



# End of Project Evaluation on Comprehensive Workplace Programs (CWPP) Report: APHIA II Coast and Rift Valley, 2010

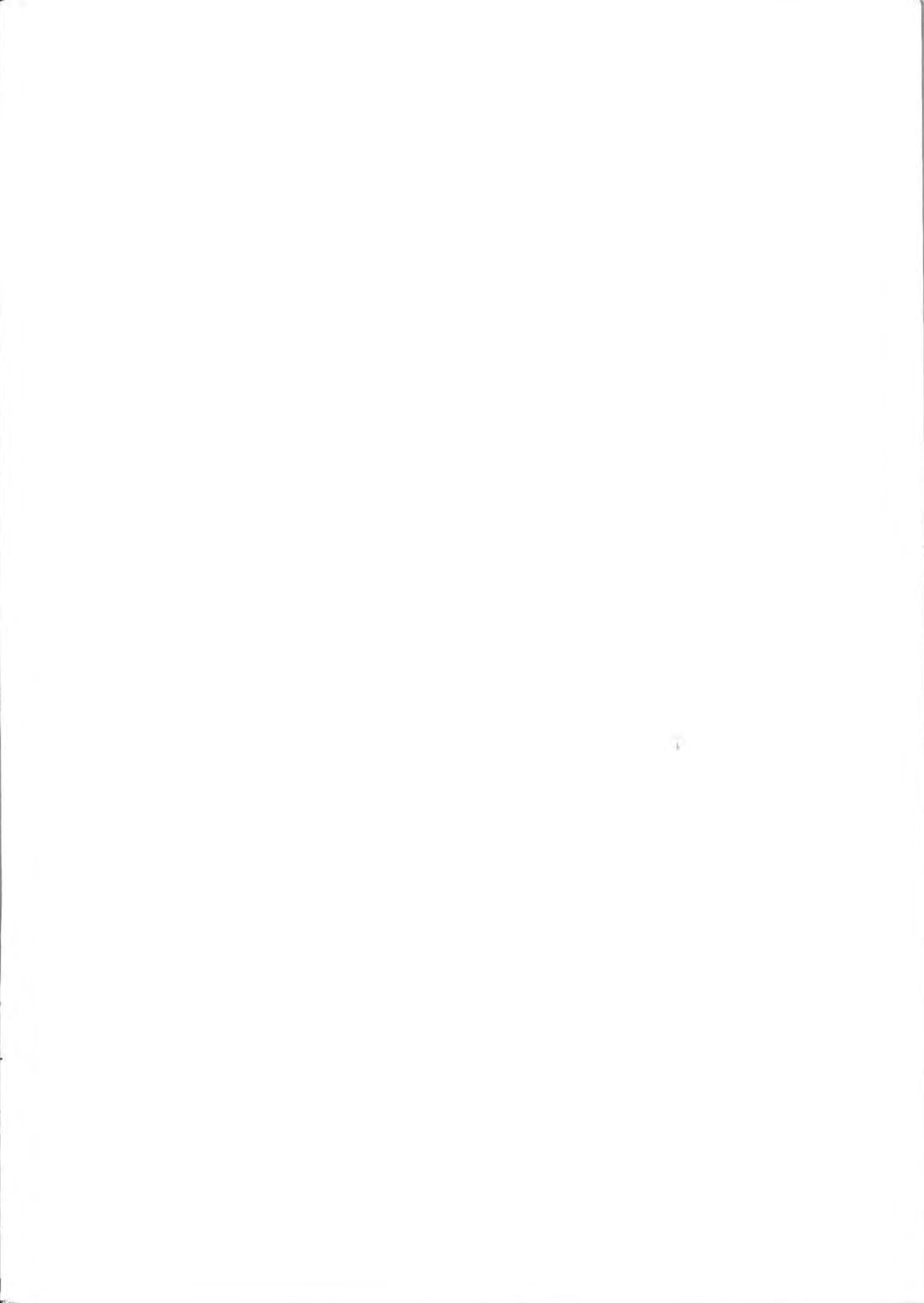
NOPE  
October 2010



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# END OF PROJECT EVALUATION ON COMPREHENSIVE WORKPLACE PROGRAMS (CWPP) REPORT: **APHIA II Coast and Rift Valley, 2010**

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# Contents

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LIST OF TABLES	iv
LIST OF FIGURES	v
FOREWORD	vii
ACKNOWLEDGEMENT	viii
EXECUTIVE SUMMARY	ix
1.0 INTRODUCTION	1
1.1 Background Information	1
1.2 Purpose of Evaluation	2
1.3 Study Objectives	2
1.4 Methodology	3
2.0 WORKPLACE CHARACTERISTICS	4
2.1 Nature of Business Enterprises by Region	4
2.2 Category and Size of Employees	5
3.0 ESTABLISHMENT OF HIV/AIDS WORKPLACE POLICY AND PROGRAMMES	8
3.1 Existence of HIV and AIDS Workplace Policies	8
3.2 HIV and AIDS Interventions Supported by the Organization	8
3.3 HIV and AIDS Capacity Building Activities	10
4.0 PROVISION OF HIV AND REPRODUCTIVE HEALTH CARE SERVICES	13
4.1 Financing of HIV/AIDS Services	13
4.2 Financing of Family Planning Services	18
4.3 Financing of Other Reproductive Health Services	20
4.4 Financing of Child Health Services	21
4.5 Beneficiaries of Health Financing	22
5.0 NON PROVISION OF HIV AND REPRODUCTIVE HEALTH CARE SERVICES	24
5.1 HIV/AIDS Services	24
5.2 Family Planning Services	24
5.3 Other Reproductive Health Services	25

5.4 Child Health Services	25
6.0 PROVISION OF SERVICES IN ON-SITE HEALTH CLINICS	27
6.1 Existence of an On-site Health Clinic	27
6.2 Motivation for establishment of on-site clinic	27
6.3 Employees in On-site health clinic	28
6.4 Laboratory Tests in on- site health clinic	29
6.5 Utilization of HIV/AIDS Service	29
6.6 Status of ARVs provision in Workplace On-site Clinics	30
7.0 STOCKING OF HIV/AIDS-RELATED HEALTH PRODUCTS IN ONSITE CLINICS	33
7.1 Source of Supplies for HIV/AIDS Related products	33
7.2 Stock Run Outs of HIV/AIDS Related Products	35
8.0 CONCLUSION AND RECOMMENDATIONS	38
8.1 Conclusion	38
8.2 Recommendations	41
ANNEXE	42
A1: Number of Employees in Workplace/Institution by Category, economic sector and Region	42
A2: Number of employees who attended training in Rift Valley by type of service	43
A3: Number of employees who attended training in Coast by type of service	44
STUDY QUESTIONNAIRE:	45
REFERENCES	46

# List of Tables

---

Table 2.1 Distribution of Workplace/Institutions by nature of business	4
Table 2.2: Number of employees by business category and province, 2007 and 2010	5
Table 2.3: Number of employees by category and region, 2007 and 2010	6
Table 2.4: Number and percentage distribution of employees by category and business sector	7
Table 3.1: Percentage of workplace/institutions with existing HIV/AIDS workplace policy	8
Table 3.2: Type of support provided by workplace/institutions in Rift Valley	9
Table 3.3: Type of support provided by workplace/institutions in Coast	9
Table 3.4: Number and percentage of employees trained on HIV/AIDS workplace roles	10
Table 3.5: Number of employees who attended training and percentage increases by training type	11
Table 3.6: Outreach activities undertaken by economic sector and province, 2007 and 2010	12
Table 4.1: Financing Mode for workplace/institution for testing and counseling of HIV/AIDS	14
Table 4.2: Proportion of workplaces financing mode of the family planning services	19
Table 4.3: Financing mode of other Reproductive health service	20
Table 4.4: Financing mode of other Reproductive health service	22
Table 6.1: Proportion of workplaces reported in 2007 to have had on -site health clinic	27
Table 6.2: Proportion of companies by motivation for establishment of an on-site health clinic	28
Table 6.3: Proportion of workplaces reporting category of employees in the on-site health clinic	28
Table 6.4 Proportion of workplaces having tests taken in the on-site health clinic	29
Table 6.5 Number of employees who received the HIV/AIDS service by business sector	30
Table 6.6 Reasons for non provision of ARVs in on site health clinics	31
Table 6.7: Proportion of workplaces with on-site clinic monitoring employees ART progress	31
Table 7.1 Proportion of workplaces experiencing stocks run out in the last 12 months	36
A1: Number of employees in workplace/institution by category, economic sector and region	42
A2: Number of employees who attended training in Rift Valley by type of service	43
A3: Number of employees who attended training in Coast by type of service	44

# List of Figures

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Figure 2.1: APHIA II Project Business Enterprises Composition, 2010	4
Figure 2.2: Proportion of employees by business sector and province	5
Figure 2.3: Proportion of employees by gender and economic sector	6
Figure 2.4: Percentage distribution of employees by category of employment and province	7
Figure 3.1: Proportion of workplaces with family and outreach activities in their workplace	12
Figure 4.1: Mode of financing for testing and counseling of HIV/AIDS	13
Figure 4.2: Mode of financing Anti Retro Viral Treatment (ART)	14
Figure 4.3: Mode of financing coordination of home based care for HIV/AIDS	15
Figure 4.4: Workplaces supporting treatment preventing mother to child transmission of HIV/AIDS	15
Figure 4.5: Workplaces mode of financing of adherence in counseling on ARVs	16
Figure 4.6: Proportion of workplaces financing counselling on abstinence	16
Figure 4.7: Proportion of workplaces by financing mode of counselling on being sexually faithful	17
Figure 4.8: Proportion of workplaces financing mode for counseling on alcohol and drug abuse	17
Figure 4.9: Proportion of workplaces by financing mode for counseling on correct condom use	18
Figure 4.10 Proportion of workplaces by categories of employees benefiting from financing of the health services	22
Figure 4.11 Proportion of workplaces by category of family members received financing in health care	23
Figure 5.1: Proportion of workplaces stating reasons for not financing some of the HIV/AIDS services	24
Figure 5.2: Proportion of workplaces stating reasons for not financing some of the Family planning services	25
Figure 5.3: Proportion of workplaces stating reasons for not financing other reproductive health services	25
Figure 5.4: Proportion of workplaces stating reasons for not financing some of the child health services	26
Figure 6.1 Proportion of workplaces with on-site clinic providing ARVs	30
Figure 6.2 Workplaces reporting Clinic ART Statistics to the Government	31
Figure 6.3 Impact of free access to ARVs to clinics ability to provide ART	32

Figure 7.1 Source of ARVs supplies for the onsite health clinic	33
Figure 7.2 Source of HIV test kits supplies for the onsite health clinic	34
Figure 7.3 Source of OI drugs supplies for the onsite health clinic	34
Figure 7.4 Source of TB drugs supplies for the onsite health clinic	35
Figure 7.5 Source Male condom supplies for the onsite health clinic	35

# FOREWORD

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HIV/AIDS epidemic is the greatest public health disaster in the past one two decades. The epidemic already is having a devastating impact on economies and markets, threatening the security and prosperity of our global society. For companies operating in hard-hit regions, HIV/AIDS will have major consequences on profitability and productivity. Kenya AIDS indicator Survey 2007, 1.4 Kenyans is living with HIV attributing to 7.1% with a majority being at employees in various workplaces.

Business not only has a responsibility to act, but an opportunity to play a crucial role in the global fight against the epidemic, particularly within their workplaces. Business can do things faster and more effectively than anyone else and it is in their own interests as well as those of society as a whole, that the APHIA II Coast and Rift Valley provinces implemented a four year Comprehensive Workplace Program and Policy (CWPP) in the two regions. The project aimed at strengthening the internal capacity of worksites to design, manage and implement innovative comprehensive workplace programs.

A healthy workforce determines productivity in terms of profit as well as social responsibility. The APHIA II project through the support of United States Agency for International Development (USAID) implemented a Comprehensive Work Place Program in various sectors to improve universal access to HIV/AIDS prevention care and treatment services, Tuberculosis, Malaria, Maternal Child Health (MCH), Family Planning (FP) and general health care.

At the end of the project implementation phase, an end term evaluation was carried out by National Organization of Peer Educators (NOPE) as part of its technical support monitoring and evaluation of interventions implemented over the past four years. The evaluation has established that companies are at impressive stages with respect to engagement on CWPP. A majority have taken action on a multiple of fronts to address the health of their workforce. Of importance to note is that of all the workplaces that were evaluated, over ninety percent had embraced the program. This is over forty percent increase as at baseline in 2007.

It is our sincere hope that this report will be a useful resource for individuals, companies, donors and government ministries in the implementation of the CWPP strategy.

*PETER MWAROGO*

**Peter Mwarogo**  
**Country Director**  
**APHIA II Coast and RIFT VALLEY**

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We thank Dr. Frank Mwangemi, Deputy Director APHIA II Coast and Ruth Odhiambo, Deputy Director APHIA II Rift Valley for diligently supporting the prevention technical teams during the End of APHIA II 2010 Evaluation on Comprehensive Workplace Policies and Programs.

APHIA II Coast and Rift Valley would like to acknowledge the following people who played a central role in the developing of the End of APHIA II Project 2010 Evaluation on Comprehensive Workplace Policies and Programs (CWPP); Mary Oruko, Program Manager Workplace, Oby Obyerodhyambo and John Ndiritu, Technical Advisors who prepared the concept on end of project 2010 APHIA II Evaluation on Comprehensive Workplace Policies and Programs.

This end term evaluation could not have been completed without the assistance of various individuals. Special thanks go to Mr. Philip Waweru, NOPE Executive Director for his insightful thoughts during the whole process.

Special thanks go to Filberts Oluoch (Coast) and Margaret Kabue (Rift Valley) for supervising and coordinating the data collection exercise in respective provinces. We are indebted to the data collection teams (Carol Rachier, Bevaline Odera, Maurine Achieng, Sophie Wangari, Bob Mulusa, Julian Onyango, Daniel Mudibo, Alex Masika, Willis Ogutu, Ian Kinyanjui and Suki Nyadawa) who worked tirelessly to ensure that data was collected from all the workplaces. We recognize the contribution by the data analysis team; Linda Muyumbu, Charles Obiero-Statistician consultant, Mary Nduta, Mary Kuiru, Jacqueline Kwamboka and Happiness Rebecca for their contribution during the data analysis process.

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Last but not least, we wish to thank Peter Njuguna of NOPE and Sunburst Communication Graphics designers for layout and printing this 2011 Evaluation Report.

# EXECUTIVE SUMMARY

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The assessment study was carried out in APHIA II project business enterprise workplaces for Coast and Rift Valley provinces as an end of project evaluation. A total of 36.4 percent of the enterprises were from the agriculture sector, 28.6 percent, goods/services, 20.8 percent, manufacturing and 14.3 percent, hotel and tour industry. The combined workforce of the workplaces was 133,396 employees involving 79 workplaces from Coast and Rift Valley province. The fulltime management/administrative accounted for 6.8 percent of The employees at APHIA II project partner work sites while 21.8 percent were full time unskilled production employees.

Comprehensive workplace policy and programs was established in 90.9 percent of the business workplaces by 2010 as compared to 50.9 percent in 2007. This implies that the APHIA II project succeeded in mainstreaming the HIV/AIDS workplace policies in the business enterprises. A 100 percent CWPP support was recorded on; condom promotion and distribution, IEC materials and referral for treatment and other care and support materials.

Capacity building activities were carried out targeting all the levels of employees. This included management sensitization that covered 800 employees drawn from Coast and Rift Valley provinces (50.4 percent and 49.8 percent). Also, program design and implementation benefited a total of 2,261 employees. In essence, employees were taken through a series of trainings on specific areas of the CWPP targeting between 55,479 employees from Rift valley and 26,034 employees from Coast. A total of 86.1 percent of the workplaces supported family and community outreach activities.

The Modes of financing HIV/AIDS service provision in the workplaces ranged from onsite clinic, private insurance, reimbursement to employees, and contract with NGO. The modes also included contract with private profit making health service providers (Private Health Facilities) and employee contributory funds. Workplaces financing testing and counseling of HIV/AIDS increased from 44.8 percent in 2007 to 83.5 percent in 2010. A total of 47 percent reported financing mode for testing and counseling of HIV/AIDS is through on site clinic. Provision of ARTs to employees increased from 44.6 percent in 2007 to 68.4 percent in 2010. Home based care of HIV/AIDS increased from 44.8 percent in 2007 to 53.2 percent in 2010. Treatment for prevention of mother to child transmission of HIV/AIDS rose from 64.1 percent to 75.9 percent. However, adherence counseling on ARVs support declined from 57.1 percent to 27.8 percent. Counseling on alcohol and drug abuse rose from 48.2 percent to 82.9 percent while counseling on alcohol drug abuse rose from 48.2 percent in 2007 to 82.9 percent in 2010. A total of 29.3 percent and 14.1 percent of the workplaces supported counseling on correct condom use in 2007 and 2010 respectively.

Only 12.7 percent of the workplaces did not finance provision of male condoms in 2010 compared to 33.9 percent in 2007. In the same period, provision for pills rose from 25.1 percent to 72.2 percent. Injectables, implants, tubal ligation recorded an increase, accounting for 72.2 percent, 58.2 percent and 45.6 percent respectively of the workplaces. The Workplaces not providing IUCD/IUD increased from 41.4 percent to 69.6 percent and conversely vasectomy provision declined from 75 percent in 2007 to 53.2 percent in 2010.

Workplaces not supporting STI diagnosis and treatment services declined from 52.7 percent in 2007 to 16.7 percent in 2010. The same scenario was replicated with ante natal care services from 56.4 percent to 16.7 percent. Labor and delivery services rose to 64.6 percent in 2010; post partum care improved; pap smear services declined to 36.7 percent; and mammogram services

to 36.7 percent. Child health care services improved from 47.3 percent in 2007 to between 67.2 percent and 72.2 percent.

Workplaces not paying for health services declined from 26.7 percent to 17.6 percent. Majority of the workplaces finance health services for fulltime, management/administrative staff at 85.2 percent. Only 49.4 percent of the workplaces reported to be financing seasonal employees up from 26.7 percent. Health service financing for the spouse and children remained nearly the same; from 64.7 percent to 63.3 percent and 63.5 percent to 60.8 percent respectively. There was improvement in support for adopted children and orphans increasing by 7.8 percent and 13.8 percent.

Availability of free government service on HIV/AIDS services (79.5 percent of workplaces) was main reason for not providing the service. Other reasons mentioned are; too expensive and low utilization. Workplaces not offering family planning services declined from 15.7 percent to 8.7 percent. Reasons for not providing the family planning services were; Free government service accounted for 59.6 percent, expensive (22.0 percent). Also, other reproductive health services and child health services were not provided due to being too expensive ( 25.6 percent and 16.9 percent) and availability of free government services(59.7 percent and 57.1 percent).

A total of 56.9 percent of the workplaces (37.5 percent in Rift valley and 19.4 percent in Coast) established an onsite health clinic. The motivation for the establishment was given as; employee demand (64.3 percent), staff retention (50.0 percent) and lack of health facilities in the community (40.5 percent). Other reasons were to reduce medical expenses (25.0 percent) and inherited service after government privatization (4.9 percent). Analysis further shows that 53.4 percent of the employees are full time permanent nurses while 23.0 percent are full time permanent physicians. Laboratory tests were carried out in the onsite clinics; 42.5 percent of workplaces carried out HIV testing tests, Basic hematology, 21.9 percent, Blood chemistry tests, 19.2 percent. CD4 counts hematology tests, 8.2 percent, Viral load test, 4.1 percent and culture tests, 13.7 percent. Information on service utilization was provided with a total 24,987 were counseled on correct condom use, 14,428 employees were provided with HIV/AIDS testing and counseling, 10,637 counseling on being sexually faithful and 8,420 counseling on abstinence.

The proportion of workplaces providing ARVs in the onsite clinic rose marginally from 13.8 percent to 14.0 percent. Most workplaces (72.5 percent) with onsite clinics stated that they did not provide ARVs since it is available free from the Government. Other reasons given were; lack of access to supplies (17.5 percent) and limitation of national regulation (20.0 percent). Monitoring of employees ART progress was reported at onsite clinic (41.9 percent), refer to government facility (83.7 percent) and refer to private clinic (32.6 percent). Only 42.0 percent of the workplaces with onsite clinics reported ART statistics to the government. About 46.3 percent of the workplaces reported that free government access improved its ability, 19.5 percent stated no impact on ability while only 2.4 percent stated reduced ability.

Onsite health clinics relied on supplies from the government, NGOs and private for profit organizations. The main supplier for ARVs to the clinics was the government (53.5 percent) and NGOs (16.3 percent) an improvement from 23.1 percent and 30.8 percent. Government free access policy resulted in fewer workplaces relying on private health facilities, declining from 15.4 percent to 2.3 percent. The Government was the highest supplier for HIV/AIDS test kits (72.1 percent), Opportunistic infections drugs (67.4 percent), Tuberculosis drugs (74.4 percent) and male condoms (90.0 percent). Cases of stock run out was lower in 2010 as compared to 2007, depicting that the workplaces were more prepared in ensuring stock adequacy. Some of the cases of stock run out were antibiotics (27.9 percent), male condoms (25.6 percent), malaria drug (23.3 percent), implants (16.3 percent), OI drugs (16.3 percent) and HIV test kits (14.0 percent). A serious concern is lack of TB drugs and ARVs as reported by 5.0 percent and 2.3 percent of the onsite health clinics.

# 1.0 INTRODUCTION

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## 1.1 Background Information

The AIDS, Population, and Health Integrated Assistance Program (APHIA II) was initiated to provide HIV/AIDS and Tuberculosis (TB) prevention, treatment, care and support and to a lesser extent, reproductive health/family planning (RH/PF), malaria, and maternal and child health (MCH) services. APHIA II is a program funded by the United States Agency for International Development (USAID) Bureau for Africa.

