PERCEIVED EFFECTIVENESS OF WORKPLACE HIV/ AIDS MANAGEMENT PROGRAMMES: A SURVEY OF KENYAN STATE CORPORATIONS

BY:

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DECLARATION

I declare that this proposal is my own original work.

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DEDICATION

This study is dedicated to my loving family, for their support, encouragement and patience during the entire period of my study and continued prayers towards successful completion of this course. My special dedication to my loving daughter, Hope for her patience and my mum for her continous support and encouragement.

May God bless you All.

ABSTRACT

The main purpose of this study was to determine perceived effectiveness of workplace HIV/AIDS management programmes in the Kenyan State Corporations. This study adopted a descriptive survey research design. The population of the study consisted of all 127 state corporations in Kenya. Stratified sampling technique was used to select the sample of 40 state corporations based on their functional categories. The primary data was collected through the use of a structured questionnaire. The data was analyzed using descriptive statistics: percentages, frequencies, means and standard deviations. The results were presented on graphs, pie charts and tables.

The study revealed that the objectives that have positively contributed to the management of HIV/AIDS in State Corporations were provision of services to reinforce behavior change, informing employees about HIV/AIDS and offering services to cope with HIV infections. It was also found that the programmes in the management of HIV/AIDS in the corporations were very effective and that education and awareness, condom promotion and distribution and behavior change communication were the programmes undertaken by the corporations to very great extent. The study further found that the perceptions in the corporation's response to the management of HIV/AIDS that had a very great influence were HIV/AIDS programmes are expensive and HIV/AIDS is a health issue and should therefore be dealt with by health professionals.

Based on the findings, it is concluded that State Corporations have integrated HIV/AIDS programs as part of their workplace activities. Most programs initiated were found to be effective. However, workplace policy implementation, condom distribution, education and awareness were the programs perceived to be very effective. The study also concludes that there is inadequate involvement and management support based on perceptions that HIV/AIDS programs are expensive, lack of adequate resources and the perception that HIV/AIDS is not a core business activity. These perceptions were found to have a great influence on the extent of involvement by the management and staff in the programs. The study finally concludes that to be effective

in mitigating the impact of the pandemic, there is need to adopt a multisectoral approach, to increase budgetary provision for the programs and subsidize some of the programs.

It is further recommended that to improve on the effectiveness of workplace HIV/AIDS management programmes in the Corporations, top management should take the lead, commit and allocate adequate resources for the prevention programs and employees at all levels should be involved in the programmes.

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INTRODUCTION

1.1 Background of the Study

The Human Immunodeficiency Virus (HIV), which leads to Acquired Immune Deficiency Syndrome (AIDS), has become not only one of the most serious public health challenges of modern times, but also a workplace issue. The increasing prevalence of AIDS and the lack of a permanent cure threaten to seriously disrupt normal commercial activity. This growing and very real business issue must be carefully and responsibly managed to maximize the protection afforded to our employees, and to minimize the social, business and economic impacts in all sectors.

HIV/AIDS was originally considered to be predominantly a health problem; however, according to Seeley and Barnet (2004) "HIV/AIDS is not just a public health issue, but also a workplace issue, a development challenge and the source of widespread insecurity. HIV affects all sectors of the economy and is more of a developmental than epidemiological challenge hence calling for a multi-sectoral approach. Hard-won gains in employment and social protection are being reversed because of the epidemic. At the enterprise level, the effects of AIDS include loss of earnings, loss of skills, reduced productivity and the loss of markets as the consumer base is whittled away.

The United Nations Programme on HIV/AIDS (UNAIDS) and the International Organization of Employers (IOE),suggested that it is desirable to document policy and principles that: 'states the company's position and practices for preventing the

transmission of HIV and for handling HIV infection amongst employees. It is usually designed to establish consistency within the company and compliance with local and national laws, as well as setting standards of expected behavior for all employees. In addition, the policy aims to provide guidance to employees on how to address HIV/AIDS, and where to go for assistance' (United Nations Program on AIDS, 2004).

In response to the challenges arising from HIV/AIDS, the Kenyan government declared the pandemic a national disaster and a public health emergency in 1999. Through Sessional paper No. 4 of 1997 on AIDS in Kenya, the government put in place a national policy, defined an institutional framework and intensified intervention measures for prevention, management, control and mitigation of HIV/AIDS impact. In March 2003, Kenya declared "Total War on AIDS" (TOWA) and established a cabinet committee to deal solely with HIV/AIDS related issues. In April 2005, the government developed a public sector workplace policy on HIV/AIDS as a guide to further development of sector specific workplace programs. This was followed by a HIV and AIDS Prevention and Control Act, 2006 gazetted in January 2007(Kenya Gazette supplement No.98). The ninth Kenyan parliament enacted the HIV and AIDS control Act N0.14 of 2006 which was assented by the president on 30th December 2006, however, the date of commencement is yet to be given in spite of the legislation integrating legal issues, human rights and HIV/AIDS policies which is critical in containing the epidemic.

1.1.1 HIV/AIDS Challenge

The rising threat of HIV/AIDS on Africa's workforce has been of concern to

governments and employers of labour. In Kenya, the HIV epidemic has been categorized as generalized- meaning that HIV affects all sectors of the population. However, various studies have revealed high prevalence amongst a number of key affected groups, including sex workers, injecting drug users, men who have sex with men, truck drivers and cross-border mobile populations (UNGASS, 2008). An estimated 1.5-2 million people are living with HIV; around 1.2 million children have been orphaned by AIDS; and in 2006, 85,000 people died from AIDS related illness (UNGASS, 2008). There have been ideally a number of descriptive and explorative studies that have been done which gives us a fair estimation of statistics on the socio-economic impact of HIV/AIDS in the workforce due to ill health and death. There is no doubt, however, as to the magnitude of the problem that faces Africa in terms of the pandemic; however the problem that faces Africa is the issue of how to deal with the pandemic and to mitigate the risks involved.

In 1983, the first case of HIV/AIDS came to the knowledge of the World Health Organization (WHO). Soon after this the WHO declared it as an epidemic disease. In the case of Kenya, the first case of AIDS was reported in 1984 (Phoolcharoen,1998). Thus, under the Ministry of Public Health, the government through the Communicable Disease Control (CDC) department implemented activities for monitoring and managing HIV/AIDS evolution and awareness by setting up an emergency unit to collect, analyze and report the situation to both policy makers and implementers in particular, and to the world in general. The HIV/AIDS epidemic in Kenya peaked in the late 1990s with an overall prevalence rate of over 14% in adults (KDHS, 2003). This declined over the next decade, with the national HIV prevalence currently

estimated at 7.1% in age groups 15-49 years, and at 7.1% in age group 15-64 years in 2007. Incidence remains high at 132,000 adults and 34,000 new pediatric infections per year in 2007(KAIS, 2007)

The HIV/AIDS epidemic threatens Kenya's long term ability to provide the infrastructure and services essential for robust economic growth. Sector reviews suggest that HIV undermines all sectors of the economy and the quality of live for most of society. The epidemic has deepened poverty among the already impoverished and has stunted national development (sector impact studies, Futures Group Europe/DFID 2004). The majority of Kenyans rely on the agricultural sector for their livelihood. It has been set back by the negative impact on labour supply. Loss of labour due to illness caring for sick family members has resulted in delays in agricultural production (NACC, 2006). The epidemic has particularly affected education with the increase in morbidity and mortality among teachers and education officials has caused a decline in educational quality (NACC, 2006). A well developed human resource base has been one of Kenya's economic mainstays but there has been a striking effect from the pandemic on the labour force. This is caused by absenteeism, frequent sick leave and funeral attendance. This marked detrimental effect from HIV and AIDS on the workforce and productivity has led to low profit margins and in some cases has caused business to close (MoH 2005a). The social impact of HIV is most evident in the orphan's crisis. Currently, it is estimated that there are 2.4 million orphans in Kenya. Half are orphans caused by AIDS pandemic and in 2003; an estimated 650,000 children were orphaned in Kenya when at least one of their parents died from the disease (NACC, NASCOP 2007). The orphans place a financial burden on the country and

medical care, drugs, and funeral costs create an economic strain on the Kenyan economy (UNAIDS 2009)

