Utilization of an HIV/AIDS Employee Wellness Program within the Workplace (Harare, Zimbabwe)

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Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own original work and that I am the sole author thereof (save to the extent explicitly stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party right and that I have not previously in its entirety or part of submitted it for obtaining any qualification.

Signed: P. T RUWENDE Date: March 2012

Abstract

This study partly assessed the utilisation of an HIV/AIDS Employee Wellness Program (HIV/AIDS EWP) offered by a bank in Harare, Zimbabwe. It was done by assessing employees' knowledge, awareness and perceptions of the Program; their utilisation thereof; as well as identifying areas of key concern within the Program.

Results showed a high level of knowledge and awareness of the organisations' HIV/AIDS EWP. Help and information vital to the HIV/AIDS EWP was found to be easily accessible. The Program was viewed as an enhancer of HIV/AIDS knowledge and consequentially vetted favourably. Utilisation of the Program was high, it showed HIV/AIDS organisational offered programs were attended well; and there was a positive view on importance of HIV seminar and forum attendance plus accessing pamphlet information pertinent to the HIV/AIDS EWP.

Respondents were in favour of knowing one's HIV status, showing a willingness to enrol with the organisation's anti-retroviral program. Results revealed a high level of knowledge on condom use and a generally positive attitude towards institutional provided condoms.

Respondents showed a good understanding of the workings of the existing organisational HIV/AIDS policies and programs. Although the majority of respondents in the study showed a willingness to continue a friendship with a colleague who is HIV positive, issues of discrimination towards HIV-positive persons were identified in the study. A need for perseverance on HIV-related education, information and communication dissemination by the Organisation for its employees (and communities they live in at large) are suggested.

Opsomming

Hierdie studie was gerig op die gedeeltelike assessering van die gebruik van 'n MIV/VIGS Werknemerswelweesprogram (MIV/VIGS WWP), wat deur 'n handelsbank in Harare, Zimbabwe, aangewend word. Dit is uitgevoer deur werknemerskennis, -bewustheid en -persepsies van die program , asook die gebruik en toepassing daarvan, te assesseer - dele van die Program, wat van sleutelbelang is, is ook geïdentifiseer.

Bevindings het gedui op 'n hoë vlak bestaande kennis en bewustheid van die vermelde instansie se MIV/VIGS WWP. So is ook bevind dat bystand en inligting, wat van die uiterste belang vir die MIV/VIGS WWP is, maklik bekombaar was. Die Program is beskou as 'n opskerper van kennis aangaande MIV/VIGS en is gevolglik gunstig gekontroleer. Aanwending van die Program was omvattend; dit het getoon dat die aanbieding van instansiegedrewe MIV/VIGS-programme goed bygewoon word en daar was ook 'n positiewe siening waarneembaar oor die belangrikheid van MIV-seminaar en -forum bywoning, asook oor die assessering van pamflet-inligting wat spesifiek op die MIV/VIGS WWP gerig is.

Respondente het die gedagte gesteun dat 'n mens van jou MIV-status bewus behoort te wees en het gewilligheid getoon om by die instansie se anti-retrovirale program in te skakel. Bevindings het ook op 'n hoë vlak van ingeligtheid oor die gebruik van kondome gedui en 'n algemene positiewe ingesteldheid teenoor die verskaffing van kondome deur die betrokke instansie.

Respondente het goeie begrip getoon wat betref die funksionering van die bestaande instansiegedrewe MIV/VIGS-beleidsrigtings en -programme. Hoewel die meerderheid respondente betrokke by die studie gewilligheid geopenbaar het om 'n vriendskap met 'n kollega wat MIV-positief is, vol te hou, is daar ook blyke van diskriminasie teenoor mense wat MIV-positief is tydens die verloop van die studie geïdentifiseer. Daar word aan die hand gedoen dat die instansie volhard deur met sy werknemers te kommunikeer en aan hulle (en die groter gemeenskappe waarin hulle woon) inligting te voorsien wat hulle op hoogte sal hou van MIV-verwante aangeleenthede.

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Abbreviations, Acronyms and Terms

AIDS: Acquired immune deficiency syndrome

ARV: Antiretroviral therapy

ART: Anti-retroviral therapy

DM: Diabetes Mellitus

DPM: Disease Management Program

EWP: Employee Wellness Program

FAQs: Frequently Asked Questions

HDI: Human Development Index

HIV: Human Immunodeficiency virus

HTP: Hypertension

IEC: Information, Education and Communication

ILO: International Labour Organisation

ISO: International Standards Organisation

MCAZ: Medicines Control Authority Zimbabwe

NEBPs: New Employee Briefing Packs

PCP: Pneumocystic carinii pneumonia

PSAPI: Private Sector AIDS Prevention Initiative

PVO: Private Voluntary Organisation

TB: Tuberculosis

UNAIDS: Joint United Nations Programme on HIV/AIDS

UNDP: United Nations Development Programme

VCT: Voluntary Counselling and Testing

WHO: World Health Organisation

ZAPSO: Zimbabwe AIDS Prevention and Support Organisation

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Chapter 1: Introduction

1.1 Background

The HIV/AIDS epidemic has been around for the past three decades and now going into the fourth decade. It has for all intents and purposes become part of the landscape of the contemporary world (Merson, O'Malley, Serwada & Apisuk, 2008). It has even been described as the worst public health crisis in at least 600 years or history (UNAIDS, 2005). No one could have envisioned that four decades later the HIV virus would have 'dominion' over human-kind: leaving brilliant researchers and scientists scrambling for a permanent cure and with society at large to deal with all its resultant devastating negative effects. The negative impact of HIV/AIDS to families, society, business enterprises and nations are great if not curbed. The resultant negative effects of this 'human tragedy' (from Economic Commission for Africa) include:

- The millions of deaths: over 25 million (children and adults) who have died over the past three decades (Merson, et al, 2008)
- Threat to economic structures
- Integrity and cohesion of societies severed and lost
- Loss of family livelihoods and incomes
- Threat to viability and continued existence of businesses (from Economic Commission for Africa)

It is vital that organisations and businesses view HIV/AIDS as both a community and workplace threat due to its incumbent negative effects across all sectors. This is vital to any organisation/business which aims to be viably operational within the coming future.

1.2 Employee Wellness Programs

For several years, businesses have implemented Employee Wellness Programs (EWP) within the workplace. These have tended to focus, target or address issues such as Hypertension (HTP), Diabetes Mellitus (DM) and obesity to name but a few chronic conditions; in a bid to have a healthier working workforce. Employee wellness programs are services, activities or resources availed to organisational employees (Berry, Mirabito & Baun 2010). These are either company organised or sponsored and are primarily intended to assist respective organisational employees lead a healthy way of life thus improving quality of life and manage chronic diseases such as DM, HTP (Berry, et al, 2010).This is at times extended to relevant qualifying family members. Within the same scope, this can similarly be extended to the management of HIV/AIDS which can be duly regarded as a 'chronic' disease.

Organisations can employ different responses to minimise the incumbent negative financial implications of HIV/AIDS. Three response strategies primarily engaged to counter these effects are:

1. Curtailing the incidence of new infections
2. Avoidance or reduction of the escalating costs posed by existing or future infections
3. Prolonging lives of infected employees by offering, treatment, care and support essentially thus extending their working lives (Rosen, Simon, Thea & Vincent, 2000).

With regards to all that has been made reference to it thus imperative to define wellness. Wellness can thus be defined as a sustained equilibrium between the psychological, emotive and physical states within an individual resulting in a quality assured prolonged and productive life. It has been defined as an integrated pattern of living focused on six aspects or dimensions which are emotional, intellectual, environmental, physical, spiritual and social dimensions (Sackney, Noonan & Miller, 2000). All these have to be in balance to derive maximum performance from any employee within the workplace.

1.3 HIV/AIDS Employee Wellness Program

The HIV/AIDS Employee Wellness Programs essentially constitute of care, support and treatment components. These essentially utilise the 3 response strategies that are made mention of above. Multinational companies such as Anglo-American plc, BHP Billiton and local South African corporate such as Eskom have implemented HIV/AIDS Employee Wellness Programs within the workplace (UNAIDS, 2005). These programs are aimed to combat the negative economic impact of the epidemic on the organisation. The HIV/AIDS Employee Wellness Programs aims to address four key areas:

- Education and awareness campaigns
- Condom distribution
- Voluntary counselling and testing (VCT)
- Treatment, care and support (Smart, 2009).

1.3.1 Education and awareness campaigns

Education and awareness campaigns entail imparting and transmitting different information to the employees. Knowledge of the different modes of viral transmission is relayed to employees. Within the same scope, knowledge on how the virus is not transmitted is relayed. Prevention of transmission knowledge is vital and necessary and falls in this category and is thus included. Education and awareness campaigns also cover disseminating information on organisational policies, procedures for handling HIV/AIDS cases, employee benefits and accessing help if need arises (Oglethorpe & Gelman, 2007) plus updates on treatment developments and research. This can be done through peer educators, pamphlets and even the organisational intranet.

1.3.2 Condom distribution

Condom distribution involves making condoms available within the workplace. These ideally have to be made available at convenient and discreet locations e.g. bathrooms, with supplies replenished as needed. Condoms made available can be supplied by either local health organisations or AIDS Programs (Oglethorpe & Gelman, 2007). Male condoms have generally and commonly been made available: if possible it is vital that female condoms are made available so as to empower women in the fight against HIV and AIDS (UNAIDS, 2006).

1.3.3 Voluntary Counselling and Testing (VCT)

Voluntary Counselling and Testing (VCT) can be considered as an essential and necessary entry point to further HIV and AIDS services (Pulerwitz, Greene, Esu-Williams & Stewart, 2004**;** George, & Quinlan, 2009). VCT involves getting tested to know one's sero-status. This is with the appropriate pre- and post-test counselling which is an essential component of the process. VCT can be done on-site at the workplace or off-site at a clinic, doctor's office or testing centres. Employees are encouraged to take up voluntary testing with the

appropriate pre- and post-counselling to enable them to understand how the test is done and the meaning of results and the action to be undertaken on either outcome of results i.e. negative or positive (Oglethorpe & Gelman, 2007). All this should be in accordance with the country's' labour laws on HIV/AIDS.

It is vital to note that Education and Awareness, Condom distribution and VCT constitute Prevention programs. They thus address the first and second strategic responses. These can be done singularly or in combination (Mahajan, Colin, Rudatsikira & Ettlc, 2007).

1.3.4 Treatment, care and support

Treatment entails different aspects depending on one's immune status (CD4 count, viral load and HIV/AIDS staging). It includes prevention and treatment of sexually transmitted infections which are associated with a higher transmission rate of HIV/AIDS (Walker, Reid & Connell, 2004). It should include treatment for opportunistic infections such as Tuberculosis (TB), Pneumocystic jirovecii pneumonia (PCP) and Crypotoccocal meningitis: which occur with the weakening of an individual's immune system. Anti-retroviral (ARV) provision is done in accordance with World Health Organisation (WHO) and country guidelines. This essentially encompasses strategic responses 2 and 4 of the HIV/AIDS response.

1.3.5 Definition of an HIV/AIDS Employee Wellness Program

An organisation's HIV/AIDS Employee Wellness Program (HIV/AIDS EWP) can thus be defined as a multifaceted, multidisciplinary workplace care, support and treatment program into which HIV/AIDS has been integrated (Smart, 2009). It utilises preventive and curative operational strategies (Sieberhagen, Pienaar & Els, 2011).This constitutes a holistic approach in managing the impending threat of the HIV/AIDS epidemic on the organisation.

1.3.6 Benefits of implementing an HIV/AIDS EWP

The benefits of an HIV/AIDS Employee Wellness program are manifold; to the organisation, employees and communities. As cited by Smart, (2009) these are:

- Benefits the organisation by extending lives of employees who can thus be available to work for longer
- For employees who happen to be infected it extends the lag phase between acquiring infection and onset of disease and prevents morbidity and mortality from opportunistic infections such as Tuberculosis
- Provides support and care services for employees who are infected and affected by the disease
- Creates a good working environment by fostering employee morale**.**

A holistic approach to the HIV/AIDS within the workplace should help in curbing the negative impact of the disease in an organisation. Benefits of a comprehensive HIV/AIDS Employee Wellness Program in the workplace are summarised below:

- ✓ Reduced absenteeism
- ✓ Increased productivity
- ✓ Lower life insurance premium
- ✓ Increased staff morale (Smart)
- ✓ Improved corporate image and corporate clout (Kotler& Lee, 2005).

This is all essentially achieved by a noted decline in both the HIV/AIDS morbidity and mortality with the right redress to the epidemic.

1.4 Research problem and research question

The following is an outline of the research problem and research question as pertaining to the study.

1.4.1Research problem

The information mainly available on the effects of HIV/AIDS on any business/organisation within either the private or public sector focuses primarily on the cost of the epidemic on the employer or organisation (Mahajan, et al, 2007). This will be outlined in the literature review. However not much has been done to look at employees perceptions of an organisational HIV/AIDS Wellness Program, utilisation and level of knowledge and awareness of the existence of such programs and functioning of the programs. This was thus identified as a knowledge gap appropriate for further study.

The research will focus on an organisation's HIV/AIDS Employee Wellness Program in Zimbabwe. The organisation will from henceforth herein be referred to as Organisation X for purposes of maintaining anonymity as requested by the organisation. Organisation X provides retail and commercial banking services. In the late 1990's the parent body of Organisation X recognised the growing HIV/AIDS epidemic as a threat to the business, customers and employees across Africa and globally. Thus there was set up a program which has evolved into a holistic HIV/AIDS programme. This program offers education; voluntary counselling and testing and clinical management of HIV infected employees with extension to spouses and children. I was interested in conducting a study on the utilisation of an HIV/AIDS EWP within the workplace in Organisation X in Zimbabwe. Being acquainted with some employees and having detected lack of knowledge and full detail on the full workings of the program as well as detecting a hint of fear of status being known in the workplace for fear of discrimination by fellow employees.

At times misinformation on a program among employees can be rife. This involves misinformation about benefits, lack of knowledge on where to get help. It even extends to employees being unaware of the organisational policy on HIV/AIDS, country labour laws on HIV/AIDS and issues like VCT and dismissals. It is thus vital to delineate their knowledge and awareness about the organisational HIV/AIDS Wellness Program. Employees at times even have a wrong perception or distrust the reasons and purposes for the program being set up and thus do not fully utilise it.

Stigma and discrimination have been synonymous with HIV/AIDS. This is because HIV/AIDS is invariably linked to sexuality, illness and death; regarded as private and sensitive topics in many cultures, which resultantly leads to stigma and discrimination (UNAIDS, 2006). HIV/AIDS has also been regarded from the earliest time as a punishment for sin e.g. divine punishment for the sin of adultery (Kopelman, 2005). Discrimination which resultantly stems from this stigma and fear of the disease can have negative connotations in the success of any organisational HIV/AIDS Employee Wellness Program. Fear of stigma and discrimination can cause workers to avoid fully utilising a program. There is a need to understand the existing uptakes of VCT and treatment for opportunistic infections and ARVs offered within the workplace. Research will expound on the reasons employees either take up or do not take up offered services within the HIV/AIDS Employee Wellness program. With

lack of such information, organisations can end up having a large expenditure bill on a program that is not fully utilised by employees. The benefits which are supposed to be derived from the implementation of the program are thus not met as expected.

1.4.2 Research question

With regards to the above mentioned it is thus imperative to pose the following question: **"How do employees utilise the organisation's HIV/AIDS Employee Wellness Program?"**

1.5 Aim and Objectives

The aim and objectives for the study are outlined as follows:

1.5.1 Aim

The aim of the study was to determine the utilisation of the HIV/AIDS Employee Wellness Programme by employees within the organisation in order to provide guidelines to make the program effective and to render the program more cost effective.

1.5.2 Objectives

The objectives for the study were five-fold and are outlined below as follows:

- To find out employee's knowledge and awareness of the HIV/AIDS Employee Wellness Program
- To find out perceptions about the program
- To find out the extent to which employees utilise the program
- To establish areas of key concern within the program to employees
- To provide guidelines to make the program effective and more cost effective

1.6 Significance of the study

It has to be noted that an employee wellness program is a form of intervention strategy specifically geared to facilitate and encourage employee wellbeing within the workplace (Sieberhagen, et al, 2011). In any scenario it is of the essence to evaluate effectiveness of an employee wellness program. This can be done through determining utilisation, reasons for employee non-participation and perceptions on and about the program. Three reasons exist for the evaluation of any employee wellness program:

- ✓ Justification for their existence
- ✓ Determining the extent to which they meet set objectives
- ✓ Finding ways of improving their effectiveness (Sieberhagen, et al).

This holds true in the management of an organisations HIV/AIDS Employee Wellness Program as well. In addition to the above mentioned reasons for evaluation of the employee wellness program, this investigation would be beneficial to the employees by finding out any ambiguities and address areas of concern such as undue fear of dismissal and stigmatisation and recrimination. For the employees this will ultimately result in a tailor made program addressing key issues and needs of employees within the HIV/AIDS program. For the organisation less time and money consumption through a better suited program which ensures higher utilisation rates and thus ensures return on investment for the organisation.

1.7 Scope of the study

The study will be limited to employees (i.e. respondents) of Organisation X in the Harare branches and offices. This will be in order to garner a perspective by way of collating data on knowledge and awareness, utilisation and perceptions on the program. It will also help identify areas of great concern and red flags in the program. In this way any redress can be done and thus rendering the program more effective and cost effective.

Chapter 2: Literature review

2.1 Introduction

The first section of the literature review looks at HIV/AIDS as a global epidemic and then shifts to the African epidemic with special focus on Sub-Saharan and Southern Africa. This is done to give a picture of the operating environment Organisation X is conducting business in. The second section looks at macro- and micro- economic impact of HIV/AIDS which can influence the organisations continued viability. Private sector impact further highlights the environment within which the organisation is operating and reveals challenges posed by high prevalence of HIV/AIDS. The third section looks at the variable factors which can affect uptake of the different components of an HIV/AIDS EWP. It gives an idea of challenges to be expected in an implemented program. The literature review thus helps in the composition of relevant questions to pose in the questionnaire to ferret out information to cover the different objectives and gives a glimpse of what results to expect in the study.

2.2 HIV/AIDS a global epidemic

HIV/AIDS has been an epidemic for human kind to contend with for years, since the early days of its discovery in 1981 (Merson et al, 2008). An epidemic can change the course of history by variable means. It leads to death i.e. mortality, incapacitation of some i.e. morbidity and result in divergence of capabilities of the physically well into the care of the sick and dying (Barnett & Whiteside, 2006). Well into the 21st century HIV/AIDS still plagues humanity with varied consequences and ramifications.

