MAPPING OF INTERVENTIONS AND ASSESSMENT OF THE IMPACT OF HIV AND AIDS IN THE INFORMAL SECTOR IN KENYA

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LIST OF ABBREVIATIONS AND ACRONYMS

ACUs	AIDS Control Units
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti Retroviral Therapy
ARV	Anti-Retrovirals
CBO	Community Based Organization
CBS	Central Bureau of Statistics
DASCO	District HIV and AIDS Coordinator
DHS	Demographic Health Survey
FGD	Focus Group Discussion
FKE	Federation of Kenya Employers
GDP	Gross Domestic Product
GJLOS	Governance, Justice, Law and Order Sector
HAART	Highly Active Anti-Retroviral Therapy
HBC	Home-Based Care
HIS	Health Information System
HIV	Human Immune Virus
HMIS	Health Management Information System
IEC	Information Education and Communication
KDHS	Kenya Demographic Health Survey
KNASP	Kenya National HIV&AIDS Strategic Plan
MDGs	Millennium Development Goals
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Progamme
NGO	Non-Governmental Organisations
NHSSP	National Health Sector Strategic Plan
OVC	Orphans and Vulnerable Children
PEPFAR	Presidential Emergency Plan for AIDS Relief
PLWHAs	People Living with HIV&AIDS
SPSS	Statistical Package for Social Sciences
STIs	Sexually Transmitted Infections
UNDP	United Nations Development programme
UNAIDS	Joint United Nations Programme on HIV&AIDS
UNGASS	United Nations General Assembly Special Session on HIV&AIDS
VCT	Voluntary Counseling and Testing

EXECUTIVE SUMMARY

Introduction

Human Immunodeficiency Virus (HIV), which leads to development of Acquired Immune Deficiency Syndrome (AIDS) has become the most important infectious disease epidemic in the last century. According to the United Nations Joint Programme on HIV&AIDS (UNAIDS), more than 33 million people worldwide are currently living with HIV and AIDS. It also states that there were 2.7 million new infections and 2.0 million deaths due HIV in the year 2007 alone. Sub-Saharan Africa is the most severely affected region with over 22 million people living with HIV and AIDS as at the end of 2007 (UNAIDS, 2008). According to UNAIDS and the National AIDS and STI Control Progamme (NASCOP), Kenya is one of the countries hardest hit by the worldwide HIV epidemic, having a population of more than 1.42 million people infected by HIV (UNAIDS, 2008; NASCOP, 2008).

Informal sector workers constitute the majority of the work force and in Kenya they contribute 80% of the GDP. Yet, very little is known about how HIV&AIDS is affecting this sector, which comprises micro, small and medium-sized industries and informal enterprises, especially those in the service, tourism, and other labour-intensive sectors.

The objective of the mapping exercise was to carry out a study in the informal sector in Kenya to find out the existing HIV&AIDS interventions in the sector; to assess key needs in relation to HIV&AIDS in the informal private sector and the extent to which the informal sector strategies meet those needs; and to conduct a rapid assessment of the impact of HIV&AIDS in the in formal sector.

Methodology

This was a cross sectional, descriptive study that utilized both qualitative and quantitative methods of collecting primary data. A survey questionnaire was developed and administered to the respondents by the research assistants. A total of 581 individual and 126 organisational questionnaires were collected. A semi-structured key informant interview guide was also developed to facilitate eliciting of information during face-to-face interviews with key stakeholders. Focus Group Discussions (FGDs) were held with groups of informal sector workers. Secondary data was collected through desk review of relevant documentation.

The mapping survey was designed to collect information from workers in the informal sector at their workplace in the selected geographical locations using multistage sampling technique. A total of 5 FGDs were conducted, and 60 Key informants interviewed.

Key findings

The findings of the study indicate that only 96 (16.6%) of the respondents reported had workplace Voluntary Counselling and Testing (VCT) services. There was a significantly higher proportion of respondents from the Nairobi sites (47.7%) who reported that their workplace had VCT services when compared to respondents from other sites. Truck drivers/touts/boda boda operators' category of informal sector reported a significantly lower proportion of availability of

VCT services at the workplace environment at 8.4%. Frequency of taking the HIV test seemed to decrease as age increased, with 15.7% of those aged 15-24 years taking the test only once when compared to 42.9% of those aged 45 and above. The most common cited reason for staff not requesting VCT services was fear of stigma and discrimination at work (46.9%) and fear of breach of confidentiality at work (31.7%).

Only 24% of the organizations indicated that they had HIV&AIDS policies and out of these 30, twenty six had HIV&AIDS prevention programmes. The majority of the organization (62.6%) provided employees with information on where they could receive HIV counselling and testing. Only 8 (6.4%) of the organizations required their employees to take an HIV antibody test prior to employment. Respondents from Nairobi and Western sites reported a higher proportion (37.7% and 26.9% respectively) with at least one operational HIV & AIDS operational program in their workplace when compared to the respondents from the other regions

Organizations that provided VCT services comprised only 8 (6.3%) of all the organizations sampled. About 14 (11.3%) of the organizations provided healthcare facilities/services on site, with 9.8% of the respondents reporting that the sector they worked in provided them with any specific HIV & AIDS related programmes and services. Where HIV programmes and services existed at the workplace, condom provision and guidance and counselling were the most commonly provided services. HIV and AIDS-related services are mainly provided by NGOs and CBOs working in the area, with the Government contributing only 28.9% of the services.

Private Sector Workplace Policy on HIV&AIDS was assessed, and thirty five (28.0%) of the representatives of organizations said they were aware of the policy. In 15 (62.5%) of the organizations that had a policy, the staff were sensitised or inducted on its provisions. Further, 52 (62.5%) of the organizations were aware of the new HIV and AIDS Prevention and Control Bill passed by Parliament in 2006. About a third (29.0%) of the organization respondents were aware of any workforce policies related to HIV and AIDS in the sector.

Awareness of HIV&AIDS was universal. Sexual activity was common with 284 (52.6%) of the respondents (comprising 227 males and 57 females) having had sex within one week preceding the interview and a further 23.9% within the preceding one month. The proportion of respondents who had sexual intercourse within the last seven days increased with age up to age 44 years. Truck drivers/touts/boda boda operators had the highest proportion of respondents who had sexual intercourse within the last week of the interview.

Among the respondents who had had sex in the preceding 12 months, condom use was low with only 109 (22.8%) of the respondents having used a condom last time had intercourse. The most common partner with whom the respondent had had the last sexual intercourse with was the husband or wife (72.8%) and boyfriend/girlfriend not living with the respondent (18.9%). Casual sex and sex with prostitutes was low at 3.5% and 1.2% respectively.

Two hundred and fifty (43.5%) of the respondents indicated that the nature of their work put them at risk of HIV infection, while 50.7% of the respondents said that the nature of their work exposed them to HIV infection. The most commonly mentioned nature of risk was ‘occupational vulnerability’ which was stated by 58.3% of the respondents. Across the sectors, a higher

proportion of truck drivers/touts/boda boda operators reported that the nature of their work put them at risk of HIV infection when compared to respondents from other sectors.

Only about one quarter (24.5%) of the respondents had heard of Post-exposure prophylaxis (PEP). A significantly higher proportion of females (32.5%) knew about PEP as compared to only 21.3% of males. Knowledge of PEP was also very low in the Coast sites when compared to the other regions. Out of those who had heard of PEP, only 25.2% said they had access to PEP in case of accidental exposure to HIV.

An assessment of the impact of HIV&AIDS in the informal sector revealed that 74.8% of the respondents had a family member or friend or colleague who was infected or affected by HIV and/or AIDS. Close to two-thirds (62.4%) of those who had an infected family member/friend reporting having ever missed work because of a family member/friend/colleague who was infected/affected by HIV and AIDS.

About two thirds of the organizations indicated that they gave support to persons openly living with HIV in the organization. The types of support given to people affected and infected included financial support, food and upkeep, treatment and medication among others, the most common being food and upkeep (33.7%) and financial support (33.2%). Financial burden and absenteeism were mentioned by 44% and 23% of the respondents respectively as the main ways in which work is affected.

Only (10.9%) representatives of organizations stated both trauma/injuries and contact with injection needles as possible potential exposure to HIV arising from the nature of the work in their organizations. The most common measure taken to decrease the risk of staff exposure to HIV included discussion of HIV & AIDS in the workplace as cited by 42% of the institutional representatives.

Factors reported to contribute to the informal sector workers' vulnerability to HIV infection included distance away from home, weak morals, multiple sexual partners, of the respondents and poverty (7.4%). Factors that made women especially vulnerable to HIV infection include low income, cultural practices such as widow inheritance, gender power dynamics, unprotected sex and rape.

About half (50.8%) of the organizations indicated that they had been affected adversely as a direct result of HIV&AIDS, which promoted shortage of staff due to frequent or prolonged absenteeism of infected staff from duty. Close to half (42.4%) of organization representatives reported that there was an increase of costs from health care provision to staff as a result of HIV & AIDS. Further, respondents from 62.3% of the organizations perceived a decline in work performance due to the HIV epidemic and 70.2% of the respondents said there was frequent staff absenteeism to attend funerals for their colleagues, family members, and friends.

In relation to the direct financial costs, 27.5% of the organizations indicated that there was an increase in overtime payments that aimed to compensate for positions left vacant due to HIV-related illness and death; 29 (24.4%) indicated that there was an increase in premiums of medical cover/health insurance resulting from HIV&AIDS and 40 (33.3%) indicated that there was an

increase in expenses (costs) related to hiring new staff. Other impacts included workers getting demoralized and/or depressed about the illness and/or death of their colleagues due to suspected AIDS-related illnesses which was affirmed by 76 (62.8%) of the organizations while 65 (55.6%) of the respondents said there was low morale due to stigma and discrimination of staff openly living with HIV and/or AIDS.

Conclusion and recommendations:
In conclusion, it was noted that the level of existence of workplace interventions in the informal sector was low, and where they existed, the services were limited to condom provision and counseling. Overall, the Government was evidently not a major provider of HIV&AIDS related services.

There was evidence of access to HIV&AIDS related services by most informal sector workers. However, the majority of the services were not provided at the workplace, and informal sector workers had to be referred or access services from nearby facilities. Again, the main services offered at these facilities were VCT and condom provision, and excluded HIV&AIDS comprehensive care services, including PEP and ARV provision.

Workplace policies were inexistent in most organizations. Nevertheless, it is worth noting that organizations that organizations that had workplace policies also had various HIV&AIDS programmes in place. This indicates that more often than not, policies encouraged translation to practice. Findings of the study revealed that stigmatization affected utilization of services where programmes existed.

It emerged from the findings of the study that workers were vulnerable to HIV&AIDS owing to the nature of occupation in the informal sector, due to the high levels of disposable incomes. The impact of HIV&AIDS in the informal sector was reported to be overwhelming, and included absenteeism; loss of productivity; lowered income due to absenteeism and reduced output, financial and social burden due to support of PLWAs and orphans.

Recommendations from the findings can be summarized as follows:

- VCT services should be provided at the workplace in all the regions and for workers in all categories in the informal sector. Special attention should be given to truck drivers/touts/boda boda operators' category of informal sector workers.

- Pre and post test counselling should be carried out as a part of the VCT process as provided for in the national guidelines. Efforts should be made to build the capacity of providers of VCT service to enhance compliance with provisions of the guidelines.

- The referral system should be strengthened to ensure that VCT clients are provided with information on where one could get follow-up services.

- Concerted efforts should be made to reduce stigma associated with clients accessing VCT services. Workplace HIV&AIDS related services should be provided in accordance with the existing guidelines, and confidentiality maintained

- Formulation and implementation of workplace HIV&AIDS policy for the informal should be done. Results of the study have shown that where policy exists, they are translated to programmes.

- Programmes should be scaled up to include comprehensive HIV&AIDS care and support services, not just VCT and provision of condoms.

- Strengthening the existing CBOs and NGOs to provide HIV&AIDS-related services should be explored as results of the study shows that they are the main service providers.

- Awareness creation should be carried out as the results indicated that most of the respondents did not have accurate knowledge especially in terms of modes of transmission. It should be noted that less than half (47.3%) of the respondents had comprehensive knowledge of HIV based on the questions recommended by UNGASS.

- Sector-specific mitigation measures should be instituted to minimize the risks that expose informal sector workers to HIV&AIDS. Special attention should be given to truck drivers/touts/boda boda operators who reported a proportionately higher risk of contracting HIV infection when compared to respondents from other sectors.

- Raising awareness of PEP should be done across all the regions, and to workers of all informal sectors, as only about a quarter of the respondents were aware of PEP. Access to PEP services should be increased.

- Mitigation of effects of HIV&AIDS at the workplace should be instituted, by way of providing treatment for opportunistic infections, ARVs, social (including orphan care, food and upkeep) and financial support.

- Informal sector workers should be involved in HIV&AIDS workplace programmes, with special attention given to male involvement.

- Further studies should be carried out to determine how to make informal sector workplaces safer especially for women in order to reduce their vulnerability to HIV&AIDS.

- Religious leaders should be facilitated to give more information about HIV/AIDS.

- There is need to avail VCT services in different settings for access by people working in the informal sector, such as static VCT sites in high density areas; moonlight VCTs and mobile ones.

- There is a need of incorporating the Ministry of health strategy of provider-initiated testing and counseling.

- There is need for VCT counselors to be picked from amongst the informal sector and be trained by NASCOP to provide the service.

- There is need for issuance of referral cards for those of members of the informal sector on ARVs, which should be recognized by all health institutions.

- There is need for increasing availability of condom dispensers at discreet spots in public places and appoint caretakers among the informal sector workers to be refilling them.

CHAPTER ONE: INTRODUCTION

1.1 Background

The HIV&AIDS epidemic is now a global crisis, and constitutes one of the most formidable challenges to development and social progress… HIV&AIDS is a major threat to the world of work: it is affecting the most productive segment of the labour force and imposing huge costs on enterprises in all sectors. – ILO Code of Practice on HIV&AIDS and the World of Work (ILO, 2001).

The impact of HIV and AIDS is felt at every level of society –in families, communities and workplaces– and in every part of the world. Of the approximately 40 million people infected with HIV today, at least 36 million are in their most economically productive period (between 15 and 49 years old). This portion of society is so heavily affected that it negatively impacts on the size and structure of populations, on the family and social cohesion, on the livelihoods of individuals and on the economies of nations.

In Kenya, the results from Kenya AIDS Indicator Survey (KAIS) indicate that 7.4% of Kenyan adults age 15-64 are infected with HIV. According to the survey more than 1.4 million people in Kenya were living with HIV. Regional variation was significant: prevalence remains high in Nyanza at 15.3%, more than double the national prevalence estimate (NASCOP, MoH, Kenya, 2008, KAIS, 2007). Other provinces with rates similar to or higher than the national level are Nairobi (9%), Coast (7.9%), and Rift Valley (7.0%). Prevalence in Eastern is 4.7% and in Central, 3.8% of the adult population is infected. North Eastern province has the lowest adult HIV prevalence at 1% (NASCOP, MoH, Kenya, 2008, KAIS, 2007).

NACC has, to date, led the national response by coordinating three five-year strategic plans covering the periods 2000 to 2005, 2005/06 to 2009/10 and 2010/11 to 2014/15. Since 1999, the national adult HIV prevalence is estimated to have dropped from over 14% to about 7.4% in 2007 (NASCOP,2008). Although this decline in prevalence can partially be explained by changes in measurement techniques, there is adequate evidence to suggest that Kenya has made progress in addressing HIV prevalence.

The results for the recently concluded Kenya AIDS indicator survey and the modes of transmission study (MOT) confirm that Kenya has both a generalized and concentrated HIV epidemic in significant proportions. The results indicate that 7.4% of the Kenya adults aged between 15 and 64 years are infected by HIV. There continues to be a substantial regional variation in the HIV infection, low levels of HIV testing, high levels of couple HIV discordance and ongoing epidemics of sexually transmitted infections (STIs) in the country.

The National AIDS Control Council (NACC) within this framework is charged with the responsibility of resource mobilization, policy development and co-ordination of multi-sectoral HIV and AIDS response campaign. In this regard the Kenya National strategic plan 2005/06-2009/10 (KNASP II) was developed and implemented. The current plan in operation is KNASP III whose strategic objectives are ensuring that:

- HIV incidence is reduced
- HIV related morbidity and mortality is reduced
- Kenyans infected and affected have access to the adequate and equitable social protection.

1.1.1 Institutional and policy responses

The Ministry of Health instituted an AIDS Control Committee in 1987, when it developed the first 5-year strategic plan for AIDS control (1987–1991). The second plan was for the period 1992–1996. The Sessional Paper No. 4 of 1997 on AIDS in Kenya marked an important change on the political front and outlined a new institutional framework. With the creation of the National AIDS Control Council, AIDS Control Units (ACUs) were put in place in all the ministries where the disastrous effects of HIV&AIDS had been felt the most and where it was anticipated that interventions would have the greatest beneficial effect. Increased public political commitment was evidenced in 1999 when President Moi declared AIDS a national disaster.

A declaration of 'Total War on AIDS' was one of the first acts of President Mwai Kibaki and bringing together an ecumenical group of religious leaders has been an important step in this fight. Constituency AIDS control committees (CACCs) and district technical committees (DTCs) embody this multi-sectoral response in partnership with ACUs and civil society. Now Kenyans are involved in a comprehensive effort to confront all aspects of the disease's spread and impact. The government has put in place policies and infrastructure to help implement programmes at all levels and has issued guidelines for conducting activities in all HIV&AIDS-related areas.

Greater international and national commitment to address HIV and AIDS throughout the world has been seen through the United Nations General Assembly Special Session on AIDS (UNGASS), the Abuja Declaration, and the Millenium Development Goals. This commitment has led to greatly increased resources and international support, including the World Bank Multi-country AIDS Project (MAP), the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), the US President's Emergency Plan for AIDS Relief (PEPFAR), and other substantial bilateral, multilateral and charitable efforts. The WHO 3 by 5 Initiative—to place 3 million people on antiretroviral therapy (ART) by the end of 2005—has been a rallying cry for efforts to bring Africa and developing countries around the world into the treatment era for HIV and AIDS.

With these efforts and resources, the last 5 years have witnessed an increase in the number of stakeholders and partners who are fighting HIV&AIDS in Kenya. The goodwill created by the high level of political commitment and the evidence of local support and action has resulted in an increased flow of resources into the country's national HIV&AIDS programmes. But increases in funding and the number of people and organizations involved have also increased challenges in coordination to maximize efficiency and to minimize wastage and duplication of effort.

1.1.2 HIV and AIDS response in the informal sector

The private sector HIV and AIDS agenda has been promoted through sector associations such as Kenya HIV&AIDS business council, Federation of Kenya employers (FKE), Kenya association of manufacturers, and the Kenya Private sector alliance (KEPSA). Trade unions such as COTU

have also been involved in the fight against HIV&AIDS in the private sector.

The Kenya Private Sector Advisory Network is a registered society with a core mandate of mobilizing and coordinating the participation of the Private Sector in the National HIV&AIDS response towards contribution to the achievement of the National Strategic Plan in HIV&AIDS in Kenya. This is through a united private sector organization and platform for action on the total war against HIV&AIDS. To be able to effectively coordinate the national response on HIV&AIDS, the Kenya Private Sector Advisory Network [KPSAN] and partners: National AIDS Control Council [NACC], United Nations Development Programme [UNDP], International Labour Organization [ILO] and Joint United Nations AIDS Programme [UNAIDS] wishes to conduct an HIV&AIDS mapping process for the informal private sector players on HIV & AIDS.

The informal sector is the biggest employer of the working population in Kenya accounting for 80% and contributing about 25% of Kenya GDP (NACC and UNDP, 2006). The sector consists of small scale enterprises engaging in a variety of economic activities on the margins of formal and mainstream establishments. (Kenya Economic Survey 2009)

People in the informal sector represent the largest concentrations of "needs without a voice". They are excluded from or under-represented in social dialogue and processes. Unlike the formal sector, there is little contact between the informal economy and other players including the formal private sector, public sector, CSOs and development partners. In addition, most Government interventions reach few if at all of its workers. Moreover the sector is usually not a focal point of service providers with regards to HIV&AIDS.

1.1.3 Definition of the Informal sector

According to the ILO, the informal sector is made up of very small-scale units producing and distributing goods and services and owned and operated by largely independent, self employed producers employing family labour or a few hired workers and apprentices. Informal sector enterprises are extremely diverse and are to be found in great numbers in all the main economic sectors, most of all in trade and services but also in manufacturing, construction, transport and urban agriculture. They operate with very little capital or none at all, and utilise a low level of technology and skills. Employment in these enterprises is highly unstable and incomes are generally very low and irregular.

For the purposes of this study, the criterion of number of employees was adopted which is also the definition used in the Medium and Small Enterprises (MSE) National Baseline Survey of 1999. In that survey, MSEs were defined as those non-primary enterprises (excluding agricultural production, animal husbandry, fishing, hunting, gathering and forestry), whether in the formal or informal sector which employ 1-50 people. Micro-enterprises are those that employ ten or fewer workers and small-scale enterprises are those that employ 11-50 workers. According to the 1999 National Baseline Survey and many other prior studies, only a small proportion of MSEs employ 11-50 people.

1.1.4 Informal sector on Kenya

Kenya's informal sector covers all semi-organized and unregulated small-scale activities largely undertaken by self-employed persons or those employing only a few workers, and excludes all farming and pastoral activities. The activities in the sector are carried out by artisans, traders and other operators. It uses simple technology and businesses are not legally registered although they may be required to obtain licenses from relevant authorities (Republic of Kenya, 1998, 2003). For statistical purposes, the informal sector is defined as a group of production units within the System of National Accounts that form a part of the household sector as unincorporated enterprises owned by households. The main features of the informal sector include ease of entry, the small scale of activity, self-employment with a high proportion of family workers and apprentices, little capital and equipment, labour intensive technology, low productivity and low incomes, limited access to organized markets and formal credit, and minimal education and training (CBS, K-REP and ICEG, 1999).

Despite its limitations the informal sector has become increasingly important in the Kenyan economy as a source of employment and income. During the last decade, the growth rate in the sector's employment has remained above that of the formal sector, which declined over the same period. The informal sector has seen its share in total employment rise from 16% in 1980, to 63.6% in 1997 and 70% in 2000. Between 2000 and 2001, employment in the sector rose by 11.4%. Its share in GDP has also recorded increases, rising from 13% in 1993 to 18% in 1999 (Republic of Kenya, 2002). Sectorally, the informal sector is the second largest source of employment after small-scale agriculture (Ministry of Finance and Planning, 2000). The 1999 national survey of micro and small enterprises (MSEs) found that about 26% of the total households in the country are engaged in some form of MSE activity (CBS, K-REP and ICEG, 1999). The sector is therefore an important source of livelihood for a majority of the country's population. Currently, informal sector's share in total employment stands at 75% (Republic of Kenya, 2004).

In Eastern Africa, according to illustrative data for Kenya in the presentation by Dr. Dorothy McCormick and Dr. Winnie Mitullah , the majority of informal sector enterprises (60 percent) are in trade, with over three-quarters located in the rural areas, and slightly more than a half of them (54 percent) being owned by men. Dr. McCormick and Dr. Mitullah noted that enterprises run by women tend to be smaller, to have less capital, to be involved in less lucrative activities and to be home-based (because of the pressure of domestic responsibilities on women). Women entrepreneurs were also found to be less educated than men entrepreneurs and to have fewer skills. Moreover, women seem to have chosen their trade "by accident". Women also seem to prefer diversifying into new areas than expanding their present business, thus, making themselves more susceptible to risk than men traders who seem to prefer augmenting their present business instead of venturing into new domains.

1.2 Rationale

Informal workers constitute the majority of the work force in many African countries including Kenya. Yet, very little is known about how HIV&AIDS is affecting smaller companies and informal enterprises, especially those in the service, tourism, and other labour-intensive sectors.

The informal economy faces pressures similar to those faced by the formal sector therefore deserves equal amount of attention. Morbidity and mortality place a great strain on the sustainability of informal sector enterprises that are highly dependent on internal generation of flows of income and savings for their survival. Savings are threatened by the demands on revenues for higher levels of health expenditures. The loss of experience, management and technical skills that are so essential for survival in small, labour-intensive enterprises is another serious concern.