HIV continues to spread around the world and it is estimated that in recent times, one in every 100 adults in the most sexually active age bracket (15-49) is infected with HIV (UNAIDS, 2008). The global percentage of people living with HIV has stabilized since 2000.However, overall the number of people living with HIV has increased as a result of the on going number of new infections and the beneficial effects of more widely available antiretroviral therapy. Sub Saharan Africa remains most heavily affected by HIV, accounting for 61% of all people living with HIV and 72% of AIDS related deaths in 2007(UNAIDS 2008). HIV infections are concentrated in the developing world, mostly in countries least able to afford to care for infected people. In fact, 68 per cent of people with HIV live in sub-Saharan Africa and the developing countries of Asia, which between them account for less than 10 percent of the global gross national product (UNAIDS and WHO, 2004). The HIV infection rate in Swaziland is unprecedented and the highest in the world at 26.1% of all adults and at over 50% of adults in their 20s (UNAIDS 2008)

1.1.2 Perceived effectiveness

Perceived effectiveness refers to the potential effectiveness of the workplace programs to the management of HIV/AIDS; relates to the degree to which the programs have been able to achieve impact and outcome goals. The concept examines the relative perceived effectiveness of the programs and assesses the extent to which real or

imagined judgments of effectiveness are related to judgments of realism, amount learned and positive and negative emotional responses

Ivancevich and Matteson (1987, 1990), defines perception as; the process by which an individual gives meaning to the environment. It involves organizing and interpreting various stimuli into psychological experience; it is the cognitive process by which an individual gives meaning to the environment. Because each person gives his or her own\\+ meaning to stimuli, different individuals will "see" the same thing in different ways. Perception involves cognition (knowledge); thus, it includes the interpretation of objects, symbols and people in the light of pertinent experience. Perception involves receiving stimuli, organizing the stimuli, and translating or interpreting the organized stimuli so as to influence behavior and form attitudes. Robbins (2007) defines perception as a process by which individuals and organizations interpret their sensory impressions in order to give meaning to their environment; he however notes that what one perceives can be substantially different from the objective reality.

1.1.3 Workplace Programmes for managing HIV/ AIDS

Various scholars have defined strategy in more or less the same terms. Strategy is an action that a company takes to attain one of its goals (Hill 2001). Johnson and Scholes(2004), further defines strategy as the process that matches resources and activities of an organization to the environment in which it operates, the direction and scope of an organization over the long-term which achieves advantage for the organization through its configuration of resources within a challenging environment to

meet the needs of markets and to fulfill stakeholder expectations.

Quinn (1999) defines strategy as the pattern or plan that integrates an organizations major goals, policies and action sequences into a cohesive whole; a well formulated strategy helps to marshal and allocate an organizations resources into unique and viable posture based on its relative internal competencies and shortcomings, anticipated changes in the new environment and the contingent moves by intelligent opponents. Programs are derived from strategies and define the activities to be done to realize the specific objectives.

The impact of HIV/AIDS from a human resource perspective has both policies as well as capacity challenges. Appropriate human resource strategies must be developed by human resource management components whilst human resource capacity in crucial areas of service delivery will have to be maintained. Workplace HIV/AIDS prevention and care programmes seek to inform employees about HIV/AIDS, promote behavior change that will reduce the spread, prevent new infections, provide services to reinforce behavior change and offer services to cope with HIV infections. It is worth noting that HIV prevention interventions are not one-time events but rather on-going coordinated activities and services. Because HIV affects all employees regardless of status, prevention programs and care efforts must be targeted and available to employees at all levels of the company and at all sites where the company works.

The Kenyan government established the National AIDS Control Council (NACC) in 1999 to lead the multi-sect oral response to HIV/AIDS. The Council developed the

Kenya National HIV/AIDS strategic Plan (KNASP) 2000-2010 which has outlined various strategies for program components for managing HIV. The KNASP strategic plan (2005-2010) has acted as a reference point in the public sector, however the sectors are not limited to the programs outlined thereof. The overall strategic objective of the programs outlined herewith is to reduce new infections and to improve quality of life of the infected by undertaking the following programs:

Education and awareness including responsible employee sexual behavior. HIV and AIDS education is an essential part of HIV prevention. The strategies employed to realize this is by training peer educators and counselors, using print and electronic information education and communication (IEC) and behavior change communication (BCC), communication materials and organization policies. Provision of patient information on opportunistic infections, drug and substance abuse.

Support groups: they are an important psychological boost. Companies can encourage staff members to form or join support groups which includes post test clubs. Condom promotion and distribution: there has been a big uptake of condoms both in government and social marketing outlets. Howe ever, condom usage remains sub-optimal the percentage of population using condom still low, it's hard to confirm usage in spite of uptake(KDHS 2003) government distribution of condoms has gone up from 2million condoms in 2002 to 7million condoms in 2004. Correct and consistent condom use is an essential factor in preventing HIV and sexually transmitted infections (STIs). The importance of regular and proper condom use should be a major focus of worker education and prevention sessions. Increase condom distribution, promote female

condom and availability.

Voluntary counseling, testing and support (VCT): although businesses are strongly discouraged from mandating HIV testing of employees or applicants, employers may choose to provide voluntary, informed and confidential testing for employees and partners as part of HIV prevention program through provision of VCT sites and training counselors. Support for HIV infected and affected employees, support groups, flexible work schedules are some of the programs that can be incorporated in the strategies.

Treatment , care and support: HIV is characterized by progressive deterioration of immune system whereby the person becomes susceptible to an expanding variety of opportunistic infections which often requires hospitalization , such are cases of TB, pneumonia such therefore require treatment, hospital and clinical based care and support such as medical covers, adequate attention and education and ensuring that PLWA stay healthy. It is also important to have adequate access to ART in line with national guidelines produced by the Ministry of Health and treatment of TB and other opportunistic infections. Social support and income generating activities to workers infected and affected financial assistance for PLWA and linkages beyond worker and family.

Post exposure prophylaxis (PEP): This is the treatment administered to any one exposed to infection within 72hours of exposure. Management of occupational transmission at work should be managed. Any employees exposed need to be provided

Act(cap 446) laws of Kenya. The corporations are categorized on functional basis mainly financial corporations, commercial/manufacturing, regulatory, public universities, training and research, regional development authorities, tertiary education and training and service corporations. Some of the state corporations are semi autonomous in that they have their own budgets and generate their revenues and therefore do not rely on the state for funding, they however operate within the Government guidelines and mandate. There are 127 state corporations in Kenya as outlined in the appendix.

1.2 Statement of the Problem

HIV/AIDS continues to ravage every sector of Kenya's economy. The pandemic has created widespread poverty and challenges to the management of human resources. Today HIV/AIDS is being recognized as a threat to human capital development requiring concerted efforts from all stakeholders. Kenya like all Sub Saharan Africa has been severely affected and the impact of HIV on the population has grown tremendously over the years. The recent Kenya demographic survey (KDHS, 2007) indicates that the national prevalence rate among adults has gone up to 7.1% from 6.7 %(KDHS,2003). This is a very worrying trend in deed. However even more worrying is the latest report from Kenya Aids Indicator Survey (KAIS, 2007) which paints a grimmer picture on the shift of Aids prevalence to rural areas which were previously assumed to be low risk. This has made as ponder how effective the programs on HIV/AIDS have been.

The impact of HIV/AIDS has been tremendous in all sectors of the economy

in terms of cost factor and service delivery aspects, there is therefore the need to implement appropriate policies and programs in order to manage and mitigate the pandemic. Therefore the possible future effects of the pandemic are a major concern to any organization.

Various local studies have been carried out examining strategies and policies on the management of the pandemic. Locally, Murambi (2002) carried out a survey on HR policy response to HIV on insurance firms in Nairobi. Kaduki (2004) did a survey on the extent to which publicly quoted companies in Kenya consider HIV/AIDS in strategy formulation while Magutu (2005) carried a survey on strategic responses of Kenya HIV and Business council member firms to HIV/AIDS pandemic. These studies have not focused on the perceived effectiveness of workplace HIV/AIDS programs in State Corporation in Kenya. Given the long term impact of HIV/AIDS to productivity, it is imperative that a study be done to investigate the extent to which the state corporations being major stakeholders have responded to the management of the pandemic and the effectiveness thereof. This study will try to fill the research gap that exists by carrying out a research on the perceived effectiveness of workplace HIV/AIDS management programmes in the Kenyan State corporations.

1.3 Objective of the Study

The main objective of this study is to determine perceived effectiveness of workplace HIV/AIDS management programmes in the Kenyan State corporations.

1.4 Significance of the Study

The study will be valuable to the following:

State corporations under survey in that it will provide a comparative insight into various initiatives in the management of HIV/AIDS.

The Government in that it will be very useful in evaluating the current policies and strategies and making sector specific policies and strategies to address the HIV/AIDS pandemic.

The academia: it will provide a useful basis for further research on workplace programs and their effectiveness in the management of HIV/AIDS in the private and public sector.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter summarizes the information from other researchers who have carried out their research in the same field of study. The specific areas covered here are overview of HIV/AIDS in workplace, HIV/AIDS effects on productivity and profitability and effectiveness of HIV/AIDS programs in the workplace.

