PARTICIPATION OF WORKERS IN THE HIV AND AIDS WORKPLACE PROGRAMMES IN THE PUBLIC SECTOR: A CASE OF CHIPATA AND SESHEKE DISTRICTS

BY

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DECLARATION

I, **CHILEKWA KEDRIC CHILEKWA** declare that this report has been composed and compiled by me and that the work recorded has been done by me, that the sources of all materials referred to have been acknowledged, and that the dissertation has not been accepted in any previous application for academic award at this or any other university

Signature:…… Date:……..

CERTIFICATE OF APPROVAL

The dissertation of **CHILEKWA KEDRIC CHILEKWA** is approved as fulfilling part of the requirement for the award of the degree of **Master of Arts in Population Studies** at the University of Zambia.

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ABSTRACT

According to the 2003 Zambia Central Board of Health (CBoH) report, the total number of people affected by HIV and AIDS within the working population is large and growing, the report further approximates that 1.6 million adult Zambians are currently living with HIV (UNAIDS: 2006). The report further estimates that 21% of the labour force between the ages of 15 to 55, who are in their most productive years, are infected with the HIV and AIDS.

In 2002, as part of the national multi – sectoral response for the prevention and combating of the spread of HIV and AIDS in the workplace, the Zambia Business Coalition on HIV and AIDS, in corroboration with the National AIDS Council and the United Nations System in Zambia, established HIV and AIDS workplace programmes whose objectives include; HIV awareness in the workplace, education, prevention, care and support. Thus HIV and AIDS workplace programs aim to keep HIV negative employees negative and keep HIV positive employees healthy and productive.

The study aimed at investigating workers participation in the HIV and AIDS workplace programmes in the public sector in Chipata and Sesheke districts. A descriptive non-experimental cross sectional design was adopted to undertake the survey. A total of 300 workers in the public sector were randomly selected.

Findings from this study indicate that inspite of the widespread awareness of the existence of workplace HIV programmes and their usefulness, very few respondents participated in the programmes and very few were familiar with their objectives. Majority (63.3%) of the workers had never participated in the HIV workplace programmes and just slightly over half, 53% know the objectives of the HIV workplace programs.

In order to increase worker participation and involvement in the designing and implementation of the HIV workplace programmes, there is need to increase dialogue by all stakeholders, management and employees alike in the planning, designing and implementation of the programmes, as well as increasing the frequency of HIV workplace meetings.

DEDICATION

I dedicate this work to my Parents Mr. Felix D. Chilekwa and Mrs. Agnes N. Chilekwa, My wife Joyce Chinyama Chilekwa for their unfailing love, support, understanding and encouragement throughout my study period. Dedications are also extended to our new born baby boy Mwamba Blessings Chilekwa my siblings; Patricia Katongo Chilekwa, Jonathan Mubanga Chilekwa, Allen Chipasha Chilekwa and Angela Changa Chilekwa for their immeasurable love and support, prayers and encouragement.

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ABBREVIATIONS AND ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
CBA	-	Cost-Benefit Analysis
CBoH	-	Central Board of Health
EWP	-	Employee Wellness Programme
GDP	-	Gross Domestic Product
HIV	-	Human Immunodeficiency Virus
ILO	-	International Labour Organisation
KAP	-	Knowledge, Attitude and Practices
NAC	-	National AIDS Council
NGO	-	Non-Governmental Organisation
STi	-	Sexually Transmitted Illness
TB	-	Tuberculosis
ZBCA	-	Zambia Business Coalition on HIV and AIDS
ZDHS	-	Zambia Demographic and Health Survey

CHAPTER ONE

1.0 Introduction and Background

Zambia is one of the Sub-Saharan African countries worst hit with the HIV and AIDS pandemic and the first AIDS case in Zambia was diagnosed in 1984. According to the Zambia Demographic and Health Survey (ZDHS) of 2001 – 2002, the estimated HIV prevalence rate stood at 16%. The 2007 ZDHS estimates the HIV prevalence rate at 14.3%. Although the 2007 ZDHS shows a slight fall in the prevalence rates, indeed prevalence has barely changed as infection rates still remain among the highest, seventh highest national prevalence in the world (UNAIDS: 2010).

The HIV and AIDS epidemic poses one of the greatest challenges to business development in Sub-Saharan Africa both in the private and public sector. The social and economic impact of the disease is intensified by the fact that AIDS kills primarily young and middle-aged adults during their peak productive and reproductive years. At the macro level, an effect of this nature on the workforce can impact the economies of entire countries by reducing the labour supply and disposable incomes. AIDS impacts markets, savings rates, investment and consumer spending. While assessing the economic impact of AIDS is very difficult, studies suggest that some of the hardest-hit countries may forfeit 2% or more of GDP growth per year as a result of the epidemic (International Labour Organisation: 2005).

HIV and AIDS pandemic have adversely affected families, the workplace and the country at large. The total number of people affected by HIV and AIDS within the working population is large and growing. Approximately 1.6 million adult Zambians between the ages, 15 to 55 who are in their most productive years, are infected with

the HIV and AIDS (MoH, *HIV and AIDS Projections Report* 2009). According to the 2012 Ministry of Health preliminary report on HIV and AIDS Projections, Imparts and Interventions, the reports estimates that actual AIDS cases stand at 9% and an additional HIV infection at 91%. It further approximates that about 30 -40 % of babies of HIV positive mothers are infected. Further, the 2013 Zambia Millennium Development Goals Progress Report, estimates an increase in the AIDS patients bed occupancy from 7% in 1989 to 45% in 2014 (Zambia MDG Progress Report:2013).

In Zambia therefore, the human toll of HIV and AIDS is a tragic reality being experienced by workplaces, families, communities and the nation at large. There is no aspect of life that has not directly or indirectly been negatively influenced by the AIDS epidemic. AIDS has become one of the major causes of illness and death among the young and middle aged Zambians, depriving households and society of a critical human resource base and thereby reversing the social and economic gains the country has attained. In effect, HIV and AIDS are limiting the realization of economic development and have the potential to continue diminishing the chances of alleviating poverty and hunger; and is one of the factors limiting achievement of the Millennium Development Goals (MDGs). AIDS threatens the country's development efforts because it affects the most productive age group of 15 to 49 years.

The loss of skilled employees and main income earners in the prime of their lives due to HIV and AIDS is costly to workplaces in terms of significant loss of productive workers, vital human skills, the incurring of huge replacement skills costs, the incurring of huge funeral costs and compromised morale and performance in the work place and thereby upsetting the operation of the productive sectors by restraining productivity and the supply of services (UNAIDS: 2010).

Recognizing the serious nature of the pandemic, the Zambia Business Coalition on HIV and AIDS (ZBCA) was formed in 2000, as an association of public and private sector companies to fight HIV and AIDS and mitigate its impact at the workplace. In 2002, as part of the national multi – sectoral response for the prevention and combating of the spread of HIV and AIDS in the workplace, the coalition, in corroboration with the National AIDS Council (NAC) and the United Nations System in Zambia, established HIV and AIDS workplace programmes whose objectives include; HIV awareness in the workplace, education, prevention, care and support. Thus HIV and AIDS workplace programs aims to keep HIV negative employees negative and keep HIV positive employees healthy and productive.

Given an enabling space, sufficient institutional support and full participation of employers and workers, HIV and AIDS workplace programmes could incredibly mitigate the impact of the epidemic on the working population through enhanced awareness, prevention and access to care, support and treatment. However, particularly important to the success of the HIV and AIDS workplace programmes is the employee participation in the HIV workplace programmes.

1.1 Statement of the problem

The high national burden of HIV and AIDS has brought about many challenges such as the need for adequate counselling and testing services, antiretroviral therapy services and to have in place care and support strategies that enhance the survival of employees and their performances at places of work. It is these continued rising challenges of HIV and AIDS cases in the work place that accounted for the establishment of HIV and AIDS workplace programmes in 2002 as part of the national multi – sectoral response for the prevention and combating of the spread of HIV and AIDS/STI/ and TB in order to reduce personal, social and economic impact of the diseases. The objectives of the HIV and AIDS workplace programmes include; awareness, education, prevention, care and support.

This was born out of the understanding that the workplace setting provides an effective environment for delivering HIV and AIDS programmes to a wide range of a population who might not otherwise access HIV and AIDS prevention, education, care and support services. Workplaces are increasingly being targeted as fertile grounds for the fight against HIV/AIDS because workers spend most of their time there; working and interacting with their colleagues. This is seen by many as something that is easily attainable as the workplace provides great convenience of having to engage a greater multitude of workers at once than would be anywhere else.

However, so far not enough research has been done to investigating participation of workers in the HIV and AIDS workplace programmes in the public sector. This is in spite of the fact that particularly individual worker participation in the HIV programmes are very cardinal in determining success of the HIV and AIDS workplace programmes.

1.2 Research Objectives

1.2.1. General Objective

The main objective of this study was to investigate participation of workers in the HIV and AIDS work place programmes.

1.2.2. Specific Objectives

The specific Objectives of this study were to investigate:

1. Awareness of the existence of HIV and AIDS workplace programmes among workers.
2. Knowledge of the objectives of HIV and AIDS workplace programmes among workers.
3. Attitudes of workers toward HIV and AIDS workplace programmes.
4. Participation of workers in the design of HIV and AIDS workplace programmes.
5. Participation of workers in the implementation of HIV and AIDS workplace programmes
6. Role of management in promoting HIV workplace programmes in the work place.

1.2.3 Research Questions

1. Are workers aware of the existence of HIV and AIDS workplace programmes in their workplaces?
2. What are possible determinants of awareness of, knowledge and participation, in the HIV and AIDS workplace programmes?
3. What are the attitudes of workers towards HIV and AIDS workplace programmes?
4. Have workers been involved in the design of HIV and AIDS workplace programmes?
5. Have workers been involved in the implementation of HIV and AIDS workplace programmes?
6. What role does management play in the promotion of HIV workplace programmes?

1.3 Study Rationale and Significance

This study was primarily conducted because of its relevance to the fight against the HIV and AIDS pandemic.

This study sought to investigate workers participation in the HIV and AIDS workplace programmes as well as to determine possible determinants that might influence awareness of the HIV workplace programmes by workers, knowledge and participation, in the HIV and AIDS workplace programmes.

This information is important to policy makers, HIV, and AIDS programmers in the designing of interventions that will address the specific issues of misconceptions concerning the purpose of HIV and AIDS workplace programmes and be in a position to package it to attract fuller enrolments and fuller worker participation in the HIV and AIDS workplace activities.

This study gives insights to knowledge, attitudes and practices (KAP) researchers in the world of HIV and AIDS regarding the factors that influence low worker involvements in HIV and AIDS workplace activities. This will also help other upcoming researchers focus their attention on some of the relevant variables related to the identified problems and provide insights, which are required to design comprehensive studies in the investigation of knowledge and attitudes of workers toward HIV and AIDS workplace programmes.

Additionally, this study may help public health specialist, and HIV and AIDS programmers to identify relevant correlates of attitudes and perceptions toward HIV workplace programme and facilitate the designing of effective communication tools and messages that will merit respect and recognition among workers.

At policy level, this study will give insights to policy makers, primarily to facilitate the refinement of current HIV and AIDS related policies and programs and secondarily to facilitate the formulation of new guidelines for comprehensive HIV prevention, education, campaigns, support and HIV care in the workplace In general terms, this study is significant in that it will contribute to the stock of knowledge that is relevant to the fight against the spread of the HIV virus as well as influence policy and programming of government departments, NGOs and the general community in matters related to the fight against the HIV and AIDS pandemic.

1.4 Definition of some key concepts in the study

- Lloyd Nigro (1984) defined the public sector to mean that portion of society controlled by a national government, state or provincial and local governments. He asserts that, a public sector encompasses universal, critical services such as defence, administration and the entire civil services whereas Richard Bowett (1997) defines public sector as organisations wholly or partially owned and controlled by the government (or local government) which aim to provide public services often free or at a minimal cost at the point of delivery and whose funding is mainly from taxation and other grants or loans incurred by the national government. In this study therefore, the public sector is taken to mean government departments within the Zambian government ministries with the exclusion of all parastatals and quasi-government institution.
- The United States Public Health Service act, as amended by the Affordable Care act of 2012, defines an HIV and AIDS workplace programmes as, " *a programme offered by an employer designed to promote health or prevent disease among employees*" More broadly, the workplace programme involves an array of workplace activities which include employment – based activities or employer – sponsored benefits aimed, " *to promote health related behaviours (primary prevention or health promotion) and disease management"*(www.aspe.hhs.gov/hsp/13/workplaceprogramme/rpt-wellness.cfm (Accessed November 2011).

