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## Support to the HIV/AIDS Response in Zambia II



**SHARE II**

### Baseline Workplace Assessment: Employee Knowledge, Attitudes and Practices (KAP) Survey Final Report

December 2013

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## List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretrovirals
CBO	Community Based Organization
CDCS	Country Development Cooperation Strategies
CHAMP	Comprehensive HIV/AIDS Management Program
CSW	Commercial Sex Worker
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
ILO	International Labor Organization
IR	Intermediate Result
IRB	Institutional Review Board
JSI	John Snow, Inc.
KAP	Knowledge, Attitudes and Practices
LTA	Livingstone Tourism Association
NAC	National HIV/AIDS/STI/TB Council
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OVC	Orphans and Other Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
RTI	Reproductive Tract Infections
SA	Situation Analysis
SHARe	Support to the HIV/AIDS Response in Zambia
SHARe II	Support to the HIV/AIDS Response in Zambia II
STD/STI	Sexually Transmitted Disease/Infection
USAID	United States Agency for International Development
USG	United States Government
HTCZDHS	Zambia Demographic and Health Survey
ZHECT	Zambia Health Education and Communication Trust
ZINGO	Zambian Interfaith Networking Group on HIV

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## **Executive Summary**

### **Introduction**

HIV and AIDS have deeply impacted Zambia; as of the latest Zambia Demographic and Health Survey (ZDHS) in 2007, approximately 1.5 million Zambians were estimated to be living with HIV. The overall adult HIV prevalence among those 15-49 years of age was 14.3%: 16.1% in women, compared to 12.3% in men.

Fortunately, studies have generally shown that workplace programs designed to prevent HIV/AIDS are both feasible and successful, and can increase the uptake of HIV testing and counseling, decrease risky sexual behavior and decrease self-reported sexually transmitted infections (STIs). Although workplaces alone cannot stop the spread of HIV (or STIs), experience suggests that workplaces are a prime environment to provide the resources and skills necessary to positively influence people's attitudes and behavior related to HIV/AIDS.

The objective of this study was to establish baseline knowledge, attitudes and practices among employees in project workplaces, thus facilitating monitoring and evaluation of changes in employee knowledge, attitudes and practices over the life of the United States Agency for International Development (USAID)-funded Support to the HIV/AIDS Response in Zambia II (SHARe II) project. Primary evaluation questions included rates of condom use among employees; knowledge and attitudes about condom use, HIV/AIDS and other STIs; experience with and attitudes towards people living with HIV; and knowledge of workplace peer education programs.

As part of its workplace engagement division, SHARe II expands access to workplace programs in the public, private and informal sectors, and fosters linkages and referral systems with community-level partners and implementers to expand access to HIV prevention, care, support and treatment services for employees, dependents and—where feasible—to defined outreach communities to reduce HIV-related employee absenteeism, and ultimately to contribute to increased productivity, profitability and economic development. These baseline findings provided SHARe II staff and workplace managers with information for improving and targeting HIV/STI prevention activities.

This KAP survey was a cross-sectional, interviewer-administered quantitative survey targeting SHARe II-supported workplaces. In order to limit the burden on workplaces faced with multiple surveys, SHARe II used the endline data collected in May-June 2010 from its predecessor SHARe project as a baseline, for those 22 workplaces that were continuing with the SHARe II project, for a total of 553 sampled employees. The second cohort of data collection took place in November 2011, with 32 newly-participating workplaces with 690 employees sampled.

### **Results**

A total of 1,243 employees (67.0% male and 33.0% female) were sampled from SHARe II-supported workplaces from across Zambia. The average age of respondents was 37 years, and 87.1% of them had worked at their jobs for at least a year. The majority (69.9%) were married.

Almost all respondents reported having ever had sexual intercourse (96.2%), with 89.2% of these respondents having had intercourse within the last twelve months. Of respondents that had intercourse within the last twelve months, the large majority had sex with a regular partner (87.1%) while 9.9% had sex with at least one non-regular partner, and 5.1% of men with a commercial sex worker.

Condom used varied based on the nature of the sexual relationship; a quarter reported using condoms with their regular partners during the last sexual encounter, while three-quarters reported condom use with non-regular partners and 89% with commercial sex workers. The primary reason respondents used a condom during the last sexual encounter with a regular partner was to prevent pregnancy (78.8%), while with non-regular partners and commercial sex workers, the primary reason was to prevent HIV/AIDS (72.9% and 93.6%, respectively).

The main reason for *not* using condoms during the last sexual encounter with both regular and non-regular partners was due to trust in their partners (80.3% and 59.7% for regular-versus non-regular, respectively). A greater percentage of women than men said that they did not use a condom during their last sexual encounter because their partner refused or objected (12.3% compared to 2.5%). A majority of respondents, however, noted that they could freely talk about condoms with both regular and non-regular partners (81.4% and 83.7%, respectively).

Nine out of ten respondents said they had received information about how to use a condom, and 88.7% of all respondents said they knew how to use condoms correctly. Top sources of information about condom use included peer educators, media, friends and health centers. However, although almost all respondents knew where they could find condoms, 24.1% said it was difficult to actually obtain one. Only 61.1% said they felt comfortable buying condoms in their neighborhood (64.2% of men and 54.8% of women), and 54.2% felt comfortable carrying condoms with them (55.8% of men and 50.6% of women).

Basic knowledge of HIV/AIDS was high across the sampled workplaces, but only 85.4% knew that there is no cure for AIDS, and only 41.5% recognized breastfeeding as a possible means of HIV transmission. Knowledge was particularly lacking on the “window period” for HIV; fewer than half (49.0% of men and 41.1% of women) correctly identified that it takes 1-3 months after exposure for someone to test positive for HIV; further, almost no respondents (1.3%) recognized male circumcision as a measure to prevent acquiring HIV. Knowledge of ARVs was high, with 98.2% of respondents correctly identifying ARVs as treatment for HIV.

When asked to list non-HIV STIs, the majority of respondents mentioned syphilis (82.9%) and gonorrhea (79.9%) but few mentioned as herpes (4.3%) or chlamydia (3.2%). Almost a sixth (15.2%) of respondents said that a woman could not protect herself from getting an STI if her husband was infected.

The vast majority (86.5%) classified HIV/AIDS to be a serious problem in their communities, with 64.0% noting that they knew someone at their workplace they believed had HIV/AIDS or had died of AIDS; the majority of respondents also believed there to be reduced stigma, absenteeism and deaths due to AIDS because of workplace programs. However, no respondents noted that their workplaces had support groups or treatment support for people living with HIV. A full 77.9% of respondents had ever been for HIV counseling and testing, almost all of whom received their results, and 93.1% of whom chose to share those results, mostly with partners.

## Recommendations

Overall, findings from the SHARe II baseline KAP survey highlight areas in need of continued programmatic attention, including stigma reduction, stressing the importance of condom use and reinforcing that there is still no cure for HIV and AIDS. Finally, the further expansion and enhancement of HIV/AIDS workplace services throughout all sectors in Zambia remains a critical need.

It may not be feasible to encourage people to always use condoms with their regular partners for STI prevention, unless it is a known discordant couple. However, interventions for those in regular partnerships can promote the benefits of condom use for non-STI purposes, including as an added contraception barrier method.

At the same time, interventions should promote that condoms *always* be used with any non-regular partners and should emphasize the role of sexual networks and multiple concurrent partnerships in spreading HIV. Programs that address STIs should emphasize the close link between HIV and STIs, and the independent risk of contracting STIs (independent of HIV) as a reason to use condoms. Women should be provided with skills in negotiating condom use and convincing partners to use condoms; messaging should also target men, emphasizing the benefits of condom use and respecting partners' choices. Finally, work needs to be done to break down social barriers to condom use, for both genders. Due to the high stigma involved in buying and carrying condoms, workplaces should make condoms accessible in private settings, including men's and women's bathrooms.

Strides need to be taken to ensure people know *all* relevant facts about HIV/AIDS, such as recognizing all modes/risks of HIV transmission, understanding the progression of infection/illness, learning the role ARVs can play in helping both infected persons and their partners and recognizing the wide variety of actions that can be taken to prevent spread of HIV. Further, since so few respondents identified mutual faithfulness or reducing partner count as ways to protect oneself from HIV, education should include messages about the risks of multiple concurrent partnerships. Finally, culturally-specific practices that can contribute to the spread of HIV (e.g., dry sex) should particularly be addressed in workplace wellness programs.

Interventions should be designed to address the attitudes and practice of two separate but at-risk groups: those who view themselves at no risk of HIV in spite of having unprotected sex, and those who view themselves at high risk, yet do not use condoms with regular and non-regular partners. An apparent discrepancy between perception of personal risk, perception of community risk and low condom use needs to be addressed by emphasizing that HIV/AIDS is not just a disease that affects "other people" – that everyone is at risk, and that those who engage in unprotected sex with non-regular partners should consider themselves at risk of HIV/AIDS.

Finally, because respondents were generally knowledgeable about HIV/AIDS and yet still engaged in unprotected sex, workplace wellness programs should not rely solely on building knowledge, and should include significant behavior change components as well.

Respondents appeared to appreciate workplace programs, noting the many benefits they saw derived from them including reduced absenteeism, death and less stigma. However, a minority of workplaces had programs that targeted people living with HIV, such as financial support, and no workplaces had support groups or treatment support. The overarching

implications for other areas of SHARe II could be the need to ensure policy changes from the national down to the workplace level. Although workplace programs are more prevalent than they were several years ago, more work must be done to ensure employees in all workplaces have access through direct services or referrals to HIV/AIDS prevention/treatment care and support at their places of employment. In particular, it is necessary to work to expand the presence of programs for people living with HIV in workplaces.

DRAFT

# 1. Introduction

## 1.1 HIV/AIDS in Zambia

HIV and AIDS have deeply impacted Zambia, and the epidemic continues to pose a major challenge to the Government of the Republic of Zambia (GRZ) to mount and sustain an effective national response. As of the latest Zambia Demographic and Health Survey (ZDHS) in 2007, approximately 1.5 million Zambians were estimated to be living with HIV. The overall adult HIV prevalence among those 15-49 years of age was 14.3%: 16.1% in women, compared to 12.3% in men. This highlights the continued disproportionate vulnerability of Zambian women to HIV. Further, there are an estimated 600,000 orphans and vulnerable children (OVC) under age 17, who need effective mitigation as well as HIV prevention, treatment, care and support services (UNAIDS 2013). Over 25,000 persons are estimated to die annually from HIV/AIDS in Zambia (Ibid.).

