ASSESSMENT OF HIV/AIDS WORKPLACE POLICIES AND PROGRAMME INTERVENTIONS IN COMMERCIAL FARMS IN IRINGA REGION

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Masters of Public Health Dissertation
Muhimbili University of Health and Allied Sciences
October 2013

ASSESSMENT OF WORKPLACE HIV/AIDS POLICIES AND PROGRAMME INTERVENTIONS IN COMMERCIAL FARMS IN IRINGA REGION

By

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A Dissertation Submitted in (Partial) Fulfilment of the Requirement for the Degree of Masters of Public Health (MPH) of Muhimbili University of Health and Allied Sciences

Muhimbili University of Health and Allied Sciences
October 2013

CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the Muhimbili University of Health and Allied Sciences a dissertation entitled ***Assessment of Workplace HIV/AIDS Policy and Programme Interventions in Commercial Plantations in Iringa Region*** in (partial) fulfilment of the requirements for the degree of Master of Public Health (MPH) of Muhimbili University of Health and Allied Sciences.

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(Supervisor)

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ACKNOWLEDGEMENT

I appreciate the support of all individuals and institutions that made this dissertation possible. I acknowledge the technical support and guidance received from my supervisor, Dr M. J. Ezekiel during the preparation and completion of this dissertation. Special thanks are extended to Mr Faustine J. Mayunga who assisted me in understanding the analysis of quantitative data. I would also want to extend my appreciation to the academic and administrative staff of the School of Public Health and Social Science (SPHSS) for their support and contribution from the conception of the research idea to the completion of this dissertation.

I would like to thank the management of Unilever Tea Company, Mufindi Tea Company, Mufindi Paper Mills, Tanganyika Wattle Company Limited (TANWAT) and Kibena Tea Company for granting me the opportunity to undertake this study in their companies. I wish to especially acknowledge Dr. Mhagama, Dr. Francis Ngw'ita, Ms. Bathsaba Liduke, Mr. Francis Mwahihula and Dr. Makweta for their support during data collection. I am also grateful to Mr. Frederick Mhhenzi for his assistance during the data collection and processing.

Last but not least I would like to thank my parents Mr and Mrs Josephat Matimbwi for their proper upbringing which made me who I am today. Thank you very much, you are wonderful parents. I will not be grateful if I do not appreciate the patience, encouragement and support received from my husband David Kiula, my son Alpha David and daughters Annalynda and Abigail David. God bless you all.

ABSTRACT

Background: For about three decades, many companies have been responding to the HIV/AIDS crisis through establishment and implementation of HIV workplace policies and programme interventions. However, little is known about the effectiveness of these policies and programme interventions.

Objective: The objective of this study was to assess the effectiveness of workplace HIV/AIDS policy and programmes interventions in commercial plantations in Iringa region

Methodology: A descriptive cross sectional study was conducted in five commercial plantations. Interviews were conducted with one representative of management from each company and self-administered questionnaires were administered to 273 employees from the commercial plantations. Data obtained was Analysed using Statistical Package for Social Scientist version 17 (SPSS).

Results: Results showed a high level of knowledge and awareness of organizations HIV/AIDS policies, programme interventions and services among employees. More than three quarters (87.2%) of respondents were aware about the existence of company policy and 77.7% knew its content. Utilisation of the organisational offered programmes and services were very high. A majority 91.2% of respondents reported that condoms made available were utilized by employees. More than half (74.4%) of respondents utilised VCT services at workplace and majority (82.8%) preferring onsite VCT clinic. The study revealed that 76.2% and 76.6% of respondents are satisfied with the HIV prevention and care and treatment services respectively.

Conclusion: Workplace HIV/AIDS interventions have contributed significantly to the employees' willingness to utilise condoms, VCT and treatment services. HIV/AIDS workplace programme interventions are effective and should be scaled-up to contribute to national efforts of reversing the epidemic.

LIST OF ABBREVIATIONS

ABCT	AIDS Business Coalition for Tanzania
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical and Research Foundation
ARV	Antiretroviral Drugs
ART	Antiretroviral Treatment
GiZ	German International Development Cooperation Agency
GoT	Government of Tanzania
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
Kibena Tea	Kibena Tea Company Limited
MPM	Mufindi Paper Mills Company
MTC	Mufindi Tea Company Limited
NACP	National AIDS Control Programme
NMSF	National Multisectoral Strategic Framework
OIs	Opportunistic Infections
PSI	Population Service International
RA	Research Assistant
RAS	Regional Administrate Secretariat
STIs	Sexually transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TANWAT	Tanganyika Wattle Company Limited
THMIS	Tanzania HIV and Malaria Indicator Survey
TPAWU	Tanzania Plantations, Agriculture Workers Union
TZS	Tanzania Shillings
UNAIDS	United Nation Programme on HIV/AIDS
Unilever	Unilever Tea Company
USAID	United State Development Agency
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WPP	Workplace Policy and Programme

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DEFINITION OF TERMS

Effectiveness: For the purpose of this study effectiveness means assessing if the HIV/AIDS workplace policy and programme has achieved its intended outcomes. It involved using descriptive research methodologies in order to determine if selected commercial plantations were doing the right things basing on the selected indicators as predetermined by the ILO (ILO Code of conduct on HIV/AIDS, 2001) on HIV workplace programme outcomes.

HIV Workplace policy: For the purpose of this study HIV workplace policy means a written document that sets out an organization's position and practice that relate to HIV/AIDS. It is a plan of action or statement of aims and ideas in dealing with HIV. Policies inform employees about their responsibilities, rights and expected behaviour on the job.

HIV Workplace Programme: For the purpose of this study: HIV/AIDS workplace programme is a set of co-ordinated interventions developed to reduce new HIV-infections and to manage HIV/AIDS in the work environment.

Condom promotion: For the purpose of this study condom promotion means providing education, counselling and encouragement to employees to use condoms for preventing HIV infections. The promotion involves education on proper and consistent use; and distribution to make condoms readily available to staff either for free or at highly subsidized prices.

Condom Utilization: For the purpose of this study condom utilization means the amount of condoms distributed and consumed by the employees at the workplace. The consumption is measured by the amount of condom picked at the distribution points within workplaces by employees.

Voluntary counselling and testing (VCT): For the purpose of this study VCT means a process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision

must be entirely the choice of the individual and he or she must be assured that the process will be confidential. VCT services could be provided onsite (at workplace) and offsite (referred to the nearby health facility).

Peer educator: For the purpose of this study a peer educator is a person with whom someone shares certain attributes or characteristics including rank in in the workplace, educational background, department, social status, age etc. A peer educator in the context HIV/AIDS is a volunteer with the right skills, who supports others in their environment (including staff) to reduce their risk of HIV infection and transmission, and whom one seek HIV services if they are infected and/or affected.

Stigma: In this study stigma means a social mark that when associated with a person, usually causes marginalization or presents an obstacle to the full enjoyment of social life by the person living with HIV.

Discrimination: In this study, discrimination means treating someone differently and unfairly because of his or her HIV status or perceived status as being affected by HIV and AIDS.

CHAPTER 1: INTRODUCTION

1.1 Background

HIV/AIDS is widely acknowledged as a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights. The epidemic undermines social and economic development and affects all levels of society; national, community, family and individual as well as the workplace (Mahajan et al, 2007). At the workplace, HIV/AIDS is recognised as a big threat to productivity and profitability of the organizations as well as the welfare of employees and their families (Bloom and Buve, 2007).

Though, HIV prevalence has been reported to be stabilising, however, the global and national figures are still high while new infections are recorded daily. UNAIDS reported that by the end of 2011, 34 million people were living with HIV worldwide, 1.7 million people died due to HIV/AIDS related diseases; and 2.5 million new infections were recorded (UNAIDS 2012). Among the people living with HIV, 30.8 million are adults who are in the working age group of 15-49 years. Although HIV/AIDS is found in all parts of the world, some areas are more afflicted than others. Sub-Saharan Africa has been hit hard by the HIV/AIDS than other parts of the world. An estimated 23.5 million people are living with virus in the region, more than two thirds of the global total (UNAIDS 2012). In 2011 around 1.2 million people died from AIDS in sub-Saharan Africa and 1.8 million people became infected with HIV (UNAIDS 2012).

In Tanzania HIV/AIDS prevalence stands at an average of 5.1 percent of the adult population aged 15-49 years. Among the 1.6 million people living with HIV, 60 percent are 25 to 49 years old, and 29 percent are 15-24 years (THMIS 2011/12). The recent survey on HIV and Malaria indicator in Tanzania show that most HIV/AIDS cases fall within the age group 20-49 years; peak age for females being 30-34 years while that for males is 35-44 years (THMIS 2011/12). These statistics portray that HIV/AIDS is strongly affecting the

productive generation and the workforce of the country's industries. Available data from voluntary HIV testing in the workplace among southern African firms indicate prevalence in the range of 12–24% (Evian et al 2004). The epidemic deprives companies of skilled and experienced employees, increases human resources costs for replacement and additional training and thus negatively affects the overall climate for investment and economic growth (Evian et al 2004).

To respond to the HIV/AIDS pandemic, in 1999 the government of Tanzania declared HIV/AIDS as a national disaster which was followed by establishment of the National HIV and AIDS Policy (2001), National Multisectoral Strategy (2004/08&2008/12) and an independent AIDS Commission 2001, (TACAIDS) to coordinate HIV interventions in the country. In 2008 the parliament enacted the HIV/AIDS prevention and control law. The HIV Policy, Strategies and the Law recognise potentials that workplace could bring in preventing and controlling HIV/AIDS. They therefore, require every employer in the country to implement workplace programmes on HIV/AIDS.

In 1990s, most work places in Tanzania, particularly multinational companies including commercial plantations, started developing and implementing HIV/AIDS workplace policy and programmes (AMREF 2003). HIV/AIDS workplace policy provides guidance on company's commitment to provide HIV/AIDS services to its employees. Workplace programmes refer to a range of company based including voluntary counselling and testing (VCT), provision of antiretroviral treatment (ART), peer education, condom distribution, awareness sessions and stigma and discrimination prohibition (Mahajan et al, 2007). HIV/AIDS workplace policies and programmes in companies including commercial plantations have been implemented in Tanzania for a long while but documentation on its effectiveness in contributing to the control of the epidemic is limited. Therefore, this study wishes to contribute to the body of knowledge on the effectiveness of HIV work place policies and programmes in the national HIV response.

1.2. Statement of the Problem

Since 1990s various organizations, both public and private, have been implementing HIV/AIDS workplace policy and programmes to manage the disease. In Tanzania most of the private companies took own efforts to initiate HIV workplace policy and programmes unlike the public sector (TACAIDS 2004). The baseline study done by Global Business Coalition in 2006 reported that large African companies and multinationals operating in Africa are leading the way in implementing workplace programmes. This is not surprising because Africa is the hardest hit region in the world, and the epidemic has potentially catastrophic implications for society and the economy. Potential drivers of business response in southern Africa include limiting the HIV burden among workforces, controlling the costs of AIDS to employers (Bloom et al, 2000), meeting legislative requirements, and fulfilling principles of corporate social responsibility (Dickinson and Stevens 2005).

In Tanzania, initially private sector received technical support from the AMREF, thereafter; in 2004 AIDS Business Coalition for Tanzania (ABCT) took over this role and was charged under the National Multisectoral Strategy on HIV/AIDS (2008/12) as national coordinator for private sector response to the pandemic (NMSF 2008/12). Large commercial plantations like Unilever Tea and Mponde tea farm were among the first companies to register membership with ABCT (ABCT, 2008). Large commercial farms, member and non-members of ABCT have put in place programmes to manage HIV/AIDS at the workplace including community outreach, but their experiences with regard to implementation of the programmes have not been well documented. A vast amount of literature on experiences and effectiveness on how organizations have responded to HIV/AIDS in communities exists, but little has been documented with regards to effectiveness of HIV/AIDS workplace interventions in particular private companies including commercial farms (TACAIDS, 2004)

It has been observed that despite of the progress that have been achieved by business companies to address the problem of HIV at both the workplace and in the communities in which they exist, there is still the need for more research on effectiveness of these programmes in particular to understand/document experiences of commercial plantations with regard to their internal functioning, policies, structures and resources to respond to the challenges posed by HIV/AIDS.

Likewise, quite a lot has been documented regarding the process of developing HIV/AIDS workplace policies in a number of organizations, but very little information has been documented on issues arising from the process of enforcing the policies and effective implementation of the workplace programmes.

Therefore, the aim of this study was to assess the effectiveness of HIV workplace policies and programmes in commercial plantations.

1.3 Conceptual analysis

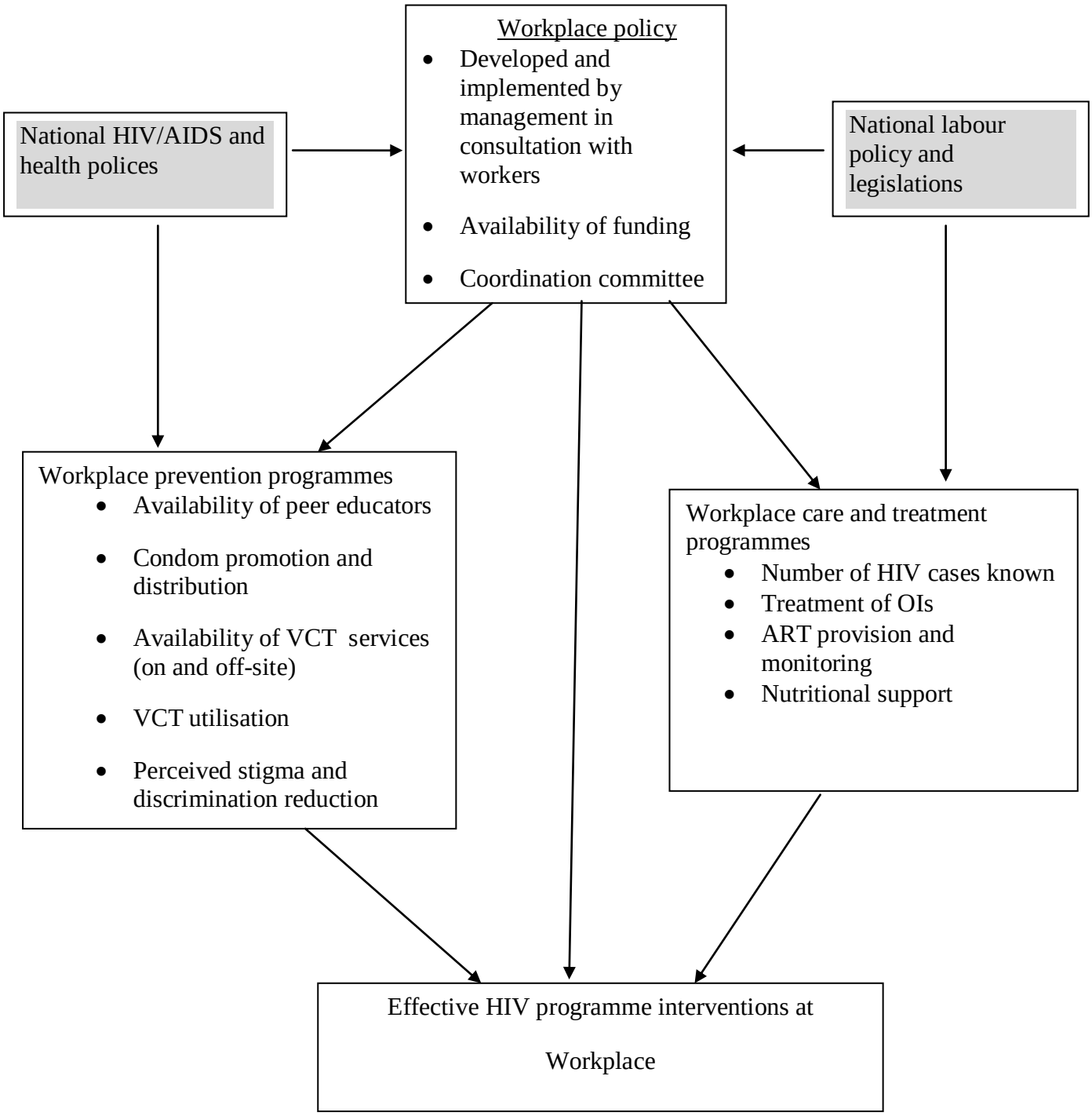


Figure 1: Conceptual model of workplace HIV/AIDS programmes for large firms

Source: Mahajan et al (2007). An overview of HIV/AIDS workplace policies and programmes in southern Africa

Figure 1 presents conceptual model of workplace HIV/AIDS programmes for large firms. Items appearing in white boxes represent categories of firm-level response to HIV/AIDS. Bullets describe type of intervention within the

category. Drivers and design of workplace policies include national health and labour legislations and policies. In large firms, workplace policies often determine the characteristics of prevention, treatment and impact mitigation programmes.