Furthermore, there is the specific vulnerability of the informal sector to HIV&AIDS. Young people, who are at higher risk to HIV in general, dominate the informal economy. In addition, incomes are low and frequently insufficient. Women are particularly vulnerable and many are forced to resort to contractual sex agreements for supplementary income. The informal sector suffers from the lack of social protection arrangements at work and health facilities, and workers receive little or no training and often work under unhealthy or unsafe working conditions. Informal groups, pointed out by the participants as particularly high risk, include commercial drivers, hawkers and sex workers.

Compared with the formal sector, intervention and mobilization on HIV&AIDS in the informal sector is made more problematic because of lack of structure and regulation. The difficulties encountered in reaching workers in the informal economy are also a major challenge. There is therefore an urgent need to address HIV&AIDS in this sector and further highlighted the need to find efficient inroads.

To effectively coordinate the HIV and AIDS national response on the National AIDS Control Council conducted a HIV and AIDS mapping to find out what organizations are doing in their respective workplaces to respond to the epidemic, establish the gaps and facilitate capacities.

1.3 Statement of the problem

HIV and AIDS in Kenya remains one of the greatest public health challenges and have even been declared a national disaster. In 2008 there were an estimated 1.4 million people in Kenya living with HIV in a country with a total population of 37 million and a prevalence of 7.8% (UNAIDS, 2008; NASCOP, 2008).

Men and women in the informal workplaces are placed at risk of HIV infection by their disposable income that leads to high alcohol consumption as well as opportunities at the workplace to develop extra-marital relationships. The informal workplaces still have low awareness of risk arising from multiple – partner sexual relationships, low skills in prevention including abstaining, being faithful and correct and consistent usage of condoms. Efforts of mobilizing informal sector workers to go for testing have been made but there is still relatively low knowledge of HIV status among them, there is also low uptake of other HIV and AIDS management services like ARVs/ART, due to high level of stigma and discrimination among the workers. The supply of condoms in the workplace is erratic and some workers associate condoms with ‘immoral’ or ‘loose’ persons. Workers who work away from their families are unable to remain abstinent or faithful after consuming alcohol. In some contexts the workers are exposed to exploitive sexual advances by fellow workers in the leadership positions and lack

assertiveness or sex negotiation skills. Workers might not know what to do, or might not know the workplace policy concerning sexual harassment in the workplace.

1.4 Objectives of the study

1.4.1 General Objective

The general objective of the study was to map the interventions and assess the impact the HIV and AIDS in the informal sector in Kenya

1.4.2 Specific Objectives:

1. To assess the current HIV and AIDS interventions in the informal private sector by undertaking a mapping exercise of the sector in the selected geographical areas;

2. To assess key HIV and AIDS needs in the informal private sector in Kenya and the extent to which the informal private sector strategies meet those needs;

3. To conduct a rapid assessment of the impact of HIV&AIDS in the informal sector.

CHAPTER 2: LITERATURE REVIEW

2.1 HIV&AIDS SITUATION

2.1.1 Global overview of HIV&AIDS:

Globally every day over 6800 persons become infected with HIV and over 5700 persons die from AIDS, mostly because of inadequate access to HIV prevention and treatment services. The HIV pandemic remains the most serious of infectious disease challenges to public health According to the United Nations Joint Programme on HIV&AIDS (UNAIDS), more than 33 million people worldwide are currently living with HIV and AIDS. It also states that there were 2.7 million new infections and 2.0 million deaths due HIV in the year 2007 alone. (UNAIDS/WHO, 2008).

2.1.2 HIV&AIDS in Africa:

AIDS continues to be the single largest cause of mortality in sub-Saharan Africa (WHO, 2001); Southern Africa alone accounted for almost one third (32%) of all new HIV infections and AIDS deaths globally in 2007. A total of 1.7 million people in sub-Saharan Africa became infected with HIV in 2008, declining from 2.2 million new infections in 2001. There are currently an estimated 22.5 million people living with HIV in the region in 2007. In sub-Saharan Africa, adult (15–49 years) HIV prevalence declined from 5.8% in 2001 to 5.0% in 2007. Of the global total of 2.1 million adult and child deaths due to AIDS in 2007, 1.6million occurred in sub-Saharan Africa. There are an estimated 11.4 million orphans due to AIDS in this region (UNAIDS/WHO, 2008).

Sub-Saharan Africa continues to be the region most affected by the AIDS pandemic. More than two out of three (68%) adults and nearly 90% of children infected with HIV live in this region, and more than three in four (76%) AIDS deaths in 2007 occurred there, illustrating the unmet need for antiretroviral treatment (ART) in Africa. The region's epidemics, however, vary significantly in scale, with national adult (15–49 years) HIV prevalence ranging from less than 2% in some countries of the Sahel to above 15% in most of southern Africa (UNAIDS/WHO, 2008).

2.1.3 HIV&AIDS in Kenya:

2.1.3.1 HIV Prevalence

HIV&AIDS spread rapidly in Kenya during the 1990's reaching prevalence rates of 20-30% in some areas of the country. Prevalence subsequently declined in some sites in Kenya but remained stable in others. National prevalence declined significantly from a peak of about 10% to under 7% in 2004. This trend is supported by data from national surveys which document changes in behavior toward fewer partners, less commercial sex, greater condom use and later age at first sex. The Kenya Demographic Health Survey (KDHS) 2003 revealed that 6.7% of adults tested are infected with HIV. Reconciliation of KDHS and sentinel surveillance data gives an adjusted prevalence of 7% (range 6.1-7.5%) implying a total of 1.1 million adult

Kenyans infected with HIV, of whom about two thirds are women. In addition there are estimated to be 100,000 children living with HIV. The gender difference is most pronounced among young people; in the 15-24 age range, female prevalence is nearly five times higher than male prevalence (see Figure 1). Prevalence rates also show significant regional and rural/urban variations, with average urban prevalence (10%) nearly twice that in rural areas (5-6%) (NASCOP, 2004).

2.1.3.2 HIV Infections and AIDS Deaths

It is estimated that approximately 65,000 adults and 25,000 children became infected with HIV in Kenya in the year 2003. Prevalence data suggests that the majority of non-pediatric infections occur among youth, especially young women aged 15-24 years, and young men under 30. The rate of AIDS deaths has risen dramatically and it is estimated that there are about 150,000 AIDS deaths per year, double the rate in 1998. This increasing death rate, which exceeds the rate of new infection, tends to reduce overall prevalence as the epidemic in Kenya moves into the "death phase". AIDS deaths in Kenya have a profound and increasing societal and economic impact; the total death rate from all causes among adults 15-49 years has more than tripled since 1990. It is estimated that 1.7 million children under 18 are orphans, about half due to AIDS. As the cumulative total of AIDS deaths rises, the impact of these deaths on society will become increasingly severe. Already, life expectancy in Kenya has dropped from 60 years in 1993 to about 47 years in 2004 due to HIV&AIDS (KAIS, 2007).

2.1.3.3 The Socio-Economic Impact of HIV&AIDS in Kenya

It is widely accepted that HIV&AIDS has major economic and social impact on individuals, families, communities and on society as a whole. In Kenya, as in other countries in sub-Saharan Africa, AIDS threatens personal and national well-being by negatively affecting health, lifespan, and productive capacity of the individual; and critically, by severely constraining the accumulation of human capital, and its transfer between generations. Research across many severely affected low income countries clearly demonstrates that HIV&AIDS is the most serious impediment to economic growth and development in such countries (IMF, 2004).

Poverty reduction, driven by economic growth, is the central objective of Kenya's Economic Recovery Strategy (ERS). The impact of HIV&AIDS on economic growth and development, coupled with the direct impact of increased mortality and morbidity on the lives of the poor, makes HIV&AIDS a uniquely corrosive threat to poverty reduction efforts in the country. Sector reviews such as those by Futures Group Europe/DFID (2004) suggest that HIV&AIDS undermines development across all sectors of the Kenyan economy and society. The review indicates that the productivity of the agriculture sector, upon which the majority of Kenyans rely for their livelihood, is undermined by negative impacts on the supply of labour, crop production, agricultural extension services, loss of knowledge and skills and at a personal level the trauma associated with death. Consequences include reduced household and community food security and decline in the nutritional and health status of smallholders and their families. Commercial agriculture, a major source of employment and foreign earnings, is detrimentally affected by increasing health costs as well as protracted morbidity and mortality of key workers.

Further, educational services suffer as teachers are lost to AIDS and children drop out of school as parents die and household incomes fall. The health service loses trained staff and has to cope with the increasing burden of HIV-related infections. The direct cost and social problems associated with caring for increasing numbers of orphans, coupled with existing high poverty levels place severe burdens on family and societal structures (Futures Group Europe/DFID, 2004).

In addition to these direct effects on production and social services, there is a growing realization that HIV&AIDS may undermine the long-term revenue base of the economy, and so reduce Government's capacity to provide the infrastructure and social services essential for long-term economic growth. Studies in countries severely affected by HIV&AIDS suggest that the impact of HIV&AIDS on public finances is large and growing. This provides an additional argument, particularly relevant for the Ministries of Finance and Planning, for greater investment in an expanded response across all sectors (Haacker, 2004).

2.1.3.4 National response on HIV&AIDS in Kenya:

In 1999 the Government of Kenya (GoK) declared HIV&AIDS a national disaster and established the National AIDS Control Council (NACC). It facilitated the development of the Kenya National HIV&AIDS Strategic Plan (KNASP) 2000-2005, which set out a multi-sectoral response to the epidemic, jointly agreed by stakeholders within Government, civil society, the private sector and development partners. As part of its duty and being the largest single employer in the country, the Government also realized the need to have a co-ordinated intervention strategy in the public sector workplace. The aim was to mitigate the impact of the pandemic in the country. Consequently, an inter-ministerial task force, spearheaded by Directorate of Personnel Management was constituted to develop the Public Sector workplace policy on HIV and AIDS.

(a) Public Sector workplace policy on HIV and AIDS:

The policy is a reference to tackling challenges brought into the public sector occupational settings by the effects of HIV and AIDS. It guides each sector on developing workplace programmes to facilitate effective and planned response to the management and prevention of HIV and AIDS at the workplace. The policy is a re-affirmation of the Government's commitment to intensify its campaign against the spread of HIV and ensure a harmonized response in the public service (GoK, 2005).

The main objective of this policy is to provide a framework to address HIV and AIDS in the public sector. Specifically, the policy aims at setting Minimum Internal Requirements (MIR) for managing HIV and AIDS in the public sector; establishing structures and promoting programmes to ensure non-discrimination and non-stigmatization of the infected and affected; contributing to national efforts to minimizing the spread and mitigating against the impact of HIV and AIDS; ensuring adequate allocation of resources to HIV and AIDS interventions; guiding employers, managers and employees on their rights and obligations regarding HIV and AIDS; and providing a framework for development of sector specific workplace policies (GoK, 2005).

The main thrust of the Public Sector Workplace Policy on HIV&AIDS revolves around initiating and carrying out programmes that include prevention and advocacy activities that are sector specific and involve creation of HIV and AIDS awareness and promotion of positive cultural and behavioral change among employees. The programmes also include care and support of the infected and affected, involving comprehensive care of the infected and affected calls for a collaborative approach involving various stakeholders.

(b) HIV and AIDS Prevention and Control (HAPC) - Act No 14 of 2006

The HIV and AIDS Prevention and Control (HAPC) Bill was gazetted in August 2004 and assented into Law in 2006. It makes specific reference to HIV and AIDS in relation to discrimination, privacy, confidentiality and personal rights.

Specifically the Act provides under section 13, that no person shall compel another to undergo an HIV test save where a person is charged with an offence of a sexual nature under Chapter XV of the Penal Code. Section 22 prohibits the disclosure of an HIV test result of another person without his written consent; and in Part VIII, the Act makes it an offence for any person to be discriminated against on the grounds of actual, perceived or suspected HIV status, in relation to employment, access to education, credit, insurance, healthcare, travel, habitation or seeking public office (HAPC Act, 2006).

(c) The Kenya National AIDS Strategic Plan (KNASP) 2005/2010

The purpose of KNASP is to provide an action framework for HIV&AIDS within which all HIV&AIDS interventions in Kenya take place. The KNASP is not intended to replace nor duplicate sectoral HIV&AIDS strategies; nor does it include detailed operational or implementation plans, or detailed budgets, for specific interventions. Rather, the KNASP provides the framework and context within which such strategies, plans and budgets should be formulated, monitored and coordinated.

The goal of KNASP is to reduce the spread of HIV, improve the quality of life of those infected and affected and mitigate the socio-economic impact of the epidemic in Kenya. KNASP focuses on the following three priority areas:

- Prevention of new infections by reducing the number of new HIV infections in both vulnerable groups and the general population;
- Improvement of the quality of life of people infected and affected by HIV&AIDS by improving treatment and care, protection of rights and access to effective services for infected and affected people; and
- Mitigation of the socio-economic impact of HIV&AIDS by adapting existing programmes and developing innovative responses to reduce the impact of the epidemic on communities, social services and economic productivity.

2.2 IMPACT OF HIV&AIDS

2.2.1 Socio-economic impacts of HIV&AIDS

According to a report on the CHGA Interactive session on HIV&AIDS and the world of work which was hosted by the Commission on HIV&AIDS and Governance in Africa (CHGA) and the International Labour Organization (ILO) under the umbrella of the Economic Commission of Africa (ECA) in Accra, Ghana on November 2004, it came clear that the impact of the HIV epidemic cuts across all sectors of economic activity and all areas of social life. The key fact that the epidemic has its primary impact on the working-age population means that those with important economic and social roles, both men and women, are prevented from participating fully in economic activities.

Moreover, the HIV epidemic disrupts the smooth functioning of economic and social systems in ways that magnify the initial disturbance. For example, the epidemic not only reduces the stock of human capital, but it also reduces the capacity to maintain those with sought-after skills and training, such as teachers and doctors. In the most affected countries in Africa, the problem is not only that employees with scarce skills and experience are being lost due to HIV&AIDS, but that the capacity of households to send children to school, and of schools, universities, technical and other training institutions to re-supply the necessary capacity and skills is also being reduced (ECA/CHGA, 2004).

Loss of labour represents a reduction in rates of return for both private and social investment in all countries, rich and poor, although the impact is greatest where human capital is a significant factor of production and where lost labour is concentrated among those with skills, higher education and managerial training (ILO, 2002).

2.2.2 Impact of HIV&AIDS on labour supply and human capital

The International Labour Organization (ILO) has estimated that by 2010 the total labour force will be over 9 per cent smaller in 35 countries of sub-Saharan Africa affected by the epidemic, with losses surpassing 20 per cent of the total labour supply in the most affected countries. By 2015, the losses would reach 12 per cent and the labour supply would be as much as 30-40 per cent smaller in the highest prevalence countries. It is also noted that the remaining workforce will contain a greater proportion of younger workers who are less experienced and less well educated than the currently employed workers. The implications are still unclear but it seems inevitable that changes of this magnitude would affect levels of productivity and incomes across the whole economy. There are also likely to be consequences for the gender distribution of the labour force, with more and younger women entering the labour market in the short-term, but the overall proportion of women falling in the long-term because of the unequal impact of AIDS on life expectancy for men and women (ILO, 2004).

2.2.3 Impact of losses of labour capacity

The efficiency of governments to respond to the HIV&AIDS crisis depends on the flexibility and organization of its structure. Increased absenteeism, mortality, loss of institutional memory and

intergenerational human capital formation are creating greater problems of efficiency for governments especially in the public sector, than compared with the more flexible private sector. Furthermore, the fundamental organizational principles of governments such as long trajectory career paths, its dependence on highly skilled and educated human resources, and lengthy procedures of recruitment and replacements are thrown into question by early deaths from AIDS (Barnett & Whiteside, 2002).

2.3 HIV&AIDS IN THE WORKPLACE

2.3.1 How workplaces respond to HIV&AIDS

It makes strong business sense for workplaces to join the response to the HIV epidemic. Increased costs, loss of productivity and overall threats to the foundation of the economies in which they operate threaten the bottom line. The workforce is placed at increased risk, with the epidemic disproportionately affecting people during their most productive years. More than 90% of HIV infections in the region have been reported in the most productive age group of 15-49 years. HIV&AIDS adversely affects employees and poses a serious threat to productivity and enterprise performance due to increased absenteeism, disruption of operations and increased expenditure resulting from employees' medical treatment, replacement and associated costs (IOE/PAEC, 2005).

Although it is not their traditional role, many workplaces are providing HIV&AIDS related services. The development of workplace policies and programmes dealing with HIV&AIDS is an ongoing human resource strategy that protects business interests, improves management practices, and has a positive impact on the overall performance of businesses in the long term. The private sector also takes action because of the pressures on public health systems as a result of HIV&AIDS and from a sense of corporate social responsibility (IOE/PAEC, 2005).

Workplaces are key institutions in contributing to the development of the national social fabric. They cannot separate their own interests from those of the societies in which they function. They are therefore directly exposed to societal dynamics and need to contribute in addressing the needs of people who are directly or indirectly affected by HIV&AIDS. To this end they have a key role to play in formulating, implementing and monitoring HIV&AIDS workplace policies and programmes - especially in small and medium enterprises (SMEs); access and disseminate information to their staff, families and dependents, including best practice on HIV&AIDS; and access technical and financial support in order to scale up their interventions (World Bank, 2007).

Workplaces have played a role in tackling the HIV&AIDS pandemic, which is gaining increasing recognition. With the impact of this deadly scourge being felt most among those of working age, HIV&AIDS is a key workplace issue. They should therefore be facilitated to advice workers in addressing this important issue and provide guidance on how they can proactively work to tackle it (IOE/PAEC, 2005).

Multinational enterprises took the lead in providing HIV&AIDS related services at workplaces, including treatment. The situation has evolved significantly, with an increasing number of small

enterprises engaged. The focus is most frequently on prevention, still the essential strategy in view of the numbers of new infections, and one well-adapted to the workplace. Even in some medium and small enterprises employers have also responded by sharing an occupational health service or by a referral system, on an agreed basis, to public hospitals or general practitioners near workplaces (World Bank, 2007).

2.3.2 Importance of mainstreaming HIV&AIDS activities at the workplace

According to the International Organization of Employers and Pan-African Employers' Confederation, HIV&AIDS workplace initiatives work better when they are integrated into an overall health and wellness package. This reduces HIV stigma and enables those affected to benefit from a wider range of wellness services. IOE revealed that setting up an HIV&AIDS Committee has helped several of the organizations to focus their efforts, build up specialist expertise and provide improved services to member organizations. In other cases the Occupational Safety and Health Committees has been given the HIV&AIDS responsibility: the choice depends on the size of the enterprise and local conditions. Further, involving workers' representatives in policy development and implementation has encouraged trust and made the workplace programmes more effective (IOE/PAEC, 2005).

It is recognized that building up a comprehensive HIV workplace programme takes time and effort. However, it has been established that providing workplace HIV education through a team of peer educators drawn from the staff is more successful in terms of meeting colleagues' needs and being cost effective than using outside providers. Peer educators then receive regular training and ongoing support. Changing personal behaviour is a gradual and often difficult process, so there is a need for continuous education and sensitization programmes to back up the work of peer educators and others. It has also been reported that in workplaces, VCT can be encouraged in a number of ways, including the use of mobile teams/clinics, regular 'testing days', offering related services such as family planning or STI testing, and the CEOs and senior managers setting an example. Monitoring and evaluation are crucial to fine tune programmes and to measure impact. Carrying out baseline surveys is a necessary first step in terms of developing a workplace programme that will be relevant and appropriate to people's needs, and to permit monitoring and evaluation (IOE/PAEC, 2005).
Once HIV&AIDS has been sufficiently recognized as a workplace issue, the challenge becomes one of addressing the subsequent human resource problems in a systematic and sustainable manner. It is clear that HIV needs to be tackled through workplace policies and programmes that aim to prevent the further spread of HIV, mitigate the effects of the disease, and address the human capacity challenges the pandemic raises. This includes the need to look into education and training requirements for key professions, and policies for retention of crucial human capacity (ECA/CHGA, 2004).

2.3.3 The role of employers in HIV&AIDS activities at the workplace

Employers' organizations are in a strong position to lead the HIV response and their efforts should be supported. They provide a direct link to the workplace, play a leadership role in mobilizing individual enterprises, offer support and guidance to their members, and have ongoing contacts with ministries of labour and workers' organizations. Interventions are more

likely to succeed when there is commitment from senior management: allocating time and money is crucial if activities are to be effective. Partnerships enhance a coordinated approach and the pooling of resources for implementation. As such, regular meetings provide an excellent opportunity to exchange information and to recognize and disseminate good practice (IOE/PAEC, 2005).

During the interactive session of ECA/CHGA in Ghana, the participants discussed the concept of "corporate governance" and its optimal operationalization in the context of HIV&AIDS and the world of work. The conventional understanding of corporate governance denotes a top-down perspective of policy formulation, guidelines and directives. It was reported that a more inclusive approach is appropriate with regard to HIV&AIDS - all stakeholders ranging from shareholders to workers need to be involved and sensitized. It was understood that broadening the concept of 'corporate governance' does not, on the other hand, imply reduced responsibility for managers. It was assessed as imperative that top management of business take the lead and make critical interventions now to protect and save their businesses from collapse in the future (ECA/CHGA, 2004).

Commitment needs to be translated into effective policies and the mainstreaming of HIV&AIDS within the workplace. There is increasing expectation that businesses need to recognize HIV&AIDS as a workplace issue and address the human resource challenges the disease raises. This calls for human resource planning in areas with high HIV prevalence, as the epidemic erodes capacity. The forum at Ghana noted that a number of large businesses, most of them multinationals, as well as a few Governments and unions, have begun to implement aggressive HIV&AIDS prevention and treatment programmes for employees and, in some cases, employees' dependants. However, many businesses and Governments are lagging behind (ECA/CHGA, 2004).

2.3.3 The role of governments in HIV&AIDS activities at the workplace

Governments face HIV&AIDS and the world of work not only as employers, but also as regulators and incentive setters for the private sector, as well as providers of social services. In this regard, therefore, Governments need to develop strategies with regard to all three areas to successfully mitigate the impact of HIV&AIDS in the workplace. It has been observed that the African countries with the greatest success in addressing the complex issues of HIV&AIDS have, in general, been those where the policy environment has been most open and supportive of discussion and policy development across sectors. The challenge is to develop policies that support an effective response to HIV&AIDS for all actors, in areas such as employment, protection against discrimination, hiring and retention and access to benefits. However, several participants pointed out the deficiencies of current policies, emphasizing the lack of an enabling environment for the private sector and unions to devise and implement programmes on HIV&AIDS. It has been stressed that Governments need to adopt national HIV&AIDS strategic frameworks with special provisions for the world of work. A number of countries have been slow to respond to this need (Cohen in ILO, 2002).

Since the impact of HIV&AIDS indirectly affects the world of work, governments are ultimately responsible for developing effective social policies to support affected populations. Key

challenges that must be addressed are comprehensive social security and social protection, including health insurance. Preventing the further spread of HIV in society at large is held up as an important responsibility of Governments, and the right policies need to urgently be put in place (Cohen in ILO, 2002).

The issues of access and availability of treatment facilities at the workplace take centre-stage for programmes to be successful, with Governments playing an important role in securing access to low cost medication. This includes policies and legislation regarding the importation of generic medication and facilitation of domestic pharmaceutical production. With the increasing markets for ARVs, domestic or regional production has become more feasible (ECA/CHGA, 2004).

2.3.4 The role of private sector in HIV&AIDS activities at the workplace

In discussing the role of the private sector in HIV&AIDS issues, it is well acknowledged that building partnerships across sectors within a coordinated national framework is essential for effective action. Ensuring the full and active involvement of employers' and workers' organizations in country coordinating mechanisms, national action plans and in all relevant areas is crucial for widening the national response and ensuring the full representation of the interests of labour and employment. Governments also need to provide the right legislative frameworks and revise their laws in the context of HIV&AIDS and the world of work to enable an effective and fair response by the private sector (ECA/CHGA, 2004).