This serious situation has resulted in a full-scale national response. The GRZ has developed a National Strategic Plan (NSP) and National HIV/AIDS Policy to guide the national response. As part of its response to the global HIV/AIDS pandemic, the United States Government (USG) announced the launch of the President's Emergency Plan for HIV/AIDS Relief (PEPFAR) in 2003, with Zambia as one of 15 focus countries. This program has resulted in an unprecedented expansion of the response to HIV/AIDS in the country.

The USAID-funded Support to the HIV/AIDS Response in Zambia II (SHARe II) project contract was signed on November 9, 2010 for a five-year period extending through November 4, 2015. SHARe II is implemented by John Snow Inc. (JSI) and international and local partners: Initiatives Inc.; LEAD Program-Zambia; the Livingstone Tourism Association (LTA); Zambia Interfaith Networking Organization on HIV (ZINGO); and Zambia Health Education and Communication Trust (ZHECT).

The SHARe II project addresses the following Intermediate Results (IRs) under USAID/Zambia's Country Development Cooperation Strategies (CDCS) 2011-2015, specifically Development Objective 3 or *DO 3 - Human Capital Improved*:

**USAID DO3 Human Capital Improved:** Human capital is a multi-dimensional concept that merges the knowledge, skills and capabilities that people need for life and work. It refers to education and health levels as they relate to economic productivity, and is a crosscutting constraint in Zambia, that must be addressed holistically rather than as discrete interventions. Human capital requires an educated populace that is able to make sound decisions that affect the health and welfare of families, and a healthy populace that is able to participate fully in education and economic opportunities.

**USAID IR 3.2 Health Status Improved:** Improved health status reduces household and government expenditures on health care, freeing resources for more productive investments thus contributing to human capital as well as rural poverty reduction;

**USAID Sub IR 3.2.2 Health Systems and Accountability Strengthened:** USAID/Zambia activities to improve health systems and accountability will include improving human resource capacity and management, drug logistics, monitoring systems and capacity to conduct research and develop new interventions; and

**USAID Sub IR 3.2.3 Community Health Practices Improved:** USAID/Zambia assistance activities will work with community organizations to reach citizens and increase their knowledge of preventive behaviors and healthy practices.

## 1.2 SHARe II Project Tasks

To achieve success toward realizing these IRs, SHARe II has four project Tasks. Under **Task 1**, SHARe II engages, mobilizes and equips leaders at all levels with the necessary skills to be effective change-agents, and strengthens and supports the enactment, formulation and implementation of appropriate HIV/AIDS-related policies and laws.

As part of its **Task 2**, SHARe II provides technical assistance to strengthen the capacities of HIV/AIDS coordinating structures in both the public and private sectors, selected umbrella civil society organizations and chiefdoms to coordinate, manage and implement the national and community-level HIV/AIDS responses. SHARe II continues its collaboration with these structures under **Task 4**, through which SHARe II provides technical assistance to the GRZ through the National HIV/AIDS/STI/TB Council to improve collaboration and coordination of the HIV/AIDS response across multiple partners and stakeholders.

**Task 3**, under which this KAP study was conducted, involves strengthening and expanding HIV/AIDS workplace programs. Through this Task, SHARe II expands access to workplace programs in the public, private and informal sectors, and fosters linkages and referral systems with community-level partners and implementers to expand access to HIV prevention, care, support and treatment services for employees, dependents and—where feasible—to defined outreach communities to reduce HIV-related employee absenteeism, and ultimately to contribute to increased productivity, profitability and economic development.

## 1.3 Workplace-Based HIV/AIDS Interventions

Since the African International Labor Organization (ILO) adopted a resolution highlighting the need for employers and employees to work together to stop the spread of HIV/AIDS in 2003, employers have gradually recognized the important role they play in decreasing the incidence of HIV (Bakuwa 2010; George and Quinlan 2009; Mahajan, et al 2007; Marwitz and Were-Okello 2010; Ojo, et al 2011; SHARe 2010). As Peter Piot, the Executive Director of UNAIDS, acknowledged, “The workplace is well recognized as a key location for informing people about how to protect themselves and for providing care and support to people living with HIV and those close to them.” (UNAIDS 2006)

The consequences of HIV/AIDS in the workplace are clear. HIV/AIDS results in increased absenteeism and increased demand for health services (Jackson, et al 2004; Sonnenberg, et al 2011), which in turn has been shown to reduce worker productivity and increase labor costs for employers (Jackson, et al 2004; Rosen, et al 2004; Rosen, et al 2007). In southern Africa, this is seen as particularly hazardous as it deters the economic advancement of African businesses and diminishes national economies (Rosen, et al 2004).

Fortunately, studies have generally shown that workplace programs designed to prevent HIV/AIDS can be both feasible and successful (Hope 2003; Ojo, et al 2011; Richter, et al 2012; SHARe 2010). The SHARe II predecessor SHARe project had a peer education HIV/AIDS prevention program, established in various workplaces, which was found to improve knowledge, attitudes and practices about HIV/AIDS and reduce risky behavior (SHARe 2010); similar results were found in Botswana (Hope, 2003). A Cochrane systematic review also

found that implementing workplace HIV programs that include HTC (HIV testing and counseling) services increased the uptake of HTC, decreased risky sexual behavior and decreased self-reported sexually transmitted infections (STIs) (Ojo 2011). Similarly, the review found education programs about HIV/AIDS and related issues in workplace programs resulted in reduced levels of STIs, unprotected sex and sex with commercial sex workers (Ojo 2011).

Other research also suggests that educational or promotional activities can positively impact the uptake of HTC in workplaces (Richtner, et al 2012; Van der Borgh, et al 2010). Such interventions create an environment more hospitable to conversations about intimacy and HIV/AIDS, even if they do not directly contribute to reduced risk or incidence (Richtner, et al 2012).

Although workplace programs benefit people in all sectors, implementers should consider the unique needs of most-at-risk populations. For example, employees—especially men—who migrate frequently (e.g., those in uniform, such as police and prison guards; temporary employees; and/or landless farmers), are known to have an especially high risk of contracting HIV; women working in rural communities are also found to be at high risk (Lurie, et al 2003). Across southern Africa, contract, unskilled and semi-skilled workers have been found to be more at risk for contracting HIV than skilled workers or managers, with the exception of skilled workers in Zambian mines, who were found to have exceptionally high rates of HIV (Evian, et al 2004).

Industries have welcomed and adopted HIV/AIDS programs differently; in Malawi, another southern African country, the service sector has readily adopted HIV/AIDS programs and policies, while the trading sector has been more reluctant (Bakuwa 2010). Also, availability of resources and general knowledge on HIV/AIDS impacts the availability of workplace programs. Small companies or places of employment often lack the capacity to respond to HIV/AIDS and can only implement workplace programs with assistance from outside organizations (Rosen, et al 2007). Research suggests that the HIV/AIDS response in workplaces will improve with outside assistance, namely that from HIV/AIDS-related institutions, which can help the workplaces develop concrete plans, strategies and policies to address their particular HIV/AIDS issues (Bakuwa 2010).

Although workplaces alone cannot stop the spread of HIV (or STIs), experience suggests that workplaces are a prime environment to provide the resources and skills necessary to positively influence people's attitudes and behavior related to HIV/AIDS (Jackson, et al 2004). However, published information on HIV/AIDS workplace programs remains sparse, and much effort is still needed to determine what factors make workplace programs successful and how they must adapt to effectively address the changing face of the HIV/AIDS epidemic (Mahajan, et al 2007; Ojo, et al 2011).

## **2. Study Objectives**

The study objective was to establish baseline knowledge, attitudes and practices among employees in SHARe II project workplaces, thus facilitating project monitoring and evaluation of changes in employee knowledge, attitudes and practices over the life of the SHARe II project. SHARe II and its project partners implement interventions focusing on the four critical components of a workplace program, including: 1) having an HIV/AIDS workplace policy, 2) peer education, 3) testing and counseling and 4) referrals.

As part of the monitoring and evaluation plan to measure the impact of SHARe II activities, a survey was implemented at baseline in order to provide a basis for overall project evaluation. The HIV/AIDS Knowledge, Attitudes and Practices (KAP) survey was administered in May 2010 and November 2012 to quantitatively measure the impact that SHARe II-supported workplace HIV/AIDS programs have had on employees' knowledge, attitudes and practices regarding HIV/AIDS. An endline follow up survey is planned for 2015.

The specific survey objectives were to:

1. Describe knowledge, attitudes and practices related to HIV/AIDS in SHARe II-supported workplaces
2. Describe the types of HIV/AIDS activities in SHARe II-supported workplaces
3. Assess the existence of HIV/AIDS policies in SHARe II-supported workplaces
4. Describe experiences related to HIV/AIDS workplace programs in SHARe II-supported workplaces

The results expected from the use of the KAP questionnaire were to track changes between baseline and endline in:

- Sexual behavior and condom use with regular partners, non-regular partners and commercial sex workers
- Knowledge and attitudes on condoms and condom use, including correct use and ease of obtaining/carrying condoms
- Knowledge about HIV and other STIs, including prevention, symptoms and treatment
- Experience with and attitudes toward people living with HIV
- Perceptions on HIV testing and counseling, including reasons for testing and barriers to testing
- Perceptions about workplace HIV/AIDS programs, including programs offered and results

The baseline findings provide SHARe II staff and workplace managers with information for improving and targeting HIV/STI prevention activities. The findings from the eventual comparative analysis of change over time are intended to demonstrate the impact of SHARe II activities on achieving intended results, as well as to inform future workplace-based HIV/AIDS activities in Zambia.

### **3. Methods**

This KAP survey was a cross-sectional, interviewer-administered quantitative survey targeting SHARe II-supported workplaces. Data collection took place during two different time periods (see Table 1). In order to limit the burden on workplaces faced with multiple surveys, SHARe II used the endline data collected in May-June 2010 from its predecessor SHARe project as a baseline, for those 22 workplaces that were continuing with the SHARe II project. The second cohort of data collection took place in November 2011, with 32 newly-participating workplaces that were either supported directly by SHARe II or through SHARe II's workplace program sub-partner, ZHECT (Zambia Health Education and Communications Trust). SHARe II-directly supported workplaces account for 76% of the data, and ZHECT-supported workplaces account for 24% of the data. Overall, 44% of the data was collected in 2010 and 56% collected in 2011.

