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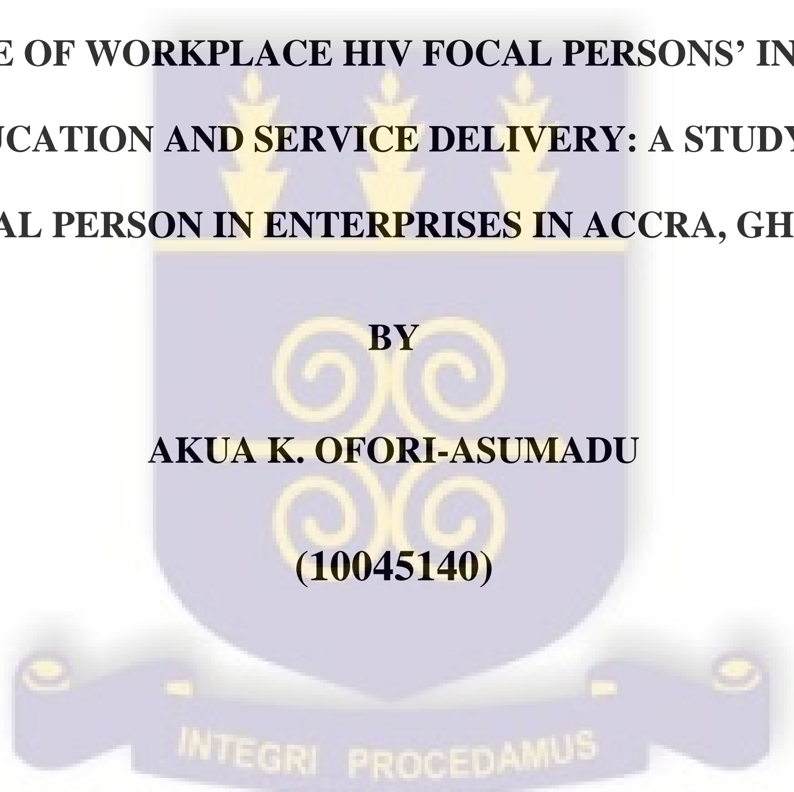
DEPARTMENT OF SOCIAL AND BEHAVIOURAL SCIENCES
SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA, LEGON

THE ROLE OF WORKPLACE HIV FOCAL PERSONS' IN HIV AND AIDS EDUCATION AND SERVICE DELIVERY: A STUDY OF THE FOCAL PERSON IN ENTERPRISES IN ACCRA, GHANA



BY

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A THESIS SUBMITTED TO THE UNIVERSITY OF GHANA LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF DOCTOR OF PHILOSOPHY (PhD) DEGREE IN PUBLIC HEALTH

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DECLARATION

I, Akua K. Ofori-Asumadu hereby declare that this is my own work produced from research under supervision of my supervisors.

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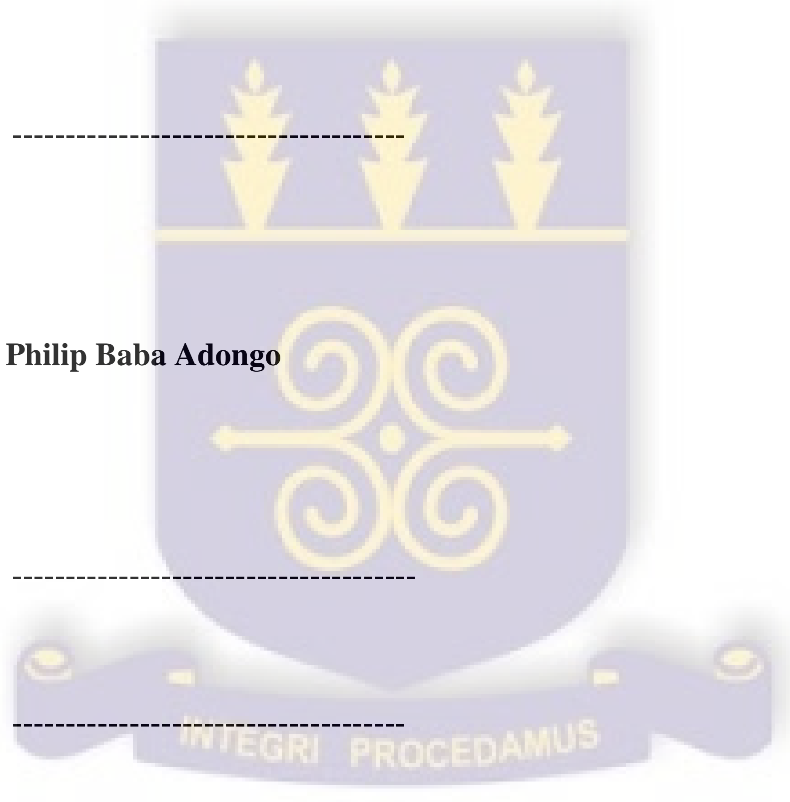

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ABSTRACT

People living with HIV and AIDS are likely to experience stigmatization and ostracism when they open up about their sero-status at work. The HIV Focal Point is a system where a staff member, referred to as a focal person is assigned to deliver HIV related services. It offers distinct opportunities and advantages as a key delivery point for HIV prevention, treatment and care programme for specific groups of people. Yet, many programmes do not explain the operational issues concerning it. The study examined the formation and operation of workplace HIV focal persons and the influence of their services on the workforce.

Methods: A descriptive study using a mix methods approach. The quantitative aspect employed a survey with close ended questions administered to 428 workplace respondents. The qualitative aspect used open-ended and semi-structured interview guides for five Focus Group Discussions and fifteen in-depth/Key Informant Interviews. Qualitative data was analysed by coding and condensation of data; identification of significant text and recording and grouping of emerging themes whilst quantitative data was analysed using the Statistical Package for the Social Sciences (SPSS) version 16.

Results: The results indicate that there was no evidence of a standard criteria for the selection of focal persons. The focal person selection process varied among enterprises: the selection were at times made in cognisance of government policy; by reasons unknown to workers; or by default appointment, if health workers were present in the enterprises' clinics. The roles and responsibilities of the HIV focal person was not a construct of their job description and specification but emanated from their respective company's HIV and AIDS policies. Focal persons' saw themselves as ill-equipped for

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their role and this inadequacy was both operational and logistical. In instances where the focal person did not have a health background, there were also technical knowledge deficits.

Using the parameters of ‘comprehensive HIV knowledge’, for example, knowledge of content of HIV policies; condom use and HIV risk perception as a proxy for measuring the influence of focal person exposure on the workforce, exposed workers reported significantly higher ‘comprehensive HIV knowledge’. When parameters were compared between exposed and non-exposed workers, knowledge of the content of HIV and AIDS policies was 64.5%:0%; condoms use was 65%:24.8%; perception of a moderate to small risk of acquiring HIV was 100%:76% with 24% of non-exposed workers reporting no risk at all in comparison with none among the exposed. Stigmatizing behaviour was also significantly reduced in the exposed workers in contrast to the non-exposed (68.7%:7%)

Conclusion: Workplace HIV focal persons influenced positively HIV behaviour outcomes of workers and the availability of HIV services at the workplace. Workplace HIV focal persons assured the availability of HIV services at the workplace and the ability of workers to respond positively to HIV. It is therefore recommended to scale up and institutionalize the focal person services; expand services to include other diseases of public health importance; incentivize private sector with tax rebates to support the position through monies thus saved; mainstream the focal person’s job description within the public /civil service and private sector and enjoin (charge) government to enforce a minimum standard for the operations of focal persons.

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DEDICATION

To Almighty God for the great things he has done and for how far he has brought us; my most supportive husband, children and parents for the times they were there for me and the sacrifices they had to make.

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I owe the completion of this work to the motivation; the push; encouragement, inspiration and support received from many.

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Again, I pay tribute to my family: to my husband, Peter Ofori-Asumadu, for being my champion and cheer leader in times when I almost gave up; to my children, (Maame Amankwaa, Nana Yaw, Nana Adu and Lasti Akosua), for whom giving up was not an option!; to my father, Professor A. G. Kese (Agyewodin Adu-Gyamfi Ampem), the one who first chartered the path and to my mother, Mrs Cecilia Kese, who held the fort at home in my absence. I also extend my appreciation to all who in diverse ways contributed to this journey that I may have failed to mention.

Finally, my highest tribute and eternal gratitude go to the Most High God, who sustained me throughout the journey; may he continue to be my Shepherd.

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KEY WORDS:

Descriptive Study

Acquired Immunodeficiency Syndrome

Delivery of HIV Services

Education

Epidemiology

HIV Infections

Health Education

Health Planning

Infection

Occupational Health Services

Peer Education

Voluntary Counseling and Testing

Viruses

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ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
BCC	-	Behaviour Change Communication
CDC	-	Centre for Disease Control
CIDA	-	Canadian International Development Association
ESR	-	Education Sector Review
GAC	-	Ghana AIDS Commission
GBCEW	-	Ghana Business Coalition on Employee Well-being
GEA	-	Ghana Employers Association
GHDS	-	Ghana Demographic and Health Survey
GSMF	-	Ghana Social Marketing Foundation
GSS	-	Ghana Statistical Service
GTUC	-	Ghana Trades Union Congress
GHANET	-	Ghana HIV & AIDS Network
HIV	-	Human Immunodeficiency Virus
HTC	-	HIV Testing & Counselling
ILO	-	International Labour Organization
ILOAIDS	-	International Labour Organization's AIDS Programme
IEC	-	Information, Education and Communication
IRIN	-	Integrated Regional Information Networks
MDAs	-	Ministries, Departments and Agencies

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MMDAs	-	Metropolitan, Municipal and District Assemblies
MOE	-	Ministry of Education
MLGRD	-	Ministry of Local Government & Rural Development
MSM	-	Men who have Sex with Men
POW	-	Plan of Work
PMTCT	-	Prevention of Mother-to-Child Transmission
NACP	-	National AIDS Control Programme
NGOs	-	Non-Governmental Organizations
NSF	-	National Strategic Framework
NSP	-	National Strategic Plan
PEP	-	Post Exposure Prophylaxis
PLHIV	-	People Living With HIV
STIs	-	Sexually Transmitted Infections
SSA	-	Sub Saharan Africa
TB	-	Tuberculosis
UN	-	United Nations
UNAIDS	-	Joint United Nations Programme on AIDS
UNFPA	-	United Nation Population Fund
UNICEF		United Nations Children Fund
UNIDO	-	UN International Development Organization
VCT	-	Voluntary Counselling and Testing
WAPCAS	-	West African Project to Combat AIDS
WHO	-	World Health Organization

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CHAPTER ONE INTRODUCTION

1.1 Background

Of the 33.3 million people living with HIV and AIDS worldwide as at the end of 2009, about 25 million were men and women of reproductive age between 15 and 49 and form the bulk of the workforce (UNAIDS, 2010). The HIV and AIDS pandemic is taking a huge toll on the human capital of most affected economies especially in Africa South of the Sahara. According to the International Labour Organization (ILO), by 2020 the size of the labour force in high-prevalence countries could be 25 per cent smaller than it would have been without the HIV and AIDS epidemic (ILO, 2008). The situation of HIV and AIDS is grim, particularly in sub-Saharan Africa, the worst-affected region in the world (UNAIDS, 2010).

Ghana's case is not any different. Trends in HIV prevalence show a steady increase in HIV prevalence since 2000. The HIV and AIDS prevalence rate has seen peaks and troughs rising from 2.4% in 1994 and peaking to 3.4% in 2002 swinging down to 1.7% 2008 then rising marginally to 1.9% in 2009 (NACP, 2009). Currently, the median prevalence in Ghana stands at 1.6% (NACP, 2015).

According to an ILO report (ILO, 2008), HIV and AIDS affects fundamental human rights, particularly with respect to discrimination and stigmatization aimed at people living with and affected by HIV and AIDS. Stigmatization against people living with HIV and AIDS is predicated on negative perceptions deeply rooted and re-enforced by ignorance. This is provoked by a mixture of shame (that HIV is a function of illicit sex and deviant behaviour) and of fear (that AIDS is highly infectious and considerably

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fatal). Beyond the suffering it imposes on individuals and their families, the epidemic is profoundly affecting the social and economic fabric of societies (ILO, 2001).

At the macro level, it impacts the economy of the country by reducing the labour supply and disposable incomes, impacts markets, savings rates, investment and consumer spending (Dickenson, 2005). While assessing the economic impact of AIDS is very difficult, studies suggest that some of the hardest hit countries may forfeit 2% or more of GDP growth per year as a result of the epidemic (ILO, 2001).

According to the ILO Code of Practice on HIV and AIDS in the 'World of Work', AIDS further damages businesses by reducing productivity, adding costs, diverting productive resources, and depleting skills (ILO, 2008). Company costs for health-care, funeral benefits and pension fund commitments are likely to rise as the number of people taking early retirement or dying increases. The same report states that, as the impact of the epidemic on households grows more severe, market demand for products and services falls. The epidemic also hits productivity through increased absenteeism, thus reinforcing the need for these issues to be effectively addressed (Jeffries, Greener, & Siphamb 2006).

The problem of HIV and AIDS is further compounded by stigma and discrimination. Various programmes undertaken by the Ghana AIDS Commission, reveal that there is widespread stigma and discrimination toward HIV positive persons which adversely affects the uptake of HIV services (GAC, 2005). According to the ILO (2005), in Ghana, the level of stigma among the workforce was high enough to prevent workers from accessing services such as treatment, STI services, and condoms even though these

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services were free. The Ghana Business Coalition have indicated that workers prefer to access HIV services through comprehensive wellness programmes that add other lifestyle diseases than stand-alone HIV programmes, as a result of the high levels of stigma (GBCA, 2008). They further report that the implementation of workplace programmes will help reduce this problem of stigma by educating the workforce about HIV and AIDS and how to accept and live with PLWHA and as well, encourage the workforce to access health care programmes that are available (GBCA, 2008).

The workplace thus offers distinct opportunities and advantages as a key delivery point for HIV prevention, stigma reduction and treatment and care programme for specific groups of people on a continuous basis (Durantini, 2006). Using a combination of dialogue, training and facilitation methods, workplace programmes create the platform and opportunities to maintain employment for workers living with HIV, reducing high-risk behaviour among workers, facilitating access to voluntary and confidential testing, treatment, care and support (ILO, 2006).

The ILO programme on HIV and AIDS, states in its Code of Practice (2001) that the development of a workplace policy is the single most effective and important action an enterprise can take in the fight against HIV and AIDS to safeguard its workforce (ILO, 2001; ILO, 2010). These guidelines encourage a consistent approach to HIV and AIDS, based on ten key principles. These key principles are: 1) HIV is a workplace issue 2) Non-discrimination against persons perceived or known to be HIV positive 3) Gender equality – more equal gender relations and empowerment of women are vital to preventing the spread of HIV 4) Healthy work environment needed to minimize

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occupational risk 5) Social dialogue – a policy needs cooperation of both management and workers 6) No screening for the purpose of employment 7) Confidentiality – personal data on HIV positive staff must be kept confidential 8) continuing the employment relationship 9) Prevention education and support for behavior change 10) Care and Support (psychosocial, nutrition, therapeutic and palliative care etc.). These guidelines are flexible enough to address the different needs of individual workplaces.

This was demonstrated by the ILO in 2008 with a total of 650 workplaces in 24 countries involved with ILO's programme entitled 'Strategic HIV and AIDS Responses in Enterprises' SHARE, (ILO, 2008). This programme established the on-going projects that informed and sought to protect almost a million working men and women from the risks of HIV. Work carried out in this field by ministries of labour, employers' and workers' organizations and partner enterprises accelerated the spread of Workplace HIV and AIDS education in Ghana and globally (ILO, 2007).

A comparative study conducted among factory workers demonstrated that peer education has the potential to reduce the incidence of HIV among the workforce (UNAIDS, 2008). This study, evaluated a health education strategy using HIV infection as the measure of effectiveness. HIV incidence rates were found to decrease more significantly in the factories where peer education was offered than in those without such a programme (AIDSlink, 1998).

It is against this background that the strategy of one staff member assigned to the position of HIV focal person to offer HIV services at the workplace is being examined. This staff

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member may be referred to as an HIV focal point or person but for the purpose of this study, the term focal person will be used in reference to this position. In addition, the term enterprise will be the one adopted throughout the document to represent workplace institutions, businesses, firms, companies, establishments, organizations etc. whether public, private or non-governmental.

1.1.1 Workplace HIV Education Programmes

The HIV response across the nation has involved a multi-sectoral approach in which all stakeholders have contributed severally to respond to its concomitant challenges. Traditionally, the health sector, and other public sector agencies, the scientific community, and non-profit organizations have laboured collectively to mitigate the impact of HIV. However, their collective efforts in education, prevention and treatment interventions have not proved sufficient to stem the tide of the epidemic (Benatar, 2004).

The private sector which had hitherto been left out is increasingly becoming an avenue to which attention is being drawn. Since 2003, the International Labour Organization, in consonance with this development, has been engaging the private sector to respond to HIV in the 'World of Work' (ILO, 2008). In its recommendation on HIV and AIDS, Recommendation 200 (2010 p3), the ILO describes worker as: "*Persons in any employment, occupation or economic sector; Persons in training (interns, apprentices and volunteers), Job applicants, job seekers, laid-off or suspended workers; Workers in the informal economy; Armed forces and uniformed services etc.*".

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From this broad definition of ‘worker’, enterprises will have to raise additional funds to cover all these categories of workers with HIV programmes in order to fulfil the tenets of this international recommendation on HIV and AIDS.

However, it has been documented that the day to day ‘business’ of an enterprise is to engage in the trading of goods or services, or both with the main aim of earning profit to increase the wealth of their owners – they may also be not-for-profit or state owned and may therefore find the HIV workplace programme as a non-core activity though because of corporate social responsibility the GEA has taken it up (GEA, 2013).

An HIV workplace programme in an enterprise refers to a range of enterprise-based interventions undertaken to mitigate the impact and prevent the spread of HIV at the workplace level. It includes instituting an HIV and AIDS policy, voluntary counselling and testing (VCT), HIV education, STI referral and treatment, condom distribution and antiretroviral therapy (ART) provision (ILO, 2001).

It must be stated that enterprise-based HIV programmes is hardly a core business of most enterprises except NGOs undertaking such specific activities, for example the Global Business Coalition (GBC) on HIV and AIDS, which is a non-governmental organization, (that has affiliates in many countries including Ghana) that seeks to raise funds for the private sector response to HIV and AIDS (GBC, 2006).

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In order to implement workplace programmes, one staff member is assigned to the duty of facilitating these interventions. The ILO Code of Practice on HIV and AIDS (2001) refers to this staff member as the HIV focal person or point. Review of extant literature does not reveal any laid down criteria for selection of this staff or worker to assume this post (Mahajan-Anish, Colvin, Rudatsikira, Jean-Baptistea, & David, 2007). However, an enterprise HIV policy guides the development of prevention and treatment programmes, as well as establish the norms and standards within which a company approaches employees with HIV and AIDS (Allen & Heald, 2004).

In both the private and public sector, the selection of HIV and AIDS focal persons is one of the initial steps that may be taken in HIV workplace programmes. According to (Elsey, Tolhurst, & Theobald, 2003), it means the identification of the staff member who has the responsibility of ensuring that HIV and AIDS activities are established within their department or enterprise. In Ghana, the Ministry of Education, for instance, began this process in 2001 with one focal point at the national level and several at the regional and district levels (Elsey *et al*., 2003).

Studies of the private sector and its AIDS response have, not surprisingly, focused on elucidating the cost of the epidemic to employers. Although companies are informed by a growing body of literature on workplace prevalence and the estimation of costs, they do not benefit from a similar body of literature for understanding the various dimensions and impact of employer-sponsored HIV and AIDS workplace programmes and the operational challenges faced by enterprise level implementers of these programmes (Booz-Allen-Hamilton, 2006).

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Dickenson and Stevens (2004) reiterated that, in general, little is known about the prevalence of a workplace programme and that even less is known about how best to monitor and evaluate the efficacy of such a programme in complicated environments such as the workplace or employer-sponsored offsite programme (Dickinson & Stevens, 2004). The existing literature consists mostly of survey studies of company executives, case studies, and qualitative research methodologies in the workplace (Benatar, 2004; Mahajan-Anish *et al*, 2007). Evidence regarding prevention programme in the workplace is particularly limited and what is available has not been systematically examined (Mahajan-Anish *et al*, 2007). The World Economic Forum sponsors annual worldwide surveys of enterprise executives in the area of businesses' response to HIV and AIDS (Bloom, Reddy-Bloom, Steven & Weston, 2006) but this only offers some indication of the prevalence of company-level HIV and AIDS policies (Dickenson & Stevens, 2004).

Several studies (AIDSCAP, 1995; GBC, 2001; Greener, 1997; Mahajan-Anish *et al*, 2007; Smith & Whiteside, 1995) have been undertaken in the southern African sub-region on workplace programmes providing a wealth of information on HIV interventions at the enterprise level. These studies have looked at condom distribution, awareness creation, STI management and policy development among others. Studies have also revealed that there has been a dramatic increase in the development of HIV workplace policies among the southern African firms. These studies illuminate noteworthy trends regarding these policies and programmes that emanate from it in the workplace but the same cannot be said for the West African sub region (Mahajan-Anish *et al*, 2007; Agbola, Damoense & Saini, 2004) and Ghana in particular.

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1.1.2 The Concept of the Workplace HIV Focal Person

According to the ILO manual on implementing the code of practice on HIV and AIDS (2008), the concept of the focal person is to identify that one staff member as the repository of HIV and AIDS information and facilitator of HIV service delivery at the workplace. The focal person achieves this through various methodologies such as peer education, condom distribution etc. This concept, is one that seeks to use the workplace as a unique setting to reach workers - the vital and productive segment of any economy on a regular basis with tailored messages and programmes. These workplace programmes also seek to address the twin problem of HIV stigma and discrimination and support positive behaviour change. The focal person led workplace programme is engineered to also provide the infrastructure for expanded access to antiretroviral drugs, as well as care and psychosocial support (ILO, 2007).

Conceptually, the focal person when in this position will facilitate the process and conduct group and individual sessions on all aspects of HIV and AIDS and its related issues at the workplace. He/she ensures that the enterprise or institutions HIV workplace programme works well (ILO, 2007). Such a person would support workmates and promote HIV prevention through strategies such as encouraging abstinence, mutual fidelity or condom use; disseminating basic facts about HIV and other sexually transmitted infections. A special focus is placed on using, and negotiating the use of condoms with a sexual partner, and promoting condom use among groups with high-risk behaviour (Greener, 1997). Focal persons also facilitate discussions on high-risk behaviours such as multiple sexual partnerships, Lesbian, Gay, Bi-sexual and Transgender (LGBT) issues and commercial sex work of both female and male sex

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workers. They also refer workers to suitable HIV resources, such as information and programmes; or to services such as STI management, VCT, psychosocial counselling and ART. These resources and services also described as quality services by the ILO Code of Practice may include at least five (5) of the following: confidential HIV testing and counselling; antiretroviral therapy; prevention of mother-to-child HIV transmission; orphan care and treatment for tuberculosis and other opportunistic infections (Koster & Neema, 2007).

It is believed that such services largely motivate workers to seek prompt and complete treatment from competent health-care workers, assist them, particularly workers infected with HIV by putting them in touch with support groups. Focal persons are also expected to help peers to assess their own personal risks; disseminate information about the HIV and AIDS workplace policy in their respective companies; conduct advocacy and influence decision makers to support HIV and AIDS programming (ILO, 2007).

Contextually, operationalization of focal person system entails the training of male and female workers who thus trained will engage their co-workers in HIV and AIDS dialogue, with the goal of encouraging them to examine and change their high-risk behaviours (Dickenson, 2005). This is often achieved through a system of peer educator networks. A system whereby, the focal person identifies and trains on site other staff members to facilitate HIV education among their peers. The difference here is that, whereas the focal person works across groups, the peer educator operates specifically among his/her own peers.

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HIV and AIDS programmes at the workplace which include peer education, have proven to be very effective (Caron, Godin, Otis, & Lambert, 2004). Workplaces have organizational structures, hierarchies and policies within which context it is relatively easy to establish a peer-education programme in an environment where people with common socio-cultural, economic and educational characteristics can be easily identified and organized (Khanyile, 2012). The overall goal of an HIV and AIDS workplace programme is to reduce the prevalence and impact of HIV in the workforce and the wider community and the HIV focal person is the one that makes this happen at the workplace (ILO, 2008).

1.2 Statement of the Problem

Over the years, the increase in morbidity and mortality due to HIV and AIDS in Ghana continues to escalate (GAC, 2006), exacerbating the already insurmountable problem of economic decadence. While HIV is not readily transmitted in the majority of workplace settings, the supposed risk of transmission has been used by numerous employers to terminate or refuse employment (Hassan, 2005). There is also evidence that where people living with HIV and AIDS are open about their sero-status at work, they are likely to experience stigmatization and ostracism by others (Panos, 1990), and this leads to people with the disease going ‘underground’ and fuelling the spread of the disease.

To address this, several interventions have been employed, including studies focusing on the effectiveness of different approaches to HIV and AIDS prevention and its spread. One such intervention is the use of peer education through focal persons (ILO, 2001). The

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focal person strategy, which is structured to utilize peer education to address threat of HIV/AIDS at the workplace, has been promoted globally as one of the effective interventions within the workplace. It has been used in many areas of public health, including nutrition education, family planning, substance use, and violence prevention (UNAIDS, 1999).

Though deemed effective by some (Pattanaphesaj & Teerawattananon, 2010; ILO, 2008; UNAIDS, 2001; Durantini, 2006; GSMF, 2003; Bora, Howard, & Carlson 2010), the problem is that, not much emphasis has been put on the HIV focal person, the one entity responsible for its (the focal person strategy) implementation at the workplace. The International Labour Organisation states that, workplace focal persons facilitate delivery of HIV services at the workplace where distinct opportunities and advantages as a key delivery point for HIV prevention, treatment and care programme for specific groups of people in a continuous and cost effective manner is possible (ILO, 2007).

Mametja (2005) has suggested workplace HIV education programmes though considered beneficial for educating the workforce, its overall impact may be insignificant. This assessment rests on relatively limited data (Setswe, 2005; Sloan & Myers 2005; Wolf & Bond, 2002). They further suggested that attempts to suggest a ‘gold standard’ to assess the effectiveness of workplace HIV education may have overlooked a number of critical factors in the desire to provide scientific credibility. He suggested the need to assess what the peer educators actually do versus what management tell researchers it is doing. Here, it is noted that all these studies refer to peer educators and not focal persons whose work goes beyond that of the peer educator, also these studies have assessed companies at the

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level of what management thinks. Setswe (2005) suggests that further research is needed to describe what barriers peer educators and by extension focal persons may encounter on the ground when measuring the effectiveness and outputs of such programmes. Ozer, Weinstein and Maslach (1997) suggest that educating one's peers (at the workplace) is something of a 'black box' and unless we are able to understand what happens within this box, any evaluation of peer educator's (and by extension focal person) activity is likely to remain flawed.

Identified gaps that need to be interrogated are: how the focal person is selected, trained and supervised; what incentives are provided for the focal person; how stakeholders are involved in HIV and AIDS issues; what attention is given to gender and sexuality; and how sustainable they are (UNAIDS, 1999). In addition, there is scarcity of literature on the job specification and description of the focal person. These are important problems to address as workplaces have taken up the mandate to mitigate and reduce the effects of HIV through education and service provision by workplace service providers called HIV focal persons.

This thesis intends to fill some of these gaps in the literature by looking intently at the role of the focal person in responding to HIV and AIDS among the workforce within the workplace setting. It also seeks to understand what roles the focal person plays to sustain workplace programmes as an effective means of HIV control and prevention mechanism. Furthermore, it investigates what motivates the focal person to execute his/her roles and explores the importance of the role of the focal person in workforce education in a bid to aid implementers and policy makers.

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1.3 General Objective

The general objective of this study is to investigate the nature and context of HIV focal person's activities in relation to the quality HIV Service delivery at the workplace in Ghana.

1.3.1 Specific Objectives

1. To assess the standard and regulations governing the selection of HIV focal persons
2. To examine the perception of the focal person's ability to perform their role of delivering HIV services and how they are equipped to do so
3. To analyse whether or not the presence of an HIV focal person affects the availability (type and number) of HIV services at the workplace
4. To examine the linkage between the presence of the focal person and HIV services beneficiaries parameters such as comprehensive knowledge and access to services

1.4 Research Questions

The study seeks to answer the following questions:

1. What is the standard criterion for selecting an HIV focal person?

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2. In what ways does the focal person see himself/herself as well equipped to provide HIV Services at the workplace?
3. How does the presence of the focal person influence (in terms of on the type and number) HIV services delivered at the workplace?
4. How does the presence of the focal person influence HIV responsive behaviour among a workforce?

1.5 Justification of Research

As morbidity and mortality due to HIV and AIDS continues to increase, exacerbating the problem of economic decline, several sectors compete for the diminishing national budgets. Prioritization of development issues becomes a problem in all sectors: health, education, roads and construction. Funding for HIV and AIDS activities is not any different; it faces the same competition. National AIDS Spending Assessments show a large proportion of donor funding being allocated to HIV and AIDS prevention and mitigation (Ankomah & Fenny, 2008). In view of these competing demands, there is the need to find cost efficient and effective ways of utilizing such resources for greater impact.

The problem of finding resources to cover National AIDS spending is of concern to all development planners. Without new approaches in HIV and AIDS education delivery, large numbers of people will be affected or infected by HIV. The WHO and other UN agencies report that the proportion of population with advanced HIV infection with

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access to antiretroviral drugs is also increasing in many countries (WHO, UNAIDS & UNICEF, 2007), yet, the coverage rate is still very low, especially when the supply is set against the demand of those in need.

Research shows the work place offers a captive audience for HIV information and service delivery (ILO, 2007). Yet the establishment of the position of the HIV focal person is not mandatory, the workforce may not know about the services available to them, and may feel intimidated to access these services due to the high levels of stigma associated with HIV/AIDS. Exploring the role of the HIV focal person where they exist will lead to an understanding of their unique experiences, and may contribute to the improvement of availability and accessibility of Workplace programmes to the workforce.

The most obvious professional issue related to the role of workplace focal person in HIV and AIDS service delivery is that research efforts to understand the role of the focal person in delivery of HIV Service (as pivotal to universal access of HIV services) are virtually non-existent. There is not much information on the harmonisation and standardization of the role of the focal person in enterprises and public institutions. There is very limited insight on the teaching methodologies employed by focal persons within the context of what directly impedes the nature and quality of services provided by them.

This study is significant in the sense that little is known about the prevalence and operational challenges of workplace programmes (Dickinson & Stevens 2004). Results of this study will help the public and private sector institutions, development partners,

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governments and HIV Implementers to create more effective programmes to prevent the spread of HIV among the working population.

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CHAPTER TWO LITERATURE REVIEW

2.1 Global Situation of HIV and AIDS

HIV and AIDS has indeed become a global health pandemic and in spite of efforts to curb its spread, reports show that with each passing day, more and more people are getting infected with the virus (UNAIDS, 2009). The global statistics of HIV and AIDS as reported by UNAIDS, WHO & UNICEF (2011) reveal that by the end of 2010, 34 million people in the world were infected with HIV and AIDS. The epidemic has resulted in an increase in the number of orphaned children, devastated families, and individuals and eroded economic growth (Gayle & Hill, 2001). The epidemic cuts across boundaries of age, race, education or gender both in developed and developing countries. Although this is a global situation, much of its victims are in the developing world, particularly Sub-Saharan Africa. Gayle and Hill (2001) found that AIDS is the fourth leading cause of death globally and but the first leading cause of death in Sub Saharan Africa.

Developed countries, overtime through the use of ART have managed to contain the spread of the HIV virus. Furthermore, discrimination and human rights violations of people living with HIV has also steadily declined over time as governments and civil society organizations have mobilized resources and developed programs to help curb the pandemic in the developed world (Parker, 2002).

This is in stark contrast to the HIV and AIDS pandemic in developing countries, majority of which are already battling with other serious public health problems such as malaria, and poverty. Indeed, for the developing world, the AIDS pandemic looks grim. Countries

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such as Botswana, although hard hit by the pandemic, are able to offer free anti-retroviral treatment to all infected people. This free access to antiretroviral treatment is however not the case for all developing countries, thereby increasing the death toll.

The pandemic has indeed constrained the health sector, labour force, economic growth and reduced national budget which could have otherwise been allocate to alternative developmental goals (ILO, 2001). The constrained national budget has also put pressure on monetary and health development organizations such as the World Bank (WB) and WHO to provide donations (especially in the case of the WB) rather than loans at favourable interest rates to developing countries to reduce their debt obligations (Parker, 2002). The ILO (2008) reports that the labour force has been the hardest hit sector of the pandemic, because of the loss of human capital, especially skills that are hard to replace once lost. Should the pandemic continue to rise in the coming years, the economic growth of countries will continue to stagnate and deteriorate further. This emphasizes the need for workplace focal person to curb the spread and loss of skilled personnel.

2.1.1 Global Practice of Workplace Programmes

HIV and AIDS has become a workplace dilemma because of its effect on labour and productivity. This is particularly serious because majority of individuals infected with the virus are in their prime productive and reproductive years (Bora *et al*., 2010) and spend a considerable amount of their lives in the workplace. Workers who are HIV positive can still live productive lives if they have support from the workplace and are not stigmatized or discriminated against. Bora and others (2010) in a study on workplace programmes in

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Cambodia showed that HIV affects the active adult population who contribute substantially to the country's socio economic development, hence workplace programmes are important to help retain the skilled workforce. The world of work as an institution on its own is comprised of different sectors. To meet the demand for workplace programmes across these diverse sectors, it would be important to design workplace programmes that suit the needs of workers in each sector. For example, workplace programmes for workers in the informal sector might differ from that for workers in the formal sector (Bora *et al*., 2010).

According to Dickenson (2008), workplace programmes have become a global instrument through which HIV and AIDS in the workplace is being addressed both in the developed and developing world. The common goal that each country seeks to achieve through these workplace programmes is to increase awareness among employees and workers on the effect of HIV and AIDS on their productivity and output. Also, the objective (of these programmes) is to improve prevention, provide treatment, care and support alternatives for people living with HIV and AIDS. Additionally, programmes also seek to establish principles for fair and equitable management of HIV and AIDS in the workplace while protecting the human rights of all workers (Dickinson & Stevens, 2004).

