

**BEHAVIOUR CHANGE COMMUNICATION ON HIV/AIDS RISK
REDUCTION IN THE WORKPLACE: A STUDY OF BROOKSIDE DAIRY
LIMITED IN RUIRU, KIAMBU COUNTY**

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DECLARATION

Declaration by Candidate

This thesis is my own original work and has not been presented for a degree in any other University. No part of this thesis should be reproduced without my prior written permission of the author and/or Moi University.

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DEDICATION

To my family, Machira, Nyokabi and Maina. I dedicate this for everything they have done. Thank you for making everything work out. I will always appreciate their efforts and your wholesome love and kindness. I am what I am because we are together as one.

I also wish to dedicate this work to all workplace peer educators who have for years volunteered to reach fellow work-mates with HIV/AIDS and wellness messages, whose efforts have promoted positive behavior change and contributed to reduction in the risk of HIV infection.

Message: May the Lord grant me peace, in my rising up and in my lying down, in laughter and in tears, in labor and in leisure, until I come to stand before Jesus on that day where there is no dawn and no sunshine.

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May God bless them all.

ABSTRACT

The study sought to establish the dynamics of behavior change communication in Brookside Kenya Limited in Ruiru, Kiambu County. The problem statement was that there was need to inform employees in order to reduce stigma because the epidemic was a direct result of unprotected sex among the employees. Lack of information dissemination channels resulting to stigmatization and discrimination. Fear of intimidation upon disclosure of an employee HIV/AIDS status when they visit the VCT clinic located in the staff clinic. This was due to lack of peer educators support programme and training on BCC. This study was based on cognitive dissonance theory (Leon Festinger 1999). The researcher used mixed method research design; that is qualitative and quantitative data collection methods. The target population was one thousand five hundred (1500) while the sample size was three hundred sixteen (316) employees were drawn across gender and age groups. The study was facilitated with the following objectives; to establish the employees knowledge about HIV/AIDS risk reduction and wellness; to assess the scope and process of behavior change communication in HIV/AIDS; to find out the effectiveness of information dissemination materials used in BCC campaigns and to establish recommendations or suggestions made to the management in order to enhance an efficient peer educators support supervisory committee. A descriptive cross-sectional survey research design was adopted to cover vital variables of the study by systematic random sampling to select the respondents within the departments. Data collection instruments used were in-depth interviews for qualitative data and was reported in verbatim quotes, narratives and selected comments. Semi-structured questionnaires with closed and open ended questions for quantitative data that was analyzed using descriptive statistics that included pie charts, frequency tables and graphs generated by statistical package for social sciences (SPSS). The discussions of results were equally related to the gaps identified in the literature review. Results from the two methods have been consolidated to produce an insightful report that answers the research questions hence achieving the pre-set objectives. The findings revealed that employees do not put in practice the information they know about the spread of HIV/AIDS. They prefer taking risks due to cognitive dissonance. The study established the effectiveness of behavior change communication campaign messages used in the reduction of HIV/AIDS in the workplace. The conclusions and recommendations have been derived from the areas discussed on successful implementation of targeted interventions including information dissemination by peer educators in the workplace. The research recommended a comprehensive workplace programme supported by top management and restructuring of HIV testing units due to stigma and discrimination. Relevant training to peer educators to equip them with the skills to disseminate the campaign messages in the workplace.

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ABBREVIATIONS

AFC	Abstinence, Faithfulness and Condom
AIDS	Acquired Immune Deficiency Syndrome
APHIA	AIDS Population and Health Integrated Assistance
ARV	Antiretroviral
BCC	Behaviour Change Communication
BDI	Behaviour Determinant Intervention
BSS	Behavioral Surveillance Survey
CBO	Community Based Organizations
CWPP	Comprehensive HIV/AIDS Workplace Programs
DK	Do not know
EBI	Evidence Based Interventions
FACES	Family AIDS Care and Education
FHI	Family Health International
FKE	Federation of Kenya Employers
HDN	Health and Development Networks
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IMPACT	Implementing AIDS Prevention and Care Project
KAIS	Kenya Aids Indicators Survey
KDHS	Kenya Demographic Health Survey
KNAA	Kenya National AIDS Authority
MARPS	MOST at Risk Populations
MDG	Millennium Development Goals

MOH	Medical Officer of Health
MPE	Milk Procurement and Extension services
NACC	National Aids Control Council
NGO	Non-Government Organizations
PATH	Program for Appropriate Technology in Health
PSI	Population Services International
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
VCT	Voluntary Counseling and Testing
VIRED	Victoria Institute for Research and Development
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter reviews background information, problem statement, and research questions, objectives of the study and scope and limitation of the study in regard to behavior change communication on employee wellness and HIV/AIDS risk reduction through peer education through peer education.

1.2 Background Information

Behaviour Change Communication, or BCC, is an approach to behavior change focused on communication. The assumption is that through communication of some kind, individuals and communities can somehow be persuaded to behave in ways that will make their lives safer and healthier (Hugh, 2003). According to Thairu (2004) BCC was first employed in HIV and TB prevention projects. Since then NGOs in Kenya, such as PATH, Liverpool, NOPE International and Aphia plus Kamili (USAID) have designed ways to bring about experience-sharing through deep dialogue in groups and theater processes. In India, Bonaldi (2008) notes that participatory community-driven theater among sex workers led to passionate and heartfelt dialogue. In many cases, the critical reflection triggered by these discourses has led participants to self-driven behavior changes. Today in Kenya almost every family has lost members or takes care of infected family members, neighbors and friends. Everybody knows the major ways of transmission of HIV, but frequently people are still not talking entirely openly and freely about it, a strategy if adopted shall bring Kenyans closer to addressing the major way of HIV transmission in this country, where it is assumed that between 80 and 90 % of infections are due to sexual

transmission. Hence, promoting the adoption of safe sexual behaviors remains at the heart of HIV prevention in Kenya (Thairu, 2004).

Fischer and Needle (2003) say that although there have been significant advances in prevention and treatment since HIV was first discovered, the virus continues to spread unabated in many parts of the world. They add that strategies to prevent new infections must match both the complexity and the multifaceted nature of the epidemic. According to Garry and Pear (2009), social and behavior change communication is one such strategy that to date has been underutilized, despite its proven effectiveness in many settings common myths and misinformation about HIV/AIDS stand in the way of greater awareness, discussion, and acceptance of individual and societal behavior change to reduce risk of infection. HIV-related stigma can also be a barrier to the uptake of HIV testing and can prevent those living with HIV from accessing resources for positive living and compassionate care. Sdorow (2003) adds that inadequate counseling services can make it difficult for someone who is infected to understand their options and make an informed choice about appropriate treatment, reproductive health, and other issues. Fortunately, according to Tabifor (2012) strategic health communication interventions can make a difference informing, equipping, and motivating people to make appropriate choices about HIV prevention and care.

Thairu (2004) suggests that HIV/AIDS communication efforts, like any HIV/AIDS strategy, must address the whole care continuum (i.e., prevention, VCT, care, support, and treatment) to be effective. A holistic approach goes well beyond prevention to include tools for the biological, psychological, and social care of people living with HIV, their families, and communities. Some organizations provide ARVs for free. More recently, frameworks such as the Joint United Nations Program on HIV/AIDS

(UNAIDS) communications framework, the Health Communication Partnership (HCP) Pathways and World Health Organization (WHO) framework seek to understand and explain the role of socio cultural influences (e.g., socioeconomic status, gender relations, cultural norms, and spirituality) and environmental influences (e.g., government policy, access to services, and occupational risks) on human behavior. These frameworks are based on the understanding that beyond an individual's social network exist larger structural and environmental determinants that affect HIV/AIDS-related behaviors (Miller, 2011).

Such an approach to communication reflects a greater appreciation of the complexity of the HIV epidemic, and a greater emphasis on social groups and contextual factors rather than individual behavior for instance, alone in Zimbabwe much has been done to achieve behavioral change over the past two decades and recent reviews indicate that these changes towards safer sexual behavior need to be maintained, but we also strongly believe that much more can and needs to be done Family Health International (FHI, 2008). Beyond awareness-raising and communication on Abstinence, Faithfulness, Condom (AFC), there was need to address underlying factors for multiple partnering including imbalanced gender relations. So far, a majority of programs has not been guided by systematic and strategic programming, nor were many programs based on evidence from research (Jackson, 2005).

A report by NACC (2013) indicates that since the inception of HIV and AIDS programs in Kenya, there has been minimal behavioral change (BC) strategy to guide various programs implementers. As a consequence there was limited focusing of prevention programs, which partially resulted in duplication of efforts, but also large gaps in geographical and thematic coverage of programs. Heath et al (2006) notes that Thailand was the first Asian nation to realize that it had a serious HIV/AIDS problem.

One that was so serious that it became a top priority on the national agenda. In the early 1990s, HIV prevalence of brothel-based sex workers had reached 15.2%, up from 3.1% in 1989. Prevalence was also rising among young Thai men from 0.5% in late 1989 to 3% in late 1991. It was soon determined that the majority of new infections were occurring through commercial sex. To address this alarming trend in new infections, Thai public health officials devised a new strategy in 1989 to promote condom usage among those engaging in commercial sex in the Ratchaburi province. They called this strategy the 100% Condom Program.

AIDS in Kenya is a growing phenomenon which presents insurmountable problems to the entire population NACC (2014). Although measures to eradicate it have been initiated, it seems that the war against the epidemic is far from being won. UNAIDS (2006) report gives the conditions of susceptibility to infection as 1.3 million adults and children out of a national population of about 34 millions are living with HIV/AIDS. The latest HIV/AIDS surveys done in Kenya by the KAIS (Kenya AIDS Indicator Survey) indicate an upward surge in HIV/AIDS prevalence from 6.7% in 2003 to 7.8% in 2008. In December 2008, HFG/Kenya recognized it needed an innovative vehicle to drive its behavior change communication to Kenya's youth segments and thus supported the creation of youth movement, G-PANGE. The iconic youth brand, G-PANGE, which means "sort yourself out" in Kiswahili, was developed by and for youth. G-PANGE uses music, entertainment, technology, and sports to engage youth and empower them to make healthy lifestyle choices. Other media statements on behavior change communication especially to the married and those persons in permanent relationships are like, *fanya hesabu, wacha mpango wakando, weka condom mpangoni and Jitambueni leo.*

According to the United Nations, MDG report (2013), millennium development goal number six – Combat HIV/AIDS, malaria and other diseases targets for universal access to antiretroviral therapy for all who need it by 2010 was not achieved but is reachable by 2011 if the current trends continue. The ultimate goal is preventing the spread of HIV, but knowledge of the virus and how to avoid transmission remains unacceptably low. It is established that young women are more vulnerable to HIV infection due to a complex interplay of physiological factors and gender inequality. Because of their low economic and social status in many countries, women and girls are often at a disadvantage when it comes to negotiating safer sex and accessing HIV prevention, information and services. It has been established that condoms are one of the most efficient means available to reduce sexual transmission of HIV, and their use has increased in many organizations. According to research conducted in 2011, almost 50 per cent of men aged between 15 and 24 used condoms the latest time they had sex with a non-regular partner. This represents an increase since the period around a decade ago. More orphaned children are now in school due to expanded efforts to mitigate the impact of AIDS.

Currently, as treatment is scaled up, fewer people are dying of AIDS and more people are living with HIV than ever before. The number of new HIV infections has significantly exceeded the number of AIDS related deaths in all years of monitoring; as a result more people are therefore living with HIV at the end of 2011. Sub-Saharan Africa still remain the most severely affected with 1 in every twenty adults are infected accounting for sixty nine per cent of the people living with HIV worldwide. Although HIV prevalence rates are nearly twenty five times higher in Sub-Saharan Africa than Asia, almost five million people are living with HIV in South, South-Eastern and Eastern Asia combined. After Sub-Saharan Africa, the region most

heavily affected is the Caribbean, where 1 per cent of adults were living with HIV in 2011 (MDG Report 2013).

1.2 Problem Statement

The problem that existed in the dairy workplace was that there was increased stigmatization and discrimination among employees due to lack of information and hence the need to inform the employees in order to reduce stigma because the epidemic was a direct result of unprotected sex among the employees. Lack of access to HIV/AIDS information dissemination leading to stigmatization and discrimination the workplace. Fear of intimidation upon disclosure of an employee HIV/AIDS status when they visit the VCT clinic located in the staff clinic. This was due to lack of peer educators support programme and training on BCC.

There are many factors that influence behavior such as beliefs, values, attitudes, family, friends or the community. Personal behavior change then, depends on changing many processes to stimulate change. It also takes time. In addition, there might have to be some environmental adjustment that helps facilitate behavior change. Behavior change can be permanent or temporary, which proves that behavior can change according to the situation and environment of that particular person. Many health and development programs use behavior change communication (BCC) to improve people's health and wellbeing. BCC is a process that motivates people to adopt and sustain healthy behaviors and lifestyles. Sustaining healthy behavior usually requires a continuing investment in BCC as part of an overall health program. The changing of one's behavior requires many supporting factors to be in place since these supporting factors are the incentive for behavior change. In a community with wide spread HIV/AIDS infection, an individual must have the confidence and belief that it is possible to change and must have the necessary skills

or knowledge to practice a new sexual behavior. Necessary skills include techniques to solve problems in case the behavior change cannot be regular enough to form a habit.

Resorting to old sexual habits can lead to a setback in the behavior change process. It is therefore necessary for a person working with behavior change to understand that one's behavior is determined by three factors. These are personal, social and environmental. Personal factors are knowledge, beliefs on HIV/AIDS, expectations, acceptance and emotional states. Social factors include partners, friends, family, and the community including social values and social norms. Environmental factors are poverty, social services, mass media and the availability of clinics or hospitals. HIV/AIDS workers have to analyze which of these factors facilitates behavior change and which factors inhibit it. Promoting the supporting factors and reducing the inhibiting factors play an important role in that person's behavior change process. In order to change the attitude and behavior towards STIs and HIV/AIDS, there was a need to talk about sex because the HIV/AIDS epidemic in the dairy workplace was a direct result of unprotected sex. Practicing unsafe sex is not necessarily due to a lack of knowledge or information rather it is a reflection of people's beliefs and values including culture and tradition.

1.3 Objectives of the Study

- i. To establish the employees knowledge about HIV/AIDS risk reduction and wellness.
- ii. To assess the scope and process of behavior change communication in HIV/AIDS reduction and employee wellness.
- iii. To find out the effectiveness of information dissemination materials used in behaviour change communication campaigns.

- iv. To establish recommendations or suggestions made to the management in order to enhance an efficient peer educators support supervisory programme.

1.4 Research Questions

- i. What do the employees know and believe about HIV/AIDS in terms of risk reduction and wellness?
- ii. What is the scope and process of behavior change communication in HIV/AIDS reduction and employee wellness?
- iii. What are the sources of information and materials used in behavior change communication campaigns?
- iv. What recommendations or suggestions would I make to the management in order to enhance an effective peer educator's support supervisory committee?

1.5 Scope of the Study

The scope of the research study was emphasized to reach all the employees at the Brookside Dairy Limited which is located in Ruiru, Kiambu County. The main departments are Administration and Finance, Production, Sales and Marketing, and Milk Procurement and Extension Services. The study specifically focused on peer education on employee wellness and the process of Behavior Change Communication campaign messages.

This study was based on theory of cognitive which is concerned with the relations among cognitions. For the purpose of this theory, cognition is thought to be a piece of knowledge. The knowledge may be about attitude, emotion, behavior, values, beliefs and information. Human beings hold a multitude of cognitions simultaneously and these cognitions form irrelevant consonant or dissonant relationships with one another. The research approach used entailed both quantitative and qualitative methodologies. Qualitative methods used in the research were aimed to gather an in-

depth understanding of human behavior and the reasons that govern such behavior. The research adopted a descriptive cross-sectional survey where the researcher had a target group explain or describe certain issues about important variables of the study, this way the associations between variables was established.

1.6 Limitations of the Research Study

Employees were available when changing shifts due to work shift programme in the workplace especially in the production department. The process of data collection incurred financial implications to cover for the expenses including purchase of stationery, printing, binding and movements. Few respondents were not willing to disclose adequate information due to lack of confidence at the beginning of the data collection process. Some had psychological stigma that if they disclosed their status and their underlying illness, they may be more affected and die faster than expected. When respondents/participants realized there was an interview they withdrew or did not attend at all.

The process of obtaining feedback from the respondents also had cost implications in order to actually determine the acceptance and or rejection of the behavior change communication campaign messages in the workplace. Retrieval and reference to records kept over time may become obsolete or overtaken by other recent research findings. Cost implication was incurred during monitoring and evaluation which called for more time. It is an exercise that also required expertise input and reporting in the workplace. Confidential records were not readily available especially on matters pertaining to health. Managers and supervisors were sometimes said to be in meetings to give approval to access information. They delegated to their juniors on what was required.

The purpose of the study was finally achieved after the employees were informed that the purpose of the study was for academic purposes and could not work against them if they shared information.

1.7 Justification of the Study

I selected the study in order to understand the reasons for increase of HIV/AIDS infections in the Dairy workplace. Employees in this sector are contracting the diseases at a very high rate owing to the fact that some of them do not have the necessary information to empower them and those who have such information are negligent and do not care much about the price they eventually pay as a result. The study also sought to create awareness on the beliefs about the infections and enlighten the ignorant individuals. The need to reduce HIV/AIDS and to improve the wellness of employees justified the necessity to conduct a research study on the effectiveness of behavior change communication on the reduction of HIV/AIDS in the dairy industry workplace. The Brookside Dairy Limited in Ruiru was ideal survey workplace as they allowed students to conduct research within Kiambu County and also the proximity access along Thika Superhighway.

1.8 Significance of the Study

A study on HIV/AIDS reduction was important for the well-being of employees in the dairy workplace, their families and the entire community. At school level, the study adds to the bulk of literature in the library thus allowing young upcoming researchers know areas of study based on the recommendations for further studies given by this paper. The study also gave many Kenyans awareness and understanding of the importance of behavior change communication on the reduction of HIV infection and employee wellness in the dairy industry workplace in Kenya. The findings of this study are useful to policy makers as it was from here that they noted issues that need

to be addressed. Stakeholders, customers and farmers in the dairy industry also know the problems that exist in addressing matters of HIV/AIDS risk reduction. I also gained knowledge on behavior change communication and its effectiveness in HIV/AIDS reduction and employees wellness.

It is important to acknowledge that it is in human nature that while working for one organization for some years leads to development of relationships that engage people into sexual activities and more so lead to marriages, permanent partners and may be; *mpangowakando*. It was therefore important that partners be tested before marriage.

1.9 Summary

In this chapter, I provided an introduction of the research study outlining what was expected to be done. It was intended to establish the dynamics of behavior change communication on HIV and AIDS risk reduction and employee wellness in the dairy industry workplace. This research study had established that peer education as an important activity in the workplace and needs to be explored further and emphasized in all areas of operations including offices, hospitals and pharmacies. As can be derived from the introduction to this chapter, healthy employees are the key to a successful business. With many employees spending over one-half of their waking hours at work, many organizations are beginning to examine the health of their workplaces.

Many organizations are recognizing the importance of investing in employee wellness programs in addition to measures taken to address HIV and AIDS in the workplace. Workplace peer education helps to optimize employee productivity, enabling them to develop and manage issues that enhance employees' capacity and to set healthy lifestyle goals that meet their physical, psychological, social and spiritual needs.