  A workplace programme may include a combination of data collection on employee health risks with population-based strategies and individually-

focused interventions to reduce risks. They may be part of a group health plan or offered outside of that context but comprehensive in nature. This study borrows the above as well as the Zambia Business Coalition on HIV and AIDS (2010) definition in which an HIV workplace programme is defined as "*a deliberate workplace incentive created by management for the employees to reward employees who participate in such programmes with an employment-based group health plans focusing on both increasing the length of people's lives and ensuring that people's lives are healthy and productive within and beyond the workplace*" (ZBCA: 2010).

- Creighton (2008) defines participation as, "*the process by which an institution consults with interested or affected persons in taking part in an activity or event either directly or indirectly*". In this study, participation is defined as an act or instance of taking part in an activity or related events, defined here as HIV workplace programmes.
- Heathfield (2004) defines a workplace as "*a location at which an employee provides work for an employer usually located in a variety of settings including offices, out –of-door facilities and in any location where work is performed*". Similarly, this study defines workplace as a physical location where an employee provides work for a pay.
- The United Kingdom government (2012), defined a worker as, "a person who is generally classed as such if they; have a contract (written or orally) or other arrangements to do work or services personally for a reward and their reward is for money or a benefit in kind as set out in the contract, and have limited right to send someone else to do the work (subcontract) and have to turn up for work even if they do not want to, such a person is said to be a worker.

This study defines a worker as a person working for a pay within the governments departments and are provided the working space by their employer, the government.

- Healthfield (2004), defines involvement as simply the *act of participating in something, an activity or event* whereas the 2010 Oxford dictionary defines involvement as acts, "*to include as a necessary circumstance, condition, or consequence, implied or not, in engagement into some activity or things*" This study defines involvement as the fact or condition of being part of something or involving oneself in the HIV and AIDS workplace programmes.
- The 2008 Oxford Dictionary defines designing as, "*roadmap or a strategic approach for someone to achieve a unique expectation. It defines the specifications, plans, parameters, costs, activities, processes and how and what to do within the legal, political, social, environmental, safety and economic constraints in achieving that objective*" (Oxford Dictionary: 2008). In this study, designing is understood to mean conceptualizing the problem in terms of a discrete sequence of stages of problem-solving and creativity in defining goals and objectives of the HIV and AIDS workplace programmes.
- Laudon K. 2010 defines implementation as, "*the carrying out, execution, or practice of a plan, a method, or any design for doing something*" As such; implementation is the, "*action that must follow any preliminary thinking in order for something to actually happen*" (Laudon, K. & Laudon, J. (2010). This study defines implementation as the process of putting a decision on HIV and AIDS workplace plans into effect by systematically executing them in order to achieve desired goals and targets.

1.5 The stakeholder theory

This study employs a multi-theory approach, integrating both the stakeholder theory and the social networks concept as the guiding theoretical frameworks. Stakeholders are people or groups of people, who are affected by the outcome**,** negatively or positively, or those who can affect the outcomes of a proposed intervention (Karl 2000: 17).

In the context of a workplace, these include employees, employers, management, financiers, and shareholders (Phillips 2004:2).

The stakeholder theory begins from the assumption that stakeholders are the owners of the company or any given workplace, and the workplace in itself, has a fiduciary duty to their needs first. This means that the firm holds assets in trust and manages them for the benefit of the stakeholders. As the owners of the firm, stakeholders including workers are owed an obligation by the firm and its top management to be informed about their rights, responsibilities and opinions. Stakeholders have a role in making decisions on the policy, design, planning and implementation of the intervention (Karl 2000:12). Stakeholder involvement and participation lies on a continuum, ranging from minimal participation or co- option to intense participation is the one where stakeholders have a role in making decisions on policy, planning, intervention design and implementation (Karl 2000:12). On the one hand, without the decision- making form of involvement, there is much danger that stakeholders may block decision making, undermine implementation of interventions or refuse to be involved in the intervention if they perceive the stakeholder participation as biased to favouring a select few. On one hand, with an all-encompassing decision- making form of involvement at planning level, design and implementation, stakeholder participation is

likely to be enhanced and would ensure co-operation and support for intervention, leading to successful outcomes and sustainability of these interventions.

The stakeholder theory is appropriate in this study: investigation of workers participation in the HIV and AIDS workplace programmes in the public sector. In the context of this study, the stakeholders refer to the employees working within the public sector in Zambia. As important stakeholders, the public service employees are owed an obligation by top management to be informed about their rights to participate at an intense level, that is, in decision – making including planning of the HIV workplace programmes, design and implementation of the prevention interventions at the workplace and to be actively in the implementation of the nature and level of involvement and participation in HIV workplace programmes.

1.6 The Social Network Concept

The term Social network refers to the web of social relationship that surround individuals or linkages between people that may influence people's health behaviours (Glanz, Rimer and Lewis 2002:186). The social networks concept sees these social relationships as having a powerful influence on individual health status, health behaviour decision making (Gretzel 2001). For example, an individual's decision to be involved and to participate in health damaging behaviours or health – promoting behaviour such as engaging in unprotected sex or the promotion HIV and AIDS awareness campaigns, peer education, care and support for the HIV infected and affected workers is largely and heavily influenced by the shared social network norms.

Glaze et al (2002:185) argues that close-knit networks exchange more trust caring, expressions of love and empathy, and therefore exert more social influence on

members to conform to the network norms. The same is true for social networks whose members are demographically similar in terms of age, gender, ethnicity, socio-economic and occupational status. In these powerful networks, a decision is not always an individual action, but is influenced by the network norms.

In the context of this study, the social networks concept is viewed as useful in investigating the influence of subpopulation norms in employee involvement and participation in the design and implementation of the HIV workplace programmes in the public sector that employs a great multitude of workers from different walks of life and statuses.

1.7. The Conceptual Framework

The framework used in this study is as a result of synthesized various literature that describes a causative model for worker participation in the HIV workplace programmes among employees as stakeholders based on the research literature.

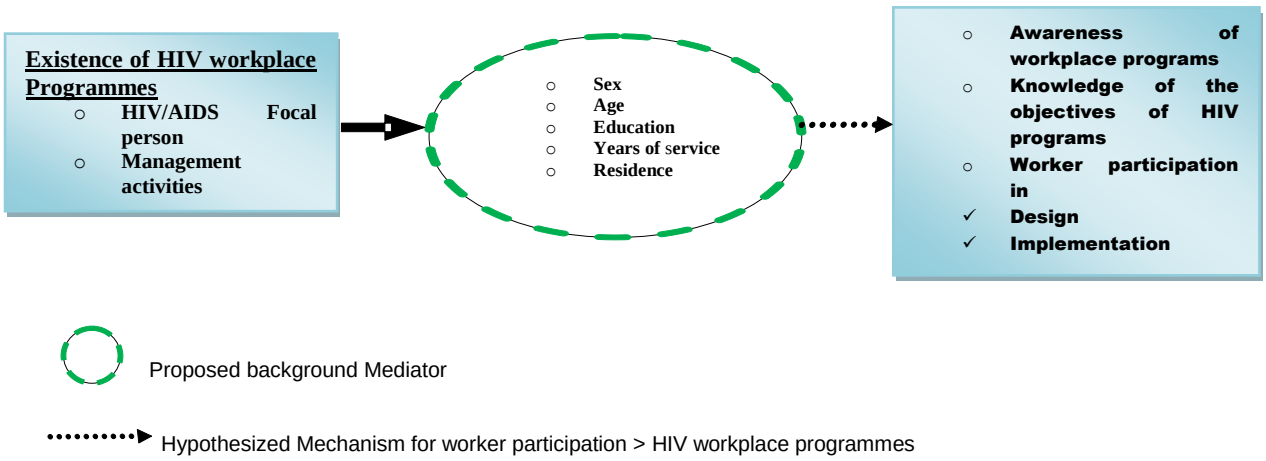

Figure 1: Conceptual Framework (Synthesized from Various Literature)

The conceptual framework examines numerous inter-relationships that influence worker participation in the HIV workplace programmes within the workplace settings.

The framework suggests that existence of HIV workplace programmes in any given workplace, active involvement of HIV and AIDS Focal person and the active participation of management can largely influence worker participation in the HIV workplace programmes. The framework assumes that, background variables (sex, age, education, years of service and residence) in turn influence the dependent variables which are worker participation (design and implementation) in the HIV workplace programmes, increased awareness and knowledge levels.

CHAPTER TWO

2.1 Literature Review

2.1.1. HIV and AIDS effects on the labour force

The AIDS epidemic has become a serious health and developmental crisis that is eroding the capacity of key national sectors through its effects on human, financial, social and institutional asserts. According to the 2007 Zambia Demographic and Health Survey (ZDHS), HIV prevalence rates in Zambia have slightly dropped from 16 percent in 2001 – 2002 to 14.3 percent in 2007 (ZDHS:2007). Indeed prevalence has barely changed since 2001, since the country still has the seventh highest national prevalence in the world (Zambia MGD Progress Report: 2013).

According to the International Labour Organization, ILO (2005) bulletin, the supply of labour is evidently reduced by HIV and AIDS, and for companies both public and private operating in hard-hit regions such as sub – Saharan Africa, HIV will have major consequences on profitability and productivity. In 2005, ILO estimated that 28 million workers globally were lost due to AIDS, and a projected 48 million will be lost by 2020 if no measures are taken. Workers who are living with HIV might be able to work for years, but their illnesses make them progressively unable to work, until they are fully unable to work. The ILO (2005) estimates that there were more than two million workers who are at any time fully or partially unable to work due to AIDS.

HIV and AIDS affect the profitability and, thus, viability of companies in a range of ways. Primarily they reduce worker productivity and increase costs. Organizations worldwide have recognized this drain and this recognition might largely explain why many workplaces have set up HIV and AIDS workplace programmes and cover the costs of treatment for workers, provide HIV education, awareness, care and support.

It is with this kind of background that workplace setting provides an effective environment for delivering HIV and AIDS programmes to a wide range of a population who might not otherwise access HIV and AIDS prevention, education, care and support services. Workplaces are increasingly being targeted as fertile grounds for the fight against HIV/AIDS because workers spend most of their time there; working and interacting with their colleagues (UNAIDS: 2009).

Because of their higher literacy levels, workers are also better placed to understand the meaning, causes, preventive measures, and other issues surrounding the epidemic, which has continued to attract the attention of governments, civil society, and other interest groups owing to its devastating effects on populations. However, of particular importance to the fight against HIV and AIDS in the workplace, is the participation of workers in the HIV and AIDS workplace programmes.

2.1.2. Existence of HIV workplace programmes in Sub-Saharan Africa

Employers' and workers' organizations, in partnership with government and other stakeholders, have taken collective and separate action to support the global response to the epidemic at international, national and workplace levels.

In 2001, delegates to the United Nations (UN) General Assembly Special Session on HIV/AIDS committed themselves to:

"…strengthen the response to HIV and AIDS in the world of work by establishing and implementing prevention and care programmes in public, private and informal work sectors…" (paragraph 49) and "...develop a national legal and policy framework that protects the workplace rights and dignity of persons living with and affected by HIV and AIDS and those at greater risk of HIV, in consultation with representatives of employers and workers, taking account of established international guidelines on HIV and AIDS in the workplace" (paragraph 69).

The International Labour Organisation (ILO) became a UNAIDS Cosponsor in 2001, and lead agency for HIV workplace action. It had produced a *Code of Practice on HIV and AIDS and the world of work* which included key principles in guiding policy development as well as practical programming advice.

In 2002, comprehensive Global Business Coalition on HIV/AIDS had been launched and today, a growing number of individual companies, employers' organizations and chambers of commerce, trade unions, and government departments have put in place HIV and AIDS policies and programmes in the workplace, while ministries of labour have integrated HIV and AIDS in their own services—especially occupational safety and health structures and national labour inspectorates following the example of the Global Business Coalition on HIV/AIDS. They encourage comprehensive HIV workplace programmes for HIV education, HIV awareness, HIV prevention, care and support (CBA Report: 2007). Southern African countries that are among the most hardest hit countries with HIV and AIDS infections in the world, are in turn among the countries that have responded well to establishing HIV workplace programmes

and these include, Angola, Botswana, Lesotho, Namibia, Malawi, Tanzania, Swaziland, South Africa, Zambia and Zimbabwe (UNAIDS: 2000).

