University of Applied Sciences
VAN HALL LARENSTEIN
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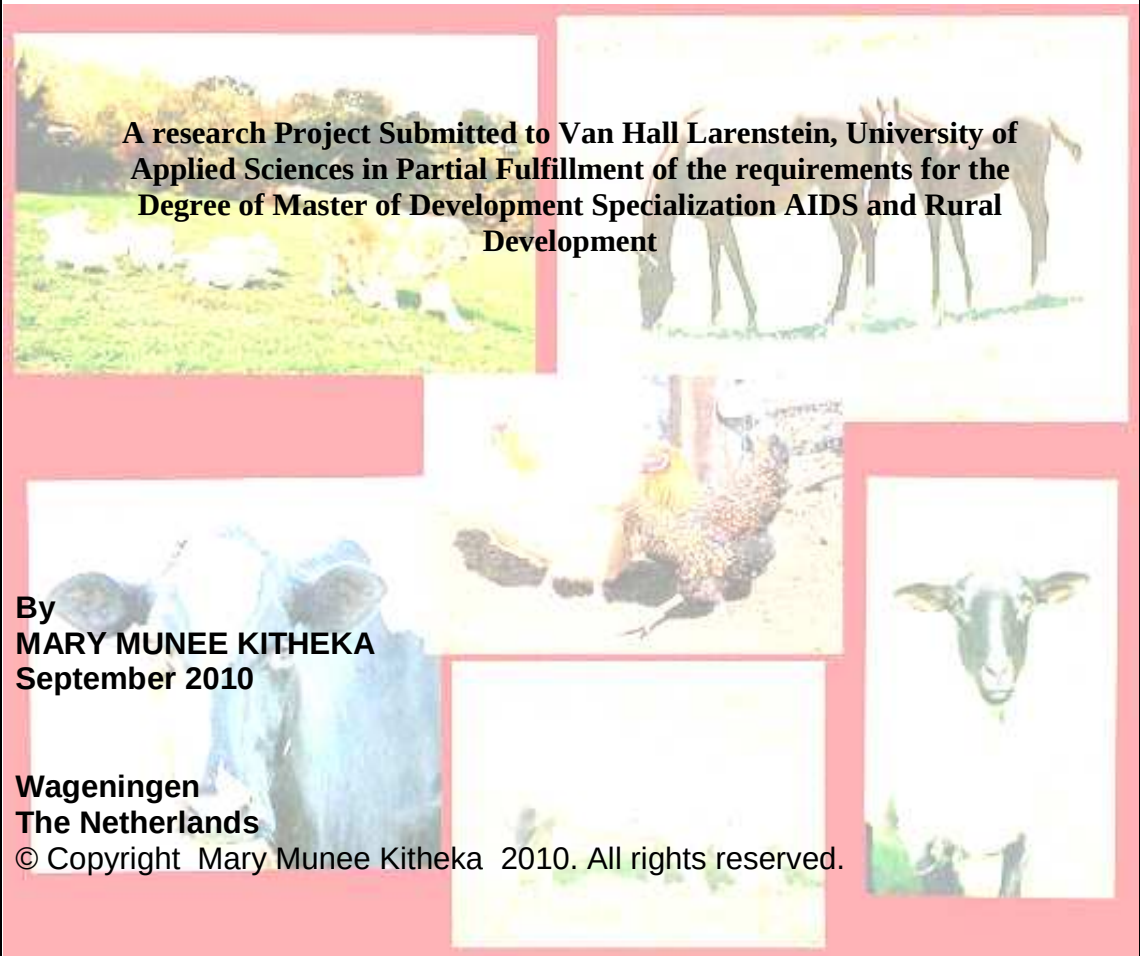
Towards improving non-technical staff competences in addressing HIV/AIDS related stigma in the workplace

A case of Ministry of Livestock Development, Central Province, Kenya



A research Project Submitted to Van Hall Larenstein, University of Applied Sciences in Partial Fulfillment of the requirements for the Degree of Master of Development Specialization AIDS and Rural Development

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Dedication

To my dear daughter Linda Mwende, whose tolerance, understanding and support enabled this thesis to be written.

May God continue to bless her abundantly.

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Most sincerely, I want to give special thanks to God the Almighty whose mercies saw me through all my studies and stay in the Netherlands. I owe special gratitude to the Royal Dutch Government for awarding me this fellowship and the Kenya Government for allowing me to come to study in the Netherlands. Special thanks go to my supervisor, Ms Tracey Campbell for her commitment and guidance she offered me throughout the research and the documentation of study. I also want to thank all the lecturers of in Van Hall Larenstein of Applied Research for the competences they have offered me. I acknowledge the support given by the Ministry of Livestock Development, Kenya in making this study possible by providing the necessary information.

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It is not easy to mention everyone here but I appreciate and thank all who directly or indirectly contributed in the completion of my study in Netherlands.

May Almighty God bless you all.

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Abbreviations and Acronyms

ACU	HIV/AIDS Control Units
ART	Anti Retroviral Therapy
ARV	Anti Retroviral Drugs
CACC	Constituency HIV/AIDS Control Committee
GIPA	Greater Involvement of People Living with or affected by HIV/AIDS
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
ILO	International Labour Organization
KAIS	Kenya HIV/AIDS Indicator Survey
KENWA	Kenya Network of Women living with AIDS
KNASP	Kenya National HIV/AIDS Strategic Plan
MDGs	Millennium Development Goals
MoLD	Ministry of Livestock Development
MSM	Men who have sex with men
MTCT	Mother to Child Transmission
NACC	National AIDS Control Council
NALEP	National Agriculture and Livestock Extension Programme
NASCOP	National AIDS and STD Control Programme
PACC	Provincial HIV/AIDS Control Committee
PDLP	Provincial Director of Livestock Production
PMTCT	Prevention of Mother to Child Transmission
PLWHA	People living with HIV/AIDS
TB	Tuberculosis
TOWA	Total War against HIV/AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary HIV/AIDS Testing Centres
WHO	World Health Organization

Abstract

HIV/AIDS related stigma has fueled the spread of the epidemic. It impacts negatively to the effectiveness and productivity of any organization. To address it, the employees of an organization need to be equipped with competences and policies need to be formulated or existing ones reviewed. This objective of this study was to contribute towards reduction of HIV/AIDS related stigma in the Ministry of Livestock Development (MoLD), Kenya. This was achieved by assessing and analyzing the current HIV/AIDS competences (knowledge, attitude and skills) among the MoLD non-technical staff members in Central Province, Kenya, determining the level of implementation of existing HIV/AIDS related policies in MoLD and finding out the staff expectations on strategies which MoLD can put in place to scale up response towards HIV/AIDS.

A questionnaire was administered to 36 respondents (12 clerks/messengers, 12 drivers and 12 secretaries/receptionists) both male and female, working with MoLD. Three case studies were carried out using checklists where in-depth interviews were carried out with officers in charge of ACU at the ministry and provincial headquarters and a trained technical officer from Central Province.

The study reveals that the respondents were aware of the main modes of HIV transmission namely unprotected sex, blood transfusion, sharing of needles among intravenous drug users and mother to child transmission (MTCT). The respondents were also aware of the main prevention methods namely: abstinence from sex, being faithful to one sexual partner and use of condoms. However, misconceptions were evident on both HIV transmission and prevention. Among the three clusters, drivers were the most knowledgeable while secretaries/receptionists were the least knowledgeable on HIV/AIDS. The radio, television and newspapers were the main sources of HIV information among the non-technical staff. Negative attitudes exist among the respondents especially the secretaries/receptionists. Most of the respondents (92%) acknowledged the rights of PLWHA in that they felt a PLWHA should be protected by law against discrimination in the workplace. Office gossip was cited as a major HIV/AIDS impact (67%) in the workplace while death is the least. Secretaries/receptionists and clerks/messengers mentioned impacts of HIV/AIDS in the workplace to be poor performance, absenteeism, overworked staff and self stigma. In addition, the drivers cited distortion of work schedules and programmes. A gap in skills on how to relate to PLWHA existed among all the interviewees. This was exhibited by the low levels of knowledge in HIV/AIDS, negative attitude towards PLWHA leading to HIV related stigma. MoLD had offered minimal training to the non-technical staff. The staff who reported to have received training on HIV/AIDS stated this was done by NGOs. Most of the respondents and the trained technical staff were not aware of the existence of the HIV/AIDS workplace policy. MoLD does not have a strategy at the moment to address HIV/AIDS in the workplace but is in the process of reviving the ACU.

MoLD needs to take HIV/AIDS as a workplace issue. MoLD needs to bring to the attention of its staff members the contents of the HIV/AIDS workplace policy and implementation of the policy should be enacted. MoLD needs to draw strategies on how to respond towards HIV/AIDS so as to reduce HIV/AIDS related stigma.

INTRODUCTION

1.1. Background of the study

In 1999, the Kenya government declared Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) a national disaster as the prevalence rate rose from 10.4% in 1995 to 13% in 1999 (Avert, 2009). The governments' response to the epidemic through the efforts of various stakeholders and implementers has seen the prevalence rate reduced to 7.4% (NASCOP, 2007) among adults aged 15-64. However, it is estimated that there are 166,000 new infections annually (NACC, 2009). The National AIDS Control Council (NACC) was then established as a corporate body under the State Corporations Act by a Presidential Order in Legal Notice No. 170 of 26th September 1999 (NACC, 2008). It is mandated to coordinate stakeholders within Government, civil societies, the private sector and development partners in the multi-sectoral response to HIV/AIDS in the country (NACC, 2008).

NACC encouraged the creation of AIDS Control Units (ACU) in the public sector (Government ministries and Public institutions) with a mandate to mainstream HIV/AIDS into public sector activities (NACC, 2007). The main role of the ACU is to facilitate the mainstreaming of the National HIV/AIDS Strategic Plan (KNASP) into the core functions of government ministries based on comparative advantage (NACC, 2007). Through this initiative of NACC, an ACU was formed in 2001 in the then Ministry of Agriculture of which Livestock Production Department and Veterinary Services Department (which have now formed the Ministry of Livestock Development-MoLD) were part of it. The initial funding for the formation and equipping of ACUs was provided by NACC. NACC also facilitated the staff training on mainstreaming HIV/AIDS in the agricultural sector. This purpose of the training was to capacity build the staff on internal and external mainstreaming of HIV/AIDS in the ministry. Internal HIV/AIDS mainstreaming is about changing organizational policy and practice so as to reduce the organization's susceptibility to HIV infection and its vulnerability to the impacts of AIDS whereas external mainstreaming is about how the HIV/AIDS pandemic was affecting the ministry's clients, the farmers and take measures to mitigate the impacts. The trainings were expected to equip staff with competences to respond to the epidemic. In 2003 this ministry was split to form the Ministry of Agriculture and the Ministry of Livestock and Fisheries Development. This then formed its own ACU in 2004. The ACU was not active and it lacked formal ACU structures both in the provinces and districts. Most staff have no place to seek information about HIV including counseling services since Sub-ACUs are either inactive or non-existent. Since HIV/AIDS is a development issue, the MoLD then re-established fully the ACU in 2009. The ACU was challenged to revitalize the provincial and district ACUs and to mainstream HIV/AIDS in the organization which is to include implementation of the workplace-based HIV/AIDS prevention, support and care programmes which are aimed at reducing risks, vulnerability and impact of HIV/AIDS and sexual behaviour change among the staff.

The HIV prevalence rate of 7.4% can be translated to mean that out of the 6320 MoLD staff (MoLD, 2009) 468 are infected with HIV. According to the Deputy Secretary MoLD, 58% of all the deaths in the ministry over the last past five years are attributed to AIDS (MoLD, 2010). Furthermore, according to UNAIDS, out of every three people going to work, two are infected by HIV (UNAIDS, 2010a). This could be attributed to two factors: the incubation period of AIDS is long before outward symptoms and the fact that most people do not know their HIV status. International Labour Organization (ILO) describes HIV/AIDS as a major threat to the world of work (ILO, 2001). This is because a highly infected labour-force can lead to absence from duty due to illness, loss of labour force, skills and experience due to death from AIDS related illness

which in turn leads to remaining staff being overworked, having low morale resulting in low productivity and hence low effectiveness.

The approach to understanding organizational effectiveness should look at the extent to which an organization satisfies the interest of its internal (employees) and external stakeholders (Rollinson, 2008). Rollinson further argues that an effective organization is one that achieves its goals since they are brought into existence to achieve some purpose. The MoLD has been designed to serve a specific purpose which is to promote, regulate and facilitate livestock production activities within the country for social economical development and industrialization (MoLD, 2008).The human resource is the most important factor in any organization as it controls the all other resources (DPM, 2005), it is therefore important for any organization to look at the issues that affect it such as HIV/AIDS. A study done in 2005 by the National Agriculture and Livestock Programme (NALEP) revealed that 3 of the 5 districts where the study was done had the staff suffer illness related to HIV namely: weight loss, skin rash, persistent cough and chronic fever whereas 57% of the respondents had lost their colleagues through death caused by AIDS related illness (NALEP, 2005). The study further revealed that, at least 3% of the staff leave the employment after testing positive. This could be due to self stigma or enacted stigma from fellow workers. Continuous education and information relating to HIV/AIDS is an important means of responding to HIV/AIDS related stigma and discrimination in the workplace (ILO, 2001). A workforce that is informed makes the working environment free of prejudices against colleagues infected or affected by HIV and at the same time facilitates prevention of new HIV infections.

For most organizations to address HIV/AIDS in the workplace, they have put in place a policy on HIV/AIDS or revised the old policy to include HIV/AIDS. The policy provides a framework for organizations to reduce the susceptibility to HIV infection and the vulnerability to the impact of AIDS among its staff. The Kenya Government has a Public Sector HIV and AIDS Workplace Policy which gives guidelines to all government departments on how to deal with HIV/AIDS issues in the workplace and outlines the employee's responsibilities, rights and expected behavior in the workplace.

1.2. Problem statement

MoLD has three departments: two technical and one administrative. The administrative department consists of staff such as: drivers, mechanics, artisans, watchmen, secretaries, receptionists, clerks, cleaners and messengers. These cadres of employees are divided between the two technical departments to assist in the effective running of the offices. The MoLD's ACU unit has been able to build HIV/AIDS competences (knowledge, attitude and skills related to HIV/AIDS) among the technical employees through training, workshops and seminars. However, the unit has not put measures in place to build HIV/AIDS competences among the non-technical staff. This has contributed to limited information about HIV/AIDS among non-technical employees leading to HIV related stigma and discrimination among staff thus affecting the ministry's effectiveness. According to the UN Secretary-General Ban Ki Moon (Avert, 2010), HIV related stigma remains the single most important barrier to public action to respond to the epidemic and thus making AIDS a silent killer. He adds that HIV related stigma is the chief reason why the AIDS epidemic continues to devastate societies around the world. The ministry would like to improve on its effectiveness to deal with this stigma, however, it lacks information on the existing HIV/AIDS competences to respond to HIV/AIDS stigma and the awareness levels about the contents on the HIV/AIDS workplace policy among its non–technical staff.