**Table 1: SHARe II Baseline KAP Survey Administrations**

	Survey Dates	Number of Provinces	Number of Sites	Number of Employees Sampled
Cohort One (SHARe)	May-June 2010	9	22	553
Cohort Two (SHARe II)	November 2011	6	32	690
Total		15	54	1,243

Over the life of the project, SHARe II will be able to track trends among the two cohorts to assess differential gains over time (for example, any differences between the first cohort, which has been exposed to HIV/AIDS workplace interventions for longer, compared to the newer participating workplaces in the second cohort).

Interviews were only conducted with persons 18 years of age and older and informed consent was obtained from all study participants. The study received Institutional Review Board (IRB) approval from the ERES Converge ethics review board in Zambia on November 1, 2011.

### **3.1 Sampling**

Every SHARe and SHARe II partner workplace was given the opportunity to participate in the study. A total of 20 workplaces across 54 sites were both willing and able to participate and gave SHARe II interviewers access to employees on the day of the survey.

To estimate characteristics of the SHARe II supported workplaces, a sample was drawn from across the country at baseline and was stratified by geography (province and district) and level of involvement with the SHARe II project (low, medium and high). The number of employees chosen to participate in each workplace was based on the total number of employees at that company (sampling proportionate to size). In cases where it was difficult to define the workplace population in advance, the sample that was drawn was a convenience sample. Data collectors were instructed to randomly select respondents to vary in gender, age and position (unskilled, skilled, middle management and senior management). It was estimated that an average of 10 employees per 250 workers would participate from each company to achieve the desired sample participation. In the analysis of the KAP data, the workplaces were grouped into industry-specific clusters which allowed for statistically valid estimates to be made at the industry/sector level.

**Comment [MC1]:** What is the source of this map?

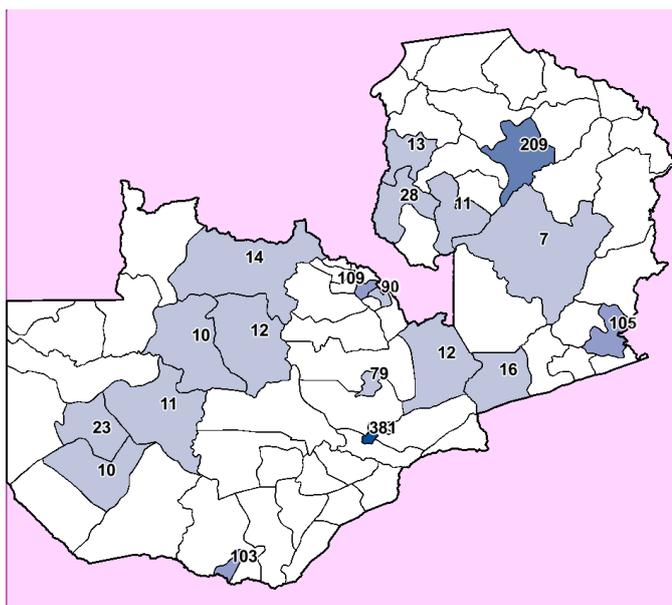


Figure 1: KAP study sample, by district

### 3.2 Questionnaire

The questionnaire used for the KAP survey was originally designed under the first SHARE project after a review of the literature and other survey questionnaires, such as the Zambia Demographic and Health Survey (ZDHS). The questionnaire was updated to include indicators directly related to PEPFAR. During the 2011 (Cohort Two) data collection, additions and modifications to the questionnaire were made after consultation with SHARE II technical staff, USAID and program managers at ZHECT and LEAD Program–Zambia Ltd.

The KAP questionnaire covered topics on HIV/STI knowledge, attitudes and beliefs, risk perception, access to and use of STI services, access to and use of condoms, primary and secondary abstinence, partner relations and condom use with different categories of partners, in addition to perceptions about HIV counseling and testing, stigma and discrimination against people living with HIV and HIV/AIDS workplace programs. The questionnaire was pre-tested in Lusaka prior to being fielded. Results from pre-tests were incorporated into revised questionnaires and retested, in an iterative process. Comments and suggestions from experienced supervisors and fieldworkers were integrated into the final version of the questionnaire for greater clarity of questions. The KAP questionnaire is included in Appendix 1.

### 3.3 Field Work

The study was designed by JSI and SHARE II staff. The recruitment of external field workers was done on the basis of previous experience in similar research. Administration was carried out by SHARE II staff. All supervisors and interviewers underwent a two-day training program to familiarize themselves with the study. The course covered an overview of the SHARE and SHARE II projects and workplace-based HIV/AIDS prevention and treatment

interventions, a detailed review of the questionnaires, sources of bias, interviewing techniques, general information about HIV/AIDS, condom use and risk perception. All enumerators were instructed about the issue of sensitive questions during training and given special emphasis on establishing reliable rapport and mutual trust before asking any sensitive questions. The enumerators were divided into five teams, and each team was overseen by one supervisor. Questionnaires were manually checked while fieldwork was being conducted.

For both Cohort One and Cohort Two workplaces, letters were distributed to all workplaces informing them of the survey and asking for their consent. For many workplaces it was necessary to set appointments for the research assistants; for example, in some workplaces, staff were only in the office on certain days of the week, or due to heavy workloads some days/weeks were not feasible to pull staff away for 30 minutes to interview them. A number of the workplaces did not set appointments in advance, but were notified of the rough time frame that interviews would be occurring; in these cases the supervisor would make an introduction and set up times for interviewing.

Each team had a workplace-specific letter of introduction to hand to the manager on duty on the first day of data collection. For the majority of the interviewing, workplaces were very receptive to the process and they allowed the data to be collected. However, in some cases the data collection time period was significantly extended while the supervisors worked with management to obtain permission to field the survey.

### 3.4 Data Management and Analysis

Completed questionnaires were data entered by contractors and every tenth one was spot-checked for accuracy. Open-ended questions were coded by SHARe/SHARe II staff and where appropriate, new variables were created to reflect common themes and concepts. Data were imported and analyzed with SAS v9.2, SPSS v18 and STATA 12.

Data between the two cohorts were analyzed on demographics and responses to key questions to check for differences between the two samples; none were significant. Descriptive analysis was done and results were summarized in tables and charts/figures. Additional tests of significance will be planned after endline data collection.

## 4. Survey Results

### 4.1 Demographics

Table 2: Survey demographics

Demographic Category	n (%)
<i>Province, as of 2012 (n=1243)</i>	
Lusaka	381 (30.7)
Northern	216 (17.4)
Copperbelt	199 (16.0)
Eastern	121 (9.7)
Southern	103 (8.3)
Central	91 (7.3)
Luapula	52 (4.2)
Western	44 (3.5)
North Western	36 (2.9)
<i>Highest Level of Education (n=1230)</i>	
≤ Primary	79 (6.4)
Lower Secondary	131 (10.7)
Higher Secondary	307 (25.0)
College Certificate	272 (22.1)
College Diploma	301 (24.5)
≥ Bachelor's Degree	140 (11.4)
<i>Work Position (n=1224)</i>	
Unskilled Staff	240 (19.6)
Skilled Staff	440 (36.0)
Middle Management	409 (33.4)
Senior Management	135 (11.0)
<i>Marital Status (n=1231)</i>	
Married	861 (69.9)
Single	273 (22.2)
Divorced	43 (3.5)
Widowed	38 (3.1)
Separated	16 (1.3)
<i>Gender (n=1238)</i>	
Male	830 (67.0)
Female	408 (33.0)

A total of 1,243 employees (67.0% male, 33.0% female) were sampled from 54 workplaces in 19 districts across every province in Zambia (Table 2). The largest number of respondents lived in Lusaka province (30.7%), with the next largest number of respondents living in Northern and Copperbelt provinces (17.4% and 16.0%, respectively). Fewer than half (42.1%) of respondents had completed at least higher secondary school, and 6.4% of respondents had completed primary school or less. The average age of respondents was 37 years old (range: 18-67). More than three-quarters of respondents reported to be, or have ever been, married.

Approximately three-quarters of married respondents (72.4%) were married between the ages of 21-28 years. Only 2.5% had married before the age of 18, with the youngest first marrying at 14 years; the oldest age at which a respondent first married was 43 years. Of those who were currently married, 6.1% were in a polygamous marriage.<sup>1</sup>

At the time of this survey, 52.0% of respondents had worked at their jobs for more than five years, 35.1% for one to five years and 12.8% for less than one year, indicating a certain level of stability in employment among the sample.

#### 4.2 Sexual Behavior and Condom Use

Almost all respondents reported having ever had sexual intercourse (96.2%), with 89.2% of these respondents having had intercourse within the last twelve months. Of respondents who had intercourse within the last twelve months, the large majority had sex with a regular partner (87.1%); of these, 86.4% had sex with a marital or cohabiting partner, and 34.9% had sex with an unmarried, regular partner. Seven percent stated they had sex with more than one regular partner within the past twelve months.

Approximately 10% of respondents noted having had sex with at least one casual partner (max: 10 non-regular partners) in the last 12 months. Notably, men were more than twice as likely as women to report having had sex with at least one casual partner (11.4% and 5.5%, respectively). In addition, 5.1% of men had sex with a commercial sex worker (CSW) (max: 8 commercial sex worker partners) in the last 12 months. Only four women reported having sex with a commercial sex worker within the past 12 months.

