ACTION RESEARCH ON INFORMAL ORGANIC RESPONSE TO HIV/AIDS IN THE WORKPLACE

DRAFT REPORT

BY

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EXECUTIVE SUMMARY

HIV/AIDS is among the greatest challenges to sustainable economic, social, and civil society
Development today; it is a global crisis that undermines all aspects and all sectors of entire societies. The pandemic is killing people in their most productive years decimating the workforce and impoverishing households. This has necessitated governments, civil society organization and private sectors to invest more on prevention, treatment, care and support for people infected and affected by the disease locally, nationally and internally. While responding to challenges associated with HIV/AIDS, these institutions have continued to strengthen their technical and institutional capacities to interact and effectively deliver their mandate. Reference to regional and international conventions on human rights and elimination of all forms of discrimination of people living with HIV/AIDS continued to be echoed by most HIV/AIDS development actors. Policies have been formulated but yet to be formally adopted by the Kenyan governments as a means enhance prevention, treatment, care and support and respect for human rights of people living with HIV.

CSOs in Kenya have consistently maintained their struggle to fight HIV/AIDS and their initiatives have continued to receive technical and financial resources from local and international donors agencies and government. Some CSOs have developed HIV policies in work place to guide and regulate interactions while providing clear plans for activities and human resource capacity development strategies to respond to HIV issues. On the other hand, some CSOs use informal responses to HIV in work place which are not documented. The informal organic responses to HIV in workplace like the formal policies are designed to meet the needs of organization employees and motivated by the need to serve as role models in the sector as well as conform to national policies and human rights conventions.

Little emphasis if any has been paid to the informal responses developed and embraced by some CSOs and community based (CBOs) by development agencies including donor community; who in most cases value the formal responses. While acknowledging the importance of the CSOs, CBOs and other institutions using the formal responses to HIV/AIDS in work place there are fears that those using informal responses might be seen as doing very little of nothing at all. This research underscored the informal responses to HIV in the workplace for CSOs in Kenya with an aim to bring to light the strategies employed, effectiveness and give recommendations on means of advancing such initiatives. This is on the backdrop of less documentation and support of such best practices that continues to work for a significant number of CSOs employees as revealed by the study findings. An effective response demands commitment, urgent, and sustained action by individuals, CSOs and governments noting the complexity of the pandemic requires innovative and multisectoral responses beyond standard public health and legal measures. The subsequent sections of this research report underscores HIV policy context in Kenya, description of the informal responses to HIV in workplace, findings and conclusion. The action research was done by Transforming, Accompanying, and Building Change in Organizations (TAABCO) Research and Development Consultants and financed by International Non-Governmental Organization Training and Research Centre (INTRAC).

1.0 CONTEXT OF HIV/AIDS POLICY DEVELOPMENT IN KENYA

Kenya's HIV/AIDS policy situation has changed in many ways over the years. Previously limited to government positions of moderate impact, strategic policy development has in the recent past expanded to include NGOs, CBOs, religious organizations and academic institutions as well. Key areas of focus have included boosting the country's policy formulation, development and advocacy; strengthening the methodologies of data collection, and complimenting government initiatives. HIV/AIDS first surfaced in Kenya in 1984 – a period after which it rapidly grew increasing from a 5% prevalence rate in 1990 to an estimated 14% by the end of 1998. During the early 1990s, HIV/AIDS issues primarily concerned health authorities and a number of CSOs. In the years that followed, however, large segments of the Kenyan population became informed and actively involved in what are essentially policy issues. For example, politicians, religious leaders, and the media pointed out that various traditional cultural practices like wife inheritance may contribute to HIV transmission while very little was underscore on workplace place HIV policies then. Despite widespread public awareness about the epidemic in 1994, most policy makers in government and other sectors chose not to consider policy responses that could help control the epidemic and moderate its impact on society and the economy. However, with an increase in awareness of the impact of HIV on social and economic issues, an entire chapter of the 1994-96 Kenya national development plan was devoted to HIV/AIDS and its impact on social well-being and economic growth. This was followed by a Sessional Paper on HIV/AIDS in Kenya developed in 1997 with issues from Non Governmental CSOs (NGOs), religious and Government CSOs on sustainable process of policy development and advocacy in cooperated.

It was in November of 1999 that HIV/AIDS was declared a national emergency by the country's then President, Daniel arap Moi. Following this, the country engaged itself to fight the pandemic through the creation of the National AIDS Control Council (NACC), a multisectoral body aimed at coordinating and developing an action plan; constituency AIDS control committees and ministerial faculties dealing with the same (Twana Twitu 2005).