In Kenya, APHIA II covered all the provinces with different strategic partners having specific mandates during implementation. The APHIA II project team in the Coast and Rift Valley is led by Family Health International (FHI). Other strategic partners in APHIA II Coast and Rift Valley provinces include: the Cooperative League of USA (CLUSA), whose primary responsibility is to support community mobilization and establish linkages between the community and health facilities; Catholic Relief Services (CRS), which leads in care and support, home-based care and orphans and vulnerable children; JHPIEGO, which facilitates health service integration and training; Social Impact, Inc., which is charged with the responsibility of ensuring organizational and human capacity development among the implementing partners; National Organization of Peer Educators (NOPE) which assists in the implementation of peer education programs in workplaces and among youth and community groups; and World Vision, whose primary responsibility is orphans and vulnerable children in Rift Valley province.

The target of APHIA II was to create decentralized and integrated networks for prevention, care and treatment services. These networks were set up to strengthen and link existing programs and resources in the public and private sectors and among faith and community-based organizations. NOPE's role is to offer technical support in workplace program at private and public sectors for effective implementation and innovation of comprehensive workplace policy programs (CWPP).

Since 2008, the public and private sector enterprises have implemented HIV/AIDS workplaces strategies with support from the various strategic partners. The areas of support include: program formulation and coordination, prevention; treatment; care and support among others. The overall goal of the workplace strategy in APHIA II project was to ensure prevention of HIV infection among employees through provision of information, education, condom promotion and distribution, improved access to sexually transmitted infections (STI) prevention and treatment, and voluntary counseling and testing and access to HIV treatment, care and support.

Seventy nine workplaces from Rift Valley (41) and Coast (38) provinces had undergone major steps in development and implementation of a comprehensive HIV/AIDS prevention care and support programs over the project implementation phase. The workplace were rated using a comprehensive HIV/AIDS program assessment tool, and gaps identified have over the past four years been addressed gradually as the project unfolded. The tool assessed, three broad categories including; HIV/AIDS prevention elements, availability and access to HIV/AIDS treatment, and also assessed if workplaces have put in place an enabling environment for the program implementation.

The implementation phase took in to account the following strategies:

- Strategic communication interventions to improve knowledge
- Advocacy among senior management and workplace leaders for ownership and commitment to enhance sustainability
- Capacity building for the CWPP coordination and implementation
- Established linkages to facility based services, to employees, their families, and communities
- Documentation and dissemination of best practices on comprehensive workplace policy programs.
- Monitoring and Evaluation

## **1.2 Purpose of Evaluation**

The end of term APHIA II project evaluation for Rift Valley and Coast Provinces of Kenya was carried out to assess the impact of the project. It is a follow up assessment after the 2007 baseline capacity assessment of workplace programs. The assessments were carried out by National Organization of Peer Educators (NOPE) as part of its technical support in monitoring and evaluation of interventions implemented in APHIA II Coast and Rift Valley. The need for the evaluation was to assist in drawing comparative analysis of achievements during the implementation of workplace HIV/AIDS programmes in the two provinces.

## **1.3 Study Objectives**

### **1.3.1 Overall Objective**

To establish the impact of comprehensive HIV/AIDS workplace program activities in provision of health care services to the employees in public and private enterprises in Rift Valley and Coast provinces in Kenya.

### **1.3.2 Specific Objectives**

The study's specific objectives were to:-

- Ascertain the number of business enterprises with established comprehensive HIV/AIDS workplace policy and programs.
- Determine the number of employees accessing workplaces health care services on prevention, treatment and care in regard to ART, tuberculosis and malaria.
- Examine the extent to which workplaces support employees in accessing maternal and child health, family planning and other Reproductive Health (RH) services.
- Ascertain the extent of implementation of HIV/AIDS prevention, care, and treatment services to employee's and family members by the workplaces.
- Evaluate extent workplaces have integrated collaborative activities on HIV/AIDS with communities, civil societies and government agencies.
- Assess extent integration of workplace activities contributed towards eliminating discrimination and stigmatization of PLHIV.
- Identify barriers to implementation of HIV&AIDS workplace policies and activities.
- Propose appropriate strategies for effective mainstreaming of HIV&AIDS programs in workplaces that address health of employees and their families.

## **1.4 Methodology**

### **1.4.1 Study Design**

The study was conducted in two provinces in Kenya; Rift Valley and Coast. The target group was formal workplaces of varied sizes and nature of business. The sampling design of study sites was purposive and predetermined targeting the areas and business in which APHIA II project was being implemented.

The evaluation targeted the business sectors under APHIA II project in predetermined clusters from Coast and Rift Valley Province. All the 79 workplaces where CWPP was being implemented were the respondents in this evaluation. The workplaces with CWPP are situated in the following districts within the two provinces; Coast (Taita, Taveta, Mombasa, Kwale, Kilifi, and Malindi) and Rift Valley (Nakuru, Kiobatek, Naivasha, Narok, Kericho and Nandi) respectively.

### **1.4.2 Questionnaires**

The content of the questionnaires were based on model questions used during the 2007 baseline survey with minimal variance to reflect the new developments in the health care services.

The questionnaire captured information from all the targeted public and private sector workplaces and covered the following topics:

- Background information about the workplaces,
- HIV/AIDS programmes and policies and sensitization of employees
- Support of HIV/AIDS & related activities at the workplace(workplace HIV activities)
- HIV/AIDS programme coordination & implementation (HIV workplace activities)
- Financing of HIV/AIDS and reproductive health services,
- Provision of Reproductive Health (Family Planning) services
- Provision of other reproductive health services
- Provision of Child Health Services
- Reasons for non provision of HIV/AIDS and reproductive health care services,
- Provision of health care to members of the employees' family,
- Existence of health services on-site,
- HIV/AIDS and health care service linkages and networking,
- Service provision points and existence of employees' and Family support activities.

### **1.4.3 Data administration**

This second Phase of the workplace CWPP evaluation was planned for the fourth year of the APHIA II project implementation. The data collection activities took place between April and June 2010 in the 79 sites.

The data collectors for the evaluation were the APHIA II focal point persons, project staff and selected health service providers in the workplaces. The questionnaire was self administered with the respondents' given adequate time to complete. The completed questionnaires were later collected by APHIA II project staff and submitted to NOPE M&E team.

### **1.4.4 Data processing**

The data processing team undertook manual validation and editing. The data was thereafter entered and analyzed using SPSS. The data was presented using frequency tables, cross tabulations, graphs and charts. Exploration of data to highlight unique attributes of the workplaces, business sectors and provinces was done. A comparative report was prepared that compared the status of the workplaces in the baseline (2007) and end term project (2010). The preliminary results of the analysis was shared with NOPE staff and disseminated to APHIA II stakeholder's.

## 2.0 WORKPLACE CHARACTERISTICS

This chapter describes the characteristics of business institutions workforce in APHIA II Project partner sites in Coast and Rift Valley provinces. The information presented describes the nature of business enterprises and number of employees, including their qualifications and gender. The data enhances understanding the scope of interventions implemented within the comprehensive workplace programs (CWPP) in the workplaces. The Workplaces with CWPP were expected to utilize the workplace implementation strategy designed to assist the managers and program leaders to design in-house approaches.

### 2.1 Nature of Business Enterprises by Region

The APHIA II Project partner sites comprised four business category enterprises as shown in Figure 2.1. Majority of the enterprises were from agriculture sector, 36.4 percent followed by goods/Services, 28.6 percent, manufacturing, 20.8 percent and lastly, tour and hotel industry, 14.3 percent.

**Figure 2.1: APHIA II Project Business Enterprises Composition, 2010**

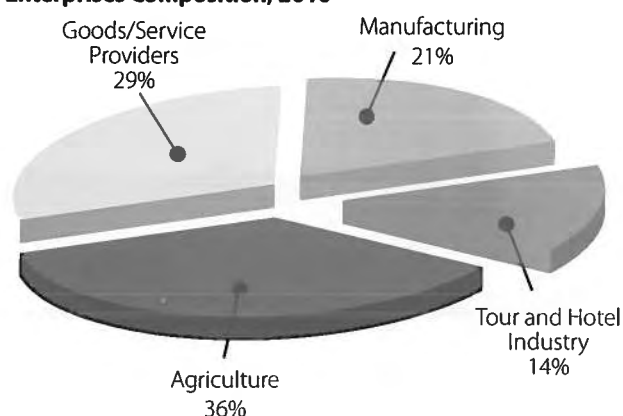


Table 2.1 presents data on the business enterprises in Rift valley and coast provinces with 54 enterprises in 2007 as compared 79 in 2010. The proportion of workplaces in Rift Valley was 55.6 percent in 2007 and 51.9 percent in 2010. During the year of evaluation, Coast province had the highest number of enterprises engaged in goods/services (22.1 percent) and tour and hotel industry (13.0 percent). Most of the enterprises in Rift valley province were from agriculture (29.9 percent) and manufacturing (14.3 percent). In all the APHIA II Project partner sites, the manufacturing enterprises (40.7 percent) was the highest in 2007 while in 2010, agriculture (36.4 percent) was higher

**Table 2.1 Distribution of Workplace/Institutions by nature of business, 2007 and 2010**

Business category	2007			2010		
	Rift Valley	Coast	Total	Rift Valley	Coast	Total
Goods/services provider	7.4	13.0	20.4	6.5	22.1	28.6
Tour and hotel industry	-	14.8	14.8	1.3	13.0	14.3
Manufacturing	29.6	11.1	40.7	14.3	6.5	20.8
Agriculture	18.5	5.6	24.1	29.9	6.5	36.4
Total	55.6	44.4	100.0	51.9	48.1	100.0

N=54 in 2007 and N=79 in 2010

## 2.2 Category and Size of Employees

Information on number of employees, employment status and skills was sought and is discussed in this section. This information is intended to provide a detailed account of the structure of employees who were targeted during the HIV and AIDS intervention activities at the workplaces.

### 2.2.1 Number of Employees in Business enterprises

Figure 2.2 shows that majority of the employees were from Rift Valley province at 76.8 percent with agriculture sector constituting 46.3 percent and manufacturing, 15.4 percent. The highest number of employees in Coast province was recorded in agricultural enterprises at 6.6 percent followed by manufacturing, 6.1 percent and goods and services, 6.0 percent. The proportion of employees in the tour and hotel industry for Rift Valley and Coast provinces was 5.2 percent and 4.5 percent respectively.

**Figure 2.2: Proportion of employees by business sector and province**

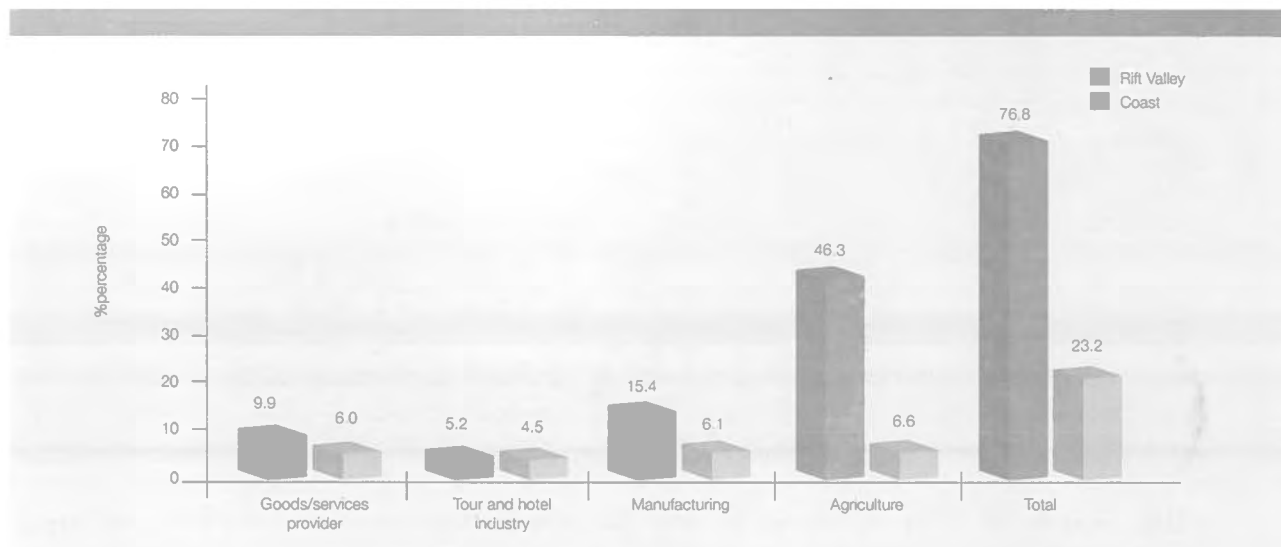


Table 2.2 presents the number of employees in the APHIA II project partner sites business enterprises for the year 2007 and 2010. The APHIA II Project partner sites recorded a total of 133,396 employees in 2010 compared to 53,668 employees in 2007. The increase is attributed to more workplaces on board during the project implementation (79) compared to the 54 during the baseline. In 2010, the largest number of employees was in the agriculture sector, 48,635 followed by manufacturing, 49,301 and the least was tour and hotel industry, 13,795 employees.

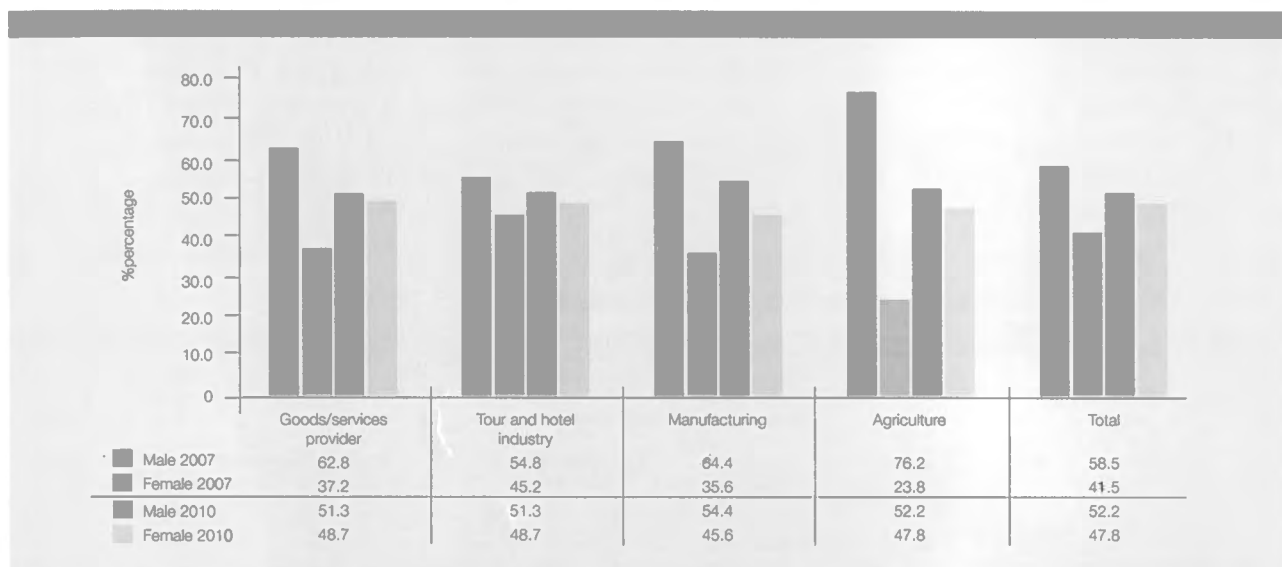
**Table 2.2 Number of Employees by Business category and province, 2007 and 2010**

Business Category	2007			2010		
	Rift Valley	Coast	Total	Rift Valley	Coast	Total
Goods/services provider	2,526	9,433	11,959	10,823	19,842	30,665
Tour and hotel industry	10,929	22,888	33,817	2,830	10,965	13,795
Manufacturing	2,095	1,199	3,294	36,604	3,697	40,301
Agriculture	3,029	1,569	4,598	43,817	4,818	48,635
Total	18,579	35,089	53,668	94,074	39,322	133,396

### 2.2.2 Gender Variation

Analysis of Figure 2.3 indicates that 52.2 percent of the workers in all the economic sectors were male employees in 2010 compared to 58.8 percent in 2007. The manufacturing sector recorded the highest male proportion of workforce at 54.5 percent while in 2007, it was agriculture with 76.2 percent. In general, the gender variation of the employees was not significant.

**Figure 2.3: Proportion of Employees by Gender and Economic Sector**



### 2.2.3 Professional Status of the Employees

Table 2.3 presents information on employees in specified employment status for each of the business category for the year 2007 and 2010. The data shows that in 2010, there were 4,961 and 4,129 full time management/administrative employees in Rift Valley and Coast provinces.

Also, analysis of Table 2.4 indicates that full time management/administrative employees constitute 40.5 percent of employees in the goods and services while 36.3 percent are from the agriculture sector. Majority of the full time, unskilled production employees were in agriculture (54.4 percent) followed by goods and services, 18.3 percent. Full time skilled employees were highest in manufacturing (44.0 percent) as compared to the least in tour and hotel industry (14.6 percent).

**Table 2.4: Number and Percentage Distribution of employees by category and business sector**

Category of Employee	2007				2010			
	Rift Valley	Coast	Total	%	Rift Valley	Coast	Total	%
Full time management/administrative employees	3,225	6,138	9,363	17.4	4,961	4,129	9,090	6.8
Full time, skilled production employees	5,709	11,155	16,864	31.4	19,393	6,869	26,262	19.7
Full time, unskilled production employees	6,415	10,535	16,950	31.6	19,619	9,478	29,097	21.8
Part-time, all year employees	1,218	2,050	3,268	6.1	25,515	9,527	35,042	26.3
Seasonal, all year employees	2,012	5,211	7,223	13.5	24,586	9,319	33,905	25.4
<b>Total</b>	<b>18,579</b>	<b>35,089</b>	<b>53,668</b>	<b>100.0</b>	<b>94,074</b>	<b>39,322</b>	<b>133,396</b>	<b>100.0</b>

## 3.0 ESTABLISHMENT OF HIV/AIDS WORKPLACE POLICY AND PROGRAMMES

This chapter illustrates the extent to which the workplaces have embraced HIV/AIDS workplaces before and after the APHIA II interventions in the project sites of Rift Valley and Coast provinces. A detailed account of the workplace interventions, capacity building activities and family outreach programmes is discussed.

### 3.1 Existence of HIV and AIDS Workplace Policies

Table 3.1 indicates that most of the workplaces have adopted HIV/AIDS workplace policy, an increase of 40 percent from 50.9 percent in 2007 to 90.9 percent in 2010 (38 in Rift Valley and 34 in Coast). In Rift Valley province, the Goods/service providers improved by 10.0 percent as compared to agriculture and Tour and hotel industry enterprises which registered 100 percent adoption of the HIV/AIDS workplace policy. Conversely, Goods/service sector in Coast province recorded 100 percent adoption of the workplace policy as compared to manufacturing (60 percent) and agriculture (80 percent). The data illustrates a positive achievement in existence of HIV/AIDS workplace policies with challenges in about 9 percent of the business enterprises.

**Table 3.1: Percentage of workplace/institutions with existing HIV/AIDS workplace policy**

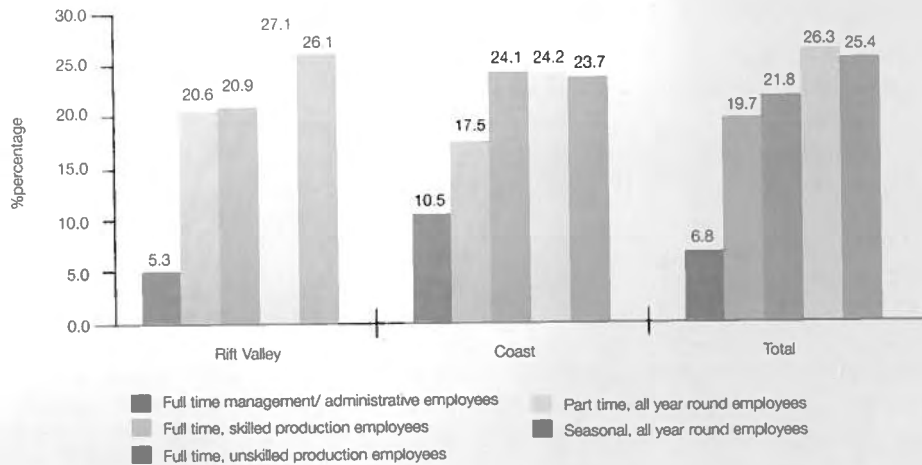
Region/Business Sector	Yes		No		Don't Know	
	2007	2010	2007	2010	2007	2010
<b>Rift Valley</b>						
Goods/services provider	50.0	60.0	50.0	40.0	0.0	
Tour and hotel industry		100.0	100.0		0.0	
Manufacturing	46.7	90.9	53.3		0.0	9.1
Agriculture	60.0	100.0	40.0		0.0	
Total	50.0	92.5	50.0	5.0	0.0	2.5
<b>Coast</b>						
Goods/services provider	57.1	100.0	8.3		34.6	
Tour and hotel industry	50.0	90.0	12.5	10.0	37.5	
Manufacturing	60.0	60.0	8.3	40.0	31.7	
Agriculture	33.3	80.0	8.3	20.0	58.4	
Total	52.2	89.2	39.1	10.8	8.7	
<b>TOTAL</b>	50.9	90.9	45.3	7.8	3.8	1.3

### 3.2 HIV and AIDS Interventions Supported by the Organization

Information on HIV/AIDS interventions that took place in the Rift Valley and Coast business workplaces is analyzed in Table 3.2 and Table 3.3 and compared with the baseline status in 2007. In Rift Valley, the data illustrates that all business workplaces (100 percent) provided staff with information on HIV/AIDS as compared to the 82.8 percent recorded in 2007. Notably, there was increased support to employees in access to STI prevention and treatment, an increase of

The data presented in Figure 2.4 indicates that 6.8 percent of the employees in the APHIA II Project partner sites are fulltime management/administrative while 21.8 percent are full time unskilled production employees. The part time all year employees in Rift Valley and Coast provinces are 27.1 percent and 26.3 percent.

**Figure 2.4: Percentage distribution of employees by category of employment and province**



*Mary Oruko, Deputy Director NOPE Awards Manager raffia Bags with a CWPP Silver Recognition Award 2009*

21.7 percent and condom distribution, an increase of 34.5 percent. Care for persons living with HIV/AIDS improved drastically from 27.6 percent to 68.2 percent. This is a positive indication of increased HIV/AIDS awareness and reduced stigmatization.