2.1.1 Overview of HIV/AIDS in the Workplace

Nine out of ten persons living with HIV belong to the working age group 15 – 49 years, usually the most productive group in any society. Out of the 33 million persons living with HIV in 2007, about 30 million were adults, (Department of Health, 1995, 1997, 1999, 2001). The devastating effect of HIV/AIDS on the economy (the workplace included) has been largely through absenteeism from work and lowered output as infected persons develop full blown AIDS. Late stage AIDS patients are unable to work at all (SwartKuger and Richter, 1997). In many developing countries Kenya included, there is already a shortage of skilled labour and a narrow underdeveloped industrial base, exacerbated by lack of resources to overcome these problems. The situation is made worse by the evidence that the pool of people who will make up the next generation of skilled workers is already diminishing (UNGASS, 2008).The psycho-social environment of the workplace is being affected when some employees have a serious and, ultimately, terminal condition. It therefore makes sense for state

corporations to adopt HIV/AIDS strategies, and to encompass not only the reactive steps but also proactive measures designed to limit the spread of HIV and its effect among the workforce and society at large.

2.1.2 HIV/AIDS Effects on Productivity and Profitability

HIV/AIDS affects both productivity and profitability. The effects of HIV/AIDS on productivity include the following; Increased absenteeism – sickness, the need to care for the sick, preparing for and attending funerals of friends and relatives result in an increase in absenteeism which in turn has negative impacts on productivity, Staff turnover – illness and death results in high staff turnover. This leads companies to increasingly focus on recruiting and training new employees rather than on company output; lower morale – as a result of illness, suffering and loss of colleagues, friends and relatives, the effects of HIV/AIDS lead to the lowering of morale among workers. The impacts of HIV/AIDS on profitability include the following; increased costs as the number of employees falling sick increases, companies have to bear the costs of health insurance, sick leave, funeral benefits, recruitment and training of new staff. Declining investment; the increasing impact of AIDS on businesses deters investment. Threat to consumer base; as more people die of AIDS, the overall demand for goods and services declines, (Swart Kuger and Richter, 1997).

The impact of AIDS on business is already visible in many parts of the world. Despite the scale of the threat posed by HIV/AIDS, the business community has been slow to respond. There are various reasons why the business community has been slow in responding to HIV/AIDS. These include: the perception that HIV/AIDS programmes

are expensive, the belief that HIV/AIDS is a health issue and that it should therefore be dealt with by health professionals, the reluctance to have workers participate in HIV/AIDS activities during working hours as it will affect productivity, lack of resources, lack of adequate knowledge on HIV/AIDS and, the feeling that HIV/AIDS is too sensitive. Aids prevention and care activities by businesses can maintain or even increase productivity and profitability. The great challenge to business organizations is how to respond to HIV/AIDS in a compassionate but cost-effective way which will balance the obligation to employees, society and the shareholders.

In order to survive today's world, businesses must be more humane and fully attuned to social needs especially as the AIDS scourge which is severely affecting all facets of life. It makes economic sense for industry and commerce to adopt HIV/AIDS policies and to encompass not only the reactive steps but also proactive measures such as education programmes designed to limit the spread of HIV among the workforce. The expense of such programmes is minimal compared with the costs of replacing someone who dies of the illness, (Herek and Capitanio, 1999). Milton Friedman and Peter Drucker have argued that it is the first responsibility of business, including its first social responsibility, to achieve profitability and growth (Abt, 1977). They argued that since business operates in a world of scarce resources, the economic efficiency of state corporations is a matter of top priority and should be the sole mission of business. According to Adam Smith, managers are answerable to shareholders only.

2.1.3 Stigma and Stigmatization in the Workplace

Falk (2001) emphasizes that modern usage of the words "stigma" and "stigmatization"

refers to an invisible sign of disapproval which permits the community, so-called insiders, to draw a line around "outsiders" in order to isolate or exclude any group judged to deviate from accepted norms and morality. Stigma is created as a result of the attribution of negative labels toward some individuals or groups who share certain distinctive characteristics that are subjected to prejudice and discrimination (Wendell, 1990; Fiske, 1993).

HIV/AIDS-related stigma is often layered on top of many other stigmas associated with specific groups such as homosexuals, sex workers, drug users, people involved in casual sex. PHAs may, therefore, suffer from double stigma as a result of the stigma attached to the disease, and the stigma duly attached to them because of their devalued identity or "deviant" behavior. Sometimes, stigma may be further complicated as a result of racism, sexual orientation, and income level. To assert that some people are systematically disadvantaged is to claim that their problems are both persistent and predictable, their origins and explanation lying within the social structure rather than being simply reflections of rough justice in the distribution of rewards, or the random allocation of bad luck. Many PHAs are disproportionately vulnerable to a majority of these other forms of stigma (Sontag, 1990) particularly in view of the undesirable structural conditions perpetuated by increasing polarization between rich and poor in an era emphasizing globalization together with a radical restructuring of the world economy (Castells, 1998).

Stigma can be divided into felt or perceived stigma and enacted stigma (Malcolm et al., 1998). Perceived stigma refers to real or imagined fear of prejudice and potential

discrimination arising from a particular undesirable attribute or disease, or association with a particular group, such as PHAs. For example, PHAs may become outsiders and refuse to disclose their positive status for fear of the possible negative reactions of the insiders (sometimes they may be significant others like family members). Enacted stigma, on the other hand, refers to the real experience of discrimination. For example, the breach of confidentiality and the disclosure of an individual's HIV-positive status could lead to the loss of tangibles, like jobs and access to healthcare facilities, and intangibles like discrimination and social exclusion (Brown et al., 2001).

Parallel with the growing number of infected cases, negative attitudes about HIV/AIDS have also created an atmosphere in which people living with HIV/AIDS (PHAs) become more afraid of the stigma associated with or caused by the disease than of the disease itself (Brown et al., 2001; Committee on Promoting Acceptance of People Living with HIV/AIDS, Hong Kong Advisory Council on AIDS, 2002). HIV/AIDS-related stigma can be described as a process of stigmatization and devaluation of PHAs. This process can result in the discriminatory and exclusionary treatment of individuals based on their real or perceived positive status (UNAIDS, 2003; Carlisle, 2002). Health care workers are supposed to play a role in monitoring the interaction between PHAs and their family and the community at large. Their attitude and behavior directly influence the rights, welfare and acceptance of PHAs, and indirectly set an example for others regarding non-discriminatory and anti-discriminatory practices, (Carlisle, 2002).

2.2 Effectiveness of HIV/AIDS management Programmes in the Workplace

A sustainable response should include strategies to mitigate the future impact of the

epidemic on the functioning of the institution. Such strategies assume that despite the implementation of awareness raising, prevention, and care and support activities, some people will still contract, become sick and die of HIV/AIDS, so it is necessary to put in place measures to address the discontinuity and loss of knowledge that results from losing employees, (Brown et al., 2001).

They acknowledge that, given both the diminished human and financial resources associated with attrition and the potential long-term effects of HIV/AIDS on the size and quality of the available recruitment pool, replacement of personnel may often be neither possible nor preferable. Continuity is, therefore, best preserved by developing 'tacit knowledge' and institutional memory within an institution, (Brown et al., and 2001). One way of reducing the effects of the epidemic on institutions is to more effectively manage non-AIDS-related attrition by, for instance, increasing the retirement age, exploring flexi-time options, improving monitoring, and adopting and enforcing appropriate leave policies, (Duffy, 2005).

Another way is to put in place strategies to actively preserve available capacity and resources.

Flint-Taylor and Burch highlight a range of non-replacement strategies that can help to improve the continuity of skills and knowledge. These can be clustered into three main categories, namely: Knowledge management: This involves improving information sharing within institutions, as well as the storage and retrieval of important organizational information. It also involves formally recording individual knowledge, contacts, and processes. Thus, for example, one might develop a manual containing information on processes and contacts for key posts within the organization, so that this

information is not lost when an employee leaves the institution or is absent, (Booth, 1993)Work design: This involves designing individual job descriptions in such a way that organizations are better able to cope with skills losses by, for example, automating simple or routine processes, or exploring whether some functions could be carried out by people with fewer skills. Work design involves teamwork and, where job descriptions are not too specialized, multi-skilling in order to ensure a degree of commonality across jobs. This approach can be contentious, and should be undertaken in consultation with employees and, where relevant, trade unions. Career development and succession planning: This involves identifying and developing employees with high potential and ensuring that enough people are equipped to take over key positions within the organization should they fall vacant. This strategy involves mentoring and coaching to pass on knowledge, skills, and institutional memory, (Whiteside and Wood, 1993).

