

UNIVERSITY OF NAIROBI

M.A PROJECT REPORT

**THE CHALLENGES HUMAN RESOURCE MANAGERS
ENCOUNTER IN THE IMPLEMENTATION OF HIV/AIDS
POLICY AT THE WORKPLACE.**

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M.A: LABOUR MANAGEMENT RELATIONS.

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DECLARATION

This project is my original work and has not been presented for examination in any other University.


8/11/07

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This project has been submitted for examination with our approval as University Supervisors:


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DEDICATION

This project is dedicated to all men and women who have died due to HIV/AIDS. Our prayer is that a cure to be found soon.

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In the process of researching and writing this project, there are certain people that have immensely contributed towards the final product.

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I may not remember all of you who helped me one way or another, but I pray that the Lord will reward you all.

ABSTRACT

This study sought to establish the challenges Human Resources Managers encounter in the process of implementing the HIV/AIDS policy at work place and also the challenges the staff encounter in the same implementation of the HIV/AIDS policy.

The study was interested in finding out how much information is available to both the managers and the staff as concerned the HIV/AIDS policy in their respective work place.

It was also interested in finding out how best equipped the policy is and how effective it is in combating the issues of HIV/AIDS at work place for both the affected and infected staff.

The study sought to finding out if the organizations have followed the Government's directive of formulating the HIV/AIDS policy and how well are the organizational issues articulated in the policies.

From the available literature it is clear that AIDS is one of the worlds leading killer disease and a concern of all nations both developing and developed. Over 42m People in the world were living with AIDS by end of the 2005. (*UNDP Report August 2006*)

It is not only in Kenya where HIV/AIDS have affected the work place but all over the world. HIV/AIDS is the single biggest threat to the

development of education and other sectors of life in Africa if not the world over. (Daily Nation 13/10/2007)

AIDS is not only a medical problem but also a socio-economic problem that affects the very livelihood of mankind. That is why the study chose to establish what happens at the work place where the economic gain is high and the infection rate too i.e. the age bracket of 15 – 49, which is seriously affected.

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ACRONYMS

ADA	-	Americans with Disability Act
AIDS	-	Acquired Immune Deficiency Syndrome
ART	-	Ant-Retroviral Therapy
ARV	-	Anti-Retroviral
CEO	-	Chief Executive Officer
CIA	-	Central Intelligence Agency
COTU	-	Central organization of Trade Union
ECK	-	Electoral Commission of Kenya
FKE	-	Federation of Kenya Employers
HBC	-	Home Based Care
HIV	-	Human Immune Deficiency Virus
HR	-	Human Resources
ILO	-	International Labour Organization
IPR	-	Institute of Primate Research
KAVI	-	Kenya AIDS Vaccine Initiative
KENWA	-	Kenya Network of women with AIDS
KHBC	-	Kenya HIV Business Council
MDR	-	Multi-Drug Resistance
NACC	-	National AIDS Control Council
NGO	-	Non-Governmental Organization
NSSF	-	National Social Security Fund
PEPFAR	-	President's Emergency Plan for AIDS Relief
SCVP	-	Special Cancer Virus Programme
SIV	-	Simian Immunodeficiency Virus
UNAIDS	-	United Nations Programme on HIV/AIDS

- UNDP - United Nations Development Programme
- UNICEF - United Nations Children Fund
- UON - University of Nairobi
- USA - United States of America
- VCT - Voluntary Counseling and Testing
- WHO - World Health Organization
- WOFAK - Women Fighting AIDS in Kenya

CHAPTER ONE

1.1 INTRODUCTION

HIV stands for Human Immunodeficiency Virus. This is the Virus that causes AIDS. AIDS stands for Acquired Immune Deficiency Syndrome. This virus destroys the human (defense) system, making the body vulnerable to other infections. When the virus enters the body, it binds itself to specific defense cells and destroys them. This makes the body too weak to defend itself against infections that the body normally resists. The virus knows no gender, age, race, or religion. It can attack anyone. Some of those who transmit it do it unawares of their status.

It is acquired because it is not inherited. A syndrome is a group of clinical signs and symptoms denoting a disease, in this case the collection of signs and symptoms resulting from lowered immunity due to HIV. As the virus multiplies and immune cells are destroyed, many infections and complications occur. These infections are referred to as opportunistic infections. AIDS may occur 3 – 10 years after HIV infection.

The HIV virus is spread through sexual intercourse, blood transfusion, sharing of skin piercing instruments like needles and from mother to child during birth or breastfeeding. (NACC 2004)

AIDS was first discovered in the USA in 1981. Since then, over 20 million people have lost their lives through HIV/AIDS related complications. By the end of 2002, adult and children estimated to be living with HIV/AIDS was 42 million and distributed as follows:

15,000	-	Australia and New Zealand
550,000	-	North Africa and the Middle East
570,000	-	Western Europe and Central Asia
980,000	-	North America
1,200,000	-	Eastern Europe and Central Asia
1,200,000	-	East Asia and Pacific
1,500,000	-	Latin America
6,000,000	-	South and South East Asia
29,400,000	-	Sub-Saharan Africa

Source: *UNAIDS, 2003*

By the year 2000, it was estimated that 17 million Africans had died of the epidemics and it was estimated that there were 12 million AIDS orphans in Africa. (*Wilis, 2002*). Estimates for 2005 infections were as follows:

North America	-	43,000
Caribbean	-	30,000
Latin America	-	200,000
Eastern Europe & Central Asia	-	270,000
East Asia	-	140,000
South & South East Asia	-	990,000
Oceanic	-	8,200
Western & Central Europe	-	22,000
North Africa & Middle East	-	67,000
Sub-Sahara Africa	-	3,200,000
Total	-	4,900,000

Source: *UNAID 2005*

The truth of the matter and from the above figures, it's evident that AIDS is an international problem, but Africa especially Sub-Saharan Africa has been hit the most.

In Kenya, AIDS was first detected in 1984 but it was not until 1999 that it was declared a National Disaster. During the period of 15 years of silence from 1984 to 1999, the epidemic took its toll among the Kenya Citizen with majority of the deaths affecting the youth and active labour force of our Nation. Despite the information and HIV/AIDS awareness campaign, over 2.5 million Kenyans are living with the virus, 1.3 million orphans have been identified and 700 Kenyans die daily from complications and infections related to HIV/AIDS. The cumulative death toll is 1.7 million. (NACC 2002)

Since the virus takes between 3-10 years before it develops into full blown AIDS, people who are HIV positive can spread the virus to many people before it is detected. The spread of the virus has been attributed to urbanization and poverty. In order to reduce the rate of infections and deaths, it is very important to target the sexually active group of people who are between the age bracket of 15 – 49 and who form the main labour force in the Nation.

1.2 PROBLEM STATEMENT

HIV/AIDS is a Labour issue that is not only affecting workers on the job but also causes a major drain on family savings and resources. Just as organizations experience increased expenses due to HIV/AIDS, so too do households when members are ill with HIV/AIDS. One outcome of this is

loss of wages as a person becomes too sick to work. Another outcome is an increase in medical expenses to treat conditions associated with the infection. Caring for a sick family member disrupts the work schedules of others both at organization and household hence limiting income.

Labour unions and other workers organizations have collaborated with employers to ensure that HIV/AIDS policies and programs are part of the work environment. One of the leading concerns of workers' organizations is protecting employees from discrimination, unfair, and unwarranted dismissal or denial of benefits because they are (or are believed to be) HIV positive. Therefore the aim of this study is to investigate how organizations craft policies and procedures that protect the HIV/Aids employees against unfair work practices.

ILO conventions of 1970 and 1975 and the Employment Act Cap 226 prohibit against discrimination of employees based on sex, race, and religion or health status. However, it has been reported that some employees suffer some form of official discrimination, though the extent and the nature of the discrimination and the form it takes is not very clear hence the focus of this study.

Social partners i.e. workers, employers and government may not always agree on all aspects of Labour including HIV/AIDS policies. However numerous issues of common interest have draw both sides together especially HIV/AIDS phenomenon which has drawn all the partners to negotiations on how to handle HIV/Aids positive employees. For example in Kenya there is a common understanding between government, union

(COTU) and employers (FKE) on how to handle HIV/AIDS employees. All agree that discrimination on that basis is an affront on Labour rights but also on the human rights hence Labour rights are human rights.

There has been a tremendous response by the tripartite partners on HIV/AIDS related issues on employment. Today most organizations have HIV/AIDS policies in place, which are observed by all employees. However, what is not clear, and which this study intends to investigate is how such policies are disseminated to the workers, their implementation and whether they keep changing, and in what aspects over time. Further the study is designed to investigate the nature of ongoing organizational support for responsible sexual behaviour among its employees. For example, what facilities do organizations provide in this respect? Are they upgraded or maintained or replenished over time.

While HIV/AIDS in the work place is generally understood it is not absolutely clear how organizations identify local resources especially in terms of information to inform the policy. For instance it is not clear what role technical experts, health and social service authorities, media, HIV/AIDS control programmes and other organizations contribute in designing an appropriate organization HIV/AIDS Policy. Therefore this study will emphasize on the level and forms of co-operation between the organization and other external groups. The study aims to find out HIV/AIDS employees perception of the organization HIV/AIDS policy and its appropriateness to their needs. For example are employees aware of its existence? Do they find it wholly relevant? Does it address their concerns?

Other researchers have adequately done the study of HIV/AIDS as a phenomenon. But most studies seem to focus on awareness creation, prevention, impact, VCT, traditional culture and HIV etc. For example, Nderitu (2004) studied men's perception of their own risk exposure to HIV/AIDS infection and responsive behaviour while Ireri (2005) in a study of Kibera slum focused on the perception of people living with HIV/AIDS on community Home Based Care. Kiragu (2004) studied communication patterns on HIV/AIDS issues among Adolescent in Nairobi Secondary Schools but Makokha (2004) focused on strategies for coping with An HIV Positive Status. However, there seems to be less effort in the area of HIV/AIDS at workplace hence this study is designed to investigate the experience of workers and HIV/AIDS positive employees at the work place with emphasis on the perception of managers of the same.

