

Workplace response to HIV/AIDS and the effect of HIV/AIDS on the carriers and occupations of the infected urban population

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Assignment presented in partial fulfillment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management)
at Stellenbosch University



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March 2009

Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: 6TH MARCH 2009

Abstract

The Uganda government through the ministry of health, collaborating with several NGOs and donors has done a commendable job in arresting the medical effects of HIV/AIDS. This has been done through provision of ARVs and treatment of opportunistic infections. As a result, Uganda has enjoyed a lot of international praise for its response to the medical effects of HIV/AIDS. However, inadequate attention has been paid to the epidemics social economic effects.

It is known that HIV mostly affects young people in their years of economic productivity. These people spend eight or more hours of every day in their work place but despite this; work places especially private institutions have not taken steps to respond to the scourge of HIV/AIDS. HIV/AIDS work place policies have not been formulated, and in some cases, they are on paper but no implementation is being done. Consequently, HIV/AIDS still affects the carriers, income and occupational activities of infected workers.

This study reveals that the working population is generally ignorant about workplace HIV/AIDS policies, and their relevance to workers living with HIV/AIDS. A significant proportion of the respondents have lost jobs because of their HIV status, while majority affirm that living with HIV/AIDS has affected their occupations, carriers and income.

Opsomming

Die studie ondersoek die mate waartoe werkers by ondernemings in Uganda bewus is van die aard en omvang van die MIV/Vigs pandemie. Alhoewel dit dikwels beweer word dat Uganda die res van die Wêreld voor is in die voorkoming van Vigs, dui hierdie studie daarop dat daar nog baie ruimte vir verbetering in Uganda is.

Voorstelle vir die verbetering van die situasie in die werkplek word voorgestel en daar word aangedui op watter areas ondernemings hulle MIV/Vigsprogramme kan verbeter.

Acknowledgements

I deeply appreciate all the hearts and minds that contributed to this research:

My clients and respondents for participating in the research

Prof: J.C.D Augustyn, my supervisor, for your guidance and encouragement

Anja Laas and the entire team at the Africa Centre for HIV/AIDS Management, for your work

My daughters Izabel and Sammy, for being patient with me when I was busy studying

My husband Patrick, for believing in me, and supporting me

Table of contents**Chapter 1: Introduction**

1.1	Background	1
1.2	Research problem	1
1.3	Aim of the study	2
1.4	Specific objectives	2
1.5	Justification of the study	2
1.6	Hypotheses	3

Chapter 2: Literature survey	3
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Chapter 3: Methodology

3.1	Research design	4
3.2	Study area	4
3.3	Types and sources of data	4
3.4	Sample size and sampling procedure	4
3.5	Data quality control	4
3.6	Data analysis	4

Chapter 4: Results

4.1	Data analysis and presentation	5
4.2	Summary of results	8
4.4	Discussion	9
4.5	Recommendations	9

5. References	11
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Glossary	12
Appendix: the questionnaire	13

List of figures

Figure 1: gender of respondents.

Figure 2: marital status

Figure 3: employment status

Figure 4: events that prompt HIV testing

Figure 5: how living with HIV/AIDS affects the income occupation and carrier of the respondents.

Figure 6: how respondents who lost jobs were terminated from their workplaces.

List of tables

Table 1: age of respondents

Table 2: type of employer

Table 3: assessing awareness about workplace HIV/AIDS policy

Table 4: areas that should be addressed by the workplace HIV/AIDS policy

Table 5: absence from work due to AIDS related illness

Table 6: whether living with HIV/AIDS affects the respondent's income, occupation and carriers

Table 7: HIV related factor that led to job loss

CHAPTER 1: INTRODUCTION

1.1 Background

Despite the effectiveness of available interventions the global and national burden of HIV continues to grow. UNAIDS estimates that there were a total of 33 (30.3 – 36.1) million people living with HIV, 2.7 (2.2 – 3.2) million new infections and 2.1 (1.9 – 2.4) million deaths due to HIV by December 2007. There were an estimated 1.7 million [1.4 – 2.4 million] new HIV infections in sub-Saharan Africa in 2007 a significant reduction since 2001. However, the region remains most severely affected. An estimated 22.5 million people living with HIV /AIDS, that is 68% of the global total are in sub Saharan Africa.

HIV/AIDS in Uganda

The Uganda AIDS Commission and the Ministry of Health estimate that the incidence of HIV in 2005 was 132,500 and that there were about 1.1 million people living with HIV and AIDS in 2006. The HIV and AIDS epidemic in Uganda peaked around 1992-1993 with a prevalence of 18.3 % and declined steadily to levels of 6%-7% from 2001-2005 among adults in the country. (UHSBS) of 2004 / 2005

HIV /AIDS policy in Uganda

In 1992, the Uganda AIDS Commission (UAC) was created to coordinate and monitor the national HIV/AIDS strategy. The strategy entailed a multi-sectoral approach to HIV/AIDS prevention, control and care that advocates for the active involvement of AIDS control activities by all members of society individually and collectively. The current efforts to combat HIV/AIDS are characterized by a policy of openness on the side of Government, civil society and lower level political, private and social institutions.