Globally, the management of HIV and AIDS in the workplace has been an important benchmark in the response in the general population. Therefore, the use of focal persons with their accompanying network of peer educators as facilitators in the workplace response constitutes a significant aspect of any national response.

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Due the popularity of peer educators, global efforts to further understand and improve the process and impact of peer education in the area of HIV and AIDS prevention, care, and support have also increased (UNAIDS, 1999). According to the UNAIDS, a review of some of the studies that have evaluated HIV and AIDS peer education programmes using experimental or quasi-experimental designs, with outcome indicators such as reduction of HIV-related risk behaviour and/or STI/HIV incidence showed that, peer education (in combination with other prevention strategies) is very effective in several populations and geographical areas (Pattanaphesaj & Teerawattananon, 2010). On the other hand, other compared to the lifetime cost of HIV and AIDS care, other effective HIV prevention interventions concluded that the clinical provider-led interventions are more cost-effective (Marseille, *et al*, 2011). Marseille and others (2011) further reported that in an incremental comparison with clinical provider sites, specialist and mixed intervention sites were not cost-effective. However, other researchers (Allen & Heald, 2004), reported the usefulness of a peer-led condom promotion intervention in Botswana that had a tremendous positive effect on the incidence of HIV in that country. They reported that in the late 1980's, Uganda was the worst HIV infected country in the world but overtime it managed to curb the spread of HIV and AIDS while decreased rates of prevalence were reported for Botswana. The low incidence of HIV and AIDS in Botswana was attributed to exposure to condom use from a young age whereas in Uganda, the late introduction of condoms and the president's negative attitude towards them invoked a negative behavioural change in the general public especially among the youth. (ECA, 2004).

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These divergent opinions lends credence to the importance of studying the role that the focal person plays in HIV service delivery in Africa and Ghana in particular.

2.2 The Situation of HIV and AIDS in Africa

HIV and AIDS is a major global health concern in Africa. The pandemic has resulted in a serious development crisis in Africa which is the most affected region in the world (Ogunbodede, 2004). The morbidity and mortality rate associated with the pandemic has major economic and social implications for Africa (Lau and Muula, 2004) among other developmental challenges it is already facing. The World Health Organization (2009) reports that 1.8 million people in Africa were newly infected with the virus and 1.3 million Africans died from HIV related illnesses which was about 72% of the death toll of the global total of 1.8 million deaths attributable to the epidemic. Although the epidemic is high in the region, according to the WHO report, Africa is not uniformly affected by HIV and AIDS as the effect of the pandemic is more concentrated in some countries than others.

Africa continues to be the region most affected by HIV and AIDS in the world, with almost 68 % of the 33.2 million people living with HIV and AIDS globally being in Central, East, South and West Africa (UNAIDS, 2007). The adult HIV prevalence rate varies from well below 1% in all Northern African countries to above 15% in many of the countries, in southern Africa (UNAIDS, 2007). In most countries, HIV prevalence rate has either stabilized or is showing signs of decline (UNAIDS, 2007). Yet, the UNAIDS reports that HIV and AIDS remains a leading cause of adult morbidity and mortality in

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all of the sub-regions, except in North Africa. In 2007, 76% of the global total of 2.1 million adult and child deaths due to AIDS occurred in Central, East, South and West Africa (UNAIDS, 2008).

In 2008, the company, AngloGold reported that 25 –30% of its South African workforce was infected with HIV (AngloGold, 2008). A study by Allen and Heald (2008) revealed that at that time, Botswana's life expectancy had been cut to 44 years, and one-third of the workforce was living with HIV and AIDS. This had vast implications for institutional memory and succession planning within enterprises as experience is not easily replaced (UN, 2004). HIV and AIDS dramatically affect labour, setting back economic and social progress as a result of low productivity which is concomitant to the low worker morale and related to the high morbidity associated with opportunistic infections that may arise as result of being HIV positive (ILO, 2008).

HIV and AIDS prevalence rates for selected African countries between the ages of 15-49 years varied greatly (UNICEF, 2009). In North Africa, the prevalence rates were Egypt (<0.1%), Sudan (1.6%), Algeria (0.1%), whereas prevalence rates in the Southern part of Africa were: Botswana (24.8%), South Africa (17.8%) and Zambia (13.5%). in the Eastern part of Africa the prevalence rates were: Kenya (6.3%), Tanzania (8.7%), Uganda 6.5%) and those in the Western Region were: Ghana (1.7%) and Nigeria (3.6%) (UNICEF, 2009).

The severity of the pandemic in Sub Saharan Africa (SSA) indeed poses a serious threat to national development. Even where effective prevention, treatment and care

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programmes are implemented, the human and socio economic loss remains significant (Ogunbodede, 2004). Apart from the death toll, it cannot be overstated that the pandemic has also brought about a loss of skills in key sectors of the economy and reduced labour productivity (Dixon, McDonald, & Roberts, 2002). In addition, it reduces the size and the age structure of a country and changes the productivity through the fallout on accumulated work experience; it could also affect future labour supply (Jeffries *et al*, 2006). Likewise, comparative studies of East African businesses have shown that absenteeism due to HIV morbidity can account for as much as 25-54 per cent of company costs (UNAIDS, 2003). All these facts back the mounting evidence for the increased need for workplace focal person programmes in Africa.

2.2.1 The Practice of Work Place Programmes in Africa

The practice of workplace programmes in Africa is not uncommon and companies, have implemented successful programmes to deal with the epidemic. One such programme described by AngloGold (2008) in its report to the board of directors, reported that their gold mine in South Africa attracts thousands of workers, often from poor and remote regions. Most live in hostels, separated from their families. As a result, a thriving sex industry operates around many mines HIV is common. They have thus implemented a workplace programme in collaboration with a number of organizations for the prevention of HIV transmission among the miners. These have included mass distribution of condoms, medical care and treatment for STIs as well as awareness campaigns.

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Chileshe, (2010) found that though an HIV and AIDS workplace programme was responsible for the care and needs of those infected and affected by HIV and AIDS, several challenges related to sustainability have been identified. These challenges he attributed to the fact that most workplace programmes are donor driven and therefore face the fate of coming to an end when the donor period is over. There is also lack of strong leadership and commitment to HIV and AIDS programmes, inadequate funding by the Government, weak monitoring and evaluation of HIV and AIDS programme (Chileshe, 2010).

These challenges mean that the enterprise level facilitators of HIV and AIDS programmes may not be fully able to source the necessary logistics to needed at the enterprise level to manage the programme. Also, in South Africa, (Dickinson & Stevens, 2004) found that although HIV and AIDS programmes existed in the workplace as part of the trade union activities, there was not much interaction between workers in the union and employers. Some workers did not know whether their workplace had an HIV and AIDS workplace programme or strategies for them. Most did not know if there were any guidelines available for dealing with HIV in the workplace. These researchers further reported that workers saw issues surrounding HIV as being confidential in nature, not often spoken about or has not yet been constructed as a typical workplace concern.

Indeed, much needs to be done about the establishment of workplace programmes in Africa because the existence of such programmes is still scanty in the region. In its 2006 report on 'best practice' of programmatic activity, the Global Business Coalition on HIV and AIDS reports of a low membership of 75 members only leading the way in

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implementing workplace programmes (GBC, 2006), though south Africa alone at that time lists a total of 550,000 registered businesses. Although these programmes are laudable, employers seem fixated on controlling the costs of AIDS to their enterprises, developing policies and fulfilling principles of corporate social responsibility (Booz-Allen-Hamilton, 2006). This fixation of employers on 'checking the box' to fulfil corporate social responsibility in providing HIV services is confirmed in a study by Mahajan and others (2007) who found that among 187 southern African firms who have HIV policy, only 48% affirmed that their policy addresses the issue of discrimination in promotion, pay and benefits based on HIV status, the larger majority (52%) had no such provisions (Mahajan *et al*., 2007).

2.3 HIV and AIDS Situation in Ghana

The Republic of Ghana is a medium sized country located in West Africa. It is bordered by Cote D'Iviore to the West, Burkina Faso to the North and Togo to the East and on the south by the Atlantic Ocean (GOG, 2010). Like most African countries, Ghana is affected by the HIV and AIDS pandemic and varied efforts have been made at addressing the epidemic.

The first official case of HIV and AIDS in Ghana was recorded in 1986 (Anarfi & Appiah, 2004). The National AIDS Control Programme reports that initially, there were 42 cases recorded mainly among women who had travelled outside the country. Nine years later, by the end of December 1995, 15,980 people had been officially diagnosed as being HIV positive. In another three years, by December 1998, the figure had risen to 29,550 and by the end of 2009, 267,069 persons comprising 112,457 males and 154,612

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females were living with HIV AIDS in Ghana and 25,666 of that were children. (NACP, 2009).

Overtime, the spread of HIV and AIDS has increased although its prevalence is not as high as the Southern part of Africa. Nevertheless, common trends can be traced in the population mostly affected by the pandemic which are people between the ages of 15 and 49, with a higher prevalence amongst females than males (Awusabo-Asare, & Marfo, 1993; Anarfi & Appiah 2002). About 80% of HIV and AIDS transmission occurs through heterosexual relations, 15% through mother to child transmission and 5% through other means such as blood transfusions (MOH, 2001). In 2007, about 260 000 people were infected with the HIV virus in Ghana (UNAIDS, 2010).

According to National AIDS Control Programme, both HIV types 1 and 2 are found in Ghana. However, the majority of cases were type 1 (91.8 %) and HIV type II (5.2 %) with mixed infections accounting for 3 % of the total positive samples (NACP, 2009). In all this, the NACP describes Ghana's epidemic as a stabilized epidemic as a line of best fit shows a decline. Furthermore, this rate being below the 5% threshold, gives Ghana an important window of opportunity to curb the spread of the infection and mitigate its impact (NACP, 2009).

The distribution of HIV and AIDS is higher in densely populated areas. Higher numbers of cases occur in the southern regions of the country particularly in regional capitals like Koforidua, Kumasi, and Accra. The prevalence of HIV and AIDS is also very high in mining towns like Obuasi and Tarkwa as well as border towns (Adjaye, 2004) Eastern

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Region has consistently reported the highest levels of HIV infection. However, AIDS cases have been reported from all the 10 regions and among all age groups and continue to rise (NACP, 2009). Furthermore the UNAIDS Epidemiological Fact Sheet for Ghana and NACP data 2001, state reported AIDS cases from 1990 to 2009 as 2,0132, 6062, 3302, 5783, 2953, 8334, 8546, 2896 , 2895, 184 and 20,313 respectively.

Efforts to control the spread of the pandemic in Ghana are underway to help alleviate pressure on health care delivery in Ghana. Since HIV and AIDS has a great potential to reverse Ghana's human capital gains, it is imperative for the government, ministries and NGOs to collaborate in containing the spread of the epidemic, particularly by instituting workplace training programmes to increase awareness about the epidemic and create behaviour change.

2.3.1 Perceptions about HIV and AIDS in Ghana

The Ghana Living Standards Survey shows that awareness of the HIV and AIDS pandemic is very high (over 95%) yet, comprehensive knowledge remains low (GDHS, 2008) as this awareness does not translate into widespread behaviour change. Comprehensive HIV knowledge is defined in the Ghana Demographic and Health Survey (2008) as knowing: 1) that consistent use of condom during intercourse and having just one HIV-negative and faithful partner can reduce the chances of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about HIV and AIDS transmission or prevention. 2) that a healthy-looking person can have the AIDS virus and in response to prompted

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questions, correctly reject local misconceptions about HIV and AIDS transmission or prevention, and the percentage with a comprehensive knowledge about AIDS by background characteristics and 3) or having heard of AIDS.

The survey also reports of a great deal of stigma, denial and unchanged behaviour. Glamorization of sex in sections of the media may have the potential to increase infection levels especially among the youth and other vulnerable groups. The report further states that some perceptions and misconceptions among sections of the population are that, casual contact such as using same household utensils and sharing a bed with an infected person could lead to the transmission of HIV.

The same report indicates that some also perceive HIV and AIDS to be a curse from the gods for an offence, a spiritual punishment for sexual promiscuity or a result of witchcraft or 'black magic' activities. When such reasons are ascribed to the disease, AIDS patients may be sent to fetish priests or traditional herbalist/doctors for treatment while the rest may be abandoned to their fate or sent to prayer camps (Addai-Yeboah, 2005). According to Addai-Yeboah (2005), the disease is also seen by some as a disease for the poor and marginalized, as the face of the people usually shown in the media with HIV and AIDS were of the lower income bracket, unemployed, homeless or orphans. Addai-Yeboah also found that the general public opinion or belief was that an active "healthy-looking" person could not have the virus as opposed to thin or lean people. Others are in denial about the existence of HIV in its totality. They think that people living with AIDS are only putting up a facade (GDHS, 2008).

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2.3.2 Economic Aspects of HIV and AIDS

HIV and AIDS affects the economic development of any country (Lau & Muula, 2004). It affects household income because one of the most obvious outcome would be the use of household income to purchase drugs and pay health bills for the PLHIV. Gayle and Hill (2004) describes a vicious cycle of HIV and AIDS that is created when the breadwinner is infected; the infection leads to poverty which may lead to prostitution and other vulnerable ways of making money for survival. It also affects children, particularly the girl child who may be forced to drop out of school and enter into child labour to create income for the household. AIDS also leaves many orphaned children and child headed households (Tiou, 1999).

The economic impact of HIV/AIDS is very obvious in the agricultural sector. According to the Ghana Statistical Service 2010 report, the agriculture sector is particularly important because the bedrock of Ghana's economy is agriculture. Agricultural work is abandoned where HIV exists which in effect increases household food insecurity (Anarfi *et al*., 2004). The report by Anarfi *et al* (2004) also finds that the education and health sectors also feel the brunt of HIV transmissions. In the health sector for example, the likely constraints they face are the availability of beds to cater for all infected patients. Furthermore, infected patients also stay in hospital longer increasing food and drug costs. AIDS increases the demand for health workers yet health workers themselves may be infected or at danger of contracting the disease (Antwi, 1999). Again, shortage of health workers increases the workload of the remaining workers, and lower salaries which contributes to the exit of health workers in search of greener pastures (Anarfi &Appiah, 1993).

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As the pandemic worsens, the education sector deteriorates. Fewer children receive basic education because they have to withdraw from school to support their families. Also, the supply of teachers is affected particularly if they too are infected with AIDS. This increases recruitment and training costs because skilled workers are not easily replaced (Bollinger, Stover & Riwa, 1999).

According to (Hacker, 2002), HIV and AIDS affects the economy and economic development through its adverse impact on the social fabric itself. He explains that the term -social fabric- extends not only to the social and economic institutions already noted—e.g. households, companies, and the government—but also to more abstract concepts such as governance and social coherence. HIV and AIDS does have a serious impact on traditional economic measures such as economic growth, income per capita and investment, because it does so by affecting very diverse areas of public, social, and economic life. The economic dimensions of the pandemic illustrates the need for HIV and AIDS workplace programmes which are still scarce in most African countries.

2.3.3 Social Aspects of HIV and AIDS Workplace Programmes in Ghana

The social aspects of HIV and AIDS, particularly in implementing HIV and AIDS workplace programmes are important. It is well documented that issues such as stigma and discrimination of persons living with AIDS has prevented people from coming out boldly to declare their status (ILO, 2007). For instance, the Integrated Regional Information Networks (IRIN, 2005), reported that the AIDS program in Ghana could fail due to stigma and a failing health system. Fear of discrimination could prevent PLWHA from accessing health measures that could improve their life. It can also prevent people

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from accessing voluntary counselling and testing services (Heyward, Batter, Malulu, Mbuyi, Mbu, St Louis, Kamenga, & Ryder, 1993) which is also true at the enterprise level.

A study by Jolly, et al (2009) on stigma and discrimination in Kumasi, Ghana revealed that about 59% of the respondents did not know why HIV made people sick. Furthermore, 36% said they would not let their child play with another child who had HIV and 28% felt that PLWHA should be isolated in towns and villages. These same Jolly *et al.,* 2009 reported that workplace discrimination existed with highly educated people, some of who claimed they would change jobs if someone they worked with became HIV positive. Social exclusion of people with HIV was found among low-level educated people. Thus, discrimination acts as a big barrier in preventing people from fully accessing workplace programmes. It would be important to offer support for disclosed persons and to promote health and education of HIV and AIDS in the workplace and community since few people are aware of the disease and how to live with PLWHA (Jolly *et al*., 2009). According to the same study, in many settings such as households, communities, public and private sector institutions, the increasing numbers of orphans and vulnerable children mirrors the impact of HIV. Concomitant to that is the deterioration in caregiver burden, child headed household and the lack of ability of the affected to deal with the result of the burden. Especially notable is the increased costs associated with responding to medical costs, stigma and discrimination, moral disillusionment and ostracizing resultant from the epidemic. AIDS deaths have been increasing over the years leaving behind many orphans.

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2.4 The National Response

The National response to HIV in Ghana was initially managed as a disease rather than a developmental issue, and was at that time directed by Ministry of Health. The earlier response led to the establishment of National Advisory Commission on AIDS in 1985; National AIDS Control Programme in 1987 and later to the establishment of Ghana AIDS Commission by an Act of parliament, Act 613, 2000.

The Ghana AIDS Commission was placed under the office of the President thereby highlighting the gravity the government placed on the socio-economic importance of HIV and AIDS, Act 613, 2002. According to the Act, the institution was established to formulate policy and direct and co-ordinate national activities in the fight against AIDS. In order to achieve this, the commission is expected to provide high-level advocacy for HIV and AIDS prevention control, provide effective leadership in national planning supervision and support of HIV and AIDS programmes. The Act further enjoins the Commission to mobilize and control resources, foster linkages among stakeholders as well as monitor and evaluate HIV and AIDS programmes.

As part of the national response, a Workplace HIV Policy on HIV and AIDS was launched in 2005 which was revised and reprinted in 2012. This policy was developed as a collaboration between the Ghana AIDS Commission and the tripartite partners (i.e. Ghana Employers Association, the Trades Union Congress and the Ministry of Manpower Development and Employment) with the support of the International Labour Organisation (GAC, 2012). According to the document, the policy goal provides broad national guidelines to direct the formulation of workplace policies and programs. The broad objectives are to provide protection from discrimination in the workplace for

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people living with HIV and AIDS; prevent the spread of HIV and AIDS amongst workers, and to provide care, support and counselling for those infected and affected. The policy further aims at developing concrete responses at enterprise, community, regional, sectoral, national and international levels; Promoting processes of dialogue, consultation, negotiation and all forms of cooperation between governments, employers and workers and their representatives, occupational health personnel, specialists in HIV and AIDS issues, and all relevant stakeholders (GAC, 2005).

In the policy document, strategies for implementation include advocacy, BCC/IEC, blood screening and testing, epidemiological surveillance, clinical nursing and home based care, counselling including VCT; STI control and management; prevention of Mother-to-Child Transmission (PMTCT); young people and AIDS as well as focusing on women and gender issues.

To date, a myriad of interventions have been undertaken in Ghana's multi-sectoral approach culminating in Ghana's median HIV prevalence which as at 2009 stood at 1.9 per cent, being reduced to 1.6% in 2014 (NACP, 2015). Ghana's prevalence rates are much lower than other countries in the West African sub region and the Sub Saharan African region in general (UNAIDS, 2010). The general trend since 2000, has seen a gradual decline after arise from 2.3 in 2000 to a peak in 2003 of 3.6; then going through a gradual decline from 3.2 in 2006 to the present prevalence of 1.6 per cent in 2014 (NACP, 2015)

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In spite of the low prevalence rate, the rate of new infections continues to rise each year and give a cause for HIV implementers to worry but the nation has responded with a National Strategic Framework I (2000 – 2005) and II (2006-2010) and a National Plan of Support (NSP) 2011-2015, in support of a multi-disciplinary, multi-sectoral approach. Government has set aside funds for prevention and other aspects to abate this problem (GOG, 2013). Still, prevention remains the cornerstone of the national strategy to overcome the epidemic (Ankomah, and Fenny, 2008).

2.4.1 Projects in Support of the Ghana Response

Government's response to the HIV and AIDS pandemic is routed through the Ghana AIDS Commission (GAC) which provides institutional arrangement for the national HIV and AIDS response. The GAC, as mandated by Act 613 (2002) coordinates and ensures smooth implementation of the national response at national, regional and districts levels. It mobilizes and allocates resources, monitors and evaluates HIV and AIDS programmes targeted at prevention, care and support and treatment.

The Ghana AIDS Commission Act further directs Ministries, Departments and Agencies within the public sector MDAs to develop HIV and AIDS sector specific plans. It also establishes HIV and AIDS committees at regional and district level to oversee HIV and AIDS programmes in their respective sectors. Furthermore, as part of encouraging broad participation, GAC has been instrumental in the setting up of the National Business Coalition for AIDS (GBCA) in collaboration with development partners, primarily to

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coordinate, monitor and enhance business/private sector participation in the national response.

In Ghana, some of the projects and programmes undertaken by some public sector agencies include that which was undertaken by the uniformed services to provide health education and educational materials using military themes using channels such as posters, T shirts, comic books, and films through their HIV workplace programme (FHI, 2004). In addition to these Family Health International Projects, a number of private sector organizations, associations and enterprises have had workplace HIV and AIDS activities as part of their core programmes. Most of these programs were designed as Information, Education and Communication (IEC) programs targeted at workers within the enterprises towards prevention of infection.

These initiatives included efforts such as Work Shield, which targeted workers in medium to large scale enterprises; Port Shield, with Ghana Ports and Harbours Authority and "Drive Protected", targeted at long distance drivers. All these programs combined condom distribution with HIV and AIDS prevention education (Addai-Yeboah, 2004). These programmes undertaken in Ghana are similar to other global workplace programmes which stress health education, condom distribution and use, and aggressive treatment of STDs. These have been acclaimed by some studies as being part of the effective peer-led health prevention strategies (Brooke, Apeagyei, Gomez, Baez, Payapvipapong, Fraser-Mackenzie, & Bailey, 1992).

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The Trades Union Congress of Ghana (TUC) programme on HIV and AIDS includes a training programme for its member unions. In this programme, focal persons in sector unions are trained as 'trainer of trainers' and they in turn train local union executives and members who together with management form HIV and AIDS committees (GTUC, 2012). However, these teams interpret and implement the HIV and AIDS policy for the workplace and train peer educators as the case may be. Such a structured HIV and AIDS programme as the TUC implements, does not extend to associations within the informal sector (Addai-Yeboah, 2004)

The 2005 Ghana National Workplace HIV Policy related the fact that employers are not adequately informed of how HIV and AIDS impacts on profits and investment (GAC, 2005). To this end, the Employers' organizations in collaboration with the United Nation Population Fund in Ghana, organized workplace programmes which continued under the auspices of the International Labour Organization's (ILO) workplace programme in Ghana. This project specifically translated the ILO Code of Practice on HIV and AIDS into four Ghanaian Languages to reach out to the predominantly informal economy (ILO, 2007).

Further collaborative efforts have been initiated to promote workplace response to HIV and AIDS in Ghana. These efforts include collaboration between the GAC and multilateral and bi-lateral agencies such as UN agencies and other development partners in Ghana. Some of these development-partner-led initiatives include the ILO, UNICEF and UNFPA workplace programmes such as the Strategic HIV and AIDS Responses in Enterprises (SHARE); the School ALERT programme targeting the education sector and

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the 'Improving SRH knowledge and Legal Literacy targeting informal sector women head porters' projects respectively.

Other bi-lateral agencies such as the GTZ and Family Health International, a US based International NGO sponsored by the US government, and the USAID, have also designed workplace programmes based on the ILO Code of Practice and implemented them in various enterprises in Ghana (GAC, 2010)

2.4.2 The HIV and AIDS Policy Environment in Ghana

Policy documents and legislative instruments that have implication for HIV and AIDS issues in the world of work include the Ghana AIDS Commission Act, 2002 (ACT, 2002), National HIV and AIDS Workplace Policy (GAC, 2005), the Labour Act, 2003 (ACT, 651) and the National STI and HIV Policy (GAC, 2004). Though the Labour Act does not make specific mention of sero-positive workers, it makes general provisions for all workers including workers with disabilities, women, young persons and casual workers concerning protection of employment; General conditions; Termination of employment; Protection of remuneration; Trade Unions and Employer associations and; unfair labour practices, including discrimination.

Other existing legal instruments of note are Labour Decree, 1967, NLCD 157; Industrial Relations Act, 1965 Act 299; Workmen's Compensation Law, 1987; Factories, Offices and Shop Act, 1990, Act 328; Patients Charter, 2002; Infectious Diseases Ordinance, Cap 78 and the Quarantine Ordinance, 1951, Cap 77 (GOG, 1992)

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2.4.3 HIV and AIDS Workplace Education Programmes in Ghana

Ghana developed a sectoral HIV and AIDS Action Plan for the period 2001 to 2005. The National Strategic Framework has created space for mobilizing all sectors including Ministries, Departments and Agencies (MDAs), Private Sector, NGOs, District Assemblies, workplaces and other stakeholders to combine their efforts in implementing the National HIV and AIDS Strategic Framework (GAC, 2005). The Government of Ghana considers workplace programmes as one of the cardinal interventions to combat the spread of HIV and AIDS in Ghana (GAC, 2001). The National AIDS Strategic Framework clearly states that, in the effort to combat HIV and AIDS at the workplaces, the Ministry of Employment and Social Welfare would be assisted to accelerate the development of HIV and AIDS workplace programmes. Advocacy efforts were to be undertaken to get employers to develop workplace HIV and AIDS programmes and vote resources for their implementation.

The framework further stipulated that promotion of IE&C on STD and HIV and AIDS would be directed through programmes designed at these workplaces. The peer education model was found as a useful tool that would motivate peers to collectively support and uphold preventive behaviours. This is because peer educators who are directly linked to focal persons are seen as being ‘someone like me’ – someone who is trusted and liked by the peer group. People feel more comfortable discussing personal issues including sexuality with peers. Peer education is one of the most effective ways of inspiring behaviour change and conducting HIV and AIDS-related education at the workplace. Peer education is based on the idea that individuals are most likely to change their

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behaviour if people they know and trust persuade them to do so. It helps to break down barriers by allowing people to discuss sensitive matters without fear (ILO, 2005).

According to the ILO Code of Practice on HIV and AIDS developed through collaboration between the ILO and its tripartite constituents, as well as cooperation with its international partners in 2001, HIV and AIDS is a workplace issue and should be treated like any other serious illness/ condition in the workplace. In 2003, Ghana signed a Memorandum of Understanding with the ILO to implement Workplace Programmes within the context of the ILO Code of Practice. To this end in 2005, under the leadership of the ILO, a National HIV and AIDS Workplace policy was developed by the National Tripartite Partners under the auspices of the Ghana AIDS Commission. The policy required that HIV and AIDS is planned for in each sector, department and institutions focusing on the internal (workplace) and external (target population served) environment of each sector (GAC, 2005).

2.4.3.1 HIV and AIDS Education within the Context of General Health Education

Behavior Change Communication Education is the fulcrum of health education and is designed on the hypothesis that if people are well informed about the benefits of not behaving in a risky manner, and they internalize this information; risky behavior will not be undertaken (Graeff, Elder, Booth, & Elm 1993). Based on this philosophy, HIV and AIDS modules and subjects have been integrated into the curricula of the teacher education training and basic school levels (MOE, 2002). Whereas the above mentioned strategies are in place at the teacher training level in the area of HIV and AIDS, provision

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of HIV education to adults is through the concept of the HIV focal person and Peer Educators system and not integrated in the professional training of other educational disciplines; training programmes in HIV for professional are usually stand-alone courses offered by educational institutions and non-governmental agencies.

It is attributed to a former Prime Minister of Ghana, Dr K.A. Busia to have said that for the African, and especially the Ghanaian, education is one of the principal media through which the goals of building a new society and raising the standard of living can be achieved (ESR, 2002). For this reason, good health and good health seeking behaviour and practices by default can be said to be based on the assumption that good quality health professionals are necessary for such progress in the health arena. This has not been the case especially in the area of HIV and AIDS Education.

Furthermore, in a less educated population as occurs in the informal workplaces in Ghana, there is another perspective to consider for recipients of health education, the perspective of the channel through which the education will flow. In studies by World Education, a US based NGO over the period of 1994 to 1999, students of Adult Basic Education (ABE) and English to Speakers of Other Languages programmes (ESOL) observed that too many community health educators do not understand how to work with limited literacy groups. Such health educators talk too fast, make too many assumptions about what people know, and use scientific jargon and statistics (MABE, 2001). Perhaps, findings such as these may support the alternative of communicating health to the workforce through their peers.

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Moreover, the study portrays that persons in a predominantly mixed literate environment (such as pertains among the Ghanaian workforce) may be intimidated by the English spoken by health practitioners. They may feel afraid of how they were treated and insecure about their rights and responsibilities. Miech & Shanahan (2000) related that adult educators' observations are substantiated by medical studies confirming that adults with less education experience more health problems than adults with higher education levels. For example, medical researchers have found that as adults with relatively low education, age, they are more likely to be depressed than adults with more education (Miech & Shanahan, 2000; Kubzansky, Kawachi, & Sparrow, 1999). Miech & Shanahan (2000) and Kubzansky, *et al* (1999) have found that people with lower literacy skills are likely to come under more stress, to have less self-confidence, and to feel more vulnerable than people with better education. Reducing this vulnerability is key to keeping a highly motivated workforce and using a trained and highly motivated (well-equipped) focal person for HIV education at the workplace is expected contribute to solving this problem.

According to the Ghana population census (2010), over nine million Ghanaians are economically active. Of these, 88.8% are privately employed with the informal sector being the highest employer, accounting for 80.4% of the working population. The private formal sector accounts for 7.8%; public sector 5.9%; semi-public and para-statal 2.9%; Non-Governmental Organisations 0.8% and other forms of employment accounting for the remaining twenty two percent (GSS, 2012).

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Again, the Census report reveals four major occupations nationally as: agriculture and related work (49.2%), production and transport equipment work (15.6%), sales work (14.2%) and professional and technical work (8.9%). This general pattern is true for the majority of regions, with slight change in Greater Accra region where the order is completely changed, with sales work taking first position followed by production and transport equipment work, professional and technical work and services.

Nearly two-thirds (65.7%) of the economically active population are self-employed whereas 14.7% are unpaid family workers, apprentices and house helps in the private informal sector. Thus, only 19.6% of the working population are employees and the self-employed with employees (GLSS, 2005). Existing workplace programmes are mainly in the public sector and the formal private sector. Thus, a large proportion of the workforces don't have access to HIV information and Services at the Workplace (Addai-Yeboah, 2004).

2.4.3.2 Vulnerability of Workers to HIV and AIDS in Ghana

Poverty, ignorance, traditional cultural beliefs and practices, migration and the disruption of social support systems and family structures are among key factors identified as contributing to the spread of HIV and AIDS in the African sub-region (Anarfi, 2002). Some of these factors also increase the vulnerability of certain groups of workers to HIV and AIDS infection (Anarfi, 1993). These work groups include migrant Itinerant workers, security services (Police, Armed forces, Customs and Immigration services), long distance drivers, market women that undertake cross border trading and inter regional

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purchasing of produce and other merchandise, mine workers, and road construction workers (Lagarde, Schim van der Loeff, & Enel, 2003). Ghana has a highly mobile population with rural-urban migration, particularly by the youth in search of non-existent jobs being prevalent (Anarfi, 2002). These youth are often left stranded in the cities, with some working as porters and living on the streets, which situation exposes them to the risk of transactional sex (Lua & Muula, 2004). Workers in the Security agencies are transferred from one duty post to another with some serving in border towns where they live away from their regular partners for long periods of time and as such are exposed to cross-border transmission of HIV and AIDS (Addai-Yeboah, 2004). Long distance drivers, miners and road construction workers are also frequently removed from their regular sexual partners while on the job. In communities where their jobs take them, their relative economic power enables them to purchase sex when they want (Addai-Yeboah, 2004).

Similar vulnerabilities are faced by women traders who move from market to market hauling food. These women face deplorable sleeping conditions and are often subjected to sexual harassment (Anarfi, 1993). Anecdotal evidence suggests that in some cases, farmers and drivers take advantage of such women whose monies are insufficient to pay for foodstuffs or transportation. Contractual sex is used to pay off debts. A study by the West Africa Project to Combat AIDS in 2010 showed that 25-35% of sex workers were HIV positive and reported working in other trades but used transactional sex to augment income (WAPCAS, 2010). The project also noted that these sex workers reported that their clients were men from all the economic sectors of life. The factors outlined above also predisposes these vulnerable workers to the risk of acquiring HIV and AIDS.

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Another group of workers vulnerable to HIV and AIDS in Ghana work in the informal and agricultural sectors (Elsey *et al*., 2003). A study conducted in 2003 by GSMF on the impact of HIV and AIDS on the informal sector also emphasized that the informal sector is the more vulnerable sector. According to the study, this is because the informal sector lacks health facilities and social protection arrangements for its employees. Most persons in the informal sector are hardly financially secure and some research findings have indicated that an estimated 27.7% of people in the informal sector, especially the women, engage in some kind of contractual sex to supplement their meagre incomes (GSMF, 2003).

The Ghana Employers Association (GEA) in February 2000 conducted a study of 250 of their member companies and businesses and found out that close to 46% of the organizations that participated in the survey had some kind of ad-hoc HIV and AIDS activity at workplace. However, a negligible number were backed by comprehensive HIV and AIDS policies and programmes (GEA, 2000), thus exposing this vulnerability of informal sector workers to high risk behaviour.

In April 2003, the GAC sponsored a research into Workplace HIV and AIDS Control and came out with revealing results. In all, 30 employers were covered: 5 in the Public sector and 25 in the Private sector. The results show that HIV and AIDS education and STI services are receiving some attention by both public and private sector organizations. Work related hazards and safeguards and condom distribution were also being pursued in the private sector. The biggest gap as far as workplace HIV and AIDS interventions revealed by the study was lack of HIV and AIDS policies at the workplace. Public sector

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companies involved in the survey had neither policies nor programs on anti-discrimination-at-work or condoms available on site.