2.1.3 Stigma and discrimination

Despite the establishment of HIV workplace programmes on the ground, employee involvement and participation in these programmes still pose a challenge because of the problem of stigma and discrimination associated with HIV and other human rights issues.

The ILO (2003:29) reports that HIV-related stigma and discrimination has a significant impact on the willingness of employees to be openly involved and participate in HIV-prevention interventions at the workplace. Fear of social isolation and ridicule from co-workers discourage them, not only from disclosing their HIV status, but also from making full use of the services available to them (ILO 2003:30). Under these circumstances, HIV transmission among employees would continue unabated.

If cases of stigmatization, prejudice and exclusions become endemic in the workplace despite the existence of workplace HIV and AIDS related programmes there is a likelihood of robbing the much needed trust from the people it is meant to benefit, the employees (Parker et al: 2001).

In many African countries; literature suggests that stigma is still very much attached to anything related to HIV and AIDS which might possibly affect knowledge, attitudes and the subsequent participation of workers in the HIV workplace programmes. This phenomenon arises due to the fact that, HIV was first identified in the developed countries in communities that were marginalized [gays, sex workers

and drug-using communities], and so it quickly became a disease that was stigmatized (Parker: 2000).

In 2007, a study of the Employees Wellness Programmes (EWP) in South Africa, in which only private firms were sampled, the study revealed that despite seemingly high workshops on the dangers of stigmatization of HIV infected employees, HIV and AIDS related programmes in the workplace still appear to have poor coordination, lack of consultation and to a certain extent stigmatization of infected workers. The study, revealed that confidentiality of the HIV and AIDS data under the custody of the HIV and AIDS focal person is highly compromised by management under the pretext of collecting statistics for the procurement of antiretroviral drugs and other essential material for HIV and AIDS workplace programmes. The abuse of the confidential records has become a trend that infected workers who disclose their status face the axe or ill-treatment (Singhal et al: 2007).

However, this tendency has the ability to limit workers potential in disclosing their status, participating in the workplace HIV programmes, and potential of developing negative attitudes towards HIV workplace programmes thus rendering the whole process of fighting HIV and AIDS in the workplace non-achievable in respect of access to HIV and AIDS prevention, education, care and support services.

In a 2009 study on religious attitudes towards HIV and AIDS related stigma particularly among Muslims in Uganda, HIV and AIDS stigma present a double-edged scenario. On the one hand, they harbour stigmatizing attitudes towards People Living with HIV (PLHIV) due to the belief that individuals acquired HIV due to immoral sexual behaviours. The close association of HIV transmission with sexual relations makes it difficult to separate HIV and AIDS from sexual immorality

(Kafuko: 2009). As such, any association related to HIV and AIDS is still largely viewed as immoral.

Thus stigmatising attitudes might affect efforts to neither promote openness and public declaration of one's sero-status nor fully actively participate in HIV and AIDS related activities. Dealing with an epidemic whose victims are not willing to open up can create a very serious challenge that may not only affect prevention mechanisms for further spread of the virus, but might work as an impediment to participate in workplace HIV activities providing awareness, education, support and care since any activities associated with HIV and AIDS are viewed as immoral.

2.1.4. Knowledge of, and worker participation in the HIV programmes

Knowledge on the objectives of HIV and AIDS workplace programmes involves the correct identification of the objectives which include: HIV and AIDS awareness, education, prevention and treatment, care and support services. Studies show that the increase in HIV related knowledge is not a sole predictor of positive attitude but is a vital prerequisite in the behavior change process acquired through attitudes (Viljoen: 2005).

For example, in an attempt to assess how increases in knowledge may translate into less risky behaviours or favourable attitudes, a 2006 study conducted among males in a rural community of Goa in India, concluded that awareness campaigns about sexual risk behaviour and acquired new levels of knowledge about HIV and AIDS accounted for an increased worker participation in the HIV workplace activities and change of

attitudes toward AIDS and STDs fight among males in Goa (Vaz, Ferreira, Kulkarni, & Motghare: 2006).

The study further suggest that, although HIV related knowledge is not a predictor of positive behaviour change, the initial knowledge of HIV education, awareness and prevention after infection can benefit in many ways. Studies show that, although some people with HIV seropositive status continue to engage in transmission risk behaviours, most persons refrain from sexual behaviour that may transmit HIV infection to others (Benotsch, Kalichman, & Kelly: 2011). Therefore, HIV related knowledge among People Living with HIV (PLHIV) played an important role in healthy living as well as preventing HIV transmission. As such, HIV awareness, education, prevention, care and support messages need to be consistently promoted in the fight against HIV in the workplace.

Knowledge therefore, is seen as being cardinal to influencing right attitudes as the more knowledge one possesses about a subject, the better are the messages understood and the more positive the attitude exhibited.

According to the 2007 Cost – Benefit Analysis (CBA) report of HIV workplace programmes in the private sector in Zambia, employees that had significantly low levels of knowledge on the goals of the HIV workplace programmes still perceived HIV workplace programmes as threatening to their employment contracts. This signals that HIV and AIDS workplace programmes are still unpopular by certain sections of workers thus the need to have HIV awareness, education, care and support services as part of the HIV workplace programmes scaled up.

2.1.5. Workplace responsibilities toward workers participation in the HIV programmes

Although business and organised labour are not responsible for the attitudes and beliefs of their employees and members, they are largely responsible for ensuring that the workplace is a fair and effective environment that fosters productivity and creativity. To this end, employers and management have an obligation to educate employees on, the objectives of the HIV workplace programmes, behaviour change and all aspects relating to HIV workplace policies and programmes, based on the impact of HIV and AIDS on productivity. It is this same education that will help foster right attitudes toward HIV and AIDS workplace programmes and increased knowledge among the employees and a realisation of a fuller worker participation in the HIV workplace programmes.

2.1.6 Lack of management support in the HIV workplace programmes

Lack of management support may take the form of severely limiting employees' active involvement and participation in HIV workplace programmes. Employees merely become passive recipients of information passed from top-down. In a 2002 study done in South Africa, Grant et al (2002:80) point out that management of the South African Department of Land Affairs limits employee involvement and participation in HIV workplace programmes only to passive activities such as dissemination of information on HIV by internal e-mail, putting prevention messages into pay-slip envelopes and placing HIV updates in lifts. Employees are not actively involved in other HIV programmes such as awareness, campaign activities, peer education training, care and support. Because employees were not actively involved,

these interventions were likely to fail, leading to the continued of HIV among the employees.

Lack of management support also manifests itself in the insufficient budgetary support for the HIV workplace programmes at the workplace. A study done by the Centre for Health Policy (2001:19) concludes that in a move to save financial resources, some workplaces employed unpopular cost-saving measures in which they prefer passive activities that neither take employees away from their core business, nor require a large budget to run. The Centre for Health Policy further argues that: "businesses do not want to pay for *'education about AIDS'*…'' (Centre for Health Policy 2001:19).

However, an International Labour Organization (ILO) report (2002:26) argues that keeping employees healthy by preventing HIV-infection from spreading is essential for the viability of the business in the long run. The report cites a study carried out in Botswana, Namibia, South Africa, Mozambique and Zimbabwe which estimates that by 2020, the labour force in these countries will be at an estimated 10 to 22 percent smaller than it would have been because of AIDS. Absenteeism due to HIV, coupled with increased entry of young unskilled personnel into the labour market is likely to lower both the quality of productivity and production. The implication of the ILO's report is in the company's interests to budget sufficiently to allow employees to get involved and ensure full participation of workers in the HIV workplace programmes.

2.1.7 Lack of role –modelling by management

Failure by management to lead by example in terms of the update of services such as attending HIV and AIDS awareness campaigns, education, care and support sessions might create a negative attitude towards the whole HIV-prevention intervention at the workplace.

The Centre for Health Policy (2001:25) argues that most HIV workplace activities such as awareness campaigns, education, care and support tend to be directed toward the unskilled and shop floor workers, and rarely so for the professionals, managers and top management. Peer educators and active members are mostly drawn from the lower-level employees and not from management.

The implications of these arguments are that a cliché of '*us*' and '*them*' may create discrimination and suspicious between workers and management. Employees may therefore feel discouraged from getting involved and participate in the HIV workplace programmes.

2.1.8 Lack of involvement of key stakeholders

Karl (2004:4) attributes the limited success of many workplace programmes to lack of involvement and participation of all key stakeholders. A few select individuals tend to hold the power over the organization and may exert either beneficial or harmful influence over it as the case might be. In case of harmful influence for example, this

might limit or exclude a vast majority of the ordinary employees from participating in planning, designing and implementation of HIV workplace programmes.

The exclusion of the employees from such important aspects of the HIV workplace programmes might lead some employees to deliberately or unwittingly work at cross-purpose to the objectives of the HIV workplace programmes, either as a way of protest or because they do not understand what is expected of them. Whatever the case may be; lack of employee involvement and participation in HIV workplace programmes is likely to lead to programme failure and the continued spread of HIV among employees. On the other hand, involvement and participation of employees in the planning, designing and implementation of HIV workplace programmes at the workplace is likely able to improve the chances of sustainability of these interventions. Employees are likely to assume ownership of, and would be committed to such programmes.

Karl's (2004) asserts that, "the level of success of implementation of an HIV workplace activity at the workplace is correlated to the level, nature and type of employee involvement and participation in these interventions. As such, the quality and extent of employee involvement and participation in HIV workplace programmes is key to the sustenance of these workplace programmes.

2.1.9 The assumed key factor versus practice

Most HIV workplace preventions and interventions at the workplace tend to focus more on increasing the unskilled and shop floor workers knowledge of HIV, perception of personal risk, and prevention of HIV transmission. The most important

issues of employees' involvement and participation in these interventions are often ignored (Centre for health policy 2001:25), nor are stigma and discrimination, respect for privacy and confidentiality, worker involvement in the design and implementation given much focus in these interventions. However, these are the potential barriers that, if not taken into account, are likely to work against employee involvement and full participations in the HIV workplace programmes at the workplace. For example, the United Nation's report on Zimbabwe (UNGASS 2007:28) is silent on the involvement and participation of stakeholders in HIV – prevention interventions at the workplace. It merely emphasizes the importance of transferring knowledge, by arguing that knowledge of how HIV is transmitted is crucial in enabling people to prevent HIV. The report therefore recommends workplace HIV workplace prevention activities that *"teach"* employees about risk- behaviour modification and the adoption of positive behaviours. However, employees are expected to be passive recipients of this knowledge, which is believed to lead to the increase in the awareness levels, uptake of prevention services and accessing of care and support services. As a result of this recommendation, most HIV workplace prevention activities in the workplace focus on displaying "information, education and communication (IEC)" materials at various points within the premises. Employee involvement and participation in other HIV workplace prevention activities such as HIV peer education training, general awareness campaigns, care and support is minimal. Such overemphasis on knowledge acquisition leads to insufficient focus on relevant issues such as employee involvement in the design and implementation and participation in HIV workplace prevention interventions as part of the major stake holders in the success of the HIV workplace programmes. Under these circumstances, limited employee involvement

and participation in HIV programmes and HIV prevention interventions at the workplace is likely to lead to limited success of these interventions in the workplace.

Campbell et al (2002) argued that employee involvement and participation in HIV workplace programmes is far more crucial to the success of the interventions than the mere knowledge of how HIV is transmitted from one person to other. Campbell findings reveal that despite high levels of knowledge about the risks of getting infected with HIV, people still engage in high-risk sex. This argument is further supported by the results obtained in the Demographic and Health Survey (DHS) conducted in Malawi, Mozambique, Zambia and Zimbabwe between 2004 and 2007.
In Zimbabwe, for example, the results of the 2005/2006 DHS showed that a high proportion of adults between the ages of 15 to 49 years (97.9 percent women and 99.2 percent men) had heard about HIV (National AIDS Council 2006:5). In spite of this high level of knowledge, however, Zimbabwe still had a high HIV – prevalence rate of 15.6 percent during 2007 (UNGASS 2007:4).

Similarly, in case of Zambia, the 2007 DHS report indicate that a general awareness of AIDS among men and women 15 - 49 is almost universal in Zambia at 99 percent. The results also show that knowledge of AIDS is high among all sub-groups of men and women by all background characteristics. The results further show that 90 percent of women and 89 percent of men agree that limiting sexual intercourse to one uninfected partner is a way to reduce the risk of contracting HIV. The study further revealed that both women and men (85 percent) agreed that abstaining from sexual intercourse is an effective way to reduce the risk of contracting HIV. As regards ruling out misconceptions about the HIV virus, eighty-three percent of women and 87

percent of men agree that a healthy-looking person can have HIV. This represents an increase in the knowledge levels obtained compared to an observation made in the 2001-2002 ZDHS (77 percent of women and 79 percent of men, respectively). However, HIV prevalence rate in Zambia in the same year (2007) was still among the highest, seventh in the world at 14.3 percent.

