

**EFFECTIVENESS OF WORKPLACE HIV INTERVENTION
PROGRAMME AMONG PRIVATE COMPANIES IN DAR ES
SALAAM, TANZANIA**

By

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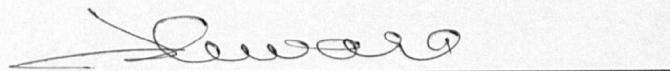
A dissertation/Thesis Submitted in (partial) Fulfilment of the Requirement for Degree of
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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance of a dissertation entitled Effectiveness of workplace HIV Intervention among Private Companies in Dar es Salaam, Tanzania in fulfilment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences



Prof. A.D. Kiwara.

(SUPERVISOR)

Date: 17 Nov 2009

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I, Dr. Erick Josiah Atugonza, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other university for similar or any other degree award

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ABSTRACT:

Introduction: Since the inception of HIV intervention at workplaces various public and private institutions have been implementing programs to fight the disease. In Tanzania little is known about the effectiveness of these intervention programmes which have been implemented by private companies.

Methods: The cross sectional study was conducted in Dar es Salaam to assess the effectiveness of workplace HIV intervention among private companies in terms of Voluntary Counselling and Testing (VCT) utilization, condom use and stigma and discrimination reduction.

Results: A total of 185 employees from six private companies were recruited where by 63% were males. Sixty five percent of (65%) participants agreed that there is VCT services conducted at their workplaces and 61% said they had ever done VCT since employed. 58.8% of participants said workplace HIV activities have contributed to the willingness for VCT among employees in which 68% of participants were males (P value < 0.05) The study has revealed that 81% of interviewees reported that condoms are available at their workplaces and they believe they are utilized by employees. The study shows that 52.2% of participants do use condoms when having sex with non regular partners and about 16% do not use condoms while the other said don't have the non regular partners. The results showed that 72% of employees were not forced to do HIV test during their employments and approximately 82% of interviewees believe they could continue working despite of being HIV positive and about 60% of respondents believed that workplace HIV programs have contributed to the reduction of stigma among employees. Those who have been at work for a period of more than ten years

seem to support more stigma reduction compared to those with short working periods that is less than five years. (P value <0.05). Sixty two percents (62.2%) of participants are satisfied with the workplace HIV intervention while 36.8% are not satisfied.

Conclusion: Workplace HIV intervention is effective. The study has shown that the majority of employees are satisfied with the workplaces HIV programs which has contributed to reduction of stigma among employees, uptake VCT, and the use of condoms.

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LIST OF ABBREVIATIONS

ABCT	Aids Business Coalition of Tanzania
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical and Research Foundation
ART	Anti Retroviral Therapy
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
NMSF	National Multi Sectoral Strategic Framework
SPSS	Statistical Package for Social Scientists
TACAIDS	Tanzania Commission for Aids
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey.
VCT	Voluntary Counselling and Testing
UNAIDS	United Nations programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

It is estimated that 33 million people are affected with the Human Immunodeficiency Virus (HIV) worldwide and that Sub-Saharan Africa is the most heavily affected, accounting for 67% of all people living with HIV/AIDS and for 72% of all AIDS deaths in the world. Worldwide, most of the infections are occurring in those aged 15-49 years i.e. the most productive age group (UNAIDS 2008).

In Tanzania it is indicated that 5.7% of those aged between 15-49 are infected. Women have higher prevalence than men in both urban and rural areas. Urban residents are almost twice as likely as rural residents to be infected with HIV. HIV prevalence is highest in Iringa (16%), followed by Dar es Salaam and Mbeya (9% each). Infection rates are lowest in Zanzibar which is less than 1%. (THMIS 2007)

The government of Tanzania has recognised that the HIV/AIDS pandemic is a major threat to the development and wellbeing of its people. This has forced it to develop a National Multi-sectoral Strategic Framework (NMSF) calling upon all parts of society to participate in the prevention of further spread of the disease. Most of the Employers from both private and public companies have responded positively as they feel the impact of the disease through high absenteeism, rising medical expenditures, loss of employees, increasing funeral costs, etc. (TACAIDS & ABCT 2006).