**Table 3.2: Type of support provided by workplace/institutions in Rift Valley**

Support provided	2007		2010			
	Baseline Total	Total	Goods/services provider	Tour and hotel industry	Manufacturing	Agriculture
Providing staff with information and education on HIV/AIDS	82.8	100.0	100.0	100.0	100.0	100.0
Access to STI prevention and treatment	73.3	95.0	80.0	100.0	90.9	100.0
Condom promotion and distribution	65.5	100.0	100.0	100.0	100.0	100.0
Access to VCT	60.0	87.5	100.0	100.0	81.8	87.0
Care for orphans and vulnerable children	17.9	35.9	80.0		36.4	27.3
Care for persons living with HIV/AIDS	27.6	61.5	80.0	100.0	36.4	68.2
Referral for treatment and other care and support services	73.3	100.0	100.0	100.0	100.0	100.0

In Coast province, the trend is similar, with proportion of workplaces supporting staff on information and education on HIV/AIDS improving from 79.2 percent to 100 percent. Support with condom promotion and distribution doubled over the intervention period from 50 percent to 100 percent. However, the lowest increase in support provided was recorded in care for orphans and vulnerable children by 5.2 percent and access to STI prevention and treatment by 4.4 percent.

**Table 3.3: Type of support provided by workplace/institutions in Coast**

Support provided	2007		2010			
	Baseline Total	Total	Goods/services provider	Tour and hotel industry	Manufacturing	Agriculture
Providing staff with information and education on HIV/AIDS	79.2	100.0	100.0	100.0	100.0	100.0
Access to STI prevention and treatment	75.0	80.6	81.3	90.0	60.0	80.0
Condom promotion and distribution	50.0	97.3	94.1	100.0	100.0	100.0
Access to VCT	58.3	86.1	82.4	100.0	80.0	75.0
Care for orphans and vulnerable children	34.8	62.2	64.7	80.0	40.0	40.0
Care for persons living with HIV/AIDS	16.7	80.6	82.4	90.0	60.0	75.0
Referral for treatment and other care and support services	62.5	88.9	82.4	100.0	100.0	80.0

### 3.3 HIV and AIDS Capacity Building Activities

The successful implementation of a comprehensive workplace policy is dependent on the capacity building opportunities that were available for the employees. Information on trainings undertaken in specific areas was sought from the respondents.

#### 3.3.1 HIV&AIDS workplace coordination and implementation mechanism

Analysis of Table 3.4 shows that 800 management staff was sensitized on HIV/AIDS workplace policy and programs in 2010 compared to 350 in 2007, an increase of 70.9 percent. Those trained on staff induction in Rift Valley were 3,124 in 2007 rising to 10,476 in 2010, an increase of 235.3 percent. The total number of employees inducted as at 2010, was 21,029 of whom 49.8 percent were from Rift Valley. In 2007, coast province had 15 staff members trained on HIV/AIDS program design & implementation with number rising to 246 in 2010. A total 2,261 employees in the project sites were trained as coordinators whose responsibility was quality assurance, monitoring and supervision.

**Table 3.4: Number and percentage of employees trained on HIV/AIDS workplace roles**

Business Category	2007			2010		
	Rift Valley	Coast	Total	Rift Valley	Coast	Total
Goods/services provider	2,521	9,433	11,959	10,823	19,842	30,665
Tour and hotel industry	10,929	22,888	33,817	2,830	10,965	13,795
Manufacturing	2,095	1,199	3,294	36,604	3,697	40,301
Agriculture	3,029	1,569	4,598	4,317	4,818	48,635
Total	18,579	35,089	53,668	94,074	39,322	133,396

#### 3.3.2 Areas of training of the employees in HIV/AIDS capacity building

Analysis of Table 3.5 reveals that number of employees who attended training from the project sites in 2007 and 2010 in various areas of HIV/AIDS. The largest number and increase in training of employees was in early cancer detection (20,547) at 5,576 percent followed by TB prevention, treatment and care at 572 percent. Rift Valley province accounted for 98.6 percent of employees trained on early cancer detection. A total of 4,340 employees were trained on STIs and HIV/AIDS by 2010 as compared to 3,572 in 2007, an increase of 21.5 percent with Coast province accounting for 47.8 percent. A total of 2,233 employees were trained on peer education. The employees also went through training on: sexuality and gender (1,354); care and support for PLWHA (2,139); behaviour change communication (2,929); TB prevention, treatment and care (2,8797) and stigma and discrimination reduction strategies(2,496).



*Philip Mbugua, NOPE Executive Director Awards KPA Manager with a CWPP Gold Recognition Award 2009*

*Mama Ruth Odindo (second from left front row) pauses for a group photo with all APHIA II Coast 2009 Gold Recognition winning Award Workplaces celebrations ceremony at Serena Beach Hotel*

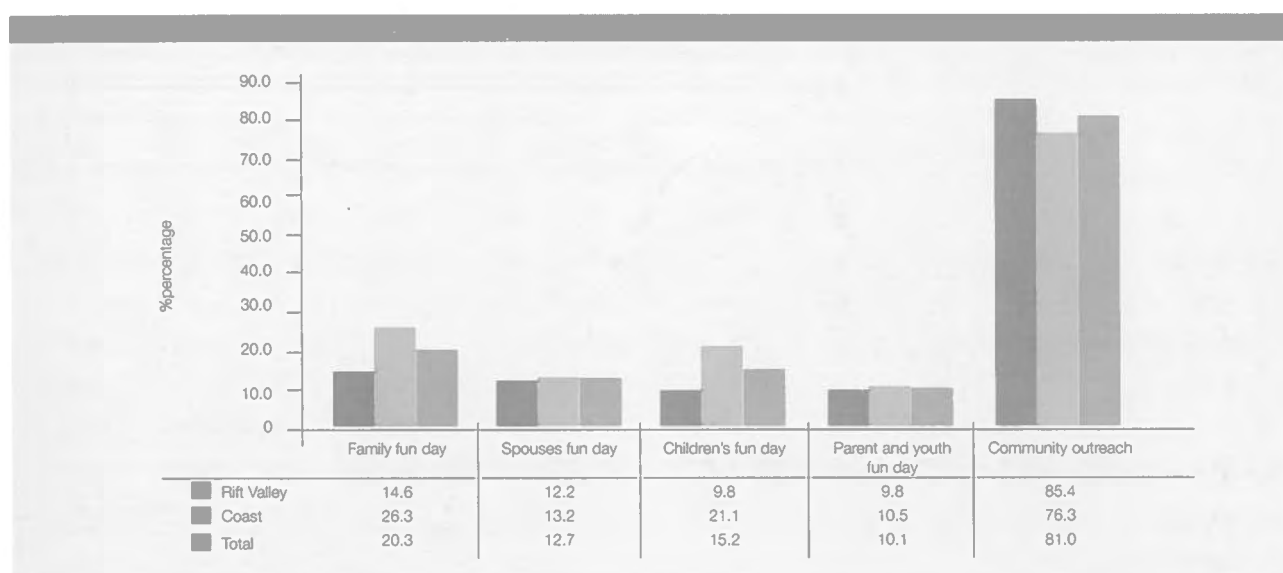
**Table 3.5: Number of employees who attended training and percentage increases by training type**

Training Attended	2007			2010			Percentage Increase		
	Rift Valley	Coast	Total	Rift Valley	Coast	Total	Rift Valley	Coast	Total
(STIs) and HIV/AIDS as part of capacity building exercise.	3150	422	3,572	2,266	2,074	4,340	(28.1)	391.5	21.5
Care and support for PLWHA	916	67	983	1,699	440	2,139	85.5	556.7	117.6
VCT	2168	78	2,246	1,332	441	1,773	(38.6)	465.4	(21.1)
ART (Antiretroviral therapy)	1489	75	1,564	1,295	249	1,544	(13.0)	232.0	(1.3)
Mother-to-child HIV transmission	1529	79	1,608	1,539	307	1,846	0.7	288.6	14.8
Facilitation skills	218	242	460	1,248	384	1,632	472.5	58.7	254.8
Peer education	496	298	794	1,412	821	2,233	184.7	175.5	181.2
Sexuality and gender	190	104	294	811	543	1,354	326.8	422.1	360.5
Training of trainers (TOT)	74	47	121	590	129	719	697.3	174.5	494.2
Social marketing of condoms	836	289	1,125	774	393	1,167	(7.4)	36.0	3.7
Behaviour change communication	547	144	691	1,170	1,759	2,929	113.9	1,121.5	323.9
Peer counseling	404	46	450	428	280	708	5.9	508.7	57.3
Malaria prevention & treatment	1530	10	1,540	1,650	1,461	3,111	7.8	14,510.0	102.0
TB prevention, treatment & care	417	11	428	1,608	1,271	2,879	285.6	11,454.5	572.7
Family planning & reproductive health	1257	16	1,273	1,483	1,230	2,713	18.0	7,587.5	113.1
Stigma & discrimination reduction strategies	1256	33	1,289	1,391	1,105	2,496	10.7	3,248.5	93.6
Nutrition and general awareness	367	34	401	1,239	1,247	2,486	237.6	3,567.6	520.0
Early (breast, cervical & prostate) cancer detection	349	13	362	20,260	287	20,547	5,705.2	2,107.7	5,576.0

### 3.3.3 Family and Outreach Activities

Figure 3.3 illustrates that majority of the workplaces supported community outreach at 81.0 percent with Rift Valley standing at 85.4 percent as compared to Coast, 76.3 percent. The family day and spouses fun day was reported in 20.3 percent and 12.7 percent respectively. The parents & youth fun day was reported to take place in 9.8 percent and 10.5 percent of the enterprises in Rift Valley and coast province respectively.

**Figure 3.1: Proportion of workplaces with family and outreach activities in their workplace**



Data presented in Table 3.6 provides details of the workplaces that have integrated outreach activities in their workplaces in the different business enterprises. Community outreach activities were reported to be taking place in all the APHIA II Project partner sites. Rift Valley province had between 81.8 percent and 100 percent of the business enterprises incorporating outreach activities in 2010 as compared to between 10.0 percent and 66.7 percent in 2007. However in 2010, family fun day, spouses fun day and children's fun days did not take place in Goods and Services provider sector in Rift Valley.

**Table 3.6 Outreach activities undertaken by economic sector and province, 2007 and 2010**

Outreach Activity		Goods and Services provider			Tour and hotel industry			Manufacturing			Agriculture		
		Rift Valley	Coast	Total	Rift Valley	Coast	Total	Rift Valley	Coast	Total	Rift Valley	Coast	Total
Family fun day	2007	66.7	50.0	55.6	-	12.5	12.5	10.0	16.7	12.5	10.0	-	7.7
	2010	-	11.8	9.1	-	40.0	36.4	8.2	20.0	18.8	13.0	-	17.9
Spouses fun day	2007	-	-	-	-	-	-	10.0	-	6.3	10.0	-	7.7
	2010	-	11.8	9.1	-	10.0	9.1	18.2	20.0	18.8	8.7	-	7.1
Children's fun day	2007	-	16.7	11.1	-	25.0	25.0	10.0	-	6.3	30.0	-	23.1
	2010	-	-	-	-	50.0	45.5	9.1	20.0	12.5	8.7	20.0	10.7
Parent and youth fun day	2007	-	-	-	-	12.5	12.5	-	-	-	10.0	-	8.3
	2010	-	-	-	-	10.0	9.1	9.1	20.0	12.5	8.7	20.0	10.7
Community outreach	2007	66.7	20.0	37.5	-	25.0	25.0	10.0	66.7	31.3	20.0	50.0	25.0
	2010	100.0	70.6	77.3	100.0	80.0	81.8	81.8	60.0	75.0	82.6	100.0	85.7

## 4.0 PROVISION OF HIV AND REPRODUCTIVE HEALTH CARE SERVICES

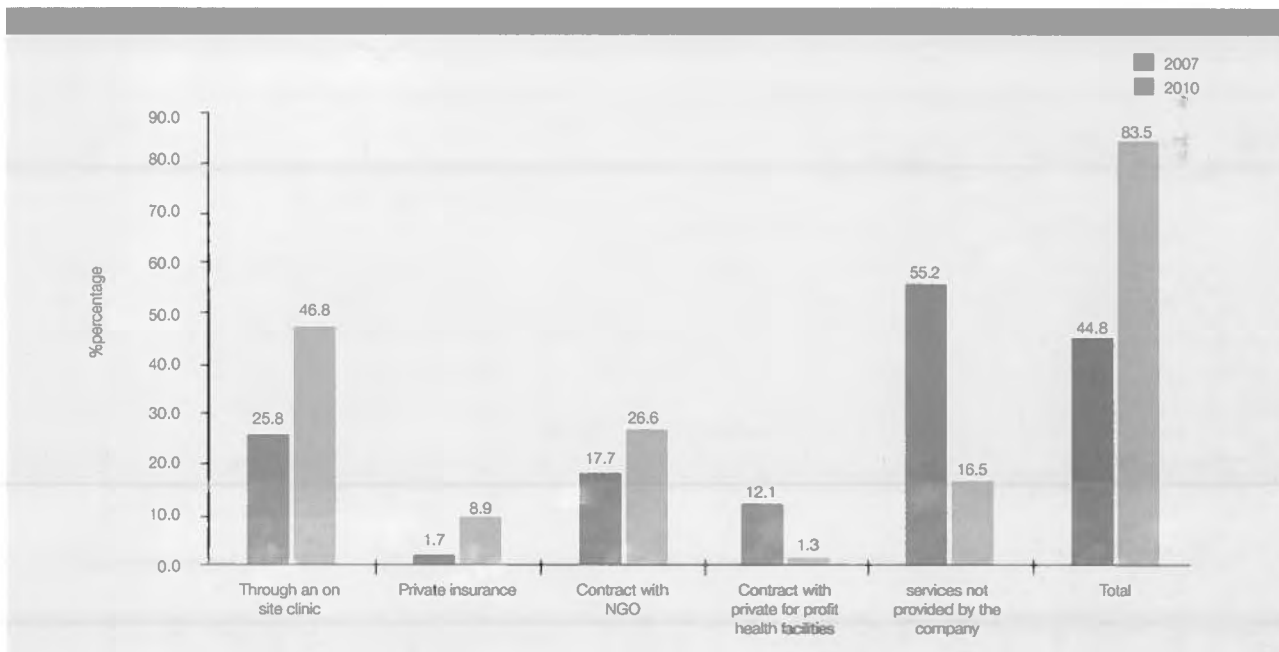
This chapter discusses issue related to financing of employees' access to HIV and reproductive health care. In the implementation of the comprehensive HIV/AIDS prevention care and support programs, one key strategy is availability of medical support to employees. This is only possible when a workplace provides budget allocation for financing of health services including those related to HIV and AIDS.

### 4.1 Financing of HIV/AIDS Services

#### 4.1.1 Testing and Counselling of HIV/AIDS

The proportion of workplaces financing testing and counseling of HIV/AIDS nearly doubled from 44.8 percent in 2007 to 83.5 percent in 2010, as illustrated in Figure 4.1. The main financing mode for testing and counseling of HIV/AIDS is through on site clinic as reported by 47 percent of the workplaces. This is followed by contract with NGOs at 27 percent and private insurance, 9 percent. However, 16.5 percent of the workplaces reported not financing this health service.

Figure 4.1: Mode of financing for testing and counseling of HIV/AIDS



Further information presented in Table 4.1 shows that a total of 45.5 percent of the workplaces financed testing and counseling of HIV/AIDS through an onsite clinic with Rift Valley constituting

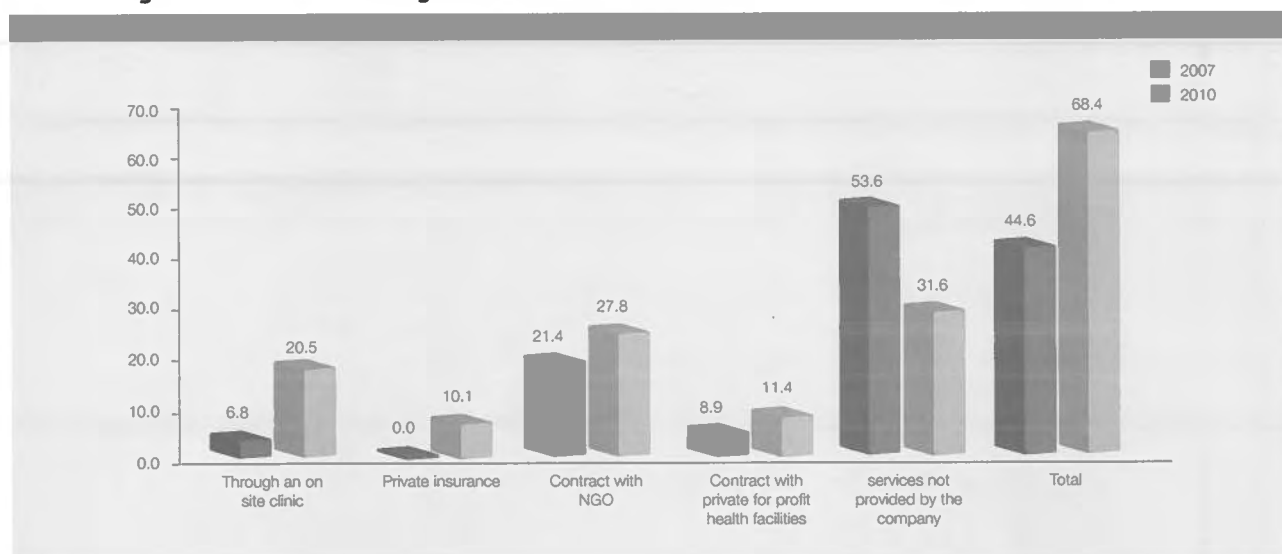
**Table 4.1: Financing Mode for workplace/institution for testing and counseling of HIV/AIDS**

Financing Mode	The business nature of the respondents company/institution(%)				Total
	Goods/services provider	Tour and hotel industry	Manufacturing	Agriculture	
<b>Through an on site clinic</b>					
Rift Valley	0.0	9.1	31.3	60.7	29.9
Coast	13.6	27.3	18.8	10.7	15.6
Total	13.6	36.4	50.0	71.4	45.5
<b>Private Insurance</b>					
Rift Valley	-	-	-	3.6	1.3
Coast	13.6	27.3	-	-	7.8
Total	13.6	27.3	-	3.6	9.1
<b>Contract through NGO</b>					
Rift Valley	13.6	-	37.5	14.3	16.9
Coast	22.7	18.2	-	3.6	10.4
Total	36.4	18.2	37.5	17.9	27.3
<b>Contract with private for profit health facilities</b>					
Coast	4.5	-	-	-	1.3
Total	4.5	-	-	-	1.3
<b>services not provided by the company</b>					
Rift Valley	9.1	-	-	3.6	3.9
Coast	22.7	18.2	12.5	3.6	13.0
Total	31.8	18.2	12.5	7.1	16.9

#### 4.1.2 Anti Retro Viral Treatment (ART)

Analysis of Figure 4.2 indicates that the workplaces financing provision of ARTs to employees increased from 44.6 percent in 2007 to 68.4 percent in 2010, an increase of 24.2 percentage points. This revealed an increase in acceptance of treatment by HIV positive employees coupled with the improved willingness by the employers to provide the services.

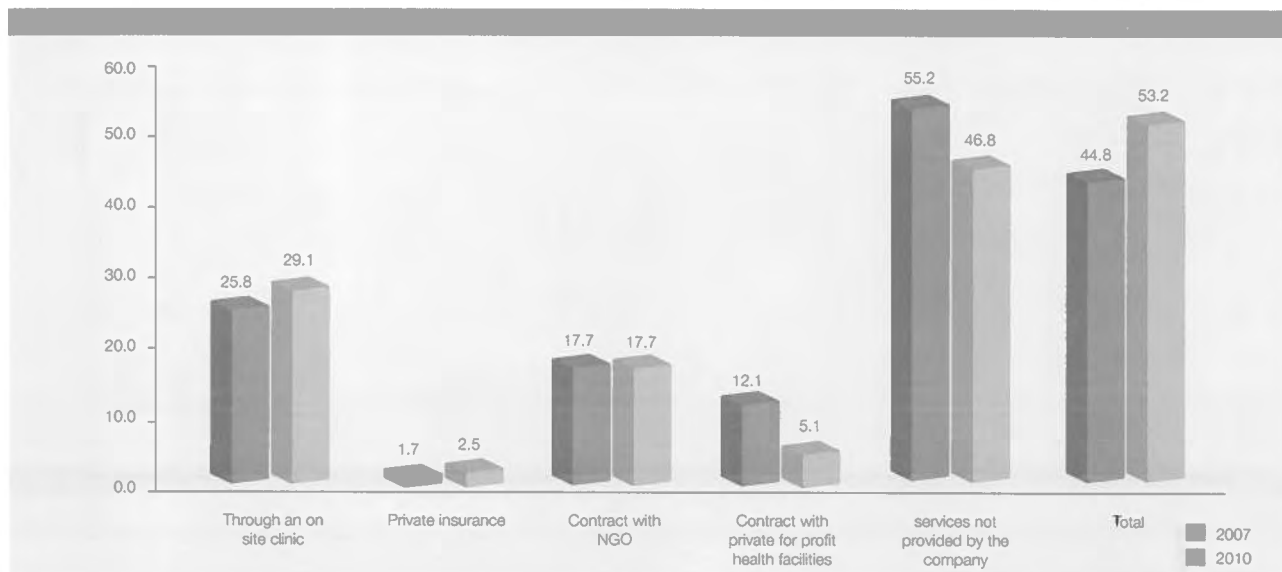
**Figure 4.2: Mode of financing Anti Retro Viral Treatment (ART)**



### 4.1.3 Coordination for Home based care of HIV/AIDS

The concept of home based care is one where quality of care is made available to all who need it, spanning from a health facility to the community and to the family. In the project sites, financing of home based care of HIV/AIDS increased from 44.8 percent in 2007 to 53.2 percent in 2010, an increase of 8.4 percent in 2010. A total of 29.1 percent of the workplaces implement it through an onsite clinic, 17.7 percent through contract NGO and 2.5 percent get services from insurance service. The data shows that contract with private for profit health facilities declined from 12.1 percent in 2007 to 5.1 percent in 2010. The provision of home based care, at health facility and at home level ensures that care focuses on the employees family-patient needs through the provision of physical, social, psychological, emotional and spiritual care.

