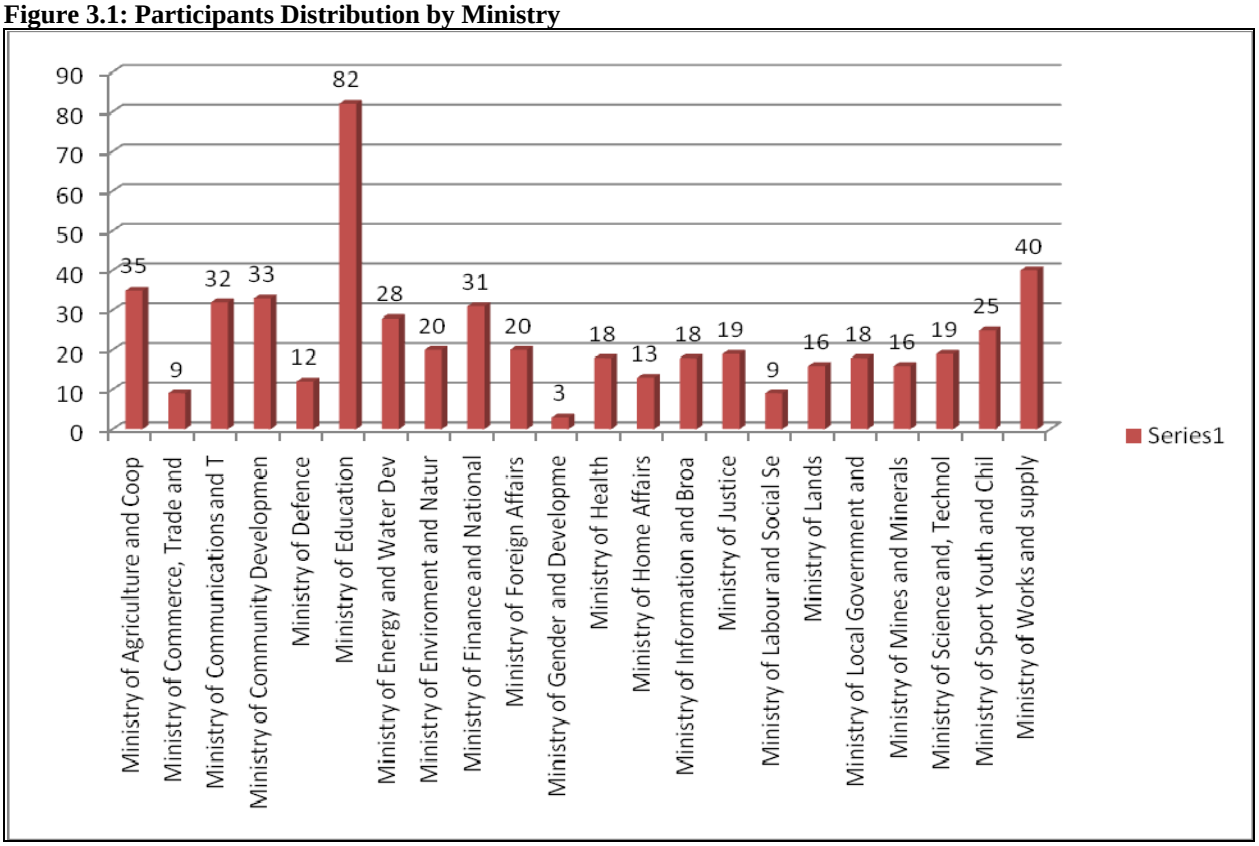
3.1 Population and Participation Distribution.

A total of 516 respondents responded to the questionnaire giving a response rate of over 100%. All respondents are employees in line Ministries. Out of the 516, about 50 percent (258) were female and about 49 percent (251) were male and 7 respondents did not indicate their sex. The age range for the respondents who participated in the survey was 20–55. The mean age for the respondents was 36 and the median age was 35.

In addition, a total of 21 key informants participated in the qualitative study. These included FPPS, acting FPPs, staff from NAC and PSMD. They were interviewed by means of an in-depth interview using an interview guide. Out of the 21 key informants interviewed, 12 were female and 8 were male.

Figure 3.1, below shows the distribution of respondents who participated in the survey across the 22 line ministries.

Figure 3.1: Participants Distribution by Ministry



3.2 Participants Characteristics

3.2.1 Education status

About 10 (2%) of the 516 respondents who participated in the survey had attained Primary level education while approximately 100 (20%) had reached Secondary school level. Approximately 135 (26%) had reached up to University while 257 (50%) had attained College or Vocational education. About 6 (1%) of the respondents reported to have attended Adult literacy classes.

Out of the 21 respondents who participated in the qualitative study, 19 (90%) had attained University level education while 2 (10%) had attended college education.

3.2.2 Employment

Out of the 516 respondents who participated in the quantitative category approximately 42 (8.3%) of the respondents work as classified daily employees (CDEs) while 16 (3.2%) are drivers in the different the line Ministries. About 93 (18.4%) work as registry clerks

and 78 (15.4%) are employed as secretaries. Furthermore, about 47 (9.3%) are employed as Accountants while approximately 24 (5%) work as planning officers. Approximately 10 (2%) work as Public Relation Officers and 17 (3.4%) of the respondents work as procurement officers. About 36 (7.1%) work as Human Resource Officers. Approximately 143 (28.3%) work in positions that were not listed on the options but respondents specified their positions on the specify option. The positions specified by the respondents include Transport officers, economists, Energy officers, Carpenters, Budget Analysts, M and E Specialists and Architects among other specified positions.

As discussed in Chapter 3 of this report, it is important to note that respondents in the quantitative survey section represented middle and lower management.

With regard to respondents who were interviewed using an interview guide, their positions of the respondents were as follows: 2 Assistant Directors, 4 Senior Human Resource Management Officers, 3 Administrative Officers, 2 Chief Human Resource Officers, 1 Superintendent, 1 Accountant and 5 Human Resource Officers. The human resource officers are also functioning as FPPs from the line ministries. Others were .the Head of Administration from PSMD and the Provincial and District Specialist from NAC.

As HIV and AIDS focal point persons in the Ministries, respondents in the qualitative study represented management.

3.2.3 Marital Status

In terms of marital status under the quantitative component, out of the 516 respondents approximately 322 (64.1%) reported to be married monogamously while about 14 (3%) were married polygamous. Approximately 106 (21.1%) to have never married while about 19 (4%) reported to be separated or divorced. About 28 (5.6%) reported have been widowed and 9 (2%) reported to be cohabiting but not married.

3.3 Description of Sample by Policy Related Characteristics

3.3.1 HIV and AIDS Policy

The extent of mainstreaming HIV and AIDS was assessed by the existence of an HIV and AIDS policy, the extent to which it has been disseminated and the extent to which it was being implemented.

Below is table 3.3.1A showing how the responses were distributed when respondents were asked whether their ministry had an HIV and AIDS policy.

Table 3.3.1A: Knowledge of the Existence of an HIV and AIDS Policy

	Does the Ministry have an HIV/AIDS Policy (N=498)	**Does the Ministry have an HIV/AIDS policy in % (N=498)**
Yes	402	80.7
No	96	19.3
Total	**498**	**100**

One of the things looked at to assess the extent of mainstreaming was the existence of an HIV and AIDS policy. When respondents were asked whether their Ministry (n=498) has an HIV and AIDS policy, about (19.3%) reported not knowing whether their Ministry has an HIV and AIDS policy. About (80.7%) affirmed to their Ministry having an HIV/AIDS policy.

In-depth interviews revealed that 18 line Ministries have HIV and AIDS policies, which were finalized and launched between 2004 and 2009. Four Ministries have not yet finalized their Ministerial HIV and AIDS policies. Below are some of the quotations from the respondents.

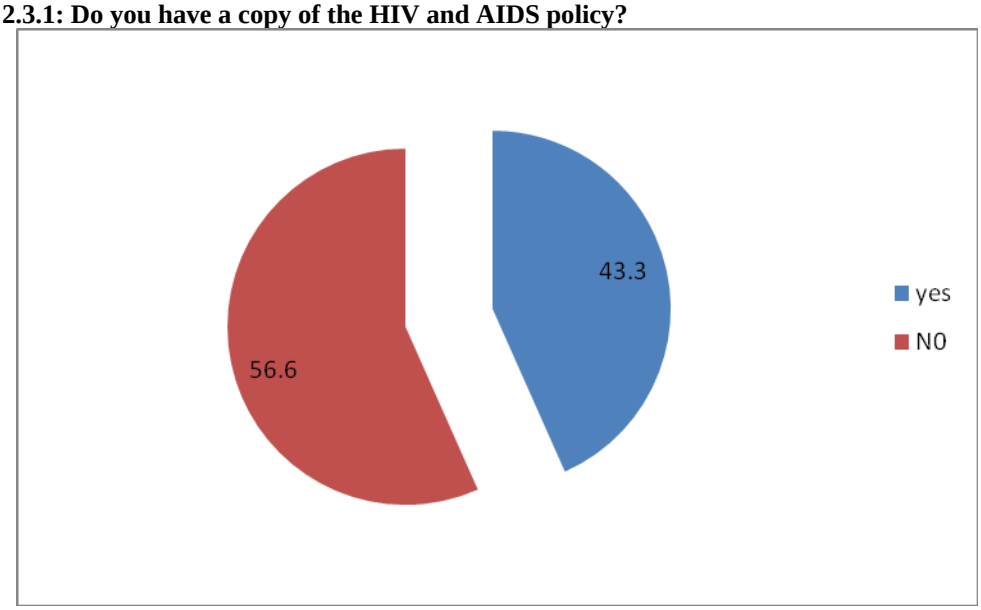
Table 3.3.1B below shows how responses were distributed when respondents were asked whether they had a personal copy of the HIV and AIDS policy.

Table 1.3.1B: Availability of an HIV and AIDS policy

	Do you have a copy of the HIV/AIDS Policy (N=502)	**Do you have a copy of the HIV/AIDS Policy in % (N=502)**
Yes	218	43.3
No	284	56.6
Total	**502**	**100**

When respondents were asked whether they had a copy of their Ministerial HIV and AIDS policy (n=502), about (43.3%) reported having a copy of their Ministerial HIV and AIDS policy while over half (56.6%) reported not having a copy of their Ministerial HIV and AIDS policy.

Figure 2.3.1: Do you have a copy of the HIV and AIDS policy?



Below is a table showing how the responses were distributed when respondents were asked whether their Ministry has shared the contents of the policy with staff.

Table 3.3.1C: Dissemination of the HIV and AIDS Policy

	Has the Ministry Disseminated the HIV/AIDS Policy (N=468)	**Has the Ministry Disseminated the HIV/AIDS Policy in % (N=468)**
Yes	251	53.6
No	217	46.4
Total	**468**	**100**

The extent of HIV and AIDS mainstreaming was also assessed by the extent to which the policy has been disseminated. When asked whether the Ministry has shared the contents of the HIV and AIDS policy with staff (n=468), (53.6%) reported that their Ministry has shared the contents of the HIV and AIDS policy with staff while (46.4) reported that the

Ministry their Ministry has not shared the contents of the HIV and AIDS policy with staff. Below are some of the quotations obtained from the in-depth interviews.

Below is a Table5, which shows how the distribution of responses when respondents were asked whether their Ministry implemented what was outlined in their HIV and AIDS policy.

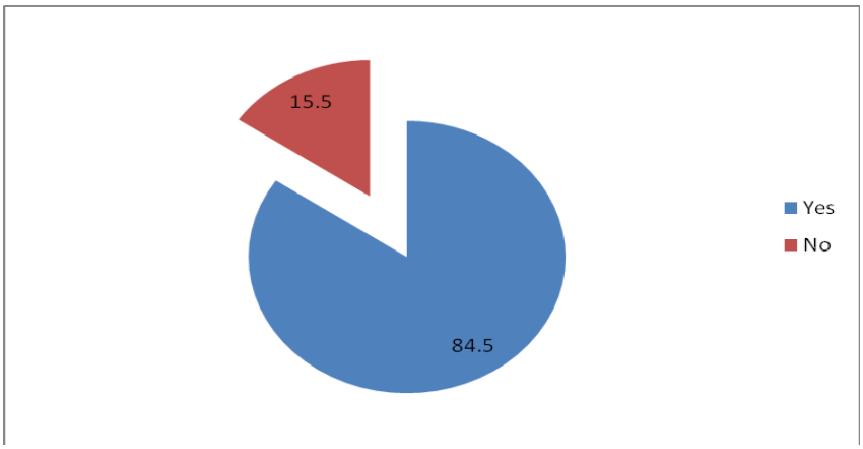
Table 3.3.1D: Implementation of HIV and AIDS policy in line ministry

	Does the Ministry implement what is in the Policy (N=410)	**Does the Ministry implement what is in the policy in % (N=410)**
Yes	199	48.5
No	211	51.5
Total	**410**	**100%**

The extent of mainstreaming was further assessed by the extent of implementation of what is outlined in the policy. When respondents were asked whether their Ministry was implementing what was outlined in the HIV and AIDS policy (n=410), about (48.5%) answered affirmatively and (51.5%) reported that their ministry has not implemented what is outlined in the HIV and AIDS policy.

