

# **UNIVERSITY OF FORT HARE**

An investigation into the management of HIV/AIDS programmes at the workplace in a highly volatile environment: A case study of selected organisations in Harare, Zimbabwe.

By

**TAURAI BOOTH WILLIAM NYEMBA**

Submitted in fulfillment of the requirements for the degree of

**MASTER OF COMMERCE IN INDUSTRIAL  
PSYCHOLOGY**

in the Faculty of

**Management and Commerce**

**SUPERVISOR : MR. C MURUGAN**

**CO-SUPERVISOR : MR. C. CHIPUNZA**

**November 2008**

## **DECLARATION**

I declare that “AN INVESTIGATION INTO THE MANAGEMENT OF HIV/AIDS PROGRAMMES AT THE WORKPLACE IN A HIGHLY VOLATILE ENVIRONMENT. A CASE STUDY OF SELECTED ORGANISATIONS IN HARARE, ZIMBABWE” is the author’s original work and has never been submitted by the author or anyone else at any university for a degree. All the sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

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TAURAI B. W. NYEMBA

November 2008

## **ACKNOWLEDGEMENTS**

I wish to express my heart-felt gratitude to:

- My Supervisor Mr. C Murugan and my co-supervisor Mr. C Chipunza for the guidance and support in carrying out the research study.
- The Patron of the Presidential Scholarship and the Director of the Presidential Scholarship His Excellence President Robert G. Mugabe and Honourable Mr. Christopher C. Mushohwe for providing me with funds to carry out this study.
- The statistician Mr. O. Bodhylera for the analysis and guidance
- To my collegeus Chipo, Tendai, Malvern, Samuel, Tinashe and Khetiso thank you very much for the support, you made my stay and my study worthwhile.
- To my friends Naison, Stan, Nicholas, Obert, Mercy, Whitehead, Wiseman, Zindoga, Nyarai, Iggie and Mugie thank you very much for the support.
- To my family Shadreck, Juliet, Chipo, Fatima, Sandra, Nicole, Curtis, Cedric, Costa, Andrew, gogo Melody thank you very much for the guidance and support.
- To Yananayi you are a blessing.

## **DEDICATION**

### **My Parents**

**Mr. Shadreck and Mrs. Getrude. Juliet NYEMBA**

**Thank you for moulding me to be the person I am today I hope I  
will be able to provide the same support to my own children  
some day.**

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## **ABSTRACT**

The HIV/AIDS pandemic has had a devastating effect in the world, as it is now rated as the world's greatest killer since its appearance in the mid 1980s. A UNICEF Report (2005) states that sub Saharan Africa is the hardest hit with countries like Botswana, Zimbabwe, South Africa, Namibia and Mozambique having an average of one in every five adults being infected. Sub Saharan Africa has less than 3% of the world's population but it has an estimated 65% of the world's population living with HIV/AIDS as it has 26 million of the 40 million infected people worldwide. In May 2003 the Government of Zimbabwe declared HIV/AIDS a national emergency a move that seems to have yielded results as the HIV prevalence rate has come down from 26.1% to 18.6% in 2005 and further to 15.6% in 2007. The Ministry of Health and Child Welfare (2004) states that if the prevalence had continued at 26.1%, about two thirds of today's 15-year-olds would die from this disease.

The deterioration of the political, social and economic situation since 1999 and the withdrawal of donor development support due to policy differences require concerted efforts from all parties concerned, now, rather than later. More commitment must be shown by private and public sector organisations to active participation in the establishing of effective workplace programmes, to assist employees, for the pandemic has placed a heavy strain on the health delivery system, as AIDS patients occupy between 50% to 70% of all hospital beds. Furthermore, the pandemic is killing the youth at the prime of their working careers so the pandemic, while being a health problem also has a negative macro-economic impact which may lead to a developmental crisis. A study was conducted of six organisations, using two questionnaires, one for management and one for non-management level employees. The study investigates whether the organisations had HIV/AIDS programmes and whether such programmes were effective.

The findings were that all six organisations had HIV/AIDS programmes in place. However, some of the programmes were not effective because the employees did not know of their existence. Furthermore, it was found that management initiated awareness programmes and made condoms available but the employees were not changing their risky behaviour.

## **CHAPTER 1**

### **INTRODUCTION, PROBLEM STATEMENT AND OUTLINE OF THE STUDY**

#### **1.1 Introduction**

The HIV/AIDS pandemic has had a devastating effect in the world, as it is now rated as the world's greatest killer since being discovered in the mid 1980's. A UNICEF report (2005) states that sub-Saharan Africa is hardest hit with countries like Botswana, Zimbabwe, South Africa, Namibia and Mozambique having an average of one in five people being infected. In May 2003, the Government of Zimbabwe declared HIV/AIDS a national emergency. This paved the way for pharmaceutical companies to import drugs into the country. Initially the declaration was for a period of six months but it was extended to December 2008 (Zimbabwe Country Report, 2005).

The situation in Zimbabwe is exacerbated by a harsh political, social and economic climate, a shortage of drugs and poverty in general. Grant, Fine, Heywood and Strode (2001:11) observe that HIV spreads fastest in conditions of poverty. The Zimbabwean economy is characterised by hyper-inflationary tendencies. In May 2007 the inflation rate was estimated at 2200 percent, in June it was estimated at 4500 percent. By October of the same year, it was estimated at 6600 percent. The negative economic growth rate and ensuing recession has resulted in a shrinking productive sector. The situation even contrasts with some economic theories like the Phillips curve cited in Hoover (2002) which states that there is a negative relation between inflation and unemployment, so that when inflation is high unemployment has to be low and vice-versa. According to Pembrey (2006) unemployment in December 2005 was estimated to be about 80 percent. Borrowing rates are very high and unpredictable. The looming foreign currency shortage has given birth to a parallel market that sees foreign currency

traded at very high rates outside formal channels of the economy. This has led to a shortage of basic commodities, especially those that require foreign currency.

In light of the above-mentioned factors the cost of living for 'an ordinary man' has risen considerably making it impossible for him to afford medical expenses. This is also true of HIV/AIDS patients. In 1999, the government introduced an AIDS policy, which required formally employed people to pay an AIDS levy from their salaries and wages (Pembrey, 2006). This levy was to help the HIV/AIDS orphans as well as to provide HIV/ AIDS infected people with free drugs, notably Anti-Retroviral drugs.

The harsh political, social, and economic climate, the shortage of foreign currency and presence of corruption have affected AIDS policy implementation such that it has failed to meet its set objectives. The UNICEF Report (2005) states that in Zimbabwe only 8 percent of the 321 000 people in need of Anti-Retroviral drugs are getting them. The report further states that some of the Anti-Retroviral drugs meant for public hospitals are sold to pharmacies where they are sold at inflated prices. Another UNICEF Report, published in October 2006, stated that the market price of Anti-Retroviral drugs had quadrupled, thus making them inaccessible for those in need.

Most organisations are either relocating to neighbouring countries, or cutting down on their production, retrenching some employees, or even shutting down completely. The political instability in the country is discouraging foreign investment. The few remaining organisations struggle to survive. Some organisations are neglecting the welfare of their workforce, especially those infected or affected with HIV/AIDS. The situation has left employees who are infected with the HIV/AIDS pandemic vulnerable indeed.

## **1.2 Problem Statement**

The HIV/AIDS pandemic has a devastating effect in Zimbabwe as in most countries of Southern Africa. The situation is worsened by a harsh politico-socio-economic climate characterised by looming shortage of foreign currency, a hyper-inflationary rate, negative economic growth, and excessively high borrowing rates. An AIDS policy that was put in place by the government in 1999 failed to achieve its results because AIDS drugs are not available. The international community especially from the European Union has put sanctions on Zimbabwe and has withdrawn donations to the impoverished country because of policy differences. Organisations in the productive sector are either closing down or fighting for survival such that the welfare of employees who are infected by the HIV/AIDS pandemic has been neglected. This has prompted the researcher to assess the situation in organisations and to report the findings of the status quo in Zimbabwe.

## **1.3 Objectives of the study**

The study is guided by the following objectives:

1. To determine whether organisations in a highly volatile environment do have AIDS programmes.
2. To establish the costs of having HIV/AIDS programmes in the workplace.
3. To enhance knowledge and deeper understanding of the management of HIV/AIDS programmes at the workplace
4. To identify the impact of not having HIV/AIDS programmes.



#### **1.4 Significance of the study**

The study is important, as it will provide knowledge and deeper understanding of the management of HIV/AIDS programmes at the workplace.

HIV/AIDS is the greatest threat to life, liberty, and the pursuit of happiness and prosperity in many African countries. Interventions, therefore, must be quantitatively and qualitatively commensurate with the magnitude of the threat posed by the disease (De Cock *et al* (2002) cited in Nattrass, 2004: 23). The HIV/AIDS pandemic affects mostly younger people in any economy (ages between 15 and 49); this is the age group at the prime of their working career. Therefore, the development of management programmes at work is significant in promoting awareness, prevention, and care among the already infected at the workplace. Furthermore, in the end, HIV/AIDS can have a big impact or has already made an impact in most organisations, as great skill have been lost. In a highly volatile environment there is a very high brain drain; hence, effective HIV/AIDS programmes may help to retain or even attract skilled employees as they appreciate an organisation that caters for their welfare.

#### **1.5 Delimitation of the study**

The study was limited to some industries in Harare. The reason for choosing Harare is that it is the capital city of Zimbabwe, where the environment is highly volatile, and HIV/AIDS rife. Most of the industries in the country have their offices in Harare. Although the study was limited to industries in Harare, the findings from these selected industries provides significant insights as to how HIV/AIDS programmes are being run in the whole country since the environment is similar countrywide.

### **1.5.1 Size of the Organisations**

Delta Corporation, which is a market leader in the beverage industry, employs four thousand employees in its operations. CAPS Pharmaceuticals employs five hundred employees. Two organisations are from the service sector, viz ZB Bank from the financial sector and the Edgars retail group with its thirty-two branches countrywide that employs two thousand five hundred people. ZUPCO a Government owned transport organisation was also included in the study. Finally the study also included the Public Service Commission a government Ministry that is in charge of personnel issues for civil servants.

### **1.5.2 Types of the organisations**

Six organisations were looked at in order to study how organisations in different sectors of the economy in a turbulent environment where HIV/AIDS is also rife are carrying out HIV/AIDS programmes. The organisations included two manufacturing organisations, which are Delta Beverages and CAPS pharmaceuticals. Delta Beverages manufactures beverages, both alcoholic and non-alcoholic. It produces alcohol beverages, both clear beer and the traditional sorghum beer. In the non-alcoholic sector, it produces carbonated soft drinks and non-carbonated drinks under the label of Mr. Juicy. CAPS Pharmaceuticals produces pharmaceuticals, personal care, and veterinary products; it distributes the pharmaceutical products through its retail wing pharmacy. Two organisations came from the service sector; these are ZB Bank from the financial sector and Edgars from the retail sector. ZUPCO, a Government owned transport organisation was also included in the study. The Public Service Commission is a government Ministry that is in charge of personnel issues for civil servants.

### **1.5.3 Geographical Demarcation**

Delta Beverages has manufacturing plants in Harare, Bulawayo and in Kwekwe, but it has distribution depots nationwide. CAPS Pharmaceuticals has its plant and offices in Harare but its distribution subsidiary, QV pharmacy, has branches in most towns countywide. ZB bank has its branches nationwide in most towns. Edgars has thirty-two branches countrywide and their head offices are in Harare. ZUPCO has its offices in Harare and in Bulawayo, and it provides transportation routes countrywide. The Public Service Commission has its offices in Harare but its operations run throughout the nation, as it is responsible for the welfare and human resources management of civil servants in the country.

### **1.5.4 Units of analysis**

In the study, data was collected from the top management, middle management, and the operational employees. Top management is the senior management in an organisation who give the organisation direction, vision, and its strategic edge. It is important to gather data from the top management because launching HIV/AIDS programmes, as stated by Achmat, cited in Irwin, Millen and Fallows (2003: 3) is a lifetime commitment as it will cost the organisation a great deal of resources as well as time and the fruits of these programmes are long term in nature. Hence, top management has to commit the organisation towards the programmes if they are to be successful.

Coakes (2003:215) defines middle management as a level that operate like entrepreneurs as they synthesize both tacit knowledge from senior executives and junior members and try to deliver the vision explicitly in terms of the creation of new products and service. Data is gathered from middle management, as these are the people who deal with the day-to-day running of the organisation and so they know exactly the impact that HIV/AIDS has on their organisation and how programmes should be structured to be effective. Operational employees

are the junior employees and the shop floor employees who work to achieve the organisational goal. The operational employees in most organisations make up the majority of the employees and they make up the young employees in the 15-49 age groups that are at risk of contracting the disease, as they are the most sexually active age group. Collecting data from the operational employees on HIV/AIDS programmes, helped with their perception on the effectiveness of the programmes.

### **1.5.5 Subjects of evaluation**

The concept of HIV/AIDS programmes can be understood from the following vantage points.

Global perspective of HIV/AIDS programmes at the workplace

Understanding the impact of HIV/AIDS on organisations in a volatile environment

Combating HIV/AIDS, using HIV/AIDS programmes at the workplace

### **1.6 Definition of Key concepts**

Human Immunodeficiency Virus is a tiny, invisible particle that works by attaching itself to a host cell then it attacks the immune system and destroys the biological ability of the human body to fight off opportunistic infections, such as tuberculosis (MoHCW, 2004: 4).

The South African Concise Oxford dictionary (2002) defines AIDS (Acquired Immune-deficiency Syndrome) as a disease, caused by a virus transmitted in body fluids, in which there is a severe loss of cellular immunity leaving the sufferer susceptible to infection and malignancy.

HIV/AIDS programmes are a planned series of events and or activities with a long-term aim of combating or reducing the impact or prevalence of HIV/AIDS.

Highly volatile environment refers to surroundings liable to change rapidly and unpredictably especially for the worse (South African Concise Oxford dictionary, 2002)

### **1.7 Outline of the dissertation**

Chapter 1: Introduction, problem statement and objectives of the study

Chapter 2: Global perspective on HIV/AIDS

Chapter 3: HIV/AIDS in a highly volatile environment of Zimbabwe

Chapter 4: Combating HIV/AIDS in the workplace

Chapter 5: Methodology

Chapter 6: Data Presentation

Chapter 7: Discussion of Findings

Chapter 8: Conclusions and Recommendations

### **1.8 Conclusion**

In this chapter the background information and the problem under investigation was presented. The next three chapters will review literature with respect to HIV/AIDS, A global perspective of HIV/AIDS, HIV/AIDS in a highly volatile environment, and HIV/AIDS at the workplace.

## **CHAPTER 2**

### **A GLOBAL PERSPECTIVE ON HIV/AIDS**

#### **2.0 Introduction**

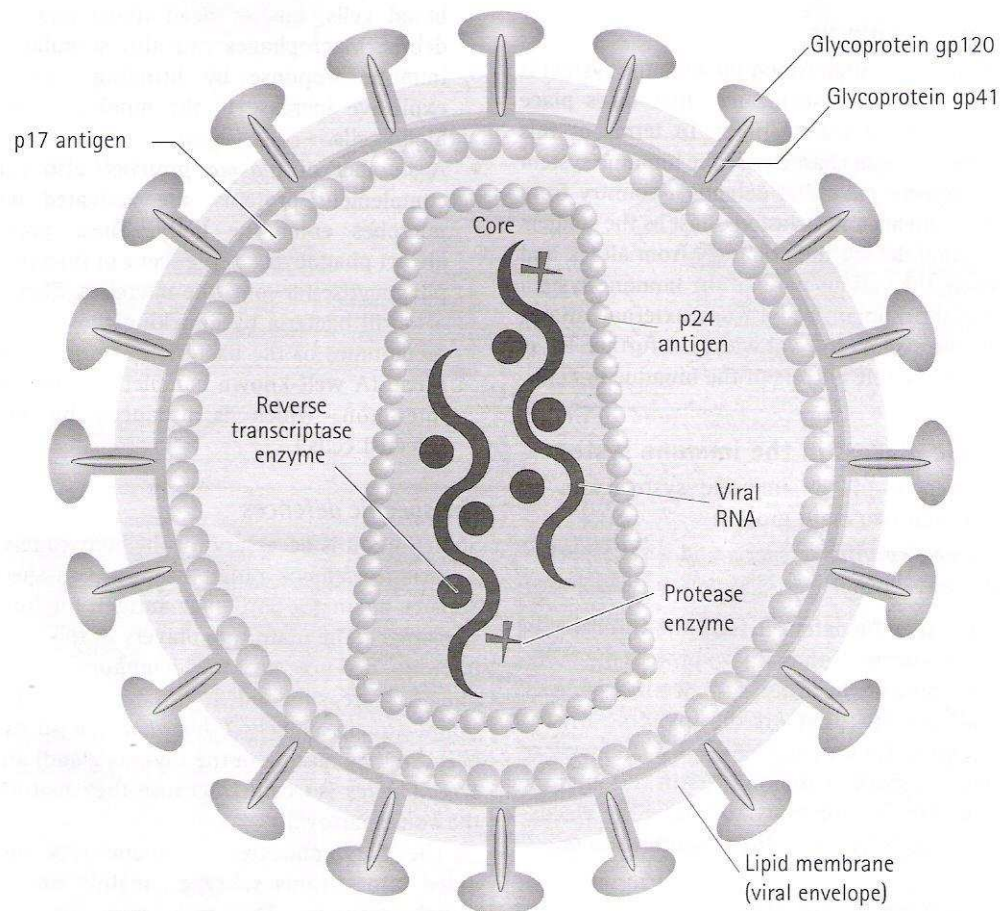
The previous chapter presented the background to the research area and the problem statement. This chapter seeks to give an overview of the relevant literature concerning the full understanding of HIV/AIDS, the global and regional trends of HIV/AIDS, and the prevalence in selected countries in Africa. It also includes a discussion of global organisations like the United Nations, World Bank and the International Labour Organisation and their views on HIV and AIDS.

#### **2.1 Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome**

Acquired immune deficiency syndrome or acquired immunodeficiency syndrome (AIDS) refers to a collection of symptoms and infections resulting from specific damage to the immune system caused by the human immunodeficiency virus (HIV) in humans, and similar viruses in other species (Dyk, 2005:10). The late stage of the condition leaves individuals prone to opportunistic infections and tumours. Although treatments for AIDS and HIV exist to slow the virus' progression, there is no known cure for the disease. According to the Ministry of Health and Child Welfare (2004:5) HIV is transmitted through direct contact of a mucous membrane or the bloodstream with a bodily fluid containing HIV, such as blood, semen, vaginal fluid, pre-seminal fluid, and breast milk. This transmission can come by way of anal, vaginal or oral sex, blood transfusion, contaminated hypodermic needles, exchanges between mother and baby during pregnancy, childbirth, or breastfeeding, or other exposure to one of the above bodily fluids. On the next page, a model of the structure of the HI virus is shown. Like other viruses, HIV can reproduce itself only by becoming a 'parasite' inside a living cell.

What makes the HI virus so dangerous is that it directly attacks and hijacks the most important defensive cells of the immune system, the CD4 or T-cell (Dyk 2005:11)

Figure 2.1 Model of the structure of the HI virus



Source: Dyk, 2005: 11

AIDS is the most severe acceleration of infection with HIV. HIV is a retrovirus that primarily infects vital organs of the human immune system such as CD4<sup>+</sup> T cells (a subset of T cells), macrophages and dendritic cells. It directly and indirectly destroys CD4<sup>+</sup> T cells. CD4<sup>+</sup> T cells are required for the proper functioning of the immune system. When HIV kills CD4<sup>+</sup> T cells so that there are fewer than 200 CD4<sup>+</sup> T cells per micro litre (µL) of blood, cellular immunity is lost, leading to the condition known as AIDS (Dyk 2005: 10) . Acute HIV infection progresses over

time to clinical latent HIV infection and then to early symptomatic HIV infection and later to AIDS, which is identified because of the amount of CD4<sup>+</sup> T cells in the blood and the presence of certain infections.

According to a Wikipedia article, in the absence of antiretroviral therapy the median time of progression from HIV infection to AIDS is nine to ten years, and the median survival time after developing AIDS is only 9.2 months on average. However, the rate of clinical disease progression varies widely between individuals, from two weeks up to 20 years. Many factors affect the rate of progression. These include factors that influence the body's ability to defend against HIV such as the infected person's general immune function. Older people have weaker immune systems, and therefore have a greater risk of rapid disease progression than younger people have.

Poor access to health care and the existence of coexisting infections such as tuberculosis also may predispose people to faster disease progression. The infected person's genetic inheritance plays an important role and some people are resistant to certain strains of HIV. An example of this is people with the CCR5-Δ32 mutation who are resistant to infection with certain strains of HIV. HIV is genetically variable and exists as different strains, which cause different rates of clinical disease progression. The use of highly active antiretroviral therapy prolongs both the median time of progression to AIDS and the median survival time (Wikipedia encyclopaedia).

## **2.2 Global and regional trends of HIV/AIDS**

The HIV/AIDS pandemic has evolved in different ways in different parts of the world, and at varying speeds. In many regions, it is still in its early stages. UNAIDS (2002:40) states that at the end of the year 2001, the global total number of people living with HIV/AIDS was estimated to be 40 million: just under half of them are women, and about 8 per cent are children. HIV/AIDS caused the



deaths of 3 million people during 2001 and, despite widespread prevention measures 5 million new cases were reported.

### **2.2.1 Latin America and the Caribbean**

The Caribbean is the region with the second highest infection rates; adult HIV prevalence is 2 per cent. In certain countries, such as Haiti and the Bahamas, it has reached over 4 per cent. UNAIDS (2007:43) states that fifty per cent of infections are among women in the Caribbean, and 30 per cent in Latin America. Brazil's comprehensive programme of prevention and care, including access to antiretroviral drugs, is resulting in falling rates of mortality and of new infections. Abreu, Noguer and Cowhill (2003:5) state that the HIV/AIDS epidemic in Latin America is concentrated in specific high-risk groups with the exception of Honduras and south-eastern Brazil where it has reached the general population.

Heterosexual sex is the main mode of transmission in Central America; in South America sex between men dominates; and drug injection plays a significant role in the Southern region (Abreu *et al*, 2003:5). The number of males living with AIDS exceeds the number of females in all countries, but the gender gap is closing due to the increasing rate of infection identified among women in their 20s, which suggests that adolescent girls are at high risk. Abreu *et al* (2003:144) further state that in all Latin American countries, sexual activity is the most prevalent way HIV is spread, which means that it is critical to have interventions focused on decreasing the risk of infections for men who have sex with men (MSM), commercial sex workers CSWs and people with sexually transmitted infections and multiple partners.

The National Institute of Health (2000) cited in Abreu *et al* (2003:144) lists the strategies that have proved their effectiveness. These strategies include counselling, health education, condom use promotion, promotion of HIV testing, management of STIs and promotion and conservation of human rights.

### **2.2.2 Eastern Europe and Central Asia**

This region is experiencing the fastest rate of new infections, especially Russia and the Ukraine. With high levels of other STIs and intravenous drug use it is likely, that prevalence will continue to rise. About 20 per cent of those living with HIV/AIDS are women (UNAIDS 2007:45).

### **2.2.3 Asia and the Pacific**

The relatively low prevalence rates in this region are deceptive as the numbers involved are large and there are areas of high prevalence, especially in cities. Approximately seven million people are infected. China's health ministry has estimated that 600,000 people were living with HIV/AIDS in 2000 and localized epidemics are increasingly common. Although India's adult prevalence rate is not exceptionally high at 0.8 per cent (end of 2001), the absolute numbers involved are large. The epidemic is concentrated in a small number of States so far. Thailand has successfully reduced annual new infections from around 100,000 in the early 1990s to about 30,000 in 2001. In 1993, one report estimated that the annual infection rate could reach over half a million by the end of the decade. Nevertheless, an estimated 700,000 Thais are living with HIV/AIDS today and it remains a major health and social issue. In East Asia and the Pacific, women make up 20 per cent of those living with HIV/AIDS, while in South and South East Asia the rate is 35 per cent (UNAIDS 2007:46).

### **2.2.4 Western Europe, North America, Australia and New Zealand**

Resurgence is being experienced in high-income countries with 75,000 people newly infected in 2001. According to UNAIDS (2002:46) between 10 and 25 per cent of those living with the disease are women.

### **2.2.5 Sub-Saharan Africa**

This region has the highest prevalence in the world, with an average of 8.4 per cent of the population infected. At 28.1 million, the region has more people living with HIV/AIDS than all the other regions of the world put together; about 55 per cent are women. UNAIDS (2002:47) states that, the recent antenatal clinic data suggest that several countries in southern Africa have adult prevalence rates exceeding 30 per cent. However, there are signs of hope-HIV prevalence is continuing to decline in Uganda, for example, and it remains relatively low in several parts of West Africa.

#### **2.2.5.1 HIV/AIDS in South Africa**

The total population of South Africa is estimated to be 47, 432,000 and an estimated 5,500,000 people, or 11.5 percent of the total population are HIV-positive, (Parker 2007:52). According to Dyk (2005:7), in South Africa, 2002 surveillance data show that countrywide, the average rate of HIV prevalence in pregnant women attending antenatal clinics has remained roughly at the same high levels since 1998 - ranging between 22 percent and 23 percent in 1998-1999 and then shifting even higher to around 25 percent in 2000-2002. In 2003 an estimated 21.5 percent of South Africans aged 15-59 were HIV-positive, with over a thousand people dying each day of AIDS (Nattrass 2004:19).

A slight decline in prevalence among pregnant teenagers was offset by consistently high HIV levels among those aged 25-34. In five of South Africa's nine provinces, including those with the biggest populations, at least 25 percent of pregnant women are now HIV positive. The epidemic varies within South Africa: in KwaZulu-Natal HIV prevalence among those who attend antenatal clinics is almost 37 percent about three times higher than in the Western Cape, the province with the lowest prevalence (Nattrass 2004:19). Based on surveillance of antenatal clinics, it is estimated that 5.3 million South Africans

were living with HIV at the end of 2003. Current trends indicate that AIDS deaths will continue to increase rapidly over the next five years at least. According to Singhal and Rogers (2003: 140), President Mbeki was against the use of antiretroviral treatment because a few years ago when he was surfing the internet he encountered the dissident ideas of Dr. Peter Duesberg. Dr Duesberg is a professor of biochemistry and molecular biology at the University of California at Berkeley. In 1987, he published an article purporting that there was no sound evidence that HIV causes AIDS. Rather, he argued that addictive drugs (like heroin and cocaine), recreational drugs (like nitrites) and pharmaceutical drugs (like AZT and DDL) caused AIDS. The Former President of South Africa Mr. Thabo Mbeki was so enamoured with Duesberg's theory that he appointed him with other scientists, to advise him on the HIV-AIDS connection.

According to Natrass (2004:13), the South African government finally bowed to public pressure and announced its support in, principle, for public-sector provision of Highly Active Antiretroviral Treatment Therapy (HAART), in August 2003, after many years of resistance and prevarication. If the treatment is offered rapidly and on a large scale, this has the potential to ameliorate the impact of AIDS substantially. However, the treatment 'roll out' will take time, and given the government's ongoing concerns about 'affordability', it is unlikely to reach many (if not most) of those who need it (Natrass 2004:13). The burden of AIDS will thus continue to be borne unevenly in South Africa largely because of the high unemployment rate and the strong connection between unemployment, poverty, and HIV infection.

