# "Walking the Talk in the Workplace"

Strengthening and Scaling up Sustainable Internal HIV and AIDS Responses for CSO Workplaces in Uganda

## ACORD Uganda Baseline Survey Report, May 2011

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# Contents

# Executive Summary

**THIS REPORT PRESENTS FINDINGS** of a Baseline Survey carried out to assess levels of internal mainstreaming of HIV and AIDS (in workplaces) among 55 CSO participating on a project for Strengthening and Scaling up Sustainable Internal HIV and AIDS Responses for CSO Workplaces in Uganda. The project is coordinated by ACORD Uganda with financial support from Oxfam Novib. The survey made inquiry on 5 Key areas on which the project focuses which include: Internal HIV and AIDS mainstreaming; reducing stigma and discrimination; access to treatment, care and support; linking and learning; and lobbying and advocacy.

The purpose of the baseline study was to gather and analyze data on HIV WPP development and implementation from participating CSOs and stakeholders in order to develop a benchmark for evaluating the project after completion.

The study targeted organizations which were purposively sampled to include those that had participated in the SAN! Pilot project on managing HIV at the workplace but still needed more support as well as organizations that were joining at the scale-up stage. Study tools were standardized in order to collect data that can be jointly analyzed for all participating organizations in the 10 countries. Two structured questionnaires, one on staff HIV and AIDS Knowledge, Attitudes, Behaviors and Practices (KABP) and another on that asked information on organizations' workplace HIV and AIDS related systems and procedures, were used for quantitative. Besides the questionnaires, Focus Group Discussion guides were also used to collect qualitative data and triangulate the quantitative information.

Findings reveal a positive response to HIV and AIDS at the workplace and the urge to support staff HIV and AIDS issues among the 55 participating organizations. Most staff interviewed were also aware of availability of, and had used the organizations' workplace policies. There, however, was a significant percentage of staff that revealed that their organizations did not have HIV workplace policies, which called for further exploration.

This study recommends adoption of participatory strategies for development of and increasing awareness on HIV workplace policies for organizations. This study also recommends that there is need for further review to establish availability of HIV and AIDS internal mainstreaming activities in organizations whose staff stated that they are aware of availability of HIV and AIDS Work Place Policies, had seen and read the HIV WPP.

Findings show that there is less of the biomedical HIV and AIDS services (treatment, care and support) available in the supported organizations' workplaces, and more of the preventive services like awareness creation and condom supply. Some organizations had informal arrangements for addressing issues of HIV and AIDS care and treatment among staff.

Documentation and sharing of information to staff on available HIV and AIDS treatment services in areas where these organizations' staff stay or live, and services near the office premises, is recommended.

The study revealed a moderate level of linking with other organizations and learning from them for purposes of tapping from their skills and also evidenced by belonging to networks. This study however, did not establish levels of behavior modification in the organizations resulting from linking and learning.

A simple assessment to establish performance of the organizations on the areas of modifying behaviors as a result of linking and learning is recommended.

Findings on lobbying and advocacy revealed that organizations were mainly involved in local level (district and community based) advocacy among fellow NGO/CSO. There was low perception of the benefits of National level advocacy to their target groups/staff, in addition to poor coordination mechanisms or institutions of national level advocacy.

Incorporation of the need and value of national level advocacy in partner CSO training programs, sharing of information on available national level workplace HIV and AIDS advocacy coalition with the partner CSO is recommended.

This study noted differences in perception of stigma and discrimination among the different staff levels and gender in the organizations with lower staff and females feeling more stigmatized than senior level and program management staff. It also noted that all staff levels would stigmatize fellow staff due to their sexual orientation.

It is recommended that Need for endangered stigma awareness sessions and strategies for especially the staff in lower level positions. There is also need to bridge the gaps in knowledge on HIV issues between managers and their staff.

# Con List of Acronyms and Abbreviations

| | |
|---|---|
| ACORD | Agency for Cooperation and Research in Development |
| ACORD | Agency for Corporation and Research in Development |
| AIC | AIDS Information Centre |
| AIDS | Acquired Immune Deficiency Syndrome |
| CSO | Civil Society Organization |
| EAC | East African Commission |
| FBO | Faith Based Organizations |
| FGD | Focus Group Discussion |
| HCT | HIV Counseling and Testing |
| HIPS | Health Initiatives for the Private Sector |
| HIV | Human Immunodeficiency Virus |
| ILO | International Labor Organization |
| MTEF | Medium Term Expenditure Framework |
| NAFOPHANU | National Forum of PHA Networks in Uganda |
| NGO | Non Governmental Organizations |
| PEAP | Poverty Eradication Action Plan |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PLHIV | People Living with HIV |
| SAN! | Stop AIDS Now! |
| TASO | The AIDS Support Organization |
| TOR | Terms of Reference |
| UAC | Uganda AIDS Commission |
| UGANET | Uganda Network on Law Ethics and HIV/AIDS in Uganda |
| UNAIDS | The Joint United Nations Programme on AIDS |
| UNGASS | United Nations General Assembly Special Session |
| VCT | Voluntary Counseling and Testing |
| WHO | World Health Organization |
| WPP | Workplace Policy Project |

# 01 Introduction and Background

**THIS REPORT PRESENTS FINDINGS** of a Baseline Survey carried out to assess levels of internal mainstreaming of HIV and AIDS (in workplaces) among Civil Society organizations in Uganda, supported by ACORD Uganda. The survey was carried under a project, initiated by Oxfam Novib and ACORD Uganda, to strengthen CSOs HIV &AIDS responses at workplace for staff and family members. The survey made inquiry on 5 Key areas on which the project focuses which include: Internal HIV and AIDS mainstreaming; reducing stigma and discrimination; access to treatment, care and support; linking and learning; and lobbying and advocacy.

The baseline study was undertaken to provide benchmark information for a project to scale-up managing HIV and AIDS in the workplaces of existing partners of ACORD Uganda and new partner Organizations joining the project for the first time. At ACORD Uganda the study was guided by an external consultant whose role was to train the research team which composed of ACORD staff, and to guide the data collection procedure by carrying out checks and balances for quality control. Other technical support and guidance was also given to the team by the international programme office at Oxfam Novib in Netherlands.

While this report gives an account of a specific country report for Uganda, it is important to note that the methods, methodology and the general guiding principles of this study were guided by a set of Terms of Reference (TOR) that were developed as a guide for all the twelve (12) countries participating in the overall project. The terms of reference mentioned are attached to this report.

## Social, Economic and Political Context

In dealing with the HIV and AIDS pandemic, the government of Uganda has adopted a multi-sector approach that calls on all actors to play their part in the struggle and conform to the Universal Access to HIV and AIDS prevention, care and treatment in line with the WHO/UNAIDS recommendations. There is also political will for accelerating HIV prevention as per the UAC (2006)[1]; and UNGASS Report (2010)[2] which viewed it as the road map for reducing HIV infection in Uganda. The National health policy (2009)[3] also encourages public-private partnerships aimed at involving all the different stakeholders in planning and delivering health services. Involvement of CSOs in HIV and AIDS prevention services has been highly recognized and is envisaged to strengthen working relations between the Ministry of Health and the government of Uganda in combating HIV and AIDS. Processes for addressing HIV and AIDS pandemic in Uganda are also guided by the National HIV and

1 UAC, 2006. Accelerated HIV prevention: The Road Map Towards Universal Access to HIV prevention in Uganda. Kampala, Uganda
2 United Nations General Assembly Special Session (UNGASS) Report (2010): Country Progress Report. UAC, Kampala.
3 National Health Policy (2009).Reducing Poverty Through promoting Peoples Health. MoH, Kampala, Uganda

AIDS Strategic Plan (2007/2008 – 2011/12)[4]. On the other hand, support to the health sector and strategies for managing HIV have been highlighted as key priorities in the National Development Plan (2010/11-2014/15)[5]. It has been agreed by the government of Uganda that mainstreaming HIV and AIDS response activities in the different social economic sector programmes, projects and workplaces would lead to reduction of HIV infections and negative impacts of AIDS on their sector performance in the Ugandan economy.

HIV and AIDS work place responses in Uganda are particularly guided by the National policy on HIV/AIDS in the World of work (2007) and the National plan of Action for implementing the National Policy on HIV/AIDS and the world of work (2010).The guiding principles of these policy documents are based on the ILO code of practice and they outlines specific roles that should be played by various sectors and stakeholders, including the Civil Society. This provides a framework and principles for mounting an optimum response to HIV and AIDS in the entire Ugandan world of work.

At the E.A Regional level, Uganda subscribes to the Eastern African community Regional Integrated Multisectoral HIV and AIDS Strategic plan (2007-2012)[6] commitments to prevent HIV and mitigate AIDS by member states. In here under strategic objective seven, approaches and initiatives for tackling HIV and AIDS work place issues by EA governments have been outlined. Chapter six of the strategic plan also outlines the funding opportunities for regional member countries that indicate a positive political will in responding to HIV and AIDS issues.