1.4 Rationale of the study

The workplace setting is considered as an effective environment for delivering HIV/AIDS programmes to a wide range of people who might not otherwise have access to HIV/AIDS prevention education and raise their awareness of care and support services (Vass and Phakhat, 2006). Business can play a vital role in HIV/AIDS prevention, care, and support efforts, by distributing condoms, providing voluntary counselling and testing, and expanding access to care and treatment. Mobilizing corporate resources in resource constrained regions may prevent further economic and social damage, which after all is in the best interests of businesses and workers alike (Vass and Phakhat, 2006). In this regards, assessing the effectiveness of these policies and programmes is paramount in order to identify strength, areas of improvement and lessons learnt for scaling up such interventions or reviewing current practices.

The results of this study will provide information on the effectiveness of HIV/AIDS intervention in and through workplaces in commercial farms. The information will enable policy makers and planers, companies and other interested organizations to develop appropriate strategies for HIV workplace interventions which respond to the needs of large commercial farms. The study findings will also contribute to the existing knowledge about HIV/AIDS workplace policy and programmes in Tanzania.

1.5 Research Questions

1. What is the level of awareness among employees in commercial plantations about HIV workplace policy?
2. What type of workplace HIV/AIDS programmes interventions exist?
3. How do HIV/AIDS workplace programmes bring changes among employee in terms of VCT uptake and condom use?

1.6 The Study Objectives

1.6.1. Broad Objective

To assess the effectiveness of workplace HIV/AIDS policy and programmes interventions in commercial plantations in Iringa region

1.6.2. Specific Objectives

1. To assess employees awareness on the content of the company HIV/AIDS policy
2. To assess the knowledge by workers on availability of different types of HIV/AIDS workplace programmes intervention services
3. To assess condom promotion at workplace
4. To assess condom utilisation among employees
5. To assess employees utilization of VTC services
6. To determine employee satisfaction with services provided through HIV workplace programmes in selected plantations

CHAPTER 2: LITERATURE REVIEW

2.1. HIV in the Commercial Plantations

Agriculture is the mainstay of the Tanzanian economy. About 80 percent of all Tanzanians are employed in the sector and derive their livelihoods primarily from agriculture. The sector accounts for about half of the national income and three quarters of merchandise exports earnings (GoT, 2006). The agricultural sector of Tanzania may conveniently be divided into two sub-sectors, namely, plantation farming (the focus of the present study) and smallholder semi-subsistence farming. Farming is a labour intensive but is highly affected by the HIV/AIDS. The sentinel surveillance data shows that HIV prevalence has remained steadily higher in the commercial plantations than in the general population. Nyemba (2008) reported that the Ministry of Health and Child Welfare (MoHCW) in Zimbabwe in 2004 recorded a prevalence of 35 percent among workers in the commercial plantations. Agro-estate in Kenya recorded a prevalence of 25 percent among employees in the commercial farms (Rugalema et al, 1999). A recent study reported that in regions with tea plantations in Kenya had higher prevalence for HIV/AIDS than the national average; for instance, Kericho, had a prevalence of 9.9 percent than the national average prevalence of 6.1 percent in the same year, 2005 (Njoroge, 2012).

High HIV prevalence in commercial plantations might have been contributed by the colonial legacy, workers' compounds on large farms constitute small, and much closed, communities that are poorly endowed with social and recreational facilities, other than the ubiquitous beer outlet frequented by young and old, men and women (Rugalema et al, 1999). This statement illustrates that there is not much entertainment on the farms besides the beer ceremonies which make the farm workers more susceptible to risky behaviour and eventually causes the high HIV prevalence. Rugelema et al, 1999 proposed that, the key to maintaining the commercial viability of agro-estates is to reduce operational costs incurred by HIV/AIDS by formulating and implementing sound workplace HIV prevention programmes.

2.2 HIV/AIDS Policy at workplace

The USAID (USAIDS, 2008) defines an HIV/AIDS policy as a statement of an organization's position and practice on how the organization will prevent and respond to HIV infection among employees. A policy that is well written and communicated should guide managers' decisions and inform staff members about their rights and responsibilities within the organization (USAIDS, 2008). A study which was done by an NGO called STOP AIDS NOW (2010) found that having a written policy assists in ensuring that all staff are treated fairly and with consistency. It enhances the possibility of continuity in response. It encourages better planning and therefore budgeting of response. Having a written document also helps to integrate the HIV response with other systems and policies, and enables legal compliance with national legislation. It also provides an accountability framework for funds received from different sources to finance HIV responses. A written document clearly demonstrates to staff that the organization takes their welfare seriously. Yet having a written policy in itself is, of course, not sufficient and needs to be complemented by programmes.

Mahajan et al 2007 found that among 187 southern African firms who have a policy, 48% affirmed that their policy addresses the issue of discrimination in promotion, pay, and benefits based on HIV status. There has been a dramatic increase in policies among the southern African firm respondents over the past 3 years, from 27% in 2003 to 58% in 2005 (Mahajan et al, 2007).

2.3 HIV/AIDS programmes at the workplace

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

employers; valuable skill and experience is lost. The majority of those who die of AIDS are adults in their prime workers at their most productive. In 2003 ILO reported that in 1999, the 80 percept of newly infected people in Rwanda, Tanzania, Uganda and Zambia were aged between 20 and 49 years(ILO, 2003:10). Therefore, workplace HIV interventions are sought to be an important strategy for prevention, treatment and mitigating the impact of HIV/AIDS.

The aims of the HIV/AIDS programmes at the workplace are to ensure that employees affected by HIV/ AIDS are not unfairly discriminated against. In employment policies and practices, to promote a healthy work environment, to screen for purposes of exclusion from work, confidentiality on HIV/AIDS status, continuation of the employment relationship, provision of prevention education programmes and care and support (ILO, 2001). These interventions may result into saving companies as it revealed in HIV economic study done in Kenya in 1992 (Strode & Smart, 1992). A study in Botswana has shown that most employees seem to respond well to the workplace HIV programmes (Barese, 1995). Despite of the response by 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 and Lukwago, 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 services (Ramachandran et al, 2007).

2.4 Condom promotion and distribution

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

A workplace intervention study done in two ministries in Tanzania indicate that 25 percent and 38 percent of the workforce did not use condoms in their last

sexual intercourse with non-spouse sexual partners respectively and 26 percent and 42 percent of workforce could not explain how to use a condom properly (Mwakitoshi and Ndenzako, 2003). The low usage of condoms is also indicated in the evaluative study on HIV workplace programme done in south Africa in 2005 which has shown that only 34 percent of subjects used condoms frequently (Meyers and Sloan, 2005). Furthermore, a study done in Senegal indicated that about 46.5 percent of participants showed positive attitude toward use of condoms after being informed by preventive programme at workplace (Mbaye, et al 2003).

2.5 Voluntary Counselling and Testing

Voluntary Counselling and Testing (VCT) is one of the determinants of the success of workplace HIV intervention programme. It has been observed that if there is an improvement in VCT sites in terms of accessibility and confidentiality more people are willing to utilise these services. This is proved in the study conducted in South Africa in 2003 that 26 percent of participants had positive towards testing due to the improvement of confidentiality and conveniences of company VCT site (Day et al, 2003). A workplace HIV VCT uptake study done in Zimbabwe in 2006 has also shown that workplace offers high uptake where 51 percent reported using the onsite VCT compared to 49 percent 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).

2.6 Stigma and discrimination at workplace

Pre-employment HIV/AIDS screening, whether for assessment of fitness to work for insurance purposes, should not be required and raises serious concerns about stigma and discrimination. A study done by Achmat and Cameron, in 1995, in South Africa show that pre-employment screening for HIV is unacceptable. The workplace HIV interventions are essential to create the climate of collective responsibility and mutual understanding required to

protect individuals with HIV/AIDS from stigmatization and discrimination by co-workers, employers or clients and union (WHO, 1998).

A study done in Kenya show that some employers need all job applicants or employees to undergo HIV testing and majority of workers thought that they would be fired if they were or suspected to be infected with HIV (Wangombe, 1995). Another study which was done in cities of Beijing, Chicago and Hong Kong on stigma and discrimination at workplace has shown that employers from all three cities are reluctant to hire people living with HIV (Rao et al 2008). As a measure to manage HIV related stigma at workplace; the ILO tenth regional meeting in Addis Ababa in December 2003, insisted that African governments should support efforts of employers and workers to oppose stigma and discrimination at workplace.

CHAPTER 3: METHODOLOGY

3.1 Study design

A cross sectional study was conducted in five commercial plantations to describe the effectiveness of HIV/AIDS workplace polices and programme interventions. The study employed a combination of quantitative and qualitative methods of data collection through interviews and questionnaire survey. The study focused on two levels: individual employees and management (HIV/AIDS coordinators).

The study conducted non-experimental direct analysis in which the assessment of effectiveness was done in companies implementing HIV interventions. It involved examining if workplace programmes were achieving intended outcomes in providing HIV services to employees.

3.2 Study area

This study was conducted in Iringa region because it hosts many commercial plantations implementing HIV/AIDS workplace programmes. Iringa has thirty five big commercial plantations; thirteen were implementing HIV/AIDS interventions at workplace during the study time. In addition, Iringa region has higher HIV/AIDS prevalence of 9.1% which is above the national average of 5.1% in the country. It is the region where major transport route to southern Africa countries and Democratic Republic of Congo passes through. Southern Africa countries contribute significantly to the global HIV new infections (UNAIDS 2012).

3.3 Study population

The study involved 5 representatives of the management, one from each company (all companies were represented by HIV/AIDS coordinators) and employees who had worked for more than one year with the selected plantations which implemented HIV/AIDS workplace policy and programmes in Iringa region.

3.4 Sampling and sample size

3.4.1 Sample size

The minimum sample required was estimated using the following formula:

$$n = \frac{z^2 p(100 - p)}{\varepsilon^2} \qquad \frac{1.96^2\ 50(100 - 50)}{6^2}$$

n = 273

Where:

p= estimated proportion of workers with knowledge on HIV/AIDS policy and programme (put at 50% since proportion is not known form the previous studies)

ε = margin of error on p (taken to be 6%)

z= standard normal deviate value that corresponds to confidence level of 95%)

Therefore n= 273

The estimated size of the sample was 273 employees distributed among the five plantations, proportionately. In addition 5 HIV/AIDS coordinators, one from each company was involved in an in-depth interview.

3.6.3 Participants' selection procedure

The study participants were selected from the list of employees who were present during the study period. The study involved those who had been in employment for more than one year in order to involve those who were exposed to the HIV/AIDS workplace programme interventions.

In order to ensure equal participants representation per company; the number of participants per company was obtained by a simple formula of taking a total number of eligible employees from a company divided by the total number of all eligible employees from the five companies times the sample size. For example, to get participants from Unilever Tea, I took 3798 eligible participant

from Unilever tea divide by 14803 as a total of all eligible participants from the five plantations times 273 (study sample) i.e. 3798/14803x273= 70. The list of eligible employees was obtained from the human resource officers.

Table: 3.1 Participant Eligible for the study from the five commercial plantations

No.	Company	Total number of Employees per company	Eligible Employees	Proportion of study participant
1	Kibena Tea Company	3766	2548	47
2	Mufindi Paper Mills	2810	2223	41
3	Mafinga Tea Company	3600	2982	55
4	Tanwat Company	4060	3255	60
5	Unilever Tea Company	5780	3795	70
	Total	20016	14803	273

3.6.3.1 Inclusion criteria

Those who have been in employment for more than one year and those were available during the study period.

3.6 Sampling technique

The study employed simple random sampling technique. The five commercial farms involved in the study were selected randomly from the list of plantations implementing workplace HIV interventions in Iringa region. The company list was obtained from the office of Regional Administrative Secretary and Regional HIV/AIDS coordinators. Names of all companies were written separately in the piece of papers, mixed in a box and picked the paper one at a time

3.5 Study variables

The principal outcome variable was:

1. Effective HIV/AIDS workplace policy and programme

Indicator variables are;

1. Endorsed HIV/AIDS workplace Policy
2. Awareness on HIV/AIDS workplace interventions and services
3. Availability of condom
4. Condom utilization by employees
5. Availability of VCT services
6. Utilization of VCT services by employees

These are among the indicators that describe effectiveness of an HIV/AIDS workplace policy and programme interventions.

3.3 Data collection techniques and tools

Data was collected using a structured questionnaire with open and closed ended questions. Self-administered questionnaires sought information on awareness on the existence and utilization of HIV/AIDS programme interventions and services by employees. Interview questions were used to collect data from the management level. Data collected from interviewing employers/management was meant to complement data from the quantitative data collected from employees. Interviews provided information on types of services provided by the company and the ways they used to inform all employees and benefit from those services.

The pretesting of the instruments was done before the commencement of the study at Kamadolesi farm in Mafinga. It involved 20 employees, Kamadolesi farm was not involved in the sampling frame for companies to be involved in the study. Results from the pre-test tool were used to improve and finalize the data collection tools.

3.7 Data collection

One day training was given to a research assistant by the principal investigator, to familiarize him with the research tools and study methodology. The training focused on the study background, objectives, tools and tasks.

Data collection tools were translated into Kiswahili. For quantitative data, questionnaires were prepared with open and closed ended questions. For collecting qualitative data, interview guide was prepared. Pre testing of the tools was done at Kamadolesi farm before collecting data.

For quantitative data, the method used was a self-administered questionnaire to collect the respondents' answers. The questionnaire constituted 37 questions. The questionnaire was distributed during weekdays working hours with permission being granted to do so from the farm authorities. The principal researcher and the assistant were present when participants were filling in the questionnaire and provided clarification when required to do so. The data collection was done from the 10th to 24th December 2012.

For qualitative data, face to face interviews were conducted with 5 HIV coordinators, one from each company. Interviews were recorded and researchers requested the interviewees to take notes during the sessions.

3.8 Data processing and analysis

Statistical Package for Social Scientists (SPSS) was used for analysing quantitative data. Cross tabulation to test response by chosen variables while frequencies were used for univariate variables. Statements, figures and tables are used to present the results.

All in-depth interviews were tape recorded and transcribed verbatim by interviewers (research assistants and principle investigator) every evening after the field work. The completed transcripts were reviewed by the principal investigator. The complete data set was coded and analysed according to themes using INVIVO8. The key study themes and the findings are presented thematically in chapter four below.

3.9 Limitation of the study

The cross-sectional design of this study whereby respondent's knowledge on availability and utilization of HIV workplace services were measured at the same point in time made it difficult to assess progress overtime. The study could not identify differences between employees in companies with and without HIV workplace policies and programme interventions. Rather, it only established awareness and utilization of HIV workplace policy and services for companies implementing workplace programmes.

The reliance of this study upon self-reported behaviour increased the likelihood of information bias occurring. Due to the sensitive nature of this study, participants were less likely to report engaging in what may be socially unacceptable behaviour such as not using condom with non-regular partners or if tested for HIV. As a result, there was likelihood of over or underreporting in different study variables. As a result of recall bias there was a greater likelihood of events, which took place in the past suffering from under-reporting. In addition, there were limitations in accessing workers in some of studied companies because they were busy finalising their annual plans because data collection for this study was conducted in December. This might have caused sampling bias in not having representation across company departments.

3.10 Ethical considerations

Ethical clearance was obtained from the Muhimbili University of Health and allied sciences. Permission was obtained from the Regional Administrative Secretary (RAS) in Iringa, District councils of Mafinga and Njombe and companies' managements. Consent from the participants was asked either by physical conversation or reading for them consent forms which were attached to the questionnaires. Information related to the aim and the rights of participants were clearly explained to participants before taking part in the study.

CHAPTER FOUR: RESULTS

4.1. Quantitative Results

4.1.1 Description of the study participants

A total of 273 participants were recruited in the study, whereby about two third (67%) were male and 33% female. Table 4.1.1 indicates that the more respondents were in the age group 25 to 34 years (38.5%). Using the statistical technique for estimating the mean from the grouped data a mean of 32.68 years (standard deviation 10.07) was calculated. The recruitment resulted into response rate of 100%.