##### Rates of Condom Use

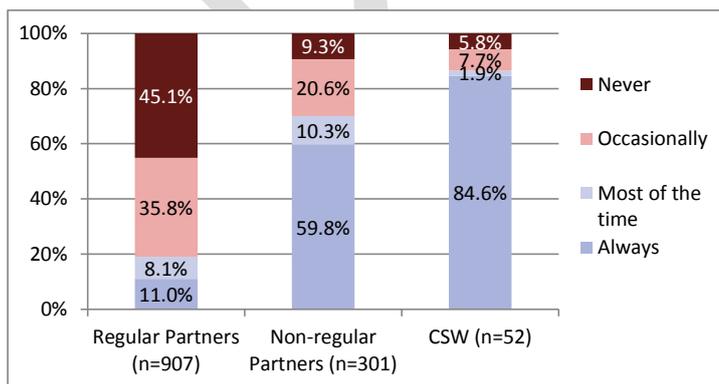


Figure 2: Frequency of condom use, by partner (n=1260)

Of respondents who reported having had sex, 84.8% had ever used a condom. Overall condom usage varied widely based on the nature of the sexual relationship (Figure 2). A majority of men and women (80.9%, including 81.2% of men and 79.9% of women) “never” or “occasionally” used condoms with regular

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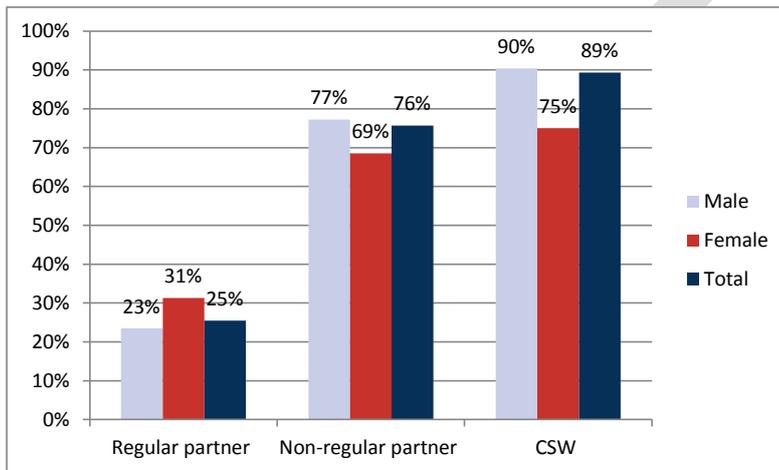
<sup>1</sup> Polygamous marriage was only asked in Cohort 2 (n=690)—see Table 1 above.

partners within the past 12 months. For non-regular partners, however, a majority of both men and women (70.1%, including 72.2% of men and 60.4% of women) used condoms “always” or “most of the time.”

Almost equal percentages of men and women reported using condoms with their regular sexual partners (among men, 10.9% used “always” and 7.8% used “occasionally,” compared to 11.4% and 8.7% among women, respectively). However, a greater percentage of men than women reported using condoms “always” or “most of the time” with non-regular partners (72.2% of men used “always” or “most of the time,” compared to 60.4% of women).

One-quarter of respondents reported using condoms with their regular partner(s) the last time they had sex (Figure 3). In comparison, three-quarters reported condom use during their

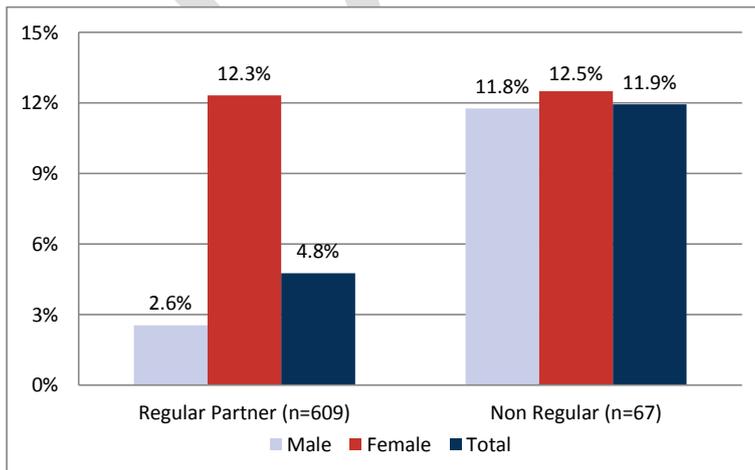
last sexual encounter with non-regular partners and 89% with commercial sex workers.



When asked about condom use during their *most recent* sexual intercourse with a regular partner, however, 31.3% of women said they used a condom, compared to 23.5% of men (25.5% overall). Of those who gave a reason for not using

Figure 3: Condom use in last sexual encounter (n=1242)

a condom during the last sexual encounter, a much greater percentage of women than men said it was because their partner refused or objected (12.3% of women compared to 2.6% of men; 4.8% overall) (Figure 4).



The discrepancy between self-reported overall condom use in regular partnerships (in which rates between men and women are almost identical) and condom use in the last sexual encounter with a regular partner (in which men report higher rates of condom use than

Figure 4: Did not use a condom because partner objected/refused (n=676)

women) may be partly explained by looking only at those 23.5% of respondents who used a condom in their last sexual encounter with a regular partner. In this group, male respondents were more likely to note that they use a condom “always” or “most of the time,” framing their recent condom use as a regular event, while female respondents were more likely to note that in general, condom use happened “never” or “occasionally” with these regular partners, framing their last condom use as more of an unusual event.

These perceptions may be due to different feelings of agency among men and women; where men make the decisions about condom use, they may overestimate the regularity with which they decide to use condoms. Women, on the other hand, may remember more strongly the times when their partner refused to use condoms and frame condom use as more of an irregular event.

*Reasons for Using or Not Using Condoms*

Reasons behind condom usage varied based on the type of sexual relationship (Figure 5). For example, the primary reason respondents used condoms with regular partner(s) was to prevent pregnancy (78.8%), while the primary reason respondents used condoms with non-regular partners and commercial sex workers was to prevent HIV/AIDS (72.9% and 93.6%, respectively).

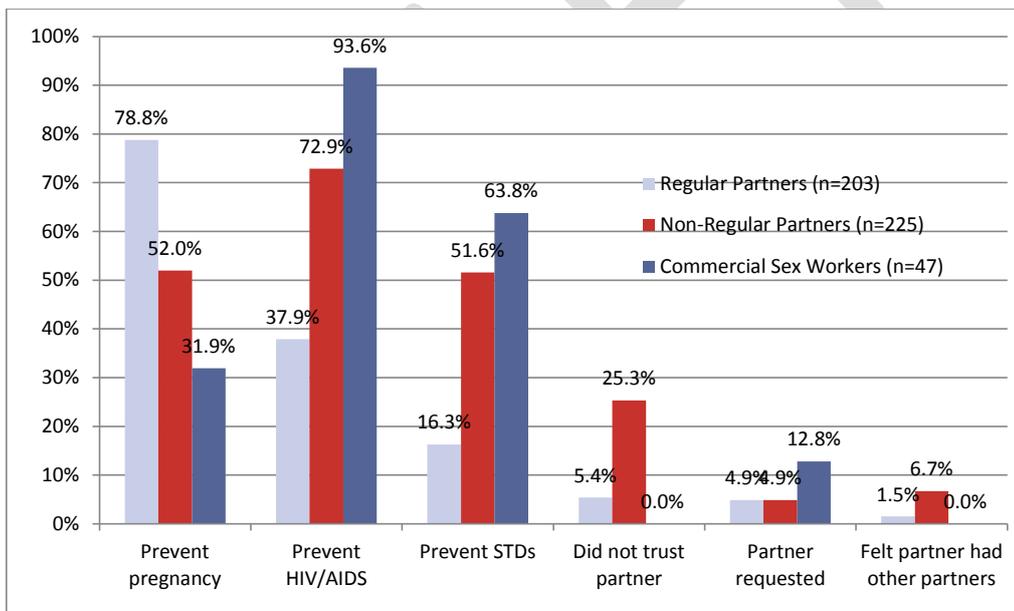


Figure 5: Reasons for condom use by type of sexual partner (n= 475)

However, among persons who did not use a condom the last time they had sex, the chief reason behind this decision was the same regardless of relationship type: trust (

Table 3). Using other forms of contraception was also one of the most common reasons provided for not using condoms in both regular and non-regular relationships. However, refusal to use condoms impacted usage more with non-regular partners than regular partners.

DRAFT

Table 3: Reasons condoms not used during last sexual encounter (n=674)

Regular Partners (n=612)	Non-Regular Partners (n=62)
Trusted partner/partner faithful (80.3%)	Trusted partner/partner faithful (59.7%)
Used other contraception (14.1%)	Partner objected/refused (11.9%)
Don't know (8.8%)	Used other contraception (9.0%)
Wanted to get pregnant (7.1%)	Didn't have one at the time (7.5%)
Dislike condoms (6.4%)	Condom not available (7.5%)
Partner objected/refused (4.8%)	Wanted to get pregnant (7.4%)
Condom not available (1.8%)	Dislike condoms (6.0%)
Didn't have one at the time (1.6%)	Too expensive (3.0%)

Many people who did not use condoms with regular partners because of trust in that partner nonetheless viewed themselves at risk of contracting HIV. Of these respondents, 44.3% viewed themselves at “moderate” or “high” risk of contracting HIV (Figure 6).

*Condom Decision-Making*

Condom decision-making differed by type of partnership and gender. The decision to use condoms was more often jointly made with regular partners than non-regular partners or commercial sex workers. In encounters with non-regular partners and commercial sex workers, the respondents largely stated that they themselves suggested using condoms (Figure 7).

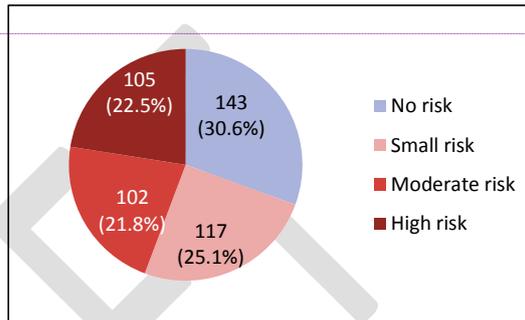


Figure 6: Perceived risk of HIV, among respondents who did not use condoms with regular partners because of trust in partner (n=467)

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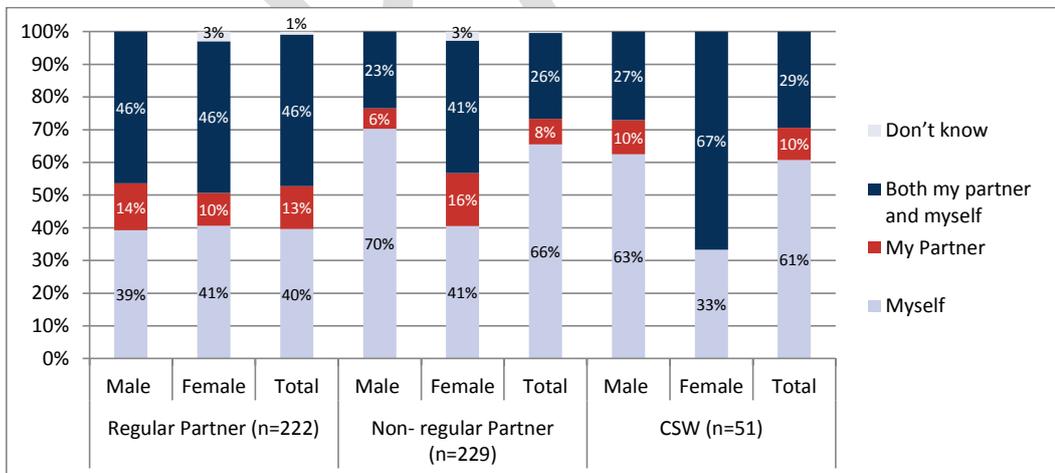


Figure 7: The last time you had sexual intercourse, who suggested using the condom? (n= 502)

However, a respondent’s regular partner was more likely to refuse to wear a condom upon request than one’s non-regular partner. Of those who asked their partner to use a condom, almost a third (32.7%) reported that their regular partners refused to use a condom, with considerable gender differences (27.8% of men and 43.5% of women reported that their

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regular partner refused to wear a condom). On the other hand, only 28.6% reported that their non-regular partner refused to use a condom (28.0% of men and 29.5% of women).