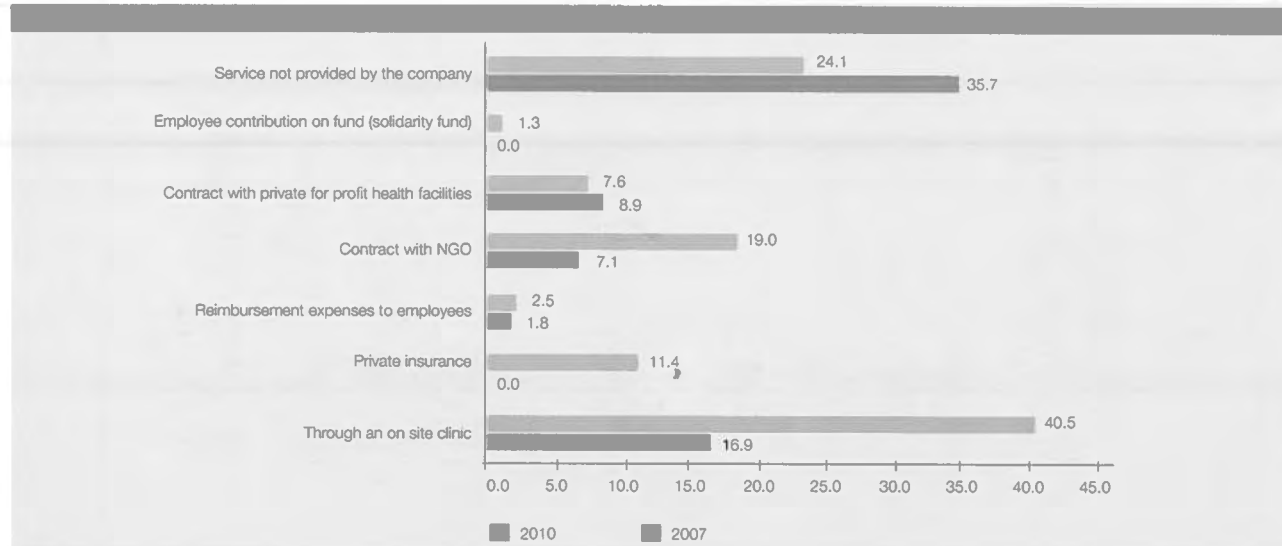
**Figure 4.3: Mode of financing coordination of home based care for HIV/AIDS**



### 4.1.4 Mother to Child Transmission of HIV/AIDS

In 2010, 75.9 percent of the workplaces provided financing support on treatment for prevention of mother to child transmission of HIV/AIDS compared to 64.1 percent in 2007. There was tremendous increase in workplaces offering PMCT through onsite clinic from 16.9 percent in 2007 to 40.5 percent in 2010. Also, the workplaces offering financial services through; private insurance, contract with NGO and contract with private health facilities constituted 11.4 percent, 19.0 percent and 7.6 percent respectively.

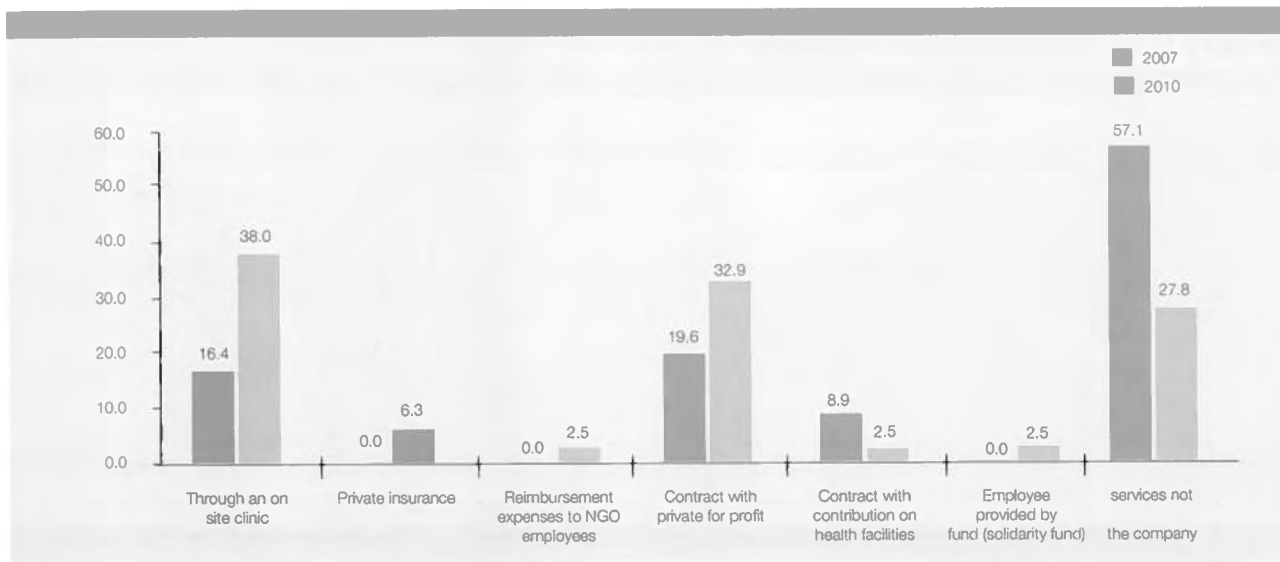
**Figure 4.4: Workplaces supporting treatment preventing mother to child transmission of HIV/AIDS**



#### 4.1.5 Adherence Counselling on ARVS

Analysis of Figure 4.5 shows that the proportion of workplaces that did not provide the financing on adherence counseling on ARVs declined from 57.1 percent in 2007 to 27.8 percent in 2010. Those that provided the support through an onsite clinic stood at 38.0 percent in 2010 as compared to 16.4 percent in 2007. The proportion of workplaces financing the service through contract with NGOs and private insurance was 32.9 percent and 6.3 percent respectively. There was a decline in number of workplaces using contract with private for profit health facilities from 8.9 percent in 2007 to 2.5 percent in 2010.

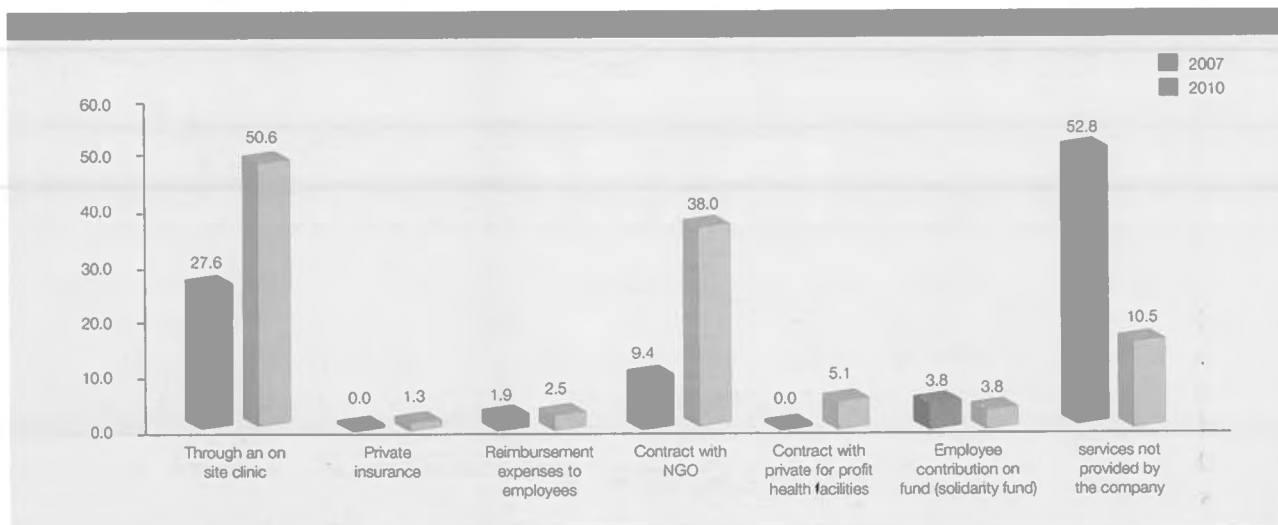
**Figure 4.5: Workplaces mode of financing of adherence in counseling on ARVs**



#### 4.1.6 Counselling on abstinence

Figure 4.6 presents information on mode of financing counselling on abstinence. The analysis indicates that 16.5 percent did not provide the service in 2010 as compared to 52.8 percent in 2007. Most of the workplaces financed through an onsite clinic and contract with NGO as reported by 50.6 percent and 38.0 percent respectively. There was improvement on workplaces offering counselling on abstinence through private insurance and contract with private for profit health facilities, an increase of 1.3 percent and 5.1 percent.

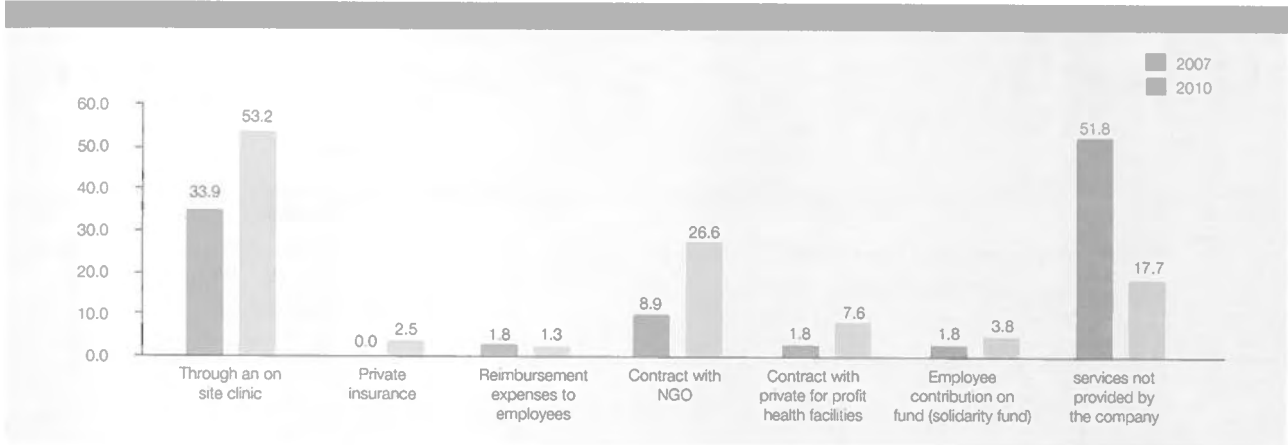
**Figure 4.6: Proportion of workplaces financing counselling on abstinence**



#### 4.1.7 Counselling on Sexually Being Faithful

Analysis of Figure 4.7 indicates that only 17.7 percent of the workplaces did provide financing for counselling on being sexually faithful. The workplaces that provided the service through an onsite clinic rose from 33.9 percent in 2007 to 53.2 percent in 2010, an increase of 13.3 percent. Proportion of workplaces financing through contract with NGOs and contract with private for profit health facilities stood at 26.6 percent and 3.8 percent respectively.

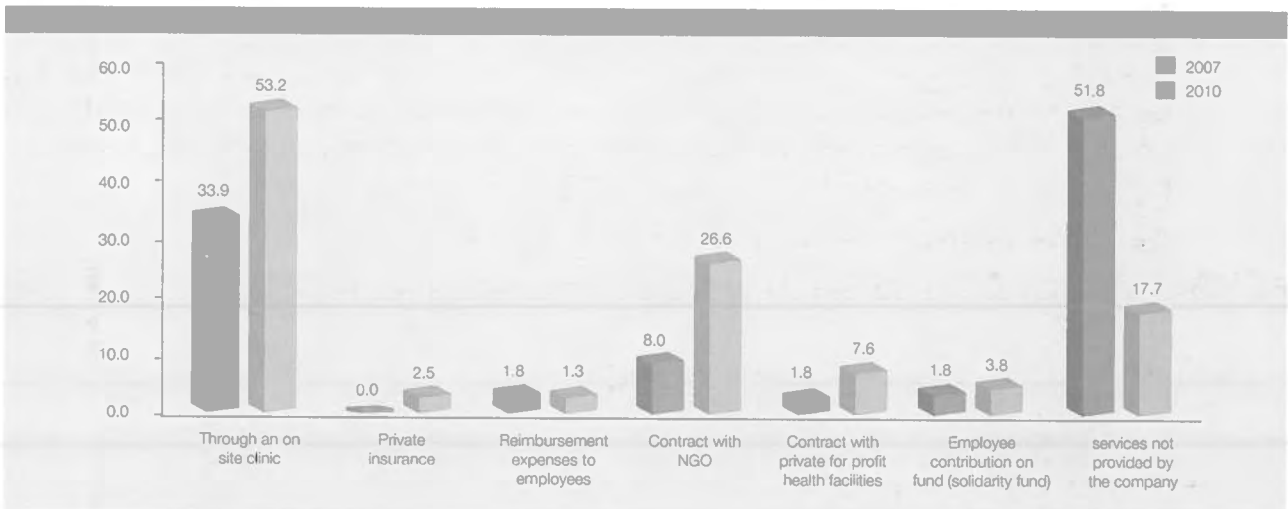
Figure 4.7: Proportion of workplaces by financing mode of counseling on being sexually faithful



#### 4.1.8 Counselling on alcohol and drug abuse

Workplaces that offered employees financing for counseling on alcohol and drug abuse nearly doubled, from 48.2 percent in 2007 to 82.9 percent in 2010. Those offering financing through an onsite clinic increased by 19.3 percent from 33.9 percent in 2007 to 53.2 percent in 2010. Contract with NGOs stood at 26.6 percent as compared to 8.9 percent in 2007.

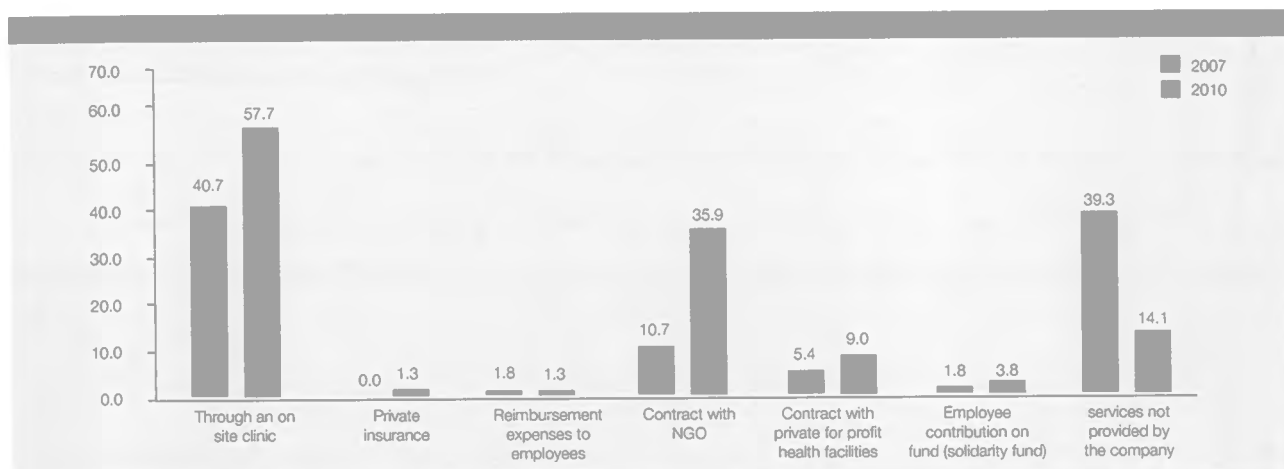
Figure 4.8: Proportion of workplaces financing mode for counseling on alcohol and drug abuse



#### 4.1.9 Counselling on correct condom use

Analysis of Figure 4.9 illustrates that only 14.1 percent of the workplaces did not provide financing of counseling on correct condom use in 2010 as compared to 29.3 percent in 2007. Those that financed through an onsite clinic increased from 40.7 percent in 2007 to 57.7 percent in 2010. Similarly, workplaces financing through contract with NGO stood at 35.9 percent in 2010 as compared to 10.7 percent in 2007.

**Figure 4.9: Proportion of workplaces by financing mode for counseling on correct condom use**



The finding revealed that more workplaces adopted information on counseling on abstinence and condom use as means of prevention among the workplace populations. This shows a more wholesome approach to prevention among the workplaces in 2010 than in 2007 due to Technical support from APHIA II project.

## 4.2 Financing of Family Planning Services

This section discusses the family planning services that employees can access and are financed by the workplaces. Information was obtained that sought to know the mode of financing in provision of male condoms, pills, IUD/UCD, injectables, implants, vasectomy and tubal ligation as shown in Table 4.2.

More workplaces (55.6%) adopted family planning during the project period than when the project started (25%).



*County Council of Kwale Manager displays the APHIA II CWPP Platinum recognition award.*

**Table 4.2: Proportion of workplaces financing mode of the family planning services**

Family Planning Service/ Mode of Financing	Through an on site clinic	Private insurance	Reimbursement expenses to employees	Contract with NGO	Contract with private for profit health facilities	Employee contribution on fund (solidarity fund)	Service not provided by the company
<b>Male condoms</b>							
2007	48.3	-	3.6	16.1	1.8	-	33.9
2010	54.4	6.3	2.5	30.4	12.7	12.7	12.7
<b>Pills</b>							
2007	21.3	-	3.5	5.3	7	-	64.9
2010	45.6	7.6	2.5	13.9	10.1	-	27.8
<b>IUD/UCD</b>							
2007	16.4	-	-	3.6	8.9	-	69.6
2010	29.1	6.3	2.5	20.3	8.9	1.3	41.8
<b>Injectables</b>							
2007	21.3	-	-	3.6	7.1	-	66.1
2010	43.0	8.9	2.5	13.9	10.1	1.3	27.8
<b>Implants</b>							
2007	14.8	-	-	3.6	7.1	-	69.6
2010	24.1	8.9	2.5	20.3	10.1	3.8	41.8
<b>Vasectomy</b>							
2007	1.6	-	3.6	1.8	12.5	-	75
2010	11.4	7.6	2.5	19.0	11.4	2.5	53.2
<b>Tubal ligation</b>							
2007	1.6	-	3.6	1.8	12.5	1.8	75
2010	11.4	7.6	2.5	20.3	11.4	1.3	54.4

#### 4.2.1 Male condoms

Analysis shows that the proportion of workplaces not financing male condoms declined from 33.9 percent in 2007 to 12.7 percent in 2010. Majority of the workplaces financed this service through an onsite clinic and contract with NGO constituting 54.4 percent and 30.4 percent respectively. Similarly, contract with private for profit health facilities and employee contribution on fund accounted for 12.7 percent each in 2010.

#### 4.2.2 Pills

There was near triple increase in workplaces financing provision of pills from 25.1 percent in 2007 to 72.2 percent in 2010. The highest mode of financing was through onsite clinic at 46.6 percent of the workplaces followed by contract with NGO, 13.9 percent and contract with private for profit health facilities, 10.1 percent.

#### 4.2.3 Intra Uterine Contraceptive Device (IUCD/IUD)

A total of 41.4 percent of the workplaces did not finance provision of IUCD/IUD in 2010 as compared to 69.6 percent in 2007. On site clinics accounted for 29.1 percent followed by contract with NGO, 20.3 percent and the least was employee contribution on fund, 1.3 percent.

#### 4.2.4 Injectables

Financing of injectables was carried out in 72.2 percent of the workplaces in 2010 as compared to 33.9 percent in 2007. Provision of injectables through on site clinic constituted 43.0 percent in 2010, an increase from 21.3 percent in 2007. In 2010, contract with NGO and contract with private for profit health facilities accounted for 13.9 percent and 10.1 percent respectively.

#### 4.2.5 Implants

The financial provision for implants took place in 58.2 percent of the workplaces in 2010 as compared to 30.4 percent in 2007. The workplaces financing the implants service through on site clinic accounted for 24.1 percent followed by contract with NGO, 20.3 percent and contract with private for profit making health facilities, 10.1 percent.

#### 4.2.6 Vasectomy

The proportion of workplaces not financing vasectomy declined from 75 percent in 2007 to 53.2 percent in 2010. Majority of the workplaces financed through onsite clinic, contract with NGO constituting and contract with private for profit health facilities (11.4 percent, 19.4 percent and 11.4 percent respectively).

#### 4.2.7 Tubal Ligation

A total of 45.6 percent of the workplaces offered financing for tubal ligation in 2010 as compared to 25.0 percent in 2007. Majority of the workplaces financed through onsite clinic, contract with NGO constituting and contract with private for profit health facilities (11.4 percent, 20.3 percent and 11.4 percent respectively).

### 4.3 Financing of Other Reproductive Health Services

This section discusses about the other reproductive health services that employees can access and are financed through the workplaces. Information was obtained that sought to know the mode of financing in provision of STI diagnosis and treatment, antenatal care labor and delivery, post partum care, pap smear and mammogram as shown in Table 4.3.

**Table 4.3: Financing mode of other reproductive health service**

Family Planning Service/ Mode of Financing	Through an on site clinic	Private insurance	Reimbursement expenses to employees	Contract with NGO	Contract with private for profit health facilities	Employee contribution on fund (solidarity fund)	Service not provided by the company
<b>STI diagnosis and treatment</b>							
2007	7.3	1.8	1.8	5.5	5.5	1.8	52.7
2010	56.4	11.5	5.1	16.7	14.1	2.6	16.7
<b>Ante natal care</b>							
2007	20	3.6	3.6	5.5	5.5	1.8	56.4
2010	56.4	11.5	5.1	16.7	14.1	2.6	16.7
<b>Labor and Delivery</b>							
2007	15	1.8	5.5	3.6	12.7	1.8	58.2
2010	25.3	12.7	3.8	17.7	15.2	7.6	35.4
<b>Postpartum care</b>							
2007	15	1.8	3.6	3.6	5.5	3.6	60
2010	29.1	12.7	3.8	19.0	12.7	6.3	31.6
<b>Pap smear(Cervical cancer detection)</b>							
2007	6.7	1.9	0	3.8	9.4	1.9	71.7
2010	17.7	11.4	3.8	21.5	17.7	5.1	36.7
<b>Mammogram(Breast cancer detection)</b>							
2007	6.7	1.9	0	3.8	9.4	1.9	71.7
2010	16.5	11.4	3.8	20.3	19.0	5.1	36.7

#### **4.3.1 STI Diagnosis and Treatment**

The number of workplaces that do not finance STI diagnosis and treatment services declined from 52.7 percent in 2007 to 16.7 percent in 2010. Majority of the workplaces supported STI diagnosis and treatment through an onsite clinic, 56.4 percent followed by contract with NGO, 16.7 percent and contract with private to profit health facilities. Also, 11.5 percent financed the services through private insurance and 5.1 percent on reimbursement expenses to employees.