To date 33.3million people are living with HIV/AIDS worldwide with a noted 2.6million people having acquired the disease in the year 2009 (UNAIDS, 2010). This is despite intervention programs on prevention of transmission and the abundant education and awareness programs. AIDS deaths were reported at 1.8million (UNAIDS). Advancements in different forms of Anti-retroviral drugs (ARVS) have been made possible through investment and research but unfortunately are still unavailable or inaccessible to the greater majority poor HIV positive persons (Walker, et al, 2004); especially in the third world countries.

2.3 HIV/AIDS and Africa

In the long enduring history of the epidemic, the African continent has been greatly affected by the HIV/AIDS epidemic. It has been reported that 70% of HIV and AIDS cases are to be found on the African continent from (Economic Commission for Africa). HIV/AIDS is thus undoubtedly an African problem; it ranks as the top killer disease above all other diseases on the African continent (Haacker, 2004; Tangwa, 2005).This spells dire consequences for the majority of the continents' already fragile or at times flagging economies.

The HIV/AIDS epidemic is at different levels and stages within the different African sub regions (Walker, et al, 2004). Of main concern is the region of Sub-Saharan Africa. Sub-Saharan Africa is the epicentre of the African epidemic for it accounts for two thirds of those living with HIV/AIDS the world over (Walker et al); this is despite Sub-Saharan Africa making up only 11% of the total of the world population (Merson, et al, 2008). HIV/AIDS is ranked as the leading cause of death in Sub-Saharan Africa (Merson, et al). This paints a gleam portrait for the African continent more so for the Sub-Saharan African region. Statistics for Sub-Saharan Africa from UNAIDS Global Report 2010 are briefly outlined in the table 2.1 below.

Table 2.1: Summary of statistics for Sub-Saharan Africa from (UNAIDS, 2010)

Adults and children living with HIV/AIDS	**22.5million**
Adults and children newly infected with HIV	**1.8million**
Adult prevalence (15 -49 years)	**5%**
Adult and child deaths due to AIDS	**1.3million**

Within Sub-Saharan Africa, it is vital to recognise that Southern Africa stands out as the most severely affected region (UNAIDS, 2010); referred to as 'hyperendemics of Southern Africa' (Merson, et al). In 2009 an estimated 11.3million people were living with HIV in Southern Africa which approximates to nearly one third more than the number of persons living with the disease 10 years earlier (UNAIDS). The reasons for pointing out these statistics will be referred to subsequently.

2.4 Macro- and Micro- Economic Impact of HIV/AIDS

HIV/AIDS poses macro- and micro-economic consequences' within any setting of high prevalence. It has implications for key macro-economic indicators which include economic growth, income per capita and economic development (Haacker, 2004). HIV/AIDS leads to a decline in economic growth through increased government expenditure in provision of prevention, treatment and care for the disease leaden population leading to weakening of the domestic tax base and thus ultimately a fall in domestic revenue (Haacker, 2004; Barnett & Whiteside, 2006). The HIV/AIDS burden will erode public services such as health, education etc and thus strain government expenditure even more; HIV/AIDS has the potential to reverse the gains in development that would have been attained by a nation or a country and spells a fiscal disaster to be averted at all cost. There can be noted to be a decline in developmental indices in countries of particularly high prevalence: micro-economic implications include loss of household incomes through death of breadwinners, pushing at times already impoverished families and communities into poverty and a decline in standard of living (Haacker).

From all that has been made reference to in the above, it can be surmised that HIV/AIDS as an epidemic has shifted from being quintessentially a health issue to a development issue with social, political and economic dimensions (Arndt & Lewis, 2000).

2.5 Private Sector Impact of HIV/AIDS

Focus and emphasis will be on the major impact of HIV/AIDS on business enterprises. HIV/AIDS spells dire consequences in the business world on all stakeholders i.e. employers, employees (workforce), shareholders and the continued viability and existence of the business in an increasingly competitive global market. This is most notably in countries with high prevalence rates as is characterised by Southern Africa countries, shown in the table 2.2 below. The adult prevalence rates range from 13% to 26% in the tabbed 'hyperendemic' Southern African region (Merson, et al, 2008). Organisations need to be made aware that the HIV/AIDS prevalence figures give a glance into the future, "It is the epidemic of AIDS as it will be some years ahead, it is not the AIDS epidemic today or even the next year" (Barnett

& Whiteside, 2006). Table 2.2 shows the adult prevalence rate as a percentage for adults in the 15 to 49 years age group from seven Southern African countries.

Table 2.2: Adult prevalence rates % (15-49years) for Southern African countries; taken from (UNAIDS, 2010)

COUNTRY	Namibia	Zambia	Zimbabwe	South Africa	Botswana	Lesotho	Swaziland
Prevalence rate % (15-49years)	**13.1**	**13.5**	**14.3**	**17.8**	**24.8**	**23.6**	**25.9**

HIV/AIDS not only poses a threat to the viability or continued existence of a business, but also negatively affects the economic environment in which companies operate (UNAIDS, 2005). It has been estimated by the World Bank that HIV/AIDS may reduce the growth of a national income by up to one-third in countries with adult prevalence rates of 10% and above (UNAIDS). As shown in the table 2.2 most Southern African countries have an adult prevalence rate (i.e. 15-49 age groups) well above 10%. This is of great concern for this is the environment in which the organisation on which the research was done is operating.

The age group mostly affected by HIV/AIDS is the 15 to 49 years age group: under any other circumstances i.e. without HIV/AIDS, this age group normally represents a section of the population with typically low levels of morbidity (illness) and mortality (death) (Barnett & Whiteside, 2006). Unfortunately this 'ill-fated' 15 to 49 year age group is the group of the population that constitutes the most productive sector of the economy (Walker, et al, 2004). The high prevalence of HIV/AIDS within the 15 to 49 year age group can thus directly impact on the work/labour force availability. Death of employees mostly from this said productive age group within any organisation leads to the loss of skilled and experienced staff but more so the loss of highly qualified individuals who are hard to replace. Resultantly this will all lead to loss of corporate memory vital in the day to day operations of any organisation or business. As a result of the above a 10-35% drop in labour force/pool (workforce shrinkage) is forecasted for 2020 in countries with high HIV prevalence (UNAIDS, 2005). As cited by Haacker, (2004), as well as causing shrinkage of the workforce, there is an erosion of competiveness amongst companies and combined with a deteriorating economic outlook may deter potential investors.

2.5.1 Progressive impact of HIV/AIDS costs on an organisation

Figure 2.1 is a stylised diagram summarily illustrating the progressive impact of HIV/AIDS cost on the public sector from the (Economic Commission for Africa). Although primarily done to outline the effects on the public sector, the same impact can be noted across the board i.e. within the private sector as well. It represents the costs that will be incurred by any business public or private in an environment of uncontrolled/uncurbed HIV.

In the year of acquiring infection (year 0), no costs are incurred by either the organization or employer as there is no linked morbidity at sero-conversion. However between years (1 -5), morbidity bills start to accrue. These are in the form of actual medical care costs and indirectly in the form of absenteeism, presenteeism etc.

Absenteeism is defined as a noted decline in workforce productivity because of an absence from work for variable reasons. This can be through illness (morbidity) of self or taking care of sick family members and through death (mortality) (Barnett & Whiteside, 2006). Death can

be in two forms either the death of the employee or absence due to increased attendance of funerals for relatives and friends.

Presenteeism has also been found to affect workplace performance. In presenteeism an individual will report for work but underperform due to illness or stress associated with HIV/AIDS. Incidents of presenteeism arise due to an employee's fear of losing a job. Employees are aware that they can be medically discharged if they take too many sick leave days and thus resort to coming to work even when they are unwell. Macabre reports of employees spending entire shifts in a toilet because they are too ill to work have been reported (Barnett & Whiteside, 2006). Both absenteeism and presenteeism will result in a lowered productivity and thus incurs an added financial burden to the organisation.

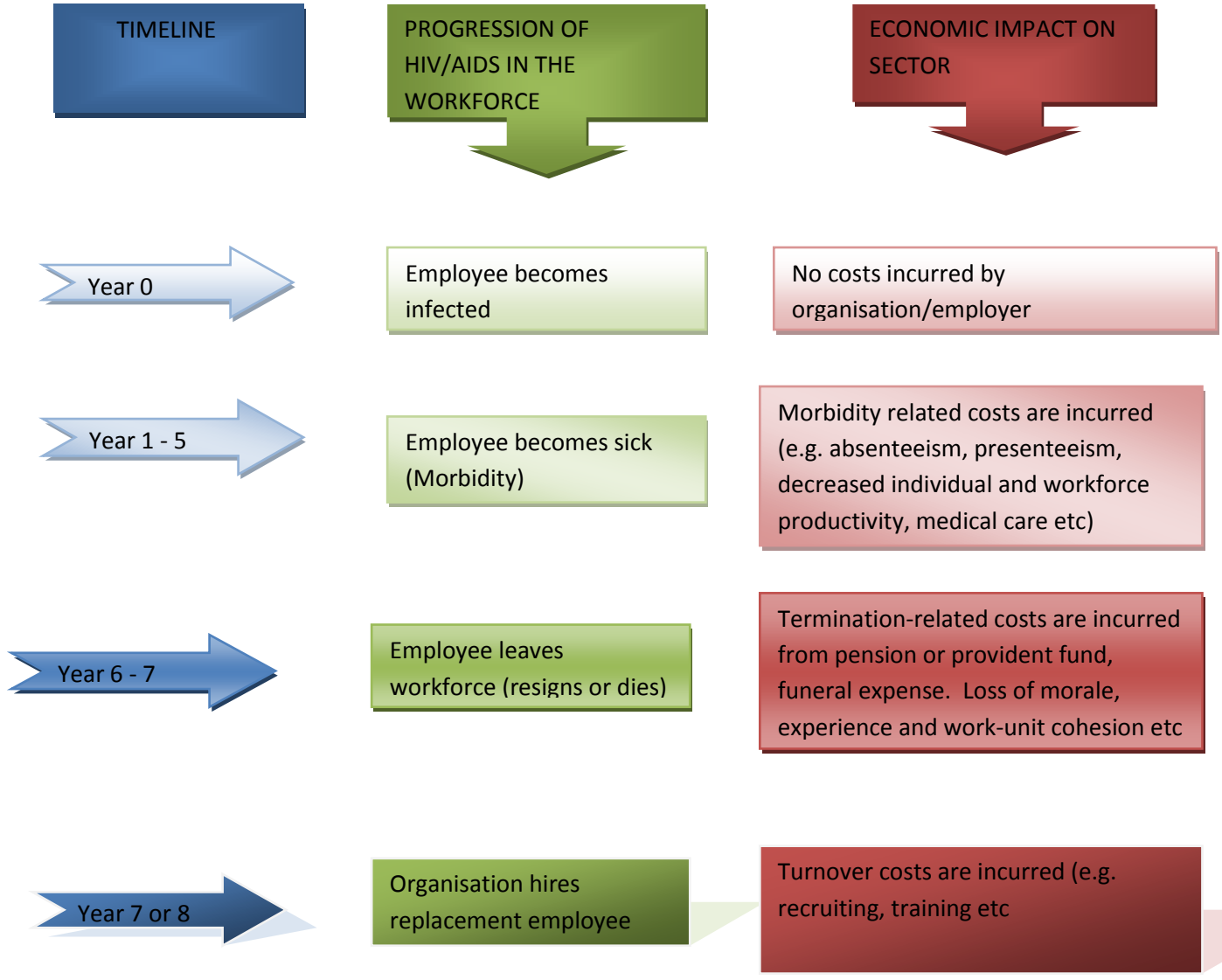

Figure 2.1: Stylised diagram of the progressive impact of HIV/AIDS cost on the public sector from the (Economic Commission for Africa).

In the years (6-7), when an employee/s resigns or dies marks an added burden of costs to the organisation in the form of provision of pension and provident funds and also funeral coverage expenses. There is also a linked loss of morale in the workforce, loss of experience and work unit cohesion. Above all else there is an incumbent corporate memory

loss. Thus in the year 7 or 8; the organisation has only the following recourse to make, mandate the hiring of replacement employee/s thus consequently incurring turnover costs in the form of recruiting and training.

The HIV/AIDS costs incurred by businesses have been dubbed the “AIDS Tax” (Rosen, Feely, Connelly & Simon, 2007). These are costs that an organisation would have to bear without pro-active action to mitigate the negative impact of the HIV/AIDS epidemic.

However what the diagram does not show is that morbidity and mortality from AIDS has far reaching negative economic consequences. It can negatively affect indices such as consumer bases, savings, investments and education (Lutalo, 2007).

Effect of HIV/AIDS on education is profound. HIV/AIDS will result in death of teachers’, lecturers’ and professors’ etc thus leading to a critical shortage within the system. In the same vein but different scene, fewer children will be attending schools due to illness or to care for sick parents, siblings or because of a necessary premature need to work to provide for families who have lost their breadwinners. Consequently there will be a reduced output of adequate numbers of educated and qualified students, an essential component in sustaining the country’s labour pool (UNAIDS, 2005). These thus further compounds on the already expected shrinkage of the labour pool that is caused by high morbidity and mortality within the 15 to 49 age group. Thus businesses that fail to redress the impending threat that is HIV/AIDS risk all the above. These are jarring statistics and scenarios for any organisation.

2.6 HIV/AIDS Employee Wellness Program

As made mention of earlier; big and thriving multinational companies with existing business enterprises within the African continent have implemented HIV/AIDS Employee Wellness Programs for some years now. This is all done in an endeavour to limit the negative effects on operational status and continued viability of the organisation. Organisations which have done so include, ESKOM, Anglo-American plc (UNAIDS, 2005), Damien Chrysler and the big mining firm De-Beers in South Africa and Botswana to name but a few. The benefits derived from implementation of such programs are either; financial (e.g. controlling the costs of AIDS to employers), humanitarian (e.g. curbing the HIV burden among workforces i.e. employees), corporate image purposes (e.g. fulfilling principles of corporate social responsibility [CSR]) or meeting legislative requirements (Mahajan, et al, 2007). Literature review shows that organisations like Anglo-America and BHP Billiton have set up programs which have been highly publicised (UNAIDS). However many challenges are encountered in running the intervention HIV/AIDS programs within the workplace.

The different components of an HIV/AIDS Employee Wellness Program have already been expounded to in the background. In looking at the set of objectives to be met it is vital to outline the variable factors that play a significant role in either promoting or inhibiting uptake of a particular program component. This way, areas of key concern are revealed or deduced in the process. Literature identifies such pertinent factors which can foil the utilisation of the HIV/AIDS EWP within the workplace.

2.6.1 Factors influencing uptake of the prevention component of HIV/AIDS EWP

Numerous factors influence the uptake of prevention programs i.e. (education and awareness, condom distribution and VCT). The factors which play a role in influencing

utilisation of the different components of the HIV/AIDS employee wellness program include perceived levels of stigma and support, confidentiality and quality of services (Dickinson & Mundy, 2004).

Stigma can be regarded as a social process which inadvertently leads to the marginalisation and labelling of those who are or who dare to be different (Stewart, Pulerwitz & Esu-Williams, 2002). In the HIV/AIDS scenario this unfortunately infers to people living with HIV/AIDS (a negatively perceived defining disease) (Letamo, 2003). Stigma is subdivided into:

- Felt or perceived stigma: This refers to shame and fear of discrimination
- Enacted stigma: refers to actual discrimination i.e. sanctions either individually or collectively visited on people living with HIV/AIDS (Mawar, Sahay, Pandit & Mahajan, 2005)

Stigmatisation invariably leads to discrimination. Discrimination in turn is defined as distinction, exclusion or restriction of any individual or group of individuals by either possession of a negatively perceived disease, characteristics, habits or way of life (Letamo, 2003). Thus pertains to those persons living with HIV/AIDS. The two processes stem from the fact that since its discovery HIV/AIDS has been shrouded in fear, ignorance and denial (Letamo). This unfortunately ultimately resulted in stigmatisation and discrimination of people living with HIV/AIDS. Contextualisation of HIV/AIDS within the marginalised poor communities, homosexual communities and intravenous drug users further compounded stigma and discrimination issues. The complexity of the stigma in the context of HIV/AIDS is thus layered upon pre-layered stigma (Mawar, et al, 2005). Stigmatisation and discrimination present a major hurdle or impediment in the successful running of any organisation's HIV/AIDS Program. It has been identified that stigma strongly correlates to care, drop out and non-adherence to treatment within management of HIV/AIDS (Mawar, et al). It inadvertently creates circumstances/environment for spreading HIV and AIDS at any point in time (Pulerwitz, Greene, Esu-Williams & Stewart, 2004).

Three categories of interactions within which HIV/AIDS associated stigma and discrimination can take place within the workplace have been identified as follows:

- Institutional Level Interactions: These encompass three important issues which are: employees' perceptions, understanding of and experience with existing organisational HIV/AIDS policies and programs. An employee's fear of being fired if they are known or revealed to be HIV positive can be typified under institutional level interactions (Pulerwitz, et al, 2004)
- Employee interactions: These refer to employee relations within the workplace. An example is undue fear of casual contact within an HIV infected co-worker (Pulerwitz et al)
- Social interaction within the workplace:
  This broadly covers interactions between employees which take place at scheduled intervals such as tea, lunch breaks etc. Employee perceptions on issues such as HIV/AIDS are causally noted to be influenced by the community from which they live and come from. This unfortunately percolates into the work environment. Examples

of this include social isolation, ridicule and refusal to share utensils with persons living with HIV/AIDS (Pulerwitz, et al). It is thus critical to highlight that stigma interacts at every level of society including the workplace.

Another external factor identified which can ultimately limit the uptake of services within any program is fear or perceived stigmatisation by co-workers. This can take the form of social isolation and ridicule by colleagues (UNAIDS, 2005); this thus falls under social interaction. Colleagues have been known to refuse to shake hands, share utensils, food or bathrooms with a colleague who is suspected of being HIV infected. It is noted with great concern that workers fear stigma from colleagues more than discrimination by their employers (UNAIDS), a status-co that needs redress in any organisation.

2.6.2 Factors influencing uptake of Voluntary Counselling and Testing

The workplace HIV/AIDS programs encourage employees to go through voluntary counselling and testing. As noted previously; VCT is a vital entry point to further HIV/AIDS services which are on offer or made available within an organisation's HIV/AIDS EWP (Pulerwitz et al, 2004; George & Quinlan, 2009). It should not be regarded as merely a means of screening for HIV (George & Quinlan). VCT is essential for the following reasons;

- ✓ It can promote behaviour change in individuals
- ✓ It can result in decline in rates of Sexually Transmitted Infections (STIs)
- ✓ It can be regarded as a precursor in the treatment of HIV-infected individuals (George & Quinlan)

The counselling in VCT must be confidential and of high quality to be highly considered. Tests should have the following criteria, accuracy, timely (same day), non-invasive and anonymous (Dickinson & Mundy, 2004). This way help, care, support and treatment services can be extended appropriately to employees. However a number of impediments have been found which can lead to a lower than expected or desired uptake of VCT.