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In Kenya today and the world over, it is a standard practice and a requirement of most organizations to develop an HIV/AIDS policy in place authorizing how to react to, and treat HIV/AIDS positive staff. This was after a revelation that initially many of them were sacked for being positive. Consequently, many organizations tasked their Human Resources Managers to develop an organizational policy framework on how to deal with such workers. Hence the study investigates the experience of the managers on the process of developing the HIV/AIDS policy as well as the contents of the policies. The study also intends to compare these policies from different organizations.

Today many such policies do exist. The aim of the study therefore is to find out the contents of these policies and compare from different organizations especially on issues of their divergence and convergence.

1.3 OBJECTIVES OF THE STUDY

General Objective

Find out the existence and relevance of HIV/AIDS policies in workplaces in Kenya.

Specific Objectives

- i) Examine the contents of the HIV/AIDS policies in the organizations.
- ii) Find out the perspectives employees on the HIV/AIDS policy.
- iii) Find out the awareness levels of the workers on the existence of the policy in the respective organizations.
- iv) Find out the experiences managers go through in developing the policies.

1.4 JUSTIFICATION OF THE STUDY

AIDS is one of the worst challenges human beings have faced in the recent days. The rate of infection and deaths in Africa is scary and disturbing. AIDS has reduced the life expectancy in Kenya and subjected families to abject poverty and reversed all the gains of economic development. The workplace is the most important resource of any nation and anything that threatens the active workforce, affects the very existence of the society. It also seeks to generally assess the implementation of the existing policies and how successful they have

been. It has been declared a national disaster and a rising proportion of the national income is today going towards handling HIV/AIDS related cases hence it is of national importance/concern.

1.5 THE SCOPE OF THE STUDY

Assess the levels of the discrimination and implementation of HIV/AIDS policy at workplace.

- Find out if there are any changes or adjustments in those policies.
- Find out if there are any organizational support facilities given to the employees within the organization.
- Assess the role of technical experts/social service authorities such as the Ministry of Health in the formulation of the HIV/AIDS policies at workplace.
- Assess the forms of corporation and experiences of the Human Resource Managers in the implementation of the policy.
- Assess the contents of the HIV/AIDS policies in regard to the employees that are both affected and infected.

CHAPTER TWO

2.1 HISTORICAL BACKGROUND OF HIV/AIDS

The origin of AIDS and HIV has puzzled scientists ever since the illness first came to light in the early 1980s. For over twenty (20) years HIV has been the subject of fierce debate and the cause of counter arguments with everything from a promiscuous flight attendant to a suspect vaccine programme being blamed. So where did AIDS come from?

The first recognized cases of AIDS occurred in the USA in the early 1980s. Five gay men in New York and San Francisco suddenly began to develop rare opportunistic infections and cancers that seemed stubbornly resistant to any treatment. At this time AIDS did not have a name but it quickly became obvious that all the men were suffering from a common syndrome. The discovery of HIV, the virus that causes AIDS was made in 1982.

HIV is a lent virus and like all viruses of this type it attacks the immune system. Lent viruses are part of a large group of viruses known as retroviruses' the name literary means "slow virus" because they take such a long time to produce any adverse effects in the body. They have been found in a number of animal including cats, sheep, horses and cattle.

However, the most interesting lent virus in terms of the investigation into the origin of HIV is the Simian Immunodeficiency Virus (SIV) that affects monkeys. Thus certain strains of SIV bear a close resemblance to HIV – 1 and HIV – 2. HIV – 2 strains were found in Sooty Mangabey also known

as green monkey in West Africa. HIV – 1 strain were found in chimpanzees in the Democratic Republic of Congo.

2.2. THEORIES OF THE ORIGIN OF HIV/AIDS

However, there are many theories that explain how these viruses entered into the body of a human being.

2.2.1 “The hunters’ theory”.

It is believed that chimps were killed and their meat eaten or their blood getting into the cuts or wounds of the hunter. This theory is trying to portray the fact that HIV/AIDS virus was first discovered in Africa among the hunters in the Congo forest. Thus because the virus is transmitted through the blood raw meat eating could result into infection. At times because the hunters used crude weapons the chances of hurting themselves while in the business could be high resulting in the open wounds which when they came into contact with the blood of the Chimps it could result into infections.

2.2.2 “The oral Polio Vaccine”

According to Edward Hooper a journalist who wrote the book entitled the ‘River’, says AIDS must have been caused by an oral Polio Vaccine called “chat” given to about a million people in the Belgian Congo, Rwanda and Burundi in the late 1950.

To be produced, live polio vaccine need to be cultivated in living tissue and Hooper believes that “chat” was grown in kidney cells taken from local chimps infected with SIV. Then when the same cells were now

injected in human beings it caused infection of what came to be known as AIDS.

2.2.3 The “Contaminated needle theory”.

In the 1950s the use of non-disposable plastic syringes became commonplace around the world as a cheap sterile way to administer medicines. Contaminated needles were used on all people without knowledge of their status, which could have caused the spread.

2.2.4 The “Colonialism theory” or “heart of darkness theory”

Jim Moore first proposed this theory in 2000. He was an American specialist in primate behaviour. He said that during the 19th and early 20th centuries much of Africa was ruled by colonial powers who forced African into camps where sanitation was poor, food scarce and physical demands extreme. He says that besides these extraneous factors, they (Africans) might also have been exposed to chimps' meat as a result of scarce food. He says that many of them (labourers) might also have been inoculated with un-sterile needles against diseases such as small pox in order to keep them alive and working, and that many of the camps had employed prostitute to keep the workers happy, creating numerous possibilities for onward transmission.

2.2.5 The Smallpox theory

The proponents of the Smallpox theory believe the virus was spread over the whole world through the smallpox inoculation program or to gay men through Hepatitis B vaccine trials. This is thought to be so because smallpox had literally affected the whole world so the management of it

could have been used as a way to create this ugly situation in the world today

2.2.6 “The conspiracy theory”

Some people say HIV is a “man made”. They believe that this is part of a biological warfare programme designed to wipe out large numbers of blacks and homosexuals.

Many believe this was done under the auspices of the USA Federal Special Cancer Virus Program” (SCVP) possibly with the help of Central intelligence Agency (CIA).

That besides the many theories and none is convincing enough as to the origin, the mystery of HIV/AIDS still remains

2.3 THE ORIGIN OF THE VIRUS

In a study of the blood or the Plasma sample to determine the earliest known instances of HIV infection. The following was established:

- (i) A plasma sample taken in 1959 of an adult male living in what is now the Democratic Republic of Congo was found to have the HIV virus.
- (ii) HIV found in tissues sample from an American teenager who died in St Louis in 1969.
- (iii) HIV found in tissue samples from a Norwegian Sailor who died around 1976.

- (iv) HIV found in people living around Lake Victoria in Uganda around 1971 (Here they referred to the disease as thread and it was through sexual contact).

A 1998 analysis of the plasma sample from 1959 has suggested that HIV 1 was introduced into human beings around the 1940s or the early 1950. Other scientists have dated the sample to an even earlier period, perhaps as far back as the end of the 19th century.

Korber of Los Alamos National Laboratory, at the 7th conference on Retroviruses and opportunistic diseases suggested that the first case of HIV 1 infection occurred around 1930 in West Africa.

Also studying the different HIV subtypes a group of Belgian researchers led by Vanda -me concluded that HIV 1 subtype A had passed into human beings, around 1940 and subtype B in 1945. Her team also discovered that the virus originated in Guinea-Bissau and that its spread was mostly likely precipitated by the independence war that took place in the country from 1963 – 1974 (Guinea Bissau was former colony of Portugal). Her theory is backed up by the fact that the first European cases of HIV-2 were discovered among Portuguese veterans of the war many of who had received blood transfusion or un-sterile injections following all the possibilities of frequenting local prostitutes.

The question of where the disease first came from has been a thorny one and many scientists feel it's just as we do not know exactly who spread

the virus from Cameroon to Kinshasa, how the virus spread from Africa to America and beyond remains a mystery as well.

It is quite possible that separate pockets of the virus could have been developing in a number of different countries years before the first cases were officially identified, making it virtually impossible to trace one single source.

2.4 HOW THE DISEASE HAS SPREAD

2.4.1 Travel

Both national and international travel undoubtedly had a major role in the initial spread of HIV in the USA. International travel and young men making the most of the gay sexual revolution of the late 1970s and early 80s would certainly have played a large part in taking the virus in Africa. The virus would probably have been spread along truck routes and between towns and cities within the continent itself.

However, it is quite conceivable that some early outbreaks in African nations were not started by Africans infected with the original Virus at all, but by people visiting from overseas where the epidemic had been growing too. The process of transmission is a global pandemic and simply too complex to blame or any one group of individual.

These were scaremongers of Gaetan Dugas or patient zero who is said to have spread the disease through air travel. Gay men to a large degree initially spread HIV in the US.

2.4.2 The Blood Industry

In the US blood donors were paid to give blood, a policy that often attracted those most desperate for cash, among them intravenous drug users. In the early stages of the epidemic, Doctors were unaware of how easily HIV could be spread and blood donations remained unscreened. This blood was then sent worldwide, and unfortunately most people who received infected donations went on to become HIV positive themselves.

In the late 1960s, hemophiliacs also began to benefit from the blood clotting properties of a product called factor viii. However, to produce the coagulant, blood from hundreds of individual donors had to be pooled; this meant that a single donation of HIV positive blood could contaminate a huge batch of Factor viii. This puts thousands of hemophiliacs all over the world at risk of HIV, and many subsequently contracted the virus.