Uganda National Strategic Framework

A statement of the country's response to HIV/AIDS forms the National Strategic Framework (NSF) for HIV/AIDS activities for the period 2000/2001 to 2005/2006 and 2007/2008 to 2011/2012. The Framework builds upon the Multi-Sectoral Approach to the Control of AIDS and the National Operational Plan (NOP) for HIV/AIDS/STD Prevention, Care and Support and Programs for AIDS Control (ACP) in line Ministries. However, partly as a result of lack of appropriate policy, ongoing HIV/AIDS interventions have not fully benefited from the contribution and support of other stake holders, especially the private sector, and the world of work.

HIV/AIDS at the Workplace

The International Labor Organization Code of Practice on HIV/AIDS and the world of work provides guidelines for the development of policies and programs critical for the responsibility on HIV/AIDS in the workplace. A workplace policy provides the framework of action to control the spread of HIV among employees and to mitigate its impact on those who are already infected, and the organizations for which they work. HIV/AIDS affects institutions, organizations and businesses through reduced productivity, increasing operational costs of recruitment, retraining, absenteeism, increased health care costs and loss of skilled labor. The corporate response to HIV/AIDS in Uganda has been rather limited, with a few exceptions of some big companies that have pioneered in protecting their workers, while others have made philanthropic contributions. The Private Sector shoulders a critical responsibility of protecting their work forces and their families against the spread of the epidemic, and supporting employees infected with HIV in remaining healthy and continuing to work.

1.2 RESEARCH PROBLEM

The workplace has not sought a leadership role in confronting the AIDS epidemic. There is a massive need for the workplace to form partnerships with other stake holders in order to maximize resources for scaling up the national response to HIV/AIDS. The greatest immediate responsibility and opportunity for the workplace is to protect their work forces and their families against the spread of the epidemic, and to support those who are already infected with the virus to minimize the social and economic impact of living with HIV/AIDS. With limited corporate response to HIV/AIDS in Uganda most of the urban workforce infected by HIV/AIDS has experienced cessation of their occupations and careers, leading to loss of income and rendering them unable to provide for their families and support their health care. The purpose of this study is to determine the effects of HIV/AIDS on the infected urban population and obtain vital information on the workplace response to HIV/AIDS.

1.3 AIM OF THE STUDY

The study attempts to check the response of different work places to HIV/AIDS. This is irrespective of their size, location or whether they are government or nongovernmental.

It further attempts to highlight the social economic effects of HIV/AIDS, and particularly the effects of living with HIV on the carriers, income and occupational activities of those who are infected.

1.4 SPECIFIC OBJECTIVES

Asses' workplace response to HIV/AIDS, through formulation and implementation of HIV/AIDS workplace policies. Determine how HIV/AIDS affects occupational activities and career opportunities among infected urban workforce. Highlight the social-economic effects of HIV/AIDS on the infected urban population

1.5 JUSTIFICATION OF THE STUDY

The study highlights the effects of HIV/AIDS on the urban workforce as a sub population, and identifying the gaps in corporate response to HIV/AIDS. The study is also expected to come up with some recommendations, which should help workplaces re-conceptualize their approaches and strategies in protecting their workers and mitigating the impact of HIV/AIDS at the workplace and their surrounding community.

1.6 HYPOTHESES

1. Work places have not put in place policies and practices to mitigate the impact of HIIVAIDS on their workers and their families.
2. Living with HIV/AIDS, has a negative effect on the infected persons work, carrier, income and occupational activities.

CHAPTER 2: LITERATURE SURVEY

Impact studies on the Private Sector

The economic Impact of HIV Epidemic study by Cohen (1993) reiterates that research at the sectoral level is more likely to be useful in informing policy than macro-modeling, and if resources are correctly allocated then sector impact studies are more likely to be productive. A survey of workplace HIV policy and interventions in 20, parastatals and private sector companies that was done in mid-2002 included representatives of 20 employers within Malawi inquiring about basic workplace interventions for HIV prevention, care, and support, coordination mechanisms and policy issues. The employers targeted included small enterprises with less than 100 employees to large enterprises with more than 20 000 employees. In conclusion, the survey of 20 employers in Malawi revealed that the majority of them are providing a core package of the prevention services with some basic care and support elements. The most obvious deficiency of this response is the lack of established workplace HIV participatory coordination mechanisms and existing workplace HIV policies. In measuring the impact of HIV most published studies tend to focus on sectors than sub populations

