THE IMPACT OF HIV/AIDS ON THE KENYA POLICE FORCE

BY

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A MANAGEMENT RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE MASTERS OF BUSINESS ADMINISTRATION (MBA) DEGREE, SCHOOL OF BUSINESS, UNIVERSITY OF NAIROBI

AUGUST, 2009
DECLARATION

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

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DEDICATION

To my loving wife Martha A.Angwekwe and daughters Diana Adhiambo,
Magdaline Akinyi,Faith Auko for their love, invaluable support, encouragement,
understanding & sacrifices throughout the course .Also in loving Memory of my
late wife, Anastasia Ambale Anyonje and my late parents, John J.Obor &
Christine A.Obor for having inculcated in me the spirit of “backward never,
forward ever”, may their souls forever rest in eternal peace.
I wish to sincerely acknowledge the assistance and support given to me by my lecturers at the University of Nairobi, in particular, to my supervisor Mr. Stephen N.M. Nzuve whose invaluable contribution in the preparation and writing of this management project report was immense. My gratitude goes to my employer, Office of the President (Police Department), especially to the Assistant Director Human Resource Management and colleagues, both at workplace and at the University, for their assistance during this period. Special thanks goes to members of my family especially to my wife Martha and my children whose support and encouragement made this project a reality.
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ACRONYMS

ACP-Assistant commissioner of Police
AIDS-Acquired Immune Deficiency Syndrome
ASTU-Anti stock Theft Unit
CIA-Criminal Intelligence Agency
CID-Criminal Investigations Department
CP-Commissioner of Police
DCIO-Divisional Criminal Investigations Officer
DCP-Deputy Commissioner of Police
DIA-Defence Intelligence agency
GDP-Gross Domestic Product
GSU-General service Unit
HEARD-Health Economics and HIV/AIDS Research Division
HIV-Human immune virus
IBEA-Imperial British East Africa
ILO-International Labor Organization
KAPU-Kenya Police Airports Unit
KDHS-Kenya Demographic Health Survey
KPC-Kenya Police College
KPSP-Kenya Police Strategic Plan
LDCs-Less Developed Countries
MSH - Management Science Health

NACC - National AIDS Control Council

OCPB - Officer Commanding Police Base

OCPD - Officer Commanding Police Division

OCPP - Officer Commanding Police Post

OCS - Officer Commanding station

PCIO - Provincial Criminal Investigations Officer

PLWA - People living with HIV/AIDS

PPO - Provincial Police Unit

PRESCOT - Presidential Escort Unit

PSWPP - Public Service Workplace Policy

PTC - Provincial Training College

TPU - Tourist Police Unit

S/ACP - Senior Assistant commissioner of Police

S/DCP - Senior Deputy Commissioner of Police

SP - Superintendent of Police

SSP - Senior Superintendent of Police

UNDP - United Nations Development Programme
ABSTRACT

The world is becoming increasingly complex and the most serious challenges are global in nature. One of these global challenges identified by the Millennium Project (one of various environmental organizations focusing on HIV/AIDS) is the control and reduction of new and re-emerging diseases and immune microorganisms. The illness and subsequent deaths of workers resulting from HIV/AIDS has an enormous impact on the national productivity and earnings. Labour productivity drops, the benefits of education are lost, and resources that would have been used for wealth creation and poverty reduction are diverted to treatment, care and support. Savings are declining and human capital is affecting production and quality of life.

The objective of the study was to determine the impact of HIV/AIDS on the Kenya police force.

This research was conducted through descriptive research design. It was based on both secondary and primary data and involved collection of information through the administration of questionnaires to the police officers in the police force, who were selected using stratified random sampling method. Data was analysed using descriptive statistics and interpreted using mean scores, frequencies / percentages. Data presentations were made using tables and graphs.

From the study, the researcher found that HIV/AIDS has a great impact on Kenya police force. These impacts are such as, some officers have died as a result of HIV/AIDS related illnesses, the officers perceived to be suffering from HIV/AIDS do not report on duty punctually, and also they leave for home before the official time which affects their performance in their assigned duties negatively. The trend of reporting for duty by those officers perceived to be suffering from HIV/AIDS is irregular, which also has a great effect on their performance and on the overall performance of the police force. HIV/AIDS also
has an impact to the Kenya police force as it spends a lot of time and money on funeral arrangements occasioned by HIV/AIDS. The study therefore recommends that in order to reduce the impacts of HIV/AIDS in the police force, the police officers should be encouraged to spend time and attend workshops on HIV/AIDS in order to have more awareness on HIV/AIDS and its impacts and also workplace policies on HIV/AIDS should be adequately implemented and also the department should mainstream HIV/AIDS in the core functions of the police officers.
CHAPTER ONE: INTRODUCTION

1.1 Background Information

HIV is defined as Human Immune virus. This is a virus that weakens the body’s immune system, Helen (2002). AIDS is the Acquired Immune Deficiency syndrome. It is a cluster of medical conditions often referred to as opportunistic infections, Helen (2002). HIV and AIDS profoundly disrupt the economic and social bases of families. It mainly affects people in their prime years of life. The hardest hit being those in the productive ages of between 15-49 years. It is also affecting the fundamental rights at the workplace, particularly in respect to discrimination and stigmatization of people living with and affected by HIV and AIDS, PSWPP (April 2005).

The illness and subsequent deaths of workers resulting from HIV/AIDS has an enormous impact on the national productivity and earnings. Labour productivity drops, the benefits of education are lost, and resources that would have been used for wealth creation and poverty reduction are diverted to treatment, care and support. Savings are declining and human capital is affecting production and quality of life. The sum total of these has a negative impact on the national gross domestic product, PSWPP (2005).

The HIV/AIDS is having a devastating effect on many developing countries of Africa, largely by undermining human capital particularly in the countries like South Africa, Ethiopia, Botswana, Kenya, Swaziland, and Uganda among others. The disease affects primarily the adult population in its most productive years thereby thwarting population incentives to save and invest. The epidemic disease of AIDS destroys the social fabric of whole communities and undermines the capacity of government to provide basic social services and essentially
curtails the potential for sustained economic development and social
transformation. Since development has to start with human resources, many
African economies suffering with problems such as, high rate of poverty and
low-skilled population, desperately need human capacity building by expanding
the institutional infrastructure and increased public awareness of AIDS, Rena

Human resources are essential and constitute the basis for the economic
development and social progress of any country. The wealth of any nation is
more dependent upon the development of its people than upon the
accumulation of material capital. The true wealth of a nation lies in the wisdom,
power of knowledge, and skills of its human resources. Since many African
countries are under the threat of the pandemic, HIV/AIDS has thus become a
major challenge for the human resource development. Education needs
opportunity, as water needs a dam, to channel its potential energy into
productive uses for society. Education needs equal access for all children, the
street child, the physically and mentally handicapped, the visually impaired, the
child solider, the child sitting in a refugee camp, the children sold into slavery,
and for the 65 million girls not allowed, or unable, to go to school, Waldman &
David (2006). Both the governmental and non-governmental organizations all
over the world particularly in Africa must work together to reach the
Millennium Development Goals.

1.1.1 The Kenya Police
The historical evolution of the Kenya Police is encapsulated in the KPSP (2004-8).The Kenya police Force has its small beginnings in the period between 1887-1902, tracing its foundation to the Imperial British East Africa (IBEA) Company and businessman, Sir William McKinnon, who, in the interest of his business found it necessary to provide some form of protection/security for his stores
along the coastline of Kenya. It is from this origin that the concept of constituting real police force was formed in Mombasa. Generally police activities were centred on protection of the business of IBEA Company where the strength was mainly of Indian origin with a skeleton staff of some Africans, otherwise known as "Askaris". During those early stages of the small police force, the duties were negligible.

It is notable that up to 1907, the Kenya police was organized along military lines and the training was military in nature. In 1906, the Kenya police was legally constituted by a police ordinance. After the end of First World War in 1918, the police force begun to be re-organized. This entailed increasing personnel and creating better administrative and residential housing. In 1926, the Criminal Intelligence Unit was established with the sole responsibility of collecting, tabulating and recording the history and data of criminals, undesirable and suspicious persons. Special sections such as finger prints bureau and Criminal Investigations Department (C.I.D) were created starting with skeleton staff, composed of some police officers from Britain and South Africa. This was the foundation of today's Kenya Police Force.

In the same year, the Railways Police Unit was established to deal specifically with prevention and detection of offences in the Railways, from Coast to Kisumu, including the Kilindini harbor and Beach lines. As the years progressed, the scope of police activities increased and it was called upon to deal with traffic problems, such as accidents and parking. They were also called upon to deal with cattle rustling in the countryside; this was the genesis of the Anti Stock Theft Unit (A.S.T.U.). In 1946, the police force was placed inside the office of the Attorney General and their powers were increased tremendously. In 1948, several important developments were made in the Police Force. The Kenya Police Reserve was formed as an auxiliary of the force. To improve the
effectiveness of crime control, a Dog Section was also introduced as well as the General Service Unit (G.S.U) in the same year.