Male and female respondents were equally likely to suggest using condoms with their regular partners (39.2% of male and 40.6% of female respondents suggested using a condom with a regular partner themselves). However, male respondents were much more likely to suggest using condoms with non-regular partners than female respondents (70.3% of male and 40.5% of female respondents suggested using a condom with a non-regular partner). Female respondents were also the only ones to note that they “didn’t know” who suggested condom use in their last sexual encounter.

Together, these findings suggest that women may continue to lack agency in sexual discourse and decisions. Women are less likely to suggest condom use in non-regular partnerships; less likely to use condoms in non-regular partnerships; and more likely to have a partner reject their suggestion to use condoms. In regular partnerships, they were more likely to view recent condom use as unusual, while men were more likely to place recent condom use into a general pattern of condom use.

### Discussing Intimate Issues with Partners

A majority of respondents stated they could freely talk about condoms with both regular and non-regular partners (81.4% and 83.7%, respectively). Overall, though, respondents stated they were more comfortable discussing issues of intimacy (STDs, HIV/AIDS, condom use and faithfulness) with regular partners (Figure 8 **Error! Reference source not found.**). Few respondents stated they felt free to discuss intimate issues with commercial sex workers.

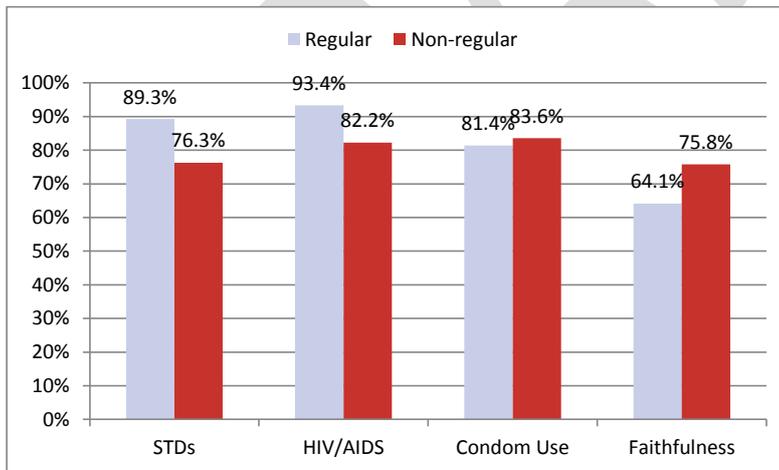


Figure 8: Ability to freely discuss issues related to sex and HIV/AIDS (n= 1203)

Within regular sexual partnerships, men and women equally reported to be able to freely discuss issues of intimacy. Almost all men (97.1%) and women (96.1%) reported that they could discuss at least one intimate issue with their regular partners (96.8% overall); in addition, 89.3% of men and 88.9% of women reported that they

could discuss at least one issue with a non-regular partner (89.2% overall).

However, these feelings of openness in discussing condom use were not necessarily reflected in behavior. Just over half of all respondents (56.2%) had discussed condom use to prevent HIV/STIs with someone in the past three months. Of these, the majority of respondents (63.9%) had discussed condom use with friends, while about a quarter had discussed with

peer educators (26.7%), relatives (25.7%) and spouses (26.3%). Only 9.3% had discussed condom use to prevent HIV/STIs with non-spousal partners.

### 4.3 Condom Knowledge and Attitudes

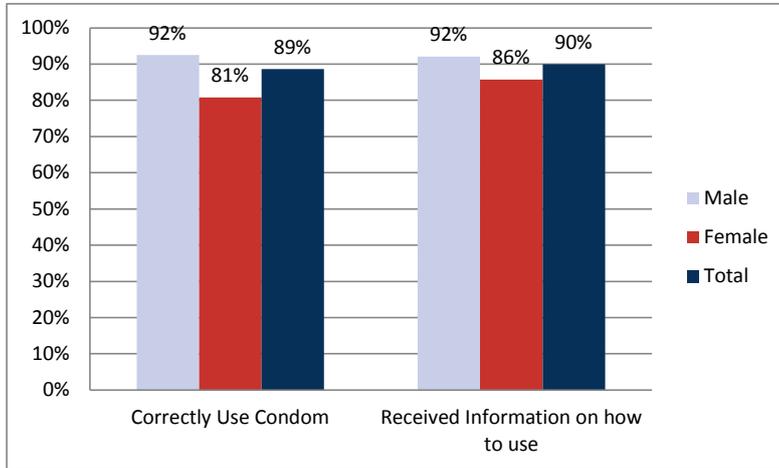


Figure 9: Knowledge on condom use (n=1206)

Nine out of ten respondents (90%, including 92.0% of men and 85.7% of women) said they had received information about how to use a condom, and 88.7% of all respondents (92.5% of men and 80.8% of women) said they knew how to use condoms correctly (**Error! Reference source not found.**). This

means approximately 10% of respondents have never received information on how to use a condom, and slightly more—including almost a fifth of female respondents—remain unaware of how to correctly use a condom, thereby lacking essential knowledge necessary to prevent HIV/AIDS

Table 4: Sources of condom information (n=1098)

Source of information	N (%)
Peer educator	539 (69.1%)
Television	241 (30.9%)
Radio	200 (25.6%)
Newspaper/ magazine	198 (25.4%)
Friends	135 (17.3%)
Health center	111 (14.2%)
Live drama	102 (13.1%)
Workshop/ seminar	101 (12.9%)
Condom package	81 (10.4%)
NGO	67 (8.6%)
School/ college	40 (5.1%)
Workplace	36 (4.6%)
Partner	23 (2.9%)
Other printed material	21 (2.7%)

To date, respondents have gained knowledge on how to use condoms from many sources (Table 4). Peer educators have been a prominent knowledge source, while media sources, such as radio, television and newspapers/magazines, have also provided information to many on proper condom use. Other sources where respondents gained information on condom use include medical centers, such as clinics or health centers, and instructions on condom packaging.

Although most people know where they can find condoms, condoms are not necessarily easily accessible. Nearly all respondents said they knew where to get a male condom (96.6%), and nearly two-thirds knew where to access a female condom (64.6%). Four percent more men than women knew where they could obtain male condoms (97.9% versus 93.8%),

but 10% more women than men knew where they could obtain female condoms (71.1% versus 61.5% percent).

In spite of knowledge about where to obtain condoms, 24.1% said it was difficult to actually obtain a condom (Figure 10). Stigma around condoms continues to exist, as only 61.1% said they felt comfortable buying condoms in their neighborhood. Even fewer, 54.2%, felt comfortable carrying condoms with them. Fewer women than men said they were comfortable buying condoms in their own neighborhood, and even fewer said they were comfortable carrying condoms.

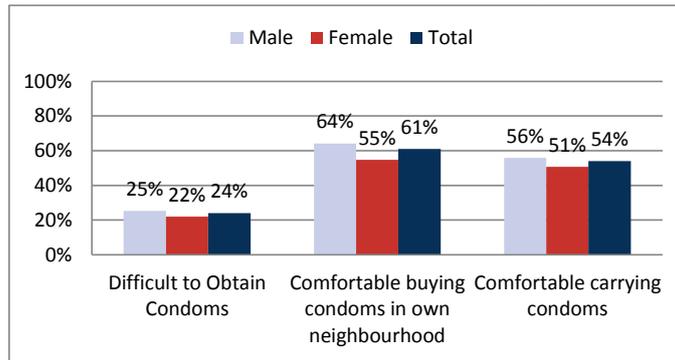


Figure 10: Comfort obtaining and carrying condoms (n=1221)

#### 4.5 Knowledge and Attitudes towards HIV/AIDS

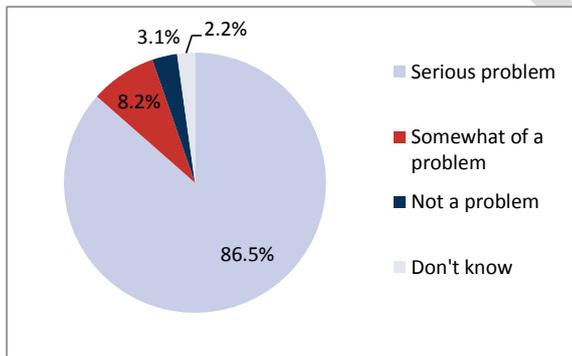


Figure 11: How serious of a problem is HIV/AIDS in your community? (n=1233)

#### Attitudes

The vast majority of respondents (86.5%) stated that HIV/AIDS is a serious problem in their community (Figure 12) and 43.2% of respondents noted that they considered themselves at “moderate” or “high” risk of contracting HIV/AIDS (**Error! Reference source not found.**). Responses for personal risk did not vary significantly by gender, although slightly more women than men considered themselves at “high” risk of

HIV/AIDS.