1.3. Justification for doing the research

This study is designed to identify competences needed by non-technical staff of MoLD in order to deal with HIV/AIDS issues in the workplace, the level of awareness about existence and contents of the Public Sector HIV/AIDS Workplace Policy and the services and other opportunities that are readily available within the workplace or in the micro-environment. It provides an insight of the existing HIV/AIDS knowledge, attitudes and skills and gaps of the same by MoLD non-technical staff. The study also highlights the staff expectations on scaling up HIV/AIDS response by MoLD in the workplace. The data generated in this study will be used by MoLD ACU as baseline information to better target and upscale the interventions to address HIV/AIDS related stigma appropriately at the workplace.

1.4. Objective

1.4.1. Broad Objective

The general objective of this research is to contribute towards reduction of HIV and AIDS related stigma and discrimination in MoLD by providing information on the existing competences among the non–technical staff to respond to HIV/AIDS in the workplace.

1.4.2. Specific Objectives

- To assess the current competences (knowledge, attitude and skills) the MoLD non-technical staff possess towards addressing HIV/AIDS in the workplace.
- To determine the staff expectations on strategies which MoLD can put in place to scale up response towards HIV/AIDS.

1.5. Main Research Questions

Question 1:
What competences do the non-technical staff of MoLD possess towards addressing HIV/AIDS in the workplace?

a) What are the levels of HIV/AIDS knowledge among MoLD non-technical staff?
b) What are the attitudes towards HIV/AIDS of MoLD non-technical staff?
c) What skills do MoLD non-technical staff have to relate with people living with HIV/AIDS (PLWHA)?
d) What changes are in the work-place due to the effects (directly or indirectly) of HIV/AIDS?
e) What training has non-technical staff members received on HIV/AIDS?

Question 2:
What strategies can be put in place to address HIV/AIDS related stigma among non-technical staff of MoLD?

a) What policies are in place regarding HIV/AIDS in MoLD?
b) What is the scope of the relevant HIV/AIDS policies?
c) How are the policies implemented in the MoLD?
d) What changes have been realized in the workplace by the technical staff who have been trained on HIV/AIDS?

2. LITERATURE REVIEW

2.1. Background

According to UNAIDS (2009), the number of PLWHA has continued to rise globally as by 2008, there were 33.3 million people living with HIV out of which 31.3 million were adults; this was 20% higher than the year 2000. Of these PLWHA 2.3 million adults were newly infected with HIV in 2008 while 1.7 million adults died from AIDS related illness. According to the same report, the estimates in Kenya were: number of people living with HIV/AIDS was 1.6-1.9 million of whom 90,000 were adults. The report further estimates that there were 90,000-110,000 deaths realized due to AIDS related illness in 2008.

With the number of PLWHA rising, there is reason to be concerned about the impact of HIV/AIDS in the workplace of various organizations. According to Bodiang (2001), the impacts realized are:

- staff absenteeism due to AIDS related illness, funeral attendance or taking care of sick family members.
- cost of medical treatment by sick employees.
- cost of replacement of sick or deceased employees.
- loss of institutional memory.
- loss of investments (training, experience, skills and productivity).
- cost of specific additional HIV/AIDS activities.

This is further confirmed by an institutional analysis for the Ministries of Agriculture and Livestock and Fisheries Development conducted by National Agriculture and Livestock Extension Program (NALEP, 2005) which revealed that effectiveness of the two ministries was being challenged by loss of skilled and experienced manpower due to HIV/AIDS related deaths, loss of man hours due to prolonged illness, absenteeism, reduced performance, stigma and discrimination.

In the year 2000, 191 UN member states signed the United Nations Millennium Declaration in which world leaders committed themselves to combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. This led to the establishment of the eight Millennium Development Goals (MDGs) derived from the eight chapters of the declaration which the leaders agreed to try and achieve by year 2015 (Annex 1). MDG 6 deals with combating HIV/AIDS, malaria and other diseases. This MDG has three targets, two of which address HIV/AIDS directly, namely: target A is “have halted by 2015 and begun to reverse the spread of HIV/AIDS” and target B to “achieve, by 2010, universal access to the treatment for HIV/AIDS for all those who need it” (UNAIDS, 2010b).

The increase in the number of people living with HIV is attributed to new infections and to the use of life sustaining impact of anti-retroviral therapy (ART) (UNAIDS, 2010b). The year 2010 is with us and although there has been a positive achievement in the global response towards HIV, the HIV/AIDS epidemic still outpaces the response (WHO, 2010).The MDG progress report released by United Nations (2010b) indicates that for every two people who start ART, there are five new HIV infections. This calls for urgent need to intensify prevention measures. Another report by the World Health Organization (WHO) namely “towards universal access 2009” indicates that AIDS related illnesses are among the leading causes of death globally and are expected to continue as a significant global cause of premature mortality in future (WHO, 2009). This calls for global action.

Stigma and discrimination have fueled the transmission of HIV/AIDS and have greatly increased the negative impact associated with the epidemic (UNAIDS, 2005). The report further says that HIV-related stigma creates a major barrier to preventing further infections, alleviating impact and providing adequate care, support and treatment.

2.2. What is HIV–related stigma?

Goffman's theory of social stigma defines stigma as "an attribute, behaviour or reputation which is socially discrediting in a particular way" (Goffman, 1968). Previously he had described a stigmatized person as one "reduced in our minds from a whole and usual person to a tainted discounted one" which is equivalent to "discrediting an individual in the eyes of others" (Goffmann, 1963).

The Avert organization puts it that AIDS related stigma refers to prejudice, negative attitudes, abuse and maltreatment directed at PLWHA (Avert, 2010) or to people perceived to have HIV/AIDS and the individuals, groups and communities associated with PLWHA. Scrambler (2004) describes it as the social process of combining the assumed presence of HIV virus in a person or group with a perceived notion of culpability. UNAIDS defines stigma as "a process of devaluation of people either living with or associated with HIV/AIDS".

There are other stigmatizing diseases like leprosy, mental diseases and tuberculosis but what makes HIV-related stigma different is the fact that it is multi-layered and tends to build upon pre-existing stigma. According to Herek (2002), AIDS is stigmatizing because of three reasons namely:

- AIDS being understood as the PLWHA's responsibility (one became infected voluntarily) due to the fact it is associated with marginalized behaviours such as men having sex with men (MSM), sex work and drug use.
- AIDS is incurable and it is a fatal condition.
- negative attitudes in that people fear they can be socially tainted by interacting with PLWHA or the dangers of fear of contagion.

Other underlying factors include: lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS and the prejudices and fears relating to a number of socially sensitive issues including sexuality, disease and death (UNAIDS, 2005).

For the purpose of this study, HIV-related stigma refers to prejudice, discrediting and discrimination directed to people perceived to have HIV/AIDS and the individuals infected with HIV/AIDS.

2.3. Types of HIV/AIDS related stigma

There are two types of HIV-related stigma namely, instrumental and symbolic stigma (Herek, 2002). Instrumental stigma is based on fear of getting HIV infection. AIDS is deemed as a communicable disease and a deadly disease hence the desire to protect oneself depicted in those helping PLWHA withdrawing their services as the AIDS related illness takes its toll on the patient. Symbolic stigma is based on strong morals and values, mostly judgmental attitudes for example those who get it deserve it. According to Herek (2002) "AIDS is used as vehicle for expressing hostility towards other groups that were already stigmatized before the epidemic started".

2.4. Why reduce HIV/AIDS related stigma

According to Malcom *et al.* (1998), HIV/AIDS related stigma fuels the spread of the epidemic since it undermines the efforts to respond to it. This is due to the wide range of reactions from individuals, communities and nations from sympathy and caring to silence, denial, fear, anger and violence. The fact that HIV related stigma is layered on pre-existing stigma has prevented people from:

- wanting to go for HIV testing to know their status (not going to Voluntary Counseling Testing Centers –VCTs
- disclosing their status when tested and found positive (ICRW, no date)
- seeking care upon being diagnosed positive,

This has led to people living in denial which in turn works against preventive measures i.e. without knowing ones HIV status it is difficult to treat for the mother to child transmission, administer anti-retro viral therapy or even the use of condoms.

Open discussions of both the causes and appropriate responses towards HIV/AIDS have been silenced by HIV/AIDS related stigma (UNAIDS, 2005). Social dialogue is viewed as one of the prerequisites for the successful mobilization of individuals, societies and even governments to respond to the epidemic. People living in denial cause delays of action and end up fueling the spread of the epidemic. Concealment causes PLWHA to be seen as a problem rather than a solution to containing the epidemic (UNAIDS, 2005).

To be able to work towards MDG 6 monitor a (Annex A), it is important to respond to HIV related stigma. One way of achieving this goal is for people to know their HIV status.

2.5. Causes of HIV related stigma

There are a number of causes of HIV related stigma sited by various authors. Campbell *et al.* (2007) and Avert organization (2010) have mentioned the causes of HIV related stigma as:

- fear in that HIV/AIDS is perceived to be contagious.
- HIV/AIDS is not well understood by people due to non availability of information.
- tainted by religious beliefs as it is linked to immorality hence perceived as a punishment from God.
- is perceived as a death sentence.
- the physical appearance of full blown AIDS patient: patients are feared and demonized.

- perceived as a disease for others (them and us).
- lack of HIV/AIDS management services.
- poverty, which has shaped reactions towards HIV.
- gender inequality.
- lack of social dialogue to discuss AIDS.
- HIV/AIDS perceived as a crime in relation to innocent and guilty victims.
- the stigma attached to AIDS is at times used to serve as a vehicle for expressing pre-existing hostility toward members of disliked social groups for example, gay men.

Holden (2007) has indicated that poverty, gender inequality, illiteracy, lack of HIV/AIDS awareness, human trafficking, distorted communities, feudal culture and migration as some of the causes of HIV related stigma.

2.6. Manifestations of HIV related stigma

HIV related stigma is manifested in various ways. According to Pryor (2010) various types are manifested differently:

- **Public stigma**: The stigmatized person is blamed for contracting HIV/AIDS, gossiping, name calling, finger pointing, people avoiding one perceived to have or with real HIV/AIDS. Emotionally, they can be positive (empathetic or compassionate) negative manifested in anger, disgust or fear. This can also happen in the workplaces. Sometimes it can be manifested in the stigmatized person being harassed, ridiculed and discriminated.
- **Self stigma:** Related to knowledge of public reaction to stigma. A person avoids HIV-testing, declaring their status, treatment and safe sex, at times withdrawing from places where ill treatment may occur.
- **Stigma by association:** It manifests itself in being ashamed and not being able to disclose concerns and psychological stress.
- **Institutional stigma**: These involve criminalization and prejudices of some behaviours such as MSM or drug users.

Holden (2007) in the twelve boxes framework also mentions isolation, social discrimination, sarcastic comments, blaming in the media and non-recognition as other forms of manifestations of stigma.

The most common forms of manifestations in the workplace are: isolation because colleagues are scared of sharing office space or issues with the infected or affected person which at times leads to social discrimination, gossiping and blaming. The PLWHA in the workplace and the staff with family members living with HIV/AIDS also retaliate by exhibiting anger or fear or even withdrawing from other colleagues.

2.7. Impacts of HIV-related stigma

Public stigma leads to stigmatized persons having less social power (issues of them and us). Self stigma makes one's personal esteem to be reduced, causes hopelessness and reduces immune functions of the body. Stigma by association contributes to social avoidance by family members or care givers (Pryor, 2010). Other impacts include social impact, no earning

opportunity, exploitation, insecurity, cut off from basic facilities, emotional breakdown or feelings of guilt (Holden, 2007).

According to UNAIDS, stigma can lead to discrimination and other violations of human rights which affect the wellbeing of PLWHA (UNAIDS, 2005). The violation of human rights worsens the impact of HIV, increases vulnerability and hinders positive responses to the epidemic.

In the workplace, HIV/AIDS infected employees often experience both felt and enacted stigma. This stigma has caused an enormous impact on the lives of employees. A number of concerns and anxieties are brought about by discovering one is HIV-positive. This results in fear and uncertainty about how other people will react. These anxieties often prevent staff from disclosing their status to colleagues, family, friends and employer. This has in turn denied them the opportunity to benefit from the support of the organization, family, colleagues or friends and from accessing health care.

Pryor *et al.* (2004) noted that sometimes the public stigma can be manifested positively, i.e. empathizing and being compassionate to the PLWHA, but at times this ends up making the PLWHA more aware of his/her status which may end up instilling more stigma than support. This has also led to "healthy staff" being overworked as they offer to assist the PLWHA.

Some employers have denied insurance cover for their employees with AIDS, while some have had PLWHA have experienced unwarranted demotions, dismissals and harassment in the workplace (Cogan and Herek, 1998).

2.8. HIV-related competences

These are knowledge, attitudes and skills which enable a person to effectively handle and resume their normal productive life when they encounter HIV/AIDS situations in their own life and those of colleagues.

2.8.1. HIV/AIDS knowledge

The Kenya Demographic and Health Survey 2008-09 Report gives the meaning of HIV/AIDS knowledge as:

- "knowing that use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus
- knowing that a healthy–looking person can have AIDS virus
- rejecting the two most common local misconceptions about AIDS transmission or prevention (mosquito bites and sharing food)" (KNBS, 2010).

For the purpose of this research, knowledge is the understanding and information which a person has about HIV/AIDS, how it is transmitted and how it can be prevented and the trend of the epidemic.

In 1994, the UN member countries made a declaration on the Greater Involvement of People living with of affected by HIV/AIDS (GIPA). This declaration was meant to respond to the epidemic by using the experiences of PLWLHA or those affected by HIV/AIDS in educating others and also giving a human face and voice to the scourge in the minds of people not directly

affected by it (UNAIDS, 1999). A study carried out in Kenya in 2008, indicated that Kenya has made progress towards applying GIPA principle (NEPHAK, 2009).

In 2006, UN member states committed themselves to scaling up targets geared towards achieving the MDG 6 (monitor b), which is about universal access to treatment for HIV/AIDS for all those who need it by 2010. By 2009, Kenya had achieved about 70% of Prevention of Mother to Child Transmission (PMTCT), about 40% ART and about 80% on knowledge on HIV/AIDS and aimed at reaching 90%, 75% and 95% respectively by 2010 (UNAIDS, 2009). One way of improving knowledge is by providing information. There are various sources of information namely the mass media (television, radio, newspapers, magazines, pamphlets, and posters) and interpersonal sources (friends, health workers, or the workplace).

Workplace programmes geared towards information and education are crucial in the fight against the spread and effects of the epidemic. They are meant to enable the staff to understand HIV transmission, risk situation and behaviour and how to live positively. According to ILO (2001), “effective education programme provides workers with the capacity to protect them against HIV infection, help reduce HIV-related anxiety and stigmatization and significantly contribute towards attitudinal and behavioral change”.

