EMPLOYEE RESPONSES TO HIV/AIDS AT KENYA PLANT HEALTH INSPECTORATE SERVICE (KEPHIS)

By

Peris Ongoro Otieno

A management research project submitted in partial fulfillment for the award of Master of Business Administration (MBA) degree, School of Business, University of Nairobi

DECLARATION

This project is my original work and has not been submitted for a degree in any other University.

Signature.....

OTIENO P. O.

This project has been submitted for examination with my approval as the University Supervisor.

Signature.....

Mr. GEORGE OMONDI

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DEDICATION

To my father and late mother, for their confidence and trust in me.

ABSTRACT

The HIV/AIDS pandemic is a global crisis which has posed a great threat to the world of work. Out of the more than 40 million people who are currently infected, about 26 million are within the most productive age bracket i.e. 15 to 49 years. Due to its fatal nature preceded by prolonged illness, HIV/AIDS is imposing huge costs on organizations in terms of additional labour costs (i.e. medical and funeral expenses, loss in productivity, absenteeism due to illness, and training of new employees).

Due to its perceived mode of transmission, those infected with HIV/AIDS face discrimination and stigmatization hence negating initiatives to manage the disease. Assessing employees' responses to HIV/AIDS gives an organization a basis for developing appropriate workplace HIV/AIDS programmes with a view to achieving and sustaining supportive attitudes/behaviour among employees.

This study was undertaken to determine responses of KEPHIS employees to HIV/AIDS and factors influencing these responses. The study revealed that the level of HIV/AIDS awareness of KEPHIS employees was high. However, contradictory responses pointed to the fact that employees were not too clear on some facts on HIV/AIDS hence making them vulnerable to risky sexual behaviours. In addition, there existed a minority who held discriminative attitudes towards infected persons. HIV/AIDS trainings at the workplace were evidently not frequent and employer's position in relation to HIV/AIDS was not clear to respondents. Positive factors influencing employee responses to HIV/AIDS included among others management and government support. Discrimination by some colleagues, lack of staff HIV/AIDS medical cover, staff living working away from families and negative influence of some media programmes/cultural practises were identified as some of the factors which need to be addressed.

Based on the above results, it is recommended that KEPHIS adopts Behaviour Change Communication (BCC) in order to develop appropriate programmes to achieve desired behaviour change objectives in targeted workplace groups. Other recommendations include developing a HIV/AIDS workplace policy, involvement of stakeholders in KEPHIS' HIV/AIDS programmes and employing persons living with HIV/AIDS to enhance confidence of job security and positive living in infected employees.

CHAPTER I: INTRODUCTION

1.1 Background

Human Resource Management (HRM) encompasses the strategic deployment of committed and capable employees using an integrated array of structural and personnel techniques with a view to achieving organizational objectives [Armstrong, 1996]. The success of this process requires that human resource managers harmonize organizational interests with that of employees [Miner and Crane, 1996]. Early psychologists like Abraham Maslow, Mintzberg and Ebert in their studies on human behaviour recognized the importance of the individual's well being to organizational effectiveness [Graham and Bennet, 1995]. This was summed up in their needs analysis for the overall satisfaction of the individual and hence the organization. They included among others, health and safety, basic physiological needs security and self-dignity [Graham and Bennet, 1995].

The HIV/AIDS pandemic has, however, posed a major challenge to employers in achieving this. Due to its fatal nature preceded by prolonged illness, HIV/AIDS is imposing huge costs on organizations in all sectors [UNAIDS, 2002]. It is estimated that costs to an organization related to HIV/AIDS deaths comprise of 59% medical, 22% loss in productivity, 15% absenteeism, 13% funeral expenses and 1% training of new employees [ILO, 2004]. Rising operational costs not only reduce current profit margins but also future profits by reducing the levels of investment capacity for increasing productivity, expansion, research and development [UNAIDS 2002].

1.1.1 HIV/AIDS in the Workplace

Whereas costs related to other factors of production can be controlled with considerable high level of certainty, human resource managers have an uphill task managing HIV/AIDS related costs. The disease is acquired mainly through behaviour patterns attributed to the employee and hence beyond the employer's control [Rau, 2005]. During the period after an employee becomes infected and before he/she becomes ill, the main problem is that of motivation. According to Snodgrass (2000), ways must be found to harmonize the motives of the employee with those of the employer to the extent possible.

Later, when sickness occurs, there are two problems – the first is how to meet whatever responsibility the employer is willing to accept for the treatment of the sick employee and the second problem is how to make up for their declining productivity.

Rau [2002] asserts that despite the fact that HIV/AIDS infection is mostly attributed to an individual's behaviour patterns, certain characteristics of an organization may put its employees at risk of acquiring HIV/AIDS. These include a large number of employees living away from their families and frequent job related traveling by employees. A survey undertaken in East Africa found that one-third of employees whose jobs involved frequent travel were HIV/AIDS positive [Rau 2002]. The study, which was limited to transport companies, did not address how employers should balance such organizational characteristics with employees' social needs in effecting behaviour change programmes.

Today, laws and policies exist in various countries to cater for HIV/AIDS infected employees. In Kenya, the Employment Act (Cap 226) requires that every employer should provide proper health care for employees during illness. The HIV/AIDS Bill (2004) and the Public Sector Workplace Policy on HIV and AIDS [GOK/DPM, 2005] are a further effort by the government to impress HIV/AIDS specific laws/policies on organizations that discourage discrimination at the workplace. Human resource managers face the challenge of translating these laws and regulations into sustainable organizational policies in the face of long term costs implications of HIV/AIDS behaviour change interventions. These laws/policies however do not state expected reponses of employees further complicating the dilemma of employers.

In addition, HIV/AIDS infected employees are invariably perceived as patients in need of care [UNAIDS 2002]. According to Health and Development Networks, there is a lack of understanding among human resource managers of how the knowledge and expertise of infected employees can be harnessed – a valuable opportunity is being lost [The Correspondent Dialogue Issue No. 12 IV]. The challenge for human resource managers is to differentiate between the role of infected employees as service recipients and their role as policy and project designers in employer efforts to instill positive behavioural responses among fellow employees. The report however does not clarify how this can be done where employees fear to disclose their HIV/AIDS status.

1.1.2 Employee Responses to HIV/AIDS

There is new evidence that adult HIV infection rates have decreased in certain organizations and that changes in behaviour to prevent infection have played a key role in these declines [UNAIDS, 2002]. HIV/AIDS infection is mostly preceded by specific behaviour patterns such as unprotected sex and multiple sexual partners. It is estimated that 80-90% of HIV infection arises from sexual contact while 5-10% arise from mother to child transmission [UNAIDS, 2002]. The above risky behaviour patterns which cause most HIV infections are controllable. Engaging in risky behaviour results from ignorance, not knowing ones HIV status, the very nature of HIV i.e. long incubation period between infection and manifestation of disease, peer pressure, influence of alcohol and occupational conditions among others [Rau, 2002]

The fatal nature of HIV/AIDS and its implications on employee productivity and hence livelihood greatly impact on employee bahaviour. A majority of HIV/AIDS positive employees fear to disclose their HIV status for fear of loosing their jobs as a result of reduced productivity [Bharat et al, 2000]. Infected employees who are frequently ill in most cases refuse to be deployed to other physically lighter duties clearly wanting their conditions to remain confidential. They also feel that revealing their HIV/AIDS status may lead to stigma that can be avoided particularly when the infected person still does not portray HIV/AIDS symptoms [Rau 2005]. T heir uptake of employer sponsored health services may also be low in a bid to maintain confidentiality of their status [Gross and Smith, 1995].

Rau [2005], asserts that with proper sensitization, employees are adequately equipped to make responsible decisions. These include support for infected colleagues, undergoing voluntary HIV/AIDS test, increased use of condoms, delay of first sexual experience, practicing abstinence and faithfulness to sexual partners. These lead to prevention of infection, management of HIV/AIDS and positive living thus leading to a healthier and more productive workforce. Positive responses reduce HIV/AIDS prevalence rates hence the number of individuals who ultimately require medication making broad access to treatment in organizations more achievable and sustainable [UNAIDS, 2002].

Alliton [1992], asserts that responses by employees towards HIV/AIDS are influenced by combination of factors. These include personal attributes, cultural and socioeconomic factors and characteristics of the work environment. An assessment and understanding of which of these factors influence employee responses towards HIV/AIDS at the workplace is of pivotal importance in developing successful HIV/AIDS workplace programmes [Rau 2005].

HIV AIDS is mostly transmitted through certain behaviour patterns. How individuals respond to the pandemic will therefore also be reflected in the behaviour patterns/attitudes they adopt. Behaviour/attitudes may be positive (those that facilitate prevention and management of the disease) or negative (those that facilitate spread of the disease). In order to develop effective HIV/AIDS prevention and management programmes, it is important to address both positive and negative behaviour/attitudes. The study will therefore address employee responses to HIV/AIDS in relation to both positive and negative HIV/AIDS related behaviour/attitudes adopted by KEPHIS employees at the workplace.

1.2 Kenya Plant Health Inspectorate Service (KEPHIS)

KEPHIS is a regulatory body established under the State Corporations Act (Cap 446) pursuant to Legal Notice No. 305 of 18th October 1996. KEPHIS is the government institution commissioned to offer regulatory services to ensure quality and health of agricultural inputs and produce. The corporation has its headquarters in Nairobi and regional offices at Nakuru, Mombasa, and Kitale and centers at Jomo Kenyatta International Airport (JKIA) and Muguga. As at the time of the study, March 2007, the corporation had a staff complement of 356 distributed as follow: Headquarters, Nairobi (124 – inclusive of the newly established offices at Kisumu and Embu); Mombasa regional office (27); Kitale regional office (56); Nakuru regional office (73); Plant Quarantine Station (PQS), Muguga (40); Plant Inspection Unit, JKIA (36).