#### **4.3.2 Ante Natal Care**

The proportion of workplaces not financing ante natal care declined from 56.4 percent in 2007 to 16.7 percent in 2010. Majority of the workplaces financed through onsite clinic (56.4 percent) followed by contract with NGO constituting, 16.7 percent and contract with private for profit health facilities, 14.1 percent.

#### **4.3.3 Labor and Delivery**

The number of workplaces financing labor and delivery services rose from 41.8 percent in 2007 to 64.6 percent in 2010. The highest mode of financing was through onsite clinic at 25.3 percent of the workplaces followed by contract with NGO, 17.7 percent and contract with private for profit health facilities, 15.2 percent.

#### **4.3.4 Post partum care**

A total of 68.4 percent of the workplaces offered financing for post partum care in 2010 as compared to 40.0 percent in 2007. Majority of the workplaces financed through onsite clinic, contract with NGO constituting and contract with private for profit health facilities (29.1 percent 19.0 percent and 12.7 percent respectively).

#### **4.3.5 Pap smear (Cervical cancer detection)**

The workplaces that did not finance pap smear services declined from 71.7 percent in 2007 to 36.7 percent in 2010. Majority of the workplaces offering support in pap smear finances them using contract with NGO, 21.5 percent, followed by through an onsite clinic, 56.4 percent, and contract with private to profit health facilities. Also, 11.5 percent financed the services through private insurance and 5.1 percent on reimbursement expenses to employees.

#### **4.3.6 Mammogram (Breast cancer detection)**

The proportion of workplaces financing mammogram decreased from 71.7 percent in 2007 to 36.7 percent in 2010. Most of the workplaces financing mammogram service use contract with NGO, 20.3 percent, followed by 19.0 percent with contract with private for profit health facilities and through onsite clinic, 16.5 percent.

### **4.4 Financing of Child Health Services**

This section discusses financing of the child health that employees can access and are financed through the workplaces. Information was obtained that sought to know the mode of financing in provision of immunization/well child visits and sick child care as shown in Table 4.4. There was improvement in immunization/child visits with data indicating decline in workplaces not supporting from 52.7 percent in 2007 to 32.9 percent in 2010. Majority (38.0 percent) were carried through an onsite clinic followed by contract with NGO at 17.7 percent. Also, support for sick child with care improved from 47.3 percent in 2007 to 72.2 percent in 2010.

**Table 4.4: Financing mode of other reproductive health service**

Family Planning Service/ Mode of Financing	Through an on site clinic	Private insurance	Reimbursement expenses to employees	Contract with NGO	Contract with private for profit health facilities	Employee contribution on fund (solidarity fund)	Service not provided by the company
<b>Immunization/well child visits</b>							
2007	7.3	1.8	1.8	5.5	5.5	1.8	52.7
2010	38.0	2.5	6.3	17.7	10.1	1.3	32.9
<b>sick child with care</b>							
2007	7.3	1.8	1.8	5.5	5.5	1.8	52.7
2010	44.3	5.1	7.6	15.2	12.7	1.3	27.8

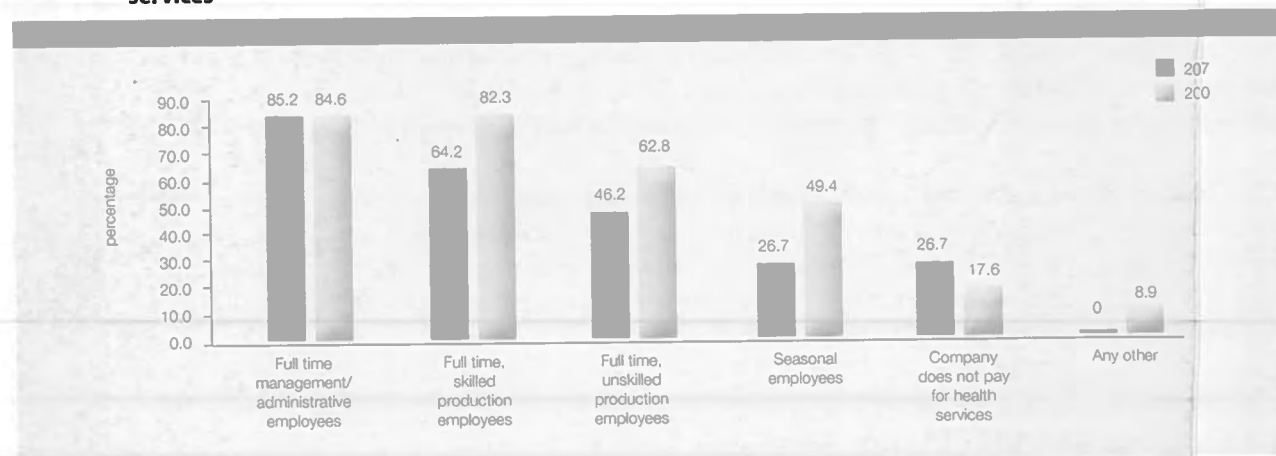
## 4.5 Beneficiaries of Health Financing

The study sought to confirm the categories of employees whose access to health services is paid for by the workplace.

### 4.5.1 Employees Benefiting from Provision of Health Service

Majority of the workplaces did indicate that the full time, management/administrative are provided with health care financing as stated by 84.6 percent in 2010 and 85.2 percent in 2007. Also, fulltime, skilled production employees benefit from health care financing as reported by 82.3 percent of the workplaces while those for fulltime unskilled employees accounted for 62.8 percent. Only 17.6 percent of the workplaces did not pay for health care service in 2010 as compared to 26.7 percent in 2007.

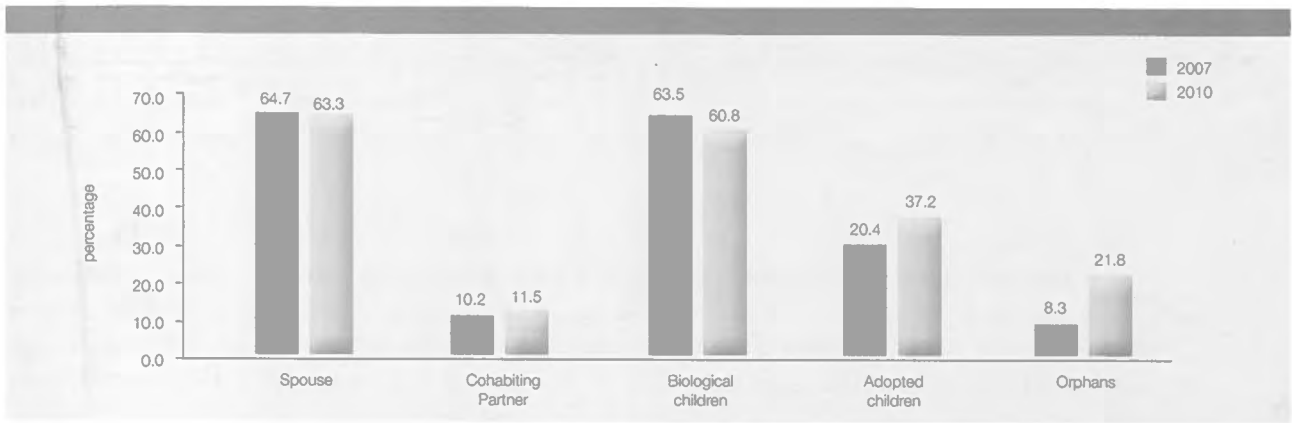
**Figure 4.10 Proportion of workplaces by categories of employees benefiting from financing of the health services**



### 4.5.2 Family Members Benefiting from Provision of Health Service

A total of 63.3 percent of the workplaces provided health care financing to spouses in 2010 as compared to 64.7 percent in 2007. Similarly, 60.8 percent of the workplaces had biological children provided in health financing in 2010 while adopted children was 37.2 percent. The proportion of workplaces supporting orphans increased from 8.3 percent in 2007 to 21.8 percent in 2010.

**Figure 4.11 Proportion of workplaces by category of family members received financing in health care**



*Peter Mwarogo FHI Country Director, awards Sarova Taita Hills Unit Manager with a CWPP Platinum recognition award.*

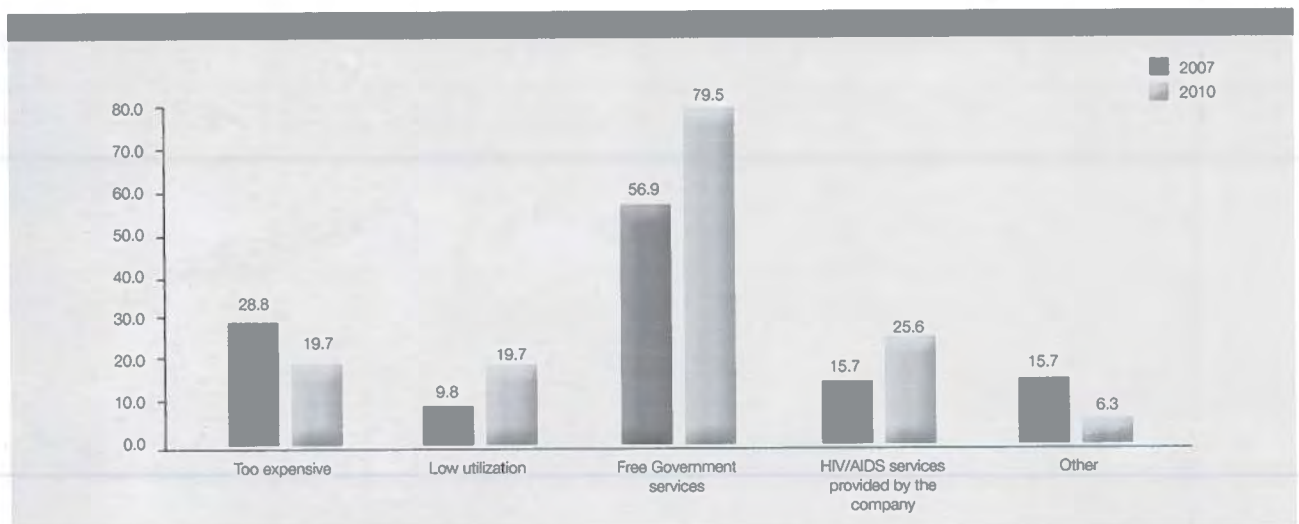
## 5.0 NON PROVISION OF HIV AND REPRODUCTIVE HEALTH CARE SERVICES

In the previous chapter the extent of provision of HIV and reproductive health care services by the business enterprises was discussed. However, in this chapter the factors that resulted into workplaces not financing any of the health care services to its employees are deliberated. The main areas being evaluated is regarding; cost of the service, utilization level, free Government service and availability of HIV/AIDS service in the workplace.

### 5.1 HIV/AIDS Services

Majority (79.5 percent) of the workplaces reported that they did not provide some of the HIV/AIDS services since they were available free Government services. In 2007, 28.8 percent of the workplaces reported that the service were too expensive as compared to 19.7 percent in 2010. More workplaces reported low utilization of the services standing at 19.7 percent in 2010 compared to 9.8 percent in 2007.

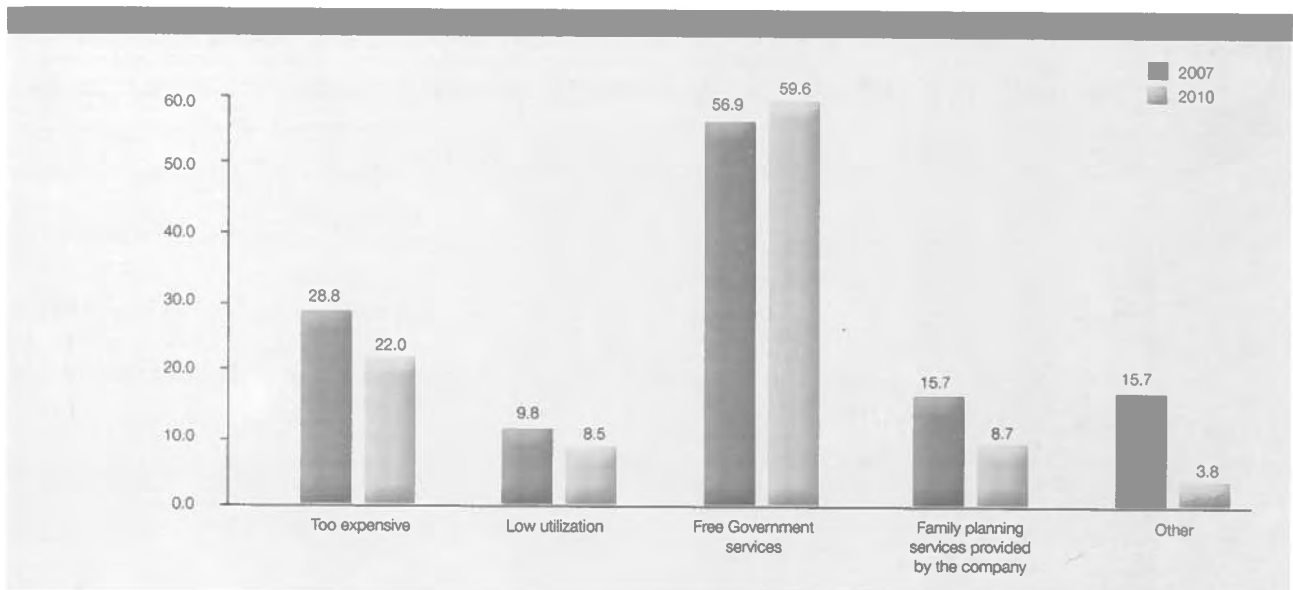
**Figure 5.1: Proportion of workplaces stating reasons for not financing some of the HIV/AIDS services**



### 5.2 Family Planning Services

The workplaces were also asked to explain reasons for not financing some of the family planning services such as contraceptives for men and/or women. In 2010, a total of 59.6 percent reported that it is free service from the Government as compared to 56.9 percent in 2007. The workplaces which reported that the service is expensive declined from 28.8 percent to 22.0 percent. The workplaces reporting that they offered all the family planning services declined from 15.7 percent in 2007 to 8.7 percent in 2010.

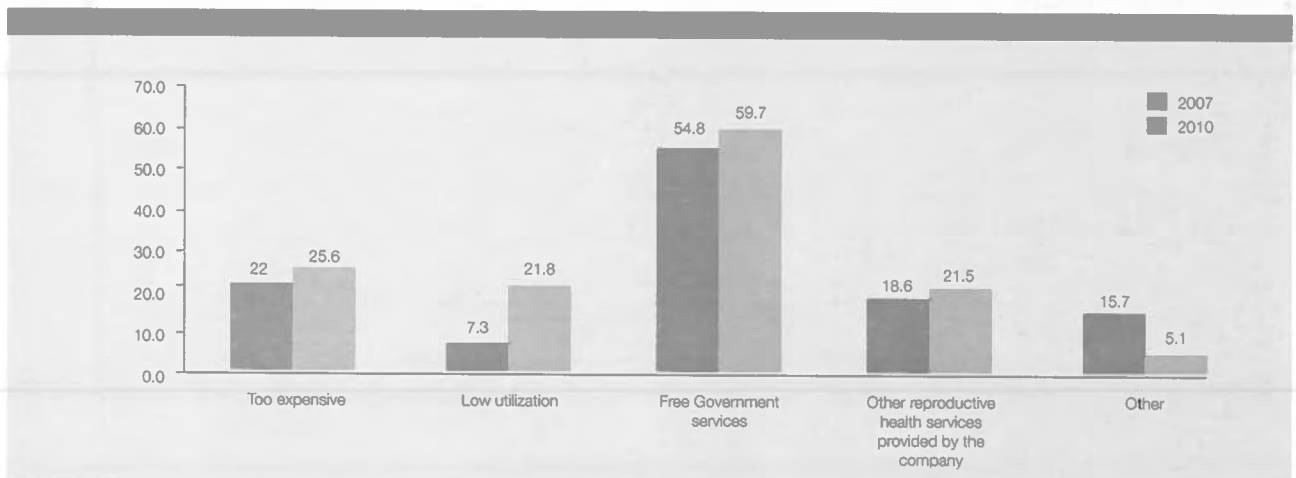
**Figure 5.2: Proportion of workplaces stating reasons for not financing some of the Family planning services**



### 5.3 Other Reproductive Health Services

The services of STI diagnosis and treatment ante natal care, labour and delivery, post partum care, cervical and breast cancer detection formed the other reproductive health services. A comprehensive provision of health services was not taken up since the workplaces felt that the services were available free in the Government facilities.

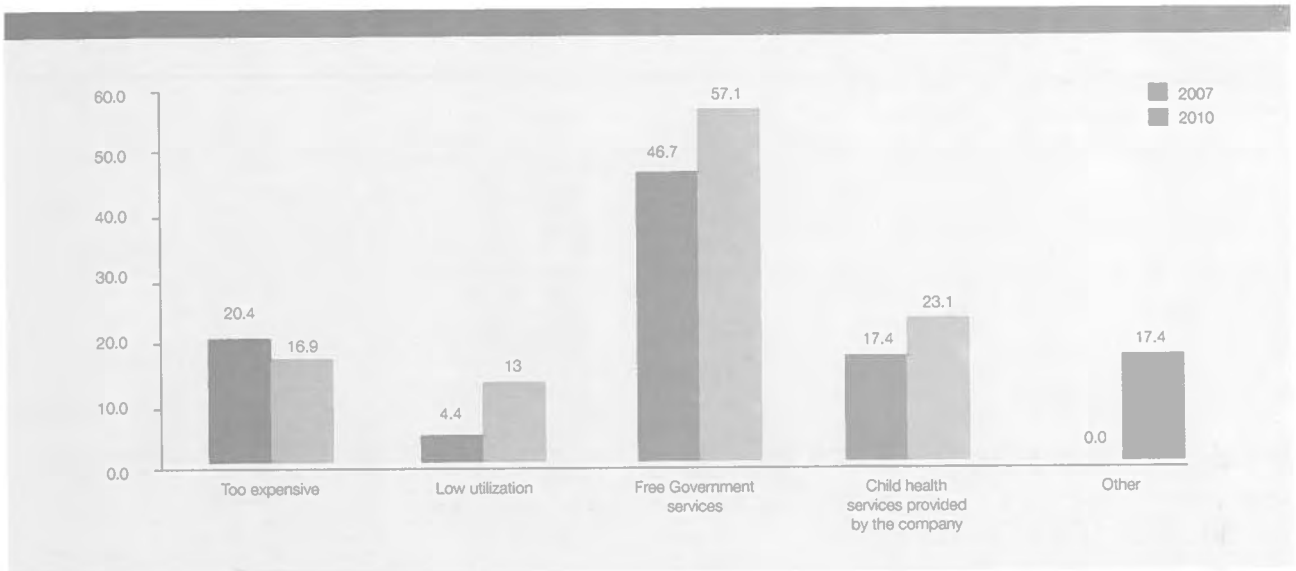
**Figure 5.3: Proportion of workplaces stating reasons for not financing other reproductive health services**



### 5.4 Child Health Services

Information was sought from the workplaces on the reasons for not financing some of the child health services. In 2010, a total of 57.1 percent reported that it is free service from the Government as compared to 46.7 percent in 2007. The workplaces which reported that the service is expensive declined from 20.4 percent in 2007 to 16.9 percent in 2010. The workplaces reporting that they offered all the child health services increased from 17.4 percent in 2007 to 23.1 percent in 2010.

**Figure 5.4: Proportion of workplaces stating reasons for not financing some of the child health services**



*Ruth Odhiambo, Deputy Director APHIA II Rift Valley, awards REA Vipingo Management with a CWPP Platinum recognition award.*

## 6.0 PROVISION OF SERVICES IN ON-SITE HEALTH CLINICS

### 6.1 Existence of an On-site Health Clinic

A total of 56.9 percent of the workplaces reported to have an established on site health clinic since 2007. Rift Valley accounted for 37.5 percent of the workplaces with an on-site health clinic and Coast, 19.4 percent. The proportion of workplaces with onsite health clinic was highest in the agriculture sector at 85.2 percent followed by tour and hotel industry at 60.0 percent.

**Table 6.1: Proportion of workplaces reported in 2007 to have had on -site health clinic**

Province/On site clinic	Goods and Services provider	Tour and hotel industry	Manufacturing	Agriculture	Total
<b>Rift Valley</b>					
Yes	5.3	10.0	31.3	74.1	37.5
No	21.1	-	25.0	11.1	15.3
Not Applicable	-	-	12.5	-	2.8
<b>Coast</b>					
Yes	21.1	50.0	12.5	11.1	19.4
No	36.8	20.0	18.8	3.7	18.1
Not Applicable	15.8	20.0	-	-	6.9
<b>Total</b>					
Yes	26.3	60.0	43.8	85.2	56.9
No	57.9	20.0	43.8	14.8	33.3
Not Applicable	15.8	20.0	12.5	-	9.7

### 6.2 Motivation for establishment of on-site clinic

The study sought to know what motivated the workplaces to establish an onsite-health clinic. Data presented in Table 6.2 indicates that 40.5 percent of the workplaces with onsite-health clinics were motivated to establish the clinics due to lack of health facilities in the community, 50.0 percent wanted to retain staff and 64.3 percent reported due to employee demand. About 4.9 percent of the workplaces inherited the services after privatization by the government and 25.0 percent due to reduced medical expenses.