According to Rollinson (2008), if an organization is to survive and prosper in the fast-moving globalised environment, it has to be a learning organization. It is therefore important for the organization to have on-going training and communication to staff. HIV/AIDS is no exception. All staff in an organization need to be trained to enable them to address HIV/AIDS. To ensure that the staff members are aware of the causes of HIV infection, the treatment and prevention methods and to care and support other staff members living with HIV/AIDS, training is needed for all levels in the organization. This training enhances positive attitudes, behaviours and practices among staff. A learning organization is better equipped to deal with the changing times. According to Rollinson (2008), some elements of a basic awareness programme might include regular meetings including all staff to discuss specific topics of interest identified by staff, perhaps supported by specialists from outside the organization. Common topics may include:

- introduction to organizational staff policy on HIV,
- overview of common opportunistic illnesses and basic treatment,
- overview of anti-retroviral treatment,
- living positively with HIV/AIDS,
- discrimination and legal rights of people living with HIV,
- drawing up a will,
- use of condoms,
- counseling skills,
- programme work on AIDS,
- provision of information in the office, in the form of pamphlets, posters and articles.

In the year 2001, the heads of states and representatives of states and governments from the United Nations member countries, made a declaration to review and address HIV/AIDS in all aspects and to secure a global commitment to enhancing coordination and intensification of all efforts to respond to it in a comprehensive manner (UNAIDS, 2001).This is a clear indication that HIV/AIDS is a global issue and there is need to address it. During the declaration, the then UN Secretary General, Koffi Annan, said HIV/AIDS is not dealt with by stigmatizing those infected but by creating awareness on the modes of HIV transmission and how prevention can be achieved.

In 2006, the Kenya Government enacted a law in its constitution on HIV and AIDS Prevention and Control Act which became fully operational on 30th March 2009. Promotion of public awareness about HIV transmission and prevention was among the goals of the act. By 2008, the Kenya Government had achieved 80% on HIV awareness creation (KNBS, 2010).

2.8.2. Attitude

Attitude is about the way we think, feel and act to the world around us (Grimme *et al.* 2008). They further state that attitudes determine the "the quality and effectiveness of all our thinking, emotions and behavior and thereby the positive or negative consequences of that behaviour" According to Skinner (2007), the feelings one projects towards people reflects their personal experiences, influences from their families and the societies they live in and their own level of understanding. According to Posner (nd), attitudes lie between the emotional perceptions about ourselves, others and life itself. He further says they are processed in between our emotions and thought processing. Posner (nd) cites three types of attitudes namely: attitudes people have concerning themselves, those concerning others and the objects around them and lastly those people have towards life itself.

The Mental Health Commission of Canada equates attitude to stigma. It further says "stigma is an internal attitude and belief held by any an individual often about a minority group" (MHCC, 2008). Attitudes can be stigmatizing (Herek, 2002) or can be supportive (Pryor, 2010). Herek further says that stigmatizing attitudes are correlated with the misunderstanding of the modes of HIV transmission as they are associated with immoral behaviours and social groups especially gay men, sex workers and injecting drug users (WHO, 2009). For example an attitude that a gay person got what he deserves because according to traditional and religious beliefs sex is meant to be between two people of the opposite sex.

For the purpose of this research, attitude is the feelings and thoughts a person has towards PLWHA. These attitudes can be positive or negative (Grimme *et al*. 2008).

2.8.3. Skills

According to research done by the Expert Group on Future Skills Needs (2005) to underpin the development of a national skills strategy in Ireland, it revealed that work has become less of routine and requires flexibility, continous learning and individual initiatives and judgment hence the inclusion of the following skills:

- "basic/fundamental skills — such as literacy, numeracy, IT literacy"
- "people-related skills — such as communication, interpersonal, team-working and customer-service skills"
- "conceptual/thinking skills — such as collecting and organizing information, problem-solving, planning and organizing, learning-to-learn skills, innovation and creativity skills, systematic thinking".

In relation to HIV/AIDS, skills required in the workplace are people related skills. For the purpose of this research, skill is the ability or knowledge that enables one to relate to PLWHA without causing stigma bearing the three components in mind.

Dyk (2009) said that interpersonal skills required to deal with PLWHA are respect, communication skills, listening skills, basic empathy and referral skills. He further clarified respect as:

- unconditional positive regard to PLWHA
- giving PLWHA his rights
- refraining from judging PLWHA
- remaining serene and composed when dealing with PLWHA
- refraining from rescuing PLWHA

Communication skills can either be verbal or non-verbal. Non verbal can be in terms expressions, words, gestures, phrases, body language voice tones and facial expressions that one uses when interacting with another person. These are vital when dealing with PLWHA as they may cause stigma or give encouragement to the PLWHA to live positively.

The way listening skills, empathy skills and referral skills are applied is also important in reducing stigma.

2.9. HIV/AIDS workplace policy

Besides providing income, the workplace can also be a place of fulfillment, health benefits and companionship. However, it poses a challenge in that if one is HIV-positive, one may need to ask for a flexible schedule to allow him/her rest or to attend to a doctor's appointment (ALRP, 2004). This often leads to public stigma from fellow colleagues who feel you are making them overworked yet you are receiving a salary.

Mullins (2002), states that specific responses that might be seen in an organization that has addressed HIV and AIDS in its internal policies and practices include staff awareness, staff health policies, performance management system, budgets and financial planning and human resource work force planning.

In the ILO Code of Practice on HIV/AIDS and the World of Work (ILO, 2001), it is suggested that workplace policies be agreed between the management and workers representatives to avoid some misunderstanding. Discussions leading to the adoption of a workplace policy on HIV/AIDS should take place in a collaborative spirit of compromise and mutual understanding.

Dyk (2009) has revealed that a workplace can provide an ideal gateway to HIV/AIDS prevention and care. He further cites the workplace as a potential HIV/AIDS information delivery point. Dyk suggested an integrated strategy to respond to HIV/AIDS in the workplace. Six tasks are identified to make the integrated programme a success, namely:

1. HIV/AIDS management team – steering committee, HIV/AIDS coordinating team and peer educators.
2. risk and impact assessment.
3. needs and resource assessment.
4. HIV/AIDS Workplace policy.
5. HIV/AIDS programme.
6. monitoring, evaluation and review.

The Kenya government, which is the largest employer, has an HIV and AIDS workplace policy in place. The aim of the HIV/AIDS policy is to mitigate the impact of the epidemic in all government departments and provide the means towards efficient service delivery.

3. RESEARCH DESIGN AND METHODOLOGY

3.1. Research area

The Research was carried out in Central Province, Kenya. According to Kenya AIDS Indicator Survey (NASCOP, 2007), Central Province had an HIV prevalence level of 3.8% which was lower than the national level (7.4%) as at 2006. Central Province was selected because:

- out of the 6230 MoLD staff who are distributed among the eight provinces in Kenya, it has 1000 staff members.
- of the 1000 staff in the province, 239 are non-technical staff (165 clerks/messengers, 29 drivers, 31 secretaries/receptionists, 2 artisans, 6 watchmen and 6 mechanics).
- it borders Nairobi Province where one of the key informants is stationed (officer in charge ACU in MoLD).
- as Figure 3.1. shows it borders Nairobi Province which is a cosmopolitan province where the HIV prevalence rate is 9% yet Central Province's prevalence is 3.8%.

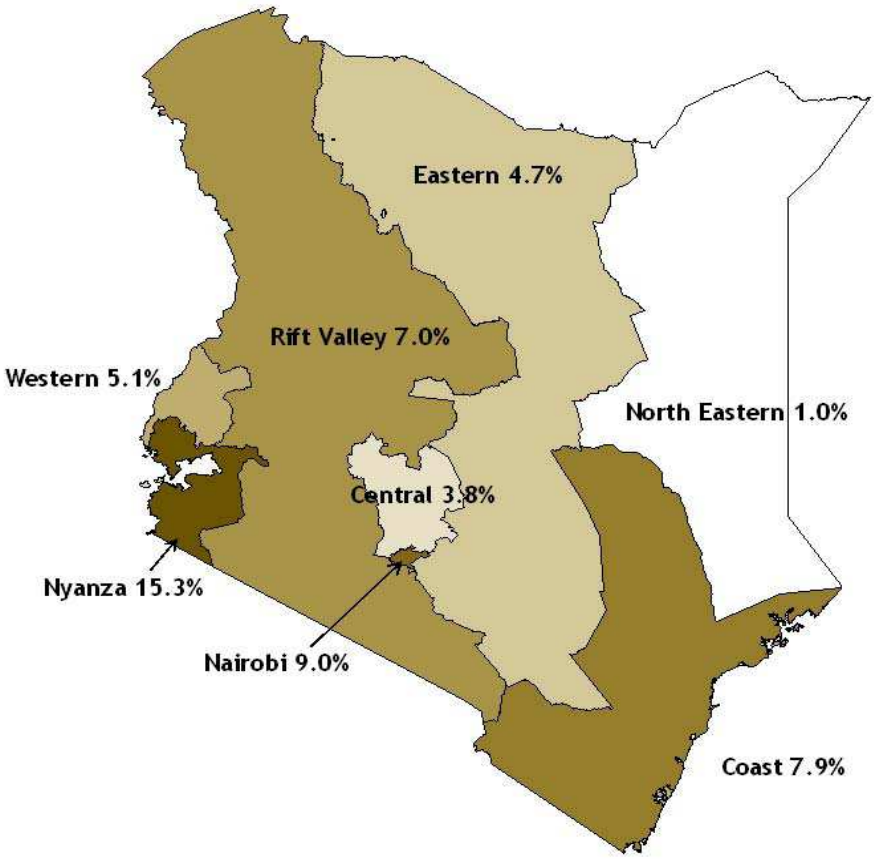

Figure 3.1: HIV prevalence in Kenya by province as at 2006 (Source: KAIS 2007)

3.2. Study design

Face to face interviews were carried out to determine the existing competences among non-technical staff towards addressing HIV/AIDS in the workplace. This was carried out on 36 non-technical staff using a semi-structured questionnaire (Annex B). Of the 36 staff, there were 12

clerks/messengers, 12 drivers and 12 secretaries/receptionists both male and female who were employees of MoLD, Central Province. These clusters were used to determine if there was a difference in the HIV competence of the staff in relation to the nature of their work, for example:

- clerks/messengers usually share office space hence they are in close contact at all times
- drivers could be more susceptible to HIV infection because of the extra allowances they receive from field trips and in addition they have free time in between assignments
- secretaries/receptionists are normally the first people visitors to the offices meet. This entails them interacting with different people in the line of duty hence it is very important for them to equipped with the HIV/AIDS competences to maintain the corporate image of the organization.

Of the total respondents, 19 were females (6 clerks/messengers, 1 driver and all secretaries/receptionists) and 17 were males (Figure 3.2).

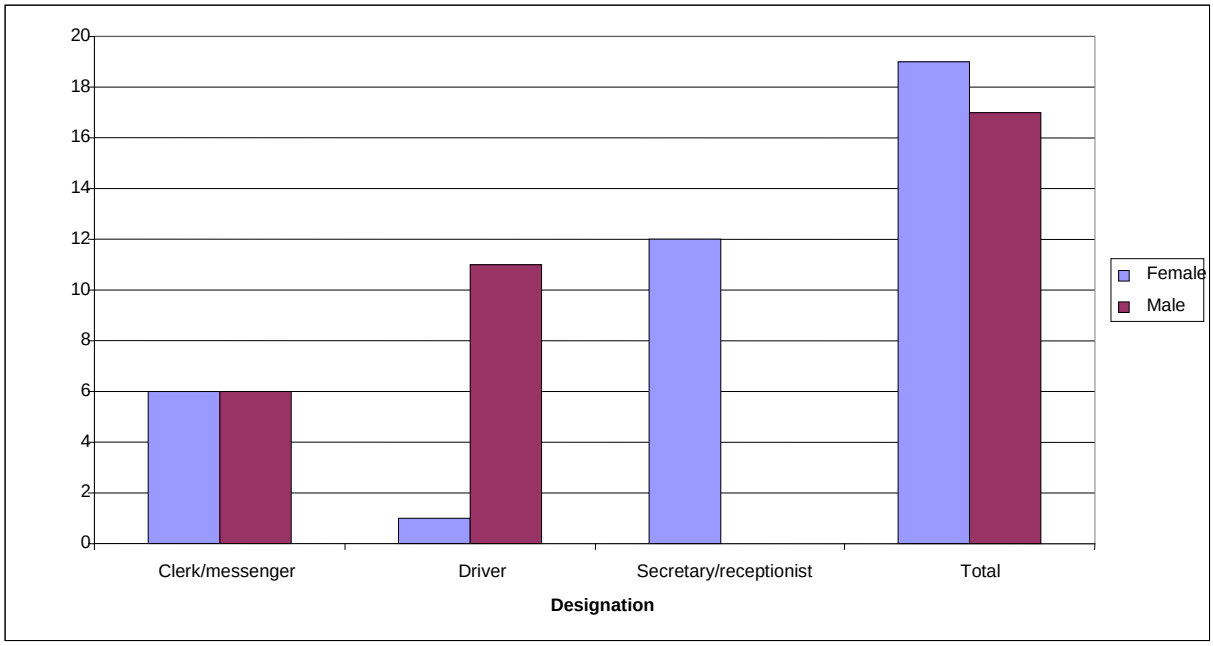

Figure 3.2: Respondents by gender

Most of the respondents were below the age of 30; this is because since the employment embargo in 1990, the ministry employed non-technical staff in the year 2009 and 2010 (Figure 3.3).