In 1949, the Police Air Wing was formed to carry out duties such as communication and evacuation of injured persons to hospitals and was made part of the force in 1953. In 1957 the Police Headquarters Building (Vigilance House) was opened and in 1958, the Force was made integrated within the Ministry of Defence. After Kenya gained her independence, from the British Government on 12th December, 1963, there was a need to make some drastic changes in the administration of the force. This led to the replacement of the expatriate officers in the senior ranks by Africans. Since then, the Force has realized tremendous achievements, in various fields of operations. Due to increased criminal activities and in line with the Police resolve, to effectively deal with security threats and bring down crime to minimal level, various specialized Units have been formed. These include the Anti motor Vehicle Theft Unit, the Tourist Police Unit, the Anti Corruption police Unit, the Presidential escort unit, the Anti Terrorism Police Unit amongst others.

The Kenya Police has more than 40,000 employees; majority of who are uniformed officers. This study shall be carried at the Police Headquarters (Vigilance House), Nairobi and any other provincial/divisional Headquarters.
1.2 Statement of the Problem

The world is becoming increasingly complex and the most serious challenges are global in nature. One of these global challenges identified by the Millennium Project (one of various environmental organizations focusing on HIV/AIDS) is the control and reduction of new and re-emerging diseases and immune microorganisms. Since the first cases of HIV/AIDS were reported in 1980, nearly 58 million people have been infected and 22 million have died - and these are only the known estimated figures. For example, in 1997 the Doyle model predicted that by the year 2000 between 8% and 10% of adults in South Africa would be infected with HIV, increasing to approximately 22% in the year 2010, Cohen (2002).

By 2001 the national prevalence rate among pregnant women had already reached 24.8%. A particularly pertinent aspect for the business environment is that infection levels are very high among young, economically active persons. This will not only influence consumer power but has an overwhelming effect on the workforce and is thus a major threat to the achievement of strategic business objectives and related business risks, forming a great concern for management. A further concern for managers of organizations is the various legislative regulations relating to HIV/AIDS. Responding to HIV/AIDS in the workplace is essentially about managing the issue as a business risk; that is having accurate and relevant information about the epidemic, monitoring progress, knowing or predicting the risk and addressing the risk.

Cohen (2002) confirms that one of the most significant features of the HIV/AIDS epidemic is its concentration in the working age population (15-49), such that those with critical social and economic roles are disproportionately affected. Laurie Garrett (2005) asserts that, for reasons of their own national security, few
governments have disclosed the HIV infection rates in their armed forces and police. During the 1990s, many agencies, including the CIA and U.S. Defence Intelligence Agency (DIA), used indirect data to conclude that infection rates in some African militaries were as high as 75%. Such speculations appear to be off target. Some critics, pointing to the wildly inflated estimates made a decade ago, now charge that in the absence of solid seroprevalence data on the world’s armed forces, it is impossible to make assertions about the impact of HIV on military and police performance and capacity.

The Police Force, being a Department established to safeguard the county’s internal security through detection, prevention of crime and maintenance of law and order is an important institution in Kenya. Given the nature of their job, the police officers are required to have a peace of mind and necessary physical health to undertake their duties. Most researchers in the past have focused on the general public without particular attention to the police force. It is in this background that this study was set to determine how HIV/AIDS has impacted on this very important institution in our country, Kenya.

1.3 Objective
To determine the impact of HIV / AIDS on the Kenya police force

1.4 Significance of the study
(i) To the Police Force
The study will provide evidence on the impact of HIV/ AIDS on the police force. This will assist the government and the Kenya police force in particular in defining mechanisms to respond to the epidemic. The study will also advise management in the police force on the appropriate approaches to address the negative impacts.
(ii) To other government Institutions
The study would outline the impact of HIV/AIDS on work performance of the police officers. Other government institutions such as other forces and parastatals can rely on this study to put their case in perspective.

(iii) To Other researchers
Other academicians will be able to use this study as a form of reference. Specifically, student undertaking social studies will appreciate the findings of this study as relates to the police force. The study will also suggest other unexplored areas of research for future studies.
CHAPTER TWO: LITERATURE REVIEW

This section explores literature on HIV / AIDS; in addition findings that relate to work place stigma will be presented. Various sections will discuss the literature as relates to the set objective.

2.1 HIV/AIDS
AIDS is the Acquired Immune Deficiency Syndrome. It is an infectious disease caused by a virus called HIV. The virus enters the white blood cells, which protects the body from infectious diseases. In the cells, it destroys genetic material and the damage is permanent. The body's immune system weakens and eventually fails. As a result of the failure, many opportunistic infections take place, often at the same time, Helen (2002)

HIV is the Human Immune Virus. This is the virus that causes AIDS and it is found mostly in the body fluids of infected persons. Suffice to point out that only body fluids with comparatively higher concentration of the virus may cause infection. These fluids are blood, semen, Virginal secretion and breast milk. Although the most efficient way for HIV to spread from one person to another is through infected blood transfusion or organ transplant, over 70% of all HIV infection worldwide is spread through sexual intercourse between men and women. In the sub-Saharan Africa this percentage is even higher, with the second most important route being transmission from an HIV-positive mother to her baby. Afar smaller number is infected through sex between men and unknown but relatively small number in Africa through injecting drug use. The sharing and use of non-sterile needles or cutting implements by traditional healers and poorly resourced health settings, unscreened blood and inadequate hygiene precautions when caring for AIDS patients are also likely to contribute to HIV transmission on the continent, Helen (2002)
The Kenya demographic and health survey KDHS(2005) estimate that 7% of adults aged 15-49 years in Kenya are infected with HIV, and that rates in women are nearly double the rates of men. Majority of the Police officers happen to fall in this category. Urban populations have higher adult HIV prevalence (10%) than do rural population (6%). Regional variation is significant; Prevalence rate in Nyanza province is 15% in adults, whereas in Nairobi it is 10%.

2.2 Institutional and Policy Response

In order to address the problem of HIV/AIDS, management needs to know the risks involved, and minimize the risks by implementing a proper strategic action plan. Control is the most important mechanism that management can use to ensure that its plans and procedures are adhered to, thus minimizing the risks threatening the organization. The implementation and maintenance of a sound control system is the responsibility of management, Treadway Commission's report (1987)

HIV/AIDS is a threat to people and, therefore, to the workforce. The control environment forms the basis of the control system. Management must thus understand the effect of the potential risk of HIV/AIDS on the control system, including the control environment. The institutional response to AIDS internationally has tended to mirror personal responses, including initial denial, blame, repression and, ultimately, a varied degree of acceptance and coping. In most LDCs the scale of response, however, remains far below what is required for effective prevention, care, long-term mitigation of the impacts of AIDS-the three critical cornerstones of AIDS policy. The primary limitations are inadequate international and local funding, weak political response within countries and too

The ministry of Health instituted an AIDS control committee in 1987, when it developed the first five years strategic plan for AIDS control (1987-1991). The second plan was for (1992-1996), Ministry of Health (2005). The sessional paper No.4 of 1997 on AIDS in Kenya marked an important change on the political front as it outlined a new institutional framework. With the creation of National AIDs control council, AIDS control Units (ACUs) were put in place in all the ministries, where the disastrous effect of HIV/AIDS had been felt the most and where it was anticipated that interventions would have the greatest beneficial effect. In 1999 the Government of Kenya (GOK) declared HIV/AIDS a national disaster and established the A.C.U. and facilitated the development of the Kenya National HIV/AIDS Strategic plan (KNASP) 2000-2005 which set a multi sectoral response to the epidemic, jointly agreed by the stakeholders within Government; civil society, the private sector and development partners, OOP (2005)

Increased public political commitment was evidenced in 1999 when HIV/AIDS was declared a national disaster, Ministry of Health (2005). Constituency AIDs control Committees (CACCs) and the District technical committees (DTCs) embody this multi-sectoral response in partnership with ACUs and civil society. Now Kenyans are more involved in a comprehensive effort to confront all aspects of the disease’s spread/impact. The government has put in place policies and infrastructure to help implement programs at all levels and has issued guidelines for conducting activities in HIV/AIDS related areas.
2.3 The Socio-Economic Impact of HIV/AIDS

In Kenya, as in other countries in the sub-Saharan Africa, HIV/AIDS threaten personal and National well-being by negatively affecting health, lifespan and productive capacity of the individual. In a nutshell, it does critically and severely constraints the accumulation of human capital and its transfer between generations. Research in across many severely affected, low income countries clearly shows that HIV/AIDS is the most serious impediment to economic growth and development in such countries. Kenya is therefore no exceptional, OOP (2005). Sector impact studies (2004) suggest that HIV/AIDS undermine development across all sectors of the economy and society, though further studies are required to quantify the impact. Major challenges, however include; the productivity of agricultural sector, upon which the majority of Kenyans rely for their livelihood, is undermined by negative impacts on the supply of labour, crop production, agricultural extension services, loss of knowledge and skills and personnel traumatized with death.