It is documented that about 68% of the companies have lost staffs because of HIV and AIDS related problems. This can be minimized by proper prevention of new infections and treating persons living with HIV/ AIDS with respect and providing proper medical care for them. This will enable the infected persons remain productive while leading normal life. To achieve this, the National Multi-sectoral Framework which was adopted in 2003 obliges TACAIDS to support the establishment and coordination of efforts against HIV/AIDS by involving all stake holders including the business companies through HIV intervention at workplace. (ABCT 2006)

Investing in HIV/AIDS prevention programs can result in considerable savings to companies at a later stage according to the HIV/AIDS economic costs study done among businesses in Kenya (Strode A & Smart R, 1992)

HIV workplace programmes refer to a range of company-based interventions including the institution of an HIV/AIDS policy, voluntary counselling and testing (VCT), and antiretroviral therapy (ART) provision, peer education, condom distribution, awareness sessions about the disease, stigma and discrimination prohibition etc (Mahajan & Colvin, 2007)

CHAPTER TWO

2.1 PROBLEM STATEMENT

Since the inception of HIV intervention at workplace various public and private institutions have been implementing programmes to fight the disease. In Tanzania, comparing with the public sector, the private sector was the first to initiate workplace HIV interventions since the late 90s. Now several private companies have HIV workplace policies and programmes in place. (TACAIDS, 2004)

Based on the national HIV/AIDS policy, most of the private companies implement HIV workplace interventions under TACAIDS through the technical assistance from ABCT.

In Tanzania little is known about the effectiveness of the intervention programmes which have been implemented by these private companies. No evaluation has been done.

According to the 2008 Tanzania UNGASS report, a comprehensiveness of HIV workplace program is not known.

It has been observed that despite the progress that has been achieved by business organisations to address the HIV/AIDS problem both at the workplace and in the communities in which they exist, there is still the need for more research on effectiveness of workplace and community HIV/AIDS programmes implemented by business organisations (Maphosa, 1997).

Therefore the aim of this study is to assess the effectiveness of the HIV intervention programmes at workplace in private companies.

2.1 SIGNIFICANCE OF THE STUDY

The results of this study will provide information on the effectiveness of HIV intervention at work places. This information will enable policy makers to develop appropriate strategies for workplace HIV intervention especially for private institutions. The study findings will also contribute to the existing knowledge about HIV intervention at workplace.

2.3 RESEARCH QUESTIONS

1. What types of workplace interventions are available?
2. Do the HIV workplace programs bring changes among employees in terms of VCT uptake, condom use and reduction of stigma and discrimination?

CHAPTER THREE

3.0 THE STUDY OBJECTIVES

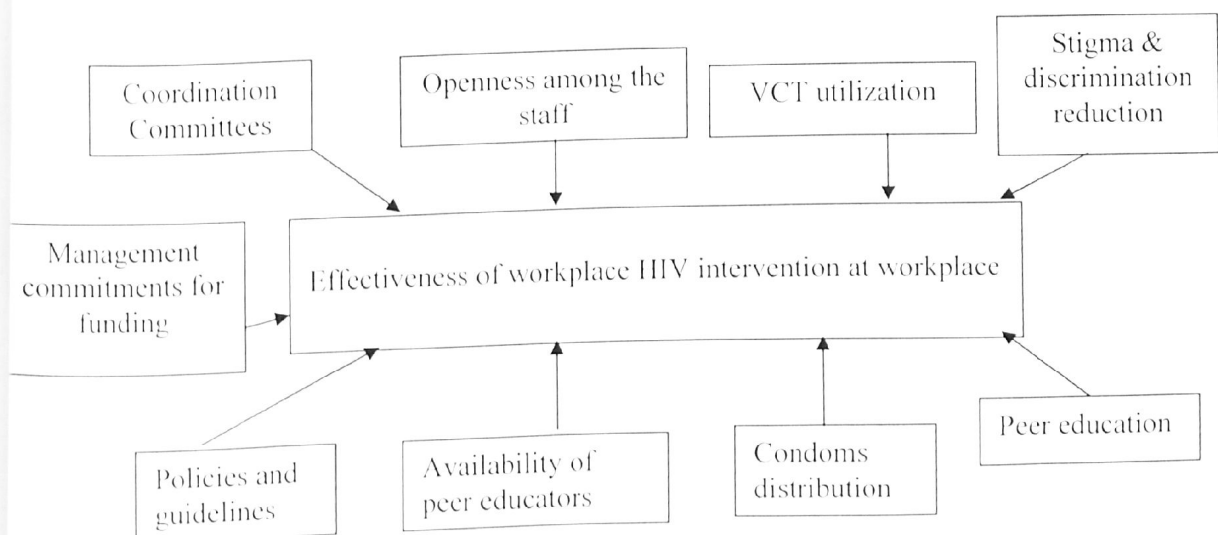
3.1 Broad Objective

To assess the effectiveness of workplace HIV intervention programmes among private companies in Dar es Salaam.