In 1998, AIDS Policy Environment Score (APES) was administered in Kenya and aimed at measuring the extent to which Kenya's policy environment supported efforts geared towards prevention of HIV/STDs including quality care for those infected; ensuring the rights of those infected and ameliorating the negative impact of HIV/AIDS. The overall AIDS policy environment increased to 38.4% over the two-year period in 1996-1998, with Legal and Regulatory Environment scoring the highest (59.5%), followed by Program Components which scored 45.8% (APES 1998).

With support from AIDSCAP, MAP International facilitated policy-oriented discussions among church leaders, while the Kenya AIDS NGOs Consortium solicited the experiences and views of local constituents during a series of district and provincial policy workshops (FHI 2008). The results of these and other efforts to shape HIV/AIDS policy include improvements in the policy climate in Kenya, better mechanisms for

strengthening HIV/AIDS prevention and care. A number of businesses and CSOs work is generally guided by the national HIV/AIDS policy Act though yet put in action while some have already adopted or are considering adopting policies related to HIV responses in the work place, with some religious denominations have made a public commitment by adopting policies that guide clergy and congregants. This research report underscores the informal responses to HIV in work place.

2.0 INTRODUCTION TO INFORMAL ORGANIC RESPONSE TO HIV/AIDS IN WORKPLACE

The effectiveness of the informal responses to HIV in workplace is yet to be determined. These involve specific activities and strategies employed by CSOs and CBO's in awareness creation, prevention, treatment, care and support for employees in workplace. Living and working in a country where an estimated 7.4% of the Kenya's population is infected, in any CSOs/CBOs with 7 employees, there is a strong probability that at least one employee is infected or directly affected with HIV. Whether there is clear knowledge that someone is infected or not, telltale symptoms on one individual can lead other employees in the company to start thinking they are infected. This starts the hallway rumours and divisiveness in the organization. There might be attempts by a few employees to repel or shun that employee or refuse to use the same dishes, and might even request that the employee be transferred to another office. If the presence of such individuals in the CSOs is considered bothersome of less productive, top management officials might resolve to terminate them from duty. Those infected or suffer symptoms of infections with HIV are likely to suffer from stigma, failure to disclose their HIV status, withdrawal from the rest of employees, resignation from work or intentional spread of the disease. Inadequate information and education of employees on HIV policies in work place, gender and general conduct, misuse of power by some organizational managers who seek sexual favours from employees and poor reinforcement of laws on sexual offenses and other human rights violations among other factors within the working environment increases risk of employees to HIV infection.

The impact of poor response to HIV in work place results to low productivity, lowers employees motivation and cause disharmony. However, CSOs including faith based CSOs and CBOs across the country that do not have formal HIV policy in the work place have continued to respond to employees needs through various strategies as highlighted in the research findings in the subsequent section of this report.

3.0 STUDY METHODOLOGY AND LIMITATION

The Study used a semi-structured interview for first hand data collection and targeted 4 CSOs and 2 Community Based Organization using informal Organic Responses to HIV in work place(see annex with list of organizations). Out of the CSOs, 5 out of 6 selected for the study were visited and 2 to 3 staff interviewed while 1 submitted written response where clarification on unclear issues was sought through telephone conversation. In additional 3 CSOs (see annex with list of organizations) pioneers in the HIV work in Kenya with formal HIV policies in place were also in cooperated in the study to shade light on actual implementation of such policies for comparative reasons. Literature review was also done to provide policy context for HIV/AIDS policies. A total of 16 respondents were interviewed. Data collected was analyzed qualitatively and findings are presented in the section below. This research was limited to CSOs and CBOs hence

private and government institutions were not consulted. In addition, literature on informal organic responses to HIV in work place was limited and the researches relied on first hand information from the respondent and internet search though was still limited.

4.0 RESEARCH FINDINGS:

According to the study findings, most CSOs interviewed reported use of the following strategies in responding to HIV in work place:

4.1 Adhoc Trainings of staff on HIV/AIDS issues

The training included prevention, treatment, care and support. This included Young Widows Advancement Program (YWAP), Grassroots Organizations Operating together in Sisterhood (GROOTS) Kenya, Shibuye community health workers (SCHW) and Gatundu Mwirutiri Women Initiatives (GMWI) and Shelter Forum. The study findings shows the CSOs conducted training to increase their knowledge on HIV/AIDS as individuals as well as enable them interact and effectively perform their duties at work. Main activities under this strategy included mobilization of employees internally to attend the training, fund raising for the actual training including facilitation costs and other logistical arrangements.