In addition, other challenges include, reduced educational services as teachers are lost to HIV/AIDS and children drop out of school as parents die and household income fail; the health services losses trained staff and has to cope with the increased burden of HIV related infections; the direct cost and social problems associated with caring for increasing numbers of orphans, coupled with existing high poverty levels, place severe burden on family and social structures. In addition to the above direct efforts on production and social services, there is a growing realization that HIV/AIDS may undermine the long term revenue base of the economy and so reduce government’s capacity to provide infrastructure and social services essential for long term economic growth.

The AIDS crisis is one of the most important factors driving the human resources crisis in Africa. UNAIDS's most recent update reports that 25.8 million adults are
living with HIV in sub-Saharan Africa, with 3.2 million adults and children infected with HIV in 2005. With sub-Saharan Africa the hardest hit by HIV and AIDS, the impact of the crisis is felt at all levels of society. Cohen (2002) indicated that, the main channels through which the HIV epidemic affects social and economic development are through its impact on the labour force and its related effects on the level and allocation of savings. In the case of the former, the effects flow from the key fact that the epidemic has its primary impact on the working age population, where HIV-related morbidity and mortality are concentrated.

Thus those with important economic and social roles, both men and women, are prevented from providing their full contribution to development. The effects are, of course, not confined to a simple calculus of labour losses, but have much deeper implications for the structure of families, the survival of communities and enterprises, and longer-term issues of sustaining productive capacity. Similarly the HIV epidemic erodes the savings capacity of households, formal and informal productive enterprises, and of government, through its effects directly on flows of income and levels of expenditure. Reduced rates of savings will over time lead to slower growth of aggregate output, with the likelihood of declining per capita income, Garrett (2005)

Cohen (2002) confirms that one of the most significant features of the HIV/AIDS epidemic is its concentration in the working age population (15-49), such that those with critical social and economic roles are disproportionately affected. Garrett (2005) asserts that, for reasons of their own national security, few governments have disclosed the HIV infection rates in their armed forces and police. During the 1990s, many agencies, including the CIA and U.S. Defence Intelligence Agency (DIA), used indirect data to conclude that infection rates in some African militaries were as high as 75%. Such speculations appear to be off target. Some critics, pointing to the wildly inflated estimates made a decade ago,
now charge that in the absence of solid seroprevalence data on the world’s armed forces, it is impossible to make assertions about the impact of HIV on military and police performance and capacity.

There are about fifty million people serving in the world’s armed forces and police forces today, the majority of whom are men under twenty-five years of age. By virtue of their youth, long periods of deployment away from family and mates, access to cash and tendency to “buy” sex partners, likelihood to drink heavily or use drugs when off duty, capacity to impose coercive methods to obtain sex, dangerous and stressful work, and general Participation in a “macho” culture, the military and police are thought to be at special risk for all sexually transmitted diseases, Garrett (2005). In most societies today, armed forces and police tend to be drawn from the ranks of the poor and disadvantaged youth. Until recently, national security studies assumed that these factors guaranteed that uniformed services personnel would have higher rates of HIV infection than the civilian society, presenting an obvious threat to local and regional stability. In some cases, this has proven true.

Armed forces and police have had higher rates of HIV infection than the general society they serve. But this has not always been the case, and it would be unwise, in the absence of firm, transparent testing data to assume any given military force has an HIV infection rate at some significant increment greater than the general population, Garrett (2005)

2.4 AIDS and the Workplace

In countries with significant HIV/AIDS epidemics, almost all organizations will incur costs due to HIV/AIDS impacts on employees. In addition, the epidemic will have profound social and economic effects which impacts on organizations,
HEARD (1999). AIDS not only causes illness, disability and death for employees and severe economic and emotional disruption for their families—it also increases the cost of doing business, UNAIDS (1998). How AIDS affects the workplace can be looked at from the employees’ and employers’ view points. For instance, employees’ needs for improved medical care, sick leave benefits, death-in-service and pension benefits increase while employers faced with the escalating costs, needs to limit expenditure and sustain production. It is in the interest of both the employers and the employees to mount an effective HIV awareness and prevention strategies, and keep employees with HIV healthy and productive as long as possible, Helen (2002). A survey conducted by GJLOS (2008) evidenced that most respondents from the police Department, Administration police, NYS, Prison Staff, Provincial Administration, Probation and Aftercare Services and immigrations Departments viewed that workplace environment contributed a greater risk to the exposure and vulnerability towards contacting HIV.

The study even found that 48.4% of the respondents felt that the nature of their work exposed them to HIV infection, while 26.0% did not know if the workplace environment increased their exposure. Studies and surveys undertaken in Kenya and the rest of Africa on socio-economic impacts of HIV and AIDS on service delivery across sectors (in agriculture, education, transport and local government), have indicated that HIV has led to a loss of skilled and experienced manpower due deaths, loss of man-hours due to prolonged illnesses, absenteeism, reduced performance, increased stress, stigma, discrimination and loss of institutional memory, among others. Consequently, business and organizations suffer loss due to decreased productivity and increase in health care costs, NACC (2006)
2.5 Linkage between HIV/AIDS and Performance

Of note is the impact of AIDS on human resource as it increases stress within a workplace in so many ways; personnel managers have to cope with staff who are increasingly unwell and unable to perform to standard, for instance failing to reach productivity levels or missing deadlines. They have to deal with the strain on the other staff whose workload increases to make up for the non-performance of their colleagues. Employees who are becoming sick, meanwhile, may try to hide their infection and illness when they know their status, for fear of stigma and discrimination and they may overwork and strain themselves in an effort not to let it show, Helen (2002).

The costs of the HIV epidemic are not confined to estimates of lost output due to early mortality, although these are clearly very significant. There are other costs that are also significant. Among these are costs to service delivery due to absenteeism both directly due to illness, and indirectly caused by funeral attendance, caring for sick relatives, disruption of the flow of work, and so on. These are estimated by the study for each of the ministries and are found to be very significant. They note that policies with respect to sick leave and more general absenteeism are not being observed, and that in any case that under present conditions require urgent reform if the public service is to be able to continue to function, Cohen (1999).

Like poverty, HIV/AIDS epidemic is affecting the sub-continent of Saharan Africa more severely than any other parts of the world (Lugalla et al, 1999) with 63% of global AIDS cases occurring in the region. Surely poverty and HIV/AIDS are cause for concern for the African continent. Sub-Saharan Africa is the only region of the world where the proportion of people living in extreme poverty is increasing. The number of Africans living below the poverty line (less than 1 US dollar per day) has almost doubled from 164 million in 1981 to 314 million
people today, Jooma (2005). She further contends that 32 of 47 African countries are among the world’s 48 poorest nations. The impact of extreme poverty is felt even more at household level. Households may find themselves spiralling into extreme poverty, making it impossible for the household to assume its “normal” functioning.

Poverty and HIV/AIDS do not occur in a vacuum, but rather in a social context, Lugalla et al (1999). Lwihula (1992) as quoted in Lugalla et al linked the AIDS epidemic with the years of economic crisis in the early 1980s that saw the scarcity of essential commodities. These economic hardships intensified poverty, destabilized families, and increased people’s movements between countries. The situation widened the web of sex networking, and in this way facilitated the early rapid spread of HIV. Understanding poverty within the context of HIV/AIDS is critical as it is viewed in this paper as both a risk factor for and the consequence of HIV infection. As a risk factor, poverty is associated with weak endowments of human and financial resources such as low levels of education, low levels of literacy and few marketable skills, generally poor health status and low labour productivity, Cohen (1998). The inability to attract endowments, through engaging in income generating activities by adults, as a result of HIV infection, morbidity and mortality sinks poor households into even deeper poverty.

Poor households may find it even more difficult to exonerate themselves from dire poverty for many more years and generations to come. Poverty, as a consequence of HIV infection could see the poor adopting various mitigation strategies to cope with the disease that often exposes them to HIV infections. Cohen (1998) argues that it is not surprising that the poor adopt behaviours that expose them to HIV infection. And that it is not simply that the IEC activities are unlikely to reach the poor but that such messages are often irrelevant and
inoperable given the reality of their lives. Whiteside (2002:320) suggests that illness and poverty affect household resources and income. One sees rising costs of medical care/treatment, and an increased need for nutritious foods. With the progression of the illness, the demand for care also rises. Children are often withdrawn from schools to care for sick adults, further compromising their basic right to education. The deprivation of education could place the household at further long-term risk for poverty, lack of skills and disempowerment. The latter results in a cycle of household impoverishment that may take decades to reverse.

Lack and/or limited education and skills also appear to influence vulnerability to HIV infection. A national household survey in South Africa has found that those with tertiary educational qualifications had lower rates of HIV infection than those with only school level qualifications, Shisana and Simbayi (2002). The assumption here might be that people with the necessary educational qualifications, thus acquiring economic independence/freedoms for survival do not engage in risky behaviours than those with limited education. Cohen (1998) argues that HIV intensifies poverty, leads to its persistence and over time generates a culture of poverty. When parents are sick and die from AIDS-related complications, there is little or no transfer of skills and knowledge to the younger generation. The circle of poverty is likely to repeat itself and felt over generations. Barnett et al (2001) argue that interventions to mitigate the effects of the pandemic on the rising generations are needed.