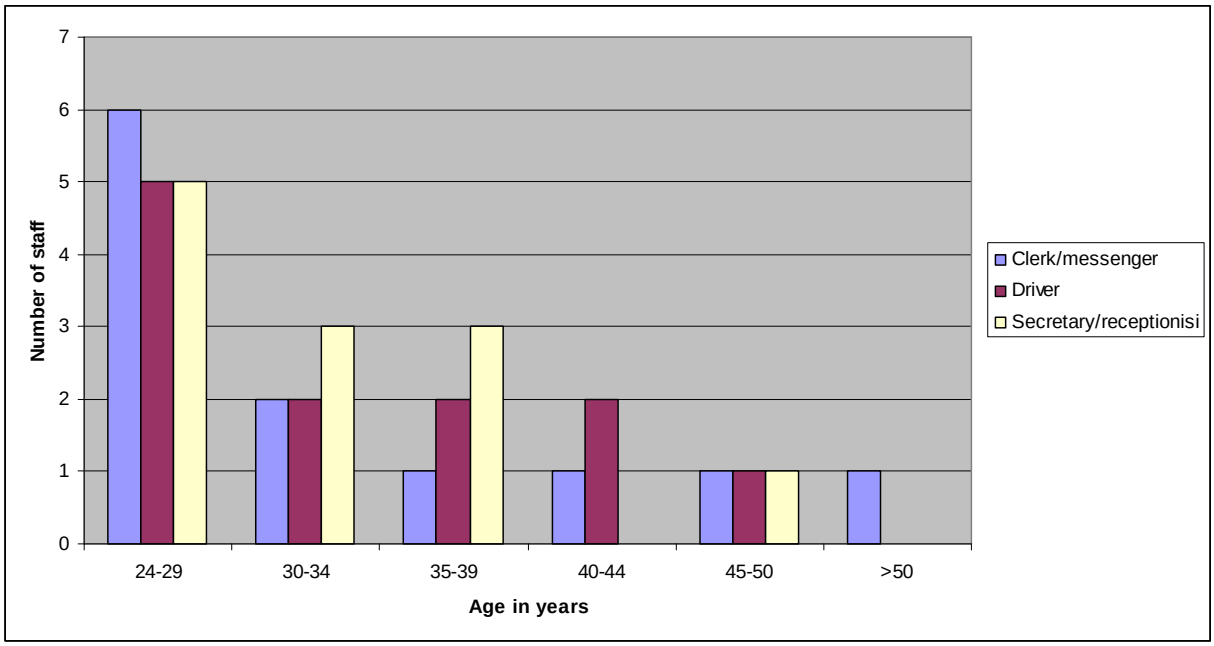

Figure 3.3: Profile of respondents by age

Three case studies were carried out using checklists (Annex C and D) where in-depth interviews were carried out with key informants. These included the officer in charge of the ACU in MoLD, Nairobi province, the officer in charge of Sub-ACU, Central Province and a technical staff member who has undergone HIV/AIDS training in Central Province. The main aim of the case studies was to explore the extent to which decision-makers support and actively pursue addressing HIV/AIDS issues in the workplace, determine changes realized in workplace due to HIV/AIDS training and determine the staff expectation on strategies which MoLD can put in place to scale–up response towards HIV/AIDS. Other than the technical staff who had been selected for HIV/AIDS competence comparison purposes, the other key informants had been chosen due to their leadership positions, their involvement in inspiring and motivating staff towards better performance, their ability to interpret and explain policies to those working under them and the development of knowledge and understanding of HIV/AIDS among staff.

The questionnaires were pretested with 5 respondents before the commencement of the study. This enabled errors and bias to be identified and changes were made on some questions.

A desk study was carried out to review other research and studies that have been done in relation to HIV/AIDS related stigma and competences and the existing information which laid a foundation for the research. It was also used to derive indicators of competences towards HIV/AIDS. Literature materials used were the latest documents from text books, documents from Government of Kenya ministries, PhD thesis, scientific journals and publications and internet sites.

3.3. Overview of the research methodology

Data was collected from key informants and individual interviews as indicated in Table 3.1. and Figure 3.4.

Table 3.1: Sources of HIV/AIDS information

Research Sub question	Data information gathered	Source
1.1	Non-technical staff perceptions on HIV/AIDS- beliefs and attitudes of staff	Non-technical staff
1.2	Levels of non-technical staff competences with regard to HIV/AIDS, interaction processes among staff, supportive environment for HIV/AIDS staff	Non-technical staff.
1.3	Levels of non-technical staff knowledge of HIV/AIDS.	Non-technical staff, ACU, Sub-ACU
2.1	Awareness of the various elements in the HIV/AIDS workplace policy.	Non-technical staff, ACU,
2.2	What the HIV/AIDS workplace policy entails.	Non-technical staff,
2.3	Extend to which decision makers support and actively pursue addressing HIV/AIDS issues.	ACU, Sub-ACU
2.4	Changes realized in workplace due to HIV/AIDS training	Technical staff, ACU, Sub-ACU

Research Framework

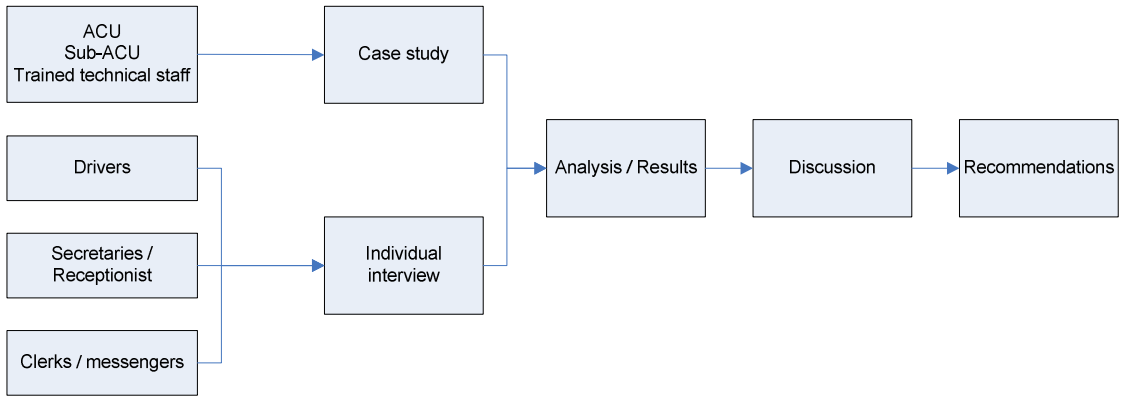

Figure 3.4: Research framework assessing MoLD non-technical staff competences to address HIV/AIDS

3.4. Data analysis

Data entry was done using the epi-info 3.3.2 programme. The SPSS programme version 16 was used for descriptive analysis for comparison of the responses and the results in tables and graphs were generated through the use of Excel programme.

The results were compared with relevant existing literature. Finally, conclusions were made based on the results of the analysis and recommendations made that will help the department to draw strategies to enhance the HIV/AIDS competencies of non-technical staff.

3.5. Limitations of the study

The ACU had been inactive and was re-established 2010. The staff member who is heading the ACU was appointed in 2009 while the HIV/AIDS focal persons at the provinces and districts were appointed this year. These officers were in the process of reorganizing the HIV/AIDS units at all levels. Therefore no challenges had been encountered in implementing HIV/AIDS workplace policy as it was just starting and implementation strategies were yet to be put in place.

4. RESULTS AND DISCUSSION

4.1 Introduction

This chapter deals with the findings and discusses the results of the study. A number of tables have been used for data presentation. Below are the formulas used to generate the percentages shown in the tables:

Total number of respondents (36)
Total number of respondents per cluster (12)

$$\% \text{ per cluster} = \frac{\text{number of respondents per cluster who gave that response}}{12} \times 100$$

$$\% \text{ total} = \frac{\text{total number of respondents from all clusters who gave that response}}{36} \times 100$$

4.2. Modes of HIV transmission

The study looked at the following variables: transmission through sex, having multiple sex partners, blood transfusion, mother to child transmission (MTCT) and breast feeding.

The study revealed that the respondents were aware of the main modes of HIV transmission namely: unprotected sex, blood transfusion, sharing of needles/syringes among drug users and MTCT. This can be attributed to enactment of a law by the Kenya Government to create HIV/AIDS awareness (GOK, 2006).

Over 90% of drivers and secretaries/receptionist said HIV can be transmitted by having multiple sex partners, 17% of the clerks/messengers said no while 8% did not know. They argued that if one is in a polygamous marriage and they are all faithful to that relationship, then one cannot get HIV (Table 4.1).

For the purpose of this study, MTCT means HIV transmission from an HIV-positive mother to her child during pregnancy, labour and delivery. The study revealed that 86% of the respondents are aware that HIV is transmitted through mother to child. However 6% did not know and 8% said no because they gave the reason that it had been proven that HIV positive parents can give birth to HIV negative children. They cited a case of Head of Kenya Network of Women living with AIDS who gave birth to one such child (Fleischman, 2007). This was their basis of argument. This is a story which was given a lot of publicity in the general print media and electronic media in Kenya in 2007.

The issue of breast feeding also was raised by 34% of the secretaries/ receptionists, of whom 17% were not sure and another 17% said no. They cited the daily newspaper (Nationrespondent, 2010) dated 30th July 2010 whereby HIV positive mothers were advised to breastfeed for 6 months since it boosts the immunity of the baby. The research was done by staff from Kenya Medical Research Institute and Centre for Disease Control and Prevention (Morgan *et al.*, 2010). This is also recommended by the WHO (WHO, 2008).

Table 4.1: Modes of transmission

Modes of Transmission	Staff Designation	Yes %	No %	Do not know %
Through sex	Clerk / messenger	100	0	0
	Drivers	100	0	0
	Secretary / receptionist	100	0	0
	Total	**100**	**0**	**0**
Multiple sex partners	Clerk / messenger	75	17	8
	Drivers	100	0	0
	Secretary / receptionist	92	0	8
	Total	**89**	**6**	**6**
Blood transfusion	Clerk / messenger	83	8	8
	Drivers	100	0	0
	Secretary / receptionist	92	8	0
	Total	**92**	**6**	**3**
MTCT	Clerk / messenger	83	8	8
	Drivers	83	17	0
	Secretary / receptionist	92	0	8
	Total	**86**	**8**	**6**
Breastfeeding	Clerk / messenger	92	0	8
	Drivers	100	0	0
	Secretary / receptionist	67	17	17
	Total	**86**	**6**	**8**
Sharing needles among intravenous drug users	Clerk / messenger	92	8	0
	Drivers	92	8	0
	Secretary / receptionist	92	0	8
	Total	**92**	**6**	**3**

What other development partners have done towards responding to HIV/AIDS cannot be underscored. The media has played a major role in creating HIV awareness, however, there is need for the media to give complete information to enable the listeners, viewers and readers make informed decisions. The way the media at times covers issues, in some cases it may cause their clients to misinterpret what the real situation is and end up with making uninformed decisions. For example the media gave publicity to the birth of a healthy baby who was HIV–negative to HIV-positive parents, but it did not give details as in the precautions and therapy the parents had to undergo. This lack of full information may be misleading and more HIV-positive babies may be born due to lack of knowledge.

Although the media has had a positive role to play in informing the public about HIV transmission, this can be an entry point into future ministerial interventions to HIV prevention. The MoLD needs to ensure that its own staff are well informed so as to ensure that they can take the right measures towards responding the epidemic. There is still a knowledge gap in prevention of MTCT and ART/ARVs hence need to give new updates of the developments which have come up for example, giving birth to HIV-negative babies by HIV-positive parents, breastfeeding babies by HIV–positive mothers. Since most of the respondents were in the age

bracket of 24 to 44 years (Figure 3.3) which is the child bearing age, MoLD needs to equip them with HIV information so that they may make informed decisions such as knowing their HIV status.

More drivers were informed on modes of transmission compared to clerks/messengers who were also more informed than the secretaries/receptions. This can be attributed to the fact that drivers have access to the radio in the vehicles which they can listen to. Secondly, drivers have more free time in between assignments compared to the other cadres which they can use to read the newspapers hence giving them opportunity to be informed.

4.3. Misconceptions on HIV Transmission

Over 80% of the respondents were aware of the main prevention methods namely abstinence, being faithful and use of condoms. However, Table 4.2 shows that 19% of the respondents reported that deep kissing can transmit HIV from an infected person to a healthy one whereas 3% had no idea if it can or cannot. The study further shows that 33% of drivers, 8% secretaries/receptionists and 8% clerks/messengers did not know if insect's bites can transmit HIV while 33% of secretaries/receptionists said insect bites can transmit. In total only 72% were aware that HIV is not transmitted through insect bites.

Table 4.2: Misconceptions on HIV Transmission

Misconception	Staff Designation	Yes %	No %	Do not know %
Kissing	Clerk / messenger	17	83	0
	Drivers	25	75	0
	Secretary/ receptionist	17	75	8
	Total	**19**	**78**	**3**
Sharing utensils	Clerk / messenger	0	83	17
	Drivers	8	92	0
	Secretary/ receptionist	8	67	25
	Total	**5**	**81**	**14**
Insect bites	Clerk / messenger	0	92	8
	Drivers	0	67	33
	Secretary/ receptionist	33	58	8
	Total	**14**	**72**	**14**
Witchcraft	Clerk / messenger	0	83	17
	Drivers	17	83	0
	Secretary/ receptionist	0	92	8
	Total	6	**86**	**8**

This study revealed that some misconceptions on how HIV is transmitted and prevented still exist among the non-technical staff especially secretaries, for example kissing and insect bites. The Kenya Government has been focusing its messages and efforts on: condom use by even providing condoms for free, staying faithful to one partner and abstaining from sex especially the youth (KNBS, 2010). From the study, indications are that the government was not focusing on HIV transmission misconceptions. This is in line with a report by the UNAIDS (2009) which indicates that misconceptions do exist.

The Kenya Demographic and Health Survey 2008-09 indicated that HIV/AIDS knowledge is rejecting the misconception about HIV transmission; this means that a gap exists in MoLD non-technical staff as only 72% of the respondents was aware HIV is not transmitted through insect bites. Another report by the UNAIDS (2009) indicated that Kenya had achieved 80% on passing on knowledge by 2008, this further emphasizes the knowledge gap among respondents since the study indicates that some.

The study shows that there was a wider gap in information among the three clusters of non technical staff. A higher percentage of secretaries/receptionists, compared to clerks/messengers and drivers had misconceptions on HIV transmission modes. The study further indicates that the media does not cover HIV/AIDS misconceptions hence the percentage of drivers (17%) having some HIV/AIDS misconception for example witchcraft. In some Kenyan societies, witchcraft plays a big role in their beliefs, for example, when an old person dies, it is taken to be natural but when young people die, it is seen as a punishment for some wrong doing or seen as the work of some supernatural being or the witches. Therefore when a person has AIDS, it is easier to blame it on witchcraft because one cannot be held accountable for his behaviour since it is believed it was beyond his control. In this way, the PLWHA does not feel stigmatized. According to Dyk (2008), these beliefs have made it difficult to respond to HIV/AIDS since the misconceptions make people not appreciate the HIV preventive methods. This calls for intensive HIV/AIDS awareness creation.

4.4. HIV Prevention methods

The study looked at the following variables of HIV prevention: abstinence from sex, being faithful, use of condoms, having sex with a healthy looking person, having sex with one partner and avoiding contact with a PLWHA.

The majority of the respondents were aware that abstinence from sex, being faithful to one sexual partner and use of condoms would prevent HIV transmission (Table 4.3). Although 72% of the respondents were aware that HIV is not transmitted by avoiding contact with a person with a PLWHA, 14% of the respondents (25% of all clerk/messengers, 8% of drivers and 8% of secretaries/receptionist) claimed HIV can be prevented by avoiding contact with a PLWHA.

The 83% of respondents who were aware that HIV prevention cannot be achieved by having sex with a healthy looking person, said that the healthy looking person can be HIV positive, it is just that he/she has not reached the AIDS stage. This is an indication of the high HIV/AIDS awareness levels.