3.3.2 HIV and AIDS Prevention

Figure 3.3.2: Does this ministry carry out any HIV and AIDS prevention activities?



The majority of the respondents (84.5%) said their ministries were carrying out HIV and AIDS prevention activities. About (15.5%) of the respondents did not affirm the existence and implementation of HIV and AIDS prevention activities in their ministries.

However, in-depth interviews revealed that the implementation of the prevention activities is dependent on the availability of resources.

Below is a table that shows the type of prevention activities carried out by the Ministries and specific activities that respondents have participated in.

Table 3.3.2A: Types of Prevention Activities

Type of Prevention activity	Activities mentioned (N=493)		Activities participated in (N=493)	
	n	%	n	%
Voluntary Counseling and Testing Promotion	238	48.3	145	29.4
Awareness Creation	272	55.2	167	33.9
Counseling services	228	46.2	151	30.6
Peer Education	219	44.4	152	30.8
Commemoration of days e.g. HIV/AIDS and VCT days	393	79.7	320	64.9
HIV and AIDS IEC materials	205	41.6	125	25.4
Provision of Male Condoms	336	68.2	155	31.4
Provision of female Condoms	265	53.9	111	22.5

Of all the respondents (N=493) who reported their ministries implementing HIV and AIDS prevention activities, commemoration of HIV and AIDS and VCT days were more frequently mentioned (79.7%) followed by distribution of male condoms (68.2%). Slightly more than 50 percent of respondents mentioned awareness creation and provision of female condoms are activities their ministries were carrying. The rest of the activities as shown in table 6 were mentioned by slightly more than 40 percent of the respondents. There were more male condoms being distributed than female condoms.

When asked about their participation in the HIV and AIDS prevention activities (N=493), less than a third said they had participated in VCT and other counselling services, peer education, provision of condoms and distribution of IEC materials as shown on table 6

above. About a third reported having participated in awareness creation and two-thirds in commemoration of HIV and AIDS and VCT days. There were no statistically significant differences between respondents in mid/lower management and 'general workers' in participation of HIV and AIDS prevention activities ($p>0.05$). The data also shows that females are as likely as the males to participate in HIV workplace activities ($p>0.05$).

Table 3.3.2B below shows the number of Peer Educators known by staff distributed by Ministry

	None		1 to 5		6 to 10		11 to 20		21 and above		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Agriculture and Cooperatives	12	38.7	18	58.1			1	3.2			31	100.0
Commerce, Trade and	3	42.9	2	28.6	2	28.6					7	100.0
Communications and Transport	3	10.7	5	17.9	8	28.6	10	35.7	2	7.1	28	100.0
Community Development	3	11.1	3	11.1	10	37.0	9	33.3	2	7.4	27	100.0
Defence	1	10.0	2	20.0	3	30.0	1	10.0	3	30.0	10	100.0
Education	1	1.4	48	68.6	14	20.0	6	8.6	1	1.4	70	100.0
Energy and Water Development	1	5.6	14	77.8	3	16.7					18	100.0
Environment and Natural resources			12	85.7					2	14.3	14	100.0
Finance and National	6	27.3	8	36.4	4	18.2	2	9.1	2	9.1	22	100.0
Foreign Affairs	2	15.4	8	61.5	2	15.4			1	7.7	13	100.0
Gender and Development	3	100.0										
Health	7	63.6	2	18.2	1	9.1	1	9.1			11	100.0
Home Affairs			1	10.0	7	70.0	1	10.0	1	10.0	10	100.0
Information and Broadcasting	2	14.3	7	50.0	3	21.4			2	14.3	14	100.0
Justice	7	70.0	1	10.0					2	20.0	10	100.0
Labour and Social Security	4	57.1	1	14.3	2	28.6					7	100.0
Lands			8	61.5	3	23.1	1	7.7	1	7.7	13	100.0
Local Government and housing	4	50.0	1	12.5	1	12.5	2	25.0			8	100.0
Mines and Minerals			10	71.4	2	14.3	2	14.3			14	100.0

Science and, Technology	3	23.1	4	30.8	4	30.8	2	15.4			13	100.0
Sport Youth and Child development	1	4.5	10	45.5	6	27.3	4	18.2	1	4.5	22	100.0
Works and supply			13	43.3	8	26.7	3	10.0	6	20.0	30	100.0
Total	**63**	**15.9**	**178**	**45.1**	**83**	**21.0**	**45**	**11.4**	**26**	**6.6**	**395**	**100.0**

When asked about how many peer educators the respondents knew in their respective ministries (n=395), about 15.9 percent reported not knowing any peer educator, almost (45.1%) reported knowing 1 to 5 peer educators, almost a quarter (21.0%) and about 11.4 percent knew 6 to 10 and 11 to 20 peer educators respectively. In addition, about 6.6 percent reported knowing more than 20 peer educators. The mean number of peer educators reportedly known was 7.65 and the median was 4.

Table 3.3.2C below shows the number of Counselors known by staff distributed by Ministry

	None		1 to 5		6 to 10		11 to 20		21 and above		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Agriculture and Cooperatives	14	42.4	17	51.5	2	6.1					33	100.0
Commerce, Trade and industry	4	80.0			1	20.0					5	100.0
Communications and Transport	6	24.0	17	68.0	1	4.0			1	4.0	25	100.0
Community Development	6	20.7	8	27.6	5	17.2	9	31.0	1	3.4	29	100.0
Defence			4	40.0	2	20.0	1	10.0	3	30.0	10	100.0
Education	2	2.7	47	64.4	10	13.7	10	13.7	4	5.5	73	100.0
Energy and Water Development	3	15.8	10	52.6	4	21.1			2	10.5	19	100.0
Environment and Natural Resources	1	6.7	12	80.0			2	13.3			15	100.0
Finance and National Planning	6	25.0	12	50.0	3	12.5	1	4.2	2	8.3	24	100.0
Foreign Affairs	2	12.5	12	75.0			1	6.3	1	6.3	16	100.0
Gender and Development	3	100.0										
Health	4	44.4	2	22.2	2	22.2	1	11.1			9	100.0
Home Affairs	1	11.1	4	44.4	4	44.4					9	100.0
Information and Broadcasting	8	61.5	5	38.5							13	100.0
Ministry of Justice	9	75.0	1	8.3					2	16.7	12	100.0
Labour and Social Services	4	57.1	1	14.3	2	28.6					7	100.0
Lands			7	70.0	2	20.0	1	10.0			10	100.0
Local Government and Housing	4	57.1	1	14.3	2	28.6					7	100.0
Mines and Minerals			11	73.3	3	20.0	1	6.7			15	100.0
Science and,	9	60.0	6	40.0							15	100.0

Technology												
Sport Youth and Child Development			10	47.6	5	23.8	5	23.8	1	4.8	21	100.0
Works and supply	2	6.1	17	51.5	12	36.4			2	6.1	33	100.0
Total	**88**	**21.8**	**204**	**50.6**	**60**	**14.9**	**32**	**7.9**	**19**	**4.7**	**403**	**100.0**

When the respondents were asked how many counsellors they knew in their respective ministries (n=403), about (21.8%) reported not knowing any counsellor, almost (50.6%) reported knowing 1 to 5 counsellors, almost (14.9%) knew 6 to 10 counsellors and about (7.9%) reported knowing 11 to 20 counsellors. In addition, (4.7%) reported knowing more than 21 counsellors. The mean number of counsellors reportedly known was 5.23 and the median was 2.

3.3.3 HIV and AIDS Care and Support

Below is a table that shows the type of care and support services carried out by the line ministries and the extent of accessibility.

Table 3.3.3: Provision of Care and Support

	Provision (N=486)		Accessibility (N=479)	
	n	%	n	%
ARVs	136	28.0%	157	32.8%
Food Supplements	287	59.1%	223	46.6%
Facilitation of Referrals	121	24.9%	125	26.2%
Medical Care	148	30.5%	325	32.2%
Financial Support	103	21.2%	107	22.4%
Emotional and psychological Support	160	32.9%	140	29.3%
Support Groups	205	42.2%	173	36.1%
Counseling	208	42.8%	182	38.0%
Nutritional Support	192	39.5%	166	34.7%
Home Based Care	133	27.4%	139	29.0%
Condoms Male/Female	311	63.9%	273	57.0%
Treatment Support	131	27.0%	130	27.1%

When asked about which type of services their Ministry provides in the area of Care and support (N=486), more than half affirmed to their Ministry providing male/female condoms (63.9%) and food supplements (59.1) respectively. More than a quarter reported

that their Ministry provides home based care (27.4%), treatment support services (27.0%) and ARVs (28.0%). Less than a quarter reported that their Ministry provides financial support (21.2%) and facilitate referrals (24.9%). About (32.9%) reported that their Ministry provides emotional and psychological support while (39.5%) said that their Ministry provides nutritional support. Thirty nine percent reported that their Ministry has support groups and about 42.2% said that their Ministry provides counselling services.

Respondents were further asked about the accessibility of the above-mentioned services (N=479). Of all the services, mentioned condoms were most accessed with 57.0% of respondents reporting that they could readily be accessed. Over a third reported that members of staff could readily access nutritional support (34.7%), financial support (22.4%) and ARVs (32.8%). Above a quarter reported that members of staff can readily access home based care (29.0%), treatment support (27.1%) and facilitation of referrals (25.8%). About (38.0%) reported that staff could readily access counseling services. Less than half (47.5%) reported that members of staff could readily access food supplements.

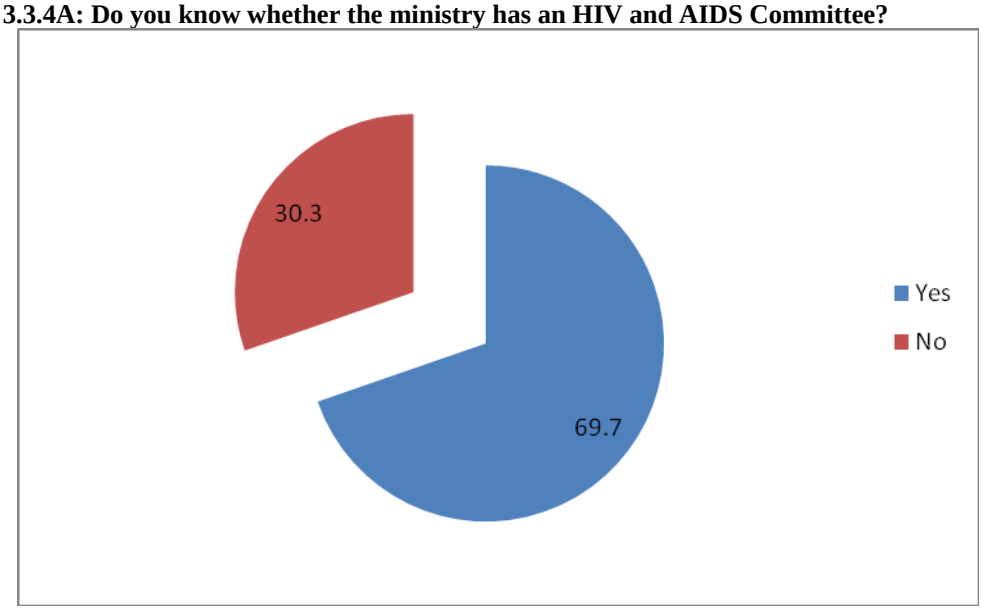
3.3.4 Coordination

Table 3.3.4 and chart below (fig.3.3.4) illustrates the level of coordination as perceived by the respondents. When asked whether the ministry has an HIV and AIDS committee (69.7%) indicated that the ministry had a committee in place while (30.3%) indicated that their Ministry does not have an HIV and AIDS committee in place.