2.5 Epidemiology of the Human Immune Deficiency Virus

2.5.1 Viruses

Viruses are obligate intracellular parasites. They consist of particles called virions which range in size from as small as 30 nm (e.g. polio virus) and as large as 230 nm (e.g. Vaccinia virus) which, may be larger than some bacteria (ref). The virion consists of an outer shell, the capsid, made of protein. The capsid is responsible for protecting the contents of the core, establishing what kind of cell the virion can attach to. Some viruses contain other ingredients (e.g., lipids, carbohydrates), but these are derived from their host cells (ref). The viruses are structured such that they have an interior core containing the genome which is either Deoxyribo Nucleic Acid (DNA) or Ribo Nucleic Acid (RNA). The genes are few in number (3 - 100 depending on the species) which encode the proteins needed for viral reproduction (Geoff, 1990)

2.5.2 Life Cycle of viruses

The virion attaches to the surface of the host cell binding to a specific cell surface molecule that accounts for the specificity of the infection. The virus that causes AIDS for instance binds to the chemokine receptor found on human lymphocytes and macrophages. Once inside the cell, the viral coat is removed. The viral genes give information to the host cell leading to the synthesis of proteins needed for replication of the viral genome and synthesis of new proteins to make new capsids and cores (Desport, 2010).

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The protein coat is called the capsid, and the complex of the genome plus capsid is called the nucleocapsid. Viral genomes are either DNA or RNA. DNA viruses can be sub-divided into those that have their genes on a double-stranded DNA molecule and those that have their genes on a molecule of single-stranded DNA (Kimball, 2011)

RNA viruses occur in four distinct groups. These are those with a genome that consists of single-stranded antisense RNA, that is, RNA that is the complement of the message sense and those with a genome made of several pieces of double-stranded RNA. For Retroviruses, their RNA (also single-stranded) is copied by reverse transcriptase into a DNA genome within the host cell an important example is the HIV (Saunders & Carter, 2007).

2.5.3 Human Immunodeficiency Virus

The HIV is also a lentivirus which forms part of the retrovirus group. The name 'lentivirus' literally means 'slow virus' because they take such a long time to produce any adverse effects in the body. They have been found in a number of different animals, including cats, sheep, horses and cattle. However, the most interesting lentivirus in terms of this study is the Human Immunodeficiency Virus (HIV) that infects Humans and retrogresses to the disease state referred to as Acquired Immune Deficiency Syndrome (AIDS). Another virus of interest with regard to the origin of HIV is the Simian Immunodeficiency Virus (SIV). Both of these viruses being Lenti viruses attack the immune system (Desport, 2010).

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It is now widely accepted that HIV emanates from the Simian Immunodeficiency Virus because certain strains of SIVs bear a very close resemblance to HIV-1 and HIV-2 (Weiss, 1993). HIV has been divided into two primary strains: HIV-1 and HIV-2. HIV-1 is found throughout the world. HIV-2 is found primarily in West Africa, where the virus may have been in circulation for over 40 years (Bennet, 2005). Both HIV-1 and HIV-2 have several subtypes. It is practically certain that more undiscovered subtypes are in existence now. It is also probable that more HIV subtypes will evolve in the future.

2.5.4 The Infection Process of the Human Immunodeficiency Virus

When the virus (HIV) infects the body, AIDS is said to be present. This happens when a complex of symptoms and diseases manifests as HIV damages the immune system. The virus enters the body through blood and body fluids. As HIV damages the immune system, infected persons become vulnerable to infections or diseases known as opportunistic diseases. These opportunistic infections generally do not pose a threat to persons with healthy functioning immune systems. The diagnosis of AIDS requires a positive HIV antibody test or evidence of HIV infection and the appearance of some very specific conditions/diseases (Allen & Heald, 2008).

When HIV enters the bloodstream, the virus affects the T-Helper lymphocyte which regulates the immune system in the event of attack from pathogens. When HIV makes contact with the T-cell, the T-cell sends signals to other cells which produce antibodies. Antibodies are produced by the immune system to help get rid of pathogens that can cause disease. Producing antibodies thus becomes an essential function of the immune

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system. It is critical for the body's survival. The body has been so designed to produce specific antibodies in reaction or response to each pathogen it encounters. In the case of HIV, the antibodies produced to fight the virus are not able perform this function as the HIV captures the T Cells. This results in the eventual decline of the immune system (Gebo, Fleishman & Conviser, 2005).

Important milestones in the infection period are the Window, Incubation and Latency periods. Being a lenti-virus, the HIV has long period between infection and manifestation of Symptoms The window period refers to the period during which the infection is not detectable. It is the time span between infection and when the body produces antibodies to the point of it being detectible in the blood. This period may span between two weeks to six months (Grabar, Selinger-Leneman, Abgrall, Pialoux, Weiss, & Costagliola, 2009). According to Graber and others (2009), the incubation period is the interval between HIV infection and the appearance of the first symptoms. It may be several months to many years before persistent symptoms occur.

The latency period is the time interval from HIV infection until the start of chronic symptoms of AIDS. This period lasts an average of ten years in the absence of antiretroviral therapy. During this time, an HIV-infected person looks and feels fine, but the virus is replicating and slowly destroying T4 cells and the immune system (Longini, Clark, & Byers, 1989).

With the advent of Anti-Retroviral Therapy, the overall progression of HIV infection to AIDS and from AIDS to death has slowed (CDC, 2005). The use of potent combination antiretroviral therapy has also been linked to the development of adverse consequences

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(e.g., metabolic complications and viral resistance), which can pose challenges to clinical management. CDC and its partners conduct supplemental studies to monitor clinical outcomes of HIV and AIDS cases, including integrating laboratory technologies with HIV and AIDS surveillance to monitor variant, atypical, and drug-resistant strains of HIV. Consequently, the detection of HIV infection in a person does not necessarily signify recent infection (CDC, 2005).

From the foregoing, it can be seen that with the slowing of the progress of disease through ARTs, the problem of mitigation of the economic impact of the disease on countries becomes more important as more and more infected persons survive and need to be provided for within the fiscal space of the country.

2.6 Theoretical and Conceptual Framework

According to the ILO Behaviour Change Communication Manual developed in 2005, Behaviour Change Communication (BCC) for the uptake of HIV Services and positive HIV responsive conduct of workplace colleagues is what the HIV focal person seeks to achieve. Over the years, several social scientists have postulated theories to explain this behaviour change concept which underpins the evolution of the role of the HIV focal person. Social learning theories largely rely on the individual's belief in his/her ability to undergo a change in behaviour or the individual's ability to support that difficult-to-deal-with behaviours that are learned or assimilated progressively through imitation and reinforcement and a rewards system.

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2.6.1 Trans Theoretical Model of Behaviour Change and the Focal Person Approach

For the purposes of this study the theories that best describe the focal person approach is the Trans-theoretical Model (TTM) or Stages of Change Model. The Stages of Change or Trans theoretical model is based on the conception that individual health related behaviour change goes through a process involving a series of five interrelated stages (Prochaska & DiClemente, 1983; 1986). Each stage depends on having passed through the previous one. The five stages are:

Pre-contemplation: At this stage, the individual is unaware or has no intention to change their risky behaviour. Individuals may be in this stage because they are uninformed or under informed about the consequences of these behaviours. The intention not to change may be due to demoralization as a result of several failed attempts at behaviour change.

Contemplation: Here, there is recognition and acknowledgement of the risky behaviour and therefore the individual has the desire/intent to change based on a personal/internal cost benefit analysis, the balance of which can produce profound ambivalence leading to stagnation over time. This phenomenon is referred to as chronic contemplation of behavioural procrastination.

Preparation/Planning: This is the decision taking stage where concrete steps or actions are put in place among several alternatives which will be effective in achieving the change.

Action: Implementation of planned behaviour takes place here within a specified time frame (usually within six months). The behaviour change is only considered

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as action based on attainment of a criterion agreed upon by a professional to be sufficient enough to reduce the risk behaviour.

Maintenance: Determination to sustain the behaviour change occurs here and such behaviour to qualify for maintenance should have been maintained for six months or more to prevent relapse and consolidate the gains attained.

The TTM is considered relevant to the study because this is where focal persons/points, through mediated planning of activities, lead their colleagues at the workplace through information provision to reach the desired level of motivational self-efficacy. Here, it is seen that the role of the focal person is critical for all the stages of behaviour change of the workforce along the continuum. According to the proponents of this model, change occurs in two aspects, progressively or retrogressively over time (Prochaska & Velicer, 1997). The temporal dimension aspect is where the HIV focal person can make their input.

One cannot be sure, however, if these behavioural change theories are familiar to focal persons and whether or not they are aware of the theories behind the -how- and the -why- of their operations and the expected behaviour of staff exposed to their services. When well understood, these theories can be used as effective guides in developing efficient and cost effective behaviour change interventions at the Workplace. In fact, some of the theories, like the Social Learning Theory and Theory of Planned Behaviour, were developed as attempts to improve health education (Crosby & Kegler, 2002). Since these theories address the interaction between individuals and their environments, they can

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provide insight into the effectiveness of education programs given a specific set of predetermined conditions, like the social context in which a program will be initiated. Although health education is still the area in which behavioural change theories are most often applied, theories like the TTM or Stages of Change Model have begun to be applied in other areas like employee training and developing systems of higher education.

Thus, here, the effectiveness of the focal person in guiding colleagues along this continuum will be juxtaposed with their job description/specification and HIV training related background and their ability to offer varied and quality services. This will be described within a conceptual framework in the ensuing section. Miles and Huberman (1994) defined a conceptual framework as a visual or written product, one that -explains, either graphically or in narrative form, the main things to be studied—the key factors, concepts, or variables—and the presumed relationships among them- this includes the actual ideas and beliefs that one holds about the phenomena studied, whether these are written down or not. A review of prior research can serve many other purposes besides providing one with existing theory (Strauss & Corbin, 1998).

This study focuses on the relationship between the HIV focal person, (the unit of analysis of the study) and their role in delivering standard or quality HIV Services at the workplace. The study seeks to find out whether there is an interface between exposure to HIV education and ability to deliver quality HIV services at the workplace. Exposure of focal persons' to HIV education include formal education of health workers; participation in structured in-service HIV training courses of a duration not less than ten days, face to

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face learning, sandwich courses or distance learning, in HIV at an accredited institution of learning designed specifically for HIV focal Persons or Peer Educators.

According to the ILO (2010), standard or quality comprehensive HIV Services include at least five out of ten of the following: the presence of an HIV Committee; full-time or part-time HIV focal person with a job description that supports the position, HIV Policy, documented HIV workplace education programmes (seminars, training and workshops); distribution of IEC and BCC Materials; STI referral or management structures, condom promotion and distribution mechanisms; Information on or onsite HIV Counselling and Testing ; onsite Treatment or referral; Psycho Social Counselling and Care and support facilities (ILO, 2006).

Following a thorough literature review, a theoretical framework is developed using the parameters of successful workplace programmes enshrined in the 2001 ILO Code of Practice on HIV and AIDS. These parameters which have been linked to the performance of the focal person are: 1) the type of HIV Services 2) the level of integration of HIV Services to the organization, and 3) the presence of an HIV focal Person and level of delivery of HIV Services and the capacity of the HIV focal Person: qualification; training; job specification and description (Setswe, 2009).

This framework sets out the key components of an HIV and AIDS workplace programme and the contextual relationship between the thematic areas of quality HIV programmes defined by the parameters in box D and the HIV focal person dependent aspects, boxes A and B. Below is a diagrammatic representation of the conceptual framework, which

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shows how the different aspects of the architecture of the focal person impinges on the behaviour change continuum for staff members.

It has been suggested that a focal person's intervention at various points on this behaviour change continuum, that an individual staff member goes through, is contingent on the standard of the focal person and it relates to his/her job description (educational background) box A and Job specification (box B). This should culminate in sustained changed behaviour, box D, of the staff member receiving standard HIV services (box C) at the workplace. The conceptual framework outlines how the focal person related aspects impinge on behaviour change and mitigation of the impact of HIV (treatment and psychosocial support and care) which is the ultimate goal of HIV Workplace programmes.

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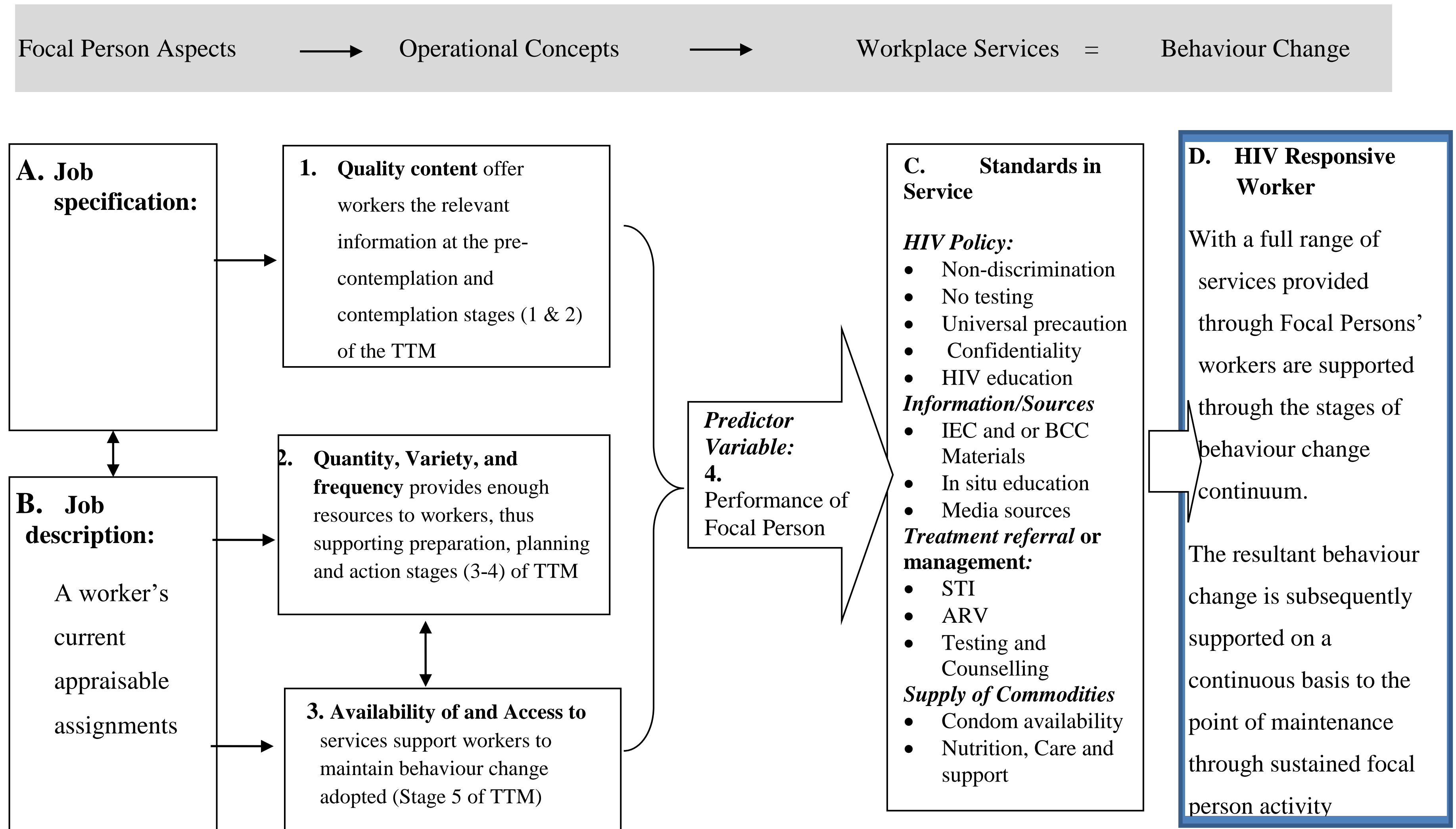
Figure 1: Conceptual Framework for the Role of the HIV Focal Person in Workplace HIV and AIDS Service Delivery



Source: Author's own construct (January, 2013)

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The penultimate goal of any HIV workplace programme should be behaviour change of the recipient or beneficiaries.

2.6.2 Contextual Implications of Job Specifications and Description on Service Delivery

In the conceptual frame work, boxes A and B which comprises job specifications (prior education and training at the time of recruitment) and Job description (current appraisable assignments) respectively; represents the focal person related variables. These are intervening variables which are summed in one predictor variable referred hitherto as performance (which is directly symmetrical to focal person presence and therefor synonymous with the word focal person). In several studies in South African Companies (Wolf & Bond, 2002; Ozer, Weinstein & Maslach 1997) workplace HIV and AIDS peer educators (similar to focal persons) reported that the profile of peer educators to their peers; personality factors and how peer educators are selected are important if programmes are to be successful. Active participation of peer educators in the planning and organisation of programmes is stressed as a critical factor for success and sustainability (Ritchie, Lewis, & Elam, 2002).

These are all overt indications that the job description of workplace HIV service providers is important and have pointed out need support and resources them to operate effectively (Campbell, 2004). The same study indicate that implementers of workplace education programmes do so within the limits of their own sexual knowledge and behaviour and general life skills and thus must have some skills and knowledge (job specification) to bring to bear on the job.

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2.6.3 Contextual Implications of Service Delivery/Performance on Availability of Services

As outlined in earlier chapters, HIV workplace programmes include the range of activities outlined in box C. This is the ideal, that a worker, the ultimate beneficiary of a programme will have this range of services to achieve sustained behaviour change (box D). The contextual relationship between the thematic areas of quality HIV programmes defined by the parameters in box C and the HIV focal person dependent aspects, Boxes A and B, set the stage to position the worker well within the continuum of the 'stages of change' that he or she goes through before reaching the ultimate which is maintenance of changed behaviour, Thus, within this conceptual framework the different aspects of the architecture of the focal person, specifically, the jobs assigned him or her in their job description (box B) and the criteria for their selection – the job specification (box A) is expected to aid the focal person, persons in their role of service delivery (box C).

In summary, it is being argued that the focal person's role is important at all stages during the continuum of change described in the TTM. During stages 1 and 2 (pre-contemplation and contemplation), where the individual is unaware or has no intention to change their risky behaviour, provision of relevant information to the individual (worker) about the consequences of their behaviour by a well-equipped focal person, is expected to adequately inform and set the stage for a transition to stage 3 and 4 (preparation and planning). These stages are where concrete steps or actions are put in place to effect the desired behaviour. As this stage spans an average of six months, the presence of the focal

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person in reinforcing information dissemination and behaviour change through work place activities is underscored.

Ideally, in stage 5, the final or penultimate stage, the beneficiary worker, having transitioned through the continuum of stages, is expected to sustain or maintain the newly adopted behaviour. In such an instance, the focal person's role is evident in supporting this behaviour change as the focal person would be deemed to have been successful if such change is sustained beyond the six-month milestone. It is conceived here that the quality and content (arrow 1); availability and quality of (arrow 2) and continued access (arrow 3) of HIV services rendered by the focal person should translate into better performance (arrow 4) that will foster and sustain and maintain responsive behaviour (box D) in a beneficiary staff.

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CHAPTER THREE RESEARCH METHODOLOGY

3.1 Introduction

In the ensuing section, the methodological issues that went into the planning of the study, data collection and analysis procedures to answer the research questions are examined and discussed in sections as follows: the Study area; rationale for the choice of research design, and data sources, data collection methods and instruments. Further explored are the measures employed to ensure credibility and validity in the study, data analysis strategies, ethical considerations and limitations.

In choosing the research methodology that best addresses the focus of this research, a search of literature was undertaken to support the choice of approach. The outcome of this search unveiled a debate on the use of various research approaches to examine phenomena. Two very commonly used approaches identified were the quantitative and qualitative approaches. This study employed a mixed method approach in which a researcher combines quantitative and qualitative research techniques, methods, approaches, concepts, or language into a single study (Johnson & Onwuegbuzie, 2004).

Both approaches have their own strong points; however, there are difficulties involved in either. Descriptive surveys are limited in that there is the problem of ensuring that the questions to be answered are not misleading; getting respondents to answer questions thoughtfully and honestly and getting sufficient number of questionnaires completed and returned so that meaningful analysis can be made (Franekle & Wallen 2000).

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For qualitative studies, lengthy data is collected, it takes time and does not have firm guidelines or specific procedures and is evolving and constantly changing (Creswell, 2007). Despite the shortcomings identified, the quantitative and qualitative approaches were used because quantitative research has the potential to provide a lot of information obtained from quite a large sample of individuals leading to the establishment of relationship between observed phenomena whilst qualitative research allows one to hear -silenced voices-(Creswell, 2007). Thus, when brought together, they draw on the strengths of each approach and minimize the weaknesses of both types of research (Connelly, 2009). Indeed, advocates of the quantitative approach, generally associated with positivist epistemology, support numerical data, explaining that such methods are objective as opposed to the subjectivity inherent in qualitative methodologies. Selection of the quantitative approach on one hand stands the chance of the objectivity of numbers in explaining reality as well as the ability to make an analysis of the role of the HIV focal person based on 'hard' data. On the other hand, qualitative researchers closely linked to interpretative epistemology demonstrate the strength of 'sensitive, nuanced, detailed and contextual' data that provides a comprehensive basis for understanding reality (Connelly, 2009).

Consequently, it is seen that arguments in support of either have merits on many dimensions that were considered during deliberations on which approach should be adopted for this study. Acknowledgement is made of the fact that deciding on an approach to adopt for this study considered in depth, the strengths and weaknesses of these approaches. Making decisions on paradigms is related to the posing of questions such as: how reality is perceived; whether it is an objective phenomenon which is

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external to people or it is the product of an individual's consciousness (Merriam, 2002). In the view of Bryman (2005), is reality that which is constructed in the light of some underlying powers and structures which define an individual's actions and constructions? What relationships exist between the 'knower' and what can be? Is knowledge or reality that which can be acquired or personally constructed (Bryman, 2005; Merriam, 2002).

Other questions that were posed include questions on how to ascertain what is suspected or can be known (Bryman, 2005; Guba & Lincoln, 2004). These researchers describe this relationship as the methodological consideration in the choice of the qualitative research approach. When a researcher concludes that reality or knowledge is an objective and tangible phenomenon which can be assessed and measured, then he or she may opt for quantitative measures. On the other hand, if there is an acceptance of the notion that knowledge is subjective, personal and lived, then the inclination is towards the choice of qualitative methods to gain data (Bryman, 2005).

In this study, the quantitative research methodology was chosen as it improves on the validity of research instruments as well as facilitates the provision of a numerical dimension to analysis when addressing phenomena (Sun, 2009). In addition, quantitative studies can simplify human experience, statistically, making the analysis of research findings easier (Creswell, 2007).

The combination with the qualitative aspect on the other hand, was to take into account the lived experiences hence enabling contextualisation of the analysis of phenomena- and, thus allowing for an in-depth understanding of phenomenon (Creswell, 2007).

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3.1.1 Study Area

The study was set in Greater Accra which is the capital of Ghana. Greater Accra was created by an act of parliament on 3rd July 1982, PNDC Law 26 as a legally separate region. It is one of the 10 administrative regions of Ghana. It is located in the south-central part of the country and shares borders with the Central Region to the west, Volta Region to the east, and Eastern Region to the north and the Atlantic Ocean to the south (GSS, 2010).

Greater Accra has sixteen (16) metropolitan, municipal Districts and sub-districes. These include Accra Metropolitan Area, Ada West, Ada East, Dangme East, Shai Osudoku (formerly Dangme West), Adenta Municipal, Ga East Municipal, Tema Metropolitan, La-Nkwantanang-Madina, Ashiaman Municipal, Ga Central District, Ga South Municipal, Ga West, Kpone Katamanso municipal, Ningo/Prampam and Lledzokuku Krowor Municipal (MLGRD, 2014).

According to the Ministry of Local Government and Rural Development and Rural Development report (2014), the major activities in these districts with the exception of Accra Metropolitan, Tema Municipal, Ga West is predominantly agriculture, fishing and commerce. By the same report, Accra Metropolitan Area (AMA) is the second most industrialised area in Ghana, next to the Tema Metropolitan Area. AMA contributing over 10% to the GDP. Over 30% of the manufacturing activities, representing over 50% of value added, are located in the area. The Ga West Municipal has also seen some remarkable growth in the past few years. The establishment of manufacturing companies

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such as Aburaaba Mineral water, Voltic Mineral water, a number of aluminium companies such as Rocksters and Instyle as well as the improved performance and reactivation of existing companies such as Isada Brick and Tile factory and Panbros Salt Ltd, just to mention a few, sector. About 95% of the farmers are small holders with 5% being large-scale holders. Productivity in the district is rather low due several factors. These include high illiteracy rate, poor soil conservation and improvement management skills, low capital, and high cost of inputs. In view of this Tema and Accra Metropolitan Areas were selected.

Furthermore, these districts were chosen purposefully due to the high preponderance of Large to Medium Scale Enterprises which are likely to have an HIV programme coordinated by a staff member. The choice of this region is further supported by the fact that it is one of the highest HIV median prevalence's (3.5%) only superseded by that of the Eastern Region of 3.6% (NACP, 2012). The prevalence of the Greater Accra Region is of interest to this study because the Tema Municipality, one of the study sites within the study area has a prevalence of 3.6% which is at par with the highest prevalence recorded per region (NACP, 2012).

The relevance of selection of these municipalities lies in the fact that the Ministry of Local Government and Rural Development reports it as an urban economy that has a comparatively large manufacturing, electricity, gas, water, and construction sector (MLGRD, 2010). To this end, the following districts were considered: Accra Metropolitan Area and the Tema Metropolitan Area.

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3.1.2 Accra Metropolitan Area – AMA

The Accra district, which is one of the five administrative districts in the Greater Accra region of Ghana, it is made up of six sub metros namely Okaikoi, Ashiedu Keteke, Ayawaso, Kpeshie, Osu Klotey and Ablekuma (AMA, 2014). AMA has a population of 1,848,614 people (GSS, 2010), which makes it one of the most densely populated in the country with an age structure which is still a youthful one, characterized by a somewhat high fertility. This has implications for HIV risk as HIV spread is linked to sexual activity as they exercise their reproductive rights. The metropolitan area covers an area that turns right to the Ashaiman Municipal road till the railway overhead bridge on the Motorway and continues to the road between the Institute of Professional Studies (IPS) and the Accra Teachers Training College (ATRACO) at East Legon.

According to the AMA Report of 2014, the metropolitan area at its west side is truncated by the Accra-Aburi Road to the University of Ghana behind the Great Hall to Kisseman and Achimota School/Christian Village to join the Accra/Kumasi Road to the Achimota Brewery Road Junction. It is bordered also by the Achimota Stream up to the Awoshie Hills along the boundary of Awoshie (Ga South Municipal) to the Sakumono Stream on the Accra-Winneba road (AMA, 2014). In summary, Mallam junction serves as the western border; the Great Hall of the University of Ghana forms the northern border, while the Nautical College in Tema forms the eastern border and the Atlantic Ocean the southern border.

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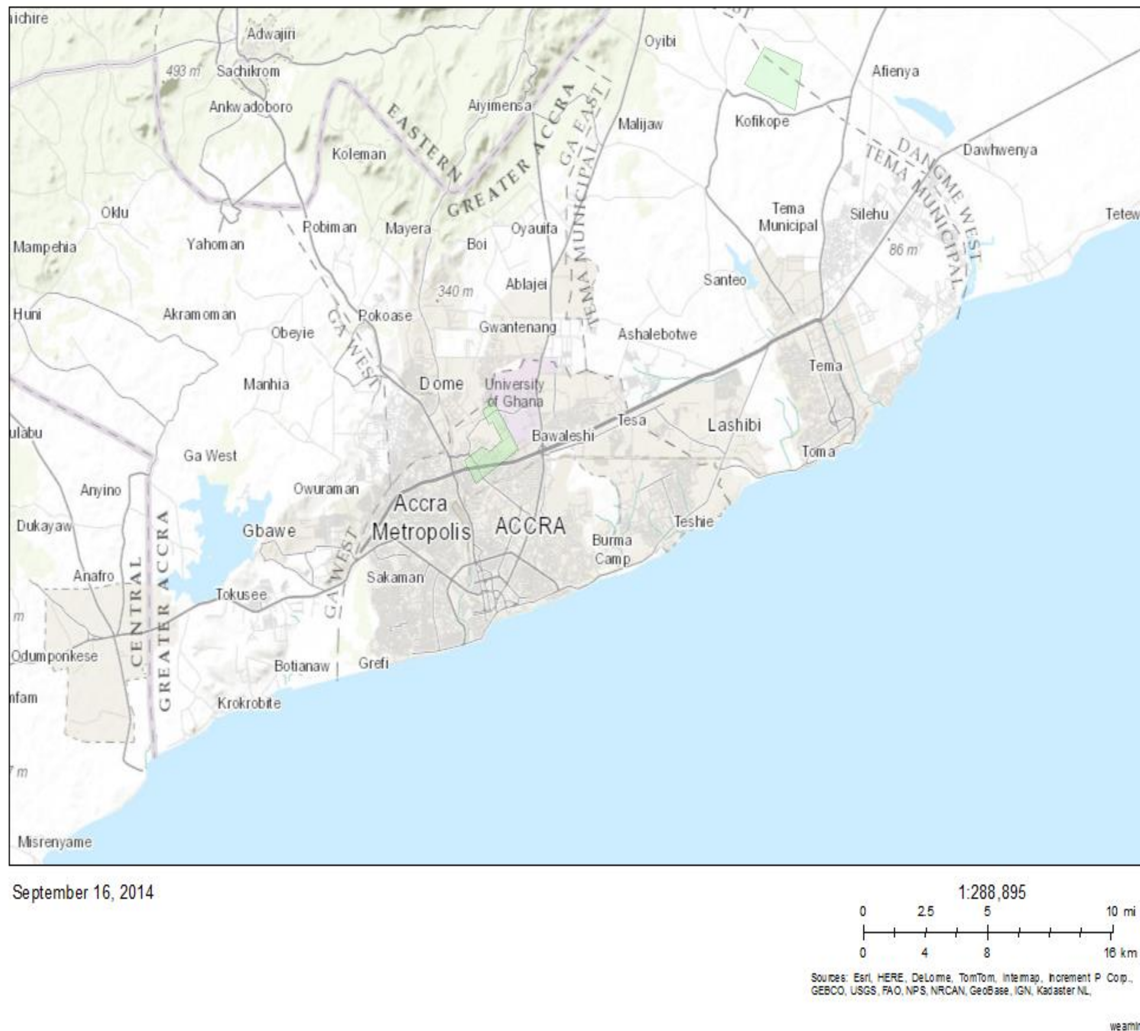
Figure 2 Map of Accra Metropolitan Area



3.1.2.1 Geography and Climate

According to the same report of the Ministry of Local Government and Rural Development, Accra features a tropical savannah climate which is semi-arid in nature owing to its location where the eastern border, the coast runs parallel to the prevailing moist monsoonal wind. Like the rest of Ghana, it has two rainy seasons which averages 730 mm annually.

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3.1.2.2 Sectors of the Economy

The sectors of AMA economy consist of Primary Sector (farming, fishing, mining and quarrying), Secondary Sector (manufacturing, electricity, gas, water, construction) and Tertiary Sector (Wholesale trade, retail trade, hotel, restaurant, transportation, storage, communication, financial intermediation, real estate service, public administration, education, health and other social services). As an urban economy the service sector is the largest, employing about 531,670 people. The second largest, secondary sector, construction, employs 22.34% of the labour force that is 183,934 people (MLGRD, 2014).

3.1.3 Tema Municipal Assembly

Tema Municipal Assembly which serves as the administrative capital of the Tema Metropolitan administrative sector is a coastal city situated 25 kilometres east of Accra. It has the Greenwich Meridian, that is 00 Longitude passing through it. It is a seaport and has a population of 402,637 people (NPC, 2010)

The Ministry of Local Government and Rural Development (2014) reports that it shares boundaries with some of the districts and municipalities of Accra, specifically, Ashaiman Municipal, Adentan Municipal, and Ledzokuku Krowor Municipal to the west respectively, Kpone Katamanso District to the easternmost side, Dangme West District to the north and on the South the coast Tema became an Autonomous Council in 1974 and was elevated to the status of a Municipal Assembly in December, 1990.

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Figure 3 **Map of Tema Municipal Area**

The metropolis of Tema, according to the 2010 population census has a population 402,637 people and is mostly urbanized. It is an industrial city and was made purposefully for industry under after independence. The Tema Municipality is divided into 4 sub-districts (sub-municipalities) as namely Tema Township, Ashiaman, Manhean and Kpone. The climate of Tema according the MLGRD (2014) report is not much different from that of Accra. The same report indicates a climate characterised as a dry equitorial one with an average annual rainfall of about 750 millimetres on par with that of the AMA. The temperature on average are similar to that of Accra.

3.1.3.1 Economy

The seaport in Tema was opened in 1962 and handles Ghanaian imports and exports as well as transit cargo destined for the landlocked countries of Burkina Faso, Mali and

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Niger. It is the main port for dealing with Ghana's main export cocoa. Tema also has a fishing harbour at its eastern end that comprises the Inner Fishing Harbour, the canoe basin, the outer fishing harbour and a commercial area with marketing and cold storage facilities.

3.1.3.2 Industry

The TMA's main industrial products include aluminium, textile, steel, refined petroleum, processed fish, textiles, chemicals, food products, and cement. Major companies operating in Tema include the Volta Aluminium Company (VALCO), Tema Oil Refinery (TOR), Nestlé Ghana Ltd., Wahome Steel Ltd to mention a few. The preponderance of industries in this district was factored into the choice of this district for the study, thus it was purposefully chosen.

The industrial sector of Tema is one of the most important productive sector's in the ccountry in terms of local revenue generation. Beside the heavy industries, a plethora of light industries and can boast of over 250 factories in the municipality engaged the secondary and tertiary sectors. Tema is perfectly suited for manufacturing. The municipality has a huge port, and has been designated a Free Port and Export Processing Zone, whereby special facilities are accorded to imports and exports without payment of customs duties or local taxes. Utilities and social services are modern (MLGRD, 2014).

The service industry comprises banks, insurance firms, hotels, legal firms, postal and communication services and transport. Others are recreation and freight services. Most importantly, a sizeable portion of Tema has been designated as an enclave for the Free

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Zone Programme. Currently, a number of industries are taking advantage of the generous concessions granted under the Free Zone Act to acquire space to operate in the zone. Efficient and good economic and social infrastructural facilities are in place and are continuously being upgraded. Tema is less than 25 kilometres away from Accra, which provides the largest and most affluent market for both consumer and intermediate goods in the country. For this reason large multi-national companies can be found in abundance (MLGRD,2014).