3.2 Specific objectives

1. Determine the types of workplace HIV intervention services available.
2. To assess HIV stigmatization among employees
3. To assess the condom utilization among employees.
4. To assess employees utilization of VCT services.
5. To determine the degree of employees satisfaction with the HIV workplace programme.

3.3 CONCEPTUAL ANALYSIS



CHAPTER FOUR

4.0 Literature Review

Workplace HIV intervention is an important strategy for prevention and mitigating the impact HIV /AIDS. These interventions may result into savings to companies as it is revealed in HIV economic study done in Kenya in 1992 (Strode A & Smart R, 1992).A study in Botswana has shown that most employees seem to respond well to the workplace HIV programs (Barese P, 1995).Despite of the response by the employees to workplace interventions still most programmes undertaken in the private sector are of limited scope as it is shown in the study done in Uganda. (Kironde S & Lukwago J 2002).A survey done in Tanzania, Kenya and Uganda has shown that approximately a third of enterprises invest in HIV/AIDS prevention and less than 50% provide VCT (Ramachandran V et al, 2007)

4.1 Discrimination and stigma factors

Pre-employment HIV/AIDS screening, whether for assessment of fitness to work or for insurance purposes, should not be required and raises serious concerns about discrimination and stigma. The workplace HIV interventions are essential to create the climate of collective responsibility and mutual understanding required to protect individuals with HIV or AIDS from stigmatization and discrimination by co-workers, employers or clients, and unions. (WHO, 1998)

It is shown in a study done in Kenya that some employers need all applicants or employees to undergo HIV testing and the majority of workers thought that they would

be fired if they were or suspected to be infected with HIV (Robert M, Wangombe 1995). As a measure to combat HIV/AIDS at workplaces it was insisted in the tenth African International Labour Organization (ILO) regional meeting in Addis Ababa in December 2003, that African governments should support the efforts of employers and workers to oppose stigma and discrimination at workplace.

Another study on discrimination and stigmatization at workplace in South Africa has indicated that the pre employment screening for HIV is unacceptable (Achmat Z, Cameron E. 1995)

A study in the cities of Beijing, Chicago and Hong Kong on stigma at workplace has shown that employers from all three cities showed reluctance to hire people with HIV (Lao et al 2008)

4.2 Condom distribution

A study done in South Africa to evaluate the preventive package for occupational HIV showed an increased uptake of VCT, Condom distribution and the decrease of HIV prevalence which indicates its effectiveness in both providing care for HIV infected individuals and preventing new infections (Morris et al. 2001)

A work place intervention study done in two ministries in Tanzania indicated that 25% and 38% of the workforce did not use condoms in their last sexual Intercourse with non spouse sexual partners respectively and 26% and 42% of workforce could not explain how to use a condom properly (Ndenzako & Mwakitoshi 2003). The low usage of condoms is also indicated in an evaluative study on HIV workplace programme done in

South Africa in 2005 which has shown that only 34% of subjects used condoms frequently (Sloan & Meyers 2005). Further more a study done in Senegal indicated that about 46.5% of participants showed positive attitude toward use of condoms after being informed by preventive programme at workplace. (Mbaye , et al 2003)

A factory based study done in Zimbabwe has shown that the effectiveness of HIV/AIDS prevention at workplace is determined by many factors including condom distribution at the workplace. (Aidslink, 1998), supported by another study done in Kenya on condom distribution and promotion as a strategy for HIV prevention at workplace which has shown the success as condom distribution and uptake over years have increased. (Nyanjom GO et al.2004). Another study done in Kenya had also indicated that about 90% of all companies involved in the study were distributing condoms at their workplaces (Robert M & Wangombe 1995)

4.3 Voluntary Counseling & Testing

Volunteering and Counselling Testing is one of the determinants of the success of workplace HIV intervention programme. It has been observed that on improvement in VCT sites in term of accessibility and confidentiality more people are willing to utilization these services. This is proved in the study conducted in South Africa in 2003 that 26% of participants had positive attitude towards testing due to the improvement of confidentiality and conveniences of a company VCT site (Day et al 2003). A workplace HIV voluntary and counselling testing uptake study done in Zimbabwe in 2006 has also shown that VCT at workplace offer high uptake where 51% reported using the onsite

VCT compared to 49% who reported using the offsite VCT. (Corbett, et al 2006). Another study done in South Africa has shown that the high uptake of VCT among the employees was due to the convenience afforded by on site testing and awareness sessions at the company (Anil et al, 2008)

CHAPTER FIVE

5.0 STUDY METHODOLOGY

5.1 Study design

A cross sectional study was conducted in six Private companies to determine the effectiveness of HIV intervention at work place.