1.10 Operationalization of Terms

Peer Education: Peer Education is a process in which peers who have undergone the relevant training make deliberate efforts to influence others in their peer group (those who share certain common characteristics with them) to change their behavior.

Behavior Change Communication: Behavior Change Communication is an interactive process with communities integrated into an overall program that develops tailored messages and approaches using a variety communication channels. It is the communication made by peer educators to all person infected and affect including the old and the young.

Cognition: Theoretically, cognition may be thought of as a piece of knowledge which may be about attitude, emotions, behavior and value.

Comprehensive Care: A range of services offered to HIV positive persons including, treatment, and clinical, physical, nutritional and psychosocial support.

Counseling: A session where a person with difficulties is assisted to think through the problem(s) to find a possible solution.

Confidentiality: The right of every person, employee or job application to have his/her medical and/or other information, including HIV status kept secret.

HIV Screening: A medical test to determine a person's sero-status.

Pandemic: An epidemic occurring simultaneously over a wide area and affecting many people.

Prevalence of HIV: The number of people with HIV at a particular point in time often expressed as a percentage of the total population.

Prevention: A programme designed to combat HIV infection and transmission.

Sexual Harassment: The act of persistently making unwelcome sexual advances or requests against the wishes of a person.

Support: Services and assistance that are provided to help a person cope with difficult situations and challenges.

Treatment: A medical term describing the steps taken to manage an illness.

Workplace Programme: An intervention to address a specific issue within the workplace.

Workplace: Occupational settings, stations and places where workers spend time for gainful employment.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

This chapter gives the literature of the study where literature review provides an insight into the dimensions and complexity of the research problem, thus placing the research in a theoretical context and providing a source for building knowledge about previous thinking. This section sought to fill the knowledge gap that exists in order to change the attitude and behavior towards STIs and HIV/AIDS and confirms the need to talk about sex since the HIV/AIDS epidemic in the dairy workplace was a direct result of unprotected sex. The chapter also covers literature focused on the objectives of the study.

2.2 Cognitive Dissonance Theory

According to Leon (1957), this theory of cognitive is concerned with the relations among cognitions. For the purpose of this study, cognition is thought to be a piece of knowledge; the knowledge may be about an attitude, an emotion, behavior, value among others. Human beings hold a multitude of cognitions simultaneously and these cognitions form irrelevant consonant or dissonant relationships with one another. Two cognitions are consonant if one cognition follows from or fits with the other. People therefore like consonance among their cognitions. Two cognitions are said to be dissonance if one follows from the opposite of another. The theory answers the question; what happens to people when they discover dissonant cognition? The answer to this question forms the basic postulate of the theory of Festinger.

Although the theory has been tested using a variety of paradigms the induced compliance paradigms has been the one most commonly used (Wicklund & Brehm,

1976). In this paradigm, participants are induced to act contrary to a previously held attitude and if they are provided minimal external justification for doing so, they will experience dissonance and reduce it, usually by changing their attitudes to be more consistent with their behaviors (Festinger & Carlsmith, 1959). The scope and application is that dissonance theory applies to all situations involving attitude formation and change. This theory is able to manipulate people into certain behavior, by doing so these people will alter their attitudes, themselves. It was therefore relevant to decision making and problem solving.

2.3 Assumptions of the Cognitive Dissonance

Human beings are sensitive to inconsistencies between actions and beliefs. According to the theory, we all recognize, at some level, when we are acting in a way that is inconsistent with our beliefs, attitudes and opinions. In effect, there is a built in alarm that goes off when we notice such an inconsistency, whether we like it or not. For example, if you have a belief that it is wrong to have unprotected sex or *mpangowakando*, yet you find yourself in the act of sexual relationship, you will notice and be affected by this inconsistency (Leon, 1999).

Leon further argues that recognition of this inconsistency will cause dissonance, and will motivate an individual to resolve the dissonance. Once someone recognizes that they have violated one of their principles, according to this theory, they won't just say that everything is well. The degree of dissonance, of course, will vary with the importance of your belief, attitude, and principle and with the degree of inconsistency between your behavior and this belief. In any case, according to the theory, the greater the dissonance the more you will be motivated to resolve it.

There are three ways through dissonance can be resolved. The first way is through change of beliefs. The simplest way to resolve dissonance between actions and beliefs is simply to change your beliefs. You could, of course, just decide that having unprotected sex and *mpangowakando* is normal. This would take care of any dissonance. However, if the belief is fundamental and important to you such a course of action is unlikely. Moreover, our basic beliefs and attitudes are pretty stable and people don't just go around changing basic beliefs, attitudes and opinions all the time, since we rely a lot on our world view in predicting events and organizing our thoughts, Jackson (2005).

The second way is through change of actions. We should ensure that we do not repeat the same action once we have realized we have done against our beliefs and opinions. For example, Lord knows that guilt and anxiety can be motivators for changing behavior. So, you may say to yourself that you will never have unprotected sex or *mpango wa kando* again and this may aid in resolving the dissonance, (Jackson, 2005). However, aversive conditioning such as guilt and anxiety can often be a painful way of learning, especially if you can train yourself not to feel these things. In addition, you may really benefit in some way from the action that's inconsistent with your beliefs. Therefore the trick would be to get rid of this feeling without changing your beliefs or your actions.

The third way is through the change of perception of action. This is the most important way of resolving dissonance. However the method is considered the most complex of resolution to change the way you view, remember and perceive your action. In more informal terms, you would rationalize your actions. For example, you might decide that having had unprotected sex or *mpango wa kando* was not necessary

after all. If you reflect on this series of mental exercises for a moment you will probably recognize why cognitive dissonance has come to be so popular Festinger & Carlsmith (2006).

2.4 Effectiveness of Peer Education on Behavior Change and HIV Risk Reduction

Health education needs to go beyond traditional education methods, especially when it concerns HIV/AIDS. Preventive interventions that only provide information about HIV/AIDS have proved to be ineffective in changing risky behavior (Sdorow, 2003). This study also supports the view that cognitive-behavioral interventions that focus on changing attitude and life skills development, in addition to information, may be more effective in modifying risky behavior. Sdorow, therefore, concludes that, peer education is a promising method in promoting risk-reduction behavior. Peer education is a successful strategy in many settings, especially as part of behavior change communication. In Ghana for example, an ILO project linked up with apprentice mechanics and trained a corps of peer educators in small garages in and near the main cities. In Abidjan, Cote d'Ivoire, peer education has been successful in building unity among sex workers to insist on condom use. In Brazil, HIV interventions with young military conscripts have been conducted since the 1990s with remarkable success: there was a consistent increase in the use of condoms among young conscripts, from 38 per cent in 1997 to 50 per cent in 2000 (ILO/FHI, 2003).

Peer education typically involves training and supporting members of a given group to effect change among members of the same group. Peer education is often used to effect changes in knowledge, attitudes, beliefs, and behaviors at the individual level. However, peer education may also create change at the group or societal level by modifying norms and stimulating collective action that contributes to changes in

policies and programs. Peer education is often implemented in tandem with other HIV prevention program components such as condom distribution and/or STI testing and treatment services (Aronson, 2003). The complexity of the causal determinants of HIV infection is well understood and therefore the need for interventions that address HIV-related behavior change on multiple levels: individual, relational (such as partner, family), environmental (e.g. community, institutions) and structural (e.g. legal, political, economic). Interventions should therefore address environmental and structural constraints to preventive behavior in addition to individual attitudinal and behavioral factors that have traditionally been the focus of HIV/AIDS peer education programs. Peer education should be integrated with or linked to basic services such as access to condoms, medical care, voluntary counseling and HIV testing, and STI management (Tabifor, 2012).

2.5 Beliefs and Attitudes about HIV/AIDS

According to Heath et al (2006) for nearly 30 years, HIV (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome) have been shrouded in many beliefs and misconceptions. In some cases, these mistaken ideas have prompted the very behaviors that cause more people to become HIV-positive. Although unanswered questions about HIV remain, Aronson et al. (2006) argue that most of these beliefs have been disputed and explanations given for the same. For instance, evidence shows that HIV is not spread through touch, tears, sweat, or saliva. Graybiel (2008) adds that one cannot catch HIV by: Breathing the same air as someone who is HIV-positive, touching a toilet seat or doorknob handle after an HIV-positive person, drinking from a water fountain, hugging, kissing, or shaking hands with someone who is HIV-positive, sharing eating utensils with an HIV-positive person or, Using exercise

equipment at a gym. According to him, the fact is that one can get infected from infected blood, semen, vaginal fluid, or mother's milk.

A more recent belief noted by Halpern (2004) is that one should not worry about becoming HIV positive since new drugs will keep one well. Despite the fact that there exist antiretroviral drugs that are improving and extending the lives of many people who are HIV-positive, many of these drugs are expensive and produce serious side effects. None yet provides a cure. Also, drug-resistant strains of HIV make treatment an increasing challenge. Jackson (2005) notes that another popular myth is that one can get HIV from mosquitos. He further explains that Because HIV is spread through blood, people have worried that biting or bloodsucking insects might spread HIV. Studies by Darton, (2008), however, show no evidence to support this instead he notes that even in areas with lots of mosquitoes and cases of HIV, when insects bite, they do not inject the blood of the person or animal they have last bitten. Also, HIV lives for only a short time inside an insect.

Some people also believe that once they have contracted HIV, their lives are over. Some even go ahead and commit suicide for that reason. In the early years of the disease epidemic, the death rate from AIDS was extremely high. But today, antiretroviral drugs allow HIV+(positive) people and even those with AIDS to live much longer, normal, and productive lives (Bonaldi, 2008). Another belief noted by Jackson (2005) is that once one is receiving treatment for HIV/AIDS, he/she cannot spread the disease to anyone else. Knott et al (2008) is quick to note that when HIV treatments work well, they can reduce the amount of virus in your blood to a level so low that it doesn't show up in blood tests, however, the virus is still "hides" in other areas of the body. Czerny, (2008) advices that it is still essential to practice safe sex so you won't make someone else become HIV-positive. Others believe that if both of

them are HIV/AIDS positive, there is no need to practice safer sex. However, Bonaldi (2008) advice that Practicing safer sex like wearing condoms or using dental dams can protect both partners from becoming exposed to other (potentially drug resistant) strains of HIV.

Jackson (2005) notes that, it is also not possible for one to tell if their partner is HIV positive by simply looking at them. Studies have shown that one can be HIV-positive and not have any symptoms for years. The only way for you or your partner to know if you're HIV-positive is to get tested. One can also not get HIV from oral sex. While it is true that oral sex is less risky than some other types of sex one can also get HIV by having oral sex with either a man or a woman who is HIV-positive. Always use a latex barrier during oral sex.

2.6 Socio Economic Impact of HIV/AIDS at Workplace

The socioeconomic impact of AIDS on society at large is already enormous in many countries and is bound to grow significantly in the years ahead. Among the direct and indirect economic costs are vastly increased spending on health care; drain on health care resources, including hospitals, drugs and staff; decimation of the workforce (loss of production and productivity in all sectors of the economy, including women's labor in and outside the home); loss of investment in the training of skilled labor and educated professionals; loss of consumers and purchasing power; and loss of tourist revenues. All sectors of the economy, private as well as public, and all nations everywhere must be involved in the effort to bring the pandemic under control. The economic impact of AIDS is felt by all sectors be it agriculture, industry, education, tourism, and the informal sector among others. The combined characteristics of HIV/AIDS adversely affect economic activity in the dairy industry and Kenya as a whole, have a high prevalence. If the working population continues to be affected

over a long period different sectors bear the blunt of negative economic consequences. The extra burden placed on both households and organizations (firms, co-operatives, associations), also undermines domestic economic performance.

According to (Mbengeranwa, 1997), HIV/AIDS affects more people who are in their most productive years. Along with the loss of labor and skill that takes many years to replace, HIV/AIDS has implications on other aspects of employment such as training, recruitment, sickness benefits, pensions and insurance. The devastating effect of HIV/AIDS on the economy has been largely through absenteeism from work and lowered output as infected persons get to the AIDS stage and are unable to work at all. In many developing countries, there is already a shortage of skilled labor and a narrow underdeveloped industrial base, exacerbated by lack of resources to overcome these problems. The situation is made worse by the evidence that the pool of people who will make up the next generation of skilled workers is already diminishing Panos Institute (1992).

The psycho-social environment of the workplace gets affected when some employees have a serious and, ultimately, terminal condition. According to Maphosa, HIV/AIDS affects both productivity and profitability. Increased absenteeism affects overall productivity; sickness, the need to care for the sick, preparing for and attending funerals of friends and relatives result in an increase in absenteeism which in turn has negative impacts on productivity. Also, staff turnover affects productivity; illness and death results in high staff turnover. This leads companies to increasingly focus on recruiting and training new employees rather than on company output. Lastly, the productivity is compromised due to lower morale – as a result of illness, suffering and loss of colleagues, friends and relatives, the effects of HIV/AIDS lead to the lowering of morale among workers.

The workplace policy, states that the impact of HIV/AIDS on profitability includes increased cost of doing business since as the number of employees falling sick increases, companies have to bear the costs of health insurance, sick leave, funeral benefits, recruitment and training of new staff. There is also declining investment as the increasing impact of AIDS on businesses deters investment. In addition, consumer base is also threatened as more people die of AIDS resulting to a decline in demand for goods and services. The impact of AIDS on business is already visible in the dairy sub-sector. Despite the scale of the threat posed by HIV/AIDS the business community has been slow to respond. AIDS prevention and care activities by organizations can maintain or even increase productivity and profitability. The great challenge to business organizations is how to respond to HIV/AIDS in a compassionate but cost-effective way which will balance the obligation to employees, society and the stakeholders.

There are two kinds of impact of HIV/AIDS on in organizations, one easily observable, as confirmed by micro-economic or sectorial studies, and the other less visible, working slowly on the organization and operational structures of the industry. At most, farm managers are concerned only about the visible effects, and then only in the context of their own business. What is needed is to seek a transitional solution to these problems that will be applicable to most industries and at the same time undertake to find out the root cause of the problem. HIV/AIDS policy at workplace recognizes the relationship between the physical health and morale of the staff on one hand, and work productivity on the other.

2.7 The Role of Trade Unions in Workplace HIV AND AIDS Programs

In February 2003 the Summit of African and American Trade Union Leaders and Government Officials on HIV and AIDS took place in Washington, D.C. One of the keynote speakers was Mr. Andrew Kailembo, the then General Secretary of the International Confederation of Free Trade Unions-Africa region. In his presentation Mr. Kailembo acknowledged the importance of the workplace policy as an effective starting point in tackling the disastrous effects of the HIV and AIDS pandemic. He cited several reasons for this: the workplace brings together large numbers of people particularly the 20-49 years age bracket, and men who are difficult to reach in the community; many workplaces have facilities that can be used for group discussions, the infrastructure in terms of clinics and condom distribution mechanisms; and workplaces have existing health and safety committees comprising both management and workers, and provide a good entry point to fight against HIV and AIDS through awareness campaigns. Mr. Kailembo also underlines the importance of trade unions in workplace HIV/AIDS programs since trade union leaders are also opinion leaders. He argues that organized workers are more likely to accept new ideas if they are brought through trade unions.

According to the Federation of Kenya Employers (FKE), ignorance about the causes of AIDS continues in spite of widespread claims of an HIV/AIDS aware society in Kenya. There is therefore need for commitment and continuous effective communication of accurate and appropriate information related to HIV and AIDS. There is also need to focus on behavior change through increased openness in discussing sex and sexuality at the workplace. The FKE Code of Conduct specifies peer education as the third “capacity building stage” in mainstreaming HIV/AIDS in the workplace. The other four stages include management sensitization, stigma and

discrimination reduction, promotional activities and follow-up. The FKE Code of Conduct is, however not a study but a framework or guide that different stakeholders can use in developing comprehensive workplace HIV and AIDS programs. The Code of Conduct is drawn from the International Labor Organization's (ILO's) Code of Practice and addresses the basic principles of workplace HIV and AIDS policies such as confidentiality, pre-employment screening, and benefits for employees living with HIV and AIDS, and stigma and discrimination on the basis of one's HIV status. In so far as peer education is concerned the FKE Code of Conduct recognizes the effectiveness of the approach in creating awareness and educating employees about the pandemic.

2.8 Behavior Change Communication

Behavior change communication (BCC) is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behavior change. BCC employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation. Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioral objectives. BCC aims to foster positive behavior; promote and sustain individual, community, and societal behavior change; and maintain appropriate behavior. Before individuals and communities can reduce their level of risk or change their behavior, they must understand basic facts about reproductive health and HIV/AIDS, adopt key attitudes, learn a set of skills, and have access to appropriate commodities and services. Societies need to confront cultural values and practices that can contribute to risky sexual behaviors and effective BCC is vital for setting the tone for compassionate, responsible interventions. BCC also can produce

insight into the broader socioeconomic impact of the HIV/AIDS epidemic and mobilize the political, social, and economic responses needed to mount an effective program to address the epidemic.

Strategic Behavior Communication (SBC) is an interactive and more targeted process, both with individuals and within communities. It develops tailored communication strategies, messages, and approaches, using a mix of communication channels and interventions to promote healthier behaviors and support individual, community, and societal behavior change. SBC supports the entire continuum of HIV/AIDS prevention, care, treatment, and support interventions, and lends communication expertise to advocacy and social and community mobilization. SBC also supports other interventions to deliver consistent messages through multilayered approaches and channels for maximum effectiveness. For example, such programs in the communities have contributed to the behavior change achievements recorded by the 2003 Kenya Demographic and Health Survey. These included increased age of sexual debut between 1998 and 2003 (from 16.8 to 17.8 for women and 16.8 and 17.1 for men), increased condom use for last reported high-risk sex (from 15.1 to 23.9 percent for women and 42.5 to 46.5 percent for men) and a reduction in the proportion of women reporting more than one partner from 4.2 to 1.8 percent (FHI, 2007).

In Kenya there are two major studies that attempt to provide information on the level of behavior change. These are the Kenya Demographic Health Survey (KDHS) and the Behavioral Surveillance Survey (BSS). These studies are held every two years and help to track trends in knowledge, attitudes and behaviors in subpopulations at particular risk of HIV infection. The BSS identifies specific behaviors in need of change among other purposes. An evaluation of Family Health International's IMPACT project in 2002 concluded that although the issue of incentives for peer

educators was under continual discussion, retention of peer educators appeared to be quite high in particular groups. This evaluation however looked at many different activities and was shallow in its information on peer education among different groups that were being targeted, including workplaces.

2.9 Dynamics of Behavior Change Communication

Workplace information and education programs are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS (Aronson et al, 2006). Knott et al (2008) also add that effective education can contribute to the capacity of workers to protect them against HIV infection as this can significantly reduce HIV-related anxiety and stigmatization, minimize disruption at the workplace and bring about attitudinal and behavioral change. According to Garry and Pear (2009) Programs should be developed through consultations between governments, employers and workers and their representatives to ensure support at the highest levels and with the fullest participation of all concerned. They add that Information and consultation should be provided in a variety of forms, not relying exclusively on the written word and including distance learning, when necessary. Programs should be targeted and tailored to the age, gender, sexual orientation, spectral characteristics and behavioral risk factors of the workforce and its cultural context. They should be delivered by trusted and respected individuals.