Many people in South Africa cannot afford HAART; a small, but growing number can access it through their companies or medical schemes, which will enable them to live longer, live more productive lives so as to cushion the impact of AIDS on economic growth. Until the public sector HAART programme can reach significant numbers of poor people living with AIDS, the income gulf between the

employed and the unemployed will continue to harden into a socio-economic divide bringing life to one side and death to the other (Nattrass, *ibid*).

There has been a debate on whether people are prepared to pay higher taxes order to support a large-scale treatment intervention that reaches all who need it. However, the discourse of affordability and cost effectiveness effectively insulates the AIDS policy debate from any discussion of raising the additional revenue through taxation. According to Farmer et al (2004) cited in Nattrass (*ibid*: 17) "There is an unmentioned elephant in the conference rooms of many scientific meetings: the prospect of providing HAART to those living with both poverty and HIV". Economic cost-effectiveness studies have attempted to estimate the size of this 'unmentioned elephant' by showing that the marginal dollar spent on prevention delivers a better dividend in terms of HIV-infections averted than the marginal dollar spent on treatment.

However, these studies do not grapple adequately with the link between AIDS treatment and prevention. Providing HAART to people with AIDS helps prevent new infections for two reasons: it lowers their viral load, thereby making them less infectious and if HAART is available, more people are likely to participate in voluntary counselling, and testing, which in turn is likely to promote safer sexual behaviour (Nattrass, 2004:18).

In South Africa, there are concerted efforts to fight the pandemic involving the government, non-governmental organisations, and the private sector. In the private sector HIV/AIDS workplace programmes are in place and organisations like DeBeers, BMW South Africa, and Daimler Chrysler South Africa provide their employees with Hyper-Active Antiretroviral treatment. However, the Mail and Guardian of 19 August 2008 states that the HIV prevalence is still very high in South Africa with 500,000 people being infected each year.

### **2.2.5.2 HIV AIDS in Botswana**

According to Parker (2007:30) the total population of Botswana is estimated to be 1 765,000, an estimated 270,000 or 15.3 percent of whom are HIV-positive. HIV prevalence varies considerably by age and gender, with young males aged 15-19 considerably less likely to be HIV-positive than females with a prevalence of 3.1 and 9.8 percent respectively. This pattern also persists in other age groups. For example, for 20-24 year-olds the comparative rates are 9.1 percent for males and 26.2 percent for females, and for 25-29 year-olds, 22.9 percent for males, and 41 percent for females. HIV prevalence in the 50-54 age group is 23.3 percent for men and 19.3 percent for women (Parker, 2007:30). HIV prevalence also varies with place of residence with Chobe (the highest) at 29.4 percent, Kgalagadi South at 11.8 percent and Kweneng West at 10.8 percent the (lowest) (Parker, 2007:30).

The national strategy for behaviour-change interventions and communications in Botswana builds on the National Strategic Framework for HIV/AIDS (2003-2009) and guides the national communication response. Decentralisation of the national response is being achieved through the development of multi-sectoral AIDS committees at the district and village levels (Parker, 2007:31). The Botswana Network of AIDS Services Organisations (BONASO) is an umbrella body of all AIDS service organisations in Botswana and was registered in 1997. Partnerships include Japan International Cooperation Agency (JICA) and the United Nations Fund for Women (UNIFEM). A radio drama called Makgabaneng ('Rocky Road') has been broadcast throughout the country in two 15 minutes episodes per week over two national stations since 2001.

Parker (2007:31) states that a cross sectional survey conducted in 2003 found that nearly half the respondents listened to the drama at least once a week and regular listeners are more open to HIV testing and knowing their status. USAID, the African Youth Alliance, BONASO, the National AIDS Coordinating Agency,

ACHAP, and the Botswana government have initiated a prevention programme linked to the Corridors of Hope project being implemented in other SADC countries. The Botswana-USA Project is a collaboration between the Botswana Ministry of Health and the CDC. This has worked since 1995 to implement AIDS and TB programmes. PSI has marketed Lovers Plus condoms since 1993 and Care female condoms since 2002.

In 2003, the government of Botswana, with funding from ACHAP, launched an extensive condom distribution and marketing campaign, installing 10,500 condom dispensers in traditional and non-traditional venues throughout the country. Talk back is a live interactive television programme aired weekly on Botswana television. It is a communication vehicle for teacher capacity building for HIV/AIDS prevention in Botswana (Parker, 2007:32). The programme allows post-broadcast discussion and it reaches teachers and students in nearly 1 000 educational institutions.

HIV/AIDS prevalence is 15.3 percent. It implies that every one person in seven is infected. There are concerted efforts to try to combat the pandemic, partnerships have been created and programmes about HIV/AIDS are being run on national radio and television stations. The government has even made efforts to reach the teachers who are civil servants. This shows that the public sector has HIV/AIDS programmes in place; however, nothing has been mentioned about efforts by the private sector to combat the pandemic in the workplace or in the community.

#### **2.2.5.3 HIV/AIDS in Kenya**

In Kenya the population is estimated at 34,256,000, while an estimated 1 300,000 people or 3.8 percent of the total population are HIV-positive (Parker, 2007:39). Parker (2007:39) states that HIV prevalence among males and females aged 15-49 varies by province, ethnicity, and religion. Parker *ibid* states that prevalence by province ranges from 0 percent in the North Eastern and 4

percent in the Eastern to 15.1 percent in Nyanza; by ethnicity, from 1.3 percent for Somalis to 21.8 percent for the Luo; and by religion from 2.9 percent for Muslims to 6.9 percent for Catholics and 7.0 percent for Protestants/ other Christians.

PSI has promoted Trust condoms since 2004 and condom use has increased rapidly in recent years. The Kenyan Government under the World Bank has supported distribution funded Decentralised AIDS and Reproductive Health project of the Ministry of Health. The Kenyan Network of Religious Leaders Living with and or affected by HIV/AIDS and the Organisation of African Instituted Churches received grants from the communities. Responding to the HIV/AIDS Epidemic (CORE) initiative, a USAID-funded global programme (Parker, 2007:42).

In 2005, PSI formed an alliance with 39 churches to involve them in preventive communication and it launched a campaign called Ni poa ku chill (slang for 'I am abstaining or I have chilled'), addressing 10-14 year olds (Parker 2007:41). Africa Alive has initiated postcards that encourage youth groups, churches, and school pupils to have their stories about HIV/AIDS published on a website. The Kenya Association of Professional Counsellors with a focus on productive health and HIV/AIDS initiated Straight Talk in 1996. Some of the donors in HIV/AIDS programmes in Kenya include HIVOS, UNICEF, the Ford Foundation, FHI/USAID, PATH, the European Union, FPIA and Equality Now (Parker, 2007:42).

In Kenya, there a number of HIV/AIDS programmes being run and financed by various organisations; both government and non-governmental organisations have come together in the fight against the epidemic. However, nothing has been mentioned on the contribution of the private sector towards the fight against HIV/AIDS or about HIV/AIDS workplace programmes in Kenya.



#### **2.2.5.4 HIV/AIDS in Mozambique**

Parker (2007:46) states that the population of Mozambique is estimated to be 19,792,000 and an estimated 1 800,000 people, or 9.1 percent of the total population are HIV-positive. Antenatal HIV prevalence is 16.2 percent with an urban-rural population ratio of 33:67. The HIV prevalence varies between provinces 5-7 percent in the northern region, 10-16 percent in the southern region and 13-21 percent in the central region.

In 2002, the National AIDS council of Mozambique initiated a five year national programme to offer hope to people living with or affected by HIV via the theme 'Yes, I can! So can you! (Parker, 2007:47). In 2005, the World Bank provided support to Mozambican media to foster coverage of counselling and advocacy. The Department for International Development (DFID) is one of the largest donors in Mozambique. It provides technical advice and funding in the areas of governance, education, education, health, HIV and infrastructure. Parker (2007:47) writes that the PSI promotes HIV/AIDS awareness, condom use and partner reduction, through a network of community-based agents and theatre groups. The audience include miners, migrant workers, truckers, and other mobile populations, at risk women and youths.

Parker (2007:47) also states that PSI has collaborated with the Ministry of Defence to develop a peer educational programme for military personnel and police services. Clearly in Mozambique, there is a lot of donor support. The idea of HIV/AIDS workplace is being brought up by PSI that has even collaborated with the Ministry of Defence. However, nothing has been stated about the role of the private sector implementing workplace programmes or collaborating with the government or non-governmental organisations in fighting the pandemic.

**Table 2.1 Global HIV/AIDS Statistics in 2001**

<b>Region</b>	<b>Total number of people living with HIV/AIDS 2001</b>	<b>People newly infected during 2001</b>	<b>Deaths due to HIV/AIDS during 2001</b>
Sub-Saharan Africa	28 500 000	3 500 000	2 200 000
Asia & Pacific	6 600 000	1 070 000	435 000
Americas and the Caribbean	2 870 000	235 000	115 000
Europe and Central Asia	1 550 000	280 000	31 000
North Africa and the Middle East	500 000	80 000	30 000
Australia and New Zealand	15 000	500	<100

Source: UNAIDS, Report on the global HIV/AIDS Epidemic 2002

From figure 2.1 above it is evident that HIV/AIDS has affected the whole world hence it has become a global crisis as it is affecting all the regions, however some regions, for instance Sub-Saharan Africa have been the hardest hit. With 28.5 million people in Sub-Saharan Africa living with HIV/AIDS there is a need for concerted efforts from all global organisations like the United Nations, International Labour Organisations, Global trade Unions, there is also a need for; governments and the corporate sector to work together in order to combat the effects of the pandemic. Zackie in Irwin, Millen and Fallows (2003:2) writes that leaving the situation in sub Saharan Africa without doing anything to help ease

the situation amounts to a holocaust for the poor, as the effects will be devastating.

### **2.3 United Nations and HIV/AIDS**

While the political leadership in most developing countries took long to accept the problem of HIV/AIDS, or at best was apathetic to it, the then Secretary General of the United Nations Laureate Kofi Annan made the fight against HIV/AIDS his personal priority (Singhal and Rogers 2003:122). Annan mobilised world leaders to join hands to address the global pandemic. The UN Security Council General Assembly session on HIV/AIDS was the first such session ever to prioritise HIV/AIDS as a global security issue in June 2001, when a special UN Assembly was devoted solely to a health issue. Singhal and Rogers (2003:122) further state that the UN special session brought delegates from 180 countries, 350 NGOs and 24 heads of state to New York, where a global declaration of commitment to combat HIV/AIDS was made. The world community was asked by Annan to raise \$7-10 billion (US) each year for ten years.

The Joint UN programme UNAIDS was created. It is a partnership among eight UN agencies, to integrate intervention efforts under a unified budget and work plan. Grant *et al* (2001:72) state that the UNAIDS international guidelines on HIV and AIDS and Human Rights advise governments that “general anti-discrimination laws should be enacted or revised to cover people living with asymptomatic HIV infection, people living with AIDS and those merely suspected of HIV or AIDS. Such laws should also protect groups made more vulnerable to HIV/AIDS due to the discrimination they face”. UNAIDS is headed by a Belgian medical doctor, Dr. Peter Piot. The current Secretary General of the United Nations Mr. Ban Ki Moon has continued with the global advocacy on combating HIV/AIDS.

## **2.4 International Labour Organisation and HIV/AIDS**

Poku and Whiteside (2004:155) state, “no country, sector, or individual is unaffected ....” The statement suggests that the whole world has been affected by the HIV/AIDS pandemic in one way or the other so it calls for international attention, also from the world labour authority. The International Labour Organisation (ILO) is the UN specialised agency that deals with the world of work. Each part of the UN system is responsible for a particular area its 'mandate' or mission. The ILO's mandate is to promote social justice and equality, set standards in employment, and improve working conditions. Vocational training, employment creation, child labour, workers' rights, social security, and safety and health at work are some of the ILO's issues.

Like all UN organisations, the ILO is financed by member states. Countries join the ILO separately from the UN. The ILO has 175 member states. The ILO is actually older than the United Nations. It was set up by the Treaty of Versailles, which marked the end of the First World War, in 1919. It became the first UN Specialised Agency in 1946. The ILO Constitution speaks of a “universal and lasting peace that can only be established if it is based upon social justice.” The ILO is unique within the UN because of its tripartite structure that includes employers' and workers' organisations, as well as governments. Each member state sends four delegates to the ILO Conference, which meets every year. Two represent the government, one represents the employers and one the trade unions. The ILO Governing Body is composed in the same way.

The International Labour Organisation has set up a Code of Conduct on HIV/AIDS in the world of work; this code is the framework for action related to the workplace. The International Labour Organisation code of conduct contains key principles and practical guidelines for programmes at enterprise, community and national level (ILO, 2007).

Among the key principles in the code are that it realises HIV/AIDS as a workplace issue not only because it affects the workforce, but also because the workplace, being part of the local community has a role to play in the wider struggle to limit the spread and effects of the epidemic. The code also emphasises non-discrimination on real and perceived HIV/AIDS status and views such behaviour as a hindrance to efforts aimed at promoting HIV/AIDS prevention. Successful implementation of HIV policies and programmes are also encouraged through a participatory approach and social dialogue between the employers, employees, the representatives, and even the government with an active involvement of infected and affected workers.

Confidentiality of employees' status is of paramount importance for an effective fight against unfair discrimination and in the light of this, the code states that there is no justification for asking job applicants or workers to disclose their HIV related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO code of practice on the protection of workers' personal data, 1997.

The issue of continuity of a work relationship after one is discovered to be HIV/AIDS positive is also mentioned in the code. Special emphasises was made that HIV infection is not a cause of termination of employment as with many other conditions. Persons with HIV related illnesses should be able to work for as long as they are medically fit, to do appropriate work, states the ILO code on HIV/AIDS.

The ILO code also pinpoints gender dimensions of HIV/AIDS that have to be recognised. It states that women are more likely to become infected by the HIV/AIDS pandemic than men due to biological, socio-cultural, and economic reasons. The code further states that the greater the gender discrimination in societies and the lower the position of women the more negatively they are

affected by HIV. Therefore, governments and organisations worldwide are urged to take a more equitable gender stance and to empower women to successfully prevent the impact of HIV infection and to enable women to cope with the HIV/AIDS pandemic.

“In the spirit of good corporate citizenship, employers and their organisations should, where appropriate encourage fellow employers to contribute to the prevention and management of HIV/AIDS in the workplace and encourage governments to take all necessary actions to stop the spread of HIV/AIDS and mitigate its effect”, (ILO, 2002:8).

Therefore the International Labour Organisation advocates partnership between employers and their full contribution to HIV/AIDS programmes and it goes on to encourage governments and employers the world over to come into partnership to combat the deadly virus and to bring their resources into the fight against HIV/AIDS. The code is clearly relevant to the study of management of HIV/AIDS in the workplace.

#### **2.4.1 HIV/AIDS and Fundamental Rights**

Grant *et al* (2001:157) state that the Bill of Rights says everyone has the right to fair labour practices. AIDS threatens and undermines efforts to provide women and men with decent and productive work in conditions of freedom, equity, security, and human dignity. Many affected by HIV/AIDS have no social protection or medical help. The poor suffer disproportionately. Discrimination against HIV-positive persons (or even people suspected of carrying the virus) aggravates existing inequalities in society. Screening people for HIV infection in order to bar them from work deny them promotion or exclude them from social protection and benefits counts as AIDS-related discrimination. This also occurs

with breaches of confidentiality or refusal to establish alternative workplace arrangements for workers with HIV/AIDS.

#### **2.4.2 HIV/AIDS and Child Labour**

HIV/AIDS is now a key factor affecting the care of children and the pattern of child labour across the world. AIDS is orphaning children. In addition, through their vulnerability to sexual exploitation, they are at risk of being infected by HIV. The ILO (2003:13) estimated that nearly 14 million children under the age of fifteen have lost their mother or both parents as a result of AIDS ninety-five per cent of them are estimated to be in Africa. This number could increase by 2010 to 35 million. The epidemic forces children out of school and forces them into child labour, often in exploitative and extremely hazardous forms of work.

Young female orphans are especially vulnerable to sexual exploitation. When an adult in a family becomes ill with AIDS-related illnesses, children, especially girls, are likely to have to take on more household tasks or to seek income-generating work in order to make up for lost income and to help pay for medical expenses(ILO, 2003:13). They will probably have to leave school. High school dropout rates are high while the level of qualifications and skills in the workforce is falling. Girls are being driven into commercial sexual exploitation at an ever younger age, often as a result of myths such as, that intercourse with a virgin can cure a person of infection or simply because clients hope that a younger person is less likely to be infected, which increases the risks for the girl child.

#### **2.4.3 Gender, Work and AIDS**

Gender inequality linked to patterns of social, economic, and cultural inequality makes women more vulnerable to infection. The situation is made worse by biological differences between men and women. As the epidemic spreads, women are faced with the double burden of having to work and cope with the

additional responsibilities of providing care and support for family and community members who fall ill. Most women are still confronted with limited access to secure livelihoods and socio-economic opportunities. This increases their dependence on male partners and their vulnerability in situations where there are risks of HIV infection. Men, too, are subject to social and cultural pressures that increase their susceptibility to infection and their likelihood of spreading it. Multiple partners and sexual infidelity are condoned for men in many societies. Grant *et al* (2001:324) state that educational campaigns directed at men to make them aware that women have the right to refuse sex will reduce the risk of HIV transmission. Certain occupations tend to encourage risk-taking behaviour, especially those that involve men spending long periods away from their families. This in turn increases the risk of infection for their partners when they return home. At the workplace organisations could increase the education campaigns about gender equity and HIV awareness and try to reduce the time that married people spend away from their families in order to combat the epidemic.

#### **2.4.4 Workplace Action through Social Dialogue**

The ILO (2003:2) defines a social dialogue as all types of negotiations or exchange of information between or among governments, employers, and workers on issues of common interest. The British Trade Union Congress as cited in by the ILO (2003:2) defines social dialogue as recognition that although [employers and trade unions] have different constituencies and at times different interests, they can serve these best by making common cause wherever possible. These definitions therefore state that in most areas employers and trade union disagree, and have opposing views, but in the fight against HIV/AIDS there should be minimum disagreement. The issue of HIV/AIDS is so serious that both employers' and workers' organisations recognise the need for swift action and the advantages of consensus. They should try to resolve any difficulties in a spirit of compromise. Working together on the issue may even improve labour relations.



The table 2.2-titled 'Workplace action through social dialogue' shows the level, the form and the subject of dialogue as well as the representatives for the employers and employees.

**Table 2.2 Workplace action through social dialogue**

Level	Forms and subjects of dialogue	Stakeholder on the workers' side	Stakeholder on the employers' side
Enterprise	<p><b>Mutual support</b> in development of non-discriminatory policies and practices</p> <p><b>Collaboration</b> in assessing impact of HIV/AIDS on the workplace, in advocacy and prevention campaigns, in risk reduction and management, and in efforts to encourage confidential voluntary testing.</p> <p><b>Consultation</b> on the development and implementation of an HIV/AIDS policy, on information, education and training programmes, on measures to reasonably accommodate workers with AIDS-related illnesses, on ensuring that factors entailing the risk of infection are addressed, on the elaboration of educational strategies and on the establishment or extension of employee assistance programmes.</p> <p><b>Negotiation of agreement</b> including provisions on protection and prevention</p> <p><b>Action to set up</b> conflict resolution mechanisms for issues related to discrimination concerning HIV/AIDS</p>	Workers' representatives	Employer
Enterprise Community (including) Partnerships with local associations and NGOs)	<b>Collaboration</b> in advocacy campaigns to support and encourage confidential voluntary testing	Local union or workers' association.	Local association of employers or chamber of commerce

Social dialogue serves to establish a common approach for effective action. Employers, workers and their organisations have a vital role to play in the fight against HIV/AIDS. It is in the interest of both groups to save the lives of the employees and to help the infected and affected employees stay as long as possible. Employers face the challenge of managing the impact of the epidemic at the workplace, including the loss of skilled and experienced employees, disruptions to production schedules, rising labour costs, and falling productivity. Trade unions, long concerned with the rights and working conditions of the labour force, now face the challenge of protecting the livelihood, health and lives of workers and their families from the threat of AIDS. Each group has its network and structures to inform and mobilise. Both, with concerted effort, can prevent the spread of the disease by protecting the livelihood, health and lives of workers and their families against the threat of AIDS.

Social dialogue can operate at all levels, in small enterprises as well as multinationals (ILO 2003: 2). It can be bilateral, between employers and workers, or tripartite, between government, employers and workers. The advantages of an agreed policy rather than one of management only published are as follows; an agreed policy demonstrates that both union and management are committed to dealing with the problem of HIV/AIDS in the workplace, an agreed policy is likely to be more effectively implemented, and the process of consultation helps to identify areas of disagreement and to resolve them. Furthermore, an agreed policy can clarify how the policy fits in with joint agreements that regulate workplace relations.

Designing HIV/AIDS programmes using social dialogue receives support from all the social partners. The International Organisation of Employers (2002:5) writes that it is imperative for business to respond to HIV/AIDS for its own benefit and that of its broader stakeholders. The early action will reap tremendous savings in

both economic and human terms. Therefore, the issue of social dialogue is of paramount importance in dealing with HIV/AIDS issues since it makes all the concerned parties to cooperate and it clears the grey areas of possible disagreements by solutions that may result in a win-win situation for all the parties concerned.

## **2.5 World Bank on HIV/AIDS devastating impact on development**

The HIV/AIDS epidemic is not only the most important public health problem affecting large parts of sub-Saharan Africa, but also an unprecedented threat to the region's development. It is, therefore, a development crisis (World Bank, 2000:6). The World Bank is mainly disturbed by the long-term nature of the HIV/AIDS epidemic's impact on life expectancy, which makes it an unprecedented catastrophe in the world's history. In nine African countries with adult prevalence of 10 percent or more it is said that HIV/AIDS will erase 17 years of potential gains in life expectancy. This means that instead of reaching 64 years, by 2010-2015 life expectancy in these countries will regress to an average of just 47 years; this represents a reversal of most development gains of the past 30 years –affecting the entire generation (UNAIDS (1998) cited in World Bank 2000:7).

While HIV/AIDS is clearly a health problem, the world has come to realise it is also a development problem that threatens human welfare, socio-economic advances, productivity, social cohesion, and even national security. HIV/AIDS reaches into every corner of society, affecting parents, children and youth, teachers and health workers, rich and poor.

The World Bank in partnership with others is working to reduce the spread of this global epidemic. As the largest long-term investor in prevention and mitigation of HIV/AIDS in developing countries, the World Bank is working with its partners to:

- Prevent new HIV infections;
- Expand treatment and care for people infected and affected by HIV/AIDS.
- Support countries to strengthen their health systems; develop and implement effective, evidence-based national HIV and AIDS strategies and action plans, build well-functioning monitoring and evaluation systems; and use multi-sectoral approaches (e.g. working in education, social safety nets, transport and other vital areas).

## **2.6 Trade Unions on HIV/AIDS**

Employee representative bodies have also joined in the fight against the HIV/AIDS due to the devastating effect the pandemic has had on their members. The fight ranges from the trade unions to their international controlling bodies. The International Trade Union is a vast membership organisation with a presence in countries throughout the world, whose agenda is to promote the interests of working people throughout the world. In December 2003, on World AIDS Day, the International Trade Union movement launched a global campaign on HIV (ILO Report, 2006). At the launch, the global unions agreed to join forces so that the combined strength of their mass organisations could be the basis for an unprecedented worldwide response the disease.

Trade unions in most countries have lived up to their word as they have initiated policies and programmes to help their members in the work place. An ILO Report (2006) states that a case study carried out by the International Labour Organisation of eleven trade unions shows that the unions have mounted bold imaginative responses to HIV/AIDS in the workplace. The Trade Unions are

challenging stigma and discrimination, are addressing the factors that increase vulnerability and risk, are providing care and treatment, are educating their members on prevention and are building worldwide coalitions that lobby governments and employers for more robust commitment in responding effectively to the disease (ILO Report, 2006).

### **2.6.1 The impact of HIV/AIDS on trade unions**

Trade unions in several countries have already lost their key staff and activists at national and branch level. Most unions in developing countries have limited resources; they invest what they can in the training and development of core staff and workplace representatives. The loss of these persons has affected how unions are able to organise and support their membership effectively. In Zimbabwe in the 1990s, the mineworkers union (AMWZ) lost almost 90 per cent of its organising staff and its national education officer. The IUF, the global union federation representing food, hotel and plantation workers, reports an increasing loss of trade union leaders amongst its affiliated unions. Unions in countries with high prevalence rates have to consider how they can best assist with programmes of prevention and care and ensure that workers are not subject to discrimination. They must also consider the direct effects of the epidemic on their own organisations.

## **2.7 Conclusion**

In this chapter, literature was reviewed concerning the HI virus and how it affects individuals, how it is spread and how it can be slowed down from killing people fast through antiretroviral treatment. A global perspective with respect to HIV/AIDS prevalence was taken to show the different prevalence rates in different continents and countries and the various programmes being

implemented to combat the epidemic. World governing bodies were also reviewed and their contributions towards combating HIV/AIDS.

## **CHAPTER 3**

### **HIV/AIDS IN ZIMBABWE**

#### **3.0 Introduction**

This chapter seeks to review literature on HIV/AIDS in Zimbabwe. It seeks to establish the historic background of HIV in the country, takes account of the general statistics, and asks how the volatile environment affects and contributes the impact on the impoverished nation. The chapter also presents the AIDS Impact Model and projections according to it for Zimbabwe.

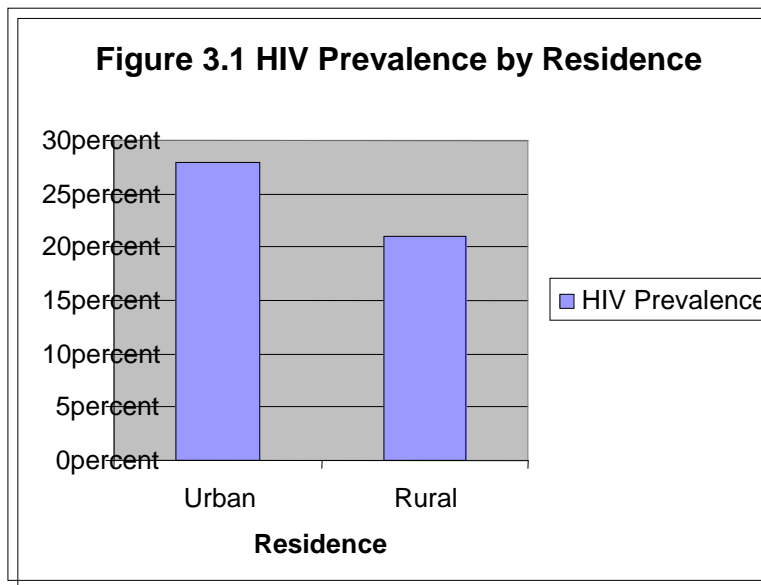
#### **3.1 Background information on HIV/AIDS in Zimbabwe**

An estimated 40 million people are living with HIV worldwide with about 26.6 million in sub-Saharan Africa (UNICEF, 2005). The HIV/AIDS pandemic continues to infect large numbers of Zimbabweans. An analysis by the Ministry of Health and Child Welfare, 2004 indicates that Zimbabwe has one of the highest HIV burdens with an HIV prevalence of 18.1 percent in 2006 and about 1.2 million persons infected. Parker (2007:66) noted a decline in HIV prevalence to 13.1 percent with 1 700,000 people being infected in an estimated total population of 13,010,000.