As such, Karl (2000:12) argues that, the involvement and participation of stakeholders in any intervention is key in building the capacity of stakeholders to take responsibility and control over their lives. In the context of HIV- workplace programmes, this means that employee involvement and participation in these interventions empower them in terms of acquiring skill and taking responsibility of protecting themselves from HIV – infection. This would result in access and sustainability of the intervention, ultimately leading to the well – being of the employees themselves and their families, as well as the viability of the company.

The arguments stated in this section, like those presented in the previous section of this literature review, seem very pertinent to the present study. Drawing from these arguments, the study assumes similar factors, conditions and impediments relating to participation of workers in the HIV workplace programmes.

CHAPTER THREE

3.0 Research Methodology

3.1 Study Design

The adopted study design was purely a post-test descriptive non-experimental design which was carried out in an uncontrolled and natural setting, the workplace. The use of the non-experimental design was preferred as it presented the multiplicity of the collected data in a coherent and functional way.

In a nut shell, descriptive study tends to identify some general characteristics of the entire set of data that can be used to describe the whole population. Workplaces, in the public sector are seen as a natural setting thus, information collected from representative sample of employees can be used to make generalization upon the entire workers in public sector populace.

3.2 Population Definition

The study population was drawn from 2 districts, Chipata and Sesheke districts. This study interviewed 300 men and women who were employees in the public sector in Chipata and Sesheke districts. The public sector employees in this study were defined to mean only workers in the government ministries or departments to the exclusion of all those in the parastatal and quasi – government institutions. The sampling unit was a worker working in the public sector at the time of the survey. The HIV and AIDS focal persons were interviewed to gain a deeper understanding of involvement of worker participation in the HIV and AIDS workplace programmes.

3.3 Sample Description

Since it was not feasible to include all the districts and all the government workers in the study, a representative sample was used. In each district, 15 government ministry workplaces were purposively selected and visited with a total of 15 HIV and AIDS focal persons interviewed.

The ordinary workers were randomly selected from only government departments from within the government ministries with the exclusion of all parastatals and quasi-government institution. In each district a total of 150 government workers were selected with the use of Simple Random Sampling using a list of all employees at a particular government ministry obtained from the Human Resource office and the registry unit. The list of all employees in a given government ministry acted as a sampling frame for that given workplace. A total of 300 government workers were interviewed.

The use of Simple Random Sampling was preferred as it allowed each member of the population to have an equal and non-zero chance of inclusion. The sampling technique was also preferred as it is ideal to use when a population is concentrated in one geographical area, as it were with the government ministries in the districts. For example, at Ministry of Livestock in Sesheke, with a total of 40 workers, to select 10 workers out of the 40 workers, the researcher used the Sampling fraction [$\boldsymbol{f = n/N}$] in which $\boldsymbol{n}$ is defined as the required sample size and $\boldsymbol{N}$ as the total population of workers at a given workplace. The researcher then used the sampling frame and the

random numbers to select elements. In this example therefore, each worker from the population had 1 chance out of 4 of being included in the sample.

3.4 Sampling of Survey Sites

Chipata and Sesheke districts were selected purposively as a setting for this study mainly because the two towns are located in Eastern and Western provinces whose HIV prevalence rates are among the highest in Zambia at 16.5% and 18.9% respectively. Furthermore, the two districts had been identified as being among the most severely affected areas with HIV and AIDS with HIV prevalence of 11.2% and 15.2% respectively, in case of Sesheke, while above the average national HIV prevalence rate of 14.3% (ZDHS: 2007). The two districts were also identified to have HIV and AIDS workplace programmes in place. There was no control group in the research. A survey approach was employed to solicit information from respondents pertaining to worker participation in the HIV and AIDS workplace programmes in the public sector.

3.5 Data collection

This study mainly used quantitative methods to investigate participation of workers in the HIV and AIDS workplace programmes and examined the levels of involvement of workers in the designing and implementation of HIV and AIDS workplace programmes.

This research used face-to-face interviews based on two different semi-structured questionnaires, one for the ordinary workers and the other for the HIV and AIDS focal

persons. The canvasser method was meant to facilitate the uniformity and accuracy of the collected data. The questionnaire was administered [by the researcher] once to all consenting workers in the public sector, in both Chipata and Sesheke districts.

Respondents were interviewed from their place of work. It was the sole responsibility of the researcher to seek permission from the Human Resource Office for an initial appointment on the days of interviews. Consultations were made with the HIV and AIDS focal person to arrange space for conducting interviews. The registry department personnel with the help of officers in the human resources office were requested to help with a list of names of all workers in a given workplace. The given list of all workers was used as a sampling frame. Simple random sample was used to select the sample, in each of the two districts, a total of 150 workers were randomly selected in each district. Respondents were sampled by sex.

3.6 Data Processing and Analysis

Data collected using semi-structured questionnaires were checked for uniformity, consistency and accuracy. Data was processed using Epi-Data 3.10 software. This programme is ideal for quantitative data as it has an advantage of permitting skip instructions for filter questions. The other advantage is that the researcher is familiar with the programme.

Data validation was performed on at least 10% of the questionnaires entered. This was done using a double data entry system. The raw data was exported to the Statistical Package for Social Sciences Software (SPSS) via a data entry query for analysis. Frequency tables and cross tabulations were produced. Bivariate analyses were performed on certain variables to establish existence of relationships. Descriptive

statistics and percentage distribution were used. Contingency tables and charts were used to facilitate presentation of findings. Qualitative data obtained from the open – ended questions from the HIV and AIDS focal persons were transcribed and then manually analysed using themes.

3.7 Ethical Considerations

The proposed study endeavoured to adhere to the following ethical principles: respect for persons, beneficence and justice. Efforts were made to protect individual autonomy, minimize harm and maximize benefits by using procedures which are consistent with sound research designs that take these issues into consideration. This study did not pose any physical risks associated with a physical procedure or intervention, such as obtaining tissue or blood samples.

Primarily, this study ensured informed consent and confidentiality of responses.

3.8 Limitations of the Study

The main limitation of this study was in terms of cooperation from management and workers as the study was done during the presidential and parliamentary elections of September 2011. In the run up to elections, campaigns at their peak, voting and the subsequent vote counting did impede the smooth flow of data collection. The fact that the study was done in two districts out of all the available districts in Zambia, the sample size may not be big enough to represent the entire population.

CHAPTER FOUR

4.0 Research findings

4.1 Background characteristics of respondents

A total sample size of the study participants in the survey was 300 respondents who were workers in the public sector, equally distributed between the two study sites. Table 1 provides a summary of some of their demographic and socio-economic characteristics which included; age, sex, marital status, education attainment, and employment status.

The mean age of the total sample was 35.79, Median age was 34 years and the Mode was 32 years. The samples minimum age was 20 and the maximum age was 69. Age distribution of the study participants shows that those in the younger age group (20 – 39) were 73.3% and those in the older age group (40 – 69) were 26.7%. Generally, majority of the respondents were married at 58.7%, single 25.7%, divorced 6.3%, widowed 5.3% and those reporting being separated 4%.

In terms of education attainment, respondents reporting attaining primary school education were 10.3%, secondary 24% and those with post-secondary school qualification were 65.7%.

In terms of job categories, 10.3% reported being in senior management, 26.7% were in middle management, 54.3% skilled staff and those indicating being unskilled were 8.7%. Respondents were also asked to indicate how long they had worked in their current workplace. Those reporting having worked less than one year made up 25% of

the sample, those who had worked for 1 – 5 years were 33.7%, and those who had worked for over 5 years made up 41.3% of the sample.

Table 1: Percent Distribution of Respondents by Selected Background Characteristics

	RESIDENCE (BY DISTRICT)		
	Chipata	Sesheke	Overall Total
Characteristics	(%)	(%)	(%)
Sex			
Male	52.0	71.0	49.7
Female	72.0	79.0	52.7
Age			
20 - 29	22.7	25.3	24.0
30 - 39	49.3	49.3	49.0
40 - 49	18.7	16.7	17.7
50 - 59	8.0	6.0	7.0
60 - 69	1.3	2.7	2.0
Marital Status			
Single	24.0	27.3	25.7
Married	56.0	61.3	58.7
Divorced	9.3	3.3	6.3
Widowed	6.7	4.0	5.3
Separated	4.0	4.0	4.0
Educational Attainment			
Primary	14.7	5.3	10.0
Secondary	28.0	20.0	24.0
College Certificate	37.3	27.3	32.3
College Diploma	16.7	34.7	25.7
Bachelor's Degree	3.3	12.0	7.7
Master's Degree	0.0	0.7	0.3
Job Classification			
Senior Management	8.0	12.7	10.3
Middle Management	24.7	28.7	26.7
Skilled Staff	54.7	54.0	54.3
Unskilled	12.7	4.7	8.7
Period of Service			
Less than 1 year	20.7	29.3	25.0
1 - 5 years	44.7	32.7	33.7
Over 5 years	44.7	38.0	41.3
Total Count	**150**	**150**	**300**
Total (%)	**100**	**100**	**100**

4.2 Awareness of the existence of HIV and AIDS workplace programmes

Awareness, as defined by the Oxford Dictionary (2010) means, "*having knowledge or cognisance of something or a situation, that kind of knowledge gained through one's own perceptions or by means of information*". In this study, awareness was defined *as an employee's own knowledge about the existence of the HIV workplace programmes gained through personal effort or by other means available within a given workplace*.

Awareness of the existence of the HIV and AIDS workplace programme in the workplace is very important for employees who would want to make a decision to participate in the activities of the programmes as well as those who would want to recommend friends to get involved or participate in such programmes.

HIV focal persons were asked to indicate whether their workplace had HIV and AIDS workplace programmes in existence and to what extent they thought their employees were aware of the programmes. Employees were also asked to indicate whether or not they were aware of the existence of HIV workplace programmes at their workplace. Research findings (Table 2) show that all work places 30 (100%) visited in the study had HIV workplace programmes in existence.

Table 2: Count and percent distribution of workplaces with HIV workplace programmes in existence

Residence	Count & percent distribution of workplaces with HIV workplace programmes in existence
Chipata	15 (100
Sesheke	15 (100)
Total	**30 (100)**

HIV focal persons were further asked to rank their employees' levels of awareness of the existence of the HIV workplace programmes using a 3-point scale of poor, fairly good and good.

Figure 2 shows that 50% of the focal persons thought that employees' awareness was poor, 20% thought it was fairly good and 30% said it was good.

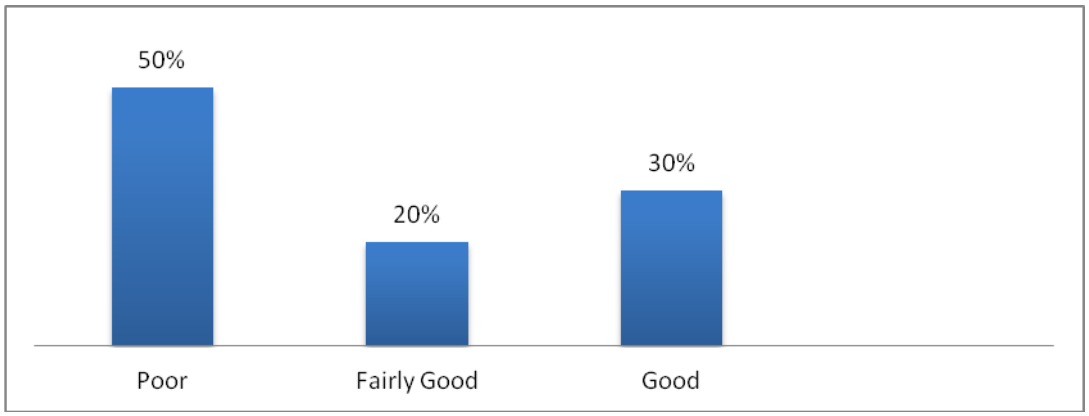

Figure 2: Percent distribution of the level of awareness of HIV workplace

A general question seeking information on awareness of the HIV workplace programmes was also asked in which workers were required to indicate whether they were aware of the HIV workplace programmes.