Table 4.3: HIV Prevention methods

Prevention method	Staff Designation	Yes %	No %	Do not know %
Abstinence from sex	Clerk / messenger	100	0	0
	Drivers	100	0	0
	Secretary/ receptionist	83	17	0
	Total	**94**	**6**	**0**
Being faithful	Clerk / messenger	92	0	8
	Drivers	92	8	0
	Secretary/ receptionist	75	17	8
	Total	**86**	**8**	**6**
Use of condoms	Clerk / messenger	100	0	0
	Drivers	92	8	0
	Secretary/ receptionist	100	0	0
	Total	**97**	**3**	**0**
Having sex with a healthy looking person	Clerk / messenger	17	83	0
	Drivers	17	83	0
	Secretary/ receptionist	8	83	8
	Total	**14**	**83**	**3**
Avoiding contact with a PLWHA.	Clerk / messenger	25	67	8
	Drivers	8	75	17
	Secretary/ receptionist	8	75	17
	Total	**14**	**72**	**14**

Reported knowledge on HIV–prevention was high except for the misconception that having sex with a healthy looking person and avoiding a PLWHA. The respondents were knowledgeable on the three main prevention methods which the government and the media have been emphasizing namely abstinence from sex, being faithful and condom use. This is in line with Myhre and Flora (2000) who noted that the media does not cover myths on HIV/AIDS. Therefore MoLD needs to train the staff so as to clarify the misconceptions.

4.5. General Knowledge on HIV/AIDS

The study revealed that 89% of the respondents agreed that HIV weakens the body's defense mechanism against infections and abuse of alcohol and other drugs can contribute to the spread of HIV/AIDS. A majority of the respondents (83%) disagree that one can tell an HIV positive person by appearance.

A total of 17% of the clerks/messengers and 8% secretaries/receptionists disagreed with the statement that at present there is no cure for AIDS. They argued that if one knew his/her status early enough, he/she may be able to prolong their life by up to 20 years The respondents cited the director of KENWA -Ms Asunta Wagura who was diagnosed 23 years ago as HIV positive and is still alive and given birth to HIV negative baby boy.

The 17% of the clerks/messengers, who agreed with the statement that AIDS was a disease of poverty and ignorance, claimed that it is the poor who engage in transactional sex in search of money to cater for their subsistence. They also claimed that the poor cannot afford the right diet

to enable them to prolong their lives and neither can they afford to purchase the ARV when the drugs are not available in government health institutions.

The study revealed that 42% of the respondents (25% clerks/messengers, 67% drivers and 33% secretaries/receptionists) did not know what the widow period is. Only 53% of the respondents were aware what it is.

Half the number of drivers (50%), 33% clerks/messengers and 33% secretaries/receptionists did not know if HIV/AIDS treatment is expensive. They claimed that the government offers free ARVs. However, 33% of the drivers, 43% of the clerks/messengers and 33% of the secretaries/receptionists agreed it was expensive. They claimed that one spends time and incurs transport expenses when going for the ARV drugs.

Table 4.4: General knowledge on HIV/AIDS

Knowledge item	Staff Designation	Agree %	Disagree %	Do not Know %
HIV weakens the body's defense against infections	Clerk / messenger	83	17	0
	Drivers	100	0	0
	Secretary/ receptionist	83	0	17
	Total	**89**	**6**	**6**
One can tell an HIV positive person by appearance	Clerk / messenger	17	83	0
	Drivers	8	92	0
	Secretary/ receptionist	17	83	0
	Total	**14**	**86**	**0**
Abuse of alcohol and other drugs can contribute to the spread of HIV/AIDS	Clerk / messenger	83	8	8
	Drivers	75	17	8
	Secretary/ receptionist	75	17	8
	Total	**78**	**14**	**8**
False information about HIV/AIDS can cause unnecessary fears	Clerk / messenger	83	8	8
	Drivers	83	0	17
	Secretary/ receptionist	100	0	0
	Total	**89**	**3**	**8**
At present there is no cure for AIDS	Clerk / messenger	75	17	8
	Drivers	92	0	8
	Secretary/ receptionist	92	8	0
	Total	**86**	**8**	**6**
AIDS is the disease of poverty and ignorance	Clerk / messenger	17	75	8
	Drivers	8	92	0
	Secretary/ receptionist	0	100	0
	Total	**8**	**89**	**3**
Widow period is when the body shows no signs of the disease	Clerk / messenger	67	8	25
	Drivers	25	8	67
	Secretary/ receptionist	67	0	3
	Total	**53**	**6**	**42**
HIV/AIDS treatment is expensive	Clerk / messenger	42	25	33
	Drivers	33	17	50
	Secretary/ receptionist	33	33	33
	Total	**36**	**25**	**39**

Over 78% of the respondents had correct general knowledge on HIV/AIDS, 25% were not quite sure about some statements which had been given for example, HIV/AIDS treatment is expensive, some argued that the government supplies drugs others were not certain about the supply of the drugs by government health facilities.

The study also showed that drivers were more knowledgeable as compared to the other cadre of non-technical staff.

4.6. ATTITUDES

4.6.1 Section A- Feelings

Table 4.5 shows that only 33% of the drivers were comfortable discussing HIV/AIDS in the office. They said it depends on who they are discussing with. If it is with their colleagues of the same cadre they were comfortable than if it was with more senior colleagues. On further probing, the respondents were reluctant to give a reason for this.

Secretaries/receptionists were the most uncomfortable (67%) regarding feelings of being associated with PLWHA. The secretaries reported that they would have different reactions or feelings depending on the relationship one had with PLWHA. They associated the feelings with how the community would react to it. One of the secretaries stated that the community would conclude that one is infected and think that he/she would die soon if the spouse is HIV positive. On the other hand, if it is a teenage child, then it is alleged that one has poor parenting skills and has brought up irresponsible children. The main concern was the gossip that goes around. The clerks/messengers had more accepting attitudes towards PLWHA compared to drivers and secretaries/receptionists.

More than half the respondents (64%) were comfortable sharing office space with a PLWHA. The secretaries/receptionists also claimed that AIDS related illnesses such as tuberculosis (TB) are contagious and as such the PLWHA should be isolated. Those who were slightly uncomfortable said it depended on if the PLWHA had started showing signs of full blown AIDS symptoms. They said when one has full-blown AIDS “one looks scary”. The same reason was given for not being comfortable being served tea by a PLWHA.

Over 80% of the respondents were comfortable with MoLD distributing condoms in the washrooms, however, in all the other attitudes, there were about 50% who were comfortable.

The study revealed that none of the respondents was comfortable declaring their own HIV status whereas they were comfortable with others declaring their status so that they may give them any assistance they require. The secretaries/receptionists were the most uncomfortable declaring their HIV status. The respondents wondered why they should declare their HIV status and what benefit there was in declaring it. They claimed it would be opening up oneself for gossip which would lead to them being discriminated against. Some respondents claimed depending on how far the disease has affected them, they would confide in their immediate supervisors so as to be able to access permission when feeling very sick and also to ease workload for themselves.

Table 4.5: Feelings of staff

Attitude	Staff Designation	Comfortable %	Slightly Comfortable %	Uncomfortable %	Not sure %
HIV/AIDS Discussion in the office	Clerk / messenger	67	8	8	17
	Drivers	33	42	25	0
	Secretary/ receptionist	58	25	17	0
	Total	**53**	**25**	**17**	**6**
Taking care of family members infected with HIV	Clerk / messenger	83	0	8	8
	Drivers	50	8	33	8
	Secretary/ receptionist	33	25	33	8
	Total	**56**	**11**	**25**	**8**
Feelings of being associated with PLWHA	Clerk / messenger	58	17	0	25
	Drivers	25	8	17	50
	Secretary/ receptionist	17	8	67	8
	Total	**33**	**11**	**28**	**28**
Sharing office space with PLWHA	Clerk / messenger	83	8	8	0
	Drivers	50	25	17	8
	Secretary/ receptionist	58	33	8	0
	Total	**64**	**22**	**11**	**3**
Being served tea by PLWHA	Clerk / messenger	50	25	8	17
	Drivers	50	25	25	0
	Secretary/ receptionist	50	25	25	0
	Total	**50**	**25**	**19**	**6**
Declaring own HIV status if found positive	Clerk / messenger	0	33	8	58
	Drivers	0	17	8	75
	Secretary/ receptionist	0	17	42	42
	Total	**0**	**17**	**25**	**58**
Other people declaring their status	Clerk / messenger	83	8	8	0
	Drivers	58	25	17	0
	Secretary/ receptionist	50	17	25	8
	Total	**64**	**17**	**17**	**3**
MoLD providing condoms in washrooms for use by staff and clients	Clerk / messenger	75	8	0	17
	Drivers	83	8	0	8
	Secretary/ receptionist	92	8	0	
	Total	**83**	**8**	**0**	**8**

The study revealed that there are negative attitudes existing among the respondents especially the secretaries/receptionists. These negative attitudes indicate that instrumental stigma exists among the non-technical staff of MoLD which is indicated by attitudes such as staff not being comfortable taking care of the PLWHA and being served tea by PLWHA. This is consistent with Herek *et al.* (2002) where he describes instrumental stigma as fear of being infected with HIV.

Table 4.5 depicts some of the causes of HIV-related stigma as cited by Campbell *et al*. (2007) and Avert organization (2010) that exists among the non-technical staff of MoLD. These are:

- fear of sharing office space among the drivers and secretaries/receptionists in that they be get infected with TB from the PLWHA (50% and 36% respectively)
- fear of being associated with PLWHA or taking care of PLWHA least they get infected (67%)
- demonizing patients with AIDS relate illnesses especially through appearance ("one looks scary)" equated to fear of sharing office space
- lack of social dialogue to discuss HIV/AIDS in the office (47%).

A UNAIDS report on HIV-related stigma, dicrimination and human rights violations (2005) indicates that open discussions both on the causes and appropriate responses towards HIV/AIDS have been silenced by stigma.

The above results also indicate the existence of HIV-related stigma by association (Pryor, 2010) among the non-technical staff as this can be manifested in respondents being ashamed and not being able to disclose concerns about psychological stress for example declaring ones HIV-status if found positive and being ashamed of being associated with a PLWHA and taking care of a PLWHA.

The study reveals gaps on effective communication skills when working with PLWHA as can be evidenced by the percentage of respondents willing to be served tea by PLWHA or sharing office space with PLWHA in figure 4.5 (50% and 64% respectively). This indicates that about half the staff do harbor negative attitudes towards PLWHA and this may fuel HIV/AIDS related stigma in the workplace.

4.6.2. Section B -Mindset

The study showed that 22% of the respondents thought PLWHA should remain anonymous since this could spare them the gossip which makes one very uncomfortable in the office and most times causes stigma. However, 72% agreed that PLWHA should speak out.

Only 44% of respondents said PLWHA should be promoted as this person has a higher expenditure on diet and drugs whereas another 44% were not sure as they claimed the PLWHA surely needed the money but then his/her work output is very low.

Table 4.6 shows that 92% of the respondents thought that PLWHA should be allowed to serve as peer educators. The interviews said the experiences of PLWHA may give those uninfected a challenge so that they may be encouraged to live healthier lifestyles. This is in line with the GIPA principle (UNAIDS, 1999) as one of the ways of involving PLWHA is through giving them a chance to educate others. This is further supported by the respondents when they revealed that they are comfortable with others declaring their HIV status (Table 4.5).

A high percentage of the secretaries/ receptionists (67%) felt PLWHA should be isolated as some of the AIDS related illnesses are contagious and they named TB. However, other than the secretaries/receptionists who felt that way, over 80% of their clerks/messengers and drivers said that PLWHA should not be isolated as this would stigmatize them and "send them faster to the grave".

The study showed that 25% of the clerks/messengers thought that PLWHA were promiscuous. Half the clerks/messengers and half the drivers did not know. Only less than 39% said no as PLWHA could have been infected through other modes of transmission and not necessarily sex.

Table 4.6: Mindset of staff

Thoughts	Staff Designation	Yes%	No%	Do not Know %
PLWHA should be protected by law against discrimination in the workplace	Clerk / messenger	92	8	0
	Drivers	83	17	0
	Secretary/ receptionist	100	0	0
	Total	**92**	**8**	**0**
PLWHA should remain anonymous for security reasons	Clerk / messenger	8	92	0
	Drivers	25	67	8
	Secretary/ receptionist	33	58	8
	Total	**22**	**72**	**6**
PLWHA should not be promoted	Clerk / messenger	17	42	42
	Drivers	8	50	42
	Secretary/ receptionist	8	42	50
	Total	**11**	**44**	**44**
PLWHA should not be allowed to serve as peer educators	Clerk / messenger	0	100	0
	Drivers	17	83	0
	Secretary/ receptionist	8	92	0
	Total	**8**	**92**	**0**
AIDS patients should be isolated as a preventive measure	Clerk / messenger	0	92	8
	Drivers	17	83	0
	Secretary/ receptionist	67	25	8
	Total	**28**	**67**	**6**
PLWHA have been promiscuous	Clerk / messenger	25	25	50
	Drivers	17	33	50
	Secretary/ receptionist	8	58	33
	Total	**17**	**39**	**44**

Table 4.6 indicates that most of the respondents acknowledged the rights of PLWHA in that they felt PLWHA should be protected by law against discrimination in the workplace.

The study revealed that there was symbolic HIV/AIDS related stigma among the non-technical staff depicted in the responses given for example, PLWHA should remain anonymous or be isolated and PLWHA have been promiscuous. These are attitudes based on judgmental values.

Instrumental stigma also exists as depicted in the percentage of respondents who were of the opinion that PLWHA should be promoted (44% do not know,11% no).

4.7. Impacts of HIV/AIDS in the workplace

Table 4.7 shows that office gossip is a major impact (67%) while death is the least. Other impacts mentioned by the respondents include: poor performance, absenteeism, overworked staff and self stigma, PLWHA being isolated by other colleagues, low morale amongst staff, lack of concern by others causing enacted stigma to PLWHA, hostility by PLWHA and programme distortion.

Office gossip was cited as the main cause of stigma as this leads to low self esteem to the PLWHA who is being gossiped about and in turn leads to self stigma. This was cited by 28% of the secretaries/receptionists.

The study revealed that 58% of the respondents cited overworked staff and this impact was mentioned by 8% of the drivers such as absentseeim. Hostility by PLWHA was cited by 22% of clerks/messengers and 19% of secretaries/receptionist.

Abstenteeism from work was mentioned by 47% of the respondents. This impact seemed to be felt by clerks/messengers and secretaries/receptionist.

The percentage of respondents who mentioned self stigma was 45% where they said that PLWHA tend to isolate themselves from the rest of the staff.