Zimbabwe was among the first countries to recognise the HIV and AIDS problem and to organise action on a national level to ameliorate HIV/AIDS effects. The first case of HIV tested positive in 1985 and screening of blood donors for HIV started in the same year. A programme to control HIV and AIDS was drawn up in 1987, led by the Ministry of Health, which emphasized prevention of transmission of the infection and surveillance of its spread. In 1999, Zimbabwe launched a national Aids policy, and the following year established a multi-sectoral National AIDS Council (NAC) to coordinate the overall HIV/AIDS response. A National

AIDS Trust Fund financed by a 3 percent levy on all income taxes paid to government was subsequently established to finance the national AIDS response.

It is estimated that among Zimbabweans between the ages 15-49, about one out of four is already HIV infected. In addition MOHCW, (2004:20) states that if current prevalence were to persist into the future, about two thirds of today's 15-year-olds would die from this single disease. In trying to understand the HIV and AIDS epidemic in Zimbabwe the Ministry of Health and Child Welfare looked at prevalence by place of residence. The country was classified into three namely urban, rural, and other. The other category includes large-scale commercial farms, administrative centres, growth points, mining areas, state land, and army encampments. According to a research conducted by the MOHCW (2004:22) in urban areas the prevalence rate among 15-to 49- year-olds was about 28 percent; in rural areas, it was about 21 percent. Although the other areas category only accommodates 10 percent of the total population, adult HIV prevalence was estimated to be 35 percent.



Source: MoHCW 2004:23



### **3.1.1 Why is HIV/AIDS concentration high in urban areas**

Prevalence in urban areas is higher than in rural areas. This is because these areas are centres of employment and income generating activities so people can afford to pay for sex. This economic security encourages people to take risks or be promiscuous as a measure of success. Migration as a livelihood strategy leads to spousal separation and encourages casual sex. Overcrowding, poor service provision and social disillusionment can lead to unsafe sex as immediate survival needs must be met using the limited resources.

Male-female sex relations in urban areas result in transactional sex, sexual networking, and unequal power. Higher rewards for unsafe sex (without a condom or any protection) encourages risk taking. Urban areas are centres of services such as medicines, hospitals, education, water, and housing so they attract more people there.

The higher cost of living in the urban areas may encourage people to live in informal settlements where sexually transmitted epidemics readily spread. Urban areas are centres of social dislocation, exclusion and equality. HIV follows social division and patterns of inequality (compare male: female infection rates). While not all poor people are HIV infected, the majority of people living with HIV are poor. Poverty is a co-factor In Sub Saharan Africa. The poorer areas and informal settlements have a higher prevalence. Urban areas are areas of social change. Diversity leads to anonymity and change in norms, values and practices including sexual behaviour.

### **3.2 Reasons for High HIV/AIDS prevalence in Zimbabwe**

HIV/AIDS is primarily spread in Zimbabwe by heterosexual contact; therefore, enough sexual networking has to take place to sustain the epidemic (MOHCW, 2004: 23). Gomo (2004: 5) states that “a sex network is a complex map or web of

sexual relationships or patterns which bring many partners of a diverse background, status, behaviour, and other attributes into direct (or immediate) and indirect (or remote) sexual contact. In support of the idea that sex networking has been the primary cause of the wide spread of the pandemic. Gomo (2004:6) gives a scenario that has been happening in Zimbabwe, which gave rise to the networking process. He writes that young women often have two types of partners: one, an older boyfriend who has accumulated assets and is able to provide money and gifts, the other, slightly younger, being cultivated as a potential husband.

The Ministry of Health and Child Welfare (MoHCW) (2004:23) cites low levels of male circumcision among the causes of the high prevalence of HIV in the country. This sentiment is also shared by Garbus and Sakutukwa (2003:10) who wrote that there is very limited male circumcision in Zimbabwe where, they say it is practiced by the Xhosa ethnic group known as the amaFengu who live in some areas of Matebeleland. Strong international evidence suggests that HIV and other sexually transmitted infections are at a much higher rate in populations where a low proportion of males have been circumcised. The foreskin has a large number of HIV target receptor cells to which the virus can more readily attach itself and gain entry into the body. With circumcision, the receptor cells are removed.

Traditionally low use of condoms combined with incorrect or inconsistent use at this critical time is a contributing factor to the rapid spread of HIV. To be effective in preventing disease transmission, condoms need to be used correctly and they need to be used consistently with all patterns as occasional use negates much of the effectiveness of condom use.

In a country heaving under an immense economic burden the often-low social and marginal economic status of women can contribute to high-risk sexual behaviour and vulnerability to HIV infection. In poverty stricken Zimbabwe where

the nation is facing a recession poor women and adolescent girls resort to exchange sex for money or gifts and so contribute greatly to the transmission of HIV.

### **3.3 Sectoral causes of high risk behaviour**

There is a common understanding among scholars that some sectors of the economy are more vulnerable to the HIV/AIDS pandemic than others, Gomo (2004: 6), assessed the various sectors of the economy including government ministries, and he highlighted various causes as contributing to the high HIV prevalence in the country. Garbus also shares the sentiment with Sakutukwa when they highlight the risks faced by cross border traders and truck drivers.

#### **3.3.1 HIV in the Agriculture sector**

The sentinel surveillance data shows that HIV prevalence has remained steadily higher in the farming than in the general population. The MoHCW (2004:22) recorded it among other areas that had a prevalence of 35 percent. This is because, as a colonial legacy, workers' compounds on large farms constitute small, and much closed, communities that are poorly endowed with social and recreational facilities, other than the ubiquitous beer outlet frequented by young and old, men and women, Gomo (2004:6). This statement illustrates that there is not much entertainment on the farms besides the beer ceremonies which make the farm workers more susceptible to risky behaviour and eventually causes the high HIV prevalence.

#### **3.3.2 HIV in the Education Sector**

In the rural areas teachers are considered to have relatively high incomes. They are also generally regarded as educated and knowledgeable, and all these

factors enhance their social status. This tends to significantly raise their level of risk to HIV infection as their relatively privileged socio-economic position conduces towards multiple relationships because they are attractive clients in transactional sex. In addition, female students and young girls generally are aware that some men pay huge amounts for unsafe sex (Gomo, 2004:7). This puts the teachers and female students at a very high risk. That is the reason for having high HIV prevalence at growth points. Growth points have a very high prevalence rate of 35 percent MoHCW (2004:22). This is because in the rural areas, growth points are the sources of entertainment and they attract the young people and also the 'elite', the teachers.

### **3.3.3 HIV in the Public Sector**

Deployment of staff without due consideration of the working locations of their spouses was cited as an important contributor to risky behaviour. For example, the Ministry of Local Government has identified several high-risk groups among employees. These include engineers, artisans, surveyors, and technicians who are highly mobile and spend long periods away from their spouses and families when they are particularly vulnerable. The Ministry of Public Service, Labour, and Social Welfare also identified highly mobile employees as being at very high risk. In addition, employees often receive substantial travel and subsistence allowances, making them relatively wealthy in the midst of poverty, especially in rural areas. Young pension clerks have been cited as being highly vulnerable as they attend to desperate clients such as young widows. The clerks are not only seduced by the widows to fast track pension claims, but they are themselves also attracted by the pension benefits of these women.

### **3.3.4 HIV in the Security Sector**

In the military, young, and socially inexperienced people are recruited and trained to be fearless and aggressive. While this is good for war situations, research shows that the young soldiers carry this approach into civilian life and into their private sexual interactions also. In addition, armies are very mobile and, often, military barracks are found in outlying areas that are poor so that the barracks are a high-income area, that makes for transactional sex.

### **3.3.5 HIV in the Prisons**

A number of causes account for the HIV profile in prisons. Chief among them is overcrowding in single-sex living conditions, which promotes casual or non-consensual homosexual relationships mostly involving anal sex. Although usually denied by Africans, anal sex between men in prisons does take place in Zimbabwe and most other countries (Gomo, 2004:7).

Highlighting the causes of risky behaviour in various sectors, is the starting point if HIV/AIDS is to be combated. However, it has to be noted that merely knowing the risky areas and not doing anything about them does not solve anything. Some of the risky sectors for example the haulage transport industry has been identified as such for over a decade now but nothing has been done by the haulage organisations to try to change the risky behaviour prevalent in the industry. No effective steps, besides just writing a policy that is more of an acknowledgement to show that it has had an impact on the industry, have been taken. In order to combat HIV/AIDS organisations and industries have to put in place effective HIV/AIDS programmes aimed at changing the risky behaviour or even to find alternatives like giving employees enough money to rent a hotel when they are travelling or find other decent accommodation. An effective HIV/AIDS programme is one that addresses problems that are peculiar to the sector and to the welfare of their employees.

### **3.4 Highly volatile environment in Zimbabwe**

The situation in Zimbabwe is highly volatile. It is characterised by a tense political climate, unstable social climate and a harsh economic climate. The Zimbabwean economy is in meltdown with hyper-inflationary conditions. In May 2007, the inflation rate was estimated at 2200 percent. In July 2007 it was estimated at 4500 percent despite the government's hard stance in the freezing and forced lowering of prices. According to the Mail and Guardian of 19 August 2008 the inflation rate reached 11.2 percent million end of June 2008 to be rated as the highest inflation rate in the world. There is a negative economic growth rate and the ensuing recession has resulted in a shrinking productive sector or, rather, an economic meltdown. are operating below capacity or even shutting down. The Managing Director of Unilever in Zimbabwe sighted viability problems while operating below capacity due to lack of foreign currency, and shortage of coal and electricity (The Herald Newspaper July 23, 2007).

In Zimbabwe, the situation is pathetic because both inflation and unemployment are high. According to Pembrey (2006) unemployment in December 2005 was estimated to be about 80 percent. This situation even contrasts some economic theories like the Phillips curve cited in Froyen (1999:216) which states that there is a negative relation between inflation and unemployment such that when inflation is high then unemployment has to be low and vice-versa. Borrowing rates are very high and unpredictable. The looming foreign currency shortage has given birth to a parallel market that sees foreign currency traded at very high rates outside formal channels of the economy. This has led to a shortage of basic commodities, especially those that require foreign currency.

The cost of living for an ordinary man has risen considerably making it impossible for an 'ordinary man' to buy basic commodities since the price of basic goods far much outstrips basic salaries of the population even that of professionals. The working class cannot afford decent medical services. Even the medical aid costs

are prohibitively high. Those with medical aid schemes have to pay more money as top up.

The tense political climate is characterised by outbreaks of violence between the ruling party ZANU PF and the divided factions of the Movement for Democracy Party. The former is blamed for corruption and policies that have led the country into an economic decline, while the latter is being blamed for calling for sanctions and isolation of the government that have not done the country any good either. The country is in the doldrums as 60 percent of the population is said to be living below the poverty datum line.

Organisations in this highly volatile environment are fighting for survival; the employees are affected by the declining economy and the high inflation rate that is destroying their purchasing power. An HIV /AIDS policy set up to help infected people with medical drugs has failed. Only 8 percent of the 321 000 people in need of Anti-Retroviral drugs are actually getting them. The report further states that some of the Anti-Retroviral drugs meant for public hospitals are sold to pharmacies where they are sold at inflated prices. Another UNICEF Report, published in October (2005), stated that the market price of Anti-Retroviral drugs had quadrupled, thus making them inaccessible for those in need. The tense political environment is deterring foreign investors who could rescue the failing organisations. Winiaski (2004:31) observes that HIV/AIDS is at the intersection of social injustice, gender inequality, poverty, hunger, lack of economic opportunities and unequal distribution of resources. This observation holds in the unstable environment of Zimbabwe.

### **3.5 Tracing the impact of the highly volatile environment on HIV/AIDS**

Zimbabwe is faced by humanitarian challenges, particularly the triple threat of Human Immunodeficiency Virus, food insecurity that has been impacted by recurring droughts and a declining capacity for basic social service provision. The

humanitarian situation is further impacted by the economic decline with its high inflation rate. The shortage in foreign currency, high unemployment and negative growth rates, all add to the vulnerability and suffering of the population.

While the HIV/AIDS prevalence is reported to have dropped to 18.1 percent, , the disease continues to cause the death of an estimated three thousand people per week (MoHCW, 2005:25). A UN Country Report (2006) reflects that poverty prevalence in urban Zimbabwe has increased by 66 percent between 1995 and 2003, with an estimated 66 percent of the population being food insecure. The Country Report goes on to say that some 57 percent of the urban population consume less than 2 meals per day, citing inflation, cost of services such as school and hospital fees, unemployment, taxes, death and illness as the main hazards and threats to their livelihood. The social fabric in Zimbabwe is being transformed as HIV/AIDS and economic/livelihood difficulties negatively reinforce each other. Economic hardship also results in increased use of negative coping mechanisms such as the commercial sex trade.

The nation's basic social service provision continues to deteriorate making it difficult even for some HIV/AIDS patients to receive home based care. For instance, in most urban areas, water and sewerage systems have broken down due to excessive load and poor maintenance. This results in large volumes of raw sewage being discharged into natural watercourses while at the same time there is water rationing with some areas going for days or weeks without water, making it very difficult for the HIV/AIDS infected as they risk contracting diseases such as diarrhoea, cholera and dysentery (UN Country Report, 2006:11).

Coupled with the general economic decline the effect of HIV/AIDS on individual, household, community and national life and livelihoods is devastating. The deterioration of the social and economic situation since 1999 and the withdrawal of donor development support due to policy differences require concerted efforts from parties concerned now rather than later. Hence, the need to get greater



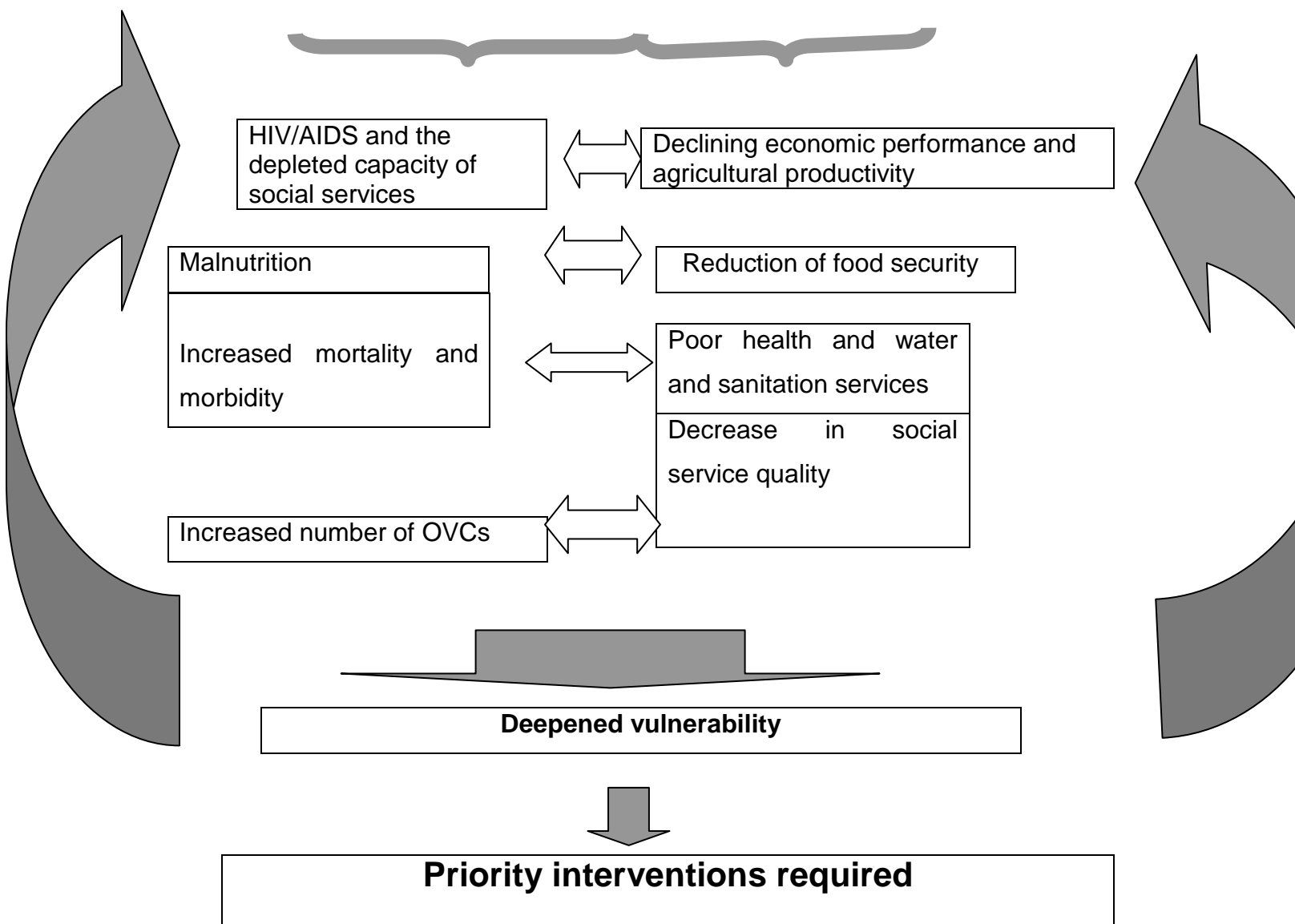
commitment from private and public sector organisations to actively participate in the establishment of effective workplace programmes. The Ministry of Health and Child Welfare has a decreased capacity to sustain such programmes. It aims to prevent and control epidemic diseases. But now the high prevalence of HIV/AIDS is a major factor in the resurgence of tuberculosis that has placed a further strain on the health delivery system, as AIDS patients occupy between 50 percent and 70 percent of all hospitals beds.

The mobility of the population in the country due to poverty, as also operation 'restore order,' also known as Murambatsvina, further increased the burden on the already overburdened population. It left some two hundred thousand people homeless (UN Country Report, 2006). The homeless women and young girls were left stranded and vulnerable as some turned to commercial sex work for survival and shelter. Some of the affected populace went to the rural areas, which caused concern as the high HIV prevalence in the urban areas could have been spread to the rural areas as a result. Furthermore, large-scale movement of people has accompanied the fast-track land reform. This led to regrouping of family units, and exposure to new sexual networks (Garbus and Sakutukwa, 2002:6). Hence the land reform programme is also seen as a vehicle that further spread the HIV/AIDS pandemic across the nation.

The next page shows a priority intervention model that indicates the relationship of the threats in Zimbabwe and the need for priority intervention if the situation is to improve. The threats, according to the model, are declining economic performance, urban displacements, low agricultural production, and HIV/AIDS. The model shows the effects of the threats and how they reciprocate each other, making it a crisis that requires priority interventions.

Figure 3.2 **The Priority Intervention Required Model**

Declining Economic Performance	HIV/AIDS	Urban displacements	Low Agricultural production	Declining capacity for basic services
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Source: UN Country Report 2006:12

The priority intervention required model shows the relationships in the volatile environment of Zimbabwe and highlights some factors that have led to this condition and how these factors continue to reinforce each other such that it becomes a vicious cycle. The main factors highlighted in the model are a declining economic performance, the high HIV prevalence and need for treatment of the AIDS infected, urban displacements, and declining capacity for basic services. The model therefore concludes that there is a need for priority interventions as there will be greater vulnerability among the populace if the situation is left to further deteriorate; hence the need for effective workplace HIV/AIDS programmes.

### **3.6 The Historical Development of HIV/AIDS policy and programmes**

In 1985 after the first HIV/AIDS case in Zimbabwe was reported, the Ministry of Health and Child Welfare (MoHCW) through the National Blood transfusion Services (NBTS) intensified the screening of donated blood and blood products. In 1987 the National AIDS Control programme NACP was established in the Ministry of Health and Child Welfare. A year Emergency Short Term plan was formulated to create public awareness of HIV and AIDS. Health personnel were trained in the different aspects of HIV and AIDS interventions to include promotion of appropriate behaviour change among targeted population groups, counselling and caring for people living with HIV and AIDS, surveillance and monitoring the epidemic through epidemiological surveillance.

The First Medium term Plan (MTP1) was launched in 1989 and remained operational until 1994. The MTP1 focused on expanding interventions to promote behaviour change, prevention and treatment of sexually transmitted Disease STD care and support for people living with HIV and AIDS. In 1994, the five year Second Medium Term Plan (MTP2) was developed to focus on mobilization of non-health sectors to integrate HIV and AIDS issues

From 1997-1999, the Government of Zimbabwe embarked on a broad-based and multi-level consultative process to develop the National AIDS Policy (1999). To operationalise the National HIV/AIDS Policy, the national HIV/AIDS Strategic framework (2000-2004) was developed and launched in 2000. Prior to that, in 1999, Zimbabwe introduced the National AIDS Trust Fund (NATF), commonly referred to as the AIDS levy, which was collected from a 3 percent tax on all taxable income. Its main purpose is to support HIV prevention efforts and care for those with AIDS. The funds are managed by NAC, which was created through an Act of Parliament in 1999 and started operating in 2000. The Zimbabwe NATF is considered an innovation approach to mobilising funds in Southern Africa.

The National AIDS Council has the mandate to coordinate the national HIV and AIDS response. The five years ranging from 2000 to 2005 the NAC managed to fully establish throughout the country, guided by a multi-sectoral board composed of 13 members, including people living with HIV and AIDS. Provincial, district, ward and village AIDS Action Committees exist, with each of the different levels intended to replicate the multi-sectoral composition and approach of the Board. The NAC secretariat in Harare as well as decentralized structures, with full time NAC staff, at provincial and district levels support these national structures. National AIDS Council's partners in the multi-sectoral response initiative for HIV and AIDS include government sector Ministries, local authorities, and civil society, CBOs, FBOs, UN and donor agencies.

### **3.6.1 The National AIDS Council (NAC) in Zimbabwe**

The National HIV/AIDS Strategic Framework (2000-2004) has governed national AIDS Council's operations since inception to date. Currently a three-year Strategic Plan (2005-2007) and an operational guideline for HIV and AIDS Programmes in Zimbabwe, guides its operations. The development of a Strategic Framework for the next five years (2005-2008) to guide National AIDS Council's operations is underway.

Table 3.1 **The Operational Guidelines for HIV and AIDS in Zimbabwe**

<b><u>Strategic Area</u></b>	<b><u>Programme Areas</u></b>
<b>Prevention</b>	<p>Prevention Of Mother To Child Transmission (PMTCT)</p> <p>Voluntary Counselling &amp; Testing (VCT)</p> <p>Behaviour Change Communication (BCC)</p> <p>Sexually Transmitted Infections (STI's)</p> <p>Condom Promotion &amp; Distribution (CP)</p> <p>Blood Safety (BS)</p> <p>High Risk Groups (HRG)</p> <p>Infection Control (Nosocomial) (IC)</p> <p>Injected Drug Users (IDU)</p>
<b>Mitigation &amp; Support</b>	<p>Orphans and vulnerable Children</p> <p>Income Generation (IG)</p> <p>People Living With HIV/AIDS (PLWHA)</p> <p>Nutrition (NUT)</p>
<b>Care For Infected</b>	<p>Tuberculosis (TB)</p> <p>Opportunistic Infections (OI)</p> <p>Antiretroviral Therapy (ART)</p> <p>General Home-Based Care or Palliative Care (HBC)</p>
<b>Advocacy</b>	<p>Advocacy (A)</p>

**Workplace**

Workplace Programmes (WP)

**Youth Focused**

Youth –in –School (YIS)

Youth-Out-of School

Source National AIDS Council, 2006

**3.6.2 HIV/AIDS Programmes by National AIDS Council**

The National AIDS Council in conjunction with some donor agencies, the Health Ministry and various other stakeholders hold HIV/AIDS programmes at a national level to cover critical issues to do with HIV and AIDS. Some of the programmes that the National AIDS Council are carrying out include prevention of Parent to child Transmission, aimed at reducing infant mortality rate, behaviour change programmes meant at further reducing the HIV prevalence. Some of the Programmes being conducted by the NAC are briefly explained below:

**Prevention of Parent to Child Transmission (PPTCT)**

This Behaviour Change Strategy is about sexual HIV transmission, and therefore does not outline a comprehensive strategy on Prevention of Mother-to-Child Transmission (PMTCT). The focus here is on the linkages between sexual behaviour change, community norms and PMTCT. The medical perspective on PMTCT shall be complemented through a broader vision of Prevention of Parent-to-Child Transmission (NAC, 2006). This vision shall be built around the concept of responsibility within the family. This includes both partners' responsibility for preventing sexual transmission as a basis for mother-to-child transmission and the entire family's as well as the community's responsibility for ensuring that a pregnant woman can participate in PMTCT. Although PMTCT services are widely available, there is not sufficient information and low male involvement in PPTCT.

Knowledge levels on PPTCT and demand for PMTCT services will be increased through mass media, community mobilization, interpersonal communication and the public health system. These efforts shall be integrated with other aspects of reproductive health promotion, which are outlined in the National Reproductive Health Behaviour Change communication Strategy by the MOHCW. Women will be targeted through family planning service providers and community-based organisations with messages on all aspects of PPTCT including family planning methods and dual protection. Through a campaign, male and family involvement in PPTCT will be promoted to increase male responsibility and risk perception of transmission of new HIV infections to the mother and the child. In this context, faithfulness during pregnancy and breastfeeding will be promoted and female condom use introduced. Couple counselling for parents will be encouraged. The role of communities and families in ensuring access of women to all steps of PMTCT services to child Transmission (PMTCT) will be highlighted in the campaign and reinforced by messages on the need to avoid stigmatization of women participating in PMTCT.

#### Home based care programmes

The World Health Organisation defines home based care programme as “a programme that through regular visits, offers health care services to support the care process in the home environment of the person with HIV infection [www.who.org](http://www.who.org) . Home visits may be the only service provided or be part of an integrated programme which offers the patient and his/her family services in the home, hospital and community”. Walker and Gilbert (2002: 82) cited in Nattrass (2002:7) observes that women are especially hard-hit because they carry the burden of the disease and yet are expected to care for other members of the household who are also positive. Hansen et al (1994) in Blackden and Wodon (2006) carried out studies on home based programmes in Zimbabwe, they concluded that the time spent on caring, diverted from other activities such as food production, employment, education and care of other household member is highest cost burden incurred by the households.€

### The National AIDS Council on HIV/AIDS at the workplace

The National AIDS Council provides for a guidelines to employers and employees on drafting an HIV/AIDS policy or when planning for the implementation of HIV/AIDS programmes in the workplace. The NCA advocates for a policy which promotes confidentiality for the infected and affected workers, and also discourages stigma and discrimination against people living with HIV and AIDS or perceived to be HIV infected. In seeing the vulnerability of the women in the African culture also in their biological make up which make them even more susceptible to the virus so the NAC promotes gender equality and equity in accessing prevention, care and treatment services and benefits. The council also provides for guides for managers dealing with individual cases while at the same time promoting social dialogue between management, workers and their representatives in the context of HIV and AIDS. A policy also has to be committed to maintaining a safe and healthy work environment for all employees, while it should acknowledge the ability of HIV positive employees to continue to work as long as they are able to perform their duties in accordance to the job requirements.