The program on Enterprise Development in Africa funded by the World Bank conducted a survey with a sample of 860 firms and 4,955 workers from Uganda, Kenya and Tanzania. It focuses on examining manager and worker perceptions on HIV/AIDS, and how firms in the private sector respond to HIV/AIDS through various measures and whether there is a cost to firms from HIV. The firms' response to HIV was quite limited with only about 34 percent of firms engaging in HIV/AIDS prevention or treatment. Larger firms and firms with better quality workforces tended to do more about HIV through various prevention activities. They conducted pre-employment health checks to screen out sicker applicants. Results revealed that where it was costly to replace workers, firms attempted to mitigate this cost by engaging in prevention activities.

While there is a large literature on the problem of HIV/AIDS in Africa, there is relatively little rigorous analysis of private sector activity. Some major studies are worth citing in this regard. A global survey in 2003 revealed that the private sector is not doing enough about AIDS (Bloom, 2004; Taylor et al, 2004). The World Economic Forum's Global Health Initiative website summarizes the results of the study as follows:

Of the nearly 8,000 businesses surveyed in 103 countries:

47% felt that HIV will have some impact on their business; this number is much lower in countries that to date have not been hard-hit by HIV. There are important regional variances – in Africa, 89% thought HIV would have some impact, but in the Middle East and North Africa that figure dropped to 33%. Worldwide, 21% of surveyed firms feel that HIV will have a severe impact on their business. The small proportion of firms that have conducted quantitative studies estimates lower rates than other firms. In summarizing the findings of their paper, David Bloom and coauthors argue that firms have taken little action regarding HIV in Africa (Bloom et al, 2004). They write that the largest discrepancy between firm perceptions and actual data is to be found in Africa, where 45 percent of firms report less than 1 percent prevalence, despite data from UNAIDS that shows only 10 percent of respondent firms in Africa are located in low-prevalence countries. They argue that as of 2003-04, the response to AIDS by the private sector has been "piecemeal" with only a few firms having HIV/AIDS policies; the response is limited even where firms are quite concerned about HIV. This response is even more sanguine, they argue, in countries which are relatively well-governed. In these cases, businesses seem to rely more on the public sector to deal with the problem.

Conclusion

Very limited or no research has been done on specific sub populations within the private sector affected by HIV/AIDS, given the tremendous effect the disease has had on various political, socio economic aspects. Considerably a lot of relevant studies must be done to identify the scale and scope for policy response to continually mitigate the impact of HIV/AIDS on vulnerable different sub populations.

CHAPTER 3: METHODOLOGY

3.1 Research Design

A cross sectional survey was carried out using both qualitative and quantitative tools.

3.2 Study Area

The study was carried out at Family Hope Centre, an urban HIV/AIDS clinic at Naguru in Kampala, Uganda. It is an outpatient clinic, offering free care PLWHA. Care includes VCT, ART, treatment of opportunistic infections and counselling and psychosocial support. The target population is of 1739 working adults, 18years and above who are receiving treatment and care from the centre.

3.3 Types and Sources of Data

The instrument used was a pre-tested structured qualitative and quantitative questionnaire.

It was directly administered through face to face interviews.

The questionnaire has four sections;

Section 1: demographic data.

Section 2: employment profile.

Section 3: assessing the client's knowledge about HIV/AIDS workplace policy.

Section 4: HIV/AIDS and work history.

3.4 Sample Size and Sampling Procedure.

In this study, a non probability technique called convenience sampling was used. This involved collecting information from clients that were conveniently available at the time of the survey. Thus the researcher interviewed every client that walked into her office during the research period. The method was chosen because there is no intent to generalize the results on the entire patient population, but just to gain more insight into the subject of inquiry. It was also the most practical approach considering the time and resources available for the study. A sample size of 100 respondents was chosen because it is manageable and the results can be subjected to statistical tests and statistical inferences can be drawn from this sample size.

3.5 Data Quality Control

To ensure correct recording of responses and improve certainty, all the interviews were carried out personally by the researcher, they were face to face interviews allowing respondents to clarify on the questions that they did not understand, and also to clarify their own responses. Data coding will be done for questions that are not pre-coded at pre-testing stage. The information was be entered using SPSS package and then cleaned.

3.6 Data Analysis

Data was analyzed using SPSS. Graphs and charts representations have been used.

CHAPTER 4: RESULTS.