5.2 Study Area

The study was conducted in Dar es Salaam. This region was selected due to the fact that most private industries implementing HIV intervention at workplace are situated in Dar es Salaam. And also Dar es Salaam is among the regions with high prevalence of HIV infection being the 2nd in the country with a prevalence of 9.3% (THMIS 2007/08).It is the largest city in Tanzania and the main business centre in the country Its population is estimated to be 4millions.

5.3 Study Population

The study involved employees from private companies which are implementing workplace HIV intervention programmes.

5.4 Sample size estimates and Sampling procedures

The formula below was used to estimate the minimum sample size required.

$$n = z^2 P (100 - P) / e^2$$

Where: $P = 50\%$ because proportional is not known from previous studies.

$$e = 7\% \text{ (Maximum likely error)}$$

$$z = 1.96 \text{ (at 95\% confidence interval)}$$

Therefore $n = 204$.

5.4.1 Sample size

The study involve 225 participants (204 minimum sample size + 10%), selected conveniently from six private companies.

5.4.2 Company selection procedures

The six private companies were selected randomly from the list of fifty four companies implementing workplace HIV interventions in Dar es Salaam which are under technical assistance from ABCT. The names of all these companies were written separately on pieces of papers and mixed together in a container. Then one paper was picked at a time until a list of six companies was attained.

Inclusion criterias:

Companies implementing workplace HIV intervention and are under ABCT technical assistance

Those companies based in Dar es Salaam

5.4.3 Participants' selection procedures

A total of 225 participants were selected conveniently.i.e those who where at workplace during the study period were included. Those who had been on employment for more than one year were recruited to ensure that the sample include participants who are exposed to the intervention programme.

To ensure equal participants representation per company, the number of participants per company was obtained by taking the total number of all eligible employees from a particular company divided by total number eligible employees from the six companies times the total number of sample size.(Example, to get the participants from TBL, I took 270 as eligible participants from TBL divided by 1920 as a total of all eligible participants from the six companies times 225, a study sample size i.e. $270/1920 \times 225 = 32$) The list of employees was obtained from Human resource managers and it included an estimation of those who could be available during the study period and those who met the recruitment criterias.

Inclusion criterias:

Those who have been at employments for more than one year.

Those who were available at work during the study period.

5.5 Data Collection

One day training was given to two research assistants by the investigator, to familiarize with the research tool and study methodology. The training focused on the study background, objectives, tools and tasks

Data collection instruments were Swahili and English questionnaires with open ended and closed questions. Pre testing of the instruments was done prior to commencement of the study at Celtel. It involved 15 employees and these employees were not included in the study. Results from the pre test tool were used to improve and finalize the study tool.

This was a supervised self administered questionnaire, where by participants were identified and provided the questionnaires. The investigator and research assistants were around for the whole study period to give clarification and to contact those respondents who left unfilled questions so that they are corrected and properly filled.

5.6 Data analysis

Statistical Package for Social Scientists (SPSS) was used for data analysis. Chi-square was used for statistical testing and associations between bivariate variables while

frequencies were used for univariate variables. Statements, figures and tables used to present the results.

5.7 Ethical consideration

Study clearance was obtained from the Muhimbili University of Health and Allied Science. Permission was obtained from the Regional Administrative Secretary (RAS), Municipals authorities and from the Companies managements. Consent from participants was asked either by physical conversation or through the consent forms which were attached to the questionnaires. Informations related to the aim and the rights of participating were also clearly communicated to the participants.