### National AIDS Council on Behaviour Change Programmes

In 2005, the National AIDS Council led a consultative Behavioural Change Review process. The purpose of the review was to provide an evidence base for the development of a Behavioural Change Strategy, which has assisted in providing insights and detail regarding behavioural change in Zimbabwe. The scope of the review covered a situation analysis of risk behaviours and vulnerability factors as well as a response analysis on past programmes.

Although Zimbabwe is in the mature stage of a generalised HIV and AIDS epidemic, there are important age, gender and geographical differences in HIV prevalence. The acceleration of the epidemic has largely been driven by sexual transmission, with 80 to 90 percent arising from heterosexual transmission (NAC, 2006:10). In part, the scale of the epidemic at country level reflects it has widely



disseminated nature. HIV prevalence in small towns, farming estates and mines located in rural areas exceeds that in the major cities, whilst transmission into and within subsistence farming areas is also extensive.

This pattern of spread reflects aspects of the country's relatively high level of development and social relations. Thus, for example, men have frequently taken up employment in cities, towns, plantations and mines, and have utilized the country's well-developed transport infrastructure to maintain and make regular visits to their families in their traditional rural homes. Large income and gender inequalities have led to the establishment of local sexual networks that facilitate transmission even in rural areas. During the course of the epidemic, a broad response to HIV and AIDS has developed in Zimbabwe with a multitude of stakeholders involved in HIV prevention initiatives with the aim of behavioural change promotion. At the same time, there was no national strategy in the area of behavioural change promotion despite some efforts to develop a behaviour change communication strategy under the 'Beyond Awareness' initiative, which, however, was not completed

#### Abstinence, age at first sex and age mixing

There is no clear trend in age of sexual debut in Zimbabwe since the beginning of the HIV epidemic. The median age at first sex (the age when half of the young people already have had sex) is above 18 for both men and women. This means that age at first sex in Zimbabwe is among the highest in Africa. Therefore, it is unlikely that early sexual debut has been and continues to be the major driving force of the epidemic in Zimbabwe. Nevertheless, a minority of young people, in particular OVC and out-of-school adolescents, engages in early sexual activity and require attention of prevention programmes. Furthermore, age differences between women and men at first sex and in subsequent sexual experience are particularly high in Zimbabwe. The majority of young women have sexual experience with partners five and more years older, which exposes them to a

group of men with high HIV prevalence. This must be seen as a major factor for the relatively high HIV prevalence in young women.

Delay of debut has been the most prominent focus in prevention efforts among young people. Although some of these programmes may have assisted specific groups of young people to remain abstinent, they did not seem to cause any major changes at the population level. Supporting the message to reduce the number of sexual partners and to delay the age of first sex should remain an important but not exclusive emphasis of prevention campaigns. Evidence points to the need for mixed strategies. This includes strategies that cater to young people who are not yet sexually active (support to delay debut), those who are already sexually active (facilitate access to condom) and those who have already experienced negative consequences (mitigate impact of Sexually Transmitted Illnesses, HIV, teenage pregnancies). There is a need for more differentiated targeting of sexually active and non-sexually active young people. International literature provides little reason to believe that the promotion of condom use among sexually active young people promotes sex. Similarly, there is little reason to believe that sexual and reproductive health education promotes sex. Programmes have hardly addressed age mixing. This does not only require attention from the perspective of the young woman, but also needs to be integrated in promotion of faithfulness among men and male responsibility.

Some IEC materials had focused on warning against so-called old “sugar daddies”, but not addressed the much larger number of relationships between women 15-29 and men 25-39, in which the majority of infections can be expected to happen. The largely urban ‘small house’ phenomenon and the cultural background of polygamy provide a supportive context for multiple partnering which must be seen as a very important driver of the epidemic in Zimbabwe (NAC, 2006).

## Condom Use

Condom use at last sex with a non-cohabiting partner in Zimbabwe is higher than in most countries in the African region and has increased during the 1990s, but still needs to be increased given the high infection risk. Condom use in regular and marriage relationships remains low despite the fact that being in long-term relationships is not necessarily a protective factor. Condom distribution and social marketing programmes, which led to increased uptake and use in casual sexual relationships, were successful elements of the Zimbabwean HIV and AIDS response. These promotion and distribution strategies have worked and need to be sustained. More emphasis needs to be placed on correct and consistent use of male and female condoms in regular relationships. The female condom has a market and its increased distribution and social marketing will give couples an additional choice for preventing HIV infection.

### **3.7 Cultural Practices that Increase HIV Infection Risk**

Winiarski (2004:35) notes the prevalent opinion that experts say that cultural beliefs and rituals were created to help ethnic groups survive. But also observes that these days' people concerned with HIV/AIDS claim that some cultural beliefs endanger, rather than protect, ethnic communities. The National AIDS Council shares that same sentiment and it highlighted some of the risky aspects of cultural practices of the nation or of some tribes in the country that pose a great obstacle combating the epidemic. Some of these local value systems allow for a number of practices that put Zimbabwean men and women at risk of contracting HIV. These include polygamy, widow inheritance, intra-vaginal practices, girl pledging and post menopausal abstinence.

Polygamy (15 percent of married women were in a polygamous union in 1999), is a situation where a man marries two or more wives and has sexual intercourse with all of his wives. Therefore, if any of his wives or he himself gets infected by the HIV virus all the wives will be infected.

Widow inheritance is a traditional African tradition practice whereby a young brother or nephew would get the wife of the older brother or uncle after his death. This practice puts the young brother as well as his wife, if the older brother died of HIV/AIDS, at risk, as the young brother would also get the disease.

Girl pledging is a custom that used to be practiced by poor families. They would charge a bridal price for their young girl child if they were in great need of money. They would even let their daughter be married to an old man even against her will if they would have accepted his bridal money.

Intra-vaginal practices (“dry sex”) are practices by women who use certain herbs to remain dry when they are having sex. This is seen as a dangerous practice as it enhances the chances of contracting sexually transmitted diseases (STDs) and HIV/AIDS. Women should desist from some such practices.

Postmenopausal abstinence for women (during which the husband may have sex with other partners). This is a situation where men are allowed either to marry a young woman or even to be given the nieces of the wife after his wife has reached menopause. If the young lady has HIV/AIDS or if the ‘old man’ in question had been having extra marital affairs and contracted the disease then it is likely to be spread to the new partner.

Behaviour change programmes should highlight the dangers that come with the various risky customs that were traditionally practiced. Failure to convince the people of the dangers that such customs in their culture constitute` would leave the combat against the HIV/AIDS pandemic incomplete. Organisations operating in a country like Zimbabwe setting up HIV/AIDS programmes must know the risky customs that are embodied in their culture, as these are starting points for effectively combating HIV/AIDS.

### **3.8 The AIDS Impact Model (AIM) Approach**

This study was guided by the AIDS Impact Model (AIM) Approach. The AIM Approach is a computer program that projects the impact of the AIDS epidemic, it projects the future number of HIV infections, AIDS cases and aids deaths given an assumption about HIV prevalence (Hollister 2000:4). The AIM Approach can also project the demographic, economic, and social development impacts of AIDS. In this study the AIM approach was used to project the demographic and economic impact of HIV/AIDS in organisations where there are HIV/AIDS programmes and in situations where there are not none. The AIM Approach can be used to lure the support of the leaders in an organisation or in a nation so that they view HIV/AIDS programmes positively and increase the financial and other infrastructural support that may be needed for the programmes.

Hollister (2000:3) states that the AIDS Impact model follows six steps in its application. The steps are as follows:

1. To conduct a preliminary review of the epidemiological information base and political environment in a country or organisation and analyse the AIM process. In this stage, one has to decide whether to use the AIDS Impact Model Approach process to try to build leadership support for HIV/AIDS programmes in the country or organisation. One must also examine the requirements and costs of implementing the AIM activity, estimate the required scope of activities, and begin to specify institutional arrangements and stakeholder groups that will become involved in implementation and dissemination activities.
2. To collect data and use AIM and its associated programmes to analyse the HIV/AIDS situation and make projections of the epidemic's impact on society. This normally involves mobilising a group of experts who analyse the data; make the necessary assumptions; critically examine both the input and out put of the model; and produce graphs, charts, and tables that will make up the content of the presentations.

3. To produce presentations and print brochures that will support the dissemination process. At least one, but often multiple presentations are aimed at different levels or types of leadership or professional audiences. These can take the form of computer-generated images using presentation software, colour overhead transparencies, colour slides, or posters. An application will typically produce written materials to hand out to target groups; these provide 'take-home' materials intended to support leaders as they speak to other groups or plan HIV/AIDS intervention activities.
4. To train presenters. Depending on the scope of activities, this may involve training just a few or many dozens of presenters who will be expected to deliver 30-60-minute presentations to a variety of audiences. It takes 5 to 10 days, depending on the level of experience of the trainees, to train mid-level professionals to effectively deliver an AIM presentation. This usually includes selecting, prioritising, and analyzing target audiences.
5. To design concurrently with the earlier steps the overall dissemination plan and develop the institutional support arrangements needed to provide presenters with transport, per diem, equipment, and materials. Smaller dissemination efforts may require much support, but larger dissemination programmes can require more complex and extensive levels of logistical support.
6. To design and use monitoring and evaluation systems to assess progress, identify problems, redesign materials, and measure the impact of the overall programme. It is never enough to just make presentations. If solid political support for HIV/AIDS programmes is to be developed and sustained, careful and purposeful use of monitoring and evaluation methods is required to obtain success.

In 1996 the AIDS Impact Model approach was used to gain the attention of the Kenyan President towards supporting HIV/AIDS programmes in the country. It yielded positive results because the Kenyan President declared AIDS a national

disaster to which the cabinet responded by supporting a huge budget allocation towards HIV/AIDS programmes (Hollister 2000:8). The AIDS Impact Model can be used to lure the top executives, the middle management and all other stakeholders concerned to have HIV/AIDS programmes for their employees as well as to eliminate stigmatisation and unfair discrimination of HIV/ AIDS employees at the workplace, to increase prevention awareness and to provide anti-retroviral treatment.

Achmat, cited in Irwin *et al* (2003:2) writes that without treatment many infected people in Africa will die and this constitutes crime against humanity. Achmat *ibid* goes on to urge “Governments, multilateral institutions, to stop a holocaust against the poor.” Achmt’s argument is in support of the idea that the private sector and civil society both in and outside Africa must act without delay. The main objective of the AIDS Impact model Approach is to entice all parties concerned to work in partnership in combating the AIDS pandemic.

However, Nel, Van Dyk, Haasbroek, Schultz, Sono and Werner (2003:296) argue that organisations per se have to take it upon themselves to decide or formulate policies on whether to use pre-employment testing for AIDS or exclusion from medical funds or termination of employment, due to HIV/AIDS status. Nel *et al* (2003:296) further recommend that employers can play an important part in sponsoring AIDS awareness programmes and providing informative training. Therefore, the AIM Approach synchronises with this study as it seeks to convince top management in organisations to have HIV/AIDS programmes in the work place to cater for the welfare of employees who are affected by the HIV/AIDS pandemic.

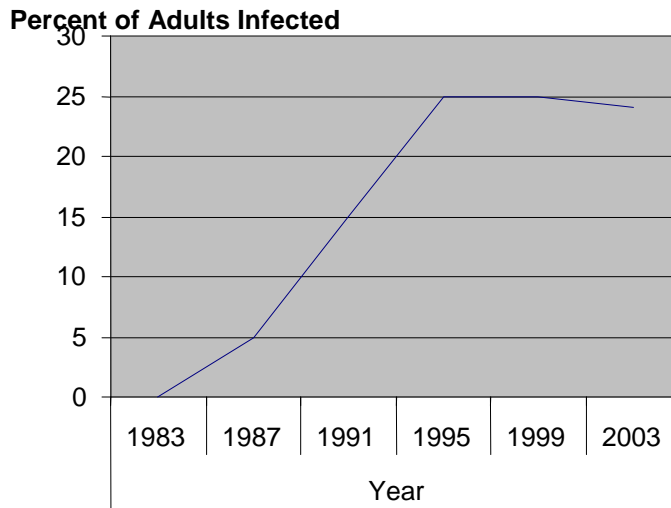
### **3.9 The AIDS Impact Model Projections on Zimbabwe**

The Model assumes that HIV prevalence will drop only slowly in the coming years from 24.6 percent in 2003 to 21 percent in 2018 (MoHCW, 2004:26). However, the projections have been outstripped by the reduced HIV prevalence of 18 percent in 2005 (UNAIDS Report, 2006). The AIDS Impact Model projection shows the increase in the number of infected persons for the two decades from 1983 to 2003. The number of HIV-infected persons in the population (including children) rose from about 390 000 in 1988 to nearly 1.8 million in 2003 as the epidemic expanded rapidly throughout the country. The AIDS Impact Model further projects that if HIV prevalence stays high between now and 2018, the number of infected persons will remain near the 1.8 million level and over that period, large numbers of people will die from the disease and be removed from the HIV-infected population (MoHCW, 2004:27).

The AIDS Impact Model was used to make projections about HIV prevalence, the number of infected persons, number of annual new AIDS cases, annual AIDS deaths, cumulative AIDS deaths and life expectancy at birth. The diagram on Figure 3.3 reflects the HIV prevalence in Zimbabwe from 1983 to 2003.



**Fig 3.3 Estimated HIV Prevalence, Ages 15-49, 1983-2003**



Source: MoHCW 2004:10, AIDS Impact Model, 2003.

The model further states that the annual new AIDS cases rose from 16 000 in 1988 to 180 000 in 2003. In the projections, the annual number of new AIDS cases stays near this mark through to 2018. Under the assumptions of this projection, about 490 persons would develop AIDS each day for the 15-year period between 2003 and 2018. This very large number of annual new AIDS cases will continue to place severe pressure on the health system, as well as on households to provide the intensive care required by AIDS patients.

The death toll from AIDS has been high and it continues to rise. In 1988, about 12 000 persons died from AIDS, in 2003 about 177 000 people died of the disease and the annual number of AIDS related deaths will stay near that level for the duration. In 2003, more than 485 people of all ages were dying every single day of the year because HIV has destroyed the ability of their immune system to resist opportunistic infections. Under the assumptions in this project, the loss of life from AIDS will continue near this level well into the future.

The devastating effects of the HIV pandemic can be seen by looking at the cumulative AIDS deaths over time. From the beginning of the epidemic until 2003, an estimated 1.5 million people in Zimbabwe have died from the disease. The AIDS Impact Model projects that from 2003 to 2018, an additional 2.7 million Zimbabweans is likely to die from the disease in the absence of widespread use of antiretroviral drugs (MoHCW, 2004: 30). Because of the long incubation period between HIV infection and AIDS, if HIV prevalence were to fall to zero by 2010 the model projects that there would still be 1.6million additional AIDS deaths between 2003 and 2018.

HIV/AIDS increases the death rate in almost all age groups over what it would have been in the absence of AIDS. The effects are however, most severe among the prime working age between 15 and 49 and among children below the age of five. The MoHCW (2004:31) states that AIDS is responsible for about nine of every ten deaths in the 15-to 49-year-old age group.

In light of the projections given by the AIDS Impact Model on HIV and AIDS it is important therefore for all business executives to take heed and take HIV/AIDS programmes very seriously as the future of their businesses and future generations lie in the effective management of these programmes. With the current HIV prevalence having dropped to 18.6 percent it is important to continue with the programmes to promote this downward trend in the prevalence rate and to discourage anymore new infections. The organisations can also offer support to the infected by offering antiretroviral treatment to the employees living with HIV and AIDS in the highly volatile conditions where the health sector has been overstrained and their employees are vulnerable as they cannot afford medical expenses in the hyperinflationary environment.

### **3.10 Legal Framework for HIV AIDS at the workplace**

The International Covenant on Economic Social and Cultural Rights (ICESCR) says that all states should recognise the rights of everyone to the enjoyment of the highest attainable level of physical and mental health (Grant *et al*, 2001:103). In 1997, the Southern African Development Community (SADC) of which Zimbabwe is a member adopted a Code on HIV/AIDS and employment (Grant *et al*, 2001:104). The law of the Republic of Zimbabwe prohibits unfair discrimination against all employees and employers alike. It is in this regard that employers are encouraged to take steps to promote equal opportunities in the workplace and to eliminate unfair discrimination in any employment policy or practice. The law states that no person may unfairly discriminate, either directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, sexual orientation, age, disability, religion, HIV status, conscience, belief, culture, language, or birth.

The law also states that medical testing of employees or applicants for employment is prohibited, unless permitted by legislation, justifiable in the light of medical facts, employment conditions, social policy, and the fair distribution of employee benefits, or inherent in a job. However, testing for HIV is permissible only if authorised by the Labour Court.

The Labour Amendment Act of 2002 states that, employers have to make arrangements so that employees are informed about HIV/AIDS during normal working hours. These education programmes are supposed to cover the following areas promotion of safe sex and risk reducing measures, acquiring and transmission, prevention of the spread of HIV/AIDS and to supposed to provide for counselling of infected people in the organisation.

On the whole, the labour law of the Republic of Zimbabwe covers most aspects to do with the management of HIV/ AIDS programmes in the workplace. The law covers the following issues recruitment and selection, unfair discrimination and stigmatization, education, confidentiality, job status and issues to do with sick and compassionate leave. Therefore, in light of above mentioned statement one may conclude that the Labour law provides a comprehensive legal framework that is conducive for effective implementation to HIV/AIDS programmes in the workplace.

### **3.11 Conclusion**

This chapter has focused on literature about HIV/AIDS in Zimbabwe. The highly volatile environment and its implications for HIV/AIDS, the historic development of HIV/AIDS programmes, the National AIDS council, the Labour legal framework in regard to HIV/AIDS and the AIDS Impact Model and its projections on Zimbabwe if the current situation does not change have all been discussed.

## **CHAPTER 4**

### **COMBATING HIV/AIDS IN THE WORKPLACE**

#### **4.0 Introduction**

Chapter three provided a literature review pertaining to the HIV/AIDS situation in the unpredictable and turbulent environment in Zimbabwe. Chapter four seeks to review literature in regard to the impact of HIV/AIDS at the workplace and ways to reduce the negative impact of the epidemic through reducing further spreading, helping the infected and creating a healthy working environment which is free from stigmatisation and discrimination. It will also look at implementation of HIV/AIDS programmes at the work place, psychosocial support and the AIDS Risk Reduction Behaviour change model, which would help in combating the HIV/AIDS pandemic even at the workplace.

#### **4.1 HIV/AIDS programmes at the workplace**

HIV/AIDS should be recognised as a workplace issue, and treated like any other serious illness/ condition in the workplace. This is necessary not only because it affects the workplace, but also because the workplace being part of the local community has a role to play in the wider struggle to limit the spread and effects of the epidemic (ILO, 2003:10). HIV/AIDS hits the world of work in numerous ways. ILO (2003:10) further state that in badly affected countries, it cuts the supply of labour and reduces income for many workers. Increased absenteeism raises labour costs for employers; valuable skill and experience is lost.

Often a mismatch between human resources and labour requirements are the outcome. Along with lower productivity and profitability, tax contributions also decline, while the need for public services increases. National economies are

being weakened further in a period when they are struggling to become more competitive in order to weather the challenges of globalization.

The labour force will be particularly affected by the impact of the epidemic on the structure of the population. The majority of those who die of AIDS are adults in their prime - workers at their most productive. ILO (2003:10) states that in 1999, the 80 per cent of newly infected people in Rwanda, Tanzania, Uganda, and Zambia were aged between 20 and 49.

The aims of the HIV/ AIDS programmes at the workplace are to ensure that employees affected by HIV/ AIDS are not unfairly discriminated against. In employment policies and practices, to promote a healthy work environment, to screen for purposes of exclusion from work, confidentiality on HIV/AIDS status, continuation of the employment relationship, provision of prevention education programmes and care and support (ILO Code on HIV/AIDS, 2001).

An example of an effective HIV/ AIDS programme is the De Beers Group HIV/ AIDS programme. The key objectives according to De Beers Group (2005) were to save lives by preventing new infections and motivating behavioural changes, extending the productive lives of employees and their life partners living with HIV/AIDS by providing treatment, care and support, to minimise the socio-economic impact of HIV/AIDS through a comprehensive Disease Management Programme and to establish mutually beneficial relationships with stakeholders in HIV/AIDS management.

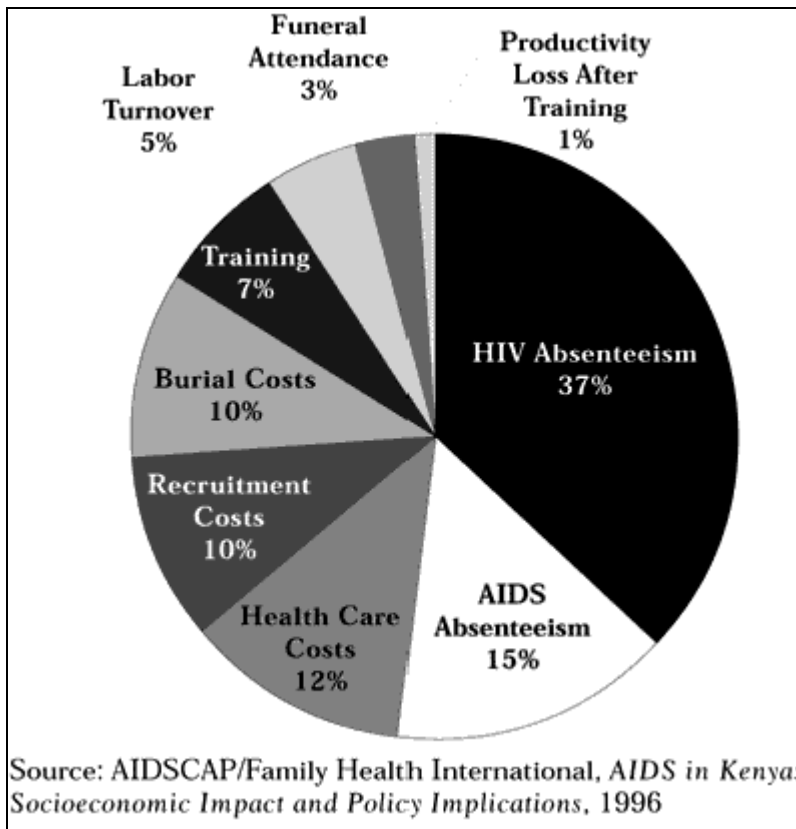
When implementing an HIV/AIDS programme the industrial psychologist or the manager has to convince the organisation that HIV/AIDS will have, or has had, an impact on the organisation. For example, how will the organisation deal with a decline in the numbers of available people to recruit from, if so many people are dying from the illness? The industrial psychologist can also show what the impact on the medical benefits that the organisation provides to employees will be.

There is a need to show the important effects the negative stereotypes associated with the illness will have. The importance of having HIV/AIDS programmes at the work place is clear because most affected people are within the working age. According to a UNAIDS Report (2007), of the over 40 million people living with HIV/AIDS at least 26 million are workers aged 15 to 49, in the prime of their working lives.

The workers are the most affected by the HIV/AIDS pandemic; therefore, effective HIV/AIDS programmes in the work place are of importance as it helps to educate people about prevention, encourages voluntary testing, and promotes condom distribution and use. The UNAIDS Report (2007) states that HIV/AIDS has led to increased demand on spending for health and social welfare and increased costs of insurance benefits for households. Companies have reported a doubling of medical expenses over a five-year period since employees who fall ill have to receive medical care. Greater claims are being made on group life insurance and health schemes.

Figure 4.1 on the next page shows some of the costs that organisations incur due to the HIV/AIDS pandemic. These include absenteeism due to HIV/AIDS related illnesses, health care costs, recruitment costs, burial costs, labour turnover, funeral attendance, and productivity loss after training. The diagram shows that organisations are incurring heavy costs due to the pandemic and hence effective HIV/AIDS programmes would be of great advantage to them. A UNAIDS Report (2007) states that some organisations in sub-Saharan Africa are now training two or three people for the job of one person in fear of losing key employees.

Figure 4.1 Organisational Costs in Kenya due to the HIV/AIDS Pandemic



Source UNDP Report 2007

### Some facts and figures on costs

- Zambia's largest cement company reported that absenteeism for funeral attendance increased by 15 times in the 1992-1995 period.
- In the mid 1990s Uganda Railways were reporting steep increases in absenteeism and an annual staff turnover rate of 15 per cent, with more than 10 per cent of the workforce dead from AIDS related illness.
- In Kenya 43 of the 50 employees of the Kenya Revenue Service who died in 1998 died from AIDS. The Kenyan Federation of Employers report that HIV/AIDS is costing companies an average of nearly US\$ 50 per employee each year.
- Some mining companies in South Africa believe that 40 per cent of their workforce may have HIV. AIDS will increase labour turnover by 3 to 6 per cent,



and the Goldfields Mining Company estimates that AIDS adds US\$ 4-10 to the cost of producing each ounce of gold.

- According to the Zimbabwe Farmers Union, AIDS has reduced the production of maize by 61 per cent, cotton by 47 per cent, vegetables by 49 per cent and groundnuts by 37 per cent.
- One major transport company with 11,500 workers in Zimbabwe found that 3,400 of them were HIV positive in 1996. Costs for the company related to HIV/AIDS amounted to more than \$ 1million or 20 per cent of company profits.
- In Chennai (formerly Madras), India, a study of large industries found that absenteeism was expected to double in the next two years, mainly as a result of STDs and AIDS-related illnesses.
- A Thai government study has calculated that the direct and indirect cost of HIV/AIDS to the nation was US\$ 1.2 billion in 2000.
- A number of firms in the US report annual costs of between US\$ 3,500 and US\$ 6,000 for each worker with HIV/AIDS.

Source: ILO (2002: 11)

Increased insurance payouts are reflected in rising premiums. Health care costs increase, particularly in enterprises that extend medical services to employees' dependents. The costs of HIV/AIDS for enterprises are both direct and indirect. Many of the hidden costs have only recently become apparent, and include psychological pressures on managers faced with decisions that could have life and death consequences for employees.

## **4.2 Managing Behavioural Risks Associated With HIV/AIDS**

HIV is a disease that shows no racial or class boundaries. It is the behaviour of the individual that places him or her at risk or protects him or her against the disease. This means that in order to manage HIV/AIDS effectively the organisation must have a behavioural risk management programme in place. The aim of behavioural risk management is to manage and to prevent risky behaviours associated with the spread of HIV. This can be done by promoting

healthy lifestyle choices and running prevention campaigns. In achieving the objectives of behavioural risk management, the industrial psychologist needs to take the following steps:

- Conduct a behavioural risk audit of current risky behaviours in the organisation associated with HIV/AIDS
- Summarise this information to provide an overall view of the risk of HIV/AIDS in the organisation.
- Analyse individual and organisational risks associated with ineffective management of HIV/AIDS in the workplace.
- Analyse the effectiveness of current risk management practices, that is, current interventions and solutions.
- Use this information to determine which interventions and solutions are reducing the risks and which programmes are still needed.
- Use all the information gathered to develop a prevention strategy and a health promotion programme.

