MANAGEMENT OF HIV/AIDS IN DIFFERENT

WORKPLACES IN Yaoundé-Cameroon

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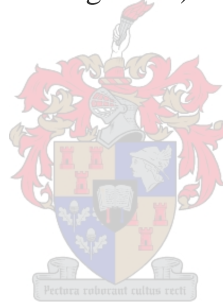
Assignment presented in partial fulfillment of the requirements for the degree of Master of Philosophy (HIV/AIDS Management) at Stellenbosch University



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DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

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ABSTRACT

HIV/AIDS is a generalised epidemic in Cameroon with a prevalence of 5.5%. Many studies have identified several groups of workers in Cameroon to be at high risk of HIV infection. Socio-economic statistics and simulation have reported HIV/AIDS to be a severe threat to the performance and survival of enterprises. The International Labour Organisation (ILO) and the State of Cameroon have developed policies, laws and regulations for the fight against HIV/AIDS in the workplace and for the protection and promotion of the rights of workers. Literature has yet to report sufficient implementation of such control provisions in the workplaces. I have reviewed the occurrence in and adequacy of Yaoundé-based workplaces with regard to HIV/AIDS from both the standpoints of providers (Management) and beneficiaries (Workers). A sample of 7 institutions from sectors such as public service, international organisations, and NGOs was investigated. A total of 7 providers and 32 beneficiaries participated. Observation was the reference method where the technique of individual interviews was used.

Generally, prevention, care and support programmes in workplaces were found to be non-existent or embryonic. Institutions seemed to still behave as if they were exempt from the problem, being only providers for others in the general population, and nothing more. Refusal to participate in the study indicated some self censure despite the fact that institutions acknowledged both the severity of the problem and their failure to put an adequate programme in place.

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OPSOMMING

Die doel van die studie is ‘n ondersoek na die hantering van MIV/Vigs in ‘n aantal geselekteerde ondrnemings in Cameroon in Wes-Afrika. ‘n Gestruktureerde vraelys is gebruik om die data te versamel.

Resultate dui daarop dat daar verskeie ondernemings in Cameroon is wat nog nie veel gedoen het om die pandemie te beveg nie. Voorstelle word gemaak vir ‘n voorkomings-en ondersteuningsprogram vir Cameroon.

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LIST OF ACRONYMS

AIDS: Acquired Immuno Deficiency Syndrome

ARV: Anti-retroviral

VCT: Voluntary Counselling and Testing

DHS: Demography and Health Survey

DAP: Does not apply

DNK: Does not know

HIV: Human Immuno Deficiency Virus

ILO: International Labour Organisation

HAART: Highly Active Antiretroviral Therapy

MSP: Ministry of Public Health

MINAS: Ministry of Social Affairs

MINDEF: Ministry of Defence

NA: Not Availible

NAP: Not Applicable

NB: Nota Bene

NRP: No Reply

OVC: Orphans and Vulnerable Children

PLWA: People Living with AIDS

Q and A: Question and Answer

UNICEF: United Nations Children Fund

UNDP: United Nations Development Programme

UNFPA: United Nations Population Fund

STI: Sexual Transmitted Infections

STD: Sexual Transmitted Diseases

SPSS: Statistical Package for Social Research

VCT: Voluntary Counselling and Testing

WHO: World Health Organisation

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PART I: THEORETICAL FRAMEWORK

Chapter 1: INTRODUCTION

1. BACKGROUND

1.1. Country and HIV/AIDS

Cameroon is located in central Africa with an estimated population of 16 900 000 (UNFPA – state of world population 2007). The heavy burden and the socio-economic impact of the HIV/AIDS pandemic are well recognized. From 1986 to 2004, the HIV sero-prevalence increased significantly from 0.5% to 5.5%.

One of the most frightening indicators of the effect of HIV/AIDS in Cameroon is the rapid decline in life expectancy. Before the onset of HIV/AIDS, average life expectancy in the country was expected to increase to 60 years in 2003. It was estimated to be only 40 years by 2005 taking into account the findings of the Demography and Health Survey 2004.

With HIV/AIDS deepening poverty, eroding public sector's capacity to deliver public services and undermining people's quality of life, the outlook for human development is quite negative. Despite various efforts, Cameroon prospects for realising the Millennium Development Goals (MDGs) are diminishing rapidly. Hence there is concern and a commitment from the Government and peoples of Cameroon, as well as from international partners, to search for ways of stepping up the fight against the pandemic.

The HIV/AIDS pandemic in the country is a major public health concern which has led to the development of a National Strategic Plan to combat the scourge using a multi-sectored approach. The first National Strategic Plan to combat HIV/AIDS was launched by the Prime Minister, as the Head of the Government, on the 13th of September 2000. With the support of development partners, the Government launched a second National Strategic Plan of Action in the fight against HIV/AIDS on the 1st of March 2006, which includes: prevention, care and support in the Public Sector, Private Sector and the Civil Society. This programme is made up of the training of peer educators and counsellors, the provision of drugs for opportunistic diseases, and the provision of care and support where it is needed.

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1.2. Workplace and HIV/AIDS in Cameroon

1.2.1. Impact

Comprehensive Research has not been conducted in Cameroon to measure the impact of HIV/AIDS in the workplace. Nevertheless, many studies (CARE, IRESCO, Ministry of Defence) have identified some socio-professional categories as high risk groups. These include the following groups with their corresponding HIV/AIDS prevalence rates:

Table 1 Prevalence of HIV/AIDS among some target groups

Group	**%**	**Source**
Truck Drivers	13.2	Sero-epidemiological and behaviour study: CARE Cameroon Ministry of Public Health August 2004
Armed Forces	11.2	Sero-prevalence and behavioural study among Armed Forces, June 2005

1.2.2. Labour Response

- **Generalities**

In Cameroon, the management of HIV/AIDS in the workplace is a priority for the Government through the Ministry of Labour and Social Security. This is grounded in the fact that HIV/AIDS erodes Cameroon's greatest asset, its people, and thus threatens its very survival as a nation. It is one of the most important development challenges facing the country. Provisions of the second National Strategic Plan of Action for the fight against HIV/AIDS entails delivery at the workplace of services such as training of peer educators, counsellors, and provision of drugs for opportunistic diseases, care and support.

Employers and employees have a vital role to play in the fight against HIV/AIDS in the workplace and in the community as a whole. The recognition that the HIV/AIDS is an issue of concern both for the employer and the employee is getting employers committed in the fight against HIV/AIDS.

The challenge is to find and replicate efficient and cost-effective interventions that limit the spread of the infection and mitigate its impact. Actions increase daily, ranging from prevention, provision of anti-retroviral drugs and care to support services.

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Involvement of employers has been made easier by, firstly, the reduction in the price of antiretroviral drugs (thanks to the World Bank Multi-Country Aids Programme) and, secondly, a partnership with the Ministry of Public Health through which the latter provides financial and technical support.

The provision of care, including antiretroviral treatment, is being introduced in a context of growing concern about the human and socio-economics consequences of the pandemic on the one hand, and of new opportunities created by the lowering of drug prices and the availability of increased resources, on the other hand. Concerted efforts are being made to increase funding through mechanisms such as the World Bank Multi-Country AIDS programme (MAP) and with Global Funds for the fight against HIV/AIDS, Malaria, and Tuberculosis.

The imperative for the labour community is to contribute to national and international efforts in controlling the spread of HIV/AIDS, and in managing and mitigating its impact.

- **Effective learning programmes on HIV/AIDS in the workplace**

Effective workplace learning programmes need to do more than provide information on risk factors alone. Experience has shown that such programmes have met with only limited success. The learning challenge is to ensure that risk information is provided, but then to go beyond this 'intellectual' or knowledge-based learning to a deeper level that results in attitudinal and behavioural changes.

The pandemic has emerged as a major health and developmental crisis, threatening to roll back progress made over the past three decades and eroding the potential for making progress against the Millennium Development Goals. Therefore, there is considerable commitment on the part of the Government of Cameroon to address HIV/AIDS, but this commitment has yet to be translated into concrete and strategic actions that can fully empower the people of Cameroon to overcome the HIV/AIDS crisis.

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2. STATEMENT OF THE PROBLEM AND JUSTIFICATION OF THE STUDY

2.1. The Problem

2.1.1. **Fact 1: In Cameroon as elsewhere workers are among those highly at risk**

Many studies have identified certain socio-professional categories as groups at risk of HIV infection (Mpoudi; Sero-epidemiological and Behavioural Study among Men in Uniform in June 2005 and Demography and Health Survey -Cameroon 2004). These categories include workers whose workplace and resulting social situation increase their risk of infection. The National Aids Control Committee has listed the following groups of workers to be at high risk of infection with HIV:

- Men in uniform;
- Truck drivers;
- Sex workers;
- Health professionals;
- Migrant and mobile workers;
- Sea port communities;
- Teachers (prevalence varying from 5 to 28%);
- Workers on industrial farms.

Such groups are listed as key targets/partners of AIDS control activities in the Strategic National Plan for the Control of HIV/AIDS.

2.1.2. **Fact 2: AIDS is a severe threat to the life Institutions**

Organisations survive by providing services or producing other kinds of output, with the aim of making profits. Labour is one of the inputs in the production of goods and services. HIV/AIDS increases costs, reduces the productivity of individual workers and changes the organisation's operating environment in the following ways:

- Increased absenteeism, which is a result of illness and frequent time-consuming funeral ceremonies;
- Falling productivity, as workers whose physical or emotional health is failing will be less productive and unable to do more demanding jobs;

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- Employees who die or retire on medical grounds have to be replaced and their replacements may be inexperienced and less skilled;
- Recruitment and training of replacement workers and hence increased payroll costs to cover absenteeism; and
- As skilled workers become scarcer, wage rates may increase.