Peer education has been found to be particularly effective, as has the involvement of people living with HIV/AIDS in the design and implementation of programmes (Tabifor, 2012). Behavior change communication (BCC). According to Weiten, (2009), peer Education is an interactive process for developing messages and approaches using a mix of communication channels in order to encourage and sustain positive and appropriate behaviors. BCC has evolved from information, education and

communication (IEC) programmes to promote more tailored messages, greater dialogue and fuller ownership. Participation of the workplace stakeholders is vital at every step of planning and implementation of the behavior change programs to ensure sustainable change in attitudes and behavior (Shorer and Onyancha, 2011). In the context of HIV and the workplace, BCC is an essential part of a comprehensive programme that includes services (e.g. care, counseling), commodities (e.g., condoms, drugs), and policies that promote non-discrimination and trust (Sdorow, 2003).

Before individuals and communities can reduce their level of risk or change their behaviors, they must first understand the basic facts about HIV and AIDS, assess and modify their attitudes, learn new skills, and gain access to appropriate products and services. They must also perceive their environment as supportive of behavior change and the maintenance of safe behaviors (Miller, 2011). Miltenberger (2007) concludes that to be effective, BCC programs need to be tailored to specific target populations. In the context of the world of work, this entails communicating with workers in homogeneous groups, based on factors such as economic sector, type of job, education, gender. It also entails developing specific messages and approaches that will most effectively resonate with a particular workplace group.

2.10 Strengths and Challenges of Behavior Change Communication

Stigma is one of the challenges that have been noted and it cuts across most of the other challenges (Weiten, 2009). According to Hugh (2003) Massive social condemnation and marginalization makes disclosure of one's status, or simply revealing ones uncertainty about possibly having the virus, one of the most difficult decisions in life. Stigma is caused by shame for one's past behavior associated with HIV and by fear of the consequences. Many people in the region tend to keeping to themselves to avoid being excluded from their family, cast out by their neighborhood

and discriminated in their work places. Even AIDS orphans are reportedly rejected by their own family. Thairu (2004) notes that VCT centers in Kenya still register few couple clients since majority are unwilling to take their spouses for couple counseling services. This therefore, leads too many being suspicious of their partners, thus, causing misunderstanding and rejection in many households. He adds that it is even common to find one couple going for test and starts taking the drugs (ART) secretly without telling their partner.

In workplaces where the testing and counseling services is offered for free, Thairu notes that Some workers even opt to go to be tested outside even at a fee for the fear of being noticed by their fellow workers. Hugh (2003) notes that fear is also one of the challenges experienced. He notes that although most human beings are afraid of acquiring a serious illness, widespread stigma in workplaces reinforce a feeling of fear to a degree that leads to strong denial on the one hand and to careless behavior and 'laissez-faire' attitudes and blame of others on the other. In many reported cases, fear of being known to be HIV/AIDS positive has also led to individuals committing suicide. Thus, Hugh concludes that at the heart of the problem lies the need to tackle these profound feelings of fear. Lack of social support systems such as social institutions present in any community ranging from hospitals, schools and churches to families, friends and neighbors has also been identified as a challenge (Garry, 2009). Gathered under the analytical concept of 'institutional mediators' the most common experience is a lack of social support encountered in these contexts.

Traditional practices and myths: many traditional, cultural practices persist especially in African communities regarding AIDS. These place a heavy burden in efforts to curb the disease. Inheritance and polygamy are still prevalent in some communities and these customs facilitate the spread of AIDS, as those involved normally do not get

tested beforehand (Thairu, 2004). He adds that an inherited wife is even more exposed, as her new partner is in most cases a married man. Similarly, to woman in polygamous marriage, since sharing the same husband is unsafe for all of them. Knott *et al* (2008) notes that if one partner is infected, the chances of infecting the other partners in the union are obvious. Misconception ideas surrounding HIV/AIDS are still common and are a major hindrance. The fight against AIDS cannot be won without sufficient financial resources (Czerny, 2008). Largely almost all the interventional programs such as BCC cannot succeed without proper funding. The AIDS pandemic presents a myriad of problems that require an enormous amount of money if any meaningful results are to be achieved. Since the problems involve generations of people, the funds need to be in a continuous flow. Language barrier makes it a challenge in communicating to an intended audience. Poverty and drug abuse also pose as challenges in the program.

2.11 Effectiveness of Behavior Change Communication

To be effective, BCC programs need to be tailored to specific target populations. In the context of the world of work, this entails communicating with workers in homogeneous groups, based on factors such as economic sector, type of job, education; gender among others (Aronson *et al*, 2006). It also entails developing specific messages and approaches that will most effectively resonate with a particular workplace group. Effective behavior change communication can: increase knowledge of HIV/AIDS; stimulate social and community dialogue; promote essential attitude change; improve skills and sense of self-effectiveness; reduce stigma and discrimination against people living with HIV/AIDS; create a demand for information and services; advocate an effective response to the epidemic; and promote services for prevention, care and support of vulnerable populations (Halpern *et al*, 2004). Czerny

(2008) notes that effective HIV/AIDS workplace behavior change communication programs, supported by practical measures, can significantly reduce HIV-related anxiety and stigmatization, minimize disruption at the workplace, and bring about changes in attitudes and behaviors among the workforce and surrounding communities. Successful programs are targeted and tailored to the age, gender, sexual orientation, and sectorial characteristics and behavioral risk factors of the workforce and its cultural context.

Peer education has been particularly effective in workplace HIV-prevention programs. To effectively develop BCC programs, Fisher (2003) says that it is important to understand who needs to be reached. The first step is to identify the different groups of people at a workplace and to consider those that may be most at risk. The target population can then be divided into subgroups that have commonalities, or according to ethnicity, language and education. Groups that have an influence over those who are most at risk must also be examined. To be most effective, HIV/AIDS Behavior change programming for the workplace must work with primary and secondary target populations: Primary target populations are the main group of individuals whose behavior we would like to influence and support (Graybiel, 2008). For example, in the transport sector, the primary target population could be truck drivers, because they are away from home for long periods of time and more likely to engage in risky behavior. Secondary target populations are those who can affect the BCC activities or be affected by them, even though these BCC activities were not designed to reach them directly. They are often people whose support or neglect determines whether or not the primary audience responds to communication messages.

They can include opinion leaders (such as government officials), gatekeepers (such as police officers and brothel owners), and policy-makers. In the case of truck drivers,

the secondary target populations may include the owners of the vehicles. They may also be vulnerable or at risk, as a result of their association with the primary audience, but they are not necessarily the main beneficiaries of HIV/AIDS programming efforts. The wives and girlfriends of men who frequent sex workers might fall into this category. There are often several secondary target populations around one primary target group, requiring different communication approaches and messages.

2.12 Expansion of Health facilities

It is gratifying to note that Kenya at 50, we can celebrate the journey to the health sector on the expansion of health facilities in that every county has at least one referral hospital, several health centers and dispensaries. Constituency Development Fund (CDF) funds have also gone a long way in increasing and expanding health facilities. Increase in Health care colleges and universities, we now have several and in addition there are many other medical health institutions that train other health professionals, including nurses, clinical officers and laboratory and pharmacy staff. Eradication and/or control of diseases including small pox that is no longer with us, we have almost eradicated polio, though refugee camps are sometimes the source of the outbreaks. The HIV/AIDS pandemic had the health system, even the country, on its knees, but we are now winning the war against HIV/AIDS. The epidemic is now stabilizing and a reversal is being seen. Similarly, Tuberculosis (TB), after over 20 years of sustained increase in TB cases, we are now seeing a reversal in the trend. Congratulations to the ever-resilient health care workers and everyone who has played a part. Regarding the maternal health, significant progress has been made to improve maternal health, with improved access to reproductive health services such as family planning as well as antenatal, hospital delivery and postnatal services. Gaps still

exist, but important strides have been made to improve the wellbeing of our women and their families.

In cases pertaining to child survival, we have seen significant reduction in child and infant mortality. At independence, 108 children out of every 1000 born alive would die before their first birthday, while 179 would die before their fifth birthday. Today, 52 out of 1000 born alive are likely to die before their first birthday, and 74 before their fifth birthday. While the deaths are still unacceptably high, there has been a drop and efforts towards reducing this further are being made by various players in the sector. These include expanding the number of diseases that children are immunized against, increasing access to hospital deliveries as opposed to traditional child delivery process, and improving nutritional services for children. Lately, the government has included vaccination against pneumonia and polio in its free vaccines schedule and plans are underway to provide vaccines against rota-virus, a leading cause of diarrhea and death in children. Some of these vaccines are already available for a fee in the private sector, a contribution that should not be ignored.

According Kimani (2014) from the Centre for Disease Control and Prevention, supported by a team from the Ministry of Health and the National Public Health Laboratory Services, medical injections are linked to new HIV infections in Kenya. The study reveals that a significant number of Kenyans are getting HIV infections from contaminated medical injections. In a rare public admission, a report for the May issue of the Journal of Acquired Immune Deficiency Syndromes says that a number of new HIV infections in Kenya were from injections self-administered or from health facilities and traditional healers. According to KAIS (2012), special supplement of the detailed analysis reported that, in 2008, it was estimated that 2.2

per cent of new HIV infections in Kenya were a result of unsafe injections in health facilities. Since then, the report says, more people, including those who are HIV positive, are receiving injections in all types of health facilities, creating serious problems of coping with the medical systems.

2.13 Projects to reduce Stigma and Discrimination for HIV-infected teens

According to National Aids Control Council NACC (2015), more than 400,000 adolescents are living with HIV, a report has shown. The report reveals that 435,225 adolescents aged between 10 and 19 are HIV positive while another 119,899 have the virus “but are not yet identified.”

As a result, about 7,500 adolescents died of the disease last year due to delayed treatment, and the overbearing stigma and discrimination associated with being HIV positive. The report explains that Nairobi city county is leading with 49,904 adolescents living with HIV. Homabay comes second with 46,530 followed by Kisumu at 37,110 and Siaya at 33,810 while Marsabit has 450, Tana River 360 and the least is 150 in Wajir. In addition, the annual new infections among children aged 0-14 is 12,511 while for those above 14 years but below 25 years is 13,148.

The new infections were attributed to early sexual encounters, where 20% of youth aged between 15 and 24 had their first sexual experience before their 15th birthday. A total number of 120,000 HIV positive adolescents do not know their status.

The Ministry of Health also said some of the infections occurred in early childhood, as currently there are over 11,000 new cases in children, mainly from infected mothers. Records from the Ministry indicate that in 2014, there were 69,815 pregnant HIV+ women but only 52,180 were given prophylaxis, a drug to prevent mother to child transmission of HIV. The rest risked exposing their children to infection.

There are 1.6 million people living with HIV and by 2017, 1.4 million are expected to be on Anti-Retroviral (ARVs). Further the Ministry of Health said there are at least 195,299 adolescents on ARVs and another 3.15 who need but are not on the treatment. The statistics were released during the launch of Kenya's fast track plan to end HIV and AIDS among adolescents and young people on in September 2015. The event saw the launch of the HIV Situation Room, an innovative tool to track progress and identify gaps in HIV programming.

According to UNICEF (2013), two million adolescents aged between 10 and 19 are HIV positive, with 15 million of the cases being in Sub-Sahara Africa. About 41 per cent of new HIV infections across the globe happen among young people aged between 15 and 4 years, with 79 per cent of new infections in Sub-Saharan Africa.

According to Geri Delarosa (2013), young people are particularly vulnerable to HIV infection due to social, political, cultural, biological and economic reasons. He states that increased access to pediatric IV care and treatment perennially infected children are living longer and reaching adolescence and adult hood. Once youth reach adolescence, they are able to fully comprehend their HIV status and the full weight of the diagnosis sets in, often leading to depression, anger, fear and their first experiences with sigma, he adds.

2.14 Ignorance and Poverty

According to study carried out by CARE International, ignorance and poverty are the main social effects of HIV spreading. A study carried out along the shores of Lake Victoria, where women trade their bodies for fish. Due to ignorance and poverty, the sex-for-fish exchange has been highlighted as a major factor in the spread of HIV among fishermen and female fish mongers, in what the fisher community have christened '*jaboya* system'. '*Jaboya* refers to the owners or operators of fishnets).

This system has survived and thrived among fisher folks over the years due to ignorance about HIV, migratory practices of fishermen (most of who do not live with their families) from beach to beach, and poverty. Women fishmongers most of whom are widowed as a result of AIDS including young and vulnerable female orphans, are pushed to offer sex to the fishermen in exchange for the best catch and good bargains. It does not end there. For those who need space in the local buses and *matatus* to transport their fish to their markets, the sex offer is extended to the turn-boys and drivers to reserve the space. The sex-chain is thus extended with multiple partners irrespective of one's HIV status and more often than not, without protection. The study reports indicate that high risks of having unprotected sex with '*jaboyas*' who refuse to use condoms as a protective measure has increased the spread of HIV and more so on re-infection thus deteriorating the weak immune system.

This behavior is fuelling the spread of HIV-infection in Nyanza region, which has the highest prevalence of HIV and AIDS infections in the country. According to the Kenya AIDS Indicator Survey, 2012, Nyanza recorded the highest HIV prevalence in Kenya among those between 15 and 64 years. Most women engage in a number of female fishmongers trading along the beaches, befriend more than one fisherman, grossly increasing the chances of getting infected with HIV and other sexually transmitted diseases. This is because the same *Jaboya* have other women as well. The infected women now owe their dramatically changed lives to an organization known as Victoria Institute for Research on Environment and Development (VIRED). The organization through the help of donor funds provides the women with boats, whose cost they are expected to repay within a certain period. This money is then used to construct more boats which are distributed to other women in the project. The

project with a slogan – ‘*No Sex for Fish*’, hopes to bring an end to the sex-for-fish menace at three beaches in the area, namely Nyamware, Ogenya and Nduru by 2015.

According to the Director of the Organization, Prof. Okeyo Owuor, the organization hopes to extend the project to all the beaches along Lake Victoria should the funds be available. He explains that, initially, they considered giving out condoms to the young men, but realized they would do little good, if any. This was because men refuse to use condoms during sexual intercourse. The other option to curb this risky behavior is to support women living along the lake region with grants that will enable them to start income generating activities other than fish trade only. It was observed that if these women had other options of making money, they would not engage in risky sexual behavior to earn a living. The pilot project has enabled 16 out of the 20 women in the pilot project to own their own boats. Owuor says the results have been encouraging, with many women get interested in the project.

A recent survey on cheating spouses on the shores of Lake Victoria reveals that 6.2% of fishermen’s wives cheat on their husbands. Women should also be included in HIV prevention and management programs so that their problems can be addressed amicably. The younger wives of below 25 years are more likely to cheat on their husbands, the study reveals. The reasons for the cheating include domestic violence, with assaulted women seeking solace from loves and women who have painful sex with their spouses are more likely to cheat on their husbands.

This is in tandem with the National Aids Control Council (NACC) report of 2013 that couples and those in stable relationships account for the highest percentage of new

HIV/AIDS infections in Kenya. Among the risk factors highlighted, marriage has consistently been reported as one of the risk factors for HIV infection partly due to extra-marital partnerships of one or both spouse in the context of low or no condom use as a preventive measure. These spouses involved in unprotected extra marital sex act as conduits through which HIV enters marriages whose partners were initially HIV negative.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter sets out various stages and phases that were used in the study. It gives detailed explanation of how the study was implemented. In this stage, most decisions about how research was executed and how respondents were approached, as well as when, where and how the research was conducted. The following are the specific subsections; research design, target population, sample design, data collection methods and procedures and finally data analysis.

3.2 Research Approaches

This study is aimed at generating knowledge regarding the behavior change communication on HIV/AIDS risk reduction. Owing to the increase in the HIV/AIDS infection rate, this study was selected. The research approach used entailed both quantitative and qualitative methodologies. In quantitative research, a structured questionnaire with open and closed ended questions was developed to raise information. Open ended questionnaires were used to encourage the respondents to express their views while the closed ended were used to give the researcher a chance to get specific answers towards the research, this, the researcher (Phillips, 2000). Qualitative methods used in the research were aimed to gather an in-depth understanding of human behavior and the reasons that govern such behavior. The qualitative method investigated the why and how of decision making, not only what, but also where and when. Hence, smaller but focused samples were often used. This method included narration, storytelling, classical ethnology and shadowing. The method therefore allowed for in-depth interview guides. Open ended questions were used to encourage the respondents to express their views freely.

3.3 Research Design

The research adopted a descriptive cross-sectional survey where the researcher had a target group that described certain issues about important variables of the study this way the associations between variables was established. This method was ideal because it was relatively quick and easy to conduct (no long periods of follow-up), Data on all variables was only collected once, able to measure prevalence for all factors under investigation and multiple outcomes and exposures can be studied. This resulted in a description of the data, in words, charts, tables, and the data analysis showed statistical relationships. This method provided descriptions of the variables in order to answer the research questions in the study. The descriptive survey research design to be adopted is concerned with information obtained by questionnaires (Miller, 1991). Descriptive studies are usually the best methods for collecting information that demonstrate relationships and describe the world as it exists. These types of studies are often done before an experiment to know what specific things to manipulate and include in an experiment. Bickman and Rog (1998) suggest that descriptive studies can answer questions such as “what is” or “what was.” Experiments can typically answer “why” or “how.” The researcher adopted research questions for the in-depth interviews. This method resulted into discussions which enabled the researcher get the details from the employees.

3.4 Target Population

Target population refers to the entire group of individuals which the researcher was interested in generalizing the conclusions. The target population usually has varying characteristics and also known as the theoretical population (Phillips, 2000). The study targeted Brookside Dairy Limited, Ruiru employees whose population was composed of the following in terms of gender and age brackets.

Table 3.1: Target Population

Department	Male	Female	Total Population
Milk Procurement	109	71	180
Finance and Accounts	193	137	330
Production	423	282	705
Sales and Marketing	165	120	285
Total	890	610	1500

Source: Brookside Dairy Registry, 2013

3.5 Sample Size Determination

To determine the sample size, the Yamane (1967) formula was used:

$$n = \frac{N}{1 + Ne^2}$$

Where: n = required responses

N = Sample size

e² = error limit

Placing the formula for the current population gave a sample size of:

$$\begin{aligned} \text{Sample size (n)} &= \frac{1500}{1 + 1500 * 0.05^2} \\ &= \frac{1500}{4.75} = 316 \end{aligned}$$

Therefore the sample size was 316 respondents as shown in table 3.2 below.

Table 3.2: Sample Size

Department	Sample (N)
Milk Procurement	38
Finance and Accounts	70
Production	148
Sales and Marketing	60
Total	316

3.6 Sampling Procedure

Sampling procedures were vital because they helped in research analysis to determine the adequate respondents from the total number of target population to be used. This made it adequate to warrant generalization of the findings to the target population. Proportional allocation was used in distribution of the selected sample for the study into the different age groups and gender. Systematic random sampling was applied to select the respondents who were surveyed. The main advantage of using systematic sampling over simple random sampling was its simplicity. It allowed the researcher to add a degree of system or process into the random selection of subjects. Another advantage of systematic random sampling over simple random sampling was the assurance that the population was evenly sampled. There exists a chance in simple random sampling that allows a clustered selection of subjects. This was systematically eliminated in systematic sampling. In cases where the selected employee was not available or not interested in the survey, a replacement was done in the same manner.

3.7 Data Collection Instruments

In quantitative research, a structured questionnaire with open and closed ended questions was developed to seek information as a quantitative tool from the employees. Through the structured questionnaire the researcher was able to contact large numbers of people quickly, easily and efficiently using a postal questionnaire. Questionnaires were relatively quick and easy to prepare code and interpret (especially in the case of closed questions).