Individual resources and risks must be identified during a behavioural risk assessment. An individual living with HIV/AIDS has to combine the following resources to effectively deal with the illness: vitality, personality, knowledge or expertise and coping skills. The risk factors associated with the poor health are negative emotional states, inadequate motivation to change behaviours, lack of coping skills and side effects of treatment. Behaviours that will promote coping resources and deal with the risk factors must be encouraged.

A behaviour risk assessment must include the identification of organisational resources and risks. On the organisational level, the following resources need to be developed: social support opportunities, and opportunities to influence decision-making. Risky behaviour associated with organisations not wanting to deal with HIV/AIDS includes a non-supportive organisational culture and an inability to detect the impact of HIV/AIDS in the workplace. Behaviour that will help develop the organisation's resources needs to be encouraged and those

that show an organisation's willingness to deal with the problem need to be developed?

After risky behaviours have been identified, organisations need to do something to change such behaviours. There are three categories of interventions or solutions. These are: educating employees about HIV/AIDS, equipping employees with behavioural skills to begin to change risky behaviour, and to maintain change and create a culture that motivates and supports individual and group behavioural changes.

### **4.3 Preventing the Spread of HIV/AIDS among Employees**

Primary prevention interventions are interventions that aim to prevent a health problem from occurring. Programmes at this level focus on those employees who are currently not at risk, and help them with accurate information about HIV/AIDS. The following benefits can be derived from HIV/AIDS education:

- HIV/AIDS education eases the fears of employees in the organisation about the virus and the syndrome. This will mean that less time is lost when employees don't want to work with infected co-workers, and so there will be an increase in productivity.
- Having HIV/AIDS education programmes promotes the intended spirit of the code of good practice: HIV/AIDS. These educational programmes help dismiss the myths about the virus and the syndrome by promoting understanding of those who are infected.
- HIV/AIDS education programmes prevent the spread of the virus by raising awareness.

Interventions are aimed at changing beliefs, attitudes, and behaviours. The primary prevention model is better and less expensive than the secondary and tertiary models. However, in order to deal with employees who are already at risk of contracting HIV, the secondary prevention model is necessary. Tertiary

prevention interventions are necessary when dealing with the employees who already have HIV/AIDS.

#### **4.3.1 Awareness Programmes**

Awareness programmes play a key role in prevention as they influence the opinions and values of the communities they work in and are potentially a great motivator of behaviour change. A ready audience in the form of employees would benefit greatly from awareness programme given by their leaders and this would assist in prevention. The same platform could be used to address issues of stigma that prevent the affected and infected from seeking help early. It would also encourage more to be tested, where those who are infected can seek treatment early and those who are not infected will be encouraged to continue or adopt healthy sexual practices. Many people once faced with an HIV positive diagnosis do not know how to proceed from there. Fear and emotional turmoil often renders them hopeless and powerless to effect change. Important decision about their own health and those of their loved ones, careers, finances, and posterity need to be taken.

#### **4.4 Dealing With Employees Who Are At Risk of Contracting HIV**

Secondary prevention interventions target those individuals who are suspected of being at high risk of contracting HIV. These interventions are only effective if high risk individuals are correctly identified and provided with the knowledge and skills that prevent them from contracting and spreading HIV. Therefore, the challenge is to reliably identify these employees. Secondary prevention interventions are more effective than tertiary prevention interventions, which focus on those employees who are already infected with HIV. The secondary interventions make sure that those whose behaviour puts them at risk of contracting HIV/AIDS realise the risks they run and will change their behaviour.

#### **4.4.1 AIDS Risk Reduction Model (ARRM)**

Catania *et al*, 1990, postulated the AIDS Risk Reduction Model (ARRM) that provides a framework for explaining and predicting the behaviour change efforts of individuals specifically in relationship to sexual transmission of HIV/AIDS. ARRM incorporates several variables from other behaviour change theories including the Health Belief Model, Efficacy theory, emotional influences, and interpersonal processes. The AIDS Risk Reduction Model (ARRM) has three main stages namely the recognition and labelling stage, the commitment stage and the action stage. The stages are explained further below.

Recognition and labelling stage of one's behaviour as high risk. For such recognition and labelling, people need knowledge of sexual activities as associated with HIV transmission. This only comes with enhanced awareness programmes on how the HIV virus is spread. In this stage, too the people must realise that they are personally susceptible to contracting HIV. In this stage furthermore, the impact and effects of the HIV/AIDS disease have to be outlined so that the people will start to believe that having AIDS is undesirable. Here too people will develop social norms and inconsequence will eliminate such sex networks as make them vulnerable to contracting the HIV/ AIDS pandemic.

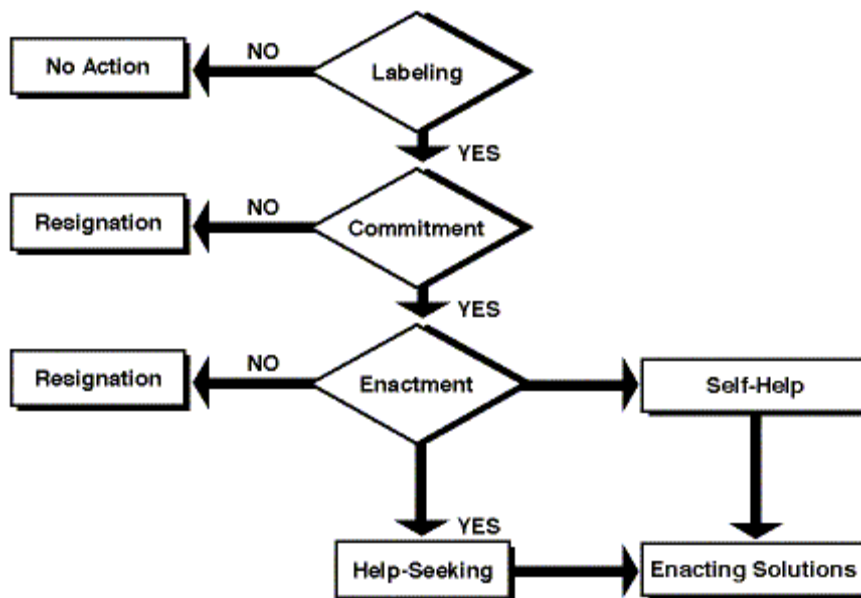
Commitment stage: In this stage, a commitment to reduce high-risk sexual contact and increase low risk activities is made. Here individuals will make a cost and benefit assessment and determine how changes will affect will affect one's enjoyment of sex and relate it to response efficacy: for example will changes; successfully reduce my risk of HIV infection? If an individual is positive, avoidance of high-risk behaviour will place that individual in a safe zone. Rather than to contract HIV/AIDS they will commit themselves to low risk behaviour. However when an individual does not see the benefits of low risk he/ she is likely to return to the old ways and practice high-risk behaviour. Self-efficacy, knowledge of the health utility and enjoyability of a sexual practice, as well as

social factors (group norms and social support) are believed to influence an individual's cost and benefit and self-efficacy beliefs.

Action stage: This stage consists of three phases namely information seeking, obtaining remedies, and enacting solutions. Depending on the individual, phases may occur concurrently or phases may be skipped. In this stage of the AIDS Risk Reduction Model, it is hypothesised that social networks and problem solving choices (self-helps informal and formal help) all conduce towards the action that an individual will take regarding HIV/AIDS. It is also hypothesised that prior experience with problems and solutions and the level of individual self-esteem also contribute significantly towards the taking action stage. Resource requirements of acquiring help and ability to communicate beliefs and behaviours also affect the action that an individual will take.

In addition to the stages and influences listed above, Catania *et al*, 1990 identified other internal and external factors that may motivate individual movement across stages; for instance, aversive emotional states high levels of distress over HIV/AIDS or alcohol and drug abuse that blunt emotional states may facilitate or hinder the labelling of one's behaviour. External motivators such as public education campaigns, an image of a person dying from AIDS or informal support groups may also cause people to examine and potentially change their sexual activities.

Figure 4.2 **Diagram to show stages in the AIDS Risk reduction Model**



Source: Catania *et al*, 1990

The AIDS reduction Model tries to make people responsible and greatly contributes the reduction of HIV prevalence and of high-risk behaviour. However, it fails to note that some people especially women in some developing countries, are still marginalised and 'oppressed' and at risk not because of their own actions or behaviours but because of the behaviour of their sexual partners.

Denison (1996:10) gives an example of a study in Kampala in Uganda that showed that women felt at risk of HIV because of the behaviour of their husbands, an issue that to them was outside their control. The model also fails to consider that some of the high-risk behavioural tendencies are embodied in people's socio-cultural contexts and hence the need to identify such bad habits in the culture and change them.

#### **4.5 Dealing with employees who have HIV/AIDS**

Tertiary prevention interventions target those employees who have already contracted HIV. The task of the industrial psychologist is to stop the HIV/AIDS

problem in the work place from getting worse by lessening the negative effects of the syndrome, both on the infected employees and on the employees not infected with HIV, and by getting the employees to stop risky behaviours that may lead to the infection of others. The tertiary interventions make sure that those who are infected with HIV/AIDS do not spread the virus to others. Primary, secondary, and tertiary interventions focus on individuals. Another type of intervention focuses on group counselling. Both individual and group interventions focus on therapy and caring for those with HIV.

#### **4.5.1 Types of intervention**

In a bid to come up with effective interventions to serve the organisation, the industrial psychologist has to ask certain questions:

1. How will you assist employees who are not HIV-positive to deal with this epidemic?
2. What are the goals when dealing with employees who have HIV/AIDS?

In a bid to answer these questions the industrial psychologist can offer interventions that are convenient at each stage. In dealing with the employees who are already infected with HIV/AIDS, there is a need for psychosocial support as a tertiary coping measure. The reason for having psychosocial support is that it helps employees to cope with the stressors that come with knowing one's HIV/AIDS status and other social stresses that come with losing a spouse or a family member. Most importantly for the organisation, if employees are stressed or depressed their performance is reduced, as is overall productivity in the organisation. In addition, employees who are depressed are more prone to accidents and errors that might even put the health of other employees at risk.



#### **4.5.2 Psychosocial support for People living with HIV/AIDS**

Psychosocial support is considered an essential element of palliative care, which is care that strives to relieve, improve, or control symptoms and maximize the quality of care (Sanei, 1998 cited in Schietinger, 1998:1). It seeks to offer an opportunity for communities to interact constructively with people affected by HIV/AIDS thereby enhancing the likelihood of a positive rather than a negative community response to the epidemic. Psychosocial support enables individuals to cope with adverse circumstances of HIV/AIDS which includes the shock of learning HIV or AIDS having been contracted by one's self, one's spouse, or one's relative; the stigma and discrimination associated with HIV/AIDS; the long period of illness; death of a productive family member and mourning for the loss of one or more family members due to the pandemic. Winiarski (2001:37) states that psychosocial support lays the groundwork for families hit with HIV/AIDS to engage in constructive problem solving to manage and plan for these and other immediate and long term needs.

Psychosocial support encompasses a wide range of activities, including:

Formal activities designed to provide counselling, psychological care, and social and spiritual support such as

- Individual counselling: providing an opportunity for those affected to express their feelings and to talk about, prioritise and solve problems and for others to express empathy and concern for them
- Group counselling : undertaking the activities related to individual counselling in a setting that provides opportunities for mutual support by other individuals experiencing the same problems
- Pastoral counselling: adding to the activities related to counselling various forms of spiritual support such as praying, singing, and reading inspirational texts.

### 4.5.3 HIV/AIDS Counselling

HIV/AIDS has forced people to think of caring rather than curing; since there has not been any cure for the disease, the focus has shifted to the physical and mental welfare of people living with HIV/AIDS. According to Gillis (1994:2) cited in Dyk (2005:174) counselling is defined as “a facilitative process in which the counsellor, working within the framework of a special helping relationship, uses specific skills to assist clients to develop self knowledge, emotional acceptance, emotional growth, and personal resources”. The single most important requirement to be an HIV/AIDS counsellor is to have compassion for another person’s struggle to live beyond the confines of a disease, and the willingness and commitment to walk the walk with the person and his or her significant others. The two main aims of a counselling process are to help clients manage their problems more effectively and to develop unused or underused opportunities to cope more fully; and to help empower clients to become more effective self-helpers in the future (Egan, 1998 cited in Dyk, *ibid*: 175).

The four fundamental questions of the counselling process

The counsellors are supposed to help the clients to answer four basic questions in an effective counselling session.

Current scenario: What are the problems (issues, concerns, undeveloped opportunities) I should work on? The answer to this question is the clients’ current scenario. According Egan (1998: 28) to elicit the current scenario, the counsellor must help the clients to tell their stories in such a way that the counsellor (as well as client) will understand the problem situation. Counsellors have to help the clients avoid the ‘blind spots’ that prevent the clients from seeing themselves and their situations as they really are.

Preferred scenario: What do I need or want instead of what I have? Answers to this question constitute the preferred state of affairs, or preferred scenario. The preferred scenario spells out possibilities for a better future, and it culminates in an agenda for change. Counsellors must help clients to discover and commit themselves to what they need and want for a better future. Gelatt (1989:255) has said that 'the future does not exist and cannot be predicted. It must be imagined and invented.' Egan (1998:28) warns that counsellors should never move from 'what is wrong?' to 'what do I do about it?' without exploring the question 'what do I need and want? Helping clients to discover what they really want has a profound impact on the entire helping process.

Strategies: What must I do to get what I need or want? Answers to this question produce strategies for goal-accomplishing action. Clients now need to discover ways of bridging the gap between the current scenario (what they have) and the preferred scenario (what they need and want). They have to ask themselves what they have to do to get what they need or want. Counsellors must help clients to see that there are many different ways of achieving their goals. Counsellors should help clients organise their actions into coherent, simple, achievable plans that they will be able to carry out to accomplish their goals (Egan, 1998: 28). A plan of action is a map the client uses to get to where he or she wants to go.

Action: How do I make all this happen? Answers to this question help clients to move from planning mode to action, getting-it-done or accomplishment mode. But action should not be the last stage of change.

#### Phases in the counselling process

There is no recipe for good counselling, but dividing the counselling process into the following four phases might provide a useful framework: establishing a working relationship with the client; helping the client tell his or her story; developing an increased understanding of the problem; and intervention or action

Phase one: relationship building

The goal of relationship building is to establish an open and trusting relationship in which the client will feel safe enough to address personal issues and to disclose information to the counsellor. This is crucial to effective and ethical counselling and is usually done in the first few minutes of counselling. The counsellor should provide a context that is unambiguously therapeutic, provide a physical setting that is conducive to enhancing the therapeutic relationship, and allow a client to negotiate the definition of the relationship by listening, observing, and confirming. He/ she should assure the client that he/she would maintain absolute confidentiality in whatever they would have discussed. Besides all this, he/she should also avoid making judgements about others in the client's life. In this phase, the counsellor should have counselling such as listening skills, observing and tracking. He/ she should also be sensitive to non-verbal behaviour, be responsive to the emotional tone of the client, and build trust through warmth, empathy, dedication, respect acceptance, and genuineness.

#### Phase two: helping the client tell his or her story

The goal of this phase is to help the client explore the situation and tell his/her story. This phase is very important because it determines the counsellors' understanding of the client's world and can be called the 'information-gathering phase. How the counsellor goes about gathering information determines whether and to what extent he/she understands the problem. Exploration of the client's story is facilitated by a supportive, client-centred approach and an active, benevolent curiosity. The counsellor should resist the temptation of entering the intervention or action phase before the client's story has been explored. Accurate empathy, genuineness, respect, concreteness, minimal verbal response, questions, and probes are the counselling skills central to this phase. These counselling skills should help the client to feel understood, open up and share his or her story with the counsellor and better understand how he or she feels and why.

#### Phase three: developing an increased understanding of the problem

The goal of this is to gain, together with the client, a deeper understanding of the problem and to form the basis for specific action. The depth of the counsellor's understanding of the client's world will depend on how well the client's story is explored. This will in turn determine the efficacy of the interventions. An increased understanding of the problem does not imply that the problems are more important than the solutions. Nevertheless, without a comprehensive understanding of the problems, the interventions or actions may be misguided and useless. Advanced accurate empathy, summarising, clarifying, questioning, feedback or challenging and immediacy are the counselling skills central to this phase. These counselling skills should help the client to explore and understand the problem; explore feelings; explore previously hidden (or suppressed) feelings, emotions, attitudes, or behaviour; and to start considering options and examining alternatives.

#### **4.5.3 The importance of Psychosocial Care**

##### **1. Coming to grip with a positive HIV test**

There is widespread agreement among experts and institutions around the world that psychosocial support is an integral aspect of counselling associated with HIV testing, particularly to assist individuals in coping with a positive HIV test result. According to Anderson (1994:5), "individuals can be empowered by knowing whether they are HIV-negative or HIV-positive-if social support is available".

##### **2. Learning to "Live positively with HIV"**

Peer support is a vital aspect of HIV care, and caring psychosocial support is the primary function of peer support. Peer support programmes provide people who have learned that they are HIV- positive with an opportunity to see that others are surviving and living meaningful lives with HIV. The experience has provided hope and strength to countless individuals who were in despair about being HIV-positive (Anderson, 1994: 5). People with HIV/ AIDS are in need of professional counselling to help cope with their lives. Equally important, however is the psychological and social support of other HIV infected people, who know exactly

what it is like to be told they are HIV-positive and to live with HIV on a daily basis. Support of this kind can help people with HIV recover their self-respect and self-confidence, lead socially useful lives, plan for their future, and, eventually, approach death with serenity.

### 3. Facing Discrimination and Stigma

Rejection of people who have HIV, or who are perceived to have HIV, occurs within couples, extended families, communities, workplaces, health care settings, and at international borders (Anderson, 1994:7). Experiencing such discrimination can be emotionally, socially, and physically devastating. Psychosocial support is essential to enable victims of discrimination and rejection to continue functioning in settings that were once safe but are now hostile. The programmes also provide assistance in rebuilding and maintaining a positive self-image in social settings that erode people's confidence and sense of self-worth, and that empowers them to disclose their HIV status to families and others in the community.

### 4. Coping with Loss and Grief

Anderson (1994:7) states that psychosocial support enables individuals and families to cope effectively with the continuous stream of losses related to HIV/AIDS. As HIV progresses, it causes gradual and unrelenting loss of function. People lose their physical strength and mobility, cognitive abilities, and, ultimately, the ability to function in their jobs and community. Both the individuals who are infected and the families who are affected need psychosocial support to cope with such loss. They need assistance in planning for the future, including making wills and selecting guardians for their children. Ultimately, the people affected by HIV/AIDS need psychosocial support to help them manage the grief that results from the death of loved ones and expression of sympathy and support that enables the family to cope with their loss and grief.

#### **4.6 Changing Behaviours and Attitudes about HIV/AIDS**

Individual level change places emphasis on changing the beliefs, attitudes, and behaviours of employees about HIV/AIDS. Individual health behaviour change is the primary focus of workplace health promotion interventions. Moorhead and Griffin (1998:86) write that attitudes are complexes of beliefs and feelings that people have about specific ideas, situations, or other people. Attitudes are not as stable as personality attributes and they can be changed by new information (Moorhead and Griffin 1998:90). To make the interventions at the individual level suitable, it is appropriate to follow the stage-phase change perspective of behavioural change. According to this perspective, the employee must go through several stages of behaviour to change. Bargraim *et al* (2007:61) state that attitudes are influenced by values and the values are principles or standards that can be adopted as behavioural guidelines. Behavioural change can be viewed as a process consisting of five stages: pre-contemplation, contemplation, preparation, action, and maintenance.

Examples of how to apply these five stages to HIV/AIDS management at the individual level are given below:

1. Individuals at the pre-contemplation stage are not yet seriously thinking about changing their risky behaviours to avoid contracting or spreading HIV. Groups and organisations at the pre-contemplation stage are under the impression that they are not being affected by HIV/AIDS.
2. Individuals at the contemplation stage start thinking more seriously about changing their risky behaviours. This happens for a period of six months after first starting to think about how to avoid contracting or spreading HIV. Groups and organisations realise the impact of HIV/AIDS in the workplace and start contemplating changes during the first six months following this realization.
3. Individuals who are more ready to change their risky behaviours start to prepare for such a change. This stage is significant because the individual has already started making small changes to avoid contracting HIV. In addition, the

individual has a plan of action for how to change risky behaviours and adopt safe behaviours. Groups and organisations understand the impact of HIV/ AIDS and start to prepare for cultural change. Groups and organisations have already made small changes to their norms, culture and policy documents.

4. During the action stage, the individual is able to continue with the safe behaviours for six months after initiating the change. Groups and organisations are able to continue dealing with the impact of HIV/AIDS in the workplace, which affects both productivity and costs.

5. The final stage, maintenance, continues until termination, which is the total commitment and ability to resist any temptation to revert to risky behaviours. Groups and organisations have undergone a total cultural change. A healthy lifestyle is promoted, and this facilitates the management of HIV/AIDS in the workplace.

#### **4.7 Changing Individual Attitudes Towards Employees with HIV/AIDS**

Groups and teams are likely to have a member who is HIV-positive. The main task of the industrial psychologist is to assist groups and teams through in service programmes to continue working with the infected employee to avoid discrimination. This can be achieved through building a positive organisational culture. Wilson (2004: 179) states that organisational culture is a popular explanatory concept frequently used to describe a company, a rationale for people's behaviour, a guideline for action, a cause for condemnation or praise or a quality that makes a company what it is. Possible interventions at the group level are programmes that emphasise disease prevention, conflict resolution and communication skills. In addition to these interventions, social support groups must be established and equipped to provide the following support to HIV-positive group members: emotional support for example empathy and trust, instrumental support, for example, tangible assistance and services, informational support, for example, advice, information, suggestions, and



appraisal support, for example, feedback, confirmation and social comparison. Group level intervention includes educating people and changing attitudes.

#### **4.8 Changing the Organisation's Attitudes Towards Infected Employees**

The aims of organisational level interventions are to facilitate and reinforce healthy behaviour by employees, to reduce risk factors and to increase organisational social support resources. This helps to build cognition in individuals. Moorhead and Griffin (1998: 89) define cognition as the knowledge a person presumes to have about something based on perceptions of truth and reality.

Organisational level interventions are important for three reasons:

1. They establish a shared responsibility within the organisation for HIV/AIDS in the organisation.
2. They are necessary to remove the barriers associated with the effective management of HIV/AIDS in the workplace. These barriers negatively affect possible healthy behavioural change
3. They create a culture that encourages and supports comprehensive HIV/AIDS management initiatives.

Before implementing interventions at the organisational level, it is advisable to apply the stage phase approach to behavioural change. This is to determine whether the organisation is in the pre-contemplation stage, contemplation stage, action, or maintenance phase in its response to HIV/AIDS in the workplace. The focus of organisational level change is on changing organisational structures, policies, priorities, and procedures to facilitate the management of HIV/AIDS in the workplace. Internal structures and organisational demands can affect the stress experienced by employees with HIV/AIDS and those working with them. Interventions at organisational level emphasise the need to streamline work demands, decrease frustration, and promote healthy coping techniques for dealing with disease.

#### **4.9 Helping Communities Change Behaviours and Attitudes to HIV/AIDS**

To help communities change their behaviours and attitudes towards those who have HIV/AIDS, the industrial psychologist can suggest a six stage process. Moorhead and Griffin (1998:90) observe that attitudes are not stable so they can be changed with new information. Just so, the six-stage process can change the views of the community about HIV/AIDS. The six stages are becoming aware, increasing knowledge, increasing motivation, learning skills, taking action and maintaining change.

The community campaign should focus on the issues related to HIV/AIDS at each stage of the process. Before any communication-behaviour change campaign is begun to change the attitudes and behaviours of the community regarding HIV/AIDS, it is important for the organisation to determine the community's current understanding of the syndrome. This forms the basis for further communication-behaviour change initiatives developed by the organisation to help the community deal with HIV/AIDS.

Stage 1: Becoming Aware. During this stage, the communication behaviour change campaign should gain the attention of the community with which the organisation is trying to communicate. Moorhead and Griffin (1998:90) state that the actual syndrome must be identified, and the community must be aware of the effect the syndrome is having on their existence. It is important to get key community leaders involved from the start of such a campaign. Emphasis must be placed on increasing the community's awareness of the risks associated with HIV/AIDS, and on providing knowledge about how to make behavioural changes. The community must be aware of the health problems associated with HIV/AIDS, as well as the ways not to contract or spread the virus.

Stage 2: Increasing knowledge. The second stage is to spread information about HIV/AIDS. This can include information on the myths surrounding the syndrome, the facts regarding the spread and contraction of HIV/AIDS, and safe behavioural

practices. The information about healthy behaviours must be easy to understand, interesting and meaningful for community members. Messages communicated to the community must reflect their culture.

Stage 3. Increasing motivation. The third stage focuses on motivating community members by emphasising the positive consequences of behavioural change. This step is the most difficult, because the result of becoming infected, which is death, is still far in the future. To facilitate this stage, community leaders must be involved, continuous contact with the community must be maintained, and behavioural change activities must be developed.

Stage 4 and 5. Learning skills and taking action: During the fourth and fifth stages, the organisation should provide and assist with training the community in dealing with and caring for those who have contracted HIV/AIDS. Training can cover preventive behaviours, the training of peer counsellors and how to help HIV/AIDS employees to take their medication. Helping young women and empowering them to try and negotiate safe behaviours is also an important aim during this phase. These women can learn conflict resolution and negotiation skills, which can be done through demonstrations and practice. In addition, the organisation can help those community members who want to change by providing feedback and advice.

Stage 6: Maintaining change: For changes in behaviour and attitude to be maintained, support must be provided to the community. This is what the sixth stage is about. Social support, self management training and training to increase self confidence can be used to encourage community members to behave in a healthy manner all of the time. The organisation can work together with local nurses and doctors and can train people to become counsellors.

#### **4.10 Coordinating HIV/AIDS Programmes and Interventions in the Workplace**

All the interventions that have been discussed so far need to be integrated with each other. In other words, it is important to integrate the different levels of health promotion interventions. In addition, these levels of intervention must be classed according to the level of prevention, that is, primary, secondary, or tertiary. Health promotion programmes and, to a lesser extent, employee assistance programmes (EAPs) can provide this integration. Health promotion programmes are designed to educate employees about healthy lifestyles and to encourage them to adopt healthy behaviours. This reduces the risks and the results of unhealthy living. In contrast, EAPs are designed to identify troubled employees who may need counselling and treatment to solve their behavioural problems. From these two definitions, it is clear that health promotion programmes and EAPs differ in terms of the following.

- Health promotion programmes focus on the primary prevention of health problems. They represent a proactive approach to the prevention of the spread of HIV/AIDS.
- EAPs focus on employees who have already developed problems that are affecting their jobs. They are reactive and deal with people who are already infected with HIV/AIDS.

Health promotion programmes are used as primary prevention tool, while EAPs function as secondary and tertiary prevention tools. Health promotion programmes focus on educating employees about HIV/AIDS and risky behaviours, and the effects of these on them and the organisation. These programmes also target the communities from which the employees come. In contrast, EAPs focus on providing assistance to already infected employees. However, high- risk individuals identified through health promotion programmes will also be referred to EAPs for assistance in the workplace.

To be effective, health promotion programmes must have the following characteristics:

- They must be visible and known throughout the organisation, and even the community.
- They must be planned and organised with care.
- They must be managed professionally with appropriate evaluation and supervision.

