A STUDY OF THE INVOLVEMENT AND PARTICIPATION OF EMPLOYEES IN A WORKPLACE HIV-PREVENTION PROGRAMME AT A BULAWAYO TYRE MANUFACTURING FIRM

by

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DECLARATION

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I declare that the work I am submitting for assessment contains no section copied in whole or in part from any other source unless explicitly identified in quotation marks and with detailed, complete and accurate referencing.

Charlie Ncube

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SUMMARY

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Employee involvement and participation in HIV-prevention interventions at the workplace remains a barrier to effective programme implementation, which contributes significantly to programme failure and the consequent continued spread of HIV among employees at the workplace. This study explores employee involvement and participation in HIV-prevention interventions at a Bulawayo tyre manufacturing firm. It assesses factors affecting employee involvement and participation in these interventions, and examines the implications of these findings for programme implementation. I used a semi-standardised interview schedule to conduct in-depth, face-to-face qualitative interviews and a self-administered questionnaire to collect quantitative data. The responses showed the nature of employee involvement in HIV-prevention at the firm was at a co-option level, and the type of participation was mere token participation. I recommended that the firm should develop a clear understanding of the importance of stakeholder involvement in HIV-prevention programmes.

Key words

Co-option, employee involvement and participation, HIV-prevention interventions, stakeholder participation, stigma, token participation and management support.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	**Acquired Immune Deficiency Syndrome**
ART	**Antiretroviral Therapy**
BER	**Bureau for Economic Research**
DCSA	**DaimlerChrysler South Africa**
DHS	**Demographic and Health Survey**
DVD	**Digital Video Decoder**
HIV	**Human Immunodeficiency Virus**
HR	**Human Resources**
IEC	**Information, Education and Communication**
ILO	**International Labour Organisation**
ISO	**International Standards Organisation**
OI's	**Opportunistic Infections**
PEP	**Post-exposure prophylaxis**
PMTCT	**Prevention of Mother to Child Transmission**
SI	**Statutory Instrument**
STD	**Sexually Transmitted Disease**
STI	**Sexually Transmitted Infection**
TB	**Tuberculosis**
UNAIDS	**United Nations Joint Programme on HIV/AIDS**
UNDP	**United Nations Development Program**
UNGASS	**UN General Assembly Special Session (on HIV-AIDS)**
UNIFEM	**United Nations Development Fund for Women**
UNISA	**University of South Africa**
VCT	**Voluntary Counselling and Testing**
WHO	**World Health Organisation**
ZNASP	**Zimbabwe National HIV-AIDS Strategic Plan**

CHAPTER 1: SITUATING THE RESEARCH PROBLEM

1.1 INTRODUCTION

In this chapter I present the research problem that prompted my study, namely, what is the extent, nature of, and challenges facing employee involvement and participation in the Human Immunodeficiency Virus (HIV)-prevention interventions at the workplace. In order to situate the whole research problem in its proper context, I first of all discuss the following seven related issues. First, I review the current status of the HIV epidemic in Zimbabwe in general. Second, I provide a brief outline of how businesses have responded to the HIV epidemic in the country. However, rather than examining the comprehensive workplace HIV and Acquired Immune Deficiency Syndrome (AIDS) programme, I only focus on the workplace HIV-prevention intervention component. This component includes workplace activities, such as HIV-prevention awareness campaigns, condom promotion and distribution, management of sexually transmitted infections (STI's), voluntary counselling and testing (VCT), and peer education training. Third, I then identify the gap between HIV-prevention interventions at the workplace and the employee involvement and participation in these interventions. The fourth issue I discuss is the research problem. Under the subheading 'the research problem', I speculate about how factors, such as the extent of budgetary support, the quality of support in the workplace environment and management's approach to leading by example may contribute to the creation of this gap. Fifth, I explain the purpose of the study, followed by the sixth issue, an outline of the research questions. Finally, I present definitions of key terms.

In chapter 2 I review literature on studies of HIV-prevention interventions at the workplace, or similar interventions. This critical review is expected to demonstrate the shortcomings in the existing literature, namely, that employee involvement and participation in these interventions is limited. I also show how I plan to address this gap. In chapter 3 I begin by outlining the exploratory

research design that I used in this study. I then explain the mixed method research strategy and the rationale for using this particular strategy. In chapter 4 I present the research findings. Since my mixed method research design is predominantly qualitative, the findings, analysis, interpretation and conclusions are also predominantly qualitative in nature. In chapter 5 I conclude the report by discussing the limitations of the study, outlining suggestions for further research and presenting the recommendations for policy and practice.

1.2 THE CURRENT STATUS OF THE HIV EPIDEMIC IN ZIMBABWE

Over 1, 3 million Zimbabweans are infected with HIV and almost all of them are in the economically productive and reproductive ages of 20 to 49 years. At the end of 2007, an estimated 1, 085, 671 adults between the ages of 15 to 49 years were living with HIV (United Nations General Assembly Special Session on HIV-AIDS report on Zimbabwe [UNGASS] 2007:4, 9). According to the Zimbabwe National HIV-AIDS Strategic Plan (ZNASP) of 2006-2010 outlined by the National AIDS Council (2006:5), an estimated 162,000 new HIV-infections were reported during 2006 alone. The greatest number of these infections (135, 000 or 83 percent) is affecting the future workforce, namely the young adults between the ages of 15 to 24 years (National AIDS Council 2006:5).

The main mode of HIV-transmission in Zimbabwe is heterosexual contact (about 92 percent) followed by perinatal contact (about 7 percent), and blood contacts (accounting for about 1 percent) (National AIDS Council 2006:5). Because there is no cure for HIV, and antiretroviral drugs are relatively expensive and largely unavailable, the emphasis of a national strategy to combat the epidemic must be on employee involvement and participation in prevention of HIV-infections from taking place in the first place. Employee involvement and participation in HIV-prevention interventions should focus predominantly on condom promotion and distribution, sexually transmitted infection (STI) diagnosis and treatment,

education about HIV-transmission as well as counselling and testing for HIV on a voluntary and private basis (National AIDS Council 2006:5).

1.3 BUSINESS RESPONSE TO THE HIV EPIDEMIC

Recognising the negative impacts of the HIV epidemic on the viability of their businesses, the manufacturing sector in Zimbabwe, like many other sectors, has established workplace HIV-prevention interventions to curb the spread of HIV-infections and alleviate these impacts. In line with the requirements of the Statutory Instrument (SI) Number 202 of 1998, as promulgated by the Government of Zimbabwe (Zimbabwe Labour Relations Amendment Act: Chapter 28:01[2]), these workplace HIV-prevention interventions operate within the national strategic plan's main priority areas of interventions which include prevention, care, treatment and support.

The comprehensive programme components of prevention, care, and support seek to inform employees about HIV by providing an opportunity on a number of prevention, care and support strategies. These include education about the modes of HIV-transmission, high-risk behaviour, prevention of occupational exposure to HIV-infection, peer education, distribution and promotion of condoms, diagnosis of STI's and the provision of voluntary counselling and testing services (VCT). In addition, some businesses offer antiretroviral therapy (ART) and management of opportunistic infections (OI's), among many other care and support services (Rau 2002:45). By 2002 HIV-prevention programmes at the workplace in 25 companies in Zimbabwe had helped reduce HIV-incidence among employees by 30 percent (Rau 2002:13). In addition, these workplace prevention programmes protect, not only the businesses from the impact of HIV, but the community at large as well, since employees are part of the community in which they live.

1.4 THE GAP IN THE IMPLEMENTATION OF INTERVENTIONS

Although I acknowledge the existence of good workplace HIV-prevention interventions in general, there is a gap in the implementation of these interventions. With reference to South African businesses, Grant, Strode and Smart (2002:80) observe that the level of employee involvement and participation in HIV-prevention interventions is very minimal at most workplaces. My assumption is that the situation is similar in Zimbabwe. Employees in general do not appear to be actively involved in the dissemination of prevention messages, nor do they participate in the implementation of these interventions at the workplace. Consequently, I identify a gap between HIV-prevention interventions at the workplace and employee involvement and participation in these interventions. This gap is likely to render the otherwise good intervention programmes ineffective, if employees, who are the important stakeholders and supposed beneficiaries of these interventions, do not get involved and participate in the interventions. Hence in this study I investigated employee involvement and participation in HIV-prevention interventions at the workplace. The investigation helped me gain an insight and understanding of the challenges faced by HIV workplace programme implementers in the manufacturing sector, in implementing HIV-prevention programmes. Furthermore, I attempted to understand some of the challenges, which employees, as the supposed beneficiaries of the interventions, experience in getting involved and participating in such HIV-prevention interventions at the workplace.

However, rather than dealing with the comprehensive workplace HIV programme, I limited the scope of my study to a single component that focuses on the HIV-prevention interventions at the workplace. The component included education about the modes of HIV-transmission, high-risk behaviour, peer education, distribution and promotion of condoms, diagnosis of STI's and provision of voluntary counselling and testing services. The study took place at a firm in Bulawayo, Zimbabwe.

1.5 THE RESEARCH PROBLEM

Drawing from my own work experience as the workplace HIV and AIDS trainer, I started off with the assumption that the main barrier to effective employee involvement and participation in HIV-prevention interventions at the workplace was the lack of employee involvement and participation in the planning and implementation of such interventions. My adaptation of Karl's (2000) model of stakeholder participation seemed to confirm my assumptions. Excluding employees from the planning and implementation of the interventions was likely to lead to the lack of ownership of, and commitment to, these interventions (Karl 2000:4). In turn, this exclusion of employees was likely to lead to programme failure. I further speculated that a number of factors contributed to this main barrier. These included lack of management support, stigma and discrimination attached to HIV, disrespect for human rights, lack of involvement of key stakeholders and socio-cultural and gender issues. These factors, I assumed, impeded effective employee involvement and participation in HIV-prevention interventions at the workplace, which in turn resulted in programme failure and the continued spread of HIV among employees. The factors listed above constituted the research problem, and I discuss them in more detail in section 2.2.

1.6 PURPOSE OF THE STUDY

I investigated the involvement and participation of employees in HIV-prevention interventions at the workplace in order to understand the challenges which workplace HIV programme implementers faced in implementing such interventions. The study was also expected to provide insight and understanding on some of the challenges employees themselves experienced in getting involved and participating in these interventions. The findings of the study could be used to influence some of the decision-making processes of enhancing the implementation of the current HIV-prevention workplace programmes at this

particular manufacturing firm. Other researchers carrying out their own studies could also consult the findings.

1.7 RESEARCH QUESTIONS

The following were the research questions that this study sought to address with regards to HIV-prevention interventions at the Bulawayo firm at which I conducted my study:

1. What are the level, nature and type of employee involvement and participation in HIV-prevention interventions at the firm?

2. What challenges do employees face in getting involved and participating in HIV-prevention interventions at the workplace?

3. What challenges do implementers face in getting employees involved and participating in HIV-prevention interventions at the workplace?

4. What needs to be done to increase the involvement and participation of employees in HIV-prevention interventions?

1.8 DEFINITIONS OF KEY TERMS

For the purposes of my study, the term 'employee participation' refers to the process in which employees co-operate and collaborate to support interventions (Karl 2000:5). Participation lies in a continuum, ranging from minimal participation to intense participation. 'Co-option' is the nature of employee involvement where participation is at its lowest level, or mere token participation. The stakeholders, who are the employees in this case, have no real input or power in the implementation of interventions (Karl 2000:12). On the other extreme of the continuum, 'decision-making' is the ideal nature of involvement

where participation is at its highest level, and stakeholders have a role in planning and making decisions on implementation of interventions (Karl 2000:12). Participation may also come in the form of employees being informed about their rights and responsibilities with regards to interventions (World Bank 1996 quoted in Karl 2000:5).

In this study I adapted Karl's (2000) model of stakeholder participation in development aid programmes in rural and agricultural development to stakeholder involvement and participation in HIV-prevention interventions at the workplace. Employee participation in interventions at the workplace ensures support, sustainability and success of the interventions, as employees feel empowered and self-reliant. Conversely, non-participation of employees in these interventions at the workplace may undermine the success of the interventions, as employees may feel excluded because the decisions may not be in line with their interests.

'Employee involvement' refers to a situation where employees actually take part in workplace activities such as decision-making and planning with regards to the implementation of the interventions at the workplace. Like employee participation, employee involvement also lies in a continuum, ranging from co-option to decision-making. Employee involvement at the decision-making level promotes self-reliance and creates a sense of ownership and commitment to interventions at the workplace.

Table 1.1 shows a continuum of employee involvement and participation in interventions at the workplace as adapted from Karl's (2000:5) model. The table shows that involvement ranges from co-option to consultation to co-operation to decision-making, while participation ranges from minimal to intense.

Table 1.1: Employee involvement and participation continuum

Nature of involvement	Minimal (Level of participation) → Intense			
	Co-option	Consultation	Co-operation	Decision-making
Type of Participation	Token participation with no real input.	Stakeholders may express suggestions and concerns but have no assurance that their input will be used.	Employees help determine priorities, but the process is directed by management.	Employees have a role in making decisions on policy, intervention design and implementation.

(Source: Adapted from Karl 2000:5).

I defined the phrase 'HIV-prevention interventions' at the workplace as one or more of the wide range of HIV-prevention programmes that an employee can get involved and participate in. These included peer education, distribution and promotion of condoms, awareness sessions, diagnosis and treatment of STI's, the provision of VCT services and dissemination of prevention messages (Connelly & Sydney 2004:13).

The terms 'employee', 'employer' and 'workplace' were defined in accordance with the Business Dictionary ([sa], sv employee, employer and workplace). An employee is a person who works for compensation, for another in return for stipulated services, while an employer is someone who hires and pays wages, thereby providing a livelihood to individuals who perform work. A workplace is a place, such as a factory, where people are employed.

A 'manufacturing firm' is a commercial partnership that employs 500 employees or more, and that makes products from raw materials by the use of manual labour or by machines. Manufacturing is carried out systematically with a division of labour (Danks 1996:444; Britannica Concise Encyclopedia [sa], sv manufacturing).

1.9 CONCLUSION

I raised a specific concern with regard to employee involvement and participation in HIV-prevention interventions at the workplace. Although HIV-prevention interventions are to be found in a number of workplaces, it appears that employee involvement and participation in these interventions may be very minimal. I suggested a number of possible reasons for this gap in the implementation of HIV-prevention interventions at the workplace. These ranged from lack of employee involvement in the planning and implementation of the programme, to stigma and discrimination attached to HIV, to lack of management support, lack of role modeling by senior management, lack of stakeholder involvement, to socio-cultural and gender issues. These factors and many others appear to diminish employee involvement and participation in these programmes. In the following chapter I engage in a detailed criticism of the literature on HIV-prevention interventions at the workplace, as well as use case studies, in order to demonstrate that the above-mentioned factors do impede employee involvement and participation in these interventions.