2.2.1 Individual Strategies for Coping with HIV/AIDS Stigma in the Workplace

How would people who are stigmatized (enacted stigma) or regard themselves as stigmatized (perceived stigma) react to or cope with stigma? Becker and Arnold (1986) observed that stigmatized individuals find themselves in a continual struggle with negative attitudes and with the devalued status that accompanies them, and in the case of older PHAs, the struggle may last until death. The degree to which the individual feels stigmatized, the degree to which the stigma is shared with outsiders in society, and the degree to which the stigma can be "normalized" will, as noted by Becker and Arnold (1986), all affect the process of adaptation that the individual undergoes in

dealing with the stigma. Some, usually a minority, may resist the stigmatic label, acting normally, sharing with or seeking support from others, undertaking personal advocacy, joining collective advocacy, and so on. In some cases, perceived stigma can be seen as a coping strategy to limit the occurrence of enacted stigma. That is, the production of perceived stigma is taken as a warning signal to prepare the individuals to be well on guard. For example, older PHAs may continue not to tell their positive status to strangers and to others who are outside their intimacy circle.

Whether people successfully manage the stigma has to depend on factors such as its perceived alterability, controllability and conceal ability (Lee, 2002; Carlisle, 2002). For most people these conditions are unlikely to be uniformly favorable, and for them the experience of stigma is likely to involve a feeling of personal responsibility for the stigma which may lead them further to internalize the stigma to the point where it becomes a permanent negative self image. Currently, a growing number of contributors regard the internalization of stigma as self-stigma, which is taken as a negative response by a person towards himself or herself (HDN Moderation Team, 2004). It is not uncommon that self-stigma incorporates feelings of shame, guilt, self-doubt and self blame. Some people exercise self-exclusion from participating in normal social activities because of their decreasing sense of self-worth. Consequences of self-stigma can be viewed along a continuum from mild reactions like silence and denial, to self-isolation, self-exclusion, and even to self-harm. By accepting the stigma, the stigmatization process looks reasonable and thus a vicious spiral is perpetuated, (Lee, 2002; Carlisle, 2002).

In a recent study by a regional PHA network on AIDS-related discrimination in Asia, the major area of discrimination was found to be within the healthcare sector itself (Asia Pacific Network of People Living with HIV/AIDS, 2003). The external review team for the Advisory Council on AIDS in Hong Kong did show their serious concerns about the use of a two-tier system of care in medical settings, in which PHAs are differentially treated in spite of strong recommendations for universal precautions against infectious and contagious diseases (External Review Team for the Advisory Council on AIDS, 1998). There are many ways that stigmatizing discriminatory measures can be taken against the PHAs, for example, refusal to treat them or offer them differential treatment on the ground of their positive status, testing without knowledge or consent, segregation in clinics or hospitals and breaching of confidentiality principle (UNAIDS, 2004). As far as the context of Hong Kong is concerned, there is yet no in-depth study of the stigmatization and exclusion suffered by older PHAs as a result of the disclosure of their positive status by/to healthcare professionals or workers, let alone examining the management strategies adopted by older PHAs aged 55 or above to conceal their positive status in healthcare settings.

2.2.2 Effectiveness of HIV/AIDS management Programmes and Awareness Culture

Defined as "the teaching or sharing of health information, values and behaviours by members of similar age or status groups" (Sciacca, 1987), the central tenet of peer-to-peer communication has intuitive appeal as a way of working effectively with hard-to-reach young people. It certainly has potential to generate meaningful participation and

to address risk and vulnerability in context. The pros and cons of the method have been discussed at length (Milburn, 1995). Much has been documented about what makes an effective peer educator. Prominent attributes include: being a credible communicator; a positive role model; and an empathic peer (UNAIDS, 1999). Much less has been written about the extent to which at-risk adolescents in resource-poor settings can successfully take on these attributes.

In 2001, GOAL Uganda (2001) embarked on an HIV prevention programme targeting street children which used peer education as a central strategy. This was a highly innovative project with a difficult-to-reach target group in a resource-poor setting. We utilized project monitoring systems and regular reviews to systematically document the implementation process. The broad aim of the study was to identify challenges, good practice and lessons learned by the project, (Chase and Aggleton, 2006).

Due to resource constraints typical of a project of this nature, it's not possible to measure effectiveness in terms of behavioral outcomes or STD/HIV incidence. Rather, the focus is on effectiveness in terms of communication – the extent to which people working in any state corporation are able to reach their target audience with clear and positive messages about HIV prevention that are understood and internalized by recipients.

2.2.3 Effectiveness of HIV/AIDS Programmes and Disclosure

Fears of rejection and exclusion from social systems play substantial roles in determining categories of disclosure. In the case of parents, studies have indicated that

they worry about sharing their HIV positive status with their children because they fear that children will not keep it secret or will be treated unjustly afterward (Dematteo et al., 2002).

Stigmatization correlated with discrimination and abuses continue to be a major problem for PLWHA and their families in Africa. Several studies reported cases of PLWHA being abandoned by families, divorced (especially women), killed, ostracized, evicted, or run out of their communities upon disclosure of their positive serostatus (Kegeles et al., 1989).Overall, disclosure of events or conditions considered threatening to one's life is complex and may in itself be stressful. Sharing one's seropositive status is a difficult process that may lead to stress (Kimberly et al., 1995; Serovich et al., 1998) as PLWHA tend to be stigmatized and discriminated against compared to people with other chronic illnesses. Thus sharing one's seropositive status becomes a challenge and one has to decide to whom, when, and how to disclose.

Conversely, in some instances, disclosure of personal and secret information is necessary to garner resources needed to survive and overcome the daily and stressful demands of the event such as HIV/AIDS. Although disclosing HIV infection to family is a taxing experience, it has been reported that social support decreases depressive symptoms among PLWHA (Hays et al., 1992) and leads to better psychosocial functioning (Klein et al., 2000). In fact, Holt et al. (1998) found that disclosure helped British men cope with living with HIV/AIDS. It also improved and increased productivity and well-being of PLWHA in Africa and Asia-Pacific region (Carlisle C.,

2002).

2.2.4 Knowledge of HIV/AIDS and Effectiveness of HIV/AIDS Programmes

Since AIDS is a "death sentence" for most Africans because of lack of resources for retroviral therapies, knowledge of a family member's terminal illness generates strain on family relationships among all members involved. Thus, people may be hesitant to disclose their seropositive status to their co-workers. Another issue people may have to grapple with is the fact that sexual intercourse is the common mode of HIV infection in sub-Saharan Africa (World Health Organisation, 2003); and since sex and sexuality are not topics that colleagues discuss with their co-workers (Oshi et al., 2005), people may feel very uncomfortable disclosing their seropositive status to their co-workers. They may fear that co-workers may ask questions that would be difficult and shameful for them to answer.

Effective AIDS educational programmes make information readily available to employees. Since not every approach is effective with each employee, a variety of approaches (brochures, bulletin board displays, envelope stuffers, newsletter articles, training programmes, videos, workshops, etc.) should be used to reach the greatest number of people. Repetition must be a key element of an AIDS education programme. Changing people's behaviours and reducing their fears are only accomplished by repeated emphasis on basic messages, (Brown et al; 1992).

An effective AIDS education programme should include at least two of the following: "Explain your company's guidelines concerning HIV/AIDS to all employees; distribute

a brochure or a pamphlet about HIV/AIDS to all employees; show a videotape on AIDS to employers; make available a videotape on HIV/AIDS for employees to take home and view with family and friends; contact your health department, local AIDS service organization, Red Cross chapter, or medical society to invite an AIDS workplace specialist to give a presentation to employees; invite an AIDS-in-the-workplace consultant to develop a comprehensive HIV/AIDS strategy and programme for your business; purchase one of the tried and tested educational programmes which are readily available; ask your industry or trade association for resources and recommendations; invite a person dealing personally with HIV infection or AIDS to speak to employees; encourage employees to read or view information about AIDS on their own after the training to keep themselves up-to-date", (Brown and Gray, 1991, Kohl and Miller, 1992).Finally, business schools must include AIDS in the workplace training in their curriculums in order to ensure that future managers are adequately prepared to deal with this problem.

2.3 Basics of an Effective Response

Within the framework of such principles, there is increasing agreement that an appropriate response to the epidemic needs to be holistic, systematic and co-ordinated and guided by a clear policy statement. As argued by UNAIDS, such an approach establishes a clear framework within which activities should take place and ensures that the response is balanced, available funds are used to best effect, and the activities undertaken work effectively together. Such a response needs to include three essential components: prevention of new infections; treatment and care of people living with

HIV and AIDS; and mitigation of the current and future impacts of the epidemic, (ILO HIV and AIDS 2000).