Loewenson & Chikumbirike (2005) argue that persistent poverty leads to what is termed “new variant famine” where chronic poverty and ill health are increased reducing household mechanisms and resources for coping with illness and mortality and further undermining long term prospects for food security and household well-being. Nicoli Nattrass (2004:28) uses the term “sexual economy” to describe sexual activities that men and young women engage in, in exchange
for money. The participation in the sexual economy activities, as a result of poverty, places young women, in particular, at higher risk of HIV transmission and infection. Nattrass quotes Akeroyd (1997) who asserts that sexual culture places women in a vulnerable situation regarding HIV infection, and poverty exacerbates it by encouraging women to engage in sex as an economic strategy for survival. Dixon-Fyle & Mulanga (2004) concurs with this by stating that young women sell their bodies to help families, and men take advantage of the opportunity, or express feelings of powerlessness and despair through sexual violence when they are not driven by a mistaken belief in the healing power of the virgin female body. Gender inequality and poverty deprives women of their ability to fulfil their socially designated responsibilities, and therefore debases them, often forcing them into prostitution, Lugalla et al (1999). Shelton et al (2005) commented in the Lancet that the poor especially women are vulnerable to sexual exploitation because HIV prevalence is partly a function of survival. They further contend that people with HIV eventually tend to lose wealth because of loss of employment and increased expenses related to the disease, thus blunting a positive relation between wealth and HIV.

A decline in government expenditure on health in many African countries translates into an increase in a number of untreated STDs that are known to facilitate the rapid transmission of HIV. This could have serious longterm health implications resulting from the rapid spread of HIV, Lugalla et al (1999) & Munyako (1994). Children raised in poor households face a large risk of achieving a low level of educational attainment and dropping out of school, Verner & Alda (2004).Girls especially are removed from school as a coping strategy, and also because the girls education is viewed as “less of a priority”, since it is expected that they will marry and will belong to another family, Grant & Palmiere (2003). This is also largely due to economic factors such as loss of income due to HIV/AIDS amidst high education costs, and the direct costs like
school fees, textbooks and uniforms. HIV/AIDS appears to interact strongly with poverty and has increased the depth of vulnerability of those households already vulnerable to shocks. HIV/AIDS has acted to intensify the disadvantages imposed on the poor households and communities.

2.6 The Impacts of HIV/AIDS on Households

HIV/AIDS and poverty continue to exceed all expectations in the severity and the scale of their impact on the households and countries in general. Piot et al (2001) already predicted then that AIDS constitutes one of the most serious crises currently facing human development, and threatens to reverse progress in the mostly affected countries by decades. There is no reason to believe that Africa as a continent is not feeling the effects of this pandemic right now especially when considering the death toll due to AIDS and the ever increasing number of orphans as a result of HIV/AIDS. HIV/AIDS and poverty impact significantly especially on the household and its ability to cope with the epidemic. Household impact is one of the points at which AIDS and poverty demonstrate their intertwined relationship, Piot et al (2001)

They assert that AIDS exacerbates and prolongs poverty in every context. For example in poorer households, AIDS takes a greater proportion of available expenditure, and limits access to food and health care. In education, it has a negative impact both in the supply of teachers and on the capacity of children to continue in school.

2.6.1 Direct Economic Impacts

While HIV/AIDS crosses all socio-economic groups, its economic impacts are greater on the poor, powerless and marginalized, Grant & Palmiere (2003:213). From the time of diagnosis, poor households feel the economic impact of the disease. Wyss, Hutton and Diekhor (2004) found in their study in Chad that the average costs of AIDS to patients and their families are very high. On average, a
household spends USD78.6 (R521.66) a month directly on AIDS treatment and care. Cross (2001) in her study on rural households in South Africa further asserts that the de facto per capita income may fall to as low as R50 per month. The households therefore spend considerable amounts of money on consultation and treatment fees, and transport. Households see a greater spending on health care and associated costs, Save the Children (2004) & Wyss et al (2004). The chronically ill person is often unable to work leading to reduced income and output in agricultural production. Chronic illness coupled with the need to care for the ill, by other household members, takes valuable time away from productive activities leading to double loss of income thus exposing households to risks such as food insecurity and exposure to HIV transmission, Save the Children (2004). In addition, De Waal & Whiteside (2003) have found that diversion of labour coupled with the care of children orphaned as a result of the death of their parents to AIDS related diseases further impoverishes the household.

HIV/AIDS strikes persons at the prime of their lives thus exerting a heavy toll on the economic well-being of the household. The death of a productive member comes with a reduced or loss of income, Cross (2001) & Save the Children (2004)); absence of savings and other assets to cushion the impact of illness and death, Cohen (2002). For households that are solely dependant on agriculture, the death of the member means that the contribution to agricultural production and income from that person is permanently lost. However, this may also be the case for people working in the industry. Grant & Palmiere (2003) found in their study in Bulawayo (Zimbabwe) that HIV/AIDS affected households experience a 40% drop in household income, which is bound to impact the decisions and the psychological outlook of the household. The lack of time is viewed as the contributory factor to dip in household income. Although the households
attempt to diversify, they are unable to add a lucrative income-generating project.

Households may be forced to change their livelihood strategies to counter the impacts of the loss and reduced household income. Grant & Palmiere (2003) established that households were forced to cut back on their livelihoods to accommodate a lower average monthly income, and an increase in the number of people living within the household. This effectively means that households sink deeper into poverty and likely chances to avert the economic impact are very low or non-existent for some very poor households. The HIV/AIDS epidemic undercuts the ability of the households to cope with shocks. Assets are likely to be liquidated to pay for the costs of care. Sickness and caring for the sick prevent people from migrating to find additional work, Wiggins (2005). Indirect Economic Impacts People Living with HIV/AIDS (PLWHA) may suffer from considerable stigmatization in their homes, communities and workplaces when their HIV+ status is known. This may lead to various forms of social and political discrimination/exclusion including reduced chances for employment and in some cases dismissal from work, and insensitive and biased institutional policies.

Lau & Wong (2001) have found that almost 20% of companies in their study would dismiss HIV+ employees to avoid anxiety and unrest among the rest of the staff. They further found that HIV+ employees would be transferred to other posts/positions against their will once their HIV+ status is known. This indicates that stigmatization may impact on the financial resources of the household that could otherwise be generated through formal employment. Following the gender bias argument, women come out the worst in-terms-of income generating activities available to them. Because there is a general expectation on women to care for others including the sick, valuable production time is lost thereby impacting on the economic ability of the household to offset the ill effects of the
pandemic, Grant & Palmiere (2003). Wyss et al (2004) found that time lost due to illness was 15.8 days a month, and family members spend time caring for the ill person instead of engaging in income generating activities. Household members provided assistance at an average of 8.3 days thus abandoning their daily activities or occupations. Average monthly productivity loss attributable to AIDS equalled 21.6 days per household. The HIV/AIDS epidemic reduces farm production and incomes. In farming, labour is lost to sickness and death, as well to the time taken by those caring for the sick. Affected households plant smaller areas and use less intensive production methods, Wiggins (2005). Capital to buy inputs is likely to be spent first on medicines, visits to hospitals, and eventually on funerals. Food Security, Nutrition and Health Household livelihood is a critical factor in understanding the impact of poverty and HIV in the overall functioning of the household and its ability to provide for the basic needs of its members.

Ellis as quoted by Niehof (2004:322) defines livelihood as comprising of assets (natural, physical, financial and social capital), the activities, and the access to these (mediated by institutions and social relations) that together determine the living gained by the individual or household. The concept of livelihood is therefore multifaceted in that it considers the activities that the household engages in and the outcomes thereof. It also reveals the interconnectedness and/or the interplay between the household activities, environmental and the social institutions in community/society that determine the outcome or living of the household. Food security/insecurity. Food security is an important element for the survival of any household across the spectrum of wealth. Households affected by HIV and poverty may find it difficult to maintain their food security. Both HIV and poverty exert tremendous pressure on the household’s ability to provide for the basic needs like food.
Agricultural activities contribute to the welfare of households in two ways. Firstly, the production of food crops and ownership of livestock contributes to food security, and secondly it provides income, Samatebele (2005). HIV/AIDS and poverty combined have a debilitating effect on agricultural sector of the poor countries, and more so, on the households. A major impact on agriculture includes the depletion of human capital, diversion of resources from agriculture, and loss of farm and non-farm income, together with other forms of psychological impacts that affect productivity, Jooma (2005). The decline in agricultural production is attributable to the effects of HIV/AIDS, De Waal & Whiteside (2003). They further assert that households with a chronically ill person see an income reduction of between 30 & 35%. HIV/AIDS and poverty affect the food security of the household. HIV is often associated with morbidity leading to labour shortage and loss of income.