4.1 Data analysis and presentation

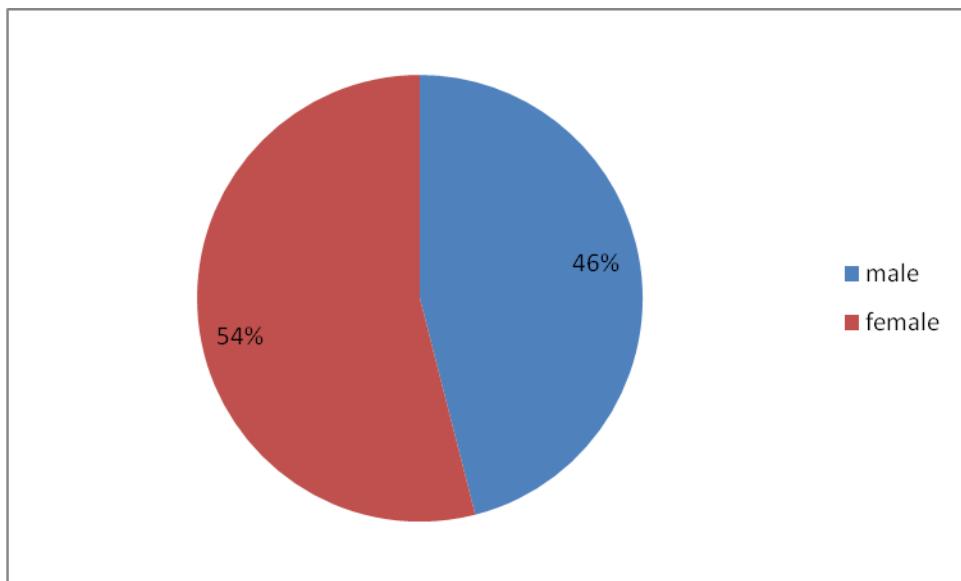


Figure 1: Gender of respondents

Table 1: Age of respondents

		Frequency	Percent
range	21-30	15	15.0
	31-40	40	40.0
	41-50	36	36.0
	51-60	9	9.0
Total	100	100.0	

The study revealed that 90% of all the clients receiving HIV care at the clinic are within the productive age group 21-50 yrs.

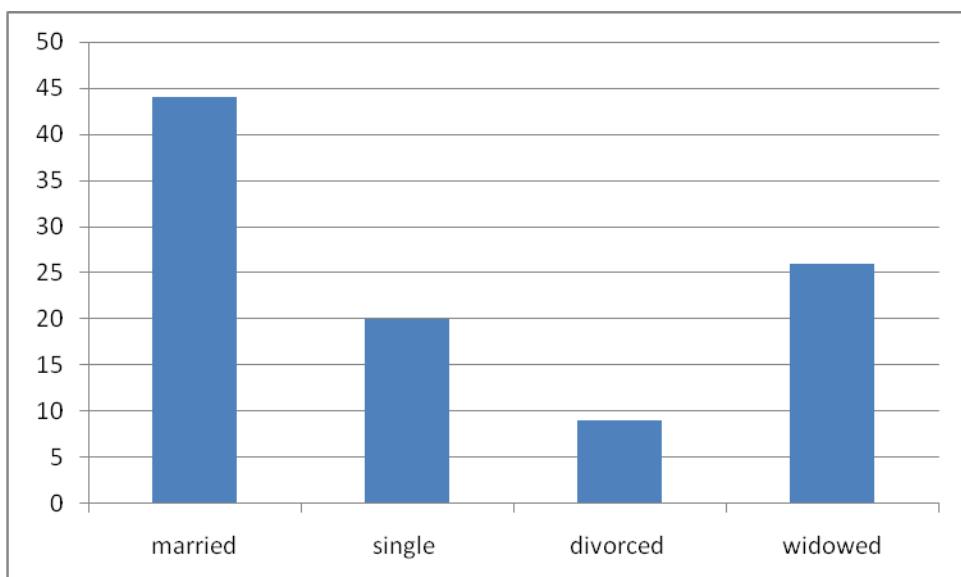


Figure 2: Marital Status

Majority of the respondents interviewed were married, but also a significant proportion; 26% are widowed, and 9% are divorced or separated.