The business environment may change with investors reluctant to commit funds if they think HIV/AIDS and its impact will compromise their investments and returns (Barnett and Whiteside).

The impact of HIV and AIDS needs to be understood at three levels:

- Individual, personal or employee level;
- Enterprise, organization or workplace level; and
- Macro- or societal level.
- For the employee, HIV/AIDS brings fatigue, physical pain, fear of death, loss of friends, and lowered morale, work performance and motivation. Later it may result in dismissal, separation package or early retirement and finally death.

A number of factors will influence the susceptibility of organisations and classes of employees. These include the location of the workplace, the location of employees' families in relation to the workplace, the travel requirements of employment, the level of knowledge of HIV and individual risk behaviour.

2.1.3. **Fact 3: Although workers are known to be at high risk in many circumstances and HIV/AIDS compromises working institutions, a prompt and adequate response towards controlling the pandemic in the workplace is generally delayed.**

2.1.4. **Problem:** From empirical evidence and the above facts or tendencies, it does not seem obvious, the gravity of the burden of HIV/AIDS non-withstanding, that effective and appropriate actions are taken towards the control of the pandemic in the workplace.

Study justification

Based on the urgency for the setting up of a workplace response worldwide, and also in the Cameroon, this study intends to shed light on the response to HIV/AIDS in the workplace in

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the Yaoundé environment. This shall satisfy a critical research mission, namely pointing out, describing or sizing up problems to raise awareness and to instruct or improve intervention.

A number of factors have motivated the choice in this assignment to investigate the situation and prospects of the workplace response to HIV/AIDS, including facts listed below:

- The fight against AIDS is becoming a priority in Cameroon
- Well-spelt out guidelines have been provided to the workplace by the ILO since 2004
- The background of the author includes an intensive and long-term involvement and interest in activities related to the control of HIV/AIDS in the workplace.

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Chapter 2: RESEARCH QUESTIONS AND DEFINITION OF CONCEPTS

2.1 Research Objectives or Questions

This assignment plans to answer the questions below:

General question:

- ***What are the situation and future prospects of the workplace response to the HIV/AIDS pandemic challenge in Yaoundé?***

Specific questions:

- ***Have employers developed a response to the HIV/AIDS pandemic in workplaces based or represented in Yaoundé?***
- ***How is the workplace response structured in Yaoundé; does it include policies and programmes?***
- ***Are the existing workplace responses to HIV/AIDS operational and in conformity with ILO norms and standards?***
- **Would they offer opportunities to foster effective learning and ensure that all employees understand the policy and experience a supportive and compassionate work environment free of fear and discrimination?**
- ***What are the future prospects towards improving on the situation of the workplace response in Yaoundé?***

2.2 Operational definitions of concepts with regards to HIV/AIDS in the workplace:

Need for a workplace HIV/AIDS control programme: The presence of one or more of the factors listed below

a) risk of being infected with HIV/AIDS;
b) presence of People living with HIV/AIDS (PLWA) among the staff;
c) risk of stigmatization of PLWA;
d) risk of discrimination of PLWA;
e) risk of the non-attainment of the workplace's objectives because of the impact of HIV/AIDS on the workforce, on the institution's social environment and on its financial resources.

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Response to HIV/AIDS: Any endeavour to control HIV/AIDS and its effects.

Situation of workplace response: The configuration of the workplace response, whether operational, conforming and effective.

Workplace response: Services provided by a workplace or working institution towards prevention or treatment of HIV/AIDS for staff members and their families.

Operational workplace response: A workplace response is termed operational if proposed activities are implemented, followed up, monitored and evaluated.

Conforming workplace response: A workplace response is termed conforming if national and international requirements on the delivery of HIV/AIDS services are being met, including ethical requirements.

Effective workplace response: A workplace response will be termed effective if set objectives are met (internal effectiveness) and if objective improvements are observable and measurable.

2.3 Expected results

- **Description of the service provided for the control of HIV/AIDS in Yaoundé workplaces**
- **Description and ranking of the operationality of HIV/AIDS control efforts in workplaces**
- **Description and ranking of the efficiency of HIV/AIDS control efforts in workplaces**
- **Description and ranking of the conformity of HIV/AIDS control efforts in workplaces**
- **Description of staff-proposed options for improving the situation**

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Chapter 3: LITERATURE REVIEW AND SCIENTIFIC INTEREST OF THE STUDY

3.1 Literature Review

The existing literature on the management of HIV/AIDS in the workplaces in Cameroon includes 2 studies respectively conducted by Professor Bikanda in 2005 and the Institute for Research, Socio-economic Development and Communication (IRESCO) in 2005.

Professor Bikanda's investigations concerned the evaluation of politics and programmes for response against HIV/AIDS in the workplace. The sample included thirty five institutions (30 enterprises and 5 ministries). The work reviewed the activities of existing programmes and described the handling of PLWHA as concerns recruitment, promotion and benefiting of social advantages such as social security.

IRESCO's investigations described the existence of politics, programmes and activities in institutions of civil society (formal and informal), as well as the juridical provisions for the protection of PLWHA in the working environment. Results showed the existence of activities in the different institutions – both embryonic and developed. Prevention activities were the most frequently found. The non respect of confidentiality resulted in PLWA not benefiting from services intended for them. Sensitisation and promotion of condom use were the main activities in the informal sector. IRESCO's work gave a picture of the state of the programmes but did not question that state.

3.2 Scientific Interest

My study plans to investigate all sectors at once, beyond the respective partial coverage of the scenery by preceding studies. However, I will exclude the informal sector because it generally does not qualify for autonomous structured programmes.

Compared to Professor Bikanda's investigations, beyond the existence of policies and programmes and their functionality, my investigation aim at determining whether targeted workers actually do receive HIV/AIDS services so that they can be the main beneficiaries of policies and programmes.

Beyond the findings of IRESCO, our study will determine how much the main targets (workers) do benefit from programmes. Furthermore, our investigations intend to explore prospects for the improvement of the management of HIV/AIDS in the workplace.

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Chapter 4: METHODOLOGY

4.1 Research Design

The study used both quantitative and qualitative information to analyze the challenges faced by different organizations in Yaoundé, Cameroon, with regards to the impact of HIV/AIDS in the workplace.

A qualitative study of a phenomenological nature was carried out. The technique used was the in-depth interview. The technique allowed for description of their experience by respondents, description of the meaning and interpretation of their experience.

A non-experimental quantitative study was carried out to collect numerical data describing HIV/AIDS services at workplaces, outlining factors and relations between respective variables.

The research used a ***factorial design.*** In this design two or more independent variables are simultaneously studied to determine their independent and interactive effects on the dependent variable (Christensen 2001 by Allyn and Bacon).

Further on in this chapter, the target institutions, the sampling procedure, data collection instruments, data analysis, constraints and lessons learnt from conducting the research are described.

4.2 Target population

The target population consisted of five (5) types of organisations working in Yaoundé, the capital of Cameroon, which are:

- **Non-Governmental Organizations** (NGOs)
- **Enterprises in the private sector**
- **International development partner organisations (diplomatic missions/donors**):
- **State-funded enterprises (para-statal sector)**
- **Governmental institutions (public sector)**

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4.3 Sample

4.3.1 Sampling procedure

A list was compiled of non-governmental, private sector, development partner, para-state sector and governmental organisations operating in Yaoundé.

A random sampling of 4 organisations from each category was selected through balloting and surveying. A total of 20 organisations were targeted.

In each organisation, the focal person in charge of the coordination of the control of HIV/AIDS in the workplace was contacted, as well as staff members. The purpose of the survey and its advantages to the organisation were explained and informed consent sought and gained before the commencement of the data collection. Staff members (beneficiaries) were systematically included by sampling office door numbers from a ballot.

4.3.2 Observed Sampled Institutions

Investigations were allowed at 7 institutions in Yaoundé from 3 workplace sectors, namely the public sector (2 ministries), the non-governmental sector (1 NGO) and the international sector (4 UN agencies).

Table 2: Sampled institutions by workplace sector
N=7

Institution	Sector			Total
	Public	**Non-governmental**	**International**	
CARE Cameroon	0	1	0	**1**
MSP/DLM	1	0	0	**1**
MINAS	1	0	0	**1**
UNDP	0	0	1	**1**
UNFPA	0	0	1	**1**
UNICEF	0	0	1	**1**
WHO	0	0	1	**1**
TOTAL	**2**	**1**	**4**	**7**

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4.3.3 Respondents

Among the 39 observed respondents there were 7 providers (Management) and 32 beneficiaries (Workers). In numbers, providers varied from 0 to 2 per institution, while beneficiaries ranged between 1 and 8. Table 3 below describes this information.

Table 3: Sampled individuals by institution and working sectors
N=39

Institution	Sector						Total	
	Public		**Non Governmental**		**International**			
	Providers	Beneficiaries	Providers	Beneficiaries	Providers	Beneficiaries	Providers	Beneficiaries
CARE Cameroun	0	0	3	8	0	0	3	8
MSP/DLM	1	7	0	0	0	0	1	7
MINAAS	2	7	0	0	0	0	2	7
UNDP	0	0	0	0	1	1	1	1
UNFPA	0	0	0	0	0	3	0	3
UNICEF	0	0	0	0	0	1	0	1
WHO	0	0	0	0	0	5	0	5
TOTAL per category	3	14	3	8	1	10	7	32
TOTAL per sector	17		11		11		39	

4.4 Data collection

Two semi-structured interview guides were used. Investigated variables included:

a. The socio-demographic characteristics of the focal person(s) in charge of the control of HIV/AIDS in the workplace (providers), the staff and the organisation.
b. The existence of a written policy on the control of HIV/AIDS in the workplace.
c. The operationality of the policy on the control of HIV/AIDS in the workplace.
d. The inclusion in programmes of characteristics such as :
   - Association of PLWA,
   - Anonymous voluntary counselling and testing,
   - Accessibility to Highly Active Antiretroviral Therapy HAART and case management facilities,
   - Support from healthy people (Non PLWA),
   - Discrimination and social stigma,
   - Employment benefits for PLWA,

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- Employment assurance.

e) The proposed implementation strategy for non-operational policies.

f) The existence and functioning of evaluation or ways of improvement.