Table 3.3.4: Knowledge of the existence of an HIV and AIDS Coordination Committee

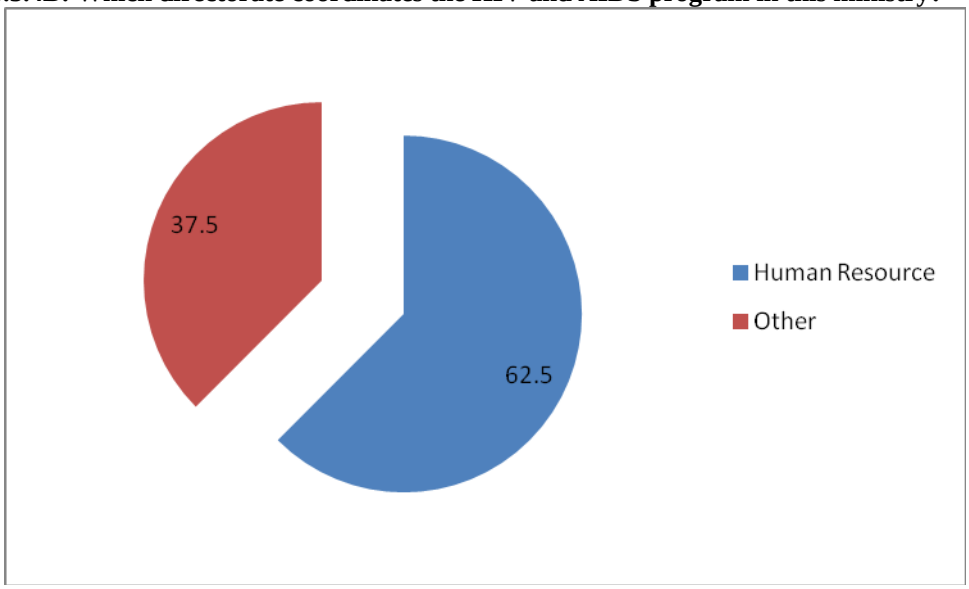
	Do you know whether this Ministry has an HIV and AIDS committee (N=471)	**Do you know whether this Ministry has an HIV and AIDS committee in % (N=471)**
Yes	**327**	**69.7**
No	**144**	**30.3**
Total	**471**	**100**

Figure 3.3.4A: Do you know whether the ministry has an HIV and AIDS Committee?



Additionally as presented below (Fig. 3.3.4B), (62.5%) identified the department of human resources as the department tasked to coordinate the HIV and AIDS program, while (37.5%) ascribed the responsibility to other departments.

Figure 3.3.4B: Which directorate coordinates the HIV and AIDS program in this ministry?



SECTION 2: PRESENTATION OF QUALITATIVE RESULTS

Mainstreaming of HIV and AIDS – Perceptions, Experiences and Observations (Ideas from In-depth interviews)

This section mainly presents the qualitative data collected by means of in-depth interviews. A total of 23 people were interviewed out of which 21 were FPPs from line Ministries, the Provincial and District Response Specialist (PDRS) from NAC and the head of Administration at PSMD.

2.1 The meaning of HIV and AIDS Mainstreaming

The majority of FPPs did not fully understand what mainstreaming means in practice. Out of the 21 Fpps interviewed, 13 said that they did not fully understand what is meant by mainstreaming. The narratives below illustrate the views of many FPPs When they were asked what they understood by Mainstreaming HIV and AIDS.

> ***I don't fully understand the concept of mainstreaming….I get confused between Mainstreaming HIV/AIDS and Integrating HIV/AIDS….but I think it has something to do with carrying out HIV/AIDS activities within the Ministry.***

> ***The concept of mainstreaming is difficult to understand especially when it comes to the implementation aspect. Of course there has recently been a lot of talk around it even from NAC but I think it'll take time for us to fully know what we have to do exactly in terms of HIV/AIDS mainstreaming.***

However, a few Fpps alluded to fully understanding what mainstreaming HIV/AIDS is. The narratives below illustrate the views of 8 fpps who said they understood what mainstreaming is.

> ***I understand it to mean implementing HIV/AIDS programs for staff in the Ministry.***

Mainstreaming is making HIV/AIDS as part of the core mandate meaning that we include it in our Ministry plans.

The Provincial District Response Specialist from NAC understood Mainstreaming to mean the following:

Mainstreaming for ministries will mean that they make HIV and AIDS their business…we don't expect them to become professionals in HIV and AIDS but through internal mainstreaming they must ensure that their programmes and plans meet the needs of the HIV and AIDS environment. Mainstreaming means that all aspects of their implementation and planning must include HIV and AIDS. This will reduce the cost of running the Ministry in the long run.

The Head of Administration at PSMD understood Mainstreaming to mean:

Mainstreaming means that a Ministry looks at its core functions and its comparative advantage then see how best this can advantage HIV and AIDS programming in the Ministry. Mainstreaming can help mitigate the impact of HIV and AIDS in the line ministries.

Interpretation

The above statements from the Fpps on the meaning of HIV and AIDS mainstreaming show that generally most of Fpps (more than 60%) did not fully understand what HIV and AIDS mainstreaming fully means. However, a few of the Fpps understood what HIV and AIDS mainstreaming means as has been shown by the statements above.

2.1.2 Status of Mainstreaming

When Fpps were asked about the status of mainstreaming in their Ministries, about 8 (38%) reported that they have mainstreamed HIV and AIDS and about 13 (62%) reported that they have not yet mainstreamed HIV and AIDS. Most of the FPPs said that they felt that they have not fully mainstreamed HIV and AIDS while a few felt that they have

mainstreamed HIV and AIDS in their Ministries. The narratives below, illustrate the views of the FPPs on the status of mainstreaming in line ministries

> ***"I would say no in the sense that we only carry out HIV and AIDS programs whenever funds are available and in addition sometimes we stay for almost a year without carrying out any HIV and AIDS activities".***
>
> ***"I cannot say that we are Mainstreaming HIV and AIDS in this Ministry right now because since the Ministerial AIDS Coordination Advisor (MACA) left, nothing much is happening in the area of HIV and AIDS. In fact, no activities have been undertaken this year".***

The narrative below illustrate the views of the 8 fpps who reported that they have mainstreamed HIV/AIDS.

> ***"We have mainstreamed HIV and AIDS into our mandate as a Ministry. You may wish to know that we have ongoing HIV and AIDS programs in the Ministry. Over the years we have also encouraged the different departments in the Ministry to budget for HIV and AIDS so that they implement departmental HIV and AIDS activities and some are actually doing that".***

Interpretation
Most of the Fpps felt that their Ministries have not yet mainstreamed HIV and AIDS while less than half (50%) of felt that their ministries have mainstreamed HIV and AIDS. The Fpps who felt that their ministries have not mainstreamed are most likely the ones who did not understand what HIV and AIDS mainstreaming means.

2.2 Policy Related Factors
2.2.1Existence of HIV/AIDS Policy

When respondents who were interviewed were asked whether they have an HIV and AIDS policy, most (18 out of 22) of them said they had finalized and launched their HIV and AIDS policies. Below are some of the quotations from the respondents

> ***"Yes…we have an HIV and AIDS policy. It was finalized and launched in December 2007"***
>
> ***"We have a policy for HIV and AIDS; we finalized and launched it in July 2006"***

Three Ministries had not yet completed their HIV and AIDS as shown by the statement below.

> ***"The policy document is still in draft form but we are planning on finalizing it soon"***

Interpretation

Generally the majority (more than 80%) of the ministries have completed their HIV and AIDS policies.

2.2.2 Dissemination of the HIV and AIDS Policy

When the FPPs were asked during the in-depth interviews whether they had disseminated their HIV and AIDS policies, most of them said that they had not disseminated their policies despite finalizing and launching them. Below are the main narratives that depict the views of the FPPs

> ***"The HIV and AIDS policy was finalized and launched. We came up with a good plan of disseminating it but the challenge we have had is that we do not have the resources to disseminate it. As you are aware our ministry is has a presence in all the nine provinces."***

> ***"The HIV and AIDS policy was launched last year (2009) in February. We only printed a few copies which were given out at the launch so I cannot say that we have disseminated it since no follow up activity has been done to explain the contents of the policy".***

Interpretation

While the majority have finalized and launched their HIV and AIDS policy documents, most of them have not disseminated them due to financial constraints as illustrated by the narratives above.

2.3 Funding the HIV and AIDS Programs

In-depth interviews with FPPs revealed that Ministries come up with work plans each year in line with what is contained in the policy but are unable to implement these activities due to inadequate funding. Out of the 21 fpps, 15 said they are unable to implement what is outlined their policy document. This is illustrated by the narratives below.

> *"**As a Ministry, we draw up work plans every year in line with what is outlined in the HIV and AIDS policy but the problem we have is that implementation of the planned activities is not done. You may have money allocated to HIV and AIDS during the budgeting but you receive less when the money actually comes and even when the Ministry receives the funding for HIV and AIDS, at times it is diverted to other Ministry programs…so at the end of the day, you implement very little of what you had planned because of low or no funding at all."***
>
> ***"We have a good work plan but the funding we get is really low so usually we are not able to carry the activities we have planned for the year" "The frequency of implementing the HIV and AIDS activities in line with our HIV and AIDS policy depends on the funding, there are times when we desperately want to carry out an activity and there is just no money under the HIV and AIDS vote".***

Interpretation

The in-depth interviews with Fpps revealed that funding for HIV and AIDS in the line ministries is low and as result ministries find it a challenge to implement HIV and AIDS programs that they plan to do. This is affirmed by the statements above.

2.4 Prevention Programs Implemented in the Ministries

Qualitative data affirmed the responses obtained from the quantitative survey that the prevention activities carried out by most Ministries are commemoration of national and international days such as VCT and World AIDS days and provision of condoms to staff. This is because commemorating VCT and World AIDS day depending on the activities carried out may not require a lot of funds and they are observed once a year. Below are responses that represent most of the views from FPPs regarding the main prevention activities carried out:

> ***"We distribute condoms on a regular basis…we especially disseminate prevention information during the World AIDS day and VCT days. On World***

AIDS day, we have a luncheon where we have drama plays and talks on prevention of HIV in addition to printing T-shirts with prevention messages on them. World AIDS sort of brings the Ministry together in relation to the fight against HIV''.

"The main prevention activity have in the Ministry is condom distribution. Most of the funding we get goes to food supplements so we remain with very little funds for other activities. We have condoms throughout because we get them for free from Medical council of Zambia. May I mention that even if our funding is low we always make an effort to participate in the World AIDS and VCT days."

Interpretation
The main prevention activity carried out by ministries is condom distribution and commemorating the international days such as VCT day and World AIDS Day where prevention information id disseminated.

2.5 Provision and Accessibility of Care and support Services
Out of the 21 FPPs interviewed, 13 reported that their Ministries provide food and nutritional supplements to their staff when funds are available as illustrated by the narratives below.

"For us as a Ministry…we provide food supplements to support the terminally ill and make home visits to those members of staff who are sick and are unable to come for work…I almost forgot to mention that we also provide condoms"

"The funding we receive for HIV and AIDS is very little…it is usually about 10 million per month so we usually use it to buy food supplements for our members of staff who are HIV positive and we get condoms from Ministry of Health which we give them".

"We provide food supplements such as Kapenta, cooking oil, beans and Millie-meal to our staff who are on HIV treatment. Sometimes we even buy Totaloe which helps them with their immunity".

"When resources are there, we buy food supplements. We also give time to staff to care for their sick and we provide emotional support to staff through our trained counselors. We distribute condoms".

Interpretation
The above stated narratives show that the majority of ministries carry out care and support programs especially provision of female and male condoms including food supplements.