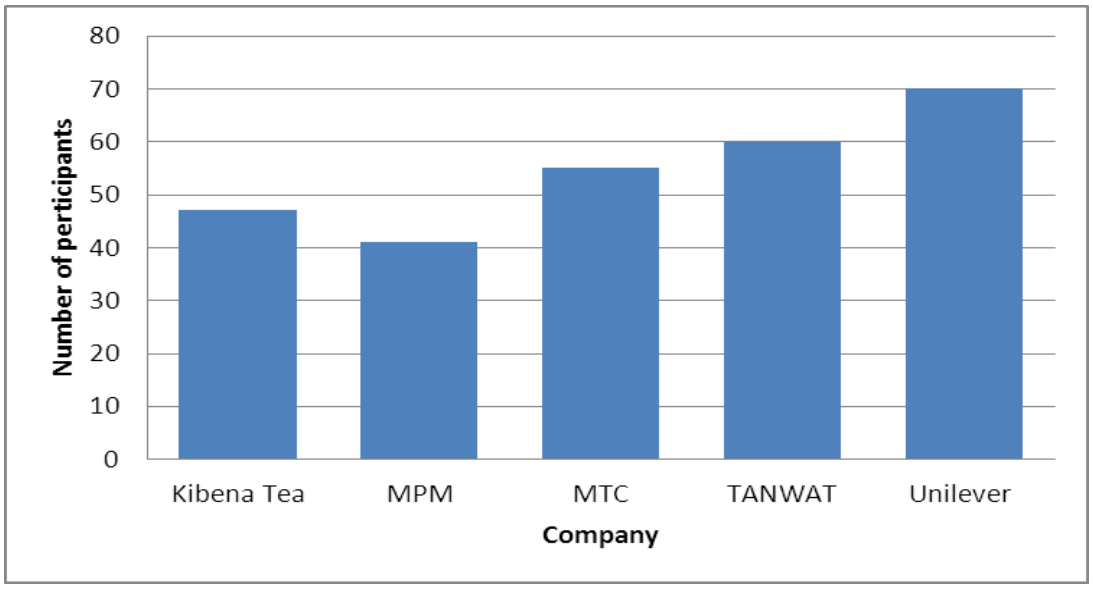


Figure 2: Participants distribution per company

Unilever Tea provided a large proportion of 25.6% of participants of a total sample while Mufindi Paper Mills (MPM) provided the smallest proportion (15%) of all participants as shown in the figure 1.

The summary results from the table 4.1.1 below show that more than half (59.7%) of participants were married while 94.5% were Christians and almost equal proportion of participants 45.5% and 43.6% had primary and secondary education respectively.

Table 4.1.1: Demographic characteristics of the study participants

Characteristics	Frequency	Percent
Sex		
Male	183	67
Female	90	33
Total	273	100
Age		
15-24	65	23.8
25-34	105	38.5
35-44	69	25.3
45+	34	12.4
Total	273	100
Marital status		
Single	90	33
Married	163	59.7
Divorced	9	3.3
Widow	11	4
Total	273	100
Religion		
Christian	258	94.5
Muslim	15	5.5
Total	273	100
Level of education		
Primary	125	45.8
Secondary	119	43.6
Tertiary	29	10.6
Total	273	100

4.1.2 Employees awareness on the content of the company HIV/AIDS policy

One of the objectives of this study was to assess employees' awareness on the content of the company HIV/AIDS policy. To assess the awareness a series of questions were asked and analysis of those who were aware of the existence of the HIV workplace policy were done in order to find out whether different companies, age and gender groups differed in their responses about knowing the HIV/AIDS workplace policy well. The results can be seen in tables 4.1.2 and 4.1.3.

Table 4.1.2: proportion of Employees who were of the HIV/AIDS company policy by demographic characteristics

Demographic Characteristics N=273	**Total N)**	**Yes N (%)**	**No N (%)**
Sex			
Male	183 (67)	155 (84.7)	28 (15)
Female	90 (33)	83 (92)	28 (15.7)
Age group			
15-24	65 (23.8)	51(78.5)	14(21.5)
25-34	105 (38.5)	93 (88.6)	12 (11.4)
35-44	69 (25.3)	63 (91.3)	6 (8.7)
45+	34 (12.5)	31 (91.2)	3 (8.8)
Level of education			
Primary	125 (45.8)	119 (95.2)	6 (4.8)
Secondary	119 (43.6)	96 (80.7)	23 (19.3)
Tertiary	29 ((10.6)	6 (20.7)	6 (20.7)

More than three quarter (87.2%) of the respondents indicated that they were aware of the company HIV/AIDS policy. Overall, employees across the demographic characteristics knew about the existence of company policy. More (95.2%) respondents attended primary level education were aware of HIV policy than respondents across other characteristics. More work is required for those who are attained higher education levels (see table 4.1.2).

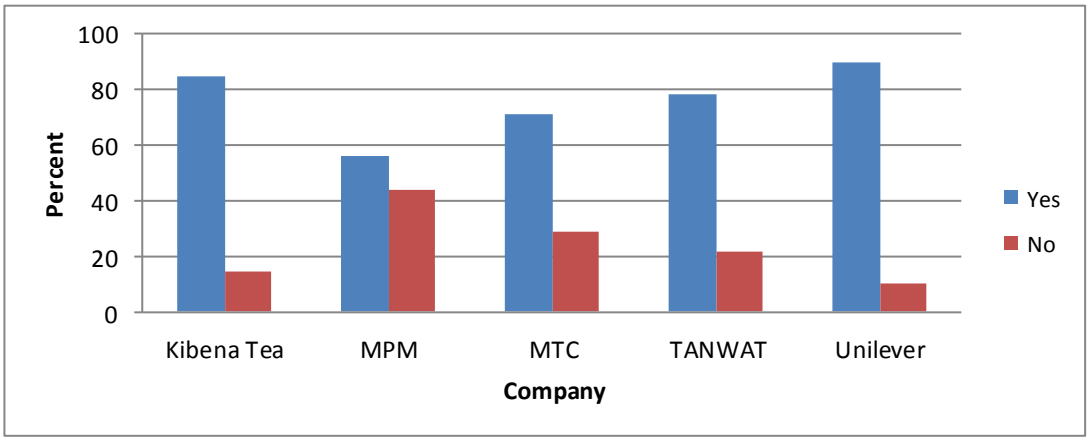


Figure 3: Proportion of employees' awareness on HIV/AIDS company policy by company

Figure 3 show that more (90%) of respondents from Unilever Tea Company were aware on the existent of company policy compare to other companies. However, it seems that more work is required for the Mufindi Paper Mills in order for them to become familiar with the company HIV/AIDS policy

Table: 4.1.3: Frequency Distribution of Employees who knew different components of HIV company policy

Components of HIV policy (n=215)	**Frequency**	**Percent**
HIV prevention services	110	51.2
HIV education	80	37.2
Treatment, care and support	9	4.2
Stigma and discrimination	16	7.4

In a further analysis, those who knew the components of company HIV/AIDS policies were collated and analysed in order to find out whether they knew the details of those policies. The results can be seen in table 4.1.3. Over half (51.2%) of respondents mentioned that they knew prevention services, HIV education 37.2%, 7.4% knew clauses that prevent HIV related stigma and discrimination and 4.2% mentioned treatment, care and support services.

Table 4.1.4: Proportion of Employees who knew components of company HIV/AIDS policy by demographic characteristic and company

Characteristics N=215	**Total N (%)**	**HIV Prevention**	**HIV education**	**Treatment**	**Stigma and discrimination**
Sex					
Male	138 (64.2)	74 (53.6)	51 (37.0)	4 (2.9)	9 (6.5)
Female	77 (35.8)	36 (46.8)	29 (37.7)	5 (6.5)	7 (9.1)
Age Group					
15-24	45 (20.9)	22 (48.9)	19 (42.2)	1 (2.2)	3 (6.7)
25-34	84 (39.1)	47 (56.0)	31 (36.9)	3 (3.6)	3 (3.6)
34-45	56 (26.0)	28 (50.0)	20 (36.7)	2 (3.6)	6 (10.7)
45+	30 (14.0)	13 (43.3)	10 (33.3)	3 (10.0)	4 (13.3)
Education level					
Primary	104 (48.4)	57 (54.8)	32 (30.8)	7 (6.7)	8 (7.7)
Secondary	88 (40.9)	47(53.4)	32 (36.4)	2 (2.3)	7 (8.0)
Tertiary	23 (10.7)	6 (26.1)	16 (69.6)	0 (0.0)	1 (4.3)

More than three quarters (77.7%) of respondents knew the content of the company HIV/AIDS policy. It was found that the entire male and female respondent knew at least one of the components of the company policy on HIV and AIDS. More male (53.6%) and female (46.8%) knew about the prevention component while very few 2.9% and 6.5% knew about treatment, care and support respectively (see table 4.1.4).

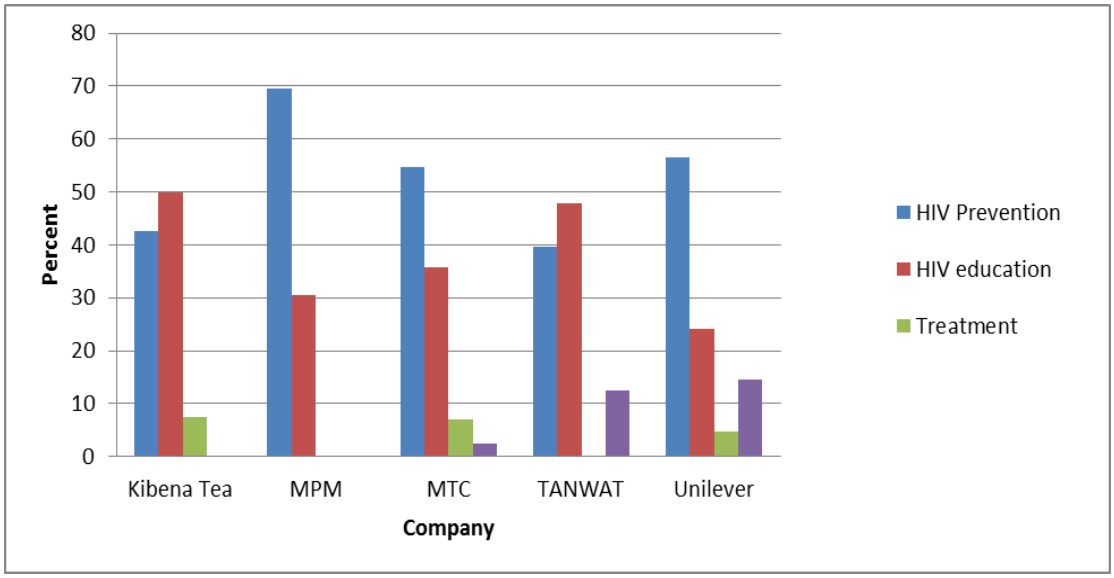


Figure 4: Figure 4: Proportion of Employees who knew components of company HIV/AIDS policy by company

Figure 4 show that more (69.9%) participants from Mufindi Paper mills said that the company policy contains prevention issues and none of them knew about stigma and discrimination and treatment, care and support components. Again no respondent from Kibena Tea Company knew about stigma and discrimination.

4.1.3 Types of HIV/AIDS workplace programme interventions and services available

In assessing whether employees knew about the availability of different types of HIV/AIDS workplace programme interventions and services in their companies, a series of questions were asked. Majority (83.2%) of respondents knew about the existence of HIV interventions and services in the company. Table 4.1.5 shows proportion of employees knowledgeable about the types of HIV workplace interventions by selected demographic characteristics.

Table 4.1.5: Proportion of Employees who were Knowledgeable of the types of HIV interventions at workplace by demographic characteristic

Demographic Characteristics N=(273)	Total N (%)	Yes N (%)	No N (%)
Sex			
Male	183 (67)	148 (80.9)	35 (19.1)
Female	90 (33)	79 (87.8)	11 (12.2)
Age group			
15-24	65 (23.8)	56 (86.20	9 (13.8)
25-34	105 (38.5)	85 (81.0)	20 (19.0)
35-44	69 (25.3)	57 (82.6)	12 (17.4)
45+	34 (12.5)	29 (85.5)	5 (14.7)
Education level			
Primary	125 (45.8)	107 (85.6)	18 (14.4)
Secondary	119 (43.6)	98 (82.4)	21 (17.6)
Tertiary	29 ((10.6)	22. (75.9)	7 (24.1)

Overall, more than three quarter of respondents across demographic characteristics were knowledgeable on the types of HIV interventions at workplace. More (87.8%) female respondents were aware about the types of workplace interventions than male (see table 4.1.5). As well, more respondents (93.3%) from Kibena Tea Company knew about components of the HIV programme interventions compared to the rest of the companies (see figure 5).

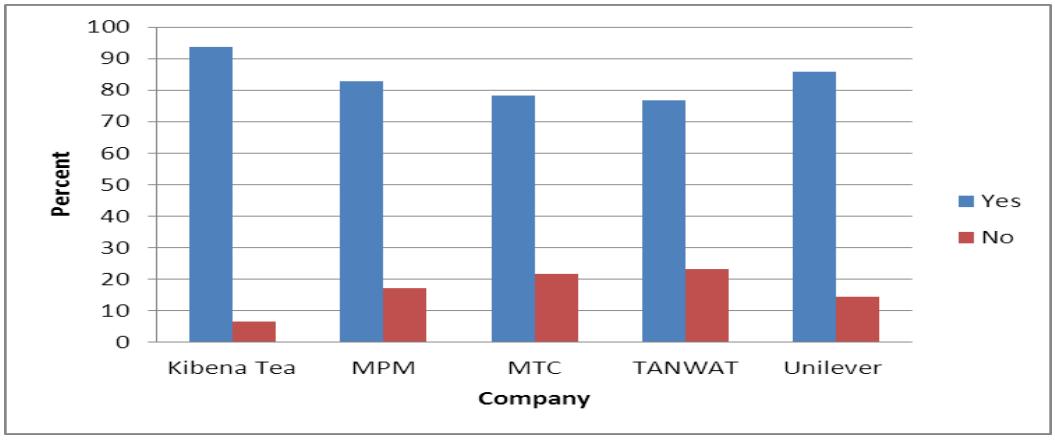


Figure 5: Proportion of employee who are knowledgeable of the types of HIV interventions at workplace by company:

Table 4.1.6: Frequency distribution of types of HIV workplace interventions mentioned by study participants

Type of intervention (N=273)	Frequency	Percent
Peer education	111	40.7
Condom provision	97	35.5
VCT	16	5.9
Treatment and care and support	46	16.8
Others	3	1.1

Those who reported to know various types of workplace HIV interventions were also asked to mention them. Majority (40.7%) mentioned peer education followed by condom provision 35.5%, treatment care and support 16.8% and lastly VCT services 5.9% (see table 4.1.6).

4.1.4 Condom promotion and utilization at workplace

In assessing condom promotion at workplaces, respondents were asked whether the company made condoms available at work places and they can be easily accessed by employees. In addition, the study assessed if condoms were utilised by employees. Respondents were asked if they think those condoms were utilized by employees and if they used condoms with non-regular partners. Further analysis was done to assess condom promotion and utilization by company and demographic characteristics of respondents. Results are summarised in subsections and table 4.1.7 and figure 6.

4.1.4.1 Condoms availability at workplace

The study result show that 76.2% of respondents reported that condoms were made available and accessed at workplace. In determining the relationship on knowledge of condom availability by demographic characteristics, the study found that more male (73.3%) respondents and those in the age group of 35-44 years (85.5%) knew about the availability of condoms at workplace than their counterparts in same demographic characteristics. In addition, more (90.9%) respondents who were widows and those reached primary level education (86.4%) knew about the availability of condoms in the company.

The result show that more work need to be done to increase awareness on the availability of condoms in the company for young people. as shown in table 4.1.7

Table 4.1.7: Proportion of employees knew about availability of condoms at workplace by demographic characteristics

Demographic characteristics N=273	**Total N (%)**	**Yes N (%)**	**No N (%)**
sex			
Male	183 (67.0)	142 (77.6)	41 (22.4)
Female	90 (33.0)	66 (73.3)	24 (26.7)
Age group			
15-24	65 (23.8)	43 (66.2)	22 (33.8)
25-34	105 (38.5)	78 (74.3)	27 (25.7)
35-44	69 (25.3)	59 (85.5)	10 (4.5)
45+	34 (12.5)	28 (82.4)	6 (17.6)
Education level			
Primary	125 (45.8)	108 (86.4)	17 (13.6)
Secondary	119 (43.6)	79 (66.4)	40 (33.6)
Tertiary	29 ((10.6)	21 (72.4)	8 (27.6)
Marital status			
Single	90 (33)	61 (76.8)	29 (32.2)
Married	163 (59.7)	131 (80.4)	32 (19.6)
Divorced	9 (3.3)	6 (66.7)	3 (33.3)
Widow	11 (4.0)	10 (90.9)	1 (9.1)

Figure 6 summarises proportion of employees (study participants) responses on availability of condoms by company participated in the study. The findings show that respondents from all companies knew about condom availability. However, more 97.9%, (respondents) from Kibena Tea Company knew about availability of condoms at workplace, than the rest of respondents from other participating companies. More work is required for TANWAT company on

making their employees aware on availability of condoms in the worksite premises (see figure 6).