4.5 Data management and analysis

Data collected was checked for the use of correct codes and completeness by the investigator. Where possible, uncompleted or poorly filled-in interview guides were returned to respondents for completion or correction.

The data was double-keyed into a computer by two data clerks using Statistical Package for Social Sciences (SPSS) and analysed by a statistician.

Dependent variables were:

Respond effectively/positively – This measured the impact of HIV/AIDS in the workplace in the organisation.

Effective learning – This measured the knowledge of the policy.

Independent variables were:

The impact of HIV and AIDS – This is the variable that can be manipulated. It is responsible for producing effects. *An opportunity to foster and experience a supportive and compassionate work environment* are also variables which can be manipulated and produce effects.

Statistical procedures used:

Tables – to show the main and interactive effect which is the influence of one dependent variable.

Graphs – to illustrate different kinds of main and interactive effects.

Percentages – to illustrate the proportions of different modalities of programs across the profiles of respondents in different organisations.

4.6 Involvement of leadership at different sectors/levels in the response to the challenge.

A national, multi-sector response to HIV/AIDS is not only contingent on the commitment and active involvement of individual leaders, leadership structures and government, but also of religious organisations, non-governmental organisations, community groups and community-

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based organisations, cultural groups, the private sector and trade unions. Given the scope and nature of the pandemic, all sectors of society need to be mobilized to play their part in stemming the pandemic and turning the country into an HIV/AIDS competent society. This is why this project will work with different organisations.

The study uses both quantitative and qualitative information to analyze the challenges faced by different organizations in Yaoundé, Cameroon, concerning the impact of HIV/AIDS.

4.7 Speculated Results

The findings will be presented according to the hypothesis, to be analyzed, rejected or confirmed depending on the data collected. General observations will also be described and the findings related to the literature reviewed in the previous sections.

4.8 Study implementation and lessons learned from the study experience

4.8.1 Research Experience

Data collection lasted 3 months instead of the planned 1 month because of a wide range of bottlenecks as listed below:

Non-adherence to the proposed data collection technique: many respondents insisted that the interview guides be given to them to complete and submit later on, instead of sitting with an investigator for an interview.

Non-availability (very busy staff) or the claim thereof: was widely prevalent, especially among United Nations agencies' staff.

Refusals**:** were also very common. Some institutions, apparently to avoid public disclosure of a weakness on their part, did not want to undergo what they perceived as an "evaluation" (the study) with their workplace response not yet in place.

Dearness: Investigations in the workplaces turned out to be both time- and money-consuming because of a rampant tendency by respondents to postpone interviews and the filing of submitted interview guides.

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Denial of responsibility: regional or local representatives of Yaoundé-based privately and state-funded organisations passed the application form for authorisation of the study to their general manager located in a different city to escape taking responsibility themselves, as they feared the sensitive nature of the study.

Context non-conducive to research: Generally research is misunderstood and there is a lack of interest in it on the part of potential participants in the country because of inadequate cultural, educational and economic backgrounds. Respondents would therefore, among other shortcomings, fear, distrust, exploit or dupe the research. During the study many respondents wanted to know what they would earn by replying to the questions.

4.8.2 Future prospects

We suggest the following for the improvement of the implementation and success of workplace studies related to the control of HIV/AIDS:

a) Appropriate budgeting and fundraising before undertaking such investigations in the future;
b) Conducting of advocacy at high level in the target institutions for study acceptance. Institutions that are reluctant because of they have no programmes must be doubly prepared, including being given a demonstration of the interest of the study in their pre-programme situation;
c) The investigation should be better afforded time, including being considerate of the necessary time a student-worker needs to take off in order to devote him- or herself to the study;
d) The investigation should be organised in such a way as to ensure that interviews are conducted face-to-face in order to avoid high rate of inadequate answers or absence of answers;
e) An investigator with some reputation and working experience in the field would attract answers, benefiting from the trust of the respondents;
f) Activities are needed at the national level (ministries in charge of education and research, media, research institutions, universities) in order to establish a culture conducive to research;
g) Studies on workplace responses to HIV/AIDS do not seem to be a first choice for busy/working students as they are excessively time consuming for doable management within the time span for a master's assignment.

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h) Studies require extensive backing from a competent gatekeeper of the target environment. Being introduced to the different institutions by such a person is critical to avoiding extensive rejection.

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PART II: PRESENTATION OF RESULTS

Chapter 5: CHARACTERISTICS OF RESPONDENTS

5.1 Sampled institutions

The descriptions that follow of the characteristics of sampled institutions include their size (number of staff), their gender balance, existence of mobile workers, existence of international staff and existence of external offices as such patterns are involved in the dynamics of HIV/AIDS and its impact. The size of institutions varied from 15 to 854 staff members. Gender ratio is generally balanced or in favour of women (variation: 0.39 to 1.4 female per male). Only one institution (CARE Cameroon), out of the 7 investigated recorded a negative ratio with regards to women. All institutions had mobile workers while 5 employed international workers and two had external offices.

Table 4: Size, gender balance, existence of mobile and international workers and presence of external services by institution

Institution	**Characteristics**							
	Size μ	**Gender balance**			**Existence of Mobile Workers***	**International staff**		**Existence of External Offices***
		Female	Male	Ratio: F/M		Existence*	Number of international staff members	
CARE Cameroon	95	27	68	0.39	1	1	5	1
MSP/DLM	15	7	8	0.87	1	0	0	0
MINAAS	854	43	42	1.02	1	0	0	1
UNDP	48	28	20	1.4	1	1	40	0
UNFPA	NA	NA	NA	NA	1	1	NA	NA
UNICEF	NA	NA	NA	NA	1	1	NA	NA
WHO	NA	NA	NA	NA	1	1	NA	NA
TOTAL	1012	105	138	0.76	7	5	45	2

μ Number of staff members

* Yes=1, No=0, NA=Not Available

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5.2 Sampled individuals

The characteristics of sampled respondents comprised the following variables: sex, age, marital status and size of family of the respondent on the one hand and his or her position and working mobility on the other hand. Such aspects are among the factors considered by scientists and policy makers as critical in regard to HIV/AIDS transmission and control in the workplace. Observed individuals included service providers (those in charge of human resources of and/or HIV/AIDS programmes in the respective institutions) and beneficiaries (staff members entitled to receiving services from workplace HIV/AIDS programmes/activities).

5.2.1 Distribution of providers according to sex

The providers consisted of 3 females and 4 males varying from 0 to 3 per institution, as shown in table 5 below.

Table 5: Distribution of sex among the sub-sample of observed providers

Institution	Characteristics		
Sex→	Female	Male	TOTALS
Age→	NA	NA	NA
CARE Cameroon	2	1	3
MSP/DLM	0	1	1
MINAS	0	2	2
UNDP	1	0	1
UNFPA	0	0	0
UNICEF	0	0	0
WHO	0	0	0
TOTAL/AGE	NA	NA	NA
TOTAL/SEX	3	4	7

NA= Not Available

5.2.2 Distribution of beneficiaries according to sex:

Observed beneficiaries amounted to 9 females and 23 males. Age distribution depicted 1 person (a male) to be less than 30 years old; 11 persons between 31-40 years old (3 females, 8 males); 16 persons aged 40 years onwards (5 females, 11 males) and 4 persons whose age was unknown (1 female, 3 males).

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Table 6: Sex distribution of the sub-sample of observed beneficiaries

Institution	Characteristics of respondents											
Sex→	**Female**				**Male**				**TOTALS**			
Age→	20-30	31-40	40+	NA	20-30	31-40	40+	NA	20-30	31-40	40+	NA
CARE Cameroon	0	1	1	0	1	4	1	0	1	5	2	0
MSP/DLM	0	0	1	0	0	1	3	1	0	2	4	1
MINAAS	0	1	1	0	0	2	3	1	0	2	4	1
UNDP	0	0	0	1	0	0	0	0	0	0	0	1
UNFPA	0	1	0	0	0	0	2	0	0	1	2	0
UNICEF	0	0	1	0	0	0	0	0	0	0	1	0
WHO	0	0	1	0	0	1	2	1	0	1	3	1
TOTAL/AGE	0	3	5	1	1	8	11	3	1	11	16	4
TOTAL/SEX	9				23				32			

*Yes=1, No=0, NA= Not Available

5.2.3 Distribution of beneficiaries according to the matrimonial status, the size of their nuclear family and their mobility at work

Replying was not exhaustive as seven (21.9%) respondents did not state either their matrimonial status or the size of their family, and 3 (9.4%) did not report about their mobility at work.

Factors exposing staff to risky sex (such as absence of marriage, working out-of-station) were notably prevalent. Many participants (11/32; 34%) did not state their marital status. From the collected answers, 19% reported being non-married (single: 13%; divorced: 3%; widowed: 3%). Mobile workers were a notable part of the staff (10/32; 31%). Families of respondents generally varied between 1 and 5 children (17/32; 53%).