2.6 Barriers to HIV and AIDS Mainstreaming

Barriers/Challenges to HIV and AIDS Mainstreaming

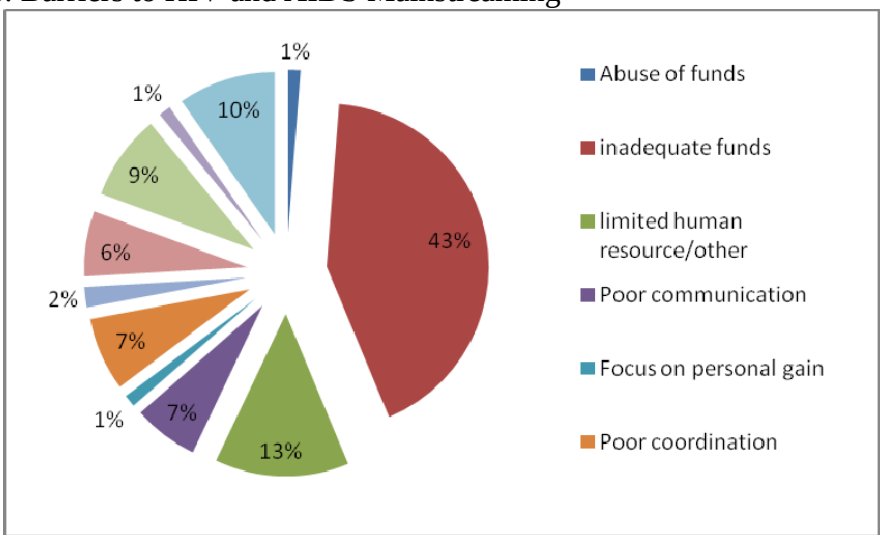
As shown in *Figure 2.6* below, the majority of respondents in the quantitative survey (43%) mentioned the inadequacy of funds available for HIV and AIDS programming as the major barrier affecting the implementation of HIV and AIDS activities. This was affirmed by the majority of the Fpps illustrated below.

> ***"As a Ministry….inadequate funding is the main barrier we face, we usually have very little resources to implement activities…that is why I said that I do not think that we are currently mainstreaming HIV and AIDS".***

"One barrier of Mainstreaming is that we depend too much on donors to fund our programs but if we want to mainstream HIV and AIDS, we need to have our own resource .If the donors don't give us money like this year then no activities will take place because our GRZ HIV and AIDS budget is very low so really a lack of resources is our biggest problem"

Figure 2.6 below shows the distribution of barriers in percentages.

Figure 2.6: Barriers to HIV and AIDS Mainstreaming



In addition to the above mentioned barriers almost all of the FPPs interviews mentioned the main challenges they face as Fpps to the mainstreaming HIV and AIDS. Out of the 21 interviewed 17 felt that the challenge they faced as Fpps was not having the capacity to implement HIV/AIDS as illustrated by the narrative below.

"The main challenge or barrier I find for me as FPP is the lack of understanding of HIV programming by the people running the program. For example, in this Ministry the committee members lack capacity in HIV programming so all they want to do when funding comes is to carry out workshops. If HIV and AIDS is to be mainstreamed there is need to train people coordinating the program in HIV and AIDS mainstreaming."

"I find lack of technical capacity by the FPPs to be a barrier. For example, I was transferred from another Ministry where I was not involved in the management of the HIV and AIDS program at all…. but here I am as FPP for the Ministry…with no idea of what I am supposed to do…..I have not received any form of training on how to manage the program. I became FPP by virtue of my current official Ministerial post….to be honest I don't yet fully understand what HIV and AIDS Mainstreaming is".

However 12 FPPs felt that the main challenge is a lack of management support and lack understanding of mainstreaming by management as shown by the statement below.

> ***" The main barriers I see to the mainstreaming of HIV and AIDS is that there is very limited or no participation at all by Top management in HIV and AIDS programs so even the other staff members do not take it seriously, I feel if management was in the forefront then we would have had a vibrant program and more funding would have been allocated to HIV and AIDS. I say because the Ministry the HIV and AIDS from the Ministry is really low because there is no management buy in."***
>
> ***"Lack of cooperation from staff especially senior management is the greatest barrier I face as FPP in this Ministry.***
>
> ***"One of the greatest challenges to mainstreaming in our Ministry and I guess this goes for other ministries as well is that the people who are supposed to lead the process do not even understand what it means, by people I mean the Permanent Secretaries as controlling officers and the directors. I think if these as decision makers understood the issues of HIV and AIDS mainstreaming then it would have been easy to include them in the Ministry's core programs."***

Out of the 21 Fpps interviewed 16 felt that time to coordinate HIV and AIDS is a challenge.

> ***"I am an assistant director and my office is very busy so I hardly find to time to coordinate the HIV and AIDS program. I usually delegate most of the time"***

Interpretation

The main challenges that Fpps face in their coordination of HIV and AIDS programs include inadequate financial resources, lack of top management commitment, lack of capacity and having HIV and AIDS program as an added responsibility in addition to their other core duties.

SECTION 3: FACTORS ASSOCIATED WITH HIV AND AIDS MAINSTREAMIG

Table 3.1: Association between Mainstreaming HIV and AIDS and awareness of Prevention activities in the Ministry

			Mainstreaming			Pearson's X^2	P Value
Activities(variable)		Mainstreamed	Total (M)	Not Mainstreamed	Total (N/M)		
Awareness							
VCT promotion	Yes	169 (54.3%)	311	69 (37.7%)	183	12.77	0.00*
	No	142 (45.7%)		114 (60.3%)			
Awareness creation	Yes	178 (57.2%)	311	93 (50.8%)	183	1.92	0.10
	No	133 (42.8%)		90 (49.2%)			
Counseling services	Yes	160 (51.4%)	311	67 (36.6%)	183	10.21	0.00*
	No	151 (48.6%)		116 (63.4%)			
Peer education	Yes	149 (47.9%)	311	69 (37.7%)	183	4.87	0.02*
	No	162 (52.1%)		114 (62.3%)			
Commemoration of International days e.g WAD	Yes	261 (83.9%)	311	132 (72.1%)	183	9.84	0.00*
	N0	50 (16.1%)		51 (29.9%)			
HIV and AIDS IEC Materials	Yes	142 (45.7%)	311	62 (33.9%)	183	6.59	0.01*
	No	169 (54.3)		121 (66.1%)			
Provision of Male condoms	Yes	231 (74.3%)	311	104 (56.8%)	183	16.07	0.00*
	No	80 (25.7%)		79 (43.2%)			
Provision of Female condoms	Yes	189 (61.0%)	310	75 (41.0%)	183	18.48	0.00*
	No	121 (39.0%)		108 (59.0%)			

*Denotes Significant Values

As reflected in *table 10* above, when all the variables hypothesized to influence awareness of prevention activities in the ministries were tested for associations using the Pearson's X^2, there was a Significant association for almost all variables $P< 0.001$ including Peer education $P=0.012$. Awareness creation did not show any significant associations.

Table 3.2: Association between Mainstreaming HIV and AIDS and Participation in Prevention activities in the Ministry

			Mainstreaming			Pearson's X^2	P Value
Activities(variable)		Mainstreamed	Total Main'	Not Mainstreamed	Total Not/M		
Participation							
VCT Promotion	Yes	93(30.0%)	310	51(27.7)	184	0.29	0.33
	No	217 (70.0%)		133 (72.3%)			
Awareness Creation	Yes	114 (36.8%)	310	53 (28.8%)	184	3.28	0.04*
	No	196 (63.2%)		131 (71.2%)			
Counselling Services	Yes	100 (32.3%)	310	50 (27.2%)	184	1.41	0.14
	No	210 (67.7%)		134 (72.8%)			
Peer education	Yes	100 (32.3%)	310	51 (27.7%)	184	1.12	0.17
	No	210 (67.7%)		133 (72.3%)			
Commemoration of International days (WAD)	Yes	206 (66.5%)	310	114 (62.0%)	184	1.02	0.18
	No	104 (33.5%)		70 (38.0%)			
IEC materials	Yes	95 (30.7%)	309	29(15.8%)	184	13.75	0.00*
	No	214 (69.3%)		155 (84.2%)			
Male Condoms	Yes	115 (37.1%)	310	39 (21.2%)	184	13.61	1.00*
	No	195 (62.9%)		145 (78.8%)			
Female Condoms	Yes	76 (24.5%)	310	34 (18.5%)	184	2.43	0.07
	No	234 (75.5%)		150 (81.5%)			

* Denotes Significant Values

When all the variables hypothesized to influence participation in prevention in activities were tested for associations using the Pearson's X^2 , there was a significant association between HIV and AIDS Mainstreaming and participation in the distribution of IEC materials P<0.001. There was also a significant association between HIV and AIDS Mainstreaming and participation in Male Condoms distribution P<0.001. A significant association existed between HIV and AIDS Mainstreaming and participation in Awareness Creation prevention activities P=0.04.

Table 3.3: Association between HIV Mainstreaming and existence and availability of the HIV and AIDS policy.

			Mainstreaming			Pearson's X^2	P Value
Activities(variable)		Mainstreamed	Total Main'	Not Mainstreamed	Total N/M		
Existence of Policy	Yes	270(85.2%)	317	132 (72.1%)	183	12.52	0.00*
	No	47(14.8%)		51 (27.9%)			
Personal copy of policy	Yes	142 (44.8%)	317	75(40.3%)	186	0.96	0.19
	No	175 (55.2%)		111 (59.7%)			
Dissemination	Yes	180 (59.4%)	303	70(42.2%)	166	12.80	0.00*
	No	123 (40.6%)		96 (57.8%)			

*Denotes Significant values

When all the variables hypothesized to influence the existence of an HIV and AIDS Policy, dissemination of the HIV and AIDS Policy and having a personal copy of the HIV and AIDS policy were tested for associations using the Pearson's X^2, a significant association was seen between HIV and AIDS Mainstreaming and knowledge of the existence of the HIV and AIDS policy $P<0.001$. Furthermore there was also a significant association between HIV and AIDS Mainstreaming and dissemination of the policy $P<0.001$. There was no significant association between HIV and AIDS Mainstreaming and having a personal copy of the HIV and AIDS.

Table 3.4: Association between HIV and AIDS Mainstreaming and Having an HIV and AIDS Coordination Committee.

			Mainstreaming			Pearson's X^2	P Value
Activities(variable)		Mainstreamed	Total Main'	Not Mainstreamed	Total N/M		
HIV and AIDS Committee	Yes	223(75.6%)	295	104 (54.4%)	178	15.33	0.00*
	No	72(24.4%)		74 (41.6%)			

When all variables hypothesized to influence having an HIV and AIDS Coordination committee were tested for associations using the Pearson's X^2, a significant association was seen between HIV and AIDS Mainstreaming and having an HIV and AIDS

Coordination Committee P<0.001.

Table 3.5: Association between HIV and AIDS Mainstreaming and Care and support services provided by Ministries.

Care and Support services Provided			Mainstreaming			Pearson's X^2	P Value
Activities(variable)		Mainstreamed	Total Main'	Not Mainstreamed	Total Not/M		
ARVs	Yes	102 (33.1%)	308	34 (19.0%)	179	11.22	0.00*
	No	206 (66.9%)		145 (81.0%)			
Food supplements	Yes	209 (67.9%)	307	78 (43.6%)	179	28.68	0.00*
	No	98(32.1%)		101(56.4%)			
Facilitation of referrals	Yes	86 (27.9%)	308	35 (19.6%)	179	4.25	0.02*
	No	222 (72.1%)		144 (80.4%)			
Medical care	Yes	115 (37.7%)	307	33 (18.4)	179	19.92	0.00*
	No	192(62.3%)		146(81.6%)			
Financial support	Yes	77 (25.0%)	308	26(14.5%)	179	7.45	0.00*
	No	231 (75.0%)		153 (85.5%)			
Emotional and psychological support	Yes	116 (37.7%)	308	44 (24.6%)	179	8.78	0.02*
	No	192 (62.3%)		135 (75.5%)			
Support groups	Yes	167 (54.2%)	308	38 (21.2%)	179	50.55	0.00*
	No	141 (45.8%)		141 (78.8%)			
Counselling	Yes	162 (52.6%)	308	46 (25.7%)	179	33.48	0.00*
	No	146 (44.2%)		133 (74.3%)			
Nutrition support	Yes	136 (55.8%)	308	56 (31.3%)	179	7.85	0.00*
	No	172(57.4%)		123 (68.7%)			
Home based care	Yes	105 (34.1%)	310	28 (15.6%)	179	19.41	0.00*
	No	203 (65.9%)		151 (84.4%)			
Condoms (male/female)	Yes	226 (73.1%)	309	85 (47.5%)	179	32.27	0.00*
	No	83(26.9%)		94 (52.5%)			
Treatment support	Yes	100 (32.5%)	308	31 (17.3%)	179	13.21	0.00*
	No	208 (67.5%)		148 (82.7%)			

*Denotes Significant values

When all the variables hypothesized to influence care and support services provided by ministries were tested for associations with HIV and AIDS Mainstreaming using the Pearson's X^2, all variables showed a significant association with HIV and AIDS Mainstreaming P<0.001, for facilitation of referrals P= 0.02.