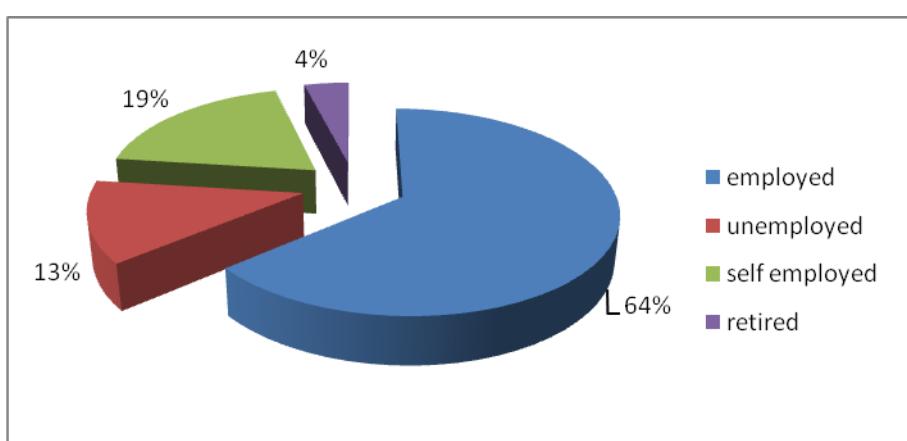


Figure 3: Employment Status

Majority of respondents were employed. This gives the researcher the privilege of finding out what is happening at different work places regardless of their size or location. The sample population gives a good representation of what is happening in the world of work because they are part of it.

Table 2: Type of Employer (current or previous)

Employer	Frequency	Percent
Government	15	15
Private	53	53
Self	19	19
Unemployed	13	13
Total		100

53% of respondents were employed by private institutions. This adds viability to the study, as the study seeks to examine the contribution of other stakeholders than government to the response to HIV/AIDS

Table 3: assessing the awareness about HIV workplace policy

Aspect	Response				
	Yes	No	I don't know or N/A	To some extent.	
Knowledge about HIV/AIDS workplace policy.	40	60(60%)	-	-	
Presence of an HIV workplace policy at the respondent's workplace.	16	30	54	-	
Participation of all employees in developing their workplace policy.	5	11	84	-	
Putting the written workplace AIDS policy in practice	2	38	50	10	
Supportiveness of the workplace to employees living with HIV/AIDS	22	42	36		

Table 4: Areas that should to be addressed by the workplace policy

	Frequency	Percent
Sick and compassionate leave	22	22.0
Terminal benefits	14	14.0
Reasonable accommodation at the work place	19	19.0
stigma and discrimination in the work place	1	1.0
No response	22	22.0
Total	100	100.0

The survey revealed that 60% respondents had not heard about an HIV/ AIDS workplace policy, while only 16% can confirm that they have one at their place of work. Furthermore, only 5% of respondents have been involved in developing their workplace AIDS policy, yet a meager 2% think that what is on paper in their policy is being put in practice.

Majority of respondents; 42%, do not think that their work places are supportive of employees living with HIV/AIDS, sighting the areas of sick and compassionate leave, terminal benefits and reasonable accommodation at the workplace as the issues that require urgent attention.

Objective 2: HIV/AIDS and work history

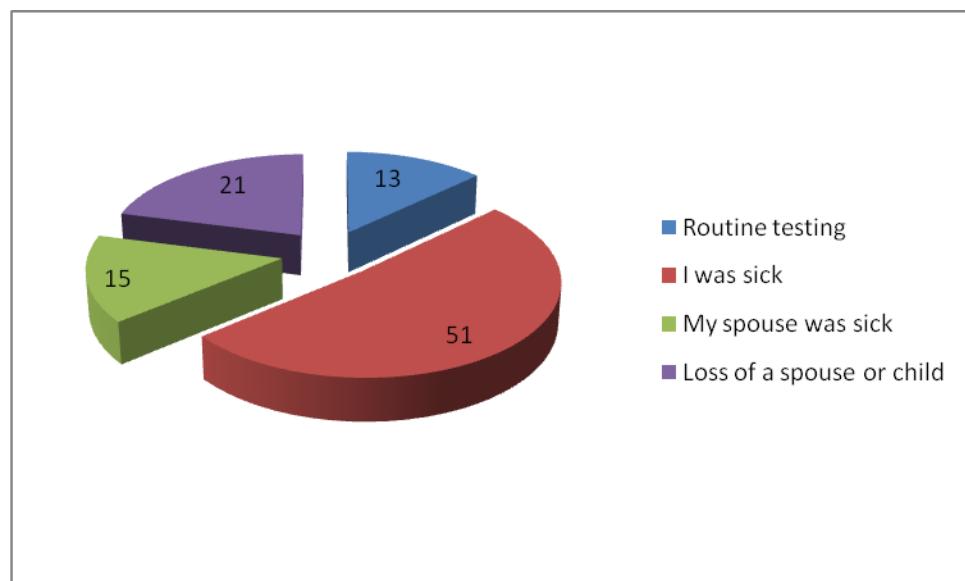


Figure 4: Events that prompt HIV testing

Sickness is the major event that prompted respondents to test for HIV, followed by loss of a spouse or a child. Only 13% of respondents found out their status through routine counseling and testing.

Table 5: Absence from work due to AIDS related illness

	Frequency	Percent
Yes	66	66.0
No	34	34.0
Total	100	100.0

More than half of all respondents admit to being unable to work at some point in their carrier due to an AIDS related illness.