Table 7: Distribution of the sub-sample of observed beneficiaries against matrimonial status

Institution	Characteristics												
	Marital Status					**Size of Family**					**Working Mobility**		
	Single	Married	Divorced	Widowed	NA	0	1-5	6-10	more	NA	NA	YES	NA
CARE Cameroon	2	4	0	0	2	0	6	1	0	1	4	3	1
MSP/DLM	1	3	1	0	2	0	3	3	0	0	6	1	0
MINAAS	0	4	0	0	3	0	4	3	0	0	2	5	0
UNDP	0	0	0	0	1	0	0	0	0	1	1	0	0
UNFPA	0	3	0	0	0	0	1	0	0	2	1	1	1
UNICEF	0	0	0	1	0	0	1	0	0	1	1	0	0
WHO	1	1	0	0	3	0	2	0	1	2	3	0	2
Column TOTAL	4	15	1	1	11	0	17	7	1	7	18	10	4
Column %	13%	47%	3%	3%	34%	0%	53%	22%	3%	22%	56%	31%	13%
Category TOTAL	32					32					32		

The standard distribution statistics of the size of families of beneficiaries were as follows:

Valid answers	25
Missing answers	7
Mean	4.76
Median	4.00
Mode	4

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Chapter 6: DESCRIBING EXISTING SERVICES FOR THE CONTROL OF HIV/AIDS (PREVENTION AND CARE)

6.1 Existence of regulatory provisions for the control of HIV/AIDS

Statements on the existence of regulatory provisions for the control of HIV/AIDS in all categories of respondents were below average (4/10th). A discrepancy was noted between providers (6/10th of them affirming) and beneficiaries (4/10th) of them affirming). This raised uncertainty about the addressed provisions, evidenced understanding of the issue among respondents and the need for adequate communication about it in the respective institutions.

Table 8: Existence of regulatory provisions for the control of HIV/AIDS
N=39

Institution	Providers			Beneficiaries			TOTAL		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
CARE Cameroon	0	3	0	2	6	0	2	9	0
MSP/DLM	1	0	0	1	5	1	2	5	1
MINAAS	2	0	0	5	1	1	7	1	1
UNDP	1	0	0	1	0	0	2	0	0
UNFPA	0	0	0	1	2	0	1	2	0
UNICEF	0	0	0	1	0	0	1	0	0
WHO	0	0	0	2	2	1	2	2	1
Column Total	**4**	**3**	**0**	**13**	**16**	**3**	**17**	**19**	**3**
Column proportion	**6/10**	**4/10**	**0/1O**	**4/10**	**5/10**	**1/10**	**4/10**	**5/10**	**1/10**
Category Total	**7**			**32**			**39**		

6.1.1 Existence of prevention programmes for HIV/AIDS in the workplaces

Less than 4/10th of the respondents acknowledged the existence of a prevention programme in their institution. All institutions were reported by at least one person to have some, making contradiction almost universal, as only one institution (UNICEF) did not record both Yes and No answers. Cross-checking of the general statement on the existence of a prevention

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programme with the availability of specific services evidenced actual programmes in a minority of institutions (2 among the 7 investigated) (MINAS and UNDP).

Table 9: Existence of a prevention programme across the institutions
N=39

Institution	**Providers**			**Beneficiaries**			**TOTAL**		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
CARE Cameroon	0	3	0	1	7	0	1	10	0
MINAAS	2	0	0	5	1	1	7	1	1
MSP/DLM	0	1	0	1	5	1	1	6	1
UNDP	1	0	0	0	1	0	1	1	0
UNFPA	0	0	0	2	1	0	2	1	0
UNICEF	0	0	0	1	0	0	1	0	0
WHO	0	0	0	2	3	0	2	3	0
Column Total	**3**	**4**	**0**	12	18	2	**15**	**22**	2
Column proportion	**4.3/10**	**5.7/10**	**0/10**	**3.8/10**	**5.6/10**	**0.6/10**	**3.8/10**	**5.6/10**	**0.5/10**
Category Total	**7**			**32**			**39**		

6.1.2 Delivered prevention services

- ***Delivery of Voluntary Testing and Counselling (VCT)***

In 2.8/10th of the institutions (2 out of the seven institutions) the non-delivery of VCT was reported. For the majority of institutions (7.2/10th) where the service was reported to be offered, it was universally reported as offered in only one institution (1.4/10th). Overall, across the different institutions, 65.62% of responding beneficiaries stated that they were not exposed to Voluntary Testing and Counselling.

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Table 10: Delivery of Voluntary Testing and Counselling (VCT) as stated by beneficiaries

Institution	**Delivery of VCT**			
	Yes	**No**	**NA**	**TOTAL**
CARE Cameroon	**0**	**8**	**0**	**8**
MINAS	**3**	**3**	**1**	**7**
MSP/DLM	**1**	**6**	**0**	**7**
UNDP	**0**	**1**	**0**	**1**
UNFPA	**1**	**2**	**0**	**3**
UNICEF	**1**	**0**	**0**	**1**
WHO	**2**	**1**	**2**	**5**
TOTAL	**8**	**21**	**3**	**32**
%	25.0	65.6	9.4	100.0

- ***Delivery of education for HIV prevention***

Delivery of education for the prevention of HIV was stated in all the institutions (7/7). But the statement faced contradiction in more than half of the institutions (5.7/10th;4/7). Such a situation indicates non-exposure in 46.9% of the respondents (target beneficiaries).

Table 11: Delivery of education for HIV prevention as stated by beneficiaries

Institution	**Delivery of education for HIV prevention**		**Total**
	Yes	No	
CARE-Cameroon	2	6	8
MINAS	7	0	7
MSP/DLM	1	6	7
UNDP	0	1	1
UNFPA	1	2	3
UNICEF	1	0	1
WHO	5	0	5
Total	17	15	32
%	53.1	46.9	100

- ***Delivery of the Distribution of Condoms***

Condom distribution was reported by 43.8% of the target beneficiaries, with the majority (53.1%) saying the service was not offered to them. The service was stated in all 7 institutions

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(10/10th) while contradiction emerged in 7.1/10th (5 out of the 7) of the cases.

Table 12: Delivery of the distribution of condoms

Institution	**Delivery of condom distribution**			
	Yes	NR	NA/NRP	TOTAL
CARE-Cameroon	4	4	0	8
MINAS	3	3	1	7
MSP/DLM	1	6	0	7
UNDP	1	0	0	1
UNFPA	1	2	0	3
UNICEF	1	0	0	1
WHO	3	2	0	5
Total	14	17	1	32
%	**43.8%**	**53.1%**	**3.1%**	**100.0%**

NA= Not Available, NRP= No Reply

- ***Delivery of screening for Sexual Transmitted Infections/Diseases***

A significant majority of respondents appeared not to be offered screening for STIs at the workplace as 78.1% of answers were in the negative across the 7 institutions. In all but one (8.6/10th of the institutions; 6 out of the 7) respondents affirmed the absence of screening for STIs. Yet there was a single exception to this negation in (0.5.7/10th; 4/7) of the institutions.

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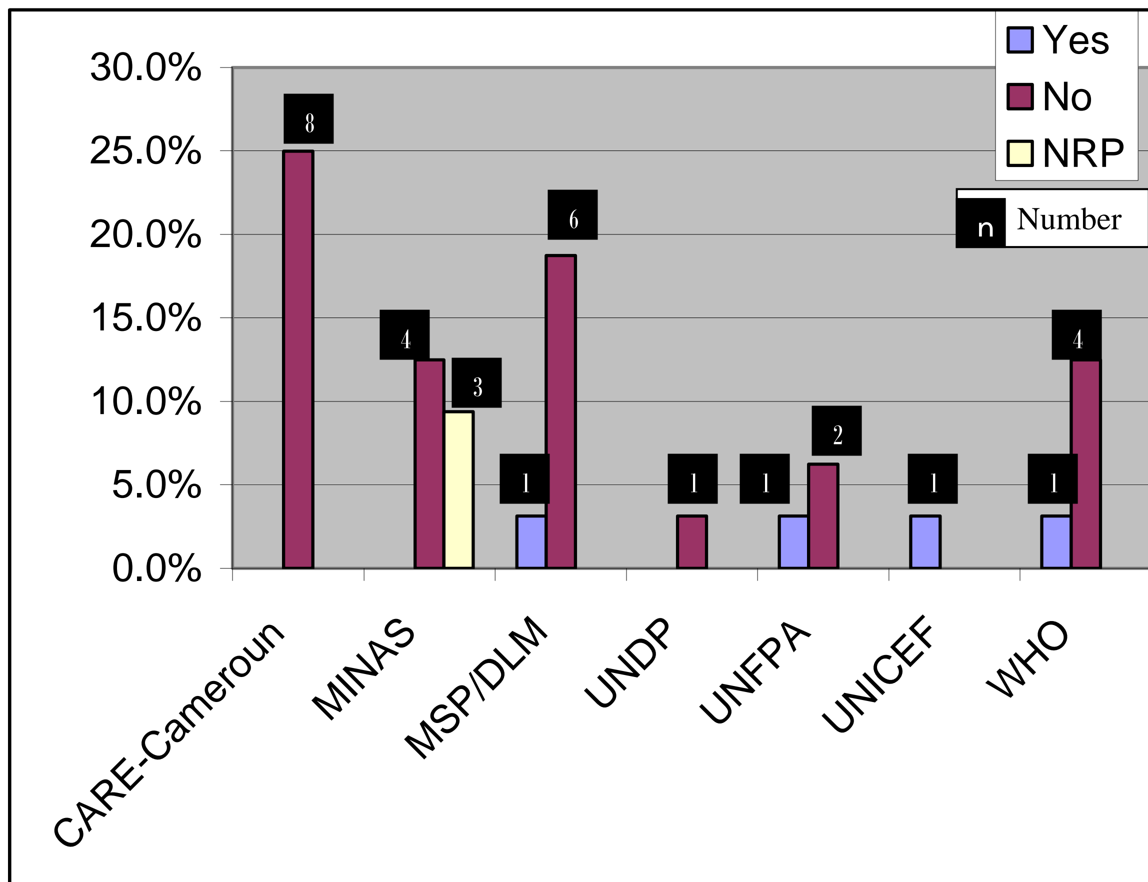
Graph 1: Delivery of screening for STIs



Delivery of screening for STIs				
Statements	Yes	No	NRP	Total
n	4	25	3	32
%	12.5	78.1	9.4	100.0

NRP= No Reply

- ***Delivery of treatment for STI***

A significant majority (78.1%) of respondents appeared not to be offered treatment for STIs at the workplace, declaring absence of such care. Out of the 7 institutions, 4 (5.7/10th)) were reported not to offer any treatment for STIs. In 4.3/10th of the cases, statements were contradictory though negation was held by a single tenant in each institution.