**Table 1: General Social Economic Profile and HIV and AIDS Estimates of Uganda**

| INDICATOR | VALUE | YEAR | SOURCE* |
|---|---|---|---|
| **Epidemiology** | | | |
| Estimated HIV prevalence (15-49 years) (%) | 6.4% | 2005/2006 | Uganda UNGASS Progress Report, Jan 2008-Dec 2009 |
| Number of people living with HIV | 1.19m | 2010 | Ministry of Health, 2010[1] |
| Deaths due to AIDS | 72,000 AIDS-related deaths per year | 2006 | MoH |
| Children orphaned by HIV/AIDS | 2m | 2005/2006 | MOH |
| **HIV and AIDS response** | | | |
| % of adults who have tested for HIV in the last 12 months and who know their results | 4.0% Women and 3.8% Men as of end of 2005[2] | 2005/6 | Uganda UNGASS Progress Report, Jan 2008-Dec 2009 |
| Number of patients receiving ART | 304,142 | March 2010 | Ministry of Health, 2010 |
| ART coverage (as % of patients with advanced HIV infection) | 97.2% | March 2010 | Ministry of Health, 2010 |
| % of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission | 51.6%14 (46,948/91,000)<br>Types of regiment<br>Combination regimen 25%<br>(11,737/46,948)<br>HAART 17% (7,982/46,948<br>Sd NVP 58% (27,229/46,948) | 2009 | National Data Quality Assessment report, MoH, 2009 |

1 MoH, (2010), Status of Antiretroviral Therapy in Uganda: Quarterly Report January to March 2010, Kampala, Uganda, June 2010
2 This indicator is based on UDHS and is estimated every 4 to 5 years, 4.0% Women and 3.8% Men as of end of 2005

4 UAC, 2007. Moving Towards Universal Access: Uganda National strategic Plan 2007/8-2011/12. Uganda Aids Commission Republic of Uganda.
5 National Development Plan 2010/11-2014. Available at: *www.finance.go.ug/docs/NDP_April_2010-Prot.pdf*
6 East African Community Regional integrated Multisectoral HIV and AIDS Strategic

However it is important to note that while Uganda has the above policies and guiding document for responding to HIV and AIDS, there is still a big challenge in implementation of the programmes and action plans due to financial constraints and logistical limitations. There are also urban-rural differences in terms of scope and quality of services. HIV and AIDS services in the urban areas are of relatively higher quality and scope than those in rural areas (MoH and Macro International Inc., 2008). This means that people living in rural areas would either have to travel long distance to access better services (incurring transport and other costs) or they would stay at home without receiving these services.

Economically, HIV and AIDS continue to pause a threat to the work force. The Uganda HIV sero-behavioural survey 2004 -05 and longitudinal studies indicated that the prevalence rates among the 15 - 49 age groups who form the majority of the labour force was 6.3%. The prevalence was higher in women than men when disaggregated by age and sex reaching a peak for women at ages 30-34 (12%) and for men at ages 35-44 (9%). The incidence among those at the workplace was 7.2%. This thus implies that the direct and indirect toll on productivity cannot be underestimated especially since this loss is felt throughout all sectors and not limited to formal employment but also the agricultural sector and industrial development and growth in Uganda (FAO, 2002)[7] . The psychological distress, extra medical costs, loss of skilled personnel, high recruitment and training costs in all sectors of production lead to low returns on labour and economic growth generally. A three country research study; 'Counting the organizational cost of HIV and AIDS on CSOs in Malawi, Uganda and Tanzania, indicates that 62% of the CSOs in the study had experienced at least one staff death in 5 years, 72% suspected that one or more of their current staff were HIV positive (Rick James et al, 2006)[8].

## HIV and AIDS Expenditure and Donor Funding in Uganda

This section provides a description of the HIV financing and the health financing status in Uganda in general, health resources, financial mechanisms and levels of expenditure in the health sector. In Uganda, households constitute a major financing source of the National Health Expenditure at 49.7% and this is followed by Development Partners at 34.9%, Central Government at 14.9% and international NGOs at 0.4%[9]

Health Expenditure from public sources in absolute terms has increased in the past 10 years, however, percentage of the total Government spending, has actually decreased. In recent years, government's allocation to health as a percentage total government budget has been on average 9.6%. It thus remains below the Abuja Declaration target of 15%...

- In the medium term, donor project funding allocation has declined. During the FY 2005/06 and 2006/07 the amount within the MTEF decreased from UGX 269 billion to UGX 189 billion and yet outside the MTEF it increased from UGX 238 billion to UGX 351 billion. Funds allocated outside the MTEF do not necessarily address sector priorities and affect overall allocation of funds by government.

The main sources for HIV and AIDS funding in Uganda include:

- PEPFAR
- Global Fund to fight AIDS Malaria and Tuberculosis
- Bi-lateral and Multilateral Donor Institutions

7 FAO (2002).The impact of HIV and AIDS on Rural Households and Land issues in Southern and Eastern Africa: Back ground paper prepared for FAO sub regional Office for Southern and Eastern Africa

8 http://www.intrac.org/data/files/resources/66/Praxis-Paper-13-The-Organisational-Impacts-of-HIVAIDS-on-CSOs-in-Africa.pdf

9 Ministry of Health. MoH. (2009).*Human resources for health bi-annual report*. Kampala: Ministry of Health. MoH.
31 UBOS Household Survey Report

# Health Sector Response to HIV & AIDS: Key Policies, Strategies and Institutions

The HIV/AIDS epidemic carries cultural, social, economic and political implications. Similarly the nature of the epidemic and therefore the response raise pertinent ethical, legal, human rights and administrative issues that demand for guidance in service delivery to ensure standards, equity, accountability and protection of human rights. The country has therefore developed tools, standards and guidelines to support implementation of the national program as follows:

- The first National policy guidelines were developed in 1993 and later revised in 1996 through processes spearheaded by the Uganda AIDS Commission (UAC). A review of the 1996 policy guidelines was completed in 2003 and the outcomes informed the process for the development of the National AIDS Policy (NAP) in 2004/05. The final draft of the NAP was submitted to Cabinet for approval in October 2005. The NAP highlights various legal measures which guided the development of an HIV/AIDS bill in Uganda. Currently the bill is under review by the national parliament and awaits approval. However the Civil Society coalition on the HIV/AIDS National Bill led by UGANET has demanded for a review and change of provisions in the bill deemed as criminalizing and stigmatizing PLHIV. The provisions are also deemed to be undermining the efforts already made by the country in HIV prevention and support to PLHIV.

Besides the above developments the National Strategic Plan 2007/8-2011/12 was initiated by UAC in December 2005. This was done through a very comprehensive consultation process which was concluded in November 2007. This National HIV & AIDS strategic Plan was also developed in line with global and national development requirements for universal access to HIV & AIDS prevention, treatment, care and support services drive. This response has also informed the development of the Uganda Health Sector Strategic plan III (HSSP, 2010) in which priorities for addressing HIV and AIDS were set. These include the following targets.

- HIV prevalence among pregnant women 19-24 yrs attending antenatal clinics reduced from 7% to 4%.
- The proportion of people who know their HIV status increased from 38% to 70%.
- The proportion of people who are on ARVs increased from 53% in 2009 to 75% by 2015 among
- Adults and from 10% to 50% in children less that 15 years of age.
- The proportion of children exposed to HIV from their mothers' access EID program increased to 75%.
- The proportion of pregnant women accessing HCT in ANC increased to 100%.
- HCT services available in all health facilities up to HC III.
- PMTCT services available in all health facilities up to HC III.
- ART services available in all health facilities up to HC IV and 20% of HC III by 2015.
- The proportion of males circumcised increased from 25% to 50

# Civil Society Response to HIV & AIDS

Within the world of work, HIV/AIDS has had a negative impact on the work force. According to ILO (2004), 37 million people of working age had HIV & AIDS and by the end of 2005, as many as 37 million workers were infected worldwide. In the absence of intensive access to treatment, the number of workers dying of HIV and AIDS related illnesses is expected to increase to 74 million by 2015, which will make the AIDS epidemic one of the biggest causes of mortality in the world of work. Given these statistics, there is growing recognition of the impact of the epidemic on national economies of developing countries such as Uganda where majority of people living with HIV (PLHIV) are adults in their productive age. In view of this AIDS threat to employment security and production within the labour force, some organisations have responded

to HIV and AIDS by advocating for the rights of PLHIV access to treatment, reduction of stigma in the work place and in some cases development of HIV and AIDS work place policies to guide management of HIV/AIDS in their workplaces. Others have formed coalitions and networks for ensuring a collective advocacy voice in pushing for better and equitable policies for addressing HIV and AIDS in Uganda. Notable among these networks and organisations are: The National Forum for Networks of Persons Living with HIV/AIDS in Uganda (NAFOPHANU), National Community of Women Living with HIV/AIDS (NACWOLA), Positive Men's Union, Federation of Uganda Employers, HIPS, Mildmay Centre for HIV and AIDS affected children, National Union of Disabled Persons of Uganda (NUDIPU) UGANET, Association of micro finance institutions of Uganda (AMFIU), the AIDS Support Organisation (TASO), ACORD Uganda among others.

However most CSOs in Uganda are faced with limitations in addressing HIV and AIDS at their work places and there is poor coordination nationally, especially of HIV WPP related issues. In addition to financial resources for supporting staff HIV and AIDS prevention, care, treatment and support activities, most CSO have low capacity to design a well informed workplace program as well as its implementation. In some organizations, there is limited appreciation of the need to address staff related HIV issues by management, while in some, the fear of raising expectations has hindered them to start discussions on how to address HIV and AIDS issues for staff. Uganda also lacks national level coordination mechanisms for promoting advocacy around the HIV workplace interventions within and among the different stakeholders. This has thus posed a challenge on feedback mechanisms on progress against implementation of the National Policy on HIV/AIDS in the World of Work. Under normal circumstances CSOs ought to play a monitoring function on implementation of national programmes and give feedback on any gaps or good practices. Therefore lack of a CSO coalition on HIV WPP in Uganda affects its progress.