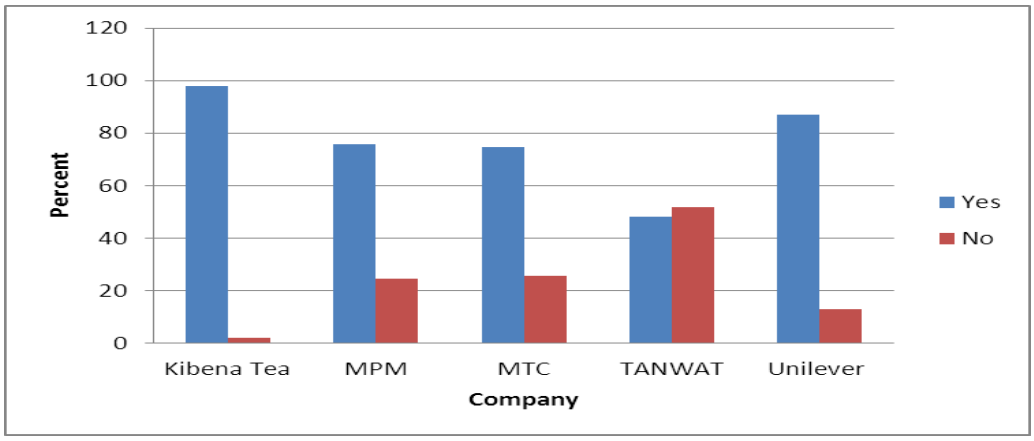


Figure 6: Proportion of employees knew about availability of condoms at workplace by Company

4.1.4.2 Condom Utilization at workplace

The study found that condoms which were made available at workplaces were utilized. A majority (91.2%) of respondents reported that those condoms available were being utilized by employees. The study results show that 63.0% of respondents used condom when having sex with irregular partners. More than half (70.7%) of respondents stated that they had ever used condoms in the past six months as presented in tables 4.1.8.

Table 4.1.8: Distribution of employees taking condoms, if ever used in the past six months and used condoms with non-regular partners

Variables	Frequency	percent
Workers are using taking condoms		
Yes	249	91.2
No	24	8.8
Ever used condoms in the past six months		
Yes	193	70.7
No	80	29.3
Used condom with non-regular partners		
Yes	172	63
No	20	7.3
I do not have irregular partner	81	29.7

Further analysis on condom utilization by company and demographic background was done. Results on condom utilization by company demographic background are summarised in table 4.1.9, 4.1.10 and 4.1.11.

The study findings present that most of the respondents by demographic characteristics knew about condom utilization at workplace, though, with varying magnitude. More females (93.3%) knew about condom utilization at workplace compare to males; more respondents (93.3%) at age range 25 to 34 years knew more about condoms utilization than the rest; while respondents with primary level education (95.2%) and all widows and divorced married respondents knew about condom utilization at workplace than others in the same demographic characteristic categories (see table 4.1.9).

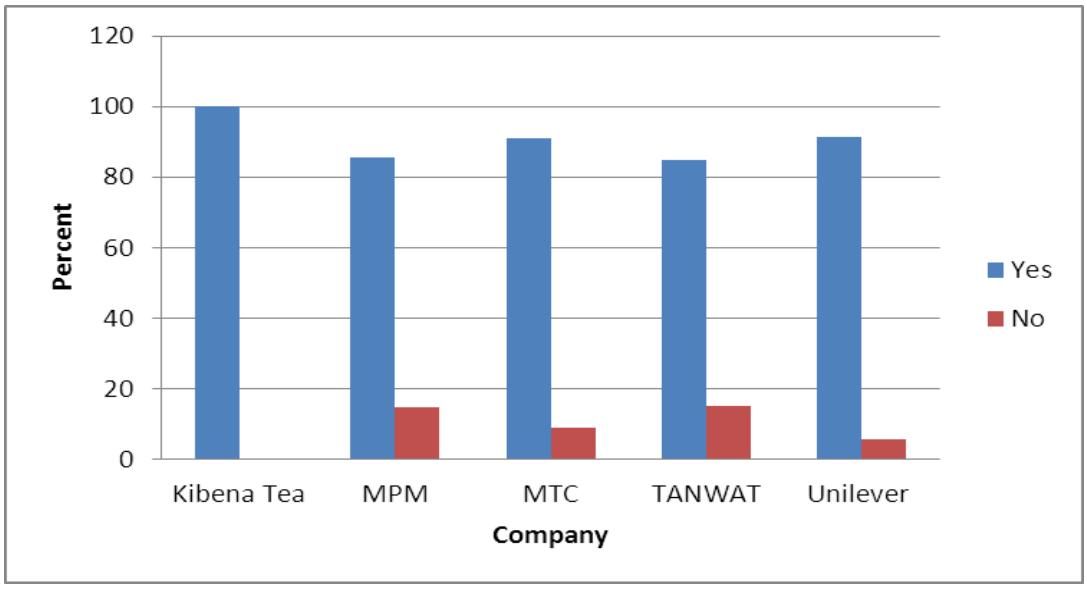


Figure 7: Proportion of Employee on utilization of condoms by company

Figure 7 shows that high proportion of study participants from all companies reported that condoms provided at workplaces were utilized by employees. All (100%) study participants from Kibena Tea Company confirmed that condoms provided at the company were utilised.

Table 4.1.9: Proportion of workers utilized condoms by demographic characteristics

Demographic Characteristics N=273	**Total N (%)**	**Yes N (%)**	**No N (%)**
Sex			
Male	183 (67)	165 (90.2)	18 (9.8)
Female	90 (33)	84 (93.3)	6 (6.7)
Age			
15-24	65 (23.8)	57 (87.7)	8 (12.30
25-34	105 (38.5)	98 (93.3)	7 (6.7)
35-44	69 (25.3)	64 (92.8)	5 (7.2)
45+	34 (12.5)	30 (88.20	4 (11.8)
Education level			
Primary	125 (45.8)	119 (95.2)	6 (4.8)
Secondary	119 (43.6)	105 (88.2)	14 (11)
Tertiary	29 ((10.6)	25 (86.2)	14 (11.8)
Marital status			
Single	90 (33)	79 (87.8)	11 (12.2)
Married	163 (59.7)	150 (92)	13 (8)
Divorced	9 (3.3)	9 (100)	0 (0.0)
Widow	11 (4)	11(100)	0 (0.0)

Table 4.1.10: Proportion of Employees ever used condoms in the past six months by demographic characteristics

Demographic characteristics N=273	**Total N (%)**	**Yes N (%)**	**No N (%)**
Sex			
Male	183 (67)	136 (74.3)	47 (25.7)
Female	90 (33)	57 (63.3)	33 (36.7)
Age group			
15-24	65 (23.8)	41 (63.10	24 (36.9)
25-34	105 (38.5)	81 (77.1)	24 (22.9)
35-44	69 (25.3)	51 (73.9)	18 (26.1)
45+	34 (12.5)	20 (58.8)	14 (41.20
Education level			
Primary	125 (45.8)	89 (71.2)	36 (28.8)
Secondary	119 (43.6)	84 (70.6)	35 (29.4)
Tertiary	29 ((10.6)	20 (69.0)	9 (31)
Marital Status			
Single	90 (33)	64 (71.1)	26 (28.9)
Married	163 (59.7)	116 (71.2)	47 (28.8)
Divorced	9 (3.3)	7 (77.8)	2 (22.2)
Widow	11 (4.0)	6 (54.5)	5 (45.5)

The study also sought to find out if employees are utilizing condoms, did they use condoms in last six months by demographic characteristics. About 70.1% of respondents used condom in the past six months. Out of these, more males (74.3%) reported used condoms in the past six months. More (77.1%) respondents of age 25-34 years reported using condoms than older and younger ages. By marital status more divorced (77.8%) reported used condoms than married. More employees with primary level education (71.2%) reported used condoms in the past six months than more educated colleagues in the sample (see table 4.1.10).

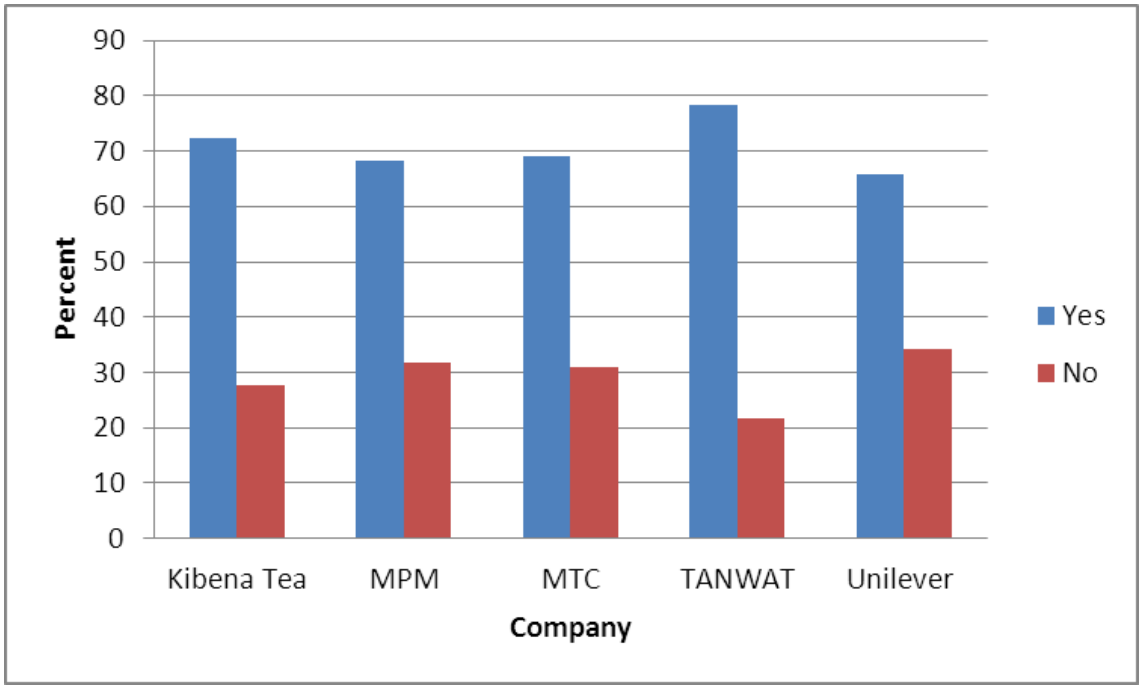


Figure 8: Proportion of employees ever used condom in the past six months by company

Findings show that more than half of respondents from all companies utilized condoms in the past six months. However, more (78.3%) respondents from Tanwat Company used condoms in the past six (see table 8).

Table 4.1.11: Proportion of employees who used condoms with non-regular partners by demographic characteristics

Demographic characteristics	**Total**	**Yes**	**No**
N=273	**N (%)**	**N (%)**	**N (%)**
Sex			
Male	183 (67)	162 (88.5)	21 (11.5)
Female	90 (33)	69 (76.7)	21 (23.3)
Age group			
15-24	65 (23.8)	49 (75.4)	16 (24.6)
25-34	105 (38.5)	91 (86.7)	14 (13.3)
34-44	69 (25.3)	61 (88.4)	8 (11.6)
45+	34 (12.5)	30 (88.2)	4 (11.8)
Education level			
Primary	125 (45.8)	108 (86.4)	17 (13.6)
Secondary	119 (43.6)	99 (83.2)	20 (16.8)
Tertiary	29 ((10.6)	24 (82.8)	5 (17.2)
Marital Status			
Single	90 (33)	73 (81.1)	17 (18.9)
Married	163 (59.7)	140 (85.9)	23 (14.1)
Divorced	9 (3.3)	7 (77.2)	2 (22.2)
Widow	11 (4)	11 (100)	0 (0.0)

Using condoms with irregular partner is recommended as appropriate means of prevention for contracting HIV and other STIs. Overall, more (88.7%) of male respondents reported using condom with non-regular partners than female. All widow respondents reported using condoms in the marital status category (see table 1.4.11).

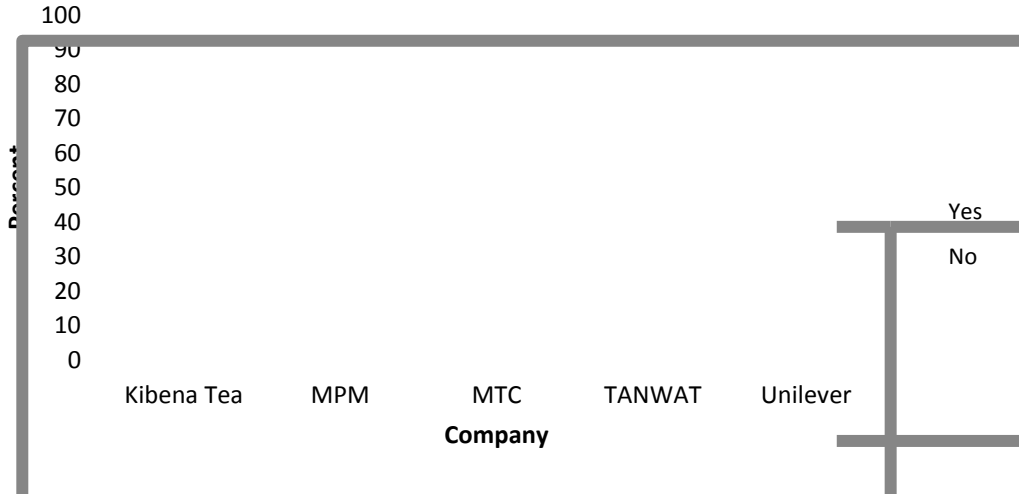


Figure 9: Proportion of employees who used condom with non-regular partners by company

Figure 9 shows that more (89.2%) of respondents from Kibena Tea Company reported used condoms with non-regular partners than other companies. However, in all companies more than half of study participants reported using condoms with non-regular partner.

4.1.5 VCT utilization at workplaces

In assessing VCT utilization among employees as a result of workplace interventions, respondents were asked if they had have ever heard about VCT services in their workplaces since they were employed in those companies and where they usually get information. They were also asked if they had ever attended VCT, where preferred to do VCT and reasons for their preference. In the further analysis the study wanted to find out if HIV workplace programme interventions had any contribution on employees' decision to go for VCT. The study results on VTC are stated and summarised in tables 4.1.12, 4.1.14, 4.1.15, 4.1.16, 4.1.17, 4.1.18.

Table 4.1.12: Reported sources of information on VCT

Where to get VCT information (n)=273	Frequency	Percent
At workplace	237	86.5
Media	13	4.8
Health facilities	14	5.1
Meetings and gathering	10	3.6

About 86.5% of respondents had heard about VCT in their workplaces. Other respondents said that they received information on the VCT from other sources like health facilities 5.1%, 4.8% through media and 3.6% from meetings and gatherings. Workplace saves as a main source of information for VCT among employees.

Table 4.1.13: Proportion of employees who knew about the availability of VCT services at workplace by demographic characteristics

Demographic characteristics N=273	**Total N (%)**	**Yes N (%)**	**No N (%)**
Sex			
Male	183 (67)	165 (90.2)	18 (9.8)
Female	90 (33)	85 (94.4)	5 (5.6)
Age group			
15-24	65 (23.8)	55 (84.6)	10 (15.4)
25-34	105 (38.5)	94 (89.5)	11 (10.5)
35-44	69 (25.3)	67 (97.1)	2 (2.9)
45+	34 (12.5)	34 (100)	0 (0.0)
Education level			
Primary	125 (45.8)	123 (98.4)	2 (1.6)
Secondary	119 (43.6)	102 (85.7)	17 (14.3)
Tertiary	29 ((10.6)	25 (86.2)	4 (13.8)
Marital Status			
Single	90 (33)	79 (87.8)	11 (12.2)
Married	163 (59.7)	151 (92.6)	12 (7.4)
Divorced	9 (3.3)	9 (100)	0 (0.0)
Widow	11 (4)	11 (100)	0 (0.0)

The study found that more than three quarter across demographic characteristics knew about availability of the VCT services at workplaces. More female (94.4%) knew about VCT services in the workplace than their male counterparts. All widow and divorced respondents knew about the availability of VCT services at workplace. The findings show that respondents

from all companies, though, at varying proportions, confirmed availability and utilized VCT services at workplaces. All respondents from Unilever Tea Company knew about availability of VCT services at workplaces as shown in table 4.1.13.