3.2 Study Design

The study was descriptive and uses quantitative and qualitative methods. The qualitative aspect was undertaken prior to the quantitative approach, and covered a review of the background data on the enterprises which was then summarised to provide context for the study.

The quantitative aspect was therefore basically designed to obtain the bulk of the data from a survey. For the quantitative aspect, 428 structured close-ended questionnaires were administered and the same number of responses, representing 100% of surveys, was obtained from workers. This was achieved due to the fact that surveys were supervised and undertaken at the leisure of respondents such as during lunch break, closing time or in small groups where possible. This was very effective to the extent that there was no 'non-return' of questionnaires. The numbers of enterprises visited for the qualitative aspect were twenty two in all and 428 workers participated in the quantitative survey.

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For the qualitative aspect, there were 15 Key Informant Interviews (KIIs) held on site at the various enterprises. An interview guide was used (Annex 3) to glean information. This information triangulated the findings of the focus group discussions (FGDs). Emergent themes or ideas obtained from the KIIs were in consonance with those of the FGDs. Participants to the KIIs also participated in the FGDs. The information they revealed in the group was not divergent from the information they gave, giving credence to the KII data. The table below shows the processes undertaken for the engagement of focal persons in the focus group discussions.

All focus group discussions were conducted in English and lasted approximately two and half hours. Each focus group discussion was tape recorded and later transcribed. As it was very difficult to have participants meet in focus group discussions and key informant interviews, an innovative strategy had to be employed. The FGDs were held at a central site. The central site was chosen by participants during key informant interviews due to anticipated workplace interferences. Participants were purposefully selected as indicated in the previous chapter. They were encouraged to talk about their experiences as focal persons and even beyond that, using the interview guide that ensured that there was a systematic and comprehensive probing of the study participants by the issues that had to be investigated.

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Table 1 Focus Group Discussion Schedule

Date	Location	Time	Participants	Men	Women
9th April	Office of the Head of Civil Service Annex Room 7	10am – 11am	7	4	3
11th April	Office of the Head of Civil Service Annex Room 2	10am–2:30pm	6	3	3
11th April	Office of the Head of Civil Service Annex Room 7	1:00pm– 2:30pm	7	4	3
16th April	Head of Civil Service Conference Room	10:00am -2:30pm	7	3	4
16th April	Office of the Head of Civil Service Annex Room 7	1:00pm –2:30pm	8	5	3
Total			**35**	**19**	**16**

Participants (table 1) were invited to participate in FGD during their lunch period. In addition, they were offered snack and reimbursed for their transport costs. As this was the staff's own time, a large majority of the participants invited, turned up. This strategy

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resulted in a very good outcome and promoted an atmosphere of relaxation which in turn resulted in a substantive amount of information being gained in a short space of time, cutting the expense and time needed as recommended by several researchers (Cohen, Manion, & Morrison, 2005; Patton, 2001). Some participants knew each other thus removing the initial inertia and the need to "break the ice". Care was taken to avoid the anticipated shortcoming of group interview where individuals with strong opinions were liable to dominate proceedings and exclude others by giving members a turn each to give their views about issues (Cohen *et al*, 2005; Patton, 2001).

During fieldwork, a total of 5 focus group discussions were held with participants selected from all the twenty two enterprises. Invitations were extended to a total of forty workers from these enterprises with the expectation of at least 80% turn up rate. Expectations were exceeded as close to 90% (35) turned up.

3.2.1 Qualitative Methodological Approach

The qualitative aspect of this study provides an in-depth knowledge of an organizational phenomenon that had barely been researched (Audet & d'Amboise, 2001). It combines several approaches to case study research, and involves the observation and analysis of several enterprises using explanation building techniques to analyse data (Audet & d'Amboise, 2001) that is, gathering in-depth insight in the different enterprises and capturing the complexity of the phenomenon (gaining 'intimacy' with the cases) to produce some level of generalization to analyse data (Ragin, 1987). Other researchers have stated that qualitative research is one research methodology that seeks to gather data

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to unearth an in-depth understanding of human behaviour and the reasons that govern such behaviour. However, on the contrary, other researchers have indicated that qualitative research was not regarded by some mainline researchers as a scientific discipline but it began to regain recognition only in the 1970s (Creswell, 2003).

For this reason, the term 'qualitative research' was often regarded as a discipline of anthropology or sociology, and referred to by terms like ethnography, field work, Chicago school and participant observation. In time, it became a significant type of research in other fields of study e.g. education, nursing, gender, human services, communication and others. Critics of qualitative studies attributed their low regard of qualitative research to its lack of precision to and reliability. In the late 1980s and 1990s, new methods of qualitative research evolved to address the perceived problems with reliability (Creswell, 2003).

In the qualitative phenomenological approach that was used, data was collected by observing and recording interactions, examining written documentation and literature, or obtaining perspectives from various people involved in the social interaction (Cutcliffe, 2000). Thus for this study, these methods described by Clutcliff as best in studying a phenomenon were adopted for gathering data on the role HIV focal person plays in Workplace HIV Service delivery because they were tenable and achievable within the time frame of the research.

The fieldwork process was further influenced by the understanding that the process was an interpretive process rather than a simple auditory or visual reality which was being

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engaged with (Van Maanen, 1993). The aim in using the qualitative aspect was also to aid in describing and also explaining the invariance or otherwise of the service delivery of HIV of focal persons in enterprises in two districts of the Greater Accra Region of Ghana.

This research applied all the usual types of explanations: by earlier events, by later events, and contextual explanation. A table of potential reasons and potential effects (index) was made, that is, if there is conformity between likely reason and likely effect (i.e. there is effect only when the reason is present) it augments the plausibility of the hypothetical explanation or supports the research findings. However, it is noted that a mere correlation between two variables does not yet definitively confirm a hypothetical explanation, because the correlation can be due to other reasons which have not been registered (Projects & Methods 2007).

The qualitative aspect was also important in that it encompasses the utilization of all resources that yield information regarding the phenomenon or social interaction under study (Patton, 2002) which in this case is the HIV focal person. The data was collected by observing and recording interactions, examining written documentation and literature, and obtaining perspectives from various people involved in the social interaction (Cutcliffe, 2000).

For this study, a conceptual framework was developed (figure 2.5) within which research questions were posed to explore relationships. This framework provided the lead for the quantitative aspect of the study (Morse, 1991). It also sought to display and discuss

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statistical significance as opposed to the qualitative aspect that upholds and sub-themes supported by quotations. The integration of quantitative results in this fundamentally, qualitative study, is an approach that was chosen to enrich the study and establish statistical reliability (VanderStoep & Johnson, 2009). Aspects of the phenomenological approach emerged as the reality of the role of the focal person was enacted during fieldwork.

To increase the credibility of qualitative measures, literature supports and recommends the adoption of multiple methods to address the same research questions (Cohen *et al*., 2005; Knight, 2002; Patton, 2001; Hammersley & Atkinson, 1995). To this end, the study included, in addition to the quantitative data collection, qualitative strategies such as FGDs, KIIs and observation in the data collection procedures. The justification for the use of observation was to reduce the shortcomings of the interview approach, helping to validate interview data with documentary evidence thus increasing the robustness and richness of data collected.

3.2.2.1 Phenomenological Perspective

The philosophical tradition of phenomenology, or the study of how people describe things and experience them through their senses, emerged from the work of German philosopher Edmund Husserl (1859-1938). Husserl's basic assumption of phenomenology was that human beings can only know what we experience by attending to perceptions and meanings that stimulate our conscious awareness. In other words, we initially receive information about our experience with a phenomenon from our senses,

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but these sensory experiences must then be described and interpreted. Phenomenologist study the way in which we put together our experience in a way that shapes our worldview. Thus, according to Hursel, in the philosophy of phenomenology, there is no single, objective reality for people. There is only what they know about their experience and the meaning they attach to it. The application of phenomenology as a research perspective in the social sciences is based on the work of Alfred Schutz (1899-1959). The purpose of phenomenological exploration in the social sciences is to grasp and interpret the meaning, structure, and essence of the lived experience of a phenomenon for a person or a group of people. Instead of proving or disproving a hypothesis, research conducted from a phenomenological perspective often leads to new variables or questions for future research (Patton, 2002).

It is important to clarify elements of phenomenological exploration that are often misunderstood in the literature (Patton, 2002). A study conducted from a phenomenological perspective is distinct from a phenomenological study. A researcher can use a phenomenological perspective to illuminate the importance of gaining information and understanding about people's experience, without conducting a phenomenological study that focuses on the nature of shared experience (Patton, 2002).

Research from a phenomenological perspective begins with determining if the research question is best examined using a phenomenological approach. The research question that best fits this framework is one in which the researcher seeks to understand several individuals' experiences of a phenomenon (Creswell, 2007). In the present study, the phenomenological perspective was the most appropriate fit for the qualitative portion of

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the study and for the research question: What do focal persons experienced in terms their roles in delivering HIV Workplace Education Services and what situations or contexts influenced his or her experiences in this role. After determining there is a good fit between the research question and approach, the researcher identifies the phenomena of interest to be studied. The researcher also identifies a group of people who have experience with the phenomenon of interest as the population to be studied (Creswell, 2007). In this study, the identified phenomenon of interest is the ability to carry out effective health education. The study investigates this phenomenon as it plays out in the activities of focal persons in the area of HIV and AIDS service delivery.

From a phenomenological perspective, using focal person's as a strategy to advance Workplace HIV service delivery is premised on what the focal person experienced in terms of the phenomenon (workplace HIV Service delivery); and what situations or contexts influenced his or her experiences with the phenomenon, In view of this, it can be said that the qualitative aspect, encompassed utilization of all resources to yield information.

3.2.2.2 Critical Incident Technique (CIT)

In this study, elements of the Critical Incident Technique (CIT) are used to inform the wording of the general interview questions (Flanagan, 1954). This interview approach elicits information about the content and context (the -what- and -how-) of participant experience with the phenomenon, thereby providing a deeper understanding of these experiences. Here information is gathered about the phenomenon itself, and the situational factors that influenced participants' experience with the phenomenon.

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Additional open ended questions were asked for the sake of elaboration and clarification (Creswell, 2007).

3.2.2.3 Assumptions

The core assumptions of the qualitative, phenomenological approach portion of the study include the following:

1. The purpose is to contribute to knowledge and theory through exploring and describing the subjective experience of a phenomenon for HIV Focal persons.

2. Research designs are emergent rather than fixed.

3. Conducting research in the natural setting is the best way to achieve knowledge about phenomenon of interest.

4. There is not a single reality; perceptions of reality are different for each person and change over time.

5. Meaning is produced through perceptually putting pieces together.

6. The researcher's active role in data collection and analysis is valued as an important part of the research process. The researcher interacts with participants and actively works to minimize the distance between the two parties. This differs from quantitative research, where the researcher maintains objectivity in an effort to remain unbiased (Creswell, 2007; Patton, 2002).

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3.2.2.4 Sensitizing Concepts

Sensitizing concepts are used in qualitative research to introduce preliminary concepts that can be refined throughout the study. According to Patton (2002), US sociologist Herbert Blumer in 1969 stated that whereas definitive concepts [hypotheses] provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look-, sensitizing concepts provide focus while allowing the researcher flexibility to include important concepts that emerge through data collection and analysis. This contrasts the quantitative, deductive approach, where hypotheses are created and variables identified before data collection begins. In qualitative research, the data are not grouped according to predetermined categories. Instead, the researcher uses a process of inductive reasoning to identify potential themes as they emerge (Guba, 1978). Thus, sensitizing concepts were used to guide the research study

The qualitative aspect looked at workplace educational materials such as hand-outs, information education and communication (IEC) materials; behaviour change communication (BCC) materials and paraphernalia, and teaching material for in-service training centres as the case may be, to ascertain whether or not it fits predetermined criteria of adequate workplace service delivery. It was also designed to cover the inspection of appointment letters of HIV focal persons in the enterprises.

In addition, the practices target enterprises that had focal persons and those that had not were examined and described. The study also focused on HIV Service delivery using Key Informant Interviews and Focus Group Discussions to generate a comprehensive view of

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the phenomenon. The views of beneficiaries were incorporated with that of focal persons to generate a holistic view of the Workplace Service delivery. The role of the focal persons in providing services within the context of their skills set or expertise was examined as well as the quality of services based on the knowledge of HIV that worker place beneficiaries had. The qualitative aspect was further sub-divided into two parts a) focus group discussions and b) key informant interviews.

A convenience sample of key informants, determined within theoretical limits, was selected per enterprise to form focus groups not exceeding 10 each. All focal persons, in all the enterprises with focal persons, were conveniently selected as key informants. They were subjected to in-depth interviews and participated in FGDs until themes emerged and saturation was reached.

3.2.2 Sample Population

For the purposes of this study, the population sample included the entire workforce in the target enterprises in the study area. For this study, the workers of enterprises which include the focal person were the unit of analysis and as such all enterprises with focal persons were of interest to the study. The sample population was not different from that used for the qualitative aspect. In order to reach the workers, first, enterprises needed to be selected. Those with focal persons were purposively selected as they were only five in the target area according to the GEA and the GBCEW. To this end, the choice of the enterprises was backed by the same thinking that went into selection during the

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qualitative aspect; it was therefore backed by the active presence of focal persons. In addition, the enterprises had to meet three basic criteria.

3.2.2.1 Selection of Participants and Enterprises for Qualitative Study

A non-probabilistic sampling method was used for the qualitative aspect of the study. As generalization in a statistical sense is not one of the objectives, this method was chosen because 'probabilistic sampling is not necessary or even justifiable in qualitative research' (Merriam, 1998). Several studies support that sample selection in qualitative studies should be dictated by replication logic instead of one based on a statistical method (Yin, 1994). Several researchers have cited the point of saturation or the point at which no new information or themes are observed in the data as the logical sample size (Guest, 2006). Field work entailed desk review of workplace education and service delivery data as well as interviews with key informants using structured interview guides. In order to reduce undesirable influences on the object of study, the cases to be compared were selected so that they are as similar as possible. The research methods employed for the qualitative aspect were Focus Group Discussions and Key Informant Interviews /in-depth interviews. Preceding the selection of participants for the focus group discussions and key informant interviews was selection of participating enterprises.

In choosing the enterprise as a unit of study, it was important to define what an enterprise was. Enterprises have been grouped according to size into micro, small, medium, and large scale (Kayanula & Quartey 2000). In view of the perceived high level of bureaucracy expected in a large scale enterprise, the following was considered in reaching a decision. Several authors have provided different definitions as to what

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constitutes a small or medium enterprise. The definition of firms by size varies among researchers. Some attempt to use the capital assets while others use skill of labour and turnover level. Others define SMEs in terms of their legal status and method of production. Storey (1994) tries to sum up the danger of using size to define the status of a firm by stating that in some sectors, all firms may be regarded as small, whilst in other sectors there are possibly no firms which are small.

The Bolton Committee (1971) first formulated an economic and statistical definition of a small firm. Under the economic definition, a firm is said to be small if it meets the following three criteria: 1) It has a relatively small share of their market place; 2) It is managed by owners or part owners in a personalized way, and not through the medium of a formalized management structure; 3) It is independent, in the sense of not forming part of a large enterprise. Under the statistical definition, the Committee proposed the following criteria: The size of the small firm sector and its contribution to GDP, employment, exports, etc. the extent to which the small firm sector's economic contribution has changed over time; applying the statistical definition in a cross-country comparison of the small firms' economic contribution. The Committee further applied different definitions of the small firm to different sectors. Whereas firms in manufacturing, construction and mining were defined in terms of number of employees (in which case, 200 or less qualified the firm to be a small firm), those in the retail, services, wholesale, etc. were defined in terms of monetary turnover (in which case the range is 50,000 - 200,000 British Pounds to be classified as small firm). Firms in the road transport industry are classified as small if they have 5 or fewer vehicles.

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To avoid this controversy, this research limited itself to the use of medium to large enterprises as defined by UNIDO (Kayanula & Quartey 2000) which categorizes large firms as firms with 100+ workers and medium as firms with 20 - 99 workers.

3.2.2.2 Criteria of Selection for Enterprises:

The target sample was identified by purposive sampling since enterprises with workplace programmes were not universal. Eisenhardt (1989) recommends a sample size of four to ten organizations (or sites) for qualitative studies. To this end, seven enterprises were chosen using a random number generator from the list of enterprises on the GEA and GBCA membership List. The following criteria were applied to the enterprises. Enterprise should: 1) Fall within the sample area 2) Be registered with the Register Generals Department 3) Fall within the UNIDO definition of a medium to large scale enterprise for developing countries (Kayanula & Quartey 2000) as shown below:

Large - firms with 100+ workers

Medium - firms with 20 - 99 workers

Small - 5 - 19 workers

Micro - < 5workers

3.2.2.3 Focus Group Discussion

The FGD is a research methodology where a small group of participants meet to discuss a particular topic in order to generate data (Wong, 2008; Patton, 2002). The advantage of focus group discussions, according to Bryman (2004), is that they probe participants' reasons for holding certain points of view. Furthermore, he posits that they often bring to

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the fore, perspectives that are significant since they allow for arguing with each other and challenging each other's views. Conclusions arrived at may thus be more realistic than in individual interviews.

The main characteristic of the focus group was the interaction between the interviewer and the HIV Focal person and beneficiaries of their services in the study sites. This interaction helped to give an understanding of the participants' perspective on the use of HIV Focal person in the workplace. For this study, the FDGs were used to generate information on the personal experiences of enterprise focal persons in executing their roles as HIV services providers at the work place.

3.2.2.4 Selection Criteria for Focal Persons and Workers

The focal persons selected were expected to i) be full time staff of the enterprise who were recognized officially by management, as such (whethr formally, as per job specification or informally) or ii) show evidence of being recognized by co-workers as an HIV Focal person.

To get a representative homogeneous sample of workers that would be comparable, 'worker' was defined as fulltime, casual or part time, that is, they must have worked a minimum of 20 hours a week at the enterprise on a daily basis for at least 3 months. The sampling frame therefore in each enterprise was the list of people that had been beneficiaries of the purported HIV programmes. According to Patton, groups are typically six to ten people with similar backgrounds who participate in the interview for

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one to two hours. To this end, a total of up to eight beneficiaries of workplace HIV service providers was determined for each of the enterprises. In all, five FGDs were planned for a total of forty beneficiaries.

3.2.2.5 Key Informant Interviews

Key informant interviews, also referred to as in-depth interviewing, is a qualitative research method which involves conducting individual interviews with a group of participants to explore their ideas on a particular perspective (Boyce & Neale, 2006). One advantage of this method is that it allows participants to be comfortable when speaking in groups, or makes it easier to differentiate between group opinions and individual opinions. It provides more detailed information compared to other data collection methods. However, some limitations of this method is that it is time intensive, interviewee responses may be prone to bias and it needs an interviewer that is properly trained in order to ask the correct questions and extract as much information as possible from the interviewee with limited bias. (Boyce & Neale, 2006).

For this study, issues raised in FGDs were further interrogated using in-depth interviews that are conducted with open ended interview guide (see Annex 2). The aim of this is to garner detailed and in-depth understanding of the personal experiences of workers who had benefited or otherwise, from HIV services delivered at the workplace via their enterprise focal persons. As Boyce and others (2006) discussed, a structured interview would not have allowed for probes and follow-ups; it would have followed the

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researcher's line of reasoning and limited deeper exploration of issues considered important by participants. In all, 15 individuals were interviewed as key informants.

The foundation for the interview guide focused on two general areas: 1) what the participant experienced in terms of the phenomenon; and 2) what situations or contexts influenced his or her experiences with the phenomenon. A specified number of research assistants were trained to assist in data collection and interviews. The approach was to elicit specific information about participants' experiences with the phenomenon of interest, in this case, HIV Service delivery as well as their feelings associated with such.

A structured interview would not have allowed for probing. In consonance with literature, findings thus gathered are significant as the potency of interviews as a data collection has been highlighted (Patton, 2001). Patton has stated the following:

> '…we cannot observe feelings, thoughts and intentions. We cannot Observe behaviors that took place at some previous point in time …the purpose of interviewing then, is to allow us to enter into the other person's perspective'

Table 2 provides a detailed breakdown of participants in each category. The interviewing process was dynamic and iterative, and helped to elicit the detailed information required.

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Table 2 Participant's for Key Informant Interviews[1]

Enterprise[2]	Persons interviewed	Type of Enterprise	Title/Status (N)
X Corporation of Ghana	2	Public	FP/ML (1); SM (1)
Ministry of Y	3	Public	FP/ML (1); SM (2)
Ghana T Coalition on Employees	2	Private	FP/ML (1); SM (1)
T Ghana Ltd	2	Private	FP/ML (1); SM (1)
U Ghana ltd	2	Private	FP/ML (1); SM (1)
Ghana T Board	2	Public	FP/ML (1); SM (1)
S Life	2		SM (2)
Total	15		

FP – Focal Person; **ML**- Management Level; **SM** –Staff Member

3.2.2.6 Selection of Key Informant Interviews

Researchers have tried to suggest some kind of guidelines for qualitative sample sizes. Charmaz (2006) for example suggests that, twenty participants are adequate for smaller projects; according to Ritchie *et al*. (2003) qualitative samples often lie under fifty; while Green and Thorogood (2009) state that the experience of most qualitative researchers is that in interview studies "little that is new' comes out of transcripts after you have interviewed twenty or so people. Morse (1994), sets the following benchmarks for sample

[1] Actual names and contact details are in appendix 1
[2] The names of enterprises have been changed

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size: a minimum of six participants for phenomenological studies; approximately thirty-fifty participants for ethnographies, grounded theory studies, and for ethno-science studies, one hundred to two hundred in qualitative ethology is recommended. Others have propounded ranges of between five and twenty-five interviews for a phenomenological study and twenty to thirty for a grounded theory study (Creswell, 1998).

In the light of the foregoing, fifteen workers were selected for Key Informant Interviews which were conducted across medium to large enterprises. This number was chosen as it is supported within the five to twenty five ranges (Creswell, 1998).

3.2.3 Data Collection Procedures - Qualitative

Data Collection is a series of interrelated activities aimed at gathering good information to answer emerging research questions (Creswell, 2007). For the purposes of this study, the above mentioned techniques were used (section 3.5) which followed the progression diagrammatically presented below:

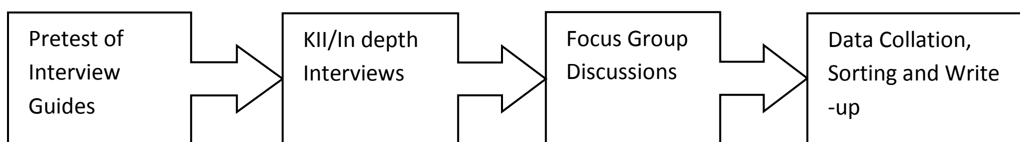

Figure 4 Data Collection Progression - Qualitative

A set of specific processes however had to be undertaken to achieve effective data collection. Deliberation on these steps will be discussed in succeeding sections.

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3.2.3.1 Enterprise Visits

Visits to the targeted enterprises began in the Greater Accra region with visits to both enterprises with and without focal persons. All field visits took place in the months of April and May 2013.

3.2.3.2 Gaining Access

All enterprises which had been selected randomly using a random number's generator were issued with letters written by the Department of Social and Behavioural Studies that had been signed by the head of department. This is in accordance with protocol demands that the authorizing stakeholder be informed of such intentions. For Davies (1977), cited in Crossley and Vulliamy, G. (1997), the question of access, arrangement and arrival incidences are critical for data collection, helping to set the tone for subsequent interviewing.

For this study, access was gained to the enterprises by personally contacting the chief executive for the Ghana Business Coalition for Employee Wellbeing and the Ghana Employers' Association with an introductory aforementioned letter (Appendix C) which explained the purpose for the data collection. The personal interaction helped to ensure some bonding and rapport thus breaking the ice for enterprise entry, for instance, access was given to the total list of enterprises within their jurisdiction of these enterprise umbrella bodies of all registered businesses in Ghana. In fact, they facilitated meetings with the enterprises through phone calls and gave personal introduction for both researcher and field workers. Furthermore, the personal introduction to management and

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related authorities at the various enterprises was to help reduce the sense of intrusion. It is therefore not surprising that in enterprises that were not registered with either of these bodies but were randomly selected, fear of inquiry was displayed by their management, to the extent that some enterprises refused to participate necessitating a change of enterprise at that point in time. When this occurred, the enterprise next to the randomly selected one on the list was chosen. This occurred in 3 instances. Note is also being made of the fact that these enterprises were owned by foreign nationals of a particular geographical area.

Another great challenge came from getting the appropriate time to interview staff without work related interruptions. This was solved by either targeting staff that had arrived very early, during lunch time and at closing time. The most difficult challenge was getting persons from different enterprises to participate at scheduled times. With each participant, techniques for ensuring anonymity was indicated clearly to them., plans for the storage and use of information given as well as the details of the research indicators outlined in the interview schedule.

3.2.3.3 The Interviewing Session

For each enterprise visited, an average of 30-minute face-to-face interviews was conducted with the staff and management at all levels. All interviews were held in private and were mostly conducted in the offices of the staff and, in rare cases, in their cars at the car park.

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The interview guide thus developed for this study featured open-ended questions that explored the 'how?', 'who?', 'why?'' when?' and 'what?' of HIV Service Delivery. In making the choice of the items on the interview schedule, I took cognizance of van de Mescht's (2002) caution to researchers to be aware that strong personal agendas could compromise interpretive enquiry, stressing that;

> '…questions …too strongly located within a preconceived theoretical framework, allowing little space in which participants might elaborate and through language, metaphor, anecdote and symbol begin to give meaning to reality'

The instrument had mainly open-ended questions related to HIV Service delivery. As it was very difficult to get participants to make time for focus group discussion, an innovative strategy had to be employed. Participants were invited during their lunch period. As this was the staff's own time, participation was universal. This gave a very good result and promoted an atmosphere of relaxation. The use of the FGD interview technique thus arranged provided a unique opportunity to gain substantive information in a short space of time, cutting the expense and time needed (Cohen *et al*, 2005; Patton, 2001).

3.2.4 Record Keeping

One of the critical activities in the data collection process is record keeping that facilitates analysis. Of the various techniques identified in the literature (Cohen *et al*, 2005; Patton,

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2001), field notes and diary-keeping was the technique employed in this study. A detailed discussion of these techniques follows next.

3.2.4.1 Field Notes

As part of the data collection procedures, a diary was kept to record impressions and thoughts of the management practices as they unfolded in the field (Appendix H). These field notes served as a representation of events, places and people that were engaged with these written documentations. These were repeatedly reviewed to inform decision making during fieldwork (Knight, 2002; Cohen *et al*, 2005; Patton, 2001)

3.2.5 Data analysis – Qualitative Aspect

During the data collection process, a journal of personal reflections was kept regarding interactions with participants. Participant interviews were audio recorded, transcribed and emailed to participants for their review. Participants were invited to clarify or elaborate upon any part of their interviews as the case may be (Creswell, 2007). According to Creswell (2007), there are five approaches to data collection depending on the activity to be undertaken (Table 3.6)

As the study approach adopted was phenomenological in nature, the data analysis and representation methodology assumed was that which was developed by Moustakas (1994) and outlined by Creswell (2007) as follows:

- Created and organized files for data

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- Read through text, made margin notes and formed initial code from highlighted significant statements
- Described personal experiences through ‘epoche’ (bracketing) and then developed clusters of meaning by forming these statements into themes
- The textural description or what the participants experienced of the phenomena was the next step
- This was followed by a structural description (-how the phenomenon was experience-)
- Then the ‘essence’ or common experiences were gelled.
- Finally followed by the narration of the essence of the experience in tables and discussion.

Data that emerged from the literature and key informants was thus analysed to ascertain common accomplishments and challenges to the implementation and efficacy of workplace policies and programme. The gathering and assessment of the evidence was an iterative process.

A codebook was developed using a standard iterative process (MacQueen, McLellan-Lemal, Bartholow, & Milstein., 1998). In this process, each code definition has five parts: (1) a brief definition to jog the analyst’s memory; (2) a full definition that more fully explains the code; (3) a “when to use” section that gives specific instances, usually based on the data, in which the code should be applied; (4) a “when not to use” section that gives instances in which the code might be considered but should not be applied (often because another code would be more appropriate); and (5) an -example- section of quotes.

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Analysis of focus group and key informant interviews data was compared and contrasted. Information from discussions of similar themes was related to the topic, issue, problem and phenomenon. Here, a voice was given to minority opinions should these develop in the context of dialogue [deviant case analysis/outlier/exceptions]. A myriad of data analysis techniques such as condensation of data, identification of significant text through further review, recording of emerging themes, and grouping of themes was employed thus providing credibility to the issue under consideration.

During the interviews, participants were asked two broad, general questions relating to: 1) what they have experienced in terms of the phenomenon and 2) what events or situations had influenced their experiences of the phenomenon (Creswell, 2007; Moustakas, 1994). Each interview transcript was read and significant responses noted. These included responses that provided an understanding of how each participant experienced the phenomenon (Creswell, 2007).

Themes that emerge by synthesizing information from these significant statements were then identified (Creswell, 2007; Moustakas, 1994). These themes are what I used to create a description of what participants experienced and how they experienced it in terms of context and situation (Creswell, 2007). The identified themes were grouped according to specific experiences, difficulties and or challenges. A summary of the essence of the phenomenon was then documented, using the common experiences of participants (Creswell, 2007), in order for the essence of the phenomenon to be appreciated by others (Polkinghorne, 1989).

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3.2.1.5 Themes and Sub Themes

Focus group discussions yielded four major themes and 13 sub-themes that are listed below. This presentation of the themes and sub themes outlined in table 3 below is not in ranking order and will be presented alongside quantitative data in the subsequent chapters.

Table 3 Themes and Sub-themes for Focus Group Discussion

Theme	Sub-Themes
A. Importance of workplace response	1 Low priority of workplace response 2 Higher risk ascribed to males 3 Differing responses across enterprises 4 Tokenistic nature of HIV programmes
B. Personal Inadequacy	1. Unspecified mode of selection 2. Exaggerated perception of Focal Persons' personal risk 3. Low level/ Non-regularized training for focal points; 4. High Level of frustration at the execution of work;
C. Inadequate Management Support and Response:	1. Unspecified/ lack of formalization of job specification 2. Low level of funds allocated to HIV
D. Dwindling interest	1. Low level of management participation in programmes 2. low risk perception of management 3. Apathy in worker/management response

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Analysis of Focus Group and key informant interviews data was mainly undertaken manually and in a limited manner by NVivo to obtain the codes and nodes. Data gleaned was compared and contrasted. Information from discussions of similar themes was related to the topic, issue, problem and phenomenon. Here, a voice was given to minority opinions should these develop in the context of dialogue [deviant case analysis/outlier/exceptions].

To conclude, the qualitative aspect was to be based on a description of experiences of eleven key informants and 40 enterprise based employees. The enterprises, representing a convenience sample, were researched in 2013. A total of some 11 in-depth interviews were conducted. Interviewees ranged from shop floor workers to senior managers. Self-identified focal persons and health professionals attached to the companies who were the company focal persons were also interviewed. In all cases, informed consent was obtained from the participants who were, in turn, assured of anonymity. Enterprise access was ensured by engaging the enterprise leadership at the highest level. The acquiesced because they had been assured that, they would receive feedback on the study.

It is also noted here that the companies that participated maintained that they wanted anonymity; thus, the study, in cognizance of that desire, has kept out the names of these companies. Data generated from the field has been used to draw comprehensive summaries on the phenomenon of the HIV focal person.

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3.3 Quantitative Methodological Approach

The use of Supervised Surveys (SS) was the main research method employed for the quantitative aspect in that, the supervised survey is an analytical process that quantifies insights and conclusions. (Patton, 2002). Based on research questions and objectives, supervised interviews were conducted through the administration of a coded structured questionnaire which was distributed among a pre-determined number of workers calculated using the Cochrane's Formula (Chadwick, 2001). A close ended coded questionnaire was the main instrument used to map out HIV Service delivery practices of HIV Focal persons in quantifiable non descriptive information outlay.

3.3.1 Study Variables

The contextual relationship between the HIV focal person dependent aspects, defined by workplace HIV services, namely: HIV and AIDS Education, HIV Testing and Counselling, STI Management and Referrals, Treatment, Psychosocial Support, Peer Education, Condom Distribution, HIV Policy and knowledge of content and Sources of HIV Information are the variables for the study. As this study was a non-experimental study, the variables are defined by the perceived cause or predictor and its resultant outcomes.

3.3.1.1 Independent or Predictor Variable

The conceptual framework outlines how the focal person related aspects impinge on performance of the focal person. Here, presence of the focal person is perceived as the

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predictor or cause of HIV service delivery and thus for the purposes of this study will be referred to as the predictor variable. This variable is further also predicated on the job description and or job specification of the focal person, that is, the parameter surrounding the workplace HIV related assignment of the focal person. It is expected that their job specification viz, their educational background, the competencies they have, training on the job etc., that is specific to HIV, can be translated to mean that they have been officially assigned the post. This is expected also to be reflected in their appointment letters or contracts as the case may be. Though this ideally should be the case, when staff self-reported that they were focal persons by means other than by designation and recruitment process they were still counted as focal persons.

3.3.1.2 Outcome or dependent Variable

The outcome study variables are the variables that can vary based on the predictor effect. It is akin to the dependent variable in experimental studies. In a non-experimental study as this one, the perceived 'cause' or influence of focal person activities will result in the 'outcome' or 'effect' of HIV services experience by the workforce in-situ. These are the HIV services as defined in the conceptual framework. They comprise HIV and AIDS education and training; testing and counselling; sexually transmitted infection (STI) management and referrals; anti-retroviral treatment and referral as well as management of opportunistic infections; psychosocial support, care and support facilities; peer education and awareness creation; condom distribution and promotion; presence of an HIV committee; presence of an HIV policy; information education and communication (IEC)

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and or behaviour change communication (BCC) materials distribution and provision of nutritional support. The entire above mentioned listed are the outcome variables.