## Overview of ACORD/Oxfam Novib HIV Workplace Project in Uganda

ACORD Uganda implemented an HIV Workplace project under the SAN! Project from July 2005 to July 2008. Up to 76 CSO that were partners of 4 Dutch organizations (Oxfam Novib, HIVOS, CORDAID and ICCO) were supported under this project which also was on a pilot basis. The project entitled: "*Managing HIV and AIDS in the Workplace" focused on* supporting the CSOs to develop and implement HIV and AIDS workplace policies. Key activities in this project included: organizational self assessments on HIV and AIDS management competence, VCT family days, internal learning sessions for staff on HIV and AIDS, Capacity builders trainings and ongoing technical support coupled with extension of small financial grants to the CSOs.

During the SAN! Pilot project implementation a number of gaps were identified that needed to be addressed if a stronger social movement against HIV and AIDS was to be built. Drawing on the past experience and lessons, ACORD proposed a 2 year initiative that will among other things prioritize the following:

- Facilitating the involvement of senior management of the respective CSOs in the HIV and AIDS responses
- Supporting to the HIV and AIDS focal persons to build sustainable HIV and AIDS committees in the work place rather than relying on a "one organization one individual" basis which suffers effects of staff turn-over.
- Identifying and supporting Regional Forum umbrella CSOs that can lobby and advocate for internal mainstreaming of HIV and AIDS issues among CSOs in their regions
- Linking the CSOs to service providers such as NAFOPHANU, AIC, TASO, Ministry of Health service centers as a "wean off" process for increased access to HIV prevention, care and treatment services.
- Capacity strengthening of targeted CSOs in skills to mobilize resources for supporting HIV and AIDS workplace interventions.

With financial support from Oxfam Novib, ACORD will scale up good practices from the SAN! Project implementation like; the organizational self assessment exercises for CSOs to identify clear entry points and strategies for responding to HIV and AIDS, Internal HIV and AIDS learning sessions, as well as staff and Family HCT interventions which inspire staff and their families to take HIV tests in a relaxed and friendly atmosphere, as well as discuss and learn more about HIV prevention, care treatment and referral to support Centers.

The scale up project, which is also implemented in 9 other countries in Africa and Asia, will be implemented in line with five program pillars. These pillars have been agreed upon by all the 10 participating countries and Oxfam Novib. The pillars are: (1) internal HIV mainstreaming; (2) addressing stigma and discrimination at the workplace; (3) access to HIV and AIDS prevention, care and treatment services; (4) Linking and Learning; and (5) Lobbying and advocacy.

# Research Purpose, Objectives and Methodology 02

## Purpose

The purpose of the baseline study was to gather and analyze data on HIV WP development and implementation from participating CSOs and stakeholders in order to develop a benchmark for evaluating the project after completion.

## Specific objectives:

(i) To assess the trends and status of management of HIV and AIDS at the workplace among 55 CSOs in Uganda.

(ii) To understand and analyze the perceptions and practices of staff and managers of organizations about the relationship between gender and HIV and AIDS, stigma and discrimination, prevention, incidence and impact of HIV and AIDS in their organizations.

(iii) To identify and analyze the opportunities and constraints for development and implementation of HIV and AIDS workplace policies and programs.

(iv) To provide baseline information that will be used as foundation for the monitoring and evaluation of the program.

To achieve the above objectives, the study focused on the following key issues: status of HIV and AIDS work place responses (internal mainstreaming); how stigma and discrimination is addressed in the workplace; access to HIV prevention, care and treatment and support for staff members and their family; the experience of lobbying, linking and learning within, between countries and globally and initiatives for advocacy.

## Methodology

### *General Approach and Design*

The baseline study was focused on two levels, namely, the organizational level and the individual staff level. At the organizational level, an organizational survey was conducted mainly focusing on the profile of the organization including its mission, policies, programs, staff size, organizational vulnerability to HIV as well its capacity to respond to the HIV epidemic. At the individual staff level, a staff survey was conducted to generate detailed data on staff knowledge, attitudes, behaviors and practices in regard to HIV and AIDS at the workplace. Focus Group Discussions (FGDs) were also used to triangulate the quantitative data findings and to capture the qualitative aspects of the study.

## Study Coverage, Participants and Sampling Strategy

The study targeted a total of 55 CSOs located in the North, North East, Central and Western parts of Uganda. The organizations were purposively sampled to participate in the study. The study selected organizations that had participated in the SAN! Pilot project but still needed more support, and organizations that were joining the project for the first time. The aim was to interview a purposively selected sample of staff at different employment levels (support staff, programs staff and managers) in the 55 organizations to participate in the study. Up to 10 staff members were targeted in CSOs that had 10 or more staff members while for those that had less than 10 all members of staff were interviewed. Organizations with more than 10 staff had them categorized by gender after which a random sampling method was used to give equal chance of participation to both gender (male and female) and management levels in the organization. In the process of selection of study participants, inclusion of PLHIV was given due consideration especially in organizations which had staff who had disclosed their HIV sero status. Staffs at head offices and those located in field offices were also included in the sample.

The study team was organized into two sub-teams each responsible to carry out data collection from designated set of organizations in the different regions of the country. Each sub team was composed of male and female researchers for efficiency in collecting data from both male and female staff members. The teams were charged with collecting the completed organizational survey questionnaires that had earlier been sent by email, as well as administering the staff survey questionnaires. The teams also assisted some support staff who could not read or write in English, to choose a member of staff that they trusted and confided in to assist them in recording their responses. Fieldwork was completed within a period of 5 weeks.

## Study Tools

Study tools were standardized in order to collect data that can be jointly analyzed for all participating organizations in the 10 countries. Structured questionnaires were used to collect quantitative data from CSOs and staff. Besides the questionnaires, Focus Group Discussion guides were also used to collect qualitative data and triangulate the quantitative information.

### *Structured Questionnaires*

Two types of structured questionnaires were used to collect data, namely, (i) the organizational survey tool – which was filled in by top executive officers of each participating CSO. This was used to collect information relevant to the organization such as the mission, goals, staff size, scope of operations, vulnerability to HIV, and existence of HIV related policies. (ii) Another questionnaire, the staff survey questionnaire was filled in by the randomly selected individual male and female staff members of CSOs. The staff questionnaire collected information on staff knowledge, attitudes, behaviours and practices in relation to HIV and AIDS at the workplace.

### *Focus Group Discussions (FGDs)*

FGDs were used to collect complementary information about the status of CSO responses to HIV and AIDS in the workplace. A focus group discussion guide was used to collect respondents' knowledge about CSOs responses on HIV and AIDS in their workplace specifically analyzing attitudes, practices and behaviors that relate to HIV and AIDS. FGD participants were disaggregated by their staff levels in the organizations, namely, top executives and middle level/programme staff. For the latter category, FGDs were further disaggregated by sex to allow participants to freely express themselves. Each FGD was facilitated by two members of the study team, one moderating the discussions and the other taking notes. Female FGDs were moderated by female facilitators, while male ones were moderated by corresponding male facilitators. Mixed sex groups of top executives were moderated by either sex. A total of 6 FGD were conducted among the different staff employment levels. 83 female and male respondents sampled from different staff employment levels in 55 CSOs were reached through the focus group discussion. Two FGD were conducted for the top executives of the organization, and four for middle and lower level staff members (two for female staff and two for male staff).

# Ethical Considerations

During the study exercise ethical issues including confidentiality and consent of participants were given consideration and the following were particularly done;

Consent was sought by use of letters of introduction of the study and its objectives written to directors of CSOs inviting them to participate in the study. Respondents' participation in the study was voluntary and no names of participants were required to appear on the study tools. Participants were assured by the research teams that information collected would be used for study/baseline purposes.

## *Limitations of the Study*

- Poor internet connectivity among some partner organizations – For some CSOs, especially those outside Kampala, necessitated downloading and printing out of questionnaires. This affected timely send back of the questionnaires. The ACORD team made telephone contacts with the affected CSO to establish the appropriate methods of delivery. To some organization in Kampala and surrounding areas, the questionnaires were hand delivered, while for the areas far away from Kampala, the questionnaires were posted.
- By the time of submitting the questionnaires to Oxfam Novib for entry and data analysis, not all the sampled staff members had returned the filled in questionnaires. The study team noted that some staff members who received the questionnaires did not respond to them in time despite being reminded of the deadlines. This affected the total number of questionnaires expected to have been collected.
- Since this study was being conducted in 10 countries, all tools and methodologies including sampling procedures were supposed to be uniform. Unfortunately, guidelines on sample size and selection were communicated when some countries had used other sampling methods. For ACORD Uganda, a smaller sample had been selected and this necessitated requesting the organizations to fill in more staff questionnaires. Although this affected data collection period, the organizations were responsive when contacted.

# 03 Findings of the Study

**THIS CHAPTER PRESENTS** and discusses the findings of the baseline study and a description of the participant demographic characteristics. The presentation of findings in this chapter looks at the extent of internal mainstreaming within organizations (development and status of workplace policies, current and future HIV related activities & training), perceived levels of and addressing stigma and discrimination, access to HIV services, linking and learning from others, and involvement in lobbying and advocacy.