Table 3.6: Association between HIV and AIDS Mainstreaming and accessibility to care and support services

Accessibility			Mainstreaming			Pearson's X^2	P Value
Activities(variable)		Mainstreamed	Total Main'	Not Mainstreamed	Total Not/M		
ARVs	Yes	123 (40.9%)	301	34 (19.0%)	179	24.39	0.00*
	No	178 (59.1%)		145(81.0%)			
Food supplements	Yes	168 (55.8%)	301	55 (30.7%)	179	28.40	0.00*
	No	133 (44.2%)		124 (69.3%)			
Facilitation of referrals	Yes	96 (32.0%)	300	29 (16.2%)	179	14.51	0.00*
	No	204 (68.0%)		150 (83.8%)			
Medical care	Yes	116 (38.5%)	301	38 (21.2%)	179	15.43	0.00*
		185 (61.5%)		141 (78.8%)			
Financial support	Yes	81 (27.0%)	300	26 (14.5%)	179	10.06	0.00*
	No	219 (73.0%)		153 (85.5%)			
Emotional and psychological support	Yes	103 (34.3%)	300	37 (20.7%)	179	10.12	0.00*
	No	197 (65.7%)		142 (79.3%)			
Support groups	Yes	141 (46.8%)	301	32 (17.9%)	179	40.86	0.00*
	No	160 (53.2%)		147 (82.1%)			
Counseling	Yes	140 (46.5%)	301	42 (23.5%)	179	25.33	0.00*
	No	161 (53.5%)		137 (76.5%)			
Nutrition support	Yes	123 (40.9%)	301	43 (24.0%)	179	14.07	0.00*
	No	178 (59.1%)		136 (76.0%)			
Home based care	Yes	105 (34.9%)	301	34 (19.0%)	179	13.78	0.00*
	No	196 (65.1%)		145 (81.0%)			
Condoms (male/female)	Yes	203 (67.4%)	301	70 (39.1%)	179	36.75	0.00*
	No	98 (32.6%)		109 (60.9%)			
Treatment support	Yes	105 (34.9%)	301	25 (14.0%)	179	24.87	0.00*
	No	196 (65.1%)		154 (86.0%)			

*Denotes Significant Values

When all the variables hypothesized to influence accessibility of care and support services were tested for associations with HIV and AIDS Mainstreaming using the Pearson's X^2, all the variables showed significant associations with HIV and AIDS Mainstreaming $P<0.001$.

SECTION 4: DETERMINANTS OF MAINSTREAMING

4.1 Logistic regression Model

All significant factors obtained from the Pearson's Chi Square tests at the 5% level of confidence were included into the logistic regression model using SPSS. Table X below gives us the results of the regression.

Table 4.1: Logistic Regression

Independent Factors					
Activities(variables)		Prevalence N (%)	Total	Univariate OR(95%CI)	Multivariate OR(95%CI)
Awareness					
VCT promotion	No	142 (45.7%)	311	1	1
	Yes	169 (54.3%)		1.97(1.35-2.86)	1.25(0.66-2.37)
Counseling services	No	151 (48.6%)	311	1	1
	Yes	160 (51.4%)		1.84(1.26-2.67)	1.06(0.53-2.37)
Peer education	No	162 (52.1%)	311	1	1
	Yes	149 (47.9%)		0.66(0.45-0.96)	0.49(0.24-1.00)
Commemoration of International days e.g WAD	No	50 (161.1%)	311	1	1
	Yes	261 (83.9%)		0.50(0.32-0.77)	1.47(0.71-3.05)
HIV and AIDS IEC Materials	No	169 (54.3)	311	1	1
	Yes	142 (45.7%)		0.61(0.42-0.89)	1.67(0.88-3.19)
Provision of Male condoms	No	80 (25.7%)	311	1	1
	Yes	231 (74.3%)		0.47(0.31-0.67)	0.71(0.34-1.50)
Provision of Female condoms	No	121 (39.0%)	310	1	1
	Yes	189 (61.0%)		0.46(0.31-0.65)	1.10(0.55-2.20)
Participation					
Awareness creation	No	196(63.2%)	310	1	1
	Yes	114(36.8%)		0.70 (0.47-1.03)	0.91(0.46-1.77)
IEC Materials	No	214(69.3%)	309	1	1
	Yes	95(30.7%)		0.42(0.27-0.67)	2.09(0.93-4.67)
Male Condoms	No	195(62.9%)	310	1	1
	Yes	115 (37.1%)		0.46(0.30-	1.36(0.70-

				0.70)	2.61)
HIV/AIDS Policy					
Existence of Policy	No	47(14.8%)	317	1	1
	Yes	270(85.2%)		0.45(0.29-0.71)	1.38(0.64-2.95)
Dissemination	No	123 (40.6%)	303	1	1
	Yes	180 (59.4%)		0.50(0.34-0.73)	1.21(0.67-2.71)
Coordination					
HIV/AIDS Committee	No	72(24.4%)	295	1	1
	Yes	223(75.6%)		0.45(0.30-0.68)	1.48 (0.80-2.18)
Care and Support services Provided					
ARVs	No	206 (66.9%)	308	1	1
	Yes	102 (33.1%)		0.47(0.30-0.74)	0.52(0.21-1.30)
Facilitation of referrals	No	222 (72.1%)	308	1	1
	Yes	86 (27.9%)		0.63(0.40-0.98)	0.41(0.16-1.00)
Financial support	No	231 (75.0%)	308	1	1
	Yes	77 (25.0%)		0.51(0.31-0.83)	1.22(0.49-3.15)
Emotional and psychological support	No	192 (62.3%)	308	1	1
	Yes	116 (37.7%)		0.54(0.36-0.81)	0.65(0.29-1.44)
Support groups*	No	141 (45.8%)	308	1	1
	Yes	167 (54.2%)		0.23(0.15-0.35)	2.73(1.32-5.63)
Counseling	No	146 (44.2%)	308	1	1
	Yes	162 (52.6%)		0.31(0.21-0.47)	1.67(0.80-3.45)
Nutrition support	No	172(57.4%)	308	1	1
	Yes	136 (55.8%)		0.58(0.39-0.85)	0.61(0.30-1.27)
Home based care	No	203 (65.9%)	308	1	1
	Yes	105 (34.1%)		0.36(0.23-0.57)	1.51(0.66-3.46)
Condom* (male/female)	No	83(26.9%)	309	1	1

	Yes	226 (73.1%)		0.33(0.23-0.49)	2.78(1.29-5.97)
Treatment support	No	208 (67.5%)	308	1	1
	Yes	100 (32.5%)		0.44(0.28-0.69)	0.98(0.41-2.36)
Accessibility					
ARVs*	No	178 (59.1%)	301	1	1
	Yes	123 (40.9%)		0.34(0.23-0.53)	3.03(1.12-8.20)
Food supplements	No	133 (44.2%)	301	1	1
	Yes	168 (55.8%)		0.35(0.24-0.52)	2.11(0.94-4.74)
Facilitation of referrals	No	204 (68.0%)	300	1	1
	Yes	96 (32.0%)		0.41(0.26-0.66)	1.51(0.58-3.90)
Medical care*	No	185 (61.5%)	301	1	1
	Yes	116 (38.5%)		0.43(0.28-0.66)	0.38(0.15-0.98)
Financial support	No	219 (73.0%)	300	1	1
	Yes	81 (27.0%)		0.46(0.28-0.75)	0.94(0.37-2.36)
Emotional and psychological support	No	197 (65.7%)	300	1	1
	Yes	103 (34.3%)		0.50(0.32-0.77)	0.92(0.36-2.36)
Support groups	No	160 (53.2%)	301	1	1
	Yes	141 (46.8%)		0.25(0.16-0.39)	1.87(0.81-4.32)
Counseling	No	161 (53.5%)	301	1	1
	Yes	140 (46.5%)		0.35(0.23-0.53)	0.85(0.35-2.10)
Nutrition support	No	178 (59.1%)	301	1	1
	Yes	123 (40.9%)		0.46(0.30-0.69)	0.60(0.26-1.40)
Home based care	No	196 (65.1%)	301	1	1
	Yes	105 (34.9%)		0.44(0.28-0.68)	0.54(0.24-1.24)
Condoms (male/female)	No	98 (32.6%)	301	1	1
	Yes	203 (67.4%)		0.31(0.21-0.46)	0.92(0.44-1.95)
Treatment support	No	196 (65.1%)	301	1	1
	Yes	105 (34.9%)		0.30(0.19-	1.76(0.69-

				0.49)	4.51)

*Denotes significant Values

However, when all confounding factors were included at 5% confidence level, results from the Multivariate logistic regression showed that only variables under care and support services had a strong association with HIV and AIDS mainstreaming.

4.2 Multivariate Analysis of Association between HIV and AIDS Mainstreaming and the provision of care and support services.

When all confounding factors were included at 5% confidence interval, results from the multivariate logistic regression showed a significant association between mainstreaming HIV and AIDS and having a support group for staff. Ministries that have mainstreamed HIV and AIDS were found to be 2.73(1.32-5.63) times more likely to have a support group for staff living with HIV and AIDS than Ministries that have not mainstreamed HIV and AIDS. In addition a strong association was seen between HIV and AIDS mainstreaming and provision of condoms in ministries that have mainstreamed HIV and AIDS were 2.78(1.29-5.97) times more likely to provide condoms for their staff compared to ministries that have not.

4.3 Multivariate Analysis of Association between HIV and AIDS Mainstreaming and the accessibility of care and support services.

When adjusted for accessibility to care and support services, results from the multivariate logistic regression showed a significant association between HIV and AIDS mainstreaming and access to ARVs. Employees in Ministries that have mainstreamed HIV and AIDS were found to be 3.03(1.22-8.20) times more likely to have access to ARVs than employees in Ministries that have not mainstreamed HIV and AIDS. In addition employees in ministries that have mainstreamed HIV and AIDS were 0.62(0.15-0.98) times less likely to have access to medical care compared to employees in ministries that have not.

4.4 Recurring Themes from the In-depth Interviews Found in The Regression.

This section highlights the recurring themes obtained from the in-depth interviews that were also included in the Logistic Regression analysis.

Results from the Logistic regression affirmed the responses obtained from the qualitative data that HIV and AIDS policy dissemination has not been done by most Ministries. In addition results from the qualitative data indicate VCT and distribution of condoms as some of the prevention activities carried out by line ministries, however, these variables did not show any significance when they were included in the logistic regression analysis. Furthermore, in-depth interviews revealed that most ministries have HIV and AIDS coordination committees, this variable showed significance during the cross tabulations and thus was included in the logistic regression analysis although it did not show any significance.

Results from in-depth interviews further showed that some of the Care and Support services provided by Ministries include ARVs, establishment of support groups, provision of condoms and food supplements. These showed significance associations during the cross tabulations and thus were included in the regression. In addition, the above mentioned variables further showed significance when the multivariate logistic regression was done, as follows: establishment of support groups 2.73(1.32-5.63) for staff living with HIV, provision of condoms male/female for staff 2.78(1.29-5.97), accessibility of ARVs 3.03(1.12-8.20) by staff and accessibility of other medical care 0.38(0.58-0.98) in addition to ARVs by staff.

CHAPTER FOUR

DISCUSSION OF FINDINGS

This chapter presents a discussion of the main findings from the study. The discussion is presented under the following sub-headings: Status of Mainstreaming of HIV and AIDS in the line ministries, Factors associated with mainstreaming and determinants of mainstreaming and barriers to HIV and AIDS mainstreaming.