KEPHIS, like other organizations, has had its fair share of adverse effects of HIV/AIDS on its employees. This study seeks to identify responses of KEPHIS employees towards HIV/AIDS.

1.3 Statement of the Problem

Since inception, KEPHIS has lost a number of employees and their spouses through death due to HIV/AIDS related complications. In addition, a number of employees are infected and continue to suffer from HIV/AIDS related complications leading to souring medical costs. A medical insurance scheme entered into in May 2001 has not improved the situation. The scheme's insurance premium currently stands at Ksh. 5,210,637.00 and provides a cover of up to Ksh. 250,000.00 per family. One contentious issue about the scheme since it was started has been the exclusion of HIV/AIDS related diseases, which is the case with local medical insurance service providers [Sunday Nation, 9th April 2006 pg. 15]. After spirited negotiations, the best the service provider could offer in the current contract is a Ksh. 30,000.00 cover in relation to first HIV/AIDS occurrence. This is a drop in the ocean given the high cost of HIV/AIDS treatment. The corporation, over the years, has therefore been obliged to meet medical expenses for these "exclusion cases" over and above the medical insurance premiums paid every year. In addition, labour costs in terms of continuous absenteeism due to ill health, replacement of employees, and training of new employees have just served to aggravate the situation further [KEPHIS Staff Advisory Committee Minutes, 2006].

Over the years, cases have been reported of KEPHIS employees refusing to undergo comprehensive medical test when hospitalized as requested by the medical insurance service provider. These employees opt to pay medical bills instead of undergoing the tests probably for fear of being diagnosed with HIV [KEPHIS Staff Advisory Committee Minutes, 2002/2003]. Those infected still live in denial and fear to publicly declare their status even though the organization continues to pay medical bills for their illnesses that are clearly "exclusion cases" [Staff Advisory Committee Minutes, 2005]. Preliminary investigation confirmed that to date, none of the infected employees has declared their HIV status.

The behavioural responses of employees towards HIV/AIDS are of pivotal importance and must be assessed if a workplace programme is to be developed and managed effectively. KEPHIS is currently developing its HIV/AIDS workplace policy [Performance Contract between the GOK and KEPHIS Board of Directors, 2006/2007].

Employee ignorance and misinformation can represent major obstacles to educational and treatment programmes hence aggravating already prevalent biases and fears about HIV/AIDS [Rau 2005].

Studies have been undertaken in respect to HIV/AIDS at the workplace. Murambi (2002), for example, undertook a study on human resource policy responses to HIV/AIDS in insurance firms in Nairobi while Katuva (2006) undertook a study on implementation of HIV/AIDS workplace policy at the Teachers' Service Commission. No study has however been undertaken to determine the responses of KEPHIS employees towards HIV/AIDS. This study seeks to bridge the gap.

1.4 Objectives of the Study

i. To establish responses by KEPHIS employees to HIV/AIDS pandemic in the workplace.

ii. To determine the factors that influence KEPHIS employees' responses to HIV/AIDS in the workplace.

1.5 Importance of the Study

The study will be useful to the following:

i. Top management of KEPHIS: so that they can develop appropriate HIV/AIDS prevention and management interventions based on proper understanding of prevailing employee responses.

ii. Employees of KEPHIS: so that they can appreciate the significance of positive responses towards HIV/AIDS pandemic in the workplace.

iii. Future researchers: who may be interested in undertaking further research on similar areas.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The HIV/AIDS pandemic is a global crisis with impacts that will be felt for decades to come. According to UNAIDS more than 25 million people have died since the first case was reported in 1981 and over 40 million people are currently infected with HIV/AIDS [UNAIDS 2005]. The report further indicates that in 2005 alone, there were 5 million new infections and 3 million deaths. Although there are treatments that can prolong life, HIV/AIDS is a fatal disease. Research continues on possible vaccines and ultimately a cure. For the moment, prevention of transmission, which is achieved through adopting appropriate behaviour, remains the only method of control [Rau, 2005].

The HIV/AIDS epidemic has brought serious implications to organizations. It is estimated that 26 million of those infected are within the most productive age bracket i.e. 15 and 49 years [ILO 2001]. In addition, 2 out of every 3 people living with HIV/AIDS go to work everyday thus making the workplace a vital entry point for the disease [ILO, 2004]. Medical advances have also been made in the treatment of HIV/AIDS which prolong the productive lives of persons living with HIV/AIDS and enable them to work for a longer period of time after being infected. Therefore, persons living with HIV/AIDS will definitely be encountered at the workplace and organizations should be well prepared to deal with cases of HIV/AIDS as and when they occur.

Although little attention was devoted to investigation of HIV/AIDS at the workplace in the 1980s and 1990s [Keil and Schellenberg, 1998; Wagner et al., 1998] the situation has since changed [Rau, 2005]. Employers are under increased pressure to develop HIV/AIDS specific policies to mitigate the impact of the disease at the workplace. According to the FKE, organizations incur many additional costs when employees or their families succumb to HIV/AIDS. Absenteeism soars as workers grow weak, attend funerals or attend to ailing relatives. Productivity plummets because of their absence and the pool of available labour shrinks. Health care costs rise since firms have to pay higher medical insurance costs, life insurance premiums, and pensions. In addition, employers must hire and train new employees to replace disabled or dead employees [FKE, 2001]. Organizations therefore must play a crucial role in the global fight against HIV/AIDS given the fact that it directly affects business productivity.

2.2 HIV/AIDS

According to Rau [2002], Acquired Immunodeficiency Syndrome (AIDS) is a pattern of devastating infections caused by Human Immunodeficiency Virus (HIV) which attacks and destroys certain white blood cells that are essential to the body's immune system. Medical evidence indicates that HIV/AIDS progresses in three distinct stages: (1) initial infection with the HIV virus; (2) AIDS-Related Complex (ARC) in which an individual develops secondary, non-life-threatening infections; and (3) AIDS, where a person's immune system collapses [Kohl and Miller, 1994]. When individuals are first infected with the HIV virus, they exhibit no symptoms of the disease since the incubation period for HIV/AIDS may be as long as 10 years or more. During this time, individuals may lead normal, healthy lives, and have no knowledge (unless they have been tested) that they are infected. It is this lack of knowledge about being infected which is largely responsible for the rapid spread of HIV/AIDS worldwide. It is estimated that 90% of HIV-infected people worldwide do not know they have the virus [UNAIDS 2002]. If people do not know they are infected, they will be less likely to take action to prevent further spread of the disease.

In the second stage (ARC), individuals exhibit certain symptoms (which, unless they have been tested, may be mistakenly associated with other medical problems) i.e. swollen lymph nodes, fatigue, low-grade fevers, unexplained weight loss, night sweats and chronic diarrhoea. In the final stage (HIV/AIDS), the immune system collapses and the individual suffers frequent recurring opportunistic infections. Death ultimately occurs as a consequence of complications resulting from one or more of these infections.

It has been empirically tested that HIV/AIDS cannot be contracted through casual contact such as touching an infected person or items used by that person, air, water, food or insect bites. Medical research has shown that HIV/AIDS is only transmitted by the exchange of body fluids and only then through specific, identifiable behaviours [Kohl and Miller 1994; UNAIDS 2002]. These include having unprotected sexual relationship with someone who is infected with HIV virus, having contact with contaminated needles, syringes or other instruments that can pierce the skin, receiving a donated organ which contains the HIV virus or contaminated blood during transfusion, from mother to child during pregnancy, delivery or breastfeeding. No cases of HIV disease have been reported as a result of contact with tears, sweat or saliva.

To reduce risk of infection therefore, one should adopt behaviours which reduce risk of HIV/AIDS transmission. These include postponing the age of initial sexual activity, abstinence/having protected sex when not with regular partner and undergoing HIV/AIDS tests. The extent to which employees are conversant and agree with these medical facts plays a key role in adoption of positive responses towards prevention and management of HIV/AIDS.

According to UNAIDS, [2002], access to HIV/AIDS treatment goes along way in prolonging the lives of infected persons. The report further provides supporting statistics that an estimated 350,000 deaths were averted in 2005 because of expanded access to HIV/AIDS treatment. To effectively mitigate the impact of HIV/AIDS therefore, it is imperative to integrate prevention and treatment efforts [UNAIDS, 2002]. How organizations are supposed to marry the financial burden that comes with HIV/AIDS prevention and treatment and their business objectives particularly of profit maximization/cost reduction still remains an issue for debate.

2.3 Employee Response to HIV/AIDS in the Workplace

Attaining positive responses call for identification of adverse HIV/AIDS related beliefs/attitudes/behaviours held by employees and developing appropriate programmes to mitigate the impact of these beliefs/attitudes/behaviours [Rau 2005].

According to Lim and Loo [2000], where as employees may be informed about the medical facts on HIV/AIDS, there still exists an element of doubt as to the degree of accuracy of these facts. In addition, there is concern that new scientific evidence may be uncovered at a later date that points to the possibility of HIV/AIDS transmission occurring through casual contact. Fear of becoming infected therefore leads to refusal to work in close contact with an employee who is known or is rumoured to be infected [UNAIDS, 2002].

Goss and Smith [1995] noted that many employers choose to terminate employment contracts of HIV/AIDS infected employees once their conditions become a financial burden to the organization. A majority of HIV/AIDS positive employees therefore fear to disclose their HIV status for fear of loosing their jobs [Bharat et al, 2000].

They also feel that revealing such sensitive information may lead to stigma that can be avoided particularly when the infected person still does not portray HIV/AIDS symptoms. Even where it is obvious that one is infected, a majority remain quiet about their condition and choose to blame their ill health on other diseases [Rau 2005]. A study undertaken by the Asia Pacific Network of Positive People in Asia found out that of the 753 respondents, 20% experienced workplace discrimination after diagnosis at the workplace, 7% lost their jobs and 9% had their duties changed because of their HIV status [The correspondent Dialogue Issue No. 12 IV, 2006]. However, to disclose or not to disclose ones HIV status may well turn out to be a double-edged sword. The former may risk dismissal while the latter risks missing out on potential emotional, social and tangible employer support.