In discussing the optimal involvement of the private sector in the response against HIV&AIDS, it is recognized that widespread disagreements exist on how the burden of HIV&AIDS should be shared between the private and the public sector. Many companies in Africa are addressing the threat of HIV&AIDS by intentionally or unintentionally "shifting the burden" of the disease onto other sectors of society. They do this by cutting or limiting employee benefits, changing the structure of employment contracts, outsourcing unskilled jobs, carrying out selective retrenchments or non-voluntary medical retirements, or mechanizing tasks that previously required human effort. Many of these practices are responses to the competitive pressures of globalization, not HIV&AIDS. It is noted that the result, therefore, is to shift the economic burden of the epidemic onto Government, NGOs, and households/ The incentives for private firms to accept social responsibility, invest in workplace programmes and engage in public-private partnerships must therefore be made clear (ECA/CHGA, 2004).

2.3.5 Challenges regarding HIV&AIDS and the world of work:

There is, in general, a denial of the existence of the spread of HIV&AIDS among employers and employees in a number of privately owned industries and businesses. There is also a high level of ignorance about the devastating impact of HIV&AIDS at the enterprise, sector and macro-level, and managers commonly fail to appreciate the link between increased medical costs and HIV&AIDS. Private sector health surveillance is infrequent and there is too little knowledge sharing among companies of workplace programmes, losses or related costs. It was believed that the lack of information is perpetuating perceptions that HIV&AIDS is a public health issue and not a problem at the enterprise level. In addition, business leaders of small firms, or firms

struggling to survive in a sometimes political and economic unstable environment, may be impelled to adopt a short-term view (ECA/CHGA, 2004).

It is apparent that HIV&AIDS needs to be integrated into the legal provisions of the workplace. These legal provisions, as well as policies and programmes on HIV&AIDS must be clearly formulated and disseminated, and take account of workers' rights in the context of HIV&AIDS. There is also need to underscore benefits of staff involvement in policy development. Creating a sense of ownership for all stakeholders is deemed crucial to making HIV&AIDS policies and programmes work successfully (ECA/CHGA, 2004).

Lessons learnt from work place programmes emphasize the pivotal role of top-level management in implementing and sustaining efforts. In a number of countries, representatives from trade unions have reported that they are implementing programmes for their members and are striving to ensure consultation with workers' representatives in the formulation and implementation of joint HIV&AIDS policies and plans for the workplace. Where collaboration is successful, both parties have been reported to be on an improved atmosphere of trust, and greater take-up of opportunities for prevention, education, voluntary testing, and treatment (Cohen in ILO, 2002).

2.3.6 Recommendations for workplace policies and programmes

It has been recommended that various essential components of workplace policies on HIV&AIDS should exist in principle. Some of these are:

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1. Investment of more money in prevention and mitigation of HIV&AIDS;
2. Ensuring that programmes are comprehensive and complimented with voluntary counselling, care and support.
3. Distribution and promotion of the use of condoms in the workplace;
4. Mainstreaming HIV&AIDS awareness at all levels within the institution or company and into all training programmes;
5. Development and enforcing an ethical code on HIV&AIDS. Establish a system for redress for misconduct and violations of policies for all employees; and
6. Development of proper policy tools and mechanisms for reviewing, evaluating and monitoring programmes.

2.3.7 HIV&AIDS and the workplace in Kenya:

In Kenya, the Federation of Kenya Employers (FKE) issued its first guidelines on HIV&AIDS in the workplace in 1994, and in 1999 was identified by the Government as focal point for workplace HIV&AIDS interventions. It first become involved with HIV&AIDS activities in 1988 when it issued 'Guidelines on HIV&AIDS in the workplace' and today supports a wide ranging programme of activities with its member companies all over Kenya. In 2000 the Federation drafted its own Code of Conduct on HIV&AIDS in the workplace. It gives guidance to employers and other interested organizations on how to handle HIV&AIDS issues in the workplace. The code has since been updated twice, drawing on the ILO Code of Practice. Major companies have sought the help of the FKE in drafting their HIV&AIDS policies, and its code is seen as a vital resource (FKE, 2001)

The Federation seeks to facilitate the active involvement of CEOs in setting up and supporting workplace programmes, and encourages them to act as HIV&AIDS champions, getting other employers on board. They provide leadership, advocacy and practical advice based on their own experiences. The Federation runs awareness-raising workshops specially tailored for CEOs, with support materials and resources available In late 2008 51 CEOs took part in a public voluntary counselling and testing (VCT) event to encourage people to know their HIV status. This was followed up with workplace testing days to provide the opportunity for managers and employees to follow their lead (FKE, 2001).

The Federation of Kenya Employers (FKE) became involved in micro (informal) and small-scale activities in 1991, when it realized that formal employment was falling and informal employment was growing. Between 1985 and 1999, the share of formal employment in total employment dropped from 42 to 19 per cent, while the share of informal employment increased from 17 to 67 per cent. Since 1991, the FKE has implemented several programmes and services aimed at improving the situation of micro- and small enterprises and at creating employment with remunerative and sustainable potential (Nyangute, 2001)

2.4 THE INFORMAL SECTOR

ILO first used the term "informal sector" to describe the activities of the working poor who were working very hard but who were not recognized, recorded, protected or regulated by the public authorities (ILO, 1972). In 1991, the 78th Session of the International Labour Conference discussed the "dilemma of the informal sector" (ILO, 1991). The dilemma was posed as whether the ILO and its constituents should promote the informal sector as a provider of employment and incomes or seek to extend regulation and social protection to it and thereby possibly reduce its capacity to provide jobs and incomes for an ever expanding labour force. The 1991 Report emphasized that "there can be no question of the ILO helping to 'promote' or 'develop' an informal sector as a convenient, low-cost way of creating employment unless there is at the same time an equal determination to eliminate progressively the worst aspects of exploitation and inhuman working conditions in the sector" The Conference discussion stressed that the dilemma should be addressed by "attacking the underlying causes and not just the symptoms" through "a comprehensive and multifaceted strategy" (ILO, 1991b).

Today, there is still a dilemma – but one that is much larger in magnitude and more complex. Contrary to earlier predictions, the informal economy has been growing rapidly in almost every corner of the globe, including industrialized countries – it can no longer be considered a temporary or residual phenomenon. The bulk of new employment in recent years, particularly in developing and transition countries, has been in the informal economy. Most people have been going into the informal economy because they cannot find jobs or are unable to start businesses in the formal economy.

2.4.1 Definition of informal sector

According to ILO (2002) different groups have been termed "informal" because they share one important characteristic: *they are not recognized or protected under the legal and regulatory*

frameworks. This is not, however, the only defining feature of informality. Informal workers and entrepreneurs are characterized by a high degree of vulnerability.

In very general terms, the informal sector is the unregulated non-formal portion of the market economy that produces goods and services for sale or for other forms of remuneration. The term "informal sector" thus refers to all economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements (Becker, 2004).

2.4.2 Characteristics of informal sector

According to Becker (2004), the informal economy is largely characterized by low entry requirements in terms of capital and professional qualifications; a small scale of operations; skills often acquired outside of formal education; and labour-intensive methods of production and adapted technology.

Informal sector is not recognized under the law and therefore receives little or no legal or social protection and are unable to enforce contracts or have security of property rights. Such sectors are rarely able to organize for effective representation and have little or no voice to make their work recognized and protected. They are excluded from or have limited access to public infrastructure and benefits. They have to rely as best they canon informal, often exploitative institutional arrangements, whether for information, markets, credit, training or social security. They are highly dependent on the attitudes of the public authorities, as well as the strategies of large formal enterprises, and their employment is generally highly unstable and their incomes very low and irregular. They are placed at a competitive disadvantage because they do not have the type of influence which those in the formal economy are often able to exert – influence which sometimes violates an essential feature of a market economy, i.e. free and equal access to markets based on efficiency rather than influence. There is no simple relationship between working informally and being poor, and working formally and escaping poverty. But it is certainly true that a much higher percentage of people working in the informal relative to the formal economy are poor, and even more true that a larger share of women relative to men working in the informal economy are poor (ILO, 2002).

2.4.3 Obstacles faced by the informal sector

Enterprises in the informal economy are facing obstacles that are sometimes similar to those experienced by formal enterprises. However, informal enterprises are much more vulnerable in relation to these problems. Such problems include infrastructure issues such as poor infrastructure such as transport, storage facilities, water, electricity, lack of working premises and poorly developed physical markets. Institutional problems include lack of access to formal training, limited access to formal finance and banking institutions and lack of access to official social security schemes. Economic obstacles faced by the informal sector include excessive registration and transaction costs of starting or operating businesses, limited access to technology, low incomes or lack of regular income as household consumption competes for the use of business earnings and lack of working capital (Becker, 2004)

These obstacles are more or less interlinked and create vicious circles of poverty and high risk. For instance, the main reasons for the lack of funds or skills is that the informal economy enterprises cannot access resource institutions generally available to the formal economy such as banks and other financing institutions, training and education institutions, marketing and consultancy firms, etc. In fact, all these various obstacles create an overall context that in itself constitutes a barrier of entry into the formal economy.

2.4.4 Informal Sector in Africa

Informal work is estimated to have accounted for almost 80 per cent of non-agricultural employment, over 60 per cent of urban employment and over 90 per cent of new jobs in Africa (Charmes, 2000). In sub-Saharan Africa, the informal sector accounts for three-quarters of non-agricultural employment, having increased dramatically over the last decade from about two-thirds. For women in sub-Saharan Africa, the informal sector represents 92 per cent of the total job opportunities outside of agriculture (against 71 per cent for men); and almost 95 per cent of these jobs are performed as self-employed or own-account workers and only 5 per cent as paid employees (ILO, 2002).

In sub-Saharan Africa in particular, street vending predominates in much of the informal economy, with women traders forming the majority in a number of countries. It is estimated that over half of informal workers are engaged in the retail trade. Considering the large size of the informal economy, formal retailing establishments, distributors and manufacturers often use informal workers in order to expand their markets to low-income groups and those in rural areas who can be reached most easily by itinerant traders and street vendors (Carr & Chen, 2001).

Cross-border trading is also very significant in the informal economy. South Africa, for example, attracts a large number of temporary immigrants who purchase goods to take back to their own or other countries for sale. It is estimated that nearly one-fifth of the women in the informal economy in Zimbabwe are involved in cross border activities, primarily with South Africa and Zambia. Cross-border trade is also common in West Africa where some traders travel as far as Dubai and Hong Kong, China, to purchase higher-quality goods that are cheap, although most informal trade is within the region itself (Carr & Chen, 2001).

In the United Republic of Tanzania the Labour Force Survey 1990/91 revealed some of the characteristics of those working in the informal sector. They tend to be poorly educated: 46 per cent had no education or had not completed primary schooling and less than 4 per cent had secondary or higher education. In terms of age structure, 75 per cent were aged between 20 and 49 years. The informal economy in this country is characterized by a high degree of self-employment (74 per cent of total informal employment); 14 per cent were unpaid family workers and only 12 per cent were paid employees. Informal enterprises are small-scale enterprises: 80 per cent of all informal enterprises were one-person businesses, while those with more than one person were mainly in transportation and construction. Most are without a formal establishment: more than a third of the informal activities took place within or beside the home of the business operator, 20 per cent were without fixed location, 10 per cent were at a market and 10 per cent were in an open space or on the street.

Women working in the informal economy outside agriculture were heavily concentrated in activities that are an extension of their domestic chores, such as the sale of home-made beer, food stalls and other forms of cooked food sale; and the manufacturing of mats and fibre products, clay products, processed food products and cloth products. Men, on the other hand, had more diversified informal activities in trading, manufacturing, construction, community and personal services, transport and mining and quarrying. Men's activities were more likely to require investment capital.

For both male and female informal workers, their main customers were individuals (94 per cent), followed by small enterprises. The Dar es Salaam Informal Sector Survey 1995 carried out by the ILO found that 41 per cent of the operators worked in the informal economy because they could not find other work or had been retrenched, including from the public sector, 30 per cent because their family needed additional income, 10 per cent because of the freedom to determine their hours or place of work and only 9 per cent because of the good income opportunities (ILO, 2002).

2.4.5 Informal sector in Kenya

In Kenya, the majority of informal sector enterprises (60 percent) are in trade, with over three-quarters located in the rural areas, and slightly more than a half of them (54 percent) being owned by men. Dr. McCormick and Dr. Mitullah noted that enterprises run by women tend to be smaller, to have less capital, to be involved in less lucrative activities and to be home-based (because of the pressure of domestic responsibilities on women). Women entrepreneurs were also found to be less educated than men entrepreneurs and to have fewer skills. Moreover, women seem to have chosen their trade "by accident". Women also seem to prefer diversifying into new areas than expanding their present business, thus, making themselves more susceptible to risk than men traders who seem to prefer augmenting their present business instead of venturing into new domains (McCormick & Mitula, 1995).

According to McCormick & Mitula, in spite of the popularization of the informal sector, a contradictory situation prevails. On the one hand, existing social attitudes tend to look down upon informal sector activities, on the other hand, these attitudes seem to be buttressed by an ambivalent public policy. The result is a policy framework that is largely ambiguous in its support for informal sector activities: This is clearly demonstrated by development policies that favour structural imbalance and promote large enterprises to the detriment of small ones; and official tolerance of, or inaction in regard to, social and legal norms, particularly of exploitation, discrimination and even violence against certain vulnerable groups involved in informal sector activities (e.g., women and children).

The absence of a policy-enabling environment consequently contributes or accentuates the formidable problems that entrepreneurs in informal sector enterprises are usually confronted, including difficulties in obtaining raw materials; difficulties of access to machinery, facilities and utilities; difficulties in gaining access to credit and finance; and difficulties in obtaining relevant training (McCormick & Mitula, 1995).

The informal economy in Kenya became known as Jua Kali (hot sun) referring to the micro-

enterprises that worked without shelter under the hot sun. In 1986, the Kenyan Government began to incorporate the informal economy into national economic policy. Policy-makers elaborated direct assistance to individuals and small businesses, including among others flexible credit schemes, encouragement of the informal economy to produce cheap alternatives to expensive imported items, promotion of cooperatives to access credit, group purchasing and marketing, information and assistance on new technologies. Government would also be able to subcontract the Jua Kali for various assignments. This work led to a policy on the informal economy in 1992, identifying the economy as having the greatest potential for employment creation in Kenya. However, there is no coordinating body in government responsible for the implementation of the policy. The Jua Kali policy needs to be seen as an integral part of overall technology and industry policy. Moreover, the voice of its principal actors is absent (WIEGO, 2001).

2.5 HIV&AIDS IN THE INFORMAL SECTOR

2.5.1 Informal sector workplace dynamics and HIV&AIDS

According to the Economic Commission for Africa, there are many factors that fuel the HIV&AIDS pandemic at the informal sector workplace. These are closely linked to the wider socio-economic context of the geographical area – the prevalence rates in the locality of the business, poverty levels, and standards of public health services. While contexts vary, and responses need to be context-specific, the participants highlighted certain factors that tend to increase the risk to HIV infection in the workplace. These include illiteracy; businesses dominated by men, particularly when located in rural areas; access to free or subsidized alcohol and tendency for alcohol abuse; frequent travel outside one's permanent place of work; location in border towns or transit areas; industries dominated by seasons; workplace located far from permanent residence; and access to reasonable levels of income in the midst of poverty (ECA/CHGA, 2004).

2.5.2 Impact of HIV&AIDS in the informal sector

HIV&AIDS has a negative impact in all sectors and at all levels of the economy. However, as indicated above, informal activities are more vulnerable than others. Profit margins are tight, and access to official support mechanisms is extremely limited. Most of the businesses are individually owned, and illness or death of the operator is therefore very likely to lead to the closure of the business. The epidemic threatens livelihoods and productivity in both urban and rural areas, with particularly severe effects on women because of their double role of caring for sick household members and earning a living. This is particularly the case in the informal sector. HIV&AIDS thus deepens poverty and intensifies economic inequalities (McKay in ILO, 2003).

The implications of the HIV&AIDS pandemic for the informal economy are serious. All 20 countries with the highest HIV prevalence are in sub-Saharan Africa and life expectancy is said to have regressed to 47 years, reversing gains made over the last 30 years. More and more elderly persons and children – the two least equipped and most vulnerable groups – are being forced to find work for their survival as workers in their most productive years fall ill and the main breadwinners die (Charmes, 2000).

The costs of HIV&AIDS for informal sector enterprises are the same as those in the formal sector, both directly and indirectly. Direct costs include expenditure on medical care, drugs and funerals. Indirect costs include loss of time due to illness, recruitment and training costs to replace workers, and care of orphans. Not only are these costs (both direct and indirect) high, they also reinforce each other. Ultimately enterprises lose their profitability and their potential for growth, if indeed they do not succumb altogether (McKay in ILO, 2003). More specifically, the following are the direct effects of HIV&AIDS in the informal sector:

(a) Decline in productivity:

A decline in productivity leads to a decline in profit, which may perhaps be manageable in the short term but is much less so when associated with a long-term, worsening crisis such as sickness and premature deaths of workers and operators as a result of HIV&AIDS.

(b) Absenteeism:

Absenteeism is one of the first signs that something has gone wrong. It probably means that employees are becoming ill due to HIV, or that they are taking time off to care for sick family members and to attend funerals. It is usually harder for smaller businesses with less flexibility and fewer reserves to cope with the consequences of absenteeism (McKay in ILO, 2003).

(c) Vulnerability:

Another reason for the extreme vulnerability of the informal sector is that workers with HIV&AIDS tend to be "colonised" in this sector. It is not uncommon for workers employed in the formal sector to face workplace prejudice and discrimination, so much so that they are pressured to leave their formal jobs. In the absence of social support, many have no choice but to find alternative means of income in the informal economy (McKay in ILO, 2003).

The nature of their work means that entrepreneurs and workers engaged in informal economic activities are often hard to reach and are consequently out of reach of educational and health interventions related to HIV&AIDS. Involvement in the informal economy is often driven by poverty. The informal nature of the sector often provides both a "last chance" opportunity for survivalist economic activities for those most hit by poverty as well as an "economic space" for those already affected with HIV. The fact that large numbers of this sector are illiterate or not functionally literate makes this sector more difficult to reach using conventional methods (McKay in ILO, 2003).

(d) Loss of means of livelihood:

Many informal sector operators and workers living with HIV&AIDS either lose their means of livelihood or see their businesses collapse due to their inability to work. Even if they enter a period of remission or recovery it is often difficult to resume work because they will have depleted their personal resources while unable to work. Since these businesses are operated or owned by sole breadwinners, woes begin as soon as a family member starts to suffer from an

HIV-related illness. This rapidly leads to loss of income of the informal sector operator and increased expenditure on medical and other expenses. Eventually there are also funeral costs. Children are often removed from school to save on educational expenses and increase the household's labour, but this ultimately reduces the family's earning potential and affects the human resource base of the whole country (McKay in ILO, 2003).

(e) Decline in quality of workforce:

HIV&AIDS does not affect only the size of the informal sector's labour force; it also affects its quality. Some of those infected with HIV are experienced, skilled workers in the sector. The loss of these workers, together with the entry into the labour market of orphaned children who have to support themselves, is likely to lower both the average age and the average level of skills and experience of the informal workforce. Its gender composition is also expected to change as more orphaned children and widows seek employment in the informal sector (McKay in ILO, 2003).

2.5.3 HIV&AIDS interventions in the informal sector

Some workplaces have taken various steps to contain HIV&AIDS-related costs, including measures to prevent their employees from contracting AIDS, changes in the types or amounts of benefits they offer, and screening and medical treatment for their employees. Among these, prevention stands out, since it is generally recognized as the most cost-effective class of interventions from the company's point of view. It can be even more cost effective from a social perspective, when one takes into account that companies bear only part of the costs of a worker's illness and death (Haacker, 2005).

Unfortunately, many companies do not have HIV avoidance policies in place, and often companies come to recognize prevention as a priority only after HIV cost avoidance has become a necessity. Conversely, a forward-looking prevention strategy that keeps down the number of infections among the workforce can reduce the financial pressure to cut costs by reducing employee benefits. On the other hand, companies who primarily employ casual workers may have little financial incentive to invest in prevention, because they incur only modest benefit costs, if any; because training costs for such workers tend to be low; and because high turnover means that most of these workers will have left the company long before current prevention efforts result in a smaller number of AIDS cases.
These trends are consistent with the conjecture that there is a positive correlation between prevention efforts and benefit levels. They may also reflect a weaker capacity of small business management to implement HIV policies; from this perspective, the rankings for smaller companies reflect a more passive attitude and an emphasis on direct costs, whereas the larger companies tend to have some active policy in place (Haacker, 2005).

Small companies are less likely to adopt prevention and awareness measures, because there is a fixed cost involved in developing an HIV&AIDS policy or contracting HIV&AIDS-related services, and they may find it harder than large enterprises to replace key staff. The impact of HIV&AIDS on a small business is also less predictable. Also, incomes are generally lower in the informal economy, and many of the instruments available in the formal sector to mitigate the impact of HIV&AIDS on households (such as medical and death-related benefits) do not exist

there. In assessing the welfare effects of HIV&AIDS, it is therefore important to give appropriate weight to small businesses (Haacker, 2005).

2.6 LITERATURE GAPS: NEEDS AND CHALLENGES OF INFORMAL SECTOR IN RELATION TO HIV&AIDS

From the foregoing literature review, it is apparent that there are gaps, needs and challenges in relation to HIV&AIDS in the informal sector.

Most economic activity in the developing world is carried out in the informal sector, yet research has been primarily concerned with impact on the formal sector, probably because of greater availability of information. More work could also be done to explore the feasibility of possible mechanisms aimed at supporting informal income generating activities in the context of high HIV prevalence (such as credit, microfinance, technical support etc), as well as the potential role of these in mitigating the epidemic's impact. As pointed out by Casale & Whiteside in IDRC (2006), the possible integration of HIV&AIDS-related interventions (e.g. information, care, support) and income-generating support mechanisms is relatively new territory for further experimentation and analysis.

Informal workers constitute the majority of the work force in African countries. Yet, while discussing HIV&AIDS and the informal sector, it was noted that very little is known about how HIV&AIDS is affecting smaller companies and informal enterprises, especially those in the service, tourism, and other labour-intensive sectors. It is assumed that the informal economy faces pressures similar to those faced by the formal sector. The informal sector therefore deserves equal amount of attention. Here too the impact of HIV&AIDS is pervasive and complex.

Morbidity and mortality due to HIV&AIDS place a great strain on the sustainability of informal sector enterprises that are highly dependent on internal generation of flows of income and savings for their survival. Savings are threatened by the demands on revenues for higher levels of health expenditures. The loss of experience, management and technical skills that are so essential for survival in small, labour-intensive enterprises is therefore a serious concern that needs addressing.

Furthermore, the specific vulnerability of the informal sector to HIV&AIDS especially the young people, who are at higher risk to HIV in general, dominate the informal economy. In addition, incomes are low and frequently insufficient. Women are particularly vulnerable and many are forced to resort to contractual sex agreements for supplementary income. This exacerbates the spread of HIV&AIDS in the sector, an area that needs to be addressed. Others groups in the informal sector that are particularly at high risk of contracting HIV&AIDS include commercial drivers, hawkers and sex workers. Compared with the formal sector, intervention and mobilization on HIV&AIDS in the informal sector is made more problematic because of lack of structure and regulation amongst these groups.

There is need to find efficient inroads to address HIV&AIDS in the informal sector. From the literature, it is argued that organizing the informal sector is a crucial first step towards reaching

informal workers. Associations of PLWHA in the informal sector are particularly central in prevention efforts. Organizing workers in the informal economy opens up opportunities for stronger collaboration between formal and informal workers. It may also open up opportunities of funding.

In addition, existing associations and NGOs working in the informal sector should be strengthened. Such associations in the informal sector should be aided to design and access funding for HIV&AIDS prevention, care and support and other HIV&AIDS programmes for their members.