CHAPTER 2: LITERATURE REVIEWED

In the previous chapter I presented the research problem that prompted my study, namely, what is the extent, nature of, and challenges facing employee involvement and participation in HIV-prevention interventions at the workplace. I raised a number of assumptions with regards to possible reasons for the lack of employee involvement and participation in HIV-prevention interventions at the workplace. The purpose of this chapter is to engage in a critical literature review in order to gain a deeper and richer understanding of certain factors that affect employee involvement and participation in HIV-prevention at the workplace.

2.1 INTRODUCTION

A large body of published work on HIV-prevention interventions at the workplace has appeared in the past decade. Attempting to include all this amount of work would not only have been impossible, but this literature review would also have lost focus. Consequently, I selected a few of the most recent sources related and relevant to my research. In order to cover a wide range of sources of information, I used electronic journals accessed via web browsers, as well as obtaining print journals from the subject librarian at the University of South Africa (UNISA). I then organised the content of these academic articles according to ideas to ensure the smooth flow of the literature review. Subsequent chapters, as far as possible, updated this literature review as I continuously searched for more literature while working on other aspects of the dissertation.

 I reviewed literature published mainly between 2000 and 2009, on studies of HIV-prevention interventions at the workplace and on employee involvement and participation in such interventions or similar interventions. The purpose of this review was threefold. First, by reviewing research studies that were closely related to my study, I hoped to gain new ideas, insights and approaches that could inform and provide signposts as to what issues are of significance to my

study and its research design. Second and most importantly, I hoped to use this critical review to gain a clearer picture of the gap I identified in section 1.4. In this regard, in section 2.2 I discuss in more detail a number of factors that are summarised in section 1.4 that are likely to contribute to the creation of this gap. Third, I used the review to help place the study in a theoretical context.

Basing my assumptions on the arguments presented in sections 2.2.1 to 2.2.5, in section 2.3 I speculate that the key factor for a successful intervention is the employee involvement and participation in these interventions. In section 2.4 I outline the theoretical framework that I used to guide the interpretation of the findings, namely the stakeholder theory and the social networks concept. In section 2.5 I conclude the chapter with a reflection on the main arguments presented, namely that there is limited employee involvement and participation in HIV-prevention interventions at the workplace.

2.2 OTHER RELATED RESEARCH ON THE TOPIC

A number of workplace HIV-prevention programmes in sub-Saharan Africa are being spearheaded mostly by large businesses, with the purpose of trying to reduce the impact of the HIV pandemic at the workplace. For example, a Bureau for Economic Research (BER) survey (Connelly & Sydney 2004:12) found that among South African companies with more than 500 employees, about 26 percent had formulated an HIV-AIDS workplace policy, and 94 percent had offered an HIV awareness programme to their employees at the workplace. Grant et al (2002:77) report that a number of South African companies were involved in HIV-prevention activities such as awareness campaigns, behaviour change interventions, training and condom distribution. Similarly, South African Breweries conducts awareness campaigns on HIV-prevention at the workplace and offers voluntary HIV counselling and testing services and free treatment for other STI's (Tawfik & Kinoti 2003:11).

DaimlerChrysler South Africa (DCSA), one of the world's largest automobile companies, provides a good example of a viable HIV-prevention programme at the workplace, as the following case study reported by the International Labour Organisation (ILO 2003:28, 29) well illustrates. The key elements of DCSA's workplace HIV-prevention programme are voluntary counselling and testing services (VCT) available on sites, prevention of mother-to-child transmission of HIV (PMTCT), treatment of opportunistic infections (OI's), sexually transmitted diseases (STD's), tuberculosis (TB) and post-exposure prophylaxis (PEP). Treatment takes place at the workplace's medical clinic. Condoms are also made available free of charge (ILO 2003:28, 29).

Heineken International in Africa, one of the world's biggest beer brewing companies, and Eskom, South Africa's electricity supply parastatal company, also run similar HIV-prevention programmes at the workplace, with VCT and management of opportunistic infections services being provided by internal and external personnel (ILO 2003:29).

2.2.1 Stigma and discrimination

Despite such HIV-prevention programmes on the ground, employee involvement and participation in these programmes still posed a challenge because of the problem of stigma and discrimination associated with HIV and other human rights issues. The ILO (2003:29) reports that HIV-related stigma and discrimination has a significant impact on the willingness of employees to be openly involved and participating in HIV-prevention interventions at the workplace. Fear of social isolation and ridicule from co-workers discourage them, not only from disclosing their HIV status, but also from making full use of the services available to them (ILO 2003:30). Under these circumstances, HIV transmission among employees would continue unabated.

Similarly, HIV-prevention interventions at the workplace are effective only if people perceived their workplace environment as being supportive and protective of their human rights. Conversely, employees who suffer disrespect for their human rights, such as issues of confidentiality, privacy and informed consent with regards to disclosure, find it difficult to get involved and to participate in HIV-prevention interventions at the workplace. For example, Holden (2003:130) observes that staff members of ActionAid, Mozambique were reluctant to get involved and to participate in consulting the peer educators, fearing that the conversations would not be kept confidential. Similarly, the staff members shunned voluntary counselling and testing services, as it was perceived as being indicative of an HIV-positive status. I found both the ILO's report on stigma and discrimination and Holden's observations very pertinent in my studies and therefore worth investigating. In this regard, I included the questions on human rights issues such as stigma and discrimination in both a semi-standardised interview (Appendix A) and in a self-administered questionnaire (Appendix B).

2.2.2 Lack of management support

Lack of management support may take the form of severely limiting employees' active involvement and participation in HIV-prevention interventions at the workplace. Employees merely become passive recipients of information passed from top-down, as the following example shows. Grant et al (2002:80) point out that management of the South African Department of Land Affairs limits employee involvement and participation in HIV-prevention at the workplace only to passive activities such as dissemination of information on HIV by internal e-mail, putting prevention messages into pay-slip envelops and placing HIV updates in lifts. Employees are not actively involved in other awareness campaign activities such as condom promotion and distribution, voluntary counselling and testing for HIV, STI diagnosis and treatment and peer education training. Because employees were not actively involved, these interventions were likely to fail, leading to the continued spread of HIV among the employees.

Lack of management support also manifests itself in the insufficient budgetary support for the HIV-prevention programme at the workplace. The Centre for Health Policy (2001:19) argues that some workplaces run HIV-prevention interventions at the workplace without a sufficient budget. As a cost-saving measure, companies prefer passive activities that neither take employees away from their core business, nor require a large budget to run. The Centre for Health Policy further argues that: "Businesses don't want to pay for [education about] AIDS…" (Centre for Health Policy 2001:19).

However, an International Labour Organisation (ILO) report (quoted in Isaksen, Songstad & Spissoy 2002:26, 27) argues keeping employees healthy by preventing HIV-infection from spreading is essential for the viability of the business in the long run. The report cites a study carried out in Botswana, Namibia, South Africa, Mozambique and Zimbabwe which estimates that by 2020, the labour force in these countries will be an estimated 10 to 22 percent smaller than it would have been because of AIDS. Absenteeism due to HIV, coupled with increased entry of young unskilled personnel into the labour market is likely to lower both the quantity and quality of productivity and production. The implication of the ILO's report is that it is in the company's interest to budget sufficiently to allow employees to get involved and to participate in HIV-prevention activities such as peer education training, VCT, STI diagnosis and treatment and condom distribution.

I felt the above arguments about lack of management support for the HIV-prevention interventions at the workplace were very pertinent and relevant to my study. Such lack of budgetary support was likely to lead to low levels of employee involvement and participation in HIV-prevention interventions at the workplace, resulting in limited success of the intervention. In this regard, I also sought to explore the quality of management support in my research. Consequently, I included questions about the quality of management support in

both a semi-standardised interview (Appendix A) and in a self-administered questionnaire (Appendix B).

However, some studies have shown that not every company was so concerned about maximizing profit to the extent of being unwilling to "pay for the education about HIV", as claimed above. For example, AngloGold, the largest gold mining company in South Africa, sets aside sufficient budget for hiring specialists to train peer educators among miners. These miners disseminate leaflets on HIV transmission modes and teach other miners as well as commercial sex workers about HIV (Tawfik & Kinoti 2003:11).

This latter example showed that there were indeed companies that appreciated the value of getting employees involved and to participate in HIV-prevention interventions at the workplace. However, as I argued at the outset of this section, there was evidence to show that there were some companies that set aside insufficient budgets for the programme, a situation that might prevent employees from getting involved and participate in HIV-prevention interventions at the workplace. The failure of employees to get involved and participate in HIV-prevention interventions at the workplace might in turn result in the continued spread of HIV amongst employees.

2.2.3 Lack of role-modeling by management

Failure by management to lead by example in terms of the uptake of services such as VCT and attending awareness sessions might create a negative attitude towards the whole HIV-prevention intervention at the workplace. The Centre for Health Policy (2001:25) argues that most HIV-prevention activities such as awareness campaigns, condom promotion and distribution tend to be directed towards the unskilled and shop floor workers, and not professionals and managers. Peer educators are drawn mostly from the lower-level employees and not from management. According to the Centre for Health Policy (2001:25), the

reasons for this lack of involvement and participation of management are that management believes HIV "doesn't affect us" and "it affects them".

The implications of the above arguments are that a climate of "us" and "them" may create discrimination and suspicion between workers and management. Employees may therefore feel discouraged from getting involved and participating in HIV-prevention interventions at the workplace. These implications seem to have a bearing on my study, and are therefore worth investigating. Consequently, I included the questions about how good management was in providing encouragement to employees (both in words and deeds) to get involved and participate in HIV-prevention interventions at the workplace in both a semi-standardised interview (Appendix A) and in a self-administered questionnaire (Appendix B).

2.2.4 Lack of involvement of key stakeholders

Karl (2000:4) attributes the limited success of many interventions to the lack of involvement and participation of the key stakeholders in the implementation of the interventions. Phillips (2004:2) also argues that stakeholders hold the power over the organisation and may exert either beneficial or harmful influence over it. Adapting Karl's and Phillip's model to HIV-prevention interventions at the workplace, limiting or excluding employees from the planning and implementation of HIV-prevention interventions at the workplace might lead to the failure of these interventions. The exclusion of the employees from these programmes is also likely to cause them (the employees) to deliberately or unwittingly work at cross-purposes to the objectives of the interventions, either as a way of protest or because they do not understand what is expected of them. Whatever the case may be, such lack of employee involvement and participation in HIV-prevention interventions at the workplace is likely to lead to programme failure and the continued spread of HIV among employees.

On the other hand, involvement and participation of employees in the planning and implementation of HIV-prevention interventions at the workplace was likely to improve the chances of sustainability of these interventions. Employees were likely to assume ownership of, and would be committed to, these interventions. Karl's (2000) and Phillips' (2004) arguments about the importance of stakeholder involvement in development interventions appear to have important implications for my study. Their assertions imply that the level of success of implementation of an HIV-prevention intervention at the workplace is correlated to the level, nature and type of employee involvement and participation in these interventions. Hence I included the questions in the Appendix about the quality and extent of employee involvement and participation in HIV-prevention interventions at the workplace.

2.2.5 Socio-cultural and gender issues

Equally important are socio-cultural and gender factors that tend to influence an individual's decision about one's health-seeking behaviour. In this regard, the International Labour Organisation (2003:7) argues that many HIV-prevention interventions at the workplace focus predominantly on health issues, distribution of condoms and awareness sessions, and insufficiently on issues related to culture and gender. However, the context within which people live, their culture and gender have been shown to have a much higher impact on final behaviour such as getting involved and participating in HIV-prevention interventions at the workplace.

For many people, a decision is not an individual action, but a product of their cultural and societal environment (Lamptey, Wigley, Carr & Collymore 2002:33). Cultural diversity at the workplace also means divergence of perceptions about how HIV is transmitted, leading to different responses regarding involvement and participation in HIV-prevention interventions at the workplace. For example, employees whose social and cultural norms overtly or tacitly accept sexual risk-taking, or those whose religious beliefs were against the use of condoms would

find it difficult to get involved and to participate in the promotion and distribution of condoms. Individual employees who come from a cultural background characterised by cultural barriers and gender norms that discourage open discussions of the behavioural risks of HIV may find it difficult to get involved and to participate in HIV-prevention interventions at the workplace.

Lamptey et al (2002:33) concur with the above arguments, pointing out that convincing people to change their behaviour is difficult if it is against their belief to do so, or if they believe that they are not personally at risk. By the same token, it would be difficult for employees to get involved and participate in condom promotion and distribution if they believe they are not personally at risk. Nor would they get involved and participate in any HIV-prevention activities if they believe that HIV is a result of witchcraft or is a form of punishment from God.

Realising the relevance of these assertions to my study, I included a number of questions in both questionnaires about employees' attitude towards the use of condoms. The aim of the questions was to explore, taking employees' contextual and cultural issues into account, the key behaviours that put people at risk of contracting HIV.

In a similar vein, gender inequality also works against the involvement and participation, particularly of female employees, in HIV-prevention interventions at the workplace. Holden (2004:8) argues that in much of Africa, women and girls who carry condoms are regarded as 'loose' and are frowned upon by the society. As the United Nations Development Fund for Women (UNIFEM) states, they are expected to passively submit to their partners' demands for sex (UNIFEM 2006:2). The implications of these gender inequalities are that even when a woman is informed and has accurate knowledge about sex and HIV- prevention, the societal expectations that a 'good' woman should be naïve would make it difficult for her to get involved and to participate actively in HIV-prevention interventions at the workplace. This gender inequality also manifests itself in the

distribution of decision-making power between men and women at the workplace. Here, gender-linked cultural and economic inequalities mean that female employees have less decision-making power, responsibilities and access to company resources. Under such circumstances it is more likely for female employees to be sidelined in decision-making processes, making it difficult for them to get involved and to participate in the planning, designing and implementation of HIV-prevention interventions at the workplace.

In addition, prevailing norms of masculinity expect men to be more knowledgeable and experienced about sex (WHO 2003:12). Such norms prevent men from seeking information or admitting their lack of knowledge about sex or protection from contracting HIV. Men who get involved and participate in HIV-prevention education often find themselves discriminated against by other men for failure to live up to the masculine ideals. They are regarded as effeminate, weak or immature (UNAIDS 2001:13). As a result of this failure of male employees to get involved and participate in HIV-prevention interventions at the workplace, the spread of HIV transmission is likely to continue among employees.

2.3 THE ASSUMED KEY FACTOR FOR A SUCCESSFUL WORKPLACE HIV-PREVENTION INTERVENTION

Basing my assumptions on the above arguments about the limited success of many HIV-prevention interventions at the workplace, I speculate that the key factor for a successful intervention is the employee involvement and participation in these interventions. To achieve this key factor, the potential barriers to a successful intervention, such as stigma and discrimination, socio-cultural and gender issues have to be taken into account. In the subsection that follows, I use case studies to show that focusing entirely on other factors at the expense of the key factor may result in the limited success of the HIV-prevention intervention at the workplace.