Health and Development Networks asserts that whereas it is wrong to stigmatize infected employees, there is need for more HIV/AIDS infected employees to come out and display positive living. Infected employees can challenge stigma and discrimination by the way they present themselves – either as people with an infection who have equal rights or as victims. Often it is up to the individual to break down attitudes of colleagues and employers. The report however fails to address cases of victimization upon disclosure [The Correspondent Dialogue, Issue No. 12 IV].

According to a study by the New York Business Group on Health (Barr, Waring and Warshaw, 1991), employees generally have a positive opinion of employers who provide information about HIV/AIDS. A survey by the National Leadership Coalition on AIDS of working American's attitudes about HIV/AIDS revealed that 96% of employees who receive HIV/AIDS at work supported workplace HIV/AIDS education. Other surveys however revel that employees prefer to get medical attention from service providers other than the employers.

In a research on the United Kingdom retail sector McLean and Moore [1997] noted that a majority of healthy employees were afraid of deliberate infection by a HIV/AIDS-infected person. This anxiety was extended to the workplace making work relations difficult. This study was however restricted only to the retail sector.

Lim and Loo [2000] conducted a study in Singapore that examined human resource managers' knowledge of HIV/AIDS transmission, their attitudes towards employing persons living with HIV/AIDS and disclosure of HIV/AIDS-related information. They observed that results of this study corroborate findings of existing research conducted in this area in the West [Barr et al., 1992; LeBlanc, 1993].

Whereas human resource mangers were clear about the main modes through which HIV/AIDS can/cannot be transmitted, they viewed employment of infected persons as having adverse consequences for the organization. Approximately 49% of respondents agreed that employing an infected person would lead to an increase in the number of grievances and complaints while about 37 per cent also felt that having HIV/AIDS-infected employees would undermine company morale. In addition, 50% of human resource managers agree that employers should have access to information about the outcome of HIV/AIDS tests for employees and 68% agreed that employers should know the identities of employees who have had HIV/AIDS tests. Another 52% also agree with the statement that potential employers should have access to the identities of those who have had HIV/AIDS tests whereas 48% of respondents disagree that workers should be privy to such information.

Vest et al. [1990, 1991] asserts that as decision makers where human resources are concerned, human resource managers must have the right beliefs and attitudes towards HIV/AIDS and those infected with the disease if they are to effectively implement policy interventions to influence employee behaviour with respect to HIV/AIDS.

2.4 Employer HIV/AIDS Initiatives and Employee Behaviour Change

According to Rau [2005], workplace HIV/AIDS prevention and management programmes are the best available sources of accurate information for employees since the workplace offers a structured environment for sharing information, reinforcing notions of acceptable behaviour and implementing interventions. HIV/AIDS can hurt business but addressing it is cost effective in the long run [UNAIDS, 2002].

A number of behavioural and social theories can be used to address behavioural change in response to HIV/AIDS. The Aids Risk Reduction Model (ARRM), introduced in 1990 by J. A. Catania asserts that for behavioural change to occur, one must pass through three stages; behaviour labeling (risk assessment), commitment to change and taking action [Catania, Keggles and Coates, 1990]. Catania further explains that behaviour change interventions are more likely to be successful if they target the audience at the relevant stage. The model however does not take into consideration factors that influence health related behaviour like personal attributes, socioeconomic and cultural factors. By using this model, human resource managers can identify different risky behaviour patterns among employees in respect to HIV/AIDS and develop appropriate interventions to reduce effects of these behaviours on the organization's overall performance.

Godfrey Hochbaum, Irwin Rosenstock and Stephen Kegels developed the Health Belief Model (HBM) in the 1950s which states that a person's motivation to undertake some health behaviour is influenced by individual perception (perception of illness, perceived susceptibility and perceived severity), modifying factors (demographic variables, perceived threats and cue for action) and likelihood of action. Once an individual perceives a threat to his/her health and is simultaneously cued to action, and his/her perceived benefits outweighs his/her perceived threats, then that individual is most likely to undertake the recommended preventive action. HIV/AIDS is a negative health consequence [Rosenstock and Becker, 1988]. The desire to avoid the devastating consequence of this health problem and the benefits arising there from should motivate employees to change their attitudes and behaviour and hence support employer HIV/AIDS interventions. Like the ARRM above, the HBM does not take into consideration other factors which influence health behaviour other than health beliefs i.e. cultural factors, previous experience and socioeconomic status.

Fisher & Fisher [1992], in their Information-Motivation-Behavioural Skills Model emphasized the role of information on behaviour change. In their model, they state that there are three fundamental determinants of AIDS-risk reduction i.e. Information regarding AIDS transmission and prevention, motivation to change HIV/AIDS risk behaviour and behavioural skills for performing specific HIV/AIDS preventive acts. This model highlights the significance of the organization in creating HIV/AIDS awareness to employees. Information thus acquired should motivate employees to change behaviour.

The model however emphasizes the role of information in behaviour change thus playing down the effects of other factors.

The Social Cognitive Theory developed by Bandura asserts that providing information alone is not sufficient to change behaviour [Bandura, 1973]. Sustained behaviour change requires skills to engage in the behaviour and the ability to use these skills consistently. He identified four components of behaviour change: An information component to increase awareness and knowledge of health risk and convince people that they change their behaviour; a component to develop the self control and risk reduction skills needed to prevent the behaviour; a component to increase an individuals self efficacy in implementing these behaviours (specific efforts to show people how to use say condoms) and a component to build social support for the individual as he/she engages in the new behaviour (support groups). Bandura however ignores the element of personal attributes which is key in determining the degree to which the other factors mentioned can be effective.

Bronfenbrenner [1979] on the other hand asserts in his Ecological Systems Theory that successful activities to promote health including HIV/AIDS risk reduction, involve not only changing individual behaviours but also advocacy, organizational change, policy development, economic support, environmental change and multi-method programmes. The model further states that behaviour is determined by: intrapersonal factors (characteristics of the individual such as knowledge, attitudes, behaviour), interpersonal processes (formal and informal social network and support systems including family, work groups and friends), institutional and community factors and public policy. He asserts that interventions are more successful if they intervene within most, if not all, levels of influence. For example, distributing condoms can reduce barriers such as price as well as change the social acceptability of carrying condoms.

Based on the above models, several interventions have been proposed for mitigating the impact of HIV/AIDS at the workplace. A HIV/AIDS workplace policy states an organization's position and practices for preventing the transmission of HIV/AIDS and for handling infected employees [Alliton, 1992]. It establishes consistency within an organization and ensures compliance with national laws and policies as well as setting standards for all employees.

A good workplace policy should address the following key issues: prevention through education and practical support for behavioural change, non-discrimination and protection of workers' rights including employment security, compliance with laws and culture of the country, entitlement to benefits and gender equality, care, support and treatment including confidential voluntary counselling and testing [ILO, 2001]. However, the extent to which employers implement HIV/AIDS policies is often left at the discretion of individual organizations. Who can regulate employers in respect to implementation of HIV/AIDS policies still remain an issue for concern. At the same time, to depend on goodwill is clearly inadequate.

According to UNAIDS [2002], effective education provides workers with the capacity to protect themselves and also reduce HIV/AIDS related anxiety hence significantly contributing towards attitudinal change. If employees lack accurate information on HIV/AIDS, work can be affected by fears of becoming infected which may lead to refusal to work with an infected employee, false beliefs and stigmatization which may lead to mistreatment of infected employees and discrimination in developing/implementing human resource policies. In addition, employees may adopt irresponsible behaviour patterns that may result in to being infected or them infecting others. For optimal results educational programmes must take into account other factors such as culture, age, gender and occupational and behavioural risk factors of the employees which all influence employee beliefs and hence behaviour. In addition, the programmes should be inclusive of top management and mandatory for all employees.

An organization can have the most comprehensive workplace policy on HIV/AIDS which covers care, treatment as well as education and prevention, but it is worthless if employees feel they cannot come forward for fear of discrimination [Rau, 2002]. Awareness and prevention messages should therefore be presented in a way that addresses barriers of stigma and discrimination that so often prevent employees from coming forward for testing, counseling and even treatment that is offered by the employer and promote prevention methods like use of condoms [Alliton, 1992].

Convincing people to change sexual behaviour is a delicate matter and most comfortably addressed in a setting among equals.

Involving peer educators and people living with HIV/AIDS not only multiplies the forcefulness of the message [UNAIDS, 2002] but also increases the sensitivity of HIV negative (or untested) employees to the realities of HIV/AIDS and the needs of infected employees.

Rau [2005] asserts that as much as is possible, employers should provide counseling and health care services to infected employees as part of the workplace programme. Where these services lack, building partnership beyond the organization helps complement and multiply an organization's impact. Collaborative linkages also enables those who choose to remain secretive about their status to seek treatment and counseling outside the organization [Alliton, 1992]. In addition, ability to sustain programmes is increased as the organization and collaborators pool resources in the fight against the scourge.

HIV/AIDS is a societal and development issue that requires partnership for it to be eradicated [UNAIDS, 2002]. Workplace based HIV/AIDS programmes are more effective when they go beyond the organization to include the surrounding community because most employees do not become infected in the workplace [Rau 2002]. Organizations have realized that to protect their employees effectively, they have to protect them everywhere. Initiatives that can be taken beyond the workplace like providing HIV/AIDS services and information to clients, suppliers and employees' families are therefore more effective [UNAIDS, 2002].