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2.4.3 Drugs

The 1970s saw an increase in the availability of heroin following the Vietnam War and other conflicts in the Middle East, which helped stimulate a growth in intravenous drug use. This increased availability and together with the development of disposable plastic syringes and the establishment of "shooting galleries" where people could buy drugs and rent equipment, proved another route through which the virus could be passed on.

It is likely that we will never know exactly how or when AIDS actually originated. Scientists investigating the possibilities often become very attached to their individual "per theories" and insist that theirs is the only

true answer, but the spread of AIDS could quite conceivably have been induced by a combination of many different events and factor. Whether through injections, travel, war, colonial practice or generic engineering, the realities of the 20th century have undoubtedly had a major role to play. So perhaps what we should be focusing on now is not how AIDS epidemic originated, but how we can treat those affected by it; continue to prevent the spread of HIV and charge our world to ensure a similar pandemic is never allowed to occur again.

2.5 HIV/AIDS IN AFRICA

At the continental level the countries hard hit are those found south of the Sahara. HIV prevalence rate greatly vary from country to country. In Somalia and Senegal the prevalence is under 1% of the adult population, whereas in South Africa and Zambia around 15-20 % of adults are infected.

In four South African Countries, the national adult HIV prevalence rate has risen higher than was thought possible and now exceeds 20%. These countries are Botswana, (24.1%), Lesotho (23.2%), Swaziland (33.4%) and Zimbabwe (20.1%).

West African has been less affected, but the prevalence rate in some countries is creeping up. In Cameroon the rate is estimated to be (5.4%), Cote d'Ivoire (7.1%) and Gabon (7.9%).

Until recently the national prevalence has remained low in Nigeria. It has grown slowly from below 2% in 1993 to 3.9 in 2005. About 2.9 million Nigeria are estimated to be living with HIV. *UNAIDS 2006 Report*

Adult HIV prevalence in East Africa exceeds 6%, in Uganda Kenya and Tanzania. Kenya and Zimbabwe have recorded a prevalence decline in the recent years. In Kenya the prevalence rate reduced from 14% in the 1990s to 7% in 2004 and now 5.1 in 2006. This is attributed to vigorous HIV/AIDS campaigns, free testing and counseling facilities the change of behaviour and attitude among the youth. Their slogan is "we must chill". This has reduced the rate of new infections. The prevalence rate in Uganda fell from 15% in early 1990s to around 5% in 2001. This has been a wonder story, which was initiated by President Yoweri Museveni when he declared AIDS a national disaster and allowed the use of condom irrespective of the religious demands. There has been an intensive HIV prevention campaign.

The prevalence rates in South Africa, Mozambique and Swaziland continue to grow. This has mainly been attributed to poor moral standards and poor attitude change. *UNAID S2006 Report*

Condoms play a key role in the prevention of HIV/AIDS infections around the whole world. In Sub-Saharan Africa most countries have seen an increase in condom use in the recent years. A study carried out between 2001- 2005 revealed that 8 out of 11 countries in Sub Saharan Africa reported an increase in condom use.

The distribution of condoms in Sub-Saharan Africa increased in 2004 e.g. 10 condoms per man unlike 4-6 condoms per one in 2001. For example in Uganda , between 120 and 150 million condoms are required annually yet only less than 40 million were distributed in 2005. *UNAIDS 2006 Report*.

The reduction in prevalence rate could be attributed also to the availability of the provision of VCT, prevention of Mother to child transmission at birth and the availability of antiretroviral drugs to all those in need as a NEPAD Millennium Development Goal. The Antiretroviral drugs (ARVS) have played a major role in sustaining the lives of those infected. They have been available in developed countries since 1996.

In Africa, Botswana pioneered the provision of ARVS having started the program in January 2002. By September 2003 the programme was providing treatment to around 54,378 people living with HIV. According to World Health Organization about 85% of those in need of treatment were receiving it by the end of 2005.

Some African countries have made advances in the same direction though the Botswana success has not been replicated. These include Uganda where more than half of those in need of treatment are receiving ARVS. In Malawi, Cameroon, Kenya, Cote d Ivoire, and Zambia between 17% and 27% were receiving treatment by the end of 2005.

South Africa though the richest in Sub Saharan Africa has not performed very well because the government has been slow on this and only 215 of

that in need are receiving treatment. In other countries such as Ethiopia, Nigeria, Tanzania, Ghana, Mozambique, and Zimbabwe, the figure of those receiving ARVS is less than 10%.

World Health Organization (WHO) has stated that besides the ARVS there is need for other form of treatment which include; voluntary counseling and testing, management of nutritional effects, follow up counseling, protection from stigma / discrimination and treatment of other sexually transmitted disease, and the prevention and treatment of opportunistic infections.

In 2003, World Health Organization (WHO) initiated "3 by 5" programs, which aimed at having 3 million people in developing countries on ARVS by the end of. 2005. Though the target not achieved but a milestone has been made by some of these countries. The latest international target is "All by 2010" This is aiming at universal accesses to treatment for all by 2010. *UNAIDS August 2006 Report*

Global Fund has funded many countries in Africa and so is PEPFAR (President's Emergency Plan for AIDS Relief.) This year Kenya has been one of the greatest beneficiaries to this by receiving 25 billion from PEPFAR. This figure has been boosted by about 11.1 million over last years figure. This is because the Kenyan programmes have been deemed very successful. *Daily Nation June 8th, 2007*

These will enhance the chances of survival and prolong employment for those affected by the disease.

2.6 THE KENYAN SITUATION

When the first few cases of a strange new ailment were reported in the USA in 1981, no one imagined the potential impact this could have on the society. In just a decade, the element however had developed into the most serious public-health crisis of modern times (Verne 1995).

In Kenya the policy makers and the press described the disease as “a disease of the westerners” especially gay men. Since similar risk groups did not exist in the country, it was assumed that HIV would only spread within a small population. When discussed in the press it was usually sensationalized. For example in 1985 the standard Newspapers headlines referred to it as the “killer disease in Kenya and the “Horror sex disease of Kakamega Forest”.

In response the Government created National AIDS Council. The Council lacked authority and resources to develop awareness and prevention efforts. The Council held no meetings until 1987 when it held its first meeting.

The disease was also politicized in that the other ministries left the responsibility of managing it to the Ministry of Health. All others viewed it as a disease just like any other. The policy makers hesitated to discuss Aids because of the harmful impact such discussions might have on tourism. It was not easy for the Ministry of Health to involve Provincial and District level policy makers on the issues of awareness and prevention activities.

It was revealed Commercial Farmers with a work plan of between 1,200-1,500 employees spent about 40% of their total income on HIV/AIDS and related cases. The study showed that the most significant factors in increased labor cost were absenteeism due to HIV/AIDS and increased burial and funeral costs. There is strong evidence that commercial farming has greatly been hit by the pandemic. Mostly affected are the tea, sugar and flower industries.

Much of the company earnings go to medical, funeral and burial expenses, and also overtime pay incurred by employees who compensate for the workforce of their sick colleagues. This in turn leads to reduced efficiency among the healthy workers due to stress incurred as a result of overtime working. (NACC 2005)

It is this number of illness and deaths from AIDS across all population groups and the expenses incurred, that provoked pressure from businesses, Media, NGO, and professional societies for clear policy directions from the government.

The government then issued an order that all employers must develop an HIV/AIDS policy on how to cope with the situation at work place. This was also extended to churches that also had to come up with a policy to deal with their members especially on the issue of marriages. Since then the government has sponsored educational programs to teach people about the risks of AIDS. Schools and universities have also joined the fight against AIDS in teaching the people about AIDS. For instance the University of Nairobi has developed an HIV/AIDS curriculum as a

compulsory subject to all under graduates. This is also echoed in the University HIV/AIDS policy. (*AIDSCAP 1996*).

2.7 THE LAW OF KENYA

2.7.1 The constitution

The constitution of Kenya states that the State will not discriminate directly or indirectly against any person on any ground including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion conscience, belief, culture, dress, language or birth.

This means that an HIV/AIDS patient is covered within the laws of Kenya. If any employer tries to terminate ones service due to HIV/AIDS, the employee has the right to seek legal redress in a court of law.

The Kenya Government being members of International Labour Organization has to a great extent adhered to the relevant ILO conventions. The government has also sanctioned the quasi-government bodies such as NASCOP and NACC to work round the clock as they create AIDS awareness and prevention of new infections in the country. This has been the major worry of our government. Thus each day there are new infections especially among the youth and the most productive part of our economy- the employed. These are between the ages of 15-49 years old.

The study has shown that young girls are exposed to sex hence causing the government to fight this new discovery to Holt fresh infections. *Daily Nation March 2007.*

2.7.2 Employment Act Cap 226

The Act prohibits discrimination of employment on matters of health. The Act ascertains that when an employee falls ill, it is the responsibility of the employer to ensure the employee is treated.(Cap 226 part 11 section 12(1-2)'Most employers if not all have adhered to this policy. It is a criminal offence if an employer will not take care of employees who fall sick within his/her employ.

Voluntary blood donors from low risk populations such as students and young adult's men in the rural areas are encouraged to give blood. This is because blood is life yet the virus attacks the blood cells. It was also established that the donors be informed that their blood would be screened for several blood transmissible diseases included HIV/AIDS and Hepatitis to ensure that these are not transmitted into the recipient and also making the donors aware of their HIV status. The government policy then demands that all donors must be informed of the outcome (NASCOP, 2000).

2.8 ON GOING INITIATIVES IN KENYA

Kenya has made tremendous efforts and achievements in the area of HIV/AIDS. Under prevention and Advocacy the following have been achieved:

- ◆ Increased number of people declaring their sero-status.