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2.3.1 The assumed key factor versus practice

Most HIV-prevention interventions at the workplace tend to focus more on increasing the unskilled and shop floor workers' knowledge of HIV, their perception of personal risk, and prevention of HIV transmission. The most important issue of employee involvement and participation in these interventions is often ignored (Centre for Health Policy 2001:25). Nor are stigma and discrimination, respect for privacy and confidentiality, socio-cultural and gender issues given much focus in these interventions. However, these are the potential barriers that, if not taken into account, are likely to work against employee involvement and participation in HIV-prevention interventions at the workplace. For example, the United Nations' report on Zimbabwe (UNGASS 2007:28) is silent on the involvement and participation of stakeholders in HIV-prevention interventions at the workplace. It merely emphasises the importance of transferring knowledge, by arguing that knowledge of how HIV is transmitted is crucial in enabling people to prevent HIV. The report therefore recommends workplace HIV-prevention activities that 'teach' employees about risk-behaviour modification and the adoption of positive behaviours. However, employee involvement and participation in these activities is not mentioned. Employees are expected to be passive recipients of this knowledge, which is believed to lead to the increase in the uptake of prevention services such as condom use and voluntary counselling and testing services. As a result of this recommendation, most HIV-prevention activities in the manufacturing sector focus on displaying 'information, education and communication' (IEC) material at various points within the premises. Employee involvement and participation in other HIV-prevention activities such as HIV counselling and testing services, peer education training and general awareness campaigns is minimal. Such overemphasis on knowledge acquisition leads to insufficient focus on relevant issues such as employee involvement and participation in HIV-prevention interventions. Under these circumstances, limited employee involvement and

participation in HIV-prevention interventions at the workplace is likely to lead to limited success of these interventions in the manufacturing sector.

Campbell and Mzaidume (2002) argue that employee involvement and participation in HIV-prevention interventions at the workplace is far more crucial to the success of the interventions than the mere knowledge of how HIV is transmitted from one person to the other. The two authors' baseline research shows that despite high levels of knowledge about the risks of getting infected with HIV, people still engage in high-risk sex. This argument is borne out by the results of the Demographic and Health Survey (DHS) conducted in Malawi, Mozambique, Zambia and Zimbabwe between 2004 and 2006. In Zimbabwe, for example, the results of the 2005/2006 DHS showed that a high proportion of adults between the ages of 15 to 49 years (97, 9 percent women and 99, 2 percent men) had heard about HIV (National AIDS Council 2006:5). In spite of this high level of knowledge, however, Zimbabwe still had a high HIV-prevalence rate of 15, 6 percent during 2007 (UNGASS 2007:4).

As Karl (2000:12) argues, the involvement and participation of stakeholders in any intervention is the key in building the capacity of stakeholders to take responsibility and control over their lives. In the context of HIV-prevention interventions at the workplace, this means that employee involvement and participation in these interventions empower them in terms of acquiring skills and taking responsibility of protecting themselves from HIV-infection. This would result in success and sustainability of the interventions, ultimately leading to the well-being of the employees themselves and their families, as well as the viability of the company.

The arguments stated in this section, like those provided in sections 2.2.1 to 2.2.5 seemed very pertinent to my study. Drawing from these arguments, I assumed similar factors, conditions and impediments relating to the HIV-prevention interventions at the workplace applied to my research. Consequently,

most of my research questions in both questionnaires revolved around employee involvement and participation in HIV-prevention interventions at the workplace. My research questions also focused on potential impediments to such employee involvement and participation, such as, stigma and discrimination, disrespect for human rights, lack of management support, lack of involvement of key stakeholders, socio-cultural and gender issues.

2.4 THEORETICAL POINT OF DEPARTURE

I employed a multitheory approach, integrating both the Stakeholder Theory and the Social Networks Concept as the guiding theoretical frameworks.

2.4.1 The Stakeholder Theory

Stakeholders are people or groups of people who are affected by the outcome, negatively or positively, or those who can affect the outcomes of a proposed intervention (Karl 2000:17). In the context of a firm, these include employees, financiers, shareholders, customers and the community (Phillips 2004:2).

The Stakeholder Theory begins from the assumption that stakeholders are the owners of the company, and the firm has a *fiduciary* duty to put their needs first. This means that the firm holds assets in trust and manages them for the benefit of the stakeholders. As the owners of the firm, stakeholders are owed an obligation by the firm and its leaders to be informed about their rights, responsibilities and opinions. Stakeholders have a role in making decisions on the policy, design, planning and implementation of the intervention (Karl 2000:12). As mentioned in section 1.8, stakeholder involvement and participation lies on a continuum, ranging from minimal participation or co-option to intense participation or decision-making. The ideal form of stakeholder involvement and participation is the one where stakeholders have a role in making decisions on policy, intervention design, planning and implementation (Karl 2000:12).

On the one hand, without the decision-making form of involvement, there is much danger that stakeholders may block decision-making, undermine implementation of interventions or refuse to be involved in the intervention if they perceive the decisions not to be in line with their interests. On the other hand, intense stakeholder participation would ensure co-operation and support for interventions, leading to successful outcomes and sustainability of these interventions.

The Stakeholder Theory is appropriate in the study of employee involvement and participation in HIV-prevention interventions at the workplace, which is the purpose of my research. In the context of my study, the stakeholders refer to the employees of the firm in Bulawayo, and not so much the firm's financiers, shareholders and customers. As important stakeholders, the firm's employees are owed an obligation by the firm to be informed about their rights to participate at an intense level – that is, in decision-making, planning of HIV-prevention interventions at the workplace and to be actively involved in the implementation of these interventions. I used the Stakeholder Theory to guide the interpretation of the nature and level of involvement and participation in HIV-prevention interventions at the Bulawayo firm that I studied.

2.4.2 The Social Networks Concept

The term 'social networks' refers to the web of social relationships that surround individuals or linkages between people that may influence people's health behaviours (Glanz, Rimer & Lewis 2002:186). The social networks concept sees these social relationships as having a powerful influence on individual health status, health behaviour and health decision making (Gretzel 2001). For example, an individual's decision to be involved and to participate in health-damaging behaviours or health-promoting behaviours such as engaging in unprotected sex or the promotion and distribution of condoms is heavily influenced by the shared social networks norms.

Glanz et al (2002:185) argue that close-knit networks exchange more trust, caring, expressions of love and empathy, and therefore exert more social influence on members to conform to the network norms. The same is true for social networks whose members are demographically similar in terms of age, gender, ethnicity and socio-economic status. In these powerful networks, a decision is not always an individual action, but is influenced by the network norms.

In the context of my study, the social networks concept was useful in investigating the influence of subpopulation norms in employee involvement and participation in HIV-prevention interventions at the Bulawayo firm.

2.5 CONCLUSION

In spite of putting in place a number of workplace HIV-prevention interventions, there are still gaps in the implementation of these interventions. Employee involvement and participation in these interventions is limited. This limitation is likely to translate into limited success of the HIV-prevention interventions at the workplace, with detrimental consequences in terms of the spread of HIV transmission among employees. I used case studies to illustrate and bring to the fore the factors likely to impede employee involvement and participation in HIV-prevention interventions at the workplace. These factors included stigma and discrimination and disrespect for human rights, lack of management support, lack of key stakeholder involvement and socio-cultural and gender factors. Basing my assumptions on all the arguments stated in the chapter, I speculated that the key factor for a successful HIV-prevention intervention at the workplace was the involvement and participation of employees in these interventions. It is these factors, including the key factor, which helped shape my research questions stated in the Appendices.

In order to gain an in-depth insight and understanding of employee involvement and participation in HIV-prevention interventions at the workplace, I employed the Stakeholder Theory and the Social Networks Concept as the guiding theoretical framework. I used the Stakeholder Theory to explain employee involvement and participation in HIV-prevention interventions at the workplace, and the Social Networks Concept to address subpopulation norms that have a powerful influence in health decision making behaviours. In the succeeding chapter I present the methodology and the research design that was informed by my literature review.

CHAPTER 3: METHODOLOGY

In chapter 2 I reviewed literature on studies of HIV-prevention interventions at the workplace with the sole aim of gaining a clearer picture of the gap in the implementation of HIV-prevention interventions at the workplace. The critical review also helped to place the study in its theoretical context, as well as affording me new ideas, insights and approaches that could inform and support my study and its research design. The present chapter then deals with the methodology of my study as informed by my literature review.

3.1 INTRODUCTION

This chapter explains the methodology and the research methods of my study. Mingers (2001:241) makes a distinction between the two terms: 'Research methods' are activities or techniques, such as face-to-face interviews, participant observation and administering and analysing a survey. Research methods are based on particular paradigms. For example, qualitative research methods are based on a subjective and interpretive paradigm, while quantitative research methods are based on objective, empirical paradigm (Mingers 2001:247). On the other hand, 'a methodology' refers to the actual research methods or a combination of these methods used in a particular research study. In the sense of Mingers' definition, the methodology of my study consists of two research methods, the qualitative research method and the quantitative research method. This mixed method research design is explained in the sections that follow.

The data was collected during the months of October and November 2009. However, since the qualitative and quantitative research designs are completely different, I discuss the core themes of the two designs separately. Before discussing these core themes separately, in section 3.2 I first examine the mixed method research design and the rationale for using this particular design. Second, in section 3.3, I outline the characteristics of the research population. In

sections 3.4 to 3.8 I then discuss the five core themes of the qualitative research design, namely, the sampling design and procedure, the measurement of variables, data collection procedures, data analysis and the ethical considerations. In sections 3.9 to 3.12 I consider the same core themes for the quantitative design.

3.2 MIXED METHOD RESEARCH DESIGN

My study was an exploratory (Neuman 2000:22) investigation of the involvement and participation of employees in HIV-prevention interventions at the workplace. The main purpose of this investigation was to understand some of the challenges in the implementation of these interventions both implementers of the programmes and employees faced.

In order to obtain detailed, varied and more extensive data in this study, I used a mixed method research design where both qualitative and quantitative research methods, approaches and concepts were combined into a single study to provide complementary information on the same phenomenon (Johnson & Onwuegbuzie 2004:17). The qualitative component was given a major status, and data was collected sequentially. This means that qualitative data was collected in more detail and analysed first, followed by quantitative data to expand the sample of participants.

Figure 3.1 summarises the qualitatively driven, sequential mixed method research I used in this study.

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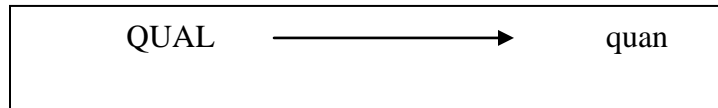
Figure 3.1: Qualitatively driven, sequential mixed method research

Key: "QUAL" denotes qualitative, "quan" denotes quantitative, " ────▶ " stands for sequential, capital letters denote high priority or weight and lower case letters denote lower priority or weight.

(Source: Adapted from Hanson, Creswell, Clark & Petska (2005:226)

3.2.2 Rationale for using mixed method research

The main reason for my using the mixed method research was that qualitative and quantitative data are both essential for the understanding of the level, nature and type of employee involvement and participation in HIV-prevention interventions at the workplace. The mixed method approach makes it possible to better understand the research problem by bringing together specific details from qualitative data and numeric trends from quantitative data (Hanson, Creswell, Clark & Petska 2005:226). For example, themes that emerged from the qualitative interview data about the nature and type of employee involvement and participation in HIV-prevention interventions at the workplace were supplemented with a closed-ended questionnaire to quantitatively measure the level of such employee involvement and participation. Corroborating findings across different approaches in this way did not only expand my understanding of employee involvement and participation in HIV-prevention interventions at the workplace, but also enhanced the validity and reliability of my research.

In addition, I used the mixed method research in this study as this method allows data obtained by using one approach to be used to inform the collection of complementary data using a different approach (Johnson & Onwuegbuzie 2004:21). For example, on the basis of the findings obtained from the qualitative

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data, I could then identify and select certain themes that needed to be verified and validated. This was done by the use of follow-up quantitative questionnaires. In this way, I was able to gain insights and understanding I might have missed when only a single method was used, leading to stronger evidence for my conclusion.

3.3 CHARACTERISTICS OF THE RESEARCH POPULATION

The target population of the Bulawayo firm where I carried out my study, namely employees who are below the managerial level, consisted of 22 female employees and 433 male employees, bringing the total population to 455 employees (Dunlop Zimbabwe (Pvt) Ltd 2009). Apart from gender, this population was also characterised by heterogeneity in respect of age, which ranged from 18 years to the retirement age of 65 years. The education level ranged from primary to university level. The population could also be divided into strata that were each more homogeneous in respect of job level than the population as a whole. For example, there were superintendents, supervisors, foremen, administration staff and general workers.

3.4 SAMPLING DESIGN AND PROCEDURE FOR QUALITATIVE DATA

I used the purposive, non-probability sampling technique to select participants for the face-to-face, qualitative interviews. This sampling technique was appropriate in my study since I needed to select a sample with the desirable characteristics among a population that might have had both desirable and undesirable characteristics (Greenfield 1996:196). This means that I used my subjective judgment to select a sample with the desirable characteristics such as age, sex, job level, and a variety of departments in the firm.

The sample consisted of six participants, five males and one female, between the ages of 18 to 65 years old. A disproportionately large number of male

participants in the sample reflected a skewed ratio of 22 female employees to 433 male employees (about 5 percent females) in this male dominated labour intensive firm. About 77 percent of the employees work in the factory; hence two participants were selected from the factory. The only female participant was the HIV-prevention programme implementer at the firm.

I selected this stratified sample with a variety of characteristics in order to allow a representative sample of all employees. I expected this to provide different perspectives that would allow me to gain a deeper understanding of the issues around employee involvement and participation in HIV-prevention interventions at the workplace.

Table 3.1 shows a stratified, purposive sample that I used for the qualitative component of my research.

Table 3.1: The stratified purposive sample

Department	Age Group	Gender	Sample
FACTORY	35 – 49	M	1
,,	50 – 65	M	1
SALES	35 – 49	M	1
FINANCE	18 – 34	M	1
HEALTH & SAFETY	50 – 65	F	1
BUYING	34 – 49	M	1
TOTAL			**6**

3.5 MEASUREMENT OF QUALITATIVE VARIABLES

Unlike with the quantitative data where precise and fixed variables were set in advance and were measurable, qualitative variables could not be measured. In this regard, I sought to make as few assumptions as possible about the data. Instead, in order to avoid influencing the information gained from the participants,

I based my interpretation on the data collected. Table 3.2 below, extracted from the attached semi-standardised interview schedule (Appendix A) provides an example.

Table 3.2: Extract from the interview schedule

SECTION 1: Perceptions of Involvement and Participation in HIV-prevention Interventions at the workplace
1. How concerned are you personally about getting involved and participating in HIV-prevention programmes?
2. During the past 4 weeks, how many times did you attend a meeting, workshop or awareness session about HIV-prevention?
3. What role have you personally played in addressing the prevention of the spread of HIV among employees at the workplace?