For qualitative, the researcher organized and facilitated in-depth interviews since they could help investigate complex behavior, discover how different groups think and feel about the study topic and why they hold certain opinions and to suggest potential solutions to problems identified. Questionnaires and discussion guides were pre-tested for validity and reliability before distribution to respondents.

3.7.1 Data Collection Procedures

The researcher delivered questions in person to ensure that all the questionnaires are collected back and also to seek clarifications in cases of doubts. Questionnaires have diverse advantages that includes; enormous information can be collected from a large number of people in a short period of time and in a relatively cost effective way. This exercise was carried out by the researcher in order to administer its validity and reliability. The results of the questionnaires were quickly and easily quantified by the researcher through the use of (SPSS) software package. It was analyzed more objectively than other forms of research and when data has been quantified, it can be used to compare and contrast other research and may be used to measure change (Ackroyd 2005).

3.8 Data Presentation, Analysis and Interpretation

Interpretation explained and summarized the results of data analyses, putting the data and research findings into a broader context. Interpreting data, whether through written reports or oral presentations, required an analyst to present research findings such that they can be understood by all audiences, regardless of their background or level of statistical knowledge. Interpretation focused on providing clear explanations and, where applicable, recommended actions based on the data and analysis, (Phillips, 2000). After the fieldwork, the qualitative data was edited for ensuring comprehensiveness and accuracy of the filled notes. All quantitative data in the questionnaires and in-depth interviews were checked for reliability and verification after which the questionnaires were coded and entered into SPSS version 20. Qualitative data was summarized and presented in verbatim narratives and explanations while quantitative was analyzed using descriptive statistics method such as contingency, tables, pie charts bar and column graphs. The two were consolidated into a final report that provided insights.

3.9 Ethical Considerations

The researcher did seek authority, approvals and permit to conduct the research from the Chief Executive Officer of the company and the National Council of Science and Technology. This enabled participants to be free of fear of the known and unknown so that they provide detailed information for the research work. It was also fair to disclose to the participant that the research study was purely for academic purposes and not ‘witch-hunting’ on their jobs. The management at the Dairy workplace reserves all the right and respect for employees HIV/AIDS status without discrimination as an equal opportunity employer. Any employee found intimidating

another suffers disciplinary action including summary dismissal as stipulated in the employment Act Cap 226, Laws of Kenya.

3.9.1 Trustworthiness of the Study

The researcher complied with the principle of informed consent to ensure that the informants knowingly agreed to participate in the research. Each participant signed consent form for participation. The respondents were assured of confidentiality, trustworthiness and objectivity of the research in order to address any risk of fear of victimization by management. The in-depth interview questions were framed in such a way that they did not cause any physical and psychological harm to all individuals concerned.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter gives the results of the analysis where the researcher has used the filled questionnaires to get the results of the study. The data was collected from employees at Brookside Dairy. The collected data was then categorized into qualitative and quantitative data based on the structure of the questionnaires and in-depth interviews. Data collection was carried out through drop and pick method for questionnaires while the interviews were scheduled and recorded for transcription purposes. From a total of 316 questionnaires issued, only 300 were returned fully completed, giving a response rate of 95%. This was a response, good enough to provide credible information for this study.

4.2 Background Information

4.2.1 Respondents Profile

As shown below, 69% of my total sample were married, 23% were single while only 8% were either widowed or divorced. This is because Brookside Dairy Limited is a rather stable company and majority of their employees are mature and married.

Table 4.3: Marital Status

Marital Status	Frequency	Percentage
Married	207	69%
Single	69	23%
Widowed/ Divorced	24	8%
Total	300	100%

Source: (Field data 2013)

4.2.2 Age

Using proportional allocation, 12% of the employees sampled were aged between 18-20 years, 22% were aged between 21 to 30 years, 47% were between 31 to 40 years and the last 19% were aged 41 and above.

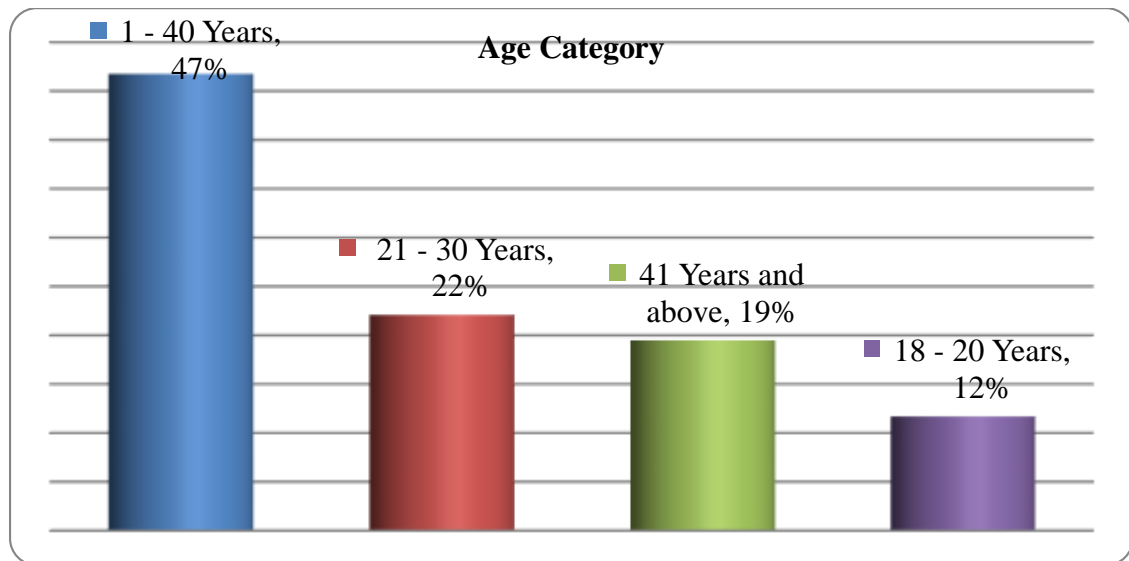


Figure 4.1: Age category

Source: (Field data 2013)

4.2.3 Education Level

Majority of staff at Brookside Dairy Limited were; college educated at 45%, followed by 39% who were university graduates and only 16% had not gone beyond post-secondary education as shown in the Table 4.4 below. This was significant especially in understanding how much education influenced communication and BCC in particular.

Table 4.4: Level of Education

Level of Education	Frequency	Percentage
University	48	16%
College	135	45%
Post-Secondary	117	39%
Total	300	100%

Source: (Field data 2013)

4.2.4 Gender

Since I expected reasonable variation in terms of thoughts across gender, I proportionately allocated and interviewed 57% males who form majority of Brookside employees and 43% females as indicated in Figure 4.2.

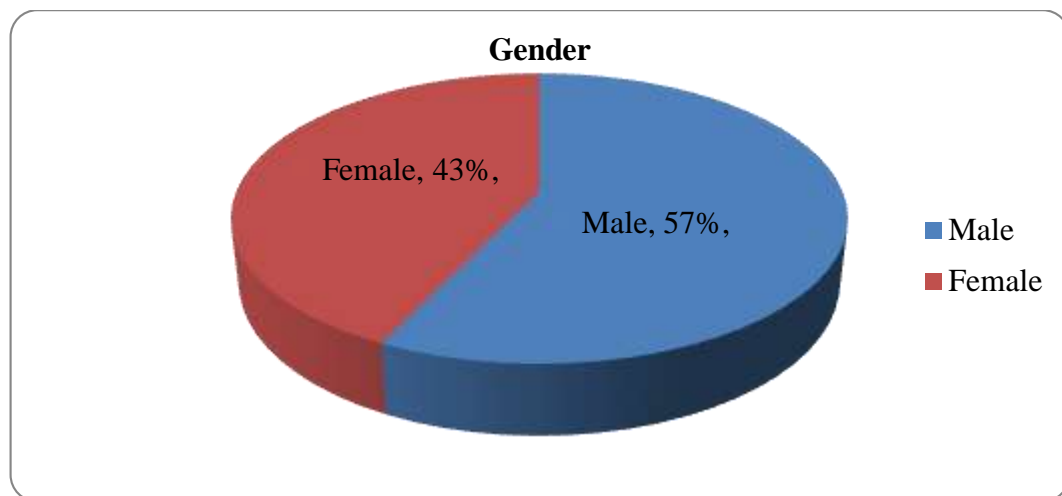


Figure 4.2: Gender

Source: (Field data 2013)

4.3 Knowledge on HIV/AIDS Risk Reduction and Wellness

4.3.1 Basic facts and myths about HIV/AIDS

The study illustrates that, 94% were convinced that HIV/AIDS virus cannot be spread by mere physical body contact as only 3% believed in that myth. The campaign messages reduce stigmatization not only in Brookside but also in the community at large.

Table 4.5: HIV/AIDS spread

Spread of HIV/AIDS (Physical contact)	Frequency	Percentage
Fact	12	4%
Fiction	282	94%
Don't Know (DK)	6	2%
Total	300	100%

Source: (Field data 2013)

A cross tabulation (see Table 4.6) revealed that those who were aged believed in the myth; that HIV/AIDS can be spread by physical contact. However, 6.7% of those aged above 41 years believed in it as 13.4% of them did not know. In addition, 16.7% of employees with secondary education believed this myth. In regard to the latter, a male respondent aged between 21 to 30 years, a college educated gave his opinion that “...*In the past, that is what people thought about AIDS; we even thought that being bitten by the same mosquito would make you sick. Some people even wore gloves. I think this made the affected feel neglected*”.

Table 4.6: Positive person on treatment

		Age Category				Education Level		
		18-20	21-30	31-40	41 +	Secondary	College	University
HIV/AIDS can be spread by mere physical contact with an infected person	DK	-	-	2.8	13.3	16.7	2.9	-
	Fact	-	-	2.8	6.7	16.7	-	-
	Fiction	100.0%	100%	94.4%	80%	66.7%	97.1%	100.0%

Source: (Field data 2013)

4.3.2 Knowledge on Spread of HIV/AIDs

As can be inferred, a positive person on treatment could spread HIV/AIDS was a fact that was known by a significant number of employees at Brookside Dairy Limited. This was indicated by a significant score of 81% among the respondents. Much communication was still to be done among the 8% who believed in the contrary and the 12% who were unsure.

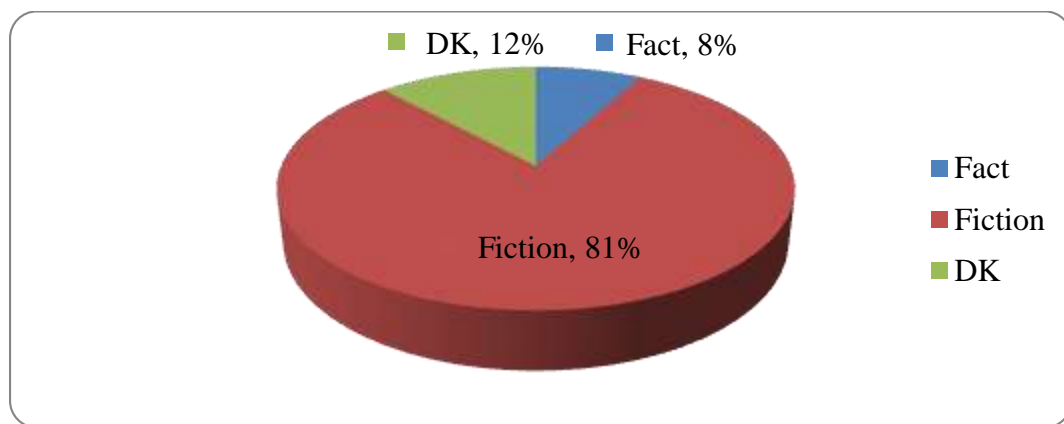


Figure 4.3: A positive person on treatment cannot spread HIV/AIDS

Source: (Field data 2013)

Further profiling pointed out that this perception was higher among the secondary school leavers, 33.3% compared to college where only 8.6% had such perceptions as there were no university graduates agreeing. In reference to a male of between 31 and 40 years who was a secondary education graduate, *“I have also heard something like that though I am not ready to risk my life. I will let other people prove it first”*.

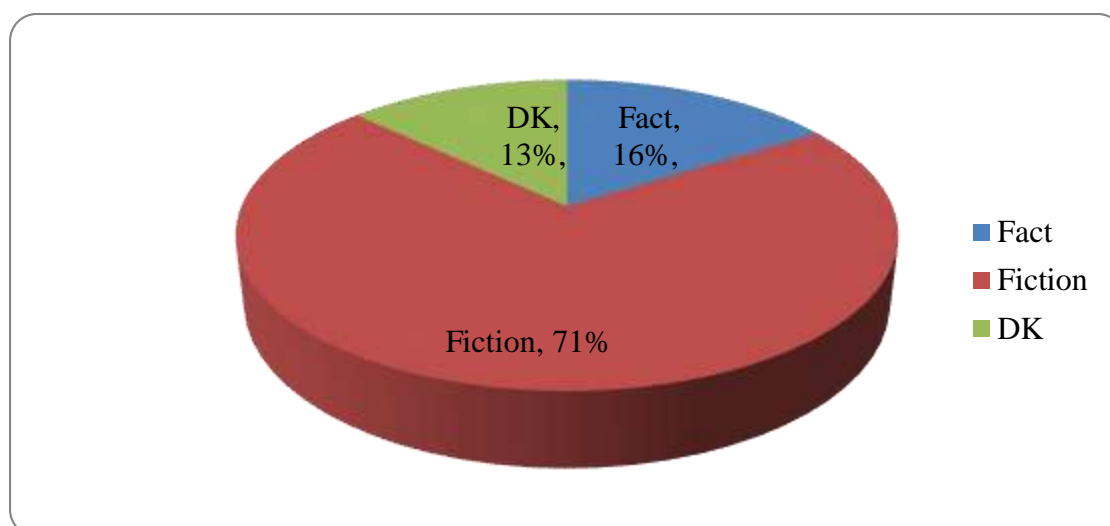
Table 4.7: Identify a positive person

		Education Level		
		Secondary	College	University
A positive person who is on treatment cannot spread HIV/AIDS	Do not Know	8.3%	5.7%	6.7%
	Fact	33.3%	8.6%	-
	Fiction	58.3%	85.7%	93.3%

Source: (Field data 2013)

4.3.3 Identification of the Infected Persons

From the study 71% of the respondents believed they can identify a positive person by simply looking at them, 16% would rather trust technology to prevail as another 13% were not so sure. In the wake of so many diseases like Tuberculosis, Hepatitis B among others that have almost similar symptoms as HIV, this could be dangerous since necessary steps to cure them may not be taken early enough hence complications.

**Figure 4.4: Identifying of a positive person by looking**

Source: (Field data 2013)

Male aged between 21 and 30 years in college belief was higher among the secondary educated employees at 41.7% compared to College and University educated

employees at 17.1% and 13.3% respectively. “...Yes even if they look healthy, me I can tell from their lips and eyes. Though, you need to have studied people keenly”. Said a male aged between 21 and 30 years, with secondary education level. “...With ARVs it is very difficult, furthermore diseases like Cancer and Tuberculosis equally has adverse symptoms on the victims. ARVs make them look healthier and I understand darker”. He added.

Table 4.8: Young virgin

	Education Level		
	Secondary	College	University
One can tell a Do not Know	83.0%	2.9%	6.7%
positive person by Fact	41.7%	17.1%	13.3%
simply looking at Fiction	50.0%	80.0%	80.0%
them			

Source: (Field data 2013)

4.3.4 Knowledge on HIV/AIDS Cure

Some good news for the young virgins since 97% of the respondents did not believe that a Positive elderly male can get cured of AIDS by sleeping with a young virgin. The other 3% were however, not sure.

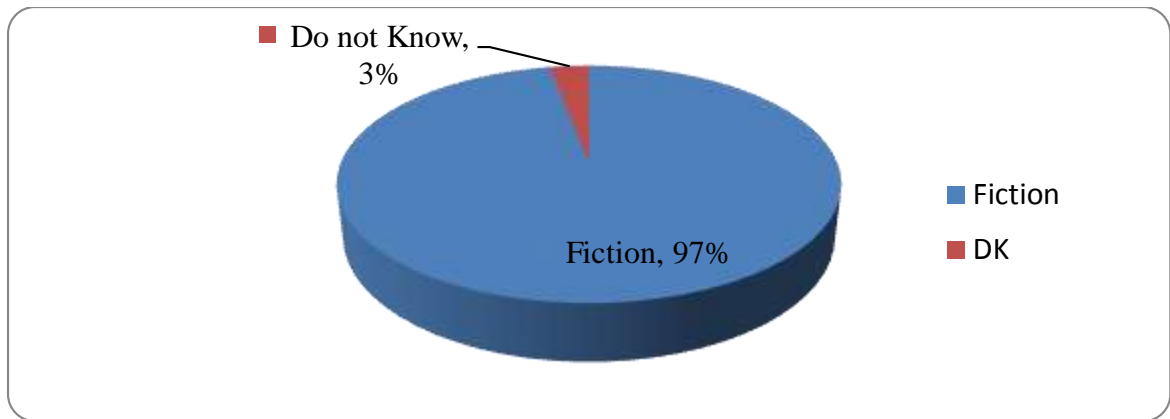


Figure 4.5: Positive elderly male could get cured of AIDS by sleeping with a young female virgin

Source: (Field data 2013)

Some respondents; 2.8% of those aged 31 to 40 years and 12% of those aged above 40 were not sure about this and also 25% of the Secondary level educated respondents were also unsure.

Table 4.9: Develop Immunity

		Age Category				Education Level		
		18 - 20	21 - 30	31 - 40	41 +	Secondary	College	University
Positive elderly male	DK	-	-	2.8%	12%	25%	-	-
can get cured of AIDS by sleeping with a young female virgin	Fiction	100%	100%	97.2%	86.7%	75.0%	94.3%	100%

Source: (Field data 2013)

4.3.5 Developing Immunity

A good number of respondents, 64% were not aware that certain people can actually develop immunity to the HIV/AIDS virus as on 21% are aware. The other 16% are not sure about this. Perhaps this is a practical case where bad becomes good in the sense that they may not go out experimenting if they are also immune.

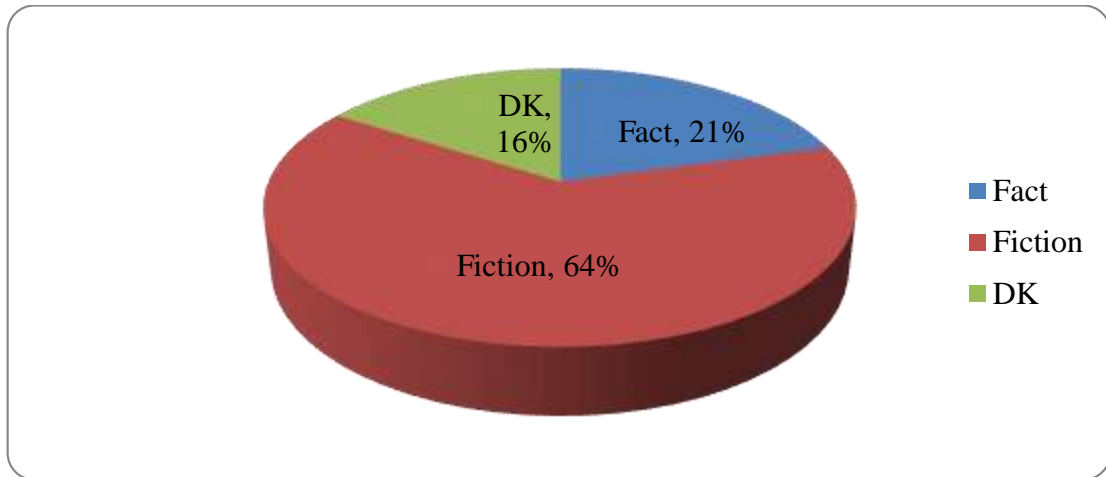


Figure 4.6: Certain people have developed immunity against HIV/AIDS

Source: (Field data 2013)

Though not so popular, the more educated respondents are more alive to this fact only discovered recently emphasizing on the value of education in information and communication. 20% of college educated and 30% of university educated were aware about this. This was higher among 30.6% of those aged between 31 and 40 years. In reference to a 24 years, female, and a college graduate who said that; “.....I heard that some prostitutes have developed immunity...but let’s wait for the doctors to prove that first...”