Employees can underutilise VCT services if they do not understand and trust the employers/institutions' purpose/reasons in advocating for this (Mahajan, et al, 2007). There is a fear of dismissals if one tests positive and discrimination at the workplace in the form of being passed over for promotion opportunities and further education opportunities; which is categorised under institutional level interactions. For example, it has been noted that VCT services offered either on-site or off-site is likely to be underutilised if perceived threats outweigh benefits (Dickinson & Mundy, 2004).

Lack of knowledge on the country's labour laws as pertaining to HIV/AIDS within the workplace can also be an attributing factor to low uptake of VCT. This further compound on employee suspicions about the organisations reasons and purposes in advocating for VCT. These essentially cover institutional level interactions. It can be thus logically deducted that it is paramount that employers/institutions create a climate which is conducive and encourages their labour force to seek VCT services (Dickinson & Mundy, 2004).

Imparting knowledge of country's labour laws applicable to HIV/AIDS to employers through the organisational HIV/AIDS policy creates an enabling environment for employees within the work environment. It is essential to clearly outline and expound and delineate on issues of discrimination within the workplace, e.g. unfair dismissals, what constitutes unfair practices and complaints and claims an employee as a complainant can be awarded in

instances in which this happens. In this way employees can feel secure in seeking offered services. The Zimbabwe Labour Relations Act [Chapter 28:01] as amended by the Labour Relations Amendment Act 2002 and the Labour Relations (HIV/AIDS) Regulations 1998 as cited by Chartier, (2005) is good example of this. It details provision of HIV/AIDS education and information during normal working hours and bans any mandatory testing. It prohibits all forms of discrimination and assures confidentiality of HIV/AIDS related data. Further amended in 2002 it bans discrimination of future employees' based on status and clearly outlines sentences for offenders (Chartier).

Confidentiality was noted to have an effect in influencing utilisation of services offered by an organisational HIV/AIDS employee wellness program. It was noted that employees need assurance on confidentiality. This extends to assurance that medical files, data or any revealing demographic data linked in any way to HIV/AIDS will not be made available to management or anyone else e.g. colleagues within the workplace (Mahajan, et al, 2007). Lack of confidentiality or perceived lack thereof can greatly jeopardise uptake of the HIV/AIDS EWP. One way this can be accomplished is by working in co-junction with an independent organisation. Assurance has to be given that no medical data or demographic data will be made available to the corporate. This has to be conveyed to employees explicitly and can resultantly lead to increased uptake of services.

2.6.3Factors influencing Condom use

A lot of reasons can exist for none or lower than expected uptake of proffered condoms within the workplace. Generally a lot of myths and false stories have surrounded the use of condoms within the HIV/AIDS context

- Likened to eating a sweet with its wrapper on
- Others believe it will lead to disease because there is no release of body fluids (Walker, et al, 2004).

These forms of negative stories and the rampant misinformation can lead to a negative attitude towards the utilisation of condoms.

Within the HIV/AIDS EWP, another negative attitude has been invariably linked to condoms within the workplace. Of great concern, mistrust exists on the quality of condoms that are either provided by institutions, governments or organisations. Individuals might have a misconstrued ideology that condoms provided by the institution/organisation are of inferior quality compared to those that are store bought (Chimbetete & Gwandure, 2011). Certain condoms are regarded as very cheap so they are considered not to be effective" (MOH-Malawi, 2005), this is mainly in reference to unbranded brands of condoms They are unquestionably treated as less durable since they are given for free (Chimbetete & Gwandure).

2.6.4 Factors influencing uptake of Antiretroviral Therapy

An organisation has a choice of four treatment schemes that it can make available to its employees within the HIV/AIDS Employee Wellness Program. The different types of schemes are briefly outlined as cited from Connelly & Rosen, (2005):

Model 1: Employer Provider - In this particular model an organisation internally finances and delivers both treatment and care for its HIV infected employees and their dependents,

spouses or partners. This is done by means of a 'closed' medical scheme and/or company clinic facilities.

Model 2: Medical Scheme - Employees have an option to make co-payment to a subsidized medical aid scheme premium. The medical aid scheme in turn hires a Disease Management Program (DPM) to handle the treatment and care of HIV infected members. Even if a member, separate enrollment into the DPM is mandated.

Model 3: Independent Disease Management Program (DPM) - An independent and specialised disease management firm is hired by on organisation to handle costs, treatment and care of HIV infected employees. This is irrespective of medical aid scheme available or an employee subscribes to.

Model 4: Clinic Provider - An external clinic provider is engaged by an organisation to provide treatment and care services for the HIV infected employees. This can be either done on the premises or an external clinic utilized.

A number of factors can affect the uptake of treatment services within an HIV/AIDS employee wellness program. Within one form, which is the Employer Provider Program, it has been noted that employees do not feel assured that confidentiality can be maintained (Mahajan, et al, 2007). This perceived lack of confidentiality can resultantly lead to low utilisation of ART program. Follow-up of treatment also suffers for; infected employees fear colleagues inferring their status by conspicuousness of clinic attendance or constant communication with persons responsible for running the program. This spells huge problems for adherence, lack of which plays a great role in development of undesirable and costly drug resistance. As noted for model 2, the specification of separate registration with 'HIV/AIDS' program, especially for the in-house programs raises questions and doubt on maintenance of confidentiality (Mahajan, et al). Thus there is an unwillingness to start ART in an employer provided program. Thus the desirable return on investment is not achieved. They also cite other factors which can lead to low uptake to include high medical premiums for low skilled workers and one for due consideration, exclusion of partners/spouse from the ART programs. It offers a difficult scenario for the spouse or partner on treatment and unfairness, resentment and ire if the spouse or partner cannot access the same level of treatment and care.

2.6.5 Other reasons for non-attendance or non-utilization of HIV/AIDS EWP

In addition to the reasons given above for non–utilisation of a program other reasons exist for non-attendance and non-utilisation. At times employees might view participation in any employee wellness program as another additional unnecessary demand being made on them by the organisation rather than as a resource which is formulated and intended to benefit them (Sieberhagen, et al, 2011). Other reasons for lack of participation can be summarised as follows as cited in Berry et al, (2010):

- ✓ Lack of time on the part of the employee who may be inundated with a high workload
- ✓ Little perceived benefit of the program on offer to the employee
- ✓ Distaste on the whole program which is on offer or made available
- ✓ Lack of knowledge or ignorance on available service or services
- ✓ Blame (unsupportive managers)

- ✓ An individual employee might have an attitude that maintains that one's' health is none of the company's business
- ✓ Mistrust management's motives in availing such a program.

It is thus essential to cover all bases so that employees may take quantum leaps in utilising the HIV and AIDS Employee Wellness Program to achieve the so earmarked and greatly desired return on investment which will in part ensure continued validation and existence of an organisation in the epidemic that is HIV and AIDS.

Chapter 3: Research Design and Methods

The following is an outline of the research design and methods utilised in the study. It also details target groups and sampling and gives a breakdown of the questionnaire which was the measuring instrument.

3.1 Research design and methods

The research design of this study was a mixture of qualitative and a quantitative research approach. A quantitative research study collects numerical data to answer a question whilst a qualitative research study collects non-numerical data; this is because qualitative data in addition to quantitative data gives an added level of understanding. The study made use of a survey as the research design. The research design refers to the outline, plan or strategy specifying the procedure to be used in seeking an answer to the research question (Christensen, 2007).

3.2 Target Group and Sampling Method

The research was conducted at Organisation X in Harare Zimbabwe. For reasons of anonymity the organisation opted not to be named. The target group for the research were permanent employees of Organisation X. The target population refers to the larger population to which results are to be generalised (Christensen, 2007). These were employees at the Head office in Harare and branches within Harare. This study targeted employees who have been employed by the Organisation X for longer than one year. The participants were selected from the pool of bank tellers and lower and middle management from different departments. A convenience sampling method was utilised. Each branch or office was visited and eligible employees i.e. those who have been working for greater than or equal to one year (≥ 1 year) requested to participate. This was done in all offices and branches until a total of one hundred respondents were reached. Participation was on a voluntary basis for those who participated.

3.3 Data Collection

A survey method was used for data collection. A survey represents a probe into a given state of affairs that exists at a given time (Christensen, 2007). The instrument which was utilised in this research was a questionnaire. The questionnaire was designed to collate employees' knowledge, awareness and perceptions about the HIV/AIDS Employee Wellness Program. The method utilised was a self administered, questionnaire to collect the respondents' answers. The questionnaire constituted of 24 questions with different sections. The questionnaire was also translated into the vernacular i.e. Shona (see Annexure) to cater for the lower grade employees if necessity arose. The Shona questionnaire also helped to serve as a template for consistent translation for the other employees who might have needed verification of a question in Shona.

The questionnaire was distributed during weekday working hours with permission having been granted to do so from the relevant authorities. This was considered the most feasible time to gain access to the organisation's employees. The organisation has a total of 13 branches and offices in Harare. With the help of the Corporate Wellness Advisor, the researcher formulated an itinerary for the branch and office visits. A day was allocated for each branch and offices from the 8th to the 22nd of November 2011. The researcher was responsible for explaining the study and getting consent from the invited participants. The questionnaires were collected at the end of the working day.

3.4 Data Analysis

Data analysis of this study utilised descriptive statistics and graphical display in the form of bar graphs. Microsoft Office Excel 2007 was utilised. By carrying out data analysis conclusions regarding the research question can be inferred (Christensen, 2007). Thus provide answers to the research question; 'How do employees utilize the organisation's HIV/AIDS Employee Wellness Program?'

3.4.1 Constitution of the questionnaire

The following gives an outline of the breakdown of questions within the questionnaire.

- A total of 10 questions were posed in a closed- ended 5 point Likert scale which is (*Strongly agree, Agree, Disagree, Strongly disagree, Undecided*). This included questions 11, 13, 14, 15, 16, 17, 19, 20, 21, and 23.
- One question; (Qn. 12), was posed in a closed- ended 5 point Likert scale (*Very good, Good, Poor, Very poor, Barely acceptable*)
- One other question; (Qn. 10) was posed in closed- ended 4 point Likert scale (*Often, Sometimes, Seldom, Never*).
- A further 6 questions out of the 24 were "*Yes"* or "*No"* questions. This included question 6, 8, 9, 18, 22 & 24. Two of these; (Qns. 6 & 22) were simple and straight-forward and required "*Yes"* or "*No"* responses from respondents'. However the other four; (Qns. 8, 9, 18 & 24) required respondents to further ***state reasons*** if they responded *"No"* to the question posed.
- One question (Qn. 7), required respondents to choose from three responses *(Co-workers, Line manager & "Other"*). Those who responded "*Other"* were further required to specify this answer.
- The remaining 5 questions required respondents to give specific responses to them. This mainly encompassed questions 1 up to 5 of the questionnaire.

The questionnaire consisted of different subsections to assess and thus meet the different objectives of the study. These are as follows:

3.4.1.1 Demographics Section

This encompassed questions 1 up to 5 of the questionnaire. Respondents in the research essentially supplied information on the following:

- age
- sex
- marital status
- grade within the organisation
- years employed in the organisation

3.4.1.2 Section on the Level of Perceived Knowledge and the Level of Awareness of the HIV/AIDS Employee Wellness Programme

This encompassed questions 6 up to 8 of the questionnaire. This assessed respondents' awareness on the existence of the organisational HIV/AIDS Employee Wellness Program and determined how they got to know about it and sought to find out if they were satisfied with how they acquired their knowledge. This basically involved respondent's supplying answers to the following questions:

- I am knowledgeable/aware of the existence of an organisational HIV/AIDS Employee Wellness Program
- How did you know about it?
- I am satisfied with how information pertaining to the HIV/AIDS Employee Wellness Program was imparted to me

3.4.1.3 Section on the Utilisation and Perceived Success of the HIV/AIDS Employee Wellness Programme

This section looked at employee metrics which were used to assess the perceived success and perceived utilisation of the organisation's wellness program.

The first sub-section looked at employee participation i.e. utilisation of the program. The following questions were utilised to assess employee levels of participation

- Have you ever attended HIV/AIDS related activities offered or sponsored by the company?
- How many times do you access information offered on pamphlet or intranet pertaining to HIV/AIDS and HIV/AIDS EWP?
- It is important to attend seminars, forums and access intranet information pertaining to HIV/AIDS EWP?

The second sub-section looked at employee satisfaction with the program. One of the vital aspects of utilisation is employee satisfaction with the running organisational HIV/AIDS EWP. Satisfaction covers a moderate range of aspects which include scope, relevance, quality and accessibility (Berry, et al, 2010).

Scope is defined as the extent of the subject matter that something deals with (Oxford English dictionary), Thus scope can be looked at as the depth of vital essential issues the program deals with and encompasses. It is quintessential to find out what employees think about the scope of the program.

Relevant is defined as closely connected or appropriate to the matter at hand (Oxford English dictionary). Thus on examining relevance it is essential to find out if the program congruently covers all issues which are supposed to be covered under the HIV/AIDS EWP.

Quality has to be accorded as high for the program to be regarded favourably by employees (Berry, et al).

They also mention that above all, scope, relevance and quality have to succinctly put, be outright comprehensive, engaging and above all excellent

The questions which were intended to measure employee satisfaction with the program were as follows:

- I would rate the organisations HIV/AIDS EWP as
- It is easy to access help and information vital to the HIV/AIDS employee wellness program
- The workplace is a valuable source of HIV/AIDS information
- The program has enhanced my knowledge on HIV/AIDS

3.4.1.4 Section on the Attitudes towards the HIV/AIDS Employee Wellness Programme

This section of the questionnaire focused on gleaning information essential in determining prevailing attitudes towards VCT, the ART program and Condom use and distribution within the organisation. This was done through use of the following statements:

- There is an advantage in knowing one's HIV status
- Stigma prevents people from seeking VCT and treatment
- If necessary I would be comfortable in enrolling in the organisational offered anti-retroviral treatment (ART) program
- Use of condoms can help prevent contraction of sexually transmitted diseases as well as HIV
- Condoms provided within the workplace can be regarded as of good quality

3.4.1.5 Section on the Level of Perceived Stigma and Perceived Discrimination in the Organisation

This looked at institutional level interactions, social interactions and employee interactions within the workplace as a way to determine any prevailing stigma and discrimination within the organization. This will be utilized to determine how this affects utilization of program, and also reveal key areas of concern to employees.

Social interactions were broadly covered by the following statement:

- People living with HIV(PLWHIV) are treated as outcasts by society

Institutional level interactions were covered by the following statement:

- In my organisation PLWHIV can lose their jobs

Employee interactions were covered by the following statements:

- In my organisation people living with HIV are shunned by fellow employees
- If a colleague is infected with HIV/AIDS he/she would still be my friend

3.5: Ethical considerations

Research ethics are a set of guidelines that assist the researcher in conducting an ethical study (Christensen, 2007). Ethical considerations include respect for respondents, autonomy, ensuring confidentiality, anonymity and autonomy.

Participant's autonomy was maintained through informed consent on all aspects of the study. This entailed providing information on the purpose of the study i.e. aim and objectives as well as informing participants that participation was on a voluntary basis; making withdrawal feasible/possible (Christensen). Participants were duly informed that the risks on participation were minimal. Confidentiality was ensured by virtue the questionnaire did not require personal identifying details, divulgence on details of one's status or whether one was on treatment or not. Assurance was given that the information was strictly for research purposes and would not be made available to anyone outside the research. Benefits of the study were inferred to in the objectives. In the study no monetary incentive was offered as this was an academic study.

Permission to conduct research at the organisation was done with proper clearance and authority from relevant organisational authority and clearance from Ethics Review Board. Permission from the organisation included permission to conduct the study during working hours. Organisational confidentiality was maintained by not naming the organisation as they had reiterated at the onset on discussions about the study.

Chapter 4: Results

This chapter outlines the results and details this by looking at the different questions individually within each section of the questionnaire.

4.1 Number of respondents

The number of questionnaires which was administered within the different branches and offices was one hundred (100). Out of this 100, 95 were returned thus giving a return rate of 95%. However of the 95 returned questionnaires, 16 could not be utilised as they were incomplete or spoilt. Thus the number of usable questionnaires was 79 **(n=79).**

4.2: Demographic Information of respondents

The demographic characteristics of the respondents that were analysed in this study included the following parameters:

- age
- gender
- marital status
- employee grade within the organisation
- number of years employed in the organisation

QN. 1

4.2.1: Age

Table 4.1: Analysis of total sample by age

Age range (years)	*Number of respondents*	*Percentage %*
20-24	1	1.27
25-29	7	8.86
30-34	19	24.05
35-39	20	25.32
40-44	21	26.58
45-49	7	8.86
50-54	3	3.80
55-59	1	1.27

The youngest respondent was aged 23 years with the oldest respondent aged 53 years, marking a difference of thirty years between them. The mean for this sample was calculated at 38 years.

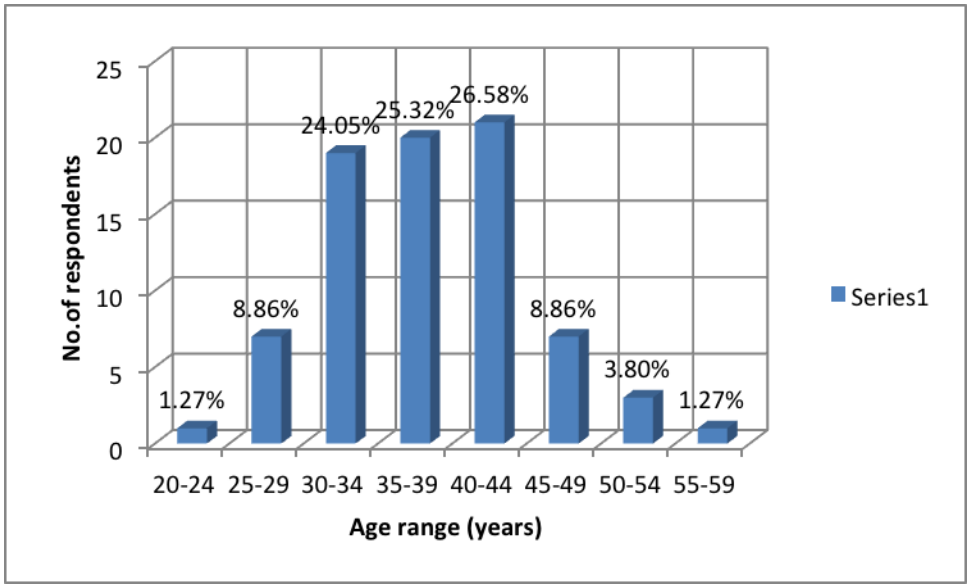

Figure 4.1: Analysis of total sample by age

Within the sample, the age groups with the most number of respondents were the 30-34, 35-39 and 40-44 years age groups with 19, 20 and 21 respondents respectively. These age groups represented 24.05%, 25.312% and 26.582% of the total respondents respectively and are shown in the bar graph in figure 4.1 above.