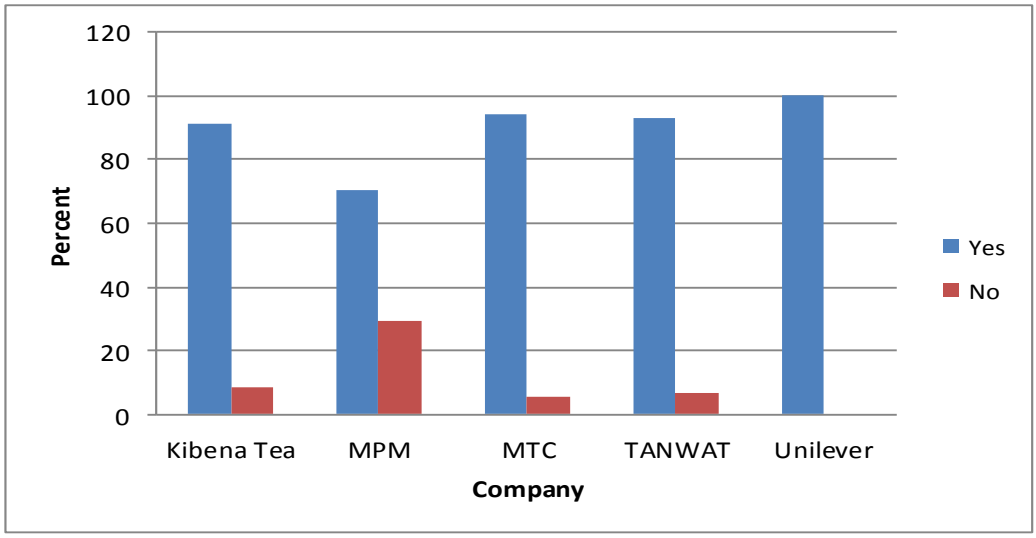


Figure 10: Proportion of employees who knew about the availability of VCT services at workplace by company

Figure 10 summarises proportion of employees (study participants) responses on availability of VCT services at workplace by company participated in the study. The findings show that respondents from all companies, though at varying proportions, confirmed availability of VCT services at workplaces. All study participants from Unilever Tea Company reported availability of VCT services at workplace. Mufindi Paper Mills presented the least response in responding on the availability of the VCT services in their company.

Table 4.1.14: proportion of employees ever tested in the past 12 months by demographic characteristics

Demographic characteristics N=273	**Total N (%)**	**Yes N (%)**	**No N (%)**
Sex			
Male	183 (67)	133 (72.7)	50 (27.3)
Female	90 (33)	70 (77.8)	20 (22.2)
Age group			
15-24	65 (23.8)	44 (67.7)	21 (32.3)
25-34	105 (38.5)	79 (75.2)	26 (24.8)
35-44	69 (25.3)	57 (82.6)	12 (17.4)
45+	34 (12.5)	23 (67.6)	11 (32.4)
Education level			
Primary	125 (45.8)	99 (79.2)	26 (20.8)
Secondary	119 (43.6)	83 (69.7)	36 (30.3)
Tertiary	29 ((10.6)	21 (72.4)	8 (27.6)
Marital status			
Single	90 (33)	62 (68.9)	28 (31.1)
Married	163 (59.7)	127 (77.9)	36 (22.1)
Divorced	9 (3.3)	6 (66.7)	3 (33.3)
Widow	11 (4)	8 (72.7)	3 (27.3)

Among the 273 study participants, majority 74.4% of respondents reported that they had received VCT services in the past twelve months. Further analyses by demographic characteristics indicated that more female (77.8%); 77.1% of respondents in the age group 35-44 years; married employees (82.6%) and primary level employees (79.2%) utilized VCT services in the past twelve months than others (see table 4.1.14).

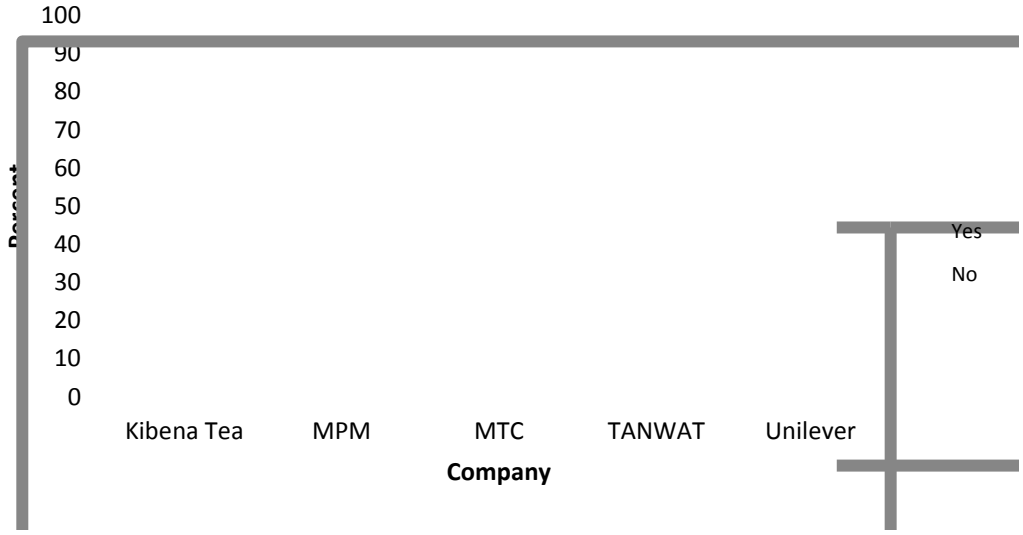


Figure 11: Proportion of employees ever tested in the past 12 months by company

Figure 11 show that a large proportion of Unilever Tea Company employees (respondents) 88.6% utilized VCT in the past 12 months while low proportion (46.35%) of employees from the Mufindi Paper Mills utilised VCT services.

Table 4.1.15: Distribution of responses by employees who took test at the workplace and preference for either onsite or offsite VCT

Variables	Frequency	percent
If tested at workplace		
Yes	167	64.7
No	91	35.3
Preference to go for VCT		
At workplace VCT clinic	226	82.8
Clinics that are outside the workplace	47	17.2

About 74.4% of respondents reported that they had ever tested at their workplaces. About 82.8% of respondents prefer onsite VCT clinic while 17.2% prefer to go for offsite VCT as summarised in table 4.1.15.

Table 4.1.16: Reasons for VCT clinic preference

Reasons for onsite and offsite VCT (n=273)	Frequency	Percent
Nearby, hence save time and cost	178	65.2
Assurance of confidentiality	3	1.1
Receive support on treatment and care	43	15.8
Good quality services	18	6.6
To avoid stigma and discrimination	10	3.7
Lack of confidentiality health care workers	21	7.7

Respondents gave different reasons for preferring either onsite or offsite VCT clinics. More than half (65.2%) of respondents said that they preferred onsite VCT because the services were provided nearby to the work station and hence minimise the cost for transport and time; about 15.8% of respondents mentioned the possibility of receiving support on care and treatment; the good and reliable services at the company service 6.6%; and 1.1% for assurance and reliable confidentiality. However, 3.7% of respondent would prefer for offsite VCT services to avoid stigma and discrimination and 7.7% were not sure of confidentiality at workplace as shown in table 4.1.16.

Further analysis on the preference for taking either onsite or offsite VCT by company and demographic characteristics was done and results are summarised in table 4.1.17 and figure 12. Higher proportion (86.1%) of female respondents preferred onsite VCT services. More employees from Unilever Tea Company (94.3%) preferred utilizing the onsite VCT services while majority (43.9%) employees (respondents) of Mufindi Paper Mills Company prefer taking offsite VCT services.

Table 4.1.17: Proportion of staff preference to take VCT services onsite or offsite by demographic characteristics

Demographic characteristics N=273	Total N= (%)	Onsite N (%)	Offsite N (%)
Sex			
Male	183 (67)	148 (80.9)	35 (19.1)
Female	90 (33)	78 (86.7)	12 (13.3)
Age group			
15-24	65 (23.8)	51 (78.5)	14 (21.5)
25-34	105 (38.5)	85 (81.0)	20 (19.0)
35-44	69 (25.3)	62 (89.9)	7 (10.1)
45+	34 (12.5)	28 (82.4)	6 (17.6)
Education level			
Primary	125 (45.8)	111 (88.8)	14 (11.2)
Secondary	119 (43.6)	91 (76.5)	28 (23.5)
Tertiary	29 ((10.6)	24 (82.8)	5 (17.2)
Marital status			
Single	90 (33)	72 (80)	18 (20)
Married	163 (59.7)	136 (83.4)	27 (16.6)
Divorced	9 (3.3)	8 (88.9)	1 (11.1)
Widow	11 (4)	10 (90.9)	1 (9.1)

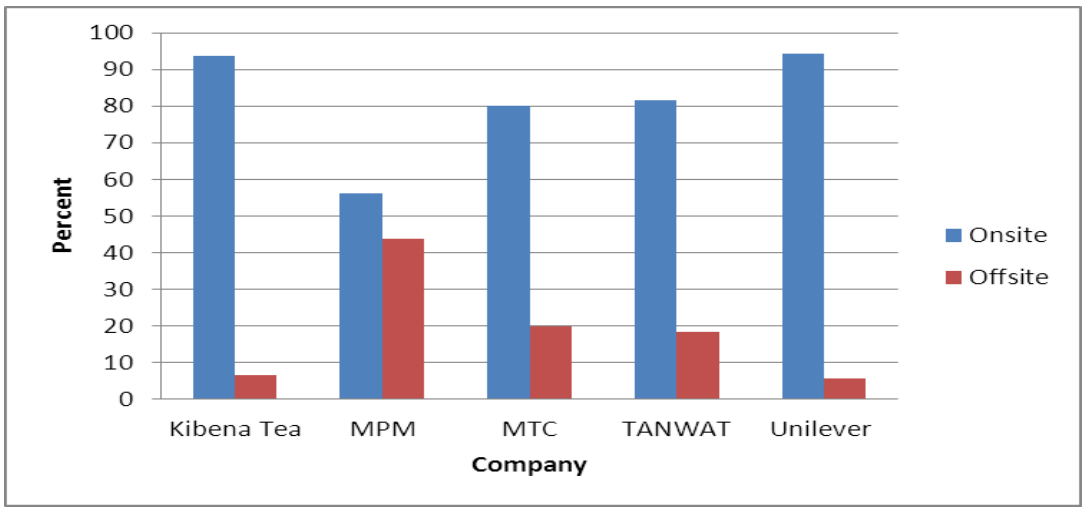


Figure 12: Proportion of staff preference to take VCT services onsite or offsite by company

More employees from Unilever Tea Company (94.3%) as well as Kibena Tea Company (93.6) preferred utilizing the onsite VCT services while majority (43.9%) of employees (respondents) of Mufindi Paper Mills Company prefer taking offsite VCT services. In addition, more proportion of employees (respondents) in TANWAT and Mufindi Tea Company (MTC) preferred offsite VCT services (see figure 12).

Table 4.1.18: Variation in reported HIV prevention interventions in increasing uptake of VCT services by demographic characteristics N=268

Demographic characteristics N=268	**Total N (%)**	**Yes N (%)**	**No N (%)**
Sex			
Male	182 (67.0)	141 (77.5)	41 (22.5)
Female	86 (32.1)	74 (86.0)	12 (14)
Age group			
15-24	62 (23.1)	45 (72.6)	17 (27.4)
25-34	104 (38.8)	80 (76.9)	24 (23.1)
35-44	69 (25.7)	61 (88.4)	8 (11.6)
45+	33 (12.3)	29 (87.9)	4 (12.1)
Education level			
Primary	122 (45.5)	112 (91.8)	10 (8.2)
Secondary	117 (43.7)	84 (71.8)	33 (28.2)
Tertiary	29 (10.8)	19 (65.5)	10 (34.5)
Marital status			
Single	89 (33.2)	65 (73)	24 (27)
Married	159 (59.3)	132 (83)	27 (17)
Divorced	9 (3.4)	9 (100)	0 (0.0)
Widow	11 (4.1)	9 (81.8)	2 (18.2)

More than two thirds (80.2%) of respondents said that workplace HIV activities have contribution to the willingness to go for VCT services. By demographic characteristics more female (86%) respondents, all elder respondents and 91.8% of respondents attained primary level education

reported that workplace HIV interventions contributed to the increased uptake of VCT services among employees than the rest across the characteristics. (See table 4.1.18).

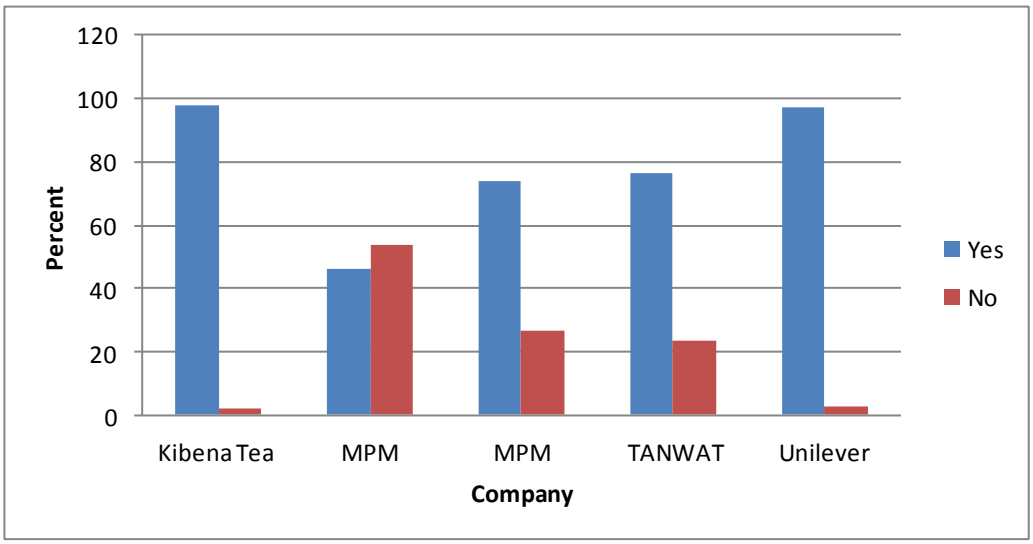


Figure 13: Variation in reported HIV prevention interventions in increasing uptake of VCT services by company N=268

High proportion (97.8%) and (97.1) of respondents from Kibene and Unilever Tea Companies agreed that HIV prevention activities contribute to higher uptake of the VCT services respectively. However High proportion of employees from Mufindi Paper Mills could not connect prevention interventions and increasing uptake of VCT services as shown in figure 13.

4.1.6 Satisfaction with the HIV services through workplace programmes

In this section the study sought to assess respondents' satisfaction with the HIV workplace programme services. In determining whether employee are satisfied with services provided through HIV workplace programme interventions, respondents were asked to respond whether they are satisfied or not. In the further analysis they were asked to rank their level of satisfaction from very satisfied to not satisfied on HIV prevention services and support on care and treatment for employees living with HIV. Results are summarised in table 4.1.19.

Table 4.1.19: Distribution of responses for satisfaction and level of satisfaction for prevention and treatment services provided by companies

Satisfied with HIV prevention services	**Frequency**	**Percent**
Yes	208	76.2
No	65	23.8
Levels of satisfaction on prevention services		
Very satisfied	96	35.2
Satisfied	114	41.8
Somehow	52	19.0
Not satisfied	11	4.0
Satisfied with support on care and treatment		
Yes	209	76.6
No	64	23.4
Levels of satisfaction on care and treatment		
Very satisfied	9	3.3
Satisfied	136	49.8
Somehow	97	35.5
Not satisfied	31	11.4

The respondents' satisfaction on HIV workplace services was tested. As can be seen in the table 4.1.19, 76.2% and 76.6% of respondents are satisfied with the HIV prevention and care and treatment services respectively. Majority of respondents felt that they were satisfied with the HIV prevention services and the support for care and treatment provided at workplace with the largest proportion 41.8% and 48.8% while 4.0% and 11.4% felt that they are not satisfied respectively. More respondents (35.2%) were very satisfied with the prevention services than care and treatment. Only 3.3% are very satisfied with treatment services. 35. 5% of respondents felt that they are somehow satisfied with treatment and care services while 19.0% for prevention services.