Table 4.7: HIV/AIDS impacts at workplace

Impact	Clerk/ messenger %	Driver %	Secretary/ receptionist %	Total who mentioned it %	Did not mention it %
Office gossip	75	42	83	**67**	33
Overworked staff	83	25	75	**58**	38
Absenteeism from work	50	17	75	**47**	53
Hostility by PLWHA	67	17	58	**47**	53
Self stigma by PLWHA	50	50	17	**45**	56
Poor performance	50	17	17	**39**	58
Lack of concern by others	33	8	42	**28**	72
Distortion of programmes	8	50	17	**26**	75
Isolation of PLWHA	33	17	17	**23**	78
Low morale	17	8	42	**23**	78
Death	0	25	0	**8**	92
No impact	0	25	0	**8**	92

Most of the secretaries/receptionists and clerks/messengers cited office gossip, overworked staff, absenteeism, however, distortion of programmes which was highly mentioned by drivers. This can be attributed to the fact that due to the drivers' nature of work, they are usually assigned one vehicle and while on assignment, as the officers are doing their work, the driver is alone in the vehicle listening to the radio or reading the daily newspaper. The clerks/messengers usually share office space, hence they have opportunity for gossip and have to take the additional responsibility for the sick colleagues. Drivers mentioned distortion of job programmes as they claimed that absence of a driver who had been assigned duties for that day usually makes planned work programmes for the day to be changed.

These impacts depict HIV/AIDS related stigma manifestations which is in line with Pryor (2010), namely:

Type	**Manifestation**
Public stigma	-Office gossip (67%) -Hostility by PLWHA (47%) -People isolating PLWHA (23%)
Self stigma	-Absenteeism (47%) -PLWHA withdrawing from the others or isolating oneself (47%) -Lack of concern (28%)
Stigma by association:	-Low morale as staff are not able to disclose their concerns (23%).

Thus the main impacts can be summarized as absenteeism (47%), overworked staff (47%) programme distortions (26%) and poor performance (19%). This is in line with a study carried out by Policy Project (Siyamkela, 2003) which reports that HIV-related stigma affects workers morale resulting in poor productivity. Absenteeism and overworked staff result in ineffectiveness of an organization which translates to poor productivity.

Office gossip can lead to self-stigma which may cause the PLWHA to keep off from duty leading to distortion of programmes. The absence of PLWHA from duty may lead to higher workload for the other staff, leading to overworked staff. Similar results were reported by Maman *et a.,* (2009), who found out that gossiping and social distancing between PLWHA and non-PLWHA are the main stigmatizing attitudes. The study further noted that gossip usually does not occur in front of the PLWHA and is normally triggered by visible signs and symptoms of AIDS. Table 4.6 confirms this as 28% of the respondents had a mindset that PLWHA should be isolated as a preventive measure against HIV transmission.

4.8. Skills

The study indicates that there was a gap in HIV/AIDS related skills particularly the communication skills as depicted by Table 4.5 and Table 4.6. The respondents said PLWHA should be isolated (28%) and they were uncomfortable sharing office space with PLWHA (Figure 4.5). Such responses could be deduced as an indication of non-verbal signals of stigma meaning that communication with PLWHA is limited. Office gossip indicates the lack of respect for PLWHA; such behaviour should not be encouraged. MoLD needs to transfer communication

and interpersonal skills to its staff members. According to Gotz (1989) skills are acquired not inborn and needs to be practiced. Therefore the staff are likely to improve skills on how to relate to PLWHA after being trained.

4.9. HIV/AIDS Workplace policy

All respondents except one secretary did not know about the existence of an HIV/AIDS workplace policy hence they were not aware of the contents. They did not have access to it either therefore they knew nothing about it. The secretary had come across it on the internet and read it. The issues in the Public Sector HIV/AIDS Workplace Policy which she could remember were:

- non discrimination of PLWHA in the workplace: non discrimination in appointment, promotion and transfer.
- one should not be compelled to undergo an HIV/AIDS test.
- an employee cannot have his/her employment terminated due to HIV/AIDS.
- an employee who is PLWHA is entitled to care and support.
- flexible working hours for PLWHA or those affected by HIV/AIDS.
- spouses are not separated due to transfer to minimize susceptibility to HIV.
- staff in remote areas will be facilitated to visit their families frequently to avoid making them susceptible to HIV infection and will work in these areas for a maximum period of three years.

Although there is currently a Public Sector HIV and AIDS Workplace policy on paper, many of the respondents do not know about its existence and the contents neither is it available or accessible in most offices. This is in line with Rau (2002) who stated that posting policies on paper does not necessarily mean implementation. This could be the reason why most of the respondents are not willing to go for HIV testing and those who have gone are not willing to declare their status since they do not see why they should. As mentioned in Chapter 2, the workplace can be a place of fulfillment, health benefits and companionship. Therefore, if staff are not aware of the benefits, then there may be non-implementation of such a policy.

According to ILO (2001), it is important to involve the beneficiaries of the HIV/AIDS workplace policy during its formulation. The Kenya Government is the biggest employer in the country therefore due to the vast number of employees it makes it impossible for it to involve the beneficiaries in the policy formulation. At the same time different government departments are affected in different ways (Barnett and Whiteside, 2008) and therefore their responses should be different. However, it is important for the MoLD to embrace the policy and bring the contents to the attention of its staff members and start implementing it. MoLD can then look at the policy and domesticate it as it continues to disseminate to its members what is available in the policy now.

Although the ACU has just been re-established, the policy came into place in 2005 meaning staff have been losing out on the benefits due to lack of knowledge. This indicates an implementation gap in the policy. For the effective implementation of a public policy, communication between beneficiaries and implementers, resources (both human and material), disposition and efficient bureaucratic structure are essential ingredients (Makinde, 2005). In addition, it needs to have point persons at all levels of management and provide resources. Lack of knowledge of its existence denies the staff any support he/she may get if infected or

affected. This could be one reason why the staff are not willing to disclose their HIV status for those who know.

A good HIV/AIDS workplace policy does not guarantee that the organization is immune from the impact of HIV/AIDS. The policy must not be “on paper” but should be implemented and the organization should fulfill its obligations as stated and outlined on the policy. Moreover, the management should make efforts to ensure that the staff members are aware of the contents, their rights and responsibilities. Above all, Holden (2007) emphasizes that “careful follow up is needed, to identify where problems exist and how they might be mitigated”.

4.10. HIV/AIDS Training

4.10.1 Sources of HIV/AIDS information

Respondents get information from various sources which include churches, radio, television, internet, Ministry of Health, VCT, newspapers, colleagues, NGOs, peer educators, booklets, agricultural shows, AIDS-day, exhibitions and seminars.

A total of 67% drivers received their information from radio, 33% from the VCT and workshops/ seminars and newspapers while none from booklets, pamphlets the internet. Sources of HIV/AIDS information for clerks/messengers were from seminars (25%), radio and newspapers while a total of 33% of the secretaries/receptionists got HIV/AIDS information from the VCTs and church while 25% from friends/colleagues (Figure 4.1).

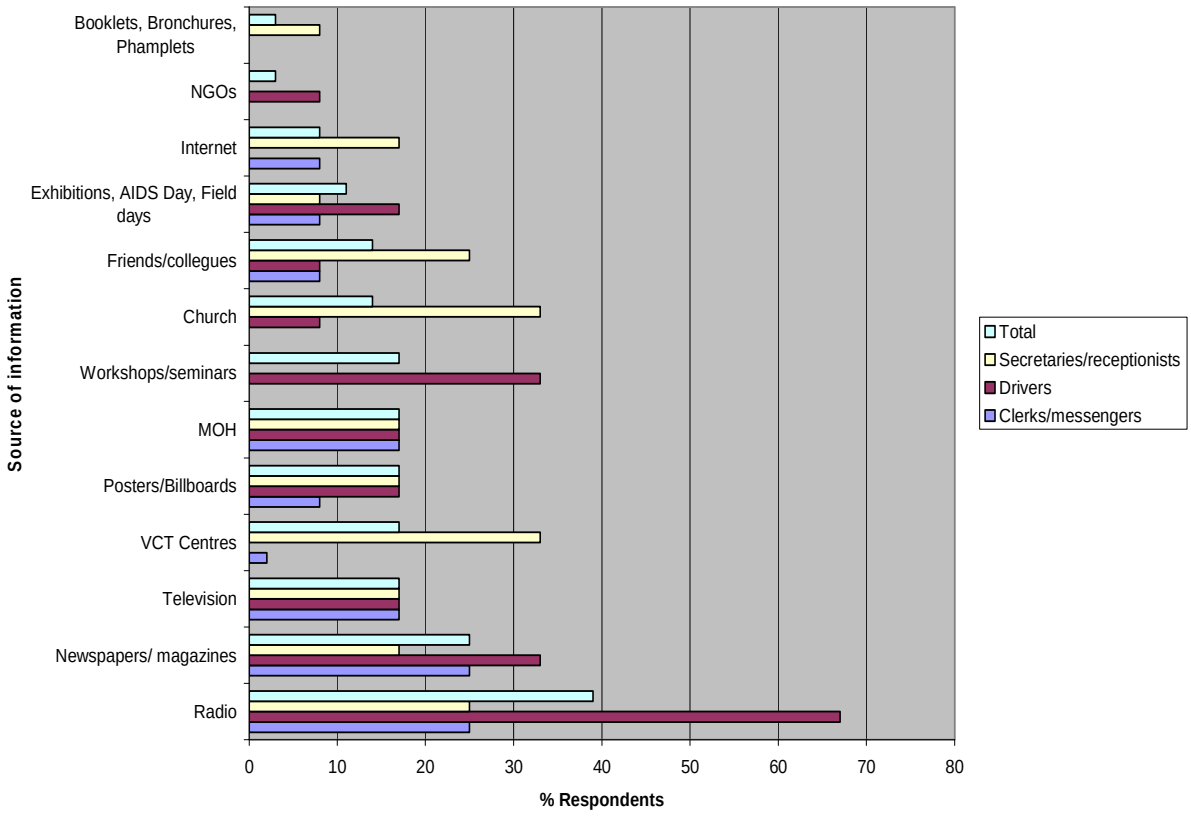

Figure 4.1: Sources of HIV/AIDS information

The study revealed that the main sources of information were the radio, television and newspapers. This is in line with a study done in Kenya which ranked radio as a major source of disseminating HIV/AIDS information (Bowen, 2010). The study further indicates that family members and friends were the other major source of information followed by television to which this study found that the radio was ranked first, newspapers second and television third whereas friends/ colleagues/ family members were ranked sixth. This is an indication of the important role the media plays in promoting HIV/AIDS awareness and educating its viewers, readers and listeners about the HIV/AIDS epidemic. In addition it highlights the new developments in the world of HIV/AIDS. However, although the media has had a part to play in informing its clients about HIV/AIDS, indications are that it only concentrates the main modes of transmission and intervention and does not cover myths on HIV/AIDS hence the debate on the precise impact of mass media on reducing HIV/AIDS risk behaviours (Myhre and Flora, 2000). This is revealed in the study as the data shows that though drivers have more access to radio (67%) and newspapers (33%), they still have misconceptions that HIV is transmitted through kissing (25%) and 33% (Table 4.2) did not know if insects can transmit HIV or not. The MoLD played a very minimal role in getting its staff informed. All the respondents showed an interest in knowing more about HIV/AIDS as is depicted in Figure 4.1 in that they were getting information from other sources like churches, internet, booklets and attending workshops/ seminars.

4.10.2. Training attended in the last five years

Figure 4.2 indicates that only 39% of the respondents have received training on HIV/AIDS from various organizations (50% secretaries/receptionists, 25% drivers and 42% clerks/messengers).NGOs have taught 17% of the trained non-technical staff and MoLD has trained one secretary/receptionist (3%). Other institutions which have offered training to the respondents include: churches, NGO's, hospitals and other government ministries for example Ministry of Education, Ministry of Health and Ministry of Transport. Secretaries/receptionists have benefitted from this training while the least number of respondents who have been trained are drivers.

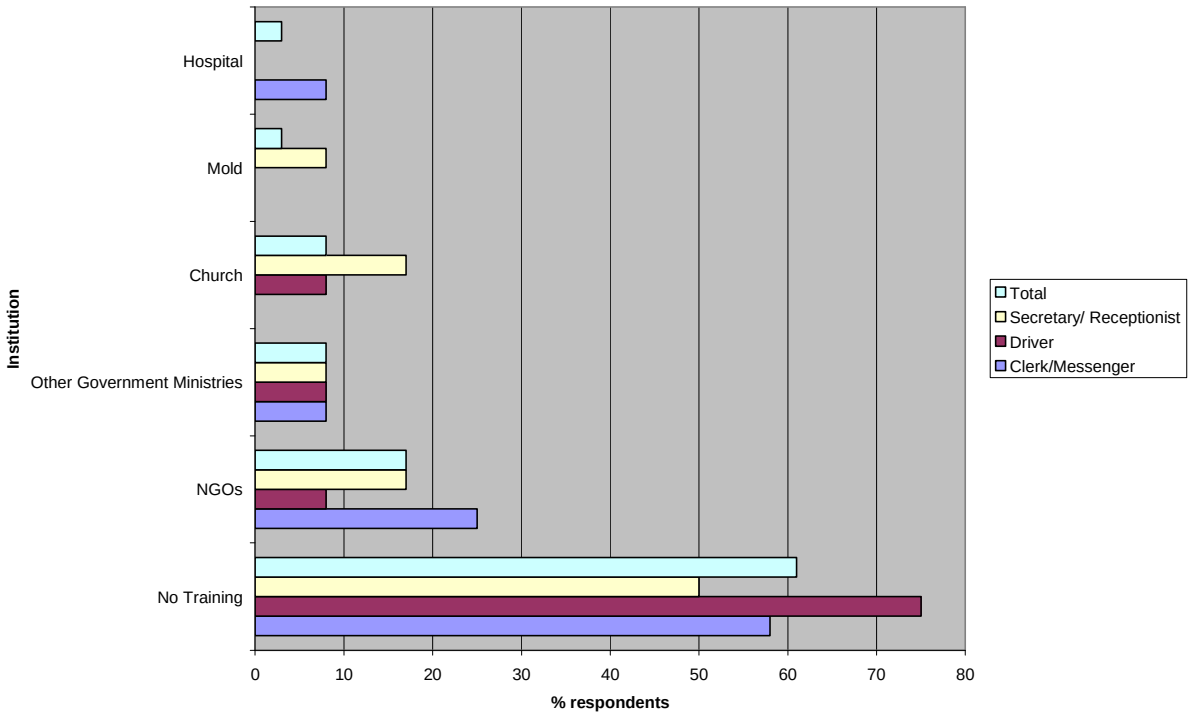

Figure 4.2: Percent staff trained and the training organization

Rollingson (2008) says that in this era of globalised environment, to survive, an organization has to be a learning one. The MoLD seems to have failed in this as the study revealed that MoLD had trained only 3% of the respondents. Another 36% were trained by other organizations while 61% relied on the media for HIV/AIDS information. This could be the reason why other than what the media is emphasizing, for example, the three main ways of HIV prevention and four ways of transmission, 17% still lacks information on how HIV is not transmitted (Tables 4.1 and 4.2). There are myths which exist about HIV/AIDS and it can be helpful if MoLD can clear them.