Governments should be called upon to intensify regulation efforts, as well as facilitating formalization of the informal sector. The activities of workers in the informal economy are normally outside the conventional scope of government regulation and assistance and suffer from a lack of social rights. While Governments vigorously address HIV&AIDS in the formal sector, the same cannot be said for the informal sector. Governments must be sensitized about HIV&AIDS and its impact and dynamic in the informal economy. Governments should more strongly address the specificities of the informal sector in the design of national AIDS strategies. The inclusion of the impact of HIV&AIDS on the informal sector in the national impact assessment is key towards this effort.

Strengthening community outreach programmes is key to finding inroads to the informal sector groups. It might be more efficient to target informal workers by strengthening the communities where they live, rather than through their workplace. Community outreach programmes often include improving public health services, social protection and education for all. It may also include strengthening prevention programmes, such as providing condom outlets and voluntary counseling and testing (VCT), raising awareness of HIV&AIDS in the general population.

There should be deliberate attention focusing on the insidious process of feminization of poverty and HIV&AIDS. More women are poor and more women work in the informal economy, which increases their risk to HIV infection. With the onset of AIDS women are further impoverished, coupled with reduced incomes and ever increasing expenses. Economic empowerment of women is crucial in the response against HIV&AIDS. Creating economic opportunities for women, ensuring gender equality in the workplace, and promoting women in all levels of working life will not only diminish gender inequality, but serve as a key strategy in the prevention of the spread of HIV&AIDS that will be of benefit to both women and men.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This was a participatory assessment involving methodological triangulation through qualitative and quantitative approaches. The assessment was conducted by two researchers assisted by 14 research assistants and 14 study guides (see Annex 1). Both primary and secondary data were collected and analyzed.

The exercise was conducted through the administration of survey questionnaires, Key Informant Interviews (KII) and Focus Group Discussions (FGDs). The fieldwork was conducted in February 2010.

3.1 Study Area

The study was national in coverage, used 10 pre-selected sites which are major towns and environs satisfying joint conditions of a high prevalence of HIV and a large informal sector community. The pre-selected sites included:

1. Nairobi & environs (including Thika, Athi River, Rongai),
2. Mombasa (including Ukunda, Mariakani, Mtwapa),
3. Kisumu & environs,
4. Nakuru and environs,
5. Busia,
6. Naivasha,
7. Malindi,
8. Eldoret,
9. Kakamega and
10. Narok.

The number of organizations sampled from each of the sites is shown in table 1 in the Results section.

The study focused on Micro and Small Enterprises (MSEs) in these study sites. The MSEs were identified through primary associations, identified through KPSAN umbrella bodies.

3.2 Data collection tools and methods

3.2.1 Primary data:

The mapping process used both qualitative and quantitative methods of collecting primary data. The following data collection tools were developed:

3.2.1.1 Survey Questionnaires:

The questionnaire comprised a set of pre-determined questions which were framed to elicit responses relevant to the study. The questionnaires were administered to the respondents by the

research assistants. Closed ended questions were used to ensure that the given answers were relevant to the subject. The research assistants phrased questions clearly in order to make clear dimensions along which responses were analyzed. For open-ended questions, space was be provided for filling of relevant additional information provided by respondents. There were two separate questionnaires – one for individual respondents (Annex 2) and the other for institutional representatives (Annex 3)

3.2.1.2 Key Informant Interviews guidelines:

A semi-structured interview guide was developed to facilitate eliciting of information that would complement the data from the questionnaires, in line with the study objectives. The guide was used to ask questions in face-to-face interviews with key stakeholders. This was particularly useful for seeking explanation to various phenomena that were encountered in the quantitative data collection exercise. The Key Informant Interview guide is given in Annex 4.

3.2.1.3 Focus Group Discussions guidelines:

These were similar to those developed for key informant interviews, designed to facilitate discussions with groups of informal sector workers and their representative groups (Annex 5). The objective of conducting FGDs was to elicit information from various groups on emerging themes elicited during the quantitative data collection exercise, for purposes of understanding issues related to the study and complement the quantitative data. The FGD facilitator asked questions to those participating in the FGDs, and gave them time to respond. The research assistant recorded the responses electronically using a tape recorder. To guard against eventualities of loss of data gathered electronically, field notes were also taken by the research assistant. Moderation of discussions was done by the facilitator, in order to encourage all participants to contribute, and to minimize domination by a few. Only consensus was recorded. The facilitator gauged that the topical issues had been discussed exhaustively before moving to the next topic.

3.2.2 Secondary data:

Secondary data was collected through desk review of relevant documentation.

3.3 Sample size and sample selection

For the quantitative component, the mapping survey was designed to collect information from workers in the informal sector at their workplace in the selected geographical locations using multistage sampling technique. First a sampling frame was constructed using a list of organizations that was provided by stakeholders in the informal sector under the umbrella of KPSAN. A random sample of organizations proportionate to the total number of organizations at each site was obtained. At the second stage, a sampling frame was constructed using the number of employees in all the selected organizations. From each organization, a random sample of respondents was then selected proportionate to the number of employees in the organization. The total sample size apportioned to the selected organizations was calculated using the formula and specifications detailed in Annex 6.

A total of 5 FGDs were conducted. Each FGD comprised of between 8-12 participants who were mainly workers in the informal sector. The criteria for selection of FGD participants was that they had been living in the area for a period of six months prior to the study and were working in the informal sector.

A total of 60 Key informants were interviewed during the study. The key informants mainly included the members of the District health management team (DHMT) namely the Medical officer of health, District Health Records Officer, District Public health nurse, District Clinical Officer, District Social work officer, District HIV and AIDS coordinator. Others included the COTU and ILO representative.

3.4 Quality control

A two day training session was conducted for the research assistants and study guides to build a shared understanding on the objectives of the mapping. They were taken through all the questions in the questionnaire that they would administer in the field.

Pre-testing of the tools was done in two organizations in Kenyatta Market and Nairobi West in Nairobi before data collection to ensure that the instruments were fine-tuned for collection of reliable data. Responses obtained did not form part of the findings of the study.

Research assistants were closely supervised in the course of data collection. Field supervisors counter-checked completed questionnaires every day to confirm completeness of data. Any concerns were clarified immediately to ascertain proper administration of the tool in subsequent days. The questionnaires were coded daily to facilitate entry, analysis and subsequent referral if necessary. Quality assurance also involved joint NACC/KPSAN M/E visits in all the study sites.

3.5 Data management and analysis

Quantitative data was entered using SPSS programme with inbuilt range and consistency checks. The data was then read in SPSS analysis module and further inspection and cleaning carried out before analysis. The results are presented in the form of frequencies and percentages and appropriate pictorial illustrations. Qualitative data was triangulated and analyzed based on the thematic areas and was mainly used in the report for detailed explanation of the quantitative data. The 95% confidence level is set for the work, the researchers having been guided to this by the generally accepted trends and realities in such studies. The analysis of data was carried out with the results presented paying particular attention to:

- Identified HIV & AIDS interventions in the informal private sector
- Key HIV & AIDS needs in the informal private sector
- Impact of HIV & AIDS needs in the informal private sector

CHAPTER FOUR: RESULTS

4.1 Introduction

The mapping/survey comprised of two main populations namely the organizations selected in the informal sector and individuals working in those organizations selected as per the guidelines in the previous section. The order of presentation of findings is guided by the objectives the mapping and the report is divided into the following sections:

4.1 Description of the respondents enrolled and organizations visited
4.2 Socio-demographic characteristics of the respondents
4.3 Current HIV and AIDS interventions in informal private sector
4.4 Key HIV and AIDS needs in the informal private sector in Kenya and the extent to which informal private sector strategies meet these needs
4.5 Impact of HIV&AIDS in the informal sector

To facilitate comparisons of various groups within the sample, the study sites are grouped into four, namely:

1. Nairobi
2. Coast – comprising Mombasa and Malindi
3. Western – comprising the sites in Kisumu, Busia, Kakamega
4. Rift Valley – comprising sites in Nakuru, Eldoret, Naivasha and Narok

Based on the number that was available and similarity in operations, categories of informal sector have also been grouped into the following in the comparative sections of the report:

1. Truck drivers, touts and boda boda operators
2. Hawkers
3. Jua kali artisans and small scale business
4. Others, comprising agricultural workers, fishing community, Tour guides/travel agents and members of self help groups.

4.1.1 Profile of study organizations

A total of 121 organizations (see Annex 7) were visited in the ten sites and the distribution is given in Table 1.

Table 1: Number of organizations surveyed, by site:

Site	No	Percent
Nairobi and environs	23	18.3
Mombasa	12	9.5
Nakuru	10	7.9
Kisumu and environs	17	13.5
Narok	9	7.1
Naivasha	10	7.9
Eldoret	10	7.9
Kakamega	12	9.5
Busia	12	9.5
Malindi	11	18.7
TOTAL	**121**	**100.0**

About half (52.3%) of the organizations were classified in the MTEF sector of Trade, Tourism and Industry, while 11.7% were in the Agricultural and Rural Development sector as shown in Table 2 below.

Table 2: Number of organizations by MTEF Sector:

MTEF Sector	No	Percent
Agriculture & Rural Development	13	11.2
Trade, Tourism and Industry	61	52.6
Physical Infrastructure	15	12.9
Environment, Water and Sanitation	2	1.7
Human Resource Development	8	6.9
Research, Innovation and Technology	3	2.6
Public Administration	1	0.9
Special Programs	9	7.8
Macro Working Group	4	3.4
TOTAL	**116**	**100.0**

Classified by the category of informal sector, the organizations comprised 28.8% Jua kali artisans, 16.9% Hawkers and another 16.9% Touts and boda boda operators as shown in Figure 1 below.

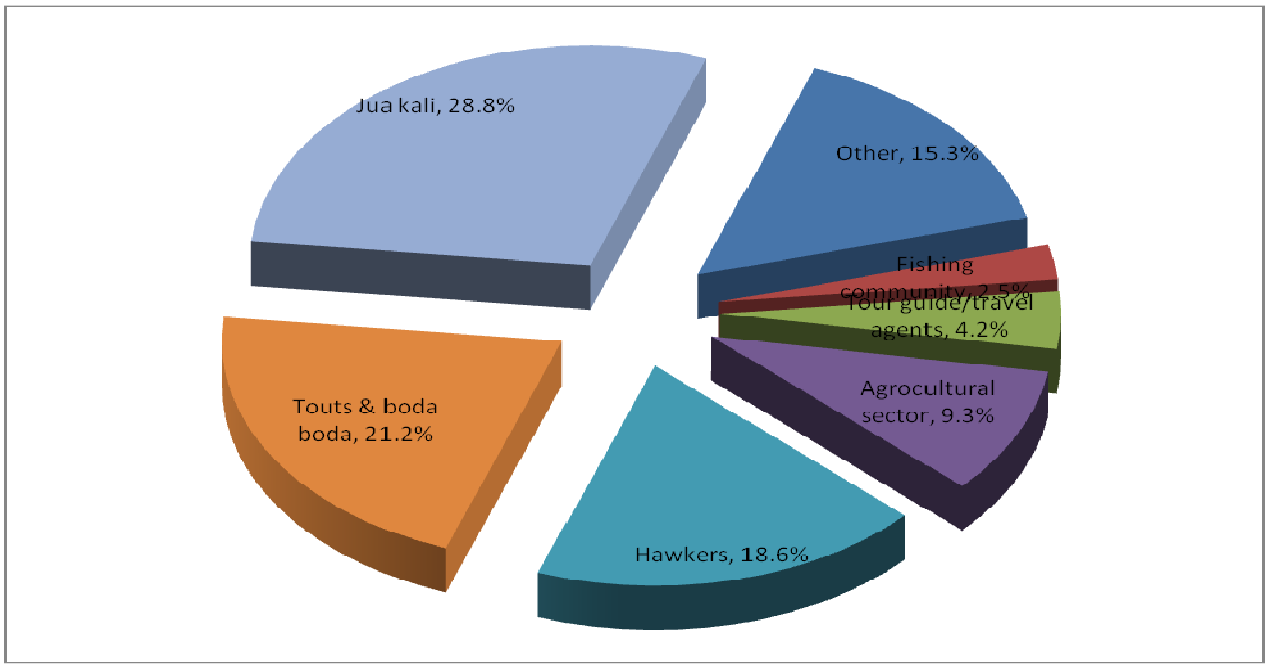

Figure 1: Number of organizations by category of informal Sector

4.1.2 Description of the individual study respondents

There were a total of 581 individuals interviewed during the study. One hundred and nine (18.8%) were drawn from Nairobi and its environs, 66 (11.4%) were from Kisumu, while 63 (10.8%) were from Mombasa. Between 40 and 50 respondents were drawn from each of the other sites (*as shown in Table 3 below*).

Table 3: Number of respondents by site and sex

	Sex		Total
SITE	**Male**	**Female**	
Nairobi	62 (56.9%)	47 (43.1%)	109(100%)
Mombasa	49(77.8%)	14(22.2%)	63(100%)
Nakuru	25(50.0%)	25(50.0%)	50(100%)
Kisumu	49(74.2%)	17(25.8%)	66(100%)
Narok	23(48.9%)	24(51.1%)	47(100%)
Naivasha	48(98.0%)	1(2.0%)	49(100%)
Eldoret	46(93.9%)	3(6.1%)	49(100%)
Kakamega	37(75.5%)	12(24.5%)	49(100%)
Busia	37(80.4%)	9(19.6%)	46(100%)
Malindi	37(72.5%)	14(27.5%)	51(100%)
TOTAL	**413(71.3%)**	**166(28.7%)**	**579(100%)**

*: Two of the respondents from this site did not have their sex indicated

By MTEF sector, two thirds (67%) were drawn from Trade, Tourism and Industry, 14.0% from Physical infrastructure, 5.8% from Special programs while 5.6% were from Agriculture & Rural Development (*refer to Table 4 below*).

Table 4: Number of respondents by MTEF by Sector and sex

	Sex		
MTEF SECTOR	**Male**	**Female**	**Total**
Agriculture & Rural Development	12(40.0%)	18(60.0%)	30(100%)
Trade, Tourism and Industry	256(71.9%)	100(28.1%)	356(100%)*
Physical infrastructure	73(97.3%)	2(2.7%)	75(100%)
Environment, Water and Sanitation	4(80.0%)	1(20.0%)	5(100%)
Human Resource Development	21(91.3%)	2(8.7%)	23(100%)
Governance, Law and Order	0(.0%)	1(100%)	1(100%)
Special programs	11(35.5%)	20(64.5%)	31(100%)
National security	2(100%)	0(.0%)	2(100%)
Macro Working Group	1(11.1%)	8(88.9%)	9(100%)
TOTAL	**380(71.4%)**	**152(28.6%)**	**532(100%)**

*: Two of the respondents from this sector did not have their sex indicated

By category of informal sector, nearly one quarter (23%) were jua kali artisans; nearly one fifth (19.9%) were touts/boda boda operators while 19.0% were hawkers (*see Table 5*).

Table 5: Respondents by Category of informal sector

	Sex		
INFORMAL SECTOR CATEGORY	**Male**	**Female**	**Total**
Truck drivers	2(100%)	0(.0%)	2(100%)
Hawkers	46(42.6%)	62(57.4%)	108(100%)
Tour guides/travel agents	12(92.3%)	1(7.7%)	13(100%)
Agricultural sector	15(51.7%)	14(48.3%)	29(100%)
Fishing community	7(58.3%)	5(41.7%)	12(100%)
Touts & Boda boda operators	136(95.8%)	6(4.2%)	142(100%)
Jua kali artisans	111(86.0%)	18(14.0%)	129(100%)*
Other	30(49.2%)	31(50.8%)	61(100%)
Small scale business	47(66.2%)	24(33.8%)	71(100%)
TOTAL	**406(71.6%)**	**161(28.4%)**	**567(100%)**

*: Two of the respondents from this sector did not have their sex indicated

4.2 Socio-Demographic Characteristics of the Respondents

4.2.1 Age by sex distribution

The study sample comprised 413 (71.5%) males and 165 (28.5%) females, indicating a preponderance of males over females in the sector. The results indicated that majority of the workers in the informal sector are aged between 20 and 39 years of age, an age group characterized by high risk of HIV infections. The age distribution of the sample disaggregated by sex is shown in Figure 2 below.

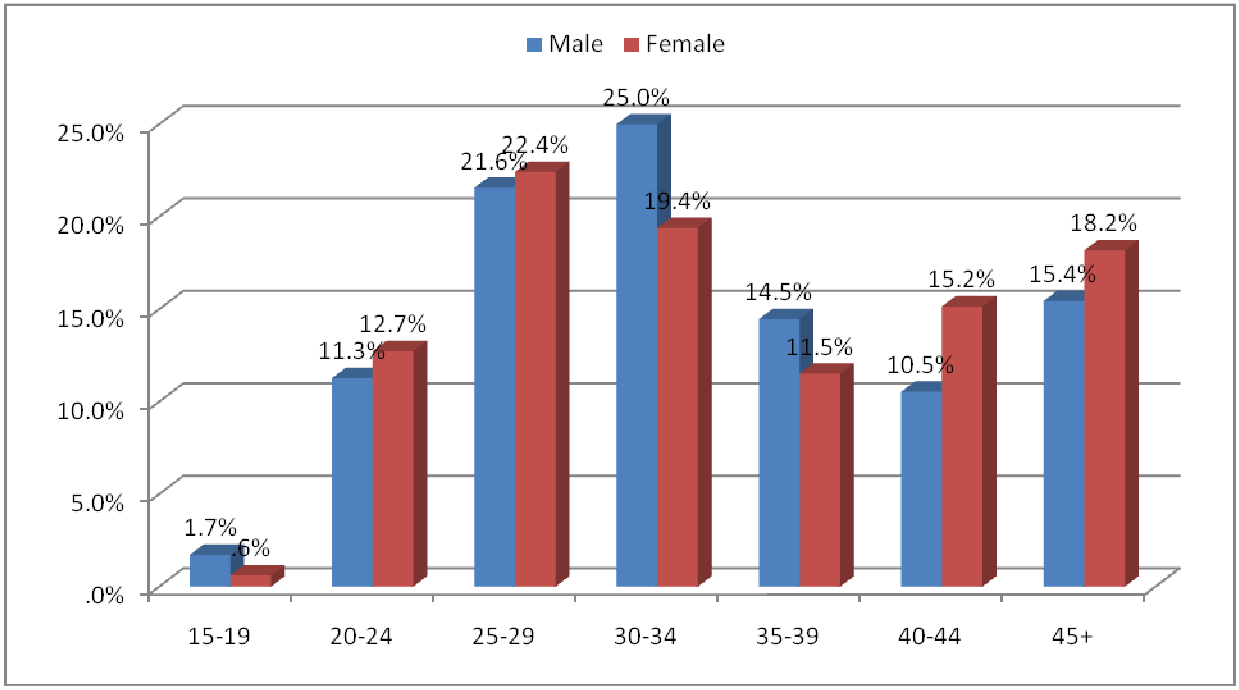

Figure 2: Age distribution of respondents

4.2.2 Educational level of the respondents

The data reveals that, 33.8% of the respondents had completed secondary education complemented by a further 18% who had incomplete secondary education. On the other hand, 27.6% of the respondents had completed primary education, complemented by a further 10.2% who had incomplete primary education while, 7.6% of the respondents had education beyond secondary school. Just about 1% had attained a university education (*refer to Figure 3 below*).

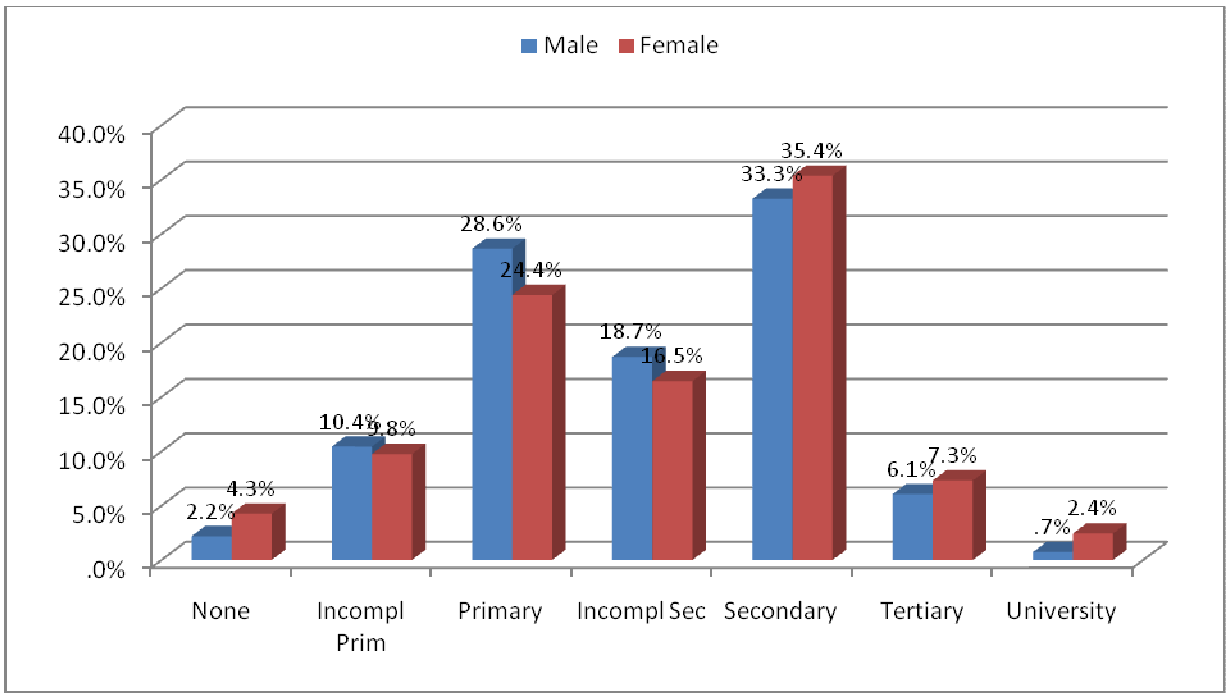

Figure 3: Education level of respondents

4.2.3 Career development after formal education

Beyond formal education, 215 (37.2%) of the respondents had been trained at a vocational training college/centre while 363 (62.8%) did not have any vocational training. There was no significant difference between the proportion of males trained (38.3%) and that of females trained (34.3%).

By region, there was a significantly higher proportion with vocational training in Nairobi (46.8%) and Western (41.5%) when compared to Coast (27.2%) and Rift Valley (34.2%) sites, as seen in Table 6 below.

Table 6: Vocational training by region

		Region				Total
		Nairobi	**Coast**	**Western**	**Rift Valley**	
Ever been trained at vocational training centre	Yes	51(46.8%)	31(27.2%)	66(41.5%)	67(34.2%)	215(37.2%)
	No	58(53.2%)	83(72.8%)	93(58.5%)	129(65.8%)	363(62.8%)
	Total	**109(100%)**	**114(100%)**	**159(100%)**	**196(100%)**	**578(100%)**

There was no significant difference in the proportion of respondents with vocational training across the informal sector categories.

For those who had vocational training, 59% had taken it after secondary school while 33.5% had taken it after primary school. There was a significantly higher proportion of females who went for vocational training after secondary school (67.2%) than males (56.3%) as seen in Table 7 below.

Table 7: Level after which vocational training was undertaken by sex

Level	Males	Females	Percent
None	8 (5.3%)	6 (10.3%)	14 (6.7%)
Primary	58 (38.4%)	12 (20.7%)	70 (33.5%)
Secondary	85 (56.3%)	39 (67.2%)	124 (59%)
University	0	1 (1.7%)	1 (0.5%)
Total	**151 (100%)**	**58 (100%)**	**209 (100%)**

Three hundred and forty nine (61.3%) of the respondents had been working in the informal sector for more than five years, 121 (21.3%) had been working in the informal sector between 3 and 5 years, 76 (13.4%) between 1 and 2 years while only 23 (4.0%) had been in the informal sector for less than a year as seen in Figure 4 below. Males were more likely to have been working longer in the informal sector (66.6% longer than 5 years) when compared to females with 48.1%.