**Table 6.2: Proportion of companies by motivation for establishment of an on-site health clinic**

Employee Category	Rift Valley				Coast				Total
	Goods/ services provider	Tour and hotel industry	Manufacturing	Agriculture	Goods/ services provider	Tour and hotel industry	Manufacturing	Agriculture	
<b>Full-time, permanent physicians</b>									
Yes	20.0	-	18.2	30.4	21.4	20.0	20.0	20.0	23.0
No	20.0	100.0	36.4	69.6	42.9	40.0	40.0	60.0	50.0
Not Applicable	60.0	-	45.5	-	35.7	40.0	40.0	20.0	27.0
<b>Full-time, permanent nurses</b>									
Yes	20.0	100.0	45.5	78.3	28.6	60.0	20.0	75.0	53.4
No	20.0	-	9.1	21.7	28.6	-	20.0	-	16.4
Not Applicable	-	-	-	-	-	-	20.0	-	1.4
<b>Full-time, permanent laboratory technicians</b>									
Yes	-	100.0	18.2	26.1	21.4	20.0	-	50.0	21.9
No	40.0	-	36.4	73.9	35.7	40.0	60.0	25.0	49.3
Not Applicable	60.0	-	45.5	-	42.9	40.0	40.0	25.0	28.8
<b>Full-time, permanent pharmacy staff</b>									
Yes	-	100.0	27.3	13.0	21.4	30.0	-	50.0	20.8
No	40.0	-	27.3	73.9	35.7	30.0	50.0	25.0	45.8
Not Applicable	-	-	-	13.0	-	-	-	-	4.2

### 6.3 Employees in On-site health clinic

Analysis of Table 6.2 indicates that in on-site health clinics, 53.4 percent of the workplaces have employed full time permanent nurses followed by 23.0 percent full time permanent physicians. Under tour and hotel industry, Rift Valley workplaces had no fulltime permanent employees, while Coast was 20.0 percent. The reported fulltime permanent nurses were highest in Tour and Hotel industry (Rift Valley) at 100 percent followed Agriculture(Rift valley) at 78.3 percent and Agriculture (Coast) at 75.0 percent.

**Table 6.3: Proportion of workplaces reporting category of employees in the on-site health clinic**

Reason for Onsite health clinic	Yes	No	Don't know	Not Applicable
Lack of health facilities in the community	40.5	54.8	2.4	2.4
Staff retention	50.0	42.9	4.8	2.4
Employee demand	64.3	26.2	7.1	2.4
Inherited services after privatization by the government	4.9	82.9	7.3	4.9
To reduce transport expenses	25.0	-	-	-
To reduce medical expenses	25.0	-	-	-
To comply with company's act	25.0	-	-	-
Free medical services to employees is a Co Policy	8.3	-	-	-
No onsite clinic Referral to MOH	0.0	-	-	-
Demand by gvt for a mandatory onsite clinic if staff is >100	16.7	-	-	-

## 6.4 Laboratory Tests in on- site health clinic

Information on whether tests are taken in the workplace in on-site health clinics is presented in Table 6.3. A total of 42.5 percent of the workplaces carried out HIV testing tests followed by Basic hematology, 21.9 percent and Blood chemistry tests at 19.2 percent. Also the proportion of the workplaces carrying out CD4 counts hematology tests, Viral load test and culture tests was 8.2 percent, 4.1 percent and 13.7 percent respectively.

**Table 6.4 Proportion of workplaces having tests taken in the on-site health clinic**

Tests taken in on site clinic	Rift Valley				Coast				Total
	Goods/services provider	Tour and hotel industry	Manufacturing	Agriculture	Goods/services provider	Tour and hotel industry	Manufacturing	Agriculture	
<b>Basic hematology tests</b>									
Yes	-	100.0	18.2	26.1	21.4	20.0	40.0	-	21.9
No	40.0	-	36.4	73.9	35.7	40.0	20.0	75.0	49.3
Not Applicable	60.0	-	45.5	-	42.9	40.0	40.0	25.0	28.8
<b>Blood chemistry tests</b>									
Yes	-	100.0	18.2	17.4	21.4	30.0	0.0	25.0	19.2
No	40.0	-	36.4	82.6	35.7	30.0	60.0	50.0	52.1
Not Applicable	60.0	-	45.5	-	42.9	40.0	40.0	25.0	28.8
<b>Cultures tests</b>									
Yes	-	100.0	9.1	8.7	21.4	20.0	0.0	25.0	13.7
No	40.0	-	45.5	91.3	35.7	40.0	60.0	50.0	57.5
Not Applicable	60.0	-	45.5	-	42.9	40.0	40.0	25.0	28.8
<b>HIV testing tests</b>									
Yes	-	100.0	36.4	56.5	35.7	30.0	40.0	75.0	42.5
No	40.0	-	18.2	43.5	21.4	30.0	20.0	0.0	28.8
Not Applicable	60.0	-	45.5	-	42.9	40.0	40.0	25.0	28.8
<b>CD4 counts hematology tests</b>									
Yes	-	100.0	9.1	-	21.4	10.0	0.0	0.0	8.2
No	40.0	-	45.5	95.7	35.7	50.0	60.0	75.0	61.6
Not Applicable	-	-	0.0	4.3	0.0	0.0	0.0	0.0	1.4
<b>Viral load tests</b>									
Yes	-	-	9.1	-	7.1	10.0	0.0	0.0	4.1
No	40.0	100.0	45.5	95.7	50.0	50.0	60.0	75.0	65.8
Not Applicable	-	-	0.0	4.3	0.0	0.0	0.0	0.0	1.4

## 6.5 Utilization of HIV/AIDS Service

Table 6.4 provides details of the employees who received the various HIV/AIDS services in the onsite health clinics from the various business sector. A total of 24,987 were counseled on correct condom use, 14,428 employees were provided with HIV/AIDS testing and counseling, 10,637 counseling on being sexually faithful and 8,420 counseling on abstinence. The least service provided was diagnosis and treatment for opportunistic infections (138) and coordination of home based care for HIV/AIDS use. Other services provided were adherence counseling on ARVs and counseling on drug/alcohol abuse

**Table 6.5 Number of employees who received the HIV/AIDS service by business sector**

HIV/AIDS Service	Goods/services provider	Tour and hotel industry	Manufacturing	Agriculture	Total
Testing and counseling for HIV/AIDS	1,520	270	6,881	5,757	14,428
coordination of home based-care for HIV/AIDS use	10	12	0	170	192
Diagnosis and treatment for OIs	23	13	7	95	138
Diagnosis and treatment for OIs	537	4	11	1,797	2,349
Adherence counseling on ARVs	724	0	1,107	240	2,071
Counseling on abstinence	195	1,081	2,280	4,864	8,420
Counseling on being sexually faithful	1,924	1,569	2,280	4,864	10,637
Drug/alcohol use as related to HIV/AIDS	282	1,187	2,330	4,614	8,413
Counseling on correct condom use	2,194	1,284	14,430	7,059	24,967

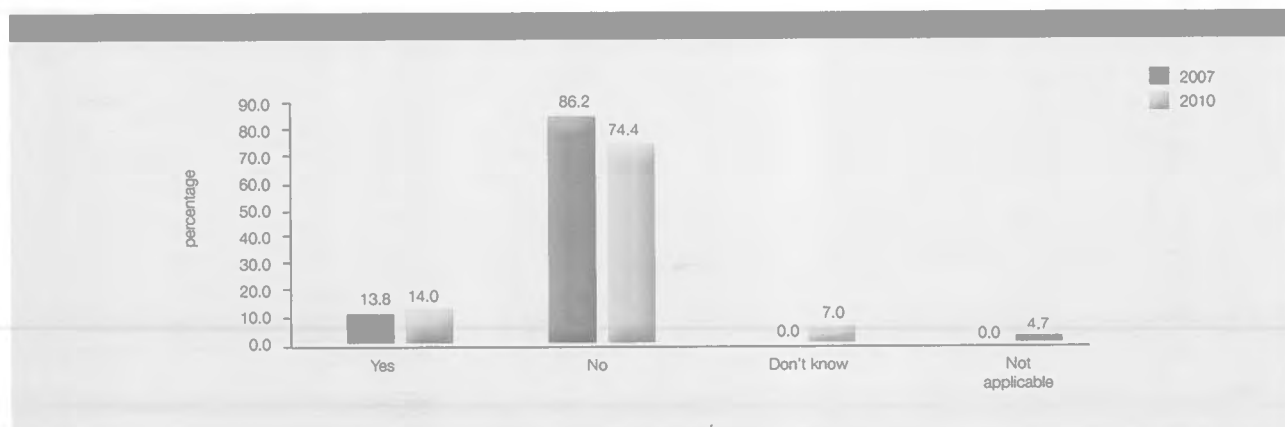
## 6.6 Status of ARVs provision in Workplace On-site Clinics

Information on provision of ARVs and reasons for not providing was sought from the workplaces.

### 6.6.1 Provision of ARVs

Analysis of Figure 6.1 indicates that the proportion of workplaces providing ARVs to their employees improved marginally from 13.8 percent in 2007 to 14.0 percent in 2010. During the period of assessment 7.0 percent stated they Don't know and 4.7 percent Not applicable.

**Figure 6.1 Proportion of workplaces with on-site clinic providing ARVs**



### 6.6.2 Reasons for Non provision of ARVs

Majority of the workplaces with on-site clinics reported not providing ARVs due to the government offering free access as stated by 72.5 percent in 2010 and 57.1 percent in 2007. Another 20.0 percent stated that it is due to costs in 2010 as compared to 28.7 percent in 2007. Other reasons are; due to lack of access to supplies and limitation of national regulation as reported by 17.5 percent and 20.0 percent respectively.

**Table 6.6 Reasons for non provision of ARVs in on site health clinics**

Reasons for Not providing ARVs	2007	2010			
	Baseline	Yes	No	Dont know	Not Applicable
Due to costs	28.7	20.0	62.5	7.5	10.0
Due to Limitation by national regulation	13.6	20.0	57.5	12.5	10.0
Due to access to supplies	18.2	17.5	67.5	7.5	7.5
Due to low utilization	9.5	20	67.5	2.5	10
Due to government offering free access to ARVs	57.1	72.5	17.5	2.5	7.5
Stigma among staff	-	25	-	-	-
Inadequate trained medical personnel	-	50	-	-	-
Done at Private Hospital to reduce Stigma	-	25	-	-	-

### 6.6.3 Monitoring Employees ART Progress

The monitoring mechanisms of employees ART progress in the onsite health clinics was sought. Table 6.7 presents data indicating that in 2010, 41.9 percent of the workplaces monitored at the onsite clinic as compared to 20.0 percent in 2007. Also, 83.7 percent refer to government facility, 32.6 percent refer to private facility and 9.5 percent refer to NGO in 2010. The proportion of workplaces not monitoring employees ART progress declined from 12.0 percent in 2007 to 9.5 percent in 2010.

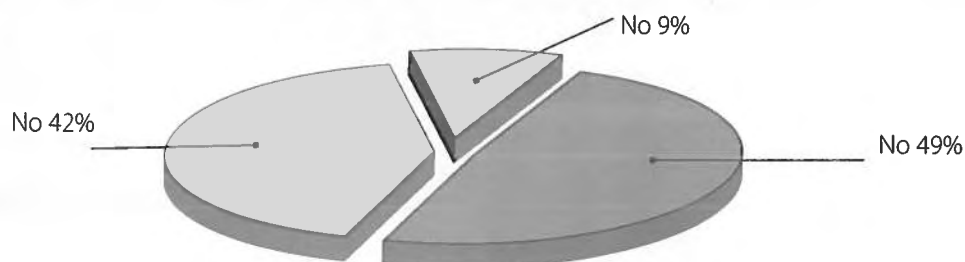
**Table 6.7: Proportion of workplaces with on-site clinic monitoring employees ART progress**

Monitor employee ART progress	2007	2010			
	Baseline	Yes	No	Dont know	Not Applicable
At on site clinic	20.0	41.9	51.2	4.7	2.3
Refer to government facility	50.0	83.7	11.6	-	4.7
Refer to private clinic	25.0	32.6	65.1	-	2.3
Refer to NGO	23.1	9.5	85.7	-	4.8
No Monitoring	12.0	9.5	83.3	-	7.1

### 6.6.4 Provision of ART Statistics Report to Government

Information in Figure 6.1 shows the status of the workplaces providing ART statistics to the government. A total of 42 percent of the workplaces with onsite clinics provided ART statistics while 49 percent did not.

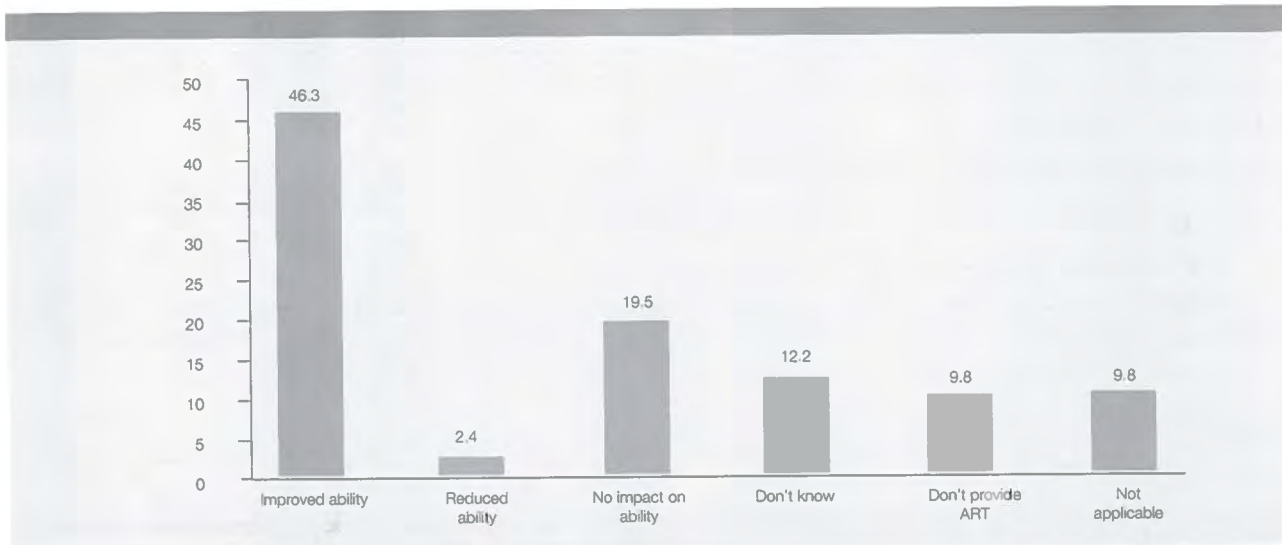
**Figure 6.2 Workplaces reporting Clinic ART Statistics to the Government**



### 6.6.5 Impact of Government policy o Free Access to ARVs

The workplaces were further asked if there was an impact on its services the Government policy of free access to ARVs. Figure 6.4 indicates that 46.3 percent of the workplaces reported it improved their ability as compared to 2.45 percent who said it reduced their ability. However, 19.5 percent stated that there was no impact on ability while 12.2 percent reported they don't know.

**Figure 6.3 Impact of free access to ARVs to clinics ability to provide ART**



*Margaret Kabue, Program Officer APHIA II Rift Valley, awards Nandi Tea with a CWPP level 2 Gold award.*

# 7.0 STOCKING OF HIV/AIDS-RELATED HEALTH PRODUCTS IN ONSITE CLINICS

Information on the supplies and stocks available in the last 12 months that addresses the employee's health service needs in onsite clinics is presented in this chapter. The ability of the onsite clinics to address the client's needs in the provision of ARVs, HIV/AIDS kits is also discussed.

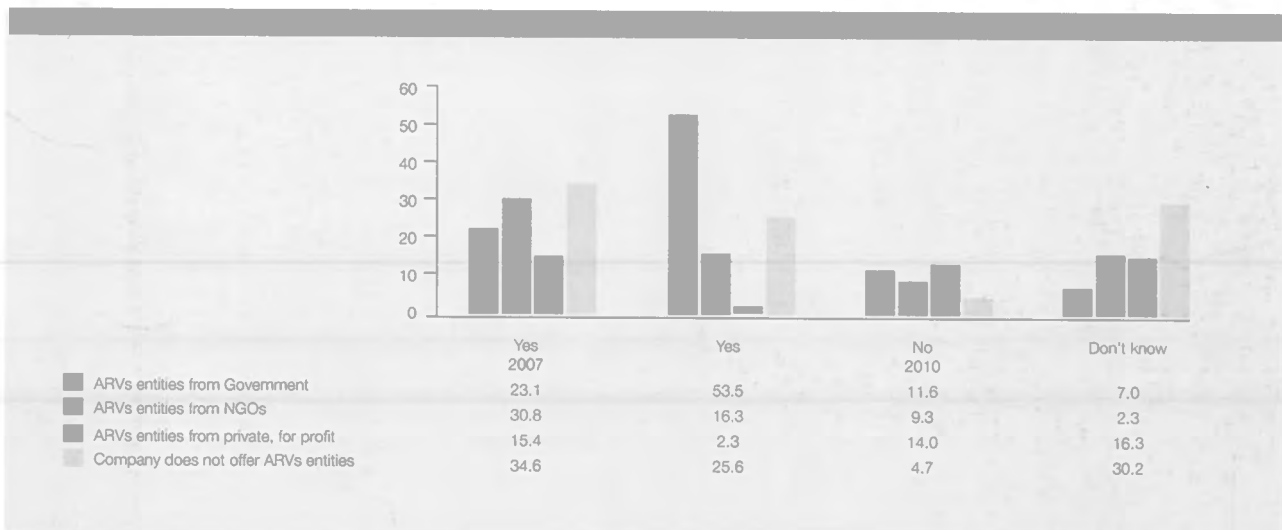
## 7.1 Source of Supplies for HIV/AIDS Related products

The workplaces onsite health clinic relied on several sources to get its supplies of the HIV/AIDS related products that included; the Government, NGOs and private for profit organizations.

### 7.1.1 Anti Retro Viral (ARVs)

Analysis of Figure 7.1 shows that in 2010, the Government is the major supplier of Anti Retro Viral (ARVs) to workplaces onsite clinics at 53.5 percent followed by NGOs at 16.3 percent. Conversely, in 2007 NGOs were the highest suppliers at 30.8 percent followed by the Government, 23.1 percent. During the period under review, the proportion of workplaces receiving ARVs from private for profit entities declined from 15.4 percent in 2007 to 2.3 percent in 2010, a reduction of 13.1 percent. In 2010, the workplaces indicating that they did not get the ARVs supplies was 11.6 percent on Government, 9.3 percent from NGOs and 14.0 percent from private for profit workplaces.

Figure 7.1 Source of ARVs supplies for the onsite health clinic

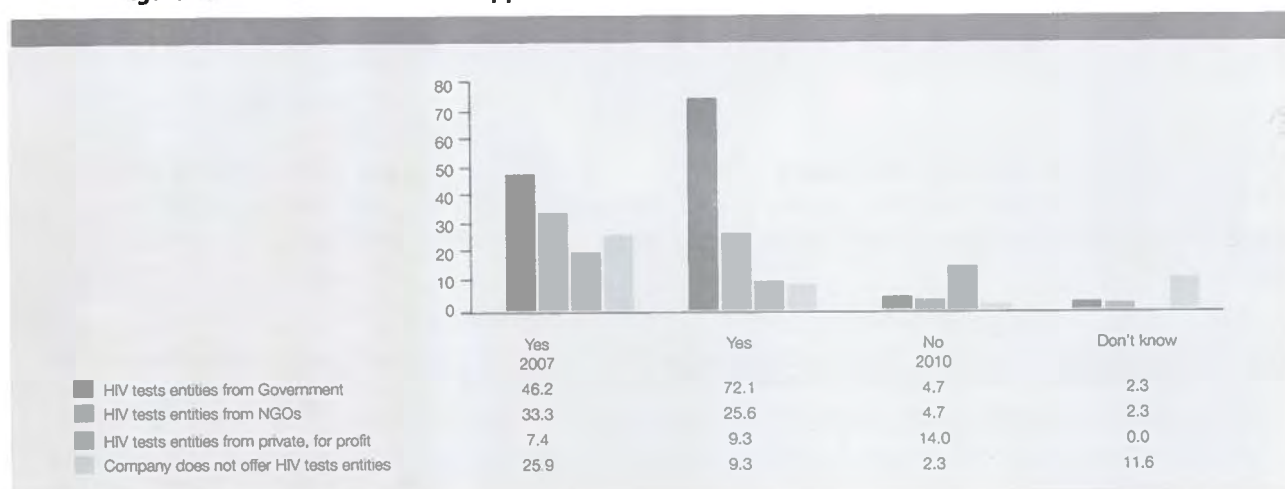


### 7.1.2 HIV Tests Kits

The proportion of workplaces receiving HIV test kits to workplaces on site clinics increased tremendously from 46.2 percent in 2007 to 72.1 percent in 2010. However, in the same period, supplies from NGOs declined from 33.3 percent to 25.6 percent of the workplaces. There was marginal increase in HIV test kits between 2007 and 2010, at 7.4 percent and 9.3 percent. On

the other hand, the proportion of workplaces not offering HIV tests stood at 7.4 percent in 2007 as compared to 9.3 percent in 2010.

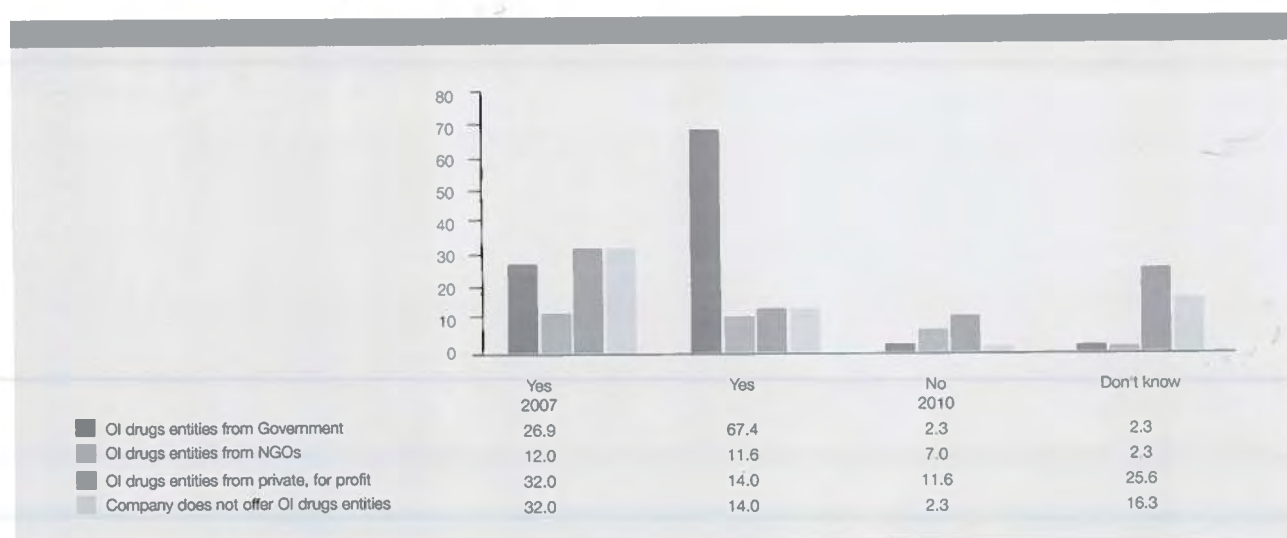
**Figure 7.2 Source of HIV test kits supplies for the onsite health clinic**



### 7.1.3. Opportunistic Infections Drugs

Figure 7.3 indicates that majority of the workplaces had opportunistic infection (OI) drugs supplied by the Government, as reported by 67.4 percent in 2010 compared to 26.9 percent in 2007. The current status of OI drugs supply from private for profit organizations accounted for 14.0 percent of the workplaces while NGOs stood at 11.0 percent. The workplaces not offering OI drugs were 14.0 percent.