3.3.2 Study Techniques

The study was a quantitative study backed by qualitative data and therefore basically designed to obtain the bulk of the data from the survey. For the quantitative aspect 428 structured closed ended questionnaires were administered to workers. This was achieved due to the fact that surveys were supervised and undertaken at the leisure of respondents such as during lunch break, closing time or in small groups where possible. This was very effective to the extent that there was no 'non-return' of questionnaires. The number of enterprises visited for the quantitative aspect were twenty two in all.

In all, 428 workers participated in the quantitative aspect that utilized detailed questionnaires with close-ended questions which were distributed to a predetermined number of workers, the numbers of which were determined scientifically using the Cochrane's formula. The questions were typically multiple choice and participants chose the most appropriate response among those listed for each question. As with all quantitative research, a huge amount of data was collected. This is important if results are to be generalized to a larger population and to allow for direct comparisons between two or more groups. It also provides a great deal of flexibility in analyzing the results.

Questionnaires were provided to the participants to gather information on the use of HIV Focal person in the workplace. The final goal of this research is to reveal the systematic

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structure, invariance or otherwise of the role of the focal person in relation to the service they provide or are expected to provide at the workplace in relation to HIV and to ascertain the generalizability of the findings. Here the credibility, or statistical significance of the findings; whether the invariance found that is, patterns which do not vary from case to case is true even outside the population, is what the quantitative aspect will not cover.

3.3.3 Sample Size Determination for Quantitative Aspect

Sample size is one of the four inter-related features of a study design that can influence the detection of significant differences, relationships or interactions (Peers, 1996). Generally, these survey designs try to minimize both alpha error: finding a difference that does not actually exist in the population; and beta error: failing to find a difference that actually exists in the population (Peers, 1996).

For the purposes of this study, data to address problem statements: Does the presence of a designated (job description and specification) focal person impact on the delivery (type and number) of HIV services offered at the workplace?; Does HIV explicit job specification: education, training, years of experience) of the focal person influence the effectiveness, that is, quality of HIV services at the workplace was collected.

Here, the outcome variables: 1) Standards in HIV Services, that is, presence of an HIV Committee; availability of Full-time/part-time HIV Focal person; HIV Policy; provision of HIV Workplace Services; 2) Delivery: number of and type of services and 3) Quality of HIV Workplace Services; were measured against the independent variable

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performance of a designated Focal person. Questions were framed to unearth the relationship between the presence of the focal person and the level and quality of HIV services at the workplace.. To assess veracity, it was important to sample also from enterprises without focal persons to ascertain whether or not the presence of a focal person made any difference at all.

A total of four hundred and nine (409) Enterprises were registered with the Ghana Employers Association, of which three hundred and seventy-four (374) are located in Accra and Tema Metropolitan areas. Of the 374, a total of 42 have HIV Focal persons and the remaining 332 do not have HIV Focal persons. There was the difficulty of getting the list of all staff from the enterprises on the GEA Membership; the GEA is not privy to the staff lists – one had to assume a large membership based on the UNIDO definition of large enterprises $\geq$ 100. To this end, the 409 enterprises yielded an estimated number of 40,900 staff. As sampling all workers was beyond the budget and time allocation for this research therefore, Cochrane's sample size formula was used to determine the number of workers to be sampled in participating enterprises.

For populations that are large, Cochrane (1977) developed the Equation below to yield a representative sample for proportions as shown below:

$$n_0 = Z^2pq/e^2$$

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Which is valid where n_0 is the sample size, Z^2 is the abscissa of the normal curve that cuts off an area α at the tails (1 - α equals the desired confidence level, e.g., 95%), e is the desired level of precision, p is the estimated proportion of an attribute that is present in the population, and q is 1-p. The value for Z is found in statistical tables which contain the area under the normal curve.

Thus, assuming a large population of unknown variability in the proportion that has quality HIV Service delivery, the following is assumed according to Cochrane' formula for proportions:

p=.5 (maximum variability)

95% confidence level

And ±5% precision

The resulting sample size becomes:

$$N_o = \frac{Z^2pq}{e^2} = \frac{(1.96)^2(0.5)\ (0.5)}{(0.05)} = 385$$

To this end, a total of 385 workers were randomly selected and administered a questionnaire. Anticipating a return rate of 90% (as questionnaires were largely not self-administered), the following Cochrane's formula for adjustment was used:

N_2 = nmin/anticipated response rate

$$\mathbf{N_2 = N_o/R}$$

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Where anticipated return rate R= 90%.

Where N_2 = sample size adjusted for response rate.

Where N_o = Minimum sample size = 385

Therefore:

$$N_2 = 385/0.9 = 428$$

To begin the sampling, the enterprises were classified into two strata defined by whether or not they had HIV focal persons. To ensure adequate numbers of completed staff interviews which would provide estimates for key indicators with acceptable precision in enterprises with focal persons, a disproportionate sampling technique was employed to sample respondents from each stratum.

This method was employed because in disproportionate stratified sampling, the sizes of different groups varied and did not represent the percentage of the any particular group within the larger population (as is the case in this study). Enterprises with focal persons have an estimated population of 500 and those without focal persons 3700. Disproportionate sampling is most appropriate where one or more of the subgroups is very small in comparison to other groups, or where the target of the study is specific and oversampling of a group may provide more accurate results. (Disproportionate-Stratified-Sampling,html)

To achieve this, sample points are awarded to each stratum to assure accuracy in the study. Points assigned to each group are the inverse of the sampling fraction. Based on

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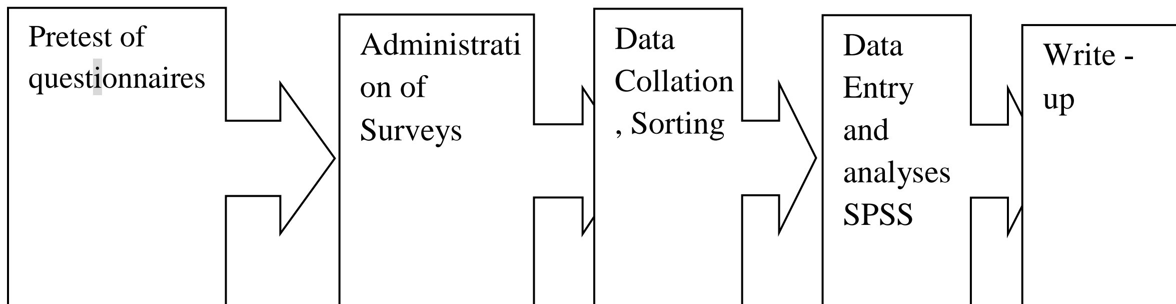
this principle of disproportionate sampling, an equal number of respondents was assigned to each stratum to achieve a sampling fraction as follows:

Enterprises with focal person	=	214/500 = 0.43
Enterprises without Focal persons	=	214/3700 = 0.06

The points assigned to each group are the inverse of the fraction in this case or 2 points for enterprises with focal persons and 16 points for enterprises without. All staff that met the inclusion/exclusion criteria were interviewed.

Figure 5 **Data Collection Progression - Quantitative**



3.3.4 Data Analysis - Quantitative Aspect

The Statistical Package for the Social Sciences (SPSS) version 16 was used for the analysis. Tables, percentages and frequencies were used to display data obtained. A

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binary logistic regression statistical tool was employed on the focal person related factors (presence and absence of focal person at the enterprise level) against outcome variables. Two categorical independent variables were considered. The categorical variables were presence of an HIV focal person or absence of an HIV focal person. The dependent variables considered are HIV policy content knowledge on discrimination, mandatory testing, medical confidentiality, universal precautions and access to education. Also, sources of HIV information were considered to ascertain whether, the significance of association between the knowledge of the worker and the presence of the focal point was not due to chance or external information (e.g. education gained through media, family and friends or health worker outside the workplace.). Binary Logistic Regression (Standard) was used for all the parameters. The Wald Test was used to test the statistical significance of the parameters in the model. Though several authors (Agresti, 1996; Menard, 1995; Trexler & Travis, 1993) have identified problems with the use of the Wald statistic, they concede that for larger sample sizes approximating 500, the Wald statistic (chi-square) value is suitable whilst the likelihood-ratio test is more reliable for small sample sizes

Cross tabulations were also done using the Pearson's Chi Square and Crammer's V test (Cohen, 1992). The value of ö or Crammer's V is explained as follows:

0.00 And under 0.10 there is Negligible association

0.10 And under 0.20 there is Weak association

0.20 And under 0.40 there is Moderate association

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0.40 And under 0.60 there is relatively strong association

0.60 And under 0.80 there is strong association

0.80 To 1.00 there is very strong associations

The Crammer's V was chosen as the statistic of choice as the dependent variables are discrete and not continuous. The Crammer's V was further utilized to test the strength of association if any. The conventions for describing the magnitude of association in contingency tables as shown above was used (Rea & Parker, 1997).

3.4 Ethical Considerations

Ethical consideration revolves around the need for researchers to have respect and consideration for people participating in research. In this context, it requires that the participant is made fully aware of the scope of the research as well as the purposes for which it would be used. The participant is to be given the full explanation of the study or research in a language that they can understand thus engendering adequate understanding of both the proposed research and the implications of participation in the research. It therefore means that participation is by informed consent, i.e. by a choice made by participants and not by coercion or pressure. This consent may be a formal written document that may be vetted by a board depending on the requirements of the codes, laws, ethics and cultural sensitivities of the community in which the research is to be conducted. In other cases it may be oral, depending on the nature and sensitivity of the study.

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Consent may be expressed orally, in writing or by some other means such as a consent being implied on the return of a survey. As much as giving consent is voluntary, when culturally acceptable, appropriate and feasible participants taking part in a research may be reimbursed for certain costs related to the research, including costs such as refreshment, travel and accommodation as the case maybe. In rare cases, a participant may be compensated for time lost from work. However, payment that is disproportionate to the time lost from work lowers their risk perception and is likely to push or coerce participants into participating. This is therefore ethically unacceptable.

In the case of children and young people below the age of consent, people highly dependent on medical care, people with an intellectual disability or a mental illness, a person or appropriate statutory body exercising lawful authority for the potential participant should stand as proxy for the participant. When a study or research involves communities, decisions about participation in research may involve interested parties such as formally constituted bodies, institutions, families or community elders. In all this, respect for human beings is the centre for ethical considerations.

For the purposes of this research, ethical approval was obtained from the Ghana Health Services' Ethical Review Committee. Participation in the study was covered by written informed consent using the template in Annex 1. Key Informant Interview Guide, Focus group discussion guide and Survey Instrument are detailed in Annexes 2, 3 and 4 respectively.

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3.5 Delimitations

Delimitations imposed to narrow the focus of this study included:

1. This study was limited to focal persons as a group and did not disaggregate for occupational backgrounds, or competence e.g. between those that felt competent to provide service (health workers) and those who did not (HR, and Administrative staff). Results were a combination of all types of focal persons.
2. It was limited by the inability to review employment records, obligating the use of self-reported and enterprise assigned focal persons.
3. Study was restricted to one region due to limitation of funding and time

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CHAPTER FOUR RESULTS

4.1 Introduction

This chapter presents the results. It draws from the initial research questions and is written up in five sections as follows: Evidence of a standard criterion for selection of an HIV Focal person; The focal person and their perception of their capacity to provide HIV Services at the workplace; The link between the presence of the focal person on the type and number of HIV services offered at the workplace; The influence of the HIV and AIDS Focal person on HIV responsive behaviour among the workforce.

The last section of this chapter presents the summary of findings. The findings from both qualitative and quantitative data sets are presented simultaneously.

4.1.2 Background Characteristics

A total of 428 workers were surveyed in two groupings of enterprises classified by the status of whether or not there was a focal person actively present on site facilitating the delivery of HIV and AID services. The status of each enterprise grouping described by the acronyms FPP and FPA meaning: 'With Focal Person' and 'Without Focal Person' respectively. The total number of respondents in each group was 214.

4.1.2.1 Distribution by Gender, Marital Status, Educational Level and Occupation

Table 4 presents the results of the background characteristics of respondents by gender, marital status, educational background, and occupation.

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Table 4 - Distribution by Gender, Marital Status, Education and Occupation by Enterprise Status*

VARIABLES	FPP N=214 Frequency	(%)	FPA N=214 Frequency	%
Gender				
Male	118	(55.1)	150	(70)
Female	96	(44.9)	64	(30)
Marital Status				
Married	83	(85.5)	125	(58.4)
Cohabiting	0	(0)	39	(18.2)
Single	31	(14.5)	50	(23.4)
Education				
JHS	9	((4.2)	28	(13.1)
SHS	98	(45.5)	121	(56.5)
Tertiary **X^2_3 =5.1, p<0.163**	1071	(50.3)	65	(30.4)
Occupational Level				
Jnr Staff	84	(39.2)	134	(61.2)
Senior Staff	130	(60.8)	83	(38.2)

***Enterprise Status**: Focal Person Present **(FPP)** and Focal Person Absent **(FPA). Cohabitation**: where two individuals live together in a sexual union without being legally or traditionally married.

Note is being made of here that, the data is not disaggregated by specific age brackets. As what was of interest to this study was whether or not the respondent fell within the

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stipulated legally approved working age bracket of 18 – 60 years. All respondents were within the nationally stipulated official working age.

Out of a total of 214 respondents in FPP enterprises, 118 representing 55.1% were male while 96, representing 44.9% were female (table 4). On the same table, FPA enterprises had 150 respondents representing 70% being male; while 64 representing 30% were female. The sex distribution ratio of the workers that participated in the survey was (100:55) men to women which is not at par with national statistics of (95:100) men to women (Census Report, 2010) suggesting some form of inequity in recruitment at the workplace.

In enterprises with focal persons, there were only two main kinds of marital statuses reported, these were being married or single out of the three types surveyed (table 4). Majority of respondents reported being married (85.54%). However, in enterprises without focal persons (FPA), close to three out of five (58.4%) were married. The results show that respondents from enterprises that had no focal persons were more likely to be in cohabitation as compared respondents in enterprises with focal persons (Table 4).

4.1.2.2 Distribution by Job Description, Specification and Years of Work

Table 5 displays results of demographic characteristics by job description, job specification and years of work in enterprise.

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Table 5 - Distribution by Job Description, Specification and Years of Work by Enterprise Status*

VARIABLES	FPP Frequency	FPP %	FPA Frequency	FPA %
Job Description (Title)				
Focal Person	2	1	0	0%
Focal Point	2	1	0	0%
Peer Educator	11	5	0	0%
HIV Committee member	2	1	0	0%
Other	197	92	214	100%
Job Specification				
HR/Admin	149	69.6	107	50
Technical	36	17.8	54	25
Training	29	13.6	53	25
Years at Work				
6 to 12 months	5	2.3	15	7
1 to 2 years	68	31.8	50	23
>2years	141	65.9	149	70

***Enterprise Status**: Focal Person **Present (FPP)** and Focal **Absent (FPA)**

Both types of enterprises, FPP and FPA reported at least a third of staff having tertiary education, 50.5% and 30.4% respectively. All occupational categories (Administrative: secretaries, human resource assistants, finance and accounts; Services: security, cleaning, catering, estate and gardens; Information technology (IT); Technical: sociologists, economists, engineers, pharmacists, doctors; Management: managing directors, human

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resource managers, chief executives and heads of departments) were represented among the respondents in both enterprise groups.

Very few respondents across groups had worked in their respective enterprises for a duration of less than 12 months. Enterprises with FPP reported 2.3% having worked between 6 to 12 months while enterprises with FPA reported an equally small percentage of 7.0%. A larger majority of respondents had been at work within their enterprises for more than 2 years, with FPP enterprises reporting 65.9% whilst FPA enterprises reported a similar percentage of 69.6%. Hence, with respect to duration of employment at their respective enterprises, there was similarity across groups.

Although qualitative data revealed some HIV activity in enterprises without focal persons, no respondents from enterprises without focal persons reported a staff member designated to undertake that role under any of the probable names given in Table 5. A respondent from a FPA enterprise reported some HIV activity:

> *In 2010, we had a blood donation exercise. In the mandatory screening exercise before donation, it was found that three of our workers had tested positive. Tension rose as to whether they should be sacked or not as we do not have an HIV policy; also my organization had a policy not to insure HIV infected persons but when anti-retroviral drugs were introduced, that policy was changed. (**Male FGD, FPP)***

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This policy change reported was not aimed at staff. Mention was made of HIV at the workplace because of a blood donation exercise.

Even in enterprises purported to have focal persons, very few were aware of staff designated as focal persons. A cumulative total of only 8% knew of any staff member tagged with an HIV related title (being: focal person (1%); focal point (1%); peer educator (5%); HIV committee member (1%) and other titles e.g. nurse, doctor etc. (92%). Job specifications of respondents were homogeneous across groups.

4.2 Selection of Focal Persons

Table 6 presents results from enterprises with focal persons only as there were no responses from the FPA enterprises.

Table 6 Focal Persons' Selection* Process [N=214]

Variable		Frequency	Percent
Reason for Selection			
	Government/Enterprise Policy	4	2
	Don't Know	140	65
	Other	70	33
Selection Procedure			
	Internal advert	4	2
	Appointment by Management	78	36
	Don't Know	132	62
Designation of position			
	Focal Person	2	1
	Peer Educator	11	5
	HIV Committee member	2	1
	Other	196	92

*There were no responses for enterprises without focal persons

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Survey results show that, while 2% of respondents attributed focal persons' selection to a directive from government policy, a large majority of 65% did not know the reasons for which focal persons were selected. Of the remaining 33%, a myriad of unrelated reasons were given which qualitative results explain. A male key informant narrated:

> *Our appointments were by nomination and, for me, it was based on my good communicative ability.* ***(KI Male, FPP)***

Other reasons given by a female participant in a focus group discussion threw further light on the selection process of the FP-:

> *A committee was set up to find out how best HIV and AIDS can be addressed within the education sector and,* ***I think,*** *based on their recommendations, the HIV and AIDS secretariat was established in 2002, mandated to coordinate HIV and AIDS ..... It was a new thing ....that was in 2002. So from there, focal persons were nominated. To mainstream HIV AIDS in their agency's work* ***(Female FGD, FPP)***

Further explanation on -other reasons- for appointment were by default as they were health workers. This is narrated by one male participant during a focus group discussion:

> *My company's key focal person is a pharmacist and he trains other subordinate focal persons at the clinic* ***(FGD Male, FPP)***

The most frequent reason for what determines selection of focal persons was 'management decision' which accounted for 36% of respondents' response. Also only

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2% reported an open competitive method using an internal advert process as a means of selection. Majority (64 %,) reported that they did not know how the selection of focal persons were made.

In table 6, an equally small percentage (2%) of the respondents alluded to knowing of a staff member that had designated solely as a full-time HIV focal person. There was only one such instance narrated by a female participant from a public sector enterprise who said:

> *The HIV and AIDS secretariat was established in 2002 .....It was a new thing so they took a consultant; she started it with two officers; myself and another officer she wrote to all the agencies of the Ministry to nominate focal person.* ***(KII, Female, FPP)***

Even so it can be seen that this person was not a staff member but a consultant:

> *As I said she was a consultant taken on board to kick-start the process of providing HIV workplace services on site*. (FGD, Female, FPP)

A key emergent theme related to the selection process was that of 'Consensus on the Importance of Workplace Programmes'. It was seen that enterprises that viewed HIV issues as important designated staff as HIV focal persons, however, their mode of selection was not found to be homogeneous across the different groups (FPP and FPA) of enterprises.

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4.2.2 Importance of Workplace Programmes

What determines the selection of focal persons was found to be proportionate to the importance management placed on workplace programmes. As an emergent theme 'importance linked to management decision' was the most reported by respondents as a likely reason for selecting focal persons. An important point related by one male key informant on this theme is as follows:

> *I think my management sees HIV as a threat because of the fact that we have focal person and a policy and the policy has certain aspects that when one is tested positive, they can take advantage of what is stated in it, so with that I think management sees it as a threat* ***(Male KI, FPP)***

> *For me, I don't think that we should even be thinking about being tired of HIV work because the lifestyle still continues so the condom distribution must still be on going, education should still be ongoing, because people would still be behaving in a certain fashion. If we give up, they would still go back to the way that they used to live but if it is still constant, embarked with sustenance, and then they are forever aware* **(KI, Female, FPP)**

> *People are going on retirement and new people are being recruited, its human nature, so long as these behaviours are there, you can't say that you would relent because you have done enough. You must be consistent (FGD* ***Male, FPP)***

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The results presented in Table 7 show significant differences between FPP and FPA enterprises with regards to what level of importance is ascribed to workplace service delivery.

Table 7 **Importance of Workplace Service delivery by Enterprise Status***

	FPP		FPA		Chi-	
Variable	**N**	**%**	**N**	**%**	**square**	**P<-value**
It is Important	142	66.4	108	50.5	49	0.001
Know Reasons	206	96.3	49	22.9	242	0.001
Have HIV Policy	139	65	-	-	224	0.001

*Enterprise Status: Focal Person Presence **(FPP)** and Focal Person Absence **(FPA);**

The Importance placed on HIV programmes was significantly higher in enterprises with focal persons, with 66.4% of respondents reporting that workplace programmes were important as compared to about half (50.5%) agreeing to its importance in enterprises with FPA.

Whereas 96.3% (n=206) respondents reported knowing the reason for its importance, only 22.9% (n=49) respondents from FPA enterprises claimed knowledge of importance of work place programmes and services. None of the respondents from FPA enterprises reported any knowledge of HIV workplace policies in comparison with 65%or

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respondents from FPP enterprises reporting availability of enterprise level HIV policy documents.

Supporting this is data from focus group discussions and key informant interviews confirming that the issue of HIV was important to the workplace for reasons of company interest:

> *We all know that HIV AIDS is a threat to organizations and is a public health crisis now. With our company we actually deal with people. We produce and sell to people so if HIV AIDS rise up; the employees are affected in a way. ....That is why we are taking so much time to be concerned* (***FGD*** **Male, FPP)**

There was further unanimous assertion that bringing HIV services to the door steps of the workforce through workplace HIV service delivery was equally important. A male participant in a focus group discussion summed the various views as:

> *This (HIV) was recognized 20 years ago and upon instruction from the head office, structures were put in place to have a full workplace program led by the human resource director supported by the focal point and Peer educator (**FGD Male, FPP)***

Notwithstanding the purported importance, there were discrepancies as to the mode the workplace service delivery should take, whom it should cover and who would lead the process. Statements below demonstrate the different levels of activities linked to the importance attributed to HIV programmes and services as per some participants of focus group discussions:

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> *We all know that HIV AIDS is a threat to organizations and is a public health crisis now. With our company, we actually deal with people. We produce and sell to people so if HIV AIDS rise up; the employees are affected in a way. ....That is why we are taking so much time to be concerned about spending money and attending workshops, signing on to policies and those things. (**FGD*** **Male, FPP)**

For others, it is a fully fledged secretariat and yet for others it comprises sensitization.

> *At the management level, initially, we didn't have HIV AIDS secretariat, now they have established a whole secretariat to coordinate HIV and AIDS activities. So this is how it affects the Ministry of Education and indeed for Ministry of Education, we recognize that it is a big threat to the sector (**FGD Female, FPP)***

Even in an enterprise without a focal person, provision of HIV services was seen as an important activity and some form of strategy was undertaken there. This is reflected by a male participant in the ensuing quote:

> *People were not interested in HIV at first but after the blood donation exercise awareness was created. When some staff tested positive. Management championed sensitization of the workers on HIV. So far, inputs such as creation of a workplace policy on non-discrimination against colleagues who have the virus is what stands out above all others. **(Male FGD, FPA)***

Though the workplace was seen by participants in both focus group discussion and key informant interviews as an important avenue for accessing HIV services, they also saw it

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as a platform for sexual networking and consequent exposure and risk of acquiring HIV. This risk was also reported as pertaining to more males than females. The following narratives by participants from three different focus group discussions represent this position clearly:

> *In my opinion, high level executives (mostly males) faced much threat. Because in my organization, retreats are organized for such executives in -hide out- hotels were, mutual relations are formed which goes beyond office work and this leads to most indulging in risky behaviours, exposing them to the virus.* (***Female FGD, FPP***)

> *We have an environment that we are dealing with transit trade. So we have truckers (males) coming in from the landlocked countries like Burkina, Mali and Niger; we have some along the corridor; as in, from Togo and Cote d'Ivoire without really having their families with them they tend to engage in sexual activities as and when they go along whichever path and so, they are predisposed to HIV.* (***Male FGD, FPP***)

> *For staff, I was talking mainly about the male staff; the Dockers, those in the operational areas. Because of the nature of the cash flows, there's a high risk.* (***FGD Male, FPP***)

Emergent sub themes around the broader theme of 'importance of workplace HIV service delivery' were the inherent challenges in the operational issues surrounding the service delivery. These operational issues that emerged were summed under the sub-themes a) unspecified mode of selection of focal persons; b) differing HIV services across

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enterprises and higher risk ascribed to males and c) the tokenistic nature of HIV programmes.

4.2.2.1 Unspecified Mode of Selection of Focal Persons

Also embedded in the issue of importance was the subtheme of the lack of specification in the focal person's appointment. Participants in focus group discussions and key informants, though appreciative of the importance of workplace programmes, felt that the focal person selection process was haphazard and too subjective, even to the extent of bordering on the whims of management. Quotations summing up findings surrounding these operational issues of selection are:

> *Our appointments were by nomination and for me it was based on my ability to communicate. (**KI Male, FPP**)*

> *A committee was set up to find out how best HIV and AIDS can be addressed within the education sector and **I think** (emphasis mine) based on their recommendations, the HIV and AIDS secretariat was established in 2002, mandated to coordinate HIV and AIDS ..... It was a new thing ....that was in 2002. So from there, focal persons were nominated. To mainstream HIV AIDS in their agency's work. (**Female FGD, FPP**)*

Focal persons' appointment and selection was not backed by any formalized job specification. At enterprise level, focal persons were from different disciplines which ranged from human resource managers through firemen to different categories of health

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workers such as pharmacists and medical doctors. Lack of formalization of job specification was re-counted by one male FGD participant as follows:

> *My company's key focal person is a pharmacist and he trains other subordinate focal persons at the clinic. We do not have peer educators at the workplace. These subordinate focal persons help with consultations but not necessarily for employees per say. It is more of facility based thus those who come by the clinic get to enjoy VCT services and this is our form of workplace policy.* ***(FGD, Male, FPP)***

> *Our company has an HIV programme led by the Human Resource director who has nominated peer educators based on their ability to communicate.* ***(KII, Male, FPP)***

4.2.2.3 Tokenistic Nature of HIV Programmes

Activities that comprised HIV service delivery differed from enterprise to enterprise. For some enterprises, having an HIV policy only counted for a workplace programme, though they conceded the inadequacy of it. For others, HIV work was mainstreamed into the day to day structures but in most cases, it was ad-hoc in nature.

> *Cocoa still plays a very pivotal role in the economy, to the extent that we have about 700000 farmers engaged in cocoa production in six out of the ten regions in the country; HIV AIDS is really a menace particularly, because you are coming into direct contact with these people who may also be engaged in other activities*

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which expose them to the threat.....and that is why it is important for us to make them ***aware about the threat of HIV IDS,*** *because even if one person is affected it's a threat to the organization.* ***(Male FGD, FPP)***

Though there is a policy available, it is not working. No encouragement to access policy or encourage staff to get tested on their own. ***(Male FGD, FPA)***

There is policy on paper and those who are interested in knowing about it go for it to educate themselves. ***(Female FGD, FPP)***

A female participant of a FGD recalled how HIV was instituted in her enterprise. The assignment for the focal person was that of mainstreaming.

A committee was set up to find out how best HIV and AIDS can be addressed within the education sector and I think based on their recommendations, the HIV and AIDS secretariat was established in 2002, mandated to coordinate HIV and AIDS ..... It was a new thing ....that was in 2002. So from there, focal persons were nominated ***to mainstream*** *(emphasis mine) HIV AIDS in their agency's work. (****Female FGD, FPP)***

For a male FGD participant, the assignment of the focal person was describes as attending workshops, signing policies and -those things- reflecting that there was no clear cut or fixed agenda for the FP.

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That is why we are taking so much time to be concerned about spending money and attending workshops, signing on to policies, having focal persons and peer educators ***and those things****. That is what I can say for now. (Male* ***FGD, FPP)***

In addition to the above, for other participants, HIV services at the workplace extended to other parties outside of the workplace. It actually was not a bonafide programme as it formed part of the day to day activities of the focal person at their company's clinic. A male focus group participants reported the following:

We ***do not have peer educators at the workplace****, our programmes is more of facility based thus those who come by the clinic get to enjoy VCT services and this is our form of workplace policy, it is* ***not necessarily for employees*** *per say.* ***(Male FGD, FPP)***

These findings show that enterprises are likely to portray themselves as having an HIV programme as long as any activity that can be linked to the work place on HIV and AIDS is reported.

4.3 Focal Person Capacity Issues

As much as focal persons and participants of focus group discussion and key informant interviews reiterated the importance of workplace programmes and its attendant services, they reported an inherent lack of capacity. Their primary concern was with process of selection.

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Respondents generally reported a lack of formal job specification and description for focal persons. Focal persons could be a staff of the enterprise or not. In one instance the focal person was a consultant:

> *The HIV and AIDS secretariat was a new thing so they took a consultant; she started it with two officers; myself and another officer she wrote to all the agencies of the Ministry to nominate focal persons.* ***(KI Female, FPP)***

Workplace policies (national or enterprise based) which had been inspected as part of desk review, were used by focal persons as proxy for their job description. Focal persons assumed roles that were specified therein. Self-identified focal persons reported that their assignments were not supported by formal documented job specifications, it neither formed part of their appraisals and job descriptions nor intimated the inclusion of it as assignments in their respective confidential staff files. This opinion is summed up thus:

> *People concentrate more on work to be done than HIV matters. The problem is that, evaluation of workers does not make room for extra curricula activities, thus people don't want to allocate working period to it.* ***(Female FGD, FPP)***

Due to the confidential nature of personnel files, they were not made available for inspection. Consequently, this information could not be verified.

In describing their current job specification in focus group discussions and key informant interviews, none of the respondents reported being formally recruited as HIV focal

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person. The subjective importance of workplace programmes reflects the selection process of FP. Qualitative data supported the quantitative findings as follows:

> *Our appointments were by nomination and for me it was based on my ability to communicate (KI* ***Male, FPP)***

Others were seconded to the position by their Human Resource Department just because they were health workers.

> *It was at the clinic and as I am the company doctor, I lead the response.* ***(Male, KI, FPP)***

> *Peer educators are selected from various groups such as among drivers, secretaries, administration etc. so that each one will be more comfortable within its own group. The staff feels comfortable and at ease to discuss HIV and services for it. (Female* ***FGD, FPP)***

Key informant interviews revealed that some focal persons were assigned by virtue of their occupations. In the instance where a staff member was a health worker, he/she would be assigned the responsibility of focal person. Examples of such were focal persons who reported being: a pharmacist; a nurse or a doctor in their respective enterprises who worked in the enterprise clinics. The remainder who were not health workers were also assigned unofficially.

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The use of the title focal person or point was used by respondents that answered in the affirmative to the question of title. They either identified themselves as focal persons or focal points. This was interchangeably used as evidenced by the following narrative:

> *So from there, focal persons were nominated. She wrote to all the agencies of the Ministry to nominate focal points in the various agencies and then these focal persons were trained; given the capacity to mainstream HIV AIDS in their agency work.* ***(Female, KI, FPP)***

With regards to assignments or job descriptions, respondents or key informants stated a uniform level of activity at the enterprise levels though these assignments were not formally communicated to them and do not form part of their appraisals. The case of job specification, findings did not reveal any uniformity. The educational backgrounds ranged from graduate to postgraduate degrees with three being health personnel; a registered nurse, a pharmacist and a medical doctor respectively. There were almost as many professions as were key informants. In total, there were a few HR Managers, a medical doctor, a nurse, a pharmacist, an administrator, an educationist, a fireman ; an actuarial scientist, development worker and insurance men. There was nonetheless gender parity.

With the exception of focal persons that were health-workers, focal persons reported low capacity to undertake their work. This was attributed to lack of continuous education and/or formal education. Table 9 displays survey results on capacity.

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Table 8 HIV/AIDS Education in Enterprises by Status* N=214

Variables	FPP		FPA		Chi Square
	n	**%**	**n**	**%**	
Capacity to provide HIV Services					
Have capacity	143	66.8	-	-	$\chi^2_3 = 234$,
Don't Have capacity	71	33.2	154	72.0	$p<0.000$
Don't know	-	-	41	19.1	
No Response	-	-	19	8.9	
HIV education in past 6 months					
Had education	55	25.7	-	-	$\chi^2_2 = 115$,
Did not have education	159	74.3	154	72.0	$p<0.001$
Don't know	-	-	60	28.0	

*Enterprise Status: Focal Person Presence (FPP); Without Focal Person Absence (FPA)

The overall percentage of workers that reported having received HIV education in the last 6 months (25.7%) were from enterprises with FPP (Table 9). None reported of having had any HIV related education in enterprises with FPA. Though 66.8% of respondents in FPP enterprises reported that their focal persons had the capacity to provide services, a large majority (74%) had not been provided any HIV education within the same period. None of the respondents from enterprises without focal points had had any education at all.

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4.3.1 Focal Persons' Inadequacy

In FPP enterprises, operational structures that supported workplace service delivery reported included: the position of focal person; peer educator networks; HIV committees and other structures which were not unpacked during data collection. Table 10 below displays work place structures. Responses were not received for FPA enterprises.

Table 9 Available Workplace Structures in FPP Enterprises

Variable	[N=214] Frequency*	(%)*
Focal Person	198	(92.5)
Peer Educators	64	(29.9)
HIV Committee	76	(35.5)
Other	4	(1.9)

*Multiple Response therefore total number > 214 and percent ≠100%

It is seen here that while focal persons were well known (92.5%), much less was known about peer educators (29.9%) or HIV committees (35.5%). Findings reveal that these supportive structures for the focal persons were largely not known. The activities of these support systems were not well known. The focus group discussions and key informant interviews revealed that focal person' feelings of inadequacy expressed revolved around: inadequate technical knowledge on health related aspects; lack of supporting structures and low management support and funding.