Table 4.10: Male circumcision

				Age Category				Education Level		
				18 - 20	21 - 30	31 - 40	41 +	Secondary	College	University
Certain	people	have	DK	22.2%	17.6%	16.7%	6.7%	33.3%	17.1%	6.7%
	developed immunity against		Fact	11.1%	23.5%	30.6%	-	-	20.0%	30.0%
	the HIV virus		Fiction	66.7%	58.8%	52.8%	93.3%	66.7%	62.9%	63.3%

Source: (Field data 2013)

4.3.6 Circumcision and HIV/AIDS

The recent campaigns for male circumcision in certain parts of the country seem to be yielding fruits. 71% of my respondents attest to the fact while only 16% does not, 13% were however unsure. This was positive especially from within a sample whose dominant community circumcise as a rite of passage.

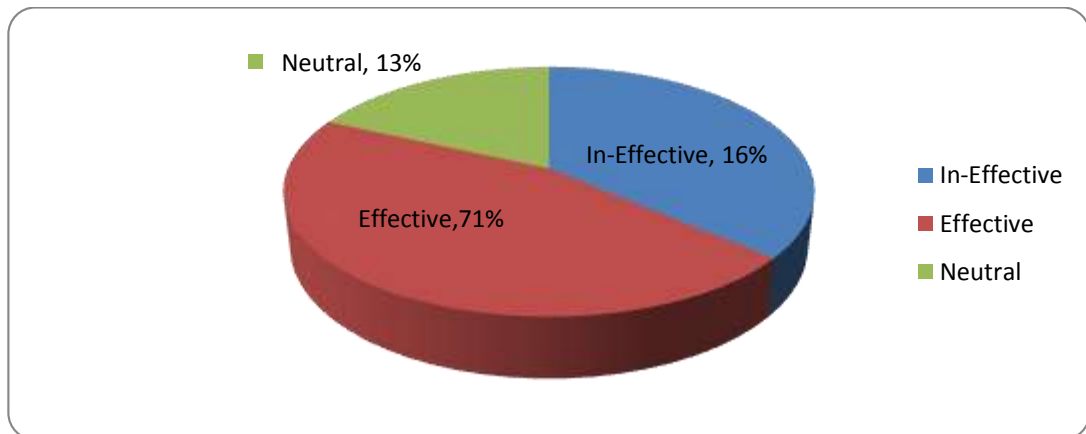


Figure 4.7 Circumcision and HIV/AIDS

Source: (Field data 2013)

The younger generations were aware of this; 77.8% among 18 to 20 years which reduces to 76.5% among 21 to 30 years, 69.4% among 31 to 40 years and finally 66.7% among 41 and above. In addition, on the education front, awareness was higher among college and university educated at 77.1% and 70% respectively as that among primary school level was 58.3%.

Table 4.11: Male circumcision without condoms reduce chances of infection

		Age Category				Education Level		
		18 - 20	21 - 30	31 - 40	41 +	Secondary	College	University
Male circumcision without condoms reduce chances of getting HIV/AIDS	DK	-	17.6%	16.7%	6.7%	25.0%	11.4%	10.0%
	Fact	77.8%	76.5%	69.4%	66.7%	58.3%	77.1%	70.0%
	Fiction	22.2%	5.9%	13.9%	26.7%	16.7%	11.4%	20.0%

Source: (Field data 2013)

Using condoms and using condoms appropriately are two different ideas when it comes to reducing the spread of HIV/AIDS. The good news was that a good percentage of 84% understood that condoms did not ensure safety in instances where they leak or burst while 13% believed that condoms were 100% safe as 3% did not have an opinion on this.

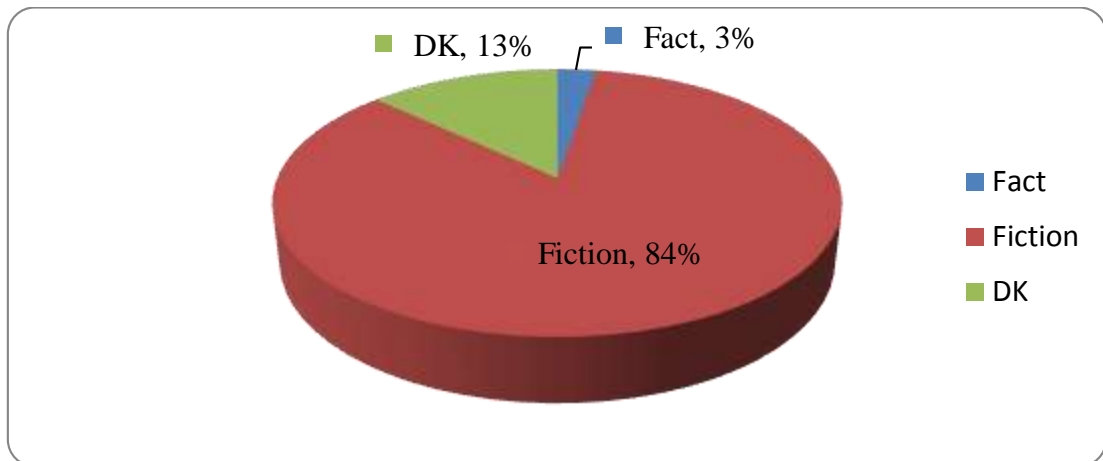


Figure 4.8: One can get HIV from having sex with a condom with someone who is infected with HIV

Source: (Field data 2013)

A close look revealed that all the respondents aged between 18 to 20 years were aware that there were instances where one can get HIV/AIDS even after using a condom, 23.5% of those aged 21 to 30 believe condoms were full proof. Majority of college educated respondents believed that condoms were safe, 91.4% of secondary level respondents trail at 66.7%. “Yes, condoms can burst or leak. Some are also below standard; we are in the china age....” said a 28 year old male university graduate.

Table 4.12 : Window period

		Age Category				Education Level		
		18 - 20	21 - 30	31 - 40	41 +	Secondary	College	University
One can get HIV from having sex with a condom with someone who is infected with HIV	DK	-	-		13.3	16.7%		2.6%
	Fact	100.0 %	76.5%	88.9%	73.3%	66.7%	91.4%	84.4%
	Fiction	-	23.5%	11.1%	13.3%	16.7%	8.6%	13.0%

Source: (Field data 2013)

Out of the respondents that I sampled, 90% of them were aware that window period is the time it takes before one is able to detect HIV/AIDS through testing, 4% of them believed that this was the time one takes to die from HIV/AIDS. 6% did not have an opinion.

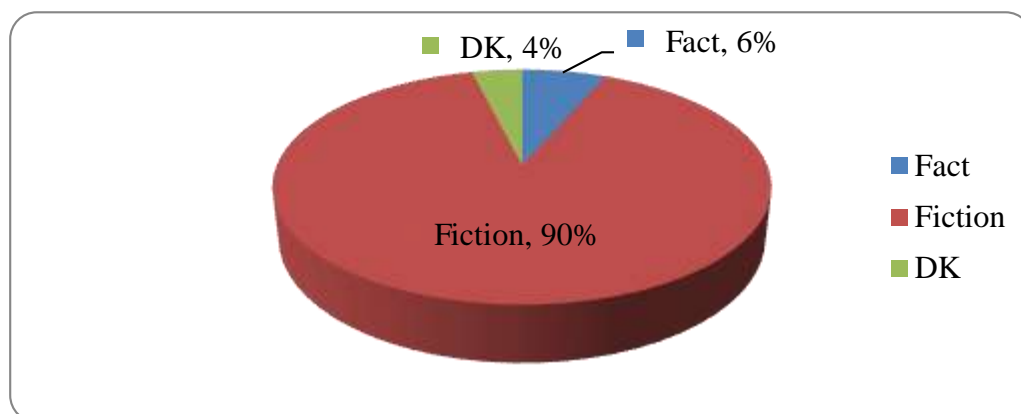


Figure 4.9: Window period

Source: (Field data 2013)

Similarly, the value of education was observed that the more educated were aware of the window period. The middle ages of between 21 and 30 also seemed more informed than their counterparts.

Table 4.13: Live Positive Segment

		Education Level		
		Secondary	College	University
The window period is the time it takes before you detect HIV through testing	DK	-	2.9%	13.3%
	Fact	83.3%	97.1%	83.3%
	Fiction	16.7%	-	3.3%

Source: (Field data 2013)

4.4 Live Positive Segment

From my survey, 66% of the respondents strongly disagreed that one should not be worried about becoming positive since there are new drugs that can heal AIDS, as 23% Disagreed and the other 10% remained neutral. Even though catching HIV/AIDS is not the end of everything, they believed that there are actually drugs that completely heal AIDS could have put them off.

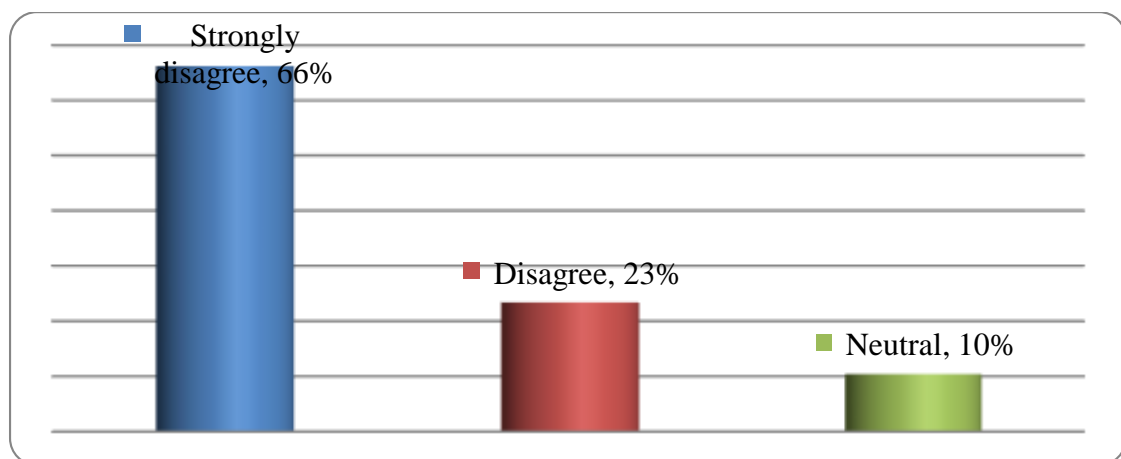


Figure 4.10: One should not be worried about becoming positive since there are new drugs that can heal HIV/AIDS

Source: (Field data 2013)

The married seemed to be stronger on this with 67.9% of them strongly disagreed compared to 55.6% of the single employees. 83.3% of the widowed/divorced also had a strong opinion on this. Looking at gender, females strongly disagreed at 72.7% compared to the males at 61.4%.

Table 4.14: Campaigns

	Marital Status			Gender		
	Single	Married	Other i.e. Widowed/ Divorced	Male	Female	
One should not be worried about becoming positive since there are new drugs that can heal HIV/AIDS	Strongly disagree	55.6%	67.9%	83.3%	61.4%	72.7%
	Disagree	38.9%	20.8%	-	31.8%	12.1%
	Neutral	5.6%	11.3%	16.7%	6.8%	15.2%

Source: (Field data 2013)

4.4.1 Campaigns on HIV/AIDS

The various campaigns aimed at encouraging informing people that there was life after HIV/AIDS had borne fruits as 40.3% of my respondents strongly disagreed with the perception that one's life is over when they contract HIV/AIDS, 45.5% disagreed as 3% remained neutral. This could be due to advancements in HIV research that has produced drugs that boost immunity among the affected. However, there was still an issue with some 12% who thought that life ends when one gets infected.

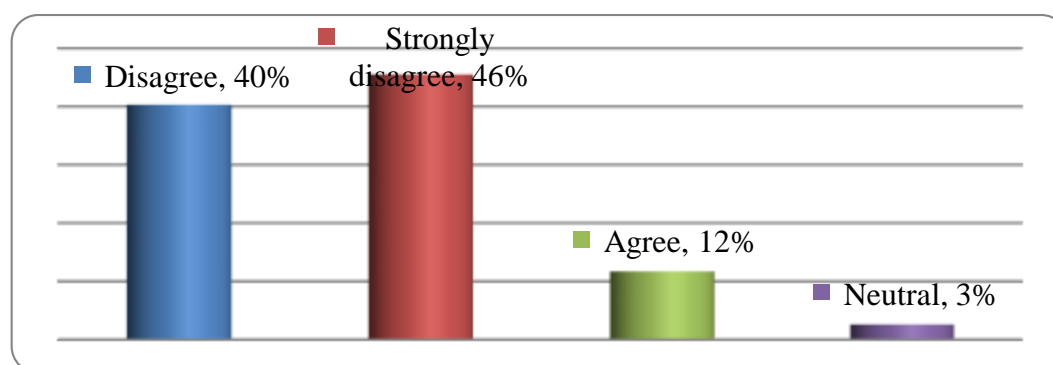


Figure 4.11: One's life is over once they contract HIV/AIDS

Source: (Field data 2013)

The unmarried seemed to be more positive at 61.1% compared to 41.5% for the married and 33.3% of the divorced. The females also tend to strongly disagreed at 51.5% compared to males at 40.9%.

Table 4.15: Safe sex after infection

		Marital Status			Gender	
		Single	Married	Other i.e. Widowed/ Divorced	Male	Female
One's life is over once they contract HIV/AIDS	Strongly disagree	61.1%	41.5%	33.3%	40.9%	51.5%
	Disagree	16.7%	49.1%	33.3%	43.2%	36.4%
	Neutral	11.1%	-	-	2.3	3.0%
	Agree	11.1%	9.4%	33.3%	13.6%	9.1%

Source: (Field data 2013)

4.4.2 Practice of Safe sex after Infection

The need to practice safe sex after infection was supported by a good percentage of my respondents; 61% disagreed that positive partners need not to practice safe sex and 18% strongly disagreeing. There is however needed to take an interest on the 19% who are neutral and the 1% who agreed.

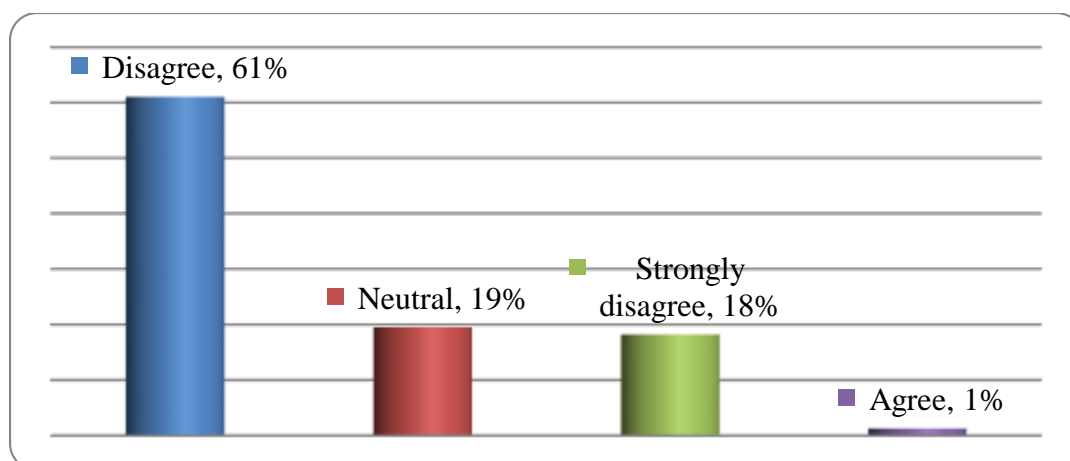


Figure 4.12: If both partners are positive there is no need to practice safer sex

Source: (Field data 2013)

Single respondents still believed in safe sex after infection compared to their married and widowed/divorced counterparts as shown by higher scores at strongly disagreed and disagreed, 27.8% and 55.6% respectively. Males and females equally disagreed based on the top two boxes of strongly agree and agree at 79.5% for males and 78.8% for females.

Table 4.16: Using condom when both partners are infected

		Marital Status			Gender	
				Other i.e. Widowed/ Divorced	Male	Female
		Single	Married			
If both partners are positive there is no need to practice safer sex	Strongly disagree	27.8%	15.1%	16.7%	20.5%	15.2%
	Disagree	55.6%	64.2%	50.0%	59.1%	63.6%
	Neutral	16.7%	18.9%	33.3%	20.5%	18.2%
	Agree	-	1.9%	-	-	3.0%

Source: (Field data 2013)

4.4.3 Use of Condoms to reduce Risk of HIV/AIDs

It was observed that using condoms reduced the risk of acquiring HIV/AIDS. This was widely supported by most of my respondents. 39% of them strongly agreed as another 47% just agree. The respondents without opinion on this were 5%, mostly married females. The other lot comprised of those who disagreed at 4% and those who strongly disagreed at 5%.

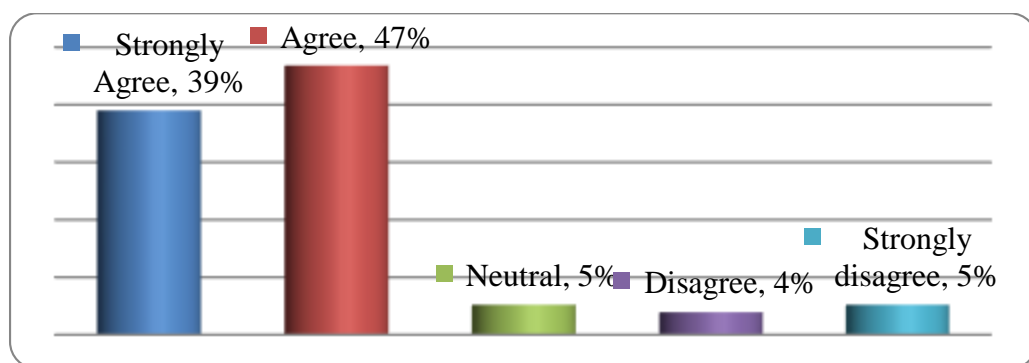


Figure 4.13: Using condoms reduces one's risk of getting HIV/AIDS

Source: (Field data 2013)

More of the single respondents supported this conception compared to the others. 61% of them strongly agreed, this compared to only 34% of the married who strongly agreed and 16.7% of the widowed/divorced. In addition, a considerable number of males supported this perception with 40.9% strongly agreed as 50% agree compared to 36.4% of the females who strongly agree and 42.4% who agreed.