To put health promotion programmes into practice the organisation must provide professional employees with specific skills and expertise, known as software. The professionals, such as psychologists, doctors and social workers, and facilities required to deliver the services, are known as hardware. Both are required to facilitate change in risky behaviours and to maintain healthy lifestyles. Software includes: access to knowledgeable advice about HIV/AIDS, steps to be taken to prevent the spread of HIV, available techniques to assist employees not to revert to risky behaviours and stress management skills. Hardware includes availability of health promotion programme staff positions, condom dispensers, private counselling facilities, assistance with medication, assistance with medical schemes, and assistance with the changing of work to accommodate HIV-infected employees.

#### **4.11 Training Managers to deal with HIV/AIDS in the Workplace**

In the future managers of organisations must be prepared to deal with HIV/AIDS in the workplace. In order to effectively manage HIV/AIDS, managers must have knowledge of the following:

How the virus is transmitted

- The stages followed by the syndrome
- Strategies that prevent discrimination against employees who are infected with HIV or who have AIDS
- Knowledge of laws protect employees who are infected or have the syndrome

- How to manage the psychological climate of teams with members who have HIV/AIDS
- How to manage the culture of the organisation to prevent disruptions and discrimination,
- How to become aware of the various services or interventions of EAPs and health promotion programmes.

#### **4.12 Antiretroviral Therapy (ART)**

The first antiretroviral drug, AZT (zidovudine), was approved for use in 1987. In 1994, ART was used for the first time to prevent mother to child transmission of HIV. In 1995, the use of triple drug therapy or HAART (Highly Active Antiretroviral therapy) was introduced. Grant *et al* (2001:13) states that antiretroviral treatment fights the HI virus such that the viral load is kept down to undetectable levels; however, it has to be noted that it does not cure HIV/AIDS because the virus remains latent or dormant through out the body and it can easily become reactivated in the right conditions. When reactivated, it continues to attack the infected person's immune system.

Grant *et al* (2001:108) writes that HIV/AIDS is a new disease discovered in 1988 and antiretroviral drugs are still patent drugs so they are expensive and the public health systems of poor countries cannot afford to buy them. Although all the world's governments recognise treatment and care, including access to antiretroviral drugs as an element of the response to the global HIV/AIDS epidemic, the cost associated with ART and the lack of political will to roll out national treatment programmes remain the most important obstacles to adequate management of HIV infection in many countries (Dyk, 2005:72). Needed therefore is a partnership of all stakeholders including the employers or the private sector and all other organisations to try to provide antiretroviral treatment for their employees.

Goals of antiretroviral therapy

Antiretroviral therapy has the following four primary goals:

1. Virological goal: to reduce the HIV viral load as much as possible- preferably to undetectable levels- for as long as possible.
2. Immunological goal: to restore and or preserve immunological functions so as to improve immune functioning, reduce opportunistic infections and delay the onset of AIDS.
3. Therapeutic goal: to improve the quality of the HIV-positive person's life.
4. Epidemiological goal: to reduce HIV-related sickness and death, and to reduce the impact of HIV transmission in the community.

#### **4.13 Ethical issues for Organisations when offering ART**

Antiretroviral treatment is a lifetime treatment that requires strict adherence in order to achieve viral suppression and avoid the risk of mutation, the development of resistant strains, and drug failure. Dyk (2005:80) states that drug resistance can develop very rapidly with missed or inadequate doses of medication. Since missing or inadequate doses of medication leads to resistance or great deterioration of the patient, if an organisation offers antiretroviral therapy to its employees it must be asked what the organisation will do if an employee on this program retires or is dismissed or retrenched from work.

To answer that when an employee is dismissed he/ she should immediately be removed from the programme seems too easy. If that person does not get an alternative way of getting the drugs the deterioration in the person's health will be quick and lead to death. It remains an ethical issue under debate but logically if an employee is no longer part of the organisation, he loses the benefits from the organisations that are meant only for its employees (Dyk, 2005:80). A case study of De Beers in South Africa shows that the organisation gives its employees antiretroviral therapy and all other services that they require for counselling and psychosocial support. The organisation however, has a policy that if an employee is dismissed then he/she ceases to be beneficiary of the HIV/AIDS programmes

but employees who retire remain beneficiaries of the scheme ([www.debeers.co.za](http://www.debeers.co.za)). It appears to be a strategy for the organisation to encourage good behaviour and to punish bad behaviour amongst its employees and involves an element of discrimination that is not desirable.

#### **4.14 Conclusion**

In the chapter emphasis was given to the steps that can be followed in implementing an HIV/AIDS program at the work place. The AIDS risk reduction model was looked at as a way of reducing risky behaviour among individuals. Psychosocial support and counselling were looked at in detail as tertiary interventions that can help employees to cope with the depression of accepting one is HIV positive status as well as coping with the grief of losing loved ones due to the pandemic. Antiretroviral therapy was also looked at as a way of making infected people live longer and better and an ethical question for which organisations to look into as they begin to offer antiretroviral therapy was put forward.



## **CHAPTER 5**

### **RESEARCH METHODOLOGY**

#### **5.0 Introduction**

The previous three chapters presented a theoretical framework tied to the research questions whilst at the same time giving the background of HIV/AIDS with respect to the Zimbabwean situation and the world at large. This chapter focuses on the methodology used during research. It covers research design, population, sampling procedure, data collection, analysis procedure, and ethics of the research.

#### **5.1 Research Design**

Kumar (2005:84) defines a research design as a plan, structure, and strategy of investigation so conceived as to obtain answers to research questions or problems. The plan is the complete scheme or program for the research.

##### **5.1.1 Research Purposes**

Babbie and Mouton (2002: 79) state that social research serves many purposes though there are three most common and useful purposes which are exploration, description, and explanation.

###### **5.1.1.1 Exploration**

Exploration is conducted when a research is conducted to explore a topic, or to provide a basic familiarity with that topic (Babbie and Mouton, 2002:79). This

approach is typical when a researcher examines a new interest or when the subject of study itself is relatively new.

#### **5.1.1.2 Description**

Description is when the researcher observes and then describes what was observed (Babbie and Mouton, 2002:80). Scientific studies are more careful and deliberate and therefore are more accurate and precise than casual description.

#### **5.1.1.3 Explanation**

A purpose of social scientific research is to explain things (Babbie and Mouton, 2002:81). A researcher has an explanatory purpose if he or she wishes to know why an event ended in a particular manner, as opposed to simply describing what happened.

### **5.1.2 Research Approaches**

There are two main types of research approaches; these are qualitative research and quantitative research.

#### **5.1.2.1 Qualitative research**

Leedy and Ormrod (2001:100) define qualitative research as research that seeks a better understanding of complex situations, it is often explanatory in nature and the observations are used to build theory from the ground up. It is often used to explore and to interpret theories. It deals with flexible guidelines, unknown variables, and the researcher's personal view. The data is collected from a small sample using either observation or interviews. Data is analysed using words, as it is deduced from narratives and individual quotes of the interviewed or observed subjects.

#### **5.1.2.2 Quantitative research**

Leedy and Ormrod (2001:100) define quantitative research as research that seeks explanations and predictions that will generalise to other persons and places with the intention to establish, confirm, or validate relationships and to develop generalisations that contribute to theory. It deals with known variables and it tests hypotheses. It uses structured instruments like the structured questionnaire, which will be using closed ended questions or rated scales. The data which is collected is analysed using statistical methods.

This research opts for quantitative research as it seeks to generalise the findings on the management of HIV/AIDS at the workplace in the selected organisation in Harare to assume that it is the similar throughout the country. Furthermore, the research seeks to explain the highly volatile environment in Zimbabwe and to predict the impact HIV/ AIDS programmes would have on the working population with regard to the impact of HIV/AIDS at the workplace.

#### **5.2 Sampling frame**

Tustin *et al* (2005:96) define a sampling frame as the listing or directory from which a sample will be drawn. In the study, the sample frame includes all the employees from the six organisations that were selected for research. From these, employees will be selected at random to meet the objectives of the research and to access the effectiveness of the HIV/AIDS programmes in place at the workplaces.

#### **5.3 Sampling**

Blanche *et al* (2006:49) defines sampling as the selection of research participants from an entire population, which involves decisions about which people, settings, events, behaviours, and /or social processes to observe. There

are two main methods for sampling which are probability and non-probability sampling.

### **5.3.1 Probability sampling**

Probability sampling is a plan in which everyone in the population has a chance of being included in the sample (Tustin *et al*, 2005:344). Probability samples are those in which members of the population have known chances of being selected in the sample. There are five main types of probability sampling methods these are; simple random sampling, systematic sampling, stratified sampling, cluster sampling and multistage sampling.

#### **5.3.1.1 Simple random sampling**

With simple random sampling, the probability of being selected in the sample is known and equal for all members of the population. For a simple random sampling sample, members are chosen randomly for inclusion in the sample with each population element having an equal probability of being selected. Each possible sample of units has a known and equal chance of being the one that is actually chosen.

#### **5.3.1.2 Systematic sampling**

The systematic sampling method chooses sample members at regular intervals and requires the computation of a sampling interval. For this method sample members are chosen at regular intervals after a random start. When the population has been arranged and a systematic sample drawn which includes each *n*th element, the result will be more or less as representative as a simple random sample of the population.

#### **5.3.1.3 Stratified sampling**

According to the stratified sampling method, the population is first divided into subgroups called strata and then random samples are drawn from each group. Each stratum may be a sample in proportion to its size in the overall population or sample members of different strata may have disproportionate chances of being selected.

#### **5.3.1.4 Cluster sampling**

In cluster sampling the population is divided into subgroups called clusters, each of which represents the entire population, and a sample of clusters is drawn. Cluster sampling is ideal when the population is geographically dispersed and travelling costs possibly prohibitive. Preference for cluster sampling occurs when there is a list (sample frame) of clusters and not individual members. This research uses cluster sampling in that six organisations were selected in Harare, the capital city of Zimbabwe. Managers and employees are to be randomly selected from these organisations to carry out the research.

#### **5.3.1.5 Multistage sampling**

With multistage sampling, the final sample members are chosen by means of one of the other probability methods described above, but a number of stages precede the final selection.

### **5.3.2 Non-Probability sampling**

Tustin *et al* (2005:344) defines non-probability sampling as instances in which the chances of selecting members from the population in the sample are unknown. Non-probability sampling relies on the discretion of the researcher.

There are five main types of non-probability sampling and these are convenience sampling, judgemental sampling, purposive sampling, quota sampling, and multiplicity (snowball) sampling.

#### **5.4 Sample size**

Gray (2006:85) states that before collection of data one must first stage determine the actual size of the sample needed, and this calls for determining the size of the confidence interval first. This is the range of figures between which the population is expected to lie. For this study, the confidence interval is set at 4 per cent, and 91 percent of the population pick a particular answer. This means that we are confident that between 87 percent ( $91-4$ ) and 95 percent ( $91+4$ ) of the entire population would have picked that answer. Stangor (2007: 146) states that increasing the sample size increases power, it is also expensive because recruiting and running research participants can require both time and money. Stangor *ibid* observes that a compromise is usually made because more participants have a greater likelihood of detecting the relationship of interest and thus of detecting relationships between variables.

#### **5.5 Sampling error**

Sampling error is one source of variance. A common cause for sampling error lies with sampling frames (Gray, 2006:116). The members in the sampling frame have to be easily identifiable to avoid under-coverage or over-coverage. Under-coverage is where the sampling frame excludes possible respondents and over-coverage is where the sampling frame includes more respondents even such as do not qualify for the particular study. In this study to avoid, under-coverage or over-coverage of the sampling frame that ultimately causes sampling error, only employees from the six selected organisations will be eligible to be respondents of this study.

## **5.6 The questionnaire**

Kumar (2005:126) defines a questionnaire as a written list of questions, the answers to which are recorded by respondents. In a questionnaire respondents read the questions, interpret what is expected and then write down the answers. The nature of the investigation influences the method for collecting data so, for example, if the study concerns issues that respondents may feel reluctant to discuss with an investigator. This research is about HIV/AIDS that many people are reluctant to talk about openly for the fear of being stigmatised not to mention cultural impediments to open up on issues of sexuality, hence a structured questionnaire is most appropriate for the study. A questionnaire is good for ensuring anonymity. When the study population, is scattered over a wide geographical area, you have no choice but to use a questionnaire, as interviewing in such circumstances would be extremely expensive.

This research employs two questionnaires one for the management and the other for general employees. The questionnaire for management was administered to employees in managerial positions on the assumption that they would give a managerial view on the issue of management of HIV/AIDS programmes in the organisation. The employees' questionnaire was administered to employees in non-managerial positions with the objective of gathering information on how they see the management of the HIV/AIDS programme in the organisation.

### **5.6.1 Management questionnaire**

The management questionnaire has six sections to enable the researcher to cover all the research questions for the study

Section A: Covers biographical information for the management employee responding to the questionnaire and company information.

Section B: covers information on HIV/AIDS workplace programme/ policy. It attempts to address the research questions relating to availability of HIV/AIDS programmes and policies at the workplace, also the sponsoring of the HIV/AIDS programmes at the workplace and problems that are encountered in implementing such programmes.

Section C: Tries to identify the impact of HIV/AIDS on the operations of the organisations. It also tries to identify whether the impacts are reduced or increased by the introduction of the HIV/AIDS programme or whether the impact remains unchanged.

Section D: covers information on the benefits that the workplace programmes have for their employees.

Section E: Has information on recommendations and opinions the management has on the running of the HIV/AIDS programme and if they feel it is a total failure/success. If it has failed, what in their opinion has led to the failure.

Section F: covers organisations that do not have the HIV/AIDS programmes. It tries to find out why these organisations do not have the programme and enquires after their plans with relation to the introduction of HIV/AIDS programme/ policies in the workplace.

### **5.6.2 Non-Management level employees' Questionnaire**

The employees' questionnaire has five sections. The sections cover the research questions, and checks on effectiveness in the management of the HIV/AIDS programmes. It also seeks the employees' attitudes towards the management and/ or implementation of the programmes.



Section A: Covers the employees' biographical information that is gender, age, years in service in the organisation, level of education, position in the organisation and marital status.

Section B: Covers information on the availability and assessment of the effectiveness of the HIV/AIDS programmes/policies in the organisation.

Section C: Assesses the benefits and the effectiveness of HIV/AIDS awareness programmes in the organisation. It also assesses the availability of protective measure instruments for the employees who want to use them.

Section D: Gives the employees a chance to give their recommendations and opinions on the way the HIV/AIDS programmes in the organisation is being managed. It also asks for the perceived reasons for the failure of the HIV/AIDS programmes at the workplace.

Section E: This section is for employees whose organisations do not have HIV/AIDS programmes. It seeks to find out from the employees why the organisation does not have the programme and any future prospects of launching any such a programme or policy.

### **5.6.3 The Summated Rating or 5 point Likert scale**

This scale is based on the assumption that each statement or item on the scale has equal 'attitudinal value', 'importance' or 'weight' in reflecting an attitude towards an issue in question. This assumption is also the main limitation of this scale as statements on a scale have equal attitudinal value. In developing a Likert scale, there are a number of things to consider. First, decide whether the attitude to be measured is to be classified into one-two- or three directional categories (that is, whether you want to determine positive, negative and neutral positions in the study population) with respect to their attitude towards the issue under study. Next, consider whether you want to use categories or numerical scale. This should depend upon whether you think that your study population can express itself better on a numerical scale or in categories. The decisions about the number of points or the number of categories on a categorical scale depends

on how finely you want to measure the intensity of the attitude in question and on the capacity of the population to make fine distinctions. In both questionnaires [one for management and the other for employees] the Likert scale was used and it uses both numerical and categorical scales. Numerically it uses a scale of 1 to 5, '1 being' strongly agree, '2' agree, '3 for' uncertain, '4 for' disagree and '5 for' strongly disagree. On the categorical scale, the possibilities strongly agree, agree, uncertain, disagree, and strongly disagree.

#### **5.6.4 Validity and Reliability of the Questionnaire**

Gray (2006:90) states that to ensure validity, a research instrument must measure what it is supposed to measure. In order for a research instrument to be valid it has to cover subject areas that have been operationally defined referred to by Gray (*ibid*) as Zone of neglect, it should however, eliminate issues of no direct relevance to the research study-Zone of invalidity. The issue of validity is more complex however as it can be defined in seven types namely: internal, external, construct, predictive, criterion, content and statistical validity. Internal validity refers to correlation between questions and the extent to which causal conclusions can be drawn, for instance the relationship that a highly volatile environment increases the impact of HIV/AIDS on an impoverished population. External validity is the extent to which it is possible to generalise from the data to a larger population or setting, for instance, to infer that the results on the management of HIV/AIDS programmes at the workplace in Harare are the same throughout Zimbabwe since all the organisations are in the same environment. Stangor (2007:93) defines content validity as the extent to which the measured variable appears to have adequately covered the full domain of the conceptual variable. Stangor (*ibid*) defines criterion validity as the extent to which a self-report measure correlates with a behavioural measured variable.

The internal consistency of the questions in the questionnaire was tested by means of Cronbach's alpha values and was found to be 0.712 for the

Management questionnaire and 0.741 for the non-management questionnaire. The purpose of the Cronbach's alpha is to provide a lower bound estimate for how much variance in the empirical scale would be explained by an imaginary perfect measure of the same theoretical construct. Factor analysis was used for determining the specific scale structure (constructs) present in a set of data. A specific scale structure for a set of theoretical constructs was established to assess the reliability of empirical measures of that structure by examining their internal consistency.

### **5.6.5 Administering the Questionnaire**

The mailed questionnaire is one sent to prospective respondents by mail. This approach presupposes that you have access to their addresses. Usually it is a good idea to send a prepaid, self-addressed envelope with the questionnaire as this might increase the response rate.

Sometimes you can administer a questionnaire in a public place such as a shopping centre, health centre, hospital, school or pub depending on the type of study population you are looking for. Usually the purpose of the study is explained to potential respondents as they approach and their participation in the study requested. Apart from being slightly more time consuming this method has all the advantages of administering a questionnaire collectively.

Collective administration one of the best ways of administering a questionnaire is to obtain a captive audience such as students in a classroom, people attending a function, participants in a program or people assembled in one place. This ensures a very high response rate as you will find few people refuse to participate in your study. You can also explain purpose, relevance and importance of the study as you have personal contact with the study population. Collective administration will be used in this research since the researcher went to the selected organisations in Harare to administer the questionnaire to the

employees at the same place with the objective of finding out how the HIV/AIDS programme in the workplace is being managed.

#### **5.6.6 Advantages of a Questionnaire**

It is less expensive than interviewing respondents; it saves time and human and financial resources. The use of a questionnaire is comparatively convenient and inexpensive. It offers greater anonymity as there is no face-to-face interaction between respondents and interviewer. In some situations when sensitive questions especially to do with HIV/AIDS or people's sexual behaviour are asked people may be reluctant to answer. They feel more comfortable completing a questionnaire since it offers anonymity. It helps to increase the likelihood of obtaining accurate information.

#### **5.6.7 Disadvantages of Questionnaires**

Application is limited to a study population that can read and write. It cannot be used on the illiterate, old, young, and handicapped. Response rate is low- questionnaires are notorious for their low response rates, that is, people fail to return them. However, the response rate is not a problem when a questionnaire is administered in a collective situation. There is self-selecting bias- not everyone who receives a questionnaire returns it, so there is self-selecting bias. Those who return the questionnaire may have attitudes, attributes, and motivations that are different from those who do not. Hence, if the response rate is low, the findings may not be representative of the total study population.

Opportunity to clarify issues is lacking if for any reason respondents do not understand some questions, there is no opportunity for them to have the meaning clarified. If different respondents interpret questions differently, this will affect the quality of the information provided. Spontaneous responses are not

allowed for mailed questionnaires are inappropriate when spontaneous responses are required, as a questionnaire gives them time to reflect before answering. The response to a question may be influenced by the response to other questions as respondents can read all the questions before answering, the way they answer a particular question may be affected by their knowledge of other questions.

## **5.7 The Ethics of the Research**

Gray (2006:58) states that ethics is a philosophical term derived from the Greek word *ethos* that means custom or character. Determining whether a research project is ethical is a difficult enterprise because there are no clearly right or wrong answers to ethical questions, as ethics involves values and not facts (Stangor, 2007:41). In light of the above statement, the ethics of the research concerns the appropriateness of the researcher's behaviour in relation to the subjects of the research or those affected by it. This study is about HIV/AIDS, that a very sensitive issue to many; for some individuals it is a matter of life and death and hence it is a delicate issue that has to be handled with caution. Cant (2003:11) shares the same sentiment that researchers should be ethical, that participants should be comfortable, not be deceived, be willing and informed and that data should be held in confidence.

Being ethical in dealing with the participants and all those concerned would help the researcher to obtain information without offending the respondents and prejudicing the results. This view is also shared by Stangor (2007: 41) who writes that treating research participants ethically matters not only for the welfare of the individuals themselves but also for the continued effectiveness of behavioural science as a scientific discipline. In this study all the information is held in confidence; the information is to be used for academic purposes only. During the analysis, there will not be any mentioning of names of individuals. The

questionnaires for this study will not be passed to anyone and after the study is completed they will be destroyed.

## **5.8 Conclusion**

This chapter has presented the methodology used to gather data in the study. It presented the research design to be followed in the research, the research purpose, the research strategy, the sampling frame and the sample size. The chapter also looked at the structure of the questionnaires, the five point Likert scale, the validity, and reliability of the questionnaires and the ethical considerations in the research study.

## **CHAPTER 6**

### **PRESENTATION OF RESULTS**

#### **6.0 Introduction**

This chapter serves to give a detailed presentation of the findings of the research on the management of HIV/AIDS programmes at the workplace in a highly volatile environment. The results will be from two questionnaires which were used in the study; one questionnaire for the management level and the other for non- managerial level employees. The descriptive statistics of both questionnaires was used to present data on demographic findings whilst inferential statistics was used to analyse the relationships between the main variables in the study.

#### **6.1 Descriptive statistics on demographics**

This section of the presentation of findings uses descriptive statistics to present the demographic findings. The demographic findings comprise of gender distribution, age, educational qualifications, number of years in service and marital status.

### 6.1.1 Gender distribution

Figure 6.1 Management

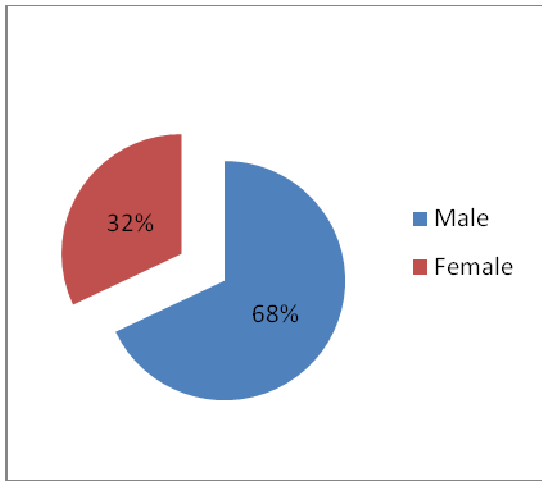
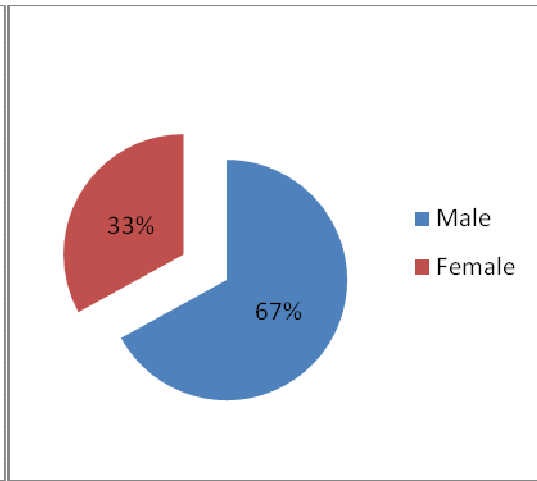


Figure 6. 2 Non-Management



From the statistics obtained of gender distribution, on management employees 68 percent of the respondents were male while 32 percent were female. Of non-management employees, males constituted 67 percent of the respondents while females constituted 33 percent.

### 6.1.2 Age Distribution

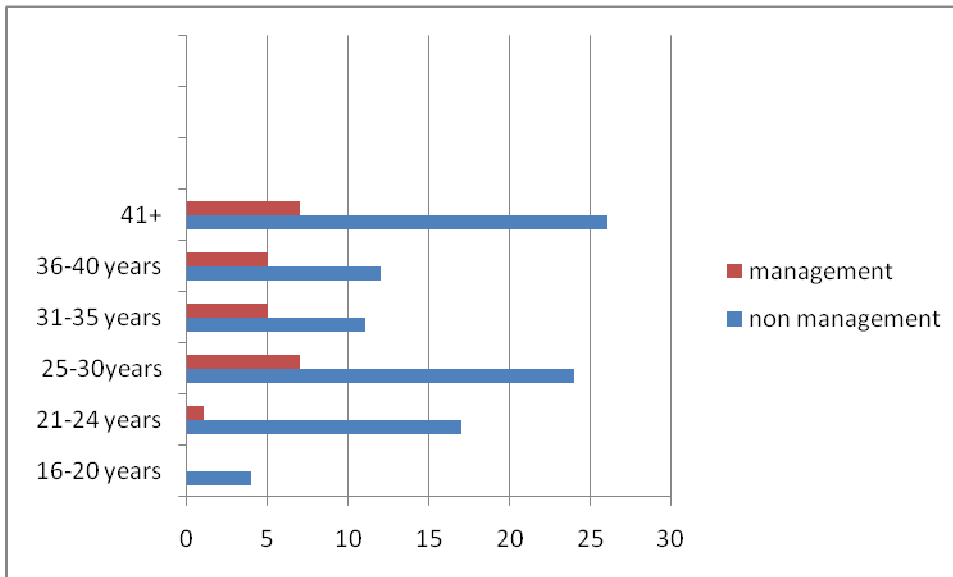


Figure 6.3



The bar above graph shows that above management employees had 1 respondent in the 21-24 age group, 7 respondents in the 25-30 age category, 5 respondents in the 31-35 age category, 5 respondents in the 36-40 category and 7 respondents in the 41+ age category. Non management employees had 4 respondents in the 16-20 age group, 17 respondents in the 21-24 age group, 24 respondents in the 25-30 age group, 11 respondents in the 31-35 age group, 12 respondents in the 36-40 age group and 26 respondents in the 41+ age group.