QN. 2

4.2.2: Gender

Table 4.2: Analysis of total sample by gender

Gender	***Number of respondents***	***Percentage %***
Male	41	51.90
Female	38	48.10

Question two looked at collating data on the male and female distribution within the sample illustrated in table 4.2 above and the bar graph in figure 4.2 below.

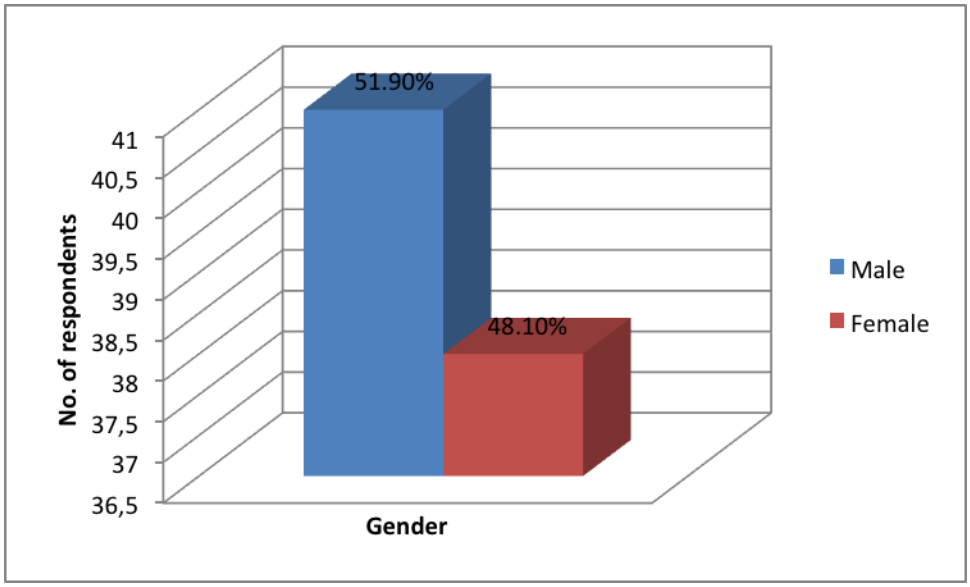

Figure 4.2: Analysis of total sample by gender

The sample consisted of a total of 79 respondents (n=79), of which 38 were female and 41 male. Women thus represented 48.10% of the respondents as compared to 51.90% of male respondents. No manipulation was done to alter the distribution of the sexes within the group.

QN. 3

4.2.3: Marital status

Table 4.3: Analysis of total sample by marital status

Marital status	***Number of respondents***	***Percentage %***
Married	*61*	*77.22*
Single	*16*	*20.25*
Co-habiting	*2*	*2.53*

Analysis of the sample by marital status showed that a total of 61 respondents out of 79 were married, with 16 being single. Only two respondents were noted to be co-habiting. This is shown graphically in figure 4.3 below.

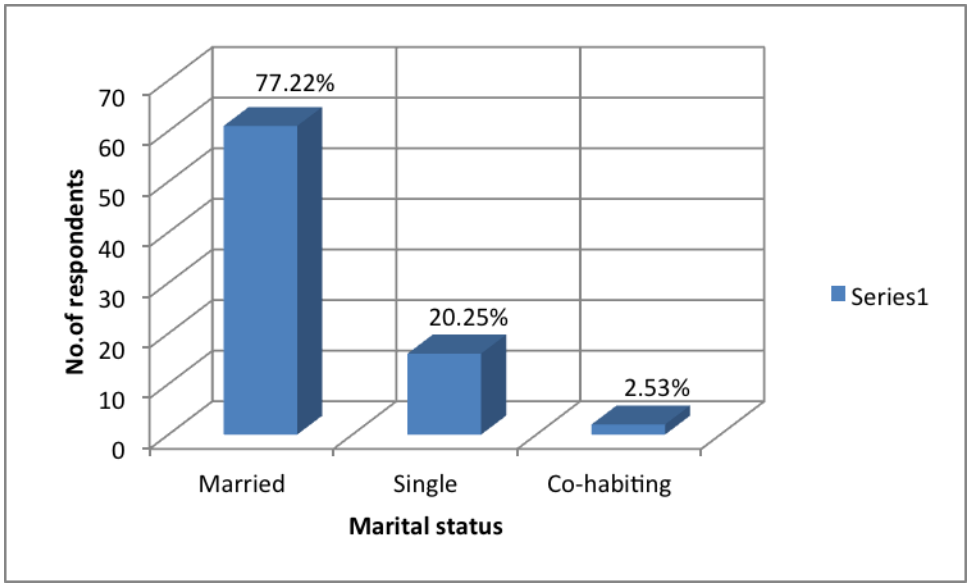

Figure 4.3: Analysis of total sample by marital status

QN.4

4.2.4: Grade within the organisation

The grading system within the organisation was been changed to the system 'A1 to A7'; the organisation's own grading system could be used as an identifier and thus violate organisation anonymity. The grades within the organisation are structured as follows, from A1 to A8 grades. The A1 grade is the lowest in the organisation and A8 the highest attainable. The A1 grade includes the non-clerical employees which include the messengers, drivers etc. The A2, A3, A4 and A5 grades include the clerical employees within the organisation. A6, A7 and A8 are managerial grades within the organisation. Of note employees within the A5 grade are also at times involved in the managerial work.

Table 4.4: Analysis of total sample by grade within the organisation

Grade	*Number of respondents*	*% Percentage*
A1	7	8.86
A2	10	12.66
A3	11	13.92
A4	24	30.38
A5	14	17.72
A6	9	11.39
A7	4	5.06

Table 4.4 above is a representation of the different grades of respondents within the organisation who responded to the questionnaire.

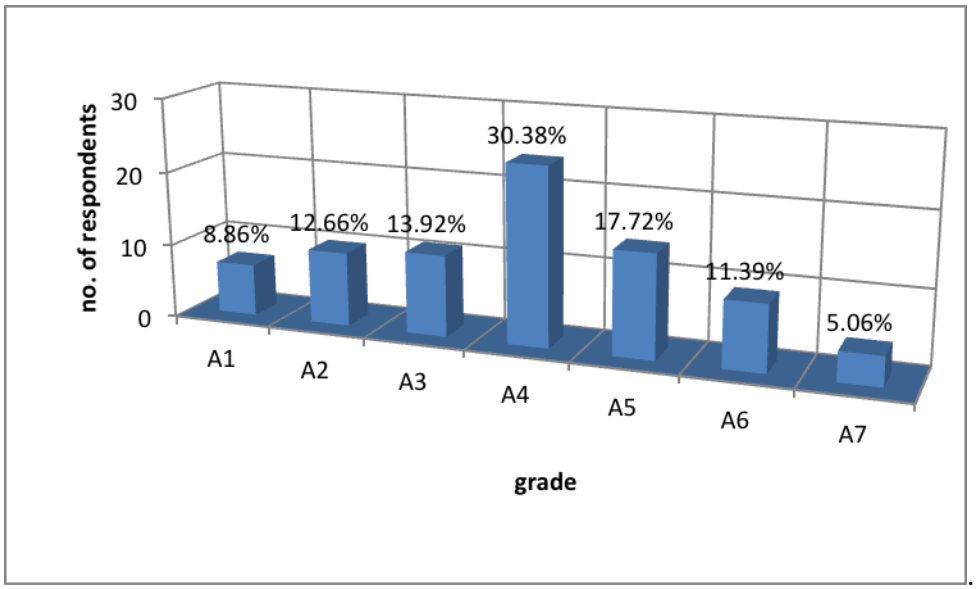

Figure 4.4: Analysis of total sample by grade within the organisation

The graph in figure 4.4 illustrates the frequency of respondents within the different grades in the sample. The A4 grade is noted as having the highest number of respondents at 24 and A7 recording the lowest with four respondents.

QN.5

4.2.5: Years employed in the organisation

Table 4.5: Analysis of total sample by number of years employed in the organisation

Years employed in the organisation	*Number of respondents*	*Percentage %*
1-4	9	11.39
5-9	12	15.19
10-14	18	22.78
15-19	24	30.38
20-24	11	13.92
25-29	4	5.06
>30	1	1.27

In meeting the target group criterion, three years was noted as the least number of years that one respondent had been employed in the organisation. On the higher end, 30 years was noted as the most number of years that one respondent has been with the organisation. The mean number of years that a respondent has been employed in the organisation is 14 years.The years range (the number of years a respondent has been employed within the organisation) with the most number of respondents is the 15 to 19 years, which has a total of 24 respondents and accounts for 30.38% of the sample group. This is as shown in figure 4.5 below.

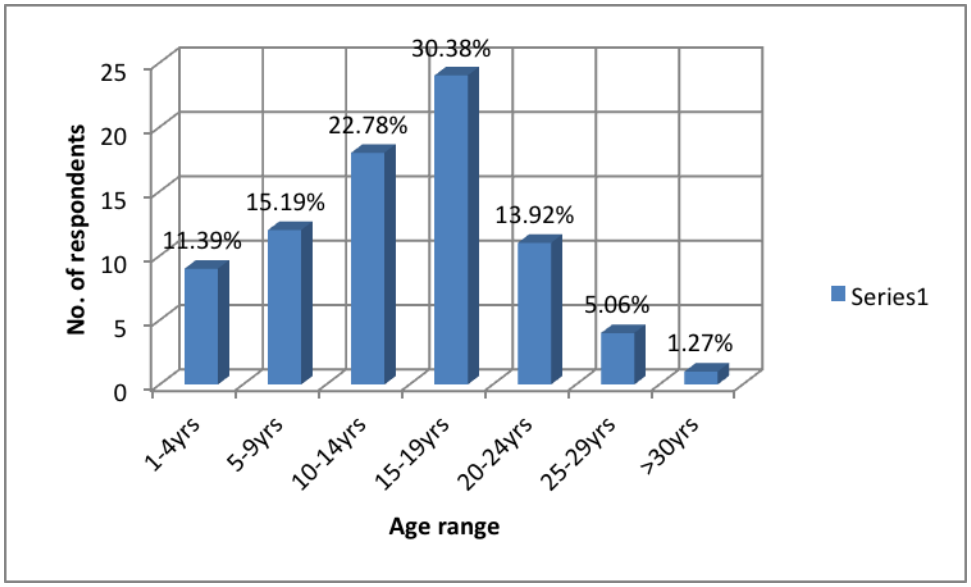

Figure 4.5: Analysis of total sample by years employed within the organisation

4.3 Section of the level of perceived knowledge and the level of awareness of the HIV/AIDS EWP

The aim of this section was to assess respondents' perceived knowledge and level of awareness of the organisational implemented HIV/AIDS EWP. This was assessed by use of a range of statements and questions.

QN.6

4.3.1: Knowledge /awareness of the organisational HIV/AIDS EWP

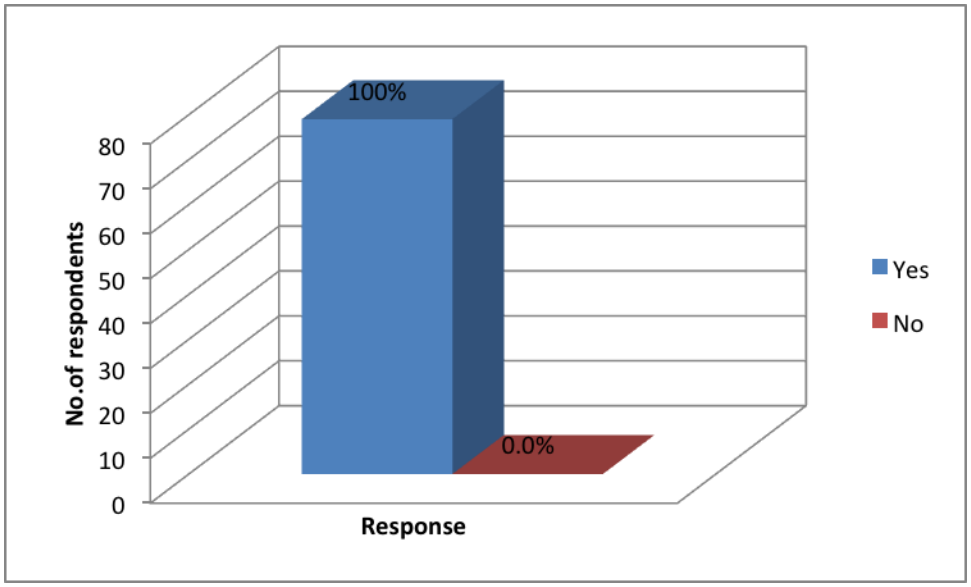

Figure 4.6: Respondents' knowledge/awareness of the organisational HIV/AIDS EWP

On the statement which was posed "I am knowledgeable/ aware of the existence of an organisation HIV/AIDS EWP", there was a one hundred positive response to the question. All respondents attested to being aware of the existence of the organisation's HIV/AIDS

EWP. This is demonstrated in the bar graph above which shows 100% response in the positive i.e. “Yes” and zero percent response in the negative that is “No”. This is a good indicator for the program for it shows that all respondents are fully informed about the program.

QN. 7

4.3.2: Acquiring information on the organisational HIV/AIDS EWP

Table 4.6: Means of acquiring information on the organisational HIV/AIDS EWP

Response	*Number of respondents*	*% percentage*
Co-workers	32	40.51
Line manager	14	17.72
Other	33	41.77

The aim of the posed question was to find out the various ways by which respondents came about their information on the existence of the HIV/AIDS program within this particular organization.

In response to the posed question, on how respondents got to know about the organisation’s HIV/AIDS EWP, three options were given i.e. Co-workers, Line manager and “Other”. Of the total, 32 respondents reported as having got to know about the program through their Co-workers whilst 14 reported as having gotten vital information from their Line manager and 33 responded “Other”. This is shown in figure 4.7 below.

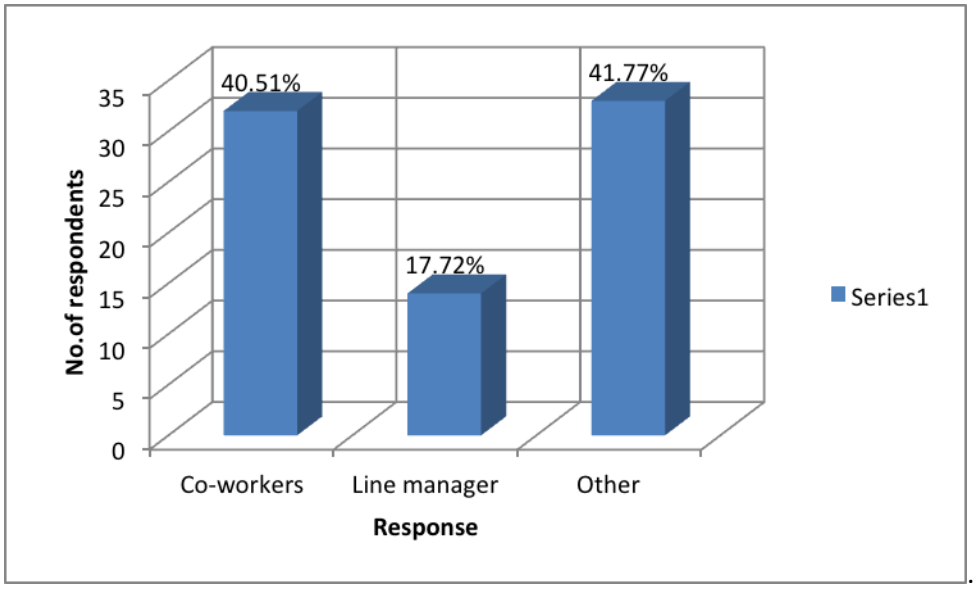

Figure 4.7: Means of acquiring information on the organisational HIV/AIDS EWP

Information relay through Co-workers accounted for 40.51% of the sample, “Other” means making up 41.77% and Line managers 17.7%. The question went further to ask for the means by which respondents got to know about the program if they responded “Other”. The

following, table 4.7 below lists the different "Other" means by which participants got to know about the program.

Table 4.7: Other means of acquiring information on the organisational HIV/AIDS EWP

Response	*Number of respondents*	*% response of Other (n=33)*	*% of total sample (n=79)*
Corporate Wellness Advisor	12	36.36	15.19
Internal communication	7	21.21	8.86
Media	6	18.18	7.59
Wellness champion	4	12.12	5.06
Training sessions ZAPSO	2	6.06	2.53
VCT centre	1	3.03	1.27
Infected relative	1	3.03	1.27

The internal communication included e-mail via the intranet, literature, forums and newsletters made available within the organisation. ZAPSO which stands for Zimbabwe AIDS Prevention and Support Organisation are a non-profit private voluntary organisation (PVO) registered in 1997. Its mission is to facilitate in the reduction of HIV/AIDS infection via information, education and communication (IEC) activities that encourage HIV/AIDS prevention in the workplace. This is done under the [PSAPI] Private Sector AIDS Prevention (Chigudu, Tichagwa & Phiri, 2003). From the above, it can be seen that the common method of information relay is through Co-workers.

QN. 8

4.3.3: Satisfaction with HIV/AIDS EWP information relay

Table 4.8: Respondents satisfaction with information relay on the HIV/AIDS EWP

Response	*Number of respondents*	*% percentage*
Yes	71	89.87
No	8	10.13

On the statement posed "I am satisfied with how information pertaining to HIV/AIDS Employee Wellness Program was imparted to me", 71 respondents answered in the positive and eight in the negative as shown in the bar graph below. Thus 89.87% were satisfied with how information was relayed to them on the program, whilst 10.13% were dissatisfied with how this pertinent information was relayed.