Table 4.17: Scope and Awareness

		Marital Status			Gender	
		Single	Married	Other i.e. Widowed/ Divorced	Male	Female
Using condoms reduces one's risk of getting HIV/AIDS	Strongly disagree	-	5.7%	16.7%	2.3%	9.1%
	Disagree		5.7%	-	4.5%	3.0%
	Neutral	5.6%	3.8%	16.7%	2.3%	9.1%
	Agree	33.3%	50.9%	50.0%	50.0%	42.4%
	Strongly Agree	61.1%	34.0%	16.7%	40.9%	36.4%

Source: (Field data 2013)

4.5 Scope and Awareness of Behavior Change Communication

From the results shown, only 45% of the respondents had attended training/session/seminar on HIV/AIDS, 55% had not.

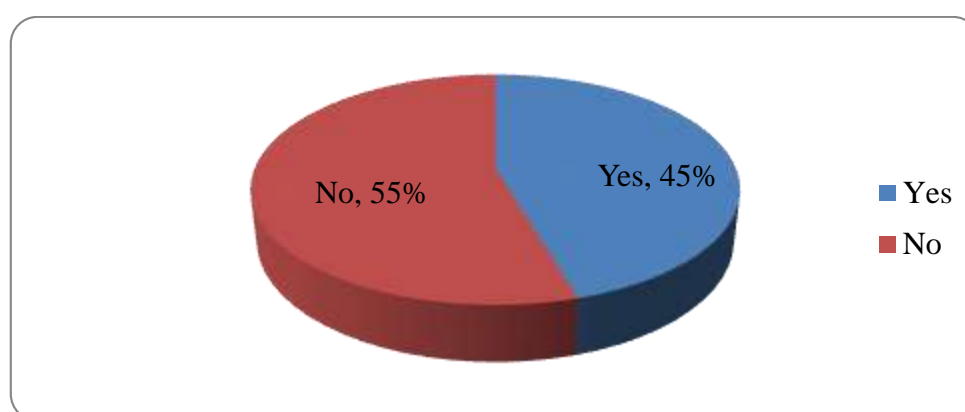


Figure 4.74: Attendance of a training/seminar on HIV/AIDS

Source: (Field data 2013)

Profiling by marriage revealed that more of the unmarried (61%) had attended such sessions as only 42% of the married respondents had attended. Only 33% of those

divorced had attended. Again, most of the younger respondents had attended, 67% of them compared to 41%, 42% and 47% respectively for the ages 21 to 30, 31 to 40 and above 41 years. More educated respondents were also seen to have attended such seminars; 51% for college leavers and 47% of university leavers compared to only 25% of primary school leavers.

Table 4.18: Attendance of a training/seminar on HIV/AIDS

	D1. Marital Status			D2. Age Category				D3. Education Level		
	Single	Married	Others i.e. Widowed / Divorced	18 - 20	21 - 30	31 - 40	41 +	Secondary	College	University
Yes	61%	42%	33%	67%	41%	42%	47%	25%	51%	47%
No	39%	58%	67%	33%	59%	58%	53%	75%	49%	53%

Source: (Field data 2013)

4.5.1 HIV/AIDS Status

While assessing the proportion of the respondents who knew their HIV/AIDS status, 47% admitted to knowing while 53% did not know.

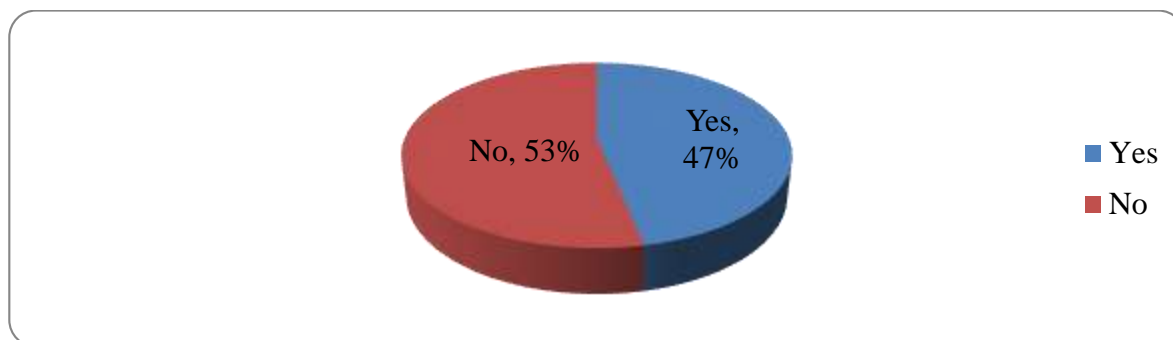


Figure 4.15: HIV/AIDS Status

Source: (Field data 2013)

It was evident that the married did not to know their status compared to unmarried maybe because of trust between them, 61.1% of the single compared to the 41.5% of the married. Within the age category, respondents aged between 18 and 20 years lead in terms of knowledge of their HIV/AIDS status at 66.7% as those between 21 to 30 years trail at 41.2%.

Table 4.19: HIV/AIDS status

			Marital Status			Age Category			
			Single	Married	Others i.e. Widowed/ Divorced	18-20	21-30	31 - 40	41+
Do you know your HIV/AIDS status?	Yes		61.1%	41.5%	50.0%	66.7%	41.2%	44.4%	46.7%
	No		38.9%	58.5%	50.0%	33.3%	58.8%	55.6%	53.3%

Source: (Field data 2013)

From one interview, respondent said; ‘.....*No, I’m scared of what I may find. I would better staying without knowing that if I know....*’. Said a 35 year old male and a university graduate. From my research findings, low productivity due to sickness, increased leave days due to sickness, stigma and discrimination among employees and high cost of insurance for employees were the top four challenges faced by Brookside Dairy Limited as a result of sickness with 42.2%, 34.4%, 26% and 26% mentions by the sampled employees.

4.5.2 Challenges due to HIV/AIDS among employees

From the findings, it was clear that the company experienced some challenges that were related to HIV/AIDS related illnesses. Among the challenges cited are; low productivity, increased leave days or absenteeism, stigma and discrimination of the infected employees, high cost of insurance, loss of staff, increased cost for counseling, training of new employees due to replacement of the departed staff as indicated in figure 4.15.

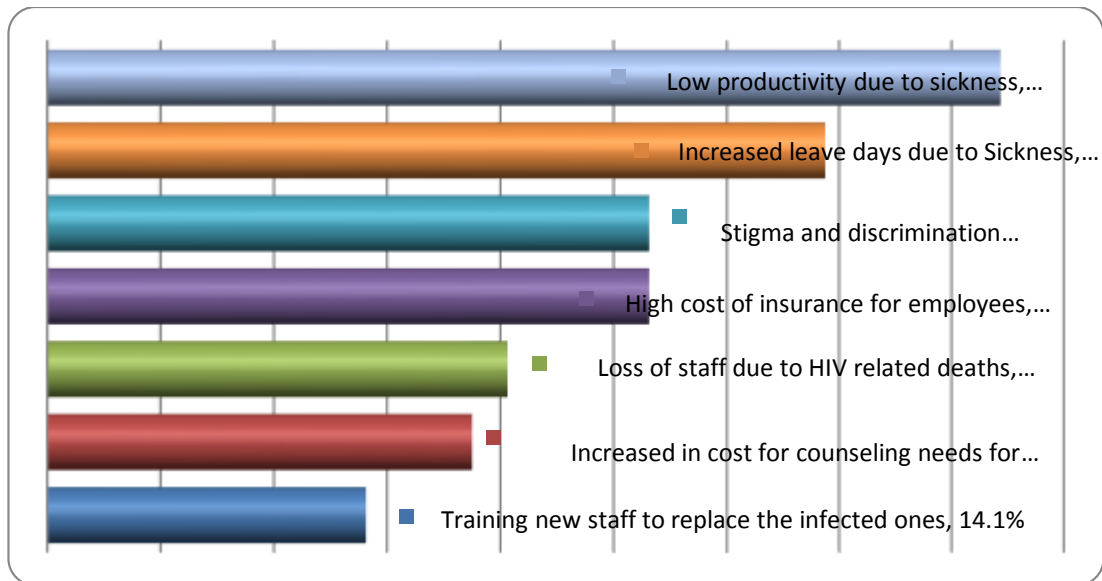


Figure 4.16: Challenges the company undergoes as a result of HIV/AIDS among employees

Source: (Field data 2013)

4.5.3 Policy on HIV/AIDS

As indicated below, 83% of the respondents (employees and General Managers) were aware that Brookside Dairy Limited has a policy on HIV/AIDS as 17% of the respondents were not aware.

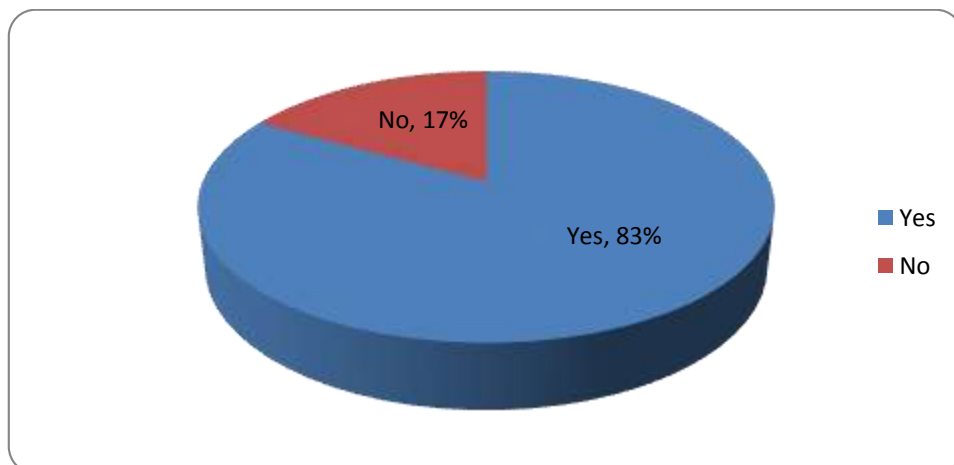


Figure 4.17: Policy on HIV/ AIDS

Source: (Field data 2013)

4.5.4 HIV/AIDS Awareness

When asked how they knew about it, majority mentioned magazines, company website and posters as the places they got to know about it; 78.1%, 76.6% and 68.8% respectively. Very few knew about the AIDS policy through their colleagues.

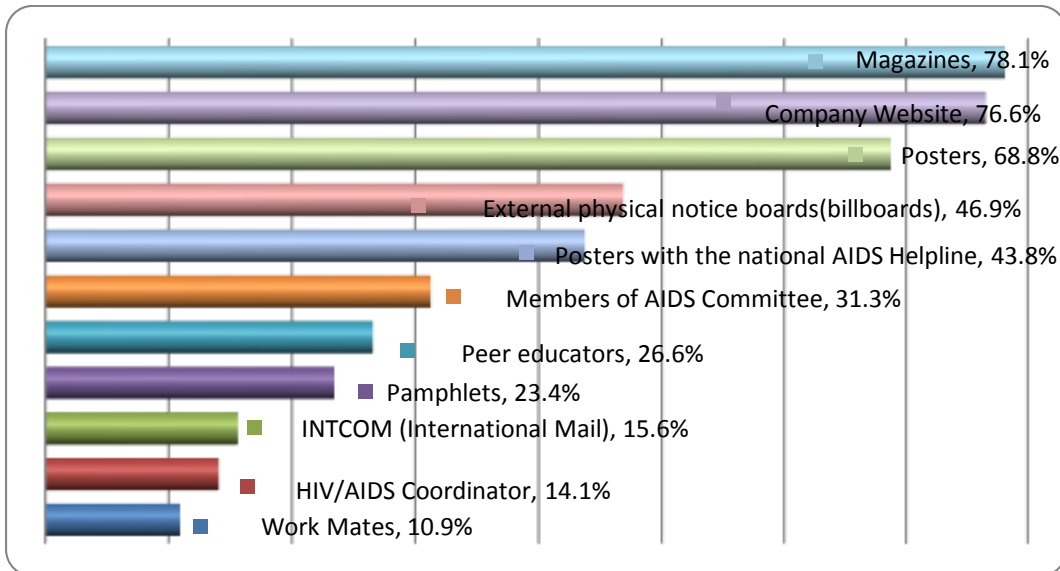


Figure 4.18: Information learnt

Source: (Field data 2013)

When asked if they knew what BCC was about, 21% admitted to knowing while 79% were contrary.

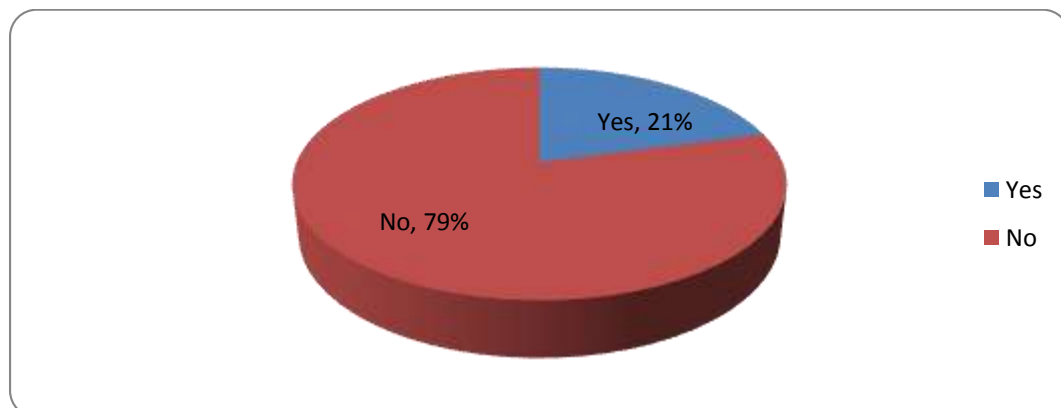


Figure 4.19: BCC awareness

Source: (Field data 2013)

It was also evident that knowledge of BCC was higher among the respondents who had attended seminars, at 25% compared to the 75% among those who had not. Also, there was a higher likelihood that those who know their HIV/AIDS status also knew about Behavior Change Communication.

Table 4.20: BCC awareness

		Have you ever attended a		Do you know your	
		training/ Seminar on		HIV/AIDS status?	
		HIV/AIDS?			
		Yes	No	Yes	No
Do you know about BCC	Yes	25.0%	75.0%	25.0%	75.0%
	No	50.8%	49.2%	52.5%	47.5%
Total (%)		45.5	54.5	46.8	53.2

Source: (Field data 2013)

4.5.5 Sources of Knowledge on BCC

Most of the respondents who said that they knew what BCC was, mentioned print media as the source of their knowledge on BCC; another 76.6% mentioned seminars as 68.8% mentioned television. Minimum information came from interaction with experts 15.5%, websites 14.1% and the HIV/AIDS coordinator 10.9%. Other sources included; through radios, fliers and leaflets, peer education program, social media, magazines, newspapers and other publications.

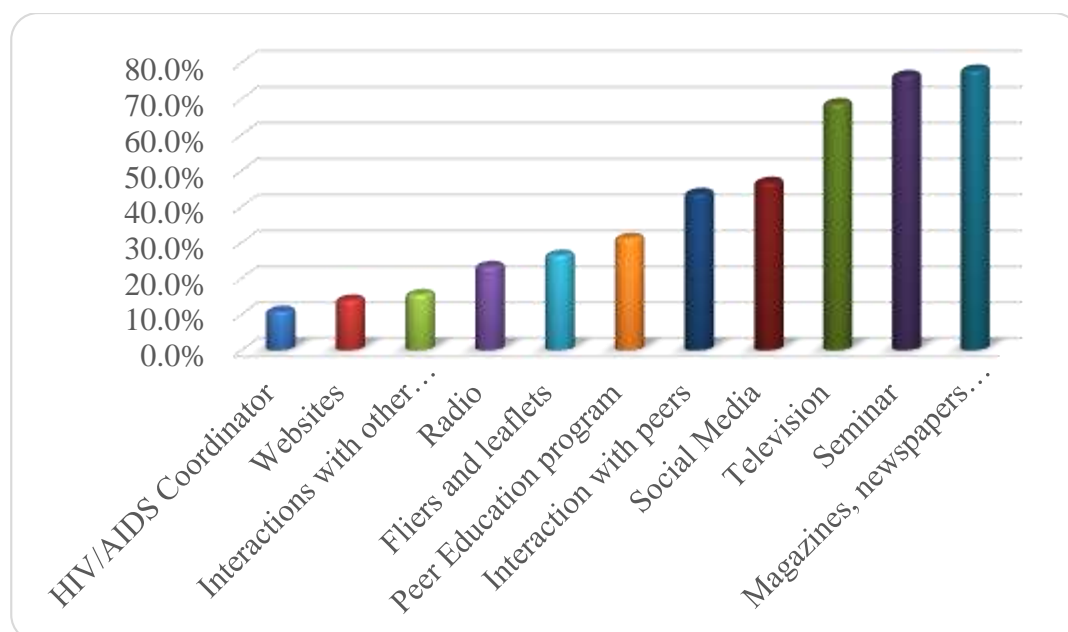


Figure 4.20: Learning about BCC

Source: (Field data 2013)

After being prompted on what BCC was, 55.3% of the identified information dissemination via e-mail as a tool used by Brookside Dairy Limited in its BCC campaign, 48.7% mentioned seminars and trainings, 22.4% mentioned Peer education, 13.2% mentioned counseling services and only 6.6% mentioned formation of discussion or HIV/AIDS groups. 17.1% were still unable to identify any tool of information dissemination.

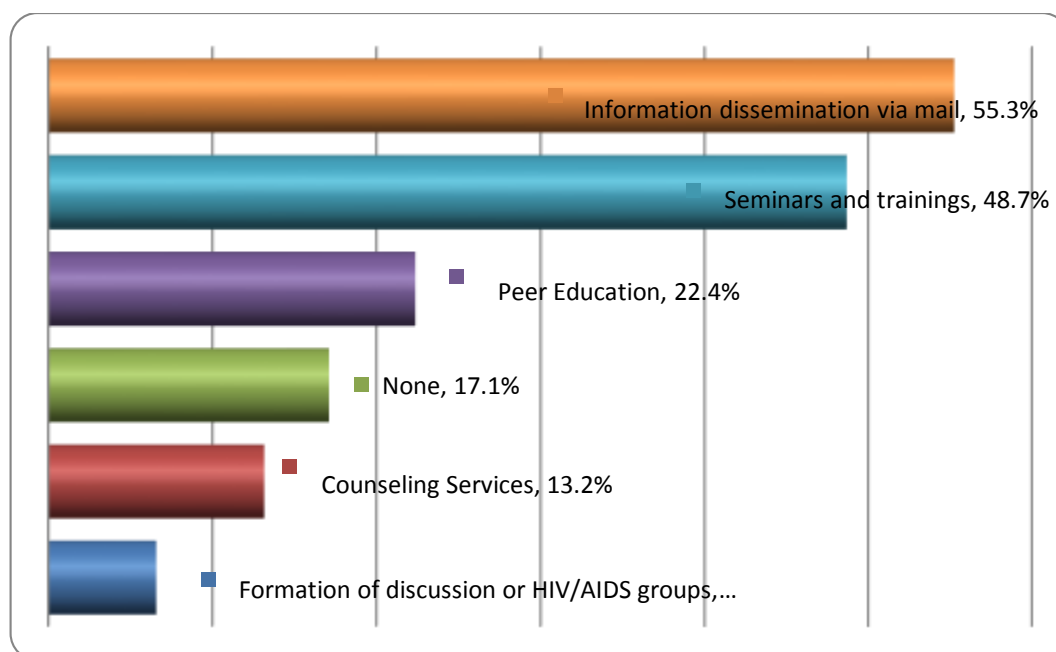


Figure 4.21: Frequency of BCC Programmes at Brookside

Source: (Field data 2013)

Most of my respondents, 36% said that BCC programs are carried out annually, 13% said monthly, 4% said weekly as 1% said they were daily. In addition, 29% said they are irregularly done as 17% said none of such programs are done. When questioned on how BCC programs were tailored, 85.3% mentioned gender, 56% mentioned age as only 34.7% mentioned according to various cadres. 4% said none. Certain employees were shy in the presence of the opposite gender on certain issues.