- ◆ Quality of knowledge on HIV transmission and prevention has increased.
- ◆ Increased condom consumption from 2m per month in 2002 to 7.3 million per month in 2004.
- ◆ Number of voluntary counseling and testing (VCT) centers has increased from 3 in 2000 to 367 in 2003.
- ◆ In 2004 nearly 400,000 Kenyan came voluntarily for testing to over 400 centers located in health facilities, communities and mobile unit's. Compare to less than 1000 that availed themselves for the service in 2000.
- ◆ Six regional blood transmission centers and 3 satellites have been established with 100% testing of the blood supplies.
- ◆ Teams of counselors have been trained to deliver high level of service according to well-developed guidelines.
- ◆ Part of this revolution is the use of rapid HIV test that does not require much time or long procedures. The result is out within 15-20minutes. This has made the process of learning one's HIV status more efficient, private, and confidential.

(NACC 2005)

In the area of treatment, continuum of care and support, the government of Kenya has achieved the following:

- ◆ Provision of ART services initiated in all government and mission hospitals free of charge.
- ◆ Institutional structures for coordinating ART at national and provincial levels have been put in place.

-ART sties have increased from 5m 2001 to 30 by June 2004 in public and mission health institutions.

- ◆ Over 20,000 patients are receiving ART
- ◆ Home based - (HBC) services have been scaled up.
- ◆ National TB/HIV coordinating committees have been formed
- ◆ Surveillance of multi-drug resistance (MDR) at central laboratory is on going. (*Kenya National HIV/AIDS strategic plan 2005/6-2009/10*).
Due to the above cited progress made by the government UNAIDS global update of 2005 cited Kenya as one of the three countries that has experienced a significance drop in prevalence.
- ◆ This has been attributed to safer sexual behaviour through successful behaviour change as well as the rapid scale up of facility based services” (*NACC 2005.*)

2.9 WORK PLACE POLICIES.

2.9.1 Private Sector

In June 2001, the International Labor Organization (ILO) launched a comprehensive code of practice on HIV/AIDS. and the world of work to provide workers , employers and governments with new global guidelines base on International labor standards for addressing HIV/AIDS and its impact at the enterprise, community and national levels. The private sector has also embraced the code of the Federation of Kenya Employers (FKE). No discrimination at work place due to one’s HIV status.

The private sector in Kenya under the umbrella of KHBC has done very well on work place HIV /AIDS policy. They did not just care about their staff but also about the community in which they operate- cooperate social responsibility. They realized that if the environment is not taken care of then their market too will be affected. Thus the private sector has promoted the national AIDS response as a supper model for best practice.

About 200 organizations took the lead. Among them are; Magadi Soda, Barclays Bank, Kenya ports Authority, Kenya Breweries Ltd, Kenya Airways, GlaxoSmithkline, British America Tobacco Nation Media Stanchart, Price Waterhouse Coopers, Brook Bond, Tetra Pack, Serena Hotels, Uniliver, Cadbury Kenya, Coca-cola Africa, Nairobi Bottlers, Kameme, FM, Rickett, Benkiser etc .

(Kenya HIV/AIDS Private Sector Business Council 2005.)

These organizations are very similar in their appearance and operation and implementation of their HIV/AIDS policy. They have health facilities within the organization with qualified Doctors and nurses. There is the availability of free HIV/AIDS counseling and testing. There is free ARVS for those infected and confidential counseling for the affected e.g. widows and widowers. There is no dismissal from work just because one has tested positive, and also there is no screening before employment.

These policies are very similar because the organizations work in partnership. They hold common seminars for the purpose of gaining new ideas and exposing their staff (both the infected and the affected) to new

realities of HIV/AIDS. Just to know that one is not alone is encouraging enough. They train peer educators and support community based institutions such as WOFAK, KENWA etc. They also work in collaboration with UNAIDS, Global Health Fund and UNICEF.

(Business AIDS Watch Jan-March 2006)

2.9.2 Government Organizations

The government bodies have not done as well as the private sector. The study has reviewed policies of National Social Security Fund (NSSF), Electoral Commission of Kenya (ECK), UON, and Ministry of Labor. They are not as elaborate as those of the private organizations. They still appear as though they are in their initial stages yet many years have passed since they were enacted

2.9.3 Human Resource Department

The Human Resource Departments are charged with the responsibility of formulating and implementation of the HIV/AIDS policies in their various organizations. The Human Resource Manager must learn to treat HIV/AIDS just like any other employment issue affecting the employees and hence requiring to be addressed without prejudice. While accepting, this helps in the creation of a corporate positive image and also reduces the stigma associated with HIV/AIDS in the wider community.

These policies ought to be reviewed from time to time since each day there is something new about HIV/AIDS - new fears on the mutation and transformation of the HIV/AIDS cells. The policy makers need to update their knowledge and skill on this subject. This helps them to re-examine

the policy's relevance in view of being outdated and hence non-responsive to environmental changes.

Monitoring and evaluation of the policy is important to determine the effectiveness of the policy.

(HIV/AIDS Private Sector Business Council 2005)

2.10. THE RELEVANT ILO CONVENTIONS

The ILO has passed many conventions that prohibit discrimination at workplace. These include:

Convention No 24 of 1927 which requires that each employer must have a health insurance scheme for their employees no matter the nature of the sickness.

Convention No 111 of 1958 prohibits discrimination on the basis of race, color, sex, religion, political opinion, national attraction, health, social, or culture which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation.

The ILO convention No 142 of 1975 on human resources development encourages that policies and programs be designed to improve the ability of the individual to understand individually or collectively to influence the working and social environment. These policies and programs shall encourage and enable all persons on an equal basis and without any discrimination whatsoever to develop and use their capabilities for work in

their own best interest and in accordance with their own aspirations, and taking into account the needs of the society. This convention protects those who have tested positive already yet are still productive and willing to work to support themselves and the society at large. Convention No 158 of 1982 which prohibits termination of employment due to illness or sickness.

In America the government passed an Act known as Americans with Disabilities Act of 1990 (ADA). Under this Act people with AIDS received the same protection offered to the disabled. The Act is against discrimination of any kind. Without such protection the fear of losing jobs and homes would stop people from seeking voluntary AIDS tests.

The opponents of ADA argued that the inclusion of AIDS victim into the Act provided special right and protection for homosexuals and other high-risk groups while putting the general public at risk. (Verne 1996). These are common incidences even in our nation today. Recently in Kenya during an AIDS conference there were those who opposed the use of ARVS because they make a victims look health hence spreading the disease. However, we heard that those who have already tested positive are very careful not to be re-infected because if this happens then they stand a very high risk of the medicine not having any impact on them due to many strains and the mutation rate of the virus.

In America the burden to treat AIDS is shared between the commercial health insurances, the Federal State and the individual/victims, although the State carries the lion's share. (Verne 1996). In Kenya just like in

America the insurance are not taking up new policy holders with large premiums unless the person is screened or tested by being asked HIV related question. This is because the cost of HIV/AIDS treatment is very high. The sessional paper No. 4 of 1997 on AIDS in Kenya recognized prevention of HIV through blood as a leading strategy in the fight against AIDS.

The Declaration of Philadelphia affirms that all human beings irrespective of their race, creed, or sex have a right to pursue both their material well-being, spiritual development in conditions of freedom and dignity, economic security and equal opportunity and considering further that discrimination constitutes a violation of human enunciated by the universal declaration of human rights.

The employer must ensure that the employee is treated whenever he/she falls sick. (Part II section 12 (1 -2). Most employers if not all in the country have adhered to the same. It is an offence if the employer does not take care of employees within his employ when they fall sick.

2.11 REDUCING STIGMA AND DISCRIMINATION

Cancer was seen as mysterious evil creatures which attacked the body and was associated with lose of hope, fear and almost certain death. Heart disease was seen as morally neutral where the machinery of the heart was malfunctioning, if caught in time the disease is manageable and did not result in stigma to the person concerned. HIV or having AIDS was viewed in terms of punishment for immoral lifestyle. These images of

illness can have a powerful effect upon how people with the disease see themselves. They feel guilty for actually having the disease

That is why the HIV-related stigma and discrimination remains an enormous barrier to fight against AIDS. Fear of discrimination often prevents people from getting tested, seeking treatment and admitting their HIV status publicly.

Since laws and policies alone cannot reverse the stigma that surrounds HIV infections, more and better AIDS education is needed in Africa to combat the ignorance that causes people to discriminate others. The fear and prejudice that lies at the core of the HIV / AIDS discrimination needs to be tackled at both community and national levels. *UNAIDS 2006 Report.*

There are many life threatening illness such as cancer, diabetes, etc, where by the victims are not stigmatized either by themselves or the society. The HIV/AIDS victims stigmatize themselves very much and this because of the way the disease is acquired. About 87% of the infections are through heterosexual relationships.

Many at times the workers are unwilling to take up HIV/AIDS test .This due to the fear of what people will think about them if they be found to be positive.

2.12 EPIDEMICS IN MODERN TIMES

In the twentieth century, several other epidemics took a toll on humanity. During the great pandemic of 1918, influenza virus killed about 20 million people worldwide and virtually brought the World War I to a halt. Influenza

like HIV/AIDS virus has the characteristics of mutation. This makes the virus very difficult to handle.

Poliovirus is another recent epidemic disease like HIV/AIDS; poliovirus was first discovered in America in 1874. There were 50,000 total deaths from paralytic polio during the first half of the twentieth century.

One epidemic that is hauntingly similar to the AIDS epidemic is syphilis. Because syphilis is a sexually transmitted disease, patients with this disease were highly stigmatized. A cure for syphilis-infected individuals was developed in 1909, but it was not until the 1940s that the epidemic was finally controlled. The disease took too long to control because the policy makers viewed the issues as a social problem and not medical/health problem.

The early policies on syphilis were repressive. The use of condom was discouraged, the prostitutes were quarantined or jailed especially during WWI, and monogamous marriages were encouraged. These policies were not very successful.

In 1930, the America Congress reprovved the repressive approaches. The new policies spelled out free and confidential treatment, a campaign was begun to educate the public and dispel misconceptions about its transmission. These policies together with new antibiotics brought syphilis under control.