## Brief Description of Demographic Trends

### *a). Organization Size, Type and Intervention Areas*

A total of 55 organisations participated in the study and were categorised as small, medium and large organizations, based on the number of staff members. Small organizations were those with staff of less than 10 members and they accounted for 25% of the organizations interviewed. Medium organizations had staff of more than 10 but less than 30. These accounted for 63.0%, while large organizations had staff number of above 30 and accounted for 11.1% of the organizations. Organisations were also categorised by type of organisations namely international, local NGO and CBOs, FBOs, Local government and network organisations. Sites of programme interventions of the sampled organisations indicated that rural based organisations were 34.5% and rural urban based organisations at 65.5%.

### *b). Gender/sex Composition, Job categories, Decision Making and Staff Employment Levels*

Results according to gender characteristics of staff within the organisations indicated that 58.8% were male, 41.2% female. On the other hand, categorisation according to employment level within organisations indicated that management comprised 29 (14.8%), programme staff, 83 (42.1%), Administration/support 70 (35.7%), Volunteers 14 (7.1%) and undisclosed employment level 1 (0.5%). The levels at which policies are made was also analysed among the organisations and indicated that most policy decisions were made at Board level (76.4%). Table 2 gives a description of these statistics. Job categories were also analysed and it was established that staff in full time jobs were 123 (62.4%), part time were 6 (3.0%), temporally 4 (2.0%), while contract were 82 (41.6%) and in permanent jobs were 4 (2.0%).

## *c). Staff Education Levels, Age, and Household Composition*

Organization and staff characteristics were further stratified in terms of, age, employment category, educational level and House hold composition. Out of the 197 staff in the sample, those in the age range of 15-24 were 17 (8.8%), those in the range of 25-49 were the majority and totalled 168 (86.6), 50 and above were 9 (4.6%) and three (3) of the participants declined to indicate their age. On educational levels of staff, 1 (0.5%) person had never been to school, 3 (1.5%), 9 (4.6%) were primary school and secondary school dropouts respectively while 38 (49.7%) were undergraduate/graduate and 56 (28.4%) post graduates. The study also indicated that the average household composition of respondents was 3 children, 2 women, 1 man and 3 dependants. Table 2 shows the quantitative description of the above.

**Table 2: Demographic Characteristics of the respondents (N=197)**

| Sex | | Count | Percentage |
|---|---|---|---|
| | Male | 93 | 47.2 |
| | Female | 104 | 52.8 |
| Age Category | | | |
| | '15-24' | 17 | 8.8 |
| | '25-49' | 168 | 86.6 |
| | '50+' | 9 | 4.6 |
| | Unknown | 3 | |
| Educational level | | | |
| | Never been to school | 1 | 0.5 |
| | Primary | 3 | 1.5 |
| | Secondary | 9 | 4.6 |
| | Vocational, Trade, College | 30 | 15.2 |
| | Under-Graduate | 38 | 49.7 |
| | Post-Graduate | 56 | 28.4 |
| Employment level | | | |
| | Management | 29 | 14.8 |
| | Programme staff | 83 | 42.1 |
| | Administration/Support | 70 | 35.7 |
| | Volunteers | 14 | 7.1 |
| | Unknown | 1 | 0.5 |
| Employment Type | | | |
| | Full time | 123 | 62.4 |
| | Part time | 6 | 3.0 |
| | Permanent | 4 | 2.0 |
| | Contract | 82 | 41.6 |
| | Temporal | 6 | 3.0 |

| House Hold composition | | | | |
|---|---|---|---|---|
| Statistics | Number of children in HH: | Number of Adult women in HH: | Number of Adult men in HH: | No of other dependants in HH |
| Mean | 2.6 | 1.6 | 1.2 | 3.5 |
| Std. Deviation | 2.6 | 1.3 | 1.0 | 4.0 |

# Stigma and Discrimination

## a). Organization Managers

Findings as shown in Table 3 indicated that managers in 30 (54.5%) organizations perceived that their staff would generally be supportive of HIV positive staff, while managers in 17 (31%) organizations would not reject HIV positive staff. In total, managers within 47 (85.5%) of organizations perceived low stigma and discrimination of HIV positive staff. However managers within 8(14.5%) organizations indicated that they do not know whether positive staff would not be rejected by fellow workers and neither did they know whether staff would support HIV positive staff. The table below indicates management perception of stigma and discrimination in their workplaces.

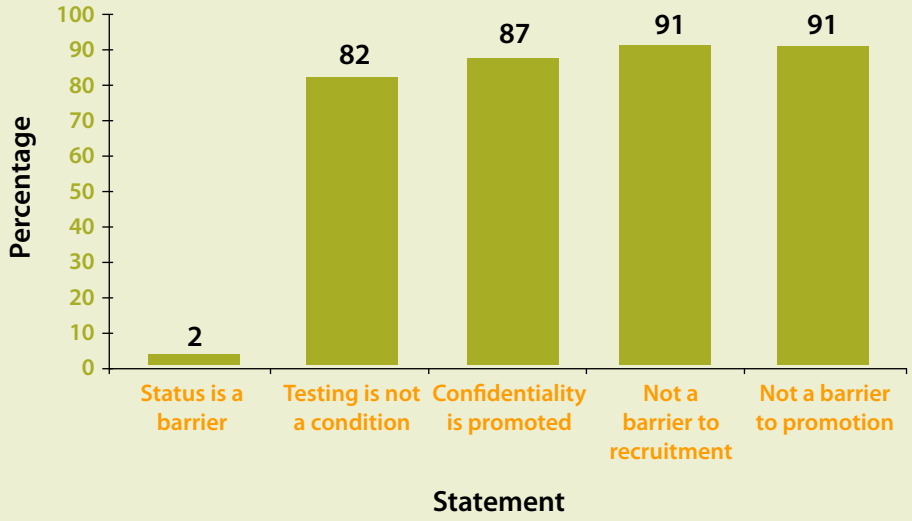
**Table 3: Management Perception on Stigma and Discrimination of the HIV positive within Organization (n=55).**

| | | # of Respondents | Percentage |
|---|---|---|---|
| Levels of stigma | Other staff would generally be supportive | 30 | 54.5 |
| | Staff would not reject HIV+ staff | 17 | 30.9 |
| | Don't know | 8 | 14.5 |
| | Total | 55 | 100 |

## b). Managers' Perceptions on HIV Testing & Employment and Promotion & Confidentiality of Staff Living with HIV.

Study findings indicated in Figure 1 shows that a small proportion (2%) of managers responded that HIV sero status would be a barrier to recruitment, while 91% indicated that HIV status is not a barrier to recruitment and promotion. Another 82% indicated that HIV testing was not a prerequisite for employment, and 87% of the managers indicated that HIV and AIDS confidentiality was promoted within their organizations. The figure below is a graphical representation of the above statistics.

**Figure1: Management Perception of Stigma and Discrimination**

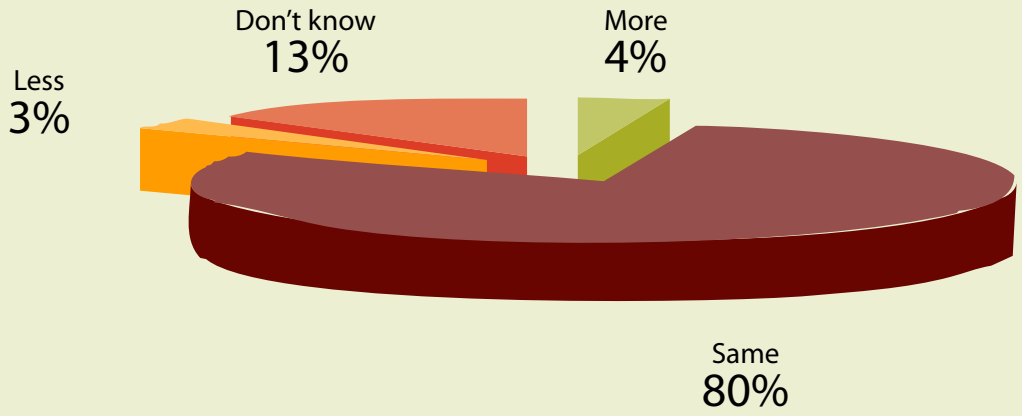



## *c). Staff Perceptions on Stigma and Discrimination in the Work Place:*

Perceptions of stigma and discrimination among staff were analyzed in consideration of the following: HIV positive person getting a job and a promotion; acceptance of HIV positive staff by colleagues;, attitudes towards sexual orientation of fellow staff and; whether staff would subject those affected by HIV to blame, shame and judgment.

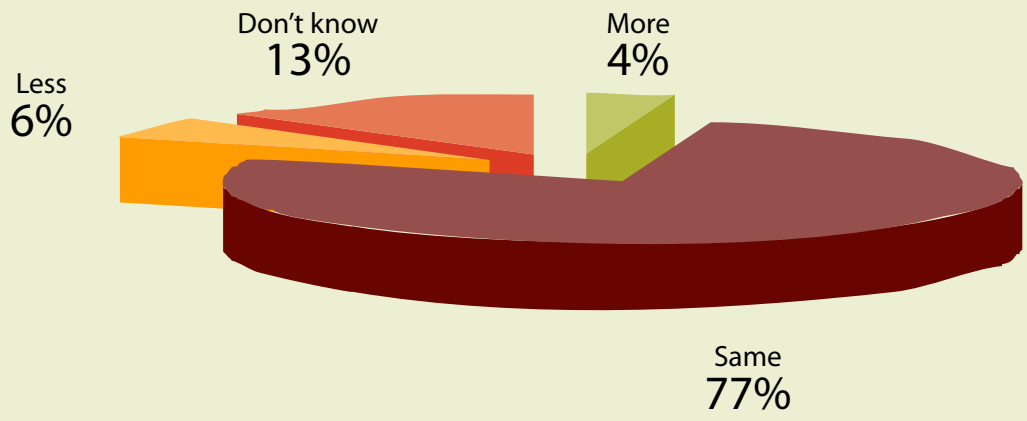
Findings from the staff survey revealed that HIV status did not affect job promotion and retention. As shown in Figure 2, a total of 80% of the respondents revealed that PLHIV had the same chances of getting jobs in their organizations like people without HIV. A significant number, 13%, revealed that they did not know. It is also worth acknowledging the 4% who revealed that PLHIV had more chances of getting jobs than people whose status were not disclosed.