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Table 13: Delivery of Treatment for Sexual Transmitted Infections/Diseases

Institution	**Delivery of treatment for STIs**			
	Yes	No	NRP	TOTAL
CARE Cameroon	0	8	0	8
MINAS	0	4	3	7
MSP/DLM	1	6	0	7
UNDP	0	1	0	1
UNFPA	1	2	0	3
UNICEF	1	0	0	1
WHO	0	4	1	5
TOTAL	3	25	4	32
%	9.4%	78.1%	12.5%	100.0%

- ***Delivery of information about HIV/AIDS***

A limited majority (59.4%) of respondents stated that information about HIV/AIDS was not offered in their institution. Contradiction occurred in 4.3/10th (3 out of the 7) of the institutions as some respondents reported no delivery of the service.

Table 14: Delivery of Information about HIV/AIDS

Institution	**Delivery of information about HIV/AIDS**		
	Yes	No	Total
CARE Cameroon	2	6	8
MINAS	7	0	7
MSP/DLM	2	5	7
UNDP	1	0	1
UNFPA	1	2	3
UNICEF	1	0	1
WHO	5	0	5
TOTAL	19	13	32
%	59.4	40.6	100.0

- ***Delivery of Post Exposure Prophylaxis (PEP)***

A significant majority (65.6%) of respondents reported the absence of PEPs. Contradiction emerged in 5.7/10th (4 out of the 7) of the institutions as some respondents reported the service present.

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Table 15: Delivery of Post Exposure Prophylaxis

Institution	Delivery of Post Exposure Prophylaxis			
	Yes	No	NRP	TOTAL
CARE Cameroon	0	8	0	8
MINAS	2	3	2	7
MSP/DLM	1	6		7
UNDP	1	0	0	1
UNFPA	1	2	0	3
UNICEF	1	0	0	1
WHO	2	2	1	5
TOTAL	8	21	3	32
%	25.0%	65.6%	9.4%	100.0%

- ***Delivery of information on institutional instructions about the control of HIV/AIDS to staff members***

A considerable majority (59.4%) of respondents reported the absence of information given to the staff about institutional instructions on the control of HIV/AIDS. Contradiction among respondents in the respective institutions was universal, were applicable/possible (5 out of 5 institutions), as the only exception emerged in an institution with a single respondent (1 out 1).

Table 16: Delivery of Information on institutional instructions about controlling HIV/AIDS N=32

Institution	Explaining institutional instructions about the control of HIV/AIDS to all staff members				
	Yes	No	NAP	NRP	Total
CARE Cameroon	1	7	0	0	8
MINAS	3	3	0	1	7
MSP/DLM	1	6	0	0	7
UNDP	1	0	0	0	1
UNFPA	1	1	1	0	3
UNICEF	1	0	0	0	1
WHO	2	2	0	1	5
Total	10	19	1	2	32
%	31.3	59.4	3	6.3	100

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- ***Delivery of the distribution of pamphlets on HIV/AIDS to all staff members***

A limited majority (53.1%) of respondents reported no distribution of HIV/AIDS pamphlets to all staff members. Statements were contradicting in all institutions (7.1/10th) with more than one respondent (5 out of the 7).

Table 17: Delivery of the distribution of pamphlets on HIV/AIDS to all staff members

Institution	**Distribution of pamphlets about HIV/AIDS to all staff members**				
	Yes	No	NAP	NRP	TOTAL
CARE Cameroon	1	7	0	0	8
MINAS	4	2	0	1	7
MSP/DLM	1	6	0	0	7
UNDP	1	0	0	0	1
UNFPA	1	1	1	0	3
UNICEF	1	0	0	0	1
WHO	4	1	0	0	5
TOTAL	13	17	1	1	32
%	40.7	53.1	3.1	3.1	100

- ***Delivery of projection of illustrative videos on HIV/AIDS associated with relevant discussion***

Respondents who denied the delivery of the screening of illustrative videos on HIV/AIDS constituted a notable majority (62.5%) across the different institutions. Contradiction within institutions was notably prevalent, appearing in 4.3/10th of the institutions (3 out of the 7).

Table 18: Delivery of the projection of illustrative videos on HIV/AIDS associated with relevant discussion

Institution	**Screening of illustrative videos on HIV/AIDS followed by discussion**				
	Yes	No	NAP	NRP	Total
CARE Cameroon	0	8	0	0	8
MINAS	4	3	0	0	7
MSP/DLM	1	6	0	0	7
UNDP	1	0	0	0	1
UNFPA	0	1	1	1	3
UNICEF	1	0	0	0	1
WHO	3	2	0	0	5

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TOTAL	10	20	1	1	32
%	31.3	62.5	3.1	3.1	100.0

- ***Delivery of presentations on HIV/AIDS from experts and PLWHA***

Across the different institutions the majority (56.3%) of respondents said they were not offered presentations from PLWHA or experts (health professionals and/or members of organizations involved in HIV/AIDS control). In all 5 institutions with more than one respondent (7/10th; 5 out of the 7), affirmative assertions contradicted this statement.

Table 19: Delivery of presentations on HIV/AIDS from experts and PLWA
N=32

Institution	**Inviting PLWA, Health and HIV/AIDS control organisation experts to make presentations to staff**				
	Yes	No	NAP	NRP	TOTAL
CARE Cameroon	1	6	0	1	8
MINAS	4	3	0	0	7
MSP/DLM	1	6	0	0	7
UNDP	1	0	0	0	1
UNFPA	1	1	1	0	3
UNICEF	1	0	0	0	1
WHO	3	2	0	0	5
TOTAL	12	18	1	1	32
%	37.5%	56.3%	3.1%	3.1%	100.0%

- ***Delivery of interactive sharing of experiences with other organisations including questions and answers involving the staff***

An overwhelming majority of respondents (71.9%) across the different institutions denied the organization by their employers of opportunities for interactive sharing of experiences with other organisations. Nevertheless, contradiction occurred in 4.3/ 10th of the institutions (3 out the 7); though held by a small minority.

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Table 20: Delivery of interactive sharing of experiences with other organizations including questions and answers involving the staff

N=32

Institution	**Inviting other organisations for interactive sharing of experience with questions and answers involving staff**				
	Yes	No	NAP	NRP	TOTAL
CARE Cameroon	0	8	0	0	8
MINAS	2	4	0	1	7
MSP/DLM	1	6	0	0	7
UNDP	1	0	0	0	1
UNFPA	0	1	1	1	3
UNICEF	1	0	0	0	1
WHO	1	4	0	0	5
TOTAL	6	23	1	2	32
%	18.8	71.9	3.1	6.3	100.0

6.2 Existence of care delivery programmes for HIV/AIDS in the workplaces

Very few respondents (2.6/10th) reported the existence of a care delivery programme in their institution. Evidence of the existence of such a programme was reported by providers in only 2 out of the 7 institutions where specific activities and a plan of action were reported actual or shown to the investigator in support of the general statement. Inconsistency was notable (appearing in 4.2/10th of the cases; 3 out of 7 institutions), opposing providers and beneficiaries and evidencing poor communication in-house, both in institutions with and without a care delivery programme.

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Table 21: Existence of a care delivery programme across the institutions

Institution	Providers			Beneficiaries			TOTAL		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
CARE Cameroon	0	3	0	0	8	0	0	11	0
MINAAS	2	0	0	3	3	1	5	3	0
MSP/DLM	0	1	0	1	5	1	1	6	0
UNDP	1	0	0	1	0	0	2	0	0
UNFPA	0	0	0	0	2	1	0	2	1
UNICEF	0	0	0	1	0	0	1	0	0
WHO	0	0	0	1	4	0	1	4	0
Column Total	**3**	**4**	**0**	7	22	3	**10**	**26**	3
Column proportion	**4.3/10**	**5.7/10**	**0/10**	**2.2/10**	**6.9/10**	**0.9/10**	**2.6/10**	**6.7/10**	**0.8/10**
Category Total	**7**			**32**			**39**		

6.2.1 Delivered care services

- ***Availability of the administering of Antiretroviral (ARVs) drugs***

An overwhelming majority of respondents (75.0%) reported the absence of the administering of ARV drugs across the respective institutions. Contradicting statements varying from 3.1% to 6.2% (1 to 2 cases) per institution appeared in 2.8/10th of the workplaces. Non-responses were as frequent as affirmative statements (12.5%), increasing the likelihood that there was poor awareness or interest on the part of staff about the availability of the service.

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Table 22: Availability of ARV treatment

N=32

Institution	**Availability of the administering of ARV drugs**			
	Yes	No	NRP	Total
CARE Cameroon	0	8	0	8
MINAS	2	4	1	7
MSP/DLM	1	6	0	7
UNDP	0	1	0	1
UNFPA	0	1	2	3
UNICEF	1	0	0	1
WHO	0	4	1	5
TOTAL	4	24	4	32
%	12.5%	75.0%	12.5%	100.0%

- ***Availability of referral to care***

Across the different institutions, a significant majority of the respondents (62.5%) said referral to care was not available. However, in one institution there was a high indication from the trend of answers (7.1/10th) that the service was actually available. Nevertheless contradiction prevailed at the proportion of 4.3/10th across the investigated institutions.