With the AIDS epidemic we are dealing with powerful biological drives such as human sexuality and drug addiction. The syphilis epidemic shows

us that policies based on abstinence are not very effective in controlling a sexually transmitted disease. We ought to seek for other alterations in behavioral to reduce the necessary transmission of AIDS and bring the epidemic under control.

Until a cure or a vaccine against AIDS is developed, changing behaviour and attitude is our most effective means of controlling the AIDS pandemic (*Fan Hung et al 2000*).

These changes in the environment have forced the organizations to adapt to the new realities. Employers could not pretend that all was well at the work place. New ideas, policies and guidelines had to be sort to deal with this new phenomenon.

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EAST AFRICANA COLLECTION

2.13 THEORETICAL FRAMEWORK

2.13.1 Theories

Sociology being a study of social behaviors in the society offers many theories to explain the occurrence of HIV/AIDS. The situation posing both social, medical challenges require that theories be sort to explain its occurrences and existence.

2.13.2 Anomie

When HIV/AIDS was first discovered, those who tested positive found life quite meaningless. Some were deserted by their spouses and loved ones .Some were disturbed and troubled as to why got the disease and who passed it on to them As a result of denial and not finding an answer to their many questions majority of them resorted to withdrawal then

suicide. At this time the society was also not prepared in that area and there were no counselors to help cope with the situation. People were afraid of the disease. At this time there were several myths most of which made the situation very scary though they were not true. To most people it was a disease of the prostitute, drug addicts and the homosexuals. It was associated with moral decadence. Anomie is a theory developed by Emile Durkheim. According to him when societal norms, values, cultures, and principles are lost leads to a situation of normlessness which results in anomie.

This is a situation where the society has lost cohesion and people don't care for one another. There is a great deal of improvement in the situation today. Most of the affected and infected have been exposed to a lot of literature that explains the pandemic. The government has provided counseling and testing facilities countrywide. The HIV/AIDS campaign on awareness and the availability of ARVS has greatly changed the perspective of people about the disease. Those who have lived positively with the disease for long such as twenty years and above are an incentive and a source of encouragement to those who may test positive today. Through counseling at work place the staff is made to understand that AIDS is an ailment just like any other, making it look real and very normal. They are also made to understand that this disease is not for the outcast but that it can attack anybody and getting it does not mean immediate death. For that matter this theory can be used to explain the HIV/AIDS situations depending on the views chosen.

2.13.3 The Hierarchy of Needs

The hierarchy of needs is a theory developed by Abraham Maslow. He explains that human beings always have needs. They desire certain things in life. According to him there are five levels of needs every human being would like to attain. These are; biological or physiological needs. They are also known as basic needs e.g. Water, air, food, shelter, and warmth and sex basic needs such as food shelter, water clothing and sex.

The next level is safety needs. These include; security, protection, stability law and order. The third level is need for belongingness or love. This includes: family affection, relationships and workgroups.

The fourth level is the need for self esteem. This includes; achievements, status, responsibility, and reputation. The last or fifth is known as self-actualization. This means personal growth and fulfillment.

While Maslow says that man climbs the five ladders in life, the HIV/AIDS pandemic does not allow for this same. What the infected person needs most is basic physiological safety and love needs. What matters to a sick person is not how affluent or influential he/she is, but good health. In other words this disease has brought an imbalance in this theory. Self-actualization is the highest status in this theory but how many actualized men and women have fallen to the pandemic? Thus their money could not buy them good health. If one gets food and medication there is hope for tomorrow. In fact both the infected and the affected need love, medication and food much more than anything else.

At the place of work the employer has to show concerned and great care by providing medication and other forms of support. Welfare to such a person is very important. He /She needs to be shown love by being understood, be given time off to rest, be allowed to go home early, be assigned light duties, improve their diet by being offered food supplements such as milk and fruits etc.

2.14 RESEARCH QUESTIONS

The study seeks to answers the following questions:

- (i) What are the experiences of Human Resources Managers in the developing of the HIV/AIDS policy?
- (ii) Do these Human Resources Managers have any formal training in the area of HIV/AIDS policy formulation?
- (iii) How much general knowledge of HIV/AIDS issues do they have?
- (iv) What organizational support facilities are available to the HIV/AIDS infected and affected staff?

CHAPTER THREE

3.1 METHODOLOGY

According to Brewer, Methodology is the philosophy of the research process. This includes the assumptions and values that serve as a rationale for research and the standards or criteria the researcher uses for interpreting data and the research conclusions (1998:20). This chapter therefore seeks to describe the methods that have been used to collect the data.

3.2 RESEARCH DESIGN

The research has used the qualitative research method in the collection of data. It has also used quantitative methods in the statistical analysis of the same data. No attempt has been made to manipulate the data and therefore the data obtained is reliable.

3.3 SITE DESCRIPTION

The study has been conducted in Nairobi. Nairobi is one of the eight provinces in Kenya and the capital city of the country. It started as a railway camp in 1899 and soon became a center of Government business. By 1960, the population of Nairobi was estimated to be 250,000 people. By 1993 the population was estimated to be about 2 million and at the moment it's about 3 million.

Why Nairobi was selected for the study:

- (i) Due to its cosmopolitan and metropolitan nature, Nairobi is one of the most affected districts / Province in Kenya by the HIV/AIDS pandemic.
- (ii) Being the capital city, the major organizations are located here.
- (iii) The researcher found Nairobi to be more suitable in terms of reduced traveling and accommodation expenses since she is self sponsored and working on a constrained budget allocation.

3.4 UNIT OF ANALYSIS

The study focused on two organizations namely:

- (i) National Social Security Fund (NSSF)
- (ii) University of Nairobi (UoN)

Sampling Procedure

The study has used purposive sampling method. There were 30 respondents from each of the above-mentioned organizations. The study had wished to have 60 from each of the organizations. But due to the sensitivity of the topic managers were not willing to give information. Some picked the questionnaire but they could not return it. Getting 30 from each of the organizations was tedious and time consuming. To get the desired number would have taken this study a whole one-year to complete. Those who accepted to be interviewed were chosen from across departments involving all carders of staff. Thus the senior and middle managers were 20 and the juniors 10 from each organization. Not only the affected and infected were interviewed but all persons to determine their level of awareness of policies within their organizations. HIV being a very sensitive issue, it was not possible to neither get key

informants nor hold discussion groups. However in one of the organizations the study managed to get a fill of a few infected persons who have declared their status publicly to their employer. This was very encouraging as they are very positive about life in their new status.

3.5 DATA COLLECTION INSTRUMENT

3.5.1 Questionnaire

In order to achieve the desired objectives, the study used questionnaires as the instrument of data collection. It was set into two forming the basis of chapter four and five of this study.

3.5.2 Secondary source

A lot of literature review has been done to find out what other organizations apart from those being studied have done .It has also included research on documents from other African countries to find out how they have managed to cope with this issue in their countries. This has given this study the standard information of what is happening world over as far as the policy implementation of HIV/AIDS policy is concerned.

CHAPTER FOUR

4.0 DATA PRESENTATION AND ANALYSIS

4.1 WORKERS RESPONSES

This study looked at the challenges encountered by employees in the implementation of HIV/AIDS policies at the work place. A total of 10 employees from NSSF and same from the University of Nairobi completed the questionnaires and below is their responses.

DISTRIBUTION OF HIV/AIDS POLICY IN PLACE

Table 4.1 below indicates that majority or 60% of the respondents had knowledge about the existence of a HIV/AIDS policy at their work place. The respondents indicated that they knew about the policy through booklets, seminars, workshops, circulars, magazine, handout, brochure, lectures. They were also told by those infected, and they also observed how they infected were treated. Some learnt of the same through peer group educators. About 40% of the respondents interviewed had no knowledge of the policy in their work place. Some felt that if at all the policy was in place, it was still very new that much of its aspects were not well known.

Table 4.1:

	FREQUENCY	PERCENTAGE
YES	12	60
NO	8	40
		100

PROTECTION/ASSISTANCE

Table 2 below indicates that majority of the respondents or 60% were aware of the protection or assistance offered by the employer to the staff/workers infected with HIV/AIDS in the work place. Asked how they knew about these they stated that it was through Counseling. They also see condoms placed in every washroom. At the University they cited the presence of a VCT at the University Health Service. Some of them learned of the same through the education programs, seminars they attended. At NSSF they cited the provision of milk and an increased medical allowance made available to those infected staff for out patient. They also have a support group registered by the infected staff. They also have a message on the pay slip every month on HIV/AIDS. About 40% of respondents had no idea of any assistance or protection offered to the HIV/AIDS infected / affected staff by the employer.

TABLE 4.2:

	FREQUENCY	PERCENTAGE
YES	12	60
NO	8	40
		100

LAWS THAT PROTECT THE PRIVACY OF HIV STAFF

Table 4.3 below indicates that majority or 65% of the respondent had no knowledge of any law that protects the privacy of HIV/AIDS people. About 35% of the respondents had some knowledge of some law that protects the privacy of those infected with the virus. They cited Cap226

laws of Kenya- Employment Act. Many of them however did not know any specific sections but were only aware of it.

TABLE 4.3:

	FREQUENCY	PERCENTAGE
YES	7	35
NO	13	65
		100

STATISTICS ON COMMUNITIES MOST AFFECTED

Table 4.4 below indicates that majority or 55% of the respondent were aware of the communities most affected by HIV/AIDS. About 45% of the respondent had no knowledge of the communities most affected by HIV/AIDS.

TABLE 4.4:

	FREQUENCY	PERCENTAGE
YES	11	55
NO	98	45
		100

SENSITIVE ISSUES ON SEX AND SEXUALITY

Table 4.5 below indicates that majority or 55% of the respondents had knowledge of the programs that teach on sensitive issues on sex and sexuality. They cited peer education, counseling on behaviour and attitude change on sex issues, sensitization or awareness programs and

the display of adverts on pay slips about HIV/AIDS. About 45% of the respondents had no knowledge of issues on sex and sexuality.