CHAPTER SIX

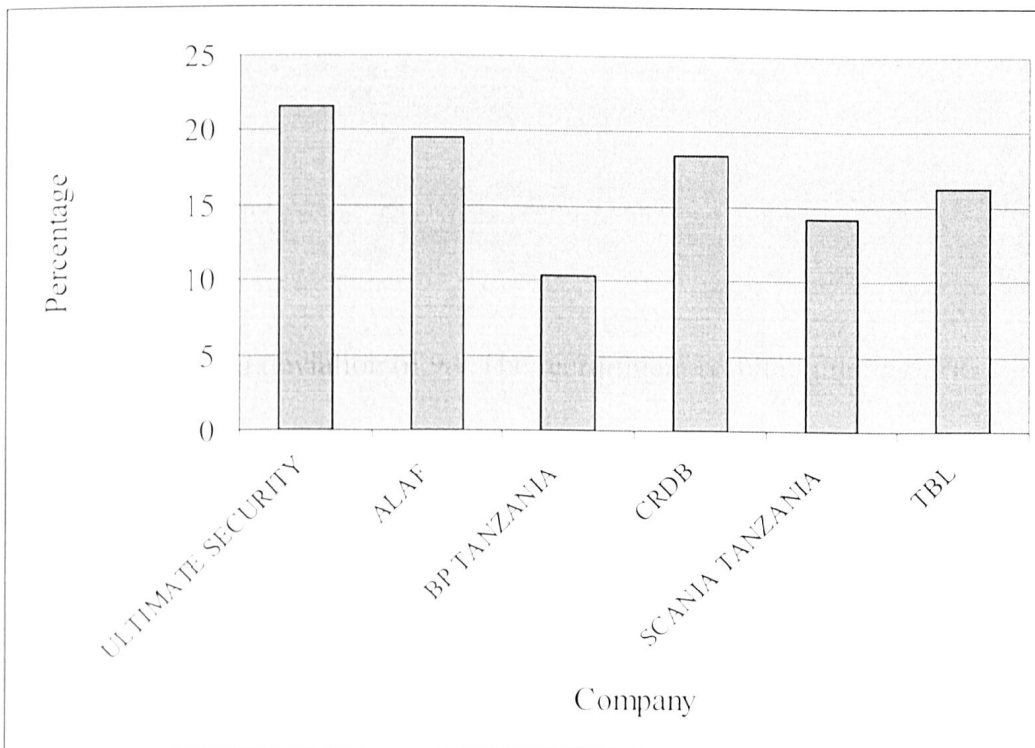
6.0 RESULTS

6.1 Description of study Participants

A total of 185 participants were recruited in the study, whereby 63.2% were Males.

Minimum age of participants was 20 years while the maximum was 59 with the mean of 35.7 and standard deviation of 9.4. The recruitment resulted into the response rate of 82.2% where by 17.8% (40) did not return the questionnaires.

Figure 1: Participants distribution per company



The study was conducted in six private companies where Ultimate security provided the large sample of 21.6% of the total sample (40) while a small sample was obtained from Bp Tanzania which 10.3% (19) of all participants as shown in Fig 1 above.

Table 1: Demographic characteristics

Characteristics	Frequency	Percent
SEX		
Male	117	63.2
Female	68	36.8
Total	185	100.0
MARITAL STATUS		
Single	61	33.0
Married	104	56.2
Divorced	13	7.0
Widower	7	3.8
Total	185	100.0
RELIGION		
Christian	117	63.2
Muslim	68	36.8
Total	185	100.0
LEVEL OF EDUCATION		
Primary	45	24.3
Secondary	83	44.9
Tertially	57	30.8
Total	185	100.0

The summary results from table 1 show that about 56% (104) percents of participants were married while 63.2% (117) were Christians and 44.9% (83) had secondary education.

6.2 Types of Workplace HIV intervention services available

In determining the types of workplace HIV intervention activities available participants were asked whether they are aware of any of the HIV intervention activities conducted at their workplaces. Those who reported to be aware were also asked to mention these services .78.4% (145) of participants reported to be aware of various types of workplace HIV intervention and the majority 39.5% (52) mentioned peer education, condom supply 10% (13) ,VCT services 7.6% (11) and combination of those as shown in table 2 below

Table 2: Frequency Distribution of the types of intervention services

Type of intervention Service	Frequency	Percent
Peer Education	52	35.9
Condom supply	13	10.0
VCT Service	11	7.6
Combination of peer education and condom supply	27	18.6
Combination peer education and VCT services	17	11.8
Combination of condom supply and VCT Service	23	15.9
Others	2	1.4
TOTAL	145	100

6.3 VCT utilization

In exploring VCT utilization among employees as a result of workplace HIV interventions, participants were asked if they have ever heard about VCT since their employment at those companies and where do they usually get these informations. They were also asked if they had ever did VCT, where do they prefer to do VCT and reasons for their preference and whether these intervention activities has contributed anything towards liking to do VCT. The results are summarised in table 3 below:

About 86% (159) of participants responded that they have ever heard about VCT. Among those responded, 38.3% (59) said they were mostly receiving these information through their workplaces HIV activities, 25.3% (39) through media and 16.2% (25) at health facilities.