The fact that respondents were not willing to have social dialogue in the office concerning HIV/AIDS and sharing office space with a PLWHA (Table 4.5), is an indication of interviewees not knowing how to relate with PLWHA or just fear of being infected. This is due to lack of knowledge.

The training organized by MoLD was funded by Total War Against HIV/AIDS (TOWA) Project. TOWA is project funded by World Bank, through NACC targeting HIV/AIDS interventions to mitigate the impacts of the epidemic. The source of the funding could be the reason why the number of trained respondents was so low. The other reason could be due to the inactiveness of the ACU which led to no or minimal activities from 2004 up to 2010. With the re-establishment of the ACU, at least 2 training sessions have been held. If it can continue that way then it may be able to train more staff.

The low percentage (39%) of the respondents trained could indicate that the non-technical staff are not aware of what other stakeholders are doing. Hence they are not aware of other places they may get training of HIV/AIDS.

4.10.3. Subjects taught during HIV/AIDS trainings

All organizations taught on basic facts on HIV/AIDS which included modes of HIV transmission, prevention methods, myths and theories and cultural practices fueling the spread of the epidemic.

Other organizations added the following topics:

- HIV/AIDS related stigma and discrimination
- home based care of PLWHA
- church and HIV
- drug abuse and HIV
- guidance and counseling (HIV/AIDS)

The secretary, who had been trained by MoLD, had the following topics in addition to basic facts on HIV/AIDS:

- impact of HIV/AIDS on Livestock Sector
- impact Mitigation at Household Level (time saving and labour saving technologies), Farm level (farmer field school approach)
- basic Counseling Skills HIV/AIDS
- nutrition/Food Security
- income Generation Activities-Agro processing

MoLD needs to incorporate other topics such as HIV/AIDS related stigma and discrimination, home based care for PLWHA and guidance and counseling (HIV/AIDS). Such topics will enhance the competences (knowledge, attitude and skills).

4.10.4. Usefulness of the subjects

The respondents gave a combination of the usefulness of the topics taught. They have been categorized into 4 for ease of analysis. Each category gives the percentage cadre of trained staff who cited it.

After the training, 43% of the respondents went for HIV testing of whom 50% were the secretaries/receptionists who had been trained while 100% of drivers changed their behaviours to adapt to HIV/AIDS reality and attitudes towards PLWHA. Only a small percentage (17%) of the secretaries changed their behaviours.

Table 4.8: Usefulness of subjects taught

Usefulness of subjects	Clerks/ Messengers %	Drivers %	Secretaries/ Receptionists %	Total %
Attitude change towards PLWHA and those affected without causing stigma (not pity them but empathize with them)	60	100	67	71
Behavior change by respondents to adapt to HIV/AIDS reality	40	100	17	43
Gone for HIV testing	40	33	50	43
Appreciate PLWHA and not condemn them	60	67	67	64

The Table 4.8 shows that the training had a positive impact on the trainees. Of much importance is the step taken by 43% of the respondents to take an HIV test. This is one way towards responding to the epidemic and in line with UNAIDS (2005). The table also gives an indication that during training, skills are passed on, for example 60% of all the respondents claimed they changed their attitudes and now empathize with PLWHA other than sympathizing.

One way of fueling stigma is to show pity to the PLWHA. What PLWHA need is empathy not sympathy (E.O.Ojofeitimi and Fakande, 1998). Hostility by PLWHA was mentioned by the respondents as one of the impacts at the workplace; this is caused by lack of skills to relate to PLWHA. With training, skills can be enhanced on how to relate with PLWHA as indicated in the results that 71% of those who have trained and also the technical staff who has been trained are able to empathize with PLWHA.

Of the 31% respondents who have been trained, 43% went for an HIV test. This is a positive impact as knowing one's status is one of the initial stages in responding to the epidemic. The study hence revealed that giving people knowledge is empowering them just as the drivers were knowledgeable and opted to go for the HIV test. In addition, those trained cited other positive impacts especially towards addressing stigma and behaviour change.

The study revealed that when people are empowered with knowledge, they may be able to make informed decisions. Training can bring change to the organization both internally and externally. The drivers were the most informed among the three cadres and all the drivers who had undergone the training had gone for an HIV test and had changed their behaviours according to them. This means that as a result of the training there was behaviour change and people took charge of their lives. The above findings call for MoLD to train all staff so that they may also be in a position to make informed decisions and reduce stigma towards PLWHA and those affected by HIV/AIDS

4.11. Case studies

This section captures discussions held with three key informants namely the Officer in Charge of the ACU in the Ministry Headquarters, the Officer in Charge of ACU in the Provincial Headquarters and an MoLD technical staff member who has been trained on HIV/AIDS.

4.11.1. The Ministerial AIDS Control Unit

Although the MoLD ACU was established in 2004, it had remained inactive. According to the officer in charge of ACU, the ACU was re-established in August 2009 and ten officers were appointed by the Permanent Secretary to represent various sections in the ministry and a focal person to coordinate those activities on a full time basis. The ACU is meant to co-ordinate and implement AIDS control activities in the Ministry. Although he claimed the ACU is not fully organized, three activities have been undertaken since then with funding from TOWA namely:

- monitoring and evaluation of status of Sub ACUs in the provinces which included staffing of ACUs, activities and perception of AIDS risk among the officers in the District and Provinces. This was done through interviewing of staff using structured questionnaires.

- capacity building for Provincial Sub-ACUs and ACU Committee held during the month of March 2010, whereby 8 participants from 7 provinces and 11 ACU Committee members from the Ministry Headquarters were trained. Various topics were covered:
    - basic facts on HIV/AIDS:
    - counseling:
    - HIV/AIDS Impact on livestock sector:
    - Impact Mitigation: Impact at farm level and household level
    - the role of Sub-ACUs, resource mobilization, and obligation of the sectors in response to HIV/AIDS.
    - the role and responsibilities of key stake holders namely the government, the private sector, NGOs and development partners.

- HIV/AIDS sensitization of staff whereby 96 staff from the districts were sensitized. Among the sensitized staff was one driver from Coast Province, 7 clerks/messengers of whom 4 were from Nairobi, and 6 secretaries of whom one was from Central Province whereas the other 5 were from Nairobi.

During the training, nothing was covered on the Public Sector HIV/AIDS Workplace Policy. The ACU has planned a refresher course for the provincial sub-ACUs in September 2010 where the provincial sub-ACU coordinators will be sensitized on the Public Sector HIV/AIDS Workplace Policy and come up with the support which will be extended to the MoLD staff infected with HIV. The sub-ACU coordinators will be expected to disseminate the contents of the HIV policy to both the technical and non-technical staff in their respective provinces. The officer in charge of the ACU said there was a Public Sector HIV/AIDS workplace Policy which is meant to cater for all civil servants however, the ACU committee is yet to sit down and customize the policy according to the needs of the ministry's staff. This will include looking into what support they can offer PLWHA and those affected by scourge. The officer in charge of the ACU said they did not have enough copies of the policy for each sector and various levels of management in the ministry namely the provinces, districts and divisions.

At the moment the ACU does not know the number of staff who are living with HIV/AIDS. According to the officer in charge of ACU, this could be because the staff are not knowledgeable about the support which can be extended to them if infected.

The ACU has procured both male and female condom dispensers which are yet to be distributed to the districts. The condoms are expected to be provided by the Ministry of Heath in the respective districts. Unfortunately, the female-condoms are not readily available and the females need to be taught how to use them.

He further reported that unchecked spread of the disease has created labour shortages as the ministry has continued to lose staff and divert resources to the scourge due to staff morbidity and deaths (funeral expenses), loss of skilled personnel who have been trained and are experienced. He quoted a speech given by the Assistant Director of MoLD (2010), where he said "the ministry was spending more on transport, funeral expenses and sick offs thus reducing funding for service provision. Staff productivity is severely compromised in some areas. Training and specialized experience is being lost. Institutional memory is being destroyed faster than it can be replaced. The cost of replacing experienced staff and training is enormous".

MoLD taught the following topics during the three day workshop for staff:

- HIV/AIDS historical perspectives-Myths, Theories, Cultural practices, Attitudes
- basic facts about HIV/AIDS.
- impact of HIV/AIDS on livestock sector
- impact Mitigation a household level (time saving and labour saving technologies), farm level (farmer field school approach)
- basic counseling skills on HIV/AIDS
- nutrition/food Security
- income generation activities-agro processing

As mentioned earlier, the ACU was re-established in 2010; it collaborated with NASCOP and NACC and the Ministry of Health during the above training. It intends to continue collaborating with other stakeholders as it continues to mainstream HIV/AIDS in the Ministry.

At the moment it expects to source for funding to enable it to train all the ministerial staff. It has been funded for a training for the Provincial Sub-ACU and the ACU where they will be trained on the HIV/AIDS Public Sector Workplace Policy which they will in turn train the districts. The training is scheduled to take place from 23rd August 2010.

4.11.2. Provincial Sub ACU Officer in Charge

The Provincial Subject Matter Specialist in charge of HIV/AIDS was transferred to the provincial office in 2009. Although the Sub-ACU was there in name it was inactive and it was reestablished in May 2010 in Central Province. The officer is in charge of all cross -cutting issues (HIV/AIDS, Gender, Drug and Substance Abuse) and therefore attends the Provincial HIV/AIDS Control Committee (PACC) on behalf of the office.

As mentioned in Chapter 3, MoLD, Central Province has a staff strength of 239 non-technical staff. The Sub-ACU does not know the number of staff living with HIV/AIDS since it became active in 2010. The Sub-ACU focal persons have attended one training session where they were sensitized of their role which includes: workplace- based HIV/AIDS prevention, support and care programmes aimed at reducing risks, vulnerability and impact of HIV/AIDS and sexual behavior change among staff. These programmes include information and education, accessibility to condoms, linking staff to medical services, provision of psycho-social support, advocacy and networking to other relevant institutions (multi-stakeholders approach).

So far not much has been done in mainstreaming HIV/AIDS within the ministry except sensitizing the staff of whom the first 6 from the districts have been trained and they are expected to train the others in their respective districts.

Members of staff have been silent about their HIV status and also about their family members who are infected. Table 4.5 confirms this as none of the respondents was willing to declare his/her HIV status. Therefore no support has been extended to those suffering. However, if there was one positive, MoLD will support him/her by giving counseling, sick leave/time off, linking with medical facilities and where need be transfer the staff to work closer to family members.

To control HIV/AIDS spread among the staff members, the province is to collect condom dispensers for both male and female condoms from the National office and distribute to the district. The districts will be expected to liaise with their respective Ministry of Health Officials at the district for the supply of the condoms. The province is also expecting to train staff to get them informed about HIV/AIDS.

The PACC held one workshop in 2009 where the members were sensitized of the Public Sector HIV/AIDS Workplace Policy. The provincial office has only one copy of the Policy but it is not available at the district level. Other staff members are not aware of the existence of the policy as mentioned in section 4.7. This calls for the dissemination of the HIV/AIDS policy to MoLD non-technical staff.

Though the PACC is expected to be meeting quarterly, only one meeting was held in 2009/2010 where discussions on Kenya National HIV/AIDS Strategic Plan III (KNASP III) were done. No specific work-plan was derived from the meeting but the ministry collaborates with the other stakeholders during field days and farmers exhibition.

The challenges faced by the province on the implementation of KNASP III is that the Sub-ACU has just been re-established and is yet to get resources to run it. It also needs to revitalize the District ACUs. They are expecting to get the TOWA funds at the provincial level to enable implementation of HIV/AIDS activities.

The ACU had initially been concentrating on extension staff so most non-technical staff have not been trained from the province by MoLD except one secretary. However during the interview, he realized the need to train non-technical staff of MoLD.

The officer in-charge of Sub-ACU was not in a position to cite the impacts at the provincial level because he was relatively new and no staff had declared HIV status. However, he mentioned self stigma which affects productivity of the staff.

4.11.3 .Trained Technical staff member

A MoLD technical staff member who has attended HIV/AIDS training claimed he was not aware of the Public Sector HIV/AIDS Workplace policy. Hence he did not know how it is implemented if it existed. He was aware of the Kenya National HIV/AIDS Strategic Plan III, but from the media. He was not conversant with what was contained in the plan but he thinks it is about how the government intends to respond to the epidemic.

He had undergone 2 training, one organized by MoLD and another by NALEP. In addition to the topics taught by MoLD, to the ACU, HIV/AIDS related stigma and discrimination and mainstreaming HIV/AIDS in the work programmes were taught by NALEP.

Competences he acquired during the training were:

- Knowledge: he was now aware of the transmission and prevention methods and basic facts about HIV/AIDS.
- Attitude: he has been able to appreciate PLWHA and has stopped stigmatizing them. He knows they are not PLWHA because they deserve it.
- Skills: He is able to relate with PLWHA, he empathizes with them and does not feel pity for them.

With the acquired competences, he claimed he has been able to reduce stigmatizing the PLWHA and he has changed his sexual behaviour. He cited examples saying, initially when he went for workshops and he had his allowances, he would have fun with it (drink and sex), but now he is more cautious. He has even gone ahead and has been tested for HIV and he knows his status though he was not willing to disclose.

The training the technical staff member received has prompted him to seek for more information from the internet, NACC, NGOs dealing with HIV/AIDS and the media (newspapers, radio and television). He was hopeful that MoLD will organize a refresher course.

He said so far he was not aware of any support given to staff as far as HIV/AIDS is concerned, but he suggested the following:

- Have flexible working schedules for staff infected or affected though he said this may be open to abuse by staff. He suggested that such staff should declare with proof that they are infected or affected and only family members of the nuclear family should be considered and not extended family.
- Giving infected staff preferential leave to attend to their health.
- Counseling of staff who are infected and giving them words of encouragement.
- Give financial support assistance.
- Offer transport to and from clinic to the PLWHA
- Start a welfare kitty for such needs even if it is at the district level.
- Transfer officers to stay with or near their spouses.

He suggested that the ministry can beef up its response to HIV/AIDS by:

- Holding more sensitization workshops targeting all staff and not just the HIV/AIDS focal persons.

- Mainstreaming the HIV/AIDS activities in the ministry programmes.
- Holding regular meetings with staff to discuss HIV/AIDS. Asked what he expected to discuss in those meetings, he said discussions on the kind of assistance the ministry should give to PLWHA and those staff with nuclear family members who are PLWHA, any new findings on HIV/AIDS for example the issue of breastfeeding children born by HIV positive mothers, diets to boost immunity, in case the government has come up with a policy, how it will be implemented.
- Supporting staff infected and affected by the epidemic.