Training of staff on HIV/AIDS issues was reported to increase employee's awareness on risk prevention and management of the disease. They also get the opportunity to interact and learn directly from people living with HIV. However, common platform for employees to share experiences at later stages was not provided for. In addition, the trainings conducted were adhoc with no clear timelines or prior arrangements while some required employees to take advantage of opportunities available from programs/project trainings. No clear follow up arrangements for the trainings like on refresher and advance trainings as this was mainly based on availability of funding and or opportunities.

4.2 Retreat

One organization (GROOTS Kenya) reported to use staff retreat to reach out the employees with HIV messages and for group counseling. The retreat is designed to have employees, board members and community project leaders have time together and HIV issues are given priority due to the nature of work that entails working with some people living with HIV. This strategy was reported to increase awareness on HIV/AIDS, employees self behaviour examination, sharing and support. Observed fear of free interaction among employees suspected to be infected and those not knowing their status, inadequate knowledge on risk behaviours and need to enhance cohesion among its employee were reported as motivation for the retreat.

However, this strategy was limited to employees, community project managers, board members and selected leaders of people living with HIV support groups. Immediate family members were not included. This was attributed to the need for those with close social interaction to be together to enhance a free environment for sharing and learning. Moreover, limited resources were cited as reasons for limiting the number of participants in the retreat.

4.3 Employee Medical Cover

CSOs provided medical insurance to their employees which included monitory support to for medical services (Kituo Cha Sheria and Shelter forum). This strategy is mainly motivated by labour laws that demand for medical cover/insurance for all employees in Kenya to facilitate access to health care. The organizations have policies that define the procedures under which this is implemented and also provided for in the human resource document. The research findings also revealed that the referral system filled in the financial gap for some organizations like YWAP in complimenting their employees' medical needs.

The study findings also showed that despite the organizations need to provide the best medical cover for its employees, financial sustainability was not guaranteed because of donor dependency. It was thus reported by some responded that medical cover was "not always a right" to employees but highly dictated by availability of funds.

4.4 Staff welfare:

It is designed to meet special needs of staff including sickness, funeral and burial arrangements through monitory support. This was motivated by the economic challenges that came with unforeseen or unplanned events that were likely to affect the employees including death of employee or immediate family members. This strategy was reported to be effective in providing financial support to those affected. However, the findings of the study revealed the package of both employee medical cover and staff welfare as significantly limited to financial support compared to psychosocial and moral support as required by the employees. Therefore organizations employing these two strategies without the use of the other strategies like trainings and retreat are likely to have their employees show less care and support to each other within the system.

4.5 Economic empowerment, Peer Education and Support Group

The findings of this study also revealed that some CSOs mainly CBOs like SCHW supported their staff and members of the groups with funds to initiate micro-enterprise like bee keeping. This was mainly motivated by financial and nutritional challenges facing people living with HIV and needed to be self sustaining. The fund targeted individuals living with HIV organized in "support groups" which staffs members are also encouraged to join. This kind of support is extended to orphans and other dependants of those infected.

Peer education among the staff members stood out as a means of creating awareness in the work place. Shelter Forum organization and SCHW trained their own staff as peer educator. The peer education play an important role in information sharing, facilitation of trainings on HIV for staff members and design of various activities aiming at responding to HIV issues in work place and at program level. For SCHW, one of the employees living with HIV; Mr. Nickson Amukhamwa is a peer educator and has continued to share his lived experience with other colleagues in the office.

4.6 Employee Sick Leave

According to the study findings 4/6 of the CSOs interviewed had sick leave that ranged from 21 days to 6 months. Kituo cha Sheria had the longest sick leave with 2 months sick leave with pay, 2 months with ½ pay and 2 months with no pay after either of which the employee is allowed to resume work. This time was reported as being convenient and sufficient for employees both infected and affected with HIV or other long term illness to seek necessary services. However, the sick leave did not give clarity and or

recognition of the challenges associated with living with HIV like flexibility of work reporting time and resting time.

4.7 Referral System:

CSOs working mainly on HIV/AIDS issues and with a significant population living with HIV (YWAP, SCHW and GMWI) reported to link their clients and employees to health facilities including government and private hospitals where they receive free medical attention.