**Figure 2: Chances of PLHIV Compared to a non HIV+ Person Getting a Job**



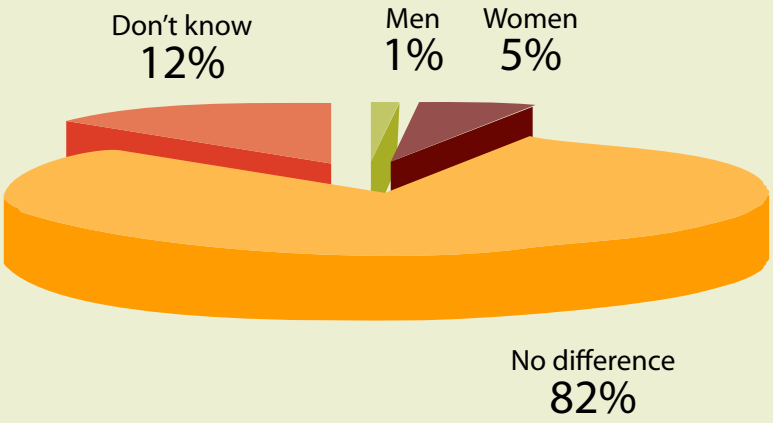

Similarly, findings also revealed that HIV sero status did not affect promotion at the job. A total of 77% of staff interviewed revealed that staff member living with HIV have same chances of promotion like those without HIV. Another 13% said they did not know, while 4% revealed that staff with HIV had more chances. These statistics are illustrated in Figure 3.

**Figure 3: Chances of Staff Living with HIV Getting Promoted**




Respondents were asked to state which gender would receive acceptance when they disclose their HIV sero status. A look at Figure 4 shows that 82% of them revealed that men and women would receive the same chance of acceptance, while 5% revealed that women would be accepted more than the men. Only 1% of the respondents pointed out that men would be accepted than the women, while 12% revealed that they did not know.

**Figure 4: Gender Representation of Acceptance after Disclosure of HIV Sero Status**




# Internal Mainstreaming

## *a). Staff Knowledge on HIV and AIDS*

**Table 4: Percentage Representation of Staff Knowledge on HIV Issues**

| Knowledge on HIV Transmission, Prevention, and Treatment | Frequency (N) | Mean (N) |
|---|---|---|
| Mean staff knowledge score (%) on prevention, 4 items | 197 | 90.7 |
| Mean number of misconceptions by staff on prevention, 7 items | 25 | 21.7 |
| Mean staff knowledge score (%) on transmission, 9 items | 197 | 85.6 |

## b). Status of HIV Workplace policies:

Findings on the status of HIV workplace policies among the 55 organizations revealed that the status of HIV workplace policies vary from one organization to the other. Whereas a good proportion of participating organizations (21.8%) revealed having policies under implementation, a significant number of them consented to having no policies (12.7%), while others lie in the development, draft and under review stages. Table 5 reflects on the details of the HIV policy status among the participating organization.

**Table 5: Status of workplace policies**

| Policy status | | # of CSOs | Percentage |
|---|---|---|---|
| | Non existent | 7 | 12.7 |
| | In process of development | 8 | 14.5 |
| | Draft | 12 | 21.8 |
| | Review | 7 | 12.7 |
| | Final(endorsed) | 9 | 16.4 |
| | Under implementation | 12 | 21.8 |
| | Total | 55 | 100.0 |

## c). Awareness of HIV Workplace Policies:

Findings revealed that most organizational staff members were aware of the availability of HIV workplace policies in their organizations. A total of 22.8% of 197 staff interviewed were aware of the availability of HIV WPP in their organizations, while 9.6%, 22.3%, 26.4% had seen it, read it and used it respectively. Table 6 indicates the distributions as discussed above

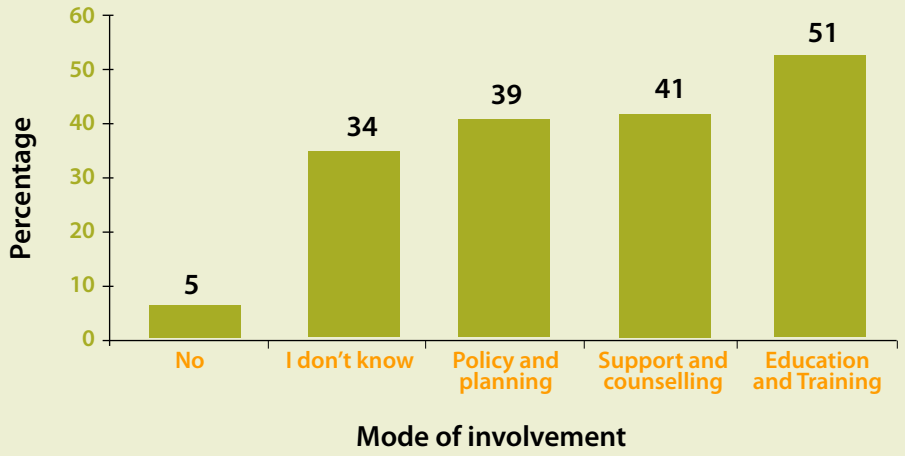
**Table 6: Shows percentages of HIV workplace policy awareness status.**

| HIV WPP awareness | | # of Respondents | Percentage |
|---|---|---|---|
| | None | 20 | 10.2 |
| | Don't Know | 17 | 8.6 |
| | Aware | 45 | 22.8 |
| | Have seen it | 19 | 9.6 |
| | Have read it | 44 | 22.3 |
| | Have used it | 52 | 26.4 |
| | | | |
| HIV & AIDS in the past 12 Months | None | 37 | 18.8 |
| | Don't know | 10…… | 5.1 |
| | Aware but not participated | 37 | 18.8 |
| | Participated | 113 | 57.4 |
| | **Total** | **197** | **100.0** |

## d). Involvement of PLHIV

The findings as shown in Figure 7 shows that the most common mode of involvement of PLHIV in workplace policy activities was Education and training accounting for 51%, followed by support and counseling, policy and planning accounting for 41% and 39% respectively. However, a relatively large percentage of participant organizations revealed that they either did not know (34%) or revealed that PLHIV were not involved in any way (5%).

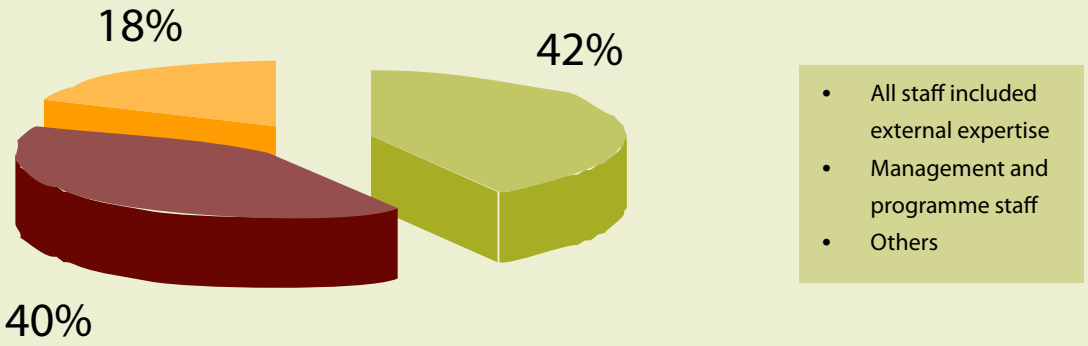
**Figure 7: Shows Levels of Meaningful Involvement of PLHIV in Workplace Programmes (n=197).**




## e). Participation in WPP development process

The question on participation in WPP development process solicited results that were compiled as given in Figure 5. Of the 55 organizations interviewed, 42% revealed that their workplace policies were developed by all staff with the support of external experts while 40% revealed that the workplace policies were developed by the management and program staff. Only 18% of the organizations did not specify.