Table 6: Whether living with HIV/AIDS has affected the respondent's income, occupation or carrier

	Frequency	Percent
Yes	70	70.0
No	30	30
Total	100	100.0

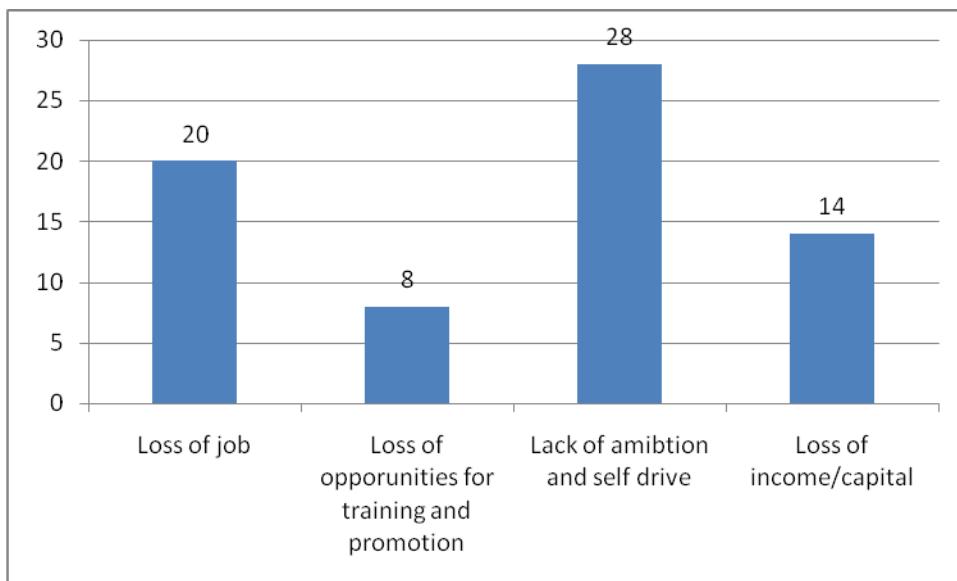


Figure 5: How living with HIV/AIDS affects income occupation and carrier

70% of respondents think that living with HIV/AIDS has affected their carrier and occupational activities. Majority of these report lack energy, ambition and self drive as a major factor. Significantly, about a quarter of the affected respondents report loss of a job due to HIV/AIDS.

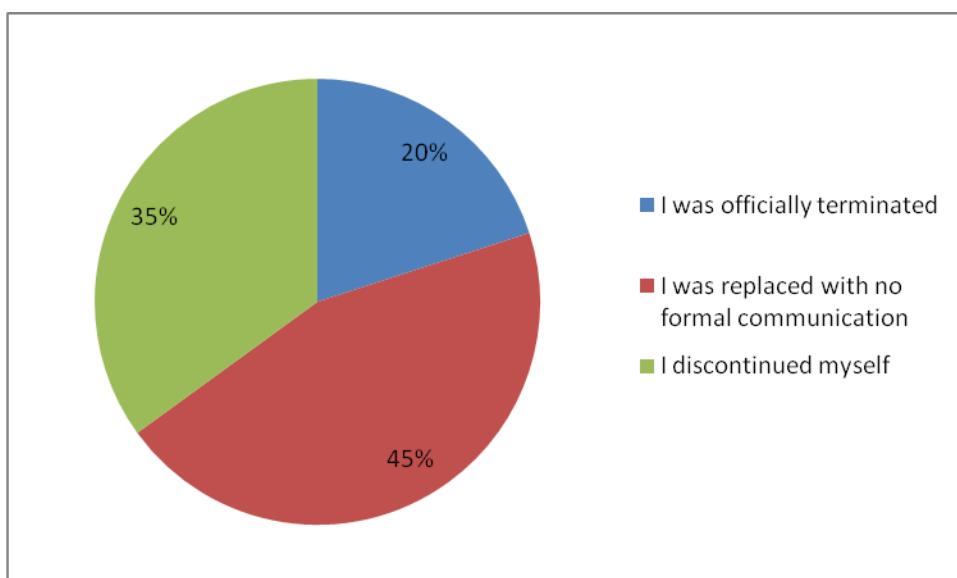


Figure 6: How the respondents who had lost their jobs had been terminated from work

Table 7: HIV related factors that led to loss of jobs

	Frequency	Percent
Prolonged absence from work	11	55
Discrimination because of my symptoms e.g. skin rash and weight	4	20
Loss of skill e.g. paralysis, blindness, tremors	4	20
Just my status	1	5
Total	20	100

Of the twenty respondents who had lost jobs because of HIV/AIDS, 55% had been absent from work as a result of prolonged illness and 45% were replaced at their workplace without any formal communication. Also a significant proportion of the workers: 35% discontinued themselves from their jobs.