4.8 Information Education and Communication Materials

CSOs developed IEC materials (mainly posters, fliers, T-Shirts and banners) or acquired from government, partners' organizations/workshops etc with HIV messages were made available to employees. Use of resource centers/library stocked with HIV material and other information which were available to employees all the time. All CSOs and CBOs that participated in this study had this facility accessible to employees and their constituencies. The study found that the accessibility to internet services for employees in workplace gave them opportunity to search for relevant information on HIV as well as newsletter and magazines made available to them as hard or e-copies. Although, this indicate opportunity for learning this study was not able to ascertain the level of significance for the same at individual or organizational level. Employees who are illiterate and suffer with disability e.g. visually and physically challenged are likely to benefit less from this strategy due to the mode of presentation of the materials and accessibility to the structures.

4.9 Networking and partnership

This was a strategy used by some CSOs and the CBOs in the study. This was mainly on knowledge and information sharing like IEC materials, sponsoring of CSOs employees to participate in HIV/AIDS workshops and trainings nationally and internationally by partners who then feedback to other through written report or meetings. In addition, referrals and waiver of medical bill for some employees can be attributed to partnership with other development actors. Most respondents indicated the need to tap into other partners' resources including technical and financial resources to compliment their initiatives. Although a number of CSOs used these strategies, the findings indicate that only a few who had the opportunity to participate in such events benefit more compared other who don't due to poor feedback system available in the organizations.

4.10 Staff Meetings and Home Visits

According to the study findings, staff meetings presented several opportunities to discuss issues of HIV/AIDS in workplace depending on how they were structured. However, 75% of the respondents reported that HIV was discussed when the agenda for the meeting had provided for such discussion or in situation where HIV issue had emerged. The findings revealed that 44% of respondents reported that informal meetings by a few employees were quite interactive and helpful for similar discussions compared to formal meetings. Formal meetings were termed by some of the respondents as "bureaucratic and time limiting" for employees to sufficiently discuss and share their thoughts. However, the formal meetings that discussed HIV issues was mainly motivated by the need to inform and encourage employees of the organizations to mainstream HIV in their program and activities while acknowledging that they were also at risk of infection. Moreover, 72% of respondents interviewed advanced that for many years some CSOs have continued to respond to HIV through implementation of

programs that were mainly “outward looking” and with a high assumption that employees had sufficient knowledge on HIV. This could have limited CSOs response to HIV in workplace.

The study findings shows that all home visits to some employees either when sick, bereaved or for other ceremonies reported by respondents were organized by the employees themselves. Respondents reported some employees making personal contributions to support their colleagues when sick, pay them a visit in hospitals and at home. The home visits were also done mainly after work or during weekends to avoid clash with the organization management. At times, formal request was made by some employees to visit the sick at home or hospital and attend burials. The study shows that home visits intended to provide moral and psychosocial support to the person in need while reaching out to them as “family members” working in the same organizations.

4.11 Condon Dispenser

Employees in some CSOs including Shelter Forum, GROOTS Kenya, YWAP and SCHW had a condom dispenser strategically placed in their office. The employees and other people who visit their premises were able to access condoms free of charge. The organization management is responsible for restocking the condoms but some CSOs like Shelter Forum the peer educators are taking a lead to have it restocked.

5.0 COSTING AND STEPPING UP INFORMAL RESPONSES TO HIV IN WORK PLACE

In reference to the strategies and activities undertaking by CSOs and CBOs that participated in this study, it is evident that HIV informal responses in work place continue to have significant results in the lives of employees. As compared to the formal HIV policies used by some CSOs like Kenya Network of Women Living with AIDs, Map International and WOFAK; HIV pioneer organizations in Kenya interviewed during this study, the informal responses does not have clear activity plan. The strategies underscored in the previous section are mainly adhoc in nature. This does not mean that these strategies or activities are ineffective since findings revealed that 84% of the respondents believed that had positive results with 52% of the respondents advanced that they were not under pressure to develop HIV workplace policies.