Households affected by HIV/AIDS are vulnerable to increased risk of HIV infection and the resultant poverty. Niehof (2004) argues that households with vulnerable livelihood systems have neither enough assets, nor capabilities to create or access them. The situation further impoverishes the household. The cycle of poverty and AIDS entrenches the system of chronic impoverishment, Jooma (2005). Families may not recover previous levels of social functioning, and may even resort to strategies that may imperil them further. These strategies may include engaging in commercial sex that puts women especially in danger of HIV infection.
CHAPTER THREE: RESEARCH METHODOLOGY

This chapter presents the research design and methodology that was used to carry out the research. It presents the research design, the population, sample size and sampling procedure, data collection and analysis.

3.1 Research Design
This research was conducted through descriptive research design. It was based on both secondary and primary data and involved collection of information through the administration of questionnaires to the sample population. The data collected provided a reliable and representative picture of the population and provided explanation as to the state of affairs about the impact of HIV/AIDS in the police force.

3.2 Population and sample design
3.2.1 Population
The population included all the staff of the Kenya police force, there were a total of 40,000 police officers in Kenya.

3.2.2 Sample
The sample was selected using stratified random sampling method. All the uniformed officers were grouped into their various ranks (strata). The advantages of this method were that one was able to represent not only the overall population, but also key subgroups of the population, especially small minority groups.
3.3 Data collection procedures and instruments

3.3.1 Data Instruments

The Researcher developed instruments with which to collect the necessary information. Questionnaires were used to obtain information from the respondent. The questionnaires contained both closed ended questions as well as open ended questions. The main advantage of closed ended questions was that they were easier to analyse since they were in an immediate usable form.

They were also easy to administer because each item was followed by an alternative answers and were economical to use in terms of time saving. The questionnaire was broken down into three parts with first part dwelling on the personal information about the respondent and his/her awareness of the existence of HIV/AIDS. The second part highlighted the socio-economic impact of HIV/AIDS on HR performance; the third dwelt on workplace policy on HIV/AIDS, its implementation and impact on HR performance.

The structured questions were used in the survey to gather data which were then subjected to quantitative analysis. Closed ended questions were used to elicit the desirable response. Due to the sensitivity of the matters surrounding the subject of HIV/AIDS, for subjectivity and ease of scoring and analysis, closed ended questions were more practicable. The likert 5-point scale, yes or no choice questions as well as the questionnaire were based on standardized or identical set of questions. Suffice to note that the main disadvantage of the self-administered survey was the low response rate. The selected method of administration thus played an important role in order to strengthen the response rate.
The following measures were therefore taken to enhance the response rate:

(i) A well written covering letter, stressing the importance of the study to the PPOs, OCPDs, Head of Departments (Vigilance House) and to the formation commanders assuring the respondents of the confidentiality and anonymity

(ii) Provided a due date which is reasonable and send reminders to the respondents

(iii) Follow up for non-response was well designed, visually appealing questionnaire

(iv) Advance notification to the respondents by phone, signals or e-mails of the survey and its intent.

3.4.2 Data Collection procedure

The study was collected using both primary and secondary data.

Primary Data - Refers to the information the researcher obtains from the field. This was obtained by use of the questionnaire.

Secondary Data - Refers to the information obtained from articles books, newspapers, internet and magazines. Secondary data indicates what other scholars have written about the topic in question.

3.5 Data Organization, analysis and presentation

3.5.1 Data Organization

Data organization included identifying and correcting errors in the data (editing), coding of the data and storing it in an appropriate form (paper storage)

3.5.2 Data Analysis

For data collected to have a meaningful application, it needed to be analyzed in a way that was easy to understand by the users. Analysis was therefore involved the examination of the coded data critically and making inferences. In this
respect, quantitative data analysis of measuring numerical values such as mean and standard deviations were made.

3.5.3 Data presentation

Data presentation was based on both statistical and graphical techniques

3.5.3.1 Statistical techniques

This included measures of central tendency (mean, median, mode) and measures of dispersion (range, variance, standard deviations)

3.5.3.2 Graphical techniques

This included cumulative frequency histograms, bars and charts
CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION

This chapter presents the data analysis and interpretations of the findings from the field. This was based on the objective of the study.

4.1 Respondents Profile

Table 1: Gender of the Respondents

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>116</td>
<td>82.9</td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
<td>17.1</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The findings in table 1 show that the majority of the respondents were males as indicated by 82.9%, while females were shown by 17.1%. This information shows that most of the officers in the police force are males.
On the age of the respondents, the study found that most of the respondents (police officers) were aged between 25-35 years as shown by 49.3% of the respondents, followed by 33.6% of the respondents who were aged between 36-49 years, 12.1% of the respondents were 18-24 years, while a small proportion of respondents as shown by 5% reported that they were over 50 years old.

These findings explain that most of the police officers (82.7%) in the Kenya police force are between 25-49 years. This therefore confirms that most police officers fall within the risk bracket of contracting HIV that is between 18-49 years.
The study also sought to establish the respondents' marital status. According to the findings, most of the respondents (78.6%) were married, 20.7% of the respondents were single, while a small proportion of respondents as shown by 0.7% were windowed.
The findings in table 4 show the respondents' job groups. From the study, most of the respondents were in job groups F-H as shown by 65.7% of the respondents. 31.4% of the respondents were in job groups J-L; while a small proportion of respondents as shown by 2.9% reported that they were in job groups 'M' and above.

**Duty Station**

The respondents were also requested to state their duty station. From the findings, most of the respondents said that they were in Nairobi province in Nairobi district. Others were in stations such as central province, Eastern province, western province & Rift Valley province.
In order to find out the respondents experience in the police force, the respondents were requested to indicate the number of years that they had served in the police force. From the findings, the majority of respondents as shown by 32.9% said that they had served for 11-20 years, followed by 27.1% of the respondents who said that they had served for less than 5 years, 22.9% of the respondents said that they had served for 6-10 years, while 17.1% of the respondents reported that they had served in the police force for over 21 years. This information shows that the majority of the police officers (72.9%) had served in the police force for over 6 years, and therefore they were well versed with the impacts of HIV/AIDS on the Kenya police force.
Table 6: Respondents Highest Level of Formal Education

<table>
<thead>
<tr>
<th>Level</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>8</td>
<td>5.7</td>
</tr>
<tr>
<td>Secondary</td>
<td>46</td>
<td>32.9</td>
</tr>
<tr>
<td>College</td>
<td>61</td>
<td>43.6</td>
</tr>
<tr>
<td>University</td>
<td>25</td>
<td>17.9</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The study also sought to establish the respondents' highest level of formal education. According to the findings, most of the respondents as shown by 43.6% had a college level of education, 32.9% of the respondents had a secondary level of education, 17.9% of the respondents had a university level of education, while a small proportion of respondents as indicated by 5.7% reported that they had a primary level as their highest level of education. From this information, the researcher was able to have confidence in the data collected as the majority of respondents (94.7%) had a secondary school level of education and above and this means that they were able to read, understand and give the most appropriate responses to the questionnaires.
4.2 Awareness of HIV/AIDS

Table 7: Awareness of HIV/AIDS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether the respondent has ever heard about HIV/AIDS</td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>Respondents Knowledge That HIV/AIDS Has No Cure</td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>whether the respondent has ever attended any HIV/AIDS behavior change seminar</td>
<td>76.4</td>
<td>23.6</td>
</tr>
<tr>
<td>Whether the respondent has ever visited any VCT centre for HIV testing</td>
<td>70.7</td>
<td>29.3</td>
</tr>
</tbody>
</table>

The findings in table 7 show the respondents awareness on HIV/AIDS. According to the findings, all the respondents reported that they had heard about HIV/AIDS and also all of them had the knowledge that HIV/AIDS had no cure. 76.4% of the respondents reported that they had attended HIV/AIDS behavior change seminar and also 70.7% of the respondents had visited VCT centre for HIV testing, confirming that most officers in the police force are aware about their HIV status.
4.3 Socio-Economic Impacts of HIV/AIDS of Performance

Table 8: Socio-Economic Impact of HIV/AIDS

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents knowledge of anybody in the workplace living with HIV/AIDS</td>
<td>40.0</td>
<td>60.0</td>
</tr>
<tr>
<td>Whether the respondent has a dependant who is HIV positive</td>
<td>23.6</td>
<td>76.4</td>
</tr>
<tr>
<td>Whether the respondent is affected by the HIV/AIDS as an individual</td>
<td>30.0</td>
<td>70.0</td>
</tr>
</tbody>
</table>

According to the findings, most of the respondents (60%) reported that they did not know anybody in the working place living with HIV/AIDS, most of the respondents (76.4%) also reported that they did not have a dependant who was HIV positive, and also majority of respondents (70%) reported that they were not affected by HIV/AIDS, in the work place, as individuals. HIV/AIDS does not therefore affect the officers' performance & service delivery; other factors could be responsible for this.
Table 9: Approximate Number of Officers That Suffer From HIV/AIDS Related Illness within the Station