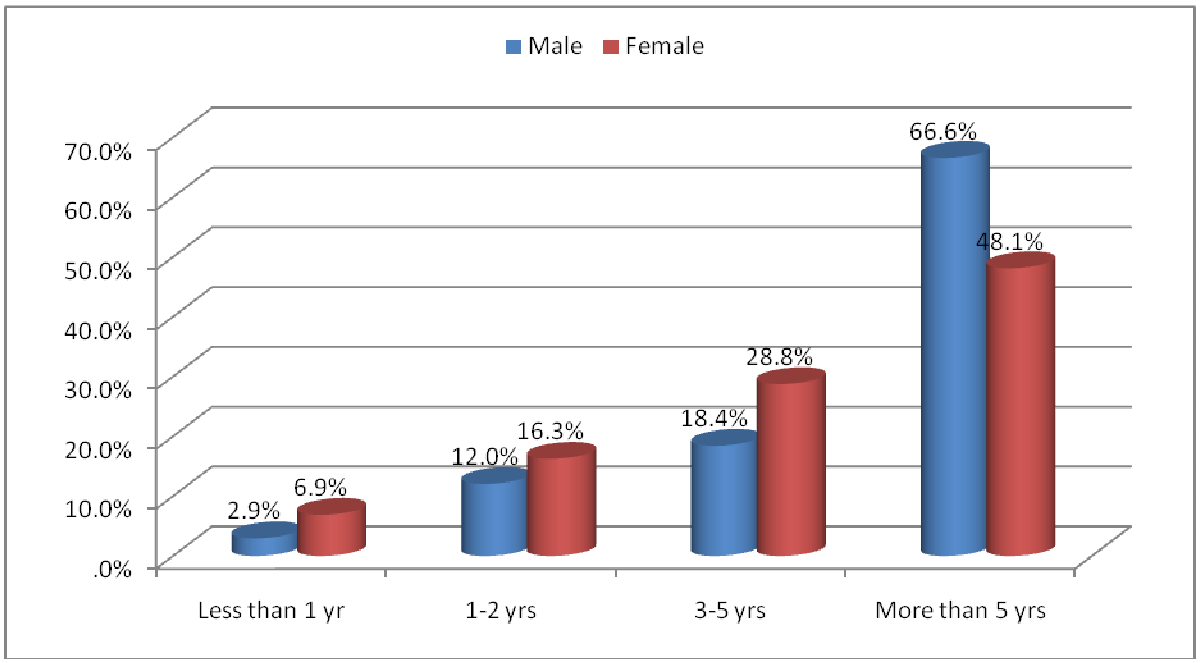

Figure 4: Duration of work in the informal sector by sex

A significantly higher proportion of respondents working in the Jua kali/small scale business had been working the sector longer than 5 years (74.5%) when compared to other sectors, as seen in Table 8 below.

Table 8: Duration working in the informal sector, by category of informal sector

		Informal sector category				Total
		Truck drivers/ touts/ boda boda operators	**Hawkers**	**Jua kali/ small scale business**	**Others**	
Duration working in the informal sector	< 1 year	7(5.0%)	7(6.5%)	3(1.5%)	6(5.0%)	23(4.0%)
	1 - 2 years	31(22.0%)	11(10.3%)	18(9.0%)	16(13.2%)	76(13.4%)
	3- 5 years	37(26.2%)	26(24.3%)	30(15.0%)	28(23.1%)	121(21.3%)
	5 + years	66(46.8%)	63(58.9%)	149(74.5%)	71(58.7%)	349(61.3%)
	Total	**141(100%)**	**107(100%)**	**200(100%)**	**121(100%)**	**569(100%)**

4.2.4 Income levels for the informal sector workers

Three hundred fifty six (62.2%) of the respondents, comprising 73.2% females and 57.6% males, on average earned Kshs 10,000 or less per month as indicated in Fig 5 below.

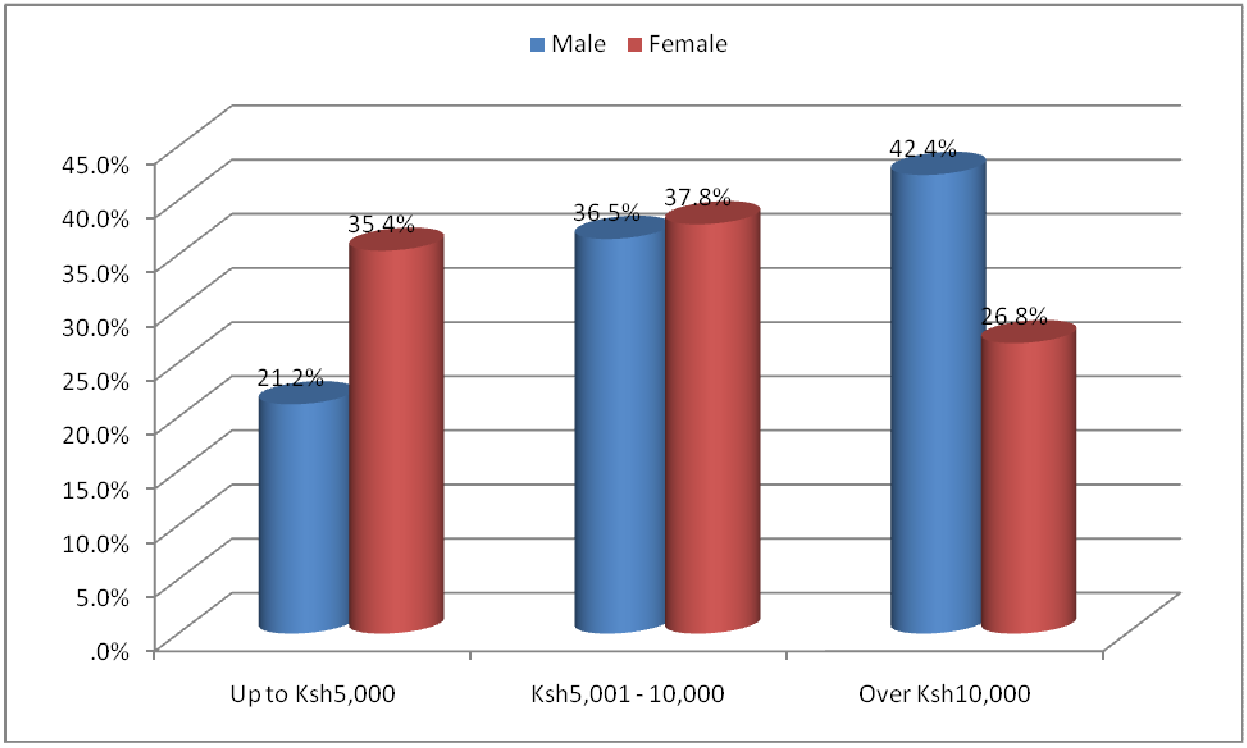

Figure 5: Income levels of respondents by sex

Income levels increased significantly with age group as shown in Table 9 below.

Table 9: Income levels of respondents, by age

		Age Category				Total
		15-24	25-34	35-44	45 +	
Earnings per month	Up to Ksh5,000	32(42.7%)	63(24.6%)	25(17.4%)	25(27.5%)	145(25.6%)
	Ksh5,001 - 10,000	25(33.3%)	104(40.6%)	49(34.0%)	29(31.9%)	207(36.6%)
	Over Ksh10,000	18(24.0%)	89(34.8%)	70(48.6%)	37(40.7%)	214(37.8%)
	Total	**75(100%)**	**256(100%)**	**144(100%)**	**91(100%)**	**566(100%)**

Income levels for respondents in Nairobi were significantly lower (only 22.2% of the respondents on average earned more than Kshs 10,000) when compared to other regions. Respondents from Coast had the highest income levels with 51.8% of them earning more than Kshs 10,000 per month (see Table 10 below).

Table 10: Income levels of respondents, by region

		Region				
		Nairobi	**Coast**	**Western**	**Rift Valley**	**Total**
Earnings per month	Up to Ksh5,000	35(32.4%)	7(6.3%)	46(28.9%)	58(30.1%)	146(25.5%)
	Ksh5,001 - 10,000	49(45.4%)	47(42.0%)	49(30.8%)	65(33.7%)	210(36.7%)
	Over Ksh10,000	24(22.2%)	58(51.8%)	64(40.3%)	70(36.3%)	216(37.8%)
Total		**108(100%)**	**112(100%)**	**159(100%)**	**193(100%)**	**572(100%)**

There were no significant differences in income levels across categories of informal sector.

One hundred sixty eight (29.5%) of the respondents earned money doing some other work apart from the current work in the informal sector. The sectors where the respondents earned some other money included agriculture/livestock (11.2%), trading/self employment/hawking (10.7%) and transport/trucking. This means that any activity involving the workers in the informal sector must cut across the various sectors. A higher proportion of males worked in the agriculture/livestock sector as a secondary occupation than females, while a higher proportion of females were involved in hawking/trading as a secondary occupation when compared to males as seen in Figure 6 below.

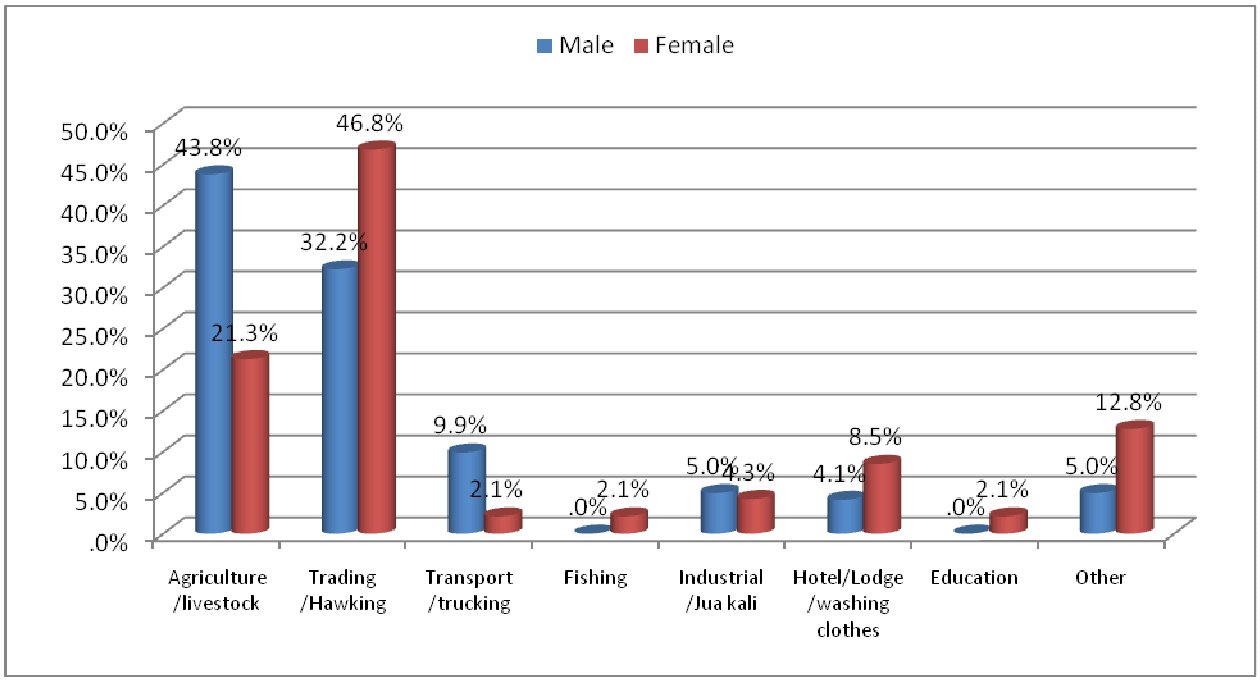

Figure 6: Other sectors where informal workers have earned a living by sex

4.2.5 Living arrangements

Two thirds (66.6%) of the respondents lived with their spouses, (72.3%) lived with their children while 13.8% lived with their relatives as indicated in Figure 7 below.

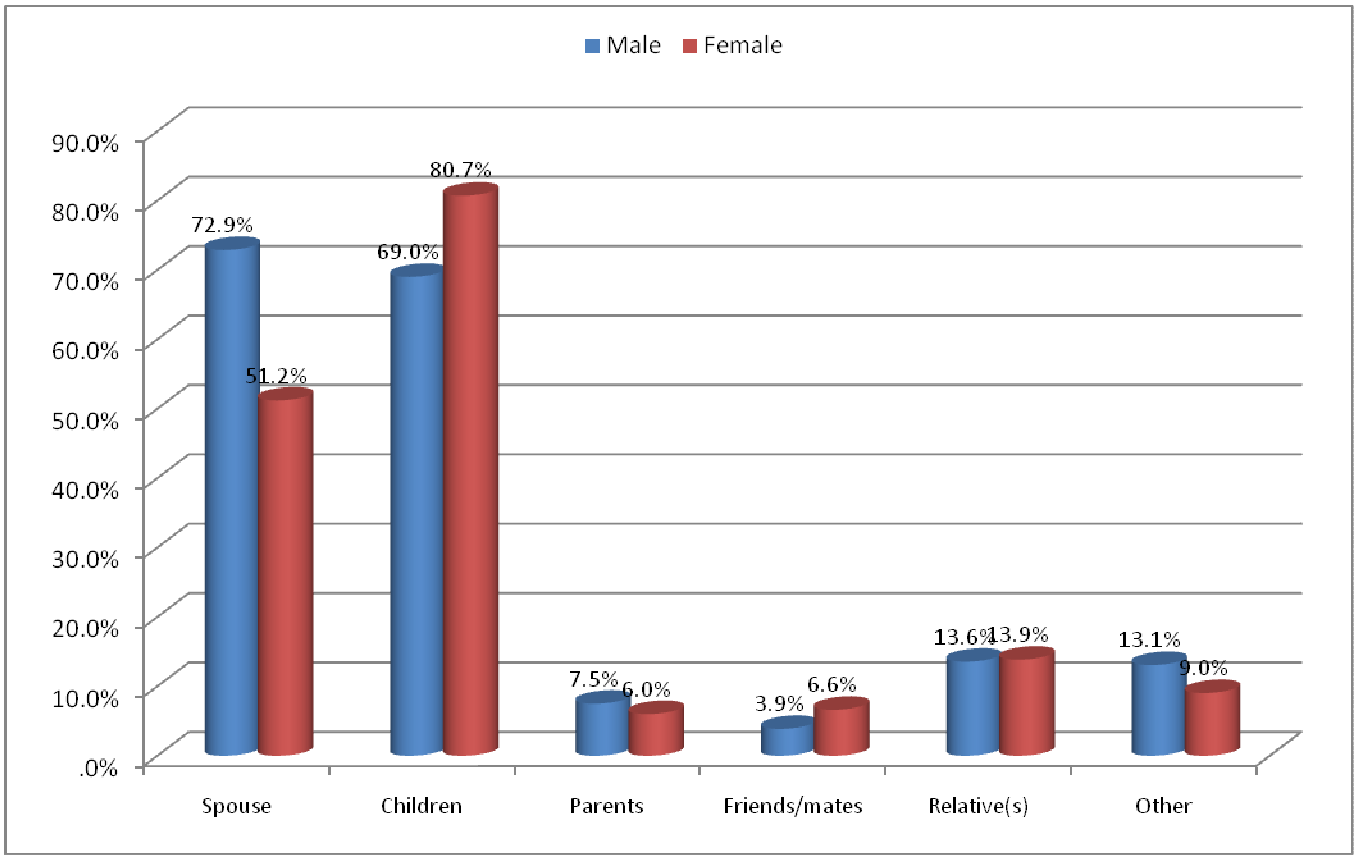

Figure 7: Persons the respondents lived with, by sex

In terms of the nuclear family, a significantly higher proportion of females, 34.9% lived with children only when compared to only 2.7% of the male respondents as shown in Table 11 below. This indicates a high proportion of female headed households among the workers in this sector.

Table 11: Members of nuclear family respondent lived with

		Male	Female	Total
Respondent lives with	Spouse only	27(6.5%)	9(5.4%)	36(6.2%)
	Children only	11(2.7%)	58(34.9%)	69(11.9%)
	Spouse and children	274(66.3%)	76(45.8%)	350(60.4%)
	Neither spouse nor children	101(24.5%)	23(13.9%)	124(21.4%)
Total		**413(100%)**	**166(100%)**	**579(100%)**

4.3 Current HIV and AIDS interventions in informal private sector

4.3.1 Existence and Utilization of Voluntary Counselling and Testing services

VCT acts as an entry point for HIV prevention and management. The results indicated that only 96 (16.6%) of the respondents reported that their workplace/environment had VCT services.

There were no significant differences in availability of VCT services in the workplace between males and females as well as across age groups.

There was a significantly higher proportion of respondents from the Nairobi sites (47.7%) who reported that their workplace/environment had VCT services when compared to respondents from other sites as seen in Table 12 below.

Table 22: Availability of VCT services in the workplace/environment, by region

		Region				
		Nairobi	**Coast**	**Western**	**Rift Valley**	**Total**
Workplace /environment has VCT services	Yes	52(47.7%)	8(7.0%)	13(8.0%)	23(11.9%)	96(16.6%)
	No/ Don't know	57(52.3%)	106(93.0%)	149(92.0%)	171(88.1%)	483(82.4%)

Respondents from the truck drivers/touts/boda boda operators' category of informal sector reported a significantly lower proportion of availability of VCT services at the workplace environment at 8.4% when compared to hawkers at 19.6% and jua kali/small scale business at 18.9%.

For the 472 respondents who indicated that they did not have access to VCT at their place of work, Table 13 shows the places that were indicated as sources of VCT services.

Table 33: Places where VCT services are available if not at place of work

Place	**Number**	**Percentage**
Nearby health centres	162	34.3
Nearby private clinics	122	25.8
Nearby district/mission/church clinic & hospitals	305	64.6
Available at provincial level	49	10.4
Mobile /Moonlight VCT	130	27.5
Don't know / No place	5	1.0
Other	13	2.8

Four hundred and fifteen respondents (71.7%) said that they had ever had an HIV test. There was a significantly higher proportion of females (80.7%) of females who reported that they had ever had an HIV test as compared to 67.9% of the males. There were no significant differences between the proportions of those who had an HIV test across the age groups nor across the categories of informal sector. However, a higher proportion (87.2%) of the respondents from Nairobi sites had ever had an HIV test when compared to 64.9% in Coast, 67.3% in Western and 70.6% in Rift Valley sites, as shown in Table 14 below.

Table 44: Ever had an HIV test by region

		Region				
		Nairobi	**Coast**	**Western**	**Rift Valley**	**Total**
Ever had an HIV test	Yes	95(87.2%)	74(64.9%)	109(67.3%)	137(70.6%)	415(71.7%)
	No	14(12.8%)	40(35.1%)	53(32.7%)	57(29.4%)	164(28.3%)
Total		**109(100%)**	**114(100%)**	**162(100%)**	**194(100%)**	**579(100%)**

For those respondents who had ever taken the HIV test, 379 (93.8%) of them said that pre and post test counselling was provided as a part of the VCT processes and further, 280 (69.5%) of them said that information on where one could get follow-up services (referral) was provided at the VCT. There were no significant differences between the proportions of males and females provided with pre and post test counselling or with information on where one could get follow-up services. There was a significantly lower proportion (88.7%) of respondents from Rift Valley sites where and post test counselling was provided as a part of the VCT processes when compared to other regions (see Figure 7). The Coast region sites also had a significantly lower proportion (52.8%) of respondents where information on where one could get follow-up services was provided at the VCT when compared to other sites (Figure 8).

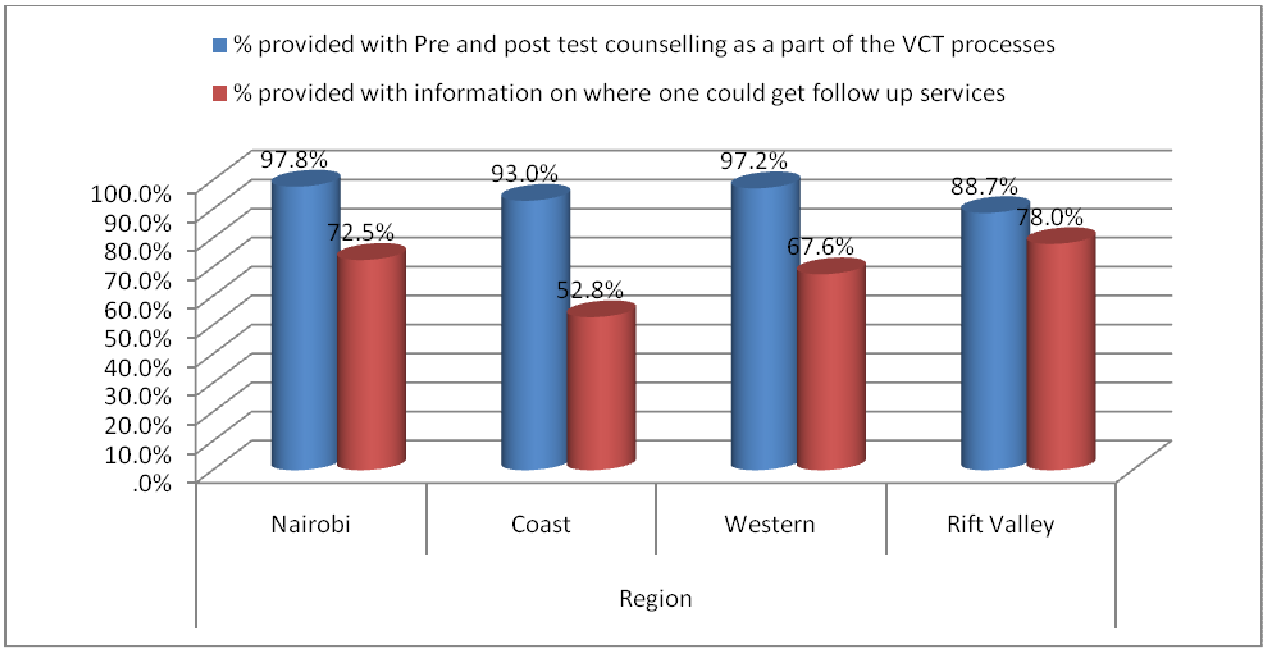

Figure 8: VCT service processes

4.3.2 Number of times respondents had taken VCT

Asked about how many times they had taken the HIV test 106 (26.0%) reported that they had done so more than three times while 111 (27.2%) indicated that had done so only once. A significantly higher proportion of females (34.9%) had taken the test more than three times when compared to 21.7% of males who had taken the test more than three times (*see Figure 9 below*).

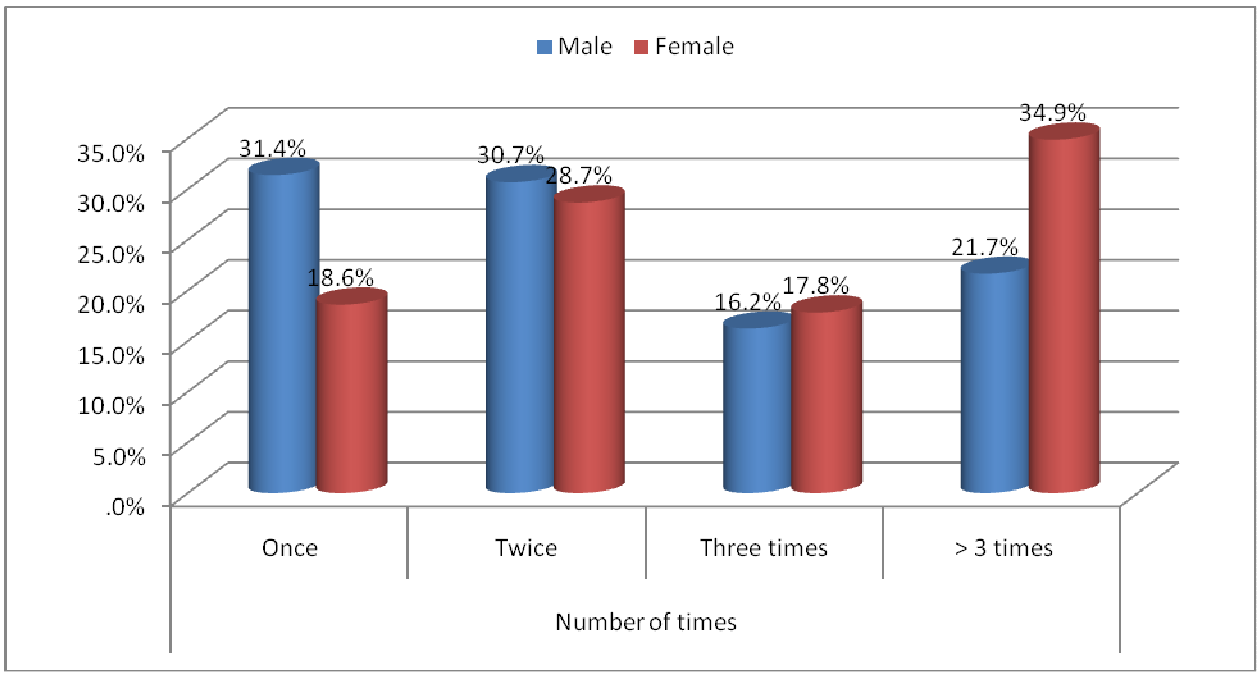

Figure 9: Number of times respondents had taken VCT

Frequency of taking the HIV test also seemed to decrease as age increased, with 15.7% of those aged 15-24 years taking the test only once when compared to 42.9% of those aged 45 and above, as seen in Table 15 below.