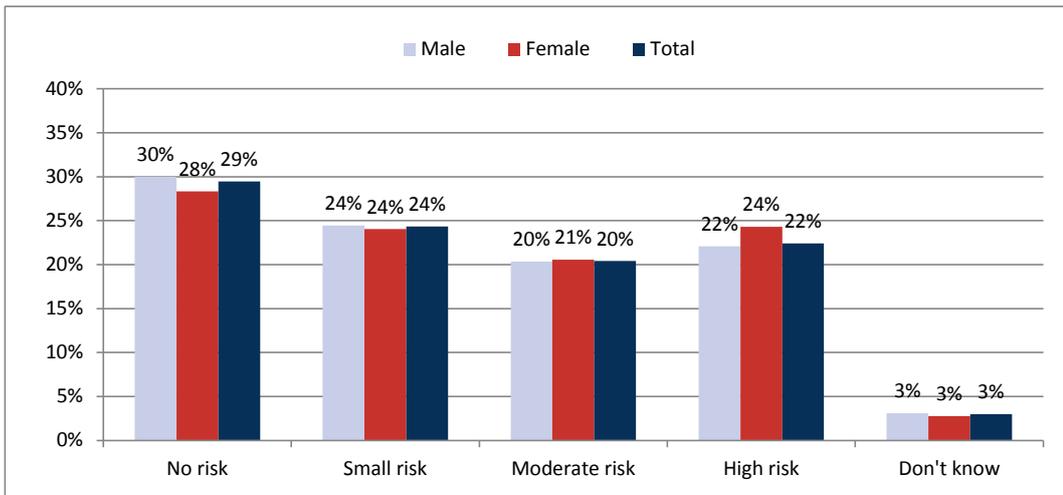


Figure 12: Whether respondent considers him/herself at risk of contracting HIV (n=1210)

The discrepancy between perceptions of community and personal risk mean that over half (54.9%) of those who felt that AIDS was a serious problem in the community nonetheless felt that they themselves were at no or small risk of personally contracting HIV/AIDS (Figure 13).

The contradiction is also reflected in respondents' behavior; of respondents who considered themselves at "no risk" of HIV and who had sex with a non-regular partner within the previous year, almost a third (32.7%) used condoms "occasionally" or "never" with the non-regular partner(s). Similarly, over four-fifths (81.2%) of respondents who noted "no risk" of contracting HIV did not use a condom in their last sexual encounter with a regular partner, and 52.6% noted that they "never" used a condom with their regular partners.

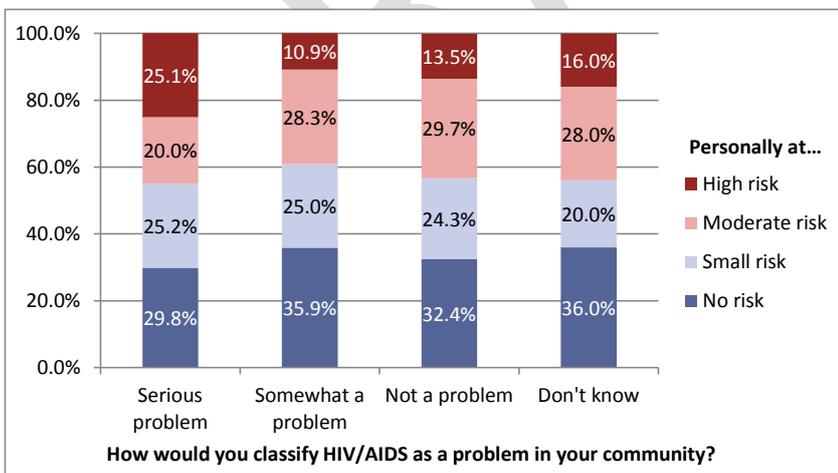


Figure 13: Perception of HIV/AIDS in community, by perceived personal risk of contracting HIV (n=902)

associated with the disease (Figure 14), with slightly more women than men identifying chronic diarrhea, persistent cough, shingles and tuberculosis as signs, while more men than women identified severe weight loss as a symptom associated with HIV/AIDS. Other

### Knowledge

Basic knowledge of HIV/AIDS was high across the sampled workplaces. All but three respondents (99.7%) had heard of HIV/AIDS, and the majority recognized at least one of the main signs or symptoms

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symptoms given by respondents included, among others: anaemia, body weakness, hair loss, cancer, chronic malaria, fever, night sweats, hair loss, a lack of appetite, paleness, sores and swollen limbs.

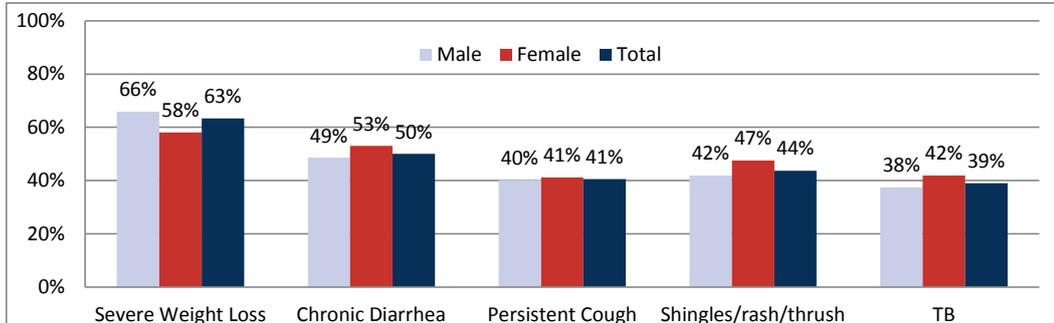


Figure 14: Main signs and symptoms respondents noted as associated with HIV/AIDS (n=1139)

Almost all respondents recognized HIV to be transmitted through unprotected sex, contaminated/unsterilized needles and contaminated blood; however, while most (91.3%) respondents noted that HIV could be transmitted from a mother to her child, fewer (41.5%) recognized breastfeeding as a mode of transmission (Figure 15). Only 85.4% of people knew that there is no cure for HIV, and a small percentage of respondents continue to hold incorrect beliefs on how HIV is transmitted, such as witchcraft (6.0%) and mosquito bites (8.9%).

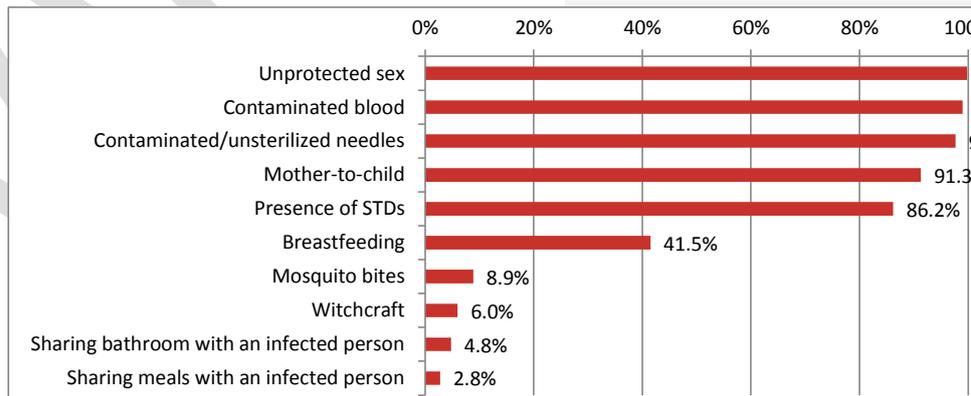


Figure 15: Modes of HIV transmission (n=1197)

Table 5: Ways respondents believe people can protect themselves from getting infected with HIV (n=1197)

Strategy	N (%)
Use condoms	970 (81.0%)
Abstain from sex	948 (79.2%)
Mutual faithfulness	545 (45.5%)
Avoid injections with contaminated needles	152 (12.7%)
Have fewer partners	114 (9.5%)
Avoid blood transfusions with contaminated blood	114 (9.5%)
Avoid sex with prostitutes	94 (7.9%)
Don't have casual partners	67 (5.6%)
Go for male circumcision	16 (1.3%)
Avoid dry sex	16 (1.3%)

Knowledge was particularly lacking on the 'window period' for HIV, and that a test during this period might result in a false negative, with fewer than half of respondents (46.3%, including 49.0% of men and 41.1% of women) correctly noting that the window period for HIV was one to three months.

Nine in ten respondents (89.9%) said they had heard or seen information on HIV/AIDS in the past six months, with television being a primary

source of this information (60.6%), followed by radio (48.5%), peer educators (36.1%), newspaper (25.0%). Friends (24.5%) and education campaigners (21.0%). In addition, 97.7% of respondents agreed that there were things HIV-positive people could do to stay healthy, and 99.0% knew that someone could look healthy but be HIV-positive.

Nearly all respondents (98.2%) believed there was something they could do to avoid contracting HIV/AIDS (Table 4). The largest percentage of respondents cited abstaining from sex and using condoms as prevention measures, with fewer people citing faithfulness and minimizing multiple concurrent partnerships (**Error! Reference source not found.**). Almost no respondents (1.3%) volunteered male circumcision as a measure to prevent acquiring HIV.

#### 4.4 Other Sexually Transmitted Infections

The majority of respondents had basic knowledge on sexually transmitted infections. When asked to list the STIs that they were familiar with, nearly all (98.9%) respondents could name at least one disease transmitted through sexual intercourse. Besides HIV/AIDS, the majority of respondents mentioned syphilis and gonorrhea but fewer listed other common STIs, such as herpes and chlamydia (Figure 16). With the exception of warts and herpes, men were more likely to identify STIs than women.

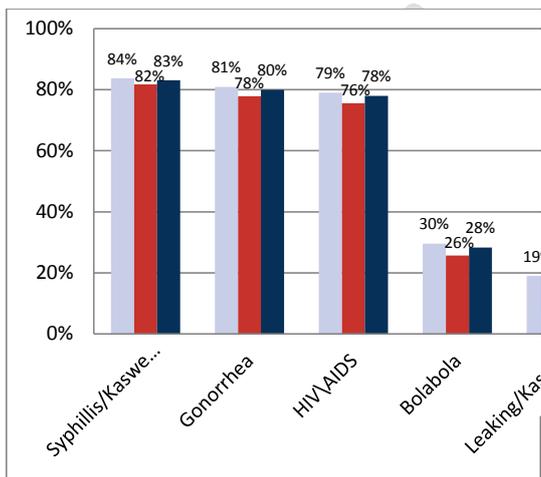


Figure 16: Percentage of respondents that had heard of common STIs prior to survey (n=1209). NOTE: Leaking/Kasele can apply to both Gonorrhea and Chlamydia

The vast majority 82.5%, including 81.9% of men and 83.7% of women) believed a woman could protect herself from getting an STI if her husband was infected, with 88.4% of these respondents stating using a condom was an effective protective measure and 27.8% saying refusing sex was an effective measure.