4.1 Status of Mainstreaming

Although mainstreaming is being increasingly recognized as a fundamental component of expanding the response to the epidemic, the results obtained from this study on the status of Mainstreaming reveal that they are a lot of challenges regarding the Mainstreaming of HIV and AIDS in the Line Ministries. Out the 21 Fpps interviewed, only 8 (38%) Fpps reported that they have mainstreamed HIV and AIDS. This result indicates that less than half of the line ministries perceive themselves to have mainstreamed HIV and AIDS. The 13 (62%) who have not mainstreamed attributed the non-mainstreaming to the challenges that come with mainstreaming with the main one being the lack of clarity and understanding of what mainstreaming means in practice. The International AIDS Alliance report on HIV and AIDS mainstreaming based on a research conducted 4 countries namely Burkina Faso, Cambodia, India and Zambia (2008) confirms that the lack of understanding and lack of consensus on what mainstreaming is and how to do it presents a challenge to Mainstreaming HIV and AIDS in a given sector.

In measuring the status of Mainstreaming, the organizational capacity assessment (OCA) tools developed by USAID's Support to the HIV/AIDS response in Zambia Project (SHARe) and NAC were used to measure internal mainstreaming in 14 key areas of organizational development namely:- policy development, planning, mobilization of resources for implementation of HIV and AIDS programs, levels of internal institutional support, degree to which information about HIV/AIDS programs is shared,

implementation of prevention activities and implementation of care and support programs for staff. (Mainstreaming Baseline Assessment, 2007, SHARe OCA tools, 2006)

4.2 Factors Associated with Mainstreaming

4.2.1 Implementation of HIV and AIDS Care and Support Programs

According to the guidelines and framework for the strategy for the prevention and mitigation of HIV/AIDS in the Public service, a wellness, care and support program should be part of the prevention/care continuum and should aim to improve the quality of life of infected persons, reduce morbidity and mortality and increase productivity.

Therefore, a care and support program is a critical element that that must be part of the workplace program, embedded in the HIV and AIDS policy outlining how an organization will provide care and support for infected and affected staff. In addition, mechanisms should be created to encourage openness, acceptance and support for those workers who disclose their HIV status, and ensure that they are not discriminated against nor stigmatized (An ILO code of practice on HIV/AIDS).

In order to mitigate the impact of HIV and AIDS on the workplace, workplaces must therefore try to provide counseling and other forms of social support to workers infected and affected by HIV/AIDS. Furthermore, the book promoting HIV and AIDS mainstreaming: A Resource for managers developed by NAC states that employers can promote and facilitate access to a comprehensive employee wellness, care and support programme which includes HIV testing, psychosocial support and counseling, the prevention of mother to child transmission, reproductive health services and STI management, Nutritional advice and support and lifestyle education, Prevention and treatment of opportunistic infections and Highly Active Antiretroviral Therapy (HAART).

The results from the study reveal that the main care and support activity is condom distribution followed by food supplements. The provision of food supplements is done upon the availability of funds. However, there are two lines of reasoning as regards food

supplements. The first one is where the Ministry provides food supplements in form of tablets, porridge or drink. Examples of these are Totaloe tablets, Selenium tablets, Soya Life drink and porridge. These understand food supplements to mean something that supplements the actual food one takes. Ministries such as Education, Home Affairs and Youth and Sport usually provide these for their staff that are terminally ill.

In contrast, other Ministries interpret food supplements to mean actual foodstuffs like Millie meal, cooking oil and sugar among other things, among such Ministries is Ministry of Community and Social Services, which provides millie-meal, cooking oil and sugar for their staff who are HIV positive every month. A few Ministries provide treatment for their staff through schemes that they have with private clinics and UTH, high cost. Ministries such as Home Affairs and Defence have their own clinics where their members of staff are able to access treatment.

Other care and support programs carried out include home based care, nutritional advice, counseling, support groups. As stated earlier, for Mainstreaming to be realized, members of staff are supposed to be readily able to access the above-mentioned services. However, even though a good number of Ministries report that they provide food supplements for their staff, psychosocial counseling, home based care, treatment support and condoms, less than 50% of staff readily access these services except for condoms were 57% of staff are readily able to access them.

Moreover, most of the care and support services mentioned above are only provided when funds are available as revealed by the in-depth interviews with FPPs. This shows that care and support programs have not been mainstreamed into the Ministry programs.

A mainstreamed HIV and AIDS program, which includes care and support, is supposed to be part of the routine function of all Ministry systems, programmes and activities. This means that staff must readily access care and support programs and the implementation of care and support programs will not be tied to availability of resources. This in turn will increase productivity because workers will be healthy. This is confirmed by the ILO

handbook on HIV/AIDS care and support, 2003, which states that providing workplace care and support ensures that employees with HIV/AIDS remain healthy and productive at work. In addition it states that “care and support programs can boost workforce morale by showing that the company is truly concerned about the health and well being of employees.”

Results of the multivariate analysis showed that mainstreaming was strongly associated with Support groups and provision of condoms. Results showed that Ministries that have mainstreamed HIV and AIDS are 2.73 (1.32-5.63) times more likely to implement care and support programs such as having a support group for HIV and AIDS for staff. Furthermore, results from the multivariate analysis also revealed that Ministries that have mainstreamed are 2.78(1.29-5.97) times more likely to provide condoms for their staff compared to ministries that have not mainstreamed. Results of the Multivariate analysis further showed that mainstreaming was strongly associated with accessibility to ARVs. Results showed that Ministries that have mainstreamed HIV and AIDS are 3.03(1.22-8.20) times more likely to access ARVs compared to ministries who have not.

These study results obtained from a study in Western Cape, South Africa on workplace interventions found that ARV treatment could reduce the risk of getting opportunistic infections significantly which will keep employees healthy and more productive. Thus providing ARV treatment for staff is significantly more cost effective than a number of interventions. (Freedberg,2001). In addition, to keeping employees healthy and productive, ARVs will contribute to reducing stigma and discrimination in the workplace because even when a person is HIV positive, they will look healthy and will not be stigmatized based on the status. This is confirmed by Stephens (2006) who found that the delivery of effective ARV treatment can be imagined as the most powerful instrument currently available to combat stigma and discrimination.

In line with the results of the multivariate analysis that having support groups for staff living with HIV are significantly associated with HIV and AIDS mainstreaming, Holden (2004) observes that having groups of people who openly and freely talk about their HIV

positive status can contribute to making HIV more real to other others and can help in challenging stigma. In addition to challenging stigma, support groups can also contribute to providing role models of positive living thereby creating a work environment that is free of stigma.

The study showed that HIV and AIDS mainstreaming was significantly associated with the provision of condoms for staff. The provision of condoms as care and support strategy for staff in line ministries was 64%. Other studies have demonstrated that correct use of a condom reduces the risk of HIV infection. A study conducted by the UNZA and AIDS Alliance on supporting adherence to ART and prevention of HIV revealed that It is therefore important to promote condom use in line ministries and also line ministries must provide facilities at workplaces which make it easy to access condoms.

4.2.2 HIV and AIDS Policy Related Factors

According to the SADC framework for HIV and AIDS Mainstreaming, mainstreaming HIV and AIDS internally means putting in place policies and programmes that protect staff and their families from vulnerability to infection and support those who are living with HIV and AIDS. The policies therefore should contain information on the areas or programmes that the workplace will carry out and what it will do for staff in terms of providing care and support to those who are infected and are affected. This will ultimately maintain the performance and effectiveness of the organization. Therefore, if Ministries are committed to mainstreaming HIV and AIDS, it is critical that they have a well outlined workplace policy and strategic plan to guide the planning and implementation of HIV and AIDS workplace programs. As noted earlier, three (3) out of the twenty-two (22) Ministries have not completed their HIV and AIDS policy documents.

Using the ILO workplace policy as a standard, a workplace should cover Prevention of HIV and AIDS, Mitigation, care and support and how the program will be managed or coordinated. Out the 15 HIV and AIDS policies reviewed, 9 did not comprehensively cover the main components of the Workplace program as outlined the ILO policy and

national HIV and AIDS strategic plan. In addition, they lacked clarity on what the Ministries would do for their members of staff.

As mentioned earlier three (3) ministries have not yet completed their workplace policies and are not using any document to guide their implementation of HIV and AIDS.

Furthermore, results obtained from the study revealed that although 18 Ministries have completed their HIV and AIDS policies and come up with yearly HIV and AIDS work plans, they do not manage to implement the programs they plan for mostly due to financial constraints and lack of technical capacity to implement HIV and AIDS. Therefore, the study results confirmed that even where an HIV and AIDS policy is in place, it is often partially or hardly utilized thereby creating a challenge for the Ministry to mainstream HIV and AIDS.

While most Ministries have completed and launched their HIV and AIDS policies, not all of them have disseminated the information in the policies. About 47% of the respondents who affirmed to the existence of an HIV and AIDS policy in their Ministry reported that their respective ministries have not shared the contents of the policy with staff and as such they do not know what their Ministry HIV and AIDS policy contains. Furthermore, about 49% reported that they do not have a copy of the HIV and AIDS policy although they know that their Ministry has an HIV and AIDS policy.

The results of the multivariate analysis showed no significance associations with the existence and dissemination of the HIV and AIDS policy. Hence there is no difference in the existence and dissemination of the HIV and AIDS policy between ministries that have mainstreamed and ministries that have not mainstreamed. This could be because of lack of funds to print and disseminate HIV and AIDS policies by ministries who have mainstreamed HIV and AIDS.

4.2.3 Implementation of HIV and AIDS Prevention Strategies

According to the guidelines and framework for the Strategy for the Prevention and Mitigation of HIV/AIDS in the public Service, prevention programmes are one of the cornerstones of a comprehensive mainstreamed workplace response to HIV and AIDS because all the resources an organization may put into a workplace program will be futile if new infections are not prevented. Therefore, mainstreaming to be effective, an organization should have a strategy on how it is going to prevent HIV infection. The strategy should be well articulated in their HIV/AIDS policy. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are age gender and culturally sensitive.

According to the ILO Code of Practice on HIV/AIDS Prevention, activities can focus behavior change communication, Peer education, VCT promotion, Condom promotion and distribution, standards and procedures to ensure a safe working environment, where any risky of occupational exposure to infected blood or body fluids is minimized and creation of a non-discriminatory environment among others.

Results revealed that most Ministries commemorate international days such as VCT Day and World AIDS day ((78%) and carry out condom promotion and distribution (68%) as their main prevention activities. In-depth interviews revealed that this is because these activities do not require a lot of finances. For example, condoms are accessed free of charge from Ministry of Health through the Medical council of Zambia and commemoration of internal days are only observed once a year. Other activities carried out include VCT, peer education, development and distribution of IEC materials, Counseling and awareness creation accounted for slightly over (40%) of prevention activities carried out.

In terms of participation in prevention activities, respondents affirmed to participating in commemoration of international days (65%) more than any other prevention activity. Less than two thirds reported as having participated in the other prevention activities such as distribution of condoms, peer education, counseling, awareness creation and VCT.

It is important to note that most Ministries had trained peer educators with the help of ZANARA, a World Bank project that has since come to an end as one of the main prevention activities. However, most of the peer educators trained by the Ministries have since been transferred to other ministries or taken up higher responsibilities which prevent them from carrying out peer education activities.

A few Ministries such as Education and Home Affairs have vibrant on-site VCT programs, which are supported by donors while most Ministries have a referral VCT program where they refer their staff to a service provider. Furthermore, results from the study revealed that in some cases Ministries do not carry out any prevention activity for a complete year due to lack of resources.

However, according to the guidelines and framework for the Strategy for the Prevention and Mitigation of HIV/AIDS in the public Service, prevention programmes are one of the cornerstones of a comprehensive workplace response to HIV and AIDS. Therefore, the prevention component is important because all the resources an organization may put into a workplace program will be futile if new infections are not prevented.

Results of the Multivariate analysis showed no significant association between HIV and AIDS mainstreaming and Prevention activities. Therefore, there was no difference in the implementation of HIV and AIDS prevention activities between ministries that have mainstreamed and ministries that have not mainstreamed. This could be attributed to the inadequate resources allocated to HIV and AIDS activities hence the failure to implement prevention activities by ministries who have mainstreamed HIV and AIDS.

4.2.4 Coordination of HIV and AIDS Programs

According to the guidelines and framework for the strategy for the prevention and mitigation of HIV/AIDS in the public service, an effective workplace HIV/AIDS response needs to be spearheaded, directed and well coordinated. It further states that it is critical that an HIV/AIDS coordinator or FPP is identified and a suitable structure is

established. The structure generally takes the form of a committee or a unit (UNDP 2004). Furthermore, in line with the Cabinet Circular of 2004, the HIV/AIDS is to be housed in the Human Resources department and the coordinator should be at the level of Assistant Director.