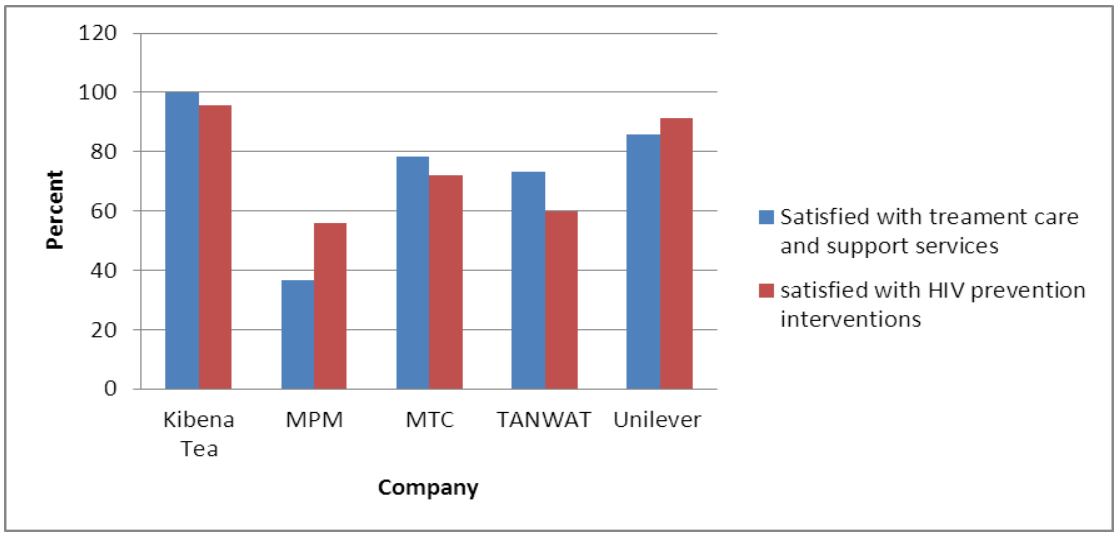


Figure 14: Figure Proportion of employees' satisfaction on prevention (n=208) and treatment, care and support services (n=209) by company

All respondents from Kibena Tea Company were satisfied with treatment, care and support services as well as large (95.7%) proportion of participants of the same company were satisfied with the prevention interventions and services provided by the company. Participants from Mufindi Paper Mills were least satisfied by both prevention (56.1 and (36.6%) for treatment care and support services (see figure 14)

4.2 Qualitative results

The study focused on gaining the insight to the effectiveness of HIV/AIDS workplace programme interventions. The interviews were designed to understand the role of employers in insuring that HIV/AIDS workplace programmes are effective. This section complements the findings of the quantitative findings which involved employees. In-depth interviews were conducted with the representatives of the management who were mainly the organisation entrusted HIV coordinators. Five respondents were involved in the interviews each from one company. Information gathered from the study was categorised into themes. These themes are:

- Employees' awareness on HIV/AIDS workplace Policy
- Awareness on HIV/AIDS workplace interventions and services
- Availability of condom
- Condom utilization by employees
- Availability of VCT services
- Utilization of VCT services by employees

4.2.1 Employees' awareness about the workplace HIV/AIDS policy and programmes

To increase participation of employees and all other parties in the implementation of the HIV/AIDS policies and programmes at work places it is required that the management and workers representative make it known to all employees. It could be communicated using information and education sessions as well as ensuring the copies of the policies and the programmes are available and accessible. For effectiveness, thus, there is an apparent duty and responsibility placed upon employers and workers in raising awareness and advocating for the implementation of those polices.

The study sought to understand how the employer/management of the participating companies adopt and inform their employees about the existence and the content of the HIV/AIDS policies and programme interventions at workplaces. All five respondents confirmed that they have HIV up to date

HIV/AIDS policies in their workplaces as presented by one of the HIV company coordinator:

"… Yes we have a much resent HIV workplace policy which was revised in 2011 accommodating current issues like male circumcision and responding to the emerging new challenges of the HIV/AIDS…Yes we are managing to reduce new infections but we have a big number of employees living with HIV which necessitated policy revision to accommodate their needs. The development process is consultative at all levels and the feedback is provided after the adoption of the policy" (HIV/AIDS Coordinator).

Table 4.2.1: Showing years which studied companies developed the HIV/AIDS workplace polices

Company	**Developed first policy**	**Revised policy**
Kibena Tea Company	1993	2008
TANWAT	1996	2008
Unilever Tea Company	1996	2011
Mufindi Tea Company	1996	2008
Mufind paper Mills	-	2010

This study found that companies used both formal and informal ways of informing employees about HIV and AIDS policy and programmes. Formal communications included official meetings and gatherings, seminars, induction sessions for new employees, internal communications using emails, notes boards, posters, leaflets and newsletters while informal communications included information from co-workers through peer education and recreational activities, video/film viewing and mass campaign (see table 4.2.2). Four companies mentioned that they received support from the GiZ and the fifth received support from PSI in crafting and distributing HIV information, education and communication materials and activities that encourage HIV prevention in work places.

Table 4.2.2: Showing common means of informing staff about HIV/AIDS policies and programmes

Main category of communication	**Means of informing staff about HIV policy and programmes**
Formal communication	Official meetings and gatherings
	Seminars
	Induction sessions for new employees
	Notes boards
	Emails
	Posters,
	leaflets
	Newsletters
Informal communication	Co-worker through peer education
	Recreational activities (sports, bonanza, family days)
	Video/film viewing
	Mass campaign
	National events like World AIDS Day and Workers' Day

In addition, all companies mentioned that workers associations (trade union) for workers in the agriculture sector: Tanzania Plantations, Agriculture Workers Union (TPAWU) provides a very effective forum for communicating and informing employees about the HIV workplace policies and programmes as stated below:

"… workers have very high trust on their association, TPAWU and their leaders, we therefore use this avenue to inform workers about company HIV/AID policies and programmes. TPAWU encourages their members to know their rights and responsibilities as stated in the company policy".

TPAWU holds quarterly meetings and a big Annual General Assembly (HIV Coordinator)

Exceptionally, one company mentioned that they reach members of the company top management through their management staff association which was uncommon in other companies.

"…We are very strategic in reaching out top leaders through their management association. This came to our attention after observing that they do not participate in sessions prepared for all staff. I personal facilitate their sessions or sometimes we invite the district AIDS coordinator… they are very comfortable when trained by senior officials…" (HIV coordinator)

Comparing the formal and informal ways of informing staff about the HIV workplace policies and programmes; the study found that informal ways were very effective and reach most of staff at different levels. The co-worker through peer education was very effectives. Peer education is done at all levels and also peers are categorised by age and in some discussions by sex. This was found to be the most common and effective as stated below:

"…Peer education is very effective means of informing and training employees about HIV and AIDS policies and programmes. We have about 119 peer educators who are distributed in each section and unit. All heads of units are part of the educators. The peer education sessions are conducted every Monday of the week. We call it Monday morning talk. We talk about HIV and other health related challenges particularly other chronic illnesses like hypertation and diabetes…" (HIV Coordinator)

However, the study found that formal communication especially the internal communication using emails, newsletters poster and leaflets did not benefit all categories of staff especially the lower carder working in the farms like tea pickers and planting tree who did not have access to computers and internet and some could not read and write.

"… For the formal communication using the electronic and print media, we rely on estate mangers and foremen to deliver this information to the employees under their sections, especially those working in the factory, farms and guards. It works better for staff who were in the administration category …" (HIV coordinator).

The study found that all companies used a combination of channels of communication which facilitated reaching out all employees with the information and education on HIV/AIDS workplace policies and programmes.

4.2.2 Condom promotion and utilization at workplaces

An important element of any HIV/AIDS workplace prevention programme is a reliable supply of free or affordable, high quality condoms. In this regard the researcher wanted to gauge the promotional practices used by employers in increasing employee's access to and utilization of condoms.

The study found that condom promotion was among the common interventions implemented in all participating companies. All respondents mentioned that they provide condoms at their work places as explained by one HIV coordinator:

"…in our company the condom programming has five components the first one is condom promotion and distribution; the second is education on condom proper and regular use; thirdly is ensuring widespread access; condom stock management and condom quality assurance. All these components are implemented in tandem and are well communicated to our employees and made them trust and use the condoms provided by the company"... (HIV coordinator)

Table 4.2.3: Showing amount of condoms procured in cartons and utilize in the past 12 months

Name of company	**Condoms procured and distributed (cartons)**	**Remained end of year**
Kibena Tea Company	60	0
TANWAT	40	0
Mufindi Tea Company	60	0
Unilever Tea Company	120	4
Mufindi Paper Mills	100	2

It was found that companies promote condom utilization by purchasing from PSI and making them available to employees. As stated by one of the coordinator

"… We distribute condoms through various ways. We put condoms in all recreational centres in each estate and in both the VIP and ordinary clubs. Also condoms are available in all eleven estate dispensaries; distributed by peer educators and in administration blocks and factories condoms are also placed in bathrooms. Our company shop also sells condoms at low price…" (HIV coordinator).

Another element of condom promotion which was found by this study was training on proper and regular use.

"…Peer educators play the key role in training and demonstrating the proper use of condom. This is done in each section in selected Monday morning talks… in addition employees are encouraged to adhere to the regular condom use. We insist on proper and consistency condom use in order to make condoms effective in reducing chance of contracting HIV and STIs. We also encourage our employees to have one trustful partner or abstain…" (HIV coordinator)

In addition it was also found that companies promote condom use through video/film viewing, sports and staff bonanzas and use of special events like World AIDS day and May Day.

"… Whenever we have special events or recreational activities we ensure that we use that opportunity to promote condom use. We mark World AIDS every year and we use this platform to inform employees about prevention measures including proper and regular use of condoms. We started social marketing too by encouraging employees to procure condoms at the company shop which are sold at low price…" (HIV coordinator)

In all studied companies, the study found that employees utilize distributed condoms (see table 4.2.3) and this is confirmed in one of the interviews as shown below.

"… Employees take all the condoms from the distribution points and from peer educators. We purchased about 100 cartons about 98 cartons were consumed in this year. This demonstrates that employees are motivated to use condom for themselves and their families…" (HIV coordinator)

Assessing the effectiveness of condom promotion and utilization at workplace, the study found that in all companies the STIs have reduced to the greater extent. In addition HIV prevalence has gone down as explained by one HIV coordinator:

"…In addition to other interventions I can say, availability and use of condoms have contributed to the significant decrease of STIs and HIV prevalence. In 1998 HIV prevalence in our company was about 24% which was reduced to 11% in 2008. Given these results, I cannot ignore the contribution of condom provided at our workplace in these achievements. Furthermore, condom usage is also used to measure and track responses to awareness, education and employee behavioural change initiatives implemented at our company. High uses of condoms demonstrate that employees mind-set is changing hence change of behaviour…" (HIV Coordinator)

4.2.3 VCT utilization at workplace

When they were asked if they provide VCT services in their workplaces, all five respondents confirmed availability of onsite VCT services. One company mentioned that they have central company hospital and eleven dispensaries located in different estates and they all provide VCT services. Other three companies provide in-situ and mobile VCT services to estate located away from the main company health centres while one company provides onsite-in-situ VCT services only.

"… we want to ensure all employees have access to VCT services wherever they are… we provide mobile VCT services which goes around once in every month in each estate. The turn up is very high in mobile VCT service than the in-situ, so we are motivated to send the VCT closer to working stations…may be they want to serve time instead of waiting for the service at the company hospital" (HIV coordinator)

Another topic explored in the interviews was to know if provided services were utilized by the employees. All respondents confirmed that the services were utilized by employees but they did not neither force nor limited employees from accessing the VCT service where they feel they were more comfortable.

"… Many employees utilize VCT services and those who are found positive are enrolled in the ART programmes. I observed that some employees are only visiting the VCT when they fill sick and they have advanced to AIDS. This necessitates continuing with the VCT campaigns so that our employees seek VCT early enough and not only for treatment but also changing life style to avoid contracting HIV…" (HIV coordinator)

The researcher asked the interviewees how they ensured confidentiality in providing VCT services. All respondents said that confidentiality is very high. They use the VCT guidelines issued by the WHO and the Ministry of Health and Social Welfare in which confidentiality is well stated and is a requirement to comply.

"…our VCT services and operations are not different from the other health systems in the country. We use the guidelines issued by the WHO and Ministry of Health. In those guidelines confidentiality is not underemphasised and is a high requirement in pre and post testing counselling… we ensure confidentiality and who ever found not adhering is sanctioned…" (HIV Coordinator)

The other coordinator said *"confidentiality is part and parcel of our HIV/AIDS company policy. So the rights of all seeking services either at the company clinic or other departments relating to HIV/AIDS are protected and the information will not be disclosed unless they themselves decide to do so…this policy real increased VCT uptake among employees*"

4.2.4 Satisfaction with the HIV/AIDS services

The researcher asked interviewees to rank and discuss if they felt that the HIV/AIDS programme interventions in their workplaces are satisfactory. One respondent ranked the programme as excellent; three respondents very good and one ranked it as satisfactory. The respondent who said excellent stated the reasons:

"… I rank our programme as excellent because we provide all services from education, condoms, VCT and treatment. In addition the coverage and access by the majority of employees and neighbouring villages is excellent. Apart from service coverage our company received an ILO award in 2010 by complying with the requirement of the 10 principles of the ILO code of practice on HIV/AIDS and the world of work (2001)…" (HIV/AIDS Coordinator)

In discussing their satisfaction with the programme, all respondents mentioned that HIV workplace programmes contributed a lot in raising awareness and increasing the knowledge about HIV and AIDS among employees and surrounding communities; increased access to VCT services,

antiretroviral treatment services, increased condom use and reporting abstinence and being faithful to one partner.

"… HIV workplace interventions in our company have a lot of good story to tell, to mention few they have contributed to the reduction of HIV prevalence among our employees from 38% in 1998 to 13% in 2008. We are experiencing much reduced STIs incidences, increased health seeking behaviour and employees are not shy to ask for condoms and even discuss openly about HIV and AIDS and sexuality issues. In addition, stigma went down leading to colleagues living with HIV disclose their HIV status…" (HIV coordinator)

CHAPTER FIVE: DISCUSSION

5.1 Awareness about HIV policy

One way to manage HIV/AIDS in the workplace is to develop and implement a HIV/AIDS workplace policy, which provides the framework for actions to reduce the spread of HIV/AIDS and manage the impact on the workplace. Having the HIV/AIDS policy in place shows that the organisation acknowledges the potential impact of HIV/AIDS and committed to address the impact in a responsible way. HIV/AIDS workplace policies, and their implementation, are an important part of a company's response to the epidemic. The study done by Ron and Zellner (2008) on HIV/AIDS services through workplace found that over 60% of the companies in the study did have formal HIV/AIDS policies. Policies increase the possibility of implementing the commitments.

The findings from the current study show that all companies involved have HIV/AIDS policy and there is a high level of awareness of those policies as reported by employees. Results from the interviews show that companies use both formal and informal channels of informing employees on the existence and the contents of the HIV policy. In this regards more than three quarters (87.2%) of respondents acknowledged being aware of the existence of the company HIV/AIDS policy. However, more work need to be done to reach the Mufindi Paper Mills employees, men and those highly educated to make them more familiar with the company HIV policies.

The study also indicates that majority of employees knew the details of the company HIV/AIDS policy which was demonstrated by the 77.7% of respondents. In mentioning the details of HIV/AIDS policy; prevention scored higher 50.9% of respondents while 37.4%, 7.5% and 4.2% of respondents mentioned HIV education, stigma and discrimination and treatment, care and support respectively. This shows that HIV prevention interventions are commonly implemented in workplaces. These findings are supported by a recent study done by Ruwende (2012) in one company in Zimbabwe which found that 100% of the study respondents knew the existence of

organizational HIV/AIDS policy. Keeping the policy available and accessible is necessary for allowing individuals to learn their status and to be cognizant of their rights and responsibilities in the HIV/AIDS management at workplaces. In addition, a recent study done in Kenya found that 71% of civil servants were aware of the HIV/AIDS policy in the work place (Kibaara 2012)

Contrary to the findings of this study, Laas (2009) found that small number of respondents (45%) were aware that their organization has an HIV/AIDS workplace policy and almost half of these (46.3%) were unsure of why the organisation implemented the policy. These discrepancies could be explained by other factors documented in other literatures that the seriousness on the development and implementation of the HIV/AIDS workplace policy depend on the size and where the company is located (Mahajan et al (2007).

5.2 Knowledge on availability of types of HIV/AIDS workplace programme interventions and services available

There is a very good level of knowledge and awareness of the HIV/AIDS interventions and services within the studied companies. From the study more than three quarters (83.2%) of respondents acknowledge being aware of the types of HIV interventions and services available in their workplaces. The mentioned services were peer education 40.7%, condom provision 35.5% treatment care and support 16.8 and VCT 5.9%. Findings of this study are in line with the study done by Dickson (2003) which found that majority (84%) of employees knew about education and HIV training services, treatment of STIs 58%, promotion and distribution of condoms 84% and access to counselling for people living with HIV 79%. Similar findings were reported by a study done by Magwaza (2008) in Zimbabwe which found that more than half of (57.3%) of respondents indicated that they knew about their company HIV/AIDS programme interventions.

In addition Ruwende (2012) found that all the six organisations studies had a 100 percent response saying that they had the HIV/AIDS programmes in their organisations and the services are well utilised by employees. In the same

organisations 90.4 percent of the non-management level employees agreed. However, 9.6 percent of non-management level employees responded otherwise, thus, they did not know of the HIV/AIDS programmes in their organisations. However, the findings of this study suggest that companies need to engage more a group of more educated employees with low proportion of respondents (75.9%) were aware on the availability of HIV workplace interventions and services.

The findings of this study and literature review do see HIV/AIDS workplace programmes interventions and services as a milestone towards reducing HIV prevalence and combating its effects. Previous research suggests that making people aware and increasing their knowledge is the only way to reduce prevalence as knowledge leads to behaviour change since knowledgeable people are likely to indulge in risk free behaviour. Furthermore, knowledgeable people are likely to utilize available services.

5.3 VCT Utilization at workplaces

The study findings show that the majority of employees (respondents) 76.6% are aware of VCT services at their workplaces and 91.6% of respondents mentioned that workplace HIV interventions was among the major source of information. This shows that HIV workplace interventions could be a factor for increasing VCT uptake among working population especially for employees in the commercial plantations which are located in isolated places. Mahajan et al (2007) reported that a successful workplace VCT uptake is preceded by the workplace testing campaigns, peer education, distributing communication packets, and conducting briefing sessions in all company units (Stevens at el 2006; Thomas at el, 2005). Mahajan et al (2007) reported again that one of the HIV testing campaign which was linked with a knowledge, attitude and practice interventions, led to subsequently high rates of participants in VCT 82% requesting for a test (Thomas at el, 2005). In this regard the emphasis on improving comprehensive knowledge on HIV/AIDS encourages employees to seek for more services including the VCT.