### 6.1.3 Level of Educational qualifications

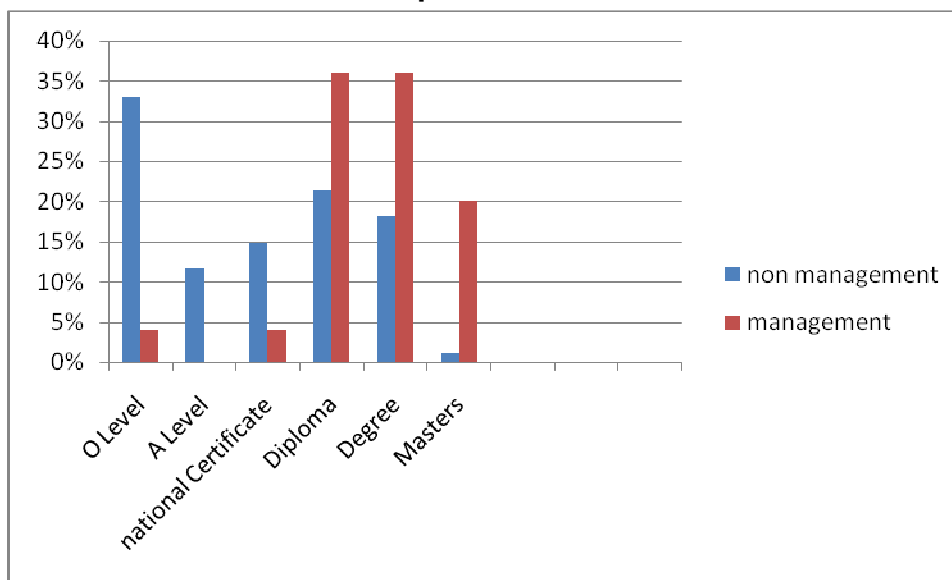


Figure 6.4

According to the research 4 percent of the management employees had ordinary level qualifications, 4 percent had National certificate qualifications, 36 percent had diplomas with another 36 percent having degrees while 20 percent had Masters Degrees. On the non-management side of respondents, 33 percent had ordinary level qualifications, 11.7 percent had advanced level qualifications, and 14.9 percent had National certificate qualifications. A further 21.3 percent had diplomas, 18.1 percent having Degrees, and 1.1 percent having a Masters Degree.

#### 6.1.4 Number of years in service

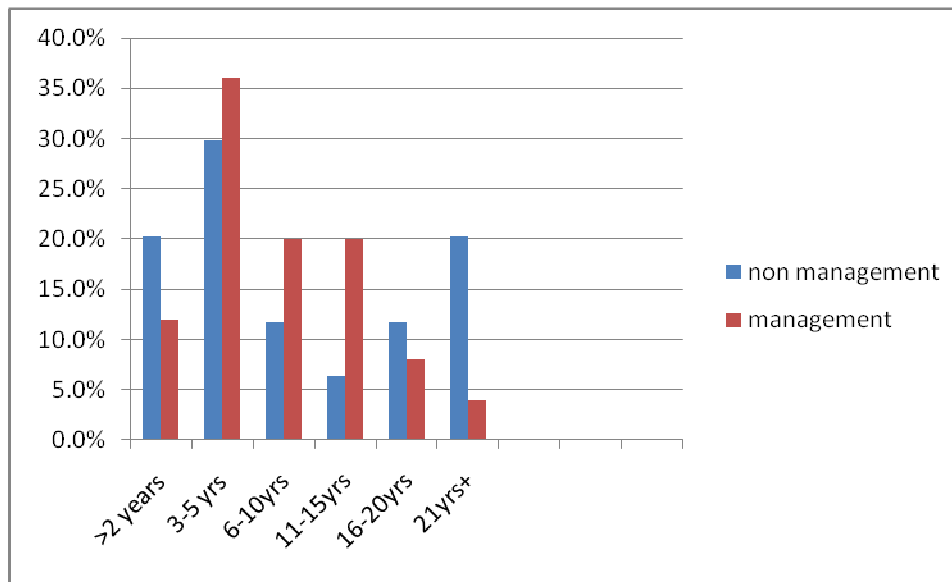


Figure 6.5

Of the management employees 12 percent of the respondents had less than two years in service in the organisation, 36 percent had between 3 to 5 years of service, 2 percent had between 6 to 10 years in service, 20 percent had between 11-15 years in service, 8 percent had between 16 to 20 years in service, 4 percent had 21 years or more in the organisation. Of non-management employees 20.2 percent had less than 2 years in service, 29.8 percent had between 3 to 5 years in service, 11.7 percent of the respondents had between 6 to 10 years in service, 6.4 percent of the respondents had between 11 to 15 years in service while 20.2 percent had more than 21 years in service.

### 6.1.5 Marital Status

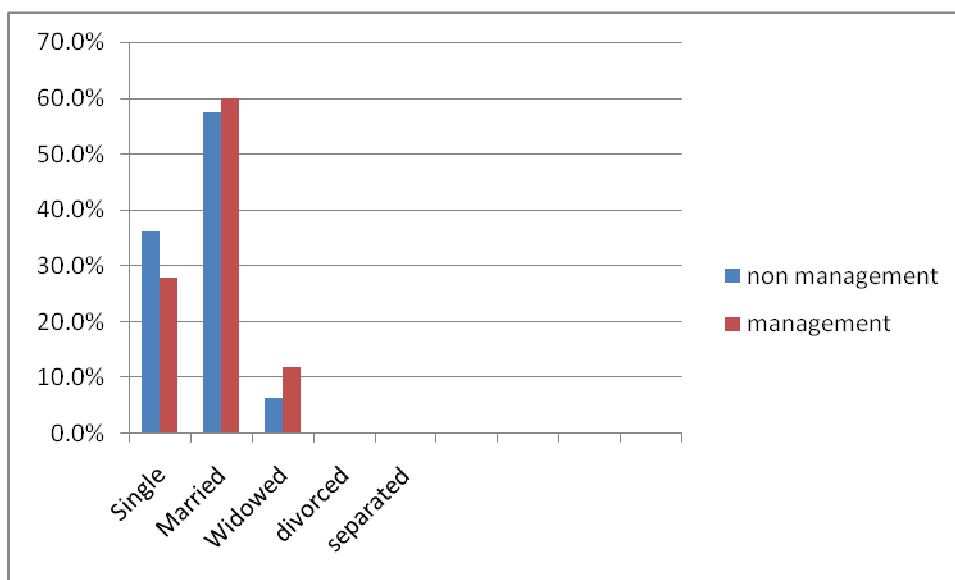


Figure 6.6

Figure 6.6 depicts that of management employees 28 percent were single, 60 percent were married, 12 percent were widowed and none were divorced or separated. From the non management side 36.2 percent of the respondents were single, 57.4 percent were married while 6.4 percent were widowed and neither of them were separated or divorced.

## 6.2 Descriptive statistics on themes

In this section, themes derived from the objectives and the sub problems of the study will be used as the guiding principles in the presentation of descriptive data on non demographic findings.

6.2.1 Availability of HIV and AIDS programmes at the workplace in a highly volatile environment.

	Frequency	percent	Valid percent
Management	25	100	100
Non-management	85	90.4	90.4

Table 6.1

Table 6.1 above shows the response to the question of availability of HIV/AIDS programmes at the workplace, all the management employees (100 percent); confirmed that they had such programmes in their respective organisations. Of non-management employees of the same organisations 90.4 percent confirmed that they had the HIV/AIDS programmes whilst 9,6 percent did not agree.

### 6.2.2 Descriptive statistics on managerial level employees

In table 6.2 below descriptive statistics in the form of mean tables will be used to present the general picture of what the respondents at management level thought of the impact of HIV/AIDS on their organisations, the reasons that pressured them to have HIV/AIDS programmes, where they got the sponsorship as well as problems they encounter in implementing the HIV/AIDS programmes at the workplace in such an unstable environment.

Table 6.2 Descriptive statistics for management

	Mean	St deviation
Question 3		
HIV/AIDS negatively impacts the organisation with respect to:		
Labour turnover	2.04	1.10
Absenteeism	2.24	1.45
Employee morale	2.42	1.32
Training costs	2.25	1.29
Productivity	1.88	1.12
Question 4		
The introduction of an HIV/AIDS policy or Program at your organisation was due to:		
Management initiative	2.13	1.26
Government legislation	2.80	1.38

Employee pressure	3.48	1.23
Collective Bargaining Agreement	3.52	1.00
Trade Unions pressure	3.36	1.11
Question 5		
The sponsoring of the HIV/AIDS is done by		
Internally in the organisation	2.24	1.51
External donors	2.80	1.32
Government	2.92	1.5
National AIDS Council	3.16	1.28
Question 6		
The following problems were encountered in implementing an HIV/AIDS programme in the organisation		
Shortage of foreign currency to import Hyper Active Antiretroviral treatment	2.83	1.52
Employee resistance to participation in the program	2.71	1.37
Inflation is making all products expensive hence the organisation could not effectively implement	2.48	1.23
Lack of capacity to engage in a programme as organisation is having survival problems	2.74	1.21
Lack of finance to engage specialists	2.92	1.21

As indicated in Table 6.2 above, concerning the impact which HIV and AIDS has on organisational operations of their workforce with respect to labour turnover the mean is 2.04, to absenteeism the mean is 2.24, to employee morale the mean is 2.25 and on productivity the mean is 1.88.

On ascertaining where the idea to introduce an HIV/AIDS programme in organisations came from management initiative has a mean of 2.13, government legislation has 2.80, employee pressure has 3.48, collective bargaining agreement has 3.52 and trade unions pressure has a mean of 3.36. The sponsoring of HIV/AIDS programmes was also assessed. Internally in the

organisation has a mean of 2.24, external donors has 2.80, government has 2.92 and National AIDS Council has 3.16.

Table 6.2 also shows the obstacles which management faced in the implementation process of the programmes in question. Shortage of foreign currency to purchase medicine has a mean of 2.83, employee resistance has a mean of 3.71. Inflation has a mean of 2.48, lack of capacity to implement a programme has a mean of 2.74 and lack of finance to engage specialists has a mean of 2.92.

### **6.2.3 Descriptive statistics for Non-Managerial Level Employees**

Table 6.3 indicates descriptive statistics in the form of means tables on non-managerial level employees. It highlights the obstacles that the employees face in using condoms, their general perceptions about the availability of HIV/AIDS programmes at the workplace, the weaknesses of the HIV/AIDS programmes in their organisations as well as their suggestions on how they could be improved.

Table 6.3 Descriptive Statistics for Non-Management Employees

<u>Question 20</u>	Mean	St deviation
The obstacles which I have in using a condom are:		
Religious teachings	3.00	1.47
Culture	3.59	1.24
Spouse	2.79	1.46
Suspicion	3.29	1.50

<u>Question 21</u> I do not support the idea of HIV/AIDS programmes at the work place, because of the following reasons		
It adds unnecessary costs to the organisation	4.20	1.08
Health issues are the responsibility of government	4.10	1.12
It only benefits the infected and affected	3.40	1.43
<u>Question 22</u> The weaknesses of the HIV/AIDS program in my organisation are:		
Lack of top management support	2.92	1.33
Inadequate funding	2.40	1.21
Lack of medicine and specialists support	2.43	1.37
No communication between employees and management	2.79	1.26
<u>Question 23</u> Suggestions to improve the effectiveness of HIV/AIDS programmes at the work place are:		
Management and employee participation in designing the HIV/AIDS policy/program.	1.78	1.19
Adequate funding, if not available, combine the program with another organisation or seek external donations.	1.78	1.19
Effective communication between management and employees on issues to do with HIV/AIDS program	1.71	1.03
Seek specialist knowledge when designing and implementing of the program/policy	1.67	1.01

Table 6.3 indicates the obstacles which some employees have in using condoms. Religious teachings had a mean of 3.00, cultural beliefs had a mean of 3.59, spouse had a mean of 2.79 and suspicion had a mean of 3.29. It also shows the perception which non-managerial level employees have of the HIV/AIDS programmes in the workplace. Unnecessary costs to the organisation had a mean of 4.20, health issues are a responsibility of government had a mean of 4.10, and it only benefits the infected and affected had a mean of 3.40.

The non-managerial level employees views on the weaknesses of the HIV/AIDS programmes were indicated in table 6.3. Lack of top management support had a mean of 2.92, inadequate funding had a mean of 2.40, lack of medicine and specialist support had a mean of 2.43 and no communication between management and employees had a mean of 2.79.

Suggestions on improving the current HIV/AIDS programmes which are in place at the workplace were also given. Management and employee participation in designing HIV/AIDS programmes had a mean of 1.78, adequate funding or seeking external donations or combined programmes with other organisations had a mean of 1.71 and seeking specialist knowledge in designing and implementation of the programme had a mean of 1.67.

### **6.3 Inferential Statistics**

In this section of the presentation of findings, inferential statistics in the form of the Pearson correlation coefficient was used. The method was specifically used to determine the relationship between the measures which the organisations have in place on HIV and AIDS programmes at the workplace and the impact they have had on employee behaviour.



Table 6.4 Pearson correlations coefficient

		Correlations					
		Condom Availability	Peer Group counsellors	Building positive behaviour	Community for people with HIV	Increased Knowledge about HIV	Discourage Discrimination
Condom Availability	Pearson Correlation	1.000	-.244	-.465**	.263*	.458**	-.090
	Sig. (2-tailed)	.	.084	.000	.044	.000	.498
	N	59	51	58	59	58	59
Peer Group counsellors	Pearson Correlation	-.244	1.000	.188	-.232*	-.311**	-.226*
	Sig. (2-tailed)	.084	.	.186	.044	.006	.049
	N	51	76	51	76	76	76
Building positive behaviour	Pearson Correlation	-.465**	.188	1.000	-.197	.147	.094
	Sig. (2-tailed)	.000	.186	.	.135	.267	.481
	N	58	51	59	59	59	59
Community for people with HIV	Pearson Correlation	.263*	-.232*	-.197	1.000	.308**	-.005
	Sig. (2-tailed)	.044	.044	.135	.	.004	.962
	N	59	76	59	87	86	87
Increased Knowledge about HIV	Pearson Correlation	.458**	-.311**	.147	.308**	1.000	.171
	Sig. (2-tailed)	.000	.006	.267	.004	.	.116
	N	58	76	59	86	86	86
Discourage Discrimination	Pearson Correlation	-.090	-.226*	.094	-.005	.171	1.000
	Sig. (2-tailed)	.498	.049	.481	.962	.116	.
	N	59	76	59	87	86	87

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

From table 6.4 above condom availability has a significant relationship of (0.263) with community programmes for people with HIV/AIDS. Similarly, condom availability has a significant relationship of (0.458) with increased knowledge about HIV/AIDS. However, condom availability has a negative relationship of (-0.465) with building positive behaviour. In addition, there was no significant relationship between condom availability, peer group counsellors and discouragement of discrimination.

There was a negative relationship of (-0.232) between peer group counsellors with community programmes for HIV/AIDS, a negative relationship of (-0.311) for increased knowledge about HIV/AIDS and a negative relationship of (-0.226) with discouragement of discriminatory behaviour. It is worth noting that peer group counsellors and increased knowledge about HIV had a strong negative significant relationship of (-0.311). On the other hand condom availability and building positive behaviour had no significant statistic relationship with peer group counsellors.

Table 6.4 also shows that building positive behaviour had a significant negative relationship of (-0.465) with condom availability. It is also shown that building positive behaviour had no significant relationship with peer group counsellors, community programmes for people with HIV, increased knowledge about people with HIV and discouraging discriminatory behaviour. Community programmes for people with HIV/AIDS had a significant relationship of (0.263) with condom availability and of (0.308) with increased knowledge about HIV/AIDS. However, it had a negative significant relationship of (-0.232) with peer group counsellors and no significant relationship with building positive behaviour and discouraging discriminatory behaviour.

Increased knowledge about HIV/AIDS had positive significant relationship of (0.458) with condom availability and of (0.308) with community programmes for people with HIV/AIDS while at the same time it had a negative significant relationship of (-0.311) with peer group counsellors and no relationship with discriminatory behaviour. There was a negative significant relationship of (-0.226) between discouraging discriminatory behaviour and peer group counselling. However, there was no significant relationship between discouraging discriminatory behaviour with condom availability building positive behaviour community programmes for people with HIV and AIDS and increased knowledge.

To summarise the correlations presented above there are positive significant relationships between condom availability and community programmes for people with HIV/AIDS, condom availability and increased knowledge about HIV and community programmes for people with HIV/AIDS and increased knowledge about HIV. There were negative significant relationships between condom availability and building positive behaviour, condom availability and discouraging discriminatory behaviour, peer group counsellors and increased knowledge about HIV peer group counsellors and discouraging discriminatory behaviour and

community programmes for people with HIV and increased knowledge about HIV. The remaining relationships were not statistically significant.

#### **6.4 Conclusion**

This chapter has presented the data using both descriptive and inferential statistics. Descriptive statistics was used to present data on the demographics of managerial and non- managerial level employees and it was used to present data on certain themes to ascertain the views of the managements and employees on the effectiveness of the workplace HIV and AIDS programmes. Inferential statistics was used to check for relations between what was presented in the programmes and whether it yielded the expected results by checking on the changes in the behaviour of the employees. The next chapter discusses the findings that were presented in this chapter.

## **CHAPTER 7**

### **DISCUSSION OF FINDINGS**

#### **7.0 INTRODUCTION**

This chapter seeks to discuss and analyse the findings that were presented in chapter six. The discussion will start with the analysis of descriptive statistics that will be followed by the analysis of inferential findings. Concluding remarks of the whole discussion will be given at the end of the chapter.

#### **7.1 Analysis of Demographic data**

This section of the chapter seeks to analyse the findings that were presented on the demographics in the previous chapter. The demographics that will be analysed in this section are age, gender, education, marital status, and years in service.

##### **7.1.1 Age**

The results that have been presented prove that both the management and non-management level employees are mostly within the risky HIV/AIDS age ranges. According to UNICEF (2005), 26 million of the 40 million infected people are in the 15 to 49 age range. This age range is comprised of the economically active people. From the presentation of findings in the previous chapter, 72 percent of the employees are between 16 and 40 years with just 28 percent being over 41. In line with the above statistics having the HIV and AIDS programmes at the workplace would help to reduce the prevalence of the disease, eliminate discrimination and stigmatisation, and above all maintain the occupational health and safety status of an organisation. This is imperative for maintaining an

organisation's productivity levels as the HIV/AIDS programme seeks to inform the employees about the dangers of contracting the virus or disease, and the negative impact it has on the organisation.

### **7.1.2 Gender**

The gender distribution is of paramount importance as it may act as an indicator of the gender balance in the country. However, it appears that most organisations are still male dominated in terms of formal employment. This study is for management shows 68 percent were males and 32 percent were females and in non-management level employees, 67 percent were males and 33 percent were females. Queen Victoria cited in Ham (2004:106) said "a woman is bodily and morally her husband's slave". This applied for most women in the west until the 1960s, and still applies for many in Southern Asia and Africa to this day. Ham (2004) goes on to say that the 'old ways' have led to the terrible catastrophe that is AIDS, but it is precisely in the consequences of that inequality that the dangers lie.

The spread of HIV and AIDS will not recede as long as men feel that they have the right to sex and women that they have the duty to comply. In light of the abovementioned statement, the government may make the laws but it is necessary to remove the stereotypes and cultural barriers that inhibit the society from effecting gender equality. Ham (2004:100) concludes that few now question that a woman has a right to make a career as a man, that she should receive the same payment for the same work as women are now found in every field of work, often able to do the job much better than their male colleagues.

### **7.1.3 Educational Qualifications**

In the study the respondents had high levels of education with both management and non-management level employees having educational qualifications which ranged from ordinary level to Masters Degree and none had less qualification. In most organisations, it is required that employment requires at least ordinary level education. Education helps to empower people as it helps them to make informed decisions. Schenker, Friedman and Francisco (1996:16) write that we have to transmit knowledge, values, skills and competences and have to open for them a perspective for their future. They concluded by stating that education is a key factor in fighting AIDS especially preventive education, with which we are concerned to fight against HIV/AIDS.

### **7.1.4 Marital status**

Of management level employees 28 percent were single, 60 percent married and 12 percent widowed. Of non-management employees 36.2 percent single, 57.4 percent married and 6.4 percent widowed. In six different organisations, of 119 respondents, there was not one who was separated or divorced. Baylies and Bujra(2000:11) observed that marriage is a context of considerable vulnerability for women in respect of HIV because they can be infected, not through 'improper' behaviour, but in consequence of complying with norms of fidelity, if their husband has unprotected sex outside of marriage. However, Quigley et al (1997) cited in Baylies and Bayra (2000:11) found that divorced and widowed women are three times more likely than those currently married to be HIV positive are and there is a higher likelihood of infection among those previously divorced or widowed than those who had a single marital partner.

## **7.2 Descriptive Statistics on Themes**

### **7.2.1 Availability of HIV/AIDS Programmes in Organisations**

In the highly volatile environment in Zimbabwe, characterised by economic woes and political instability, organisations are closing down or migrating to neighbouring countries. It was an objective of this study to establish whether in such a turbulent environment organisations could spare their strained resources to have HIV/AIDS programmes for their employees. The results were interesting in that management of all the six organisations had a 100 percent response saying that they had the HIV/AIDS programmes in their organisations. In the same organisations 90.4 percent of the non-management level employees agreed. However, 9.6 percent of non-management level employees responded otherwise, thus, they did not know of the HIV/AIDS programmes in their organisations. It remains to be seen if some of the organisations have pseudo-programmes in place since it is a government requisite that the organisations should implement them.

### **7.2.2 Analysis on Descriptive Statistics for Management Level Employees**

This section of the chapter seeks to analyse the findings that were presented using the descriptive statistics for management level employees. It seeks to analyse whether the pandemic was influencing the organisations. It seeks to analyse who is funding the HIV/AIDS programmes in the workplace and on whose initiative they were implemented.

Management employees agreed that their organisations are being negatively impacted by HIV/AIDS with respect to labour turnover, absenteeism, employee morale and training costs and productivity. This is because the management level employees also share the mean on the analysis ranged between 1.8 to 2.25. This sentiment suggests that the introduction of HIV/AIDS programmes in

the organisation was a management initiative and government legislation. It could have been due to by negative impact which the organisations are experiencing due to the pandemic. Also well to note is that the president of the country declared AIDS a state of emergency in 2003. This led to legislation and a call for concerted efforts by all parties to fight HIV/AIDS. However management were uncertain about the contribution of employees' pressure, collective bargaining and trade unions' pressure on the introduction of HIV programmes in the organisation. This is seen in the means of between 3.36 and 3.52.

The sponsoring of HIV/AIDS programmes is done internally in the organisations as seen by mean 2.24 except for the Public Service Commission, which is a department in the government. In the organisation however, it showed that there was no follow-through by the National Aids Council given a mean of 3.16 which is neutral or uncertain.

The organisations' main problem seems to be inflation that has a mean of 2.48 which shows that it is an implementation problem, given rising costs and prices. The management's response reflect a mean of neutral on shortage of foreign currency to import antiretroviral treatment, employee *résistance*, lack of capacity to engage the problem and lack of finance. This might be because when the President of the Republic of Zimbabwe declared AIDS a national emergency in 2003 it was stated that the State gave authority and allocation to those organisations that wanted to introduce ARVS.

### **7.2.3 Descriptive Statistics on Non-Managerial Employees**

Whilst management may initiate and introduce the HIV/AIDS programmes at the workplace, non-management employees may have their own perceptions and attitudes towards the programmes. This section seeks to analyse the findings on obstacles that employees face in using protection, their perceptions of the HIV/AIDS programmes in the workplace, the weaknesses of the programmes



and suggestions on ways to improve the effectiveness of the HIV workplace programmes.

In Zimbabwe HIV/AIDS is primarily spread by heterosexual contact, therefore enough sexual networking has taken place to sustain the epidemic (MoHCW, 2004: 23). This implies that there was a lot of sex networking without using protection. In light of the above statement, it means that there were issues, which kept people from using condoms. However, religious teachings, cultural practices and suspicion had a mean of between 3 and 3.59, which shows that people were indifferent to religion culture and general suspicion when it comes to using condoms. However, spouse had a mean of 2.79 most married people agreeing that the use of protection in marital sex was a problem because their spouse would not allow it, (also for reproductive purposes).

As to attitudes of non-management level employees to HIV/AIDS programmes at the workplace non-management level employees did not agree that HIV programmes add unnecessary costs to the organisation or that health issues are the responsibility of government as the mean was 4.20 and 4.10 respectively. However, they were uncertain as to whether they only benefited the infected and affected as reflected in a mean of 3.40.

The study also sought to identify non-management views of the weaknesses of HIV/AIDS programmes in the organisations. The respondents agreed that the weaknesses in their organisations are inadequate funding and lack of medicine and specialist support as these had a mean of 2.40 and 2.43 respectively. This sentiment is in line with the management response which also highlighted inflation as an obstacle to implantation given the high cost of all products and services.

However, the non-management employees were uncertain as to whether there was lack of top management support or no communication between employees

and management. These factors had a mean of 2.92 and 2.79 respectively. The non-management employees agreed on the suggestions that could improve the effectiveness of HIV/AIDS programmes at the workplace. They suggested management and employee participation in designing HIV/AIDS programmes which had a mean of 1.78. They also suggested adequate funding or combining programmes with another organisation, showing a mean of 1.78. The non-managerial level employees also suggested effective communication between management and employees on issues to do with HIV/AIDS, which had mean of 1.71. Lastly, they agreed on seeking specialist knowledge when designing and implementing the programme, which had mean of 1.67.

### **7.3 Analysis on Inferential Statistics**

In the previous chapter, relationships between variables were presented using inferential statistics. This section seeks to examine and to analyse the relationships in order to determine whether the implementation of HIV/AIDS programmes in the workplace has reached the intended result or are yet to achieve what they were meant to achieve which is risk free behaviour, a work environment free from stigma and care for the infected.

There is a positive significant relationship between community programmes for people living with HIV/AIDS and increased knowledge about HIV/AIDS. When an organisation conducts HIV/AIDS community programmes for people living with HIV/AIDS, it increases knowledge about HIV and AIDS especially for employees who would have visited and helped the ill people. The information of the activities of the community programme would spread through the whole organisation and some employees would realise that HIV/AIDS is a reality.

The other positive significant relationship is between condom availability and increased knowledge about HIV/AIDS. Although it might be a good start that people have increased knowledge about HIV and AIDS it is only when people

know how the virus is spread that they see the need for protected sex. The organisation will help by making condoms available. However, there is a need for constant and proper use of the condoms if there is to be a decline in HIV prevalence.

The positive significant relationship between condom availability and community programmes for people living with HIV/AIDS implies making condoms available after conducting the community programmes. It is ineffective and inconsistent as condoms have to be made available all the time if the HIV/AIDS workplace programme is to be effective and relevant.

On the contrary, the negative significant relationships show that despite the action which was been taken by the organisation in the HIV/AIDS programme there was no positive behaviour change from the employees. It implies that the attitudes or behaviour continued as was, or may even have worsened.

There is a negative significant relationship between condom availability and peer group counsellors. This is an irrelevant relationship. It implies that peer group counsellors reduce the availability of condoms. There is a negative significant relationship between condom availability and building positive behaviour. This is also an irrelevant relationship since building positive behaviour is in line with availability of condoms at the workplace.

There is a negative significant relationship between peer group counsellors and community programmes for people with HIV/AIDS. This is also irrelevant in that peer group counsellors cannot be seen to be reducing the effectiveness of community programmes for people living with HIV/AIDS. There is also a negative significant relationship between peer group counsellors and increased knowledge about HIV. This relationship implies that the peer group counsellors are doing nothing to increase the knowledge of their colleagues.

There is also a negative significant relationship between peer group counsellors and discouraging discrimination. This implies that peer group counsellors are not doing anything positive to reduce discrimination in organisations judging from the negative relationship. They seem to be getting it all wrong in the implementation of HIV/AIDS programmes. They are seen to be reducing the effectiveness of community programmes. They are not seen to be increasing knowledge about HIV/AIDS and they are not teaching employees to desist from discriminatory behaviour.