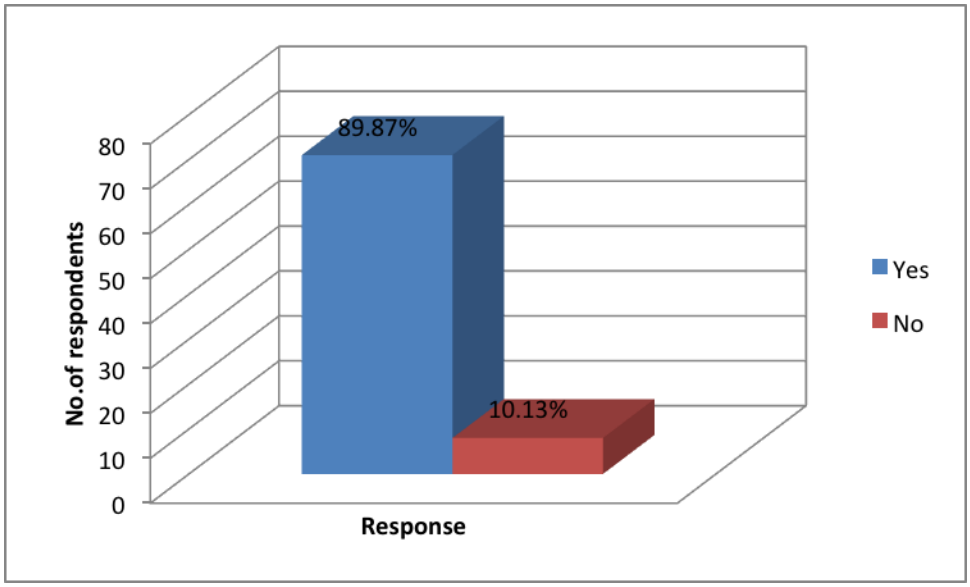

Figure 4.8: Respondents satisfaction with information relay on the HIV/AIDS EWP

Of the 10.13% of respondents who said they were not satisfied with how the information was imparted to them, the following reasons were given:

- For some respondents who acquired their knowledge through co-workers, various reasons abound for dissatisfaction with how knowledge on the organisations' HIV/AIDS EWP was relayed to them. Two respondents stated that information with regards to the HIV/AIDS EWP was not readily imparted. In addition to scarcity of information they are those who cited that the program information relayed by co-workers was lacking in substance for it was not fully explained to them. This thus prompted one respondent to state that they would appreciate a formal way of being informed about the HIV/AIDS EWP within the organisation
- "I think there is room for more information to be given, during the 'Zim-dollar error' it was disseminated well but nowadays it's been quiet, I thought it was phased out". This was one respondents' reason for dissatisfaction. The 'Zimbabwe dollar error' referred to marks the turbulent economic melt-down in Zimbabwe were the local currency was the mode of trade. With various devaluations the currency became next to useless and thus the introduction of the United States dollar (US$) and South African rands for trade.
- For one respondent, the fact that not much focus is given to HIV/AIDS as before was a cause for concern and goes on to further elaborate, 'we have become comfortable with the subject and now focus on other diseases like cancer.'
- One respondent expressed his/her view that there no pamphlets or write ups available in branches to remind employees of the program and how to get ARVs and stated this as reason for discontent.
- A particular respondents' major concern was with regards to availability of information pertaining to acquiring ARV drugs. This respondent felt dissatisfaction due to his/her view that no information on how staff with HIV/AIDS can acquire ARV drugs through the company's' medical aid scheme is not readily or easily available.

4.4: Section on the Utilisation and Perceived Success of the HIV/AIDS EWP

LEGEND:

SA: Strongly agree
A: Agree
UN: Undecided
DS: Disagree
SD: Strongly disagree

VG: Very good
G: Good
P: Poor
VP: Very poor
BA: Barely acceptable

QN. 9

4.4.1: Attendance of HIV/AIDS related activities

Table 4.9: Attendance of HIV/AIDS related activities

Response	*Number of respondents*	*% percentage*
Yes	65	82.28
No	14	17.72

In response to the question posed "Have you ever attended HIV/AIDS related activities offered or sponsored by the company?" to find out participation; 65 respondents answered "Yes" representing 82.28 percent of the total sample. 14 respondents answered "No" accounting for 17.72% of the total sample. This is shown in table 4.9 above and bar graph in figure 4.9 below.

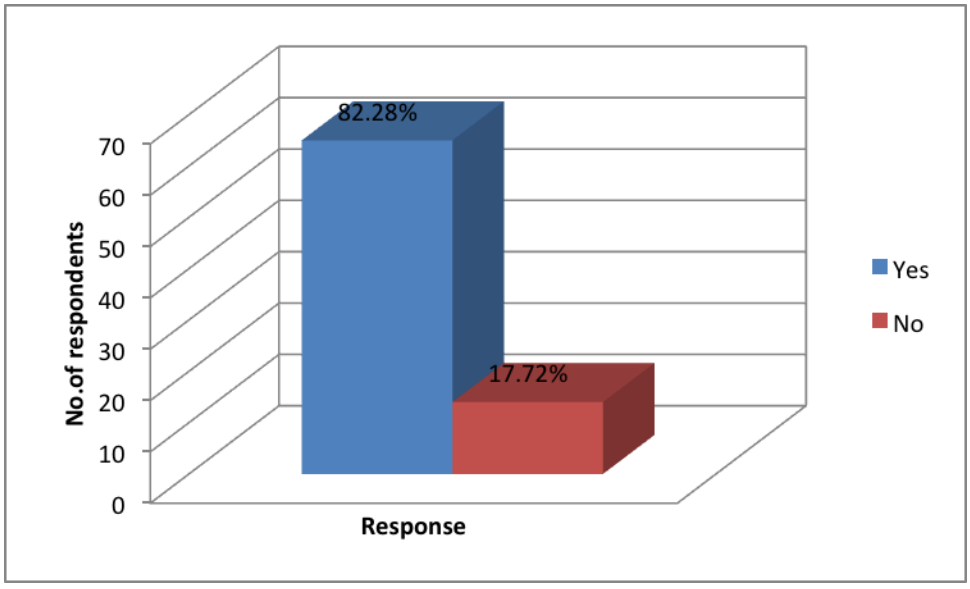

Figure 4.9: Attendance of HIV/AIDS related activities

As shown in figure 4.9 above, 17.72% of the sample responded "No" in answer to the posed question. The following list outlines the various reasons that were given for non-attendance by respondents:

- Pressure of work was cited by two respondents as reason for non-attendance
- Lack of time
- Non-availability during the slotted session
- Not selected to attend
- Have never been invited to one
- Not many programmes have been on offer
- Our company has none of activities
- No workshop has been done so far
- I was not informed or aware of such activities
- I have never heard of any programmes
- Some programmes are run during working hours and one is unable to attend
- For two of the respondents, no reason was given for non-attendance of activities

QN. 10

4.4.2: Frequency of accessing pamphlets or intranet

Table 4.10: Frequency of accessing pamphlets or intranet information on HIV/AIDS & HIV/AIDS EWP

Response	*Number of respondents*	*% Percentage*
Often	22	27.85
Sometimes	38	48.10
Seldom	13	16.46
Never	6	7.59

On the question posed, on how frequently respondents' accesses information from pamphlets or intranet pertaining to HIV/AIDS and HIV/AIDS EWP, a majority of 38 respondents revealed that they "Sometimes" access these modes of information transmission, with 22 respondents doing so "Often". Of the remaining number, 13 respondents revealed that they "Seldom" do so. However six respondents admitted to "Never" accessing any form of information relay relevant to HIV/AIDS and the HIV/AIDS EWP be it either the pamphlets or organisational intranet. This is illustrated in the bar graph 4.10 below.

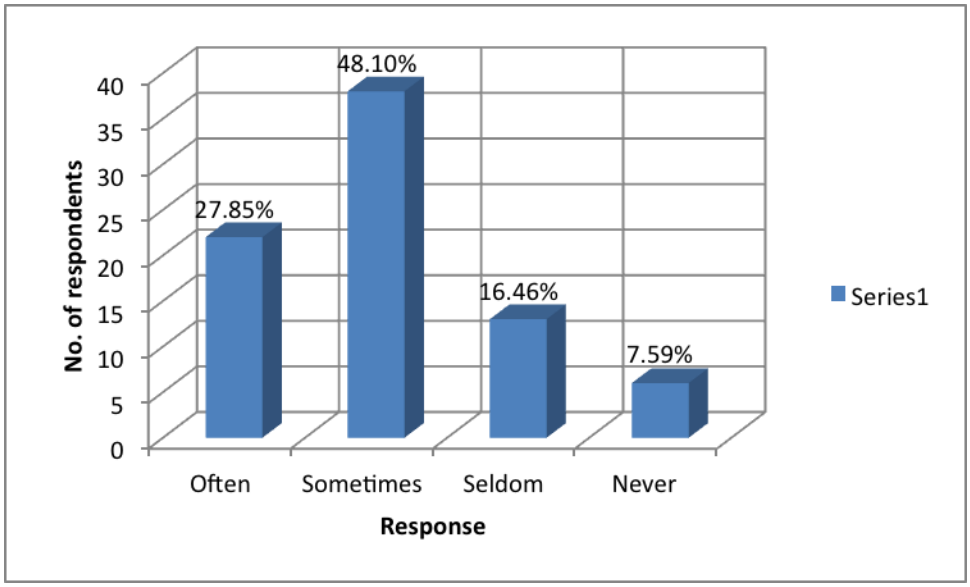

Figure 4.10: Frequency of accessing pamphlets or intranet information on HIV/AIDS & HIV/AIDS EWP

QN. 11

4.4.3: Importance of attending seminars and forums and accessing intranet

Table 4.11: Respondents' view on importance of seminar and forum attendance and accessing intranet information

Response	*Number of respondents*	*Percentage %*
Strongly agree	61	77.22
Agree	16	20.25
Undecided	1	1.27
Disagree	0	0.00
Strongly disagree	1	1.27

The statement posed in question 11 intended to find out whether respondents thought it was important to attend seminars, forums and access intranet information pertaining to the HIV/AIDS EWP. The majority of respondents 77 concurred (Strongly agree- 61: Agree- 16) with this statement. They made up 97.47% of the total sample. Only one respondent was "Undecided" on the issue whilst one other respondent did not find it important at all by "Strongly disagreeing" to the statement. This is shown graphically in figure 4.11 below.

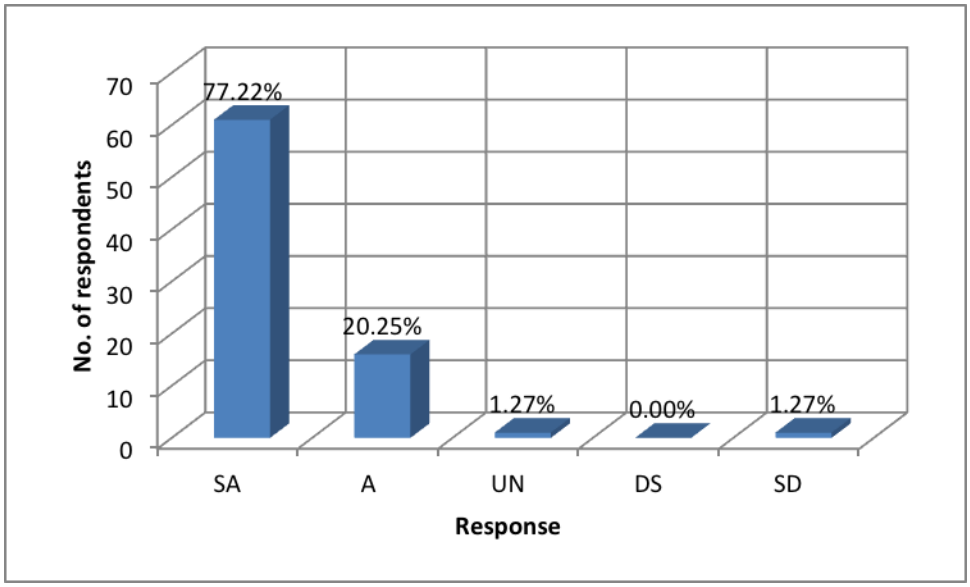

Figure 4.11: Respondents' view on importance of seminar and forum attendance and accessing intranet information

QN 12

4.4.4: Rating the organisations HIV/AIDS EWP

Table 4.12: Rating of the organisations' HIV/AIDS EWP

Response	*Number of respondents*	*Percentage %*
Very good	26	32.91
Good	48	60.76
Poor	5	6.33
Very poor	0	0.00
Barely acceptable	0	0.00

There was a favourable response to the rating of the organisation's HIV/AIDS EWP. The majority of respondents rated the organisations HIV/AIDS EWP as "Good" i.e. 48 respondents surmounting to 60.76% of the total sample. Another 26 admitted to finding the program "Very good" with five respondents rating the program as "Poor". All this is shown in figure 4.12 below.

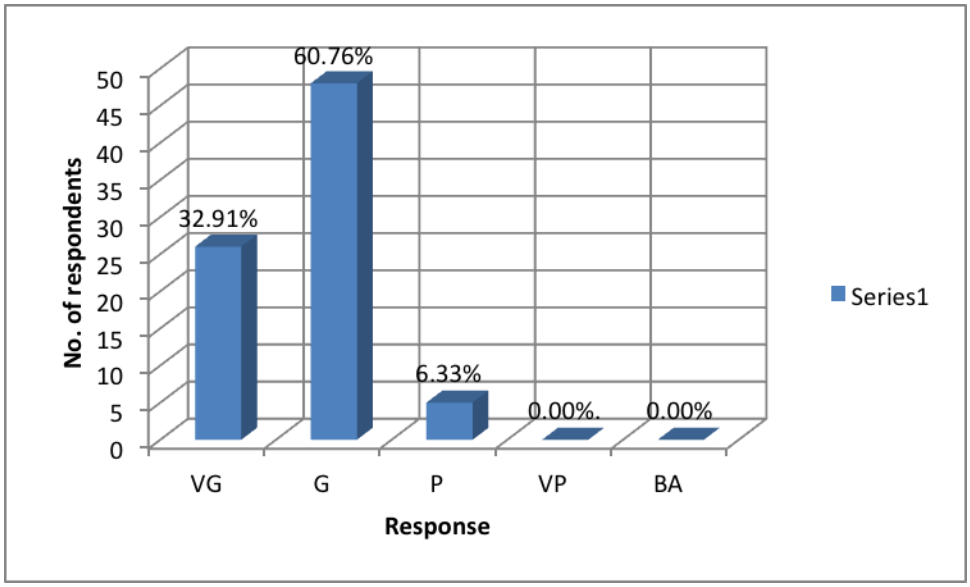

Figure 4.12: Rating of the organisation's HIV/AIDS EWP

No respondent reported finding the program as either "Very poor" or "Barely acceptable".

QN. 13

4.4.5: Ease of access to help and information on HIV/AIDS EWP

Table 4.13: Ease of accessing help and information on HIV/AIDS EWP

Response	*Number of respondents*	*% Percentage*
Strongly agree	26	32.91
Agree	41	51.90
Undecided	11	13.92
Disagree	1	1.27
Strongly disagree	0	0.00

On the issue on how easy it is to access help and information vital to the HIV/AIDS EWP, the majority of respondents concurred that they found it easy to do so. This constituted of 26 respondents "Strongly agreeing" and 41 respondents "Agreeing" to this. Thus 84.81% of respondents found it easy to access help and information pertaining to the HIV/AIDS EWP. Eleven of respondents however were "Undecided" on the issue. Only one respondent "Disagreed" with this statement. All this is illustrated in table 4.13 above and figure 4.13 below.

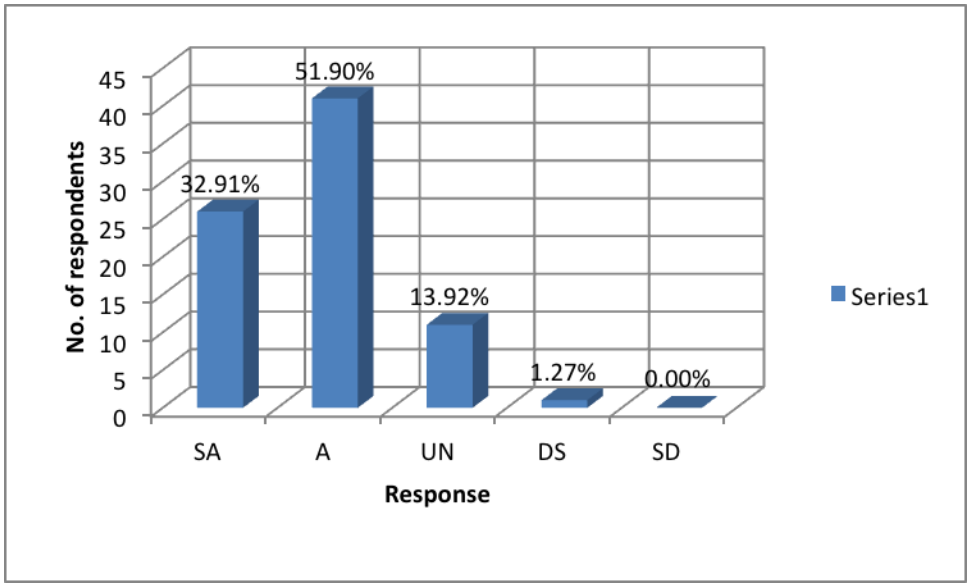

Figure 4.13: Ease of accessing help and information on HIV/AIDS and HIV/AIDS EWP

QN 14

4.4.6: The workplace as a valuable source of HIV/AIDS information

Table 4.14: The workplace as a valuable source of HIV/AIDS information

Response	*Number of respondents*	*% Percentage*
Strongly agree	30	37.97
Agree	38	48.10
Undecided	6	7.59
Disagree	4	5.06
Strongly disagree	1	1.27

The majority of respondents find the workplace a valuable source of HIV/AIDS information. This is evidenced by 30 respondents “Strongly agreeing” and 38 “Agreeing” to the posed statement. A minority did not concur with this i.e. five respondents. However six respondents were “Undecided” on the issue. This is illustrated in the table 4.14 above and figure 4.14 below.

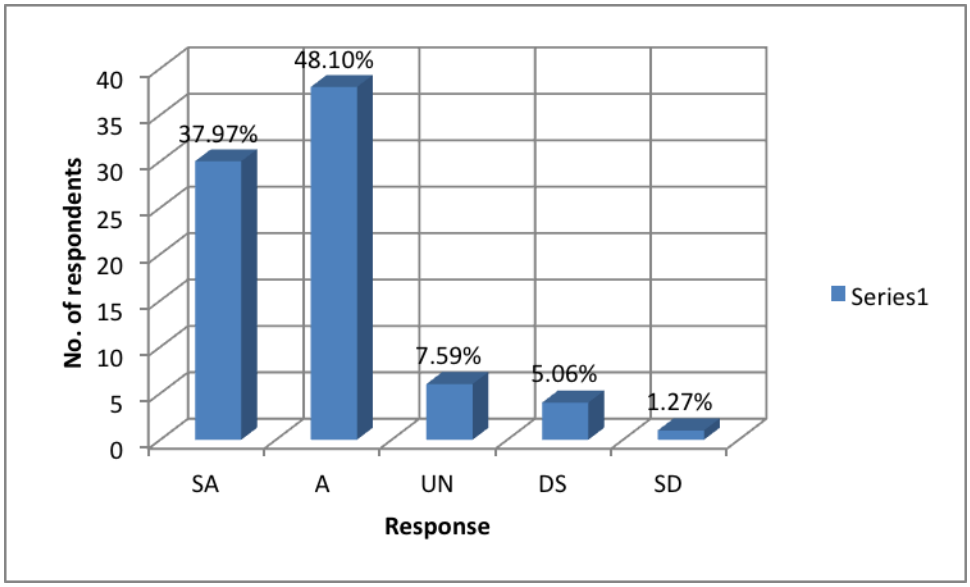

Figure 4.14: The workplace as a valuable source of HIV/AIDS information

QN 15

4.4.7: The program on enhancing knowledge on HIV/AIDS

Table 4.15: HIV/AIDS EWP on enhancing respondent's knowledge on HIV/AIDS

Response	*Number of respondents*	*% Percentage*
Strongly agree	29	36.71
Agree	41	51.90
Undecided	5	6.33
Disagree	3	3.80
Strongly disagree	1	1.27

On the statement posed, most respondents acknowledged that the workplace has enhanced their knowledge on HIV/AIDS as shown by 70 respondents concurring to this (29- Strongly agreeing and 41-Agreeing). Only four responds did not find the workplace as enhancing their knowledge on HIV/AIDS. The remaining five respondents were on the fence being "Undecided" on what they thought. This is illustrated diagrammatically in the bar graph in figure 4.15 below.