Results in Table 3 show that 83.3% (n=250) of the workers indicated being aware of the HIV workplace programmes in existence. Respondents in Sesheke 87.3% (n=131) were more likely to report awareness of the HIV workplace programmes as compared to those in Chipata 79.5% (n=119). However, findings suggest that the relationship between residence and awareness of HIV workplace programmes is not significant ($p>0.05$).

Table 3: Count and percent distribution of respondents' awareness of the existence of the HIV workplace programmes

Residence	Count	Percent	Total
Chipata	119	79.3	150 (100)
Sesheke	131	87.3	150 (100)
Total	**250**	**83.3**	**300 (100)**

4.3 Knowledge of the benefits of the HIV and AIDS workplace programmes

Study participants were asked a general question to state any benefits of the HIV and AIDS workplace programmes they knew of regardless of whether they were aware of the existence of the HIV workplace programmes at their workplace or not.

Table 4: Count and percent distribution of respondents' views on the benefits of participating in the HIV and AIDS workplace programmes by selected background characteristics

Background Characteristics	There are no benefits at all	Ability to access treatment, care & support	Acquire more knowledge on HIV & AIDS	Accords workers chance to seek clarification on HIV counseling	Promotes good interpersonal relationships and reduces stigma & discrimination	Total
Residence						
Chipata	21 (7.0)	35 (11.7)	50 (16.7)	15 (5.0)	29 (9.7)	150
Sesheke	2 (0.7)	26 (8.7)	37 (12.3)	30 (10.0)	55 (18.3)	150
Sex						
Male	8 (2.7)	22 (21.7)	65 (21.7)	33 (11.0)	21 (7.0)	149 (49.7)
Female	15 (5.0)	39 (7.3)	22 (7.3)	12 (4.0)	63 (21)	151 (50.3)
Education						
Primary	4 (1.3)	3 (1.0)	10 (3.3)	2 (0.7)	11 (3.7)	30 (10.0)
Secondary	8 (2.7)	17 (5.7)	23 (7.7)	9 (3.0)	15 (5.0)	72 (24.0)
College Cert.	7 (2.3)	22 (7.3)	33 (11.0)	14 (4.7)	21 (7.0)	97 (32.3)
College Dip	4 (1.3)	16 (5.3)	15 (5.0)	6 (2.0)	28 (9.3)	77 (25.7)
Bachelor's	0 (0)	3 (1.0)	5 (1.6)	0 (0)	9 (3.0)	23 (7.7)
Master's	0 (0)	0 (0)	1 (0.3)	0 (0)	0 (0)	1 (0.3)
Total	**23 (7.7)**	**61 (20.3)**	**87 (29)**	**45 (15)**	**84 (28)**	**300 (100)**

Results presented in Table 4 show that 7.7% (n=23) of the respondents mentioned that the HIV and AIDS workplace programmes offer no benefits at all. On the other hand, 20.3% (n=61) said that HIV workplace programmes offer ability to access treatment,

care and support, 29% (n=87) indicated that one would acquire more knowledge on HIV and AIDS education and awareness, 15% (n=45) said it accords workers chance to seek clarification on HIV counselling and VCT uptake and 28% (n=84) said it promotes good interpersonal relationships and reduces stigma and discrimination in the workplace.

These findings suggest that only between 20.3% and 29% of the workers could mention the benefits of the HIV workplace programmes.

4.4 Initial Sources of information on HIV workplace programmes

HI focal persons were asked to indicate how they disseminate information on HIV workplace programmes. Figure 3 shows the percent distribution of how HIV workplace information is disseminated as cited by HIV focal persons.

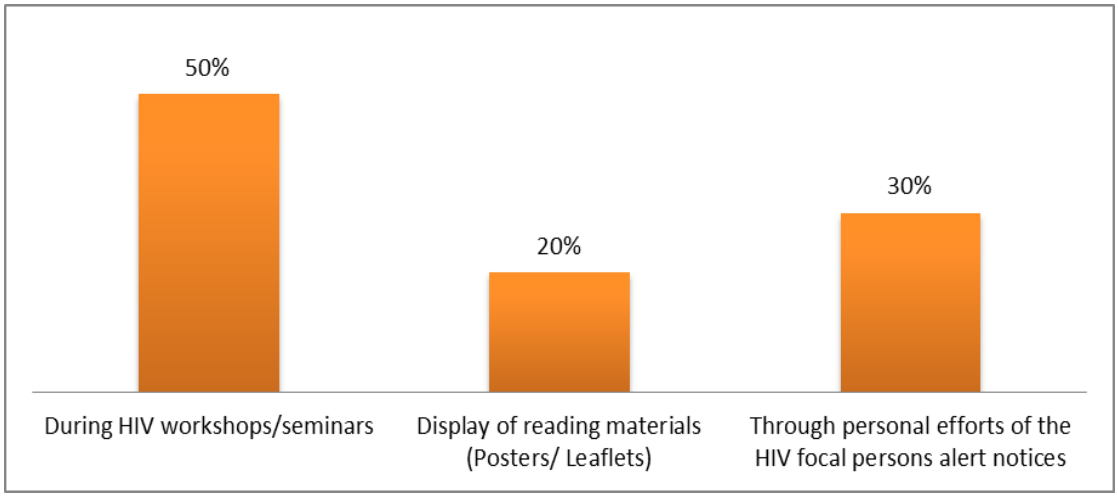

Figure 3: Percent distribution of the source of information on HIV awareness in the workplace from the focal persons' perspective.

Findings in Figure 3 show that the most cited way of communicating HIV information for awareness in the workplaces as cited by key informants was during HIV workshops/seminars (50%), display of reading materials (posters/leaflets) 20% and

30% mentioned that it is through personal efforts of HIV focal person's alert notices. This is also confirmed by the larger proportion of workers who indicated that the common source of information on HIV workplace programmes was through workshops/seminars (48%), poster/flyers 15.7% and only 5.3% mentioned that they were first notified by focal persons (Table 5).

Table 5: Percent distribution of workers on how they became aware of the HIV & AIDS workplace programmes

Residence	Workshop/ Seminar	Posters/ Flyers	Company Bulletins/ Newspaper	Friends	From the HIV Focal person notices
Chipata	44	19.5	2.7	11.3	6.7
Sesheke	52	12.0	2.0	14.0	4.0
Total (%)	**48**	**15.7**	**2.3**	**12.7**	**5.3**

4.5 Organization and attendance of the HIV workplace meetings/workshops

Regular organization of the HIV and AIDS workplace meetings has a profound effect on the subsequent stimuli among workers to attend meetings and participate in the HIV and AIDS workplace programmes.

HIV focal persons indicated that ideally HIV workplace meetings should be organized twice in each quarter of the year making a total of 8 meetings annually. As such, information was sought from focal persons with regards to the number of times they organized HIV and AIDS workplace meetings in the workplace.

Figure 4 show that 50% of the workplaces organized the HIV and AIDS workplace programmes *once a year*, 10% said they organized the meetings *twice a year*, 20% said *five times a year*, 10% said *over five times a year* and 10% said that *in some years, never at all*.

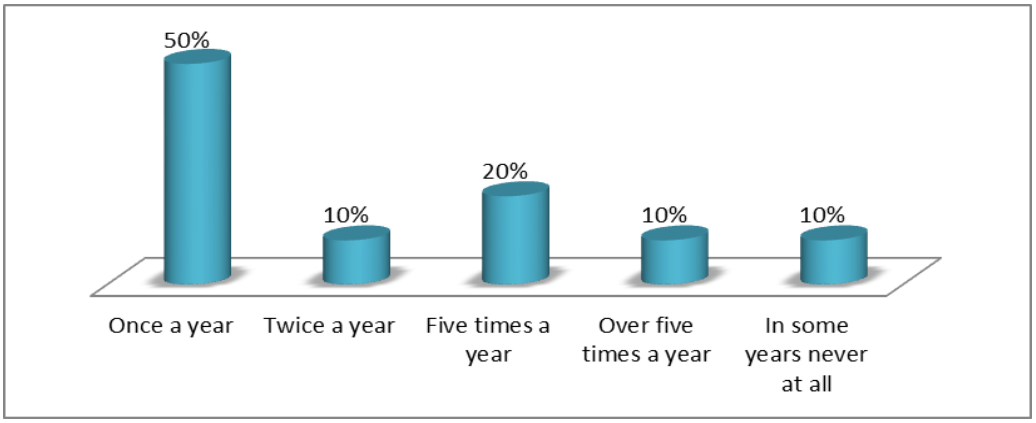

Figure 4: Workplace frequency of organizing HIV and AIDS workplace programmes

Study participants (n=110) who had indicated that they had participated in the HIV workplace activities were further asked to state the number of times they had attended the HIV workplace meetings/workshops in their workplace in last 12 months prior to the time of the interview. Results from Figure 5 show that 50% *had not attended any* HIV and AIDS workplace meetings/workshop, 27.7% said *once*, 13.7% *twice*, 4% said *three times* and 4.7% said *four times*.

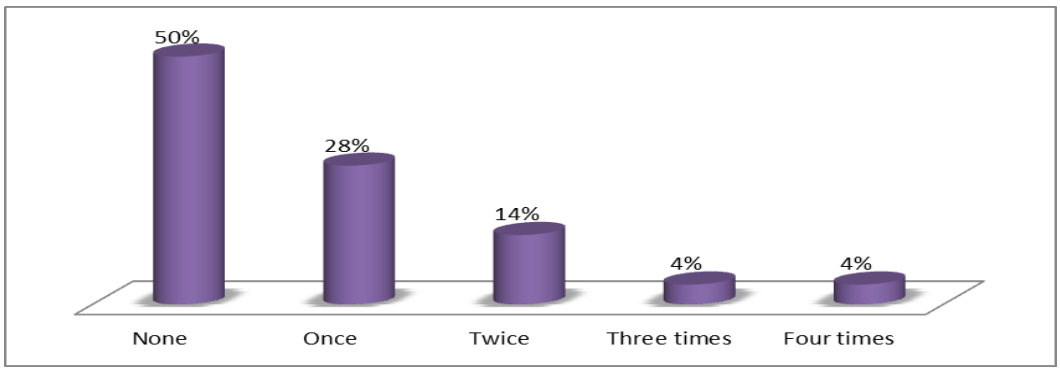

Figure 5: Respondents number of HIV/AIDS meetings attended in last 12 months

4.6 Workers attitudes toward HIV workplace programmes

According to psychologist Gordon Allport (1935), attitude, "*is an expression of favour or disfavour toward a person, place, thing or event. It is a psychological tendency that is expressed by evaluating a particular entity with some degree of*

favour or disfavour". In this study, attitude is defined as a readiness of the psyche to act or react in a certain way or as a positive or negative evaluation of HIV and AIDS workplace programmes

All study participants in the study were asked some general question to indicate their views towards the HIV and AIDS workplace programmes on a five point scale of strongly agree, agree, uncertain, agree and strongly disagree as presented in Table 6.

Table 6: Count and percent distribution of respondents' attitudes towards HIV workplace programmes

	Strongly Agree	Agree	Uncertain	Disagree	Strongly disagree
HIV/AIDS workplace programmes should only be for the HIV+ employees	63 (21.0)	34 (11.3)	26 (8.7)	91 (30.3)	86 (28.7)
HIV/AIDS workplace programmes are a sheer waste of resources that could be used for other things by companies/workplaces	6 (2.0)	10 (3.3)	34 (11.3)	122(40.7)	128(42.7)
Speaking on my own behalf I find that taking part in the HIV/AIDS workplace is sheer waste of time	2 (0.7)	13 (4.3)	3 (1.0)	136(45.3)	146(48.7)
HIV/AIDS workplace programmes should be established in all workplaces	143 (47.7)	151 (50.3)	1 (0.3)	2 (0.7)	3 (1.0)
I would be comfortable attending/participating in the HIV and AIDS workplace programmes	117 (39)	171 (57)	5 (1.7)	2 (0.7)	5 (1.7)

From the study findings, overall results show that 32.3% (n=97) of the workers were in *agreement* with the idea that HIV and AIDS workplace programmes should only be for the HIV+ employees and 59% (n=177) *disagreed.*

Only 5.3% (n=16) of the study participants were in *agreement* with the idea that HIV and AIDS workplace programmes are a sheer waste of resources that could be used for other things by companies/workplaces, majority 83.4% (n=250) disagreed.