Table 3: Distribution of source of information on VCT

Where to get VCT information	Frequency	Percent
At workplaces	59	38.3
Media	39	25.3
Health facilities	25	16.2
Meetings and gatherings	9	5.8
Combine of workplace & media	9	5.8
Combine of workplace & health facilities	3	2.0
Combine of media & health facilities	8	5.2
Others	2	1.4
Total	154	100

Table 4: Distribution of responses if any VCT Services, if they have ever tested there and where do they prefer for VCT

IF any VCT service	Frequency	Percent
Yes	120	65.2
No	64	34.8
Total	184	100%
IF ever tested there		
Yes	57	46.3
No	66	53.7
Total	123	100
Where prefer for VCT		
at workplace VCT clinics	90	51.1
The clinics that are outside of the workplaces	86	48.9
Total	176	100.0

Sixty five percent of participants agreed that there is VCT services conducted at their workplaces. 53.7% (66) reported that they had never tested at their workplaces and among of these about 62% (44) were males. (P Value > 0.05). About 51% (90) prefer the onsite VCT clinics while the 49% (86) prefer the offsite clinics as summarised in table 4 above.



Table 5: Distribution of Reasons for VCT Clinics preference:

Reasons for onsite VCT Clinics		
	Frequency	Percent
Can be given the support from employers	18	19.8
Nearby hence serve time and costs	55	60.4
On assurance of confidentiality	10	11.0
Others	8	8.8
Total	91	100.0
Reasons for Offsite VCT		
To avoid stigma and discriminations	42	48.3
Not sure of confidentiality at workplace	34	39.1
Others	11	12.6
Total	87	100.0

The major reasons mentioned for preferring the onsite VCT were: because of being near by to the work and hence minimize inconveniences (60.4%), that they can be given support from employers when they fall sick (19.8%), maintaining confidentiality (11%) and others reasons 8.8% While the major reasons for offsite VCT were to avoid stigma and discrimination (48%), not sure of confidentiality at workplace 39% and others 12.6% as shown in table 5 above

Table 6: Distribution of responses on the Contribution of workplace HIV towards VCT among employees.

	Frequency	Percent
Yes	104	58.8
No	73	41.2
Total	177	100.0

About 59% (104) of participants said workplace HIV activities have contributed to the willingness for VCT among employees in which 68% (71) of participants were males. P value < 0.05 as summarised in table six above.

6.3 Stigma and Discrimination reduction among employees

In measuring stigma and discrimination among employees, participants were asked whether they are open on their HIV status and explanations of being open or not, if during their employments were forced to do HIV tests and exploring if any employees confirmed to be HIV would continue working. They were also asked whether the HIV workplace activities available have contributed to the reduction of stigma at the workplaces. The following were the results as shown below:

The study indicated that 72% (131) of participants were not requested to do HIV intervention during their employments while 28% (51) were requested to do the test. Among of who were not requested to test, about 53.4% were from the group of those worked for less than 5 years ($P > 0.05$)

Table 7: Distribution of responses on openness about HIV status and the given reasons for being open or not.

Response on Openness	Frequency	Percent
Yes	49	26.5
No	132	71.4
Total	185	100.0

Reasons for being open on HIV status

Sensitization and awareness given	25	56.8
Company policy to in courage & support those who become open	9	20.5
Others	10	22.7
Total	44	100.0

Reasons for not being open on HIV status

To avoid stigma and discrimination	61	48.4
No enough sensitizations on openness	18	14.3
The majority do not know their HIV status.	20	15.9
Others	13	10.3
Fear to loose job and other benefit	14	11.1
Total	126	100%

Among the participants 71.4% (132) said there is no openness among employees about their HIV status. The reasons mentioned for most employees of not being open about their status includes to avoid stigma and discrimination (48.4%), no enough sensitization on openness(14.3%),majority do not know their status (15.9%), fear to loose job (11.1%)

and others (10.3%). For those who reported openness among employees the major stated reasons were: Sensitizations and awareness sessions 56.8% (25) and workplace policy which encourages and supports those who become open 25%(9)

Table 8. Possibilities of continue working among employees if found HIV positive and the given reasons

	Frequency	Percent
Yes	148	81.8
No	33	18.2
Total	181	100.0
Reasons for continue working		
Never heard anybody fired because of HIV infection	34	24.5
Management commitments to support HIV positive employees	37	26.6
Because of workplace HIV policy against stigma and discrimination	56	40.3
Others	12	8.6
Total	139	100.0