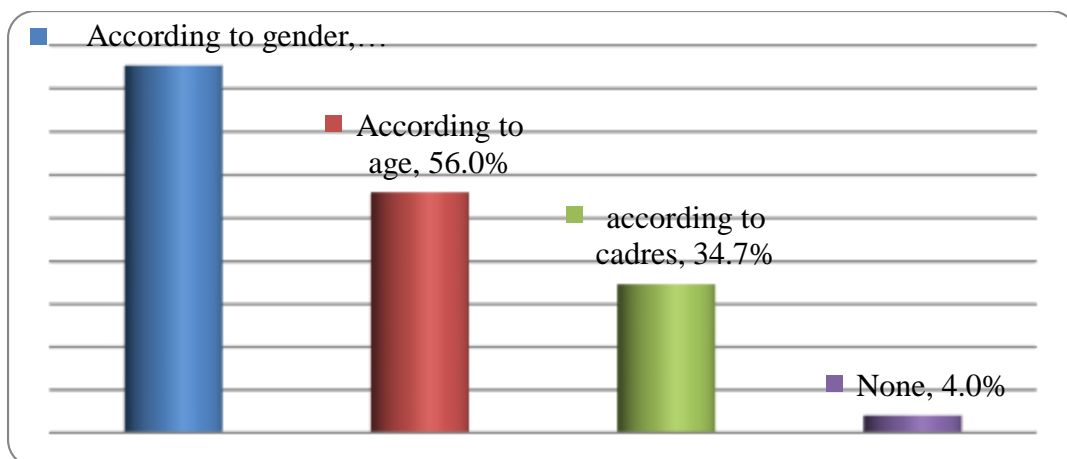


Figure 4.82: Tailoring BCC program

Source: (Field data 2013)

Information, Education and Communication materials at Brookside Dairy Limited are provided from various quarters. When asked about the people who provide them, 81.8% mentioned HIV/AIDS coordinator, 70.1% mentioned peer educators, and 63.6% mentioned members of HIV/AIDS committee as 35.1% mentioned senior management. There were also mentions of other quarters such as immediate director (27.3%) and colleagues at 10.4%.

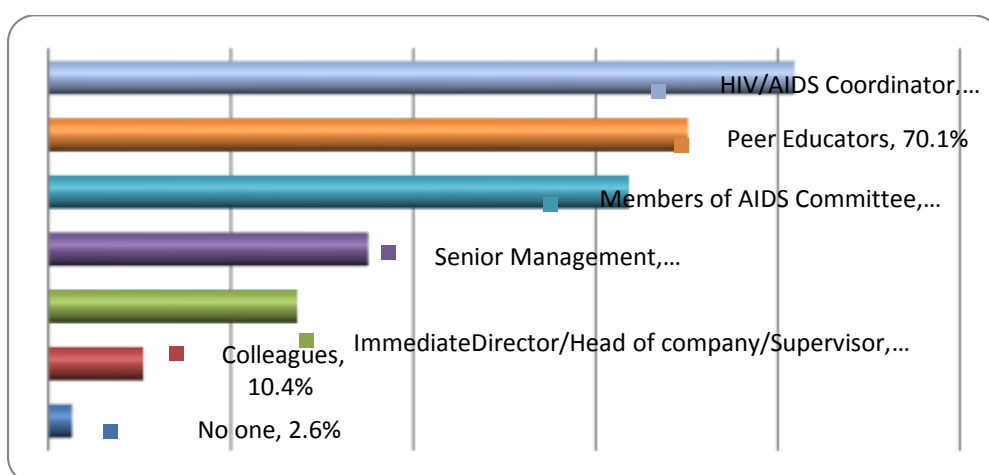


Figure 4.9: Provision of IEC materials

Source: (Field data 2013)

While estimating how often different persons discussed issues related to HIV/AIDS in the past 3 months, I realized that Peer educators were mentioned by 55.2% of the respondents, there was a 47.8% mention of HIV/AIDS coordinator, members of the HIV/AIDS committee were mentioned by 61.2% of the respondents, 43.3% mentioned their colleagues, 10.4% mentioned their immediate supervisors as 14.9% mentioned senior management.

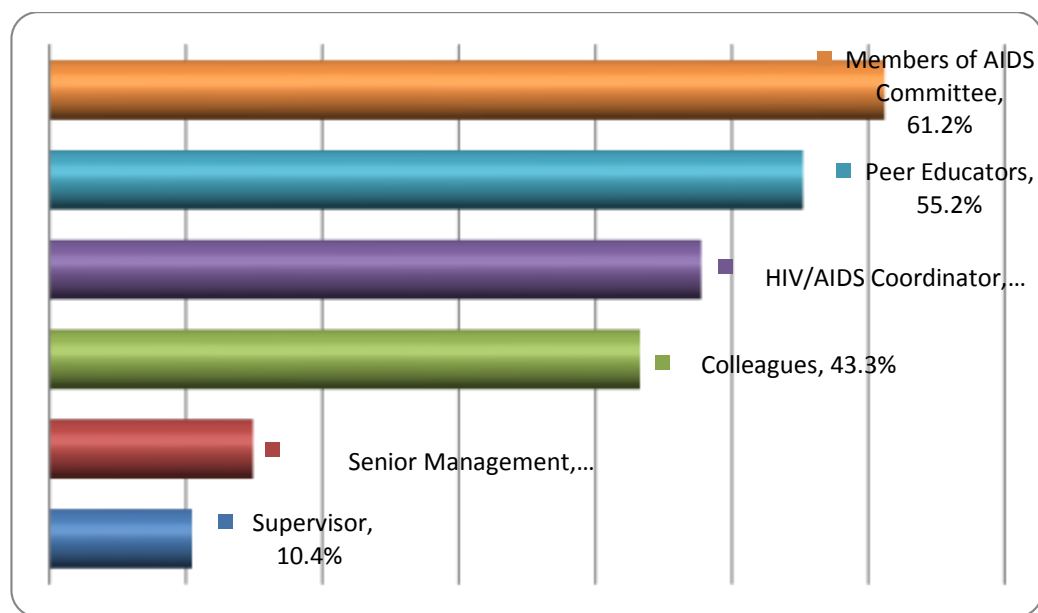


Figure 4.104: Discussion of BCC and HIV/AIDS

Source: (Field data 2013)

4.6 Effectiveness and challenges facing Behavior Change Communication

From the results, 46% believed that the approaches applied by Brookside were effective, 36% of the respondents believed that they are in-effective as 18% were neutral. This is after being informed about BCC.

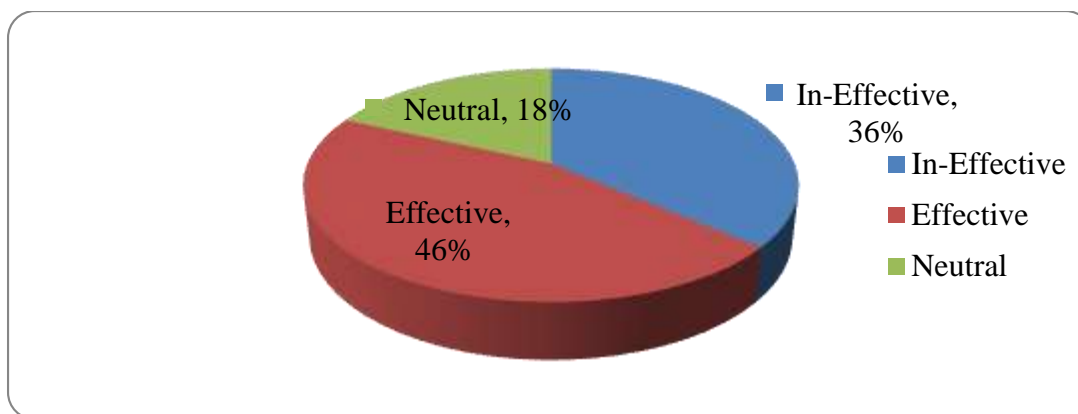


Figure 4.115: Effectiveness of the approach and materials used

Source: (Field data 2013)

4.6.1 Awareness of BCC program

The likelihood of saying that the program is in-effective was higher among those who knew about BCC before being prompted, 60.7% compared to 39.3% for those who did not know about BCC.

Table 4.21: Awareness of BCC program

		Are you aware that your Brookside Dairy Limited has BCC program	
		Yes	No
How effective are BCC programs	In-Effective	60.7%	39.3%
	Effective	57.1%	42.9%
	Neutral	78.6%	21.4%
Total (%)		62.3	37.7

Source: (Field data 2013)

“There are never serious to me it is a total waste of time though it should not. The organizers are disorganized and it’s never fun. We attend just for records and so that the company feels we are supportive” FDG female respondent aged 39.

4.6.2 Benefits of BCC Program

On the benefits that Brookside Dairy Limited had accrued by running BCC, 52.6% mentioned that there has been reduced discrimination to the people who are HIV/AIDS positive, 51.3% mentioned reduced HIV/AIDS related anxiety and stigmatization both at the work place and at community, 48.7% mentioned improved understanding of basic facts about HIV. In addition, 25% mentioned change in behavior, 22.4% mentioned improved attitude towards HIV/AIDS among others.

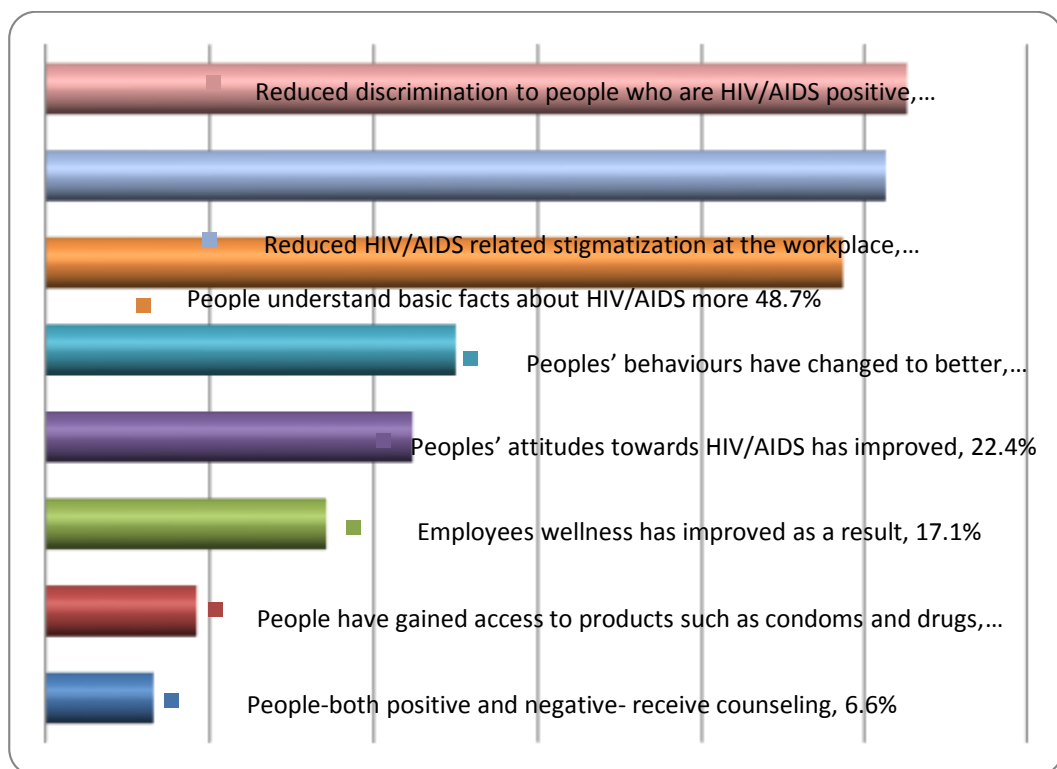


Figure 4.26: Benefits of BCC

Source: (Field data 2013)

4.6.3 Challenges affecting BCC process

With all the gains made so far in terms of BCC program at Brookside Dairy Limited, 70.1% believed that stigmatization was still a challenge, 55.8% believed that the fear of being known to be HIV/AIDS positive was challenge as 51.9% think there was no proper co-operation among employees. Traditions and myths, language barrier and

funding were not seen as major challenges as they were the least mentioned by 10.4%, 10.4% and 9.1% of the respondents respectively.

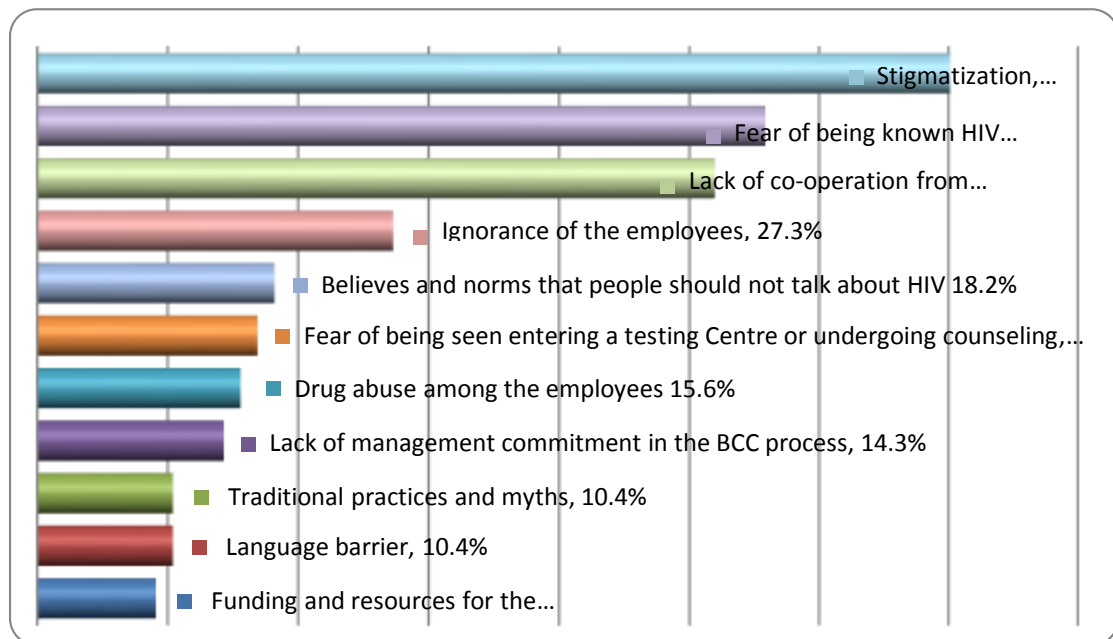


Figure 4.127: Challenges affecting BCC process

Source: (Field data 2013)

4.7 The discussion responses from General Managers and the first aiders

Results under this section were based on the responses given during in-depth interviews with General Managers and first aiders. The following responses were obtained;

4.7.1 General Managers and first aiders knowledge about the company

Most respondents; General Managers and first aiders reported that they have worked for the company for more than five (5) years. Majority of employees were aged between 31 and 40 years while some have worked for less than five (5) years and employees were aged between 18 and 20 years. The respondents were also asked the type of work they do for the company; most of them said that they are middle-level

managers who delegated administrative tasks, leading and directing employees while managers implemented workplace policies.

4.7.2 Entertainment

Majority of respondents revealed that they liked singing, dancing and taking alcohol when they were not busy while the minority liked watching super-sport and movies. The General Managers were also asked about the type of bars they visit frequently. Most of them indicated that they frequently went to bar while some frequently went to restaurants. The respondents later reported that the reason for liking bar was that they relieved job related stress by interacting freely with friends.

4.7.3 Alcohol and drug abuse

The respondents were asked if the company employee's take alcohol and if there were cases of alcohol and drug abuse; majority were in agreement while a few disagreed. They responded that employees poor work performance was attributed by over consumption of alcohol abuse and drug abuse.

Majority of managers sampled revealed that alcohol and drug abuse caused absenteeism, low production and weakened the immune system while others said that alcohol and drug abuse led to poor decision making.

The respondents were asked to give their opinion about the risk of alcohol and drug abuse on HIV. The researcher found out that most of the respondents agreed on the risk of alcohol and drug abuse on HIV as it contributed to further weakening of the body.

4.7.4 Knowledge about HIV/AIDS

The respondents were interview on other factors that exposed them and fellow employees to the risk of HIV/AIDS and sexually transmitted infections. Most of them

reported that the behavior of practicing unsafe sexual intercourse, having sex with more than one sexual partners among colleagues and alcohol and drug abuse, some respondents said needle sharing while and blood transfusion.

They were also asked if they know any people living with HIV/AIDS and if they had any problems living or working together with PLWHA. All respondents agreed that they know their colleagues who are HIV positive. A few respondents agreed that they may have problems with those victims who have persistent skin disorders as a result of the disease. Some employees have disclosed their positive status to the management while stigma and discrimination still affects others.

4.7.5 General Managers and the first aiders response on peer education

The interviewer sought to know if the company had peer educators and their benefits as such the respondents were asked to report if there were peer educators, the activities they carried out and how often they attended peer education meetings.

The general managers' respondents revealed that the first aiders play the role of peer educators in the company. They have acted role models and the management supports by attending the quarterly meetings to provide the management support. Most of respondents were in concurrence that first aiders have model positive employees' behavior, affecting social norms, as well as model constructive relationships between employees and the management enhancing qualities which are all too rare in our workplace.

The other respondent reported that peer educators have made them improve on healthy behaviors, including seeking appropriate health care programs on nutrition and physical fitness exercises to promote wellness.

4.7.6 Other health issues

The respondents were asked if there were other health issues that affected employees in the company most and if they know how HIV/AIDS was spread;

Respondents indicated that employees were more affected by stigma and discrimination that caused depression and anxiety. They all confirmed that they knew how HIV was spread. The other health issues were Tuberculosis, diabetes, high/low blood pressure and these conditions caused stress and therefore the company should continue holding the quarterly meetings and more comprehensive thematic integrated outreaches to include, BMI, reproductive health various cancers, blood pressure and lifestyle diseases.

4.7.7 Measures taken to reduce HIV/AIDS risk

The study sought to know the measures taken to reduce HIV/AIDS risk, how often they use condom and where they get them from. Therefore the respondents were asked about the measures they are taking to reduce the risk of contracting HIV/AIDS. According to the finding most of them consider using condoms during sexual intercourse while some use of clean needle or male circumcision, they also reported that they use condoms every time they have sex and they buy condoms from the shops respectively.

The researcher also sought to know if there were any programs to prevent HIV/AIDS, the activities that were carried out to educate and make employees aware of HIV/AIDS, where they access treatment and care services and who conducts HIV/AIDS activities. Managers sampled indicated that the company had a workplace HIV policy and conducted quarterly thematic integrated outreaches to create HIV/AIDS awareness among the employees. The study also revealed that most of the

employees sought treatment in clinics and hospitals outside the company due to stigma.