The purpose of asking open-ended questions and prompting, as opposed to providing a series of fixed variables to choose from, was to ensure that participants opened up and revealed their subjective experiences. This also ensured that the interpretation of data was based on the data collected.

3.6 QUALITATIVE DATA COLLECTION PROCEDURES

Neuman (2000:370) suggests the use of a semi-standardised interview schedule because it permits an in-depth face-to-face collection of qualitative data. For this reason, I also used the semi-standardised interview schedule to conduct face-to-face qualitative interviews to gain an in-depth understanding of employees' experiences on getting involved and participating in HIV-prevention interventions at the Bulawayo firm that I studied (Appendix A). I also made use of probes to explore employees' feelings and thoughts towards these interventions from an insider's understanding.

The use of a semi-standardised interview schedule meant that the issues for discussion were decided in advance. However, during the interviews I ensured that the content of the participants' responses to these issues were, as much as possible, determined by them. Participants were free to go in whatever direction they liked, speaking their views pertinent to the research questions.

Before conducting each interview, I explained the purpose of the interview to the prospective participant, and then gave him or her the informed consent form (Appendix C) to read. If the participant consented, I then proceeded with the interview. Each participant was interviewed independently of the others for about 30 minutes, in a private office set aside for my use by the company. Following the stated language preferences of the informants, two of the interviews were conducted in *Ndebele*, the mother tongue spoken by many people in the immediate surrounds of Bulawayo. Four interviews were conducted in English. I audiotaped all the interviews and then manually transcribed them verbatim. The data was then coded and categorised into themes in accordance with the data analysis method described in section 3.7.

Neuman (2000:371) advises that a researcher begins by building rapport with his subjects in order to encourage them to reveal their inner subjective feelings. To this effect, besides expressing interest in, and listening carefully to, what they had to say, I also shared some experiences with them about my work experience. In this way I expected to gain important insights about employee involvement and participation in HIV-prevention interventions at the firm. Furthermore, depending on the language preference of the participant, I conducted the interviews either in English or *Ndebele*, a vernacular language spoken by the majority of the people in the immediate surrounds of Bulawayo.

I also tape-recorded what was said immediately, incorporating direct quotations and noting the social context of the interview. In this way I was able to guard against forgetting what the participant would have said. It also ensured that I

captured important details such as emotions and feelings, thereby ensuring that the coding and interpretation of data was based on evidence rather than on subjective perceptions.

3.7 QUALITATIVE DATA ANALYSIS

First of all I transcribed all the qualitative interviews from the tape recorder. I then organised data into categories, then into themes. Following this, I summarised the emergent themes into narratives and integrated quotations and my own observations. These themes that emerged from the qualitative interview data were then interpreted, compared to, and contrasted with other similar researches on the field. They were also compared to and contrasted with the quantitative data results, either to corroborate or refute the qualitative findings.

3.8 ETHICAL CONSIDERATIONS

O'Grady (2004:208) recommends that a researcher should protect the human rights of his or her participants prior to, during and after the research process. In this regard, I also ensured that I protected the human rights of my participants and respondents prior to, during and after the interviews, as enshrined in the Universal Declaration of Human Rights. Article 12 of the Declaration was of particular interest to my research as it states that no one shall be subjected to arbitrary interference with his or her privacy, family or home, nor attacks upon his honour and reputation (O'Grady 2004:208). In the following subsections I show how I protected the human rights of the participants in my study.

3.8.1 Privacy and confidentiality

In order to protect the privacy of the participants, I ensured that interviews took place at a venue away from the public eye, and that no unnecessary disturbances from other people occurred. Before the interviews took place, I

engaged with the Human Resources Manager and supervisors about conducting the interviews at a private office at the firm.

Furthermore, I kept all participants' responses strictly confidential and anonymous. In order to protect the identity of the participant, I disguised his or her name by using a pseudonym in the field notes and transcripts of the interviews. I also reported the study results in my dissertation only in group form. I ensured data was kept under lock and key to protect the confidentiality of the information from others.

3.8.2 Informed consent

Neuman (2000:96) points out that a researcher must never coerce anyone into participating; participation *must* be voluntary (emphasis in original). In this regard, I ensured voluntary participation by all participants by seeing to it that they signed a statement of 'informed consent' (Appendix C). In order to make sure that participants made informed decisions, I informed them about the purpose of the study, the procedure of the research, the duration of the research, the interview process, and how information would be used. A guarantee of confidentiality of records and the protection of the identity of the participant was also included in the written informed consent statement. In addition, I assured participants that they could withdraw from the interview at any time without any prejudice to them.

3.8.3 The principle of human dignity

Egan (2006:6) advises that when considering the selection of participants for the research, the researcher must be aware of the dignity of all persons. The dignity of persons means that every person is entitled to respect by virtue of being a human person. This right cannot be violated independent of race, religion, nationality or socio-economic background. For this reason, I ensured respect for all participants by making sure that they participated out of their volition, and not

for the small benefits they received from me as allowances for their time. I also ensured that the research respected the basic human dignity of the participants by avoiding personal questions that might show disrespect for their religious, spiritual and cultural beliefs.

3.8.4 The right to self-determination

Schnarch (2004:82) urges researchers to respect the participants' right to self-determination, rather than treating the research subjects as merely a source of data. By the same token, I ensured that general workers in particular, who, because of their subordinate position, were to a great extent powerless and voiceless, did not feel pressured to participate in my study because management had consented. I made sure I explained my study in a language and manner adequate to ensure fully informed consent.

3.8.5 The right to full disclosure and protection from harm

While clients are generally encouraged to disclose their HIV status to persons who may need to know, during the interview I explained to the participants that such disclosure was absolutely voluntary. I therefore avoided persuading participants to disclose their HIV status to me. I also explained the risks and the potential impact of such disclosures on the employee's immediate friends, workmates and superiors in terms of stigma and discrimination.

3.9 SAMPLING DESIGN AND PROCEDURE FOR QUANTITATIVE DATA

I employed the stratified, systematic probability sampling technique to obtain respondents for the collection of quantitative data. This sampling technique is appropriate in the selection of respondents as it generates random results where each respondent has an equal probability of being selected (Neuman 2000:203).

The technique has the advantage of yielding a sample that is representative of the population.

In order to apply this technique, I used the firm's human resources list of all employees below the managerial level, as the sampling frame. I also used a stratified systematic sample of size 104. Rather than randomly selecting this sample from the total target population of 455, I ensured that appropriate numbers of employees were drawn from homogeneous strata using the sampling ratio of **1/k**. This was obtained by taking the same proportion of employees in each stratum, using the formula:

N/n=k

Where **N** is the total target population, **n** is the sample size, **k** is the sampling interval and **1/k** is the sampling ratio (Babbie 1990:85).

In practical terms, this means that the sampling interval was 455/104 or 4,375 (4 to the nearest integer), and the sampling ratio 1/4 or 23 percent. The sample distribution over the strata was obtained by taking the same proportion of employees in each stratum, that is, 23 percent.

A random number between 1 and 4 was selected from the Human Resources list of all the 455 employees. The employee having the selected number was included in the sample, plus every fourth employee following it until all the 104 employees were selected. Following this selection exercise, 104 self-administered questionnaires were distributed accordingly (Appendix B).

However, out of the 104 questionnaires that were distributed, only 80 were returned, or a 77 percent return rate. Table 3.3 shows that the most defaulters were the general employees, with 21 unreturned questionnaires.

Table 3.3 also shows that 77, 5 percent of employees were general workers who were largely unskilled or semi-skilled. This was due to the labour intensive nature of the firm. Administration staff followed as the second largest stratum, at 11, 3 percent. The 'other, specify' category was mostly occupied by either female intern employees in the administration department or male apprentices in the factories.

Table 3.3 presents the stratified, systematic sample for the quantitative interviews that I carried out to complement the qualitative face-to-face interviews. The table shows the numbers of employees stratified according to job level and sex. It also shows the intended stratified systematic sample of size 104 and the final sample of size 80.

Table 3.3: The stratified systematic sample (N=80)

JOB LEVEL	GENDER	POPULATION	PLANNED SAMPLE	FINAL SAMPLE	PERCENTAGE OF FINAL SAMPLE
SUPERINTENDENTS	Males	13	3	2	2,50
	Females	0	0	0	
SUPERVISORS	Males	18	4	3	3,75
	Females	0	0	0	
FOREMEN	Males	10	2	2	2,50
	Females	0	0	0	
ADMIN STAFF	Males	31	7	6	10,00
	Females	19	4	2	
GENERAL WORKERS	Males	361	83	62	78,75
	Females	3	1	1	
OTHERS (SPECIFY)	Males			1	2,50
	Females			1	
TOTALS		**455**	**104**	**80**	**100,0**

3.10 MEASUREMENT OF QUANTITATIVE VARIABLES

In order to measure the quantitative variables, I made use of the fully structured questionnaire with a number of itemised variables. Quantitative measures were

appropriate in my study as they provided two types of measures: the number of respondents who fell into a particular category and the strength or the degree in which they fell into that category. The example in Table 3.4 below, extracted from the attached questionnaire (Appendix B), illustrates this point.

Table 3.4: Extract from the attached questionnaire

Q14	Would you say that you are very confident, somewhat confident, a little confident, or not confident that you could do something to help prevent the spread of HIV among your co-workers if:	Very confident	Some confident	Little confident	Not confident	Do not Know
Q14a	No one else at your workplace was doing it.	1	2	3	4	8
Q14b	Other co-workers were opposed to doing it.	1	2	3	4	8

From the questionnaire extract in Table 3.4, I could find out, by asking respondents Question 14, the strength or the degree to which they felt confident that they could do something to help prevent the spread of HIV at their workplace under the named conditions. I could then go on and add together the individual responses to get the number of the respondents who fell into any specific category.

3.11 QUANTITATIVE DATA COLLECTION PROCEDURES

 I used a fully structured, self-administered questionnaire with closed-ended questions (Appendix B) to collect quantitative data. Unlike in the face-to-face qualitative interviews where the participants were free to go in whatever direction they liked, saying whatever they wanted, the questionnaire contained the same

standard questions in the same sequence. The respondents were also expected to choose their responses from those provided in the questionnaire, in the same order that they were presented.

3.12 QUANTITATIVE DATA ANALYSIS

With quantitative data analysis, my focus was on the magnitude of the responses, in numbers and in extent, as well as on the correlation of the data. I categorised the responses according to their similarity. I then counted the number of respondents who fell into a particular category and the extent to which they fell into that category. In this way, I was able to identify specific numeric trends from the quantitative data in a way that enriched my understanding of the employee involvement and participation in HIV-prevention interventions at the firm. I then used these quantitative data results to corroborate, refute or augment the findings from the qualitative interview data. In this way the findings from the qualitative analysis were connected to the results of the quantitative data analysis.

Throughout the process of both qualitative and quantitative data analyses I ensured that arguments in the pertinent literature I reviewed, the Stakeholder Theory and the Social Networks Concept, constantly guided me as the theoretical frameworks.

3.13 CONCLUSION

My research used the mixed method research design in which both qualitative and quantitative methods provided complementary information on the same phenomenon. Because of the mixed nature of the methodology, it followed that all the other elements of this methodology reflected this mixture. Hence the sampling design, the measurement of variables, the data collection procedures and the data analysis, all reflected both the qualitative and quantitative

components of my research methodology. Using a mixture of both qualitative and quantitative methods has the advantage that the two methods have complementary strengths, which enhanced validity and reliability, leading to stronger evidence for my conclusion. I also stated that I conducted an ethical research by protecting the human rights of my participants as enshrined in the Universal Declaration of Human Rights.

The following chapter presents the findings and the results of the study that were obtained using the above-mentioned mixed method research design.

CHAPTER 4: FINDINGS

Chapter 3 focused on the methodology and the research methods of my study, namely, the mixed method research where both qualitative and quantitative research methods were combined into a single study. The chapter also outlined the rationale for using this particular research design. In chapter 4, I present the findings that were obtained using this mixed method research. As mentioned in chapter 3, the mixed method research design I used is predominantly qualitative, with the quantitative component used to corroborate, refute or authenticate the qualitative findings. Consequently, the findings, analysis, interpretation and conclusions I present in chapter 4 are predominantly qualitative. The quantitative results are used sparingly.

4.1 INTRODUCTION

As suggested by Hanson et al (2005:227) and Onwuegbuzie and Leech (2006:479), in this chapter I presented the qualitative findings and the quantitative results separately as the two designs are different. I also carried out the analyses of qualitative and quantitative data separately. I then compared and contrasted and then integrated the two sets of the findings in the discussion.

The findings and the results I present in this chapter are for the data I collected during the months of October and November 2009. I discuss these findings in the light of the research questions outlined in section 1.7. In each of the sections 4.2 to 4.5 I present the findings for the qualitative data, with each section being devoted to a single research question. In sections 4.6 I discuss the results for the quantitative data, while section 4.7 is a discussion of the findings and the results summarised in the report, offering interpretation and conclusions of the study.

4.2 QUALITATIVE FINDINGS FOR RESEARCH QUESTION 1

In this section I focus on the nature and type aspects of the first research question about the level, nature and type of employee involvement and participation in workplace intervention programmes, as listed in section 1.7.

The responses to the questions listed in a semi-standardised interview schedule (Appendix A) indicated that employees seldom attended HIV-prevention workshops at firm because these sessions were too few and far apart. For example, three of the six participants lamented the fact that HIV-prevention workshops were now too infrequent at the firm. The words of one participant aptly capture this sentiment: "This time it happens here and there. It's no longer like in the old days…now we are almost in December, it's almost a year and we have already forgotten. I wish it could be done more frequently…" Two of the participants claimed they had never attended any HIV-prevention workshops at the firm. One of them said: "To be honest, so far I have never heard of an [HIV] programme here at the workplace. I have never attended one."

Of those participants who reported to have at one time played a role in HIV-prevention interventions at the firm, three reported to have done so through informal discussions with workmates during tea or lunch breaks. One claimed to have taken part, once or twice, in a question-and-answer session, or in answering a questionnaire as a group, during an HIV-AIDS workshop facilitated by an external facilitator. Two of the participants confessed to have played no role at all in addressing the problem of HIV at their workplace. One of them stated: "For others, I have done nothing; the only thing I can say is that I have tried to have a positive attitude towards those I suspect are living with the disease."

In relation to decision-making, all but one participant, or 83 percent, invariably claimed that employees were neither involved in making decisions about the

nature and type of the HIV-prevention programme at the workplace, nor did they take part in the planning and implementation of the activities. The nursing sister, the implementer of the programme, made all the decisions concerning HIV-prevention interventions. Employees were only informed, through their heads of departments, to attend the sessions as and when external facilitators were invited to the firm. When pressed further to clarify the claim that employees did not take any part in deciding whether they want to be trained as peer educators or not, one participant said: "Do we even have a platform where employees discuss such things?" My reading of his facial expression and gesticulations was that this was a rhetorical question.