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>121</td>
</tr>
<tr>
<td>6-10</td>
<td>14</td>
</tr>
<tr>
<td>11-15</td>
<td>1</td>
</tr>
<tr>
<td>over 21</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
</tr>
</tbody>
</table>

In table 9, the respondents were requested to indicate the approximate number of officers that suffered from HIV/AIDS related illnesses within their stations. According to the findings, most of the respondents as shown by 86.4% said 0-5 officers, 10% said 6-10, 2.9% of the respondents said over 21 officers, while a small proportion of respondents as shown by 0.7% said the 11-15 officers in their stations were suffering from HIV/AIDS related illnesses within the station. HIV/AIDS may therefore not be a major cause of illnesses within the force.
Table 10: Approximate Number of Officers in the Department That Have Died Due To HIV/AIDS Related Illnesses in the Last Six Months

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>115</td>
</tr>
<tr>
<td>6-10</td>
<td>15</td>
</tr>
<tr>
<td>11-20</td>
<td>4</td>
</tr>
<tr>
<td>over 21</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
</tr>
</tbody>
</table>

The respondents were also requested to state the approximate number of officers in their respective departments that had died due to HIV/AIDS related illnesses in the last six months. According to the findings, most of the respondents as shown by 82.1% said approximately 0-5 officers had died in their stations due to HIV/AIDS related illnesses, 10.7% said 6-10, 4.3% of the respondents said over 21 officers, while a small proportion of respondents as shown by 2.9% said 11-20 officers. Most deaths within the police force may not therefore be blamed on HIV/AIDS.
Table 11: Whether People Perceived To Be Suffering From HIV/AIDS Report on Duty Punctually

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>68</td>
<td>48.6</td>
</tr>
<tr>
<td>No</td>
<td>72</td>
<td>51.4</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

According to the findings in table 11, a slight majority of respondents as indicated by 51.4% reported that people perceived to be suffering from HIV/AIDS did not report on duty punctually, while 48.6% of the respondents indicated that they reported on duty punctually.
Table 12: Whether People Perceived To Be Suffering From HIV/AIDS Leave for Home before the Official Time

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>71</td>
<td>50.7</td>
</tr>
<tr>
<td>No</td>
<td>69</td>
<td>49.3</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The respondents were also asked whether people perceived to be suffering from HIV/AIDS left for home before the official time. According to the findings, a slight majority of the respondents (50.7%) reported that they left for home before the official time, while 49.3% of the respondents said that they did not leave for home before the official time.
Table 13: If Yes in table 12, How This Affects Their Performance in the Assigned Duties

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positively</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Negatively</td>
<td>67</td>
<td>48</td>
</tr>
<tr>
<td>no effect</td>
<td>62</td>
<td>44</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The respondents who reported that the people perceived to be suffering with HIV/AIDS left for home before official time were also requested to indicate how this affected their performance duties. According to the findings, most of them as shown by 48% said that it affected their performance negatively, 44% said that this had no effect on their performance, while 8% said that this affected their performance positively.
Table 14: How This Affects the Respondents' Performance as Someone Working Closely With Them

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positively</td>
<td>18</td>
<td>12.9</td>
</tr>
<tr>
<td>Negatively</td>
<td>58</td>
<td>41.4</td>
</tr>
<tr>
<td>no effect</td>
<td>64</td>
<td>45.7</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The respondents were also requested to state how this affected their performance as someone working closely with them. From the study, most of the respondents (46%) said that this had no effect on their performance as someone working closely with those perceived to be suffering from HIV/AIDS, 41% said that it had a negative effect on their performance, while 13% of the respondents said that it affected their performance positively.
The respondents were also asked whether the trend for duty for those perceived to be suffering from HIV/AIDS was regular or irregular. According to the findings, most of the respondents as shown by 69.3% said that it was irregular, while 30.7% of the respondents said that it was regular.
The study also sought to establish whether the police department spent a lot of funds and time on funeral arrangements occasioned by HIV/AIDS. From the findings, most of the respondents (70%) reported that the police department spent a lot of funds and time on funeral arrangements occasioned by HIV/AIDS, while 30% of the respondents disagreed with this.
Table 17: Whether the Respondent Has Spent a Lot of Time Attending a Workshop on HIV/AIDS

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>53</td>
<td>37.9</td>
</tr>
<tr>
<td>No</td>
<td>87</td>
<td>62.1</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The researcher also sought to find out whether the respondents had spent a lot of time attending workshops on HIV/AIDS. Most of the respondents as shown by 62.1% said that they had not spent a lot of time attending workshops on HIV/AIDS, while 37.1% said that they had spent a lot of time attending workshops on HIV/AIDS.
Table 18: The Nature of Duty Given To Officers Perceived To Be Suffering from HIV/AIDS

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Light</td>
<td>83</td>
<td>59.3</td>
</tr>
<tr>
<td>Heavy</td>
<td>3</td>
<td>2.1</td>
</tr>
<tr>
<td>Normal</td>
<td>54</td>
<td>38.6</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

According to the findings in table 18, the study revealed that the officers perceived to be suffering from HIV/AIDS were given light duties as shown by 59.3%, 38.6% said that they were given normal duties, while 2.1% of the respondents felt that the officers perceived to be suffering from HIV/AIDS were given heavy duties.
The respondents were also asked to state how those perceived to be suffering from HIV/AIDS were treated. According to the findings, most of the respondents said that they were treated as any other person as indicated by 74.3%, 24.3% said that they were treated cautiously, while 1.4% of the respondents felt that they were treated discriminatively.
Table 20: Relationship between the Superiors and Those Perceived To Be Suffering from HIV/AIDS

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>71</td>
<td>50.7</td>
</tr>
<tr>
<td>Fair</td>
<td>61</td>
<td>43.6</td>
</tr>
<tr>
<td>Bad</td>
<td>8</td>
<td>5.7</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The study also sought to establish the relationship between the superiors and those perceived to be suffering from HIV/AIDS. According to the findings in table 20, most of the respondents said that the relationship between the superiors and those perceived to be suffering from HIV/AIDS was good as shown by 50.7%, 43.6% reported that it was fair, while a small proportion of respondents said that it was bad.
The respondents who reported that the relationship between their superiors and those perceived to be suffering from HIV/AIDS was bad or fair were also requested to state how this affected the performance of those officers. According to the study, 35% of the respondents said that it affected the performance of the officers negatively, while 14.3% of the respondents reported that this had no effect on the performance of these officers.
Table 22: Respondents Agreement

<table>
<thead>
<tr>
<th>Question</th>
<th>Q</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether the colleagues take leave/off duty to attend to their HIV sick relatives</td>
<td>Q1</td>
<td>50.7</td>
<td>49.3</td>
</tr>
<tr>
<td>Whether some colleagues ask for sick leave frequently due to sicknesses</td>
<td>Q2</td>
<td>40.0</td>
<td>60.0</td>
</tr>
<tr>
<td>Whether officers perceived to be suffering from HIV/AIDS are transferred from one station to another fairly</td>
<td>Q3</td>
<td>52.1</td>
<td>47.9</td>
</tr>
<tr>
<td>Whether those perceived to be HIV positive are being denied promotion/developmental training</td>
<td>Q4</td>
<td>20.0</td>
<td>80.0</td>
</tr>
</tbody>
</table>

The respondents were also requested to state whether they agreed or disagreed with the statements in the above table. According to the findings, most of the respondents (50.7%) said that some of their colleagues took leave/off duty to attend to their HIV sick relatives.
attend to their HIV sick relatives, 60% of the respondents disagreed that some colleagues asked for sick leave frequently due to sicknesses, most of the respondents (52.1%) agreed that officers perceived to be suffering from HIV/AIDS were transferred from one station to another fairly and most of the respondents (80%) disagreed that those perceived to be HIV positive were being denied promotion/developmental training.

Table 23: If Yes in 22 above, How This Has Impacted On Performance/Service Delivery

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positively</td>
<td>19</td>
</tr>
<tr>
<td>Negatively</td>
<td>40</td>
</tr>
<tr>
<td>no effect</td>
<td>81</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
</tr>
</tbody>
</table>

The respondents who reported that some of the colleagues asked for sick leave frequently due to sicknesses and those who said that those perceived to be HIV
positive were being denied promotion/developmental training were requested to state how this impacted on their performance/service delivery. From the findings, 29% of the respondents said that this impacted negatively on their performance, 57% of the respondents said that this had no effect on their performance, while 14% of the respondents said that it had a positive impact on their performance.