Table 55: Frequency of taking the HIV test, by age group

		Age Category				Total
		15-24	**25-34**	**35-44**	**45 +**	**Total**
Frequency of taking the HIV test	Once	8(15.7%)	44(23.4%)	35(32.1%)	24(42.9%)	111(27.5%)
	Twice	21(41.2%)	53(28.2%)	35(32.1%)	12(21.4%)	121(30.0%)
	Three times	9(17.6%)	39(20.7%)	13(11.9%)	7(12.5%)	68(16.8%)
	> 3 times	13(25.5%)	52(27.7%)	26(23.9%)	13(23.2%)	104(25.7%)
	Total	**51(100%)**	**188(100%)**	**109(100%)**	**56(100%)**	**404(100%)**

There were no significant differences in frequency of taking the HIV tests across the regions as well as across the categories of informal sector. Collection of HIV test results was almost universal at 98.8%.

4.3.3 Need for VCT Services in the workplace

Four hundred and eighty (84.1%) of the respondents indicated that they would like to take an HIV test in the future. Demand for HIV test was similar across the sectors, age groups and gender.

Among the 91 (15.9%) of the respondents who said that they would not like to take the test in the future, nearly half (47.3%) stated that they were faithful and so they did not need one. The other reasons stated for not needing a test included fear of knowing status (22.0%), no idea how to handle status (14.3%) while 8 (8.8%) did not see the importance of the test as there is still no cure, among others. These reasons are shown in Figure 10, disaggregated by sex.

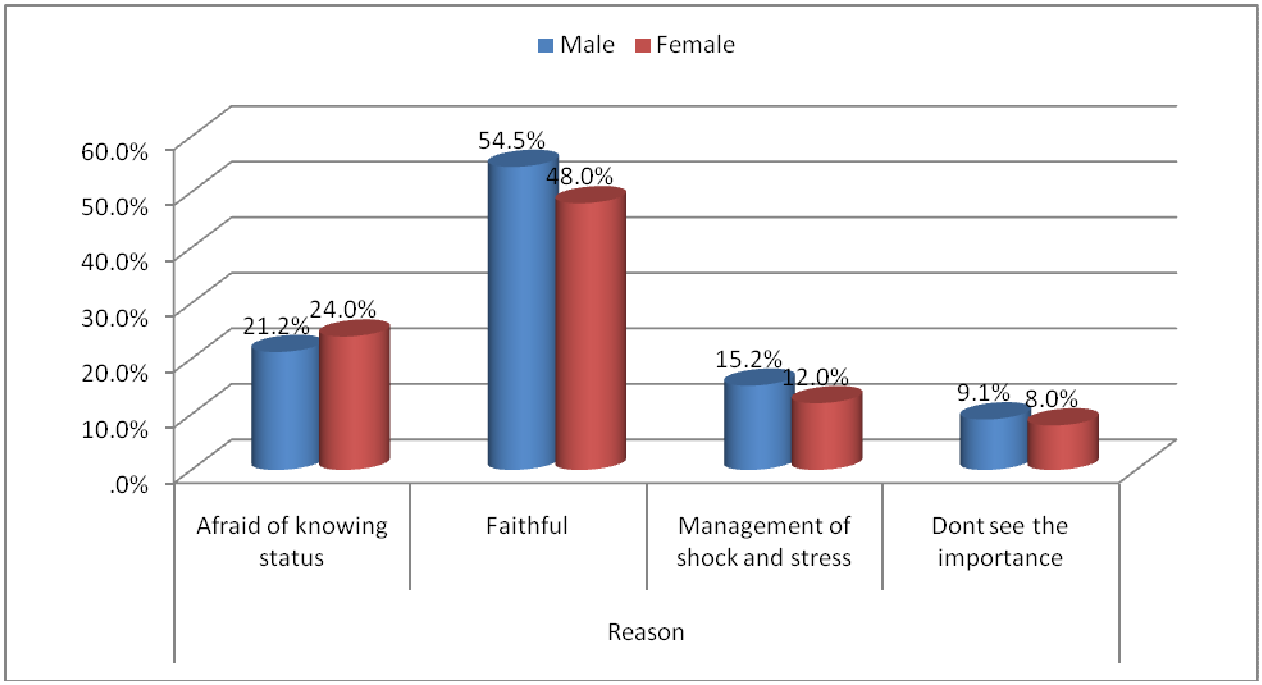

Figure 10: Reasons for not going for HIV testing, by sex

From the institutional interviews the most common cited reason for staff not requesting VCT services was fear of stigma and discrimination at work (46.9%) and fear of breach of confidentiality at work (31.7%) as seen in Table 16 below.

Table 66: Reasons why staff are not asking for VCT services:

Reason	Total valid responses	Number responded affirmative	Percent affirmative
Absence of VCT facilities at workplace	65	14	21.5
Absence of a workplace HIV awareness and prevention programme	64	13	20.3
Fear of stigma and discrimination at work	64	30	46.9
Fear of breach of confidentiality at work	63	20	31.7
Ignorance on importance of knowing ones' status	63	16	25.4
Ignorance on provisions of workplace policy and programs on HIV&AIDS	63	9	14.3
Other reason	61	21	32.3

4.3.4 Existence of Workplace HIV&AIDS Policies and Programmes in the informal sector

Only 24% of the organizations indicated that they had HIV&AIDS policies and out of these 30, twenty six had HIV&AIDS prevention programmes, as shown in Table 17 below. Organizations that said they had policies were mostly HIV&AIDS related organizations and those associated with large organizations such as Chamber of Commerce.

Table 77: Existence of workplace HIV&AIDS Policy and Prevention Programmes

Workplace has HIV&AIDS policy	**Number**	**%**
Yes	30	24.2
No	94	75.8
Total	**124**	**100%**

Workplace provides HIV/ AIDS prevention programmes	**Number**	**%**
Yes	26	92.9%
No	2	7.1%
Total	**28**	**100%**

The representatives of the organizations were interviewed on various aspects of HIV prevention programmes and the findings are presented in Table 18 below. It is noted from these findings that only 8 (6.4%) of the organizations required their employees to take an HIV antibody test prior to employment, and only 36 (29.0%) had a prevention programme within the previous three months. However the majority of the organization (62.6%) provided employees with information on where they could receive HIV counselling and testing. About one third (32.2%) of the organization had on site or nearby workplace sponsored clinic for employees. Almost all the clinics provided HIV testing, ARV treatment, treatment of opportunistic infections and referral services.

Table 88: Availability of HIV&AIDS programmes

Availability of HIV&AIDS programmes	**Total valid responses**	**No. responded 'Yes'**	**Percent affirmative**
Employees required to take an HIV antibody test prior to employment	125	8	6.4
Workplace had a prevention programme within the last 3 months	124	36	29.0
Workplace provides employees with information on where they can receive HIV counseling and antibody testing	123	77	62.6
Workplace provides on-site or nearby peer education on HIV prevention	121	39	32.2
Workplace sponsored clinic on-site or nearby for employees	122	9	7.4
Clinic provides HIV counselling and antibody testing to employees	8	7	87.5
The clinic provide anti-retrovirals to employees	7	5	71.4
The clinic provide treatment* of opportunistic infections to employees	7	6	85.7
The clinic provide referral services to clinics where employees can receive care for STIs including HIV&AIDS	7	7	100.0

Access to quality health care & support

To obtain information regarding access to quality healthcare and support in the informal sector a series of questions were posed to the representatives of the selected organizations. The number and percentage of those who responded "yes' to these questions are summarized in Table 19 below.

Table 19: Access to quality health care & support

	Total valid responses	**Number responded affirmative**	**Percent affirmative**
Organisation provides VCT services for staff	126	8	6.3
Are your staffs asking the organisation to assist them access to HIV counselling and testing services (VCT)	117	47	40.2
The employer provide referral services for VCT	92	30	32.6
Pre-test counselling provided to those taking the HIV test within the institution/organization	48	44	91.7
Post-test counselling provided before giving the results of an HIV test to staff	47	43	91.5
Pre and post test counselling services explain to staff the nature of health care and support (comprehensive care) services available to infected and affected staff	51	43	84.3
Condoms provided at the VCT centre	85	69	81.2
Organisation provides healthcare facilities/services on-site	124	14	11.3
The health care facilities available in all workstations	22	7	31.8
Organisation provide access to HIV-related referral services off-site	109	53	48.6
The above mentioned health care services in Q314 provided free?	47	35	74.5
Staff have a health/medical cover	123	24	19.5
There referral services for HIV-related illnesses provided by your organization for staff to public and private health institutions	4	2	50
Does your organization offer medical insurance coverage and HIV-related health care services to members of staff's immediate family	32	5	15.6

Only 8 (6.3%) of the organizations provided VCT services and only in 47 (40.2%) of the organizations were the employers asking the organization to assist them to access HIV counseling and testing services while 30 (32.6%) of the organizations provided referral services for VCT. 44 (91.7%) of the organizations provided pre-test counseling to those taking the HIV test within the organization. The number of organizations that provided post test counseling before giving the results of an HIV test to staff, and pre and post test counseling services to explain the nature of health care and support services available to infected and affected staff was 43 and 91.5%, 84.3% respectively. A large number of employees – 69 (81.2%) said that condoms were provided at the VCT centre. 14 (11.3%) of the organizations provided healthcare facilities/services on site, while only 7 (31.8%) healthcare facilities were available in all workstations. A number of organizations-53 (48.6%) reported that they provided access to HIV-related referral services off-site with 35 (74.5%) of the organizations reporting that the referral healthcare services were provided for free. Twenty four (19.5%) of the organizations reported to have a health/medical cover, however only 5 (15.6%) organizations offered medical insurance coverage and HIV related healthcare services to members of staff's immediate family. Only 2 (50%) organizations provided referral services for HIV related illness for staff to public and private health institutions.

In the individual respondent interviews, the results indicated that only one hundred and fourteen (19.8%) of the respondents indicated that they had at least one operational HIV & AIDS operational program in their workplace. This meant that majority of the informal sector workers do not have an operational workplace HIV policy. There were no differences in the proportions of those who reported that their workplace between males and females as well as across age groups. A higher proportion (21.1%) of respondents from the Jua kali/small business sector reported that they had at least one operational HIV & AIDS operational program in their workplace when compared to the truck divers/touts/boda boda operators each at 14.6%.

Respondents from Nairobi and Western sites reported a higher proportion (37.7% and 26.9% respectively) with at least one operational HIV & AIDS operational program in their workplace when compared to the respondents from the other regions, see Figure 11.

Only 9.8% of the respondents reported that the subsector they worked in provided them with any specific HIV & AIDS related programmes and services. Nairobi and Western regions also reported a significantly higher proportion of respondents working in a sub-sector which provided them with any specific HIV & AIDS related programmes and services.

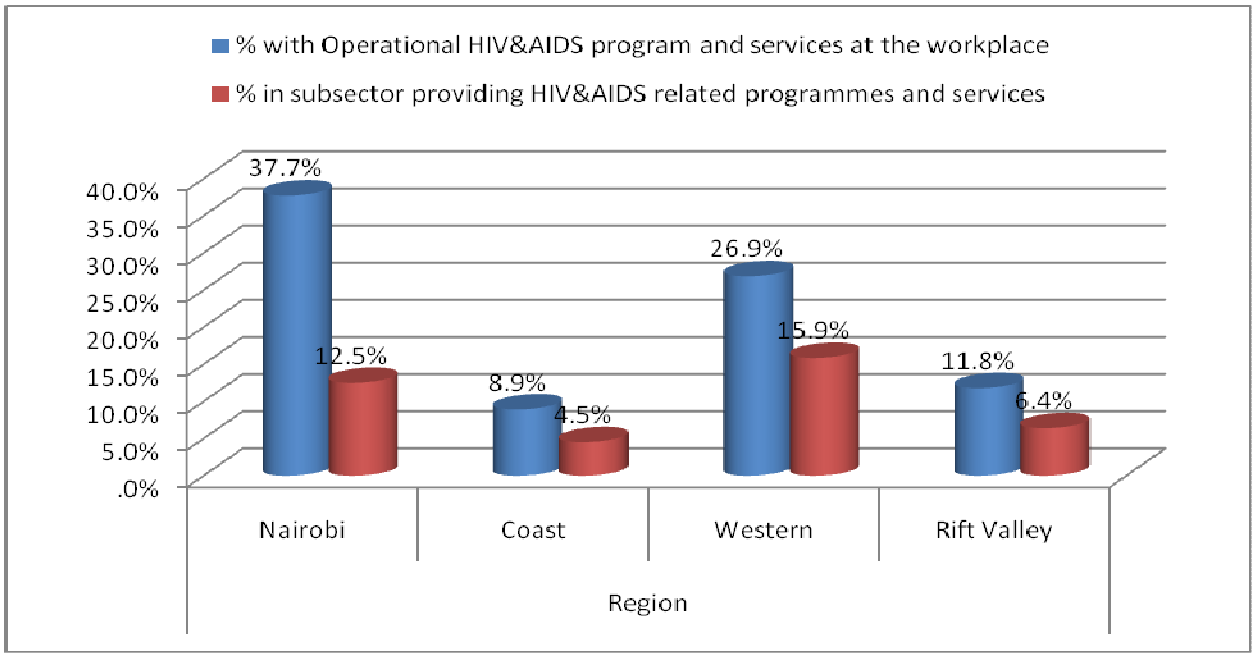

Figure 51: Availability of HIV&AIDS Programmes and services by region

For respondents who reported that they had HIV programmes and services at their workplace, condom provision and guidance and counselling were the most commonly mentioned as seen in Figure 12 below.

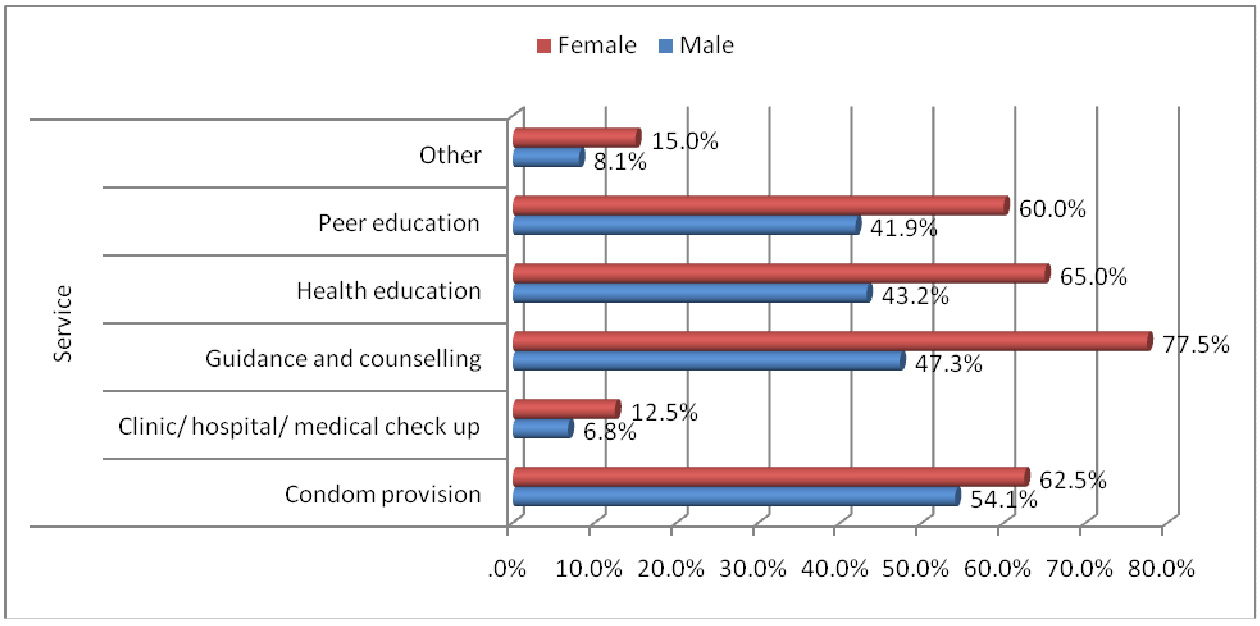

Figure 12: HIV&AIDS Services at the workplace

It also emerged that in cases where the services existed they were mainly provided by NGOs and CBOs working in the area. Indeed government only provided 28.9% of the services (see Figure 13 below).

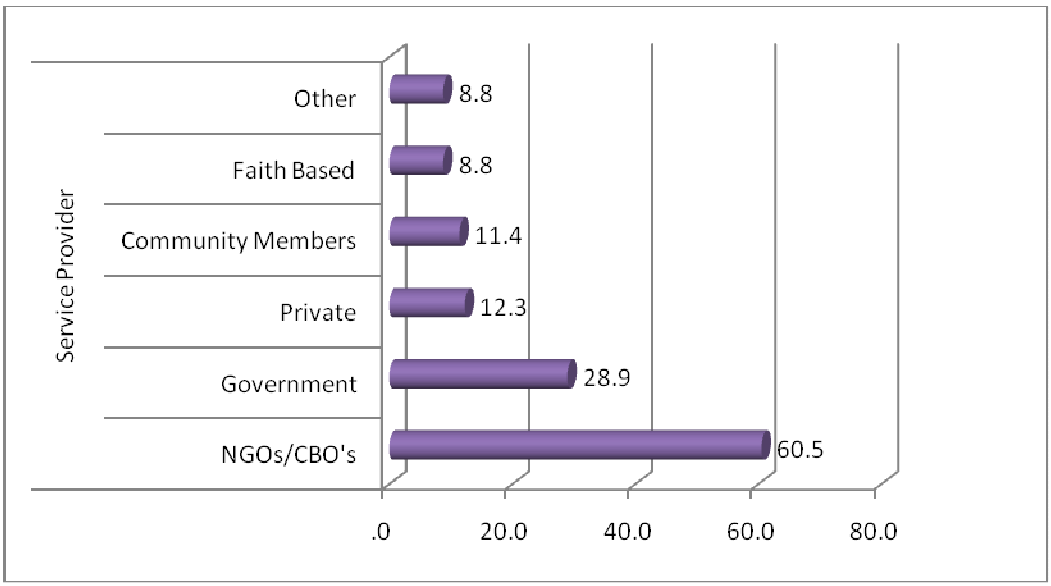

Figure 63: **Institutions providing services**

Satisfaction with the services provided was fairly good with 15 (13.2%) of the respondents rating them as excellent, 51 (44.7%) of the respondents rating them as good, 37 (32.5%) rating them as fair. Only 4 (13.2%) rated the services as excellent while only 4 (3.5%) said the services were of poor quality. Males were less satisfied with the services when compared to their female counterparts, see Figure 14 below.

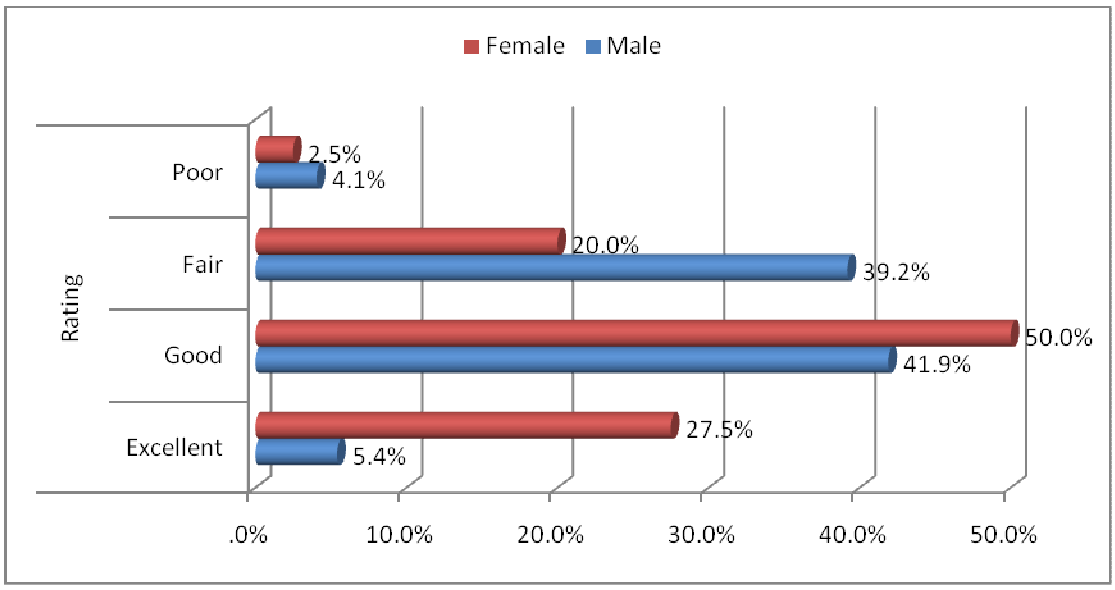

Figure 74: Satisfaction with services

4.3.5 Awareness of HIV and AIDS policy and bills

Thirty five (28.0%) of the representatives of organizations said they were aware of the Private Sector Workplace Policy on HIV&AIDS and in 15 (62.5%) of these organizations the staff were

sensitised or inducted on the provisions of the policy. Further 52 (62.5%) of the organizations were aware of the new HIV and AIDS Prevention and Control Act of 2006 and 36 (29.0%) of the organization respondents were aware of any workforce policies related to HIV and AIDS in the sector as shown in Table 20 below.

Table 20: Awareness of HIV and AIDS policy

Responses to HIV&AIDS	Total valid responses	Number responded affirmative	Percent affirmative
Awareness of the Private Sector Workplace Policy on HIV&AIDS	125	35	28.0
Staff sensitization/induction on the provisions of the Work place HIV&AIDS Policy	24	15	62.5
Awareness on HIV&AIDS Prevention and Control Act of 2006	125	52	41.6
Awareness on workforce policies related to HIV and AIDS in the sector	124	36	29.0

4.4 Key HIV and AIDS needs in the informal private sector in Kenya

4.4.1 HIV and AIDS Knowledge, Attitudes, Practices and Beliefs

4.4.1.1 Awareness of HIV and AIDS

Awareness of HIV&AIDS was universal with only one respondent out 581 saying they had not heard of it. When asked about how they had heard of HIV&AIDS, most of the respondents (60.8%) mentioned mass media/radio, friends/family were the next most common at 39.6%, followed by awareness forums at 20.5% and electronic media (TV) at 18.6%. The proportion of respondents mentioning various sources of information are shown in Figure 15 below, disaggregated by sex.