4.2 Summary of results

The survey clearly revealed that the majority of respondents are ignorant about workplace HIV/AIDS policies, and their relevance to workers living with HIV/AIDS. It also shows that HIV testing is commonly done following a catastrophic event like a major illness or

loss of a family member and that there is still a lot of room to scale up VCT. Finally, 70% of respondents assert that living with HIV/AIDS has affected their carriers, occupational activities and income in different ways.

4.3 Discussion

WORKPLACE HIV/AIDS POLICY AND PRACTICE

The study clearly revealed that majority respondents are ignorant about work place HIV/AIDS policies, and that of the few who could confirm that they have one in their work place an even smaller proportion were involved in developing the policy. Many feel that their work places are not supportive of employees living with HIV/AIDS. The first step toward a workplace response to HIV/AIDS is the development of an HIV/AIDS policy. This is a set of guidelines and rules that are followed in dealing with matters regarding HIV/AIDS in the workplace. A good workplace AIDS policy is formulated in consultation with all employees regardless of their level of education or expertise, thus contrary to the survey results, all employees should have at least heard about an HIV/AIDS policy, and those who can confirm that they have one at their workplace should have participated in developing it. When the policy is developed with all employees involved, they own it, and even though it may not meet all their personal needs, employees will feel protected and supported by their workplace. The limitation to this finding is that the researcher did not consider specific features of the workplace like; size and number of employees. Smaller businesses tend to overlook such policies and responsibilities, leaving them for bigger institutions like banks, telecom companies and factories.

The HIV/AIDS human rights and legal services country assessment for Uganda in May 2008 summarizes that “while the country has received international praise for its response to the adverse medical effects of HIV/AIDS, it has paid limited attention to the epidemics legal and human rights implications. The employment act (2006) encompasses all the ideals regarding employees living with HIV/AIDS and strengthens the principles of the HIV/AIDS workplace policy. As far back as 2003, the Uganda Ministry of Gender, Labor and Social Development formulated a National Policy on HIV/AIDS and the World of Work. The goal of the policy is to “provide a framework for prevention of further spread of HIV/AIDS and mitigation of the socio-economic impact within the world of work in Uganda”. There is a clear gap between policy and practice whereby Government has not translated its commitments on paper into concrete deliverables. Additionally the policies lack effective monitoring and enforcement mechanisms and require more intensive advocacy in order to secure accountability”. Only 13% of the respondents had discovered their HIV status through VCT. This exposes a glaring gap in the workplace response to HIV; 90% of the respondents are within the working age range of 21-50 yrs. These people spend eight or more hours of everyday in the work place. VCT is an important component of the workplace response to HIV/AIDS, as it not only provides an incentive for workers to remain HIV negative but it also provides early diagnosis of HIV infection thus early treatment and prevention of complications and ultimately maintaining a healthy and productive workforce.

THE EFFECT OF HIV/AIDS ON WORKERS INCOME, CARRIERS AND OCCUPATIONAL ACTIVITIES

70% the respondents assert that living with HIV/AIDS has negatively affected their income and carriers. Majority report lack of energy, ambition, and self drive as major factors slowing down their income generating activities. About a quarter of these respondents report losing a job as a result of HIV/AIDS, sighting prolonged illness and absence from work as the commonest cause of termination from employment. Most of the employees who lost jobs were terminated without formal communication, while others discontinued themselves. These findings underscore the fact that HIV not only affects ones personal life but also their work and ultimately their employers. Work places can no longer afford to ignore the problem of HIV/AIDS, because if workers are lacking motivation and ambition, they are not of maximal productivity. Employers cannot afford to lose quality employees in whom they have invested time and money for training when they discontinue themselves for fear of stigma and discrimination in the work place. A workplace AIDS policy deals with issues of stigma and discrimination in the workplace, it addresses sick leave, termination due to incapacity and reasonable accommodation in the workplace. When put to practice, Issues of sick leave. Lack of ambition, missing opportunities for training and promotion and unlawful termination should be controlled, thus mitigating the impact of HIV/AIDS on carriers and occupational activities.

4.4 Recommendations

There is still a great need for employers whether private, or government to take up the responsibility and take centre stage in managing HIV/AIDS. They should focus on preventive measures like VCT, sensitization through talks, films and brochures at the workplace, provision of condoms and protecting those who are already infected from stigma, and discrimination. Where applicable, infected workers should be linked up with health care providers.

Government should invest in sensitization of the general public about the rights of people living with HIV/AIDS. This can be done through mass media campaigns, using radio, TV and newspapers, to send out messages against discrimination in the workplace, let the public know that it is unlawful to terminate a workers employment just because they are infected with HIV, and direct the public on where they can get legal aid, against related grievances.