4.11.4 Discussion on case studies

The study revealed that the trained technical staff was not aware that MoLD can give support for AIDS treatment. This could be attributed to lack of HIV/AIDS focal person at the district levels who could pass similar information which is a result of the inactive ACU.

The trained technical staff member gave suggestions on support to be given to PLWHA in line with those of the workplace policy, for example transferring PLWHA to work near their family members. This is an indication of the need to have the HIV/AIDS policy brought to the attention of the would be beneficiaries since the policy has taken these issues into account. The gap can be attributed to the inactiveness of the ACU.

The ACU needs to disseminate the contents of the policy to all staff. This in line with Makinde (2005) who says that “no matter how beautiful a blueprint of a programme is, a defective implementation will make non-sense of the whole programme” just as there is an HIV/AIDS workplace policy meant for the staff but due to an inactive ACU, the MoLD have not seen beneficiaries of it. The policies of an organization regarding HIV/AIDS can have significant effect on the lives of its staff who are living with HIV/AIDS. This emphasizes the need for the dissemination of the Public Sector HIV/AIDS Workplace Policy to all staff so that they be aware of their entitlement.

Bearing in mind that government officers can be transferred, fall sick, die, resign from job or even leave the office for further studies and normally one staff is appointed to man that position, there is need for the ACU to equip more staff. This is succession planning where positions are filled effectively (McNamara, 2010). The ACU and Sub-ACUs should organize continuous trainings on HIV/AIDS education for all staff.

The study showed that the ACU depended on funding from TOWA, which is a national kitty which many organizations depend on. This could be the reason why the ACU was inactive since it had no resources. But Rollingson (2008) cites regular meetings including all staff to discuss specific topics of interest identified by staff and provision of information in the office in the form of pamphlets, posters and articles as one way of basic awareness programme. This implies that, if the HIV/AIDS focal persons were in place and had information, they would require minimal resources to equip the staff with the required competences within their districts.

The technical staff suggested member the need for the ACU to hold discussions with staff so that they may know the kind of assistance the ministry should extend to PLWHA. This is an indication of the need for the beneficiaries to be involved in making decisions regarding their own development.

The multi-sectoral approach is not as active as expected at the provincial level. This can be deduced from the report by the Sub-ACU officer in charge who claimed that only 1 meeting has been held by the PACC from the expected 4 meetings per year. Launching a programme and implementing it are different just as Makinde (2005) noted a beautiful blueprint of a programme is not a sure implementation.

A concern from the above findings is the rate at which MoLD is building competences among its non-technical staff members. For a start it has been able to train one in Central Province among 239 staff. At this rate some non-technical staff will reach the retirement age of 60 years without having undergone any training. This means HIV/AIDS related stigma will continue prevailing and this will affect the productivity hence effectiveness of MoLD. According to Dyk (2008), there is a need come up with strategies to set up an integrated HIV/AIDS workplace program to address HIV/AIDS. This may hasten bridging of the HIV/AIDS competence gap among the non-technical staff.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusions

5.1.1. Levels of knowledge on HIV/AIDS by non-technical staff

The awareness levels of HIV transmission and prevention was high among the respondents.However, there exists a knowledge gap:

- on misconceptions in terms of transmission (insect bites) and prevention (prevention of MTCT and ART/ARVS).
- on the trends of the epidemic, stages of HIV/AIDS and new research developments on HIV/AIDS.
- among the secretaries/receptionists which was evidently wider than the drivers and clerks/messengers.
- from the trained technical staff on the stand of MoLD to respond to HIV/AIDS epidemic.
- among the non-technical staff on what other organizations are doing on HIV/AIDS.

Drivers were the most informed about transmission and prevention methods compared to the clerks/messengers and secretaries/receptionists.

The respondents are eager to learn more on HIV/AIDS as they were knowledgeable on the new developments in the world of HIV/AIDS.

The coverage by media on HIV/AIDS misconceptions was low as depicted by the HIV/AIDS misconceptions among the drivers. Misconceptions at times lead to gossips which is one of the main causes of HIV/AIDS related stigma. The role the media plays in HIV/AIDS awareness would be more beneficial if it included myths and misconceptions of HIV/AIDS transmission and prevention. This means there is a need for MoLD to upscale its awareness creation among its non-technical staff members.

5.1.2. Current perceptions of non-technical staff on HIV/AIDS

There exist some negative attitudes towards PLWHA among all respondents. There is a degree of HIV-related instrumental and symbolic stigma among the non-technical staff. None of them were willing to declare his/her HIV status indicating denial or perhaps pride or other. This stigma cuts across all the three clusters of respondents. The secretaries/receptionists had accommodating attitudes towards PLWHA compared to the clerks/messengers who had more accepting attitudes towards PLWHA. The drivers had less acceptable attitudes than clerks/messengers.

Most of the respondents advocate the involvement of PLWHA in HIV/AIDS training and the distribution of condoms in workplace washrooms and concur that condom use prevents HIV transmission.

5.1.3. Skills

A gap exists in communication skills among the non-technical staff to deal with PLWHA. There is need to capacity build them so that are equipped with skills to effectively communicate with PLWHA without stigmatizing them. This can also be used to help break the barrier while interacting with PLWHA.

5.1.4. Changes in the workplace due to effects of HIV/AIDS

Office gossip, absenteeism, overworked staff, hostility by PLWHA, PLWHA withdrawing from the others, lack of concern, programme distortions and poor performance are the major impacts HIV/AIDS in the workplace. Absenteeism and overworked staff lead to ineffectiveness of MoLD due to overworked staff and distortion of programmes. Office gossip was the main cause of HIV/AIDS-related stigma.

5.1.5. Trainings received by non-technical staff on HIV/AIDS

Majority of the respondents did not have the skills to relate with PLWHA, however, those who had been trained had positive attitudes towards PLWHA. There is need for MoLD to inculcate skills among its staff to ease HIV-related stigma in the workplace.

The media was the main source of HIV/AIDS information. It has been able to create awareness on the modes of transmission and prevention but has not been able to demystify the myths and beliefs. This indicates there is a need for training of non-technical staff to clarify the misconceptions of HIV transmission and prevention.

The MoLD has played a minimal role in disseminating HIV/AIDS information to its non-technical staff members. Most of its staff members have to rely on other organizations for training. The training sessions have had a positive impact on the staff. They were able to address attitudes towards PLHWA thus reducing stigma in the workplace. This calls for greater advocacy of MoLD to capacity build its staff on HIV/AIDS so as to mitigate the effects of the epidemic at the workplace such as reducing stigma and enhancing productivity. The training offered by MoLD improved the HIV competences (knowledge, attitude and skills) of the technical staff trained.

The ACU has no funds set aside to implement HIV/AIDS activities within the ministry. There MoLD should include HIV/AIDS activities in their budgets.

5.1.6. Policies in place regarding HIV/AIDS in MoLD

Majority of the respondents are not aware of the existence of the workplace policy on HIV/AIDS. They were not aware of the employers' medical support on HIV/AIDS. The districts did not have copies of the Public Sector HIV/AIDS Workplace Policy, only the province had a copy.

MoLD had not domesticated the policy neither had it disseminated its contents among its employees. Staff have shown interest in having communications with the ACU to come up with modalities of how they can support staff members who are PLWHA or are affected. MoLD should seize the opportunity to involve the staff and get inputs from them as they domesticate the HIV/AIDS policy.

Other than the HIV/AIDS policy, it is also important for the staff to know about other policies that deal with HIV/AIDS, for example the HIV/AIDS and human rights, HIV/AIDS and gender, HIV/AIDS and male circumcision and also what the Kenyan Law says about HIV/AIDS. None of the staff, even the ACU mentioned it.

5.1.7. Scope of the HIV/AIDS policy

Most of the staff did not know the scope of the policy. This has contributed to staff not bothering to know their status as they are not aware of the medical benefits.

5.1.8. Implementation of the HIV/AIDS Workplace Policy in MoLD

The ACU lacks information on the staff who are PLWHA. This is triggered by the fact that the staff are not aware of the assistance they can get. The ACU though established in 2004 and the policy came into being in 2005, has not brought the contents of the policy to the attention of its staff.

No support has been forthcoming for the PLWHA. Most of what was suggested by one of the respondents is what is in the HIV/AIDS policy. However, the ACU has taken a step forward towards HIV prevention by procuring condom dispensers for the districts. This is a gesture which is also welcome by the staff members. The ACU needs to appoint an HIV/AIDS point person at the district level and capacity build him so that he/she can coordinate HIV/AIDS activities as well as pass any information on HIV/AIDS to the other staff. The need to enhance the workplace policy implementation is paramount.

MoLD should take advantage of the overwhelming desire by the respondents to know more about HIV/AIDS and train them. The invitation of ACU by staff to discuss HIV/AIDS issues is an opportunity which can be used as an entry point to open up office dialogue on HIV/AIDS, disseminate the contents of the HIV/AIDS workplace policy and new developments in the world of HIV/AIDS.

5.1.9. Changes in the realized in the workplace by the trained technical staff

The technical staff member trained revealed that he had acquired HIV/AIDS competences. He was aware of the modes of HIV/AIDS transmission and prevention and the misconceptions of HIV transmission had been clarified. The respondent further claimed that he now looks at PLWHA positively without judging them and he can comfortably relate with them. This is an indication of what training can do for non-technical staff too. The competences indicated by the trained technical staff, if gained by the non-technical staff, would go a long way to reduce HIV-related stigma in the workplace.

5.1.10 Staff expectation on strategies to respond to HIV/AIDS

The staff expected MoLD to give support to staff members who were PLWHA. They also expected more HIV/AIDS sensitization workshops to be held for all staff and having more interactive meetings with ACU to discuss issues pertaining to HIV/AIDS and any new developments concerning the epidemic.

5.2. Recommendations

The study has shown the existing competence gaps among non-technical staff towards responding to HIV/AIDS in terms of knowledge, attitudes, skills and highlighted the staff expectations on the strategies which MoLD can put in place to scale up the response towards HIV/AIDS in the workplace. However, the ACU has to be pro-active to be able to accomplish the recommendations appended below:

Having re-established the ACU is an entry point to start an integrated HIV/AIDS programme and having done the HIV risk assessment in the districts is a step in the right direction. However, there is need for the ACU to undertake a needs and resource assessment so that it can be in a position to draw up strategies on the way forward. This will also enable it to see where it can source funding for HIV/AIDS activities.

There is need for the ACU to create District-ACUs so as to appoint an HIV/AIDS focal person at the district level. This will be bringing services closer to the staff members. The District–ACUs need to be capacity built and be given resources so as to be able to coordinate HIV/AIDS related issues at the district level. The fact that respondents were able to defend their opinions (case of the HIV negative baby) by quoting their source of information is an indication that the non-technical staff are eager to know more about HIV/AIDS. They try to get updates of what is happening around them in the world of HIV/AIDS. The MoLD needs to ensure that its own staff are well informed so as to ensure that they can take the right measures towards responding to the epidemic.

The awareness levels of the respondents are high on HIV transmission and prevention methods but the level of misconception is also high. The ACU should organize training so as to fill the existing HIV/AIDS knowledge gap among the staff. The GIPA principle can be implemented whereby PLWHA can share their real life experiences. These trainings can also be used to transfer HIV/AIDS skills and at the same time change the attitudes of the staff towards PLWHA. This will contribute to HIV-related stigma reduction. Such trainings will also become entry points for HIV/AIDS discussions in the workplace which also reduce stigma.

There exists a degree of HIV-related stigma among the non-technical staff. None of them was willing to declare his/her HIV status indicating denial. In addition to training, the ACU should also formulate user-friendly interventions to encourage the up-take of HIV testing by the staff and declaration of their HIV status. This will enable the ACU to have data on staff who are PLWHA and utilize it for decision making on what interventions to undertake, advocacy and awareness creation.

There is need for the ACU to domesticate the Public Service HIV/AIDS Workplace policy and incorporate it in training to ensure staff at all levels are aware of its contents. Copies of the policy should be distributed to all levels of management and made accessible to all staff. This will enhance the efficacy of the workplace policy on HIV/AIDS.

The ACU should draw strategies to reach all staff at the shortest time possible. If need be, it should decentralize the trainings to the district level. The ACU can make use of the multi-sectoral approach and partner with organization in the respective districts to scale up the trainings.

The introduction of district point persons can encourage HIV/AIDS discussions in the workplace. Topics on HIV/AIDS can be introduced bit by bit during the weekly planning meetings at the district level. This will ensure that information is passed and staff can give suggestions on the kind of support PLWHA may require. Such dialogues will help in reducing office gossip to help reduce HIV-related stigma.

Positive change has been cited by the trained technical staff. Which implies that if all staff can be trained, then, HIV/AIDS related stigma can be reduced in the workplace.

There is need to create stronger collaboration at the district level among stakeholders especially the MOH to enhance condom supply.

This undertaking may experience challenges in terms resources. It may not be an easy undertaking, however, where there is a will, there is a way. The main challenge as mentioned

earlier would be the time resource. Among the over 6000 staff members, the ACU was able to train about 100 staff in a year (and among the technical 239 non-technical staff in Central province, only 1 trained). This means to train all the 6000 staff it needs 60 years. Therefore MoLD needs to rethink its non-technical staff capacity building strategies.

The employees are distributed all over the country, and therefore for the ACU or Sub-ACU to reach them, they need resources such as funds. Though funding of HIV/AIDS activities have been cited as a challenge, the ACU should be proactive in sourcing for funding to have the HIV/AIDS activities implemented just as much as it has the livestock activities.

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ANNEXES

ANNEX A: MILLENNIUM DEVELOPMENT GOALS (MDGs)

Goal No	MDG Goal	MDG Monitor
1	Eradicate extreme poverty & hunger	a) Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day. b) Achieve full and productive employment and decent work for all, including women and young people. c) Halve, between 1990 and 2015, the proportion of people who suffer from hunger.
2	Achieve universal primary education	a) Ensure that, by 2015 children everywhere boys and girls alike will be able to complete a full course of primary schooling.
3	Promote gender equality and empower women	a) Eliminate gender disparity in primary and secondary.
4	Reduce child mortality	a) Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.
5	Improve maternal health	a) Reduce by three quarters the maternal mortality ratio. b) Achieve universal access to reproductive health.
6	Combat HIV/AIDS, malaria and other diseases	a) Have halted by 2015 and begun to reverse the spread of HIV/AIDS. b) Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. c) Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
7	Ensure environmental sustainability	a) Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources. b) Reduce biodiversity loss, achieving, by 2010 a significant reduction in the rate of loss c) Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation d) By 2010, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.
8	Develop a global partnership for development	a) Address the special needs of least developed countries, landlocked countries and small island developing states, b) Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. c) Deal comprehensively with developing countries' debts. d) In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries. e) In cooperation with the private sector, make available benefits of new technologies, especially information and communications.

Adapted from: We can end poverty 2015 The Millennium Development Goals (UNAIDS, 2010c)