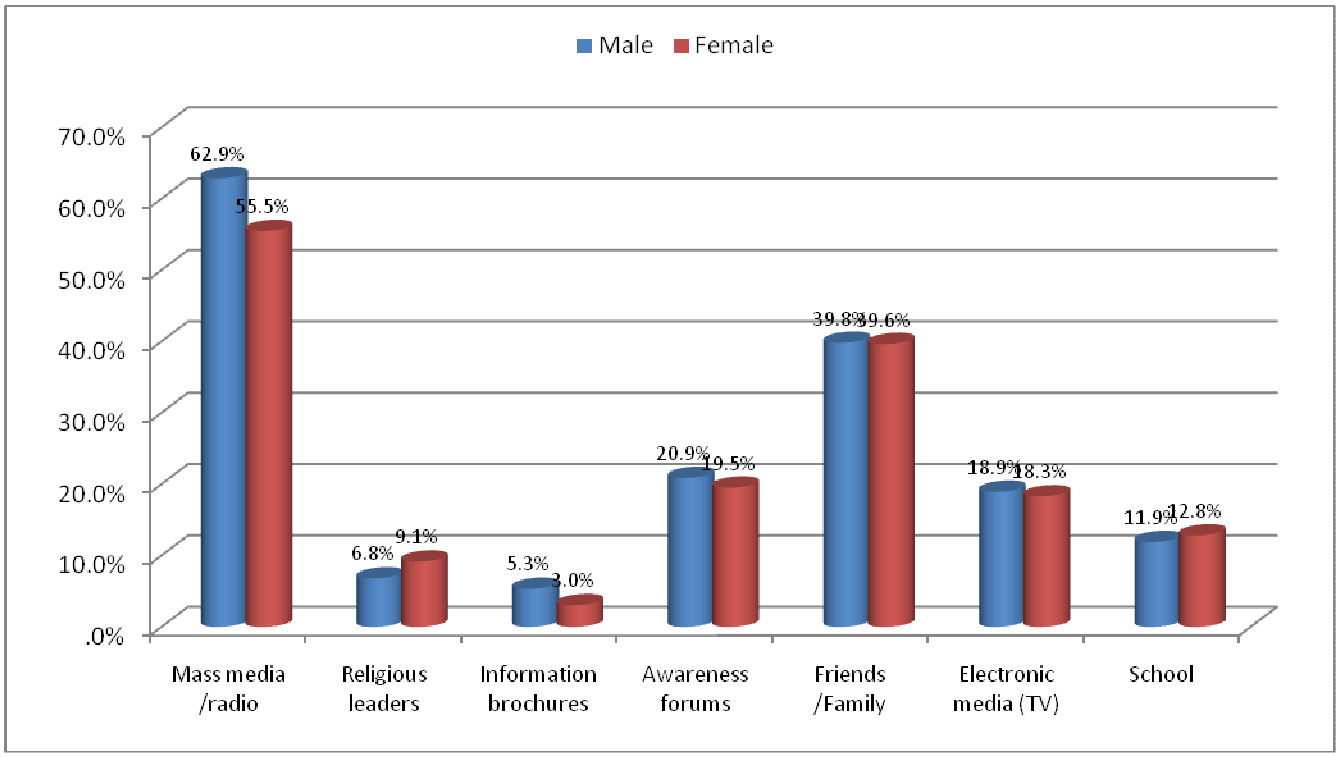

Figure 85: Source of information on HIV&AIDS, by sex

To gauge the respondents' knowledge on HIV&AIDS, a series of questions on prevention, transmission and misconception were posed to them. The results indicated that most of the respondents did not have accurate knowledge especially in terms of modes of transmission. They also had a lot of myths on HIV and AIDS. The responses to all the ten questions posed are given in Annex 8.

Overall, 47.3% of the respondents had comprehensive knowledge of HIV based on the five questions recommended by the UNGASS guidelines (2009) on indicator construction (Annex 9). The results of these knowledge questions, showing the number and percent that answered correctly to all the five questions and disaggregated by age and sex, are shown in Table 21.

Table 91: Comprehensive knowledge of HIV&AIDS by age and sex

	Males		**Females**	
Age group	**Number**	**Percent**	**Number**	**Percent**
15-19	2	28.6	-	-
20-24	18	42.2	11	52.4
25-29	39	44.3	19	51.4
30-34	43	42.2	23	76.7
35-39	28	47.5	10	52.6
40-44	16	61.9	13	52.0
45 & above	28	44.4	16	53.3
Total	**174**	**100%**	**92**	**100%**

4.4.1.2 Sexual Activity

Over 85% of HIV transmission occurs through heterosexual intercourse. The results indicated that sexual activity was common with 284 (52.6%) of the respondents (comprising 227 males and 57 females) having had sex within one week preceding the interview and a further 23.9% within the preceding one month. Frequency of having had sex within the previous one week as well as the previous one month was lower in females than in males (*see Figure 16*).

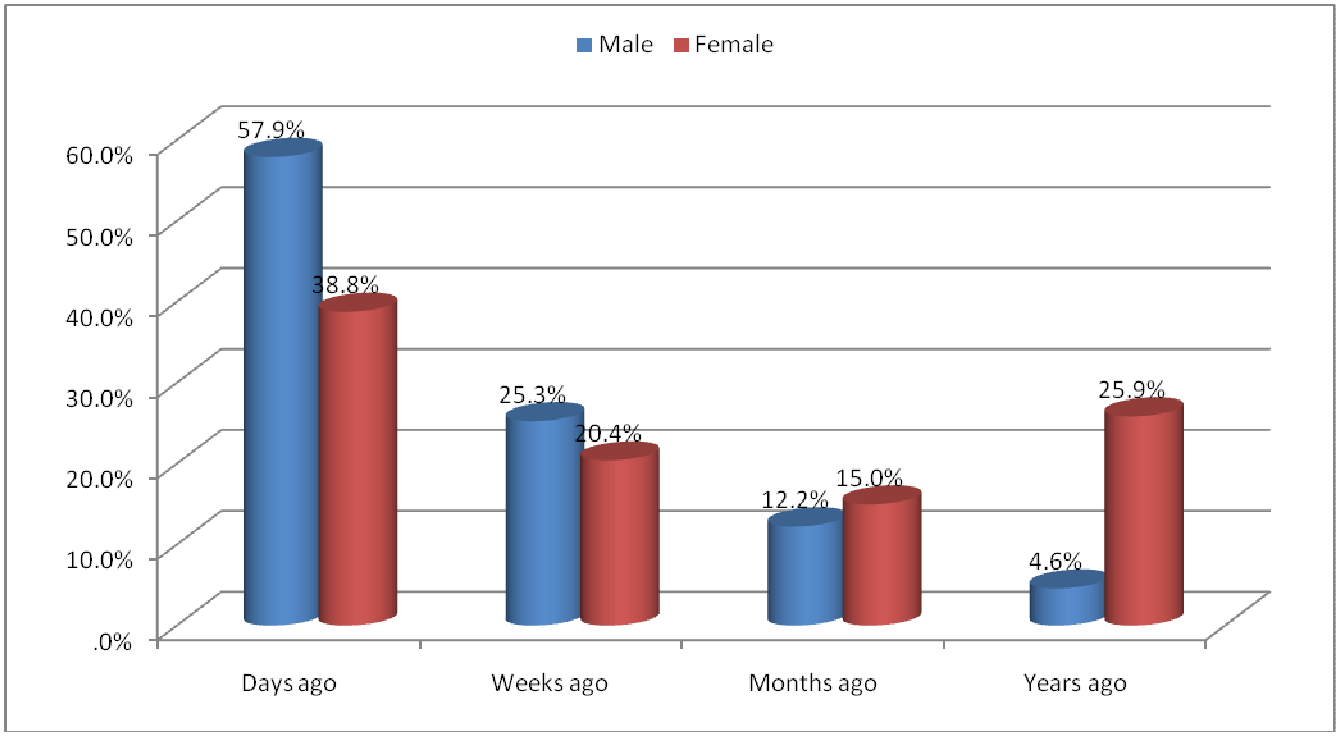

Figure 96: Frequency of sexual activity, by sex of respondent

The proportion of respondents who had sexual intercourse within the last seven days increased with age up to age 44 years, as seen in Table 22 below:

Table 102: Frequency of sexual activity, by age of respondent

		Age Category				
		15-24	**25-34**	**35-44**	**45 +**	**Total**
Last time respondent had sexual intercourse	Days ago	32(47.8%)	136(56.2%)	84(60.4%)	27(31.0%)	279(52.1%)
	Weeks ago	19(28.4%)	58(24.0%)	30(21.6%)	22(25.3%)	129(24.1%)
	Months ago	9(13.4%)	28(11.6%)	16(11.5%)	18(20.7%)	71(13.3%)
	Years ago	7(10.4%)	20(8.3%)	9(6.5%)	20(23.0%)	56(10.5%)
	Total	**67(100%)**	**242(100%)**	**139(100%)**	**87(100%)**	**53(100%)**

Rift Valley sites had the highest proportion of respondents who had sexual intercourse with the week preceding the interview (63.4%), followed by Western at 52.3% while Nairobi and Coast had 42.5% and 45.2% respectively (see Table 23).

Table 113: Frequency of sexual activity, by region

		Region				Total
		Nairobi	Coast	Western	Rift Valley	
Last time respondent had sexual intercourse	Days ago	45(42.5%)	47(45.2%)	81(52.3%)	111(63.4%)	284(52.6%)
	Weeks ago	32(30.2%)	26(25.0%)	36(23.2%)	35(20.0%)	129(23.9%)
	Months ago	14(13.2%)	17(16.3%)	19(12.3%)	21(12.0%)	71(13.1%)
	Years ago	15(14.2%)	14(13.5%)	19(12.3%)	8(4.6%)	56(10.4%)
	Total	**106(100%)**	**104(100%)**	**155(100%)**	**175(100%)**	**540(100%)**

By informal sector category, truck drivers/touts/boda boda operators had the highest proportion of respondents who had sexual intercourse within the last week of the interview at 67.4% followed by jua kali and small business operators at 54.9% as seen in Table 24 below.

Table 124: Frequency of sexual activity, by informal sector category

		Informal sector category				
		Truck drivers/ touts/ boda boda	**Hawkers**	**Jua kali /small scale business**	**Others**	**Total**
Last time respondent had sexual intercourse	Days ago	91(67.4%)	43(43.9%)	106(54.9%)	44(38.6%)	284(52.6%)
	Weeks ago	26(19.3%)	24(24.5%)	46(23.8%)	33(28.9%)	129(23.9%)
	Months ago	14(10.4%)	16(16.3%)	24(12.4%)	17(14.9%)	71(13.1%)
	Years ago	4(3.0%)	15(15.3%)	17(8.8%)	20(17.5%)	56(10.4%)
Total		**135(100%)**	**98(100%)**	**193(100%)**	**114(100%)**	**540(100%)**

4.4.1.3 Condom use during the last sexual intercourse

Among the respondents who had had sex in the preceding 12 months, condom use was low with only 109 (22.8%) of the respondents having used a condom last time had intercourse and again only 97 (23.2%) saying they had used a condom every time they had had sexual intercourse with the partner with whom they had the last sexual intercourse. Females were more likely to be consistent in using a condom every time, as seen in Figure 17 below.

There were no significant differences in level of condom use in last sexual activity across the categories of informal sector and by region.

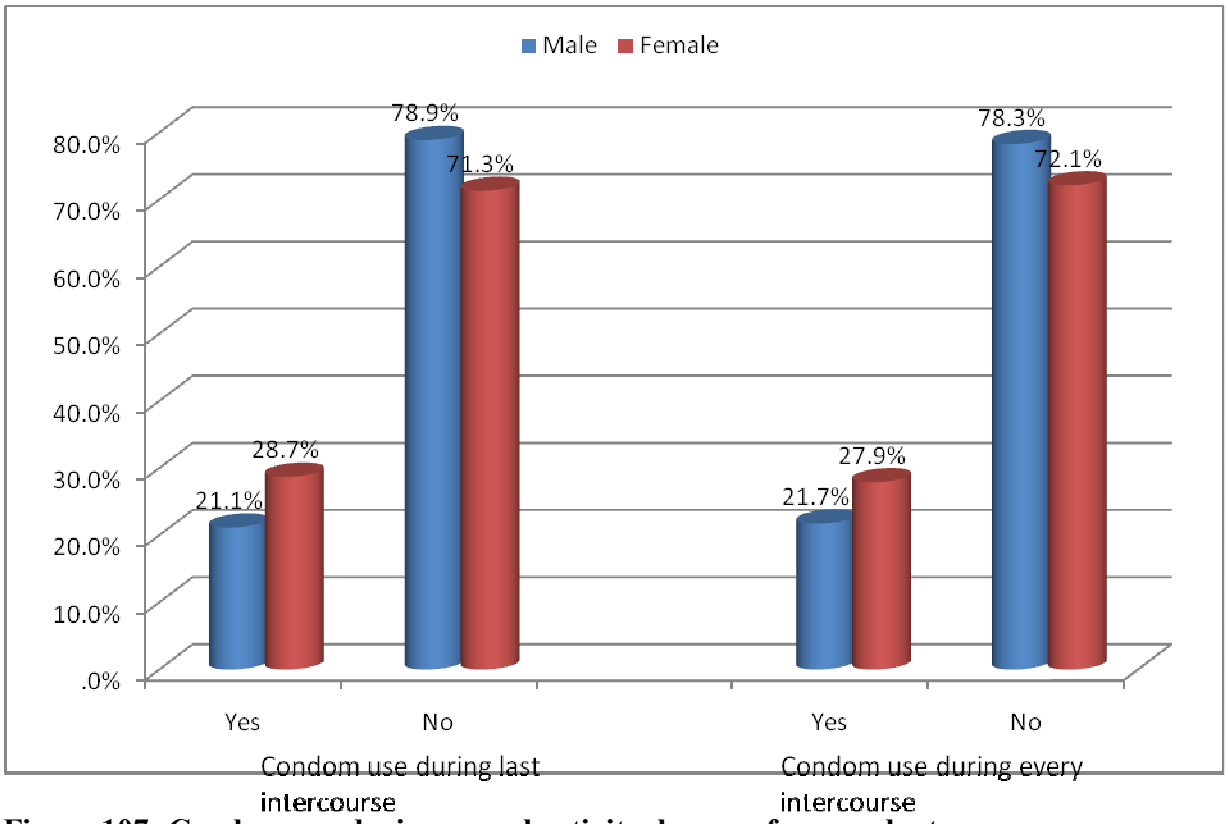

Figure 107: Condom use during sexual activity, by sex of respondent

A higher proportion of the respondents in the in the younger age groups had used a condom in the last sexual intercourse compared to those in the older age groups. This younger age group was more consistent in condom use as a higher proportion of them who used a condom every time they had sex with the partner whom they had the last sexual encounter with see Figure 18.

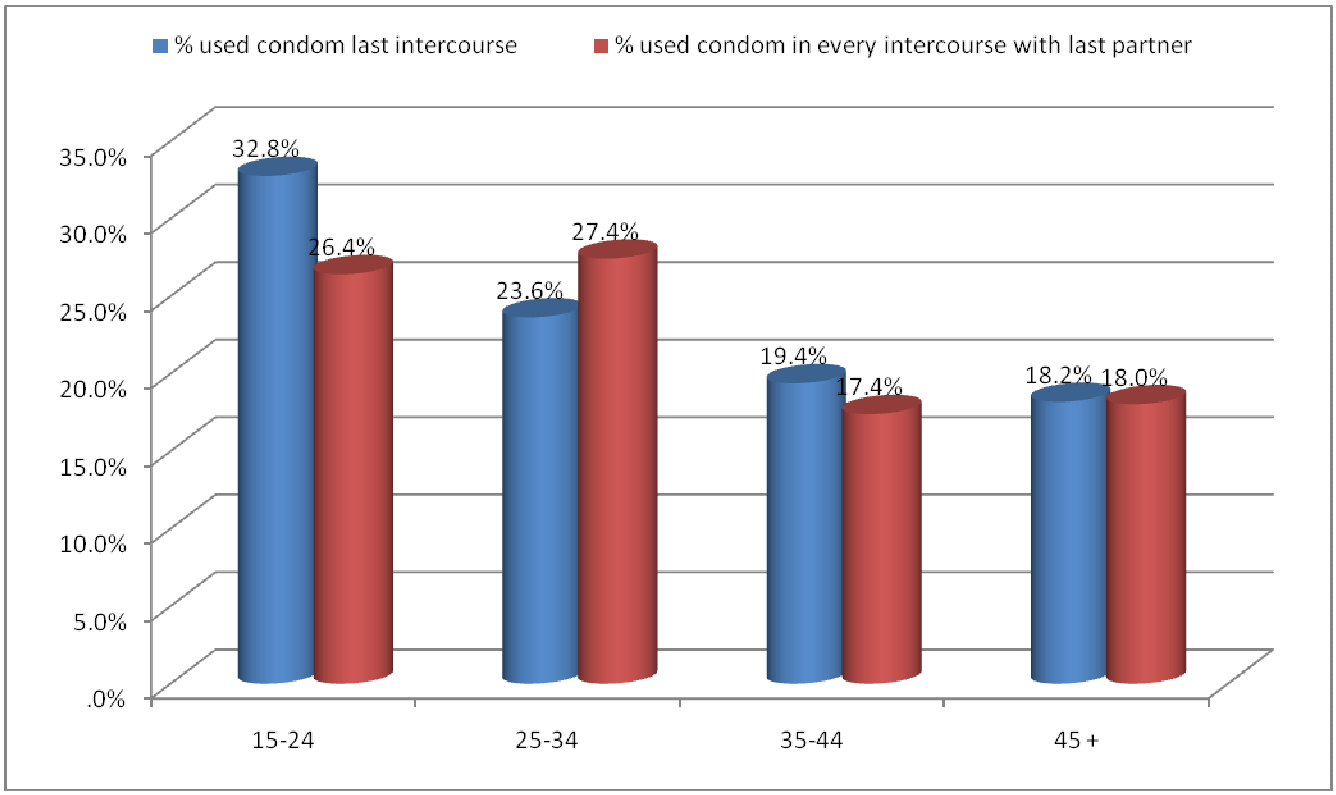

Figure 118: Proportion of respondents who used condom, by age group

4.4.1.4 Sexual partners

The most common partner with whom the respondent had had the last sexual intercourse with was the husband or wife (72.8%) and boyfriend/girlfriend not living with the respondent (18.9%). Casual sex and sex with prostitutes was low at 3.5% and 1.2% respectively. A higher proportion of females (26.4%) had sex with a partner who did not live with them as compared to 17.3% of the males (*see Figure 19 below*).

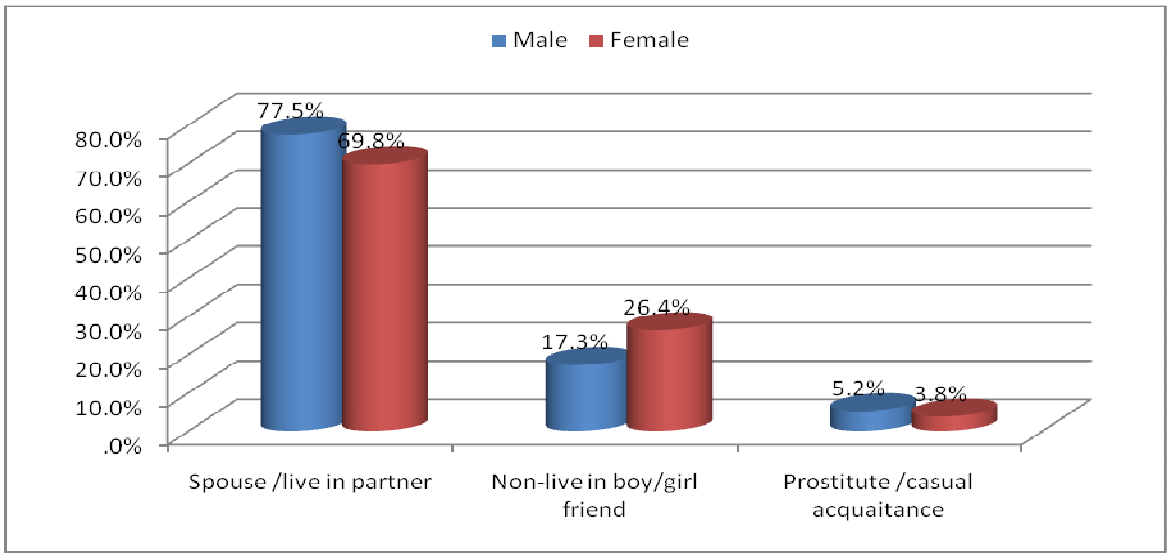

Figure 129: Relationship to the sexual partner with whom the respondent had last sexual intercourse

4.4.2 Risk of Infection with HIV

Two hundred and fifty (43.5%) of the respondents indicated that the nature of their work put them at risk of HIV infection, while 50.7% of the respondents said that the nature of their work exposed them to HIV infection. The most commonly mentioned nature of risk was 'occupational vulnerability' (which puts workers in positions where they get tempted to have sex with their clients either for favour or just by attraction) which was stated by 58.3% of the respondents, followed by contact with sharps/sharing of sharps (12.4%) and possibility of motor vehicle accident (5.6%). The types of risk mentioned by the respondents are presented in Table 25 below, disaggregated by sex.

Table 13: Nature of risk by sex of respondent

		Male	**Female**	**Total**
Nature of risk	Occupational vulnerability	125(60.4%)	30(51.7%)	155(58.5%)
	Separation from spouse	9(4.3%)	1(1.7%)	10(3.8%)
	Contact with body fluids	10(4.8%)	3(5.2%)	13(4.9%)
	Meet with CSWs at night	8(3.9%)	1(1.7%)	9(3.4%)
	Deals with many HIV people	1(.5%)	6(10.3%)	7(2.6%)
	A lot of cash flow	12(5.8%)	0(.0%)	12(4.5%)
	Contact with sharps/sharing of sharps	22(10.6%)	11(19.0%)	33(12.5%)
	In case of an accident	12(5.8%)	3(5.2%)	15(5.7%)
	Unprotected sex	2(1.0%)	1(1.7%)	3(1.1%)
	Peer pressure	2(1.0%)	0(.0%)	2(.8%)
	In Hospital where I work	0(.0%)	2(3.4%)	2(.8%)
	Substance abuse	3(1.4%)	0(.0%)	3(1.1%)
Total		**206(100%)**	**58(100%)**	**264(100%)**

A higher proportion of truck drivers/touts/boda boda operators reported that the nature of their work put them at risk of HIV infection when compared to respondents from other sectors as seen in Fig 20 below.

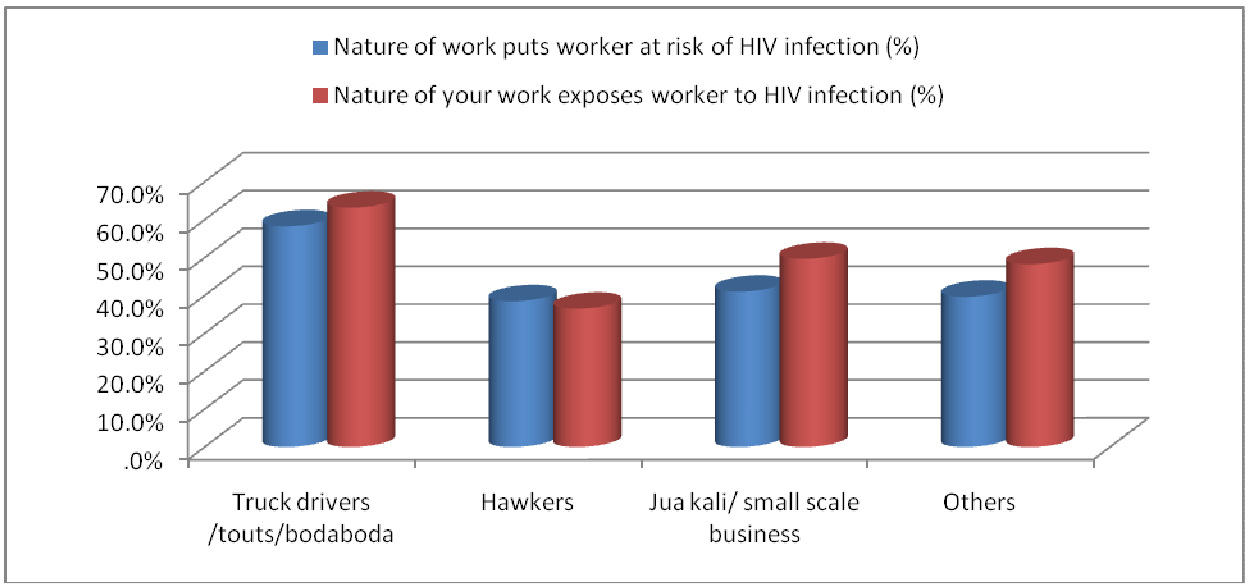

Figure 20: Risk of HIV infection by sector

For those who thought that they were not at risk of HIV infection, the reasons they gave together with the corresponding number (%) who mentioned these reasons are summarized in Table 26.