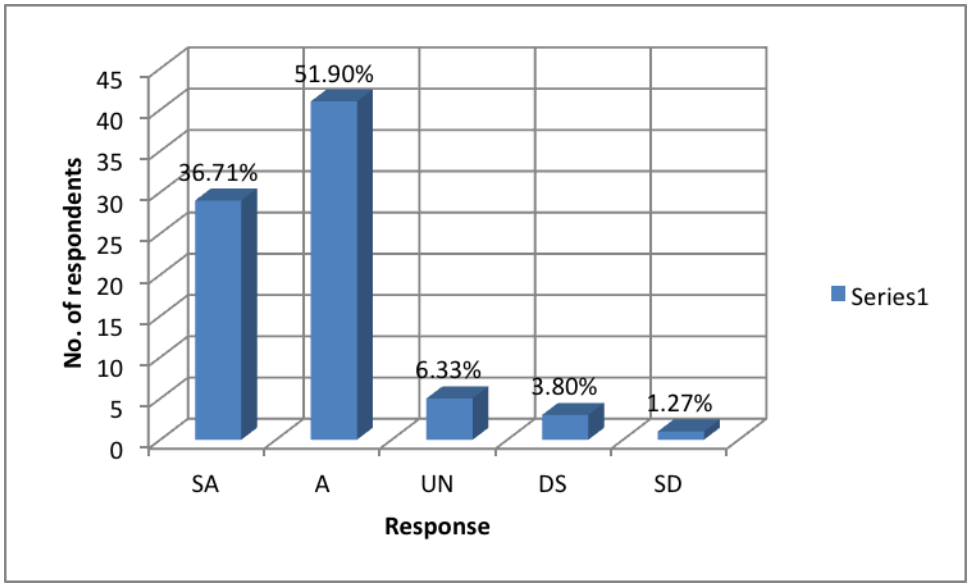

Figure 4.15: HIV/AIDS EWP on enhancing respondent's knowledge on HIV/AIDS

4.5 Section on the attitudes towards the HIV/AIDS EWP

LEGEND:

SA: Strongly agree
A: Agree
UN: Undecided
DS: Disagree
SD: Strongly agree

QN 16

4.5.1: Knowledge on individual HIV sero-status

Table 4.16: Attitude towards knowing one's HIV sero-status

Response	*Number of respondents*	*Percentage %*
Strongly agree	62	78.48
Agree	16	20.25
Undecided	0	0.00
Disagree	0	0.00
Strongly disagree	1	1.27

On determining whether respondents thought there is an advantage in knowing one's HIV/AIDS status, there was a strongly affirmative response, with 78 respondents "Strongly agreeing" and "Agreeing" with the statement. The breakdown of respondents concurring is shown in figure 4.16 below; one respondent however "Strongly disagreed" with the posed statement.

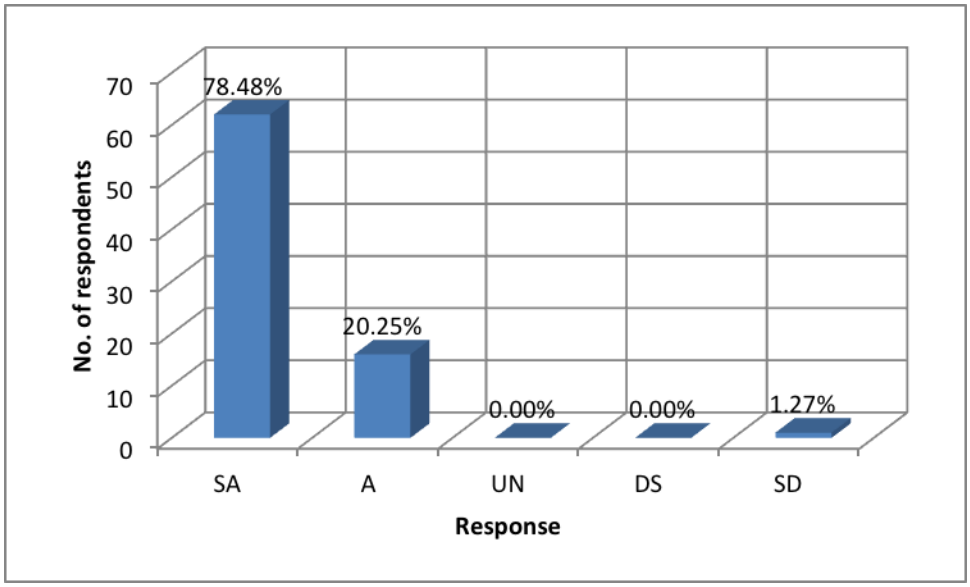

Figure 4.16: Attitude towards knowing one's HIV sero-status

QN 17

4.5.2: Stigma, an inhibitory factor of VCT and ART

Table 4.17: Stigma in preventing people from seeking VCT and ART

Response	*Number of respondents*	*Percentage %*
Strongly agree	51	64.56
Agree	26	32.91
Undecided	1	1.27
Disagree	0	0.00
Strongly disagree	1	1.27

Most of the respondents, 77 in total indicated that stigma does prevent people from seeking out VCT and ART program. Only one respondent was on the fence being "Undecided" and only one "Strongly disagreeing" thus essentially saying that stigma does not prevent people from seeking VCT and treatment. This is shown in figure 4.17 below.

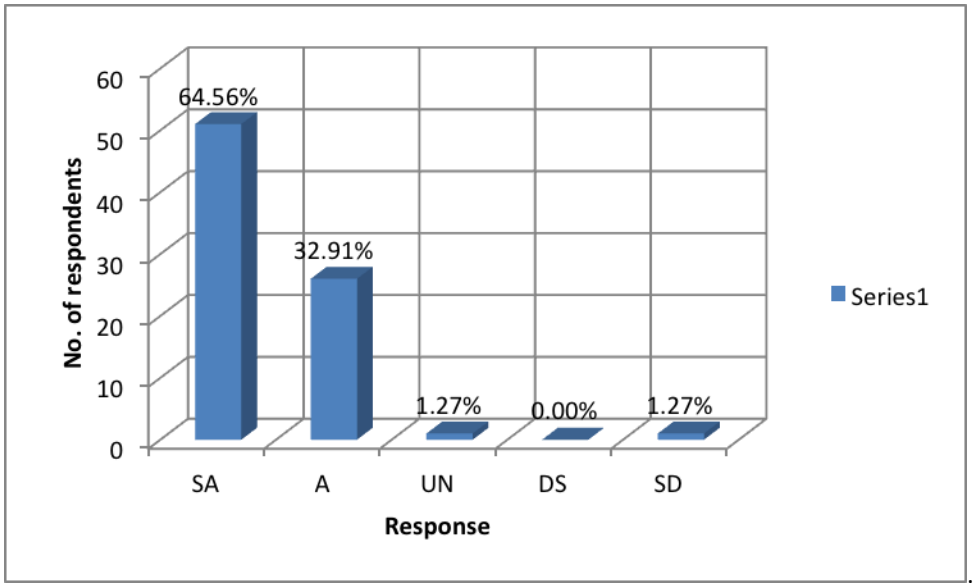

Figure 4.17: Stigma in preventing people from seeking VCT and ART

QN 18

4.5.3: Enrolment into organisational ART program

Table 4.18: Enrolling into the organisational ART program

Response	*Number of respondents*	*% Percentage*
Yes	71	89.87
No	8	10.13

On the statement posed, on whether respondents would feel comfortable in enrolling in the organizational offered ART program, a majority responded favourably. A total of 71 respondents which is 89.87% of the sample said “Yes” they would enrol in the program if necessary. However eight of the respondents who represent about 10% of the sample vetoed “No” to this statement. This is illustrated in figure 4.18 below.

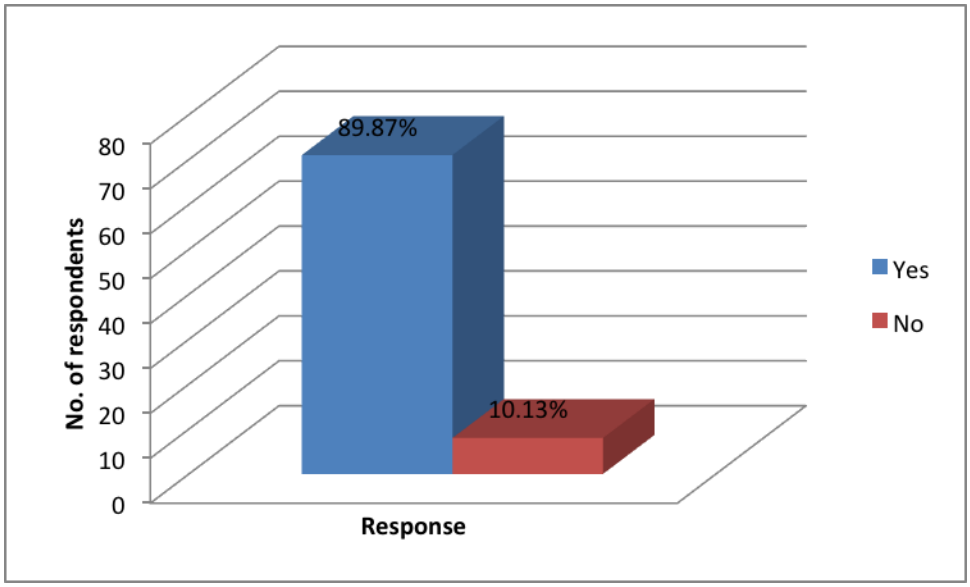

Figure 4.18: Enrolling into the organisational ART program

Of the respondents who responded no to enrolling into the organisational ART program, the following is a list of the reasons given for the unwillingness to do so:

- 'It is always difficult to be comfortable, to be confident in the integrity of such a program in any organisation especially that which you work for', was the reason stated by one respondent.
- confidentiality reasons and fear of stigma were cited by another respondent
- One respondent expressed, 'sometimes there is non-confidentiality and other colleagues would end up knowing my status'.
- Fear of stigma was one respondents' reason for answering no to enrolling into the organisational offered ART program
- 'Ndinoziva sei kuti havazotauriri vamwe vanhu nezveurwere hwangu?' which translates to, 'how do I know information on my illness will not be told to colleagues?' was a question counter-posed by one respondent.
- 'Not sick, was one respondents reason for non-enrolment into the program
- One respondent responded no because they felt it will never be necessary
- One respondent felt it necessary to elaborate the response no by stating, 'I have tested HIV negative but suppose I was positive I would definitely enrol'.

QN 23

4.5.4: Condoms in the prevention of contraction of STIs and HIV

Table 4.19: Condoms on preventing contraction of STIs and HIV

Response	*Number of respondents*	*% Percentage*
Strongly agree	40	50.63
Agree	35	44.30
Undecided	0	0.00
Disagree	3	3.80
Strongly disagree	1	1.27

In determining the prevailing attitude toward condom use, the majority of respondents which is 94.93% concur that the use of condoms can help prevent contraction of sexually transmitted diseases as well as HIV. This consisted of 40 respondents “Strongly agreeing” to the statement and 35 “Agreeing”. No responds were “Undecided” as noted in table 4.19 above. However a minor number of the respondents did not concur with the statement. Three respondents “Disagreed” with the statement with one respondent “Strongly disagreeing”. They represent 5.07% of the respondent sample. This is illustrated graphically in figure 4.19 below.

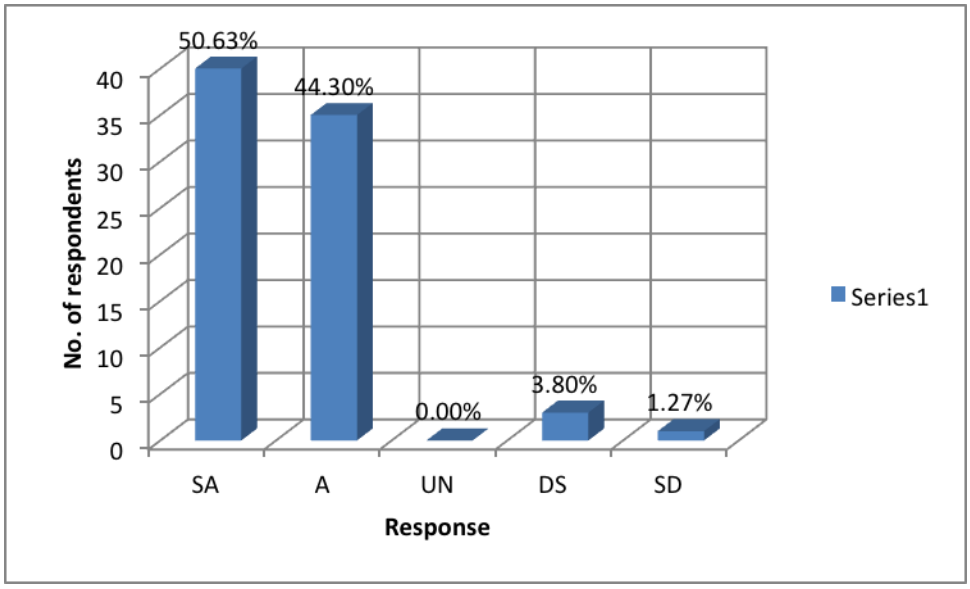

Figure 4.19: Condoms on preventing contraction of STIs and HIV

QN 24

4.5.5: Attitude towards quality of condoms within the workplace

Table 4.20: On whether condoms provided within the workplace are regarded as good quality

Response	*Number of respondents*	*% Percentage*
Yes	54	68.35
No	25	31.65

The aim of the question was to wean out the prevailing attitude towards the condoms which are supplied within the workplace. This revealed a variation in response. Of the total of 79 respondents, 54 who make up about two thirds of the sample concurred that condoms provided are of good quality. However a good 25 representing about one third of the respondents begged to differ. This is illustrated in table 4.20 and figure 4.20 below.

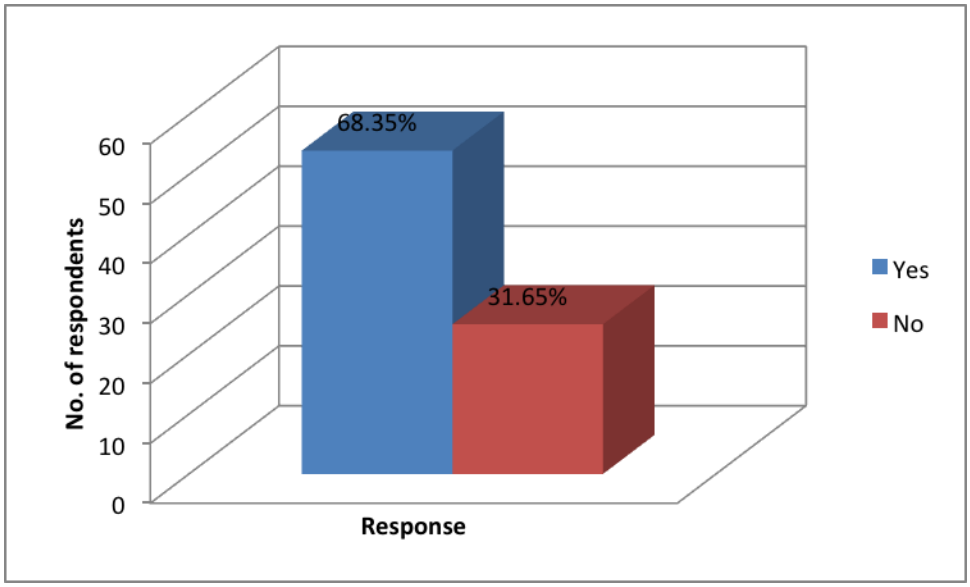

Figure 4.20: On whether condoms provided within the workplace are regarded as good quality

For the 25 respondents who answered “No” to this question the numerous following reasons were given:

- Respondents, who answered no, viewed the condoms supplied by the organisation with varied scepticism. Whilst one respondent was unsure of the quality, one respondent regarded them as of the lowest quality whilst a further two stated that the condoms were of poor quality. Other respondents even went further to qualify that the condoms made available are very poor mass products and another stated, to quote directly, ‘they are poor quality, we know quality when we see it.’
- The condom brands supplied within the organization were viewed as outdated by one respondent. This is supported by another respondent who further qualifies this by stating that there are better brands like carex, for the ones provided are the old type, old fashioned and smelly. One respondent was of the opinion that the brands provided are questionable and thus requests a supply of brands found in supermarkets and pharmacies. These better quality brands referred to by respondents include brands like Carex which is thrice mentioned. Another condom brand made reference to is the ‘Protector’ brand; in the respondents’ own words, “men want protector brands, not other no name brands.” In reference to supplying brand names, ones respondent view is, “I think if the bank supplies us with branded condoms, their use will be increased, cheap is not strong that is what I believe.”
- One respondent’s opinion was that public things are hard to trust, and felt it is better to use own condoms acquired from a pharmacy. The respondent went on further to state that organisations are there to minimise costs and some would rather provide the lowest cost condoms.
- For three of the respondents no reason was given in further response to the answer no
- Some respondents had issues with the storage of the condoms made available. This was expressed by two respondents. One respondent strongly stated, “For condoms to be of good quality they need to be kept at right place with right temperatures. The

condoms at the workplace are kept in open space like on a window seal which in my opinion I think should not be appropriate. The temperatures are not known." The other respondent stated that the condoms have been sitting in toilets for ages and are gathering dust.

- The other variable reasons are given in the list below:
    - never used or touched them so I don't know whether they are of good quality
    - I have not yet tried them as I am not yet sexually active, so I do not know what quality they are
    - they are no longer available and seemed to be of low quality
    - I do not like condoms
    - types not known, hence unable to make comparison

4.6: Section on the level of perceived stigma and perceived discrimination in the organisation

QN 19

4.6.1: Treatment of PLWHIV in society

Table 4.21: Respondents regard on treatment of PLWHIV in society

Response	*Number of respondents*	*% Percentage*
Strongly agree	8	10.13
Agree	30	37.97
Undecided	11	13.92
Disagree	26	32.91
Strongly disagree	4	5.06

On the statement posed PLWHIV are treated as outcasts by society, table 4.21 above and figure 4.21 below illustrate the respondents' responses; this was done to assess discrimination focusing on social interactions. A total of 38 respondents concurred that PLWHIV are treated as outcasts in society. Of this number eight "Strongly agreed" to the statement fact. Eleven respondents were unsure as they were "Undecided" on how they felt. A sum total of 30 respondents did not concur with the statement, (Strongly disagree- 4: Disagree- 26). Thus those who concurred with the statement represent 48.10% of the sample in comparison to 37.97% who did not concur with the statement.