4.3 QUALITATIVE FINDINGS FOR RESEARCH QUESTION 2

Here I present the qualitative findings of the second research question about the challenges employees faced in getting involved and participating in HIV-prevention interventions at the workplace.

Three of the six participants reported that some employees simply refused to take part in HIV-prevention workshops because, as one of them put it: "They don't care about HIV and AIDS; they say if you get it, hard luck." Employees are more obsessed with issues of remuneration and grievances, and not so much about issues that relate to their health, claimed one participant. According to another participant, the last time a huge number of employees went for an HIV test was when the external organisation conducting the tests was issuing T-shirts, hats and rubber bands. Yet another participant said that he had never gone for an HIV test or used a condom because he had never seen any reason why he should do so.

The other challenge was related to the nature of the work in the firm. Almost all the participants said that some heads of departments were not so keen in allowing employees to go for training sessions and workshops: "If you guys go,

who's gonna be at the machine? I want covers; I want that…" said one participant, mimicking his manager. Concurring with this assertion, another participant said: "Yeah, the job must not suffer…at the factory machines must run always, because there is target per hour." Admitting that he did not attend the last workshop on HIV-prevention which was held more than a year ago, one participant paused for a few seconds and then said: "Sometimes some of these programmes that are not mandatory, when they clash with certain business commitments, they suffer."

Many participants were concerned about the relationship obtaining between management and employees.   One participant raised his voice and said: "Supervisors and managers are good when you are still fit. But when you start to be something else, they don't look after you. If you get sick here, you can go for one week, two weeks, no visit". The participant went on to narrate an incident when he once "got very sick with smallpox". For the three weeks that he was homebound because of illness, none of the managers paid him a visit. It was only his workmates who did so, he said.

One participant lamented what he called 'lack of management commitment' in relation to an effective HIV-prevention programme at the firm: "It's about quality issues, quality programmes like ISO Certification and Accreditation," he said. There was a deliberate commitment and policy from top management when it comes to issues of product quality, claimed the participant. On the other hand, there was no visible commitment or action plan concerning HIV at the workplace. It all depended on organisational priorities: "Truly speaking, I have never heard any top guy talking about HIV and AIDS," said another participant. When prompted to explain how management's talking about HIV-prevention would help matters, the participant said that he felt it would lend a lot of weight if the employer as well were to talk about these things: "Maybe it's because management employees are not affected; they don't think it's an issue," he said.

As a result, very few managers and supervisors attended workshops on HIV-prevention, he added.

All the six participants condemned social stigma attached to HIV, and argued that an HIV positive co-worker should be allowed to continue working at the firm, and that they could personally easily work side-by-side with such a co-worker. Nevertheless, all the six participants concurred that it was not easy for anyone to disclose their HIV positive status at the workplace. If they were to disclose their HIV status at the firm, they preferred to do so to the clinic nursing sister because, in the words of one participant: "She signed a declaration to keep employees' health records confidential". The quantitative data results also showed that 42, 42 percent of the respondents, which was the largest proportion in this case, preferred to disclose their HIV positive status to the firm's clinic nursing sister. This seemed to confirm participants' assertion that, by and large, people were secretive about their HIV statuses; they felt uncomfortable telling others about it. Admitting that he would not disclose his HIV status to anyone because it was his secret, one participant said: "The problem is that once you tell someone your status, he will go singing about it." Some may pass on the gossip, and some yet may even shy away from the HIV-positive co-worker, he said. When prompted to explain further why employees, including himself, were reluctant to disclose their HIV status at their workplace, another participant said: "There are issues to do with discrimination. Perhaps one might calculate that if they disclose their status and there is a vacancy… they may miss out on brilliant opportunities."

4.4 QUALITATIVE FINDINGS FOR RESEARCH QUESTION 3

This section reports on the findings for the question about the challenges that implementers faced in getting employees involved and participating in HIV-prevention interventions at the workplace.

The findings showed that, according to the programme implementer, there was a lack of interest shown by many employees in taking part in an HIV-prevention programme at the firm. She said: "…and every time we have tried to implement the programme, they will not be interested. They want to know what's in it for them." The participant said that out of the 480 employees, only about 32 attended a whole day workshop on HIV-prevention that was held two months ago. The rest of the employees refused to attend. The high staff turnover over in the firm has also seen a decrease in the number of HIV-prevention peer educators, she said: "I feel I need peer educators, but the attitude is, 'fine, we become educators, but what remuneration are we going to get? Are we going to get a salary increment?'" When asked what could be the cause of this negative attitude, the participant cited low employee morale as a result of low wages at the firm: "Our minimum wage is US$89, 00…they are just struggling at home there. Their attitude is 'how can you call us and talk about AIDS; call us and talk about our salaries, about money.'" According to the participant, this low morale did not start with workers; it started with the managers and cascaded right down to the lowest paid worker.

The programme implementer also cited the negative influence of certain employees on their co-workers against getting involved and participating in HIV-prevention interventions at the workplace. As a result, only a few employees, those who had been with the firm through the good days in the past (that is, before Zimbabwe's 2007/2008 hyperinflation), were still very keen in the programme: "But you can't like implement something for 30 or 40 guys when the majority is not interested," she said.

The participant also claimed that the need to meet production targets interfered with the HIV-prevention programme at the firm: "Yes, [the programme] comes infrequently because, remember, we have got targets to meet in production. So I cannot implement a programme without going through the operations department," she said.

Social stigma and discrimination associated with HIV was not a challenge at the firm because she had not allowed it, said the participant. The clinic was very confidential, even management could not access employees' health records, she added.

4.5 QUALITATIVE FINDINGS FOR RESEARCH QUESTION 4

The fourth research question about what needs to be done to increase the involvement and participation of employees in HIV-prevention interventions at the workplace took into account the three preceding research questions. The following findings to this research question therefore attempted to offer a solution to the findings of the preceding research questions.

The findings indicated that in order for HIV-prevention interventions to be successful at the firm, there was a need for a combined effort and consultation between programme implementers and employees. "We have to work together with the Sister, to organise the programmes…and to keep on trying [engaging] the bosses, that we want these programmes such that [the interventions] are not deemed an HR [Human Resources] or accounts programme, but "our" programme," said one participant. Yet another participant wished to see what he called 'active participation' by establishment of a joint HIV-prevention committee comprising management and workers from various departments. The programme, according to the findings, should be tailor-made to suit the needs of the employees at the firm.   Management needed to show a deliberate commitment and support for the programme, and should put in place effective review mechanisms on the effectiveness of the programme. Co-workers, on their part, needed to be active and stand up and share their experiences. Another participant advocated for 'less talking, more action' with the help of DVDs (Digital Video Decoders) and slides screenings. They were tired of being told where AIDS comes from, how one gets it, and of being told about multiple partners, said one participant. "They are not addressing the workers' plight. We want to know

about healthy living, we want to know how to handle it [HIV] at home, how to break the news to [our] wives," said one participant.

Three of the participants acknowledged that, even though they wished to run their own HIV-prevention programme at the firm, they needed external expertise, at least at the initial stages of the programme, to help with technical support. "However, most guys here are not health professionals. They may not have the experience to run those programmes…we may need one or two specialists who can assist in crafting and formulating the programme," said one participant.

Three of the six participants said that they would like to see a structured action plan, where everyone would be participating, including management. Management had to show a deliberate commitment "to say we will support, we will make sure that all the programmes are given the support and the weight and seriousness that they should have," said one participant. The participant also felt that management should regularly follow up the programmes and put in place effective review mechanisms on the effectiveness of the programmes: "We need a follow up to say how far have we gone, what are the results, is it benefiting us running these programmes?" he said. Another participant said that for these programmes to be a success there was a need to revive the training of peer educators. "We need programmes to be led by energetic people, who personally have strong convictions [about the programme].

The HIV-prevention programme implementer at the firm expressed a different view. According to her, the first thing to do was to raise the employees' morale by ensuring that they were earning a decent salary. "As you know, a happy worker is a healthy worker, a safe worker and a productive worker," she said. The second thing to do was to increase the frequency of the HIV-prevention sessions to two or three per month.

4.6 QUANTITATIVE RESULTS

The quantitative results address the level and extent of employee involvement and participation aspect of the research questions that are outlined in section 1.7.

4.6.1 Attendance at HIV sessions

Figure 4.1 shows the frequency of the responses to the question about the attendance to HIV-sessions in the last 4 weeks. It shows that about 87 percent of the respondents did not get involved or participate in HIV-prevention programmes at the firm in the last 4 weeks. A combined 13 percent reported to have attended at most twice.
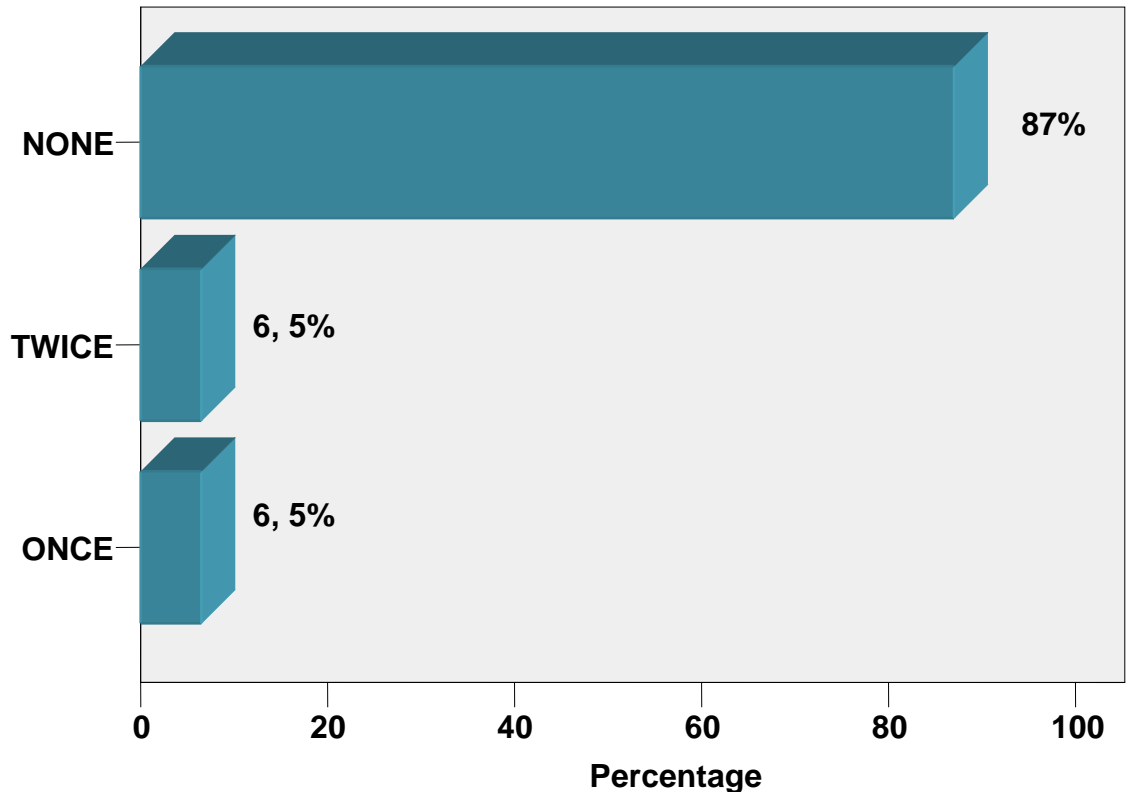
Figure 4.1: HIV-sessions attended in last 4 weeks (N=80)

Table 4.1 presents the frequency of the responses regarding attendance to HIV-prevention workshops in the last 6 months. It indicates that 45 respondents or 56,3 percent admitted they had not attended any HIV-prevention workshop at the firm in the last 6 months. Only 33 (41, 3 percent) agreed to have attended such a workshop during the same period at their workplace. Two respondents gave no response.

Table 4.1: HIV workshops attended in last 6 months (N=80)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	YES	33	41,3	42,3	42,3
	NO	45	56,3	57,7	100,0
	Total	78	97,6	100,0	
Missing	NO RESPONSE	2	2,4		
Total		80	100,0		

4.6.2 Management support

Table 4.2 shows the distribution of the responses regarding how good management was in providing opportunities to employees to get involved in decision-making on HIV-prevention issues.

Table 4.2: How good is management in providing opportunities to employees to make decisions on HIV-prevention? (N=80)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	VERY GOOD	12	15,0	15,2	15,2
	GOOD	14	17,5	17,7	32,9
	FAIR	15	18,8	19,0	51,9
	POOR	28	35,0	35,4	87,3
	DON'T KNOW	10	12,5	12,7	100,0
	Total	79	98,8	100,0	
Missing	NO RESPONSE	1	1,3		
Total		80	100,1		

According to Table 4.2, a large proportion, or over 35 percent of the respondents, reported management was poor in affording employees opportunities to air their views about the HIV-prevention programme at the firm. Only 15 percent reported that management was doing a very good job in involving employees in decision-making, while 12, 5 percent did not have an opinion.

4.6.3 Willingness to disclose one's HIV-positive status

Figure 4.2 summarises the responses to the question (Appendix B) about respondents' willingness to disclose their HIV-positive status to anyone at the firm.
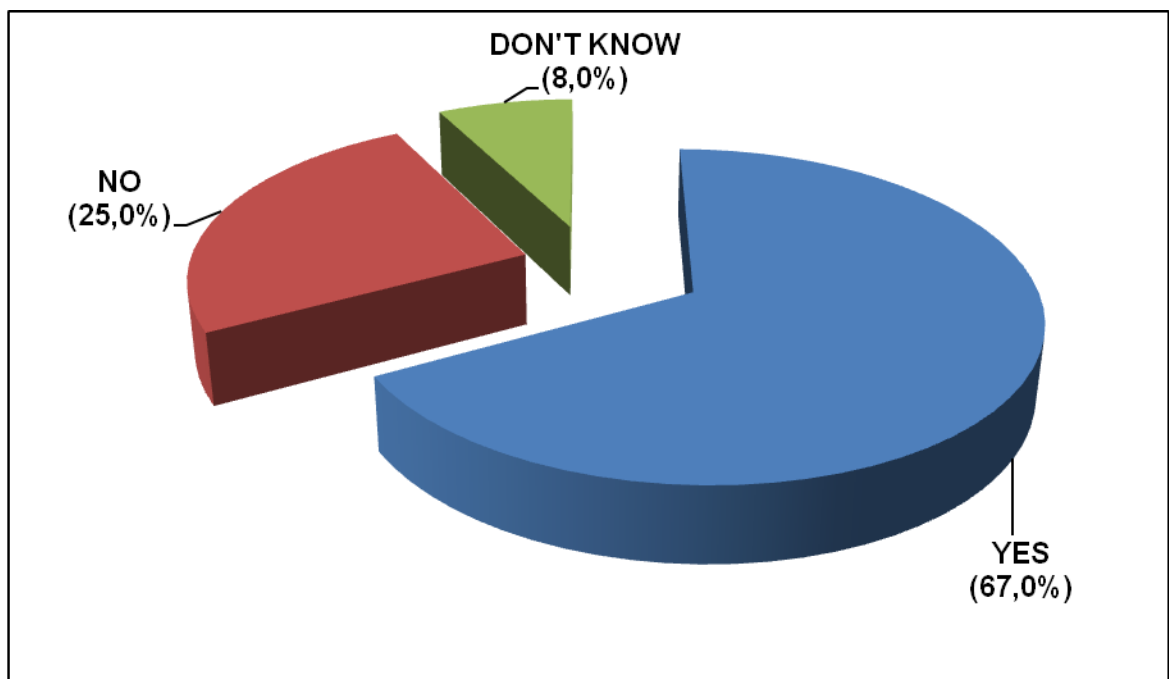
Figure 4.2: Respondents willing to disclose their HIV status (N=80)

According to Figure 4.2, 67 percent of the respondents were willing to disclose their HIV status to someone else at the firm. Twenty-five percent said that they would not disclose their HIV status to anyone, while 8 percent reported that they did not know.