In addition, this study show that 80.2% of respondents reported that the workplace HIV activities have contributed to the employees willingness for VCT uptake. This could be explained by the regular sensitization and awareness raising sessions and campaigns about VCT at the studied commercial farms. This is also supported by a study done in South Africa which has shown that workplace HIV intervention is an effective tool in promoting VCT of which 61% of employees who visited the clinic agreed to take VCT (Noko et al, 2002).

The findings from this study show that VCT services are available at workplace as about 76.6% of participants reported the availability of these services. These findings are supported by the study done by the Ron and Zellnerin 2008 in four Sub-Saharan African countries which found that cumulatively, 69% of companies offer VCT services either onsite, finance them, or use both mechanisms. Comparing with other HIV services, the study by Ron and Zellner (2008) found that VCT is among the most commonly financed HIV/AIDS service compared to others by 52%. In addition, the utilisation of VCT services is increasingly recognised as a cornerstone to HIV/AIDS programmes (Sangiwa et al 2000), and companies are making concerted efforts to reduce HIV/AIDS prejudices and maximise the number of employees who decide to know their HIV status (Ron and Zellner 2008).

This is contrary to the study done in East African countries in private firms which shows that less than 50% of these firms had VCT services (Ramachandran et al 2007). Similar differences are recorded with the study done in Zambia which shows that about 15% of business firms have VCT services (Baggaley et al 1995). The observed difference could be due to deference in study methodologies whereby in this study participants were employees and management while in the other study information was obtained from employers/management only.

More than half (64.7%) of employees participated in this study reported that they have ever tested at their workplaces and more than three quarter (82.8%) preferred to go for onsite VCT services at the company clinic. These

results are compared to the study done in Zimbabwe in 2006 which found that 51% reported using the onsite VCT compared to 19.2% reported using the offsite VCT (Corbett at el, 2006). This can be explained mainly by the findings of this study that 65.2% of respondents wanted to serve time and cost by getting the services at closest clinic, 15.8% thought that by testing at the company clinic they will subsequently receive support on care and treatment and 6.6% felt that company clinics provide good quality services. The study report by Ron and Zellner (2008) noted that onsite clinics are a focal point of delivery because they offer employees immediate and convenient access to HIV/AIDS services. Ron and Zellner (2008) found that 75 companies in the sample that have onsite health clinics, shows that onsite clinics delivery more services in addition to VCT, they provide services on opportunistic infection management and TB services.

However, given that there is no cure for HIV infection and that stigmatisation and discrimination related to HIV/AIDS are still common, both in the society and at the workplace, it is difficult for employees to access and utilise VCT services at the workplace (Engender Health 2008). In ensuring the successful utilisation of the VCT services, those who administer VCT services must be sensitive to employees' rights and needs for confidentiality, privacy and non-judgemental pre and post-test counselling. Though to a lesser extent, this study also found that 7.7% and 3.7% of respondents reported to take offsite VCT to avoid stigma and lack of confidentiality among company clinic personnel respectively.

Basing on findings of this study and reviewed literatures, it is noted that VCT provides a powerful tool for management and workers to tackle HIV/AIDS, but only if it is done in the right way. A successful VCT programme must be part of a wider workplace response to HIV/AIDS that is the shared responsibility of managers, and workers. VCT will only be effective if HIV positive workers can access antiretroviral drugs and treatment of opportunistic infections. This calls for workplace HIV/AIDS programmes to create proper linkages between the VCT and ART services for more effective response to HIV/AIDS.

5.4 Condom promotion and utilization

Promoting the use of condom is among the critical ways of preventing the spread of HIV and other sexually transmitted infections (STIs) within workplaces. It is also important to promote condom use because in decreasing STIs due to the fact that the presence of an STI facilitates the transmission and acquisition of HIV (Walter et al 2004). From this study, it is noted that plantations involved in the study promote condoms by making them available to be utilized by employees and provide trainings on proper and consistence use. More than half (76.2%) interviewees reported that condoms are available at their workplaces. These findings are supported by a study which was done in Kenya which noted that about 90% of all companies involved in the study were distributing condoms at their workplaces (Robert and Wangombe, 1995).

In addition, in assessing employees awareness on different types of HIV/AIDS workplaces services provided in their workplaces, 42.7% of respondents mentioned condom provision which came after peer education 48.9%. This shows that plantations involved in the study provide both peer education and condom services to employees. The peer education and workplace trainings are effective means of promoting condom use among employees. A meta-analysis of 34 articles from developing countries: 16 from Sub-Saharan Africa, 16 from East and Central Asia and 2 from Latin America, found that peer education was significantly associated with increased condom use (Kennedy et al, 2009).

A study done by Chimbetete and Gwandule (2011), on the impact of a workplace-based HIV and AIDS training programme on employees found that participants who went through the workplace based training programme reported less risk condom use behaviours than participants who did not attend the HIV and AIDS risk reduction training intervention. The results indicated that the workplace-based training interventions had a positive impact on attitude change towards condom use among employees (Chimbetete and Gwandule 2011). Chimbindi et al. found that workplace-based training

intervention helped participants learn safer and correct methods of using condoms. Employees who participated in the training intervention showed a reduction in myths about condom use (Chimbindi et al. 2010).

The importance of regular and proper condom use is a major focus to ensure that condoms provided are being utilized by employees and reduce new incidences of STIs and HIV in the company. It has been argued that unprotected heterosexual sex is the single most important factor in the transmission of HIV world-wide" (Gender-health, 2004:1). Studies have indicated that consistent condom use can reduce the risk of HIV transmission by 87% (NIH, 2000). Results of this study show that majority respondent (91.2%) reported that condoms made available in their workplaces are being utilized. About 70.7 of respondents reported used condoms in the past six months. This demonstrates that condoms are utilised by employees. These findings are supported by the study done by Ashby (2011) which noted the high level of condom use amongst construction workers with 31.9% of respondents reporting regular condoms use and 34.3% reporting occasional use.

These findings, however, are contrary to other studies in Botswana which reported much lower levels of condom use, with only 15.7% are using condoms (NACA, 2003c) and only 22% respondents used condoms during the last ten sexual encounters (Talbot, et al., 2001). Ashby (2011) reported that in South Africa condom use was very low among migrant workers with only 24.3% of miners reported consistently used condom while 66.9% never used condom (Ijsselmuiden, et al., 1990). However it is difficult to make such comparisons with surveys from different years, given that they will reflect different stages in the progression of the HIV epidemic.

The finding from this study has shown that only 7.3% of interviewees do not use condoms when having sex with non-regular partner in comparing to the study which was done in two ministries in Tanzania which has indicated that 25% and 38% of workforce did not use condoms in their last sexual intercourse with non-regular partners (Mwakitoshi and Ndenzako 2003).

Another study has shown that 66% of respondents did not use condom frequently (Meyers and Sloan 1995). This indicates the decline of individuals who do not use condoms with non-regular partners which could be a result of HIV workplace prevention interventions.

5.5 Satisfaction with the HIV and AIDS services

On assessing the effectiveness of the workplace programmes one of the criterion set was to find out about the satisfaction on the HIV/AIDS workplace interventions and services. In the study, the majority of respondents were satisfied by the HIV/AIDS services provided by the companies.

In accordance, majority of respondents i.e. 76.2% and 76.6% of the sample employees reported being satisfied with the HIV prevention and treatment care and support services respectively. Majority of respondents were moderate with 41.8% and 48.8% felt that they were satisfied with prevention and treatment services respectively. However, a good number of respondents (11.4%) were not satisfied with treatment services while few 4% for prevention services. This suggests that prevention services are well delivered compared to treatment, care and support services.

Thus one would say that workplace HIV/AIDS programme interventions and services can be regarded as being a successful and effective means of reaching out employees as majority of respondents reported to be satisfied by the service offered.

6.0 CONCLUSIONS AND RECOMMENDATIONS

Conclusions

This study set out to find information on the effectiveness of workplace HIV programmes interventions in commercial plantations. It focussed on assessing employees awareness on the content of the company HIV/AIDS policy; the knowledge by workers on availability of different types of HIV/AIDS workplace programmes intervention services; condom promotion at workplace; condom utilisation among employees; employees utilization of VTC services; and to determine employee satisfaction with services provided through HIV workplace programmes in selected plantations.

The study revealed a high level of knowledge and awareness of the existence of the organizational HIV/AIDS workplace policies and programme interventions. The informal communications constituted a greater mode of disseminating information on HIV workplace policies and programmes. In addition, the study has shown that access and utilization of services at workplaces is a function of properly written HIV policies and programmes which are well communicated to employees. Policies encourage employees to understand their company obligations, their rights and responsibility in the HIV responses at workplaces.

The study has shown that all studied companies promoted condom use and made them available and accessed at workplaces. This indicated that companies knew about the importance of condoms use as a means of preventing contraction of HIV and other STIs. There was also a general high utilization of condoms by employees. Thus, it is important to continue with condom programing at workplace for effective HIV prevention interventions.

Although, it is noted that in greater society stigma inhibits VCT uptake, the study has shown that respondents were in favour of knowing one's HIV sero-status and majority had a willingness to utilize VCT services at company

clinic. Workers expressed satisfaction with the HIV services provided at their workplaces.

In general, HIV/AIDS workplace interventions have contributed significantly to the employees' willingness to utilise condoms, VCT and treatment services. HIV/AIDS workplace programme interventions are effective and should be scaled-up to contribute to national efforts of reversing the epidemic.

Recommendations

On the basis of study findings, I recommend that:

1. Realising that informal communications played an effective role in informing employees about HIV/AIDS Workplace policy and programme interventions, it is important to take advantage of it but there is a great need of ensuring that those involved get full and correct information. It is also important to promote the formal communication to ensure that management and administrative staffs are well informed about the company HIV policies and programmes. Companies should develop accessible print media e.g. pamphlets, posters or fact sheets which are fun and easy to read but giving valuable information on the HIV workplace policy and programmes and should conduct periodic knowledge, attitudes, behaviour and practice surveys;
2. HIV/AIDS workplace programme provides a major route for employees to access reliable and quality HIV services such as condoms. Therefore, companies should continue with the condom distribution and provision of education on condom use in the commercial plantations. Vigorous marketing and promotion of condoms could be done through focus group discussions, drama plays, peer education, newsletters and messages in building entrances. Progressively, companies should start introduction of social marketing on condoms by selling them at subsidised price and provide brands with different flavours;

3. To ensure greater utilization of VCT services it is important to continue with the HIV education to clear out myths around AIDS and living with HIV; HIV polices should clearly state the rights of workers living with HIV and combine the onsite and outsource VCT services to competent health facilities where it will not be easy to identify those who do not want to be known their HIV status. In addition, companies should consider having workplace programme that create proper linkages between the VCT and ART services for more effective response to HIV/AIDS.

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APPENDICES

Annexe 1: Questionnaires (English version)

Questionnaire no…… Company/Organization name…….....

Date……

1. Age ……years

2. Sex: a) Female b) Male

3. Marital status a) Single b) Married c) Divorced d) Widow e) widower

4. Level of education: a) Primary b) Secondary c) Tertially

5. Religion a) Christian b) Muslim

6. How long have you been working with this company……

7. Do you know if this company have workplace HIV/AIDS policy?
   a) Yes b) No

8. Do you know components of the HIV workplace?
   a) Yes b) No

   If yes can you mention components of the company workplace HIV policy?
   …….
   ……
   …….

9. Are there any workplace HIV interventions and services you know that have been conducted at this company?
   a) Yes b) No

10. If Yes, what are this HIV activities and services available ……
    ……..
    …….
11. Have you heard about Peer education programme on HIV/AIDS at your workplace?
    a) Yes b) No

12. Do you think Peer education reached all employees in your office?
    a) Yes b) No

13. Have you heard about VCT since you have been employed in this company?
    a) Yes b) No

14. If yes where do you think you get more information ……..
    …….

15. Have you attended VCT for testing since last year?
    a) Yes b) No

16. Is there any VCT services in your company premises
    a) Yes b) No
17. If yes have ever tested here? a) Yes b) No

18. In your view where do you think employees would prefer to go for testing?
    a) Onsite clinic b) Offsite clinic

19. Why do you think so …….
    .....
    .....

20. Do you often talk about VCT with your family members and relatives?
    a) Yes b) No

21. Do you think at this company there is regular talk about VCT among employees? a) Yes b) No

22. Have you ever tested for the period you have been here?
    a) Yes b) No

23. Do you think HIV preventive activities conducted here have contributed anything toward liking testing among employee?
    a) Yes b) No

24. During your employment were you requested to do HIV testing?
    a) Yes b) No

25. Do you think there is openness among employees about their HIV status?
    a) Yes b) No

26. Why do you think so ……
    ……

27. Do you think if the management confirm any staff is HIV positive, will he/she continue working?
    a) Yes b) No

28. Why do you think so? ……
    ……

29. Are there any ART services provided by your company to workers living with HIV?
    a) Yes b) No

30. Do you think employees are informed about the availability of treatment , care and support services for workers living with HIV?

a) Yes b) No

31. Is there any condom available in this company?

a) Yes b) No

32. If yes do you think those condoms are being utilised by employee?

a) Yes b) No

33. Have you ever used condom in the last six months?

a) Yes b) No

34. Do you use condom with your non regular partners?

a) Yes b) No

35. Are you satisfied with your HIV prevention services at provided in your company? (condoms, VCT, HIV education, PMTC …)

a) Yes b) No

Please choose the level of satisfaction in below (choose one)

1. Very satisfied
2. Satisfied
3. Somehow
4. Not satisfied
5. Not satisfied at all

36. Are you satisfied with your HIV treatment, care and support servicesat your company? (dawa, matibabu, ushauri …)

Please choose the level of satisfaction in below (choose one)

1. Very satisfied
2. Satisfied
3. Somehow

4. Not satisfied
5. Not satisfied at all

37. Do you think the presence of the HIV programme here have contributed anything toward stigma and discrimination reduction among employee?

a) Yes b) No

Thank you for the cooperation

Annexe 2: Questionnaire (Kiswahili version)

Namba ya dodoso …….. Jina la kampuni…….

Tarehe ya usail ……

1. Umri …….. Jinsia: a) Me Ke

2. Hali ya ndoa a) sijaolewa/sijaoa b) Nimeolewa/nimega c) tumetengana d) Mjane

3. Kiwango cha elimu: a) Msingi b) Sekondari c) Elimu baada ya sekondary

4. Dini a) Mkristo b) Muislam

5. Muda gani umefanya kazi katika kampuni hii?

6. Je unajua kuwa shilirika hili lina sera ya ukimwi ya mahali pa kazi?
   a) Ndio b) hapana

7. Je unajua baadhi ya vipengere vya sera ya ukimwi la shirika hili?
   a) Ndiyo b) hapana

Kama Ndio vipengere hivyo ni vipi?.....
.....
.....

8. Je kunashushuli zozote unazifahamu za kuzuia maambukizi ya virusi vya ukimwi? A) Ndio b) Hapana

9. Kama Ndio Shughiuli zipi hizo?.....
   .....
   .....

10. Je kuna programmu ya elimu rika juu ya maswala ya VVU/UKIMWI hapa ofisini kwenu?

    Ndiyo hapana

11. Je unafikikiri elimu rika imewafikia wafanyakazi wengi hapa ofisini?

    Ndio Hapana (kama hapana kwa nini?)

12. Je umewahi kusikia habari za upimaji wa virusi vya UKIMWI kwa hiari tangu umeajiriwa hapa? a) Ndio b) Hapana

13. Kama ni ndio ni wapi zaidi umekuwa ukipata taarifa hizo? ……...

    ……

14. Je umewahi kupima virusi toka mwaka jana?

    a) Ndio b) Hapana

15. Je kuna huduma zozote za upimaji hapa?

    a) Ndio b) Hapana

16. Kama ndio umewahi kupima hapa?

    a) Ndio b) Hapana

17. Kwa mawazo yako wapi unadhani ungependelea kupima virusi vya UKIMWI? a) kwenye kliniki iliyopo hapa b) Klinic iliyopo nje ya hapa?

18. kwanini ungependa Hivyo? .....

    .....

    .....