On the statement 'speaking on my own behalf, I find that taking part in the HIV and AIDS workplace programmes is sheer waste of time' 94% (n=282) of the respondents were not in *agreement with the idea.*

Ninety-eight percent (n=294) of the workers were in *agreement* with the idea that HIV and AIDS workplace should be established in all workplace programmes. Ninety-six percent (n=288) of the study participants were in *agreement* with the idea 'I would be comfortable seen attending/participating in the HIV and AIDS workplace and only 2.4% (n=7) *disagreed.*

From the study findings in Table 6 it can be deduced that majority of the workers seem to have positive reinforcing attitudes towards HIV and AIDS workplace programmes. However, positive attitude in itself did not translate into increased worker participation in the HIV and AIDS workplace programme nor the subsequent involvement in the design and implementation of the HIV workplace programmes. This is evidenced from the responses to the question on whether or not respondents were aware of the objectives of HIV and AIDS workplace programmes in their respective workplaces.

4.7 Knowledge of the objectives of HIV workplace programmes

Knowledge, as defined by Stanley Cavell (2002), "*is the state or fact of knowing, familiarity or awareness and understanding gained through experience, told [tradition], or study. It is a collection of facts and data*." In this study, knowledge is defined as facts, information, truth, principles and skills acquired through experience or education; the theoretical or practical understanding of the objectives and activities of the HIV workplace programmes.

Study participants who had indicated being aware of the existence of HIV workplace programmes (n=250) were further asked to indicate whether they knew the objectives of the programmes and the results are presented in Table 7 by selected background characteristics.

Table 7: Count and Percent distribution of workers reporting knowledge of the objectives of the HIV and AIDS workplace programmes by selected background characteristics

Background Characteristics	Count	Percent (%)	Total
Residence			
Chipata	47	39.5	119
Sesheke	87	66.4	131
Sex			
Male	67	54.9	122
Female	67	52.3	128
Education			
Primary	11	39.3	28
Secondary	27	46.6	58
College Certificate	41	50.0	82
College Diploma	42	65.6	64
Bachelor's Degree	12	70.6	17
Master's Degree	1	100	1
Years of service			
Less than 1 year	41	70.7	58
1 - 5 years	40	44.9	89
Over 5 years	53	51.4	103
Total	**134**	**53.6**	**250**

Research findings in Table 6 show that overall, slightly over half of the respondents 53.6 (n=53.6%) indicated knowledge of the HIV workplace programmes. In terms of residence, 66.4% (n=87) respondents in Sesheke and 39.5% (n=47) in Chipata indicated knowledge of the objectives of the HIV workplace programmes.

The low proportions of respondents indicating knowledge of the objectives of HIV and AIDS workplace programmes in their workplaces cut across most of the background characteristics. For example, respondents reporting knowledge of the objectives ranged from a high of only 54.9% among males to as low as 52.3% among females. In terms of education, respondents reporting knowledge of the objectives ranged from a high of 70.6% with bachelor's degrees to as low as 39.3% with primary education. It is interesting to note that those with only less than a year in service were reported knowing of the HIV workplace objectives at 70.7% as compared to those with 1 to 5 years of service (44.9%) and those with over 5 years at 51.4%.

Respondents who indicated knowing the objectives of HIV workplace programmes were further asked to mention any one of the HIV workplace objectives. Findings from Table 7 show that only slightly more than (53.6%) were able to mention at least one objective of the programmes. Specifically, only 30.6%, 19.4%, 20.1% and 29.9% were able to mention awareness and sensitization, education, care and support, prevention and treatment respectively, as objectives of the HIV/AIDS workplace programmes.

It is interesting to note that even those who claimed to be aware of the objectives of the HIV workplace programmes, only slightly over half (53.6%) were able to name at

least one such objective as shown in Table 8. Only between 19.4% and 30.6% could mention any one of the objectives of the workplace programmes.

Table 8: Count and Percent distribution of workers who were able to state at least any one HIV workplace objectives by some selected background characteristics

Background Characteristics	HIV/AIDS awareness & sensitization	HIV/AIDS education	HIV/AIDS care & support	HIV/AIDS prevention & treatment	Total
Residence					
Chipata	18 (13.4)	16 (11.9)	12 (8.9)	6 (4.5)	52 (38.8)
Sesheke	23 (17.2)	10 (7.5)	15 (11.2)	34 (35.4)	82 (61.2)
Sex					
Male	22 (16.4)	16 (11.9)	13 (9.7)	21 (15.7)	72 (53.7)
Female	19 (14.2)	10 (7.5)	14 (10.4)	19 (14.2)	62 (61.2)
Education					
Primary	4 (3.0)	4 (2.9)	0 (0.0)	2 (1.5)	10 (7.5)
Secondary	9 (6.7)	1 (0.7)	8 (5.9)	6 (4.5)	24 (17.9)
College Cert.	15 (11.2)	9 (6.7)	10 (7.5)	12 (8.9)	46 (34.3)
College Diploma.	12 (8.9)	10 (7.5)	6 (4.4)	12 (8.9)	40 (29.9)
Bachelor's	1 (0.7)	1 (0.7)	3 (2.2)	8 (5.9)	13 (9.7)
Master's	0 (0.0)	1 (0.1)	0 (0.0)	0 (0.0)	1 (0.7)
Years of Service					
Less than 1 year	7 (5.2)	6 (4.5)	12 (8.9)	9 (8.9)	34 (6.7)
1 – 5 years	22 (16.4)	7 (5.2)	5 (3.7)	14 (10.4)	48 (10.4)
Over 5 years	12 (8.9)	13 (9.7)	10 (7.5)	17 (12.7)	52 (12.7)
Total	**41 (30.6)**	**26 (19.4)**	**27 (20.1)**	**40 (29.9)**	**134 (53.6)**

4.8 Participation in the design and implementation of HIV workplace programmes

HIV and AIDS workplace programmes that are collaborative in nature are more likely to appeal to workers to participate in the HIV workplace activities as they are likely to instil a sense of ownership among workers who would have been involved in the designing and the subsequent implementation of the same programmes within the workplace.

In this study, participation was captured by looking at worker's involvement in the design and implementation of the HIV workplace programmes. In order to establish whether HIV workplace programmes were collaborative in nature within any given workplace, information was collected from both key informants and workers alike.

HIV focal persons were asked to indicate whether or not workers; (a) had ever been involved in the design of HIV and AIDS workplace programmes in their workplace and, (b) ever been involved in the implementation of the HIV and AIDS workplace programmes as shown by the results in Figure 6.

Results in Figure 6 show focal person's views as regards workers' involvement in the design and subsequent implementation of the HIV workplace programmes. Findings show that only 30% of the HIV focal persons indicated that workers in their workplaces were involved in the design of HIV and AIDS workplace programmes. In terms of implementation, 69% of the focal persons indicated involving workers in the implementation of HIV workplace programmes.

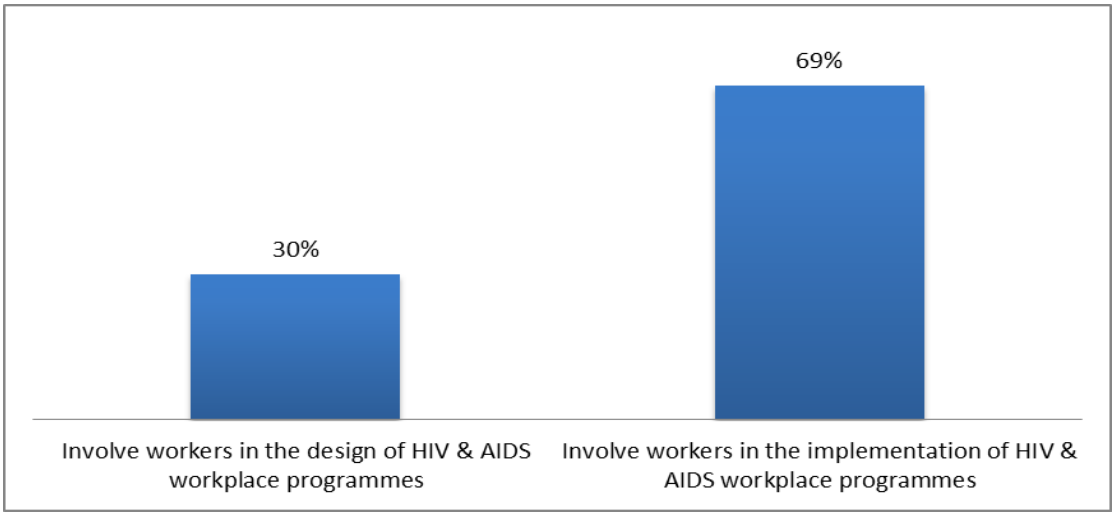

Figure 6: HIV focal persons' view on workers involvement in the Design and implementation of HIV and AIDS workplaces programmes

4.8.1 Workers participation in the Design of HIV workplace programmes

As already defined earlier, designing is a, "roadmap or a strategic approach for someone to achieve a unique expectation. It defines the specifications, plans, parameters, costs, activities, processes and how and what to do within the legal, political, social, environmental, safety and economic constraints in achieving that

objective" (Oxford Dictionary: 2008). In this study, designing is understood to mean conceptualizing the problem in terms of a discrete sequence of stages of problem-solving and creativity in defining goals and objectives of the HIV and AIDS workplace programmes.

Information was also sought from the study participants (n=250) who had indicated being aware of the existence of HIV workplace programmes to indicate whether they had: (a) ever been involved in the design of the HIV workplace programmes, (b) ever been involved in the implementation of the programmes and (c) ever participated in the HIV workplace programmes.

Table 9: Percent distribution of workers involvement in the design and implementation of HIV workplace programmes

Background Characteristics	Ever been involved in the design of HIV workplace programmes	Ever been involved in the implementation of HIV workplace programmes
Residence		
Chipata	22 (8.8)	33 (13.2)
Sesheke	42 (16.8)	43 (17.2)
Sex		
Male	35 (14.0)	40 (16.0)
Female	29 (11.6)	36 (14.4)
Age		
20 – 29	12 (4.8)	14 (5.6)
30 – 39	31 (12.4)	33 (13.2)
40 – 49	14 (5.6)	18 (7.2)
50 – 59	4 (1.6)	8 (3.2)
60 - 69	3 (1.2)	3 (1.2)
Education attainment		
Primary	2.0 (0.8)	4.0 (1.4)
Secondary	22 (8.8)	21 (8.4)
College Certificate	15 (6.0)	27 (10.8)
College Diploma	21 (8.4)	20 (8.0)
Bachelor's Degree	4 (1.6)	4 (1.6)
Master's Degree	0 (0.0)	0 (0.0)
Years of Service		
Less than 1 year	20 (8.0)	18 (7.2)
1 – 5 years	17 (6.8)	21 (8.4)
Over 5 years	27 (10.8)	37 (19.2)
Total	**64 (25.6)**	**76 (30.4)**

Research findings in Table 9 show that 25.6% (n=64) of the workers had ever been involved in the design of the HIV and AIDS workplace programmes. It is of interest to note that both responses as captured from HIV focal persons (30%) and as well as from the workers (25.6%) indicate low worker participation in the design of HIV workplace programmes relative to the (n=250) that had indicated being aware of the existence of HIV workplace programmes.

The low proportions of respondents indicating involvement in the design of HIV workplace programmes range from a high of only 16.8% in Sesheke to as low as 8.8% in Chipata. In terms of sex, more males 14% (n=35) than females (11.6%) were more likely to report ever been involved in the design of HIV workplace programmes. However, findings suggest that there is no significant relationship between sex and involvement in the design of HIV workplace programmes ($p>0.05$).

Workers (n=64) who mentioned that they were involved in the designing of HIV workplace programmes were further asked to indicate the tasks they were involved in. Fourteen - point three percent (n=6) were involved in the designing of written literature for the topics to be considered for the discussion/meetings, 22.7% (n=8) HIV and AIDS programme designing and coordination, 12.2% (n=6) advocacy and programme adoption committee and 24.5% (n=27) discussant/facilitator.

4.8.2 Workers participation in the implementation of HIV workplace programmes

As defined earlier, implementation is the, "*carrying out, execution or practice of a plan, a method, or any design for doing something*" As such; implementation is the, "*action that must follow any preliminary thinking in order for something to actually*

happen" (Laudon, K. & Laudon, J. (2010). This study defines implementation as the process of putting a decision on HIV and AIDS workplace plans into effect by systematically executing them in order to achieve desired goals and targets.

Of the (n=250) respondents who indicated being aware of the existence of the HIV workplace programmes, information was sought whether they had ever been involved in the implementation of the programmes. Results from Table 9 show that 30.4% (n=76) of workers indicated ever been involved in the implementation of the HIV workplace programmes.