TABLE 4.5:

	FREQUENCY	PERCENTAGE
YES	11	55
NO	9	45
		100

RISKY BEHAVIOUR

Table 4.6 below indicates that majority of the respondents or 80% had talked to colleagues about avoiding risky behaviour. They cited the following to be risky behaviors which should be avoided; multiple sexual partners, unfaithfulness to a sexual partner, sharing of surgical materials such as needles, razor blades and injections (especially used by the drug addicts), casual sexual activities, excessive drinking of alcohol which could lead to casual sexual behaviour, unprotected sex especially with an infected person or one not well known to the partners, extra marital affairs as well as office affairs or zero grazing. About 20% indicated that they have never talked to colleagues to avoid risky behaviour. They are afraid of their colleagues' reaction.

TABLE 4.6:

	FREQUENCY	PERCENTAGE
YES	16	80
NO	4	20
		100

COMMUNITY SERVICE

Table 4.7 below indicates that majority or 60% of the respondent had knowledge of what their organizations were doing in terms of offering service to the community. They cited the following issues as service to the community; their employers organized workshops to raise funds to assist persons infected with HIV/AIDS. They also visited orphans in HIV/AIDS homes to donate aid. Thus they donated food and clothing to the HIV/AIDS victims. At the University of Nairobi, there was a mention of a trait vaccine by KAVI (Kenya Aids Vaccine Initiative) which intends to change the lives of those infected if the vaccine went through successfully. They also cited the provision of "Red Ribbons" as a sign of solidarity with the infected and also raising awareness within the community. At the NSSF they cited the "Road Show" as a way of raising awareness. They also indicated that they are associated or connected to Cana Ministries in Mukuru slums that take care of HIV/AIDS victims. About 40% of the respondents had no knowledge of any community services offered by their employers.

TABLE 4.7:

	FREQUENCY	PERCENTAGE
YES	12	60
NO	8	40
		100

INFECTED OR DIED OF HIV/AIDS

Table 4:8 below indicates that majority or 65% of the respondents had no knowledge of their colleagues infected with the HIV virus or those who

have died of AIDS. Only about 35% were aware of their colleagues who had succumbed to the scourge or those who are infected with the virus.

TABLE 4.8:

	FREQUENCY	PERCENTAGE
YES	7	35
NO	13	65
		100

HEALTH RELATED POLICY ON HIRING & FIRING

Table 4.9 below indicates that majority or 75% of the respondent that had no knowledge of a health related policy on hiring and firing. About 25% of the respondents were aware of a health related policy on hiring and firing in the work place.

TABLE 4.9:

	FREQUENCY	PERCENTAGE
YES	5	25
NO	15	75
		100

SCREENING BEFORE EMPLOYMENT

Table 4.10 below indicates that the majority or 70% of the respondents had no knowledge of a policy on screening before employment in the work place. About 30% of the respondent were aware of such a policy in place in the work place, but did not understand how it operates.

TABLE 4.10:

	FREQUENCY	PERCENTAGE
YES	6	30
NO	14	70
		100

EDUCATION PROGRAMS BY EMPLOYER

Table 4.11 below indicates that majority or 55% of the respondents had not attended any education program on HIV/AIDS organized by their employers. About 45% of the respondents had attended such programs organized by their employers. Respondents from NSSF indicated having attended such programs organized by their employers through FKE. One of such fondly remembered was held at Panafric Hotel in 2005. Those respondents who are HIV positive have attended such programs organized by their employer, whose theme was "Living with HIV/AIDS". They were taught how to live positively with the scourge and accept their new status.

TABLE 4.11:

	FREQUENCY	PERCENTAGE
YES	9	45
NO	11	55
		100

4.2 MANAGERIAL RESPONSES

This study looked at the challenges encountered by Managers in the implementation of HIV/AIDS policies at the workplace. This was the core of the study. A total of 20 Managers from NSSF and 20 Managers from University of Nairobi completed the questionnaires. The responses were as follows:

STAND ALONE POLICY ON HIV/AIDS

Table 4.12 below indicates that the majority of the respondents or 97.5% in both organizations stated that their organizations have a stand-alone policy on HIV/AIDS. About only 2.5% or one person did not know whether the policy on HIV/AIDS was a stand alone or not. These 97.5% were very much aware of many aspects in the policy such as who is in charge of the implementation. They were also aware of the broad areas covered by the policy which includes, medical and treatment, counseling, education such as seminars advocacy, awareness programs, preventions and many more.

TABLE 4.12:

	FREQUENCY	PERCENTAGES
Yes	39	97.5
No	1	2.5
		100

SCREENING

When asked about their organizations policy on screening of HIV/AIDS, they stated that this was done on voluntary basis. However, the organizations encourage their staff/students to know their HIV status.

RECRUITMENT

When asked about the organizations policy on recruitment and employment as far as HIV/AIDS is concerned, they stated that screening was not a pre-requisite for employment. They said there was equal opportunity for all those who qualified for the job irrespective of their HIV status. Thus they were aware of the government policy and FKE Code of Conduct, which assured everybody employment without discrimination as far as HIV/AIDS is concerned.

CONFIDENTIALITY

It came out very clearly from the respondents that HIV/AIDS report are treated with absolute confidentiality except for authorized persons. At the University of Nairobi most of the respondents stated that such reports were the preserve of the Chief Medical Officer and the top organ of the University's administration. At the NSSF, it was found that such reports are kept by the Special Programs Manager and can only be made available to the Chief Executive.

HIV /AIDS PREVENTION

Asked about the organizations policy on HIV/AIDS prevention, the respondents stated that their organizations supplied condoms free of charge; educate their members to avoid risky behaviors such as multiple

sexual relationships, having unprotected sex, sharing surgical materials. The organizations have also put programs in place to educate their members on behaviour, attitude change and self-respect. They are taught the principles of ABC in every seminar and workshop.

OCCUPATIONAL EXPOSURE

When asked about what the organizations policy on HIV/AIDS occupational exposure was, most of the respondents stated that those employees in high risky areas were provided with preventive or protective equipments. At the NSSF the staff's working in Registration and Cheque Collection office are issued with gloves to ensure no blood contact because they handle the claimant's hands when taking fingerprints and if they have wounds or are bleeding this could be risky.

At the University of Nairobi, the staffs working in the VCT Centre, the health services, the laboratories are also provided with gloves since these are very high-risk areas.

INFORMATION AND TRAINING

On information and training the respondents from the NSSF stated that they have a well-equipped library or resource centre with good literature and videos on HIV/AIDS pandemic. The staff is encouraged to create time to read these materials, borrow books, watch videos and find knowledge on many issues concerning HIV/AIDS. They are also trained professional Counselors, Peer Educators, and e.t.c. There are organized programs such as seminars and workshops to educate staff on living positively with the virus for those who already have it and total avoidance for those who have tested negative. At the UoN the respondents sated

that there is an AIDS Control Unit which is charged with awareness including advocacy, implementing the UoN HIV/AIDS policy and developing educational materials as well as sensitization.

DISCRIMINATION AND STIGMATIZATION

Majority of the respondents stated that their organizations have upheld the governments' policy on HIV/AIDS, the ILO Convention No.111 of 1958 and the FKE Code of Conduct on HIV/AIDS, which states that nobody should be discriminated or stigmatized on the basis of their HIV/AIDS status. They said also staff/students are treated normally and have equal opportunities to the benefits available to all staff in the organization. That the HIV/AIDS positive staff/students are regarded as any other staff/student with life threatening illness such as cancer, diabetes, high blood pressure, e.t.c. The message to all staff is to live, accept, support, love encourage all persons living with HIV/AIDS to be positive about their new status. Stigmatization and discrimination is not allowed at all.

TERMINATION OF EMPLOYMENT

No member of staff is terminated from employment on the basis of their HIV/AIDS conditions. They are encouraged to soldier on until they die or retire. The organizations have put mechanisms in place to help them, such as flexibility in terms of alternative job assignments, modification of performance standards, multitasking, flexible work schedule and work sharing. In other sections those who are negative are allowed to do overtime to cover up the duties, which would have been done by those who are positive. This is also due to their sick offs and admissions. They could only be laid off on the recommendations of a medical

doctor/practitioner if it is in the interest of the patient. Thus they can be retired on medical grounds if the doctor finds that they are unable even to move to their workplace; hence not being able to perform their duties.

The respondents also stated that an HIV positive staff could be terminated if he/she posed a risk to the rest of the staff. For instance if one moved around with piercing or surgical equipment with an aim of infecting others then he/she could be terminated from employment.. However such an incident has not occurred in either of the organizations in question. They may also resign voluntarily but cannot be forced to.

DISCIPLINARY MATTERS

Asked about the organizations policy on disciplinary on HIV/AIDS related matters, most of the respondents stated that disciplinary action is applied uniformly both to the positive and negative staff. This is because the HIV staff is expected to lead a normal life just like any other staff. However some stated that it's difficult to discipline a HIV positive staff because they are too emotional. Any action taken against them is viewed as a form of discrimination even if it is not. In. NSSF some heads of Departments find it difficult to handle disciplinary issues because all the time these group of people tend to seek sympathy, empathy and redress from the Special Programs Department. They interpret disciplinary as discrimination, which makes their Heads of Departments unable to carry out disciplinary action against them.

HIV /STATUS IN THE ORGANIZATION

Asked about the HIV/AIDS status in their organization, some said it was low others fairly high, others not very clear because no statistics are made available. At the NSSF about 20 -30members of staff have declared publicly of their HIV positive status. This shows that there is an enabling environment at NSSF.

At the University of Nairobi it was stated that there was an increase in mortality rate of the University Community (both staff and students). They also cited that they are at a high risk because majority of them are in the high-risk age bracket of 20 – 49 years for both students and lecturers. It was also cited that about 20% - 30% of the staff at NSSF are either infected or affected.