**Figure 5: Percentage Distribution of Involvement in the Development Process of the HIV Workplace Policy (n=55)**

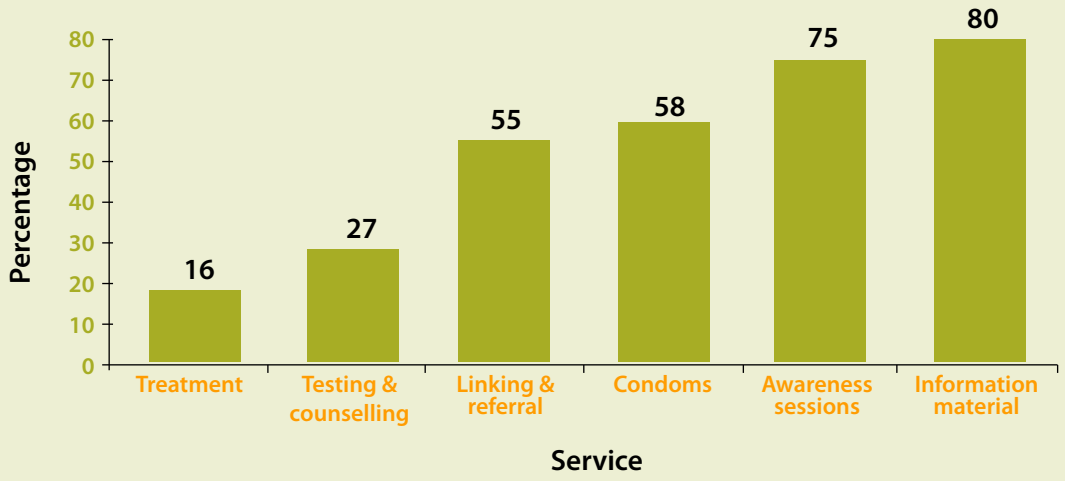


# Access to HIV and AIDS Services

## a). Services available at the Workplace

In regards to HIV service available at the workplace, respondents revealed that information materials and awareness sessions were the most frequent HIV services in their organizations with 80% and 75% respectively. Other HIV services accessed at the work place that were mentioned include: HIV treatment (16%), testing and counseling (27%), linking and learning (55%) and availability of condoms (58%). Figure 6 below shows graphical representation of this.

**Figure 6: Percentage distribution showing HIV services available in the workplace.**




## b). Availability of VCT Services at the Workplace

Findings as presented in Table 8 shows that VCT services are mainly accessed through other service providers (49%) but not within or at the workplace (14.5%). It is worth noting that 34.5% of the 55 organizations revealed that there were no VCT services available at the workplace while 1 organization revealed that it did not know.

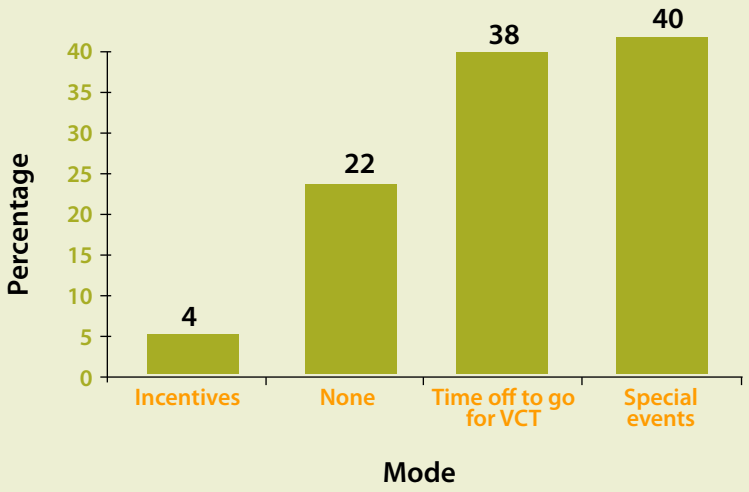
**Table 8: Shows the availability of VCT at the workplace**

| | Frequency | Percentage |
|---|---|---|
| Within workplace | 8 | 14.5 |
| None | 19 | 34.5 |
| With others | 27 | 49.1 |
| Don't know | 1 | 1.8 |
| Total | 55 | 100.0 |

## c). Strategies in place to encourage staff to Access VCT

When asked whether there was anything in place to encourage staff to go for VCT, most organizations (40%) revealed that staffs were encouraged to attend VCT during special events, while another (38%) said that they were given time off by their organizations to go for VCT. Figure 7 is a reflection of their responses.

**Figure 7: Percentage showing strategies by Organizations for encouraging Staff to attend VCT**

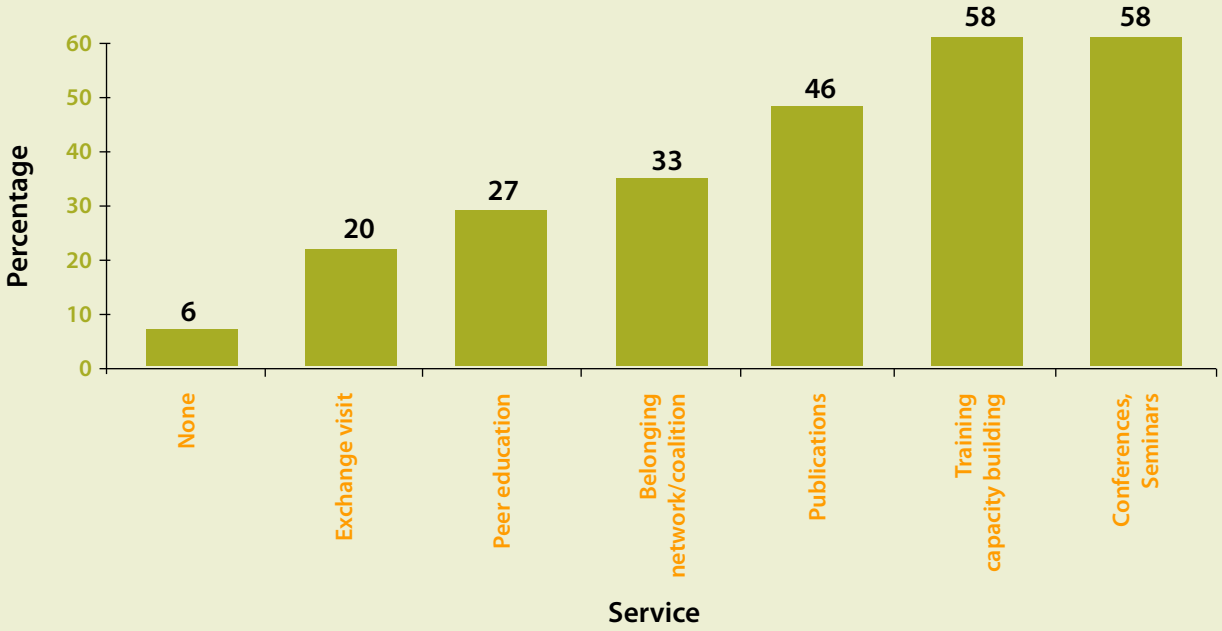



# Linking and Learning

## a). Methods/ways for Learning from one Another

Organizations were asked to state the methods they had used in the past 12 months to learn from other organizations. Their responses include; 58% revealing that it was through conferences and seminars, another 58% pointing out that it was through capacity building training, while 20% said through exchange visits. The figure below reflects these and other methods mentioned by the organizations. These statistics are presented in Figure 8.

**Figure 8: Percentage distribution of methodologies used by organizations to learn from other Organizations**



## b). Belonging to Networks or Coalitions

Organizations were also asked whether they belonged to networks or coalition. The responses reveal that organizations that belong to networks (32) are slightly more than those that are not (23) as shown in Table 9 below.

**Table 9: Percentage of Organizations that belong to Networks**

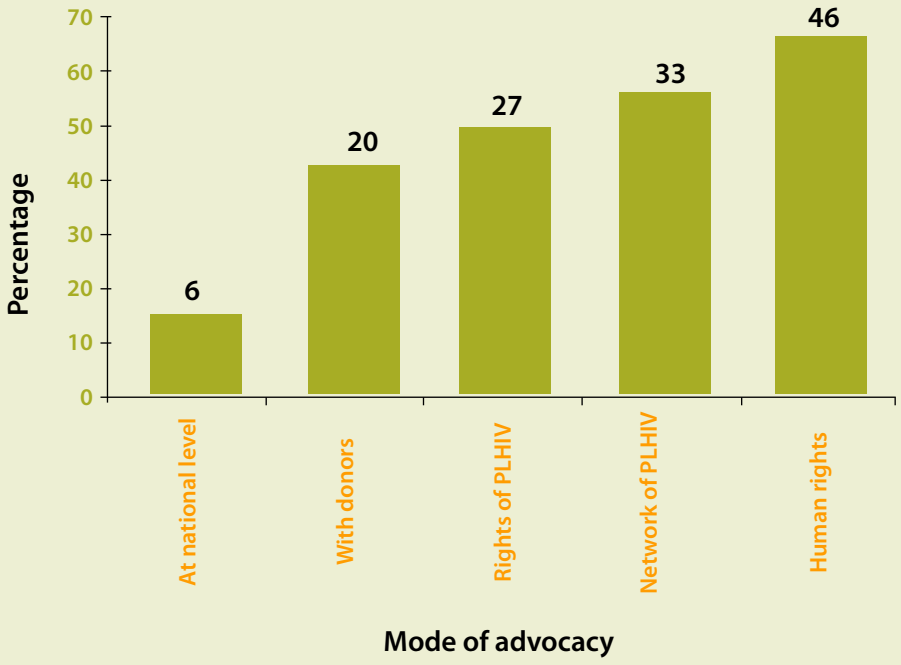
| | Frequency | Percent |
|---|---|---|
| Yes | 32 | 58.2 |
| No | 23 | 41.8 |
| Total | 55 | 100.0 |

# Lobbying and Advocacy

## a). Type of Advocacy Activities in which Organizations are Involved

Findings show that organizations participate in diverse HIV related advocacy activities. In Figure 9, a total of 64% of the organizations mentioned that they were involved in Human Rights related HIV advocacy, 55% involved in networks of PLHIV, 47% in PLHIV rights, while 40% and 13% were involved in advocacy with donors and 13% respectively.