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> *I feel inadequate. When people ask me technical questions about the disease, I am unable to handle it as I am not a health worker. I have to refer them to a nurse and so they feel their confidentiality is at stake.* ***(Female FGD, FPP)***

> *I don't know very much but . . . We look at this issue from the perspective of the nature of the business that we are into... as I said we normally travel with some of these PL HIV and those are people who are actually infected. There could be accidents, and whilst there is an accident, you know what would happen, so most of the threat that we face as I said is our regular engagement with these guys and also in our line of work.* ***(Male FGD, FPP)***

With regards to feelings of Personal Inadequacy, the emergent sub themes were a) exaggerated perception of focal persons' personal risk, b) Low level of funds allocated to HIV and c) non-regularized training.

Participants of FDGs and KIIs gave insight on the depth of their state of inadequacy. This ranged from the tight economic situation resulting in budget cuts for HIV activities at the enterprise level to dwindling interest in stand-alone HIV workplace programmes. Cited also among the problems was lack of management support by way of non-participation of management in workplace HIV activities to lack of relevant training in service training.

Lack of funds to execute their role was important to them as implementation of a successful programme was dependent on funds to procure IEC materials, protective

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devices like condoms, lubricants, test kits (in the case of clinics) and services of external resource persons. Below are some sentiments expressed by some participants in FGDs and KIIs on the lack of budget and access to training:

> *I don't have any budget for my work and the last time I was trained was four year ago for one week by the GBCA. I do not feel adequate for my job…what I would like is refresher training. (**Male KII, FPP**)*

> *As for training, it's been a long time; there should be constant yearly programs and periodic discussions. Even though I report to the company Doctor who has been working for the company for twenty years and who is also part of it, I need training in filling forms for data collection and such, we get a lot of information. (**Male KII, FPP**)*

> *With ours, the emphases is changing gradually to wellness policy where we have included other diseases like Hepatitis B, TB and others, we need more education on these. **(Female, KI, FPP)***

Interestingly, though focal persons reported a high level of frustration in the execution of work their work, there was one important divergent view from a participant of the focus group discussion who expressed the opinion that it was a two way affair and that lack of innovation may be a reason for dwindling interest and unsustained management support:

> *We mostly tend to blame top management about some of these issues but sometimes; the focal persons are also not so committed. They have to sensitize*

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*management about the work they want to do and if management sees that they are committed then they can come in to help but if the focal person is not showing results then you don't expect management to show interest in whatever you are doing. (**Female FGD**)*

4.3.2 Management Support/Response

Many respondents reported low level of management participation in work place programmes as contributory to their inadequacy. Emerging from qualitative data was another theme "Inadequacy of Management Support and Response" with concomitant subthemes: unspecified mode of selection; non-formalization of job specification and low level of funds allocated to HIV. These important findings related as follows by key informants reiterated managements purported lack of interest in enterprise level HIV activities:

*A memo was circulated, for those who could avail themselves for peer education at the workplace and quite a number of staff turned up for the training though the directors and ministers did not volunteer. (**Key Informant, Female, FPP**)*

The focal persons and participants of FGDs considered lack of management interest as contingent on their capacity to sustain interest of workforce in the enterprise level activities:

*It (my inadequacy) will all go down to the fact that if management is interested in HIV issues, then the Barometer will go up but if not, then it will diminish. (**Female FGD, FPP**)*

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Participants also reported that lack of training was an outcome of uncooperative top management who invariable pleaded budgetary constraints:

> *They've (Focal Persons) been trained, but they do not have budgets to do the work. If you've been trained, you have the skills and you don't have the support at your workplace in terms of the resources to implement.* (***Female, FGD, FPP***)

The issue of management involvement was consistently mentioned as key to the focal persons' ability to deliver consistent service. It was suggested that not being in a decision making position put focal persons' at a disadvantage. This situation was captured in the following statements by participants:

> *A lot of focal persons are not in managerial position so whatever the focal person set up to fulfil, it may be discarded because his superior is not interested in HIV issues. So the information the focal person wants to get across to the top management may not reach top management and in situations like that, it makes it a bit difficult.* (***Female FGD, FPP***)

> *Even if there is a relationship but management still says they don't have the money to support the project, then it still comes to nothing.* (***Male KII, FPP***)

From the forgoing and ensuing statements, it can be seen that focal persons need to be at par with management to enable sustain delivery of services and to assure a 'voice' is given to HIV activities at the work place where it matters. The quote below captures what most participants had to say about the issue of management involvement:

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*For the sake of the kind of job entrusted to the focal person, I think it will be important for the focal person to develop some personal kind of relationship with top management to help him push his agenda in addition up to date knowledge on the issue. (**KII, Female**)*

Even in instances when the respondent felt adequate in terms of capacity, they reported an inadequacy in terms of time allowed them for HIV related activity:

*-I will not call myself a full time focal point, but I am an advisor, I spend less than 10% of my time on the HIV programme but I think it would be better if I were fulltime. As a doctor, I feel adequately capacitated to undertake the job but I have not got it; as I said I spend only 10% of my time on HIV work. My position should be formalized…at the moment I report to the HR Director and I am given a budget for the work out of the general health budget. (KII **Male**)*

4.3.3 Inadequacy of workplace response

Focal persons reported a dwindling interest by workers in at the enterprise level as a result of their inability to offer comprehensive, sustained services. They reported this reduced options of workplace responses also increased the apathy of the workforce.

*With ours, the emphases is changing gradually to wellness policy where we have included other disease like Hepatitis B, TB and others, we need more education on these**. (Male KII, FPP)***

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Focal persons interviewed during key informant interviews stated that they had been trained by an NGO over a period ranging between three days to four weeks. Many felt it was inadequate though some were comfortable with it.

> *I have been trained to undertake my role over a period of four weeks, but that was four years ago. The workshop was a policy review, implementation and change management workshop.* ***(KII Male, FPP)***

> *Yes I have been trained by the GBCA and the GAC for about three to five days. For the GAC it took almost two weeks. The content was basic facts, counselling, stigma reduction etc. The last time I was trained was in 2012.* ***(KII, Female)***

The key informants, who were mostly focal persons, reported lack of formal training in HIV and AIDS because none of their training led to accredited certification. In addition, they reported that the duration of the training was short, with the maximum time for training they had ever had being four weeks and the most frequently reported being 3 days.

4.4 Type and Number of HIV Services Offered and Focal Person Presence

Table 10 displays the results between the link between the presence of HIV and AIDS focal points and services available is assessed by the reported availability and types of services present in enterprises.

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Table 10 Knowledge of Services Available in Enterprises with Focal Persons

	N=214
Variable	**With Focal Person n (%)**
Knowledge of Services Provided *	
Workplace education/training programmes	100
Distributing IEC/ BCC Materials	100
STI referral/ management	100
Condom promotion/distribution	100
HIV Testing and Psycho Social Counselling	40
Treatment or referral	40

Multi-response. There were no responses for FPA enterprise

There was universal (100%) awareness of the services delivered by focal persons. The prevalent services were: workplace education/training programmes; distributing IEC/ bcc materials; STI referral/ management and condom promotion/distribution. HIV testing, psycho social counselling and ARV treatment and/or referral however were not as well-known (40%) at the workplace.

Focus group discussions introduced other services that survey data did not cover: One of such service was narrated by a female participant as pertaining to curriculum review

> *For example, in the University of Cape Coast, they say that passing HIV course is a pre-requisite, like how African Studies at the University of Ghana; you must pass it to get your certificate. At the tertiary level, what they do normally is research, taking it as a*

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course and then also doing peer education, distribution of condoms and so on. At least this is our contribution from the sector towards the national response. ***(Female KI, FPP)***

Results in Table 10 shows that there was universal knowledge however, table 11establishes that the practice is different from what was reported.

Table 11 Availability of Services* in Enterprises with Focal Persons [N=214]

Variables	Frequency	Percent
Awareness of Services	144	67.3
Education in the Past 6 Months	55	25.7
Types of Services:		
Condom	96	44.9
VCT	10	4.7
Information	48	22.4
Care/Support	55	25.7

*Multiple responses. There were no responses in enterprises without focal persons

During the period under study, no work place HIV education or services were undertaken or available in the enterprises without focal persons as compared to those with the services of focal persons in which 67.3% of respondents reporting awareness of services. HIV services at the enterprise level was low even in FPP enterprises. Only, one out of four (25.7%) had received education in the past six months of the study.

With regards to the variety of services available, condom promotion was the highest at 45%, with Voluntary Counseling and Testing (4.7 %,) being the least popular.

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Table 12 Knowledge of Workplace HIV and AIDS Policy (N=214)

Variable	FPP (%)	FPA (%)
Knowledge of HIV Policy		
Yes	63.1	0.00
Don't Know	1.9	100.0
No Response	35.0	0.00
$X^2_2 = 412, p<0.001$		

It was also found that enterprises with focal persons were more likely to report having HIV and AIDS policies (65%) disseminated to the workforce than enterprises with FPA. FGDs and KIIs participants reiterated availability of HIV Policy in line with the survey results.

> *I think my management sees HIV as a threat because of the fact that we have a policy and the policy has certain aspect that when one is tested positive, they can take advantage of what is stated in it. (Female **FGD FPP**)*

> *We do not have a policy for our workers but my organization had a policy not to insure HIV infected persons but when anti-retroviral drug was introduced, that policy was changed. (**Male FGD FPA**)*

4.5 Influence of HIV Focal Persons on Workforce Behaviour

Retention of HIV information by staff members exposed to focal person services was used as an indicator to measure the influence of focal persons on workforce behaviour. Workers exposed to the services of HIV focal persons demonstrated openness as they

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were more likely to talk about HIV (69.2%) than those that had not (21.5%) been exposed (refer Table 13).

Table 13 Openness about HIV [N=214]

Variable	FPP n (%)		FPA n(%)		χ^2 p<0.001
Knowledge of HIV:					
Did not Influenced me to talk about it	0	0%	4	1.9	$\chi^2_2 = 98$,
Influenced me to talk about it	148	69.2	46	21.5	
Don't know	70	31.7	168	78.5	

The exposure of workers to the services of the focal person was further supported by reports on sources of HIV and AIDS information at the workplace. Findings support the fact that there are differences between groups.

4.5.1 Analysis of Focal Person on knowledge of Content of HIV Policy

Results from the regression model (Table 14) show that knowledge of HIV policy content, specifically, discrimination clauses: no mandatory testing; medical confidentiality; universal precautions and access to education were significantly affected by the presence or absence of an HIV focal person.

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Table 14 Regression Analyses of FPP and FPA on knowledge of content of HIV Policy

	FPP				FPA			
Outcome variables	**Beta**	**d/f**	**P**	**OR**	**Beta**	**P**	**d/f**	**OR**
No Discrimination	**0.62**	**1**	**0.00**	**1.85**	**-1.09**	**0.00**	**1**	**0.34**
Mandatory Test	**-0.7**	**1**	**0.00**	**0.49**	**-21.2**	**0.99**	**1**	**0.00**
Confidentiality	**0.46**	**1**	**0.01**	**1.58**	**-21.2**	**0.99**	**1**	**0.00**
Precautions	**-0.68**	**1**	**0.05**	**1.50**	**-1.09**	**0.99**	**1**	**0.00**
Access to Education	**0.41**	**1**	**0.00**	**0.51**	**-1.09**	**0.63**	**1**	**0.34**

Predictor Variables: Focal Person Presence **(FPP);** Focal Person Absence **(FPA)**

The direction of confidentiality and access to education as contributory factors to the model was negative. This implies that workers are less likely to report knowledge in these parameters. The direction for enterprises without focal persons are negative and the P values are above 0.5 and therefore, shows no significance. In FPP enterprises, the odds ratio of all the above parameters in the model is between 0.497 and 1.853, thus supporting the model and indicating significant association. The direction of mandatory testing, Universal Precautions and discrimination clauses were positive indicating the tendency of staff to report more on those parameters. In FPP enterprises though knowledge was less, the difference in knowledge between workers exposed to a focal point and one that was not was still significant.

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4.5.2 Regressions analysis of Influence of Focal Persons on Information Access

One of the research questions sought to investigate the influence of the focal person on the beneficiary workforce; this influence is measured within this study by the knowledge, attitude and practices with regards to HIV. Results from the regression model in Table 15 show that the influence of the HIV focal person significantly contributed to sources of HIV information at the work place.

Table 15 Regression Analysis of the Influence of Focal Persons on access to HIV Information

	FPP					FPA				
Outcome variable	**B**	**S.E**	**WALD**	**df**	**Exp (B)**	**B**	**S.E**	**WALD**	**df**	**Exp (B)**
HW	1.295	0.166	60.591	1	3.625*	-.398	0.139	8.135	1	0.672**
WP	0.658	0.144	20.844	1	1.933*	-2.33	0.24	93.875	1	0.097**
NGO	-3.96	0.505	61.579	1	0.019*	-2.82	0.297	90.293	1	0.059**
FAF	-0.46	0.14	10.581	1	0.634*	-21.2	2747.5	0	1	0.00*
Co – W	0.852	0.149	32.545	1	2.34*	-21.2	2747.5	0	1	0.00*
HPOW	-0.32	0.36	81.263	1	0.39*	-1.11	0.158	49.227	1	0.329**
LUR	-0.56	0.142	15.321	1	0.574*	-21.2	2747.5	0	1	0.00*

Sig * p<0.001; **Sig ** p>0.05**

Health Worker **(HW),** Work Place **(WP),** Labour Union **(LUR),** Non-Governmental Organization (**NGO),** Family and Friends (**FAF),** Co-Worker (**Co-W),** Health Provider Outside the Workplace **(HPOW). Predictor Variables:** Focal Person Presence **(FPP);** Focal Person Absence **(FPA)**

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These attitudes, knowledge and practices was also recorded in enterprises without focal persons and contrasted with the workforce that had been exposed to the services of focal persons in an attempt to ascertain whether the difference is due to the phenomenon of the focal person or chance.

The direction of sourcing information from an NGO (-3.96); family and friends (-0.046); health worker outside the workplace (-0.32) or labour union representative (-0.56) were negative. This implies that workers in enterprises with focal persons are less likely to report these source of information as relevant sources of information than workers in enterprises in which focal persons were absent. This further implies that findings on knowledge levels can be attributed to the presence of the focal person. The Wald test gave an odds ratio of between 0.497 and 1.853 on all the thus, supporting the hypothesis and showing there was significant association between focal person presence and information sources.

4.5.3 Influence of Focal Persons on Workforce knowledge on modes of Transmission and Prevention

One of the research questions sought to investigate the influence of the focal person on the beneficiary workforce; this influence is measured in the parameters of this study by the knowledge, attitude and practices with regards to HIV among respondents.

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4.5.3.1 Knowledge on Modes of Transmission

There is an association between the presence of an HIV focal person and workers' knowledge of the modes of transmission.

Table 16 **Knowledge of Modes of Transmission by Enterprise Status***

Variables	FPP n (%)	FPA n (%)	Chi-square	>p-value	Crammers v
CN	214 (100)	53 (25)	2.581	0.000	0.777
MTCT	214 (100)	53 (25)	2.581	0.000	0.777
CBF	214 (100)	107(50)	1.427	0.000	0.577

*Mother to Child Transmission (**MTCT**); Use of Contaminated Needle **(CN);** Transfer of Contaminated Body Fluids **(CBF)**

There is a statistically relationship between focal person presence and the knowledge of HIV transmission in enterprises with focal persons. There is universal knowledge about the modes of transmission among the workforce in enterprises with focal persons (100%) with regards to sharing contaminated needles and transmission from infected mother to an unborn child. Results (Table 16) displays Crammers V values between 0.577 and 0.777 supporting a moderate to relatively strong association between the presence of the focal person and workforce knowledge on modes of transmission[3].

[3] Note that though the GDHS (2008) reports high awareness among the general population (a sample comprising all the age groups and gender), comprehensive knowledge is low (refer section 5.5)

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5.3.2 Knowledge on Modes of Prevention

Knowledge on HIV modes of prevention was significantly lower in enterprises without focal persons with only 25% reporting condom use and avoiding unsafe sexual practises; 50% reporting abstinence and having only one sexual partner as the means of prevention.

Table 17 Knowledge on Modes of Prevention by Enterprise Status*

Variable	FPP .n = 214 (%)	FPA .n = 214 (%)	Chi-square	P value	Crammers v
Avoid Unsafe Sex	75 .5)(35)	53 (25)	5.395	0.020	0.112
Abstinence	4 (2)	107 (50)	1.29	0.000	0.549
Have one sex partner	143(67)	107 (50)	12.465	0.001	0.171
Avoid sex worker	64(30)	0 (0)	75.253	0.000	0.419
Correct Condom Use	139 (65)	53 (25)	69.86	0.000	0.404

*Enterprise Status: Focal Person Presence **(FPP)** and of Focal Person Absence **(FPA)**

In enterprises with focal persons, higher percentages of workers reported on five (5) methods of prevention as opposed to four methods reported by workers of enterprises without focal persons. These were: avoidance of unsafe sex (35%), abstinence (2%), and 'have only one sex partner' (67%) 'Avoid sex worker' (30%) and correct use of condoms (65%).

All p-values are less than 0.05 indicating that these variables are dependent on the presence of the focal person. Furthermore, the statistical relationship between the

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presence of a focal person and the knowledge on modes of transmission among the workforce presents a mild to moderate association at a Crammers V statistic of between 0.112 and 0.549.

4.5.4 Stigma and Risk Perception Indices

Workers exposed to HIV focal persons demonstrated a higher perception of risk of acquiring HIV: with 69% reporting a small risk and 31% reporting moderate risk as opposed to workers in enterprises FPA that reported that they had a small risk (76%) or no risk at all (24%) refer table 18.

Table 18 HIV and AIDS Risk Perception

Risk Perception	**[N = 214]FPP**	**(%)**	**FPA N= 214**	(%)
Chances of getting AIDS				
Small	147.66	69	162.64	76
Moderate	66.34	31	0	0
No risk at all	0	0	51.36	24

X^2_2***=121, p<0.001)***

Though some risk was perceived, it was attributed mostly to males; some participants in FGDs and KIIs explained thus:

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High level executives faced much threat. Because in my organization, retreats are organized for such executives in -hide out- hotels were, mutual relations are formed which goes beyond office work and this leads to most indulging in risky behaviours, exposing them to the virus. Nurses are also exposed to risk because of the nature of their work. Exposure to blood and other conditions surrounding their work put them at risk of getting infected. They also built relationships with some patients which continue patients are discharged. ***(Male KII, FPP)***

*These are mainly men; truck drivers, their apprentices and by the nature of their trade, they tend to engage in sexual activities as and when they go along whichever path. (**KII Male, FPP)***

This preoccupation with males being at more risk was further elaborated by other participants in the narratives below:

*For staff, I was talking mainly about the male staff; the Dockers, those in the operational areas. Because of the nature of the cash flows, there's a high risk (**FGD Male, FPP)***

*It's like somebody said at their place, it's not sexual harassment alone but they move from sexual harassment to the actual thing because a superior would want a sexual favour from a junior. (**Female FGD, FPP)***

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Data was collected on stigma, specifically relation to the perception of the workforce in relating to persons living with HIV and results presented in table 19.

Table 19 Stigma Indices by Status of Enterprises N= 214

Indication of Stigma	FPP N= 214	%	FPA N= 214	%	χ^2
Willing to eat food at a company canteen prepared by an HIV- positive co-worker					$\chi^2_2 =$ **121, p<0.000**
Willing to eat	147	68.7	15	7.0	
Not willing to eat	3	1.4	185	86.4	
No Response	64	29.9	14	6.5	
Willing to share utensils with an HIV-positive co-worker					$\chi^2_2 =$ **316, p<0.000**
Willing to share	144	67.3	58	27.1	
Not willing to share	57	26.6	156	72.9	
No Response	13	6.1	0	-	
Willing to receive treatment from an HIV-positive healthcare worker					$\chi^2_3 =$ **180, p<0.001**
Willing to receive	71	33.2	0	-	
Not willing to receive	75	35.0	161	75.2	
Don't Know	4	1.9	53	24.8	
No Response	64	29.9	12	5.6	

***Enterprise Status:** With Focal Person **(FPP) and** Without Focal Person **(FPA)**

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Workers in enterprises with focal persons are less likely to demonstrate stigmatizing behaviour than those without focal persons.

With regards to stigmatizing behaviour, enterprises with HIV focal persons demonstrate a high acceptance of HIV positive persons than workers in enterprises without focal persons. Whereas 67% from enterprises with focal points demonstrate acceptance of HIV positive persons by their willingness to eat food prepared by an HIV positive co-worker, only 7% were prepared to do so in an enterprise where workers were not exposed to the services of a focal person. None were prepared to receive medical treatment from a medical doctor with HIV compared to workers with focal person exposure (33%)

4.6 Conclusion

Findings on the role of HIV focal persons in workplace service delivery was examined using three intervening variables: job description, Job specification and prior exposure to systematic HIV education and two predictor variables: 'Focal Person Presence' (FPP) and Focal Person Absence (FPA) against the dependent/outcome variables: HIV education, STI management, VCT, condom distribution etc. which constitute the multiplicity of HIV services at the workplace provided by the focal person. The resultant effect of predictor variables on the outcome variables as defined in the conceptual framework revealed the following:

Enterprises without focal persons reported insignificant level of workplace programmes. There was no evidence of a standard criteria for selection of focal points. Appointment of focal persons was more likely to be informal and based on willingness to serve or by default if staff have a health background. Some focal persons had master's degrees while

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others had first degrees. Their occupational background revealed a diverse spectrum, from health personnel: registered nurse; pharmacist and a medical doctor; HR Managers, administrators, educationist, a fireman (Ghana fire service); an actuarial scientist, development worker and insurance men were reported.

The link between job specification (education, training, years of experience) of focal point and effectiveness in delivery of HIV Services at the work place was ascertained by qualitative data as staff files would not be made available. Results further revealed that roles and responsibilities of HIV Focal Persons in delivery of HIV Services at enterprise level was not a construct of their job description and specification. It was observed however that, focal persons took their roles and responsibility from what was spelt out in their respective company HIV and AIDS policies. It was also found that HIV and AIDS policy availability influenced positively the availability of services and gave direction to the work of the HIV focal point.

The relationship between knowledge of workforce exposed to HIV focal point services revealed that focal point presence translated into a high awareness of HIV responsible behaviour and a reduction in stigmatizing behaviour among workers. Workers thus exposed, were more likely to exhibit comprehensive knowledge of HIV. Enterprises with focal points were more likely to have HIV services than those without. Desk review of enterprise documents revealed that workplace policies were based on the ILO Code of practice and the 'world of work'; and therefore had similar content. Most focal persons' roles were derived from respective enterprise HIV policies which stipulated the standard for HIV workplace programmes. However, enterprises picked and chose which services

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to implement. Services available were a) HIV education and sensitization b) provision of VCT services to a limited extent c) care and support d) condom promotion and e) treatment to a limited extent. Availability of funds and management commitment influenced directly accessibility, that is, number and types of services at enterprise level. Focal person reported being ill equipped to provide workplace HIV Services due to technical and financial inadequacies as well as lack of management support however focal persons who were health personnel did not report technical inadequacies.

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CHAPTER FIVE: DISCUSSION OF RESULTS

5.1 Introduction

This chapter discusses the findings, interrogating it with literature. It cross-examines the findings from the quantitative and qualitative aspects of the study and juxtaposes it on what literature ascribes to HIV workplace programmes and its related actors. Literature describes HIV workplace programme as a range of enterprise-based interventions including the institution of an HIV and AIDS policy, voluntary counselling and testing (VCT), and antiretroviral therapy (ART) provision (ILO, 2001) where one staff member is assigned to the duty of facilitating these interventions. This person is referred to as the HIV focal person, focal point and in some cases peer educator. The study revealed that staff members that provide HIV and AIDS Services at the workplace were also referred to by these names.

Literature search did not reveal any laid down criteria for the selection of this staff or worker to assume this post (Mahajan-Anish *et al*., 2007). After much probing through in-depth interviews, FGDs and KIIs it was revealed that there was consensus on the importance of HIV as a Workplace issue. Indeed, participants in enterprises with focal persons recounted the importance of HIV to their institutions. Issues emerging from this suggest four main themes: 1) the perfunctory nature of HIV programmes and services, 2) Low self-confidence of Focal persons in the delivery of their role coupled with a pervasive lack of formalization and/or lack of written job description and specification – and this was the case regardless of the economic sector or categorization (public or private) to which the enterprise belonged 3) consensus on the importance of HIV service

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delivery at the workplace and the importance of the role of the focal person in availability of services 4) Influence of focal persons on employee HIV behaviour in the face of low level of management support/participation and funding support for work place programmes

5.2 Perfunctory Nature of HIV Services and Selection of Focal Persons

The Government of Ghana considers workplace programmes as one of the cardinal interventions to combat the spread of HIV and AIDS in Ghana (GAC, 2001). The National AIDS Strategic Plan clearly states that, in the effort to combat HIV and AIDS at the workplaces, the Ghana AIDS Commission through the relevant ministry would be assisted to accelerate the development of HIV and AIDS workplace programmes. Advocacy efforts were to be undertaken to get employers to develop workplace HIV and AIDS programmes and vote resources for their implementation (GAC, 2005). The Plan further stipulated that promotion of IE&C on STD and HIV and AIDS would be directed through programmes designed at these workplaces. The Focal person model was found as a useful tool that would motivate peers to collectively support and uphold preventive behaviours and this supports the findings of Bora and others (2010) that workers spend a considerable amount of their lives in the workplace; thus the selection of one staff to uphold behaviour change.

In view of this, it was one of the objectives of this study was to find out if the focal persons were selected based on a laid down criterion as they have specific roles to play.

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They are to lead the workforce to put up HIV responsive behaviour (ILO, 2008; UNAIDS 2007) with the aim of contributing to a reduction of national prevalence and a reduction in incidence. However, evidence from this study indicates that though HIV Focal persons were indeed present in some enterprises, not all referred to themselves as focal persons. Mahajan-Anish (2007) in their study found out that there was no evidence of standard criteria for selection of focal persons across enterprises they studied. It was no different in the enterprises studied in 2013 almost six years later in Ghana. The modalities for the appointment of focal persons were not known by workers surveyed. Focal persons were appointed by management in a manner that was not transparent to all staff as they did not know how their appointments were made.

5.2.1 Staffing the Position

Literature search does not reveal any laid down criteria for selection of this staff or worker to assume this post (Mahajan-Anish *et al* 2007) and neither did the study find any laid down criteria across board that specifies qualification (job specification), training, and job description (Setswe, 2009). As discovered by Mahajan-Anish and others (2007), the study also revealed that enterprises had different means of appointing focal persons. Their appointments were arbitrary in nature and focal persons indicated their appointments were by government directive as per the Ghana National Workplace Policy (2005) or by company's corporate global HIV and AIDS Workplace Policies in the case of multi-national enterprises.

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There is no gainsaying the importance of the focal person to enterprises. Literature carries a wealth of information in this regard (ILO 2007; 2008; 2009; AIDSLink 2010). For instance, a costing model that estimates the present value of new HIV infections in the formal business sector in southern Africa was developed by researchers from the Center for International Health at Boston University (UCSF, 2000). The study found that new infections can cost between 3.4 percent and 10.7 percent of annual salaries depending on skill level, associated benefits, and prevalence in the area. Similarly, a research undertaken by the University of California-San Francisco that compared HIV-related business costs for large Ugandan companies (500+ employees) with the cost of providing prevention, care and treatment to employees concluded that even programs offering the most expensive treatment — anti-retroviral care —can be cost-effective (especially, in light of 85% price reductions offered by drug manufacturers for sub-Saharan Africa).

Kwarimpa-Atim (2008), reports on a study carried out by the Community Development Resource Network, designed to support their partners to manage HIV and AIDS at the workplace. In this study, a self-assessment form to gauge capacity to respond to challenges caused by HIV and AIDS was self-administered by partner organizations where it was revealed that partner organizations did not have mechanisms in place to respond to HIV and AIDS internally. The study then recommended that each participating organization select a staff member to become a focal person to support enterprise HIV service delivery. These focal persons were selected according to their unique needs. They did not want to impose on them what position and level of influence these individuals should hold. It can be seen that even here there was no laid down criteria confirming an ambiguous and amorphous mode of selection that was highly

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subjective and dependent on the views of management at the time. This buttresses the findings of this current study where focal persons cut across all professional levels and educational backgrounds. Not only did focal persons have different educational backgrounds, they also occupied varied occupational positions ranging from Human Resource staff to educationists.

According to Elsey (2003), one of the first steps that many government sectors take in initiating HIV and AIDS mainstreaming is to establish focal persons that have the responsibility of acting as a catalyst. Findings from this study supports this. However, the most critical aspect of workplace HIV education, after focal persons have been identified, is without any quality assurance or uniformity in the level of competence and expertise of the focal person. The danger in this inherent lack of standards and uniformity is that operations of the focal person vary across enterprises and quality is not assured. Elsey *et al* (2003) attests to the fact that the number and level of the focal persons vary from country to country. The situation was not much different across the enterprises that were studied under this research. Some enterprises actually had a team of focal persons whereas others had just one or two.

Literature supports the establishment of HIV and AIDS workplace programmes and as well calls for the mobilization of relevant staff and allocation of funds to support their operations (ILO, 2010; GAC, 2010; 2011-2015; GAC, 2012). Contrary to this however, findings revealed that where focal persons existed they were not adequately supported financially nor appointed based on relevance. There was no transparent or competitive recruitment process but rather based on willingness to serve or by default if focal persons

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were health workers at an enterprise health facility such as a clinic or health post. It was apparent that the situation of different levels of competence described by Elsey (2003) was what pertained in the enterprises studied. This led to the situation where focal persons were at different levels of competence in technical knowledge in HIV and AIDS issues. Likewise, this study also revealed that workers and management alike saw HIV as a workplace issue of importance. In spite of the above, the selection of the focal person, that one person, assigned to sustain workplace programmes, remains an enigma..

5.2.2 Educational Level of Focal person

The key informants unanimously indicated that they had not been adequately or formally educated on HIV and AIDS. Where training had been provided, the duration was not more than four weeks and as short as half a day. Training was usually offered by NGOs sponsored by the GAC or the Ghana Business Coalition on AIDS (now Ghana Business Coalition on Employee Well-being).

This is quite interesting in the sense that though there are formal training/educational programmes offered by the University of Ghana's Institute of Continuing Education, none of the respondents of key informant interviews cited taking a course there as part of their training. According to the institute's website, there were two programmes relevant to HIV, Counselling and Care-giving and the HIV Stigma Reduction Course. The former is a four month course delivered through the distance mode which was instituted in October 2003, and is being run with the support of the United Nations Population Fund (UNFPA), while the latter is a six year project being supported by the Canadian

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International Development Association (CIDA) through the Association of Universities and Colleges in Canada. (www.ug.edu.gh/icde/index1.php?linkid=315&sublinkid=175).

Qualitative and survey data stated educational backgrounds ranging from graduate to post graduate levels with two being health personnel. There were almost as many professions as were focal persons. With regards to selection or appointment to the job, there were as many reasons for selection as there were respondents, though for the multinational enterprises, focal person selection was based on directive from mother enterprises outside Ghana.

Their occupations included clinicians and other allied health personnel (e.g. registered nurses, pharmacists and public health practitioners). There were almost as many professions as were FPs, the other professions were HR Managers, administrators, an educationist, a fireman (Ghana fire service), an actuarial scientist, development worker and insurance men. Management did not seem too concerned about who should be, as none of the enterprises had a formal job description for the position as it was not appraisable. This position across enterprises had not been advertised with strict criteria as perhaps would have been done for managerial or administrative or general service positions (cleaners, drivers and watchmen). This is significant as the focal person position should be distinguished from the position of peer educators who are ordinary employees or community members who are trained to educate their peer group (ILO, 2008).

In one public sector enterprise there was not only one focal person but many across regions. Focal persons also reported having mainstreamed HIV into the curriculum and as

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well extending their activities beyond the workplace to their clients (student, pupils, parents and community members) in line with their HIV workplace policy. There is overwhelming evidence from the study that there are no laid down criteria with regard to educational background for selection of HIV focal persons.

5.3 Low self-confidence of Focal Persons

HIV workplace programme refers to a range of enterprise-based interventions including the institution of an HIV and AIDS policy, voluntary counselling and testing (VCT), and antiretroviral therapy (ART) provision (Ghana National HIV and AIDS Policy, 2012). In most cases, one staff member is assigned the duty of facilitating these interventions, this person is referred to as the HIV Focal person (Mahajan-Anish *et al*., 2007). Focal persons that participated had varied backgrounds and different levels of expertise. Specifically, focal persons with non-health related backgrounds had low levels of self-confidence. They attributed this to a lack of basic health education which focal persons who were health workers had by virtue of the education they received for their core occupations.

The Global Business Coalition on HIV and AIDS, has encouraged companies to develop programmes to respond to HIV and AIDS. In its 2006 report on 'best practice' of programmatic activity, GBCA reported that large African companies and multinationals operating in Africa are leading the way in implementing workplace programmes; and focal persons are the actors at the core if this response. In spite of this responsibility, the study has attempted to bring to the fore the lack of uniform measures for their selection and reports for the first time the feelings of inadequacy that surrounds this position.

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Focal persons that participated in the study disclosed that they were members of the Business Coalition on HIV and AIDS, an affiliate of the Global coalition and have received some training from the coalition. Notwithstanding, they indicated that it was important for them to have some level of technical expertise required for the execution of their role. They explained that, although HIV was not essentially a medical issue, staff members often confronted them when issues of a technical nature arose. Albeit they could refer to technical experts from time to time at the workplace, lack of management support and the pervasive low funding allocation made that option of little consequence.

Focal person's capacity was important as they needed a myriad of resources and knowhow to navigate through interventions which comprised impact mitigation, policy development, provision of biomedical information and management of the disease and its accompanying opportunistic infections where possible; peer education; voluntary counseling and testing (VCT), and antiretroviral therapy (ART) provision (Booz-Allen-Hamilton, 2006; ILO, 2001).

Studies of the private sector and AIDS programmes have focused on elucidating the cost of the epidemic to employers. According to Booz- Allen –Hamilton, even as companies are informed by a growing body of literature on workplace prevalence and the estimation of costs, they do not benefit from a similar body of literature for understanding the various dimensions including the focal person operational dynamic. This study corroborates this as it revealed the operational challenges of workplace programmes and the frustrations faced by the actors.