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TRAINING IN HIV/AIDS POLICY FORMULATION

Table 4.13 below indicates that majority of the respondents or 55% have not been formally trained in the formulation of HIV/AIDS policy. About 45% have been trained. This means majority of the staff do not know how to formulate an HIV/AIDS policy.

TABLE 4.13:

	FREQUENCY	PERCENTAGES
Yes	18	45
No	22	55
		100

FLEXIBLE WORK SCHEDULE FOR MEDICAL APPOINTMENTS

Table 4.14 below indicates that majority or 92.5% of the respondents are willing to let the HIV positive staffs set their own flexible work schedule to enable them meet or accommodate their doctor's appointments. About 7.5% said they were not sure of what they could do in such a situation.

TABLE 4.14:

	FREQUENCY	PERCENTAGES
Yes	37	92.5
No	3	7.5
		100

COST & VALUE OF IMPLEMENTING A HIV EDUCATION PROGRAM

Table 4.15 indicates that majority or 60% of the respondents are not familiar with the cost and value of implementing a HIV Education Program. About 40% of the respondents are aware of the cost and value of implementing the HIV education programs. The HIV / AIDS management and treatment is very expensive in terms of medical expenses, time taken off duty for sick off, absenteeism, late coming on duty, desire for lighter duties etc. The sick members of staff also makes it difficult for the organizations to make any sound strategic plans

TABLE: 4.15

	FREQUENCY	PERCENTAGES
Yes	16	40
No	24	60
		100

PRIVACY OF HIV POSITIVE PERSONS

Table 4.16 below indicates that majority or 65% of the respondents know what to do when a worker reveals to them that he/she is HIV positive. They stated that they would keep it to themselves as a secret but they would encourage the staff, to see a counselor, seek medical advice and take the matter up with the Department or personnel concerned with HIV/AIDS matter in the organization. Some said that much as you keep it to yourself also help the HIV positive staff to cope with that new situation. Some said you make the employee your friend by inviting them to your office frequently; develop a close relationship with them. This will enable the employee to be free and confide more in the Manager. As such the employee that is HIV positive will gain confidence in the boss and this will make them realize the value and worth of living – “talking is therapy.” The more they talk about themselves and their situation the better for them.

Some said you assure them of total secrecy and confidentiality and encourage them to seek medical treatment and counseling. Some said when an HIV positive staff reveals their status to you as a manager; you should encourage them to join the support group where they would meet with other positive staffs that have declared their status publicly. Some said you treat them normally just like any other staff with life threatening illness. No sympathy but you may empathize with them.

About 35% of the respondents in both organizations had no idea of what they would do if any employee revealed to them their HIV/AIDS status.

TABLE 4.16:

	FREQUENCY	PERCENTAGES
Yes	26	65
No	14	35
		100

LAWS THAT PROTECT HIV POSITIVE STAFF

Table 4.17 below indicates that majority or 55% of the respondents in both organizations did not know of any law that protects persons with HIV/AIDS in the workplace.

About 45% of the respondents knew some of the laws that protect the persons with HIV/AIDS at workplace but not sure of any particular section. This protection is against any form of harassment such as discrimination, stigmatization, and victimization and being sidelined due to their HIV status. Some of the laws cited were; ILO Convention, No.111 of 1958 which prohibits, discrimination of employees due to sex, health, race or religion. They also cited Employment Act, Cap.226 laws of Kenya which states that workers should be treated equally regardless of their race, sex religion or health condition. The Act also calls for medication or treatment of the staff by employer or the validity of the medical cover or health insurance for all employees. They also cited the National Policy on HIV/AIDS, which prohibits discrimination and stigmatization of persons living with HIV/AIDS at the workplace. This prohibits even screening for

HIV as an employment pre-requisite So long as someone is still with some energy to perform their duties, they should not be interfered with.

Some cited the guidelines such as the Code of Conduct for the HIV positive at workplace by FKE, UNDP. They also cited the HIV/AIDS Bill recently passed by Parliament (September 2003).Parliament approved a bill which rendered any manner of discrimination at work place a criminal offence.

TABLE 4.17:

	FREQUENCY	PERCENTAGES
Yes	18	45
No	22	55
		100

AVAILABLE SUPPORT

Asked about the support facilities available to the HIV/AIDS infected and affected staff within the organization, the respondents had this to say: there is free supply of condoms in every washroom in both organizations. NSSF has increased the outpatient medical allowance for the HIV positive to enable them visit the Doctors as much as required. They (Staff) are also given nutritional food daily e.g. a packet of milk each. They have also been allowed, encouraged and supported to form a support group where all who have declared their status publicly are told to register. They meet regularly to share their experiences and encourage one another with a better understanding. The organizations have also spent a

lot of money on the training of Counselors and regularly call for professional Counselors to speak to the entire staff. They also have a well equipped resource center.

The University has a VCT Centre and a well-furnished clinic that offers free ARV to both student and staff who are HIV positive.

It has many organized lectures on HIV/AIDS. Infact it is a compulsory subject for all freshers. However, we still had some respondents who did not know if there was any support facility offered by the organization.

This part of the questionnaire has been very interesting and has brought out quite a lot of interesting revelations. One would think that most Managers know their responsibilities as concerned HIV/AIDS and that they are very conversant with what is happening in their organization as regards the HIV/AIDS pandemic. Some of them are not aware of the existence of the HIV/AIDS policy at their workplace.

CHAPTER FIVE

5.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 SUMMARY

An HIV/AIDS policy whether as a stand-alone policy or as part of a larger policy addressing non-discrimination of life threatening illnesses, defines the company's/organizations position and practices as they relate to staff/workers with HIV infections. Developing HIV/AIDS policy is meant to help de-stigmatize HIV/AIDS among staff/workers and create an environment where staff/workers feel comfortable seeking more information on the disease. This is the major reason why the Government through the Ministry of Health issued a directive that all organizations or employers must formulate an HIV/AIDS policy to help safe guard the interest of the staff infected and even those affected at work place. The treatment and management of an HIV+ staff is very costly. Their medical bill is always higher due to frequent opportunistic infections. They are also off duty most of the time due to the sick off given by the doctors. Due to their weak health condition their performance is low and so is their output.. The cost of training a counselor is also very high. In 2003 a bill was approved by parliament to prohibit all forms of discrimination at work place. Discrimination and stigmatization can cause serious emotional condition that could be difficult to handle or even lead to death. This is part of what makes the cost of implementing the HIV/AIDS policy at the work place very exorbitant. Thus to cope with the emotional status caused by the virus the employer must have counselors who from time to time must talk to both the affected and infected staff. This training is not cheap at all. A lot of money is spent on treatment of

the infected staff. About 45% of the total income of the organization is spent on medication, funeral and burial costs eg in commercial faring such as sugar, tea, coffee, and flower firms.

The managers also encounter challenges interims of the unwillingness of the general workers to go for VCT. Many at times the staff is not willing to be tested so that they can know their status yet the managers cannot force them to do so because it is voluntary. The attitude and behavior change is another challenge that managers encounter at their work place. It is not easy to stop people from having affairs at the workplace. Thus why the management has decided to put condoms in the washrooms for whoever may be in need.

The work place policies are always guided by the National HIV/ AIDS policy. The organizations do not know the best practice, which is to be outlined by the National HIV/AIDS policy. That is why we say; there is no set standard for the best practice. Each organization is offering what they are can manage according to their budget.

An organization's HIV/AIDS policy should:

- Form the foundation for its entire HIV/AIDS program
- Set the standard of communication about HIV/AIDS
- Let all staff/workers know where to go for assistance
- Instruct supervisors on how to address HIV/AIDS staff working under them.
- Establish compliance with other laws and statutes in the land

The study focused on the work place with a view of finding out what the Human Resources Managers undergo in terms of implementing the HIV/AIDS policy.

The study also sought to understand the responses of the employees as far as the implementation of the policy is concerned. The organizations chosen for the study were National Social Security Fund (NSSF) and the University of Nairobi (UoN). These are government parastatals.

The findings were both interesting and surprising. From the study it was noted that most of the management staff of these organization were not so conversant with the policy e.g. who should implement, and how. Just a few of them were aware of who should implement how, and what other laws protect employees against discrimination at work place do exist. Thus most respondents had very little factual information on HIV/AIDS policy at work place unlike the generally held belief that most organizations have a well-implemented HIV/AIDS policy at work place.

The junior staff in both organizations happened to articulate the policy implementation better than their managers. This is because they deal and have their colleagues among the infected and the affected groups. Majority of them have been trained as peer educators or counselors, giving them an upper hand in the knowledge of HIV/AIDS.

The study also managed to get some of the infected to participate. They gave a good outline of what they would like done to any infected persons.

They are those who have been counseled severally and have accepted the situation and are living positively with their new status. They have also attended many seminars and workshops on how to live with the scourge

The question of HIV/AIDS is a very sensitive one even to the learned. Most of the staff interviewed did not want to be associated with the diseases other than those that had gone public on the issue or those who have gone through counseling processes.

The study did a compare the two policies on their issue of: contents, points of convergence and divergence in terms of implementation.

The study established the following:

That the policies were more or less the same in their content since they were both based on the code of regulation from International Labour Organization (ILO), the Kenya Federation of Employers (FKE), and the National HIV/AIDS policy from the government. It is part of the policy to supply condoms to all staff that are in need. It is also part of the policy to provide protective clothing for all those working in high-risk areas such as gloves, or masks

That at the University of Nairobi there is a fully equipped staff clinic that handles all health issues HIV inclusive. That there is an existing VCT center where students and workers who want to find out their HIV status visit at their own time and those found positive are given free ARVS straight away.