2.5 Factors that Influence Employee Response to HIV/AIDS in the Workplace

HIV/AIDS is mainly transmitted through specific controllable behaviour patterns of an individual. How one responds towards HIV/AIDS is therefore first and foremost dependent on an individuals intrapersonal attributes [Bronfenbrenner, 1979]. A person's motivation to undertake some health behaviour is influenced by the individual's perception of the disease and his/her perceived susceptibility to the disease. Once an individual perceives a threat to his/her health and his/her perceived benefits outweighs his/her perceived threats, then that individual is most likely to undertake the recommended preventive action. The reverse also holds Rosenstock and Becker [1988].

Rau [2002], asserts that workplace HIV/AIDS interventions play a pivotal role in influencing employee behaviour. Workplace policies reduce stigma and discrimination while counselling and testing services provide support for infected employees thus encouraging employees to adopt appropriate behaviour patterns. Fisher & Fisher [1992], emphasize the significance of information regarding HIV/AIDS transmission and prevention in motivating individuals to change HIV/AIDS risky behaviour. Workplace HIV/AIDS awareness forums provide knowledge about HIV/AIDS transmission, prevention and treatment. Stigma stems from lack of awareness about the disease and from the various myths and misconceptions regarding its routes of transmission.

According to Goss and Adam-Smith [1995], there are certain organizational characteristic that encourage risky behaviours among employee. Work conditions that require employees to travel frequently or stay away from their spouses for long periods and proximity of a relatively well paying workplace to areas of high employment/poverty expose employees to risks of adopting negative behaviour patterns.

Lim and Loo [2002] assert that laws and policies specifically designed to address HIV/AIDS at the workplace also contribute significantly to employee behaviour patterns at the workplace. Non discriminatory laws and policies on terms of employment encourage positive responses towards HIV/AIDS since employees are assured of job security [Rau, 2005]. Where such laws and policies are non existent, employees are likely to be more apprehensive about their HIV/AIDS status [Rau, 2002].

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Research Design

The study was carried out using a descriptive survey design. This method was preferred because it seeks to explain factors that account for issues like, attitudes, values, characteristics and behaviour patterns of a given unit, as was the case in this study.

3.2 Population

The population of study consisted of all the 356 KEPHIS employees as at end of March 2007.

3.3 Sample

A sample of 50 employees was used for the study. Proportionate stratified random sampling was employed. The sample was stratified based on the number of employees in each region/center so as to ensure proportionate representation of the regions/centers in the sample. The number of employees selected from each center is given below;

Headquarters, Nairobi	-	17
Mombasa regional office	-	4
Kitale regional office	-	8
Nakuru regional office	-	10
Plant Quarantine Station (PQS), Muguga	-	6
Plant Inspection Unit, JKIA	-	5
Total		**50**

Simple random sampling was used to select employees from each center so as to give each of the sampling units an equal and non–zero probability of being selected. For each center, slips of papers bearing individual personal numbers of all staff in that center were placed in a container and mixed thoroughly after which the required number of slips (as per the numbers indicated above) were drawn from the container. The below listed personal numbers of employees from each center were picked to form the sample.

Table 3-1: Personal numbers of employees in the sample

	Headquarters, Nairobi	Nakuru Regional Office	Mombasa Regional Office	PQS, Muguga	PIU, JKIA	Kitale Regional Office
1.	1087	1098	1424	1478	1275	1433
2.	1346	1215	1350	1170	1272	1148
3.	1028	1117	1121	1258	1026	1202
4.	1484	1193	1259	1273	1286	1411
5.	1420	1342		1338	1481	1207
6.	1442	1168		1376		1431
7.	1308	1054				1463
8.	1371	1091				1182
9.	1327	1209				
10.	1419	1490				
11.	1403					
12.	1389					
13.	1395					
14.	1363					
15.	1037					
16.	1446					
17.	1445					

3.4 Data Collection

A structured questionnaire was used to collect data. The questionnaire consisted of both closed and open-ended questions. The "drop and pick later" method was used to administer the questionnaires to the respondents.

3.5 Data Analysis

Data was edited for errors and organized after which it was coded. Data was thereafter entered into the Statistical Package for Social Sciences (SPSS) software package and cleaned before being analyzed. The analysis employed basic analytical procedures such as frequency distribution, mean, mode, minimum and maximum and range as measures of central tendencies and dispersions. Cross tabulations and chi-square test were used to detect any significant associations between variables.

CHAPTER 4: DATA ANALYSIS AND FINDINGS

4.1 Introduction

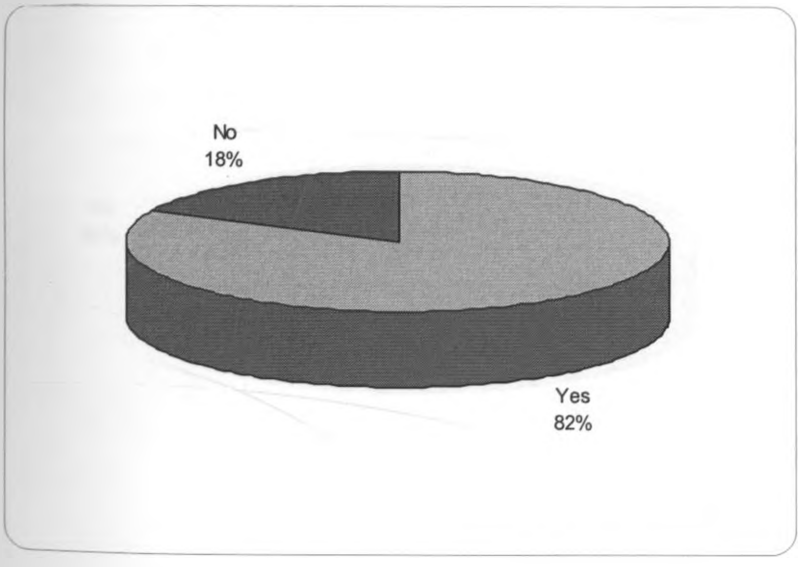
This section discusses the findings of the study. The aim of the study was to determine responses of KEPHIS employees to HIV/AIDS at the workplace and factors attributed to these responses. The sample of 50 was drawn from all KEPHIS centers to ensure proportionate representation. Data was captured through administration of questionnaires consisting of both closed and open ended questions. Cross tabulation was done to establish whether any significant relationships existed between various variables and responses provided. Based on research findings, recommendations for HIV/AIDS prevention and management at KEPHIS were made.

4.2 Research Findings

4.2.1 HIV/AIDS Awareness

According to results as presented in Figure 4-1, most respondents (82%) had received awareness training on HIV/AIDS.

Figure 4-1: Attendance of HIV/AIDS awareness training



In 51.8% of the responses by those who had attended awareness trainings, the trainings had been organized by KEPHIS.

48.2% of respondents had attended HIV/AIDS awareness forums organized by external bodies including, churches, NGOs and government units. Those who had not attended any awareness training gave lack of opportunities as the main reason (Table 4-1).

Table 4 – 1: Reasons for not attending HIV/AIDS awareness training

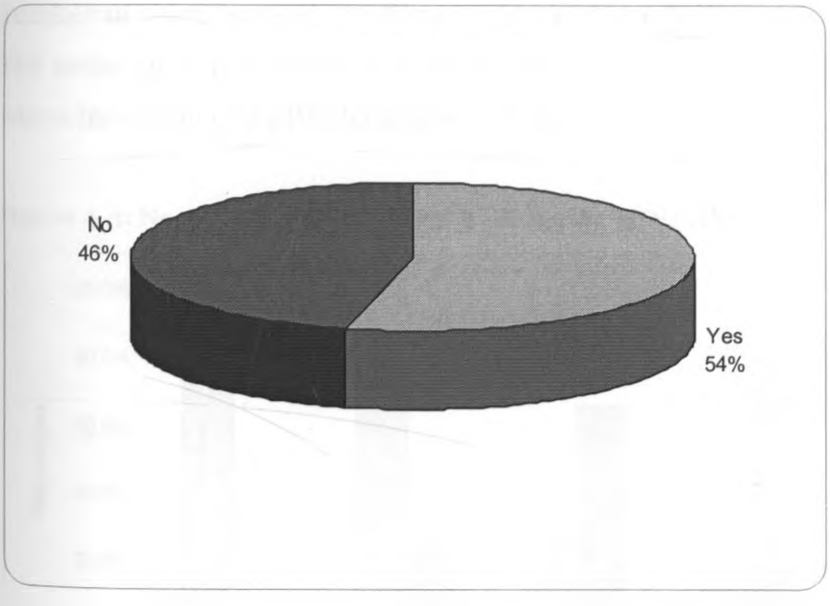
	Reason	%
1.	Lack of opportunity	77.9
2.	Received awareness through media	11.1
	TOTAL	**100**

These results give an indication that awareness forums at the workplace are not regularly held. The major challenge is to ensure that the 18% who have not received HIV/AIDS training get an opportunity to do so at the workplace.

4.2.2 HIV/AIDS Tests

Despite the high HIV/AIDS awareness, Figure 4-2 indicates that 46% of respondents had never undergone a HIV/AIDS tests and therefore did not know their HIV/AIDS status.

Figure 4-2: Proportion of staff who have undergone HIV/AIDS test



Reasons given for not taking HIV/AIDS tests (Table 4-2) i.e. having not had a reason to do so (48.2%), confident of status (37%) and have not been faithful to partner (14.8%), gives an indication that the respondents have not internalized the significance of undertaking HIV/AIDS tests.