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Operational challenges unearthed by this study (lack or capacity, low self-confidence, lack of management support etc.) facing focal points have been documented by (Elsey, 2003; Dickenson, 2005). They indicated that focal person's admitted to having limited knowledge and experience of what is involved in the job, what the difference between mainstreaming and HIV and AIDS work was and how they should implement a mainstreamed response. According to Elsey (2003), many focal persons have described similar experience of receiving a request from a superior to take on the role the HIV focal person but had very little support in establishing what was expected of them and how they should go about mainstreaming in their sector. Though the study by Elsey (2003) was about HIV and AIDS mainstreaming and not workplace programmes and service delivery per se, their findings are relevant and related to the operational activities of HIV focal persons in enterprises.

Other studies conducted by Dickinson and Stevens (2004) confirmed that even less is known about how best to monitor and evaluate the efficacy of workplace HIV and AIDS programmes in complicated environments such as the workplace or employer-sponsored offsite programme. This complexity is reinforced by this study, in that, not only was there limited budgetary support to undertake the programmes but also lack of formalized training of focal persons in HIV from accredited institutions. Not even those with health backgrounds reported having taken a formal stand-alone HIV and AIDS related course of study from an accredited educational institution. Though some level of training was reported by respondents, training, when received, was not deemed enough to bolster their expertise and confidence.

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The existing literature in Ghana consists mostly of strategic plans such as the Ghana National AIDS Strategic Plan II (2011 -2015), medium term development plans of regional coordination councils and district assemblies. These plans advocate the promotion of peer education/focal person model as a useful tool that would motivate the workforce to collectively support and uphold preventive behaviours. It clearly states that, employers are to develop workplace HIV and AIDS programmes and vote the requisite resources for implementation in the effort to combat HIV and AIDS at workplaces.

5.3.1 Motivation of the Focal person

The study found that focal persons were not motivated in the roles they played as they did not get the needed support from management. Their assignments were not formal and depended on the support of external parties such as the GBCA and other NGOs. Nonetheless, focal persons provided HIV services based on their respective workplace policies. They motivated themselves by their inherent belief that the roles they played were important.

There are various training manuals for different workplace actors such as the ILO manual, 'Implementing the Code of Practice' (2005) and Implementing Workplace Programmes manual by FHI (2004). These are however tailored for a one size fits all concept that assumes focal persons are of a homogeneous background with regards to literacy, support and HIV competence. Not only were such resource material not widely available to focal persons, where they were, focal persons were daunted by the fact that they were not supported financially to implement the modules in these manuals. From the study, workplace focal persons ranged from HR practitioners, Nurses, doctors,

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pharmacists, firemen insurance brokers, Public relations officers to civil servants of various categories and reported discouragement when they were faced with confidential technical issues they could not handle.

Most focal persons reported that they relied on their workplace policies where they existed as an operational manual, which assisted them to engage in sustained workplace programmes. Focal persons reported being motivated by the feelings of accomplishment they felt when they were approached by their peers. In addition, focal persons were motivated by their belief in contributing to the good and welfare of society.

This finding is in line with findings by Elsey and others (2003) who also identified some rewarding and positive aspects of being an HIV and AIDS focal person. One positive aspect of being an HIV and AIDS focal person is that it afforded them the opportunity to meet with high level decision makers and this served as a motivator.

In the majority of cases, however, HIV and AIDS activities are add-ons to the existing workload of the focal persons. Due to the low support by management and the unappraised nature of the post, staff members thus appointed hardly sacrifice their core assigned job description in favour of workplace programmes. This lack of commitment is a problem that focal persons grapple with and are worried about. With assignments not appraised, they tend to neglect the jobs for which they had been employed and sometimes its accompanying benefits should they spend too much time on HIV and AIDS related work.

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According to Elsey and others (2003), focal points have found it difficult to convince others within their organisations that HIV and AIDS is an important issue within the sector, especially when no training on how to address it has been provided. Seventy five percent of HIV and AIDS focal persons, as per their findings, often have limited or no budget to carry out activities. They stated further that many focal persons must also negotiate complicated and time-consuming bureaucratic processes to access money for HIV and AIDS related work. Often a programme outside the official systems of their sector holds the funds earmarked for HIV and AIDS mainstreaming work. This then requires separate reporting and monitoring systems, often directly to the donor providing funds. This present study on the role of the HIV focal person concur with findings on workplace programmes by others researchers (Addai Yeboah, 2004; Adjaye, 2004; Allen & Heald, 2004; Benatar, 2004; Bora *et al*., 2010; Dickinson & Stevens, 2004; Chileshe, 2010; Hassan, 2005;ILO, 2007, 2008 and UNAIDS, 2004; 2009 & 2010)

5.3.2 The Role of Management in Shaping the Focal Persons Delivery Outcomes

The International Monetary Fund (IMF, 2015) reports that the emergence of large fiscal and external imbalances in Ghana has currently led to a slowdown in growth, is putting Ghana's medium-term prospects at risk. This has been characterized, according to the report, by the sharp depreciation in the exchange rate fueling inflationary pressures. This has led the Ghanaian authorities to request a three-year arrangement under the Economic and Financial Committee (ECF) in support of their medium-term economic reform program. These reforms include but is not limited to improving revenue collection through tax policy and tax administration reforms. This sets the tone for harsh economic

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conditions in Ghana, particularly felt by the private sector and renders it difficult for them to support initiatives that they may not deem as core activities such as workplace HIV and AIDS service provision.

From the results, focal person's reported inability to fulfil their objective was due to budgetary constraints and lack of cooperation from top management. This situation was as a result of the predominance of focal persons in non- managerial position. The focal person's initiative may be entirely dependent on the disposition of their immediate supervisor which is detrimental to workplace programmes if the superior is not interested in HIV issues.

This is at par with findings by James (2002) that in resource-poor communities, "the primary impact of HIV education programmes may be the personal mobility of (peer educators) focal persons, and that while these issues present challenges of greater or lesser magnitude in a range of settings, there have been recent suggestions that peer education is not an effective response within (companies) enterprises". These statements are important to note because where the 'personal mobility' of the workplace service provider is hampered by management through a lack of logistic and financial support, service delivery will not "happen".

The frustration felt by the focal points by way of management disinterest was evident in the qualitative narratives. Workers and focal person's alike stated that even in instances where the focal person felt adequate in terms of capacity, they reported an inadequacy by way of budgetary support.

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This study has revealed that most enterprises pay lip service to HIV workplace programmes, similar to studies by Dickenson (2002; 2003 & 2005). Dickenson further stated that the more intense the problem, the seemingly faster the enterprise takes measures to "do something" about it. Moreover, he claims that the visibility of HIV and AIDS within companies has influenced the responses of often relatively weak, internal agents who have been attempting to drive companies' HIV and AIDS programmes. He postulates that the push factors for the above may be due to the legal requirements, the policy agenda of the country, what is pertinent on the business barometer at the time and social pressures.

Similarly, this study concurs that the general visibility of the AIDS epidemic is also a significant factor in explaining company's responses to HIV and AIDS. Thus, this current study revealed that though companies with focal persons had programmes, some were just perfunctory and lacked regularity. It is also important to recognise from the results of this study that, workplace HIV education and service delivery by focal persons in enterprises in Ghana exists within the context of being a process that management is able to advance or obstruct. Focal persons were unanimous in their assertion that, for the sake of the kind of job entrusted to them, it would be important for them to develop a personal relationship with top management, or to be part of top management to help them push the HIV workplace agenda. The focal person's level is unique and differs from the peer educator who can be from any level and is selected to reflect their peers.

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5.4 Importance of HIV Service Delivery and Availability of Services

According to Benatar (2004), HIV responses across nations has involved a multi sectoral approach in which all stakeholders have contributed severally to the challenges of the epidemic. Benetar further intimates that, collective efforts in education, prevention, and treatment intervention has not proved sufficient to stem the tide of the epidemic. Pattanaphesaj and Teerawattananon (2010); Marseille, Shade, Myers and Morin (2011) in their respective studies, examined the effectiveness of different approaches to HIV and AIDS prevention and spread. They have also concluded that other intervention methods such as school based-sex education plus life-skill programs; voluntary and routine HIV counselling and testing; male condoms, street outreach programs, needle and syringe programs; programs for the prevention of mother-to-child HIV transmission; male circumcision; screening blood products and donated organs for AIDS virus and increased alcohol tax were effective in reducing HIV infection among target populations in a cost-effective manner as opposed to mixed methods as implemented in workplace programmes undertaken by focal persons. Although this study did not undertake a cost benefit analysis, it was demonstrated clearly by the outcome of the statistical analysis that focal persons significantly influenced the knowledge outcomes of the workforce positively. Enterprises with focal persons were more likely to have HIV programmes and staff could demonstrate comprehensive HIV and AIDS knowledge above the awareness in the general population cited by the GDHS (2008).

Additionally, there was a strong association between the influence of focal persons and HIV preventive knowledge among the workforce. Workers that had been exposed to the services of focal persons were more likely to exhibit preventive measures as they

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exhibited higher HIV knowledge. This was associated with more self-efficacy for condom use, higher perceived risk of acquiring HIV infection, and more intent to use condoms, reduction in multiple partnerships; more acceptability of checking ones HIV status; openness to talk about HIV and an exhibition of less stigmatizing behaviour. They are also more likely to know the correct modes of HIV transmission.

When this is juxtaposed with the Trans Theoretical Model, the role the focal person plays in facilitating and supporting the individual worker to uphold behaviour change at the stage of ‘maintenance’ of changed behaviour is apparent. This so because as all the various services focal persons provide support the worker through the various stages of the TTM model. At the ‘awareness’ and contemplation stage, sustained awareness and sensitization activities at the workplace by focal persons provide the necessary arsenal for the workers. Positive peer pressure or herd behaviour encourages ‘trial behaviour’ which may translate to ‘sustained’ behaviour change which will be eventually maintained.

5.5 Influence of Focal persons on Employee HIV Behaviour

The lack of an established standard for measurement of HIV knowledge in sub-Saharan Africa has been a factor limiting research to better understand these issues. Most published studies used an *ad hoc* questionnaire or interview to ascertain HIV knowledge and do not report the specific items or psychometric properties of the measure, limiting the reproducibility and comparability of findings (Noden, Gomes, & Ferreira 2009). In spite of this, there is no gainsaying the importance of the focal person to enterprises revealed by this study is important. Various studies (Dickinson & Stevens, 2004; Addai-

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Yeboah, 2004; Booz-Allen-Hamilton, 2006; ILO, 2001; ILO, 2007; Elsey *et al*., 2003; Hassan, 2005; Johnson, Kennedy, Harris, Lincoln, Neace, & Collins, 2005; Graeff *et al*., 1993) reiterates the importance of the role of HIV focal persons. What is interesting however is that, the influence of the focal person on the reduction of new infections does not seem important to management as it is mainly not formally recognized.

Though this study was limited to focal persons as a group and did not disaggregate for health and non-health background characteristics; and limited by lack of access to employment records the study revealed that the outcome of influence which was defined in the conceptual framework could result in quality HIV services. These were more likely to be achieved in an enterprise with focal persons than one without. Quality services were listed as follows: 1) presence of an HIV Committee 2) Full-time/part-time HIV Focal person 3) HIV Policy 4) HIV Workplace Education programmes 5) distribution of IEC and or BCC Materials e.g. STI referral/MGT, Condom promotion/distribution etc. 6) HIV Counselling and Testing 7) Treatment or referral 8) Psycho Social Counselling, Care and Support (ILO, 2001).

The importance that enterprises attach to the HIV service delivery at the workplace is confirmed by focus group and survey data. One hundred per cent of focal persons reported delivering all HIV workplace services in four categories; namely; workplace education and training programmes; distribution of IEC/ BCC Materials; STI referral/ management and condom promotion and distribution activities.

The study also revealed that the presence of focal persons did affect the number and types of services available. This is similar to the findings of the final Joint Review of National

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Strategic Framework undertaken by the Ghana AIDS Commission (2010). In a survey of 30 companies by the Private Enterprise Foundation (PEF), it was found that seventy-seven (77%) had HIV and AIDS workplace policies (GAC, 2010). Indeed, the joint review revealed that, the policies and programmes encompass information, awareness, education, condom distribution, Post Exposure Prophylaxis (PEP), universal precaution awareness. The report further stated that public sector workplace programmes had not been as widespread as the private sector response.

This study, akin to the GAC study, confirms that there is currently no organized programme or standard by which enterprises are to provide the full package of the workplace programmes for staff. This is interesting in the face of the fact that though several authors have reiterated the importance of the focal person (Bora *et al*., 2010; Dickinson & Stevens, 2004; Chileshe, 2010) management does not seem to pay much attention to such workplace programmes. So, though influential, the reach of focal person's influence does not go far.

5.5.1 The Role of the Focal Person in Stigma Reduction

Several authors have cited HIV related stigma and discrimination as a threat to achieving universal access to HIV services (Hasan, 2007; Panos, 1990; IRIN, 2005). HIV programmes could fail due to stigma and a failing health system, indeed, fear of discrimination could prevent PLWHA from accessing health measures that could improve their life.

The ILO Code of Practice on HIV in the World of Work (2001) also reiterates that stigmatization against people living with HIV and AIDS is predicated on negative

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perceptions deeply rooted and re-enforced by ignorance. A study by Jolly and others (2009) on stigma and discrimination in Kumasi, Ghana revealed that about 59% did not know why HIV made people sick. Furthermore, 36% said they would not let their child play with another child who had HIV and 28% felt that PLWHA should be isolated in towns and villages.

It is obvious from these studies that the success of any HIV programme is highly contingent on eroding this ignorance which is what focal persons are mandated to do in providing workplace services. In addition, the constant reinforcing of behaviour change and uninterrupted supply of information at the workplace level helps to sustain behaviour change along the continuum of change described by the Trans Theoretical Model (TTM) of Behaviour change.

The findings of this study therefore support the positive role focal person's play in influencing a reduction in stigmatizing behaviour. The survey revealed low stigmatizing behaviour in the workforce exposed to focal person activity. The GAC (2010), recommends the involvement of PLWHIV in workplace programmes as very important in eroding the fears attached to HIV by demystifying the condition of HIV. A review of enterprise focal person meeting reports showed the involvement of persons living with HIV the Network of Person Living with HIV (NAP+) in Ghana through education and testimony sharing. It is not surprising that workplace programmes work in reducing stigmatizing behaviour.

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5.6 Conclusion

In Ghana, steps have been taken by government to effectively improve the quality of care and ensure that HIV services are provided in enterprises (GAC 2001). Standardization is very critical in ensuring quality. The concept of quality removes differences that may arise due to different enterprise cultures and value systems. Many definitions are used to describe quality. According to the WHO, all may be justified depending on the perspectives and objectives of the defining party. A common aspect at the centre of the concept of quality is the needs of a client or community. The International Organization for Standardization (ISO) defines quality as -the totality of features and characteristics of an entity that bears on its ability to satisfy a stated or implied need. In the case of workplace HIV service provision quality assurance as an aspect of quality control is a more comprehensive approach to quality in standard setting. Some of the steps the government of Ghana has taken to improve the quality of care and ensure HIV services are provided include the establishment of the Ghana AIDS Commission by an act of parliament in 2002 (GAC, 2002); adoption of Practice guidelines and standards for comprehensive programmes in Ghana (ILO, 2001) in the 2012 revised Workplace HIV and AIDS policy; and the establishment of the GBCA. Though the guidelines include among others the following,: a) National Guidelines for the Development and the Implementation of HIV counselling and Testing (Ministry of Health, 2008; Guidelines for Quality Assurance of HIV testing in Ghana (MOH, 2008); Guidelines for Management of Sexually Transmitted Infections (MOH, 2008) and the like, none of these include national guidelines on the education and training of HIV focal persons. There are also no guidelines that sustain training that will ensure that focal persons have the latest

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information on HIV management, care and support and policies available globally and nationally.

The results of this study suggests that utilization and up-scaling of the focal person in the workplace will ensure the availability of HIV services and increase knowledge levels of the workforce. Additionally, the relationship between anti-stigmatizing behaviour among the workforce exposed to the services of an HIV focal person was significant. Finally, focal person's presence translated into a high awareness of HIV responsible behaviour and reduction of stigmatizing behaviour among workers.

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CHAPTER SIX: SUMMARY AND CONCLUSION

6.1 Summary of Study Findings

Much has been said about the importance of workplace HIV and AIDS service provision (Mahajan *et al* 2007; Setswe, 2009; Dickinson & Stevens, 2004) and the steps Government and the private sector have taken to ensure some level of response toward mitigation of the impact of HIV and AIDS on the general population and the workforce in particular (GAC, 2010).

That being said, the findings of this research reveal the challenges HIV Focal persons face after being appointed to deliver HIV related services at the workplace; some of which have been identified by other researchers to include lack of emphasis on HIV by management and a disconnect between the work of the HIV focal person and management (Bora *et al*, 2010; Dickinson and Stevens, 2004; and Chileshe, 2010). A situation that affects the quality and type of services provided at the workplace is the probability that management may not release funds or free official time for the training and education of the workforce.

The study has revealed unequivocally that the activities of the focal person is able to influence the behaviour choice outcomes of workers which is positive. This therefore provides a basis for arguing that the presence of an HIV Focal person is beneficial and assures the provision of some level HIV services at the workplace. Evidence from the study further indicates that efforts to deliver HIV services at the workplace need to be geared towards areas that increase the likelihood of high quality comprehensive services.

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According to the ILO Code of Practice on HIV and AIDS (2001), comprehensive services are based on ten key principles which include:

1. Recognising HIV and AIDS as a workplace issue, meaning the combined issue of HIV and AIDS is a workplace issue, and should be treated as such and as with any other disease or serious illness or condition workers may face during their working life.

2. Ensuring non-discrimination that is there should be no discrimination against workers on the basis of real or perceived HIV status.

3. Recognition of gender equality. Gender plays a very important role in the acquisition of HIV and AIDS. Certain jobs put women more at risk that men and vice versa.

4. Promoting a healthy work environment is the fourth tier of quality workplace programmes, to this end they recommend that the work environment should be healthy and safe, in order to prevent transmission of HIV. Especially in the disposal of sharp instruments, provision of personal protective equipment, and even condom distribution.

5. Promoting social dialogue; this is the successful implementation of an HIV and AIDS policy and programme that requires cooperation and trust between employers, workers and their representatives and government,

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6. Prohibiting screening for purposes of exclusion from employment or work processes. They insist that under no conditions should HIV and AIDS screening should not be required of job applicants or persons in employment

7. Ensuring confidentiality, which involves ensuring that access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality. This is not to infer secrecy as confidentiality assures the worker that the private information of his or her HIV status is not for public consumption but may but may be used by management solely for purposes of offering care, support, treatment and other related care the HIV positive worker may need.

8. A quality programme also ensures and maintains the continuation of the employment relationship. HIV should not cause one to loose ones job, which means persons with HIV-related illnesses should be allowed to work for as long as medically fit.

9. A quality HIV programme according to the code of practice should aim at preventing new infections through changes in attitude and behaviour which will be achieved through provision of information and education, and addressing socio-economic factors.

10. Finally, providing care and support including reasonable accommodation, (that is, arranging the work schedule to fit the worker's need for time off to visit the hospital, to suit his or her health need etc.) to all workers, including workers with HIV including affordable health care services.

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Indeed, most HIV policies reviewed during the study had most of these principles. In addition the Ghana National STI and HIV Policy states that -Keyline Ministries have been identified as critical to the success of mainstreaming HIV within the public sector. They are therefore expected to incorporate HIV into their core business. In the same document, the private sector was enjoined to develop and implement workplace policies and programmes for the management of HIV and AIDS. This perspective emphasizes the importance of focusing on the deployment of HIV focal persons for the management and mitigation of the impact HIV within the adult working population. In spite of this, there is no dedicated section in the enterprise HIV policies in which the criteria for the selection of focal persons was documented. What was evident also was that not much importance was placed on implementing an HIV workplace policy once it was developed.

Developing a policy that recognizes the importance of workplace programmes or appointment of HIV Focal persons cannot guarantee the effectiveness of service provision. This is because focal persons reported that after they are appointed, problems with lack of personal and technical capacity, management support, financial constraints, and lack of recognition affects their overall performance in executing their role.

Where focal persons were at site and working, HIV work had not necessarily been mainstreamed into their job description or assignment. Particular emphasis or attention was not found to be focusing directly on mainstreaming the position of the HIV focal person into the workforce. There was no harmonization of the job description of the focal person to ensure equal delivery across board, there was also no quality assurance in the delivery of HIV services.

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Some researchers (Dickenson *et al*, 2005; Brown., Trujillo, Macintyre, 2003) have detailed the difficulty enterprises have in mainstreaming and sustaining HIV programmes, and suggest that not only do peer educators find it difficult to translate theory into effective practice but find that beginning a new program within an organization is always a challenge as focal persons' activities do not constitute part of the bureaucratic routine. This statement is fundamentally the reason why HIV may tend to fall off the barometer of most enterprises, especially more so in resource poor settings. The study findings are direct support of this statement and go further to indicate that it is more so for the focal person.

In fact, in 2000, a study of two hundred and fifty (250) member companies and businesses of the Ghana Employers' Association (GEA, 2000) found that close to 46% of the organizations that participated in the survey had some kind of ad-hoc HIV and AIDS activities at workplace however, in 2005, a study by the Ghana AIDS Commission revealed that of the three hundred and seventy four (374) members of the Ghana Employers Association surveyed, only a total of forty two (42) had any HIV focal persons or any form of workplace programme on HIV and AIDS. This leaves a staggering number of three hundred and thirty two (332) which did not have programmes. This is a matter of concern as this represents a drop from 46% to 12%. It also buttresses the study's finding in which businesses according to the focal persons were more or less paying lip service to the issue of HIV and AIDS.

However, it can be said that this is not surprising as it is documented that setting up a health system is a costly investment in the early years, this cost should not be seen, as an

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additional burden, but as an investment which would become profitable after so many years, depending on the firm (Avetin & Huard 1998).

Additionally, there was a strong association between exposure to HIV focal persons and undertaking of preventive measures and higher HIV knowledge by workers. The study further concludes that workers who had engaged with focal persons demonstrated such knowledge in adopting less risky behaviours. Specifically, by accepting condom use; tended to value more stable unions as most were married and reported a reduction in multiple partnerships; could talk about HIV more openly and a lesser likelihood of demonstrating stigmatizing behaviour.

The study also showed that within the setting of the Trans Theoretical Model (TTM), the focal person's role is pivotal to all aspects of the stages of behavior change, ensuring the maintenance of sustained desired behaviour change is sustained. The on-going workplace programmes and services supports maintenance, prevents relapse and consolidates the gains attained by the individual worker. As focal person's activities are ongoing, it is expected that the information and paraphernalia necessary for sustaining behaviour change will be accessed through the focal person.

Thus, when focal persons are not supported to execute their assignments, their feelings of inadequacy increases and their ability to support their colleagues along the behavior change continuum described in the TTM is compromised. Focal persons believed that the arbitrary nature by which they were selected cast a slur on the position. Furthermore, focal persons believed that management did not view the position of the focal person as

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highly important despite consensus on the importance of the role among the rest of the workforce.

Other challenges they reported included often being inundated by the demands of their substantive jobs and lack of technical capacity. Indeed, when pushed to make a choice, they would sacrifice an HIV assignment in the interest of the assignment for which they are to be appraised. Lack of funds and time remained important constraints to delivering quality services.

In the public sector, this particular problem of inadequate funding was more prevalent. In some cases, there was zero funding by respective Ministry, Department or Agency for HIV programmes. In such cases, funds for HIV had been mostly accessed through external financing by donors such as the Global Fund for TB, Malaria and HIV and multilaterals and bi-lateral donors such as the UN System and USAID/PEPFAR respectively. In recent times, the Government of Ghana has advanced a stipulated amount to the Ghana AIDS Commission (2013) towards co-financing the AIDS response in the public sector. This initiative is still not without its challenges of late disbursements and redirection of funds; a common phenomenon in the fiscal space prevailing in the country's resource challenged economic environment.

In the private sector this phenomenon of low funds was also prevalent in the small and medium sized locally owned enterprises or SMEs. The large scale private sector enterprises that were internationally owned had better programmes that were funded from their respective headquarters with an accompanying budget.

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6.2 Conclusions

Several studies (Addai Yeboah, 2004; Adjaye, 2004; Allen & Heald, 2004; Bora *et al*., 2010; Dickinson & Stevens, 2004; Chileshe, 2010; Hassan, 2005; ILO, 2007 and UNAIDS, 2004) have looked at the issue of HIV services at the workplace but have not focussed particularly on the nature of selection of HIV Focal person for HIV and AIDS workplace programmes in Ghana, which has been covered by this study

The Ghana UN General Assembly Report (2006) states that one out of every five (20%) public sector organizations and 17 out of every 25(68%) private sector organizations had policies and programmes that addressed HIV and AIDS. However, by 2009, the Ghana AIDS Commission UNGASS report for 2009 -2010 reported nothing on the status of workplace HIV policies. It had fallen off the 'barometer'. This was not contrary to the findings of the study concerning the diminishing importance that management ascribed to workplace programmes.

Findings further conclude that there is a general lack of awareness of the existence of HIV and AIDS policies and services at the workplace and absence of legislation to enforce policy implementation and focal person recruitment. This study further confirms that focal person absence leads to shortfalls in HIV Service provision at the workplace.

The study diagnoses the possible explanations behind these findings. One such explanation is the casualization of the important role the focal person plays in HIV service provision. This statement is backed by the lack of evidence of a laid down criteria for selection of a focal person beyond 'willingness' to undertake the assignment; by

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default in the instance where the focal point was a health worker (doctor, nurse or pharmacist); or by the volition of the staff members themselves.

Furthermore, the role a focal person plays in delivering HIV Services at the workplace has been shown by this study to be linked to the indicative assignments prescribed in their respective company HIV Workplace policies. In instances where the enterprise did not have its own workplace HIV policy, focal persons took up their HIV assignments from the National HIV and AIDS Workplace place policy. The study did not find any evidence of a job description specifically for HIV and AIDS focal person except where HIV assignments were indicated in the job description of a focal person (one who was a healthcare professional e.g. pharmacist, doctor or nurse).

The standard of workplace HIV services varied across enterprises and was found to be dependent on whether or not there was a focal person or clinic. The predominant services were condom promotion and distribution with VCT services being the lowest. In cases where VCT was present, it was limited to the enterprises with clinics or to ad hoc programmes on designated days such as the World AIDS Day. In enterprises with focal persons, there were attempts at workplace education but this was infrequent and highly dependent on availability of funds or the disposition of management.

In sync with other studies (Dickinson, 2004), the initial response of enterprises to HIV and AIDS in Ghana had been slow as in other countries like South Africa, but this appears to be accelerating; this has been observed by other researchers (Barnett &

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Whiteside, 2002; Clarke & Strachan, 2000; ILO, 2001; Rosen, Simon, Thea & Vincent, 2000; UNAIDS, 2000; Whiteside & Sunter, 2000).

This study has succeeded in explaining and describing the role of the focal person and the challenges they face. There is also a considerable body of literature on why companies respond to HIV and AIDS; why companies respond when they do; and why they respond in the ways that they do (Dickinson & Innes, 2004; Dickenson & Stevens, 2001; Sabcoha, 2002; Sabcoha, 2004; Stevens *et al*, 2003). However, there seems to be a paucity of literature aimed at explaining and describing the role of the focal person in the workplace response to HIV and AIDS among the workforce; the role they play to sustain workplace programmes as an effective means of HIV control and prevention; what motivates the focal person to execute his/her roles and the importance of the role of the focal person in workforce education.

Contrary to what is frequently presented on the economic impact of HIV (Haacker, 2004) and the influence of the financial impact in determining the response of enterprises (Dickenson *et al*, 2005), the study suggests that cost-benefit analyses used to calculate the financial impact of HIV and AIDS, while possibly explaining indirect and macro-implications, are not necessarily the only parameters driving enterprise responses to HIV and AIDS but HIV workplace policies and the presence of focal persons. These two parameters have influenced, and to some extent determined direction of the response of enterprises to HIV and AIDS.

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Social pressures on enterprises to respond to the epidemic are an important dimension in the enterprise response though there is no AIDS Law in Ghana presently. The scale and complexity of the need for workplace programmes have still relied on the motivation of the HIV focal person. Of greater reference in determining responses has been what other enterprises are doing, as focal persons are networked and interact through the Ghana Business Coalition on Employee Wellbeing and the Ghana Employers Association. This interaction has become a kind of push factor or peer pressure of 'what are other enterprises doing? It also forms a kind of positive peer review and motivation for the establishment of a workplace programme by enterprises which at times, may result in the recruitment or designation of a focal person.

This dynamic helps explain both the slow reaction of companies to the epidemic and the current acceleration in their responses as enterprises pick up on what other enterprises are doing. In Ghana, the limited visibility of the AIDS epidemic due to low HIV prevalence is also important in explaining the somewhat slow response of companies to HIV and AIDS. Moreover, the visibility of HIV and AIDS within other enterprises has influenced the responses of, generally weak, internal agents, the focal persons, who drive enterprise responses.

To date, there has been no attempt by policy makers to provide an overall framework in which the focal person operates. The interaction of the motivating factors or 'drivers' within the enterprise environment, and the nature of the actual responses by the workforce as influenced by the focal person still remains subjective. How these drivers of

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enterprise response to HIV behaviour change translate into concrete responses is made clear by the findings of this study. It gives understanding to the subject of focal person dynamics and an appreciation of the enterprise environment or context within which these focal persons must operate. This is important as understanding why focal persons and enterprises respond in particular ways will assist policy makers and financiers of workplace programmes (including the enterprises themselves) to pay critical attention to the issue of workplace HIV service provision. When the evidence is clear that it 'works', it will be easy for it to remain on the enterprise agenda. This will ensure that focal persons do not get frustrated when achievements fall short of their aspirations; instead they will come to appreciate or understand what is feasible within the context in which they operate.

6.3 Implications of Findings for Practice

The discussions and conclusions drawn from the findings of this study make it clear that the focal person system is feasible within the Ghanaian context. The study finds that activities of focal persons influence positively workers knowledge and attitudes towards the HIV positive as the indices of stigmatizing behaviour were found to be low. Thus, the study provides a firm basis for arguing that the focal person's presence is beneficial in assuring the provision of HIV services at the workplace. In view of the fact that the study revealed that some workplace programmes had expanded to include other illnesses, there is much mileage to be gained in using focal persons for HIV education in particular and health promotion in general. Details of implications of this for practice have been summarised as follows:

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6.3.1 Motivation of the Focal person

Motivation of the Focal person by way of recognition of the role as an appraisable job description is incumbent to the provision of quality HIV services. More importance should be placed on the role of the focal person positioning it as a formal one and institutionalized as a Health focal person. There was overwhelming evidence that the focal person is strongly associated with positive HIV and SRH choice outcomes among the workforce exposed to them. The possibilities to promote health at the workplace are unlimited.

Based on evidence from this study, the main areas that should be targeted in efforts to improve focal person service provision are training, financing and management involvement. The focal person can be a likely conduit for public health education on issues such as smoking, life style diseases, HIV and AIDS, Infectious diseases: cholera, Ebola, HINI etc. and sanitation/hygiene education.

6.3.2 Advocacy for the Enactment of Required Policy – Public Sector

The Public Services Act, Act 482 and the Civil Servants Act, Act 1960 currently does not have an appraisable position for the HIV focal person and thus does not have in its annals the job description nor specification. In view of the finding, consideration should be given to policy change towards the formalization and institutionalization of the position of the Health Focal Person. The mileage to be gained by government in job creation by formalizing that position and reduction in the health budget will be unparalleled. Many are the complaints of a mismatch between educational programmes and the needs of the

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nation, in the area of health education therefore the HIV focal person position possibly to be staffed by graduates of the schools of public health will provide many jobs.

6.3.3 Advocacy for the Enactment of Required Policy – Private Sector

As enshrined in the National Employment Policy (2014), incentivising private sector to establish and maintain this position will add to employment creation opportunities; possible incentives could be given by way of tax rebates by the Ghana Revenue Authority for companies with focal persons. This will encourage more workplaces to undertake health promotion programmes as budgetary constraints and low management involvement seemed quite high on the list of challenges facing focal persons.

6.3.4 Advocacy for setting of Minimum Standard for Selection of Focal Person in Workplaces

The Ghana AIDS Commission was established by an act of parliament to formulate policy and direct and co-ordinate national activities in AIDS response. The Commission as enshrined in Act 613, 2002, has to date been providing high-level advocacy for HIV and AIDS prevention control and effective leadership in national planning, fostering linkages among stakeholders as well as monitoring and evaluating HIV and AIDS programmes.

To this end, the commission is well poised to liaise with the Office of the Head of Civil Service, the Public Services Commission and the Ghana Employers' Association as well as the Trades Union Congress for concurrence on the setting of an agreed minimum

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standard for the selection of HIV focal points at the workplace. The GAC being mandated to spearhead the national response should set the criteria based on international good practice (the ILO Code of Practice on HIV and the World of Work and the ILO Recommendation 200 (2010).

This proposal is premised on the fact that, the Commission has mobilized resources for HIV interventions but complains of dwindling funding for the various aspects of the national response (Ankomah & Fenny, 2008). The minimal funds available should therefore be put to the most judicious use such as mainstreaming the role of the focal person within the Civil/Public service and the labour laws.

Furthermore, review of workplace documents during the study revealed that the Ghana National Workplace HIV Policy (2012) though indicating a collaboration between the Ghana AIDS Commission and the tripartite partners (i.e. Ghana Employers Association, the Trades Union Congress and the Ministry of Manpower Development and Employment) with the support of the International Labour Organization, does not set a criteria for the selection of HIV focal person.

Though the policy goal provides broad national guidelines to direct the formulation of enterprise workplace policies and programs, it is silent on the selection criteria for the workplace implementer, the focal person. Secondly, the broad objectives of the policy are: provision of protection from discrimination in the workplace for people living with HIV and AIDS; prevention of the spread of HIV and AIDS amongst workers, and to provide care, support and counselling for those infected and affected. This is somehow

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being met in enterprises with focal person, although slowly, it could be higher should there have been a standard criteria for workplace implementation.

Based on evidence from this study, the main areas that should be targeted in advocacy efforts for enhancement of the output of HIV workplace service providers (focal persons) are:

1) Workplace HIV standards setting for focal point selection.