In terms of coordination, results from the study reveal that HIV/AIDS is housed in the Human resources department in all the line Ministries although the position of the HIV/AIDS FPP varies from Ministry to Ministry. Less than half of the Ministries have Assistant directors as FPP. The positions of FPP in include Human Resource officers, Administrative officer, Chief Human resource officer and senior Human resource officer.

Therefore, not all the line ministries are following the cabinet directive of having an FPP who is at the level of Assistant director. The idea of having an FPP at the level is that the person able to make decisions and is in close contact with management. The FPP at the level of Human resource officer does not attend management meetings and does not have any authority to make any decisions or approvals regarding finances and programs.

However, the FPPs interviewed who are Human resources officers argue that the Assistant director is very busy with their core functions and are unable to take up an extra load of coordinating the HIV and AIDS program. This was seen from the in-depth interviews because only two (2) were available for the interview while the others delegated to their assistants due to their busy schedules.

The multivariate analysis showed no significant association between HIV and AIDS mainstreaming and the coordination of HIV and AIDS.

4.3 Barriers to HIV and AIDS Mainstreaming

According to Schuler (2004), there are several common barriers to HIV and AIDS mainstreaming which include limited capacity of organisations to facilitate the mainstreaming process particularly human resources, inability to identify HIV and AIDS as a strategic priority, a reluctance to take on unfunded mandates especially by

government institutions and other competing development issues.

In line with Schuler (2004), results from this study reveal that on their own Ministries do not have the capacity to Mainstream HIV and AIDS especially in terms of human resource. The staff who are coordinating the HIV and AIDS program often have their core functions for which they are appraised, moreover, HIV is not part of their job description or an area included in the annual performance appraisal system(Guidelines and framework for the Public Service:8).

Therefore, whether or not they spend time coordinating HIV/AIDS activities will not have a bearing on their annual assessment. This means that very little time will be spent on HIV programming because staff coordinating HIV and AIDS will concentrate on their core functions as they will be appraised for that annually (Competing demands on time).

Furthermore, Schuler (2004) identifies a reluctance to take on unfunded mandates and the inability to identify HIV and AIDS as a strategic priority by government institutions as another barrier to HIV and AIDS mainstreaming. Results from this study reveal that HIV and AIDS is poorly funded or allocated little resources by the (ministries) government which has resulted in Ministries having inadequate resources to implement HIV and AIDS activities which in turn has affected the effective mainstreaming of HIV and AIDS. Moreover, lack of commitment and support from management has resulted in HIV and AIDS taking a back sit when it comes to priority areas of the ministry.

Although Ministries budget for HIV and AIDS, the funds allocated to the HIV and AIDS vote is very little to effectively and efficiently mainstream HIV and AIDS. In some cases, Ministries have not allocated any GRZ funds to the HIV and AIDS vote and depend on donors to give them resources to implement HIV and AIDS programs. The study revealed that HIV and AIDS accounts for less than (1%) of the GRZ budget in all line Ministries with the average budget for HIV and AIDS in 2009 being 200,000,000. The highest GRZ Ministry budget was 500,000,000 and the lowest GRZ Ministry was 60,000,000 for the year 2009 (Ministry budgets and work plans, 2009).

According to the guidelines and framework for the strategy for the Prevention and mitigation of HIV/AIDS in the public service, lack of a formal mandate for HIV work prevents a challenge in the coordination of HIV and AIDS. Results from this study confirmed that it has been a challenge for Ministries to come up with structures to mainstream HIV and AIDS because their formal mandate does not include HIV and AIDS.

Although Mainstreaming has been around for decades, its application in the area of HIV/AIDS is more recent and represents uncharted waters (NAC, 2005) and according to Elsey et al (2003) the lack of clarity on what mainstreaming involves and how sectors should respond has lead a sense of confusion within government sectors as what exactly they should be doing to mainstream HIV and AIDS.

This study confirmed that Ministries do not fully understand what mainstreaming means and what it entails to mainstream HIV and AIDS. Most ministries believed that mainstreaming means to carry out HIV and AIDS activities and that the frequency of carrying out the activities does not matter. Furthermore, most ministries thought that they have mainstreamed HIV and AIDS by having an HIV and AIDS policy document for staff.

However, according to the paper on the impact of HIV/AIDS on the public service mainstreaming involves much more than having a policy document and implementing HIV and AIDS activities when funds are available. It states that mainstreaming HIV/AIDS involves adopting HIV/AIDS related issues into the strategic, operational or programmatic planning or policies of all sector structures and institutions in short, medium and long term as well as in day-to-day running of the organisations and sectors (UNDP,2004).

Furthermore, even if the Ministries have operational plans and HIV and AIDS policies, results revealed that ministries do not have Ministerial M and E plans, which are in

conformity with the national M and E plan from NAC to help them monitor and evaluate their HIV and AIDS programs. The weakness in monitoring and evaluation of the implementation of polices and dearth of reliable data and research on the nature and impacts of these interventions have resulted in inadequate assessment of how mainstreamed HIV/AIDS is in the public and private sectors (UNDP, 2004).

Other barriers include, lack of technical capacity in the area of HIV and AIDS of FPPs to coordinate the HIV and AIDS program. Most FPPs do not have the skills needed to spearhead the program. The findings revealed that most FPPs lack the basic skills of HIV/AIDS programming and therefore are finding it a challenge to coordinate the HIV/AIDS program in addition to their core responsibilities. Furthermore, there is no additional allowance paid to FPPs for the added responsibility they take on. This is demotivating for them because a lot is involved in coordinating the HIV and AIDS program.

The results also revealed that depending on the Ministry, HIV/AIDS FPPs assume the position by virtue of the position they hold in the Ministry. Some find it a challenge to carry out their Ministerial functions and also coordinate the HIV/AIDS program because the position of FPPs is "forced on" them as it were.

In addition, according to the cabinet circular, the FPP is supposed to be at the level of Assistant director. This is a very demanding office on its own without adding the coordination of HIV and AIDS. Results revealed that most FPPs delegate the coordination their subordinates who also at times delegate to others.

Workers link HIV and AIDS programs to allowances. If allowances are not given, then members of staff shun the program. Ridde (2010) notes the impact of such practices on the delivery of health care services "…very often, these practices have dramatic impacts on the healthcare system. The players plan their actions around the primary goal of acquiring per diems, rather than of effecting changes among the publics targeted by their intervention. We are witnessing the notorious 'workshop syndrome'". Findings in this

research suggest that the widespread mainstreaming within the line ministries is compromised given such practices.

Included among the barriers to mainstreaming HIV and AIDS are Ministerial transfers, results revealed that most ministries have no peer educators or psychosocial counsellors because the ones they had trained had been transferred to other ministries. NAC trained Staff from all the line ministries in HIV/AIDS mainstreaming but most of these have been transferred or promoted and have not utilised the skills acquired from the mainstreaming training.

Limitations

This study was limited to ministry headquarters in Lusaka only so the results have not been generalised to provincial and district offices of the ministries. However, the study would have generated more insights if it was extended to the provincial and district offices especially for big ministries with representation up to district level like Education, Community and Health.

Furthermore, since the issue under investigation bordered on HIV and AIDS, participants in the research may have been reluctant to disclose personal views, which are vital to answering the research questions. To improve the openness of participants, the researcher shared the ethical considerations binding the research process and measures to ensure anonymity.

Additionally, the Ministerial AIDS Coordination Advisors who were supposed to be key Informants in the study had not had the contracts renewed by UNDP. Therefore, they were not available for interviews at the time of the study. These people were critical to the study because they were in charge of coordinating the HIV/AIDS programs in the ministries including HIV/AIDS mainstreaming and therefore had a lot of information, which would have benefited the study. Moreover, the availability of Focal Point persons was a challenge. This is because of the busy schedule they have as regards their Ministerial position. They were either in meetings or out of town and could not honour

the appointments.

Furthermore, some participants selected by the researcher were transferred from the ministry or they had been in the Ministry for less than six months, which disqualified them from the study. In some cases, some participants who had been selected for the study had gone on leave or long tours at the time of the study.

At the time of collecting numbers that each Ministry has, the Human Resource Departments gave the researcher the total number of staff on the establishment lists, however when the researcher went to administer the questionnaires, most Ministries had less staff than the number that was initially given because not all the positions on the establishment lists are filled. This affected the number of questionnaires to be distributed in a particular Ministry.

Other limitations include resources to cover adequately the scope of the study and time.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

In summary, the literature reviewed confirms that Mainstreaming of HIV and AIDS is seen as an effective way to mitigate the impact of HIV and AIDS on any given sector. The study finds that there are elements that constitute a functioning HIV and AIDS mainstreaming program. The elements are implementing a care and support program, provision of condoms for staff and provision and accessibility of ARVs by staff.

Furthermore, from the results obtained from the key informants we conclude that it is a challenge to mainstream HIV and AIDS due to lack of understanding of what it means in practice and due to poor allocation of resources towards HIV and AIDS. The poor allocation of resources to the HIV and AIDS programs has resulted in poor implementation of programmes.

Furthermore, although most ministries have HIV and AIDS policies and operational plans, the implementation of these policies and operational plans is poor. The ministry budgets revealed that HIV/AIDS accounts for less than 1 percent of the Ministerial budget. Therefore, the Ministries do not manage to fully implement what is outlined in the policies and operational plans. In addition, most of the HIV and AIDS workplace policies reviewed lacked clarity in terms of what the Ministries will do for their staff and do not comprehensively cover the key elements as outlined by ILO. Added to financial resources are inadequate office space, equipment, transport, lack of capacity and fulltime human resource to facilitate the mainstreaming of HIV and AIDS.

Finally, while ministries are making an effort to mainstream HIV and AIDS, the barriers identified in the study present a challenge to effective HIV and AIDS mainstreaming in line ministries.

5.2 RECOMMENDATION AND IMPLICATIONS FOR TRAININGS, POLICY AND RESEARCH

This section presents recommendations and implications for policy and research for the purpose of strengthening the mainstreaming of HIV and AIDS in the line ministries.

Funding and Advocacy: More financial resources need to be allocated to HIV and AIDS by the government in order to facilitate the effective mainstreaming of HIV and AIDS in the line ministries. They must not rely solely on donor funding. A deliberate policy must be developed that a certain percentage of resources in the Ministries be allocated to HIV and AIDS

Training: The FPPs need to undergo training for them to acquire skills in HIV/AIDS programming. There must be a system in place to continuously provide training and strengthen the capacity of FPPs. A one-off training is not sustainable because of the high stuff turnover in the line ministries.

Coordination and Leadership: Ministry HIV and AIDS committees must have representation from top management. This will promote leadership commitment to HIV and AIDS programming. In addition, the HIV and AIDS coordination committee must have a clear coordination plan of how the HIV and AIDS response will be coordinated in that particular Ministry. In addition, Ministries must have a permanent member of staff recognized on the staff establishment to spearhead the HIV and AIDS mainstreaming program.

Research: Ministries must carry put periodic research to assess how effective their policies and programs are. This will help them ensure that their programs meet the needs of an HIV and AIDS environment. Furthermore, it is important that ministries carry out periodic research to establish the impact of HIV and AIDS on their sector.

In addition, ministries must carry out research to assess areas which they need to address in order to mitigate the impact of HIV and AIDS on their respective sectors. The periodic research carried out will help ministries to plan programs that will effectively and efficiently mitigate the impact of HIV and AIDS on the respective sectors.

Monitoring and Evaluation: All ministries must have an HIV and AIDS M and E plan which conforms to the national HIV and AIDS M and E plan from NAC. This will help them to monitor HIV and AIDS programs on a regular basis and report to NAC. In addition, a good monitoring plan will result in good evaluations of programs from which lessons can be learnt for the improvement of future HIV and AIDS programs.

HIV and AIDS Policies: Ministries that have policies which lack clarity and do not cover the key elements must review the policies to include all important elements. Ministries who have not completed their HIV and AIDS policies must complete them.

Finally, government with cooperating partners must develop clear specific and guidelines on how to mainstream HIV and AIDS in the line ministries. The current guidelines lack clarity hence the challenges faced by line ministries in mainstreaming HIV and AIDS.

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ANNEXES

Annex 2: Consent Form

Informed Consent Form: In-depth-Interviews/Survey

Mainstreaming HIV and AIDS in Line Ministries

Introduction

My name is Alice M. Mwewa, and I am a Master of Public Health student registered with the University of Zambia, School of Medicine.