Figure 4.3 shows the distribution of the responses to the question about the respondents' preferred confidant in disclosing their HIV-positive status.
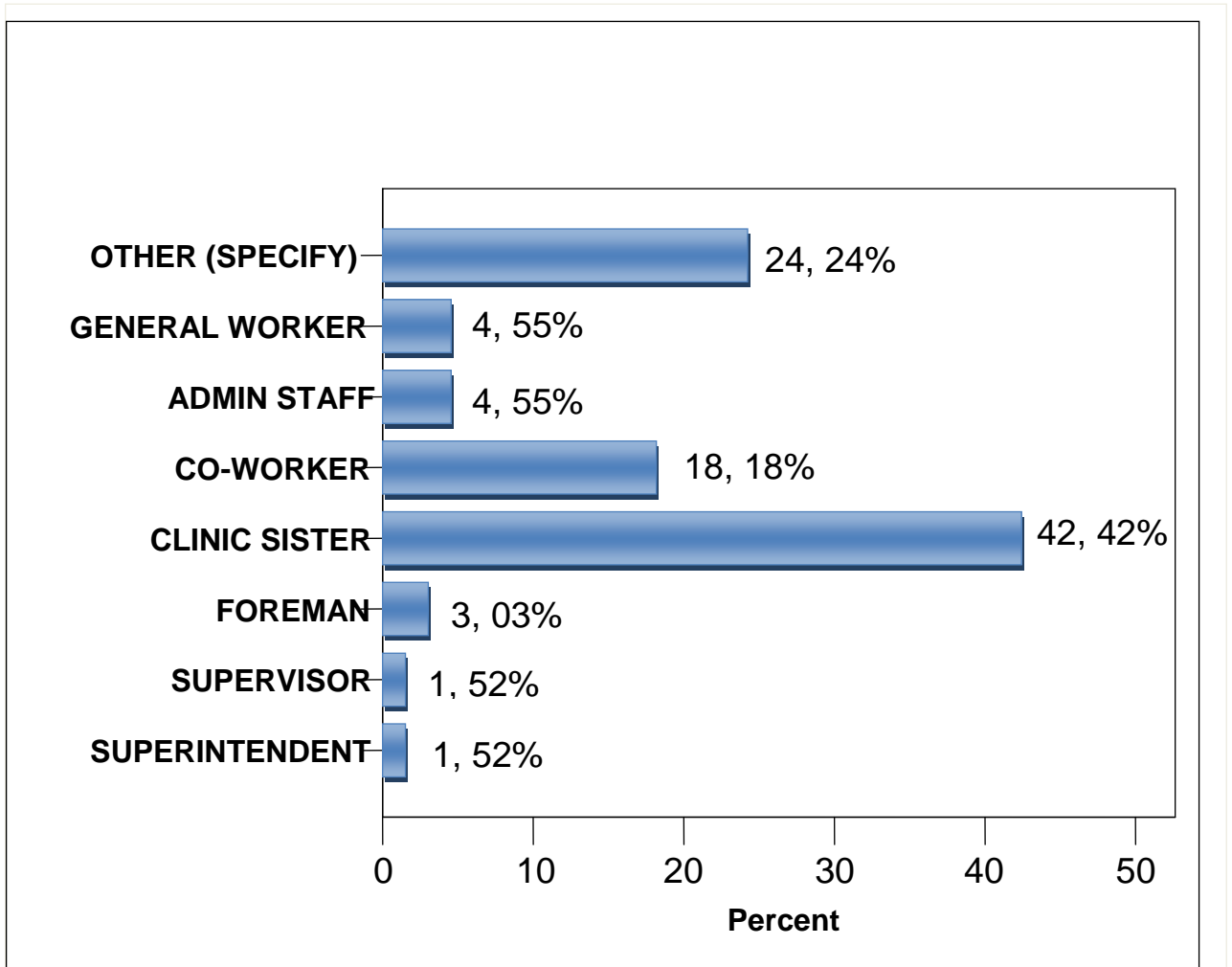
Figure 4.3: Respondents' confidant (N=80)

Figure 4.3 indicates that over 42 percent of the respondents said that they would disclose their HIV-positive status to the firm's clinic nursing sister. Very few respondents said that they would disclose their HIV-positive status to their immediate superiors. An equal number of respondents (1, 52 percent) chose superintendents as supervisors to be their confidant, while 3 percent chose foremen.

4.7 DISCUSSION: SUMMARY AND INTERPRETATION

In this section I report on the main findings of the study. I then focus on the interpretation and conclusion about the findings. I also attempt to synthesise, analyse and compare the findings with other similar studies.

4.7.1 Brief summary of the main findings

The findings indicated that, of the six qualitative interviews conducted, only two of the participants admitted to have played a role in HIV-prevention activities. But even then, this was done through informal discussions with workmates during tea or lunch breaks. The low rate of employee involvement and participation in HIV-prevention interventions at the firm was corroborated by the quantitative results, which showed that 58 percent of the respondents did not attend any HIV-prevention sessions in the past 6 months, and 85 percent did not participate in any way in the past 4 weeks. Of those who attended, they did so at most twice during the period in question.

The findings showed that both the programme implementers and the employees themselves agreed that the reasons for such low involvement and participation were employees' lack of interest in the programme. The employees claimed that their lack of interest stemmed from the fact that they were neither involved in making decisions about the nature and type of the HIV-prevention programme at the firm, nor did they take part in the planning and implementation of the activities. According to the findings, the implementers of the programme, together with the Human Resources manager, made all the decisions concerning HIV-prevention interventions at the firm. Quantitative results seemed to confirm these findings. Over 35 percent of the respondents, which was the largest portion in this case, reported that management was poor in affording employees an opportunity to air their views about the HIV-prevention programme at the firm. The findings also indicated that lack of management support and commitment in

relation to putting in a place an effective action plan and follow up mechanism for the workplace HIV-prevention programme also led to employees' lack of interest in the programme.

The study also revealed that there was an air of suspicion between employees and management. In turn, this suspicion created a divisive "us" and "them" atmosphere, which led to resentment by employees of any programmes initiated by management. As a result, some employees simply refused to take part in HIV-prevention programmes. The findings also revealed that the need to meet production targets interfered with the HIV-prevention programme at the firm. As a result, some heads of departments were not so keen in allowing employees to go for training sessions and workshops.

According to the findings, all participants, without exception, agreed that an HIV-positive co-worker should be allowed to continue working at the firm, and that they could personally work side-by-side with such a co-worker. In fact the programme implementer even claimed that social stigma and discrimination associated with HIV-positive status was non-existent at the firm. The quantitative results supported these findings. About 53 percent of the respondents said that they were very confident that they could go for an HIV test at the firm's clinic even if none of the employees was doing so. On the other hand, however, the findings also indicated that it was not easy for anyone to disclose their HIV-positive status at the workplace for fear of losing out on promotional opportunities.

As shown above, the findings indicated that, in order for these programmes to be successful, both management and employees needed to show commitment by establishing a joint HIV-prevention committee comprising management and workers from various departments. The programme, according to the findings, should be tailor-made to suit the needs of the employees at the firm. Management needed to show a deliberate commitment and support for the

programme, and should put in place effective review mechanisms on the effectiveness of the programme.

4.7.2 Interpretation of the study

The findings of the study led me to conclude that the nature of involvement, the type of participation and the level of participation in HIV-prevention interventions at the firm were very low. According to the conceptual framework outlined in Table 1.1 in section 1.8, the nature of employee involvement in these interventions is just co-option, where the type of participation is at its lowest or just 'token' participation, and the level of participation is 'minimal'. The findings indicated that employees did not have any input with respect to making decisions about programme planning and implementation. For example, when prompted to clarify the claim that employees did not make any decisions concerning the HIV-prevention programme at the firm, one participant retorted: "Do we even have a platform where employees discuss such things? No, employees don't decide, they just go." Thus, when employees had to take part in a programme in which they did not have any input, I feel safe to conclude that this was token participation. The following quotation from another participant also indicated the level of co-option in HIV-prevention interventions at the firm: "…it's the Sister [the clinic nursing sister] who decides, they can just hand-pick and say whoever wants to go to the lessons can go."

This co-option and token participation of employees in the HIV-prevention programme may help explain the reasons for employee reluctance to take part in these interventions. While acknowledging that low employee morale may have led to employees' lack of interest in HIV-prevention interventions at the firm, the alternative interpretation could be that employees resented the imposition of programmes from above. Imposing programmes on employees without consulting them may have undermined employees' sense of ownership and commitment to the programme. This imposition could have led to disinterest and

resistance to the programme, perhaps as a form of protest by employees. Boredom may also explain employees' lack of interest in HIV-prevention programmes: the HIV awareness sessions repeated the same subjects about HIV transmission, at the expense of what employees considered the pertinent issues, such as healthy living and issues of disclosure. Involvement and participation of employees in the planning and implementation of these interventions could have resolved these issues.

Employee co-option and token participation also seem to be linked to the low levels of employee involvement and participation in HIV-prevention interventions at the firm. The quantitative results appear to uphold this conclusion, with 58 percent of the respondents not having attended any HIV-prevention session in the past 6 months, and 85 percent not having participated in any way in the past 4 weeks. This conclusion is not new, as other studies have drawn similar conclusions. Karl (2000:4) attributes the limited success of many development interventions to the lack of involvement and participation of the key stakeholders, such as employees, in the implementation of the interventions. Phillips (2004:2) also argues that stakeholders hold the power over the organisation and may exert either beneficial or harmful influence over it. Applying Karl's and Phillips' models of stakeholder participation to HIV-prevention interventions at the workplace, I drew the conclusion that non-participation of employees in these interventions at the firm may also have undermined the success of the interventions.

Apart from token participation, the findings indicated that there was also passive participation by the few employees who said they had taken part in HIV-prevention. Two of the participants claimed they sometimes discussed HIV with their co-workers during work-breaks. For others, participation was limited to displaying a positive attitude towards employees living with HIV: "For others I have done nothing; the only thing I can say is that I have tried to have a positive attitude towards those I suspect are living with the disease," said one participant.

From these findings, I drew the conclusion that such passive participation came as a consequence of the lack of a functional and properly structured HIV-prevention programme at the firm. The following quotation from one participant confirmed this conclusion: "The employer is doing nothing about it [the HIV-prevention programme]. We are not even seeing any structures or any action plan…" If this conclusion is correct, then this passive participation could be construed as positive individual efforts at getting involved and in participating in HIV-prevention interventions at the firm. It may be concluded that employees genuinely desired to be involved in HIV-prevention, but their efforts lack management support and guidance. The minimal employee involvement and participation in HIV-prevention interventions at the firm was therefore a making, not of the employees, but that of management. Under these circumstances, HIV transmission among employees could continue unabated.

If the above interpretation were anything to go by, then it would refute the programme implementer's assertions that employees had a negative attitude towards the HIV-prevention programme at the firm. Indeed, there was no evidence in the findings to support the programme implementer's assertion that there were some employees in the firm who negatively influenced their workmates against the programme. For example, 53 percent of the respondents said they would continue engaging in HIV-prevention activities even if no one at the firm was doing it. This percentage stands in stark contrast to the 11, 8 percent of those respondents who said they were not confident of doing so. In addition, 37 percent of the respondents, which was the largest portion in this case, reported that they would continue engaging in HIV-prevention activities even if their workmates and supervisors were opposed to it, as opposed to 12 percent who were not confident of doing so.   I find it safe, therefore, to conclude that influence of network was not a factor in employee involvement and participation in HIV-prevention interventions at the firm.

The alternative explanation for the employees' apparent lack of interest in getting involved and participating in HIV-prevention interventions at the firm could be embedded in other competing programmes at the firm. The research findings revealed that the firm prioritised issues of product quality, such as ISO Certification and Accreditation and meeting production targets. There was a deliberate commitment and policy from top management when it came to issues of product quality, he said. Similarly, because of the overemphasis on meeting production targets, the findings indicated that some heads of departments were reluctant to allow employees to go for training sessions and workshops. Another participant summed it up this way: "Sometimes some of these programmes that are not mandatory, when they clash with certain business commitments, they suffer." Profit considerations overshadowed employee health issues. Perhaps management regards employees as dispensable because they can be replaced with minimum cost to the company.

The quantitative results, as shown in Figure 4.4, supported the conclusion that there was indeed a lack of management support and commitment for employee involvement and participation in HIV-prevention interventions at the firm. A large portion of the respondents, or 40, 8 percent, felt that management was poor in encouraging involvement and participation in HIV-prevention interventions at the firm. This percentage contrasted sharply with 14, 5 percent of those respondents who considered management was doing a good or a very good job in the same aspect. Such a lack of management support and commitment was likely to lead to ineffective employee involvement and participation in HIV-prevention interventions at the firm. HIV transmission was therefore likely to continue spreading among employees, with negative consequences for productivity and production at the firm.