4.4 Response Rating

Table 24: Response Rating

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>disagree</th>
<th>I don't know</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Mea</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS in my work station is one of the main reasons for low morale, less motivation and less concentration on job assignments</td>
<td>30.7</td>
<td>32.9</td>
<td>6.4</td>
<td>19.3</td>
<td>10.7</td>
<td>2.36</td>
</tr>
<tr>
<td>HIV/AIDS in my work station often disrupts my work schedule and output</td>
<td>32.1</td>
<td>40.0</td>
<td>2.1</td>
<td>17.1</td>
<td>8.6</td>
<td>2.26</td>
</tr>
<tr>
<td>HIV/AIDS in my work station often leads to breakdown of workforce discipline due to lateness, absenteeism, desertion and unmet work deadlines</td>
<td>29.2</td>
<td>35.0</td>
<td>4.3</td>
<td>18.6</td>
<td>12.9</td>
<td>2.36</td>
</tr>
</tbody>
</table>
In table 24, the respondents were requested to state their level of agreement in the statements in the above table. The researcher then used mean scores to interpret the findings. According to the findings, most of the respondents disagreed that HIV/AIDS in their work station was one of the main reasons for low morale, less motivation and less concentration on job assignments as shown by a mean score of 2.36, HIV/AIDS in their work station often disrupts their work schedule and output as shown by a mean score of 2.26 and also HIV/AIDS in their work station often led to breakdown of workforce discipline due to lateness, absenteeism, desertion and unmet work deadlines as shown by a mean score of 2.39.
4.5 Workplace Policy on HIV/AIDS

Table 25: Workplace Policy on HIV/AIDS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents awareness that there is a government policy on HIV/AIDS at the workplace</td>
<td>Q 1</td>
<td>72.1</td>
</tr>
<tr>
<td>Whether there is any workplace policy on HIV/AIDS in the police department</td>
<td>Q 2</td>
<td>70.0</td>
</tr>
<tr>
<td>If yes, whether it has been adequately implemented</td>
<td>Q 3</td>
<td>36.4</td>
</tr>
<tr>
<td>Whether the department has mainstreamed HIV/AIDS in the core functions</td>
<td>Q 4</td>
<td>35.7</td>
</tr>
</tbody>
</table>

According to the findings in table 25, most of the respondents (72.1%) said that they were aware that there was a government policy on HIV/AIDS at the workplace, 70% of the respondents also said that there was a workplace policy on HIV/AIDS in the police department, where most of the respondents (63.6%)
reported that it was not adequately implemented. Most of the respondents (64.3%) said that the department had not mainstreamed HIV/AIDS in the core functions, while 35.7% of the respondents said that the department had mainstreamed HIV/AIDS in the core functions by conducting awareness campaigns, by forming a section to deal with the affected and passing the right information, by organizing HIV sensitization programmes to the stations of work regularly and also through HIV/AIDS control unit.

Table 26: Any Support the Department Is Giving To Those Perceived To Be Suffering From HIV/AIDS

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>87</td>
<td>62.1</td>
</tr>
<tr>
<td>No</td>
<td>53</td>
<td>37.9</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The study also sought to establish whether there was any support the department was giving to those perceived to be suffering from HIV/AIDS. Most
of the respondents as shown by 62.1% said that there was support given to those perceived to be suffering from HIV/AIDS, while 37.9% of the respondents reported that there was no support given to those perceived to be suffering from HIV/AIDS.

Table 27: Support given by the department to those suffering from HIV/AIDS

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through counseling?</td>
<td>63</td>
<td>45.0</td>
</tr>
<tr>
<td>Provision of ARVs?</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>General welfare?</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Not reported</td>
<td>52</td>
<td>38</td>
</tr>
<tr>
<td>Total</td>
<td>140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

![Pie chart showing the distribution of support given to those suffering from HIV/AIDS.](chart.png)
The respondents who reported that there was support given to those perceived to be suffering from HIV/AIDS were also requested to state how they were supported. Most of the respondents as shown by 45% said that the support was through counseling, 9.3% of the respondents said through provision of ARVs, while 7.9% of the respondents said through general welfare.

Table 28: If No, How This Has Affected the Performance of Such Officers

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negatively</td>
<td>46</td>
<td>31</td>
</tr>
<tr>
<td>Somehow</td>
<td>29</td>
<td>19</td>
</tr>
<tr>
<td>No effect</td>
<td>38</td>
<td>26</td>
</tr>
<tr>
<td>Not reported</td>
<td>36</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>140</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

![Graph showing the distribution of responses](image-url)
The respondents who reported that there was no support given by the department to those perceived to be suffering from HIV/AIDS were also requested to suggest how this affected the performance of such officers. According to the findings, most of the respondents (31%) said that it negatively affected their performance, 19% said that it somehow affected their performance, while 26% said that it had no effect to the performance of such officers. 24% of the respondent never responded to this question.

What the employer should do for employees who are either infected or affected by HIV/AIDS in order to enable them improve their performance

The respondents were therefore requested to suggest on what the employer should do for the employees who are either infected or affected by HIV/AIDS in order to enable them improve their performance. From the findings, the respondents suggested that the employees who are infected or affected by HIV/AIDS should be counseled, provided with ARVs, given less strenuous duties and be allowed to work for fewer hours. In case of training, infected officers should be exempted from the strenuous parts of course work and should be monitored closely. They also suggested that those infected/affected should be factored-in while conducting transfers, they should be transferred preferable to their home areas away from hardship areas and that they should be treated just like any other officers in order to improve their performance. The officers also recommended that the housing problem should be addressed immediately since it is one of the contributing factors to the pandemic within the Force.
CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Discussions
This chapter presents the discussions, conclusions and recommendations of the findings, based on the objective of the study.

From the study, all the respondents had heard about HIV/AIDS and also all of them had the knowledge that it has no cure. Most of the respondents (76.4%) had attended an HIV/AIDS behavior change seminar and also most of them (70.7%) had visited VCT centre for HIV testing.

On the socio-economic impact of HIV/AIDS on performance, the study found that most of the respondents (60%) did not know anybody in their workplace that was living with HIV/AIDS and also most of them (76.4%) did not have a dependant who was HIV positive. Most of the respondents (70%) were also not affected by the HIV/AIDS at the workplace. The study also revealed from most of the respondents (86.4%) that approximately 0-5 officers suffered from HIV/AIDS related illnesses within the stations and also most of the respondents (82.1%) said that approximately 0-5 officers in their respective departments had died due to HIV/AIDS related illnesses in the last six months. From the study, most of the respondents (51.4%) reported that people perceived to be suffering from HIV/AIDS did not report on duty punctually and also most of them (50.7%) reported that these people left for home before official time and this had a negative effect on their performance in their assigned duties (47.9%). According to most of the respondents (45.7%) this had no effect on their performance as people working closely to them. The researcher also established from most of the respondents (69.3%) that the trend of reporting for duty by those perceived to be suffering from HIV/AIDS was irregular. Most of the respondents (70%) also felt that the police department spent a lot of funds and time on funeral arrangements occasioned by HIV/AIDS. The majority of respondents (62.1%) reported that
they did not spend a lot of time attending workshops on HIV/AIDS. The study also revealed that the officers perceived to be suffering from HIV/AIDS were given light duties (59.3%) and they were treated as any other person (74.3%). The researcher also found from most of the respondents (50.7%) that there was a good relationship between the superiors and those perceived to be suffering from HIV/AIDS. Most of the respondents (50.7%) reported that some colleagues took leave/off duty to attend to their HIV sick relatives, and most of the respondents (60%) disagreed that the colleagues asked for leave frequently due to sicknesses. The study also found from most of the respondents (52.1%) that the officers perceived to be suffering from HIV/AIDS were transferred from one station to another fairly, and they were not being denied promotion/developmental training.

On response rating, most of the respondents disagreed that HIV/AIDS in their work station was one of the main reasons for low morale, less motivation and less concentration on job assignments as shown by a mean score of 2.36, HIV/AIDS in their work station often disrupts their work schedule and output as shown by a mean score of 2.26 and also HIV/AIDS in their work station often led to breakdown of workforce discipline due to lateness, absenteeism, desertion and unmet work deadlines as shown by a mean score of 2.39.

On workplace policy on HIV/AIDS, most of the respondents (72.1%) were aware that there was a government policy on HIV/AIDS at the workplace, and most of them (70%) said that there was a workplace policy on HIV/AIDS in the police department but most of these respondents (43.6%) said that it had not been adequately implemented and also the department had not mainstreamed HIV/AIDS in its core functions. Most of the respondents (62.1%) reported that there was some support the department was giving to those perceived to be suffering from HIV/AIDS and most of them (45%) said that this support was
through counseling.

The respondents were therefore requested to suggest on what the employer should do for the employees who are either infected or affected by HIV/AIDS in order to enable them improve their performance. From the findings, the respondents suggested that the employees who are infected or affected by HIV/AIDS should be counseled, provided with ARVs, given less strenuous duties and be allowed to work for fewer hours. In case of training, infected officers should be exempted from the strenuous parts of course work and should be monitored closely. They also suggested that those infected/affected should be factored-in while conducting transfers, they should be transferred preferable to their home areas away from hardship areas and that they should be treated just like any other officers in order to improve their performance. The officers also recommended that the housing problem should be addressed immediately since it is one of the contributing factors to the pandemic within the Force.

5.2 Conclusions

From the findings and the discussions, the study concluded that all the police officers in the police force had heard about HIV/AIDS and they were also aware that it had no cure. Most of the police officers had also attended HIV/AIDS behavior change seminar and also most of the police officers had visited VCT centre for HIV testing which is a clear indication that they know their status very well.