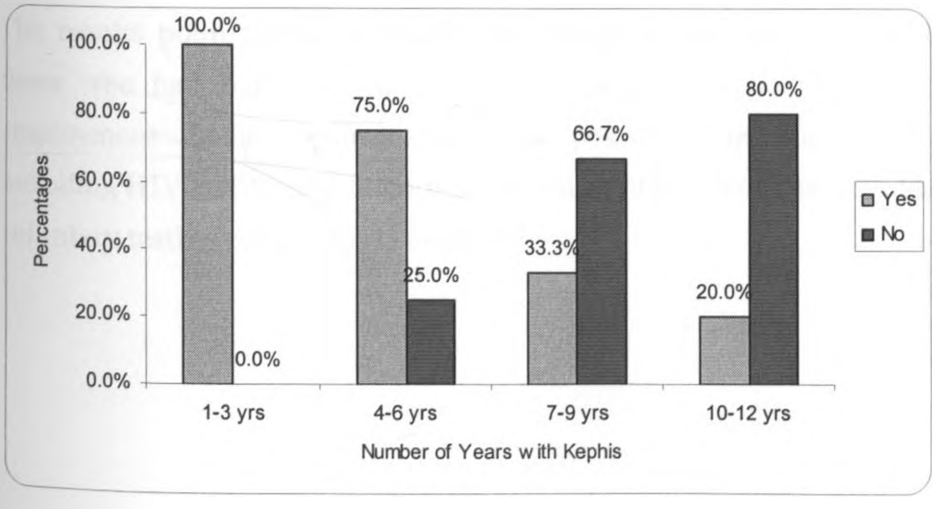
Table 4-2: Reasons for not undergoing HIV/AIDS tests

	Reason	%
1.	Have not had reason to do so	48.2
2.	Confident about HIV/AIDS positive status	37
3.	Have never been faithful to partner	14.8
	TOTAL	**100**

Out of the 54% who had undergone the tests, 71% had done so voluntarily while the rest indicated that they were forced by circumstances. The high percentage of voluntary testing is an indication that with increased awareness and support, many more would be willing to be tested.

One interesting revelation of the study was the fact that there was a very significant relationship between number of years worked and having been tested (Chi-square value 19.665; degree of freedom – 4; Significance level – 0.001). Figure 4-3 reveals that the percentage of respondents who had undergone HIV/AIDS tests decreased with the number of years worked. 100% of employees who had worked for KEPHIS for 1-3 years had undergone HIV/AIDS test while only 20% of those who had worked for 10 years (since inception of KEPHIS) had been tested.

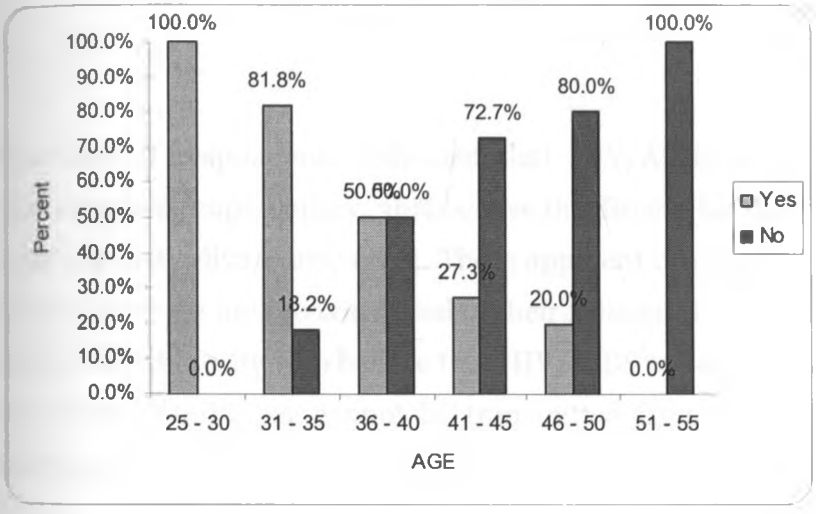
Figure 4-3: No. of years worked and undergoing HIV/AIDS test



Those who had worked for 1-3 years indicated that they were tested as a requirement by the employer giving an indication that they might have been required to undergo medical examination prior to employment. The requirement for such medical examination could have been enforced slightly over 3 years ago thus explaining why most respondents who were employed earlier had not been tested.

The above findings are supported by the significant relationship that exists between ages of the respondents and whether they had undergone HIV/AIDS tests or not (Chi square value – 22.149; degree of freedom – 5; significance level – 0.000). Figure 4-4 shows that the older the respondents, the lower the proportion that had been tested. 100% of respondents within ages 25 – 30 had undergone the tests, the proportion decreasing to zero for ages 51 – 55.

Figure 4-4: Age and undergoing HIV/AIDS test

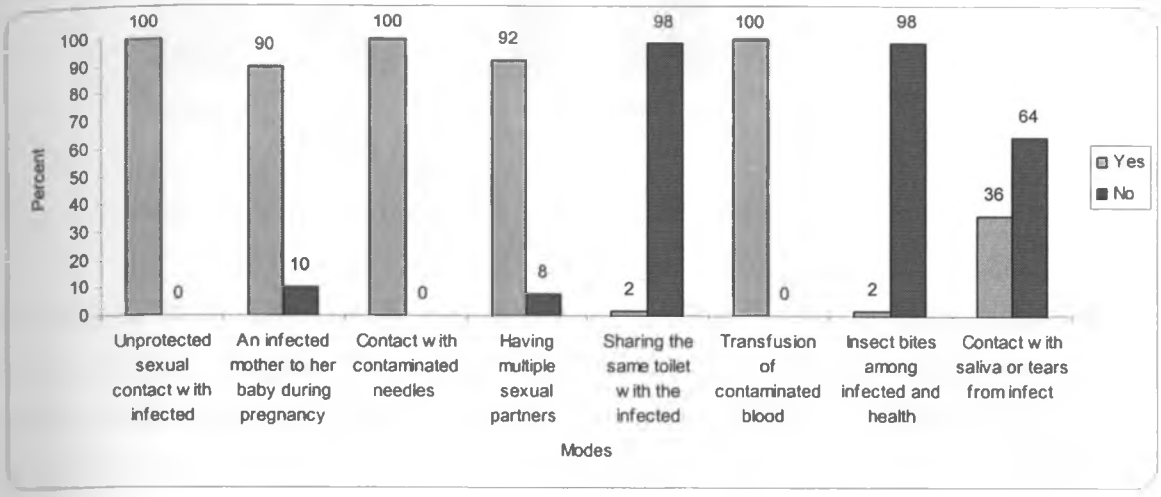


The results point to the possibility of younger respondents falling in the category of those who had recently joined the organization and had therefore undergone pre-employment medical examination. The possibility of these medical examinations including HIV/AIDS tests can not be overruled. The need to target older respondents for voluntary testing campaigns is evident.

4.2.3 Transmission of HIV/AIDS

Table 4-5 shows that majority of respondents were aware of ways through which HIV/AIDS is transmitted.

Figure: 4 - 5: Knowledge on modes of HIV/AIDS transmission

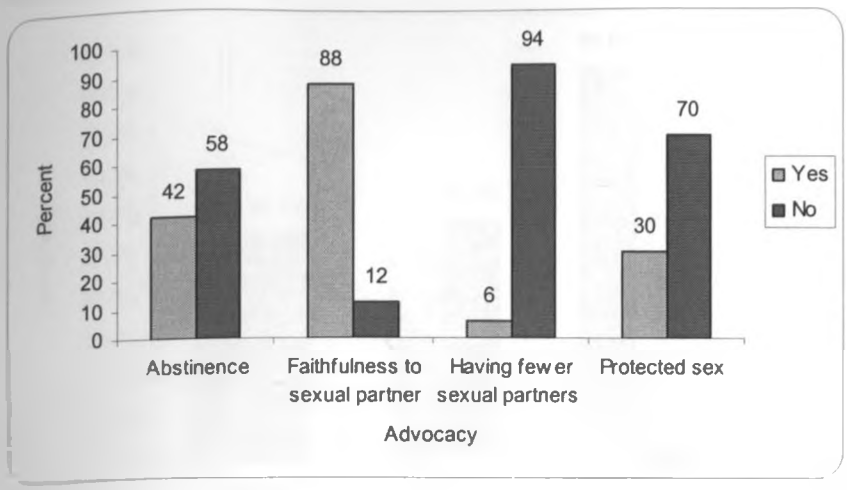


Whereas all respondents indicated that HIV/AIDS cannot be transmitted through sharing plates/cups/cutlery, 36% believe the disease can be transmitted through contact with infected saliva/tears/sweat. These apparent contradictions in responses imply that respondents are not too convinced of their facts on HIV/AIDS transmission. This is also true for the minority who believe that HIV/AIDS can be transmitted through insect bites and sharing toilets or cannot be transmitted from mother to child/having multiple partners.

4.2.4 Sexual Behaviour

As per Figure 4-5 above, respondents were aware of sexual behaviours through which HIV/AIDS is transmitted. Figure 4-6 however reveals that despite this, a significant proportion of respondents surprisingly indicated that they do not advocate/practice sexual behaviours known to reduce risk of contracting HIV/AIDS.

Figure 4-6: Influence of knowledge on HIV/AIDS and advocacy

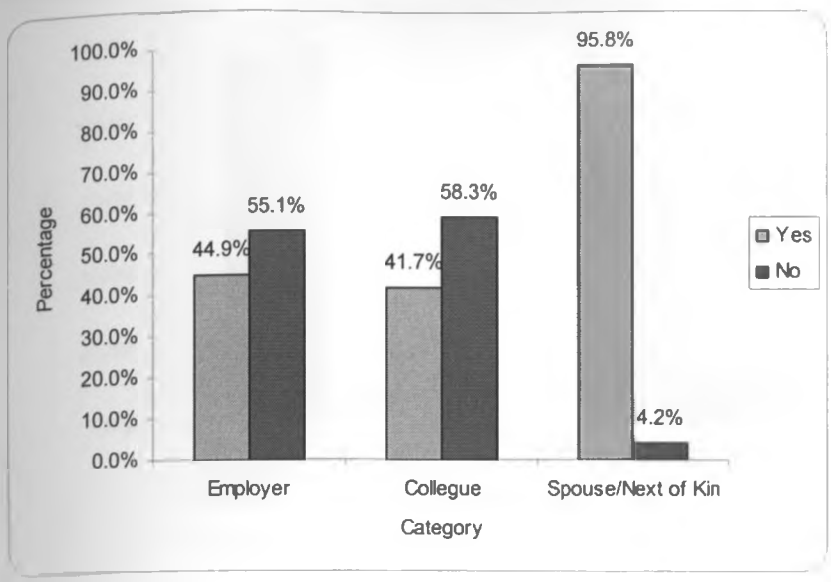


Whereas 88% of respondents indicated they would advocate/practice faithfulness to sexual partners, surprisingly, only 6% indicated they would advocate/practice having fewer sexual partners. In addition, only 30% of respondents indicated advocacy for protected sex when not with regular sexual partner implying that the significance of using condoms has not been fully internalized. These results are strong indications that most of the respondents are still very vulnerable to risky sexual behaviours.