#### **7.4 Conclusion**

The findings presented in the previous chapter were discussed and analysed in this chapter. The demographic data was discussed first followed by, descriptive statistics for management and non-management data and, finally, the inferential statistics. The next chapter seeks to make conclusions about the study, suggestions on how to improve the HIV/AIDS workplace programmes and directions for future research.

## **CHAPTER 8**

### **CONCLUSIONS, RECOMMENDATIONS, LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH**

#### **8.0 Introduction**

This study sought to investigate the management of HIV/AIDS programmes at the workplace in a highly volatile environment. How HIV/AIDS programmes succeed, or fail to do so, in conducting awareness programmes, providing the much-needed antiretroviral treatment to the infected, preparing a non-discriminatory environment and to identify the problems encountered in implementing some such programmes in an unstable and turbulent environment.

The study was conducted in six selected organisations, which operate in a volatile environment, in Harare, Zimbabwe. These organisations are the Public Service Commission that is the government organ responsible for recruiting in all government departments, Edgars, a leading retail store in the country, ZB Bank, a financial institution and a commercial bank operating in Zimbabwe, Zimbabwe United Passenger Company (ZUPCO), a government owned public transport company, and CAPS Private Limited, a pharmaceutical company that produces and distributes pharmaceutical products countrywide.

The research problem lies in the fact that HIV/AIDS has had devastating effects in sub Saharan Africa as the infected contribute more than half of the worlds' infected people. Furthermore, of the 40 million infected people 26 million are between the age ranges of 16 to 49, which is an age group at the prime of their working careers. Organisations, or rather, employers, are feeling the impact of HIV and AIDS on their workforce, and this impacts is likely to be even more disturbing in a country characterised by hyper-inflation, economic woes and a political crisis like Zimbabwe. Although an AIDS policy was enacted in 1999 it did

not overcome all the problems as treatment fell short of the vast numbers desperately in need. It is therefore important to investigate how organisations operating in a turbulent environment manage the HIV/AIDS workplace programmes.

The study was guided by the following sub-problems:

- To find out if organisations in a highly volatile environment have HIV/AIDS workplace programmes for their employees
- To determine how HIV/AIDS affects organisations operating in an environment affected by an economic meltdown.
- To establish who funds the HIV/AIDS workplace programmes in organisations.
- To identify the weaknesses and obstacles to implementing HIV/AIDS programmes in such a turbulent environment.
- To establish how do employees perceive HIV/AIDS programmes at the workplace.

The related literature review does see HIV/AIDS workplace programmes as a milestone towards reducing HIV prevalence and combating its effects .Previous research suggests that increasing people's knowledge is the only way to reduce prevalence as knowledge leads to behaviour change since knowledgeable people are likely to indulge in risk free behaviour. Furthermore, knowledgeable people are unlikely to discriminate against their infected colleagues.

In chapter 5 the research methodology of the study was discussed. The findings of the study were presented in chapter six and discussed in chapter 7. The current chapter seeks to present the conclusions, recommendations, limitations and directions for future research

## **8.1 Conclusions**

The findings of the study indicate that:

- Organisations in a highly volatile environment do have HIV/AIDS programmes and policies for the welfare of their employees.
- The HIV/AIDS pandemic impacts negatively on the workforce in organisations. It impacts with respect to labour turnover, training costs, absenteeism, health costs and funeral costs.
- The obstacles to the implementation of HIV/AIDS programmes include inflation and lack of specialists.
- The organisations being run in all the six organisations in the study were being internally funded by the organisations themselves.
- Employees have a positive attitude towards HIV/AIDS programmes at the workplace.

## **8.2 Recommendations**

The HIV/AIDS programmes at the workplace in organisations are still to achieve their objectives as HIV prevalence is still 18.1 percent in the country. Many people are still affected by the pandemic so there is a need to improve the workplace programmes as a matter of urgency. The programmes have to aim towards a totally risk free behaviour, without any stigmatisation and a healthy work environment. In light of the findings of the study, the researcher suggests to make the following recommendations:

- Participatory approach in the design and implementation of HIV/AIDS workplace programmes. There is a need to form a committee during the design process that will comprise of management representatives, worker's representatives, National AIDS Council member/s, and specialists in the form of psychologists and medical doctors.
- There is a need for a free flow of information in the organisation. The organisation should allow flow of information on awareness programmes, voluntary counselling and testing as well as AIDS workshops being

conducted in the organisation. Information can be made available through brochures, charts, and electronic mail.

- Training of effective peer leaders and counsellors, not necessarily the managers. There is usually a problem in that some employees are not free to share their problems with members of management for fear of victimisation. The managers are always thought to be using authoritative power, so employees will not share and express their problems freely to them.
- Promote gender balance in the organisation. The awareness programmes should be structured to educate the men to respect and empower their wives and to promote gender equity in the home. This will lessen women's vulnerability to the pandemic. Encourage the women to refrain from traditional malpractices like polygamy or where young unmarried women date married men (a practice often referred to as small- house in Zimbabwe).
- The organisations can introduce social functions so that employees can bring their spouses and wives so that they get to learn about HIV/AIDS together. In such functions, they can encourage the idea of safe sex and remove the suspicion among the married as to the use of condoms. This can be effective in that, according to the study, most organisations are male dominated and only teach men about HIV and AIDS without also teaching their wives. This may not yield positive results as quickly. Teaching both may help in that it eliminates suspicion and makes to see the couples view HIV/AIDS in the same way.
- The awareness programmes in the organisation should encourage those single to go for voluntary counselling and testing for HIV before marriage. This would help them to plan for their future.
- Organisations should try to offer psychosocial support for the infected and affected members of the organisation. This provides them with a place for seeking counselling whenever they feel stressed. It provides them with a



place to accept their status and to continue with their lives, not to view their status as a death sentence.

- Organisations should conduct seminars to train for care and support to the infected families. Seminars where specialists would come and train the infected families on care and support of the infected could be held occasionally in the organisation.
- Medical doctors and dieticians have agreed that a good diet contributes a great deal to the longer survival of the infected. If the organisation has the capacity it can prepare food hampers for their infected employees to allow them access to some nutritious food to help them to live longer

### **8.3 Limitations of the study**

- The study only considered six organisations, all in Harare. As a result, the results of the present study are not easily generalisable. This is because organisations are affected differently by the HIV/AIDS pandemic and hence organisations in other cities and towns may be having different approaches to the management of HIV/AIDS in the workplace.
- The study used a quantitative research design. Respondents did not have a chance to explain most of their responses hence the researcher had to use predictions using the mean to denote the feelings from the Likert's scale to explain the responses.
- The study used questionnaires as data collection instruments only. In some cases, the respondents would have wanted some clarity before answering the questions, but they could not get it.

#### **8.4 Directions For Future Research**

- Since there was no proper flow of information in some organisations with respect to HIV/AIDS programmes, there might be a need to investigate the establishment of effective communication strategies in order to facilitate risky behaviour change in HIV/AIDS programmes at the workplace.
- Since there are many infected people in sub Saharan Africa who are also employed, there might be a need to investigate the role of psychosocial support systems in helping infected people to cope with the depression and stress that comes with HIV/AIDS in the workplace.

#### **8.5 Concluding Remarks**

This chapter presented an overview of the study. It drew conclusions regarding the study and provided ways of improving the management of HIV/AIDS in the workplace. It also highlighted factors that limited the quality of the findings and provided suggestions for future research in the same field of study.

## REFERENCES

Abreu, G. A, Noguer I and Cowhill K (2003) HIV/AIDS in Latin America countries, The challenges ahead, World Bank, Washington D.C

Babbie, E and Mouton, J (2005) The practice of social research, Oxford University Press Southern Africa, Cape Town South Africa

Bagraim J, Cunningham P, Potgieter and Viedge C (2007) Organisation Behaviour: A contemporary South Africa perspective 2<sup>nd</sup> Edition, Van Schaik Publishers, Pretoria South Africa

Blanche M. T, Durrheim K and Painter D (2006) Research in Practice, Applied Methods for the Social Science, 2<sup>nd</sup> Edition, University of Cape Town Press, Cape Town South Africa

Cant M (2003) Marketing Research, New African Book Press, South Africa

Catania, J.A., Kegeles, S.M., and Coates T.J. (1990) Towards an Understanding of risk behaviour: An AIDS risk reduction model (ARRM). Health Education Quarterly, 17(1), 53-72.

Coakes, E. (2003) Knowledge management: Current issues and challenges, IRM Press, University of Westminster, United Kingdom

Denison, J. (1996) Family Health internal: Building positive behaviour, Behaviour Research Unit, Kampala

Dyk, A.V. (2005) HIV/AIDS Care and counselling 3<sup>rd</sup> Edition, Pearson Education, Cape Town South Africa

Egan, G. (1998) The skilled helper: a problem management approach to helping 6<sup>th</sup> edition, Pacific Grove, Brooks

Garbus, L. and Sakutukwa, G. (2002) Country AIDS Policy Analysis Project: HIV/AIDS in Zimbabwe, San Francisco

Gelatt, H.B (1989) Positive uncertainty: A new decision making framework for counseling, Journal of counseling psychology 36:252-256

Gomo, E. (2003) Redirecting our responses to HIV/AIDS, ZHDR, Harare

Grant K. B, Fine D, Heywood M and Strode A (2001) HIV/AIDS and the Law; A resource manual 2<sup>nd</sup> Edition, the AIDS law project, Cape Town South Africa

Gray, D. (2006) Doing research in the real world, Sage Publications, New Delhi, London

Ham, F. (2004) AIDS in Africa How did it ever happen, Kachere Series, Zomba Malawi

Hollister, R. (2000) HIV/AIDS Toolkit: AIDS Impact Model Approach, New York, U.S Agency for International Development

Hoover, D.K. (2002) The Concise Encyclopedia of Economics Phillips Curve, Prentice, Oxford

International Labour Organisation (2001), Code of Practice on HIV/AIDS and the World of Work, Geneva.

International Labour Organisation (1997), Code of practice on protection of workers' personal data, Geneva

International Labour Organisation (2003), Workplace action through social dialogue, Geneva

International Labour Organisation (2006), Impact of HIV/AIDS on Trade Unions, Geneva

International Labour Organisation (2007), World of work: The magazine of the ILO, Geneva

International Organisation of Employers (2002) Employer's Handbook on HIV/AIDS: A guide for action, UNAIDS, Geneva

Irwin, A, Millen, J and Fallows, D. (2003) Global AIDS: Myths and Facts Tools for fighting the AIDS Pandemic, South End Press, Cambridge

Labour Relations Amendment Act (2002), Government Printer, Harare Zimbabwe

Leedy P.D and Ormrod J.E (2003), Practical Research Planning and design, 7<sup>th</sup> Edition, Prentice Hall, New Jersey

McKenzie, N. F. (1999) The AIDS Reader Social, Political, Ethical Issues, Middlesex, Penguin Books.

Ministry of Health and Child Welfare (2004) The HIV and AIDS Epidemic in Zimbabwe, National AIDS Council, Harare

Moorhead and Griffin (1998) Organisational Behaviour: Managing people and Organisations.

Nattrass, N. (2004) The Moral Economy of AIDS in South Africa, Cambridge University Press, United Kingdom

National AIDS Council (2004) Zimbabwe National Strategic Framework (2000-2004), Harare, Zimbabwe

National AIDS Council (2006) Zimbabwe National HIV/AIDS Strategic Plan 2006-2010, Harare, Zimbabwe

Nel, P. S, Van Dyk, P.S, Haasbroek, G.D., Schultz, H.B., Sono, T.J and Werner,A. (2004) Human Resources Management (6<sup>th</sup> Edition) New York, Oxford University press

Parker, W. (2007) HIV/AIDS communications in selected African countries: interventions, responses and possibilities, SIDA, Lusaka, Zambia

Pembrey, G. (2006) HIV and AIDS in Zimbabwe, University of Zimbabwe, Harare

Schietinger (1998) Psychosocial support for people living with HIV/AIDS, United States Agency for International Development, Arlington

Singhal A and Rogers E M (2003) Combating AIDS Communication Strategies in Action, Sage Publication, New Delhi India

South African Concise Oxford dictionary (2002), Oxford University Press, Cape Town, South Africa

Stangor, C (2007) Research methods for the Behavioural Sciences, 3<sup>rd</sup> edition, Houghton Mifflin Company, New York

Tustin D. H, Ligthelm A. A, Martins J. H, and Van Wyk J H (2005) Marketing Research in practice, University of South Africa Press, Pretoria

UNAIDS Report (2002) Report on Global HIV/AIDS Epidemic, United Nations, Geneva

UNAIDS Report (2007) HIV in the workplace, United Nations, Geneva

UNICEF Report (2005) Background Country Report, Zimbabwe , United Nations Geneva

UNICEF Report (2006) Countries Report for Southern African countries, Geneva

Wilson F, M (2004) Organisation Behaviour and work: A critical introduction, 2<sup>nd</sup> Edition, Oxford University Press, New York USA

World Bank (2000) HIV/AIDS a developmental crisis, Geneva

Winiarski M, G (2004) Community based counselling for people affected by HIV and AIDS, Longman, Windhoek Namibia

Zimbabwe Country Report (2005) Follow up to the Declaration of commitment on HIV/AIDS (UNGASS), Harare.

#### Internet sources

[www.debeers.co.za](http://www.debeers.co.za) [accessed on 20 September 2007 at 1047]

[www.wikipediaencyclopedia.com](http://www.wikipediaencyclopedia.com) [accessed 20 July 2007 at 1200hours]

Mail and Guardian online newspaper [accessed 12 September 2008 at 1400 hours]

The herald newspaper online newspaper [accessed 23 July 2007 at 0900 hours]

# ANNEXURE 1



University of Fort Hare  
Together in Excellence

## Management questionnaire

My name is Taurai B. W. Nyemba and I am doing a Masters of Commerce degree in the Department of Industrial Psychology. I am carrying out a research on the management of HIV/AIDS programmes at the work place in Harare, Zimbabwe. Please complete this questionnaire as honestly and constructively as possible. The information received in this research will be used for academic research purposes only. Your responses will be kept in strict confidentiality. No answer is correct or wrong. The success of this study depends on your co-operation.

### Instructions

1. Comment freely in the space provided for open-ended questions.
2. Indicate your answer by marking X in the appropriate box provided.

## SECTION A: BIOGRAPHICAL INFORMATION

Gender	Male
	Female
Age	16-20
	21-24
	35-30
	31-35
	35-40
	41+
Nature of business	
Years of service in the organisation	Less than 2yrs
	3-5
	6-10
	11-15
	16-20
	21+
Level of Education	Ordinary Level
	Advanced Level
	National Certificate
	Diploma
	Degree



	Masters
	PhD
Position in the organisation	
Marital Status	Single
	Married
	Widowed
	Divorced
	Separated

## **SECTION B: HIV/AIDS WORKPLACE PROGRAM/POLICY**

1. Does your organisation have an HIV/AIDS policy/ program?

Yes	No
-----	----

**If no, answer question 2 and section E only.**

2. When did your organisation introduce an HIV/AIDS program/policy? .....

**Indicate your choice by marking an X in the appropriate block where:**

(1) = Strongly Agree

(2) = Agree

(3) = Uncertain

(4) = Disagree

(5) = Strongly disagree

<u>Question 3</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
HIV/AIDS negatively impacts the organisation with respect to:					
<b>3.1 Labour turnover</b>					
<b>3.2 Absenteeism</b>					
<b>3.3 Employee morale</b>					
<b>3.4 Training costs</b>					
<b>3.5 Productivity</b>					
<b>3.6 Other (state)</b>					
<u>Question 4</u>					
The introduction of an HIV/AIDS policy or program					

at your organisation was due to:					
<b>4.1 Management initiative</b>					
<b>4.2 Government legislation</b>					
<b>4.3 Employee pressure</b>					
<b>4.4 Collective Bargaining Agreement</b>					
<b>4.5 Trade Unions pressure</b>					
<b>4.6 Other (state)</b>					
<p style="text-align: center;"><u>Question 5</u></p> <p>The sponsoring of the HIV/AIDS program is done by:</p>					
<b>5.1 Internally in the organisation</b>					
<b>5.2 External donors</b>					
<b>5.3 Government</b>					
<b>5.4 National AIDS Council</b>					
<b>5.5 Other (state)</b>					
<p style="text-align: center;"><u>Question 6</u></p> <p>The following problems were encountered in implementing an HIV/AIDS program in the organisation</p>					
<b>6.1 Shortage of foreign currency to import Hyper-Active Antiretroviral treatment</b>					
<b>6.2 Employee resistance in participation in the program</b>					
<b>6.3 Inflation is making all products expensive hence the organisation could not effectively implement.</b>					
<b>6.4 Lack of capacity to engage into a program as organisation is having survival problems</b>					
<b>6.5 Lack of finance to engage specialists</b>					
<b>6.6 Other (state)</b>					

## **SECTION C: Impact of HIV/AIDS on the organisation**

**Indicate your choice by putting an X in the blocks provided**

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
7. The HIV/AIDS programmes being implemented so far have been effective					
9. The impact of HIV/AIDS has decreased since the introduction of HIV/AIDS program.					
10. The budget allocation on HIV/AIDS is adequate					
11. The organisation has access to purchase Anti retroviral drugs whenever the need arises.					
12. The cost of establishing an HIV/AIDS programmes overweighs the burden which HIV/AIDS has on the organisation					

## **SECTION D BENEFITS TO EMPLOYEES**

**Indicate your choice by putting an X in the blocks provided**

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
13. The HIV/AIDS programme in the organisation benefit every employee					
14. There has been an attitude change in the way employees' view HIV/AIDS in the organisation since the introduction of awareness programmes.					
15. The organisation offers Antiretroviral treatment for all employees who are infected with HIV/AIDS.					
16. The organisation does not provide specialists to help employees cope with depression or stress caused by HIV/AIDS.					

17. The employees participated in the implementation of HIV/AIDS programmes.					
18. The organisation offers assistance if a close member of an employee dies of AIDS.					
19. The organisation does not offer any assistance when employees retire from the organisation if they are infected with HIV/AIDS.					
20. The organisation does not offer alternative duties for employees who are no longer fit for their usual jobs.					
21. The organisation provides HIV/AIDS programmes for the community.					
22. The organisation provides training for employees to be peer educators/counsellors.					

### **SECTION E: RECOMMENDATIONS AND OPINIONS**

**Indicate your choice by marking an X in the appropriate block where:**

(1) = Strongly Agree

(4) = Disagree

(2) = Agree

(5) = Strongly disagree

(3) = Uncertain

<u>Question 23</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
Which of the following benefits does your organisation derive by implementing the HIV/AIDS programmes in your organisation?					
<b>23.1 Reduced labour turnover</b>					
<b>23.2 Reduced absenteeism</b>					
<b>23.3 High employee morale</b>					
<b>23.4 Improved management and employee relations</b>					
<b>23.5 Improved productivity</b>					
<b>23.5 Low retraining costs</b>					
<b>23.6 Other</b> (state)					
<u>Question 24</u>					
I do not support the idea of HIV/AIDS programme at					

the work place, because of the following reasons					
<b>24.1 It adds unnecessary costs to the organisation</b>					
<b>24.2 Health issues are the responsibility of government</b>					
<b>24.3 It only benefits the infected and affected</b>					
<b>24.4 Other</b> (state)					
<p style="text-align: center;"><u>Question 25</u></p> <p>The weaknesses of the HIV/AIDS program in my organisation are:</p>					
<b>25.1 Lack of top management support</b>					
<b>25.2 Inadequate funding</b>					
<b>25.3 Lack of medicine and specialists support</b>					
<b>25.4 No communication between employees and management</b>					
<b>25.5 Other</b> (state)					
<p style="text-align: center;"><u>Question 26</u></p> <p>Suggestions to improve the effectiveness of HIV/AIDS programmes at the work place are:</p>					
<b>26.1 Management and employee participation in designing the HIV/AIDS policy/program.</b>					
<b>26.2 Adequate funding, if not available combine the program with another organisation or seek external donations.</b>					
<b>26.3 Effective communication between the management and employees on issues to do with HIV/AIDS program</b>					
<b>26.4 Seek specialists knowledge when designing and implementation of the program/policy</b>					
<b>26.5 Other</b> (state)					

26.6 If you have any more suggestions, please feel free to express them in the space provided.

.....

.....

This section is for organisations without HIV/AIDS policy/program only

### Section E: Not having HIV/AIDS policy /program

Indicate your choice by marking an X in the appropriate block where:

(1) = Strongly Agree

(2) = Agree

(3) = Uncertain

(4) = Disagree

(5) = Strongly disagree

<u>Question 27</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
The organisation does not have an HIV/AIDS program because:					
<b>27.1 No funding for the program as organisation is fighting for survival.</b>					
<b>27.2 No management support for the program.</b>					
<b>27.3 Employees do not see any need for it.</b>					
<b>27.4 Organisation is not affected by HIV/AIDS.</b>					
<b>27.5 Organisation does not have the capacity to implement the program</b>					
<b>27.6 Other (state)</b>					
<u>Question 28</u>					
Does the organisation have any plans of implementing an HIV/AIDS program?					
<b>28.1 Have never thought of it and has never been discussed.</b>					
<b>28.2 Do not see any need for it</b>					
<b>28.3 Will implement it soon.</b>					
<b>28.4 Will implement it when its operations improve.</b>					
<b>28.5 If it gets funding it will implement it</b>					

*Your time and participation is greatly appreciated.*

## ANNEXURE 2



**University of Fort Hare**  
*Together in Excellence*

### ***Employee's questionnaire***

My name is Taurai B. W. Nyemba and I am doing a Masters of Commerce degree in the Department of Industrial Psychology. I am carrying out a research on the management of HIV/AIDS programmes at the work place in Harare, Zimbabwe. Please complete this questionnaire as honestly and constructively as possible. The information received in this research will be used for academic research purposes only. Your responses will be kept in strict confidentiality. No answer is correct or wrong. The success of this study depends on your co-operation.

### ***Instructions***

1. *Comment freely in the space provided for open-ended questions.*
2. *Indicate your answer by marking X in the appropriate box provided.*

### **SECTION A: BIOGRAPHICAL INFORMATION**

Gender	Male
	Female
Age	16-20
	21-24
	35-30
	31-35
	35-40
	41+
Nature of business	
Years of service in the organisation	Less than 2yrs
	3-5
	6-10
	11-15
	16-20
	21+
	Ordinary Level
	Advanced Level

Level of Education	National Certificate
	Diploma
	Degree
	Masters
	PhD
Position in the organisation	
Marital Status	Single
	Married
	Widowed
	Divorced
	Separated

## **SECTION B: HIV/AIDS PROGRAMME AT THE WORKPLACE**

1. Does your organisation have an HIV/AIDS policy/ program?

Yes	No
-----	----

**If no, please answer Section E only.**

2. When was the HIV/AIDS programme introduced in the organisation? .....

**Indicate your choice by putting an X in the blocks provided**

	Strongly agree	agree	uncertain	disagree	Strongly disagree
3. HIV awareness programmes conducted in the organisation are very effective.					
4. There is disciplinary action against employees who unfairly discriminate against, people who are HIV positive.					
5. Employees took part in drawing up the HIV/AIDS program for the organisation.					
6. Employees are encouraged to go for voluntary counselling and testing of HIV/AIDS.					
7. The organisation hires doctors and counsellors to help employees who are infected with HIV/AIDS.					



## **SECTION C: BENEFITS TO EMPLOYEES**

**Indicate your choice by putting an X in the blocks provided**

	Strongly agree	agree	uncertain	disagree	Strongly disagree
8. Some employees were sent for training in order to help their fellow employees as peer educators/ counsellors.					
9. I always use a condom whenever I have casual sex.					
10. People in the organisation do not shun working with HIV infected people.					
11. The organisation does not offer any form of assistance to families of employees who died of HIV/AIDS.					
12. The organisation provides Anti-retroviral drugs for employees who are suffering from AIDS.					
13. My knowledge about HIV/AIDS has been enhanced through the HIV/AIDS program in the organisation.					
14. The AIDS awareness programmes offered by the organisation have no effect on employees.					
15. The organisation is doing its best to help employees who are suffering from HIV/AIDS.					
16. The HIV/AIDS program benefits everyone in the organisation.					
17. The organisation has community programmes for people living with HIV/AIDS					
18. The organisation offers support if a close member of an employee dies.					
19. Condoms are easily available at the work place					

## **SECTION D: RECOMMENDATIONS AND OPINIONS**

**Indicate your choice by marking an X in the appropriate block where:**

(1) = Strongly Agree

(2) = Agree

- (3) = Uncertain  
 (4) = Disagree  
 (5) = Strongly disagree

<u>Question 20</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
The obstacles which I have in using a condom are:					
<b>20.1 Religious teachings</b>					
<b>20.2 Culture</b>					
<b>20.3 Spouse</b>					
<b>20.4 Suspicion</b>					
<b>20.5 Other</b> (state)					
<u>Question 21</u>					
I do not support the idea of HIV/AIDS programme at the work place, because of the following reasons					
<b>21.1 It adds unnecessary costs to the organisation</b>					
<b>21.2 Health issues are the responsibility of government</b>					
<b>21.3 It only benefits the infected and affected</b>					
<b>21.4 Other</b> (state)					
<u>Question 22</u>					
The weaknesses of the HIV/AIDS program in my organisation are:					
<b>22.1 Lack of top management support</b>					
<b>22.2 Inadequate funding</b>					
<b>22.3 Lack of medicine and specialists support</b>					
<b>22.4 No communication between employees and management</b>					
<b>22.5 Other</b> (state)					
<u>Question 23</u>					
Suggestions to improve the effectiveness of HIV/AIDS programmes at the work place are:					
<b>23.1 Management and employee participation in designing the HIV/AIDS policy/program.</b>					
<b>23.2 Adequate funding, if not available combine the program with another organisation or seek external donations.</b>					

<b>23.3 Effective communication between the management and employees on issues to do with HIV/AIDS program</b>					
<b>23.4 Seek specialists knowledge when designing and implementing of the program/policy</b>					
<b>23.5 Other (state)</b>					

If you have any more suggestions, please feel free to express them in the space provided.

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**This section is for an organisation without HIV/AIDS policy/program only**

### **Section E: Not having HIV/AIDS policy /program**

**Indicate your choice by marking an X in the appropriate block where:**

(1) = Strongly Agree  
(2) = Agree  
(3) = Uncertain

(4) = Disagree  
(5) = Strongly disagree

<u>Question 24</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
The organisation does not have an HIV/AIDS program because:					
<b>24.1 No funding for the program as organisation is fighting for survival.</b>					
<b>24.2 No management support for the program.</b>					
<b>24.3 Employees do not see any need for it.</b>					
<b>24.4 Organisation is not affected by HIV/AIDS.</b>					
<b>24.5 Organisation does not have the capacity to implement the program</b>					
<b>24.6 Other (state)</b>					
<u>Question 25</u>					

Does the organisation have any plans of implementing an HIV/AIDS program?					
<b>25.1 Have never thought of it and has never been discussed.</b>					
<b>25.2 Do not see any need for it</b>					
<b>25.3 Will implement it soon.</b>					
<b>25.4 Will implement it when its operations improve.</b>					
<b>25.5 If it gets funding it will implement it</b>					
<b>25.6 Other (state)</b>					

***Your time and participation is greatly appreciated.***