Legal aid should be made available and affordable to fight for those who suffer discrimination and unlawful termination at the work place; Whereas there have been attempts to provide legal services for people living with HIV, the services targeting those who are affected and at risk are disproportionately poor. On the other hand meeting the need for HIV related legal services requires the public to generate a reasonable demand for the services. The demand for these services is still low because; people do not know their rights, they are fearful, powerless, and the services are expensive and inaccessible. Interventions by the LAW and Health Initiative (LAHI) should focus on taking advantage of preexisting systems. E.g. the country has established a wide network for care and treatment of HIV. Integrating legal services in programs providing health care would reach so many people, yet through a system that is already functional and organized. HIV legal services can also be integrated within already existing legal aid programs and in the local council courts. This should be done together with massive sensitization campaigns to demystify legal proceedings and direct the public to where and how legal services can be accessed.

Every employer, who has a critical number of employees, (e.g. 10 and more), should come up with an AIDS policy that is applicable within the unique situation and financial structure his organization, and this should be required by the law. Implementing this can be tagged along annual business licensing, to ensure that every business that is licensed to operate is aware of and responding to HIV/AIDS in the workplace. Finally, more effort and resources should be put into supervision, and implementation of the so many policies that already exist on paper.

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GLOSSARY

Living with HIV/AIDS	People who have had a confirmatory HIV/AIDS test and are receiving medical care for HIV/AIDS
Senior clients	Clients who have been attending the AIDS clinic for two years and more
Occupational activities	Income generating activities, including both employment and self employment
Employment	Working for someone else or for an organization, with regular predictable monthly income
Self –employment	working for oneself with predictable income
Unemployment	Able to work, yet unable to find a job No source of regular or predictable income Depending on others for economic support
Prolonged illness	being sick and unable to work for two weeks (14 days) or more
HAART	Highly Active Anti Retroviral Therapy
ARVs	Anti Retro Viral Drugs
Opportunistic infection	HIV/AIDS related illnesses as listed by the WHO clinical staging for HIV/AIDS
N/A	Not applicable

APPENDIX - QUESTIONNAIRE

QUESTIONNAIRE FOR PLWHA RECEIVING CARE FROM FAMILY HOPE CENTRE KAMPALA.

1. DEMOGRAPHIC PROFILE.

1.1 SEX.

- a) Male.
- b) Female

2.2 Age in yrs

1.3 MARITAL STATUS.

- a) Married
- b) Single
- c) Divorced/separated
- d) Widowed

EMPLOYMENT PROFILE

1.2 EMPLOYMENT STATUS

- a) Employed
- b) Unemployed
- c) Self employed
- d) Retired

1.3 TYPE OF EMPLOYER (current or former)

- a) Government
- b) Private
- c) Self

2. ASSESING THE CLIENTS KNOWLEDGE OF THE HIV/AIDS WORKPLACE POLICY

2.1 Have you ever heard about an HIV/AIDS workplace policy?

- a) Yes
- b) No

2.2 Do you have one at your place of work?

- a) Yes
- b) No
- c) I do not know
- d) N/A

2.3 If yes did you participate in developing your work place policy?

- a) Yes
- b) No
- c) N/A

2.4 Do you think that the work place policy on paper is being implemented in practice?

- a) Yes
- b) To some extent
- c) Not at all
- d) N/A

2.5 Do you feel that your work place is supportive of employees living with HIV/AIDS?

- a) Yes
- b) No
- c) N/A

2.6 Are there any areas that you think your workplace should be improved on?

- a) Sick and compassionate leave
- b) Terminal benefits
- c) Reasonable accommodation at the work place
- d) Stigma and discrimination in the work place
- e) N/A

3. HIV/AIDS AND WORK HISTORY

3.1 What prompted you to do the test that confirmed you were infected with HIV?

- a) Routine testing
- b) I was sick
- c) My spouse was sick
- d) Loss of a spouse or child

3.2 Have you ever been absent from work because of an AIDS related illness?

- a) Yes
- b) No
- c) N/A

3.3 Do you think that living with HIV/AIDS has affected your carrier and occupational activities?

- a) Yes
- b) No

3.4 If so; how?

- a) Loss of a job
- b) Loss of opportunities for training and promotion
- c) Lack of energy, ambition and self drive
- d) Loss of income/capital

3.5 If you have lost a job because of HIV/AIDS how did it happen?

- a) I was officially terminated
- b) I was replaced with no formal communication
- c) I discontinued myself
- d) N/A

3.6 Why do you think you lost your job?

- a) Prolonged absence from work.
- b) Discrimination because of my symptoms e.g. Skin rash and weight loss.
- c) Loss of skill e.g. paralysis, blindness, tremors.
- d) N/A