4.2.5 Disclosure of HIV/AIDS Status

According to Figure 4-7, the workplace seems to be the least preferred place for employees to disclose their HIV/AIDS positive status. Only 44.9% of respondents indicated they would disclose their status to the employer and 41.7% to a colleague.

Figure 4-7: Disclosure of HIV/AIDS status to employer, colleague, spouse/ next of kin



Reasons given for not disclosing status at the workplace included reasons related to stigmatization/discriminated and job security as indicated in Table 4-3 below.

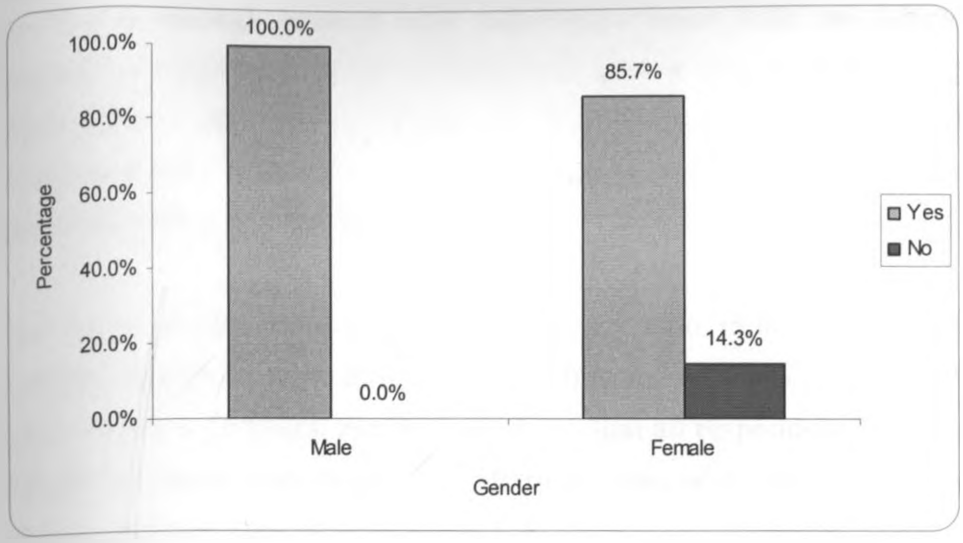
Table 4-3: Reasons for not disclosing HIV/AIDS status to employer

	Reason	%
1.	Stigmatization	56.25
2.	Job security	43.75
	TOTAL	**100**

Those who would disclose status to the employer indicated that they would expect support from the employer to manage the disease. None of the respondents gave reasons related to existing employer HIV/AIDS management programmes. This is a pointer to the fact that the employer's position on HIV/AIDS infected employees was not very clear to respondents.

Respondents (95.8%) preferred disclosing their HIV/AIDS status to their spouses/next of kin mainly because of support they know they would get in coping with the disease. Figure 4-8 reveals that the 4.2% who would not disclose status were all female.

Figure 4-8: Gender and disclosure of HIV/AIDS status to spouse and next of kin

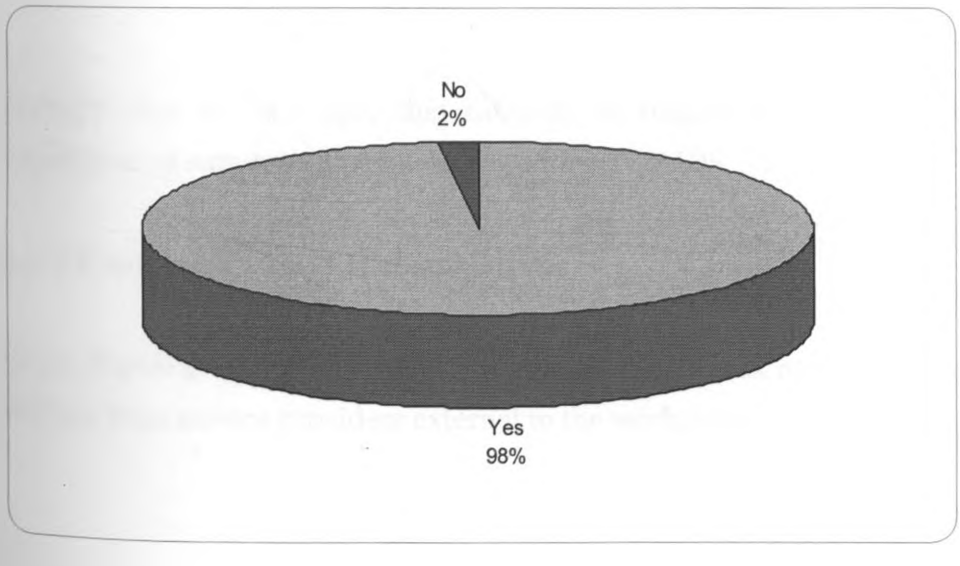


While all male employees would disclose their status, 14.3% of their female colleagues would not. Main reason provided was fear of being rejected by spouses.

4.2.6 Support for Infected Colleagues

As per Figure 4-9, 98% of respondents would knowingly work closely and even share facilities/items with infected colleagues because they are aware of how HIV/AIDS is transmitted.

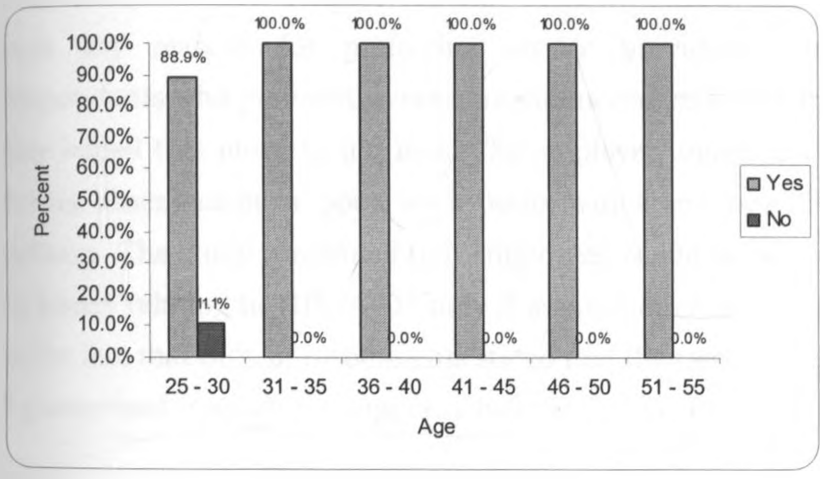
Figure 4-9: Willingness to undertake joint assignments/share facilities/items with HIV positive colleague.



However, contrary to the above, 36% of respondents believe that HIV/AIDS can be contracted through contact with saliva/tears/sweat from an infected person. This category of employees will most likely have reservations in undertaking assignments or sharing items with infected colleagues where they might get into contact with the above mentioned body fluids. The above contradicting data indicate that respondents to some extend did not give conclusive responses.

The study further revealed that all the 2% who indicated they would not share facilities/undertake joint assignment with infected colleagues belonged to the lowest age group i.e. 25 – 30 years. Figure 4-10 shows that all respondents in other age categories stated they would knowingly work/share facilities with infected employees while 11.1% of those between ages 25 – 30 would not.

Figure 4-10: Age and knowingly undertaking assignments with HIV/AIDS positive colleague

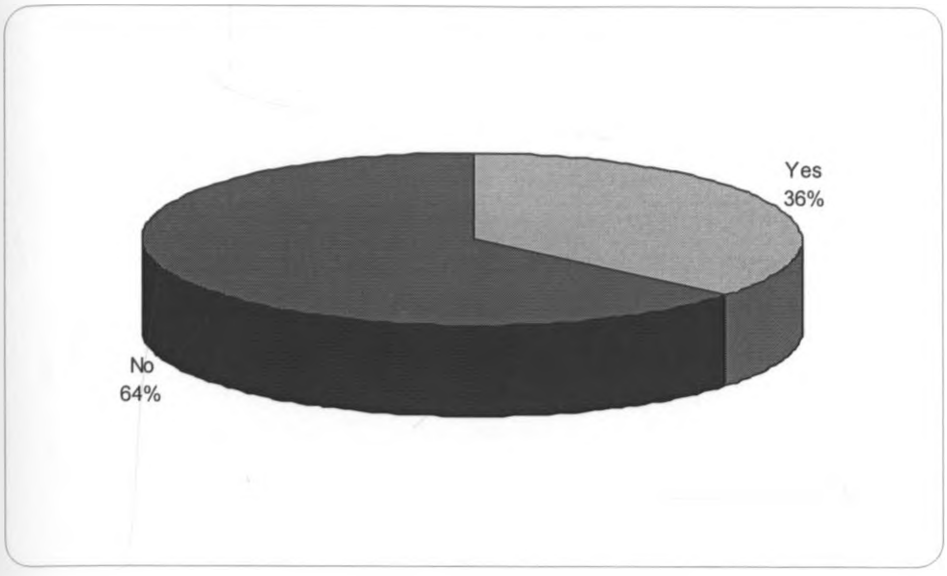


Probably due to their age, this category of respondents has not internalized the importance of supporting people living with HIV/AIDS.