**Figure 9: Percentage showing advocacy activities in which organizations are involved**



## *b). Staff awareness of the Organizations' HIV Advocacy Related Activities*

Staff awareness of advocacy activities in which staff were involved was another variable on which organizations activities on advocacy were assessed. Findings show that 58.4% of the staff interviewed (N115) said their organizations were proactively involved in HIV related advocacy, 63 staff members (32.2%) said their organizations were involved passively, 12 (6.1%) said they did not know, and only 7 staff members (3.6%) said their organizations were not involved in any advocacy at all. Table 10 reflects what the staff revealed.

**Table 10: Showing staff Awareness of employer advocating for rights and services of PLHIV.**

| | Frequency | Percentage |
|---|---|---|
| No | 7 | 3.6 |
| Don't know | 12 | 6.1 |
| Yes passively | 63 | 32.0 |
| Yes proactively | 115 | 58.4 |
| **Total** | **197** | **100.0** |

# Conclusions and Recommendations: Internal HIV and AIDS Mainstreaming 04

**FINDINGS REVEALED A POSITIVE RESPONSE** to HIV and AIDS at the workplace and the urge to support staff HIV and AIDS among the 55 participating organizations, evidenced by the number of organizations that have HIV policies that are being implemented (21.8%), policies under development (14%), that are in draft form (21.8%) and that are under review (12.7%).

> *"HIV and AIDS should be addressed at work place because employees spend most of their time at the workplace. It is through there that they can get information on where to receive services from the service providers."*
>
> Participant in Male FGD, Kampala

Findings revealed that most staff were aware of availability of and had used the organizations' workplace policies. 26.4% of the 197 staff interviewed had used them, 22.3% had read the policies, and an even bigger number (113 out of 197) had participated in their development. However, percentages of staff that revealed that their organizations did not have HIV workplace policies (10.2%) and those that did not know whether their organizations had HIV WPP (8.6%) cannot be ignored. The percentages are significant to indicate gaps in the organizations' HIV and AIDS internal mainstreaming activities especially in the areas of workplace policy development, implementation and dissemination across all staff levels and gender. More so, the aspect of staff that had seen and read the policies does not indicate implementation of the policies and therefore, needs further exploration.

## *Recommendations:*

Based on the above, it is imperative that organizations with HIV workplace policies should adopt strategies for increasing awareness on their HIV workplace policies to all levels of staff. Some of these strategies could include developing reader/user friendly versions of the policies, that is summarized versions highlighting the main sections of the policies. Some of these could be translated into the main local languages to benefit staff that is weak in the English language. For the organizations in which policies are under review, and those whose policies are under development, the processes should be participatory, involving all levels and gender of staff, and the final policy should be disseminated to all staff using some of the above suggested strategies.

This study also recommends that there is need for further review to establish availability of HIV and AIDS internal mainstreaming activities in organizations whose staff stated that they are aware of availability of HIV and AIDS Work Place Policies, had seen and read the HIV WPP. This is because these variables do not conclusively indicate HIV mainstreaming, or implementation of the policies.

# Access to HIV Prevention, Treatment and Care Services

Study findings show that there is less of the biomedical HIV and AIDS services (treatment, care and support) available in the supported organizations' workplaces, and more of the preventive services like awareness creation and condom supply. There are also limited opportunities to encourage staff to go for VCT services. FGD showed that staff accessed HIV treatment services from nearby health service providers. FGD also showed that many organizations, especially those with workplace policies, had arrangements for their staff treatment, care and support services.

> *"Each individual is given some money then..(they)… know how to cater or use that money. We also cater for those that fall sick, we give first Aid only in the organization".*

> *"For us we had a staff saving scheme but later the amount of money was limited. Since we had TASO and Uganda cares, we … link them (to these organizations) and then they go and get the services. And if one is sick we identify specific clinics (though) this is limited".*

Participants in the All-female FGD, North Eastern Uganda

### *Recommendation*

It is recommended that organizations should identify and document information on Health services in areas where their staff stay or live, and those near the office premises. The information should be shared with staff during internal learning sessions on HIV and AIDS or by displaying it in strategic locations in the office (like on HIV and AIDS corners). The information could also be printed and copies directly given to staff members for reference purposes.. This information could be on names of the service providers, nature and location of HIV and AIDS services provided (VCT, CD4), the days of services, among others. In here, ACORD also needs to play a supportive role in linking the CSOs to ASOs since it has already established good working relations with them as strategic partners to support the HIV and AIDS work place project implementation in Uganda.

# Linking and Learning

Organizations revealed a moderate level of linking with other organizations and learning from them for purposes of tapping from their skills and also evidenced by belonging to networks. However, organizations attach relatively high importance to linking and learning as evidenced from this quotation:

*"In Karamoja you have to coordinate all the programs like the ... (5) W's. Who does what? Where? When? ... And they (other organizations) will need to have all the contacts of your staffs. So all organisations seem to know what other organisations do in the Karamoja region (to be able to see what they can learn from them)."* FGD Participant, Senior Management, North Eastern Uganda meeting

Although this study revealed that a significant number of organizations were involved in some level of linking and learning , there are no indicators to show how this linking and learning benefits the organizations and its staff in responding to HIV and AIDS at the work place. Garvin, (1993:80)[1], stated that "*a learning organization is one that is skilled at creating, acquiring and transferring knowledge and at modifying behavior to reflect new knowledge and insight*; This study did not establish levels of behavior modification in the organizations resulting from linking and learning. Linking and learning, as according to Garvin, does not only involve participation in some of the linking and learning activities, but involves other aspects like replicating the good practices learnt from the linking, and documentation and sharing of good practices.

### Recommendation:

ACORD Uganda should conduct a simple assessment to establish performance of the organizations on the areas of modifying behavior. The study should reflect on knowledge and insights learnt through documentation and sharing of good practices within and among the partner organizations. It should then conduct capacity development programs for the partner organizations in relation to the identified gaps.

## Lobbying and Advocacy

Though findings indicate that organizations are engaged in HIV and AIDS related advocacy and lobbying as each organization mentioned engagement in at least one advocacy activity, it was evident that this was mainly at the local (district and community) levels and among fellow NGO/CSO. National level advocacy on workplace policy related activities was low (13%), mainly because organizations did not perceive benefits of National level advocacy to their target groups/staff, and there were limited or no national level advocacy coordination mechanisms or institutions During one of the FGD, participants revealed the following:

*"We have pushed it up to the district level. When they are passing their annual LGDP, we look at the aspect of HIV&AIDS. The district fails to come up with a clear cut budget for HIV&AIDS and they end up making it a component within the (district) medical department".*

Participant in the male FGD, Kampala

1 Quoted from: The Journal of Academy of Marketing scheme, Volume 25, number 4, pages 305 to 318

*"I think we need a representative at the national level. Because we have been at the ministry of health's office in Kampala but things didn't work out the way I expected them to be."*

FGD participant, Female Group, North Eastern Uganda

### Recommendations:

ACORD should incorporate in its partner CSO training programs, sessions on the need and value of national level advocacy. This can set precedence to discussions on issues of how national policies influence practices of organizations, and why organizations should join coalitions and networks that facilitate discussion on national level HIV and AIDS issues.

In addition, ACORD should identify and share information on available national level workplace HIV and AIDS advocacy coalition with the partner CSO – including what they are, coordinating organizations, how to join them and specific issues discussed. This can go alongside supporting the partners to develop advocacy action plans and strategies that are in line with national level advocacy issues.

## Stigma and Discrimination

The study revealed differences in Perceptions of stigma and discrimination among the different organizations' staff levels. It was revealed that the general program staff and senior managers had higher knowledge of stigmatizing characteristics within their organizations than the lower level staff. These differences on stigma prevalence knowledge between managers and other staff is likely to be caused by lack of open sharing on HIV and AIDS between managers and their staff on day today welfare of the staff within their working environment. However, it is important to note that differences on stigma is more on daily relations at the workplace and not in terms of promotion and access to jobs during recruitment. On the issue of promotion and recruitment both managers and general staff indicated that HIV status is not prerequisite for recruitment or promotion.

### Recommendations:

There is need to bridge the gaps in knowledge on stigma awareness between managers and their staff. In here managers should endeavour to discuss issues of HIV and AIDS with their staff on a regular basis in order to get such feedback. This can be achieved by increasing stigma awareness and management sessions at the workplace and creation of useful linkages with ASOs.

Need to pay particular attention to the gendered stigma within organizations since the studies indicated that female staff and the elderly seemed to be more stigmatized on the basis of their HIV status as compared to men. Here incorporation of Gender analysis during organizational self assessments, HIV and AIDs Internal and trainings should be emphasized, highlighting the needs of female staff and their risks and vulnerabilities to HIV infection.

Although there was no question for analyzing stigma in the context of persons with disabilities (PWDS), during the FGDs it was realized that PWDs living with HIV and AIDS highly stigmatized and vulnerable. This therefore calls for awareness sessions on the rights of PWDs in context of managing HIV and AIDS in the workplace. ACORD and participating CSOs need to create linkages and plans for practical involvement of PWDs in addressing HIV and AIDS related issues at the work.