An effective response should also seek to address HIV/AIDS internally, among an institution's employees, and externally, among its 'clients'. As employers, government institutions need to acknowledge that HIV/AIDS may have potentially significant implications for their staff and functioning, and take steps to mitigate the impact of HIV/AIDS on infected and affected employees. Externally, they should work to mitigate the impact of HIV/AIDS on the communities they serve. This involves 'mainstreaming' HIV/AIDS, or integrating responses to

HIV/AIDS into their core functions, (World Health Organization, 1992)

The success of such activities in turn usually rests on certain prerequisites, such as an accurate understanding of the problem, a comprehensive policy framework, clear programmes to implement these policies, and adequate resources, capacity, and commitment to ensure their implementation. These are outlined below.

To effectively mitigate the impact of the epidemic, it is important to first know how HIV/AIDS may impact on the institution. Statistical models, which use a variety of epidemiological, demographic, and organizational data to estimate the future impact of epidemic, have proved useful in planning long-term responses to the epidemic. Situational analyses, in the form of institutional audits, have also been shown to be useful in determining the dimensions of the required response. This tool is at present used almost exclusively in the private sector, but is beginning to be used in the public

sector. It consists of the following components, which form a series of linked steps in a process: Personnel profiling to determine the demographic profile of employees, the different skills levels in the organization, and whether there are groups of employees who are particularly susceptible to infection. Critical post-analysis to determine whether the institution contains personnel who would be particularly difficult to replace, or on whom a production or administrative process depends. Assessment of organizational characteristics to determine the size of the organization and the flexibility of employees. Liabilities to ascertain the potential costs or liabilities likely to be incurred as a result of increased demand for employee benefits and the like. Productivity to determine how any declines in output will be detected and managed. Organizational context to determine the legislative and policy environment in which the institution operates (SwartKuger and Richter, 1997).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter sets out various stages and phases that were followed in completing the study. It involves a blueprint for the collection, measurement and analysis of data. Therefore, in this section the procedures and techniques that were used in the collection, processing and analysis of data are identified. Specifically the following subsections are included: research design, target population, sampling design, data collection instruments, data collection procedures and finally data analysis.

3.2 Research Design

This study adopted a descriptive survey research design of state corporations in Kenya with a view to establishing the effectiveness of HIV and AIDS management programs. Descriptive studies are concerned with finding out what, when, where, who, and how of a phenomenon. The descriptive survey research was preferred because it describes the relevant aspect of the phenomenon of interest in this case effectiveness of the HIV/AIDS management programs, which is the focus of this study.

3.3 Target population

The population of the study consisted of all 127 state corporations in Kenya (see appendix 1). These firms are preferred because their workers constitute about 40% of

the Kenyan working population. Their geographical distribution is in all major towns of Kenya.

3.4 Sampling Design and technique

The sample size was 40 state corporations from the various functional categories to be representative enough of the 127 state corporations. Stratified sampling technique was used to select the sample of 40 state corporations based on their functional categories. The stratums were based on functional categories of the Corporations; this enabled the sample to be representative of all the categories of the state corporations. From each stratum, the study used simple random sampling to select the respondents.

3.5 Data Collection

The study used primary data from respondent's perception on the effectiveness of HIV/AIDS management programs. The primary data was collected through the use of a structured questionnaire. The questionnaire was structured into two parts with part one seeking information on respondents and organization profile. The second part collected data on respondent's perception on effectiveness of HIV/AIDS management programs. The questionnaire consisted of both open and closed ended questions.

The questionnaire was pre-tested and where appropriate adjusted before data collection to establish the effectiveness of the instrument. This thus enhanced the reliability and effectiveness of the study and the improved scope of the information to be gathered.

3.6 Data Analysis

Data was analyzed using the statistical package for social sciences (SPSS). The data was analyzed using descriptive statistics: percentages, frequencies, means and standard deviations. This qualitatively harnessed descriptive statistics. The results were presented on graphs, pie charts and tables.

CHAPTER FOUR

4.0 DATA ANALYSIS, DISCUSSION AND INTERPRETATIONS

4.1 Introduction

This chapter presents analysis of the data obtained from a survey of State Corporations on the perceived effectiveness of HIV and AIDS management programs. The data targeted a sample of 40 state corporations based on their functional categories of which only 35 filled in and returned the questionnaires, making a response rate of 87.5%. This response rate was good and representative and conforms to Mugenda and Mugenda (1999) stipulation that a response rate of 50% is adequate for analysis and reporting, a rate of 60% is good and a response rate of 70% and over is excellent.

4.2 Biographic Information

Table 1: Distribution of the respondents by Gender

	Frequency	Percentage
Male	26	74.3
Female	9	25.7
Total	35	100.0

The findings in the table 1 show the gender of the respondents. From the findings, it was established that the majority of respondents were males as shown by 74.3%, while females were 25.7%. This reflects the actual situation in most institutions where males are more than females.

Figure 1: Distribution of respondents by Gender

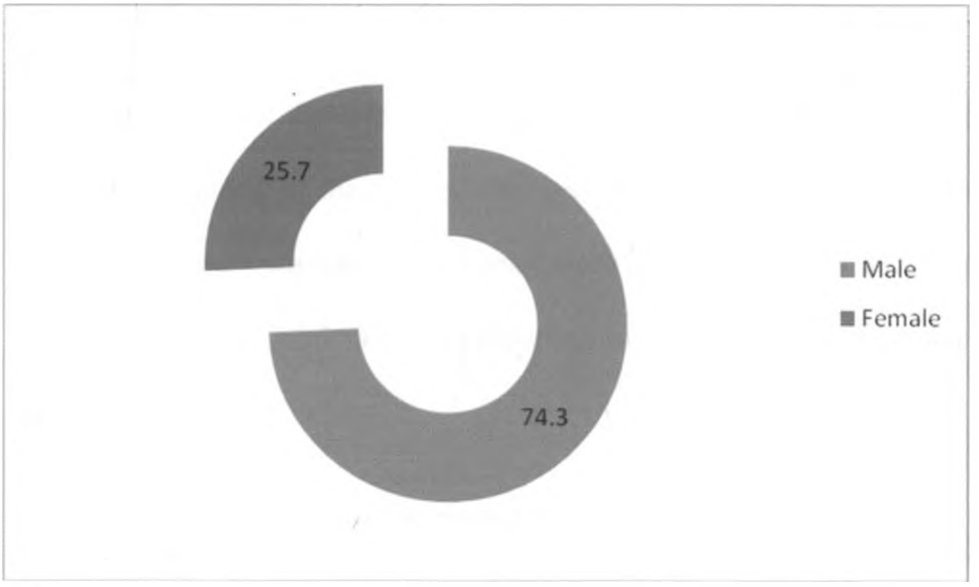


Table 2: Distribution of respondents by Age.

Age Bracket	Frequency	Percentage
20-29	7	20.0
30-39	6	17.1
40-49	12	34.3

50-59	7	20.0
60+	3	8.6
Total	35	100.0

The distribution of the respondents based on age is presented in table 2. As shown in the table, majority of the respondents were between 40-49 years as shown by 34.1%, those aged 20-29 years and 50-59 years were represented by a 20% each, 17.1% were aged 30-39 years, while a small proportion of respondents as indicated by 8.6% were above 60 years old.

Figure 2: Distribution of the respondents by Age

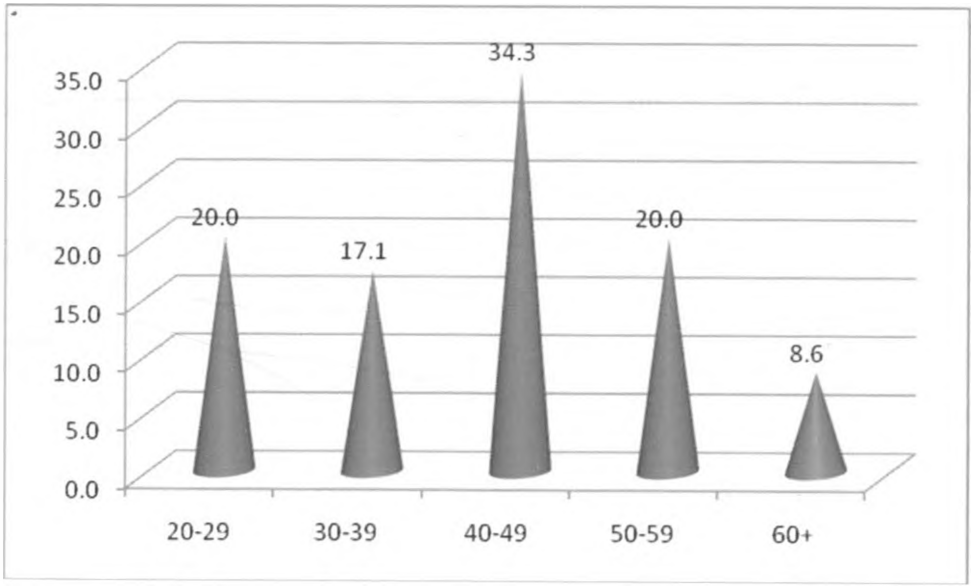


Table 3:Distribution of respondents by level of education

Level of education	Frequency	Percentage
Postgraduate	2	5.7
Degree	22	62.9
Diploma	11	31.4
Total	35	100.0

The study also sought to establish the respondents' highest level of education. According to the findings, the majority of respondents had an undergraduate degree as shown by 62.9% of the respondents, 31.4% had a diploma, while a small proportion of respondents as indicated by 5.7% had a postgraduate degree as their highest level of education. This point towards the fact that majority of the officers had at least first degrees and hence could be in a position to make sound comments on the subject of the study.