4.2.7 E mployer HIV/AIDS Initiatives

As per Figure 4-11, 64% of respondents would rather seek medical attention/counseling services from service providers external to the workplace.

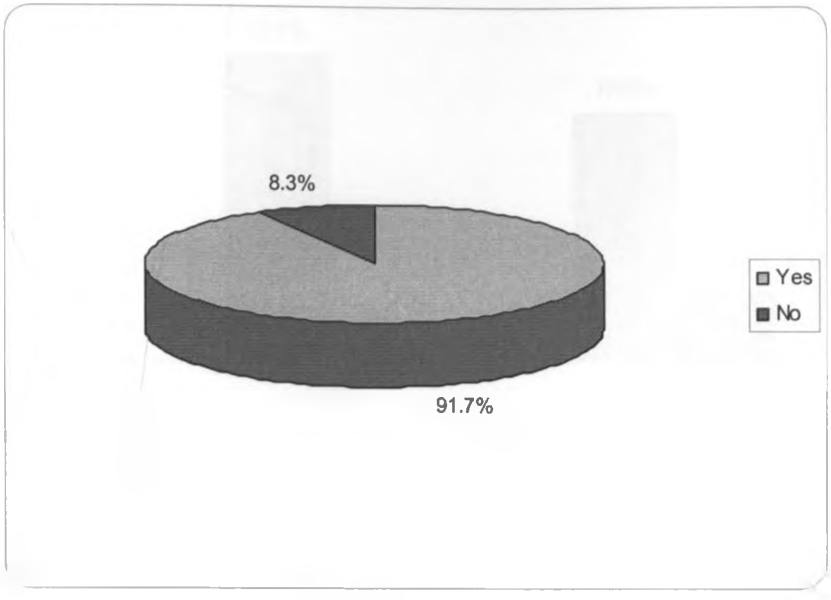
Figure 4-11: Preference for HIV/AIDS management service provider contracted by the employer



Concealing HIV/AIDS status for fear of victimization/discrimination and loss of job were key reasons for preferring service providers external to the workplace. Respondents who preferred service providers contracted by the employer indicated that they hoped this move would make the employer understand their situation especially during absenteeism or poor work performance and provide medical support during sickness. The study confirmed that employees would be willing to involve the employer on issues relating to HIV/AIDS only if assured of employer support. This is supported by the fact that 88% of respondents stated that they would regularly take HIV/AIDS test if guaranteed of employer support whatever the outcome.

The study further revealed that respondents were aware of the significance of extending employer HIV/AIDS awareness forums to external stakeholders. As per Figure 4-12, 91.7% of respondents agreed with the fact that employer awareness forums should be extended to stakeholders.

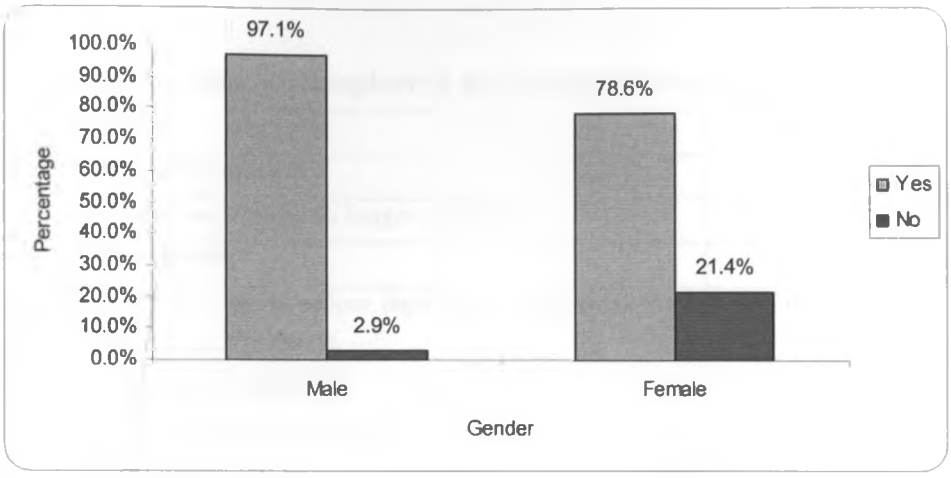
Figure 4-12: Opinion on importance of employer extending HIV/AIDS awareness campaigns to external stakeholders.



Respondents recognized the fact that the fight against HIV/AIDS can only be won through concerted efforts by all. Employer involvement in HIV/AIDS awareness, prevention and management forums targeting employees' families, clients and the surrounding community was identified as key in the national fight against HIV/AIDS. It was evident that a few employees do not understand the corporate role of their employer in relation to HIV/AIDS. Reasons given for opposing employer awareness forums to external stakeholders i.e. should involve only family members, it is contrary to employer's Mission and it would involve large financial investment, confirm the need to educate employees on the essence of corporate social responsibility in mitigating the impact of HIV/AIDS at the workplace.

Figure 4-13 reveals the interesting fact that majority of the 8.3% who opposed employer involvement in external stakeholders HIV/AIDS awareness forums were female.

Figure 4-13: Gender and opinion on importance of employer extending HIV/AIDS awareness campaigns to external stakeholders



Whereas 21.4% of the female respondents were against the idea, only 2.9% male respondents disagreed. The corporate responsibility in fight against HIV/AIDS is apparently not clear to more women than men.

Respondents further indicated that were willing to support and participate in employer HIV/AIDS prevention and management programmes. According to the study, 87.8% of respondents indicated they would be willing to be peer educators if requested to do so while 98.9% indicated they would be positive about awareness forums facilitated by colleagues. Respondents expressed keenness in advocating positive attitude/behaviour towards HIV/AIDS infected people at the workplace in order to phase out discrimination and stigmatization.

Table 4-4 shows the reactions of respondents to the employer's decision to employ a HIV/AIDS infected person.

Figure 4-4: Reactions to employer's decision to employ a HIV/AIDS positive person.

	Reason	%
1.	Very positive move	56%
2.	HIV positive persons no longer a rebuke	2%
3.	Understanding	12%
4.	This would provide proper conditions at the workplace in relation to HIV/AIDS	10%
5.	HIV is real and affects all	4%
6.	Commendable and humanitarian	4%
7	As affirmative action	2%
8.	Employer should provide support in terms of medication	4%
9.	Unfair	4%
10.	Very unwise decision	2%
	TOTAL	**100**

Most employees (94%) would loud the employer's decision to employ a HIV/AIDS positive person as this would confirm the employer's commitment towards non discrimination against people living with HIV/AIDS and hence reduce the stigma associated with the disease. Such a move would further encourage infected employees to live positively.

4.2.8 Factors Influencing Employee Responses to HIV/AIDS at the Workplace

Positive efforts so far by the employer had contributed positively to respondents' attitude towards HIV/AIDS. These included support for medical expenses incurred by infected employees, support to families of diseased employees (who were infected), non-discrimination by management and provision of condoms. Respondents however indicated that employer should consider providing condoms of better quality. In addition, positive living by some infected colleagues had gone along way in assuring respondents that even with HIV/AIDS, one can still have a fruitful future.

The study revealed that respondents felt that issues such as lack of confidentiality, stigmatization and discrimination by some colleagues, exclusion of HIV/AIDS in staff medical cover should be addressed in order to enhance and sustain the above mentioned employer efforts. Deliberate effort, where possible, should be made to limit the number of employees who live away from partners due to transfers since this increases vulnerability of employees to having multiple sexual partners. In addition, existence of colleagues who regularly indulge in risky sexual behaviours makes it difficult for colleagues to sympathize with them when they get infected.

Government HIV/AIDS supportive policies had impressed on employers the need to undertake HIV/AIDS preventive and management programmes seriously. Other initiatives both by government, non-governmental bodies and mass media which include VCT services, treatment and awareness creation were also identified as important in supplementing employer efforts and enhancing positive reactions from respondents.

Respondents indicated that the mass media, though very instrumental in awareness creation, has also contributed to some extend to decay in morals by airing "dirty" programmes. General belief that HIV/AIDS is associated with promiscuity and cultural beliefs that enhance spread of HIV/AIDS can also greatly negate workplace HIV/AIDS initiatives if concerted efforts to address them are not made.

CHAPTER 5: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

This study was undertaken to determine responses of KEPHIS employees to HIV/AIDS and factors influencing these responses. A sample of 50 was proportionately chosen from all regional offices/centers of KEPHIS and questionnaires used to collect data. Data was subsequently analyzed using Statistical Package for Social Sciences (SPSS) software package.

The study revealed that the level of HIV/AIDS awareness of KEPHIS employees was high. However, contradictory responses pointed to the fact that employees were not too clear on some facts on HIV/AIDS hence making them vulnerable to risky sexual behaviours. In addition, there existed a minority who held discriminative attitudes towards infected persons. HIV/AIDS trainings at the workplace were evidently not frequent and employer's position in relation to HIV/AIDS was not clear to respondents. The study further revealed that some responses were specific to certain categories of employees giving an indication that certain issues were perceived differently depending on factors like age, gender and level of education.

Positive factors influencing employee responses to HIV/AIDS at the workplace included among others management and government support. Discrimination by some colleagues, lack of staff HIV/AIDS medical cover, staff working away from families and negative influence of some media programmes/cultural practices were identified as some of the factors which need to be addressed.

5.2 Conclusion

From the above, it can be concluded that most KEPHIS employees have positive attitude towards HIV/AIDS, a prerequisite for successful employer HIV/AIDS programmes. KEPHIS needs to develop appropriate HIV/AIDS prevention and management programmes to facilitate adoption and maintenance of appropriate behaviour by employees. The employer can however achieve so much. KEPHIS employees and stakeholders should also maintain their part of the bargain since everyone is a soldier in the war against HIV/AIDS.