Similarly, low proportions of respondents indicating involvement in the implementation of HIV workplace programmes cuts across most of the background characteristics. The proportion of employees indicating involvement in the implementation of the programmes ranged from 13.2 % in Chipata to 17.5% in Sesheke. However, the relationship between study site and involvement in the implementation of HIV workplace programmes in not significant ($p>0.05$).

A consensus implementation of a programme is a fundamental organizational practice that is critical for any strategy to take hold as it creates employee ownership. Study participants (n=76) who mentioned being involved in the implementation of the HIV workplace programmes were further asked to state any of the tasks they were involved in. 21.1 percent (n=16) of the study participants reported being involved with organization of workshops/seminars for the HIV and AIDS meetings, 18.4% (n=14) outlaying of the workshop/seminar for the HIV and AIDS meetings, 15%

(n=19.7) selected to visit the sick workmates (visitation), 25% (n=19) drama and HIV and AIDS poems presentation and 15.8% (n=12) counselling.

4.9 Management's participation in the HIV workplace programmes

The value of encouraging participation and cooperation by management and employees alike in the implementation of the HIV and AIDS workplace programmes cannot be underestimated. Empirical evidence suggests that many barriers in achieving success in workplace programmes lies in human resource rather than technical ones. On-going motivation and participation in the HIV workplace activities including boosting employee morale lies in consistent and effective participation by management.

In all the 30 workplaces visited, focal point persons were asked to indicate management's level of involvement in the HIV workplace programmes on a 3-point scale of low, moderate and high.

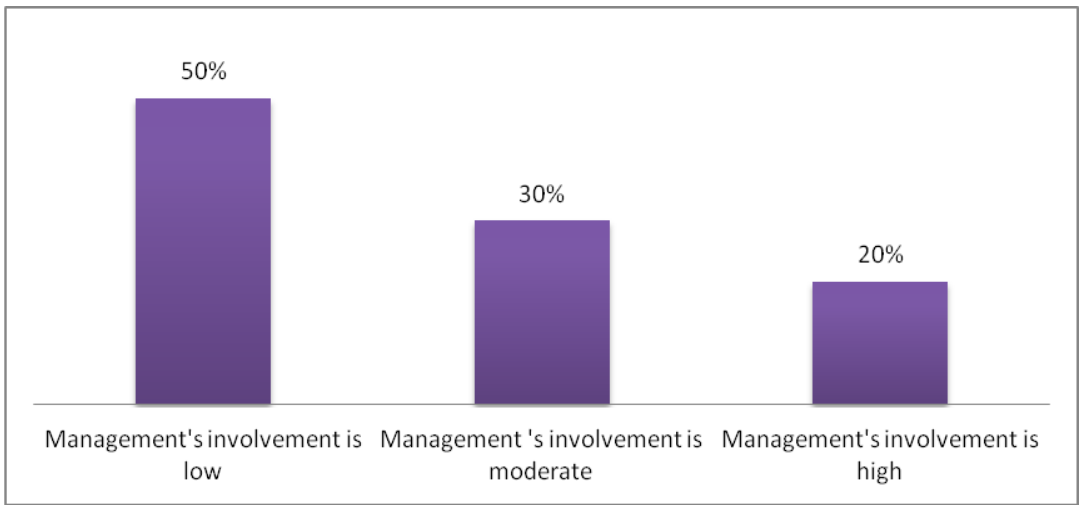

Figure 7: Management's level of involvement in the workplace Programmes

Research findings in Figure 7 show 50% of the focal point persons rated management's level of participation as being low, 30% rated it moderate and 20% rated it high.

Focal point persons were further asked to state how management involved itself in the HIV workplace programmes, below are some of the excerpts given:

a. *"Management is mostly involved in the supervisory role of the HIV/AIDS committee" (Sesheke HIV Focal Person)*
b. *"Through formulation of HIV and AIDS activities and budgeting for the workshops and seminars" (Sesheke HIV Focal person)*
c. *"Their role is not well defined; it's highly irregular and inconsistent. Their participation, if ever they participate, is that of being reminded of what they are supposed to do, they have never been part and parcel of the programmes but do so out of duty and obligation" (Chipata HIV Focal Person)*

Focal point persons were further asked to state what they thought needed to be done for management's activities to be more useful / effective. Most of the reasons cited by HIV focal persons are illustrated in the following excerpts:

d. "*There is need to have exchange programmes by and for management from among government ministries including interactions with the private sector at both district and provincial level so as to exchange ideas and learn from each other on how to improve worker enrolment and consistently participate in the workplace HIV programmes" (Sesheke HIV Focal Person)*

e. "There is need to organize quarterly refresher courses for management and key informants alike so as to keep abreast with many issues surrounding the recruitment of participants, group maintenance as well as counselling" (Chipata HIV Focal Person)

f. "There is usually no seriousness in the HIV and AIDS workplace programmes neither among employees nor management alike. Emphasis is only made on December 1 mainly for the Worlds AIDS Day celebrations, as such just like we have the work performance appraisals, appraisals can be extended even to management staff and key informants alike and those who are consistently underperforming can be excused from performing duties relating to HIV workplace programmes" (Sesheke HIV Focal Person)

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This study aimed to determine knowledge of the objectives of HIV and AIDS workplace programmes among workers as well as to investigate attitudes of workers toward HIV workplace programmes. The study further investigated participation of workers in the design and implementation of HIV workplace programmes as well as to investigate possible determinants of awareness, knowledge and participation of workers in the HIV and AIDS workplace programmes.

This study included 300 respondents who were workers in the public sector in Chipata and Sesheke districts of Zambia. A questionnaire containing both open and close ended questions was used for data collection from both employees and focal point persons.

Among the major findings of the study is that, notwithstanding the high levels of awareness of HIV workplace programmes (83.3%) among workers, knowledge on the objectives of the HIV workplace programmes is lamentably low among the workers who participated in this study. Only slightly above half 53.6% of those interviewed indicated knowledge of the objectives of the workplace programmes and out of these, only between 19.4% to 30.6% were able to mention at least any one of the objectives of the HIV workplace programmes.

Inadequate knowledge of the objectives of the HIV workplace programmes could be attributed to the fact that majority of the respondents (63.3%, n=190) had never participated in the HIV and AIDS workplace programmes neither in the design (74.4%, n=186) nor in the implementation (69.6%, n=174) of the HIV workplace

programmes. The stakeholder theory was appropriate in this study in investigating worker participation in the HIV and AIDS workplace programmes in the public sector. One conclusion of the stakeholders' theory is that, "*without the decision-making form of involvement, there is much danger that stakeholders may block decision making, undermine implementation of interventions or refuse to be involved in the intervention if they perceive the stakeholder participation as biased to favouring a select few"* This is evidenced from the study results were majority of the respondents had never participated in the design (74.4%, n=186) nor in the implementation (69.6%, n=174) of the HIV workplace programmes.

Further, management's low involvement in the HIV workplace programmes may be responsible for low worker participation (design and implementation) in the workplace programmes.

This is notwithstanding the fact that in general, the workers seem to be appreciative of the importance of such programmes. This is evidenced from the research findings that majority (98%) of the workers were in *agreement* with the idea that HIV and AIDS workplace programmes should be established in all workplaces. Similarly, majority (96%) of the study participants indicated that they would be comfortable seen participating in the HIV and AIDS workplace programmes.

Low levels of worker involvement both, in the design of HIV workplace programmes (25.6%) and in the subsequent implementation of the programmes (30.4%) may invariably act as an obstacle to the fuller participation of workers in the workplace

programmes as many workers perhaps lack a sense of ownership as they feel left out in such programmes.

These results confirm the findings of the 2005 study done in South Africa by Siyamkela, measuring HIV/AIDS Stigma, in which he asserts that "Employees feelings of alienation from management were strong and pervasive with regard to the issue of HIV and AIDS in the workplace especially as regards workers involvement in the designing and planning of such workshop programmes". Ill-feelings caused by non-involvement of workers in the designing and implementation of the HIV and AIDS workplace programmes may, by and large, result in the "*them and us*" attitude which may hamper a conducive, caring and supporting work environment thus undermine the very core objectives of the HIV workplace programmes.

The conceptual framework used in this study had suggested that, the existence of HIV workplace programmes in any given workplace, active involvement of HIV and AIDS focal person and the active participation of management can largely influence worker participation in the HIV workplace programmes.

The framework further assumed that, background variables (sex, age, education, years of service and residence) in turn influence the dependent variables which are worker participation (design and implementation) in the HIV workplace programmes, increased awareness and knowledge levels.

Study findings suggest that, residence, age and marital status are the possible determinants in determining worker participation in the HIV workplace programmes

and in terms possible determinants of design and implementation, only age, residence and marital status were shown to influence worker determination in the designing and implementation of HIV workplace programmes. Study however, has revealed that sex, education and years of service were insignificant in determining worker participation, designing and implementation of the HIV workplace programmes.

Analysis of the relationship between background characteristics, that is, residence, sex, age, marital status, education and years of service, was done to establish the possible determinants of awareness, knowledge of objectives, involvement of workers in the design and involvement of workers in the implementation of HIV workplace programmes.

Findings showed a significant relationship for residence and marital status when analysed in respect of knowledge of the objectives of the HIV workplace programmes. In terms of participation in the HIV workplace programmes, only residence, age and marital status when analysed in respect of participation of workers in the HIV workplace programmes showed a significant relationship.

Findings show that possible determinants in the participation of workers in the design of HIV workplace programme were residence, age and marital status whose analysis showed a significant relationship. However, no significant relationship was established for sex, education and years of service. In terms of implementation, analysis only showed age as having a significant relationship when analysed in respect of the involvement of workers in the implementation of HIV workplace programmes.

5.1 Conclusions

Zambia recognises the consequences of the high national burden of HIV and AIDS. It is these continued rising challenges of HIV and AIDS cases in the work place that accounted for the establishment of HIV and AIDS workplace programmes in 2002, as part of the national multi – sectoral response for the prevention and combating of the spread of HIV and AIDS/STI/ and TB in order to reduce personal, social and economic impact of the diseases. This was born out of the understanding that the workplace setting provides an effective environment for delivering HIV and AIDS programmes to a wide range of a population who might not otherwise access HIV and AIDS prevention, education, care and support services.

Literature suggests that headways have been made in the launch and implementation of the HIV and AIDS workplaces programmes in both the private and the public sector. However, the success of what has been, and what is and what may be done in future largely depends on how effective and consistent the HIV and AIDS workplace programmes shall be in meriting trust, attracting huge enrolments in the workers taking part in the workplace HIV activities as well as providing accurate information about the objectives of the HIV and AIDS workplace programmes and the intention and purpose as to the existence of the programmes.

The present study findings have clearly demonstrated low levels of awareness of the objectives of the HIV and AIDS workplace programmes among workers which can be attributed to low worker involvement (participation) in the design and implementation of the programmes and management's poor commitment in spearheading the HIV workplace activities.

5.2 Recommendations

Findings from this study indicate that inspite of the widespread awareness of the existence of workplace HIV programmes and their usefulness, very few respondents participated in the programmes and very few were familiar with their objectives. In order to address this, the following recommendations are made:

1. There is need by government, through the Ministry of Health, individual workplaces and focal point persons to increase awareness levels and knowledge on the objectives of HIV workplace programmes among the workers. Effective communication is, thereby essential for the success of the programmes. There should be a deliberate goal of communicating early and often, but also have a long-term communication strategy. Communication can be made using multiple media including among others, formal e-mails, progress celebrations, informal conversations, posters, fliers and through organized talks.

2. There is need to have individual workplaces to have successive levels of the organization (from top to bottom) included in a dialogue especially in the design and implementation of the HIV workplace programmes so as to accord workers within any given workplace an opportunity for intellectual, emotional and psychological reaction to the desired course and plan on how best they want to see the workplace programmes operate.

3. There is need to scale-up the frequency of holding HIV workplace meetings and although the overall goal of HIV workplace programme

design for the meetings need to be comprehensive, starting with modest targets is often beneficial as such targets need not be over-ambitious.

4. There is need by management and HIV focal persons alike, to promote employee participation in the development, design, implementation, and evaluation of the HIV workplace programs so as to ensure that employees are not just recipients of HIV workplace packages but are engaged actively to identify relevant HIV and AIDS workplace issues of their interest and contribute to programme design and implementation.

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Appendix 1: Workers questionnaire

THE UNIVERSITY OF ZAMBIA
SCHOOL OF HUMANITIES AND SOCIAL SCIENCES
DEPARTMENT OF POPULATION STUDIES
Knowledge and attitude of workers toward HIV and AIDS workplace programmes in the public sector: A case of Chipata and Sesheke Districts.