The informal responses can be stimulated by ensuring proper participatory planning and documentation of the responses and activities at the organizational level similar to how programs are planned for. Clear activities should be outlined and resources mobilized to actualize the plans. Due to the nurture of work in most CSOs that demand employees to work for 8 hours in a day for 5 days in a week though out the year, learning to create time for their employees to share ideas and lived experiences on HIV in work place will enhance these responses. Peer learning and exchange between employees in CSOs using informal and formal responses to HIV will create a platform for learning and exchange of ideas on the same. Strengthening HIV/AIDS mainstreaming at both institutional and program level continue to enhance awareness an sensitivity of employees to HIV/AIDS at work place. The National AIDS Control Council (NACC) mandated to coordinate and regulate HIV/AIDS sector should also include compliance review of government, CSOs and Private sectors with HIV policies both formal and informal responses acknowledged. However, a standardized criteria for measuring

compliance needs to be developed to ensure equal treatment across the sectors for those using formal and informal responses to HIV in workplace.

To integrate the informal responses into policy, a review of policy documents including human resource manual and CSOs/CBOs code of conduct to provide for explicit clauses for HIV is required. This will also strengthen provision for legal back up in case of sexual violation and other forms of harassment by employers, employees or clients in workplace. The study finding revealed the limitation of the informal responses in providing legal directions as some of the clauses in the human resource manuals and code of conduct are too general. In addition, 88% of the respondent advanced their interest to develop a formal HIV policy in work place which will help streamline the implementation procedure, provide for resources and time for the activities as well as make the CSOs/CSOs compliant with the national HIV/AIDS Act. The need for formal policy was mainly reported to be internally driven by the employees with the support of the CSOs management and not from donor or partners. However respondents advance the need for donors to sponsor development of formal policy as well as implementation of activities under informal responses.

Costing of the informal responses to HIV in workplace require cross examination of the specific strategies employed by CSOs/CBOs. This will entail review of budget implications for trainings, retreat/workshops, development of IEC material, capital for income generating activities and other activities that require resources both financial and technical. In addition, time spent by employees for home/hospital/burial participation should also be costed in monitory terms to ascertain the implication of this at the organizational level. A research on the work efficiency for HIV positive employees in institutions with and without formal policies could provide insight on aspects of stress associated with stigma, poor working condition etc versus productivity in their workplace. This could set projection on cost implications at the national level for advocacy.

6.0 CONCLUSION

The informal organic responses to HIV in work place continue to have significant positive results to the lives of employees in work place with its effects trickling down to people they interact with including program beneficiaries, family members and friends. The HIV/AIDS Act which received Presidential Assent in 2006 is yet to be put into action since it not given a commencement date neither is the HIV/AIDS Tribunal formed. This limits enforcement of its provisions by those with or without formal policies. For example requirement by some employers to have job applicants tested before employment. It is clearly stated in the Act that unless specified "that a person be in a particular state of health or medical and clinical conditions" (HIV/AIDS Act 2006 section 31) compulsory HIV testing should not be exercised. Continued silence over the issue negates the Government's initial commitment to the fight against HIV/AIDS in the country as shown by the passing of The HIV and AIDS Act 2006 and the positive stand taken in domesticating international frameworks in the context of HIV and AIDS into our national laws. The Act contain good piece of legislation integrating legal issues, human rights and HIV and AIDS policies which is critical to the country's efforts to contain the epidemic.

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7.0 ANNEX 1

7.1 List of Organizations and Respondents Interviewed/Contacts

GROOTS Kenya- Nairobi

1. Esther Mwaura Muiru – Executive Director
2. Jael Amati - Institutional Development Officer
3. Benson Huria - Finance and Administration Officer

Kituo Cha Sheria- Nairobi

4. Dalmas Owino - Deputy Executive Director
5. Soipan Tuya - Legal Aid Program Coordinator
6. Leah Muthigani - Human Resource Manager- intern

Young Widows Advancement Program – Kayole Nairobi

7. Esther Aguta - Executive Director
8. Susan Maina - HIV/AIDS project Officer

Shelter Forum – Nairobi

9. Clement Tulezi -Information and Communication Officer
10. Philip Gathugu - Policy and Advocacy Officer

Shibuye Community Health Workers – Kakamega

11. Violet Shivutse - Director
12. Mercy Amunya - HIV/AIDS Coordinator
13. Agrey Majimbo - Property program adviser

Gatundu Mwirutiri Women Initiatives

14. Hellen Kamiri – Director
15. Margeret Ngina – HIV/AIDS program coordinator
16. Jane Nyokabi - Gender adviser

List of others HIV Pioneer NGO's with HIV policy interviewed

1. Women Fighting AIDS in Kenya (WOFAK)
2. Map International
3. Kenya Network of Women with AIDs (KENWA)

7.2 List of References