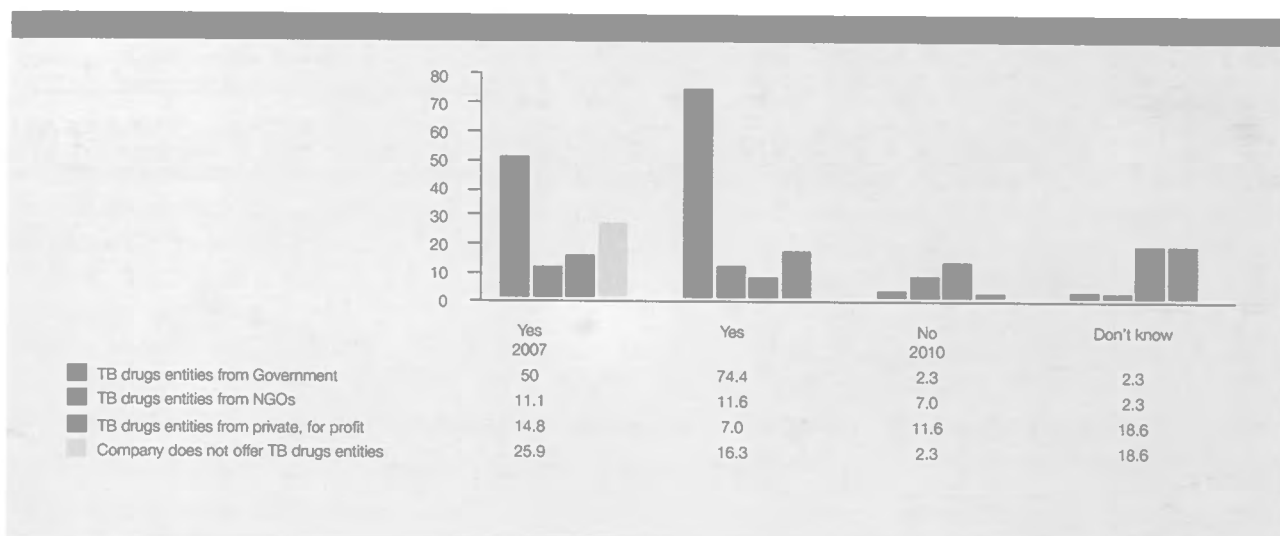
**Figure 7.3 Source of OI drugs supplies for the onsite health clinic**



### 7.1.4 Tuberculosis Drugs

Analysis of Figure 7.4 illustrates that the government is the major supplier of Tuberculosis Drugs (TB) drugs at workplaces onsite clinics standing at 74.4 percent in 2010, an increase from 50.0 per cent in 2007. In 2010, TB supplies from NGOs and private for profit entities accounted for 11.6 percent and 7.0 percent respectively. In 2007, TB supplies from NGOs and private for profit entities accounted for 12.0 percent and 32.0 percent respectively. Very few workplaces stated that NGOs and private for profit organizations provide them with TB drugs at 11.1 per cent and 14.8 per cent respectively. 25.9 per cent of the conducted workplaces do not provide TB drugs.

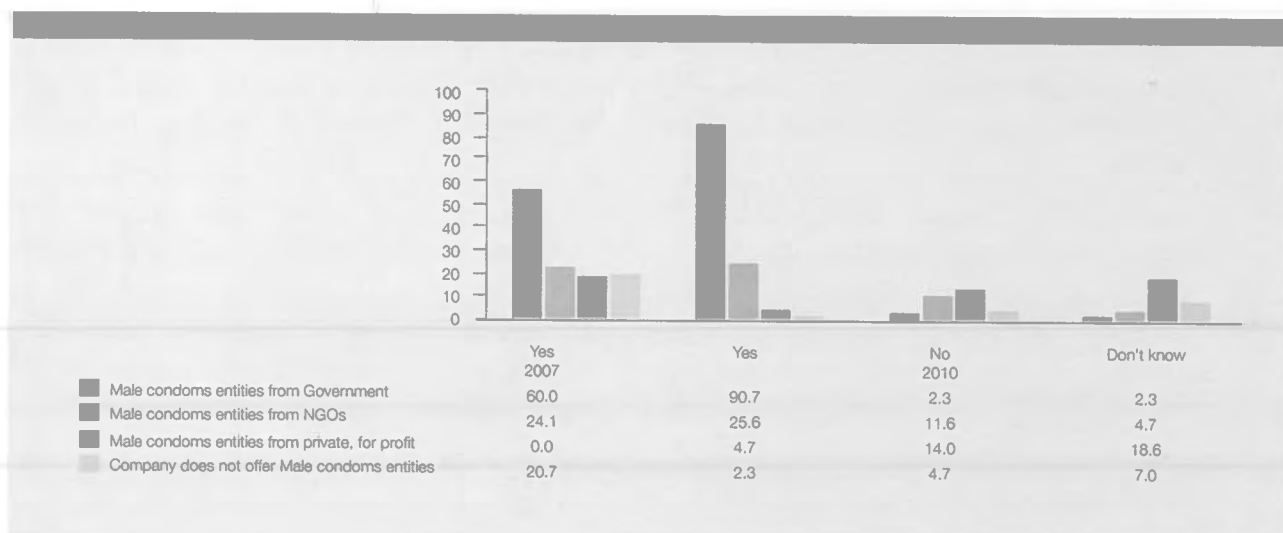
**Figure 7.4 Source of TB drugs supplies for the onsite health clinic**



### 7.1.5. Male Condoms

In 2010, majority of the workplace onsite clinics (90.0 percent) cited Government as the supplier for male condoms and increase from 60.0 percent in 2007. The workplaces onsite clinics reporting supplies of male condoms from the NGOs marginally increased from 24.1 percent in 2007 to 25.6 percent in 2010. Only 4.4 percent of the workplaces stated to have sourced male condoms from the private for profit entities in 2010 while 2.3 percent did not offer condoms at the workplaces.

**Figure 7.5 Source Male condom supplies for the onsite health clinic**



## 7.2 Stock Run Outs of HIV/AIDS Related Products

Table 7.1 presents data on the reported status of stock run outs in the last 12 months of the various HIV/AIDS related products such as ARVs, HIV test kits and OI drugs among others. This section provides a detailed account of the status in 2007 compared to 2010.

**Table 7.1 Proportion of workplaces experiencing stocks run out in the last 12 months**

Stocks	2007	2010			
	Yes	Yes	No	Dont know	Not Applicable
ARVs	3.7	2.3	41.9	7.0	48.8
HIV tests	12.0	14.0	67.4	2.3	16.3
OI drugs	16.0	16.3	53.5	-	30.2
TB drugs	26.1	5.0	47.5	-	47.5
Malaria Drug	44.0	23.3	69.8	-	7.0
Male condoms	40.7	25.6	72.1	-	2.3
IUD/IUCD	21.7	9.5	40.5	-	47.6
Pills	29.2	18.6	65.1	-	16.3
Injectable	29.2	21.4	61.9	-	16.7
Implants	20.8	16.3	37.2	-	44.2
Antibiotics	29.6	27.9	62.8	-	9.3

### 7.2.1 Ante Retro Viral Drugs

Table 7.1 indicates that in 2010, 2.3 percent of the workplaces onsite clinics ran out of ARVs stocks in the last 12 months prior to the study as compared to 3.7 percent in 2007, an improvement of 1.4 percent. In 2010, a total of 41.9 percent stated they had enough ARV stock while 7.0 percent stated don't know. Though the proportion of workplaces onsite clinics with ARVs stocks running out is small, it has a significant impact on the employees relying on the supply.

### 7.2.2 HIV Test Kits

There was a 2.0 percent increase of workplaces onsite clinics running out of HIV test kits from 12.0 percent in 2007 to 14.0 percent in 2010. However, in 2010, 67.4 percent reported to have adequate stocks while 2.3 percent stated don't know and 16.3 percent were not applicable. It is important that the workplaces maintain consistency provision to enhance user confidence in the service.

### 7.2.3 Opportunistic Infection Drugs

There was no significant change in workplaces onsite clinics running out of stock for OI drugs between 2007 and 2010 as reported by 16.0 percent and 16.3 percent respectively. However, in 2010, 53.5 percent of the clinics reported to have adequate stock while 30.2 percent stated not applicable.

### 7.2.4 Tuberculosis drugs

There was great improvement in proportion of workplaces running out of stock of TB drugs from 26.1 percent in 2007 to 5.0 percent in 2010, a decline of 21.1 percent. However, the five percent cases of TB drugs stock run out is a concern, since the patients will require consistent availability of the drugs. The analysis further shows that in 2010, 47.5 percent of the onsite clinics had enough stock and 47.5 percent stated not applicable. It is therefore important the supply of TB drugs needs to be maintained to avoid the patients missing out their drug intake.

### **7.2.5 Malaria drugs**

Reliable stocking of malaria drugs at the clinic is important so that patients access them as soon as possible. The data shows that there has been tremendous decline of 16.7 percent in workplaces with malaria stocks run out from 44.0 percent in 2007 to 23.3 percent in 2010. In 2010, a total of 69.8 percent of the workplace onsite clinics reported having adequate stock while 7.0 percent stated not applicable.

### **7.2.6 Male Condoms**

Supply of male condoms in the 12 months prior to the study improved, with workplaces reporting stock run out declining by 15.1 percent from 40.7 percent in 2007 to 25.6 percent in 2010. In 2010, the workplaces stating adequate male condoms stock were 72.1 percent and those not applicable were 2.3 percent. However, the proportion reporting shortages is high and therefore a need for constant supply of condoms to reduce the employees' risk of HIV infections.

### **7.2.7 Intra Uterine contraceptive devices**

The workplaces that ran out of stock of IUD/IUCD declined by 12.2 percent from 21.7 percent in 2007 to 9.5 percent in 2010. In 2010, 40.5 percent workplaces with onsite clinics reported to have adequate IUD/IUCD stock while 47.6 percent stated not applicable.

### **7.2.8 Pills**

In 2010, the workplace with pills out of stock in the period of twelve months prior to the study, were 18.6 percent as compared to 29.2 percent in 2007. A total of 61.9 percent workplaces with onsite clinics reported to experience adequate stock while 16.3 percent stated not applicable.

### **7.2.9 Injectable**

The data shows that 21.4 percent of the workplaces had run out of injectables in 2010 as compared to 29.2 percent in 2007, a decline of 7.8 percent. A total of 61.9 percent of the workplaces with onsite clinics reported to have adequate stocks in 2010 while 16.7 percent stated not applicable.

### **7.2.10 Implants**

The supply of implants to the workplace onsite clinics was adequate for the 12 months prior to the study in 2010 as reported by 37.2 percent while 44.2 percent stated not applicable. However, 16.3 percent reported to have implants stock run out in 2010 as compared to 20.8 percent in 2007.

### **7.2.11 Antibiotics for STIs**

There was minimal change of 1.9 percent in workplaces with onsite clinics reporting antibiotics stock run out in 2010 at 27.9 percent compared to 29.8 percent in 2007. A total of 62.8 percent of the onsite clinics reported to have adequate stock in the 12 months prior to the study while 9.3 percent stated not applicable.

# 8.0 CONCLUSION AND RECOMMENDATIONS

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## 8.1 Conclusion

### **APHIA Project sites and workplace**

The assessment study was carried out in APHIA II project business enterprise workplaces for Coast and Rift Valley provinces. The aim of the study was to determine the impact of interventions under the comprehensive workplace policy programs (CWPP) for the period 2008 to 2010. In all, 36.4 percent of the enterprises were from the agriculture sector, 28.6 percent, goods/services, 20.8 percent, manufacturing and 14.3 percent, hotel and tour industry. The workplaces had a total of 133,396 employees in the 79 workplaces with Coast and Rift Valley province accounting for 29.5 percent and 70.5 percent. A total of 6.8 percent of The APHIA II Project partner sites employees were fulltime management/administrative while 21.8 percent were full time unskilled production employees.

### **Comprehensive workplace policy and programs**

There has been great improvement of uptake of comprehensive workplace policy and programs by the business workplaces from 50.9 percent to 90.9 percent in 2010. This indicates a positive achievement of the APHIA II project in mainstreaming of HIV/AIDS workplace policies in the business enterprises. Support by workplaces on aspects of CWPP was enhanced with condom promotion and distribution reported at 100 percent, IEC materials, 100 percent and referral for treatment and other care and support materials.

Several capacity building activities were carried out during the study period targeting all the levels of employees. This includes management sensitization that covered 800 employees drawn from Coast and Rift Valley provinces (50.4 percent and 49.8 percent). Program design and implementation was among other trainings conducted benefiting a total of 2,261 employees. The employees were taken through a series of trainings on specific areas of the CWPP targeting between 55,479 employees from Rift valley and 26,034 employees from Coast. Majority (86.1 percent) of the workplaces supported family and community outreach activities.

### **HIV/AIDS Services**

There was considerable improvement in HIV/AIDS service provision in the workplaces with financing mode ranging from onsite clinic, private insurance, reimbursement to employees, contract with NGO, contract with private for profit and employee contribution on fund. The proportion of workplaces financing testing and counseling of HIV/AIDS rose from 44.8 percent in 2007 to 83.5 percent in 2010. Majority (47 percent) reported financing mode for testing and counseling of HIV/AIDS is through on site clinic. The proportion of workplaces financing

provision of ARTs to employees increased from 44.6 percent in 2007 to 68.4 percent in 2010. The same case for home based care of HIV/AIDS increasing from 44.8 percent in 2007 to 53.2 percent in 2010. Service provision on treatment for prevention of mother to child transmission of HIV/AIDS rose from 64.1 percent to 75.9 percent. However, adherence counseling on ARVs support declined from 57.1 percent to 27.8 percent. On the other hand counseling on alcohol and drug abuse rose from 48.2 percent to 82.9 percent. Workplaces that offered employees financing for counseling on alcohol drug abuse rose from 48.2 percent in 2007 to 82.9 percent in 2010. Only 14.1 percent of the workplaces supported counseling on correct condom use in 2010 as compared to 29.3 percent in 2007.

### **Family Planning Services**

The proportion of workplaces not financing male condoms declined from 33.9 percent in 2007 to 12.7 percent in 2010 while provision of pills rose from 25.1 percent to 72.2 percent in the same period. A total of 41.4 percent of the workplaces did not finance provision of IUCD/IUD in 2010 as compared to 69.6 percent in 2007. Financing of injectables was carried out in 72.2 percent of the workplaces in 2010 as compared to 33.9 percent in 2007. The financial provision for implants took place in 58.2 percent of the workplaces in 2010 as compared to 30.4 percent in 2007. The proportion of workplaces not financing vasectomy declined from 75 percent in 2007 to 53.2 percent in 2010. A total of 45.6 percent of the workplaces offered financing for tubal ligation in 2010 as compared to 25.0 percent in 2007.

### **Other Reproductive Health Services**

There proportion of workplaces' not financing STI diagnosis and treatment services declined from 52.7 percent in 2007 to 16.7 percent in 2010 as well as ante natal care from 56.4 percent to 16.7 percent. Labor and delivery services rose from 41.8 percent in 2007 to 64.6 percent in 2010 while post partum care improved from 40.0 percent in 2007. Pap smear services declined from 71.7 percent in 2007 to 36.7 percent in 2010 and the same case for mammogram services from 71.7 percent to 36.7 percent.

### **Child Health Services**

There were two levels of child health care financing; immunization/well child visits and sick child with care reported by 67.1 percent and 72.2 percent of the workplaces in 2010. This was an improvement from the status of 2007 where only 47.3 percent of the workplaces financed the child health services.

### **Beneficiaries of Health Care services**

The proportion of workplaces not paying for health care services declined from 26.7 percent in 2007 to 17.6 percent in 2010. The study also showed that majority of the workplaces finance health services for fulltime, management/administrative staff at 85.2 percent. A total of 49.4 percent of the workplaces reported financing seasonal employees in 2010, an increase from 26.7 percent in 2007. Health service financing for the spouse was reported by 63.3 percent of the workplaces, a slight decline from 64.7 percent in 2007. The trend was similar for support of biological children declining from 63.5 percent to 60.8 percent. However, there was improvement in workplaces supporting adopted children and orphans, an increase from 7.8 percent and 13.8 percent respectively.

### **Barriers to implementation of HIV/AIDS workplace policies and activities**

The study looked at factors that inhibit provision of a CWPP based on cost of the service, utilization level, free government service and availability of HIV/AIDS service in the workplace. In provision of HIV/AIDS services, 79.5 percent of workplaces reported not providing it because it was a free Government service. During the study period the proportion of workplaces that reported HIV/AIDS services were too expensive and low utilization declined by nearly half. The proportion of workplaces not offering family planning services declined from 15.7 percent to 8.7 percent. However, free government service accounted for 59.6 percent of the workplaces not financing Family planning service while 22.0 percent stated it was expensive. Reasons for not providing other reproductive health services and child health services were; too expensive (25.6 percent and 16.9 percent) and availability of free government services (59.7 percent and 57.1 percent).

### **Health service provision in workplace onsite clinics**

The onsite health clinics were established in 56.9 percent of the workplaces (37.5 percent in Rift valley and 19.4 percent in Coast). The motivation of establishing the onsite clinics was due to employee demand (64.3 percent), staff retention (50.0 percent) and lack of health facilities in the community (40.5 percent). Other reasons were to reduce medical expenses (25.0 percent) and inherited service after government privatization (4.9 percent). Analysis further shows that 53.4 percent of the employees are full time permanent nurses while 23.0 percent are full time permanent physicians. Laboratory tests were carried out in the onsite clinics; 42.5 percent of workplaces carried out HIV testing tests, Basic hematology, 21.9 percent, Blood chemistry tests, 19.2 percent. CD4 counts hematology tests, 8.2 percent, Viral load test, 4.1 percent and culture tests, 13.7 percent. Information on service utilization was provided with a total 24,987 were counseled on correct condom use, 14,428 employees were provided with HIV/AIDS testing and counseling, 10,637 counseling on being sexually faithful and 8,420 counseling on abstinence.

The proportion of workplaces providing ARVs in the onsite clinic rose marginally from 13.8 percent to 14.0 percent. Most workplaces (72.5 percent) with onsite clinics stated that they did not provide ARVs since it is available free from the Government. Other reasons given were; lack of access to supplies (17.5 percent) and limitation of national regulation (20.0 percent). The monitoring of employees ART progress was reported mainly to take place at onsite clinic (41.9 percent) and refer to government facility (83.7 percent) and refer to private clinic (32.6 percent). Only 42.0 percent of the workplaces with onsite clinics reported ART statistics to the government. Further investigation was done on the impact of free government ARV services on site clinic provision. About 46.3 percent of the workplaces reported it improved their ability, 19.5 percent stated no impact on ability while only 2.4 percent stated reduced ability.

The results showed that HIV/AIDS related products for the onsite health clinics relied on supplies from the government, NGOs and private for profit organizations. In 2010, the major supplier to ARVs to the clinics was the government (53.5 percent) and the NGOs (16.3 percent) compared to NGOs (30.8 percent) and government (23.1 percent) in 2007. It is likely that the Government free access policy resulted in less workplaces relying from the private entities which declined from 15.4 percent to 2.3 percent. The government was the highest supplier for HIV/AIDS test kits (72.1 percent), Opportunistic infections drugs (67.4 percent), Tuberculosis drugs (74.4 percent) and male condoms (90.0 percent). The NGOs and entities from private for profit organizations supplied to a limited number of workplaces' onsite clinics. It was also noted that there were cases of onsite clinics having stock run out in the last 12 months prior to the

study. However, cases of stock run out was lower in 2010 as compared to 2007, depicting that the workplaces were more prepared in ensuring stock adequacy. The highest cases of stock run out was noted with Antibiotics(27.9 percent), male condoms(25.6 percent), malaria drug(23.3 percent), implants(16.3 percent), OI drugs(16.3 percent) and HIV test kits(14.0 percent). However, lack of TB drugs and ARVs was reported by 5.0 percent and 2.3 percent of the onsite health clinics is a serious concern.

## 8.2 Recommendations

The partnership with Government of Kenya for access to services improved access to services. There is therefore a need for formalize partnerships to enhance on accountability in reporting.

There is need for the workplaces to move a step further to carry out a program Cost-Benefit Analysis. This is because the increased confidence in workplace on-site health facilities could be reflected as an increase in medical cost which could be undesirable to investors.

The integration of other health services including maternal and child health, family planning and other reproductive health services was successful indicating that other related interventions with the UNAIDS Continuum of Prevention, Care and Support can be included in the workplace program like alcohol and drugs control, succession planning, economic sustainability services, etc

The successful linkage with government health facilities as evident in the preferred and actual sources of the services in the survey showed that the workplace can fit very well into the community strategy of the government of Kenya. The number of workplaces providing Home-Based Care increased during the period surveyed which shows referral from the facilities to the workplaces as per the community strategy.