2) Enhancing managerial support for the position of focal person by the enactment of an appropriate legislation

3) Institute tax cuts for companies that utilize funds in support of workplace and community programmes

4) Formalize and institute a minimum level of academic requirement for focal persons and

5) Provide motivation and in-service training for focal persons.

6.4 Suggestions for Future Research

The purpose of this study was to gain information and understanding about the phenomenon of the HIV focal person; explore, grasp and interpret the meaning, structure, and essence of the lived experience of the HIV Focal person (Patton, 2002). The study did not engage in a cost benefit analysis; that is, the determination of the quantum of funds advanced for services played against effectiveness, efficiency and utilization of services by the end user. There is little comparative cost information, as programmes varied across enterprises in many ways.

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To this end, new suggestions for future research are: 1) Undertake a cost benefit analysis of the services of the workplace HIV Focal Person approach against other social behaviour approaches (e.g. Social/mass media approach) or Bio-medical approach (e.g. Treatment) to determine which is better. 2) Investigate whether or not the phenomenon of the HIV focal person existed within the informal economy and the operational challenges faced there. This is relevant because the study did not look at the phenomenon of the focal person within the informal economy setting where majority of Ghanaians work (GSS, 2010).

6.6 Contribution to Knowledge

The study highlights important gaps in public health education for the working population. There have been several approaches to health promotion, using mass media methods as means to reach the general public (Wellings & Macdowall, 2000); and those that have looked at the cost-effectiveness of these media approaches and concluded that it is problematic to evaluate (Wellings K.& Macdowall W., 2000).

This study has described the operational challenges faced by focal persons, largely non-health staff and the loss of opportunity in educating a large captive adult population that results when this facility is not exploited. It can therefore be said that the study has contributed a wealth of literature on the operational challenges faced by focal persons; it also sets an important benchmark for future use by programme implementers and policy makers in Ghana

The study has also revealed that the FP's presence affects significantly, comprehensive knowledge of HIV and reduces stigmatizing behaviour of workers in Ghana.

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CHAPTER SEVEN: RECOMMENDATIONS

7.1 Introduction

In spite of the harsh economic conditions that make it difficult for management to give the needed financial resources and logistical support to focal persons, the evidence of the usefulness of the services has been made evident by the study. The study also shows that for this reason, enterprise initiatives on HIV and AIDS workplace service provision must be encouraged. Findings from this research further reveal the challenges focal persons face after being selected/identified. These challenges hinder their ability to deliver effective and efficient services at the workplace and provide a basis for arguing that just assigning a staff member to the position of HIV workplace focal person in an enterprise is not enough to ensure quality HIV services albeit their influence is better than not having one at all.

Evidence from the study further indicates that efforts to ensure quality service delivery at the workplace need to be geared towards issues surrounding the recruitment and selection of the HIV focal person; resourcing the position and motivating the HIV focal person to ensure continuity of service provision; improving quality of services and increasing the premium placed on services rendered by the focal person.

To this end, recommendations are being made in the following areas for the under-listed agencies and establishments in the areas of i) standardization of the focal person position ii) establishment of a Minimum Criteria for Workplace Service Delivery iii) development of educational programmes/curricula and iv) private sector involvement as follows:

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7.1. Standardization of Focal person Position by Responsible Government Agencies: GAC, MELR, OHCS and PSC

The Ministry of Employment and Labour Relations, Office of the Head of Civil Service (OHCS) and the Public Service Commission (PSC) should liaise with the Ghana AIDS Commission to institutionalize and set criteria for the post of FP across all sectors as the credibility of programmes are linked to standards and the credentials of implementers.

The voluntarism and arbitrariness of selecting focal person unveiled by the study does not assure a uniform standard in the credentials of the focal persons involved in workplace HIV service delivery. In view of the lack of standard protocols for the selection of focal persons and delivery of services unearthed by the study, it is recommended that a measure or instrument be developed and used as a tool for the selection of focal persons and the implementation of workplace HIV-related services.

The standardization process can further be strengthened by giving official recognition to the position within the Civil/Public Service structure. It is being advocated that policy reforms be instituted to formalize and institutionalize the position of FP. This will ensure optimization of service delivery by staff assigned to the workplace.

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7.1.2 Establishment of a Minimum Criteria for Workplace Service Delivery across Workplaces by the Ghana AIDS Commission

Due to mixed array of backgrounds of FP and for quality assurance purposes, the Ghana AIDS Commission should enforce a benchmark for what qualifies as workplace programme and service delivery and as well establish standardized training/refresher training to sustain these programmes once established.

Quality assurance, a process of improving the outcome of functional ability, well-being and satisfaction of beneficiaries of a service must be introduced into workplace HIV service provision by the GAC. This will entail, setting up a quality assurance mechanism that looks at the structures and inputs required; assists in analysing and re-engineering service delivery processes and measuring workplace service provision outcome.

Based on evidence from this study, the main areas that the GAC should target in efforts to set a standard for workplace service delivery should be as follows:

a) Set standards and accreditation protocols aimed at continuously improving overall performance of focal persons. Protocols should include a robust monitoring and evaluation tool as well as a performance monitoring plan.

   The proposed standard for HIV workplace service delivery should include:

   i. An HIV Committee with the duties to ensure engagement the relevant human resource and financial management

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ii. Information management that is underpinned by the principles of privacy and confidentiality, informed consent, autonomy and dignity

iii. HIV/AIDS prevention activities at the workplace should include the promotion of safe sex and condom use as well as condom distribution.

iv. HIV Education at the workplace which should be on the following issues:

- Provision of information on or referral for HIV testing and counselling,
- Preventing and treating opportunistic infections including TB, delivering antiretroviral therapy, preventing mother-to-child transmission adhering to treatment support where the enterprise has a clinic. In the event of such not being available referrals to the relevant agencies must be made.
- Providing psychosocial support, with links to home- and community-based care.

v. Delegation of a ministerial authority for public and civil service accreditation; and non-governmental agencies such as the Ghana Business Coalition on Employee Wellbeing and the GEA to manage private sector accreditation. This should be done in an inclusive manner with consultation of all relevant stakeholders.

vi. Enact laws governing the operation of focal persons or the institution of HIV workplace service provision as part of the HIV Law currently being drafted or ensure that an enforceable legal framework exists. Enforcement of such a law will warrant the development of budget lines for HIV across sectors, as the absence of it will amount to an offence. This will guarantee funding is available for workplace provision of services and increase the value placed on the interventions provided by the HIV focal person.

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vii. Formulate written plan on human, logistic, and financial resources that are available for the HIV and AIDS programme to be endorsed by senior management in all implementing agencies. The plan should clearly define the governance and leadership of the programme at the enterprise level. This would include the position of focal person being stipulated on enterprise organizational charts.

viii. Build a compendium of HIV services required within the workplace setting through broad stakeholder consultation and expert advice.

b) The GAC should liaise with the Ministry of Health to consider the expansion of the role of the HIV focal person to cover other illnesses of Public Health Importance. This is because in resource poor settings (in low to middle income countries) such as Ghana, it is more pertinent to employ a myriad of interventions to support workers through the stages of behaviour change in potentially low-cost ways. This will ensure public safety in other diseases of public health importance such as Ebola, HINI, Cholera, and HIV etc. as well as life style diseases, reproductive health and issues on environmental health. The recent scourge of Ebola in Liberia, Sierra Leone and Guinea, and the unprepared community and workforce response (WHO, 2014) lends credence to the above statement

7.1.3 Educational Programmes and Curriculum Development

The School of Public Health (The department of Social and Behavioural Sciences - SOBS in particular) should consider a sandwich course in workplace education for FP. Such educational programmes and courses or modules should be designed and incorporated into non-health worker educational programmes and curricula for all non-health disciplines e.g. human resource personnel and administrative workers who form the bulk of workplace HIV focal persons. These

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courses or modules could include health education and promotion, adult education, behaviour change communication, HIV and sexual reproductive health etc. It is therefore being recommended that candidates to the position of focal person should have the possibility of being formally trained in this area in a sandwich programme as is done for occupational health and safety officers at the school of Public Health, University of Ghana, Legon in Ghana and other such schools in Ghana.

7.1.4 Private and Public Sector Engagement – GEA, PEF and AGI

Small and medium scale enterprises could hardly provide funds for workplace service delivery. Besides the need for resources, the resolve of management is also required to commit to the workplace HIV service provision. To this end, private sector stakeholders such as the Ghana Employers' Association (GEA), Association of Ghanaian Industries (AGI) and Private Enterprises Foundation (PEF) should lobby government through the Ghana AIDS Commission for tax rebates to support the position of HIV focal person. Money thus freed will be used for the activities of focal persons and as well mitigate the impact of HIV on both the infected and affected workers in enterprises. These entities should engage in continuous advocacy and capacity building of management and policy makers within their network as part of the standard setting to ensure HIV remains on the private sector workforce agenda

7.1.4.1 Capacity Building at Enterprise Level – Ghana Chamber of Commerce and GEA

The private and public sectors should engage in continuous capacity building of all HIV focal persons through individual and group mentoring. Building focal person capacity at the individual

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level through in-service training, structured refresher courses, and knowledge exchange fora (e.g. during Annual General Meetings) will improve the outcomes of workforce education in non-health settings such as the workplace. This recommendation is proposed to be implemented by human resource managers of both public and private sector in the light of the findings that majority of focal persons were human resource personnel, who by the nature of their training are not exposed to health promotion and education methodologies.

Finally, findings suggests that, the problems facing HIV focal persons in Ghana are surmountable however, it would take the political will and commitment of relevant stakeholders: Ghana AIDS Commission; Law makers; Public Services Commission; Head of Civil Service; relevant training institutions and private sector leadership to resolve them. There is the need for a holistic approach to develop coordinated strategies to address workplace standards in the selection and grooming of HIV focal persons at the enterprise and public sector levels. Taking an all-inclusive view of the problems and solutions is necessary to developing strategies that aim at consolidating the work of the workplace HIV service provider.

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ANNEX 1 CONSENT FORMS

Title: The Role of Workplace HIV and AIDS Focal Person in HIV and AIDS Education and Service Delivery

Principal Investigator: Ms Akua Ofori-Asumadu

Address: School of Public Health

University of Ghana
P.O Box LG 25
Legon, Ghana

General Information about Research

You are invited to participate in a research study on the Role of Workplace HIV and AIDS ocal person in HIV and AIDS Education and Service Delivery. For the purpose of this study, we are defining HIV and AIDS focal person personnel as the staff member assigned the duty of facilitating these workplace HIV and AIDS programme interventions. We hope to learn more about the attitudes, perceptions and experiences associated with using these focal person personnel in Ghana. With your permission, we would like to collect information about you. Most of this information was collected through focal group discussions, in-depth interview and questionnaires.

Time Involvement

Your participation in this study will involve an initial visit where this study is explained to you, after which you will participate in focal group discussions, in-depth interviews and fill a questionnaire.

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Compensation

You will not be paid to participate in this study. You will also not be compensated for costs including your time of travel to the research site or place of interview. However, research assistants may be available to visit you and conduct follow up interviews at your convenience at a pre-designated private location of your choice. This is intended to defray the costs of your participation in this study.

Possible Risks and Discomforts

We will ask questions about your sexual behavior and what you think about HIV and AIDS

Possible Benefits

We cannot and do not promise or guarantee that you will receive any benefits from this study apart from contributing to greater knowledge about the Role of Workplace HIV and AIDS focal person in Ghana.

Alternatives to Participation

Your participation in this study is completely voluntary. You can choose not to be involved or you can discontinue at any time. You can also choose which segment of the interview process to participate in. That is, whether the focus group discussion, in-depth interview or questionnaire.

Confidentiality

We will protect information about you to the best of our ability. Your name or any other identifying information will not be given in any reports or private details that may be used to identify you. Your occupation or place of residence may be changed or altered in order to protect your identity. Some staff, including the principal investigator, co-investigators and research

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assistants may sometimes look at your research records for the purpose of data management and analysis.

Additional Cost

Additional costs that you may incur would involve your time and travel to the site of interview. However, we can arrange for interviews to occur after your normal scheduled appointments or a research assistant may also meet you at a convenient time and place for follow-up interviews.

Voluntary Participation and Right to leave the Research

Your participation in this research study is completely VOLUNTARY. If you have read this form and have decided to participate in this project, please understand that your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty.

Contacts for Additional Information

If you have any further questions, concerns or complaints regarding your rights to participate, please contact:

Akua Ofori-Asumadu

Principal Investigator

Email: aoasumadu@yahoo.com

Your rights as a participant

This research has been reviewed and approved by the College of Health Sciences at the University of Ghana and the School of Public Health's Committee for Biomedical Research in Ghana. If you have any questions about your rights as a research participant you can contact (name of person) between the hours of through the landline or email address

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Volunteer Agreement

The above document describing the benefits, risks and procedures for the Role of HIV and AIDS Focal Person has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

----------------------------------   ---

Date   Name & Signature of Volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

----------------------------------   --

Date   Name & Signature of witness

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

----------------------------------   ---

Date   Name & Signature of person who obtained consent

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ANNEX 2 KEY INFORMANT INTERVIEW GUIDE

Key Informant Interview Guide

For Interviews with Focal Persons for A Study of Ghana on The Role of Workplace HIV and AIDS Focal Person in HIV and AIDS Education and Service Delivery

Name of Organisation : Person interviewed:

Function of interviewee: Date:

…………………………………………………………

HIV and AIDS in the Workplace

Why this research?

Mainstreaming HIV and AIDS in the workplace is critical. This research will therefore focus on this issue. Currently workplace programmes are gaining popularity. There is more and more the call for evidence based results for donors to commit themselves to releasing, money for workplace programmes and also the need to harmonize the responses across workplaces. This is becoming of critical importance as there is lukewarm donor interest in HIV in the workplace due to downsizing due to budget cuts. It is unclear what the total contribution of workplace responses is to HIV prevention or the capacity needs of those that implement workplace programmes.

The prime audience for the findings from this research was for academic purposes to enrich knowledge in workplace programmes and provide data for programme development, design and implementation. It will give hard evidence needed to better support workplace responses to HIV

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and AIDS.

Aim of research:

1. To assess the current status of HIV and AIDS workplace Programmes in Ghana

2. To assess the roles and responsibilities of the HIV focal person in delivery of HIV Services at the Workplace in different settings

3. To verify the existence or otherwise of a uniform standard in HIV services delivery at the workplace.

Questions to address:

Internally

1. How much of a threat to your organisation is HIV and AIDS?
2. What have you done about it? (e.g. policy, awareness, education, care, treatment activities) Has this come from your head office as a matter of policy or locally as a response to local needs?
3. Is this more or less than 12 months ago (are HIV workplace issues gaining or diminishing in importance?) Why is this do you think?
4. How is access to VCT and ARVs in your country?
5. What impact is this having on HIV in the workplace?
6. How much does your response to HIV in the workplace cost you (% of staff costs)?
7. A) What has been the staff response? B) To what extent are they taking up the HIV and AIDS services you are offering? C) Why do they think there has there been

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success/failure?

8. What kind of organisation do you belong to?
9. What has been the impact of your HIV response on your organisation?
10. How do you know? What monitoring system do you use?

Personally

1. What is your role in Workplace programmes
2. What is your level of Education
3. Have you been ever formally trained to undertake your role
4. What was the duration of the training
5. When was the last time you were trained
6. What was the content of the training
7. What are the tools you use in your job
8. Do you have a written Job Description for the HIV work you do
9. Are you appraised for promotion purposed on HIV
10. Are you a full time HIV focal person
11. What is the percentage of time you spent on HIV is you are not full time
12. do you feel adequately capacitated to undertake your role
13. What are your training needs if any
14. What would you recommend for your position
15. Who is your supervisor
16. Do you have a yearly budget for your activities

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ANNEX 3 FOCUS GROUP DISCUSSION GUIDE

Guide for Focus Group Discussions with Beneficiaries of HIV Work Place programmes for A Study of Ghana on The Role of Workplace HIV and AIDS Focal Person in HIV and AIDS Education and Service Delivery in Selected Ghanaian Enterprises

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Name of Organisation: Names of People being interviewed:

Function of interviewees:

Date:……………………………………

Why this research?

According to the Global Fund Observer, an independent newsletter about the Global Fund provided by Aidspan to over 8,000 subscribers in 170 countries, the Global Fund Board for HIV and AIDS Malaria and Tuberculosis cancelled Round 11 funds disbursement in light of the Global Fund's financial difficulties. According to the Observer, the estimate of funds available for Round 11 declined to $0.8 billion in September 2011, and then to a negative amount in November 2011. The decline was caused primarily by some donors changing their minds regarding their pledges, and other donors saying that they would delay payment of their pledges (Issue 167: 23 November 2011).

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From above it is evident that there is a current decline in funds to the AIDS response . Though workplace programmes are gaining popularity, the call for evidence based results for donors to commit themselves to releasing money for workplace programmes and also the need to harmonize the responses across workplaces is gaining importance in these resource constrained times. This is becoming of critical importance as there is lukewarm donor interest in HIV in the workplace due to downsizing due to budget cuts. It is unclear what the total contribution of workplace responses is to HIV prevention or the capacity needs of those that implement workplace programmes.

The prime audience for the findings from this research was for academic purposes to enrich knowledge in workplace programmes and provide data for programme development, design and implementation. It will give hard evidence needed to better support workplace responses to HIV and AIDS.

Aim of research

1. To assess the current status of HIV and AIDS workplace Programmes in Ghana
2. To assess the roles and responsibilities of the HIV Focal Person in delivery of HIV Services at the Workplace in different settings
3. To verify the existence or otherwise of a uniform standard in HIV services delivery at the workplace.

<u>Questions to address:</u>

1. How much of a threat to your organisation is HIV and AIDS?

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2. What has been done about it? (e.g. policy, awareness, education, care, treatment activities)
3. Do you feel what has been done is adequate, if so why?
4. If there is a policy, is it Drafted; accepted; disseminated; or is the review process in place? Does it cover Medical and pension benefits etc?
5. Has this come from your head office as a matter of policy or locally as a response to local needs? E.g. Critical vulnerabilities identified and covered by training or other responses?
6. Is this more or less than 12 months ago (are HIV workplace issues gaining or diminishing in importance?) Why is this do you think? Are there guidelines; training and support for managing HIV and AIDS issues?
7. Do you have an HIV Focal Person, Do you know his/her name?
8. What impact is this having on HIV in the workplace?
9. What HIV and AIDS services have you accessed? If you have not, why?
10. Does management take active part in the HIV programmes?

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ANNEX 4 WORKPLACE SURVEY TOOL

DATE: _______ / _______ / _______

DAY MO YR

Questionnaire Number: ______________ Interviewer: ____________________

Workplace: __________________ Country _______________________

Interviewer Instructions (READ OUT LOUD): -My name is... I am undertaking a research in the role of the focal Person in HIV service delivery. I will be interviewing you to see what you understand about HIV and AIDS and the level and quality of service you have at the workplace. The information from this interview will help to increase the knowledge in HIV prevention at the workplace, a key intervention method for communicating behaviour change in HIV to the adult population. As well it will give a wealth of information necessary for implementers to monitor programs designed to assist workers to protect themselves against HIV and AIDS with help from employers and HIV Focal Person assigned to offer workplace HIV education and services.-

Confidentiality and Consent: -I'm going to ask you some personal questions about your sexual behaviour and what you think about HIV and AIDS. (Signature of interviewer certifying that informed consent has been given verbally/ and in writing - see

Consent form- by respondent)

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Section 1: Socio-demographic Information

Number	Questions and Filters	**Categories**	Code	**Skip to**
Q100	What is your occupation, what kind of work do you mainly do?	Administrative Services (Security cleaning, gardening etc) Technical Management Other .... Don't know	1 2 4 5 100 88	
Q101	Sex of Respondent	Male Female	1 2	
Q102	How old were you on your last birthday?	Age in completed years Don't know No response	(…..) 88 99	
Q103	Have you ever attended school?	Yes No	1 2 →	 105
Q104	What is the highest level of formal school you have completed?	Primary JHS Middle School SHS Tertiary No response	1 2 3 4 5 99	
Q105	What is your position at work?	Non-Management/Worker Management Other: Specify…………...………… HIV focal person/Person Health Worker(e.g. Nurse, doctor)	1 2 100 88 99	
Q106	How long have you been working here?	0 to 6 months More than 6 months to 12 months More than 1 year to 2 years Over 2 years No Response	1 2 3 4 5 99	
Q107	What is your current job Specification?	HR Administrative	1 2	

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Number	Questions and Filters	**Categories**	Cod e	**Skip to**
		Technical Training/Academia No Response	3 4 99	
Q108	What is your marital status now?	Married Cohabiting/live in partner widowed Divorced Alone Other…………………………… No Response	1 2 3 4 5 100 99	
Q109	What is your ethnic group	Asante Fanti Akuapem Sefwi Brong Nzema Ga/Dangbe Wali/Dagari Sissala Other ------------------- Don't know	1 2 3 4 5 6 7 8 9 100 88	
Q110	Can you read and understand a letter or newspaper in (a language) :	Easily with difficulty or not at all	1 2 88	
Q111	What is your religion?	Christianity Traditional Religion Islam No Religion Other..............................	1 2 3 4 100	

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Section 1B - This section is for Focal persons or Staff responsible for HIV only				
Q101B	Have you been officially designated to deal with HIV at the Workplace?	Yes No Don't Know No Response	1 2 88 99	 →201
Q102B	What is your title?	Focal Person Focal Person Peer Educator HIV Committee member Other Don't Know No Response	1 2 3 4 100 88 99	
Q103B	Your official Assignments or Job description include ensuring:	Workplace education/training programmes distributing IEC/ BCC Materials STI referral/ management Condom promotion/distribution HIV Testing and Psycho Social Counselling Treatment or referral Other Don't know No response	[ ] [ ] [ ] [ ] [ ] [ ] [ ] 100 88 99	
Q104B	What is the specification of your position?	Full-time part-time Other Don't Know	1 2 100 88	
Q105B	What are the types and number of HIV services you are able to offer at the workplace?	Workplace education training programmes distribution of IEC/ BCC Materials STI referral/ management Condom promotion/distribution HIV Testing / Psycho Social Counselling Treatment or referral Nutrition, Care and support facilities Other Don't Know	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] 100	

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		No Response	88 99	
Q106B	How many years have you been a focal person?	0 to 6 months More than 6 months to 12 months More than 1 year to 2 years Over 2 years	1 2 3 4	
Q107B	Do you see yourself as well equipped to provide HIV Services at the workplace	Yes No No Response	1 2 99	→ Q109B
Q108B	What are the areas you require training in?	Basic Fact in HIV Teaching Skills Behaviour Change Communication STI Management Health Promotion methodologies Counselling Skills Treatment or referral Public speaking Record Keeping Other No Response	[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] 100 99	
Q109B	What is the longest you have been trained on HIV or Health?	1-10 days 1– 6 Months 1 year and over Other	1 2 3 100	
Q110B	What type of training have you received?	Peer Education Focal person training HIV Counsellors training Health Worker Training (Doctor, Nurse, Pharmacist etc) Other	[ ] [ ] [ ] [ ] [ ] 100	
Q111B	Were you trained by your enterprise?	Yes No No Response	1 2 99	

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Section 2 HIV and AIDS Knowledge and Attitudes

Number	Questions and Filters	Categories	Code	Skip to
2.0 The next set of questions asks you if and how you heard about HIV and AIDS addresses objective 2: To assess the roles and responsibilities of the HIV focal person in delivery of HIV Services at the Workplace as a construct of their job description and specification viz a viz the services the staff have accessed				
Q201	Have you ever heard of HIV or the disease called AIDS? NOTE: questions 201-210 are to access retention of purported HIV training and measure exposure	Yes No Don't Know No Response	1 → 2 → 88 99	202-209 204
Q202	From what sources have you heard about HIV AND AIDS? **Interviewer: check appropriate boxes**	Mass Media Health Provider Outside Workplace Workplace Labour Union Representative NGO Family or Friends Co-worker Other……………………………	[ ] [ ] [ ] [ ] [ ] [ ] [ ] 100	
Q203	Which was the best source of information for you about HIV AND AIDS **Interviewer: check one box**	Mass Media Health Provider Outside Workplace Workplace Labour Union Representative NGO Family or Friends Co-worker Other……………………………	[ ] [ ] [ ] [ ] [ ] [ ] 100	

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Number	Questions and Filters	**Categories**	Code	**Skip to**
2.1 The next set of questions asks you about how you can become infected with HIV, the virus causing AIDS. One question uses the term 'penetrative sex.' By this we mean vaginal or anal sex (stigma index related to level of HIV education that workers have received research question 3 -Does the presence of a designated (job description and specification) focal person impact on type and number of HIV services offered at the workplace?				
Q204	Is there anything a person can do to get infected with HIV	Yes No Don't Know No Response	1 2 88 99	 → 206 → 206
Q205	What can a person do? Any other way? Record all other ways mentioned	by having unprotected penetrative sex with a person who is infected with HIV by transfer of bodily fluids, such as blood or breast milk, from a person who is infected with HIV by sharing needles with a person infected with HIV From a mother infected with HIV to her unborn child Other	1 2 3 4 100	
The next questions ask you about how you can keep yourself from becoming infected with HIV, the virus causing AIDS				
Q206	What can a person do to avoid HIV	Use a Condom Abstain from Sex Have only one faithful Sexual partner Avoid sex with Female/male sex workers Avoid needle sharing Avoid sharing blades	1 23 4 5 6 7 8 9	

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Number	Questions and Filters	**Categories**	Code	**Skip to**
		Avoid mosquito bites Avoid kissing Seek protection from traditional healer /pastor Safe sex Other .... Don't know	10 11 100 88	
Q207	What does safe sex mean?	Abstain from sex Use condoms Have only one sexual partner Avoid sex with commercial sex workers Other .... Don't Know No Response	1 2 3 4 100 88 99	
The next questions ask you about what you think should be done at the workplace and in the community concerning HIV				
Number	Questions and Filters	**Categories**	Code	**Skip to**
Q208	Do you think your chances of getting AIDS are	Small Moderate Greate No risk at all Already have it Don't Know No Response	1 2 3 4 5 88 99	
Q209	Is HIV a workplace Problem	Yes No Don't Know No Response	1 2 88 99	 211
Q210	What do you suggest the workplace should do for infected workers	Provide free medical treatment Help family members Dismiss Worker Should not be involved Other Don't Know	1 2 3 4 100 88	

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Number	Questions and Filters	**Categories**	Code	**Skip to**
		No Response	99	
211	Why is HIV not a workplace problem?	It is a Health Problem Not the mandate of the workplace No staff adequately trained to deal with it Don't Know No Response	1 2 3 88 99	
Q212	Has your knowledge of HIV influenced or changed you to talk about it at:	Yes No Don't Know No Response	1 2 88 99	
The next questions ask you about how you feel about using condoms if you have penetrative sex with a person other than your spouse or live-in partner, meaning vaginal or anal sex.				
Q213	Do you believe a condom should be used if you have penetrative sex with a person other than your spouse or live-in partner?	Yes No Don't Know No Response	1 2 88 99	
Q214	Which of the following do you believe is acceptable to be found carrying condoms: or to carry condoms with them?	married men single men Single women married women any person older than: 16[ ] 18[ ] 21[ ] Don't Know No Response	1 2 3 4 5 6 7 99 88	
Number	**Questions and Filters**	**Categories**	**Code**	**Skip to**
Q215	Do you believe that it is acceptable for to use condoms in marriage situations?	Yes No Don't Know No Response	1 2 88 99	
The next set of questions asks you about how you feel about people who have HIV or AIDS				
Q216	Would you be willing to	Yes	1	

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Number	Questions and Filters	**Categories**	Code	**Skip to**
	work alongside a co-worker who is HIV positive?	No Don't Know No Response	2 88 99	
Q217	Would you be willing to use the same toilet as a co-worker who is HIV positive?	Yes No Don't Know No Response	1 2 88 99	
Q218	Would you be willing to eat food at a company canteen prepared by a co-worker who is HIV positive?	Yes No Don't Know No Response	1 2 88 99	
Q219	Would you be willing to share utensils with a co-worker who is HIV positive?	Yes No Don't Know No Response	1 2 88 99	
Number	**Questions and Filters**	**Categories**	**Code**	**Skip to**
Q220	Would you be willing to share an desk with someone who is HIV positive?	Yes No Don't Know No Response	1 2 88 99	
Q221	Would you be willing to receive medical treatment from a healthcare worker who is HIV positive?	Yes No Don't Know No Response	1 2 88 99	
Q222	In the last 3 months, have you heard or known of someone in your workplace gossiping about a co-worker	Yes No Don't Know No Response	1 2 88 99	

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Number	Questions and Filters	Categories	Code	Skip to
	suspected of being HIV positive?			
Number	Questions and Filters	**Categories**	Code	**Skip to**
Q223	In the last 3 months, have you heard or known of someone in your workplace refusing to work with a co-worker suspected of being HIV positive?	Yes No Don't Know No Response	1 2 88 99	
Q224	In the last 3 months, have you heard or known of someone in your workplace refusing to eat with a co-worker suspected of being HIV positive?	Yes No Don't Know No Response	1 2 88 99	
2.2 The next set of questions asks about how your company treats people who might have HIV and AIDS and assesses how integrated the company's HIV Policy and programme may be related to objective 3 To verify the existence or otherwise of a uniform standard in HIV services delivery at the workplace.				
Q225	Do you believe a physically fit worker in your company would be sacked if he/she was known to be or was suspected of being HIV positive?]]	Yes No Don't Know No Response	1 2 88 99	
Q226	Does your employer have a	Yes	1	

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Number	Questions and Filters	**Categories**	Code	**Skip to**
	policy that keeps people who are HIV positive employed as long as they can perform their duties?	No Don't Know No Response	2 88 99	
Q227	Do you believe a physically fit worker at your workplace would be denied promotion, salary increases, training or other career development opportunities if he or she was known to be or was suspected of being HIV positive?	Yes No Don't Know No Response	1 2 88 99	

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Section 3 HIV and AIDS Services

Number	Questions and Filters	**Categories**	Code	**Skip to**
The next questions ask you about HIV and AIDS services you may have received at the workplace. This set of questions assesses the types and extent (the quality) of HIV services at the workplace – objective 3				
Q301	Are you aware of any HIV AND AIDS services available at your workplace?	Yes No Don't Know No Response	1 2 → 88 99	 401
Q302	If so, which HIV and AIDS services at your workplace are you aware of? **Interviewer: please check boxes**	Education Condom Availability STI Treatment Information VCT Information HIV Treatment Care and support information Other (Specify)	[ ] [ ] [ ] [ ] [ ] [ ] 100	
Q303	In the past 6 months have you received any HIV and AIDS education, such as a training course, that was led by an expert or peer counsellor at your	Yes No Don't Know No Response	1 2 88 99	

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Number	Questions and Filters	**Categories**	Code	**Skip to**
	worksite?			

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Section 4 HIV and AIDS Policy Environment

Number	Questions and Filters	**Categories**	Code	**Skip to**
4.0 The next set of questions asks you about your knowledge of HIV and AIDS policy at your workplace. This is to address Research question To verify the existence or otherwise of a uniform standard in HIV services delivery at the workplace. This is because a policy is an indication of a standardized way of delivering a service				
Q401	Does your employer have an HIV and AIDS policy statement that protects employees who have HIV and AIDS?	Yes No Don't Know No Response	1 → 2 → 88 → 99 →	402 405 405 405
Q402	What are the components of the workplace HIV and AIDS policy/statements? **Interviewer: please check boxes of components mentioned by respondent**	Non discrimination No mandatory HIV AND AIDS test Medical confidentiality Universal precaution Access to education Other………………	[ ] [ ] [ ] [ ] [ ] 100	
Q403	According to workplace policy, do all employees have the right to the same treatment regardless of HIV status?	Yes No Don't Know No Response	1 2 88 99	
Q404	According to workplace policy, are job applicants or workers required to take a test for HIV for employment or promotion?	Yes No Don't Know No Response	1 2 88 99	

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Number	Questions and Filters	**Categories**	Code	**Skip to**
	(Note: -YES- is a negative answer in this question)			
Q405	According to workplace policy/guidelines, are employees' medical records confidential?	Yes No Don't Know No Response	1 2 88 99	
Q406	What are the HIV structures at your work place:	HIV Focal Person Peer Educators Health Worker HIV Committee Other Don't Know No Response	[ ] [ ] [ ] [ ] 100 88 99	
Q407	How was the selection of the above effected	Internal Advert External Advert Appointment by management Self appointment Other Don't Know No Response	1 2 3 4 100 88 100	
Q408	What necessitated the appointment of the committee or the position?	Staff became positive Company policy Government policy Staff becoming positive Other Don't Know No Response	1 2 3 4 100 88 100	

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Annex 5 Budget and Activity Plan

No	ITEM	No. units	unit cost	no. days	Total	Extd.
A.	**1-DAY TRAINING FOR SUPERVISORS AND FIELD STAFFAND ORIENTATION OF RESEARCH TEAM**					
1.	Workshop package (meals, meeting room)	10	15	1	150	
3.	Transport refund for participants	10	20	1	200	
B.	**PILOT-TESTING OF QUESTIONNAIRE**					
1.	Honourarium for field staff	5	35	1	175	
2.	Transportation to field sites	5	20	1	100	
3.	Meals	5	10	1	50	
4.	Analysis and Review [1/2 day]	3	22	1	66	
C.	**Field work**					
2.	Transportation to field sites	6	20	2	240	
4.	Honorarium for Field Staff	6	35	4.5	945	
5.	Meals	6	10	4	240	
					1425	1425
F	**PROFESSIONAL INPUT**					
2.	Data Analyst	1	50	10	500	
4.	Data Entry[per questionnaire]	230	1	1	230	
5.	Secretary	1	100	1	100	
G.	**Dissemination of Baseline findings Seminar**	25	10	1	250	
					250	250
H.	**SUPPLIES**					
1.	Duplicating Paper	4	10	1	40	
2.	Toner	1	130	1	130	
					170	170
I.	**5% Contingency**	1		I		170.8
	J. Grand Total					**3586.8**

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Activity Plan

	Month						
ACTIVITY	**1**	**2**	**3**	**4**	**5**	**6**	7
Training	x						
Pre-Test	x						
Analysis and Review	x						
Data Collection		x	x	x			
Data Analysis				x	x		
Report Writing				x	x	x	
Finalise Report withSupervisor							x