Table 23: Availability of referral to care

n=32

Institution	**Availability of referral to care**			
	Yes	No	NRP	TOTAL
CARE Cameroon	0	8	0	8
MINAS	5	2	0	7
MSP/DLM	1	6	0	7
UNDP	1	0	0	1
UNFPA	0	1	2	3
UNICEF	1	0	0	1
WHO	1	3	1	5
TOTAL	9	20	3	32
%	28.1%	62.5%	9.4%	100.0%

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- ***Availability of palliative cares and treatment for STDs/HIV/AIDS***

An overwhelming majority (84.4%) of the respondents across the different institutions reported the absence of palliative cares and treatment of opportunistic infections. Contradiction was not very common and in only 2.8/10th of the institutions (2 out of the 7) were there only one respondent answering in the negative in each case.

Table 24: Availability of palliative cares and treatment for STDs/HIV/AIDS

n=32

Institution	**Availability of palliative cares and treatment for STDs/HIV/AIDS**			
	Yes	No	NRP	TOTAL
CARE Cameroon	0	8	0	8
MINAS	1	5	1	7
MSP/DLM	1	6	0	7
UNDP	0	1	0	1
UNFPA	0	2	1	3
UNICEF	0	1	0	1
WHO	0	4	1	5
TOTAL	2	27	3	32
%	6.3%	84.4%	9.4%	100.0%

- ***Availability of Post Exposure Prophylaxis (PEP)***

A large majority (71.9%) of respondents reported the absence of PEP. Contradiction to this statement was rare, as only in 2.8/10th of the institutions (2 out of the 7) were both Yes and No answers given. Exponents of the affirmative statement never exceeded one person per institution.

Table 25: Availability of Post Exposure Prophylaxis

n=32

Institution	**Availability of Post Exposure Prophylaxis**			
	Yes	No	NRP	Total
CARE Cameroon	0	8	0	8
MINAS	0	5	2	7
MSP/DLM	1	6	0	7
UNDP	1	0	0	1
UNFPA	1	1	1	3
UNICEF	1	0	0	1

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WHO	1	3	1	5
TOTAL	5	23	4	32
%	15.6%	71.9%	12.5%	100.0%

- ***Availability of nutritional care for PLWA***

An overwhelming majority (75.0%) of the respondents reported the absence of nutritional care for PLWHA. This seems quite believable as VCT was generally reported unavailable (see table 10 above; 65.6 % stated its absence) and the serologic status of the staff was generally unknown. Even if it was known, confidentiality would normally lead to underreporting. Contradiction to the answers in the negative on the availability of nutritional care for PLWHA was quite limited, as only 2.8/10th of the institutions (2 out of the 7) gave both Yes and No answers.

Table 26: Availability of nutritional care for PLWA

n=32

Institution	**Delivery of nutritional care to PLWA**			
	Yes	No	NRP	Total
CARE Cameroon	0	8	0	8
MINAS	2	4	1	7
MSP/DLM	2	5	0	7
UNDP	0	1	0	1
UNFPA	0	1	2	3
UNICEF	0	1	0	1
WHO	0	4	1	5
TOTAL	4	24	4	32
%	12.5%	75.0%	12.5%	100.0%

- ***Delivery of home care for PLWA***

No answers (81.3%) largely outweighed yes answers (6.3%) of the delivery of home care for PLWHA. Across the institutions, the No answers (8.6/10th; 6 out of the 7) given were more than the No Responses as well; with only exception. Overall, a significant proportion of the respondents (12.5%) abstained from replying, which contextually suggests that the case was not applicable or that the respondent lacked the information needed to answer.

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Table 27: Availability of home care

n=32

Institution	**Delivery of home care**			
	Yes	No	NRP	Total
CARE Cameroon	0	8	0	8
MINAS	2	4	1	7
MSP/DLM	0	7	0	7
UNDP	0	1	0	1
UNFPA	0	1	2	3
UNICEF	0	1	0	1
WHO	0	4	1	5
TOTAL	2	26	4	32
%	6.3%	81.3%	12.5%	100.0%

- ***Delivery of psychosocial care***

Across the institutions the majority (65.6%) reported the absence of psychosocial care. Contradiction occurred in only one institution (1.4/10th). The institution (MINAS) was one of only two with an actual control programme. A number of respondents (15.6%) sounded insufficiently at ease or equipped to provide the information.

Table 28: Availability of psychosocial care

n=32

Institution	**Delivery of psychosocial care**			
	Yes	No	NRP	TOTAL
CARE Cameroon	0	8	0	8
MINAS	4	2	1	7
MSP/DLM	1	6	0	7
UNDP	0	0	1	1
UNFPA	0	1	2	3
UNICEF	1	0	0	1
WHO	0	4	1	5
TOTAL	6	21	5	32
%	18.8%	65.6%	15.6%	100.0%

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6.3 Existing psychosocial care programmes for PLWA and persons affected.

A proportion of 4.3/10th of the key respondents (providers) reported the existence of a programme in 2.8/10th of the institutions (2 out of the 7). Contradiction about the existence of a psychosocial care programme appeared in 5.7/10th (4 out of the total 7) of the institutions. This constituted a reverse affirmation from beneficiaries against the statement of the providers in charge in 4.3/10th of the cases and contradiction among beneficiaries in the same of institution. This outlined a deficiency in communication in general and in the exposure of beneficiaries to services in the two institutions with a minimum of services (UNDP and MINAS).

Table 29: Existence of psychosocial care programmes for PLWA and persons affected.
n=39

Institution	**Providers**			**Beneficiaries**			**TOTAL**		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
CARE Cameroon	0	3	0	0	8	0	0	11	0
MINAS	2	0	0	5	2	0	7	2	0
MSP/DLM	0	1	0	1	5	1	1	6	1
UNDP	1	0	0	0	1	0	1	1	0
UNFPA	0	0	0	1	2	0	1	2	0
UNICEF	0	0	0	1	0	0	1	0	0
WHO	0	0	0	0	5	0	0	5	0
Column Total	**3**	**4**	**0**	8	23	1	**11**	**27**	1
Column proportion	**4.3/10**	**5.7/10**	**0/10**	**2.5/10**	**7.2/10**	**0.3/10**	**2.8/10**	**6.9/10**	**0.3/10**
Category Total	**7**			**32**			**39**		

6.4 Existing support programmes for PLWA and relatives

Only one provider respondent in one organisation (1.4/10th) declared the existence of support services for PLWA and relatives. However, 2.5/10 of the beneficiaries claimed there were such services in their workplaces, in contradiction with 3.7/10th (3 out of 8) of their peers and with all the providers in the other 6 institutions, who reported no such programmes.

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Table 30: Existence of support programmes for PLWA and affected ones across the institutions

Institution	Providers			Beneficiaries			TOTAL		
	Yes	No	NA	Yes	No	NA	Yes	No	NA
CARE Cameroon	0	0	3	0	8	0	0	8	3
MINAAS	1	0	1	5	2	0	6	2	1
MSP/DLM	0	0	1	0	6	1	0	6	2
UNDP	0	0	1	1	0	0	1	0	1
UNFPA	0	0	0	1	2	0	1	2	0
UNICEF	0	0	0	1	0	0	1	0	0
WHO	0	0	0	0	4	1	0	4	1
Column Total	**1**	**0**	**6**	8	22	2	**9**	**22**	8
Column proportion	**1.4/10**	**0/10**	**8.6/10**	**2.5/10**	**6.9/10**	**0.6/10**	**2.3/10**	**5.6/10**	**2.1/10**
Category Total	**7**			**32**			**39**		

6.4.1 Availability of support for PLWA in creating or integrating associations of PLWA

- ***Availability of support for PLWA in creating or integrating associations***

A minimal majority (50%) of respondents stated no provision existed to help PLWA create or integrate associations. The statement was notably contradicted as contrary standpoints were observed in 4.3/10th (3 out of 7) of the institutions with 46.9% of respondents involved An important proportion of respondents (25.0%) sounded insufficiently at ease or equipped to give an answer.

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Table 31: Availability of support for PLWA in creating or integrating associations of PLWA

n=32

Institution	**Availability of support for PLWA in creating or integrating associations**			
	Yes	No	NRP	Total
CARE Cameroon	0	8	0	8
MINAS	5	1	1	7
MSP/DLM	2	3	2	7
UNDP	0	0	1	1
UNFPA	0	0	3	3
UNICEF	0	1	0	1
WHO	1	3	1	5
TOTAL	8	16	8	32
%	25.0%	50.0%	25.0%	100.0%

6.4.2 Availability of support for relatives of PLWA

- ***Availability of support for persons affected by HIV/AIDS.***

A significant majority (59.4%) of respondents stated that there was no provision to support those persons affected by HIV/AIDS. Contradiction was notable, occurring in 4.3/10th of the institutions and involving 53.1% (17/32) of the respondents, where those denying the delivery of the service (31.2%; 10/32) outweighed those affirming (21.3%; 7/32). A high number of contradictors (5 against 1) asserting the existence of the service was observed in one of the institutions with an actual HIV/AIDS control programme.