*Oby Obyerodhyambo, Senior Technical advisor, awards Kapset Tea Factory with a CWPP level 2 Gold award.*

# ANNEXE

## A1: Number of Employees in Workplace/Institution by Category, economic sector and Region

Category of Employee	Goods/services provider		Tour and hotel industry		Manufacturing		Agriculture		Total
	Rift Valley	Coast	Rift Valley	Coast	Rift Valley	Coast	Rift Valley	Coast	
<b>Full time management/ administrative employees</b>									
Male	137	2,212	550	258	109	740	3,006	61	7,073
Female	637	1,519	134	68	20	74	2,730	16	5,198
Total	774	2,910	684	326	284	814	3,219	79	9,090
<b>Full time, skilled production employees</b>									
Male	767	2,699	988	2,633	1,676	528	4,042	207	13,540
Female	163	2,364	988	2,212	1,406	157	3,549	43	10,882
Total	1,789	3,076	988	2,858	10,875	685	5,741	250	26,262
<b>Full time, unskilled production employees</b>									
Male	1,056	4,088	988	2,163	3,908	176	9,841	2,372	24,592
Female	1,035	4,111	988	2,034	3,544	52	10,602	1,397	23,763
Total	1,117	4,260	988	2,210	4,454	228	13,060	2,780	29,097
<b>Part-time, all year employees</b>									
Male	3,996	3,211	170	3,221	8,001	1,184	12,330	1,403	33,516
Female	3,996	3,099	988	3,047	7,986	1,140	12,210	1,171	33,637
Total	3,996	3,324	170	3,293	8,786	1,325	12,563	1,585	35,042
<b>Seasonal, all year employees</b>									
Male	2,997	6,190	.	2,212	1,114	561	7,985	1,056	22,115
Female	2,997	6,027	.	2,053	617	84	7,009	67	18,854
Total	3,147	6,272	.	2,278	12,205	645	9,234	124	33,905
<b>Total Employees</b>									
Male	1,967	1,693	1,800	1,307	3,563	2,054	9,768	2,076	24,228
Female	2,223	822	400	597	2,910	528	9,765	686	17,931
Total	3,191	9,540	2,200	2,031	5,486	2,942	15,024	2,762	43,176

A2:

## Number of employees who attended training in Rift Valley by type of service

Training Attended	Goods/services provider	Tour and hotel industry	Manufacturing	Agriculture	Total
Managers sensitization	36	4	187	170	397
Staff induction/all employees awareness forum	379	100	1,686	8,311	10,476
HIV/AIDS committee training	35	7	81	156	279
HIV/AIDS program design & implementation	45	7	560	1,403	2,015
coordinator training (quality assurance, monitoring, supervision)	9	2	43	56	110
(STIs) and HIV/AIDS as part of capacity building exercise.	224	100	1,077	865	2,266
care and support for PLWHA	99	100	913	587	1,699
VCT	61	-	1,051	220	1,332
ART (Antiretroviral therapy)	59	-	1,051	185	1,295
mother-to-child transmission HIV	100	100	1,054	285	1,539
Facilitation skills	130	100	640	378	1,248
Peer education	132	100	654	526	1,412
Sexuality and gender	131	100	145	435	811
Training of trainers (TOT)	16	12	529	33	590
Social marketing of condoms	91	100	525	58	774
Behaviour change communication	121	-	630	419	1,170
Peer counseling	10	4	72	342	428
Malaria prevention & treatment	114	100	628	808	1,650
TB prevention, treatment & care	139	100	626	743	1,608
Family planning & reproductive health	132	100	426	825	1,483
Stigma & discrimination reduction strategies	131	100	426	734	1,391
Nutrition and general awareness	75	100	367	697	1,239
Early (breast, cervical & prostate) cancer detection	23	-	20,003	234	20,260
Any other	4	.	2	1	7

**A3:**  
**Number of employees who attended training in Coast by type of service**

Training Attended	Goods/services provider	Tour and hotel industry	Manufacturing	Agriculture	Total
Managers sensitization	172	154	42	35	403
Staff induction/all employees awareness forum	7,813	1,249	1,376	115	10,553
HIV/AIDS committee training	153	99	11	46	309
HIV/AIDS program design & implementation	102	55	79	10	246
coordinator training (quality Assurance, monitoring, supervision)	48	27	7	7	89
(STIs) and HIV/AIDS as part of capacity building exercise.	490	432	1,088	64	2,074
Care and support for PLWHA	246	87	86	21	440
VCT	305	79	37	20	441
ART (Antiretroviral therapy)	128	83	21	17	249
Mother-to-child transmission HIV	98	98	92	19	307
Facilitation skills	112	164	71	37	384
Peer education	443	195	116	67	821
Sexuality and gender	191	164	102	86	543
Training of trainers (TOT)	85	18	23	3	129
social marketing of condoms	218	83	75	17	393
Behavior change communication	519	113	1,078	49	1,759
Peer counseling	93	54	89	44	280
Malaria prevention & treatment	269	365	788	39	1,461
TB prevention, treatment & care	231	173	788	79	1,271
Family planning & reproductive health	206	156	788	80	1,230
stigma & discrimination reduction strategies	472	105	461	67	1,105
Nutrition and general awareness	161	393	654	39	1,247
Early (breast, cervical & prostrate) cancer detection	17	165	102	3	287
Any other	10	3	-	-	13

# STUDY QUESTIONNAIRE:

## APHIA II COAST & RIFT VALLEY PROJECTS

Confidential

### COMPREHENSIVE HIV/AIDS WORKPLACE PROGRAMME ASSESSMENT

#### Introduction

The APHIA II project through its partner National Organization of Peer Educators (NOPE), is carrying out a situation analysis of comprehensive HIV/AIDS workplace initiatives in public and private companies/institutions in selected districts (Taita Taveta, Mombasa, Malindi, Kwale, Kilifi, Nakuru, Naivasha, Koibatek, Kericho, Narok, Nandi). The information obtained will assist in the improvement of ongoing and new HIV/AIDS workplace programs as well as identify and strengthen linkages to prevention, treatment, care and support services. The results of this assessment will help in proposing appropriate strategies to enhance mainstreaming of HIV/AIDS and wellness programs in the normal business of the organizations to benefit their employees and families.

The questionnaire shall be self administered and shall take approximately 30 minutes to complete. Be assured that information you share will be kept strictly confidential and results generalized. We therefore request that you respond to the questions as honestly as possible. If you have any questions about this survey, you can contact \_\_\_\_\_ of APHIA II in \_\_\_\_\_ District, on Tel: APHIA II \_\_\_\_\_ on telephone number \_\_\_\_\_ or by email at @nope.or.ke, or moruko@nope.or.ke

#### Instructions (PLEASE READ)

To answer each question, please check or code the appropriate response. If you work in a branch that is part of a larger company or institution, please answer questions based on the business practices in the location you work in.

This survey is intended for human resource personnel and health clinicians. If you find during any point in the survey that there is a term you do not understand and need defined, please read the glossary of terms that is attached to the questionnaire.

Because this survey asks questions about a wide variety of topics, there may be some questions that you may not be able to answer. If you don't know the answer to a question, this is not a problem. Simply respond, "I don't know". If some of your work colleagues may be able to answer the questions you don't know, please seek clarification with them and complete the questions.

Finally, in the report that will come from this survey, we will categorize the company or institutions based on comprehensiveness of the HIV/AIDS workplace initiatives and recommend on areas of improvement.

Thank you for sparing some of your time to fill-in the questionnaire.

# STUDY QUESTIONNAIRE:

## A. Background

First, we would like to ask you about your company/institution and your job.

A1. What is the name of the company/institution where you work? \_\_\_\_\_

A2. What is the business nature of your company/institution?

1= Goods/services provider

2= Tour and Hotel Industry

3= Manufacturing

4= Agriculture

5= Other (specify) \_\_\_\_\_

A3. What is your job title? \_\_\_\_\_

A4. What is your email address? \_\_\_\_\_

A5. what is your phone number? \_\_\_\_\_

A6. Date: \_\_\_\_\_ / \_\_\_\_\_ 2010

## B. Background Information about Employees

Next, we would like to ask you some questions about the employees at your company/institution.

B1. How many employees work at this location based on each of the categories below?

B1a. Full-time management/administrative employees

Male       Female       Total       Don't Know       Not Applicable

B1b. Full-time, skilled production employees

Male       Female       Total       Don't Know       Not Applicable

B1c. Full-time, unskilled production employees

Male       Female       Total       Don't Know       Not Applicable

B1d. Part-time, all year employees

Male       Female       Total       Don't Know       Not Applicable

B1e. Seasonal employees

Male       Female       Total       Don't Know       Not Applicable

B2. Approximately how many employees work for your company in this region? (If response is you don't know, tick the box.)

Male       Female       Total       Don't Know       Not Applicable

# STUDY QUESTIONNAIRE:

## C: HIV/AIDS PROGRAMS AND POLICIES

The questions that follow are seeking answers regarding HIV & AIDS programs in your company/institution

C1. Does your company/institution have an HIV & AIDS workplace policy?

Code: 1= Yes 2= No 3= Don't Know

C2. Which of the following activities is your organization supporting? (check all that apply)

a. Providing Staff with information and education on HIV & AIDS

(Code: 1= Yes 2= No 3= Don't Know)

b. Access to STI prevention and treatment

(Code: 1= Yes 2= No 3= Don't Know)

c. Condom promotion and distribution

(Code: 1= Yes 2= No 3= Don't Know)

d. Access to VCT

(Code: 1= Yes 2= No 3= Don't Know)

e. Care for orphans and vulnerable children (OVC)

(Code: 1= Yes 2= No 3= Don't Know)

f. Care for persons living with HIV and AIDS

(Code: 1= Yes 2= No 3= Don't Know)

g. Referral of staff for treatment and other care and support services

(Code: 1= Yes 2= No 3= Don't Know)

h. Other (specify) \_\_\_\_\_

C3. As part of HIV&AIDS workplace coordination and implementation mechanism, how many employees have ever received training in the following areas?

1= Managers sensitization

2= Staff Induction/all employees awareness forum

3= HIV/AIDS committee training

4= HIV/AIDS program design & implementation

5= Coordinator training (quality assurance, monitoring, supervision)

C4. As part of the HIV&AIDS capacity building activities for the company/institution, how many employees have ever received some training in the following areas?

1= Sexually transmitted infections (STIs) and HIV/AIDS

2 = Care and support for People Living With AIDS (PLWHA)

3= Voluntary Counseling and testing (VCT)

4 = Antiretroviral therapy (ART)

5 = Mother-to-child transmission of HIV

6 = Facilitation skills

7 = Peer education

8 = Sexuality and Gender

9 = Training of Trainers (TOT)

10 = Social Marketing of Condoms

11 = Behavior change communication

12 = Peer Counseling

13 = Malaria prevention & treatment

14 = TB prevention, treatment & care

15 = Family planning & reproductive health

16 = Stigma & discrimination reduction strategies

17 = Nutrition & general wellness

18 = Early (breast, cervical & prostate) cancer detection

19 = Other (specify) \_\_\_\_\_

# STUDY QUESTIONNAIRE:

**C5** As part of your HIV & AIDS work place activities, does your company /Institution carry out the following activities? (check all that apply)

a) Family Fun day

(Code: 1= Yes 2= No 3= Don't Know)

d) Parent & youth fun day

(Code: 1= Yes 2= No 3= Don't Know)

b) Spouses fun day

(Code: 1= Yes 2= No 3= Don't Know)

e) Community outreach

(Code: 1= Yes 2= No 3= Don't Know)

c) Children's fun day

(Code: 1= Yes 2= No 3= Don't Know)

f) Others (Specify) \_\_\_\_\_

\_\_\_\_\_

## D. General Financing of HIV and Reproductive Health Care

This section pertains to general financing of HIV/AIDS care and treatment and reproductive health by your company.

**D1** For each service, please indicate how your company/institution provides for employees' health care. (Check all that apply.)

HIV/AIDS SERVICES	Through an on-site clinic	Private insurance	Reimburse expenses to employees organizations	Contract with non governmental facilities	Contract with private, for profit health solidarity fund)	Employee contribution fund (i.e.	Service not provided by company	Don't know
Testing and counseling for HIV/AIDS								
Antiretroviral treatment (ART) for AIDS								
Coordination of home-based care for HIV/AIDS								
Treatment to prevent mother-to-child transmission of HIV/AIDS (Nevirapine)								
Post Exposure Prophylaxis								
Diagnosis and treatment of opportunistic infections (OI), not including tuberculosis (TB)								
Diagnosis and treatment of TB								
Psychosocial support/ counseling for people living with HIV/AIDS (PLWHA)								

# STUDY QUESTIONNAIRE:

HIV/AIDS SERVICES	Through an on-site clinic	Private insurance	Reimburse expenses to employees organizations	Contract with non governmental facilities	Contract with private, for profit health solidarity fund)	Employee contribution fund (i.e.	Service not provided by company	Don't know
Adherence counseling for ARVs								
Counseling on abstinence								
Counseling on being sexually faithful								
Counseling on drug/alcohol use								
Counseling on correct condom use								

## D2 Family Planning Services

HIV/AIDS SERVICES	Through an on-site clinic	Private insurance	Reimburse expenses to employees organizations	Contract with non governmental facilities	Contract with private, for profit health solidarity fund)	Employee contribution fund (i.e.	Service not provided by company	Don't know
Male condoms								
Pills								
IUD/IUCD								
Injectables								
Implants								
Vasectomy								
Tubal Ligation (TL)								

## D3 Other Reproductive Health Services

HIV/AIDS SERVICES	Through an on-site clinic	Private insurance	Reimburse expenses to employees organizations	Contract with non governmental facilities	Contract with private, for profit health solidarity fund)	Employee contribution fund (i.e.	Service not provided by company	Don't know
STI diagnosis and treatment								
Antenatal care								
Labor/delivery								
Postpartum care								
Pap smear (cervical cancer detection)								
Mammogram (breast cancer detection)								

# STUDY QUESTIONNAIRE:

HIV/AIDS SERVICES	Through an on-site clinic	Private insurance	Reimburse expenses to employees organizations	Contract with non governmental facilities	Contract with private, for profit health solidarity fund)	Employee contribution fund (i.e.	Service not provided by company	Don't know
Immunizations/well child visits								
Sick child care								

E1 If some or all HIV/AIDS services in D1 are not provided through your company, why aren't they? (Check all that apply.)

Too expensive

(Code: 1= Yes 2= No 3= Don't Know)

All HIV/AIDS services are provided by the company

(Code: 1= Yes 2= No 3= Don't Know)

Low utilization

(Code: 1= Yes 2= No 3= Don't Know)

Other (please specify) \_\_\_\_\_

Services available for free from the government

(Code: 1= Yes 2= No 3= Don't Know)

E2 If some or all family planning services D2 (e.g. contraceptives for men and/or women) are not provided through your company, why aren't they? (Check all that apply.)

Too expensive

(Code: 1= Yes 2= No 3= Don't Know)

All family planning services are provided by the company

(Code: 1= Yes 2= No 3= Don't Know)

Low utilization

(Code: 1= Yes 2= No 3= Don't Know)

Other (please specify) \_\_\_\_\_

Services available for free from the government

(Code: 1= Yes 2= No 3= Don't Know)

E3 If some or all other reproductive health services in D3 (e.g. STI services, pregnancy care) are not provided through your company, why aren't they? (Check all that apply)

Too expensive

(Code: 1= Yes 2= No 3= Don't Know)

All reproductive health services are provided by the company

(Code: 1= Yes 2= No 3= Don't Know)

Low utilization

(Code: 1= Yes 2= No 3= Don't Know)

Other (please specify) \_\_\_\_\_

Services available for free from the government

(Code: 1= Yes 2= No 3= Don't Know)

E4 If some or all child health services in D4 are not provided through your company, why aren't they? (Check all that apply.)

Too expensive

(Code: 1= Yes 2= No 3= Don't Know)

All child health services are provided by the company

(Code: 1= Yes 2= No 3= Don't Know)

Low utilization

(Code: 1= Yes 2= No 3= Don't Know)

Other (please specify) \_\_\_\_\_

Services available for free from the government

(Code: 1= Yes 2= No 3= Don't Know)

# STUDY QUESTIONNAIRE:

E5 For which of the following types of employees will the company pay for health services? (Check all that apply.)

Full-time, management/administrative employees

(Code: 1=Yes 2=No 3=Don't Know)

Seasonal employees

(Code: 1=Yes 2=No 3=Don't Know)

Full-time, skilled production employees

(Code: 1=Yes 2=No 3=Don't Know)

Company does not pay for health services

(Code: 1=Yes 2=No 3=Don't Know)

Full-time, unskilled production employees

(Code: 1=Yes 2=No 3=Don't Know)

Other (please specify) \_\_\_\_\_

E6 For which of the following family members will the company pay for health services? (Check all that apply.)

Spouse

(Code: 1=Yes 2=No 3=Don't Know)

Adopted children

(Code: 1=Yes 2=No 3=Don't Know)

Cohabiting partner

(Code: 1=Yes 2=No 3=Don't Know)

Orphans

(Code: 1=Yes 2=No 3=Don't Know)

Biological children

(Code: 1=Yes 2=No 3=Don't Know)

Only staff member is eligible for paid health services

E7 Up to what age does the company pay for health services for children? (If you don't know the age up to which benefits are offered, please type "don't know" in the box.)

Years

Don't Know(tick)

F1 Did you report earlier that you had an on-site clinic at your work location?

1=Yes 2=No 3=Don't Know. (if No, go to end)

F2 Does your clinic have any of the following full-time, permanent staff? (Code the correct response)

Code: 1=Yes 2=No 3=Don't Know

Physicians

Nurses

Laboratory technicians

Pharmacy staff

F3 Which of the following lab tests can be performed at this location? (Code the correct response)

Code: 1=Yes 2=No 3=Don't Know

Basic hematology

HIV testing

Blood chemistry

CD4 counts

Cultures

Viral load

F4 Do you share information about the number of employees that have been served with HIV/AIDS services at to staff of programs/institutions that support you?

1=Yes 2=No 3=Don't Know.

# STUDY QUESTIONNAIRE:

F5 In the past 12 months, approximately how many employees at your company received the following HIV/AIDS services at your on-site clinic? (If you don't know, please tick "Don't know" in the corresponding box.)

Testing and counseling for HIV/AIDS

Number

Don't Know

Coordination of home-based care of HIV/AIDS

use

Don't Know

Diagnosis and treatment of opportunistic infections, not including TB

Don't Know

Psychosocial support/counseling for people living with HIV/AIDS (PLWHA)

Don't Know

Adherence counseling on ARVs

Don't Know

Counseling on abstinence

Don't Know

Counseling on being sexually faithful

Don't Know

Counseling on drug/alcohol use as related to HIV/AIDS

Don't Know

Counseling on correct condom use










F6 Are antiretroviral (ARVs) provided to employees by this clinic to manage HIV/AIDS?

1=Yes 2=No 3=Don't Know. (if Yes, go to F8)

F7 What is the reason for not providing ARVs in this clinic?

(Check all that apply.)

a. Cost

(Code: 1=Yes 2=No 3=Don't Know)

b. Limited by national regulation

(Code: 1=Yes 2=No 3=Don't Know)

c. Access to supplies

(Code: 1=Yes 2=No 3=Don't Know)

d. Low utilization

(Code: 1=Yes 2=No 3=Don't Know)

e. Government offer free access to ARVs

(Code: 1=Yes 2=No 3=Don't Know)

g. Other (please specify) \_\_\_\_\_

F8 How do you monitor employee progress on ART (i.e. CD4 and follow-up health care visits)? (Check all that apply if Yes in either F7:- a, b, c, d and e)

a. At on-site clinic

(Code: 1=Yes 2=No 3=Don't Know)

b. Refer to government facility

(Code: 1=Yes 2=No 3=Don't Know)

c. Refer to private clinic

(Code: 1=Yes 2=No 3=Don't Know)

d. Refer to NGO

(Code: 1=Yes 2=No 3=Don't Know)

e. Don't monitor progress on ART

(Code: 1=Yes 2=No 3=Don't Know)

F9 Do you report your clinic's ART statistics to the government?

1=Yes 2=No 3=Don't Know.

F10 How has free access to ARVs affected your clinic's ability to provide ART? (code the correct response)

1= Improved ability

2= Reduced ability

3= No impact on ability

4= Don't know

5= Other(Specify)

# STUDY QUESTIONNAIRE:

F11 From which entities do you procure the following HIV/AIDS-related health products for your clinic? (Check all that apply.)

	Government 1=Yes 2=No 3=Don't Know.	Non governmental organizations 1=Yes 2=No 3=Don't Know.	Private, for profit 1=Yes 2=No 3=Don't Know.	Don't offer this product	Other
ARVs					
HIV tests					
OI drugs					
TB drugs					
Male condoms					

F12 Have you had stock outs of any of the following health products in the last 12 months? ( Code the correct response in the box provided)

1=Yes 2=No 3=Don't 4=Don't offer this know product

ARVs	<input type="checkbox"/>	IUD/IUCD	<input type="checkbox"/>
HIV tests	<input type="checkbox"/>	Pills	<input type="checkbox"/>
OI drugs	<input type="checkbox"/>	Injectables	<input type="checkbox"/>
TB drugs	<input type="checkbox"/>	Implants	<input type="checkbox"/>
Malaria Drugs	<input type="checkbox"/>	Antibiotics for STI	<input type="checkbox"/>
Male condoms	<input type="checkbox"/>		

F13 What motivated your company to establish an on-site clinic? (Check all that apply.)

- a. Lack of health facilities in community  
(Code: 1= Yes 2= No 3= Don't Know)
- b. Staff retention  
(Code: 1= Yes 2= No 3= Don't Know)
- c. Access to supplies  
(Code: 1= Yes 2= No 3= Don't Know)

- d. Inherited services after privatization by the government  
(Code: 1= Yes 2= No 3= Don't Know)
- e Other (please specify) \_\_\_\_\_  
\_\_\_\_\_

# REFERENCES

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1. Workplace Implementation Strategy: Comprehensive HIV/AIDS Prevention, care and Support Programs (CWPPs) APHIA II Coast and Rift Valley 2007
2. Kenya AIDS indicator Survey 2007, September 2009.
3. Kenya National AIDS Strategic Plan 2009/10-2010/13 November 2009