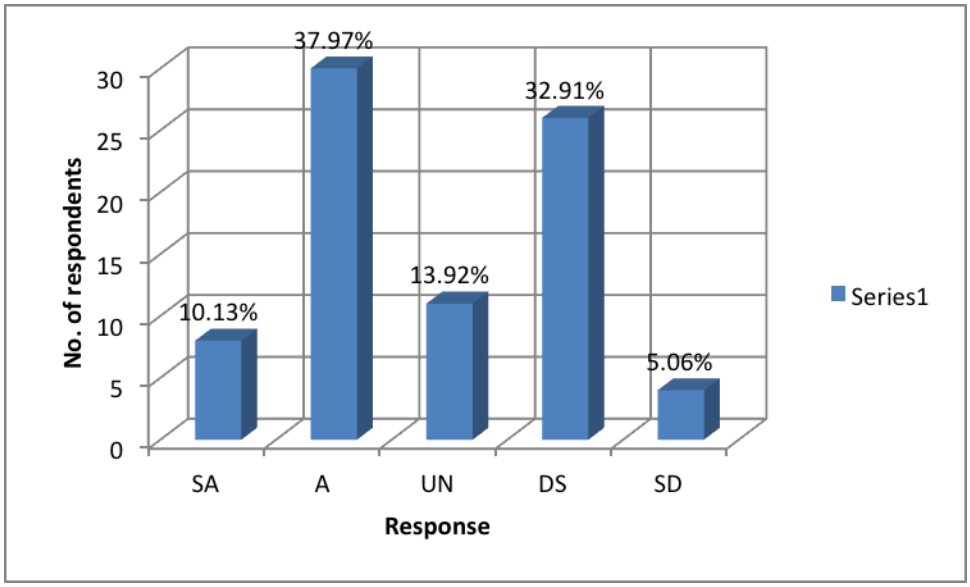

Figure 4.21: Respondents regard of treatment of PLWHIV in society

QN. 20

4.6.2: Treatment of PLWHIV by fellow employees in the organisation

Table 4.22: Respondents view on treatment of PLWHIV by fellow employees

Response	*Number of respondents*	*% Percentage*
Strongly agree	4	5.06
Agree	12	15.19
Undecided	12	15.19
Disagree	35	44.30
Strongly disagree	16	20.25

In response to the statement that people living with HIV/AIDS are shunned by fellow employees, to determine employee interaction on discrimination, four respondents “Strongly agreed” and 12 “Agreed” with the statement. A majority of respondents did not concur with the statement. A total number of 51 respondents, making up 64.55% of the sample either “Disagreed” or “Strongly disagreed” with the posed statement; 35 respondents “Disagreed”, whist 16 “Strongly disagreed” with the statement. It is noted that twelve respondents were “Undecided” on the subject.

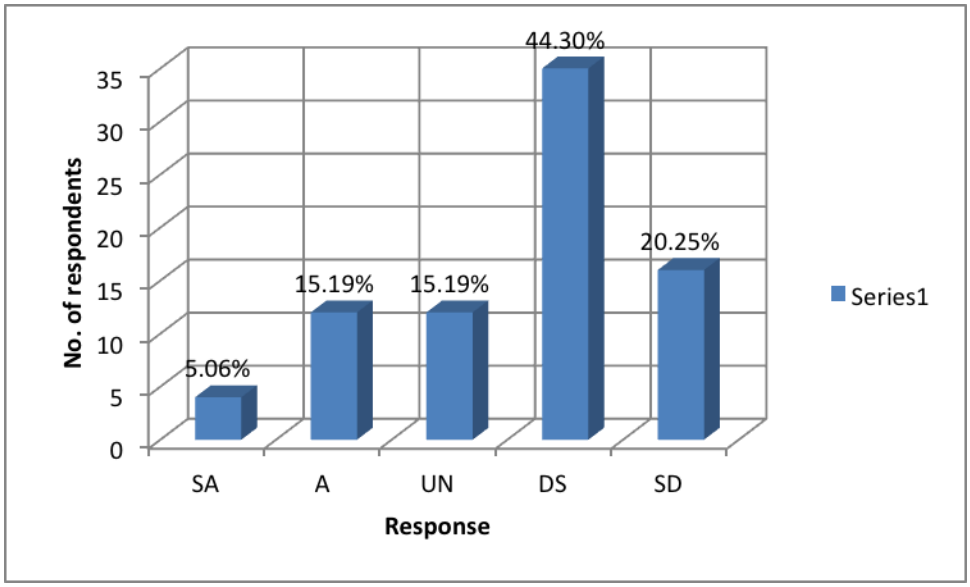

Figure 4.22: Respondents view on treatment of PLWHIV by fellow employees

QN 21

4.6.3: Perception/understanding of organisational HIV/AIDS policies and HIV/AIDS EWP

Table 4.23: Respondents view on possibility of job loss for PLWHIV within the organisation

Response	*Number of respondents*	*% Percentage*
Strongly agree	3	3.80
Agree	3	3.80
Undecided	3	3.80
Disagree	33	41.77
Strongly disagree	33	41.77

The posed question sought to find out employees perceptions, understanding of and exposure with the existing HIV/AIDS policies and programs i.e. institutional level interactions. Of the whole sample, six respondents felt that PLWHIV can lose their jobs within the organisation. Three were sitting on the fence being “Undecided”. However 66 respondents did not concur with the posed statement marking, a majority of the sample.

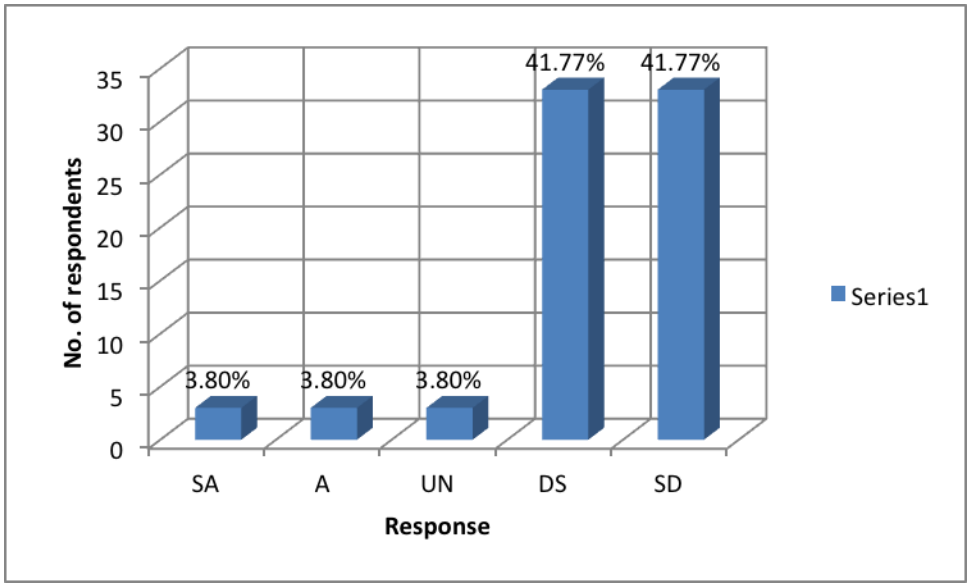

Figure 4.23: Respondents' view on possibility of job loss for PLWHIV within the organisation

QN 22

4.6.4 : Friendship with an HIV positive colleague

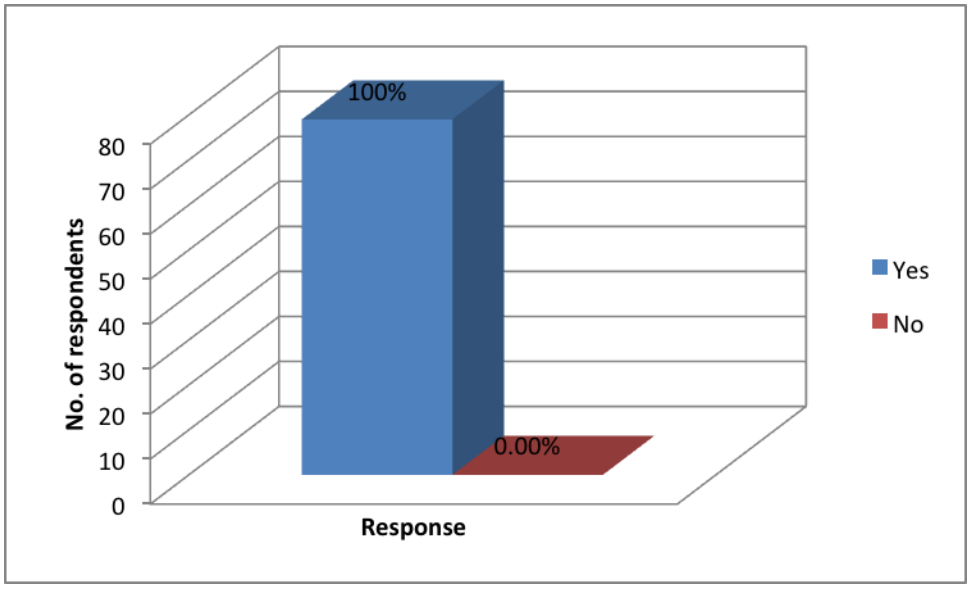

Figure 4.24: Continued friendship with an HIV positive colleague

In regard to the posed statement, if a colleague is infected with HIV/AIDS he/she would still be my friend; there was a one hundred percent response in the affirmative for continued friendship despite the colleagues HIV/AIDS positive status.

Chapter 5: Findings and Recommendations

5.1: Demographic section

In overall view, the sample group is made up of a fairly equal representation of male and female respondents across the different grades within the organisation that were targeted. This sample is also characterised by fairly young participants, with a mean average age of 38 years and with the majority of these being married.

It is vital to note that there has not been much new blood injection into the organisation considering that employees have been employed on average for 14 years by the same organisation. The number of years one is employed within one organisation is indicative of a number of factors concerning the financial climate the organisation is operating within:

- there is a lack of job opportunities within the market
- individuals want to secure their pensions to cushion their old age

This is not a good status quo for the organisation. This leads to stagnancy and lack of flow of activity in the organisation. However it is not within the objectives of this study to give a detailed breakdown of the demographic aspects of the sample.

5.2: Section on the level of perceived knowledge and the level of awareness of the HIV/AIDS EWP

There is a very good level of knowledge and awareness of the HIV/AIDS EWP within the organisation as well as a high satisfaction with mode of information relay on the program. From the study all respondents acknowledged being knowledgeable or aware of the existence of the organisational HIV/AIDS EWP, as accorded by one hundred percent affirmative response to (question 6) of the questionnaire. This is through having acquired information by variable means which will be categorised as formal or informal. These are tabulated into the two groups in table 5.1 below:

Table 5.1: Formal and Informal means of information acquirement on the HIV/AIDS EWP

Formal means of knowledge relay	***Informal means of knowledge relay***
Line manager	Media
Wellness champion	Co-workers
Corporate wellness advisor	Infected relative
Organisational internal communication	Voluntary counselling and testing centre
Training sessions with ZAPSO	

It was noted that the majority of respondents got their information via co-workers. Co-workers accounted for 40.51% of the means via which respondents got to know about the program. It would thus be imperative to take advantage of this process.

On assessment of satisfaction on mode of information relay, 89.87% segment of the sample was satisfied with how they acquired their information on the HIV/AIDS program with only about 10% expressing some form of dissatisfaction.

5.2.1 Recommendation

Realising that co-workers have played a big role in informing fellow employees about the program, it is imperative to take advantage of this but at the same time there is great need to ensure that full and correct information is relayed. It would be ideal to facilitate this mode of information conveyance by

- displaying the HIV/AIDS policy and HIV/AIDS EWP in public places within the organisation
- uploading the HIV/AIDS policy and HIV/AIDS EWP on the organisational intranet
- developing accessible media e.g. pamphlets, posters or fact sheets which are fun and easy to read but offering valuable in tell on the HIV/AIDS policy and EWP (Africa Centre for HIV/AIDS Management, 2007).

This wipes out problems which can arise such as;

- Misinformation: wrong or misleading information, which is an accidental falsehood (Stahl, 2006)
- Misinterpretation: to interpret, explain or understand inaccurately (the free dictionary). Within the definition, inaccurately can be substituted with incorrectly or wrongly.

Thus in the end no misunderstandings or confusion, on how the program works and fully entails arise as employees have a point of reference on the program readily at hand. This would also address lack of information and detail in some areas as cited by the respondent who stated being unaware of information on how staff with HIV/AIDS can acquire ARV drugs through the company's' medical aid scheme.

It is vital to relay the information on the organisational HIV/AIDS policy as well as the HIV/AIDS EWP to new employees during the organisational socialisation process i.e. induction process. Organisational socialisation is defined as the due process by which new employees are transformed into effective members of an organisation (Noe, Hollenbeck, Gerhart & Wright, 2008). Organizational socialisation includes three processes

- ✓ being prepared to perform the job effectively
- ✓ learning about the organisation
- ✓ establishing working relationships (Noe, et al, 2008)

The second process i.e. learning about the organisation can be used to the organisations advantage. It can be utilised as a vital focal point in the mandate for knowledge on the HIV/AIDS Policy and HIV/AIDS EWP to be imparted to the future employees. New employees can be supplied with induction packs. These will be called New Employee Briefing Packs (NEBPs) which can be distributed by Human Resources department. These would explain the program, how it works, how to access the different resources plus Frequently Asked Questions (FAQs) and contact details for the Corporate Wellness Advisor for any further queries and concerns.

5.3 Section on the utilisation and perceived success of the HIV/AIDS EWP

On assessing utilisation and perceived success of the organisational HIV/AIDS EWP, participation and satisfaction with the program were looked at.

5.3.1 Participation

The majority of respondents which is 97.47% concurred that it is essential to attend seminars, forums and access intranet information pertaining to the HIV/AIDS EWP. It is thus vital to make a comparative analysis between view on importance of attendance of seminars, forums and accessing intranet information to the actual task of doing so. On a comparative basis there is a positive correlation link. This is evidenced by respondents often (27.85%) and sometimes (48.10%), surmounting to three quarters of the total number of respondents; accessing information offered on pamphlets or intranet pertaining to HIV/AIDS EWP. The majority of respondents have also attended HIV/AIDS related activities offered or sponsored by the organisation as evidenced by 65 of respondents who attested to have done so. A small number i.e. eight respondents cited the reasons such as pressure of work, not being selected as reasons for non-attendance. As in any form of employee wellness program within the workplace this is to be expected for such programs offered within the workplace.

5.3.2 Satisfaction

One of the criterion to be met for a program to be rated satisfactory to those it is targeted at, is that it has to be accessible. In the survey the majority of respondents concurred that it is easy to access help and information vital to HIV/AIDS EWP with this supported by 26 strongly agreeing and 41 agreeing to the posed statement.

In accordance the majority of respondents i.e. 86.07% of the sample group found the workplace a valuable source of HIV/AIDS information with the program reported by a majority (70 respondents) as helping in enhancing their knowledge on HIV/AIDS. In accordance respondents thus rated the organisations HIV/AIDS EWP as either very good (26 respondents) or good (48 respondents).

Thus one would say that the program can be regarded as being a success for it has a high participation rate and is found satisfactory by respondents thus leading to it being rated as good or very good and an educational enhancer on HIV/AIDS information.

5.4 Section on the attitudes towards the HIV/AIDS EWP

On assessing attitudes towards the HIV/AIDS EWP, it was noted that almost all respondents which is 78 out of 79 representing 98.73% of the sample concurred that there is an advantage in knowing one's HIV sero-status. However this cognisance that there is an added adage in knowing one's status can be affected by certain variables. Stigma and discrimination have been identified as factors that can act as deterrents in one seeking VCT and ART treatment. Question 17 of the questionnaire sought to determine issues on stigma and discrimination surrounding VCT and ART. Of the sample, 77 respondents concurred to the statement that stigma does prevent people from seeking VCT and ART. However this was looked at in general terms, so is more a reflection of status quo in greater society and not necessarily that which prevails within the organisation. However as previously discussed on stigma and discrimination in the literature review, societal instilled perceptions on stigma and discrimination may permeate into the organisation and influence an otherwise

established positive organisational culture. Thus there is a need for perseverance and regular checks to see VCT and ART attendance.

Following on the high cognisance of an added adage on knowing one's HIV sero-status, 89.97% of sample of respondents said they would be comfortable in enrolling in the organizational ART program. This phenomenal positive response shows great confidence in the organisations run HIV/AIDS EWP. This might stem from a good understanding of the workings of the existing organisational policies and programmes such as the awareness that there will be no discrimination towards PLWHIV in the organisation as shown by 83.54% of respondents not concurring to the statement that in the organisation PLWHIV can lose their jobs. Only 10% of the respondents answered 'no' there would not enrol, with reason rebounding back to issues on stigma and confidentiality.

Promoting the use of condoms is one of the critical ways of preventing the spread of HIV/AIDS and STIs within the HIV/AIDS EWP. It is also vital to promote condom use in decreasing STIs due to the fact that the presence of an STI facilitates the transmission and acquisition of HIV (MOH-Malawi, 2005; Walker, et al, 2004). From the study it is noted that the knowledge of the value of condom use for the purposes of HIV and STI prevention is high within the sampled group. Of the sample, 75 respondents concurred that condoms can help prevent HIV and STI contraction with only four saying no.

In line with saying that condoms help prevent contraction of HIV and STIs, the majority of respondents are of the laudable perception that the condoms supplied within the organisation are of good quality. Of the 79 respondents, 54 said condoms supplied within the workplace are of good quality, however 25 of the respondents i.e. about one third, though a minority thought otherwise.

5.4.1 Recommendation

As noted already there is a positive willingness to enrol into the organisational ART program if the need does arise. For those who said no, issues on confidentiality reveal a lack of knowledge and confidence in the organisational handling of sensitive information. To ensure even greater enrolment it would be advantageous to utilise co-workers who have been identified as the significant information conveyors to educate others on procedural handling of issues and reassure fellow employees on confidentiality issues. A readily accessible HIV/AIDS policy and HIV/AIDS EWP outline within the workplace can be thus used as a form of reference to avert fears for the employees who need to refer to it as well as ensuring open access to the corporate wellness advisor.

There is a commendable largely positive regard towards the quality of condoms that are made available within the organisation. It would be precarious however not to note that one third of the sample thought otherwise. Plausible reasons are available to explain this. Myths and misconceptions abound about condoms within greater society and the workplace as already inferred to in the literature review. It is essential to dissuade these myths and misconceptions. There is a need for quality reassurance on the condoms supplied within the organisation especially for the lowly regarded non-branded condoms. This can be via availing information on the pivotal role government plays in enforcing strict requirements for quality assurance on condoms for both public and private sector use, through such actions as maintaining technical information for branded and non-branded condoms and maintaining World Health Organisation (WHO) and International Standards Organisation (ISO)

specifications on all condoms. Supplying information that in Zimbabwe all the condoms that are ultimately distributed are initially tested by the main regulatory authority, Medicines Control Authority of Zimbabwe (MCAZ) would be essential. This includes in tell on quality control for branded and non-branded condoms which is done through various tests. These include measures of the quality of condoms in terms of leakage, physical aberrations, bursting pressure, strength, elasticity, size specifications, elasticity, and package seal integrity and ageing tests.