Table 32: Availability of support for persons affected by HIV/AIDS.

n=32

Institution	**Availability of support for affected ones**			
	Yes	No	NRP	TOTAL
CARE Cameroon	0	8	0	8
MINAS	5	1	1	7
MSP/DLM	1	6	0	7
UNDP	1	0	0	1
UNFPA	0	1	2	3
UNICEF	1	0	0	1

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WHO	1	3	1	5
TOTAL	9	19	4	32
%	28.1%	59.4%	12.5%	100.0%

- ***Availability of support for OVC (Orphans and Vulnerable Children)***

A notable majority (59.4%) of respondents denied the delivery of support services to OVC across the different institutions. Two institutions (2.9/10th) witnessed a contradiction where exponents of "yes" (21.9%; 7/32) slightly outnumbered exponents of "no" (18.8%; 6/32).

Table 33: Availability of support services for Orphan and Vulnerable Children

n=32

Institution	**Delivery of support services for OVC**			
	Yes	No	NRP	TOTAL
CARE Cameroon	0	8	0	8
MINAS	6	1	0	7
MSP/DLM	1	5	1	7
UNDP	0	0	1	1
UNFPA	0	1	2	3
UNICEF	1	0	0	1
WHO	0	4	1	5
TOTAL	8	19	5	32
%	25.0%	59.4%	15.6%	100.0%

6.5 Protection of the rights of PLWA

Of the 5 rights the situation of which is reported here, all were reported to be protected by beneficiaries in the majority of institutions 8.6/10th (6 out of the 7). But contradiction was equally prevalent as negation was observed from peers in the very same 8.6/10th of the institutions. For the respective rights, the proportion of institutions where uncertainty, ignorance or silence about their protection appeared to vary between 0 and 8.6/10th. The most frequent proportion was 5.7/10th (8 occurrences) followed by 1.4/10th (6 occurrences). Generally, respondents saying that a given right was protected represented 38% while in one case (protection against stigmatisation) they represented 41%. Statements of lack of protection varied from 13% to 16% for the respective rights of PLWA.

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Table 34: Protection of rights of PLWA

n=32

Situation of rights		Yes	No	NAP	No	NA	DNK	Sample size
Protection against stigmatisation	Nb of institutions	6	2	0	4	1	4	7
	Proportion of institutions	0.86	0.29	0.00	0.57	0.14	0.57	
	Nb of respondents	13	4	0	6	3	6	32
	% answers	0.41	0.13	0.00	0.19	0.09	0.19	
Protection of confidentiality	Nb of institutions	6	2	1	4	1	3	7
	Proportion of institutions	0.86	0.29	0.14	0.57	0.14	0.43	
	Nb of respondents	12	4	1	6	3	6	32
	% answers	0.38	0.13	0.03	0.19	0.09	0.19	
Protection of equal opportunity for employment	Nb of institutions	6	2	0	4	1	3	7
	Proportion of institutions	0.86	0.29	0.00	0.57	0.14	0.43	
	Nb of respondents	12	4	0	7	3	6	32
	% answers	0.38	0.13	0.00	0.22	0.09	0.19	
Protection of equal chances to conserving employment	Nb of institutions	6	3	0	4	1	4	7
	Proportion of institutions	0.86	0.43	0.00	0.57	0.14	0.57	
	Nb of respondents	12	5	0	6	3	6	32
	% answers	0.38	0.16	0.00	0.19	0.09	0.19	
Protection of equal access to insurance and health coverage	Nb of institutions	6	3	0	4	1	4	7
	Proportion of institutions	0.86	0.43	0.00	0.57	0.14	0.57	
	Nb of respondents	12	5	0	6	3	6	32
	% answers	0.38	0.16	0.00	0.19	0.09	0.19	

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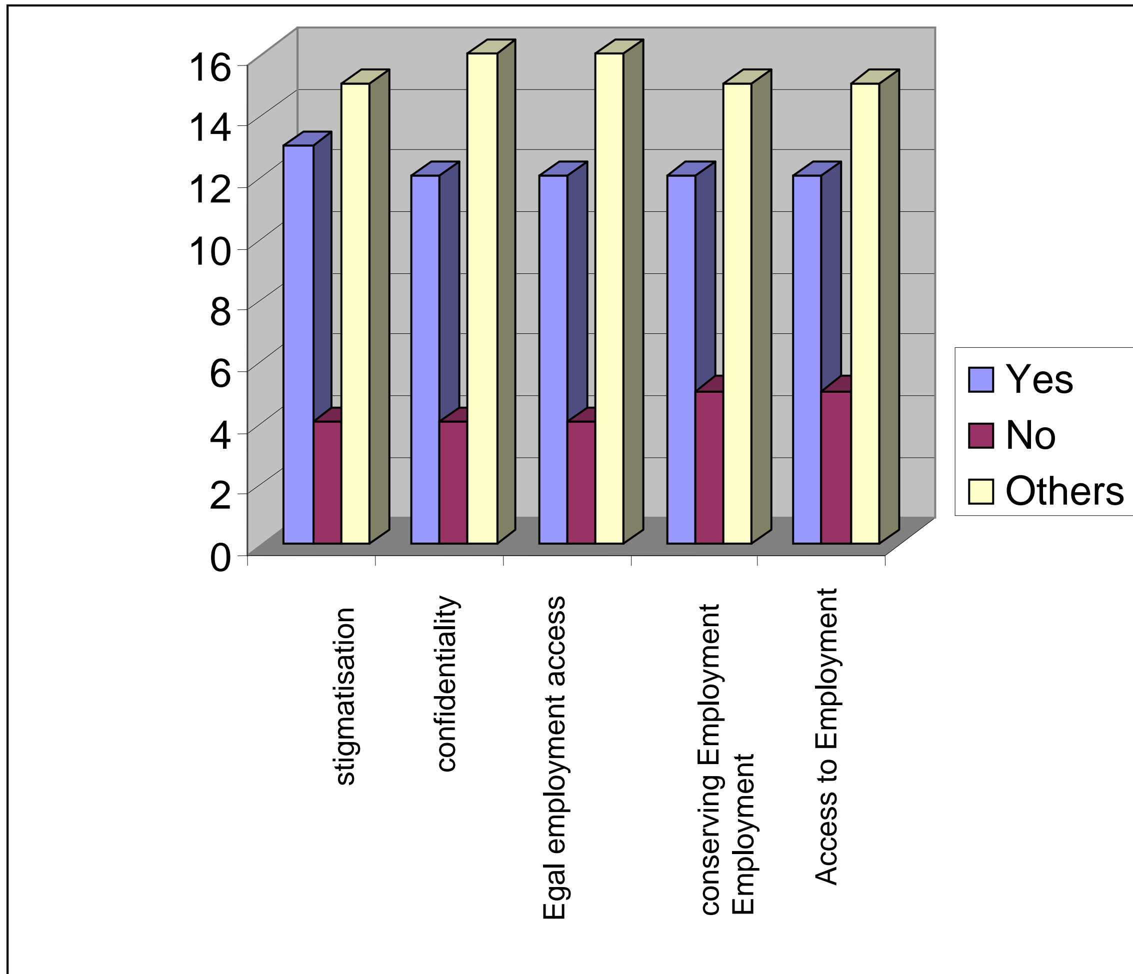
Graph 2: Statement of beneficiaries on the protection of the rights of PLWA in the workplaces

n=32



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Chapter 7: DESCRIBING OPERATIONALITY OF HIV/AIDS CONTROL ENDEAVOURS IN THE WORKPLACE

7.1 Describing the functionality of HIV/AIDS control endeavours

7.1.1 Mobilisation of resources (Human, financial and material)

Only one institution (1 in 7 institutions; 1.4/10th) explicitly appeared to allocate resources to HIV/AIDS control activities. No answer was given in the other institution with a control programme (UNDP). This underlined the embryonic state or nullity of control programmes in participating workplaces. For the institution where funding was reported, a budget of 23, 042, 000 CFA Francs (US$ 46,084) was stated for the 854 staff members (US$53.96/head/year)

Table 35: Allocation of resources for HIV/AIDS control in the different organisations

Institution	**Allocation/Endowment of resources**								
	Infrastructural			**Material**			**Financial**		
	Yes	**No**	**DAP/NA**	**Yes**	**No**	**DAP/NA**	**Yes**	**No**	**DAP/NA**
CARE Cameroon	0	1	2	0	1	2	0	1	2
MSP/ DLM	0	0	1	0	0	1	0	0	1
MINAS	0	1	1	0	1	1	1	0	1
UNDP	0	0	1	0	0	1	0	0	1
UNFPA	0	0	0	0	0	0	0	0	0
UNICEF	0	0	0	0	0	0	0	0	0
WHO	0	0	0	0	0	0	0	0	0
Column Total	0	2	5	0	2	5	1	1	5
Column proportion	**0/10**	**2.9/10**	**7.1/10**	**0/10**	**2.9/10**	**7.1/10**	**1.4/10**	**1.4/10**	**7.1/10**
Category Total	**7**			**7**			**7**		

DAP= Does Not Apply, NA= Not Available

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7.1.2 Existence and implementation of a plan of action

- **Existence of a plan of action**

Answers from the key respondents (providers) indicated the existence of a plan action in only one institution (1.4/10th), where a copy of the document was presented for evidence, while in the other institution with some control activities a non-response was found. In 3 institutions (MINAS, MSP/DLM and WHO) out of 7 (4.2/10th), there were inconsistency between affirmations by providers and beneficiaries and negation among beneficiaries. It seemed that, apart from the NGO sector, where such language is common, many staff members in the different workplaces needed to be told what a plan of action or strategic plan is. Proper communication with beneficiaries is needed.