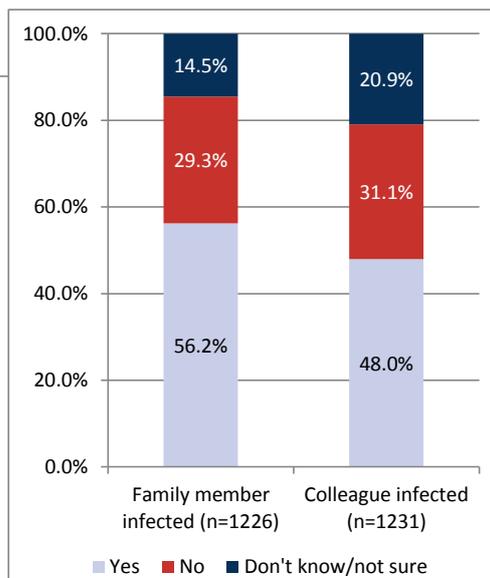


Figure 17: Respondent thoughts on if infected family or colleagues should keep HIV status a secret

#### 4.6 Experience with and Attitudes towards People Living with HIV/AIDS

Approximately two-thirds of respondents (64%) had known someone at their place of work they believed had HIV/AIDS or who had died of AIDS.

Respondents overwhelmingly stated their support for people—family, friends and colleagues—living with HIV/AIDS. For example, 94.4% said they would be willing to take care of a colleague with HIV. Similarly, 90.4% believed that a colleague with HIV/AIDS should be allowed to work; only 4.3% believed they shouldn't be allowed to work.

However, secrecy around HIV remained, suggesting continued stigma about HIV/AIDS. Respondents predominantly wanted both family members and colleagues who were infected with HIV to keep their status a secret (Figure 17).

#### 4.7 HIV Testing and Counseling

Almost all respondents (98.2%) knew where they could go for HIV/AIDS testing. Respondents predominantly cited government facilities as both the closest place they could go to receive HTC and the place they would choose to go for HTC (Figure 18).

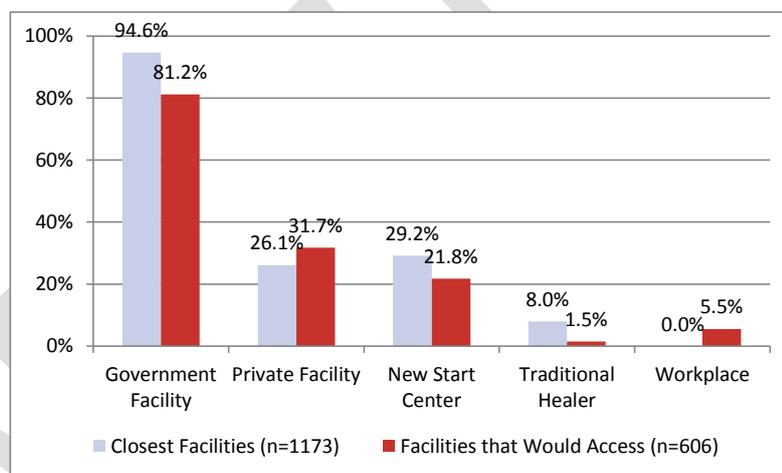


Figure 18: Comparison of facilities offering HTC – facilities closest to respondents vs. facilities respondents would choose to use for HTC

About three-quarters of respondents (77.9%) had ever been for testing, with 82.3% of those having gone voluntarily. Respondents—both those who had gone for HTC and those who had not—saw many benefits to knowing one's status, with planning for the family's future being the most commonly stated benefit (57.6%**Error! Reference source not found.**), followed by knowing one's status (38.9%), avoiding spread of HIV to others (37.3%), peace of mind (36.3%) and planning for pregnancy (5.1%).

A full 86.4% of respondents said they intended to use a confidential HIV counseling and testing service over the next year. The majority of respondents who said they would not go for HTC in the next year cited fear of discovering they were HIV-positive as the primary deterrent. Approximately one-quarter (23.1%) said they would not to go for HTC because of fear that the results would not actually be confidential and 7.7% said they would not go because there is no cure.

Of persons who had been for HTC, 97.7% received their results and 93.1% chose to share these results. The majority shared their HIV status with their partner (83.7%), and far fewer

disclosed their status with a family member or friend (Figure 19). Almost no one chose to disclose their HIV status with people in the workplace, including coworkers and supervisors.

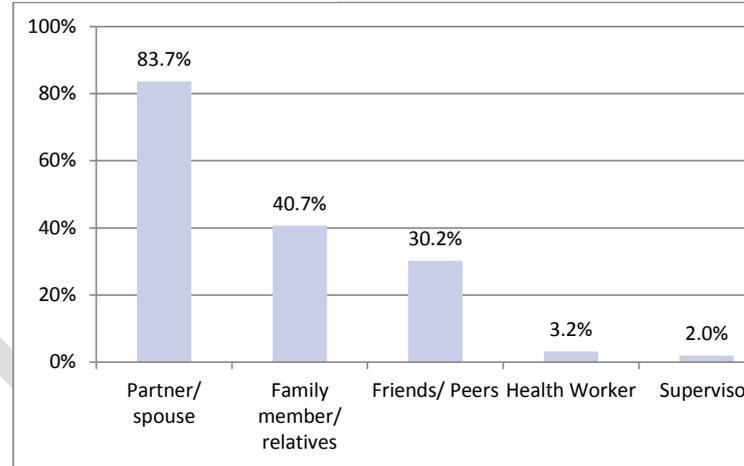


Figure 19: People to whom respondent revealed HIV status (n=883)

#### 4.8 Antiretroviral Drugs (ARVs)

Knowledge of proper HIV treatments and ARVs in general was high across respondents. Almost all (94.6%) knew there were treatments available for people with HIV/AIDS, and 98.2% correctly stated ARVs to be this treatment. Other beliefs about treatment for HIV were scarce, with only 1.2% citing nevirapine, 0.6% citing traditional medicine, 0.1% stating sex with a minor and no one citing prayer. Even among those who did not know treatment existed for HIV or did not know ARVs were medicine for HIV, 94.6% had still heard of ARVs.

People who had heard of ARVs largely correctly identified their function. Of those who had heard of ARVs, 98.4% acknowledged that ARVs prolong the lifespan of an HIV-positive patient; only 2.8% of people believed ARVs could actually cure AIDS. However, despite almost everyone recognizing the value of ARVs, 5.9% of respondents said they would be unwilling to take ARVs if they were found to be HIV-positive and recommended to do so by a health professional.

ARVs also appeared to be readily accessible across sites. 97.6% of respondents said they knew where to get ARVs, citing government facilities as the primary place to do so (Figure 20).

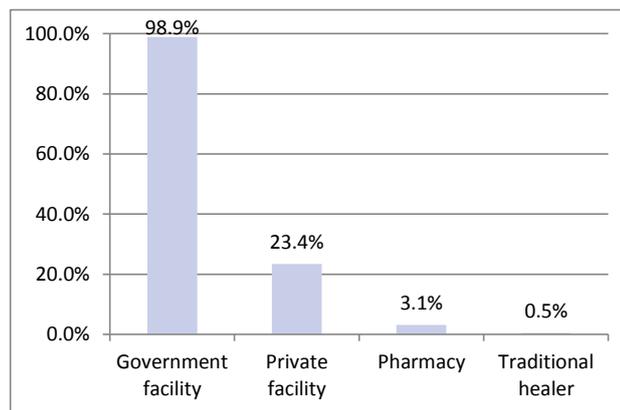


Figure 20: Locations where one can access ARVs (n=1178)

#### 4.9 Workplace Programs

Approximately two-thirds of respondents (67.3%) reported knowing of HIV/AIDS-related activities that occurred in their workplaces. Of the 416 who provided insight into what type of activities were available,<sup>2</sup> the most common activities reported were peer education programs (87.5%) and condom distribution (74.8%). No respondent reported HTC or counseling services to be available at the workplace.

Respondents noted a wide array of changes as a result of workplace HIV/AIDS programs (Figure 21). Most notably, respondents said such workplace programs created an environment that was more open to discussing HIV/AIDS. The majority of respondents also believed there to be reduced stigma, absenteeism and deaths due to AIDS because of these programs.

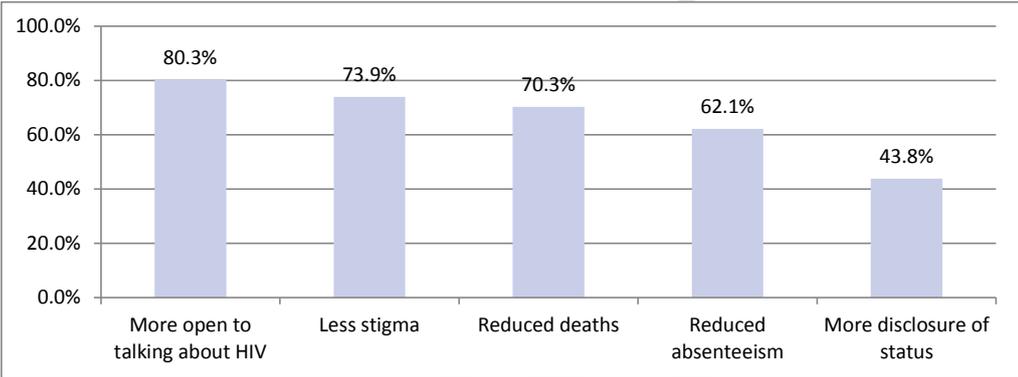


Figure 21: Perceived changes due to workplace programs (n=792)

Support targeting HIV-positive employees was less common—or less recognized—than programs focusing primarily on HIV/AIDS prevention. Only 37.9% said their workplace had specific activities/programs that targeted people living with HIV, while 21% did not know if there was any form of support their workplace provided HIV-positive employees. Of respondents knowing about programs/activities targeting HIV-positive employees, 60% had participated in at least one such program/activity. The primary types of support provided to HIV-positive employees included food supplementation and medical schemes (**Error! Reference source not found.**). Support groups and general treatment support were not mentioned by any respondents to be available at their workplaces, but 29.9% reported that their workplaces provided HIV-positive employees with access to a group providing palliative care.