5.3 Recommendations

KEPHIS should first and foremost develop a HIV/AIDS workplace policy which should be aligned to national policies on HIV/AIDS at the workplace. The policy should be communicated to all employees. A HIV/AIDS workplace policy defines an organization's position and practices for preventing HIV transmission and handling HIV/AIDS infection among employees. This would assure employees on employer's position in relation to job security and stigmatization and discrimination of infected employees and medical support for infected employees which were key concerns of employees. These concerns formed the basis for majority of respondents expressing reservations on disclosing HIV/AIDS status to employer or visiting employer contracted testing and counselling institutions. It is also on the basis of the policy that focused HIV/AIDS programmes are developed.

The need to encourage and sustain appropriate behaviour was evident from the study. To effectively do this, KEPHIS should adopt Behaviour Change Communication (BCC) programmes. Workplace Behaviour Change Communication programmes entail comprehensive effort to inform employees about HIV/AIDS, promote behaviour changes that will reduce the spread of the virus, reduce discrimination and support workers who are living with HIV/AIDS. It includes services (e.g. care, testing, counselling), commodities (e.g. drugs, condoms) and policies that promote non-discrimination and trust (ILO/FHI, 2005).

To be effective, Behaviour Change Communication should be tailored to specific target groups (ILO/FHI, 2005). At the workplace, this entails developing specific messages and approaches based on factors like nature of work, age, level of education, and gender. The study revealed that there were significant relationships between specific groups of respondents and responses provided.

Based on these target groups, specific behaviour change objectives (like increasing condom use, increasing number of employees who undergo HIV/AIDS test) can be set and appropriate communication channels used to pass the information.

Involvement of peer educators in the design and implementation of HIV/AIDS programmes have been proven to produce very positive results and should be used by KEPHIS in its Behaviour Change Communication programmes to reach employees of different categories. Majority of respondents indicated that they would be willing to undertake this responsibility. This would particularly be effective if people living with HIV/AIDS are involved.

Fear of loosing job, stigmatization/discrimination and disclosure of HIV/AIDS positive status can be reduced by KEPHIS deliberately employing persons living with HIV/AIDS. Existing infected employees would therefore be assured of employer support. Pre-employment medical screening will subsequently not be viewed as targeting infected job applicants but as a way of ensuring general medical fitness of potential employees. If all new employees are HIV negative, it will be difficult for the employer to convince employees that its pre-employment medical examination is not biased towards infected job applicants.

As much as it is possible, KEPHIS should minimize cases of employees living far away from families due to transfers. Employees should perceive their environment as supportive of behaviour change and maintenance of safe behaviours.

Fight against HIV/AIDS requires concerted efforts. Both employer and employees must play their role. Observation of some respondents that some colleagues regularly engaged in risky sexual behaviours and some of those infected did not live positively indicates that employees also have a key role to play in the fight against HIV/AIDS at the workplace. An employee who regularly and knowingly engages in risky behaviour is unlikely to get sympathy from colleagues when infected. Infected employees should also purpose to live positively since this will make it easier for both employer and colleagues to support them.

Stakeholder inclusion in KEPHIS HIV/AIDS programmes should be considered. Respondents emphasized the need for involving particularly immediate family members since they stand to be directly affected when an employee is infected. Even where an infected employee is accepted at the workplace, discrimination/rejection at home can greatly affect the employee and reduce his/her performance at work.

Other stakeholders who interact with employees on regular basis e.g. clients and surrounding community will most likely get intimately involved with some employees and should therefore not be forgotten.
In addition, clients' acceptance to be served by an employee they know is infected is also key in sustaining moral of those infected at the workplace.

Collaboration with Government bodies, private organizations and other Non Governmental Organizations (NGOs) would supplement KEPHIS' HIV/AIDS initiatives in areas like provision of free condoms, VCT services and supply of antiretrovirals to infected employees and their families since the organization does not provide these. In addition, joint efforts by all stakeholders in pushing for reforms in the media in relation to vetting of programmes can not be understated.

5.4 Recommendations for Further Research

Organizations are under continuous pressure from employees, government and other bodies to provide support for HIV/AIDS employees as evident in this study. The cost implications of undertaking this responsibility is however enormous calling for joint effort with other players in providing awareness, counseling and medication. Further research to determine the challenges of partnerships to organizations in mitigating the impact of HIV/AIDS would go along way in shading some light as to why some organizations like KEPHIS do not have strong collaborative linkages in relations to HIV/AIDS.

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APPENDIX 1: LETTER TO RESPONDENTS

P. O. BOX 298
NAIROBI
23rd April, 2007

Dear Sir/Madam,

RE: RESEARCH ON EMPLOYEE RESPONSES TO HIV/AIDS

This questionnaire has been designed to gather information on responses of KEPHIS employees towards HIV/AIDS. This information will be used to complete a research project, a requirement for a Master of Business Administration (MBA) degree course.

You have been randomly selected to take part in this research by completing the attached questionnaire. The information provided should, as much as possible, be accurate and truthful. The information gathered will be used strictly for the research and will be treated in confidence.

Thanking you in advance for your cooperation.

Yours faithfully,

OTIENO P. O.

APPENDIX 2: QUESTIONNAIRE

PART 1:

1. Center.....
2. Sex: [ ] Male [ ] Female
3. Designation.....
4. Years of service at KEPHIS.....
5. Level of education:

   [ ] Primary
   [ ] Secondary ("O" level)
   [ ] "A" level
   [ ] University

6. Age bracket

   [ ] 20 - 25
   [ ] 25 - 30
   [ ] 31 – 35
   [ ] 36 - 40
   [ ] 41 – 45
   [ ] 46 - 50
   [ ] 51 - 55

7. Marital status:

   [ ] Single
   [ ] Married
   [ ] Widow/er
   [ ] Separated
   [ ] Divorced

PART 2

1. Have you attended any HIV/AIDS awareness training(s)?

   A) Yes [ ] B) No [ ]

   If yes, who organized the training(s)?.....

   .....

   .....

   If No, why?.....

   .....

   .....

2. Have you ever undergone an HIV/AIDS test?

   A) Yes [ ] B) No [ ]

   If yes, did you do so voluntarily or were you forced by circumstances?.....

   .....

   .....

   If No, why?.....

   .....

   .....

   .....

3. If you were to discover that you are infected with HIV/AIDS, would you voluntarily disclose your status?

   i) To your employer? A) Yes [ ] B) No [ ]

   Please give reasons for your answer.....

   .....

   .....

ii) To a colleague? A) Yes [ ] B) No [ ]

Please give reasons for your answer.....

.....

.....

iii) To your spouse/next of kin? A) Yes [ ] B) No [ ]

Please give reasons for your answer.....

.....

.....

4. Your knowledge on HIV/AIDS has influenced you to advocate/practice the following;

Please tick against all the correct answers in the boxes provided.

[ ] Abstinence
[ ] Faithfulness to sexual partner.
[ ] Having fewer sexual partners.
[ ] Protected sex e.g. use of condoms when not with regular partner.

5. Would you knowingly;

i) Undertake a joint assignment with a colleague who is HIV/AIDS positive?

A) Yes [ ] B) No [ ]

Please give reasons for your answer.....

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ii) Share facilities/items (e.g. office, telephones, toilets, cutlery, cups) with a colleague who is HIV/AIDS positive?

A) Yes [ ] B) No [ ]

Please give reasons for your answer.....
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6. If you were to seek HIV/AIDS counselling, testing and management services, what would you opt for?

[ ] A service provider contracted by your employer.

[ ] Other service providers.

Please give reasons for your answer.....
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7. If a colleague was to declare his/her HIV positive status, what would be your reaction?.....
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.....

8. How would you view your employer's decision to knowingly employ a HIV positive person?.....
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.....

9. Do you think it is important for your employer to extend its HIV/AIDS awareness campaigns to its external stakeholders (e.g. clients, families of employees, suppliers, community around the workplace etc.)?

A) Yes [ ] B) No [ ]

Please give reasons for your answer.....
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10. Given the opportunity, what would you do in support of your employer's HIV//AIDS awareness and prevention initiatives?.....
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.....

11. If you were requested by your employer to be a peer educator for its HIV/AIDS programmes, would you accept?

A) Yes [ ] B) No [ ]

If No, why.....
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.....

12. What would be your reaction if you were to attend a HIV/AIDS awareness forum where one of your colleagues is the facilitator?.....
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.....

13. If assured of employer support whatever the results, would you regularly go for HIV/AIDS tests?

A) Yes [ ] B) No [ ]

If No, why?.....
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14. Given the opportunity to make proposals for your employers HIV/AIDS programme, please list the issues you would include in your proposal.

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PART 3

1. Please list;

i) Factors at your workplace which have positively influenced your attitude/behaviour towards HIV/AIDS.

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ii) Factors at your workplace which have negatively influenced your attitude/behaviour towards HIV/AIDS.

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2. Please list;

i) Factors external to your workplace which have positively influenced your attitude/behaviour towards HIV/AIDS.

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ii) Factors external to your workplace which have negatively influenced your attitude/behaviour to wards HIV/AIDS.

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3. The HIV virus can be contracted through;

Please tick against all the correct answers in the boxes provided below.

[ ] Unprotected sexual contact with infected persons.
[ ] An infected mother to her baby during pregnancy/breast feeding.
[ ] Contact with contaminated needles and other objects that puncture the skin.
[ ] Having multiple sexual partners.
[ ] Sharing cups, plates or cutlery with an infected person.
[ ] Sharing the same toilet with an infected person.
[ ] Transfusion of contaminated blood.
[ ] Insect bites among infected and healthy persons.
[ ] Contact with saliva, sweat or tears from an infected person.