Figure 3: Distribution of respondents by level of Education

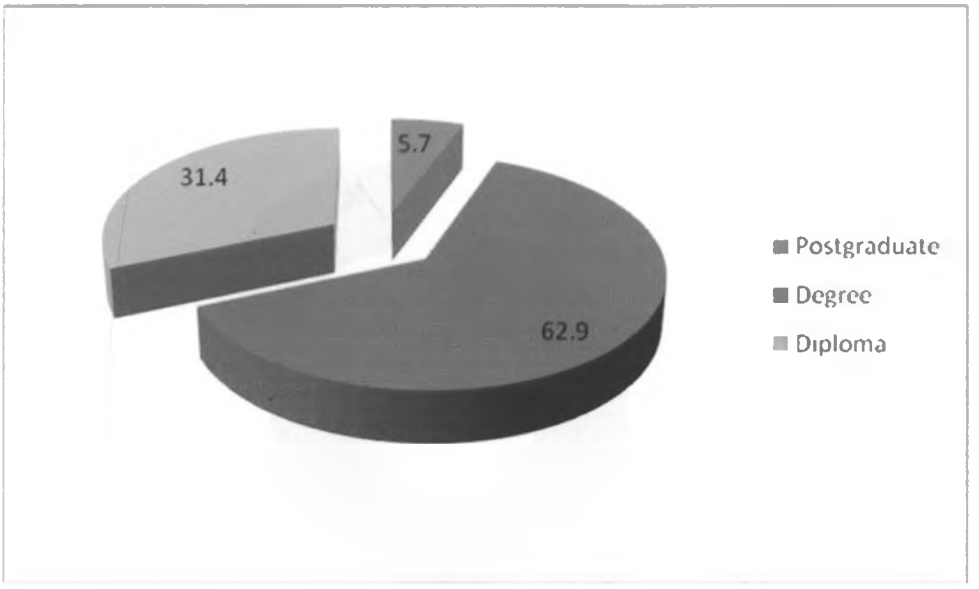


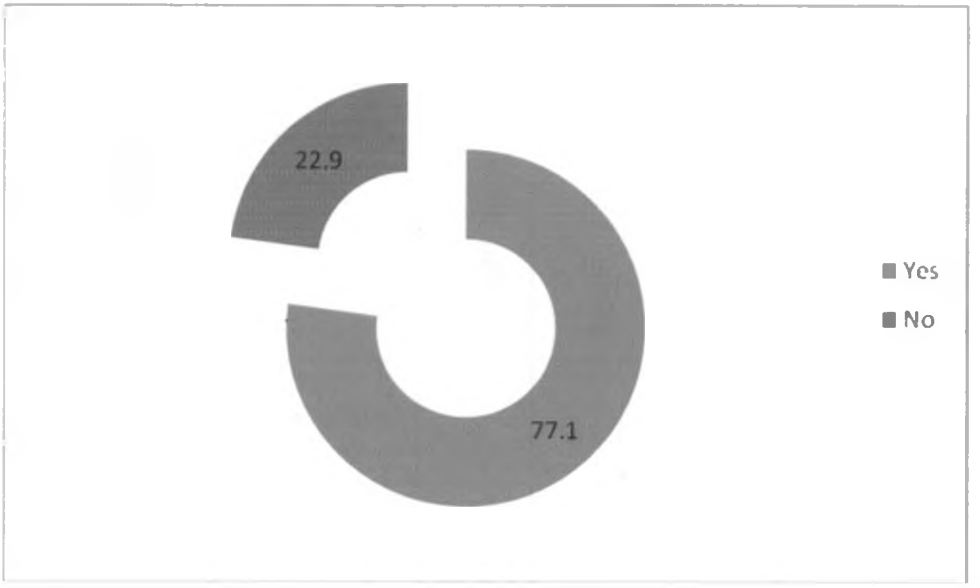
Table 4: Training on HIV/AIDS Management

	Frequency	Percentage
Yes	27	77.1
No	8	22.9
Total	35	100.0

The respondents were also requested to indicate whether they have been trained on HIV/AIDS management. According to the responses given, 77.1% of the respondents were trained in HIV/AIDS management while 22.9% were not but were coordinating

and involved in the workplace programs.

Figure 4: Training on HIV/AIDS Management



The respondents were further requested to state their areas of training. From the findings represented in table 4, it was established that 77.1% of the respondents were trained in comprehensive workplace program (CWPP) management, modes of transmission (MOT), peer education, community mobilization, VCT advocacy, HIV/AIDs prevalence and trends, prevention of mother to child transmission and guidance and counseling.

4.3 HIV/AIDS Management Programmes

Table 5: Contribution of HIV/AIDS programme objectives to the management of HIV/AIDS in the State Corporations under study.

HIV/AIDS PROGRAMME OBJECTIVES	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean	Std. Deviation
Inform employees about HIV/AIDS.	0	85.7	14.3	0	0	1.4429	.35635
Promote behavior change that will reduce the spread.	14.3	42.9	42.9	0	0	2.2857	.71270
Prevent new infections.	0	57.1	14.3	14.3	14.3	2.8571	1.14550
Provide services to reinforce behavior change.	11.3	57.1	28.6	3	0	1.4029	.65060
Offer services to cope with HIV infections.	14.3	71.4	14.3	0	0	2.0000	.54433

Using a five point scale from strongly agree to strongly disagree, the respondents were further asked to indicate their level of agreement or disagreement with the statements

of objectives on the programmes for the management of HIV/AIDS in their corporations. As shown in table 5, majority of the respondents (mean=1.4029) strongly agreed that the objectives that have positively contributed to the management of HIV/AIDS in their corporation were provision of services to reinforce behavior change, informing employees about HIV/AIDS (mean score 1.4429), offering services to cope with HIV infections (mean score 2.0000), promoting behavior change that will reduce the spread (mean score 2.2857) and prevention of new infections (mean score 2.8571). This implies that the main objectives of the programs in the corporations was to reinforce behavior change and to create awareness on the HIV/AIDS with a view to preventing new infections.

Table 6: Extent of application of various workplace HIV/AIDS management programmes.

HIV/AIDS PROGRAMMES	Very great	Great	Moderate	Little	Not at all	Mean	Std. Deviation
Education and awareness	85.7	14.3	0	0	0	1.1429	.35635
Condom promotion and distribution	28.6	42.9	14.3	14.3	0	1.3429	1.00791

Behaviour-change communication (BCC)	57.1	42.9	0	0	0	1.5286	.50395
Treatment, care and support	28.6	42.9	28.6	0	0	2.0000	.76980
Employee support groups	0	85.7	14.3	0	0	2.1429	.35635
Voluntary counseling and testing(VCT)	0	0	28.6	71.4	0	2.4143	.46004
Voluntary medical male circumcision (VMMC)	28.6	42.9	14.3	14.3	0	3.0000	.94281
Post exposure prophylaxis (PEP)	0	42.9	28.6	14.3	14.3	3.0000	1.08866

The study further sought to establish the extent to which various programmes are undertaken by the corporations as part of workplace HIV/AIDS management programmes. From the results in table 6, the programmes undertaken by the corporation as part of the workplace HIV/AIDS management programmes were education and awareness with a mean of 1.1429, Condom promotion and distribution which had a mean of 1.3429 and Behaviour change communication (BCC) with a mean of 1.5286.