# Appendices 05

## Appendix I:

### *Number of Questionnaires filled in by ACORD Field Team*

| Region | Name of Organization and Acronym | Organization Survey tool (Yes/No) | Number of Staff Tools Filled |
|---|---|---|---|
| **Northern** | Development Training and Research Center (DETREC) | 1 | 2 |
| | Community Organization for Rural Enterprise Activity Management (CREAM) | 1 | 2 |
| | Christian HIV/AIDS Prevention and Support (CHAPS) | 1 | 2 |
| | Kitgum Women Peace Initiative (KIWEPI) | 1 | 2 |
| | War Child Organization | 1 | 6 |
| | Initiative for Community Empowerment and Support (ICES) | 1 | 7 |
| | Community Empowerment for Rural Development (CEFORD) | 1 | 3 |
| | Agency for Sustainable Rural Transformation (AFSRT) | 1 | 3 |
| | Concerned Parents Association (CPA) | 1 | 2 |
| | Facilitation for Peace and Development (FAPAD) | 1 | 3 |
| | North East Chili Producers Association (NECPA) | 1 | 3 |
| | Camkwoki Grass Roots Initiative for Development (CGRID) | 1 | 7 |
| | SUB-TOTAL | 12 | 42 |
| | | | |
| **Central** | ISSIS Women's International Cross Cultural Exchange (ISSIS WICCE) | 1 | 2 |
| | BUSO Foundation | 1 | 5 |
| | Kyetume Community Based Health Care Programme | 1 | 4 |
| | Literacy and Adult Basic Education (LABE) | 1 | 3 |
| | Inter Religious Council of Uganda (IRCU) | 1 | 3 |
| | Uganda Joint Christian Council (UJCC) | 1 | 4 |
| | Volunteer Efforts for Development Concerns (VEDCO) | 1 | 9 |
| | Foundation for Human Rights Initiative (FHRI) | 1 | 3 |

| Region | Name of Organization and Acronym | Organization Survey tool (Yes/No) | Number of Staff Tools Filled |
|---|---|---|---|
| Central | Participatory Ecological Land Use Management (PELUM) | 1 | 2 |
| | Forum for African Women Educationalists Uganda Chapter (FAWE) | 1 | 3 |
| | Uganda Land Alliance (ULA) | 1 | 2 |
| | Southern and Eastern Africa Trade Information and Negotiations Institute (SEATINI) | 1 | 3 |
| | Women of Uganda Network (WOUGNET) | 1 | 3 |
| | Eastern and Southern Africa Small Scale Farmers Forum (ESSAF) | 1 | 4 |
| | The Eastern African Sub-Regional Support Initiative for the Advancement of Women (EASSI) | 1 | 5 |
| | National Union of Women with Disabilities of Uganda (NUWODU) | 1 | 5 |
| | Edukans Local Expertise Center Uganda | 1 | 0 |
| | Community Development Resource Network (CDRN) | 1 | 1 |
| | Katwe Youth Development Association (KAYDA) | 1 | 0 |
| | Community Development and Welfare Initiatives (CODI) | 1 | 0 |
| | Forum for Women in Democracy (FOWODE) | 1 | 1 |
| | Council for Economic Empowerment of Women (CEEWA) | 1 | 3 |
| | National Organic Agriculture Movement of Uganda (NOGAMU) | 1 | 2 |
| | Uganda Reach the Aged Association (URAA) | 1 | 4 |
| | Uganda Women's Network(UWONET) | 1 | 5 |
| | Trans-cultural Psychosocial Organization (TPO-Ug.) | 1 | 6 |
| | SUB-TOTAL | 26 | 82 |
| | | | |
| **Western** | Child Concern Initiatives Organization (CCIO) | 1 | 3 |
| | Good Hope Foundation for Rural Development | 1 | 4 |
| | Foundation for Urban and Rural Development (FURA) | 1 | 3 |
| | SUB-TOTAL | 3 | 10 |
| | | | |
| **Eastern** | Organization for Rural Development | Yes | 5 |
| | Church of Uganda Teso Diocese Planning and Development Office (COU TEDDO) | Yes | 5 |
| | Catholic Education Research and Development Organization (CEREDO) | Yes | 6 |
| | Church of Uganda Diocese Education Department | Yes | 2 |
| | Teso Women Peace Activists (TEWPA) | Yes | 5 |
| | Moroto Nakapiripirit Religious Leaders Initiative for Peace (MONARLIP) | Yes | 1 |

| Region | Name of Organization and Acronym | Organization Survey tool (Yes/No) | Number of Staff Tools Filled |
|---|---|---|---|
| **Eastern** | Dodoth Agro pastoralist Development Organization (DADO) | Yes | 5 |
| | Warrior Squad Foundation (WSF) | Yes | 9 |
| | Kotido Peace Initiative (KOPEIN) | Yes | 2 |
| | Vision Teso Rural Development Organization (Vision TERUDO) | Yes | 3 |
| | Jinja Diocesan Development Coordinating Organization (JIDDECO) | Yes | 3 |
| | Tororo Civil Society Network (TOCINET) | Yes | 3 |
| | Karamoja Diocesan Development Services (KDDS) | Yes | 0 |
| | Health Need Uganda (HNU) | Yes | 11 |
| | SUB-TOTAL | 14 | 60 |
| | | | |
| | **OVERALL TOTAL** | **55** | **194** |

# Appendix II:

## *Study Training Attendees*

1. Moses Mugabi – ACORD Kampala
2. Alex Tweheyo – ACORD Kampala
3. Flavia Birungi – ACORD Kampala
4. Bernard Ouma Wabwire – ACORD Karamoja
5. Dinah Nabwire – ACORD Kampala
6. Leticia Katushabe – ACORD Mbarara
7. Alice Aloka – HNU Uganda (Soroti)
8. Ben Kahunga – External Consultant for Burundi
9. Denis Muhangi – External Consultant for ACORD Uganda

# Appendix III:

## *Training Programme*

**ACORD - Uganda**

(Thursday 27-01-2010 to Friday 28-01-2010)

| Time | Activity | Responsible/ Facilitator |
|---|---|---|
| **DAY 1 – THURSDAY** | | |
| 9.00-9.05 | Introduction of members | ACORD |
| 9.05-9.15 | Opening Remarks:<br>• About the Upscale Workplace HIV&AIDS Project<br>• About the Baseline Study<br>• Objectives of the Baseline Study | ACORD |
| 9.15-9.20 | Objectives of the training | Consultant |
| 9.20-9.40 | Methodology for the Baseline Study: Study design, study sites, sampling, target informants, data collection methods, data analysis & report writing | |
| 9.40-10.00 | Roles of Team Members | Consultant |
| 10.00–11.00 | Using the Interview Method to collect data: what is involved, key skills required, tips for good interviewing | Consultant |
| 11.00 – 11.15 | B-R-E-A-K | |
| 11.15–1.00 | Review of tools (tool by tool; question by question) | All/Consultant |
| 1.00 – 2.00 | L-U-N-C-H | |
| 2.00 – 4.30 | Review of tools continued | All/Consultant |
| 4.30 – 5.00 | Plans for the Pre-test | ACORD/Consultant |
| **Day 2 – FRIDAY** | | |
| 9.00-10.00 | Role plays | All/ Consultant |
| 10.00-1.00 | Pre-test | All |
| 1.00-2.00 | L-U-N-C-H | |
| 2.00-3.30 | Sharing feedback from the Pre-test | All |
| 3.30-4.00 | Fieldwork Schedule and Administrative Issues | All |
| 4.00 -4.15 | Next Steps and closing | ACORD |

# Appendix IV:

## *Fieldwork Schedule*

| 2010 | | SUN 06th Feb. | MON 07th Feb. | TUE 08th Feb. | WED 09th Feb. | THUR 10th Feb | FRI 11th Feb. | SAT 12th Feb. |
|---|---|---|---|---|---|---|---|---|
| TEAM 1 | 9.00am | | | LABE | UJCC | ORUDE (Jinja) | CDRN | |
| | 11.00am | | | | IRCU | Tujijenge (Jinja) | | |
| | 2.00pm | | | FAWE | FHRI | JIDDECO (Jinja) | VEDCO | |
| TEAM 2 | 9.00am | | | ULA | PELUM | SEATINI | | |
| | 11….00am | | | | | | | |
| | 2.00pm | | | WOUGNET | ISSIS-WICCE | EDUKANS (SNV) | Kyetume CBHC (Mukono) | |
| | 11.00am | | | | | | | |
| | 2.00pm | | | | | | | |

| 2010 | | SUN 20th Feb. | MON 21st Feb. | TUE 22nd Feb. | WED 23rd Feb. | THUR 24th Feb. | FRI 25th Feb. | SAT 26th Feb. |
|---|---|---|---|---|---|---|---|---|
| TEAM 1 | 9.00am | | Vision-TERUDO (Kumi) | COU-TEDDO (Soroti) | Travel to Kotido | KDDS (Kotido) | Travel to Kampala | |
| | 11.00am | Travel to Kumi | | CEREDO (Soroti) | | WSF (Kotido) | | |
| | 2.00pm | | TEWPA (Soroti) | Soroti COU Educ Dept. | | | | |
| TEAM 2 | 9.00am | Travel to Arua | CEFORD (Arua) | CPA (Lira) | CGRID (Lira) | War Child (Gulu) | KIWEPI (Kitgum) | Travel to K'la |
| | 11.00am | | CREAM (Arua) | DETREC (Lira) | NECPA (Lira) | Travel to Kitgum | Christian HIV Prev & Support Org (Kitgum) | |
| | 2.00pm | | Travel to Lira | ICES (Lira) | Travel to Gulu | | | |
| TEAM 3 | 9.00am | Travel to Kasese | FURA (Kasese) | Child Concern (Bundibugyo) | BUSO Foundation (Mityana) | | | |
| | 11.00am | | Good Hope Foundation Kasese for Rural Development | Travel to Mityana | Travel to Kampala | | | |
| | 2:00pm | | Travel to Bundibugyo | | | | | |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