From table 8 above approximately 82% (148) of interviewees believe that the management will still retain them despite of being HIV positive and the given reasons were workplace HIV policy (40.3%), Management commitments to support HIV positive employees (26.6%), Never heard anybody fired because of HIV infection (24.5%)

The study showed that about 60% (106) of respondents believed that workplace HIV programs have contributed to the reduction of stigma among employees while 40% (72) did not believe on that. Those who have been at work for a period of more than ten years seem to support more stigma reduction compared to those with short working periods. (P value<0.05)

6.4 Condom Utilization

In assessing condom utilization among employees, participants were asked whether there is a place where they can easily access condoms and if do they think those condoms are utilized. Further more they were asked if they had ever used condom in the last six months and if they do use condoms when with non regular partners. Here are results:

The results showed that 81% (146) of employees reported that condoms are available and accessed at the workplaces and 87.0 % (146) of respondents reported that those condoms available are being utilized by employees.

Table 9: Distribution if ever used condom in the last six months and frequency of condom use with non regular partners

If ever used condoms	Frequent	Percent
Yes	99	55.3
No	80	44.7
Total	179	100.0

Condoms use with non regular partners		
Yes	93	52.2
No	28	15.7
I don't have a non regular partner	57	32.1
Total	178	100.0

The study showed that 52.2% (93) of participants do use condoms when having sex with non regular partners; about 16% (28) do not use condoms and 32.1% (57) said don't have irregular partners. About 55% (99) of participants stated that they had ever used condom in the last six months and among of these 64% were males P value < 0.05.

6.5 Satisfaction with the workplace HIV interventions

In determining whether employees are comfortable with the workplace HIV intervention activities participants were asked to respond whether they are satisfied or not. They were further requested to give reasons for their options. These were the findings:

The results shows that 62.2% (115) of participants are satisfied with the workplace HIV intervention while 36.8% (36.8) are not satisfied. The reasons mentioned for satisfaction or dissatisfaction is summarised in table 10 below:

Table 10: Distribution of responses for satisfaction of workplaces and the given reasons

Responses	Frequency	Percent
Yes	115	63.2
No	67	36.8
Total	182	100.0

Reasons for Satisfaction		
Provides good education on HIV issues	50	46.7
Have brought behaviour changes among employees in VCT and condom use	19	17.8
Various services are provided like education, Condom, VCT	19	17.8
Others	19	17.8
Total	107	100.0

Reasons for Dissatisfaction		
few sensitization and awareness given	31	50.8
No much changes seen due to these activities	18	29.5
Others	12	19.7
Total	61	100.0

CHAPTER SEVEN

7.0 DISCUSSIONS

The study was designed to assess the effectiveness of workplace HIV interventions among private companies in terms of VCT utilization, condom supply and use, and stigma and discrimination reduction among employees.

7.1 VCT utilization

The study showed that the majority of employees 85.9% (159) are aware of VCT services at their workplaces and that the major sources of information which were mentioned include workplace intervention activities 38.3% (59) which could be a good source for increasing VCT uptake.

The findings from this study showed that VCT services are available at workplaces as about 65% (120) of participants reported the availability of the services. This is in contrary to a study done in East Africa in private firms which indicated that less than 50% of these firms had VCT services (Ramachandran, 2007). Similar differences are recorded with a study done in Zambia which showed that about 15% of business firms have VCT services (Baggaley, et al 1995). The observed differences can be due to the national campaign on VCT program. This campaign scaled up the VCT services in the country and also the difference in study methodologies where in this study participants

were employees while in the other studies information were from employers/management.

Despite that the fact that the majority reported the availability of workplace VCT services, only 46% reported to have ever tested at their workplaces. This can be explained by mainly two reasons of preferring the offsite VCT; (i) To avoid stigma and discrimination at works if found positive 48% and (ii) 39% of them were unsure of confidentiality at workplace. This observation is supported by a study done in South Africa which revealed barriers to uptake of VCT in the workplace, including among others: - perceived violations of confidentiality by healthcare staff and fear of discrimination. (Bhagwanjee et al 2008). Also a study by Robert Stewart et al supports the findings of this research where by participants reported that VCT at the workplace is not being utilized by workers because of fears of HIV-related stigma and discriminations. (Robert Stewart, et al 2002)

This study also revealed that about 51% of participants preferred doing VCT at their workplace in comparison of 41% preferring the off site VCT, which is similar to the results of a study done in Zimbabwe in 2006 which indicated that 51% reported using the onsite VCT compared to 49% who reported using the offsite VCT. (Corbett, et al 2006)

This study showed that 58.8% (104) of respondents reported that the workplace HIV activities have contributed to the willingness among employees for VCT uptake. This

could be explained by the regular of sensitizations and awareness sessions and campaigns about VCT at the studied companies. It is also supported by a study done in South Africa which has shown that workplace HIV intervention is an effective tool in promoting VCT as 61% of workers who visited the clinic agreed to do VCT (Noko et al, 2002).