WORKERS QUESTIONNAIRE

Questionnaire Identification Number |___|___|___|___|___|

Country_____

Province Name_____

District Name _____

Name of Workplace_____

Introduction: "My name is……. I am a Postgraduate student at the University of Zambia. I am currently gathering information relating to Knowledge and attitudes of workers toward HIV and AIDS workplace Programmes. The information that you will provide is to be used purely for academic purposes; that is, for my thesis/dissertation report writing which is a requirement for the award of the Master's Degree in Population Studies of the University of Zambia. Therefore, information provided will be treated with utmost confidentiality and your name will not be published nor any thing you say attributed to you.

DATE OF INTERVIEW: _____\ ____ \ _____

NAME OF INTERVIEWER_____ :

	RESPONDENTS' BACKGROUND INFORMATION		Skip	Official Use Only
Q.1	Sex of the respondent	1. Male ☐ 2. Female ☐		☐
Q.2	How old were you at your last birthday?	……		☐
Q.3	What is your current marital status?	1. Single ☐ 2. Married ☐ 3. Divorced ☐ 4. Widowed ☐ 5. Separated ☐		☐
Q.4	What is your highest level of educational attainment?	1. Primary ☐ 2. Lower secondary ☐ 3. Higher secondary ☐ 4. College certificate ☐ 5. College Diploma ☐ 6. Bachelor Degree ☐ 7. Master's Degree ☐ 8. Doctorate ☐ 9. None ☐		☐
Q.5	How do you categorize the type of job you do?	1.Senior Management ☐ 2.Middle Management ☐ 3.Skilled Staff ☐ 4.Unskilled staff ☐		☐
Q.6	How long have you worked here?	1. Less than 1 year ☐ 2. 1 - 5 years ☐ 3. Over 5 years ☐		☐

	AWARENESS OF THE HIV AND AIDS WORKPLACE PROGRAMMES		Skip	Official Use Only
Q.7	Are you aware of the existence of HIV & AIDS workplace programmes in this place?	1. Yes ☐ 2. No ☐	If no → **Q.9**	☐
Q.8	How did you get to know of the of the HIV and AIDS workplace programmes?	1. Workshops/Seminars ☐ 2. Posters ☐ 3. Flyers ☐ 4. Through company bulletins/newspaper ☐ 5. Friends ☐ 6. Others (specify) ☐ ……		☐
Q.9	In the last 12 months, are you aware of the HIV & AIDS activities taking place at your workplace?	1..Yes ☐ 2. No ☐		☐
Q.10	Do you know the objectives of the HIV AIDS workplace programmes?	1. Yes ☐ 2. No ☐	If no → **Q.12**	☐
Q.11	If yes, state any that you know of?	…….. …….. …….. …… ……		☐
Q.12	Have you ever been involved in the of the HIV and AIDS workplace Programmes?	1. Yes ☐ 2. No ☐	If no → **Q.14**	☐

	WORKERS INVOLVMENT IN THE DESIGN / IMPLEMENTATION OF THE THE HIV & AIDS WORKPLACE PROGRAMS		Skip	Official use only
Q.13	If yes, how were you involved?	…… …….. …….. …… …… ……..		☐
Q.14	Have you ever been involved in the implementation of the HIV & AIDS Programmes?	1. Yes ☐ 2. No ☐	**If no → Q.16**	☐
Q.15	If yes, how were you involved?	…… …….. …… …….. …… ……		☐
Q.16	Have you ever participated in the HIV workplace activities in this place?	1.Yes ☐ 2.No ☐	**If no → Q.18**	☐
Q.17	Which activities did you participate in?	…… …… …….. …… …….. ……		☐
Q.18	In the last 12 months, how many HIV meetings held by peer educators did you attend in this place? (Insert #).	……		☐

PERCEIVED BENEFITS OF HIV AND AIDS WORKPLACE PROGRAMMES BY WORKERS				Official use only
Q.19	Are there benefits of participating in the HIV workplace Programmes?	1.Yes ☐ 2.No ☐	**If → Q.2**	☐
Q.20	What are the benefits of participating in the HIV workplace Programmes?	…… …… …… …… ……		☐
	ATTITUDE OF WORKERS TOWARD HIV & AIDS WORKPLACE PROGRAMS			
Q.21	HIV workplace programmes should only be for the HIV+ employees.	1.Mostly agree ☐ 2. Agree ☐ 3.Uncertain ☐ 4.Disagree ☐ 5. Completely disagree ☐		☐
Q.22	HIV workplace programmes are a a sheer waste of resources that used for other things by company's/ workplaces.	1.Mostly agree ☐ 2. Agree ☐ 3.Uncertain ☐ 4.Disagree ☐ 5. Completely disagree ☐		☐

ATTITUDE OF WORKERS TOWARD HIV & AIDS WORKPLACE PROGRAMS				
Q.23	Speaking on my own behalf, I find that taking part in the HIV & AIDS workplace programmes is a sheer waste of time.	1.Mostly agree ☐ 2. Agree ☐ 3.Uncertain ☐ 4.Disagree ☐ 5. Completely disagree ☐		☐
Q.24	HIV workplace programmes should be established in all workplaces.	1.Mostly agree ☐ 2. Agree ☐ 3.Uncertain ☐ 4.Disagree ☐ 5. Completely disagree ☐		☐
Q.25	I would be comfortable seen attending / participating in the HIV & AIDS workplace Programmes.	1.Mostly agree ☐ 2. Agree ☐ 3.Uncertain ☐ 4.Disagree ☐ 5. Completely disagree ☐		☐
Thank you very much for your time and cooperation				

Appendix 2: HIV focal person questionnaire

THE UNIVERSITY OF ZAMBIA
SCHOOL OF HUMANITIES AND SOCIAL SCIENCES
DEPARTMENT OF POPULATION STUDIES
Knowledge and attitude of workers toward HIV and AIDS workplace programmes: A case of Chipata and Sesheke Districts.

SITUATION ANALYSIS QUESTIONNAIRE – HIV FOCAL PERSON

Questionnaire Identification Number |___|___|___|___|___|

Country_____

Province Name_____

District Name _____

Name of Workplace_____

Introduction: "My name is……. I am a Postgraduate student at the University of Zambia. I am currently gathering information relating to Knowledge and attitudes of workers toward HIV and AIDS workplace Programmes. The information that you will provide is to be used purely for academic purposes; that is, for my thesis/dissertation report writing which is a requirement for the award of the Master's Degree in Population Studies of the University of Zambia. Therefore, information provided will be treated with utmost confidentiality and your name will not be published nor the information provided attributed to you.

DATE OF INTERVIEW: _____\ ____ \ _____

NAME OF INTERVIEWER_____ :

RESPONDENT'S BACKGROUND INFORMATION				Official Use only
Q.1	Sex of the respondent	1. Male ☐ 2. Female ☐		☐
Q.2	How old were you at your last birthday?	……		☐
Q.3	What is your current marital status?	1. Single ☐ 2. Married ☐ 3. Divorced ☐ 4. Widowed ☐ 5. Separated ☐		☐
Q.4	What is your highest level of educational attainment?	1. Primary ☐ 2. Lower secondary ☐ 3. Higher secondary ☐ 4. College certificate ☐ 5. College Diploma ☐ 6. Bachelor Degree ☐ 7. Master's Degree ☐ 8. Doctorate ☐ 9. None ☐		☐
Q.5	How do you categorize the type of job you do?	1.Senior Management ☐ 2. Middle Management ☐ 3.Skilled Staff ☐ 4.Unskilled staff ☐		☐
Q.6	How long have you worked here?	1. Less than 1 year ☐ 2. 1 - 5 years ☐ 3. Over 5 years ☐		☐

	Workers Involvement in the design & implementation of the HIV & AIDS Workplace programmes		**Skip**	**Official use only**
Q.14	Do you involve workers in the design of HIV and AIDS workplace programmes?	1. Yes 2.No ☐	**If No → Q.16**	☐
Q.15	If yes to Q14, How is this done?	…… …… …… …… ……		☐
Q.16	Do you involve workers in the implementation of HIV and AIDS workplace programmes?	1. Yes ☐ 2. No	**If No → Q.18**	☐
Q.17	If yes to Q16, How is this done?	…… …… …… …… ……		☐
Q.18	Is management involved in the implementation of your HIV and AIDS workplace programmes?	1. Yes ☐ 2. No	**If No → Q.22**	☐
Q.19	How is management involved in the implement-ation of HIV and AIDS workplace programmes?	…… …… …….. …….. ……..		☐

Q.20	How would you rate managements' level of participation in the HIV and AIDS workplace programmes?	1. Low ☐ 2. Moderate ☐ 3. Somewhat high ☐		☐
Q.22	How frequently do you organize the HIV & AIDS workplace meetings/workshops in a year at your workplace?	1. Once a year ☐ 2. Twice a year ☐ 3.Three times a year ☐ 4. Four times a year ☐ 5. five times a year ☐ 6. over 5 times a year ☐ 7. In Some years never At all ☐		☐
	Thank you very much for your time and cooperation			

Appendices 3: Informed consent form

Good morning/afternoon. My name is ***Chilekwa Kedric Chilekwa*** I am post-graduate student at the University of Zambia currently collecting information on the topic; ***Participation of Workers in the HIV and AIDS Workplace Programme in the Public Sector: A case of Chipata and Sesheke District.*** If it is alright with you, I would like to interview you.

Who is conducting this study and why: This study is being coordinated by the University of Zambia, School of Humanities and Social Sciences, Department Of Population Studies. It is primarily being conducted as a partial fulfilment for the award of a Master of Arts Degree in Population Studies. This study is aimed at investigating knowledge levels and attitudes of employees towards HIV & AIDS workplace programmes and their participation in the HIV workplace programmes.

Who will be in the study: About 300 people working in the public sector in Chipata and Sesheke Districts will participate in this study the sample will comprise both men and women.

Procedure: I am going to give you full details about this study and on the basis of which, you will have to decide whether to participate or not. If you agree to participate in the study, I will ask you questions about your age, marital status, job title, your education attainments (schooling), your knowledge and attitudes toward HIV and AIDS workplace programmes. This study is purely verbal and no physical examinations will be conducted. The interview will take about 30-45 minutes.

Benefits & Risks: The information you give will assist to establish and improve future HIV communication programming. A risk to participating in this study is that you may be stressed with questions that you will be asked and the time spent answering the questions. On the other hand, the benefit of your participation is that you will contribute useful information to researchers and public health managers so they may better provide HIV related programs in Zambia especially in the fight of HIV and AIDS in the workplace.

Possibility of withdrawal or declining specific questions: your participation is completely voluntary. You may ask me to stop discussions if you are uncomfortable, or you may also decline to answer any single question. Not participating in the study will not attract any penalty or jeopardize your access to the services and or good that you may be receiving.

Confidentiality: The interview is strictly confidential; so your responses will not be shared with anyone. Your name will not appear on the questionnaire, any of my notes, or any of the reports.

Reimbursement: You will not be charged, nor will you be paid for participating in this study.

Who has reviewed the study: The study has been reviewed by the Humanities and Social Science ethical Committee of the University of Zambia.

Offer to answer questions: I can answer any questions you may have. If I do not have the information you require, I will tell you so and, if you wish, I will try to get an answer for you.

Do you have any questions? (If yes, note the questions) ☐Yes ☐No

_____

Do you consent to participate? ☐Yes ☐No

PARTICIPANT AGREEMENT

The above document describing the benefits, risks and procedures to participate has been read and explained to me, the participant. I also understand that participating in this study is voluntary and that I can withdraw at any time. I have been given an opportunity to ask any questions about the activity and be satisfactorily answered.

_____ _____ _____

Date Signature of respondent *(mark)

*In case the respondent is not able to sign this form, this attests that the consent form has been read and explained accurately by a member of the research staff, and that the respondent has fixed his/her thumbprint as consent.

If you have any doubts or questions in future, you may contact:

The Chairperson Research Ethics Committee, University of Zambia, Great East Road Campus, P.O Box 32379 Lusaka and or ***Chilekwa Kedric Chilekwa*** who is the Principal Investigator, University of Zambia, Population Studies Department, P.O. Box 32379, Lusaka. Cell: +260-0977 414194, 0967 414194. *Thank you.*

I, the undersigned interviewer, have explained to the participant in a language he/she understands, and he/she understands the procedures to be followed in the study and the risks and benefits involved.

_____ _____

Signature of interviewer Date