19. Je unakawaida ya kuzungumza habari za upimaji wa virusi vya UKIMWI na UKIMWI na jamaa ama marafiki zako?

    a) Ndio b) hapana

20. Je kuna kawaida ya kuzungumza habari za upimaji wa virusi vya UKIMWI miongoni mwa wafanyakazi wa hapa?

a) Ndio b) Hapana

21. Je umewahi kupima virusi vya UKIMWI toka umekuwepo hapa?
    a) Ndio b) Hapana

22. Je Unadhani shughuli za kuzuia maaambukizi ya virusi vya UKIMWI zilizopo hapa zimewasaidia kufanya wafanyakazi wa hapa wapende kupima?
    a) Ndio b) hapana

23. Je wakati unajiriwa ulitakiwa kupima virusi vya UKIMWI
    a) Ndio b) Hapana

24. Je unadhani wafanyakazi wa hapa wako wazi kuhusu afya zao, yaani kama wameambukizwa virusi au la?
    a) Ndio b) Hapana

25. Kwa nini undhani hivyo?.....
    .....
    .....
    .....

26. Je uongozi ukigundua kuna mfanyakazi an virusi vya UKIMWI unadhani ataruhusiwa kuendelea na kazi?
    a) Ndiyo b) Hapana

27. Kwanini Unafikiri hivyo? .....

28. Je kuna huduma zozote za matibabu zinatolewa kwa wafanyakazi wanaishi na virusi vya UKIMWI?
    a) Ndiyo b) Hapana

29. Je wafanyakazi wanaarifiwa juu ya huduma, misaada na matibabu kwa wafanyakazi wanaishi na virusi vya UKIMWI hapa shirikani?
    a) Ndiyo b) Hapana

30. Je kondom zinapatikana humu ofisini/shambani?
    a) Ndiyo b) Hapana

31. Kama ndio unadhani wafanyakazi wanazichukua?
    a) Ndiyo b) Hapana

32. Je umewahi kutumia kondom kwa kipindi cha miezi sita iliyopita?
    a) Ndiyo b) Hapana

33. Je huwa unatumia kondom unapokuwa na mpenzi asiye wa kudumu?
    a) Ndiyo b) Hapana

34. Je unaridhika na shughuli za kuzuia maambukizi ya virusi vya ukimwi zilizopo hapa ofisini kwako?
    a) Ndiyo b) Hapana

35. Je Unadhani kuwepo kwa shughuli za kuzuia maambdukizi ya virusi vya ukimwi zimesaidia kupunguza unyanyapaa?
    a) Ndio b) Hapana)

    Kwakiwango gani: (weka tick kwenye moja)
    1. Naridhika sana
    2. Naridhika
    3. Narika kidogo
    4. Siridhiki

36. Je unaridhika na huduma na matimbabu yanayotolewa hapa shirikani? (dawa, matibabu,ushauri, n.k)
    Ndio b)hapana
    Kwakiwango gani: (weka tick kwenye moja)
    1. Naridhika sana
    2. Naridhika
    3. Naridhika Kidogo
    4. Siridhiki

37. Je Unadhani kuwepo kwa shughuli za kuzuia maambdukizi ya virusi vya ukimwi zimesaidia kupunguza unyanyapaa?
    a) Ndio b) Hapana

Tunashukuru kwa ushirikiano wako

Annexe 3: Interview Guide for Company Management

Name of the company …….....

Name ……Job position ……

1. How many staff who are employed in your organization? F: M:
2. What is your current HIV and AIDS workplace program?
3. Do you have a stand along HIV policy? If not what framework do you use to guide the work on HIV and AIDS?
4. How do you inform your employees about the content of the HIV workplace policy?
5. How do you inform your employee about the HIV/AIDS workplace programme?
    a) Do you have educational programme?
    b) Do you have any IEC material for employees?
    c) Do you have any awareness raising activities?
    d) Do you conduct training for staff on HIV and AIDS? If yes, in the past one year how many employees were trained? Of which category?
6. Do you have peer education programmes? If yes how many?
7. What kind of HIV/AIDS services do you currently provide?
8. What measures do you use to promote use of condom?
9. Are condoms available at the workplace?
10. How do you rate the utilization of condoms by staff?
11. How do you provide VCT services to your employees? Onsite or offsite?
12. In that past one year how many employees utilized VCT services?
13. How many employees are living with HIV?
14. Do they receive ART?
15. What is your policy on confidentiality?
16. In your organization are there any employees disclosed their HIV status?
17. What are the measures to protect all HIV positive employees from stigmatization and discriminations?

18. Do employees living with HIV have same rights and obligations as all staff members?
19. Is HIV testing a prerequisite for recruitment?
20. Do you have a designated employee or committee that is in charge of monitoring and evaluating this system?
21. If yes, how often does this person or committee monitor your program?
22. What are the standards to measure the success of your program?
23. What different ideas are you currently pursuing towards prevention of HIV/AIDS in your organization?
24. Do you have any ideas that could help improve the HIV situation in the commercial farms?
25. How do you rate your HIV services provided to your employees:
    a) excellent
    b) Very good
    c) Good
    d) Satisfactory
    e) Poor
    f) Very poor

Annexe 4: Interview Guide (Kiswahili Version)

Jina la kampuni …….....

Jina ……daraja la mfanyakazi ……

1. Kampuni yako inawafanyakazi wangapi? Me: Ke:
2. Kwa sasa mnafanya shughuli zipi kuhusu VVU na UKIMWI mahala pa kazi?
3. Je kuna sera ya VVU/UKIMWI inayojitegemea? Kama sio, mnatumia mwongozo gani katika kufanikisha shaghuli zanu za VVU/UKIMWI?
4. Mnatumia mbinu gani kuwafahamisha wafanyakazi kuhusu sera ya VVU/UKIMWI mahala paka
5. Mnatumia mbinu zipi kuwajuklisha wafanyakazi wenu kuhusu shughuli za shirika za ukimwi mahala pa kazi?
    a) Mnatoa elimu juu ya VVU/UKIMWI?
    b) Mnatoa elimu kwa njia ya vipeperushi na machapisho mbalimali?
    c) Huwa mnafanya shughuli zozote za uhamasishaji?
    d) Je huwa mnatoa mafunzo kwa wafanyakazi juu ya VV/UKIMWI? Kama Ndio, kwa mwaka uliopita mmetoa mafunzo kwa wafanyakazi wangapi? Wafanyazi wa kazi zipi?
6. Je mnatoa mafunzo ya waelimisha rika? Kama ndio, ni wangapi?
7. Je kwa sasa mnatoa huduma za aina gani kwa wafanyakazi wenu?
8. Je mnatumia utaratibu gani kuhamasisha matumizi ya Kondom?
9. Je mnatoa Kondom hapa ndani ya shirika?
10. Unaweza kupima kiwango cha matumizi ya Kondomu kwa wafanyakazi?
11. Je mnatoa huduma za ushauri nasaha na upimaji wa VVU, kama ndio ni wapi wanapata huduma hii?
12. Kwa mwaka uliopita, je ni wafanyakazi wangapi wameshapata huduma za ushauri nasaha na upimaji wa VVU?
13. Je unajua wafanyakazi wangapi wanaishi na VVU?
14. Je wanapata huduma ya dawa za kupunguza makali ya VVU na magonjwa nyemelezi?
15. Je mna sera ya usiri juu ya wafanyakazi wanaishi na VVU?

16. Je kuna wafanyakazi ambao wamejitangaza kuwa wanaishi na VVU/UKIMWI
17. Je mna mikakati gani ya kudhibiti unyanyapaa na ubaguzi kwa wafanyakazi waishio na VVU?
18. Je wafanyakazi wanaoishi na VVU wana haki sawa kwa za kisheria kama wafanyakazi wengine?
19. Je kupima VVU ni lazima kabla ya kuajiriwa?
20. Je mna mfanyakazi maalumu au kamati ya kufuatilia na kutathimini utekelezaji wa shughuli za VVU/UKIMWI?
21. Kama ndio tathmini huwa inafanyika kila baada ya muda gani?
22. Je mnatumia viashiria gani kupima mafanikio ya shughuli zanu za VVU mahala pa kazi?
23. Je unamawazo gani ya tofauti ambayo unafikiria yanaweza kufanikisha kuwakinga wafanyakazi wenu wasipate maambukizi mapya?
24. Je unamawazo gani ya tofauti ambayo yanaweza kuboresha na kupunguza hali ya VVU/UKIMWI katika mashamba makubwa
25. Je huduma mzitoazo kwa wafanyakazi wenu unaweza kutathimini kama:
    a) Nzuri sana
    b) nzuri
    c) inaridhisha
    d) hafifu
    e) hafifu sana

Annexe5: Consent to participate in the study:

MUHIMBILI UNIVERSITY COLLEGE OF HEALTH SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS, MUHAS

ASSESSMENT OF WORKPLACE HIV/AIDS POLICY AND PROGRAMME INTERVENTIONS IN COMMERCIAL PLANTATIONS IN IRINGA REGION: CONSENT FORM

Principal Investigator: Tulanoga Josephat Matimbwi

Introduction

This consent form contains information about the research named above. In order to be sure that you are informed about being in this research, we are asking you to read (or have read to you) this Consent Form. You will also be asked to sign it (or make a statement of whether you agree or not in front of a witness). This consent form might contain some words that are unfamiliar to you. Please ask us to explain anything you may not understand.

Reason for the research: you are being asked to take part in this research to assess the effectiveness of workplace HIV/AIDS policy and programme interventions in commercial plantations in Iringa region.

General information about the research: we are interested to assess types of interventions available at workplace, contribution of these HIV workplace programmes in changing behaviour of employee in terms of VCT uptake, condom use, and access to ART and reduction of stigma and discrimination at workplace. The results of this study will provide information on effectiveness on HIV interventions at workplaces and hence enable policy makers and management to develop appropriate strategies for workplace HIV interventions especially for commercial plantations.

Your part in the research: if you agree to participate in this study, you will be required to answer a series of question that have been prepared for the study in a questionnaire.

Possible risks: you will spend your time at maximum of 30 minutes answering the questions.

Possible benefits: you will not be paid for participating in this study and will receive no other form of compensation however the findings from your participation will further the knowledge of improving workplace services for HIV/AIDS in your company and across the country.

If you decide not to be in the research: participating in this study is completely voluntary. You are free to decide if you want to be in this research. Refusal to participate of withdraw from the study will not involve penalty or loss of any benefit to which you are otherwise entitled.

Confidentiality: we will protect information about you and you're taking part in this research to the best of our ability. Your identifiable particulars such as names, phone numbers and your address will not be taken and you will not be named in any reports.

If you have a problem or have other questions: if you have a problem that you think might be related to taking part in this research or any questions about the research, please call Tulanoga Matimbwi 0755750 661. If you need more help, you can also contact Dr. M. Ezekiel at Muhimbili University.

Your rights as a participant: This research has been reviewed and approved by the IRB of Muhimbili University of Health and Allied Sciences. An IRB is a committee that reviews research studies in order to help protect participants. If you have any questions about your rights as a research participant you may contact Chairperson MUHAS IRB, address P.O. Box 65001, Dar es salaam, telephone number 2150302-6.

Volunteer agreement,

The above document describing the benefits, risks and procedures for the research titled (ASSESSMENT OF WORKPLACE HIV/AIDS POLICY AND PROGRAMME INTERVENTIONS IN COMMERCIAL PLANTATIONS IN IRINGA REGION) has been read and explained to me. I have been given an opportunity to ask any questions about the research and they have been answered to my satisfaction. I agree to participate as a volunteer.

Signature (or thumb print) of Participant:

_____

Signature of witness (if participant cannot read):

_____

Signature of research assistant:

_____

Date of signed consent:

_____

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Annexe 6: Consent (Kiswahili version)

CHUO KIKUU CHA AFYA –MUHIMBILI
KURUGENZI YA UTAFITI NA MACHAPISHO

TATHIMINI YA SERA NA MIPANGO YA VIRUSI VYA UKIMWI NA UKIMWI MAHALA PAKAZI KATIKA MASHAMBA MAKUBWA YA KIBIASHARA MKOANI IRINGA: FOMU YA RIDHAA

Namba ya utambulisho: _____

Ridhaa ya kushiriki kwenye utafiti

Mtafiti Mkuu: Tulanoga Josephat Matimbwi

Utangulizi

Fomu hii ya ridhaa ina taarifa zinazohusiana na utafiti wa jina lililotajwa hapo juu. Ili kuhakikisha kuwa unaelewa juu ya utafiti huu, tunakuomba kusoma au kusikiliza wakati ukisomewa fomu hii.Utaombwa kuweka saini au kuweka alama ya kukubali au hukubali mbele ya shahidi. Ikiwa fomu hii ya ridhaa ina maneno mengine ambayo huyaelewi, tafadhali uliza iliupewe ufafanuzi na maelekezo.

Madhumuni ya utafiti:tunakuomba ushiriki kwenye utafiti huu juu kuainisha mafanikio ya sera na mipango ya virusi vya ukimwi na ukimwi mahala pa kazi katika mashamba makumbwa mkoani Iringa. Pia kupata maelezo juu ya njia mbalimbali zinazoweza kuboresha hali halisi ya huduma virusi vya ukimwi na ukimwi mahala pa kazi katika maeneo ya mashamba makubwa.

Taarifa kuhusu utafiti*:* Utafiti huu unalenga kutafuta mafanikio ya mpango wa kuzuia maambikizi na kupunguza athari ya virusi vya ukimwi na ukimwi mahala pa kazi. Mafanikio hayo yanapimwa kwa kuangalia kama kuna mabadiliko ya tabia miongoni mwa wafakazi kwa kutimia viashiria kama: kupima virusi vya ukimwi mara kwa mara, matimizi ya kondom, kupata

matibabu ya kupunguza makali ya vrisi vya ukimwi na kupungua kwa suala la unyapaa mahala pa kazi.

Ushiriki wako katika utafiti, Ikiwa utakubali kushiriki katika utafiti huu, utahitaji kujibu maswali kadhaa kutoka kwenye muongozo wa maswali ambayo yameandaliwa katika utafiti huu ilikuweza kupata taarifa zinazohitajika. Itachukua kati ya dakika 10 hadi 30 katika kujibu maswali hayo.

Usumbufu unaweza kujitokeza: utatoa muda wako wakati wa kujibu maswali kwa kipindi cha takribani dakika 10 hadi 30.

Faida ya ushiriki,: ushiriki wako katika utafiti huu ni wa kujitolea, hivyo hauna malipo ya fedha au fidia yeyote, lakini taarifa utakazozitoa zitasaidia kutoa taaarifa juu ya mafanikio ya mpango wa kuzuia virusi vya ukimwi mahala pa kazi, na utasaidia watunga sera na vingozi wa makampuni koboresha mpango huo hasa katika mashamba makubwa na ya kibiashara na nchini kote.

Kama utaaumua kutoshiriki kwenye utafiti: ushiriki katika utafiti ni suala la kujitolea. Unauhuru wa kuamua endapo unapenda kushiriki au la hautakuwa na madhara yoyote katika huduma za VVU na UKIMWI uzipatazo sasa mahala pako pa kazi.

Usiri: taarifa zitakazokusanywa kutoka kwako kupitia dodoso la utafiti huu kutakuwa na usiri kadiri tunavyoweza. Pia hatutaandika taarifa za utamburisho binafsi kama vila jina, nambari ya simu na hata anuani yako na pia jina lako halitatajwa kwenye ripoti ya utafiti huu.

Kama una Tatizo au Swali lolote:kama una tatizo unalofikiri linahusiana na kushiriki kwako katika utafiti huu au una swali lolote juu ya utafiti huu, tafadhali piga simu 0755750661 ya Tulanoga Matimbwi. Ikiwa unahitaji maelezo zaidi waweza wasilina na Dr. M. Ezekiel wa chuo kikuu cha Afya Muhimbili.

Haki ya Mshiriki

Utafiti huu umepitiwa na kupata ridhaa ya ruhusa ya utafiti (IRB) ya chuo cha Muhimbili. kamati ya kutoa ruhusa ya utafiti ilipitia maelezo ya kufanyika kwa utafiti huu ili kuhakikisha inajiridhisha na maelezo juu ya washiriki ilikuwalinda. Ikiwa unaswali lolote kuhusu staili zako kama mshiriki unaweza kuwasiliana namwenyekiti wa kamati ya utafiti na uchapishaji, S.L.P 65001, Dar es salaam, simu 2150302-6

Makubaliano ya hiari

Nyaraka hii inaelezea juu ya faida, madhara, na taratibu za utafiti wenye kichwa cha habari (TATHMINI YA SERA NA MIPANGO YA VIRUSI VYA UKIMWI NA UKIMWI MAHALA). Nimesoma na kuelezewa na nimepewa nafasi ya kutosha kuuliza maswali na nimepewa majibu ya kuridhisha. Nakubali kushiriki kwa hiari.

Sahihi (au alama ya dole gumba) ya Mshiriki _____

Sahihi ya shahidi (kama mshiriki hawezi kusoma) _____

Sahihi ya msaidizi wa mtafiti _____

Tarehe makubaliano yaliposainiwa_____

Nakubaliana kwamba taratibu na madhumuni, faida za msingi, na changamoto au hasara zinazoweza kutokea kwa kushiriki kwenye utafiti huu zimeelezwa kwa ufasaha kwa mshiriki hapo juu.