7.2 Stigma and discriminations

The findings of this study showed that 18% of participants were required to do HIV testing in the course of their employment. Apart from the possibility that those who were found positive could not be employed but also it is against the ILO code of conduct. These findings are comparable to a study done in Beijing, Hong Kong and Chicago where all employers were reluctant to employ HIV positive individuals (Rao et al, 2008). The same findings were established in a study done in Kenya whereby six companies required all applicants or employees to undergo HIV testing. (Roberts , Wangombe, 1995) as well as in a study done in Zambia which showed that 5 out of 33 business firms requested all employees to do HIV Tests. (Baggaley et al 1995)

It was revealed that most of employees are not open on their HIV status if they are positive or negative. More than 71% of participants said that they don't think if there is openness among employees. Among the reasons mentioned behind this were to avoid stigma and discrimination (48.4%) and fear to loose their jobs or other benefits (11.1%). In concurrence to the mentioned reasons , findings from a study done in South Africa showed that 23% of workers were worried that they would be fired if the

company learns that they are HIV-positive (Robert, et al 2002). Similar findings revealed that many employers when they get information that employee(s) have got HIV/AIDS, either give them transfer to their nearest domicile places (if their offices are available on those places) or dismiss them from employment and sometimes fellow workers do stigmatize them. (Abinery M, 2002)

Approximately 82% (148) of employees believe that the management will still retain them despite of being HIV positive. From the study there were several reasons to support this, 40.3% believe on workplace HIV policy available, 26.6% of the interviewees believe in management commitment to support HIV positive employees. While 24.5% said that they have never heard of any body being fired because of HIV. It is also supported by the findings from the study which showed that almost all businesses offered some medical benefits to their employees (Roberts ,Wangombe 1995).

The study showed that about 60% (106) of respondents believed that workplace HIV program have encouraged the reduction of stigma among employees. Those who have been at work for a period of more than ten years seem to support more stigma reduction compared to those with short working period. These findings are an indication that if the programs is sustained and implemented to all workplaces it could bring good results into stigma reduction.

7.3 Condom use

The study has revealed that about 81% (146) of interviewee reported that condoms are available at their works and they believe they are utilized by employees. This is similar to the findings in a study done in Kenya which had indicated that about 90% of all companies involved in the study were distributing condoms at their workplaces (Robert & Wangombe, 1995)

The findings from this study has shown that only 16% of interviewees do not use condoms when with non regular partners in comparison to a study done in two ministries in Tanzania which has indicated that 25% and 38% of the workforce did not used condoms in their last sexual Intercourse with non spouse sexual partners respectively (Ndenzako & Mwakitoshi 2003). Another study has also shown that 66% of respondents did not use condom frequently (Sloan & Myers 1995). This indicates the decline of individuals who don't use condom with non regular partners which could be a result of HIV workplace preventive activities.

7.4 Satisfaction of employees with workplace HIV Intervention

The findings from this study have shown that 63% of participants are satisfied with work place HIV intervention. This is supported by the given reasons that they get good education on HIV issues (50%) which brought changes among employees in terms of VCT and Condom use.

CHAPTER EIGHT

CONCLUSION AND RECOMMENDATION

Workplace HIV intervention is effective. The study has shown majority of employees are satisfied with the workplaces HIV programs which has contributed to most employees to reduce stigma, uptake VCT, and the use of condoms and hence recommend the following:

1. Workplace HIV intervention should be promoted and strengthen because it is the major source of information to most employees about HIV related issues. It is also the route to VCT as most employees prefer testing at workplace
2. The management of the companies should consider incorporating ARV provision because some of the participants stipulated it as the barrier to VCT. Also the sensitization and awareness sessions should be frequently conducted.
3. The government should support and make sure that all private companies /institutions implement workplace HIV intervention because it is effective and an important tool in fighting the diseases

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