Figure 4.4 presents the distribution of responses on how good management was in encouraging employee involvement and participation in HIV-prevention interventions at the workplace.
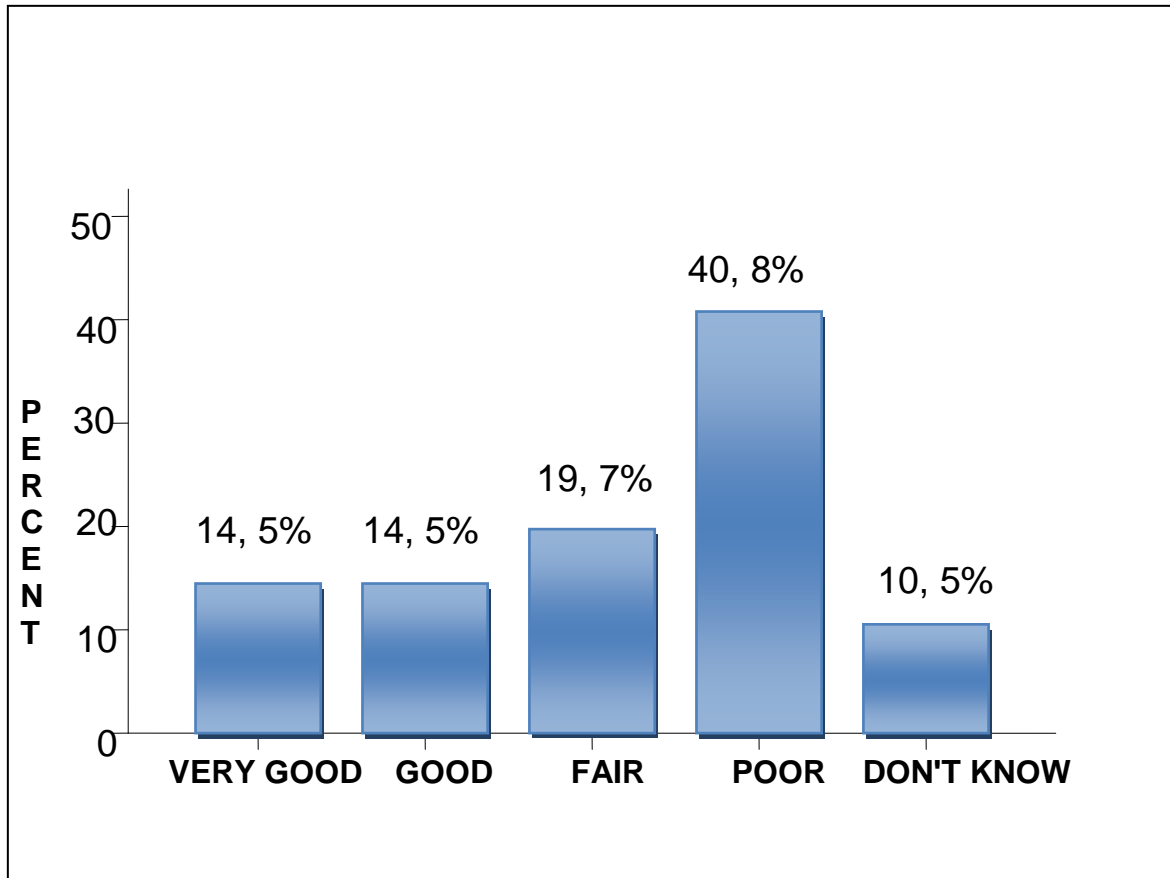
Figure 4.4: How good is management in encouraging employee involvement and participation in HIV-prevention interventions? (N=80)

The International Labour Organisation's (ILO) report strengthened my conclusion that lack of management support was another factor that impacted negatively on employee involvement and participation in HIV-prevention interventions at the workplace. In its report on the DaimlerChrysler South Africa (DCSA) case study, the ILO concludes:

> "The unsupportive [workplace] environment is also likely to be behind the low uptake of care and support services provided at the workplace. Employees' attitude and behaviours will only evolve if the changes are supported by management" (ILO 2003:29).

According to the programme implementers, however, lack of management commitment and support were not the issue. The company was taking HIV-

prevention programmes very seriously. "After all, the programme comes at no cost to the company," said the programme implementer. The real challenge, according to the findings, was that employees were not interested in anything that was initiated by the firm; be it first aid, fire-fighting or HIV-prevention programmes. The root cause of this disinterest, according to the programme implementer, was the low employee morale as a result of low wages.

These findings may suggest that, faced with competing needs – the need to fight the spread of HIV versus the need for immediate survival – employees of the firm may have been forced to prioritise   immediate survival needs at the expense of their general health issues. Their attitude is: "How can you call us and talk about AIDS; call us and talk about our salaries…our families are starving!" said the programme implementer, referring to employees. This conclusion is supported by other studies carried out on the relationship between poverty and susceptibility to HIV-infection. Holden (2004:7) argues that poverty and income inequality leads to susceptibility to HIV-infection because vulnerable people are forced to make decisions that expose them to the risk of HIV infection, such as engaging in unprotected sex for material gains. Therefore, success in preventing the spread of HIV hinges on reducing poverty and income inequality (Drimie & Mullins 2005:283; UNDP 2002:2). The implications of this inextricable linkage between HIV and poverty may lead to the conclusion that success in improving employee involvement and participation in HIV-prevention interventions at the firm depends on taking into account employees' immediate survival needs, namely, improving their standard of living.

Of particular interest about the findings was the seeming absence of social stigma and discrimination associated with HIV at the firm. A preliminary analysis of data collected had revealed that all participants would live openly with HIV, and the quantitative results had also seemed to corroborate these findings. About 53 percent of the respondents said they were very confident   that they could go for an HIV test at the firm's clinic even if none of the employees was doing so.

However, when the second analysis was carried out involving listening to the tapes and rereading the transcripts a number of times, the overall picture presented by the participants portrayed fear and unwillingness to disclose their own HIV-positive status at the firm. The words of one participant well captured these sentiments: "Why should I tell you; you will start preaching, telling people that this is what I am." I therefore conclude that HIV-associated social stigma and discrimination did indeed exist at the firm. A re-examination of the quantitative results also suggested that this conclusion could be correct. There was a tendency for those respondents who claimed to be willing to disclose their HIV-positive status to prefer a particular confidant and to avoid certain ones. For example, a comparison of Figures 4.2 and 4.3 indicated that, of the 67 percent of the respondents reported in Figure 4.2, about 43 percent preferred to disclose their HIV-positive status to the nursing sister. This was comparatively the largest portion of the respondents. The words of one participant illuminated the possible reasons for the preference of the nursing sister to the employees' superiors. When pressed to explain why he would not reveal his HIV-positive status at the workplace, he said: "There are issues of stigma and discrimination…one may miss out on brilliant [promotional] opportunities." It may be concluded therefore that employees shunned involvement and participation in HIV-prevention interventions at the firm, in the words of one participant: "To give an impression that they [were] still clean." Being active in these interventions could be perceived as being indicative of an HIV-positive status, and could prejudice one's chances of promotion or continued employment.

Other studies on the subject draw similar conclusions. The International Labour Organisation (2003:29) reported that although DaimlerChrysler South Africa succeeded in having 40 percent of its employees submit to VCT at its launch in 2001, employees' willingness to get involved and to participate in HIV-prevention workplace programme remained a challenge because of the social stigma associated with HIV. The intensity of the social stigma and discrimination

associated with HIV was shown by the fact that by October 2002 not a single employee had publicly admitted to be HIV positive.

The possible explanation for the initial denial of the existence of social stigma attached to HIV could be that the participants were telling me what I wanted to hear. They knew that stigmatisation was a form of 'bad' behavior and they were consequently saying they were 'good' people. Another explanation could be that there was, in fact, a genuine desire to see the firm being rid of the social stigma associated with HIV, and participants were therefore wishing it away, albeit in vain. In any case, the findings showed how difficult it is to determine people's attitudes towards a phenomenon. What employees reported about themselves was not necessarily a true reflection of their feelings and attitudes towards people living with HIV.

The study revealed that for the HIV-prevention interventions to be successful at the firm, employees have to be involved in the planning and implementation of these interventions: "We want to give an opinion, how you can prevent it in your view, how you see it," said one participant. Employees desired to see what one participant called 'active participation' where co-workers could stand up and share their experiences. This finding indicated that there was a degree of responsibility and commitment on the part of the employees, but only if they were consulted and had an assurance that their input would be taken into account. Conversely, the implication of the finding could be that imposition of the HIV-prevention programme on employees would be perceived as unfair and would therefore be resented.

According to the study, both management and employees need to show commitment to the HIV-prevention programme at the firm by establishing a joint HIV-prevention committee composed of management and workers from various departments. Through this committee: "All would have an input, all would have an opinion, and all would run the programme together, such that it is not deemed

an HR [Human Resources] or accounts programme, but "our" programme," said one participant. In addition, management has to show a deliberate commitment and proactive stand to say, as stated by one participant: "We will support, we will make sure that all the programmes are given the support and the weight and seriousness that they should have."

4.8 CONCLUSION

From the research findings summarised in this report, and the comparisons made with other studies, I concluded that the nature of employee involvement in HIV-prevention interventions at the firm was at a co-option level, and that the type of participation was mere token participation. The study identified a number of factors that may have impeded the effective employee involvement and participation in HIV-prevention interventions at the firm. These are lack of employee involvement and participation in the planning and implementation of the programme, the need to meet production targets, lack of management commitment and support as well as the spirit of "us" and "them" between employees and management. Social stigma attached to HIV was also identified as one of the major possible factors that could impede effective employee involvement and participation in HIV-prevention interventions at the firm.

The study made it clear that the success of HIV-prevention interventions at the firm hinged on genuine employee involvement and participation in these interventions. Co-option of employees and token participation in the interventions may breed resentment of, and resistance to, these programmes, leading to ineffective interventions. In this regard, it is only when the firm has developed a clear understanding of the importance of stakeholder involvement, employees in this case, that it can begin to witness improvement in the HIV-prevention interventions at the firm. This also holds the implications for addressing the factors that impede effective employee involvement and participation in such HIV-prevention interventions at the firm.

CHAPTER 5: CONCLUSION

5.1 INTRODUCTION

In the previous chapter I presented both the qualitative findings and the quantitative results of my study. I then conducted the analysis and interpretation of these findings   within the context of similar findings obtained from previous studies. The present chapter concludes the whole report by reflecting on the limitations that could have affected my data collection, analysis and interpretation.   It also lists and briefly explains the topics that researchers could profit from by conducting further research on, and presents recommendations for practice by the firm at which I conducted my study.

5.2 LIMITATIONS OF THE STUDY

My study had two main limitations: the possible researcher bias and the narrow focus, coupled with possible interviewer effect. This section discusses these two limitations in relation to the findings and interpretation of my study. In order to place the discussion on possible researcher bias into perspective, I include a brief reflection on my background as the researcher, and the values that motivated my choice of the study topic.

5.2.1 Possible researcher bias

The origins of the standpoint, values and emotions (Mauthner & Doucet 2003) that motivated my choice of the research topic can be traced to, and were all embedded into, my work experience. As the Matabeleland AIDS Council HIV-AIDS workplace trainer, the two- or three-day workshops I conducted with employees of various companies and organisations provided a platform where I freely interacted with employees. During these open discussions, employees frequently raised concerns relating to their exclusion from the planning and implementation of the workplace HIV-prevention interventions. Employees also

lamented the imposition of these HIV-prevention interventions and policies from above and the lack of management support for these interventions. I felt I had the responsibility 'to do something' to address these concerns, hence the choice of this particular research topic in order to gain a deeper insight into these concerns.

The desire to provide a voice to the 'silenced workers' may have biased me towards the interest of employees. The implications for this possible bias were not limited only to the adoption of a particular research method, but might also have influenced the data collection process and analysis. My preconceived ideas and values influenced my choice of certain participants for the interviews, affected the ways I coded the interviews and represented the research participants' narratives in the findings (Mauthner & Doucet 2003). As Malacrida (2007:1329) argues, the ways that social reality is understood and represented have much to do with the choices of the researcher.

However, while I agree with Colombo (2003) that objective interpretation of data "is an impossibility," and that all research is ideologically driven (Quaye 2007), I argue that, in writing this report, I tried to take into account my standpoint and values in order to produce an accountable research. In addition, as Malacrida (2007:1329) points out, the research process also affects the researcher's values, emotions, and standpoints. In a similar vein, my study improved my ability to understand my own actions and biases, to compare and contrast different standpoints and frameworks, to reconsider and rework my initial standpoint, values and emotions in order to produce a balanced and accountable study.

5.2.2 Narrow focus and possible interviewer effect

The second limitation was that the study focused on one specific firm and the findings could therefore only be interpreted with reference to this particular

sample. The study also depended on personal self-reported data, which might have been influenced by the participants' desire to give the answers that were likely to satisfy me as the interviewer.

However, in this study I tried to keep the interviewer effect to a minimum by employing a combination of methods, to compensate for the shortcomings of one specific method. For example, the in-depth qualitative interviews were followed by a quantitative questionnaire to authenticate or shed more light on the information.

5.3 SUGGESTIONS FOR FURTHER RESEARCH

In carrying out this study, it became clear to me that the issue of employee involvement and participation in HIV-prevention interventions at the workplace was very critical if the programme was to be successful. The findings presented in this report suggested that there were a number of areas where more research was required in order to achieve effective employee involvement and participation in HIV-prevention interventions at the firm. Here, I list some of the topics that could generate a new round of research questions and open new avenues of research:

5.3.1 The impact of other competing workplace programmes on HIV-prevention at the workplace

In this report I suggested that other competing, profit-oriented workplace programmes such as ISO Certification and Accreditation have the potential to draw management's attention away from HIV-prevention interventions at the workplace. Further research is needed on this potential role of such programmes to ascertain the extent to which this is probable.

5.3.2 The relationship between employee wellbeing and involvement and participation in workplace programmes

As mentioned in the findings chapter, other studies have shown that there is an inextricable relationship between poverty and susceptibility to HIV-infection (Holden 2004:7). However, the studies were done in the context of mainstreaming HIV and AIDS in development programmes. More in-depth casework is needed on the specific relationship between employee wellbeing – their conditions of service, including remuneration – and their willingness to get involved and participate in HIV-prevention interventions at the workplace.

5.3.3 The climate of mistrust and suspicion between employees and management in relation to effective employee involvement and participation in HIV-prevention interventions at the workplace

According to the findings, participants felt that there was a chasm between them and management, and expressed resentment for this. More detailed work on this spirit of "us" and "them" was needed to determine the degree to which it could impact on the employee involvement and participation in HIV-prevention interventions at the workplace.

I felt that researchers could profit from paying explicit attention to the above-mentioned research topics that have the potential to produce insightful programme design and successful implementation of HIV-prevention interventions at the workplace.

5.4 RECOMMENDATIONS FOR POLICY AND PRACTICE

A major finding of this research was that employee involvement and participation in HIV-prevention interventions at the firm was very minimal in terms of employee attendance to, and taking part in, HIV-prevention activities. Several barriers to

effective employee involvement and participation, and hence to effective implementation of HIV-prevention interventions at the firm, were identified. Some of these barriers are recapped here: lack of employee involvement in decision-making, lack of management commitment and support, social stigma attached to HIV, and the perceived chasm between employees and management. Based on these findings, I recommended the following:

5.4.1 Lack of employee involvement in decision-making

To address challenges related to this barrier, there was a need for a greater understanding of the relationship between stakeholder involvement, employees in this case, and successful implementation of a programme. Greater involvement of employees in the planning and implementation of HIV-prevention interventions at the firm had several advantages. It could create a sense of responsibility, ownership of the programme and commitment to it by employees. This was likely to facilitate smooth and effective programme implementation.

5.4.2 Lack of management commitment and support

Lack of management commitment and support impacted negatively on the effectiveness of employee involvement and participation in HIV-prevention interventions at the firm. Management, in consultation with the employees, needed to develop adequate implementation plans, including timelines and persons responsible for carrying out the actual implementation. A full monitoring and evaluation system had to be introduced to determine the effectiveness of the implementation.