On the issue concerning condom dispensing which was raised, it is vital to provide condom dispensers. In Malawi, these are referred to as non-human condom dispensers; lockable, durable metal boxes which are hung on a wall (MOH-Malawi, 2005). The key to the dispenser is kept by the responsible person who fills it depending on consumption. In this case the organisation can choose to elect the wellness champions to be responsible for this as well as restocking. The location of dispensers should be discreet to ensure the identity of people who access the condoms is protected (MOH-Malawi) and thus the workplace toilets would be more appropriate locality for them.

5.5 Section on the level of perceived stigma and perceived discrimination in the organisation

The majority of respondents reveal a good understanding on the workings of the existing organisational HIV/AIDS policies and programs. This is evidenced by the majority of respondents being aware that PLWHIV will not be discriminated against within the organisation (institutional level interaction). Of the sample 66 respondents either disagreed or strongly disagreed to the statement in my organisation PLWHIV can lose their jobs. This shows understanding and knowledge with regards to rights of an employee who is HIV positive employee within the organisation.

Social interactions as previously inferred to in the literature review covers a range of interactions between employees which take place at scheduled intervals such as tea or lunch (Pulerwitz, et al, 2004). Employee perceptions on issues such as HIV/AIDS are noted to be influenced by the community from which they live and come from. Question 19 looked at discrimination within society as a determinant of social interactions within the workplace; 38 respondents concurred that PLWHIV are treated as outcasts in society with 30 respondents not concurring. Thus have a response which favours discrimination in society. As noted, forms of discrimination permeate from pockets of society from which individual employees hail and percolate into the organisation to influence organisational culture. This might ultimately influence those on the right track and lead to a distortion in non- tolerance to stigma and discrimination within the organisation.

In response to the statement, if a colleague is infected with HIV/AIDS he/she would still be my friend; there was a one hundred percent affirmative response to continued friendship. In response to the statement, in my organisation people living with HIV are shunned by fellow employees, 51 respondents did not concur. However 16 respondents a minority concurred thus essentially saying that PLWHIV are shunned by fellow employees within the organisation.

From the above one can say that where there is friendship there will be no discrimination as shown by respondents' willingness to continue with friendship despite a colleague's positive HIV sero-status. However this might not necessarily hold water for a fellow employee who is

not a friend. Not everyone is friends with everyone else in any organisation. This can thus lead to shunning of other employees who are perceived or thought to be living with HIV/AIDS. This can arise from stigma and discrimination as alluded to before, permeating from societies which employees hail filtering into the organisation. Perseverance is required by organisations in eliminating the social process of stigma and any lingering discrimination within an organisation. This can be done through education in organisation and in community via community involvement processes on IEC information and education and communication.

Chapter 6: Conclusion

HIV/AIDS Employee Wellness Programs are implemented by businesses to avert an added financial 'AIDS Tax' (Rosen, et al, 2007) burden that can be exerted by HIV/AIDS disease if unmitigated. For organisation X, this is against a backdrop of a high prevalence setting in Zimbabwe at 14.3% (UNAIDS, 2010), plus a low Human Development Index (HDI); Zimbabwe was ranked second lowest at number 173 in the world , only higher than Ethiopia by the United Nations Development Programme (UNDP) (Musarurwa, 2011). The HDI is a comparative measure of life expectancy, literacy, education and standards of living in a country (Musarurwa). A low HDI can be indicative of a country population's increased vulnerability to HIV/AIDS. All this is in addition to a shaky political economic environment; as cited in Gilbert, et al, (2002) countries experiencing political and or economic instability have been more vulnerable to the spread of diseases such as HIV/AIDS.

The study revealed a high level of knowledge and awareness of the existence of the organisational HIV/AIDS EWP. Co-workers constituted the greater mode of information relay or dissemination and thus deemed imperative to take advantage of this by improving mode. Information and help on the HIV/AIDS EWP and is found to be accessible leading to the program being regarded as good or very good and an enhancer of HIV/AIDS knowledge. There also exists a positive view on importance of attendance of seminars, forums etc pertinent to the HIV/AIDS EWP, which is evidenced by a high attendance rate of organisational offered programs on HIV/AIDS.

Variable attitudes prevail towards the different HIV/AIDS EWP components. Although it is noted that in greater society stigma inhibits VCT and ART, respondents were in favour of knowing one's HIV sero-status and had a willingness to enrol into the organisational ART program. This might stem from a good understating of the workings of the existing organisational policies and awareness of non-discrimination to PLWHIV in organisation at institutional level interaction.

The study revealed a high knowledge of the importance of condom use as barrier in preventing contraction of HIV and STIs. There was also a general positive trend on attitude towards condoms provided within the workplace. Although some negativity was detected towards 'unbranded' condoms by some who consider them low quality and cheap. Thus it is essential to dissuade these myths and misconceptions and also to make available non-human condom dispensers.

Stigma and discrimination which are noted to be there in greater society can pose a danger to the culture of non-tolerance to stigma and discrimination within the organisation. Thus there is need for perseverance on education and communication on the organisation with its employees and communities from which they hail.

As for any other programmes that are run by an organisation regular assessment is vital to keep checks and balances on the HIV/AIDS EWP through monitoring, evaluation and reviews. Taking into consideration the organisation's operating environment a working program is of the essence for a continued success and forging forward into the future.

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7.2 Annexure

7.2.1 Consent form

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CONSENT TO PARTICIPATE IN RESEARCH

UTILIZATION OF AN HIV/AIDS EMPLOYEE WELLNESS PROGRAM WITHIN THE WORKPLACE

You are asked to participate in a research study conducted by Dr. P.T. Ruwende (MBChB UZ) a student from the Africa Centre for HIV/AIDS Management at Stellenbosch University. The results of this study will be anonymously processed into the study report on Utilization of an HIV/AIDS Employee Wellness Program within the workplace in partial fulfilment of the requirements of the degree of Master of Philosophy (HIV/AIDS Management). You were selected as a possible participant in this study because of working for this organization which has been selected to participate in the research.

1. PURPOSE OF THE STUDY

The aim of the study is primarily to determine the utilization of the HIV/AIDS Employee Wellness Program by employees within the organization, in order to provide guidelines to make the program effective and to render the program more cost effective. This will be done by meeting the following objectives:

- To find out employee's knowledge and awareness of the HIV/AIDS Employee Wellness Program
- To find out perceptions about the program
- To find out the extent to which employees utilise the program
- To establish areas of key concern within the program to employees
- To provide guidelines to make the program effective and more cost effective

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following:

Complete a questionnaire.

This will assess your knowledge, awareness and utilization, of the organizational HIV/AIDS Employee Wellness Program. It will also assess your perceptions about the organizational program and identify areas of key concern within the program to you as an employee within the organization.

This will take approximately 20 to 30 minutes of your time at a time that has been identified and deemed as convenient.

3. POTENTIAL RISKS AND DISCOMFORTS

The information to be obtained through your participation will need to establish your views and concerns about the organizational HIV/AIDS Employee Wellness Program. This might cause you some level of discomfort for it may seem ungrateful, irresponsible or even disloyal. You should not at any time regard your participation as ungrateful, irresponsible or disloyal. Also be rest assured that your participation will not in any way earn you reproach from management or adversely affect

your continued employment with/in the organization. Instead the information you make available will make it possible to identify areas within the program which need due addresses.

Please feel free to contact the Corporate Wellness Advisor, Ms E.T.M. Charimari on +263 (4) 758 280/99 or myself, Dr P.T. Ruwende on +263 772 871 886 for referral to support services such as counselling from discomfort which may arise due to participation.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The research is intended to strengthen the organizational HIV/AIDS Employee Wellness Program by identifying areas which need redress and areas of key concern. You (the participant) will thus benefit through an improved and enhanced program and society through the extension of the program to your families and partners.

5. PAYMENT FOR PARTICIPATION

No payment will be made available to you for participation in the study. This is a voluntary study that is contingent on your participation.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Confidentiality will be strictly maintained during this study. No request will be made for identifiable personal information such as names or employee numbers at any point in time and thus maintaining your confidentiality. Data collected will be kept locked away in a safe away from persons not involved with the study.

The information might be inspected by the Stellenbosch University, Human Research Ethics Committee. The records will only be utilized by them in carrying out and satisfying their obligations relating to this study.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact

Principal investigator: Dr. P.T. Ruwende cell: 0772 871 886 or e-mail: phoebetar@yahoo.com

Study supervisor: Mr. Burt Davis tel. +27 21 808 3006 or e-mail: burt@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me_____by

Phoebe T. Ruwende in English/Shona. I am in command of this language_____or

were necessary it was satisfactorily translated to. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____ _____

Signature of Participant **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____

_____. He/she was encouraged and given ample time to ask me any questions

This conversation was conducted in English/Shona and no translator was used.

_____ _____

Signature of Investigator Date

7.2.2 English Questionnaire

UTILISATION OF AN HIV/AIDS EMPLOYEE WELLNESS PROGRAM WITHIN THE WORKPLACE

In answering the questions please put a tick in the appropri ✓ ***in response to your answer.***

1. **Age:** ☐ *years*
2. **Sex :** ☐ *male* ☐ *female*
3. **Marital status:** ☐ *married* ☐ *single* *living together (co-*habiting) ☐
4. **What is your grade?**

.....

5. **Years employed in the organization:** .....*years*

6. **I am knowledgeable/aware of the existence of an organizational HIV/AIDS Employee Wellness Program**

Yes ☐ *No* ☐

7. **How did you know about it**

Co-workers ☐ *Line manager* ☐ *Other* ☐

If you stated **other**, please specify.....

.....

8. **I am satisfied with how information pertaining to HIV/AIDS Employee Wellness Program was imparted to me.**

Yes ☐ *No* ☐

If you answered **no** please state reasons for this dissatisfaction

.....

.....

.....

9. **Have you ever attended HIV/AIDS related activities offered or sponsored by the company?**

☐ ☐

Yes *No*

If you answered **no** please state the reasons for non-attendance

.....

.....

10. How many times do you access information offered on pamphlets or intranet pertaining to HIV/AIDS and EWP

Often ☐ *Sometimes* ☐ *Seldom* ☐ *Never* ☐

11. It is important to attend of seminars, forums and access intranet information pertaining to HIV/AIDS EWP

Strongly agree ☐ *Agree* ☐ *Undecided* ☐

Disagree ☐ *Strongly disagree* ☐

12. I would you rate the organizations HIV/AIDS Employee Wellness Program as

Very good ☐ *Good* ☐ *Poor* ☐

Very Poor ☐ *Barely acceptable* ☐

13. It is easy to access help and information vital to the HIV/AIDS Employee Wellness Program

Strongly agree ☐ *Agree* ☐ *Undecided* ☐

Disagree ☐ *Strongly disagree* ☐

14. The workplace is a valuable source of HIV/AIDS information

Strongly agree ☐ *Agree* ☐ *Undecided* ☐

Disagree ☐ *Strongly disagree* ☐

15. The program has enhanced my knowledge on HIV/AIDS

Strongly agree ☐ *Agree* ☐ *Undecided* ☐

Disagree ☐ *Strongly disagree* ☐

16. There is an advantage in knowing one's HIV status

Strongly agree ☐ *Agree* ☐ *Undecided* ☐

Disagree ☐ *Strongly disagree* ☐

17. Stigma prevents people from seeking Voluntary Counseling and Testing (VCT) and treatment

Strongly agree ☐ *Agree* ☐ *Undecided* ☐

Disagree ☐ *Strongly disagree* ☐

18. If necessary I would be comfortable in enrolling in the organizational offered Anti-retroviral treatment (ART) program.

Yes ☐ *No* ☐

State the reasons if you answered NO.

.....

.....

19. People living with HIV (PLWHIV) are treated as outcasts by society

Strongly agree ☐ *Agree* ☐ *Undecided* ☐

Disagree ☐ *Strongly disagree* ☐

20. In my organization people living with HIV are shunned by fellow employees

Strongly agree ☐ *Agree* ☐ *Undecided* ☐

Disagree ☐ *Strongly disagree* ☐

21. In my organization People Living with HIV (PLWHIV) can lose their jobs

Strongly agree ☐ *Agree* ☐ *Undecided* ☐

Disagree ☐ *Strongly disagree* ☐

22. If a colleague is infected with HIV/AIDS would he/she would still be my friend

Yes ☐ *No* ☐

23. Use of condoms can help prevent contraction of Sexually Transmitted Diseases as well as HIV

Strongly agree ☐ Agree ☐ Undecided ☐

Disagree ☐ Strongly disagree ☐

24. Condoms provided within the workplace can be regarded as of good quality.

Yes ☐ No ☐

If you answered No please state your opinion/s

.....

.....

The end

7.2.3 Shona Questionnaire

UTILISATION OF AN HIV/AIDS EMPLOYEE WELLNESS PROGRAM WITHIN THE WORKPLACE

Pakupindura mibvunzo isayi chinyoro munzvimbo yakakodzera sezvizvi

1. **Makore (Age):** ☐ *(years)* ☑
2. **Sex *:*** *murume* ☐ *mukadzi* ☐
3. **Marital status:** *married* ☐ *single* ☐ co-habiting ☐
4. **Muri pachidanho chipi pabasa? (Grade)**

.....

5. **Mune makore mangani muchishandira bhanga?**

.....

6. **Ndine ruzivo nekuvapo kwehurongwa hweHIV/AIDS muvashandi pabasa pano (HIV/AIDS Employee Wellness Program)**

Hongu ☐ *Kwete* ☐

7. **Makaziva nezvehurongwa uhwu sei?**

Kubva kune vandinoshanda navo ☐ *Kubva kumukuru wangu wepabasa* ☐

Kuburikidza nedzimwewo nzira ☐

Kana manyora nedzimwewo nzira tsanangurai zvizere.....

.....

8. **Ndinogutsikana nenzira yandakawana nayo ruzivo maererano nehurongwa hweHIV/AIDS muvashandi pabasa pano**

Hongu ☐ *Kwete* ☐

Kana mapindura kwete nyorai chikonzero kana zvikonzero zvacho

.....
.....

9. Makambopinda/ kana kuenda muzvirongwa (activities) zviri maererano neHIV/AIDS zvinopihwa kana kurongwa nebhanga?

Hongu ☐ *Kwete* ☐

Kana mapindura kwete nyorai chikonzero kana zvikonzero zvacho

.....

.....

10. Kangani kamunotora chidanho chokutsvaga ruzivo/rudzidziso zviri maererano neHIV/AIDS kana nezvehurongwa hweHIV/AIDS muvashandi pabasa kubva muzvinyorwa kana mukutauriririrana kwechizvino-zvino (intranet)?

Kazhinji ☐ *Dzimweni dzenguva* ☐

Nenguva iri kure ☐ *Kana!(never)* ☐

11. Zvakakosha kuenda kumisangano nekushandisa kutaurirana kwechizvino zvino (intranet) kuwana ruzivo zviri maererano nezvehurongwa hweHIV/AIDS muvashandi pabasa

Ndinobvuma zvikuru ☐ *Ndinobvuma* ☐ *Handizivi* ☐

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

12. Ndinoona urongwa hweHIV/AIDS muvashandi pabasa mubhanga rino se-

Hwakanaka zvikuru (Very good) ☐ *Hwakanaka (Good)* ☐ *Hwakaipa (Poor)* ☐

Hwakaipisisa (Very poor) ☐ *Hwakanyanyoipisisa (Barely acceptable)* ☐

13. Zviri nyore kuwana rubatsiro kana ruzivo rwakakosha rurimaererano nehurongwa hweHIV/AIDS muvashandi pabasa

Ndinobvuma zvikuru ☐ *Ndinobvuma* ☐ *Handizivi* ☐

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

14. Pabasa inzvimbo yakakosha kuwana ruzivo/dzidziso maererano neHIV

Ndinobvuma zvikuru ☐ *Ndinobvuma* ☐ *Handizivi* ☐

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

15. Chirongwa chepabasa chabatsira kupamhidzira ruzivo rwangu nezvechirwere cheHIV/AIDS

Ndinobvuma zvikuru ☐ *Ndinobvuma* ☐ *Handizivi* ☐

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

16. Zvakakosha kuziva mamiriro maererano nekuvapo kwechirwere cheHIV mandiri (HIV status)

Ndinobvuma zvikuru ☐ *Ndinobvuma* ☐ *Handizivi* ☐

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

17. Kushorwa /Kusarurwa/Kusemwa (Stigma) kunoita kuti vanhu vazeze kana kutya kuzvipira kuenda kunodzidziswa nekunoongororwa chirwere cheHIV uyezve kurapwa chirwere ichi.

Ndinobvuma zvikuru ☐ *Ndinobvuma* ☐ *Handizivi* ☐

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

18. Kana zvichikodzera (if necessary) ndainzwa kusununguka kupinda muhurongwa hwekurapwa kweHIV/AIDS (Anti-retroviral treatment program) hunopihwa pabasa

Hongu ☐ *Kwete* ☐

Kana mapindura kwete nyorai chikonzero kana zvikonzero zvacho

.....

.....

19. Vanhu vanorarama nechirwere cheHIV vanoshorwa (are outcasts) munharaunda

Ndinobvuma zvikuru ☐ *Ndinobvuma* ☐ *Handizivi* ☐

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

20. Vanhu vanorarama nechirwere cheHIV vanoshorwa nekusekwa nevamwe vavanoshanda navo

Ndinobvuma zvikuru ☐ *Ndinobvuma* ☐ *Handizivi* ☐

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

21. Vanhu vanorarama nechirwere cheHIV vanokwanisa kudzingwa kumabasa

☐ ☐ ☐

Ndinobvuma zvikuru *Ndinobvuma* *Handizivi*

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

22. Kana shamwari yangu yava nehutachiwana hweHIV/AIDS inongoramba iri shamwari yangu

Hongu ☐ *Kwete* ☐

23. *Kushandisa makondomu (condoms) kunobatsira kudzivirira kutapurirana kwezvirwere zvenjovhera neutachiona hweHIV*

Ndinobvuma zvikuru ☐ *Ndinobvuma* ☐ *Handizivi* ☐

Handibvumirani nazvo ☐ *Handibvumirani nazvo zvachose* ☐

24. *Makondomu (condoms) anowanikwa pabasa anotarisirwa kuti ndemhando yepamusoro*

Hongu ☐ *Kwete* ☐

Kana mhinduro yenyu iri Kwete, nyorai mafungiro enyu

.....

.....

Magumo