Purpose of the study

The purpose of this research is to document the extent to which ministries have mainstreamed HIV/AIDS in their programs and then identify the barriers in order to recommend ways of effectively mainstreaming HIV in the line ministries. It is part of the academic requirement for me to complete the Master of Public Health with the University of Zambia. In undertaking this study, I will also be learning how the mainstreaming of HIV and AIDS is being undertaken in this ministry. Specifically, I would like to know about your knowledge of HIV and AIDS and the activities being undertaken within this ministry. The findings from this study may be shared with interested groups or individuals within the faculty for academic purposes and possibly for future research.

Procedures to be followed

You are being asked to participate in an interview that will take between 45 and 60 minutes.

If you agree to participate, we will ask you questions from a printed questionnaire and will note your answers on the questionnaire.

The risks to you as a participant in this study are minimal. Please note that you may skip any questions that you do not wish to answer or stop the interview at any time, without giving any reasons.

Your responses will be kept confidential. Your name will not appear on the interview record. No identifying information will be reported with your response. Your responses will be seen by me and some individuals assisting me to complete this work. All questionnaires and other records will be stored in a locked and secured place.

Agreement to participate and right to refuse or withdraw

You understand that your participation in this study will not benefit you directly, but it will help us increase our understanding about ways to improve mainstreaming of HIV

and AIDS in line ministries.

You understand that your participation in this study is voluntary. You will be free to decline if you wish. If you agree to participate, you can decide not to answer certain questions and can stop the interview at any time.

If you do participate, you understand that a representative of the researchers may contact you to ensure that you have consented to do so.

You understand that you are free to ask questions before signing this form and that if you have any further questions, you may contact the following:

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The Chairperson
Biomedical Research Ethics Committee
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Head of Department
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School of Medicine
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Lusaka

Consent statement for signature

I have read this entire consent form, or had it read to me, and any questions have been answered to my satisfaction. I agree/ disagree to participate in this study.

Signature of Respondent: …….

Signature of Interviewer: …..……..

Date:…….. Place:…….

θ MARK HERE IF THE PARTICIPANT HAS DECIDED NOT TO PARTICIPATE

Annex 3: Interview Guide

IN-DEPTH INTERVIEW WITH MANAGEMENT-LEVEL STAFF IN LINE MINISTRIES

Purpose and form (note to the Interviewer):
The aim of this interview is to try to enable the participant to tell their 'story' of the experiences as they perceive them in HIV and AIDS mainstreaming within their ministry. The focus will be in on trying to solicit from the respondents their perception of the current level of HIV and AIDS mainstreaming, the successes, challenges, or bottlenecks as well opportunities. Furthermore, the interview will focus on the knowledge of the management representative on tools provided by the National Aids Council for mainstreaming of HIV and AIDS in line ministries.

1. **Introduction**:

I would like to thank you for taking the time to meet with me today.

This interview should take about an hour. I will be taping the session because I do not want to miss any of your comments. Although I will be taking some notes during the session, I may not be able to capture all of the points. Should you wish to have it back, the tape will be availed to you after this research

2. Policy Development and Planning
    - Does the ministry have an HIV and AIDS policy?
    - When was it Finalized and launched?
    - To what extent has the policy been disseminated and implemented?
    - How many copies so far of the HIV and AIDS policy copies have been distributed?
    - Does this Ministry have a work plan which outlines how it will meet the objectives of the HIV and AIDS policy?
    - In addition to the HIV and AIDS policy, does this ministry any other document which guides the implementation the of HIV and AIDS work program?

3. Coordination
    - Which directorate coordinates HIV and AIDS activities within the ministry?
    - What is the position of the HIV and AIDS Focal Point person?
    - How many members of staff are directly working on HIV and AIDS activities?
    - Are all directorates involved in planning and participating in HIV and AIDS activities?

4. HIV and AIDS Mainstreaming
    - In your view, what does it mean to mainstream HIV and AIDS?

- What structures have been created to facilitate the mainstreaming of HIV and AIDS?
- Are you aware of any mainstreaming tools that have been formulated by the National AIDS Council? If yes, please name some.
- To what extent would you say this ministry is using the HIV and AIDS mainstreaming tools?

5. Prevention Strategies
    - What strategies are being implemented by the ministry to prevent further HIV infections of members of staff?
    - To what extent would you say these strategies are successful?
    - What guided the development of these strategies?
    - Would be in a position to state how often the prevention programs are carried out?

6. Care and Support Strategies
    - What care and support strategies are being implemented by this ministry?
    - What type of support is provided to members of staff who are HIV positive?
    - How often is the support provided?
    - How many members of staff are currently receiving care and support services such as food supplements and ART
    - How many members of staff on record have received VCT through programs initiated by the ministry in the past year?

7. Budget and Resources
    - What are the sources of funding for HIV and AIDS programs in this ministry?
    - What percentage of the HIV and AIDS funding is from government?
    - Are you in a position to estimate the amount of money spent on HIV and AIDS activities in 2008?
    - Are HIV and AIDS activities budgeted for at the time that the ministry is preparing the main annual ministry budget? Are they included as part of the ministry's core programs in the annual budget?
    - Would you be in a position to say whether this ministry receives any other form of support apart from financial support from any Organization?

8. Challenges
    - What would you say are the challenges or barriers that this ministry faces in mainstreaming of the mainstreaming HIV and AIDS?

Thank you very much for your time.

Annex 4: Questionnaire (Survey)

Mainstreaming HIV and AIDS in Line Ministries

Questionnaire for members of staff in Ministry of

_____

Instructions

- To be administered by the Research Interviewer
- To be administered at a line ministry within Lusaka
- The research interviewer should have obtained informed consent for the study prior to administering this questionnaire. Signed consent form to be stored in the Master file.

Informed Consent obtained **1 Yes** **[__]**
2 No

Date of informed consent (dd/mm/yyyy): [__|__/__|__/__|__|__|__]

Research Assistant **[__|__]**

Start Time (24 hour time): [__|__:__|__]

SECTION 1: DEMOGRAPHIC INFORMATION				
101	Sex of respondent	Female **1** Male **2**	**[__]**	
102	How old are you? What is your birthday? (dd/mm/yyyy)?	**[__|__]** **[__|__/__|__/__|__|__|__]**	**[__|__]**	
104	What is your highest educational grade level that you have completed? (Completed years)	None/Never attended school **00** Primary 1 **01** Primary 2 **02** Primary 3 **03** Primary 4 **04** Primary 5 **05**Primary 6 **06** Primary 7 **07** Junior Secondary 8 **08** Junior Secondary 9 **09** Secondary 10 **10** Secondary 11 **11** Secondary 12 **12** University level **13** Adult literacy **14** College/Vocational **15** Other **66** Specify_____	**[__|__]**	
105	What position do currently you hold in the Ministry?	CDE **01** Driver **02** Registry clerk **03** Secretary **04** Accountant **05** Planning Officer **06** Public Relations Officer **07** Procurement Officer **08** Human Resource officer **09** Other **66** Specify_____ ____	**[__|__]**	
106	What is your current marital status?	Married monogamously **01** Married polygamously **02** Cohabiting (Not married but living with partner) **03**	**[__|__]**	**If (01-04)**

		Never Married **04** Divorced or Separated **05** Widowed **06** Other **66** Specify_____		**or (66) Skip to 108**
SECTION 1: HIV and AIDS PREVENTION ACTIVITIES				
107	Does this ministry carry out any HIV and AIDS prevention activities?	Yes No	**[__|__]**	
108	If yes to Question..What type of prevention activities does the ministry usually carry out? (Read and Tick all that apply)	a) VCT promotion 1 2 b) Awareness creation 1 2 c) Counseling Services 1 2 d) Peer Education 1 2 e) Comemoration of International days e.g World AIDS Day, VCT day 1 2 f) HIV and AIDS IEC materials g) Provision of male condoms h) Provision of female condoms i) Other 1 2 Specify_____	**[__|__]**	
109	Which of the HIV and AIDS prevention activities have you recently participated in?	a) VCT promotion 1 2 b) Awareness creation 1 2 c) Counseling Services 1 2 d) Peer Education 1 2 e) Comemoration of International days e.g World AIDS Day, VCT day 1 2 f) HIV and AIDS IEC materials g) Provision of male condoms h) Provision of female condoms i) Other 1 2 Specify_____	**[__|__]**	
	How many Peer educators do you know in this ministry?	Number of Peer educators**[__|__]**		

	Questionnaire Number: **[__|__|__|__]** **Date of Interview (dd/mm/yyyy): [__|__/__|__/__|__|__|__]** **Interview Site: [__]** **1. Ministry of Agriculture and Cooperatives** **2. Ministry of Commerce, Trade and Industry** **3. Ministry of Communications and Transport** **4. Ministry of Community Development and Social Services** **5. Ministry of Defence** **6. Ministry of Education** **7. Ministry of Energy and Water Development** **8. Ministry of Environment and Natural Resources** **9. Ministry of Finance and National Planning** **10. Ministry of Foreign Affairs** **11. Ministry of Gender and Development** **12. Ministry of Health** **13. Ministry of Home Affairs** **14. Ministry of Information and Broadcasting Services** **15. Ministry of Justice** **16. Ministry of Labour and Social Security** **17. Ministry of Lands** **18. Ministry of Local Government and Housing** **19. Ministry of Mines and Minerals** **20. Ministry of Science, Technology and Vocational Training** **21. Ministry of Sport Youth and Child Development** **22. Ministry of Works and Supply**		**_|__]**	
110				
	Section 2: HIV and AIDS Policy			
111	Do you know whether the ministry has an HIV and AIDS policy	**Yes** **No**	**[__|__]**	
112	Do you have a copy of the HIV and AIDS policy?	Yes No	**[__|__]**	
113	Has the ministry shared the contents of the HIV and AIDS policy with all employees including yourself?	Yes No	**[__|__]**	
114	In your view, is the ministry implementing what is outlined in the HIV and AIDS policy?	Yes No Give reasons for your answer…… …… …… ……	**[__|__]**	

		…… . …… .. …… . …… ……		
	Section 3: HIV and AIDS Coordination			
115	Which directorate coordinates the HIV and AIDS program in this ministry?	(Specify)_____ ____	**[__|__]**	
116	Do you know whether the ministry has an HIV and AIDS committee?	**Yes** **No**		
	How many people do you know are directly working on HIV and AIDS activities?	**[__|__]**		
117	What is the position of the HIV and AIDS Focal Point person in this ministry?	**State position.……..……**	**[__|__]**	
SECTION 4: CARE AND SUPPORT PROGRAM				

118	Kindly tick items or services that that Ministry is currently providing to members of staff who are HIV positive ***Are members of staff readily able to access the above mentioned services?***	Yes=1; No=2 Yes No **a) ARVs** 1 2 **b) Food supplements** **1 2** **c) Facilitation of Referrals** **1 2** **d) Medical care** **1 2** **e) Financial support** **f)Emotional and psychological Support** **1 2** **1 2** **g) Support groups** **1 2** **h) Counseling** **1 2** **i) Nutrition information** **1 2** **j) Home based care** **1 2** **k) Condoms (Male/Female)** **L)Treatment Support** **1 2** **1 2** **q) Other** **1 2** **Specify_____**	[__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__] [__]	[__]
119				

			[__] [__] [__] [__] [__] [__]	
		a) ARVs **1 2** b) Food supplements **1 2** c) Facilitation of Referrals **1 2** d) Medical care **1 2** e) Financial support **1 2** f)Emotional and psychological Support **1 2** g) Support groups **1 2** h) Counseling i) Nutrition information **1 2** j) Home based care **1 2** k) Condoms (Male/Female) **1 2** L)Treatment Support **1 2** q) Other **1 2**		

		Specify_____ **1 2** **1 2**		
120	***Does this Ministry have an HIV and AIDS support group for staff ?***	Yes No	**[__|__]**	
121	***If yes to Question…would you in a position to know how often the support group meets ?***	a)Bi-annually b)Quarterly c)Monthly d)Weekly Any Other……	[__] [__] [__]	
122	***In your view, what challenges or barriers does the ministry face in the implementation of HIV and AIDS activities ?***		[__] [__] [__]	

			[__] [__] [__] [__] [__]	

End Time (24 hour time): [__|__:__|__]