4.7.8 Measures taken to minimize risk of contracting other diseases and avoiding stress

The study sought to know the measures taken to minimize risk of contracting other diseases, avoiding stress and how many times they have been absent from work as a result of being ill in the past one year. The majority of respondents emphasized on controlled alcohol intake, attending quarterly meetings to minimize risk of contracting other diseases that contribute adversely to the underlying conditions an individual could be having. Physical fitness exercises organized by the company will help to reduce stress. Team building sessions within the company were said to be a better forum for colleagues to meet and interact at the workplace. They also reported that they have been on sick-off for more than twice in the past one year as a result of being ill, while some twice a year.

The independent analysis is that HIV/AIDS will only be effectively reduced and the wellness of workers in the dairy industry workplaces improved only if there is extensive use of behavior change communication. This was the reason why the study aimed at establishing the effectiveness of behavior change communication campaign messages on HIV/AIDS reduction and employee wellness in the dairy workplace. Information dissemination using the campaign messages will fill the gap of stigmatization and discrimination in the workplace. Myths and stereotypes will be demystified by the information contained in the messages.

While information is power, awareness is key in the workplace. This will be derived from the campaign messages and the channels used for information dissemination.

The more educated and informed the better the employee. This is because of the levels of understanding and access to information dissemination materials that are use for the campaigns against HIV/AIDS.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives the summary, conclusions and recommendations of the study based on the study findings where it compares the researchers' findings against the findings in the literature after which the researcher makes conclusions and recommendations based on the study findings.

5.2 Summary of Research Findings

Employees generally have basic ideas about the spread and prevention of HIV/AIDS. Most of the information was however not being put to its right practice. People prefer taking risks however expensive. That pointed out the need to carryout emotional campaigns that will emphasize to the respondents the need to live and stay healthy. These campaigns should be multiphase in that to the already infected, it tells them the need to live positively; that there is still life after infection. To the uninfected it should convey the message on the importance of living free of the virus. Therefore, caution needs to be taken since such campaigns when not properly communicated can discourage the already affected. Recent developments in the fields of science and medicine that are meant to bring hope are not yet communicated properly, respondents seem mixed up when asked such and those who are aware do not believe them. Adequate education needs to be done through extension services, within all areas of operations.

As can be inferred from the introduction, we observe that it was therefore necessary for a person working with behavior change to understand that one's behavior is determined by three factors. These are personal, social and environmental. Personal factors are knowledge, beliefs on HIV/AIDS, expectations, acceptance and emotional

states. Social factors include partners, friends, family, and the community including social values and social norms. Environmental factors are poverty, social services, mass media and the availability of clinics or hospitals. HIV/AIDS workers have to analyze which of these factors facilitates behavior change and which factors inhibit it. Promoting the supporting factors and reducing the inhibiting factors play an important role in that person's behavior change process. In order to change the attitude and behavior towards STIs and HIV/AIDS, there is a need to talk about sex because the HIV/AIDS epidemic in the dairy workplace was a direct result of unprotected sex. Practicing unsafe sex is not necessarily due to a lack of knowledge or information rather it was a reflection of people's beliefs and values including culture and tradition. HIV/AIDS will only be effectively reduced and the wellness of workers in the dairy industry workplaces improved only if there is extensive use of behavior change communication. This study therefore, has established effectiveness of behavior change communication on HIV/AIDS reduction and employee wellness in the dairy workplace. The risk factors have been identified and discussed accordingly.

Today, new research shows that infidelity has stalled war on AIDS, as researchers we advise that infidelity could reverse the gains of 6.2% deduction already achieved by 2012, reflecting more than half as compared with 14% in 2000 on HIV prevention and management.

5.3 Conclusion

From the analysis, it is important to encourage employees to visit the VCT clinic so that they can know their HIV status without fear. Provision of adequate information dissemination materials that contain BCC campaign messages is paramount. Male circumcision was observed to be necessary to curb infection. The more educated

employees were aware of the HIV/AIDS management. Use of condom to reduce HIV infection risk is significant in reducing the risk of infection.

The challenges revealed by the study indicated that low productivity, increase leave and off duty due to HIV related sicknesses; stigma and discrimination among employees, High cost of insurance and loss of staff due to HIV/AIDS were revealed by the analysis.

About awareness, most of the employees got the information from reading materials like magazines, posters and pamphlets. About 75% got information from the company website. This was found to be encouraging. Learning about BCC, information dissemination through mail and through seminars and trainings were the highest. However, counseling and formation of discussion were low. Provision of IEC materials was mainly done by the members of the first aiders stationed at the workplace clinic and some in the departments.

Benefits of BCC were found to be reduced stigmatization towards the HIV positive employees, understanding the basic facts of the killer disease and improved behavior change. The challenges derived revealed that very few employees received counseling and adequate supply of condoms and medicine. This is because stigmatization was still high at 70.1%. This caused fear of being known to the HIV positive. Lack of cooperation and ignorance were prevalent.

In the past five years, surveys have become an essential tool in informing national HIV and AIDS estimates, and they have an important role to play in shaping policy. Now is the time to dramatically improve their frequency, granularity and precision as the foundation for improved program implementation. The first step is including this strengthened survey function in estimates of the cost of the future HIV and AIDS

response. This is in line with achievement of Vision 2030 and the millennium development goal as we get close to the target time of 2015.

This conclusion opens room for further studies by other researchers who may be interested in behavior change communication and HIV risk reduction by conducting extensive awareness campaigns addressing why approximately half of the people living with HIV are unaware of their status. This could be due to ignorance and fear of the unknown whose price is costly. Numerous research studies have been carried out by various scholars and conferences addressing this issue in terms of achievements towards a HIV free society.

5.4 Recommendations

From the respondents' front, a comprehensive workplace program needs to be developed at Brookside Kenya Limited, at Ruiru in Kiambu County. This should highlight and simplify the whole business of Behavior Change Communication and make employees comfortable with it. The first aiders in the organization be trained to become peer educators across all ages and cadres so as to have a holistic and comprehensive scenario. The staff clinic be elevated equipped with testing kits, and a VCT testing unit be restructured to reduce stigma and discrimination so as to cater for voluntary individuals. Below are the roles and the actions to be taken by each of them summarizing the recommendations: The steering committee members that may include; The Human Resources Manager – Chair, Wellness Coordinator – Secretary, Focal Person, Department Representatives (of existing special Committees (Health and safety) and Lead Peer Educators (representatives). However, the specific objectives of the above named committee would include but not limited to ensuring the wellness policy dissemination, take lead in Implementation and reviewing the

program and support the focal person. In addition, a HIV Prevention Officer may be employed whose main objective will be as follows:

To directly oversee the implementation of Community based Evidence Based Interventions (EBI's) including interventions targeting Key Populations. Under the direct supervision of the Program Manager, the HIV Prevention Officer will ensure the successful implementation of Evidence Based Interventions in Brookside Dairy Limited assigned the following key responsibilities; considering that most of the staff here are adequately and for proper communication and respect the person should be an undergraduate Degree or Diploma holder in the Social Sciences / Community Development / Community Health or other relevant discipline. It is also advised that he/she has training in EBIs, Peer Education and Key Population Implementation/Project Management/Community Mobilization.

Screen flash shows similar to the ones in banks can be place along the corridors, halls and conference rooms for every employee to read and become aware of HIV/AIDS dynamics, This will attract attention to employees especially the youth who may not access the written pamphlets, newsletter and leaflets that are found in the staff clinic.

Inclusion of BCC campaign messages in the monthly pay slips will disseminate information to every employee in the dairy workplace and awareness. The youth do not read the written BCC materials, instead, they interact more with their peers in the social media using their mobile phones; like what's app, instagram, twitter, facebook and in the electronic media. This would be a better channel of information dissemination in order to reach the youth.

5.5 Recommendation for Further Studies

As a student researcher, I call upon scholars to join hands in participating in conferences organized by NOPE International conference on peer education, sexuality, HIV & AIDS, The recent theme was “Zero AIDS Now..., Miles and Misses”. I wish to call upon the valuable and indelible participation of all players to contribute to the number 1 agenda of the UNAIDS Strategy 2010 – 2015. Reduction of new HIV infections will be the main focus, albeit other concern areas outlined in both global and national initiatives and strategies. This will also harness efforts that revolve around identifying key priority areas that need fresh focus, situating the AIDS response within the broader social economic development agenda and suggesting sustainability plans for governments and national mechanisms in the overall response. From the grassroots perspective, the conference shares the milestones (miles) made while also examining the missed opportunities (misses) in our response towards Zero AIDS.

I recommend further studies to be carried in the following areas:

- i. The impact of sex education on HIV/AIDS risk reduction.
- ii. The effectiveness of peer education on employee wellness and HIV risk reduction in large and medium-scale workplaces in Kenya. This is a study that can effectively compare organization with peer educators with those without peer educators and the result would prove the significance of peer education in the workplace.

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APPENDICES

Appendix I: Questionnaire

BEHAVIOUR CHANGE COMMUNICATION ON HIV/AIDS RISK REDUCTION IN THE WORKPLACE: A STUDY OF BROOKSIDE DAIRY LIMITED IN RUIRU, KIAMBU COUNTY

I am a student at Moi University undertaking a Master of Science in Communication Studies. As part of my academic work, I am carrying out the research study on ‘Behaviour Change Communication on HIV/AIDS risk reduction in the workplace: A study of Brookside Dairy Limited in Ruiru, Kiambu County’. Kindly provide the information as requested in the questionnaire. The findings will be used solely for the purposes of research and no individual shall be intimidated based on their response. The study results shall be availed to the interested parties upon request.

SECTION A: DEMOGRAPHICS

Marital Status (D1)		Age Category(D2)		Education Level(D3)	
Single	1	18 – 20	1	Primary	1
Married	2	21 – 30	2	Secondary	2
Divorced	3	31 – 40	3	College	3
Windowed	4	41 and above	4	University	4

Gender (D4)	
Male	1
Female	2

SECTION B: ATTITUDES AND BELIEFS OF EMPLOYEES

Q1. Below are statements of fact or fiction about HIV/AIDS. Please indicate fact/fiction for each.

	Description	Fact	Fiction	DK
1	HIV/AIDS can be spread by mere physical contact with an infected person	1	2	0
2	A positive person who is on treatment cannot spread HIV/AIDS	1	2	0
3	One can tell a positive person by simply looking at them	1	2	0
4	Positive elderly male can get cured of AIDS by sleeping with a young female virgin	1	2	0
5	Certain people have developed immunity against the HIV	1	2	0
6	Male circumcision without condoms reduce chances of getting HIV/AIDS	1	2	0
7	One can get HIV from having sex with a condom with someone who is infected with HIV	1	2	0
8	The window period is the time it takes before you detect HIV through testing	1	2	0

Q2. On a scale of 1 to 5: where 1 is strongly disagree and 5 strongly Agree, Please rate the following according to how you agree/disagree with them

	Description	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	One should not be worried about becoming positive since there are new drugs that can heal HIV/AIDS	1	2	3	4	5
2	One's life is over once they contract HIV/AIDS	1	2	3	4	5
3	If both partners are positive there is no need to practice safer sex	1	2	3	4	5
4	Using condoms reduces one's risk of getting HIV/AIDS	1	2	3	4	5

Q3. a) Have you ever attended a training/Session/Seminar on HIV/AIDS?

YES NO

b) Do you know your HIV/AIDS status?

YES NO

Q4. Which of the following challenges does the company undergo as a result of HIV/AIDS among its employees? (Tick as appropriate)

Increased leave days due to Sickness	1
High cost of insurance for employees	2

Loss of staff due to HIV related deaths	3
Increased in cost for counseling needs for employees	4
Low productivity due to sickness	5
Stigma and discrimination among employees	6
Training new staff to replace the infected ones	7

Q5. a) Are you aware that Brookside Dairy Limited has a policy on HIV/AIDS?

YES NO

b) If yes how did you learn about it?

Posters	1
Pamphlets	2
Magazines	3
External physical notice boards(company or billboards)	4
Peer educators	5
Company Website	6
Members of AIDS Committee	7
Posters with the national AIDS Helpline	8
INTCOM (International Mail)	9
HIV/AIDS Coordinator	10
Work Mates	11
Other sources	12

SECTION C: SCOPE AND PROCESS OF BEHAVIOR CHANGE COMMUNICATION

Q6. a) Do you know about Behavior Change Communication?

YES NO

b) Which of the following ways/places did you learn about Behavior Change Communication?

Television	1
Radio	2
Magazines, newspapers and other print media	3
Social Media	4
Fliers and leaflets	5
Seminar	6
Peer Education program	7
Interaction with peers	8
Interactions with other experts	9
Websites	10
HIV/AIDS Coordinator	11
Other(s)	12

c) Are you aware that Brookside Dairy Limited has BCC program

YES NO

Q7. Behavior Change Communication, (BCC), is an approach to behavior change focused on communication. This is to somehow persuade employees to behave in ways that will make their lives safer and healthier in relation to HIV/AIDS.

a) Which BCC campaigns is Brookside Dairy Limited involved in?

Peer Education	1
Seminars and trainings	2
Information dissemination via mail	3
Counseling Services	4
Formation of discussion or HIV/AIDS groups	5
None	6

b) How frequent are such programs?

Daily	1
Weekly	2
Monthly	3
Yearly	4
Irregularly	5
None	6

c) How is the Behavior Change Communication (BCC) program tailored?

According to age	1
According to gender	2
According to cadres	3
None	4

d) Who provides IEC materials in your company?

Senior Management	1
-------------------	---

Immediate Director/Head of Company/Supervisor	2
Colleagues	3
Members of AIDS Committee	4
HIV/AIDS Coordinator	5
Peer Educators	6

Q8. Who among the following persons has discussed BCC and HIV/AIDS in the last three months?

Senior Management	1
Supervisor	2
Colleagues	3
Members of AIDS Committee	4
HIV/AIDS Coordinator	5
Peer Educators	6

Q9. a) On a scale of 1 to 5, please rate the effectiveness of the approach and materials used by your company in reduction of HIV/AIDS and improvement of employees' wellbeing in the workplace

Effective		Neutral	Not Effective	
1	2	3	4	5

b) Why would you say they are effective/Ineffective?

Q10. a) Which of the following would you say are the benefits that have been accrued by your company running BCC?

People understand basic facts about HIV/AIDS more	1
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Peoples' attitudes towards HIV/AIDS has improved	2
People have gained access to appropriate products such as condoms and drugs	3
People-both positive and negative- receive counseling	4
Peoples' behaviors have changed to better	5
Employees wellness has improved as a result	6
Reduced HIV/AIDS related anxiety and stigmatization both at the workplace and in the community	7
Reduced discrimination to people who are HIV/AIDS positive	8

b) In your opinion, what should your company improve so as to ensure such programs benefit the employees more? (Open question)_____

SECTION D: CHALLENGES OF BEHAVIOR COMMUNICATION PROCESS

Q11. Below is a list of challenges affecting BCC process in reduction of HIV/AIDS and improving employee wellness, tick the ones you feel have the most effects.

	Negative effects	Most Negative
a	Stigmatization	1
b	Fear of being known to be HIV/AIDS positive	2
c	Fear of being seen entering a testing Centre or undergoing counseling	3
d	Lack of management commitment in the BCC process	4
e	Drug abuse among the employees	5

f	Language barrier	6
g	Funding and resources for the programs	7
h	Lack of co-operation from the employees	8
i	Traditional practices and myths	9
j	Ignorance of the employees	10
k	Believes and norms that people should not talk openly about HIV issues	11

Thank you for your responses

Appendix II: In-depth interview guide


1. For how long have you worked in this company? What is the average age of most people in the company?
2. What type of work do you do?
3. What form of entertainment do you engage in when you are not working? Which entertainment pubs do you frequent? Why do you like these pubs?
4. Do many employees in this company take alcohol? Are there cases of alcohol and drug abuse? Please explain if yes.
5. In your opinion, what are the negative effects of alcohol and drug use and abuse on the lives of the concerned individuals and the performance of the company? Does this behavior contribute to the risk of HIV? If yes, please explain.
6. What other factors expose you and fellow employees to the risk of HIV/AIDS and sexually transmitted infections? Do you know of any people living with HIV/AIDS?
7. Do you have any problem living or working together with PLWHA? Please explain.
8. Does this company have policy on HIV/AIDS and/or employee wellness? If so what issues does the policy address? How did you learn about the policy?
9. Is there any program to prevent HIV and AIDS among employees in this company? What activities are carried out to educate and make employees aware of HIV/AIDS? Where do they access treatment and care services? Who conducts HIV/AIDS activities?
10. Are there any peer educators in this company? What activities do they carry out? How often do you attend peer education meetings/sessions or participate in other peer education activities per week/month?
11. What would you say have been the benefits of peer education to you and other employees? Have you or others changed their sexual behavior as a result of

peer education activities? Please explain and give examples. (Probe for specific examples of people whose behaviour has changed. If there is no peer education, ask about other HIV/AIDS activities).

12. What are the other health issues that affect employees in this company most? Are these problems addressed? How and by whom?
13. Do you know how HIV is spread? What measures are you as an individual taking to reduce your risk of contracting HIV? How often do you use condoms and where do you find them?
14. What measures are you taking to minimize the risk of contracting other diseases? What do you do to avoid stress and to keep physically fit? How many times have you been absent from work as a result of being ill in the past one year?

Appendix III: Research Clearance Permit

CONDITIONS	
1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.	 REPUBLIC OF KENYA  National Commission for Science, Technology and Innovation RESEARCH CLEARANCE PERMIT Serial No. A 4327 CONDITIONS: see back page
2. Government Officers will not be interviewed without prior appointment.	
3. No questionnaire will be used unless it has been approved.	
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.	
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.	
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.	

<p>THIS IS TO CERTIFY THAT: MS. ELIZABETH WANJIKU MACHIRA of MOI UNIVERSITY, NAIROBI CAMPUS, 0-232 Ruiru, has been permitted to conduct research in Kiambu County</p> <p>on the topic: HEALTH INVESTMENTS FOR HIGHER PRODUCTIVITY AND PROFITABILITY</p> <p>for the period ending: 31st August, 2015</p> <p> Applicant's Signature</p>	<p>Permit No : NACOSTI/P/15/6865/4103 Date Of Issue : 3rd March, 2015 Fee Recieved :Ksh. 1000</p>  <p> Secretary National Commission for Science, Technology & Innovation</p>
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Appendix IV: Research Authorization



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: 254 20 2213471,
2241349, 310571, 2219420
Fax: 254 20 318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote:

9th Floor, Ualili House
Ualili Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref. No:

Date:

3rd March, 2015

NACOSTI/P/15/6865/4103


Elizabeth Wanjiku Machira
Moi University
P.O. Box 3900-30100
ELDORET.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on *“Health investments for higher productivity and profitability”* I am pleased to inform you that you have been authorized to undertake research in **Kiambu County** for a period ending **31st August, 2015**.

You are advised to report to the **County Commissioner and the County Director of Education, Kiambu County** before embarking on the research project.

On completion of the research, you are required to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.


DR. S. K. LANGAT, OGW
FOR: DIRECTOR GENERAL/CEO

Copy to:

The County Commissioner
Kiambu County.

The County Director of Education
Kiambu County.