Over half of respondents from Cohort Two (58.9% of 683) said their company had an HIV/AIDS-specific workplace policy in place, with 29.1% of respondents from this cohort

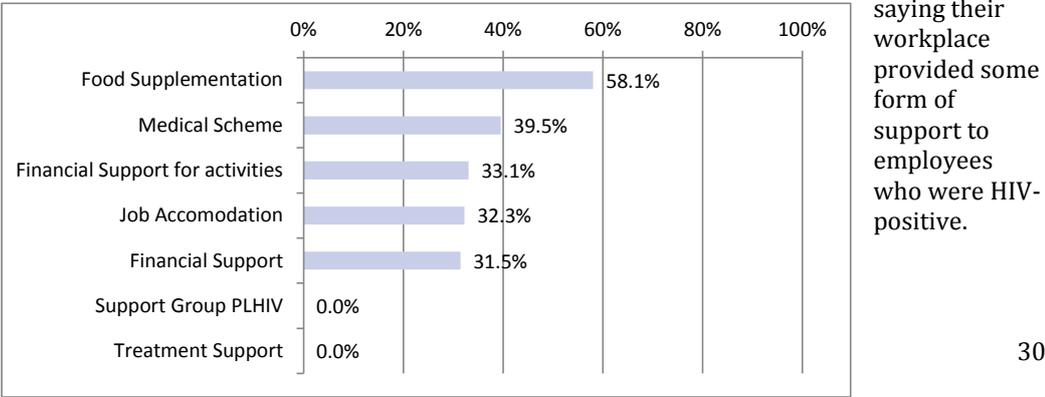


Figure 22: Support available for HIV-positive employees (n=1119)

saying their workplace provided some form of support to employees who were HIV-positive.

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## 5. Limitations of the Study

Some limitations of the KAP study include:

- Due to the differences in the size of the various workplaces included in the study, the KAP study was not able to provide workplace-specific estimates, thus limiting its utility as a programmatic management tool.
- The workplaces were chosen based on a convenience sample and included predominantly public sector businesses or large private sector enterprises. Thus, the sample was not randomly selected from among all Zambian workplaces, and as a result the findings cannot be extrapolated to other, non-SHARe II-supported Zambian workplaces.
- Some of the questions in the KAP survey were worded differently from question formats in other surveys (e.g., questions about condoms, regular/non-regular partners and stigma). The results for these questions are sufficient for SHARe II evaluation purposes, but cannot be compared to national trends noted in other surveys.
- The sample included more than twice as many men as women, which meant that some of the gender-specific analyses had small sample sizes.
- Because this study was not designed for collection of biometric data, SHARe II will be unable to track changes in HIV/AIDS prevalence or incidence over time in the workplaces that participated in this study.
- Due to the sensitive nature of the survey topics, which included questions about sexual behavior and attitudes, and the fact that this survey was conducted in-person, these results might have been affected by response bias.

## 6. Discussion and Recommendations

Overall, findings from the SHARe II baseline KAP survey highlight areas in need of continued programmatic attention, including stigma reduction, stressing the importance of condom use and reinforcing that there is still no cure for HIV and AIDS. Finally, the further expansion and enhancement of HIV/AIDS workplace services throughout all sectors in Zambia remains a critical need.

### Condom Use

Condom use rates remain low, particularly with regular partners, and should continue to be emphasized. Approximately three-quarters of respondents used a condom in their most recent sexual encounter with a non-regular partner, while only a quarter used a condom in their last sexual encounter with a regular partner. Reasons for not using condoms include trust in one's partner and the use of other methods of contraception.

SHARe II and other organizations that conduct workplace HIV/AIDS programs should consider their target audience when designing interventions to encourage condom use. For example, it may not be feasible to encourage people to always use condoms with their regular partners for STI prevention, unless it is a known discordant couple. However, interventions for those in regular partnerships can promote the benefits of condom use for non-STI purposes, including as an added contraception barrier method, even if other contraceptives are already being used.

At the same time, interventions should promote that condoms *always* be used with any non-regular partners and should emphasize the role of sexual networks and multiple concurrent partnerships in spreading HIV. Interventions can focus on providing people—particularly women—with skills in negotiating condom use and convincing partners to use condoms. Messaging should also target men, who were more likely to refuse to wear condoms in the survey, emphasizing the benefits of condom use and respecting partners' choices. Finally, work needs to be done to break down social barriers to condom use, for both genders.

Similarly, much growth is needed in people's ability to discuss issues of intimacy with both regular and non-regular partners. Work should focus on giving people the skills to discuss and address these issues. This finding reinforces the need for interventions like the SHARe II-supported Gender and Sexuality in HIV/AIDS (GESHA) program, which aims to address issues of gender relations, sexuality and culture in HIV/AIDS.

### **Condom Knowledge/Access**

Much effort is still needed to raise awareness on how to use condoms correctly, with 7.5% of men and 19.2% of women noting that they do not know how to use condoms. Peer educators appear to remain an effective way of providing information about condoms, with a majority of respondents noting that they received information on condom use from peer educators. As people become more fatigued with information about the epidemic, new and innovative strategies of educating about condom use need to be identified and deployed.

Work still remains in making condoms more accessible and reducing stigma associated with buying condoms. Almost a quarter of respondents—and over a fourth of female respondents—noted that it was difficult to obtain condoms. Less than two-thirds of respondents were comfortable buying condoms in their own neighborhoods, with just over half of female respondents noting that they were comfortable buying condoms in their own neighborhood and carrying condoms. Workplaces should make condoms accessible in private settings, including men's and women's bathrooms. Secondly, stigma around buying and carrying condoms—particularly for women—should be reduced, so that employees feel comfortable procuring condoms in their communities.

### **Sexually Transmitted Infections**

When asked to name STIs, most said that they were familiar with syphilis, gonorrhea and HIV/AIDS. However, considerably fewer could name chancroid, warts, herpes or chlamydia. Programs that address STIs should emphasize the close link between HIV and STIs and the independent risk of contracting STIs (independent of HIV) as a reason to use condoms. Further, interventions should emphasize the importance of encouraging one's partners to get tested for STIs, either as part of a health facility partner notification program, or through couples testing.

### **Knowledge of HIV/AIDS**

Although it is encouraging to note that nearly all respondents had basic knowledge on HIV/AIDS, this knowledge is incomplete. Strides need to be taken to ensure people know *all* relevant facts about HIV/AIDS, such as recognizing all modes/risks of HIV transmission, understanding the progression of infection/illness, learning the role ARVs can play in helping both infected persons and their partners and recognizing the wide variety of actions that can be taken to prevent spread of HIV.

Particular areas of education include raising awareness about the benefits of male circumcision, prevention of mother-to-child transmission (including the possibility of HIV transmission through breastfeeding) and the presence of STIs as a risk factor for HIV. Further, since so few respondents identified mutual faithfulness or reducing partner count as ways to protect oneself from HIV, education should include messages about the risks of multiple concurrent partnerships. Finally, culturally-specific practices that can contribute to the spread of HIV (e.g., dry sex) should particularly be addressed in workplace wellness programs.

### **Contradictions in Knowledge and Behavior**

There were multiple contradictions between the knowledge, attitudes and practices of the respondents in this survey, which highlight the need for continued sensitization and messaging for this population.

Firstly, respondents were generally knowledgeable about HIV/AIDS but still engaged in risky behaviors, such as unprotected sex. As noted above, knowledge about HIV/AIDS and condom use was generally quite high, with most respondents being able to identify at least one mode of transmission, symptom and means of protection from HIV/AIDS. In spite of this knowledge, however, condom use remained inconsistent; in this population, knowledge does not appear to have been enough to compel behavior change. Workplace wellness programs should not rely solely on building knowledge, and should include significant behavior change components as well.

Secondly, some respondents who viewed HIV as a serious problem in their communities, and who also have unprotected sex, nonetheless do not view themselves at personal risk of contracting HIV. Almost a third of respondents who viewed themselves at no risk of contracting HIV noted that they used condoms “occasionally” or “never” with non-regular partners. This discrepancy between perception of personal risk, perception of community risk and low condom use needs to be addressed by emphasizing that HIV/AIDS is not just a disease that affects “other people”—that everyone is at risk, and that those who engage in unprotected sex with non-regular partners should consider themselves at risk of HIV/AIDS.

Finally, many respondents viewed themselves at risk of HIV/AIDS primarily because of a lack of trust in their partner(s) and yet they cited “trust in partner” as the primary reason for not using condoms. Almost two-thirds of those who viewed themselves at risk of HIV/AIDS cited a lack of trust in their partner as the reason for being at risk. At the same time, many people who did not use condoms with regular partners because of trust in that partner, nonetheless viewed themselves at risk of contracting HIV. Of these respondents, over 40% viewed themselves at “moderate” or “high” risk of contracting HIV.

Considering these contradictions, interventions should be designed to address the attitudes and practice of two separate but at-risk groups: those who view themselves at no risk of HIV in spite of having unprotected sex and those who view themselves at high risk, yet do not use condoms with regular and non-regular partners.

### **HIV Testing and Counseling**

There remains a need to address stigma surrounding HIV/AIDS, as secrecy around HIV infection remains prevalent. This stigma may be discouraging respondents from going for

HTC, with a quarter of respondents saying that they have never gone for testing and counseling. Other barriers to testing included fears of a positive result, fear of depression and a perceived lack of confidentiality at the testing site. Interventions should stress that while there is no cure for HIV/AIDS, HTC is a crucial step to planning one's future and that with ARVs, HIV is no longer a death sentence.

### **Workplace HIV/AIDS Programs**

Respondents appeared to appreciate workplace programs, noting the many benefits they saw derived from them including reduced absenteeism, death and a reduction in stigma. However, a minority of workplaces had programs that targeted people living with HIV, such as financial support, and no workplaces had support groups or treatment support. The overarching implications for SHARe II's work in policy advocacy should be the need to ensure policy changes from the national down to the workplace level. Although workplace programs are more prevalent than they were several years ago, more work must be done to ensure employees in all workplaces have access through direct services or referrals to HIV/AIDS prevention/treatment care and support at their places of employment. In particular, it is necessary to work to expand the presence of programs for people living with HIV in workplaces.

Given the stability in employment for many study participants—with over half having worked at their jobs for more than five years—HIV/AIDS programs in these workplaces can not only improve the health of employees, they can also see returns on investment through emphasizing prevention. Each infection averted in an employee can save the workplace time, money and human resources down the line, as that employee maintains his or her productivity.

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Appendix 1: Questionnaire

Appendix 2: Protocol

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