5.4.3 Social stigma attached to HIV

There needed to be a greater recognition of the impact of social stigma associated with HIV on the involvement and participation of employees in HIV-

prevention interventions at the firm. Management needed to make efforts to address this major hurdle in the fight against HIV by adopting deliberate steps to implement the firm's HIV-AIDS workplace policy. Emphasis should be on such policy themes as penalties for stigma and discrimination on the basis of one's HIV status, privacy and confidentiality, and guarantees for continued employment and promotional opportunities regardless of one's HIV status.

5.4.4 The perceived chasm between employees and management

This negative perception by many employees seemed to create an environment of mistrust and suspicion concerning all management-initiated workplace programmes. Therefore, management needed to begin working with the workers' representatives to correct this negative impression and anger held by employees about management.

5.5 CONCLUSION

I have highlighted two main possible limitations, namely the possible researcher bias and the narrow focus of the study, coupled with possible interviewer effect. These limitations had the potential to influence data collection, analysis and interpretation. I also suggested that there were a number of areas where further research was required in order to gain deeper insights into employee involvement and participation in HIV-prevention interventions at the workplace.

I further argued that it was only when the firm had developed a clear understanding of the importance of stakeholder involvement, employees in this case, that it could begin to witness improvement in the HIV-prevention interventions at the workplace. This held implications for addressing the factors that impeded effective employee involvement and participation in HIV-prevention interventions at the firm.

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IN-DEPTH, SEMI-STANDARDISED INTERVIEW SCHEDULE

IMPROVING EMPLOYEE INVOLVEMENT AND PARTICIPATION IN HIV-PREVENTION INTERVENTION AT THE WORKPLACE

Introduction

A. INTRODUCE YOURSELF AND THE STUDY YOU ARE CARRYING OUT

I am **Charlie Ncube**, Master's student at the University of South Africa (UNISA). I am interested in workplace HIV-prevention programmes. I am currently working with SOS Children's Village, Bulawayo.

B. INTRODUCE OBJECTIVES OF THE STUDY

I am talking to employees of this firm to find out about their thoughts and opinions particularly in relation to their involvement and participation in HIV-prevention programmes and activities at the workplace. Your ideas will help me to develop programmes that I hope will better meet the needs of employees in your firm.

C. INTRODUCE FORMAT OF THE INTERVIEW

I want you to feel free to say exactly what you think; there is no right or wrong answer to the questions that I ask. Your opinions and experiences are important to me. Everything you say will be kept confidential and anonymous. No one will ever know what you personally said. I have already engaged with the Human Resources Manager and supervisors about conducting the interviews at private venues at the firm before or after work or during work-breaks. If you agree to be interviewed, you can suggest a place to go where no one can hear us talking. With your permission, I will write down what you say as well as use a tape recorder to record the session. This will enable me to accurately capture everything that we discuss today. Thank you in advance for your participation.

D. OBTAIN CONSENT FROM PARTICIPANT

Your participation in this study is voluntary. Some of my questions will be personal. If you are uncomfortable with a question, you do not have to answer it if you wish. You may also stop the interview at any time. It will take about 30 minutes to complete the interview. After that, you may ask me questions if you want. Is there a place we can go where we can talk? (SUGGEST A PLACE IF THE PARTICIPANT DOES NOT) Do you have any questions?

SECTION 1: Perceptions of Involvement and Participation in HIV-prevention Interventions at the workplace

1. First, I would like to hear about the problems and concerns of the employees in this firm about getting involved and participating in HIV-prevention activities.

2. How concerned are you personally about getting involved and participating in HIV-prevention programmes?

3. During the past 4 weeks, how many times did you attend a meeting, workshop or awareness session about HIV-prevention? PROBE.

4. What role have you personally played in addressing the prevention of the spread of HIV among employees at the workplace?

5. What can your firm do to encourage employees to get involved and to participate in HIV-prevention activities at the workplace?

6. What roles have supervisors and managers within this firm played in addressing the problem of the spread of HIV transmission in this firm?

7. What role have other employees of this firm played in addressing the problem of the spread of HIV transmission in this firm?

8. I would like to ask your opinion about how well the supervisors and managers provide opportunities for every employee to voice their opinion about the HIV-prevention programme.

9. What are some of the challenges that employees face in getting involved and participating in HIV-prevention programmes at this firm?

10. What are some of the challenges that you, as the HIV programme implementer, might be facing in getting employees involved and participating in HIV-prevention programmes at this firm?

SECTION 2: Decision-making in getting Involved and Participating in HIV-prevention Programmes

11. How well, in your opinion, have the decisions about HIV-prevention activities in this firm reflected the opinions of all the employees? How well did they include the opinions of those employees who are living with HIV?

SECTION 3: Attitude toward People Living with HIV

12. People have many different feelings when they think about people who have HIV. What feelings do you have? Do you feel sympathetic towards them? Are you angry? Are you afraid? Are you disgusted?

13. If a co-worker has the HI virus but is not sick, should he be allowed to continue working in this firm? PROMPT: Would you be willing to work with him/her in the same place? PROMPT: Would you be willing to share a meal with him/her?

14. How do employees in this firm act towards co-workers with HIV?

SECTION 4: Influence of Social Networks on Individual Potential for Action

15. Please tell me how confident you are that you could do something to help prevent the spread of HIV among your co-workers if:

i.   No one else at your workplace was doing it.

ii.   Your supervisor or manager was opposed to helping this person.

iii.   Other co-workers were opposed to doing it. PROBE: Why/why not?

16. Your fellow workmates tell you that they have been having sex without a condom, and are pressuring you to do the same. If you didn't want to imitate your fellow workmates in having sex without a condom, please tell me how confident are you that you could refuse? PROBE.

SECTION 5: Goals and Objectives for Future Involvement and participation

17. I would like you to think about the future. What are some things that employees of this firm can do to reduce the problem of HIV-infection among the employees?

(SOURCE: Adapted from 2003 CFSC Congregation Study Questionnaire; Horizons Project: Survey for Peer Educators, and Horizons Project Survey for Construction Workers in Ho Chi Minh City (CD-ROM: AIDS Quest))

Appendix B

SELF-ADMINISTERED QUESTIONNAIRE

No _____

<table>
<tr><td colspan="2">IMPROVING EMPLOYEE INVOLVEMENT AND PARTICIPATION IN HIV-PREVENTION INTERVENTION AT THE WORKPLACE</td></tr>
</table>

SECTION 1: Level of Involvement and participation in HIV-prevention Interventions

First, we would like to know about your involvement and participation in HIV-prevention activities at this firm. (PLEASE CIRCLE THE APPROPRIATE NUMBER)

No.	Questions and filters	Coding categories	Skip to
Q1	In this firm have you attended any session in the last 6 months talking about HIV-AIDS?	YES...1 NO..2	
Q2	During the last 4 weeks, how many times did you go to a meeting about HIV-AIDS?	TIMES……………..………[__|__] NONE…………………………88	
Q3	During the past 4 weeks, have you discussed HIV-AIDS with anyone at your workplace?	YES……………………………...1 NO…………………………….2	^Q5
Q4	With whom have you discussed HIV-AIDS during the past 4 weeks? (CIRCLE ALL THAT APPLY. MORE THAN ONE ANSWER IS POSSIBLE)	SUPERINTENDENT...............1 SUPERVISOR........................2 FOREMAN.............................3 CLINIC SISTER…………......4 CO-WORKER.........................5 ADMIN STAFF…………….....6 GENERAL WORKER………...7 OTHER (SPECIFY)................8	

Q5	For each task mentioned below, please indicate whether you think management is Very Good, Good, Fair, or Poor at these tasks. How good is management at:	VERY GOOD	GOOD	FAIR	POOR	DON'T KNOW
Q5a	Encouraging participation from all employees in HIV-prevention activities in your workplace?	1	2	3	4	98
Q5b	Providing opportunities for everyone to voice their opinion about the HIV-prevention programme?	1	2	3	4	98
Q5c	Obtaining the resources that are needed to address the HIV-prevention programme problems?	1	2	3	4	98

SECTION 2: Attitude toward People Living with HIV and Testing

In this section, we would like to know your opinion about people living with HIV and about testing for HIV. (PLEASE CIRCLE THE APPROPRIATE NUMBER)

No.	Questions and filters	Coding categories	Skip to
Q6	If a co-worker has HIV but is not sick, should he be allowed to continue working at the workplace?	YES...1 NO...2 DON'T KNOW.................................98	
Q7	If you knew that a co-worker has HIV would you be willing to work with him/her in the same place?	YES...1 NO...2 DON'T KNOW.................................98	
Q8	If you knew that a co-worker had HIV would you be willing to share a meal with him/her?	YES...1 NO...2 DON'T KNOW.................................98	
Q9	We don't want to know the results but, the question to you is: have you ever been	YES...1 NO...2	

	tested to see if you have HIV?		
Q10	Do you know of a place where you can go for an HIV test?	YES...1 NO..2	
Q11	If you got tested for HIV, and were told after the test that you had HIV, would you tell anyone the results?	YES...1 NO..2 DON'T KNOW.................................98	^Q13 ^Q13
Q12	With whom would you share this information? Would you tell your... (CIRCLE ALL THAT APPLY. MORE THAN ONE ANSWER IS POSSIBLE)	SUPERINTENDENT…………………1 SUPERVISOR………………………2 FOREMAN……………………………3 CLINIC SISTER…..………………….4 CO-WORKER………………………5 ADMIN STAFF………………………6 GENERAL WORKER………………7 OTHER (SPECIFY)………………....8	

SECTION 3: Influence of Social Networks on Individual Potential for Action

The following questions describe situations. On a scale of 1 to 10, where 1 is the least amount of confidence and 10 is the highest amount of confidence; please describe how confident you would be about taking the action stated in the situation. (PLEASE CIRCLE THE APPROPRIATE NUMBER)

No	Questions	Degree of confidence									
Q13	Some of your friends tell you that they have been having sex without condoms, and are pressuring you to do the same. If you didn't want to imitate your friends in having sex without a condom, how confident are you that you could refuse?	1	2	3	4	5	6	7	8	9	10

Q14	Would you say that you are very confident, somewhat confident, a little confident, or not confident that you could go for an HIV test at the firm's clinic if:	Very confident	Some confident	Little confident	Not confident	Do not Know

Q14a	No one else at your workplace was doing it.	1	2	3	4	98
Q14b	Other co-workers were opposed to doing so.	1	2	3	4	98

Q15	In your opinion, which person has the most influence at your workplace?	SUPERINTENDENT……………..…1 SUPERVISOR…………………..…2 FOREMAN………………………….3 CLINIC SISTER…...………………4 CO-WORKER……………………..5 OTHER (SPECIFY)………….…...6 NO ONE………………………….88 DON'T KNOW…………………….98	
Q16	In your opinion, which person has the least influence at your workplace?	SUPERINTENDENT…………..…1 SUPERVISOR………………….....2 FOREMAN………………………….3 CLINIC SISTER…...……………....4 CO-WORKER………………….....5 OTHER (SPECIFY)………….…...6 NO ONE………………………….88 DON'T KNOW…………………….98	

SECTION 4: Personal information

Finally, we would like to know just a little about you so we can see how different types of people feel about the issues we have been examining. (PLEASE CIRCLE THE APPROPRIATE NUMBER)

No.	Questions and filters	Coding categories	Skip to
Q17	CIRCLE SEX	MALE......................................1 FEMALE.............................. 2	
Q18	What is your age group?	18 – 34………………………….1 35 – 49…………………………2 50 – 65 …………………………3	
Q19	What is the highest level of school you attended: primary, or ZJC, or 'O' level or 'A' level or higher?	PRIMARY .... 1 ZJC .... 2 'O' LEVEL .... 3 'A' LEVEL............................ 4	

		COLLEGE/UNIVERSITY…….5	
Q20	When did you join this firm?	IN OR BEFORE OCTOBER 2007……………………………1 AFTER OCTOBER 2007..…..2	
Q21	What is your current position in the firm?	SUPERINTENDENT …….…..1 SUPERVISOR………………..2 FOREMAN……………………3 ADMIN STAFF……………….4 GENERAL WORKER………..5 OTHER (Specify……………...6	
Q22	For how long have you held this position?	THREE YEARS & ABOVE…..1 LESS THAN THREE YEARS.2	

That is the end of the questionnaire. Thank you very much for your time and cooperation.

(SOURCE: Adapted from 2003 CFSC Congregation Study Questionnaire;

Horizons Project: Survey for Peer Educators, and Horizons Project Survey for

Construction Workers in Ho Chi Minh City (CD-ROM: AIDS Quest))

INFORMED CONSENT FORM

IMPROVING EMPLOYEE INVOLVEMENT AND PARTICIPATION IN HIV-PREVENTION PROGRAMMES AT THE WORKPLACE

Dear employee

My name is **Charlie Ncube**. Thank you for taking the time to read this 'informed consent form'. I am a Master's student at the University of South Africa (UNISA). I am carrying out a study on HIV-prevention programmes conducted at the workplace in order to measure how effective these programmes have been.

I will be interviewing employees and programme implementers of Dunlop Zimbabwe regarding their involvement and participation in HIV-prevention programme(s). I am also interested in their experiences and challenges that they might be facing in implementing these programmes. It is very important for me to collect accurate information, which will be used to help develop better HIV-prevention programmes at your workplace and in other Zimbabwean firms.

I would like to interview you as part of this study. The interview will be conducted in private and your answers will be kept strictly confidential and anonymous. No one will ever know what you personally said. The information I collect from you will not be shown to anyone in the firm, not even your superiors. The study results will be reported in my dissertation and subsequent publications in medical and other scientific journals only in group form. With your permission, I will write down as well as tape-record what you say. Some of my questions will be on sensitive topics and about very personal matters, which I would like you to answer as truthfully as you can. You may choose not to answer certain questions if you wish. You may also terminate the interview at any time or refuse to

participate in the study entirely without any prejudice. The interview will last about 30 minutes.

I have already engaged with the Human Resources Manager and supervisors about conducting the interviews at private venues at the firm during the working hours. If you agree to be interviewed, please complete the blank spaces below.

If you have any questions about this study, you may contact my supervisor below. He will gladly answer your questions or address your concerns.

Mr. Christopher G Thomas, supervisor. Department of Sociology, University of South Africa, Box 392 Pretoria, 0003, Rep. of South Africa. Telephone: +27 12 429 6560, E-mail: thomacg@unisa.ac.za

Do you agree to participate?

Yes/No
Print Name of Respondent:_____
Signature or Mark of Respondent_____ Date_____

Signature of Person Obtaining Consent: _____Date_____

_____

      DATE OF INTERVIEW: _____
      TIME INTERVIEW: Started_____
      Completed_____

DECLARATION BY RESEARCHER:

I declare that I will comply with the ethical principles set out in the UNISA Policy on Research Ethics.

Charlie Ncube ……………………………..

Signed copies of this consent form must be 1) retained on file and 2) given to the Respondent

_____