Table 36: Existence of a plan of action and/or strategic plan across the different workplaces

Institution	Providers				Beneficiaries				TOTAL			
	Yes	No	NA	NAP	Yes	No	NA	NAP	Yes	No	NA	NAP
CARE Cameroon	0	0	0	3	0	8	0	0	0	8	0	3
MINAAS	1	0	1	0	6	1	0	0	7	1	1	0
MSP/DLM	0	0	0	1	2	5	0	0	2	5	0	1
UNDP	0	0	1	0	0	1	0	0	0	1	1	0
UNFPA	0	0	0	0	1	2	0	0	1	2	0	0
UNICEF	0	0	0	0	1	0	0	0	1	0	0	0
WHO	0	0	0	0	1	4	0	0	1	4	0	0
Column Total	**1**	**0**	**2**	**4**	11	21	0	0	**12**	**21**	2	4
Column proportion	**1.4/10**	**0/10**	**2.9/10**	**5.7/10**	**3.4/10**	**6.6/10**	**0/10**	**0/10**	**3.1/10**	**5.4/10**	**0.5/10**	**1/10**
Category Total	**7**				**32**				**39**			

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- **Implementation of plan of Action**

Table 37: Strategies used for estimating/assessing HIV/AIDS in the different workplaces

Institution	**Strategy for estimating/assessing HIV/AIDS in the workplace**			
	Study	None	NRP	TOTAL
CARE Cameroon	0	2	1	3
MSP- DLM	0	0	1	1
MINAS	0	1	1	2
UNDP	1	0	0	1
UNFPA	0	0	0	0
UNICEF	0	0	0	0
WHO	0	0	0	0
Column total	**1**	**3**	**3**	**7**
Column Proportion	**1.4/10**	**4.3/10**	**4.3/10**	**10/10**

NRP: Non Response

– Implementation of HIV/AIDS control activities over the recent past (last 3 years)

Control activities went on in less than half (4.2/10th; 3 out of 7) of the organisations over the 3 years preceding the study of which, only one had an implementation programme alongside the NGO. Continuous implementation each and every year seemed even rarer, occurring in only one of the organisations (1.4/10th).

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Table 38: Implementation of HIV/AIDS control activities over the recent past (last 3 years)

Institution	**Implementation of activities over the recent past Years**					
	Existence of activities over the last 3 years			Conducting of activities each year		
	Yes	No	NRP	Yes	No	NRP
CARE Cameroon	1	0	2	0	0	3
MSP-DLM	0	0	1	0	0	1
MINAAS	1	0	1	1	0	1
UNDP	1	0	0	0	1	0
UNFPA	0	0	0	0	0	0
UNICEF	0	0	0	0	0	0
WHO	0	0	0	0	0	0
Column total	3	0	4	1	1	5
Column Proportion	4.2/10	0/10	5.7/10	1.4/10	1.4/10	7.1/10
Variable total	7			7		

– Effectiveness and quality control of the implementation of HIV/AIDS control activities in the workplaces

The existence of a monitoring and evaluation system could only be traced in one out of the seven institutions (1.4/10th). In most cases (5.7/10th) there was no control system, while the situation could not be discovered in two cases (2.8/10th).

Table 39: Existence of monitoring and evaluation system for HIV/AIDS control activities in the workplaces

Institutions	**Existence of monitoring and evaluation system**			
	Yes	No	NRP	Total
CARE CAM	0	2	1	3
MSP/DLM	0	0	1	1
MINAS	1	1	0	2
UNDP	0	1	0	1
UNFPA	0	0	0	0
UNICEF	0	0	0	0
WHO	0	0	0	0
TOTAL	1	4	2	7

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Chapter 8: DESCRIBING CONFORMITY OF PROGRAMMES WITH ILO NORMS AND STANDARDS

8.1 Conformity of prevention programmes with international norms

Only 19% of the respondents said that the prevention programmes were conforming to international norms. While 3% stated the opposite, the remaining 78% sounded mitigated, were ignorant or stayed silent.

Table 40: Conformity of HIV/AIDS prevention programmes at the workplace with international norms

Institution	**Conformity of the prevention programme with international norms**						
	Yes	No	Mitigated	DNK[1]	NRP	NAP	TOTAL
CARE Cameroon	0	1	0	0	0	7	8
MINAS	4	0	0	0	0	3	7
MSP/DLM	0	0	1	3	1	2	7
UNDP	1	0	0	0	0	0	1
UNFPA	0	0	0	2	1	0	3
UNICEF	0	0	0	0	1	0	1
WHO	1	0	0	1	3	0	5
TOTAL	6	1	1	6	6	12	32
%	19%	3%	3%	19%	19%	38%	100%

8.2 Conformity of care delivery programmes with international norms

Only 13% of the respondents said that care delivery programmes were conforming to international norms. While 3% stated the opposite, the remaining 84% sounded mitigated, were ignorant or stayed silent.

[1] DNK : Does not Know

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Table 41: Conformity of HIV/AIDS care delivery programmes at the workplace with international norms

n=32

Institution	**Conformity of care delivery programmes vs. International Norms**						
	Yes	No	Mitigated	DNK	NRP	NAP	Total
CARE-Cameroon	0	1	0	0	0	7	8
MINAS	2	0	1	0	1	3	7
MSP/DLM	0	0	1	3	1	2	7
UNDP	1	0	0	0	0	0	1
UNFPA	0	0	0	2	1	0	3
UNICEF	0	0	0	0	1	0	1
WHO	1	0	0	1	3	0	5
TOTAL	4	1	2	6	7	12	32
%	13%	3%	6%	19%	22%	38%	100%

8.3 Conformity of the support programmes for PLWA and the persons affected with international norms

Only 9% of the respondents said that care delivery programmes were conforming to international norms. While 3% stated the opposite, the remaining 88% sounded mitigated, were ignorant or stayed silent.

Table 42: Conformity of support programmes for PLWHAs and the affected ones at the workplace with international norms

n=32

Institution	**Conformity of support programmes for PLWHA and the affected ones at the workplace with international norms**						
	Yes	No	Mitigated	NSP	NRP	NAP	TOTAL
CARE Cameroon	0	1	0	0	0	7	8
MINAS	2	0	1	0	1	3	7
MSP/DLM	0	0	1	3	1	2	7
UNDP	0	0	0	1	0	0	1
UNFPA	0	0	0	2	1	0	3
UNICEF	0	0	0	0	1	0	1
WHO	1	0	0	1	3	0	5
TOTAL	3	1	2	7	7	12	32
%	9%	3%	6%	22%	22%	38%	100%

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Chapter 9: DESCRIBING PROSPECTS FOR IMPROVEMENT OF HIV/AIDS CONTROL IN THE WORKPLACE AS SUGGESTED BY DIFFERENT INSTITUTIONS

Suggestions made by the different respondents as concerns ways to improve on HIV/AIDS control in the workplaces were based on identified strengths and weaknesses of the existing efforts as listed below.

9.1 Strengths of HIV/AIDS control in the workplaces

- Experience in controlling HIV/AIDS in the workplace existed in some institutions that may be used as leadership structures assisting other workplaces in putting in place and strengthening their programmes.
- The United Nations system has a standard policy that can be applied by the different organisations of the system and be introduced in order workplace.
- The ILO has elaborated specific norms for the effectiveness and quality of workplace programmes that can be shared with other institutions.
- Certain institutions had remarkable expertise in controlling HIV/AIDS, for instance international organisations such as the WHO and the Ministry of Health.
- There are sector-specific plans of action for the different ministries, elaborated in collaboration with the National Aids Control Committee. These can help assist other institutions in developing their own plans.

9.2 Weaknesses of existing programmes

- There were almost no policies, except for in one organisation.
- Programmes were described as embryonic (no planning, no control of effectiveness and quality).
- Management was generally uninvolved, leaving the responsibility to staff with low decision-making and enforcement powers.
- Communication was generally insufficient as many staff members across the different organisations were not aware of existing activities and the HIV/AIDS control situation;
- Actions were generally carried out by outsiders and therefore there was a rampant lack of competence in-house.
- Generally HIV/AIDS control activities were not budgeted or funded.
- Workplaces did not have effective fundraising mechanisms set up.

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- In the majority of institutions the baseline situation concerning HIV/AIDS was not assessed, therefore the activities of programmes were conducted blindly.

9.3 Improvement

A communication and advocacy plan needs to be put in place in the respective institutions in order to reach at the necessary awareness and create an adequate demand for the appropriate HIV/AIDS control services.

- HIV/AIDS control activities need to be integrated in the general plan, organisation chart and budgeting of the institutions in order to insure an effective implementation.
- A capacity-building strategy needs to be put in place in different structures in order to insure quality and continued implementation.
- The working community needs to create a network within which experiences will be exchanged towards the harmonisation and faster development of the respective interventions.

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PART III: INTERPRETATION AND CONCLUSION

The main research purpose for this assignment was describing the situation and future prospects of the response to the HIV/AIDS pandemic in some workplaces of Yaoundé.

From the methodological standpoint, it was assumed that:

1) A combine phenomenological approach mainly grounded in face-to-face interviews and integrating both qualitative and quantitative variables, through semi-structured interview guides and associating direct observation where applicable, was relevant to the investigations; and
2) Collecting data from providers (those in charge of HIV/AIDS control in the respective institutions) and staff members could help gather the relevant information via interviews with key providers and beneficiaries.

From the heuristic standpoint it was assumed that:

1) Questions inserted in the two respective interview guides, which applied to providers and to beneficiaries, enabled the collection of relevant data, which helped to describe:
   a. Whether employers have developed a response to the HIV/AIDS pandemic in Yaoundé-based workplace;
   b. The structure of said workplace response (inclusion of policies and programmes);
   c. The quality of (including functionality, conformity to international norms and effectiveness) existing workplace responses to HIV/AIDS (Would they offer opportunities to foster effective learning and ensure that all employees understand the policy and experience a supportive and compassionate work environment free of fear and discrimination?); and
   d. How the situation of the above-mentioned response can be improved for better control of HIV/AIDS in Yaoundé-based workplaces in the future.

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