It was also established that the programmes undertaken by the corporations as part of workplace HIV/AIDS management programmes were treatment, care and support with a mean of 2.0000, employee support groups which had a mean of 2.1429 and voluntary counseling, testing and support (VCT)with a mean of 2.4143. Further, as shown in table 6, it was established that the programmes undertaken by the corporation as part of workplace HIV/AIDS management programmes were Post exposure prophylaxis(PEP) and voluntary medical male circumcision(VMMC) with a mean of 3.0000 in each case.

Table 7: Rating of the effectiveness of the various programs in the management of HIV/AIDS in the Corporations

HIV/AIDS MANAGEMENT PROGRAMMES	0-25%	26-50%	51-75%	76-100%	Mean	Std. Deviation
Support groups and employee assistance programs	0	42.9	57.1	0	2.0143	0.50395

Voluntary medical male circumcision (VMMC)	14.3	28.6	57.1	0	1.4743	0.92009
Voluntary counseling and testing (VCT)	14.3	71.4	14.3	0	1.8353	.54433
Post-exposure prophylaxis (PEP) as a health and safety measures at workplace in case of exposure.	0	71.4	28.6	0	1.4857	.46004
Prevention of mother to child Transmission (PMTCT)	34.4	23.6	12.6	29.2	1.3620	1.23207

Treatment care and support (medical scheme, provision of Anti-retroviral, referrals and linkages)	18.8	24.0	17.6	39.6	2.7800	1.15857
Behavior change communication (BCC)	0	42.9	28.6	28.6	2.8571	.84828
Education and awareness	42.9	28.6	28.6	0	2.8571	.84828
Condom promotion and distribution	17.0	17.0	13.2	52.8	3.5050	1.12255
Workplace policy implementation	14.3	71.4	14.3	0	3.6429	.84828

The respondents were also requested to rate the effectiveness of HIV/AIDS management programmes in their organizations. The results are presented in table 7. The rating of the program was from least effective to most effective. As shown in the

table, the respondents indicated that the programs for the management of HIV/AIDS in the Corporations were 76-100% effective. These comprised of workplace policy implementation and condom promotion and distribution shown by a mean score of 3.5050 and 3.6429 respectively.

Programmes rate at 51-75% level of effectiveness were treatment, care and support (medical scheme, provision of Anti-retroviral, referrals and linkages) with a mean score of 2.7800, behavior change communication (BCC) and education and awareness with a mean score of 2.8571in each case while those that were 26-50% effective were Voluntary counseling and testing (VCT) shown by a mean score of 1.8353 and support groups and employee assistance programs shown by a mean score of 2.0143. Further, those that were 0-25% effective were prevention of mother to with a mean score of 1.4857.

Table 8: Perceived influence on the Corporation's response to the management of HIV/AIDS

PERCEPTIONS	Very great influence	Great influence	Moderate influence	Little influence	Not at all	Mean	Std. Deviation
HIV/AIDS programmes are expensive	77.6	10.0	1.6	0.2	0.6	1.1288	1.07970
Lack of adequate resources	61.2	16.0	6.2	2.0	0.4	1.3742	1.76168
HIV/AIDS is not a core business activity and the reluctance to have workers participate in HIV/AIDS activities during working hours	42.8	24.8	8.4	1.4	5.4	1.7154	1.52786
HIV/AIDS is a health issue and should be dealt with by health professionals	28.6	42.9	14.3	14.3	0	2.2857	1.30120

Lack of adequate knowledge	14.3	71.4	14.3	0	0	3.1429	.84828
HIV/AIDS matters are too sensitive	42.9	42.9	14.3	0	0	1.7143	.71270

The study sought to establish perceived influences on the Corporation's response to the management of HIV/AIDS. From the findings in table 8, majority of the respondents (1.13 and 1.37) indicated that the major influences on the Corporation's response to the management of HIV/AIDS are perceptions that programs are expensive and lack of adequate resources as shown by a mean score of 1.3742. These were followed by the feeling that HIV/AIDS matters are too sensitive, shown by a mean score of 1.7143, HIV/AIDS is not a core business activity and the reluctance to have workers participate in HIV/AIDS activities during working hours as shown by a mean score of 1.7154 and HIV/AIDS is a health issue that should be dealt with by professionals shown by a mean score of 2.2857, coming least were perceived lack of adequate knowledge on HIV/AIDS shown by a mean score of 3.1429.

On how to improve on the effectiveness of workplace HIV/AIDS management programmes in the corporations, the respondents indicated that there is overwhelming need for top management to be involved in the programs, the need to have a budgetary allocation for the workplace programs and implementation of HIV/AIDS workplace policy, that all the employees should be involved in the programmes, the management should encourage members to participate in the programme and there should be

numerous workshops and seminars on HIV/AIDS management, respectively.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATION

5.1 Introduction

This chapter presents, conclusions as drawn based on research findings in chapter 4 and recommendations as well as conclusions. A summary of the findings on the perceived effectiveness of workplace HIV/ AIDS management programmes in Kenyan state corporations is presented. Based on the findings in chapter four, the study gives recommendations on what Kenyan state corporations should do to improve workplace HIV/ AIDS management programmes. The limitations of the study and suggestion for further research are also presented. From the analysis and data collected, the following discussions, conclusions and recommendations were made. The recommendations were based on the objectives of the study.

5.2 Summary

From the research in the chapter 4, majority of the officers had at least first degrees and hence were in a position to make sound response on the subject of the study. Most of the respondents were trained in HIV/AIDS management. In the areas of community mobilization, VCT advocacy, HIV/AIDs prevalence and trends, prevention of mother to child transmission and guidance and counseling. Though a significant number had no formal training in the subject of study, it was noted that they were involved in the management of the programs and therefore knowledgeable on the subject matter.

The study found that the objectives that have positively contributed to the management of HIV/AIDS in the corporations were provision of services to reinforce behavior change, informing employees about HIV/AIDS, offering services to cope with HIV infections and promoting behavior change with a view to reducing the spread and new infections. It was also clear from the study that the programmes undertaken by the corporation as part of workplace HIV/AIDS management programmes were education and awareness, condom promotion and distribution, Behaviour change communication (BCC), treatment, care and support and employee support groups with post exposure prophylaxis and voluntary medical male circumcision being moderately undertaken.

On the perceived effectiveness of the various programs in the management of HIV/AIDS in the Corporations, it was found that the programs in the management of HIV/AIDS in the Corporations that were very effective comprised of HIV/AIDS workplace policy implementation, condom promotion and distribution, behavior change communication (BCC) and education and awareness and treatment care and support (medical scheme, provision of Anti-retroviral, referrals and linkages).

On the influence of various perceptions on the Corporation's response to the management of HIV/AIDS, it was established that the perceived influence of the Corporation's response to the management of HIV/AIDS which had the greatest influence were HIV/AIDS programmes are expensive and lack of adequate resources. Those that have a great influence were HIV/AIDS matters are too sensitive, HIV/AIDS is not a core business activity and the reluctance to have workers participate in HIV/AIDS activities during working hours and HIV/AIDS being a health issue as

shown by a mean score of 2.2857. Those which had a moderate influence were lack of adequate knowledge on HIV/AIDS.

5.3 Conclusion

Based on the findings, it is concluded that state corporations have integrated HIV/AIDS programs as part of their workplace activities. Most programs initiated were effective. However workplace policy implementation, condom distribution, education and awareness were the most effective programs. This calls for state corporations and the government to put more emphasis on these programs to boost their impact on HIV/AIDS management.

Though VCT was perceived to be effective in the management of HIV/AIDS, the extent to which it was undertaken in most corporations was moderate notably in state corporations with VCT facilities. This implies that there is need for increasing accessibility of VCT sites to most workers. Voluntary medical male circumcision was noted to be undertaken very minimally. This accounts for its perceived effectiveness being moderate. This calls for more awareness and strategic approach on the program for more impact.

The study also concludes that there is inadequate involvement and management support based on the perceptions that HIV/AIDS programs are expensive, lack of adequate resources and the perception that HIV/AIDS is not a core business activity. These perceptions were found to have a great influence on the extent of involvement by management and staff in the programs .This implies that there is still need for the

government, state corporations and stakeholders to review policies and strategies to ensure more involvement of all stakeholders.

The study finally concludes that unless a multisectoral approach is adopted, increased budgetary provision for the programs, and government subsidizing some of the programs, then the effectiveness of the programs initiated to mitigate the impact of the pandemic might take a long time to be realized

5.4 Recommendations

From the study findings, it is recommended that to improve on the effectiveness of workplace HIV/AIDS management programs in the Corporations, there is need for state corporations and the government to have program focus through top management involvement, implementation of workplace policy, to commit and allocate adequate resources in HIV/AIDS prevention programs embrace strategies of reinforcing the programs to enhance maximum impact. Finally, there should be continuous education and awareness programs, accessibility to VCT facilities and involvement of workers at all levels in the management of the programs.