That at the National Social Security Fund there is no health service, and no VCT center. That they have made arrangement with a mobile VCT that offers their staff services periodically. There is a medical scheme where staffs are entitled to outpatient and inpatient medical allowance which has been increased by Kshs 60,000 per year for out patient for those who have declared their HIV+ status publicly. Those who have gone public at t NSSF are given nutritional food e.g. a packet of milk each day per person.

At NSSF about 20-30 staff have declared their HIV+ status. This would mean that at NSSF there is an enabling environment for that to happen. That those found HIV+ at NSSF have been allowed to form a support group where they meet and share their experiences. The group is registered by the Ministry of Gender, Sports, Culture and Social Services

That the mortality rate at the University of Nairobi is high yet no staff has gone public on their HIV/AIDS status. That at the UON the chief medical officer handles all health related issues including HIV/AIDS and not the Registrar in charge of Human Resources. At NSSF the treatment of HIV/AIDS and other health related issues are handled by the Human Resources Manager. The Special Programmes Manager handles Counseling and training aspect of HIV/ AIDS.

That NSSF engages professional counselors periodically to back up their own, but the University has specialized counselors. That disciplinary action on those positive staff at NSSF is not easy because they will hide

behind discrimination and victimization. That at the UON disciplinary action is take on equal basis irrespective of the status.

The research hoped to get one private and one public organization to compare the two and find out which of the two has done well on the implementation. The study also hoped to interview more than 60 persons as it did. The ideal number was 120 e.g. 60 from each of the organizations However due to the sensitivity of the HIV/AIDS issues many people refused to complete the questionnaire Some picked but they could not return it. Many organizations also refused to undertake the study. In one of them the Human Resources manager could only allow the senior staff to complete the questionnaire and not the junior. These included Uniliver, Kenya Breweries Ltd, British America Tobacco, GlaxoSmithkline, Uchumi Supermarket, Copper Motors Corporation (CMC), Commercial Bank of Africa, and FedEx Courier services. We can now understand from the above explanations why the Managers did not want to allow the study, they were afraid the juniors could out shine them. In one organization the Managing Director emphatically stressed that they never give out data no matter the issue. This was quite frustrating and time consuming.

5.2 CONCLUSION

It was very useful and important to involve the work place in the study of HIV/AIDS policy. This is because the disease has affected mostly the age group from 15 – 49 which is the most active work force of a nation; the study has opened interesting information for further research in the socio economic aspects related to AIDS in Kenya and abroad.

Many of the staff that did not know that there is a policy in their work place now knows. Many of those who had been afraid of being victimized now can confidently declare their HIV status. They are now aware of the facilities available to them. Those who were afraid of stigmatization and discrimination now know it is a thing of the past

AIDS is both a social and economically challenging problem. In the words of the former President of the World Bank, James D. Wolfensohn, this is how he described it: "AIDS is turning back the clock on development. In too many countries, the gain in life expectancy is being wiped out. In too many countries more teachers are dying each week than can be trained" (World Bank report 2002:1)

The government has a good idea of making sure that each employer has an HIV/AIDS policy in place to give direction on the treatment or how to handle both the infected and affected staff. However this has lacked the CEOs support in most organizations. It may have also lacked the political goodwill in that after issuing the directive to formulate the policy in 2001 there has not been a serious number of follow ups. The budget set aside

for the purpose is also very slim and not unless it is improved, much result may not be forthcoming.

However there is a ray of light in the tunnel. Just like Pearl Omega and Kemron, Kenya has made another stride in the battle against HIV/AIDS by developing a product at the Institute of Primate Research (IPR) that is capable of checking the spread of the deadly virus. According to the researcher Peter Mwethera, they have developed a gel known as Unipron whose ability is capable of killing the HIV virus by making the vaginal environment too acidic for the virus to survive. There is an ongoing successful research on the baboons.

According to the patent number 218 Mwethera has been credited with the development of a vaginal spermicide and microbicide to prevent pregnancy and the transmission of HIV. (*Daily Nation 12/10/2007*) Therefore all people in all sectors of our economy should join hands to fight this deadly scourge from spreading. AIDS must be stopped before it stops all of us from the face of the earth. The spread is rapid and all of us young and old must stand up against it using all manner of formulas around us in achieving our success.

May be one day with time and research, a cure for HIV infection will be found and AIDS will no longer exist. Until then, the smartest thing to do is to know the facts and not put yourself at risk.

. "Life is sweet and living healthy is golden".

5.3 RECOMMENDATIONS

From the study, it is recommended that:

- (i) Chief Executive Officers of the organizations should own the implementation of the HIV/AIDS policy, assisted by the Human Resources Department and other lines managers.
- (ii) The government should put mechanisms in place to monitor how well organizations are implementing the HIV/AIDS policy at the work place.
- (iii) Organizations that have succeeded in the implementation of the HIV/AIDS policy should be given awards and be made role models for others to learn from.
- (iv) The government should give a time frame within which all organizations should have a well-documented and practically implementable policy.
- (v) Organizations should set aside funds to assist HIV positive members of staff to acquire nutritional food supplements, which will enable them not to fall sick as often as they do.
- (vi) That the out patient allowance should be increased to cater for the many opportunistic infections, which need to be treated as soon as they come.
- (vii) All organizations should establish mechanisms of supplying ARVS to the infected members of staff.
- (viii) That HIV/AIDS policy should be simplified, translated to Kiswahili and cascaded down to all levels of employees.
- (ix) Organizations should train peer educators at all levels to assist the infected staff with respect to counseling, care and support.

- (x) HIV positive persons should be allowed to negotiate for lighter duties when they feel challenged.
- (xi) All Organizations should establish and maintain a well-equipped gymnasium and physiotherapy unit for exercises.
- (xii) All employees should receive information and continuous counseling on matters related to HIV/AIDS.

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APPENDICES

UNIVERSITY OF NAIROBI

A Study of the challenges encountered by employees in the implementation of HIV/AIDS policies at the work place.

Good morning / Good afternoon.

My name is Vicky Owaki Webuye (Mrs.). I am an M.A student at the University of Nairobi. I am conducting a study on the implementation of HIV/AIDS Policy at workplace.

This research is in fulfillment of the requirements for the degree of Masters of Arts of the University of Nairobi. May I please ask you a few questions?

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Name of the Organization _____

1. Please mention some of the ways through which HIV/AIDS is transmitted?

2. Do you know whether your employer has a HIV/AIDS Policy?

A. Yes B. No

If Yes, what aspects do you know? _____

How did you know about it? _____

3. Are you aware of how your employer protects or assists people with HIV/AIDS in the workplace?
A. Yes B. No
If yes, specify _____

4. Do you know any laws that protect the privacy of people who are HIV positive?
A. Yes B. No
If Yes, which ones? _____

5. Are you familiar with the latest statistics about which HIV hardest hits communities?
A. Yes B. No
6. Does your employer offer programmes that teach sensitive issues on sex and sexuality?
A. Yes B. No
If Yes, which ones? _____

7. Do you find it easy to talk to colleagues/workers about avoiding risky behaviors?
A. Yes B. No
If Yes, which behaviour do you consider risky? _____

8. Does your organization participate in any HIV/AIDS related community service activities?
A. Yes B. No
If yes, specify _____

9. Do you know if any employee is infected or has died of HIV/AIDS infections?
A. Yes B. No
10. Does your employer have health related policies for hiring /firing employees?
A. Yes B. No
11. Do employment policies, letters or practice call for test for HIV offer visit to VCT Centers or counseling services before employment?
A. Yes B. No
12. Have you attended any HIV/AIDS Education programme organized by your employer?
A. Yes B. No
If yes, specify _____

13. What recommendations would you make to improve on how HIV positive employees should be treated by the employer?

Thank you for your assistance. God bless you.

UNIVERSITY OF NAIROBI

A Study of the challenges encountered by Human Resource Managers in implementing HIV/AIDS policies at the work place.

Good morning / Good afternoon.

My name is Vicky Owaki Webuye (Mrs.). I am an M.A student at the University of Nairobi. I am conducting a study on the implementation of HIV/AIDS Policy at workplace.

This research is in fulfillment of the requirements for the degree of Masters of Arts of the University of Nairobi. May I please ask you a few questions?

Name of the Organization _____

1. Does your organization have a HIV/AIDS stand-alone policy addressing HIV/AIDS?
A. Yes B. No

2. Who is in charge of the implementation of the Policy?
_____ (Specify)

3. What are the broad areas that your Policy covers?

4. What is the organization's Policy on HIV/AIDS screening?

5. What is the organization's Policy on recruitment and employment as far as HIV/AIDS is concerned?

6. What is the organization's Policy on confidentiality on HIV/AIDS related matter?

7. What is the organization's Policy on HIV/AIDS prevention?

8. What is the organization's Policy on HIV/AIDS occupational exposure?

9. What is the organization's Policy on information and training on HIV/AIDS?

10. What is the organization's Policy on HIV/AIDS stigmatization and discrimination?

11. What is the organization's Policy as regards termination of employment due to HIV/AIDS related complications?

12. What is the organization's Policy on counseling of HIV/AIDS related matter?

13. Do you have any difficulties disciplining an HIV/AIDS employee? _____

14. What is the HIV/AIDS status in the organization?

15. Have you been formally trained in the area of HIV/AIDS policy formulation and related matters?

A. Yes No. B

_____ Specify

16. Do you allow individuals with challenges including HIV/AIDS, to set a flexible work schedule in order to accommodate medical appointments?

A. Yes B. No

_____ Specify

17. As a manager/Employer, are you familiar with the cost and value of implementing a HIV education program?

A. Yes B. No

_____ Specify

18. As a manager, if a worker reveals that he/she is HIV positive, how do you ensure privacy is maintained?

_____ Specify

19. Do you know any laws that protect people with HIV/AIDS in the workplace?

A. Yes B. No

Which ones? _____

20. What do you do if one prospective employee is found positive?

21. What organizational support facilities are available to the HIV/AIDS infected and affected staff?

Thank you for your assistance.

God bless you.