The study also concludes that HIV/AIDS has a great impact on Kenya police force. These impacts are such as, some officers have died as a result of HIV/AIDS related illnesses, the officers perceived to be suffering from HIV/AIDS do not report on duty punctually, and also they leave for home
Before the official time which affects their performance in their assigned duties negatively. The trend of reporting for duty by those officers perceived to be suffering from HIV/AIDS is irregular, which also has a great effect on their performance and on the overall performance of the police force. HIV/AIDS also has an impact to the Kenya police force as it spends a lot of time and money on funeral arrangements occasioned by the pandemic.

The officers perceived to be suffering from HIV/AIDS are also given light duties and also this condition makes them to be transferred from one station to another in favor of their status.

The study also concluded that although the police officers were aware that there is a government policy on HIV/AIDS at the workplace and there is also a workplace policy on HIV/AIDS in the police department, it is not adequately implemented and also the department has not mainstreamed HIV/AIDS in its core functions, however, the department is giving some support to those perceived to be suffering from HIV/AIDS mainly through counseling.

5.3 Recommendations

The study therefore recommends that in order to reduce the impacts of HIV/AIDS in the police department, the police officers should be encouraged to spend time and attend workshops on HIV/AIDS in order to have more awareness knowledge on the disease and its impacts.

The study also recommends that workplace policies on HIV/AIDS should be adequately implemented and also the department should mainstream HIV/AIDS in the core functions of the police officers.
The study also recommends that the police department should put more efforts in providing counseling to the officers, besides availing ARVs and other drugs for addressing the cases of opportunistic infections amongst all the infected officers. Condoms should also be made adequately available and accessible to the officers.

Also the study recommends that the transfer of those officers who are already infected be done in a more humane manner, possibly after consultation with the ACU office at the Vigilance House or the provincial/divisional sub ACUs. Such approach will enable the infected officers to be transferred to either near their home areas where they will be able to get proper care/support from their relatives or to the police divisions where they will be able to get drugs/medical attention easily. Infected officers should also not be subjected to the very extraneous parts of the promotional courses.

The above recommendations, if observed by the police department, may go along way in reducing the impacts brought about by HIV/AIDS and also help in improving the overall performance/delivery of services by the officers to members of the public whom they serve.

5.4 Suggestions for Further Research

From this study, the researcher suggested that further research needs to be done in other similar security providing organizations in order to determine the exact impacts of HIV/AIDS in those areas, this might, in away, give a clear picture about the overall state of affairs within all the security providers within our country.
REFERENCES


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Ministry of Justice and Constitutional Affairs (June 2008). GJLOS Reform Programme; Study on Socio-Economic Impact of HIV and AIDS on service Delivery in GJLOS Institutions in Kenya.


Public Sector work place policy document on HIV/AIDS (April 2005), Nairobi, Kenya.
APPENDIX 1: RESEARCH QUESTIONNAIRE:

PART A (1): RESPONDENT PROFILE

1. Gender: Male ( ) Female ( )

2. Age: 18 - 24 ( ) 25 - 35 ( ) 36 - 49 ( ) 50+ ( )

3. Marital Status: Single ( ) Married ( ) Separated ( )
   Divorced ( ) Windowed ( )


5. Duty Station: Province .................. District ..................

6. How long have you been in service? Less than 5 years ( ) 6 - 10 years ( )
   11 - 20 years ( ) Over 21 years ( )

7. What is your highest level of formal education?
   Primary ( ) Secondary ( ) College ( ) University ( )

PART A (2)-AWARENESS OF HIV/AIDS

1. Have you ever heard about HIV/AIDS? Yes ( ) No ( )

2. Do you know that HIV/AIDS has no cure? Yes ( ) No ( )

3. Have you ever attended any HIV/AIDS Behavior Change seminar?
   Yes ( ) No ( )

4. Have you ever visited any VCT centre for HIV Testing?
   Yes ( ) No ( )
PART B (1) - SOCIO-ECONOMIC IMPACT/PERFORMANCE

1. Do you know anybody in your workplace that is living with HIV/AIDS?  
   Yes ( )  No ( )

2. Do you have a dependant who is HIV positive?  
   Yes ( )  No ( )

3. As an individual, are you affected by the HIV/AIDS at the workplace?  
   Yes ( )  No ( )

4. Approximately how many officers suffer from HIV/AIDS related illness within your station?  
   0-5 ( )  6-10 ( )  11-15 ( )  16-20 ( )  Over 21 ( )

5. Approximately how many officers in your Department have died due to HIV/AIDS related illnesses in the last six months?  
   0-5 ( )  6-10 ( )  11-15 ( )  16-20 ( )  Over 21 ( )

6. Are people perceived to be suffering from HIV/AIDS reporting on duty punctually?  Yes ( )  No ( )

7. Are people perceived to be suffering from HIV/AIDS leaving for home before the official time?  Yes ( )  No ( )

8. If yes above, how does this affect their performance in the assigned duties?  
   Positively ( )  Negatively ( )  No effect ( )

9. How does this affect your performance as someone working closely with them?  Positively ( )  Negatively ( )  No effect ( )

10. How is the trend of reporting for duty by those perceived to be suffering from HIV/AIDS?  Regularly ( )  Irregularly ( )

11. In your opinion, does the police Department spend a lot of funds and time on funeral arrangements occasioned by HIV/AIDS?  Yes ( )  No ( )

12. Have you ever spent a lot of time attending a workshop on HIV/AIDS?  Yes ( )  No ( )
11. What is the nature of duty given to officers perceived to be suffering from HIV/AIDS? Light ( ) Heavy ( ) Normal ( )

12. How do you treat those perceived to be suffering from HIV/AIDS? Discriminatively ( )? Cautiously ( )? As any other person ( )?

13. How is the relationship between your superior and those perceived to be suffering from HIV/AIDS? Good ( ) Fair ( ) Bad ( )

14. If bad or fair above, how does it affect the performance of the officers? Positively ( ) Negatively ( ) No effect ( )

15. Do some of your colleagues take leave/off duty to attend to their HIV sick relatives? Yes ( ) No ( )

16. Do some of your colleagues ask for sick leave frequently due sicknesses? Yes ( ) No ( )

17. Are officers perceived to be suffering from HIV/AIDS transferred from one station to another fairly? Yes ( ) No ( )

18. Are those perceived to be HIV positive being denied promotion/Developmental training? Yes ( ) No ( )

19. If yes in NOs 16-18 above, how has this impacted on your performance/service delivery? Positively ( ) negatively ( ) No effect ( )

PART B (2): RESPONSE RATING

For the following questions in this section please use a five point rating scale as follows: 1-Strongly Disagree 2-Disagree 3-I don’t know 4-Agree 5-Strongly Agree

1. HIV/AIDS in my work station is one of the main reasons for low morale, less motivation and less concentration on job assignments:
   1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( )

2. HIV/AIDS in my work station often disrupts my work schedule and output:
   1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( )
3. HIV/AIDS in my work station often leads to breakdown of workforce discipline due to lateness, absenteeism, desertion, and unmet work deadlines

1 ( )  2 ( )  3 ( )  4 ( )  5 ( )

PART C - WORKPLACE POLICY ON HIV/AIDS

1. Are you aware that there is a government policy on HIV/AIDS at the Workplace? Yes ( ) No ( )

2. Is there any workplace policy on HIV/AIDS in the Police department? Yes ( ) No ( )

3. If yes above, has it been adequately implemented? Yes ( ) No ( )

4. Has your department mainstreamed HIV/AIDS in your core functions? Yes ( ) No ( )

5. If Yes above, how? ............................................................................................

6. Is there any support the Department is giving to those perceived to be suffering from HIV/AIDS? Yes ( ) No ( )

7. If yes, how? Through counseling ( ) Provision of ARVs ( ) General welfare ( )

8. If no above, how has this affected the performance of such officer? Negatively ( ) Somehow ( ) No effect ( )

9. In your opinion, what should your employer do for employees who are either infected or affected by HIV/AIDS in order to enable them improve their performance?


Thank you for your input, your views will be treated with utmost confidentiality.
Appendix 2: Letter of introduction

George O. Obor
University of Nairobi
Faculty of Commerce
P O Box 30197
NAIROBI

May, 2009

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: THE IMPACT OF HIV/AIDS ON THE KENYA POLICE FORCE

This survey is part of a research project, it is meant to diagnose and understand better the above topic.

I am a student at the school of Business Studies, University of Nairobi.

I am undertaking this research in partial fulfillment of the degree of Masters of Business Administration (MBA) in Human Resource.

You have been carefully selected to form part of this study.

I am therefore kindly requesting you to spare sometime and provide information by filling the attached questionnaire. Any information that you provide will be treated with the utmost confidentiality and will only be used for the purpose of this study. In no instance will your name or that of your command station be mentioned in the report.

Your co-operation will therefore be very much appreciated.

Thank you in advance.

Yours faithfully,

George O. Obor
MBA Student

S.N.M. Nzuve
Supervisor
Appendix 3: Organization Organogram