5.5 Areas of Further Research

HIV/AIDS programs have been adopted by most workplaces in all sectors however, the impact of HIV pandemic continues to be felt and new issues on infection prevalence are emerging among various groups. The study only focused on state corporations and did not look into other sectors. The study therefore recommends that further research be done on the perceived effectiveness of workplace HIV/AIDS management programmes

in sectors other than the state corporation such as in the private sector and non-governmental organizations (NGOs).

5.6 limitations of the study

The study was limited to Kenyan state corporations. Inclusion of other firms in the private sector may have enriched the study and its findings but it was not possible to include them as this would have resulted in a different group of study unit. Collecting data from state corporations outside Nairobi was challenging due to slow response. Though the questionnaire was sent by email, a follow up was done by calling severally.

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Appendices

Appendix I: Questionnaire

The purpose of this questionnaire is to establish the perceived effectiveness of workplace HIV/AIDS management programs in the state corporations in Kenya. Kindly fill the questionnaire as appropriate.

SECTION A: GENERAL INFORMATION.

I. Name of Corporation ----------

II. Contact Person*----------Designation----------

III. Gender(Male/Female)----------

IV. Age Group: 20-29 [ ] 30-39 [ ] 40-49 [ ] 50-59 [ ] 60+ [ ]

V. Level of Education (choose the highest level attained).Please tick.

Postgraduate	[ ]
Degree	[ ]
Diploma	[ ]
Others(pleasespecify)	[ ]

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VI. Are you trained in HIV/AIDS management? [Yes] [No] If yes please state the areas of training----------

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*contact person in the research is one with the ability /capacity to provide information on the subject of study

SECTION B

1. To what extent do you agree that the following objectives have positively contributed to the management of HIV/AIDS in your Corporation?

(Please tick as appropriate)

Program Objectives	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
Inform employees about HIV/AIDS.					
Promote behavior change that will reduce the spread.					
Prevent new infections.					
Provide services to reinforce behavior change.					

Offer services to cope with HIV infections.					

2. To what extent are the following programmes undertaken by your Corporation as part of workplace HIV/AIDS management programmes?

HIV/AIDS Programs	Very great	Great	Moderate	Little	Not at all
Education and awareness					
Behaviour change communication(BCC)					
Condom promotion and distribution					
Voluntary counseling, testing and support(VCT)					
Treatment, care and support					
Behaviour change communication(BCC)					

Post-exposure prophylaxis(PEP)					
Employee support groups					
Voluntary medical Male circumcision(VMMC)					

3. Please rate the effectiveness of the following programs in the management of HIV/AIDS in your Corporation.

HIV/AIDS Programs	0-25%	26-50%	51-75%	76-100%
Workplace policy implementation				
Behavior change communication(BCC)				
Education and awareness				
Support groups and employee assistance programs				

Condom promotion and distribution				
Voluntary counseling and testing (VCT)				
Treatment care and support (medical scheme, provision of Anti-retroviral, referrals and linkages)				
Post exposure prophylaxis (PEP) as a health and safety measure at workplace in case of exposure through injury, sexual abuse. Etc				
Prevention of mother to child Transmission (PMTCT)				
Voluntary medical male circumcision(VMMC)				

4. What influence have the following perceptions had on your Corporation's response to the management of HIV/AIDS?

Perceptions	Very great influence	Great influence	Moderate influence	Little influence	Not at all
HIV/AIDS programmes are expensive					
HIV/AIDS is a health issue and should therefore be dealt with by health professionals					
HIV/AIDS is not a core business activity and the reluctance to have workers participate in HIV/AIDS activities during working hours.					
Lack of resources					
Lack of adequate knowledge on HIV/AIDS					
HIV/AIDS matters are too sensitive					

5. Please make recommendations on how to improve on the effectiveness of workplace HIV/AIDS management programmes in your corporation

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Thank you for your candid input and time.

Appendix II: List of State Corporations in Kenya

1. Agricultural Development Corporation
2. Agricultural Finance Corporation
3. Agro-Chemical & Food Company Ltd
4. Athi Water Services Board
5. Bomas of Kenya Ltd
6. Capital Markets Authority
7. Catchment Area Advisory Committee
8. Catering Tourism and Training Development Levy Trustees
9. Central Water Services Board
10. Chemilil Sugar Company Limited
11. Coast Development Authority
12. Coast Water Services Board
13. Coffee Board Of Kenya
14. Coffee Research Foundation
15. Coffee Development Fund
16. Commission for Higher Education
17. Communication Commission of Kenya
18. Consolidated Bank of Kenya
19. Cooperative College of Kenya
20. Council for Legal Education
21. Deposit Protection Fund Board
22. East African Portland Cement Co.
23. Egerton University
24. Ewaso Ng'iro South Development Authority
25. Export Processing Zone Authority
26. Export Promotion Council
27. Gilgil Telecommunications industries
28. Higher Education Loans Board
29. Horticultural Crops Development Authority

30. Industrial and Commercial Development Corporation
31. Industrial Development Bank
32. Investment Promotion Centre
33. Jomo Kenyatta University of Agriculture and Technology
34. Jomo Kenyatta Foundation
35. KASNEB- Kenya Accountants and Secretaries National Examinations Board
36. Kenya Agricultural Research Institute
37. Kenya Airports Authority
38. Kenya Anti-Corruption Commission
39. Kenya Broadcasting Corporation
40. Kenya Bureau of Standards
41. Kenya Bureau of Standards (KEBS)
42. Kenya Civil Aviation Authority
43. Kenya Coconut Development Authority
44. Kenya College of Communication & Technology
45. Kenya College of Communications Technology
46. Kenya Dairy Board
47. Kenya Electricity Generating Company
48. Kenya Ferry Services Limited
49. Kenya Forestry Research Institute
50. Kenya Industrial Estates
51. Kenya Industrial Property Institute
52. Kenya Industrial Research & Development Institute
53. Kenya Institute Of Administration
54. Kenya Institute of Public Policy Research and Analysis
55. Kenya Literature Bureau
56. Kenya Marine & Fisheries Research Institute
57. Kenya Maritime Authority
58. Kenya Meat Commission
59. Kenya National Assurance Company
60. Kenya National Bureau of Statistics

61. Kenya National Examination Council
62. Kenya National Library Service
63. Kenya National Shipping Line
64. Kenya National Trading Corporation Limited
65. Kenya Ordinance Factories Corporation
66. Kenya Pipeline Company Ltd
67. Kenya Plant Health Inspectorate Services
68. Kenya Ports Authority
69. Kenya Post Office Savings Bank
70. Kenya Railways Corporation
71. Kenya Re-insurance Corporation
72. Kenya Revenue Authority
73. Kenya Roads Board
74. Kenya Safari Lodges & Hotels
75. Kenya Seed Company Ltd
76. Kenya Sisal Board
77. Kenya Sugar Board
78. Kenya Sugar Research Foundation
79. Kenya Tourist Board
80. Kenya Tourist Development Corporation
81. Kenya Utalii College
82. Kenya Water Institute
83. Kenya Wildlife Service
84. Kenya Wine Agencies Limited
85. Kenyatta International Conference Centre
86. Kenyatta University
87. Kerio Valley Development Authority
88. Lake Basin Development Authority
89. Lake Victoria South Water Service Board
90. Local Authority Provident Fund
91. Maseno university

92. Moi University
93. National Aids Control Council
94. National Bank of Kenya
95. National Cereals and Produce Board
96. National Council for Law Reporting
97. National Environmental Management Authority
98. National Hospital Insurance Fund
99. National Housing Corporation
100. National Irrigation Board
101. National Museums of Kenya
102. National Oil Corporation of Kenya Ltd
103. National Social Security Fund(NSSF)
104. National Water Conservation and Pipeline Corporation
105. National Co-coordinating Agency for Population and Development
106. New K.C.C -New Kenya Co-operative Creameries
107. NGO's Co-ordination Bureau
108. Numerical Machining Complex
109. Nyayo Tea Zones Development Corporation
110. Nzoia Sugar Company
111. Pest Control Products Board
112. Postal Corporation of Kenya
113. Pyrethrum Board of Kenya
114. Retirement Benefits Authority
115. Rift Valley Water Services Board
116. School Equipment Production Unit
117. South Nyanza Sugar Company
118. Sports Stadia Management Board
119. Tana and Athi Rivers Development Authority
120. Tina Water Services Board
121. Tea Board Of Kenya
122. Tea Research Foundation Of Kenya

123. Teachers Service Commission
124. Telkom (k) Ltd
125. University of Nairobi
126. Water Resources Management Authority
127. Water Services Regulatory Board