Table 14: Reason respondent thought they are not at risk, by sex

Reason for not getting infected with HIV infection	Males	Females	Total
Faithfulness	47 (32.9%)	16 (25.8%)	63 (30.7%)
Takes care of self	39 (27.3%)	11 (17.7%)	50 (24.4%)
No contact with body fluids/ sharps	18 (12.6%)	8 (12.9%)	26 (12.7%)
Does not share tools	20 (14.0%)	3 (4.8%)	23 (11.2%)
Abstaining/Does not sleep around	8 (5.6%)	8 (12.9%)	16 (7.8%)
Already HIV positive	-	6 (9.7%)	6 (2.9%)
Other reason	11 (7.7%)	10 (16.10%)	21 (10.2%)
Total	**143 (100%)**	**62 (100%)**	**205 (100%)**

Only about one quarter (24.5%) had heard of PEP. A significantly higher proportion of females (32.5%) knew about PEP as compared to only 21.3% of males. Knowledge of PEP was also very low in the Coast sites when compared to the other regions as seen in Figure 21 below.

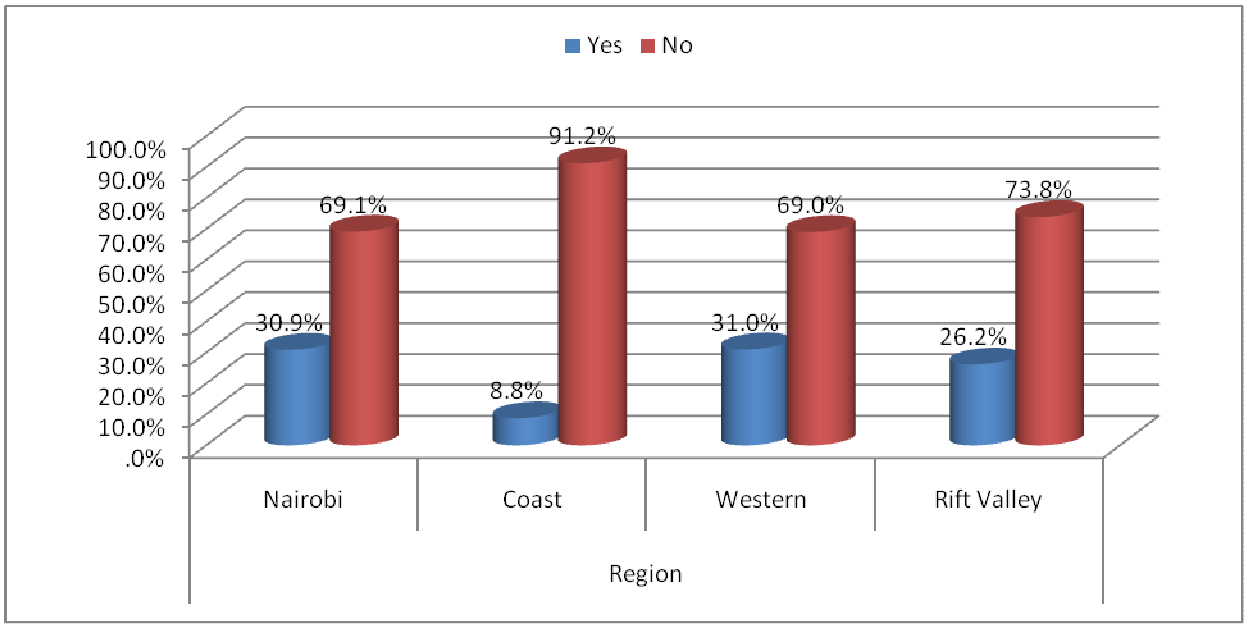

Figure 131: Knowledge of PEP by region

However, there were no significant differences in awareness of PEP across the categories of informal sector as well as the age groups.

Out of those who had heard of PEP, only 25.2% said they had access to PEP in case of accidental exposure to HIV. There were no significant differences in access to PEP between males and females, across age groups, sectors or regions.

For the 90 respondents who did not have PEP in their work environment, 78.9% said they obtained PEP at the nearby district/mission/church clinic & hospitals, 13.3% at nearby health centres while only 7.8% said they accessed PEP at nearby private clinics.

4.5 Impact of HIV&AIDS in the informal sector

4.5.1 Informal sector workers with friends and relatives affected/ infected by HIV and AIDS

As a measure of the impact of HIV and AIDS in the workplace, the respondents were asked to state if they ever had a family member or friend or colleague who was infected or affected by HIV and/or AIDS. Four hundred and thirty one (74.8%) of the respondents indicated that they ever had, and out of these, two hundred and seventy (62.4%) said that they had ever missed work because of a family member/friend/colleague who was infected/affected by HIV and AIDS. There was no difference between males and females in the proportion of respondents who ever had a family member or friend or colleague who was infected or affected by HIV and/or AIDS. However, respondents from Nairobi and Rift Valley had a higher proportion of respondents who ever had a family member or friend or colleague who was infected or affected by HIV and/or AIDS when compared to those from Coast and Western sites as seen in Figure 22 below:

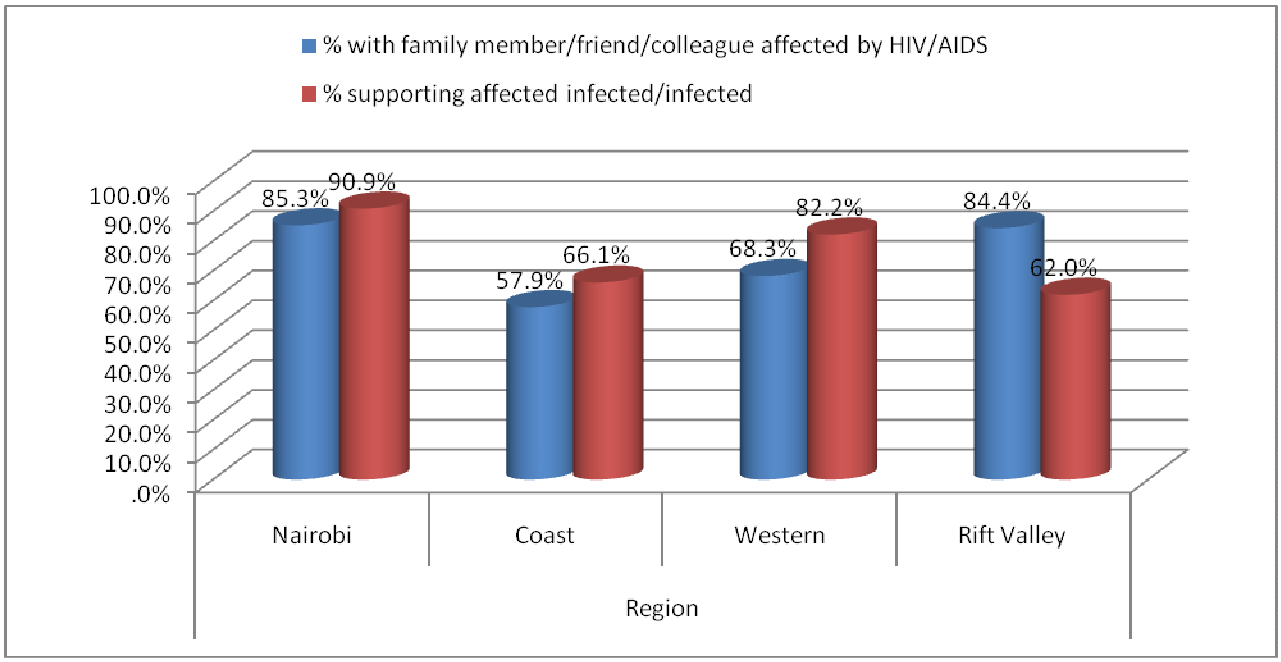

Figure 142: Support for those infected/affected by HIV&AIDS

The respondents were then asked if they had been involved in supporting those infected/affected. Three hundred and ten (73.6%) of the respondents said that they supported the infected /affected family members/ friends/colleagues. The proportions of respondents giving support by region are also given in Figure 22 above.

The distribution of the number of days missed due to the illness of family member/friend/colleague is shown in Figure 23.

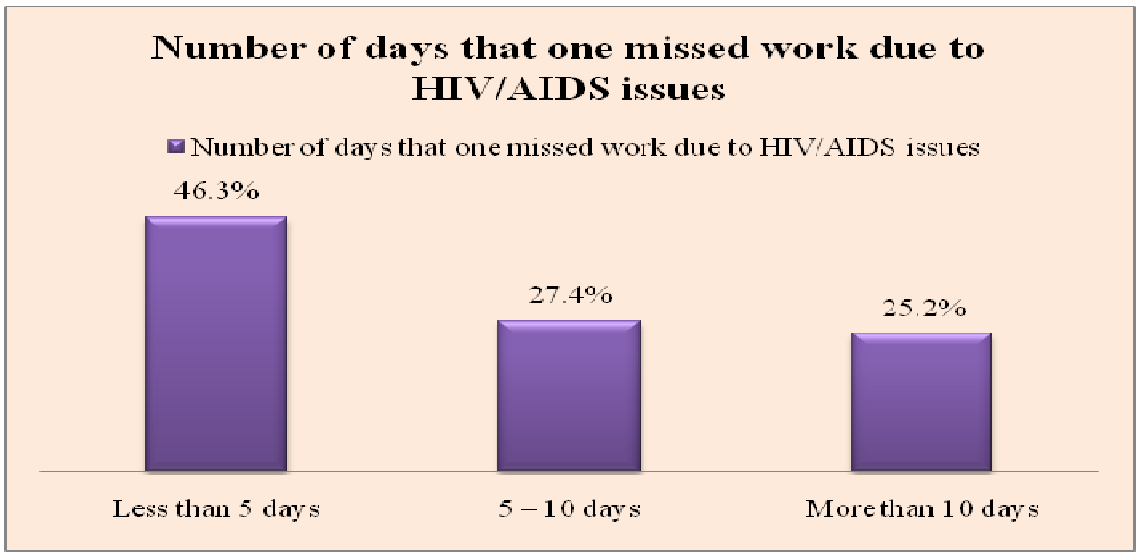

Figure 153: Number of days that informal sector worker missed work due to HIV&AIDS related issues

The type of types of support given to people affected and infected included financial support, food and upkeep, treatment and medication among others as shown in Table 27 below.

Table 15: Type of support to people affected and infected

Type of support	Number	Percent
Lives with relative	37	6.4%
Provides for treatment and medication	67	11.5%
Provides food and upkeep	196	33.7%
Takes care of the orphans	51	8.8%
Takes care of the widow	12	2.1%
Provides financial support	193	33.2%
Other	84	14.5%

There were no differences between males and females for the types of support given apart from providing financial support where a higher proportion of females (52.0%) were giving financial support when compared to males (33.8%).

Financial burden and absenteeism were mentioned by 44% and 23% of the respondents respectively as the main ways in which work is affected, as depicted in Figure 24 below.

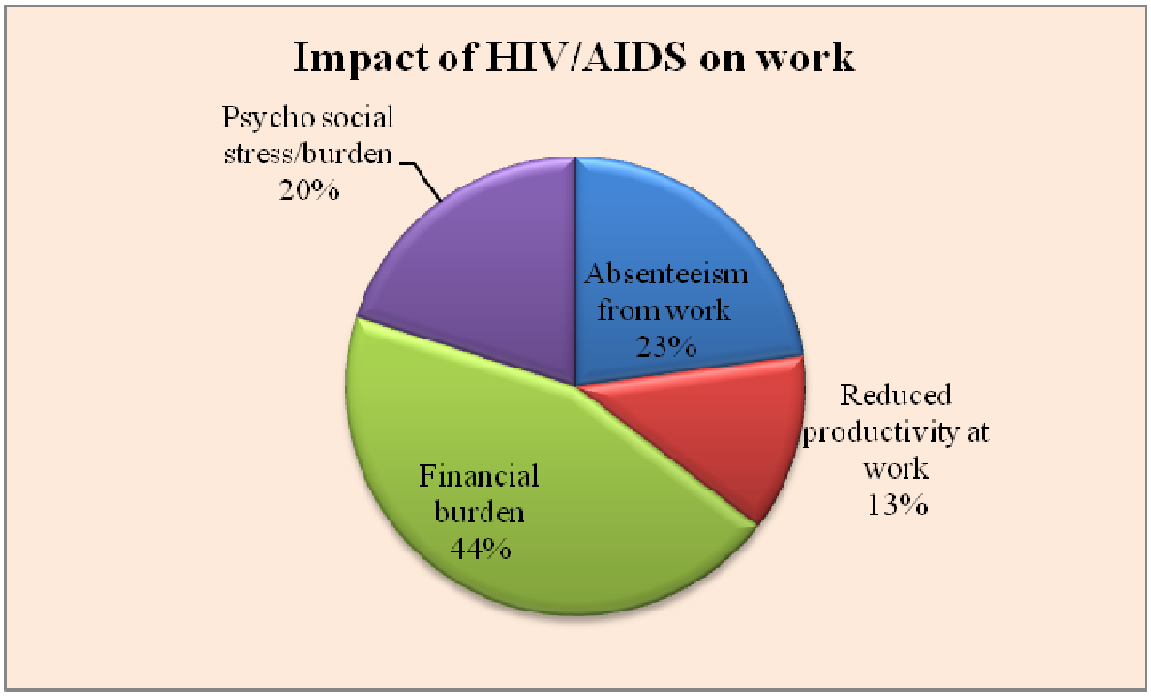

Figure 164: Impact of HIV&AIDS on ability to work

There were no sex disparities in the types of impacts. However, there were regional disparities as shown in Figure 25 below:

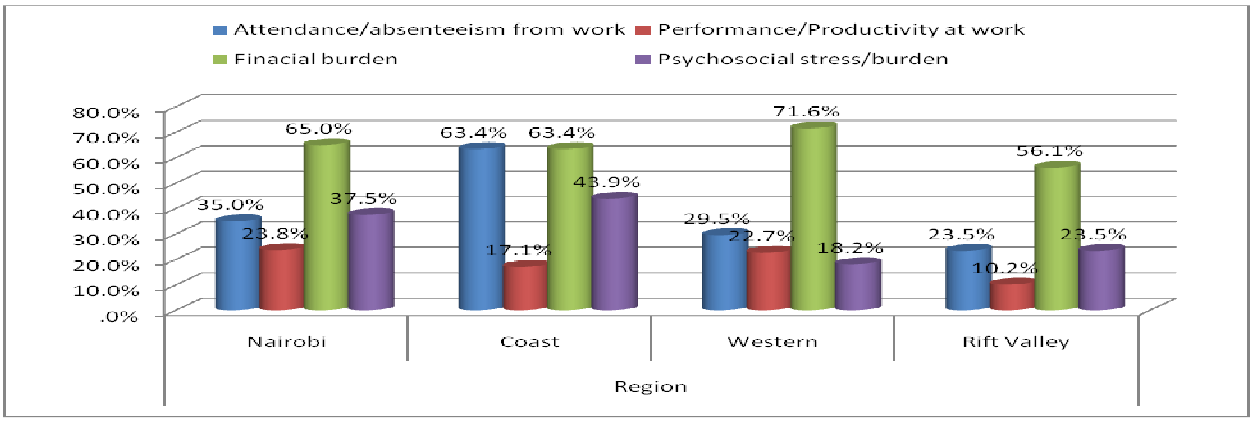

Figure 175: Impact of HIV&AIDS on work by region

4.5.2 Experience of impacts of HIV by the workers in the informal sector

In the institutional interviews, only 7 (5.6%) of the organizations indicated that it was mandatory for their staff to take HIV tests at tine time or another and half of the organizations indicated that the nature of their work exposes their staff to HIV infection. In 39 organizations the respondent indicated that they knew of a staff member who was openly living with HIV.

In the organizations where there was a staff member openly living with HIV, the majority indicated that the HIV positive staff experienced opportunistic infections (80%), the member missed work due to illness (82.4%), the HIV positive staff missed work to travel or access HIV&AIDS related medical services (79.5%) but only 14 respondents (37.8%) indicated that the HIV positive staff missed any opportunity for training and promotion due to their status. About two thirds of the organizations indicated that they gave support to persons openly living with HIV in the organization. These findings are presented in Table 28 below.

Table 16: Impact of HIV&AIDS

	Total valid responses	**Number responded affirmative**	**Percent affirmative**
Is it mandatory for your staff to take HIV tests	125	7	5.6
The nature of work in your institution/organization expose staff to HIV infection	126	63	50.0
Do you know of any staff member who is openly living with HIV	126	39	31.0
The HIV+ staff experience opportunistic infections	40	32	80.0
The HIV+ staff been missing work due to illness	34	28	82.4
The HIV+ staff been missing work to travel/access HIV&AIDS related medical services	39	31	79.5
HIV+ staff miss any opportunities for promotion and training because of their status	37	14	37.8
Do you give any support to persons who are openly living with HIV in your organization	39	25	64.1

In the individual respondent interviews, 198 (35.1%) of the respondents said that they knew someone in the informal sector who was openly living with HIV, this being so for a higher proportion of females (see Figure 26 below).

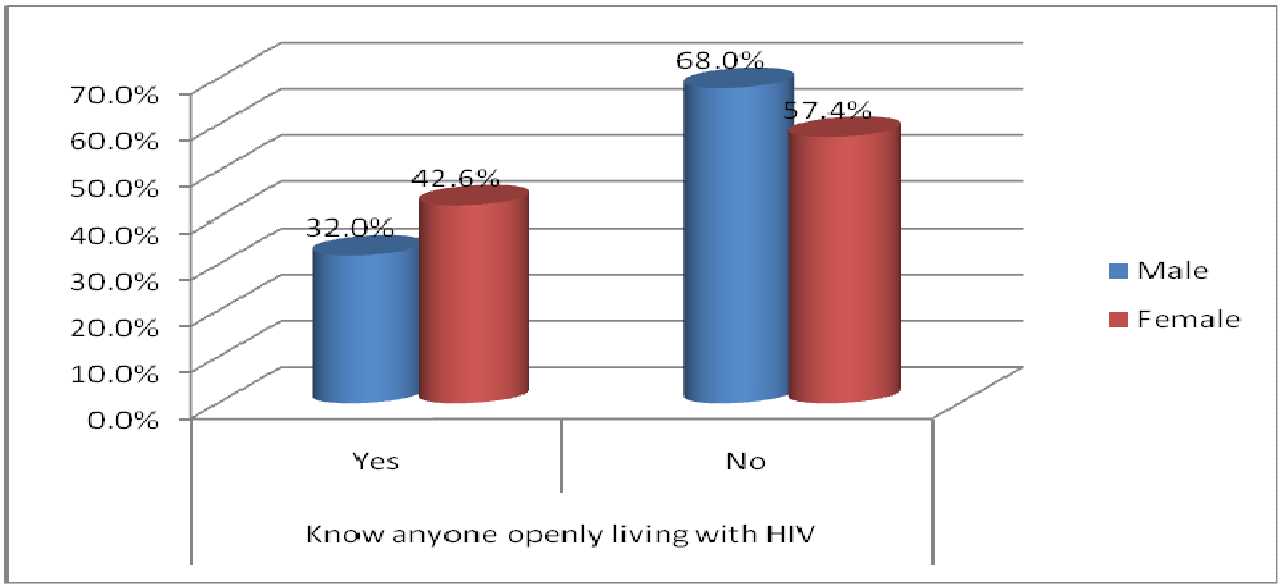

Figure 186: Awareness of someone living openly with HIV, by sex

Only 79 (13.6%) of the respondents indicated that they play any role in any HIV&AIDS workplace programmes. Again a significantly higher proportion of females (23.1%) of the females were playing a role as compared to 11.9% of the males, as seen in Figure 27 below.

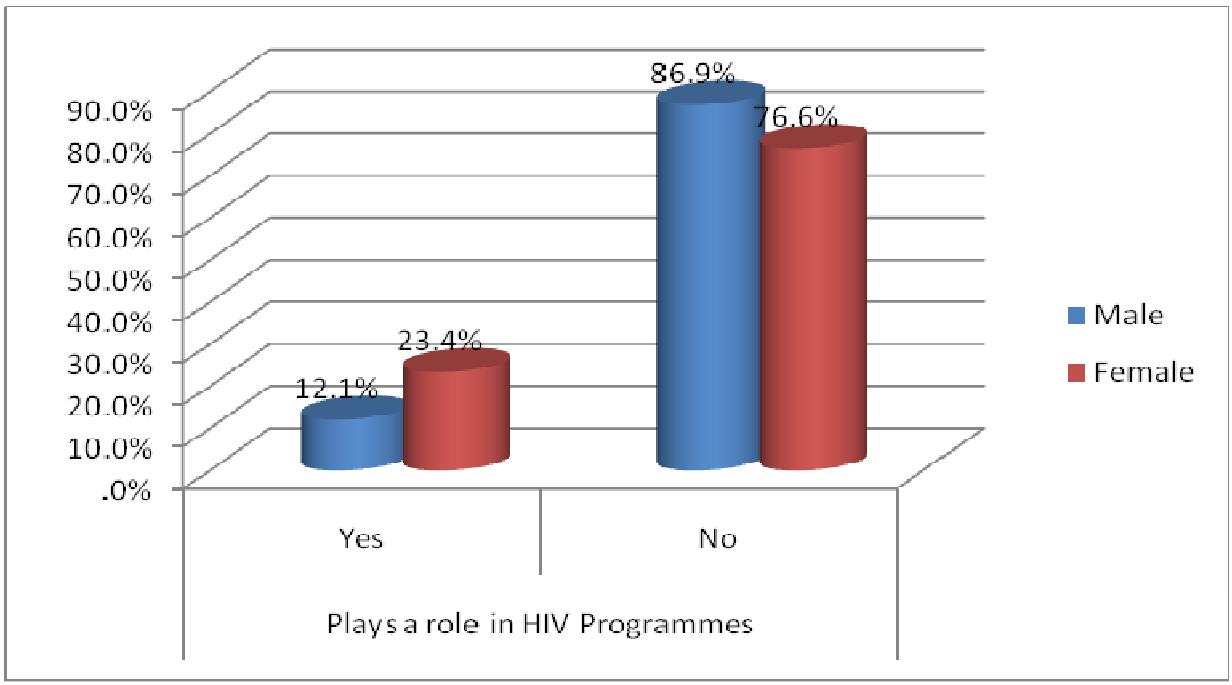

Figure 27: Whether respondent plays any role in HIV Programmes, by sex

The representatives of the organizations were asked to state possible potential exposure to HIV arising from the nature of the work in their organizations. Only 7 out of 64 representatives (10.9%) mentioned both trauma/injuries and contact with injection needles (see Table 29).

Table 17: Nature of work posing potential HIV exposure in workplace/organization

Reason	Total valid responses	Number responded affirmative	Percent affirmative
Contact with blood	64	5	7.8%
Trauma and injuries	64	7	10.9%
Contact with injection needles	64	7	10.9%
Handling of contagious specimens	64	2	3.1%
Other	64	52	78.8%

Factors that make employees vulnerable to HIV infection include distance away from home cited by 37.3%, weak morals/ multiple sexual partners (13.4%) of the respondents, staff who are single (17.4%), low income/poverty 17.4% among others.

Factors that make women employees more vulnerable to HIV infection include low income cited by 43.3% of the respondents, the small number of women cited by 15%, cultural practices (36.4%), unprotected sex (27.3%), rape 18.2%.

The most common measure taken to decrease the risk of staff exposure to HIV included discussion of HIV & AIDS in the workplace as cited by 42% of the institutional representatives. It is noted that 19.8% of the representatives said nothing was being done, see Figure 28 below.

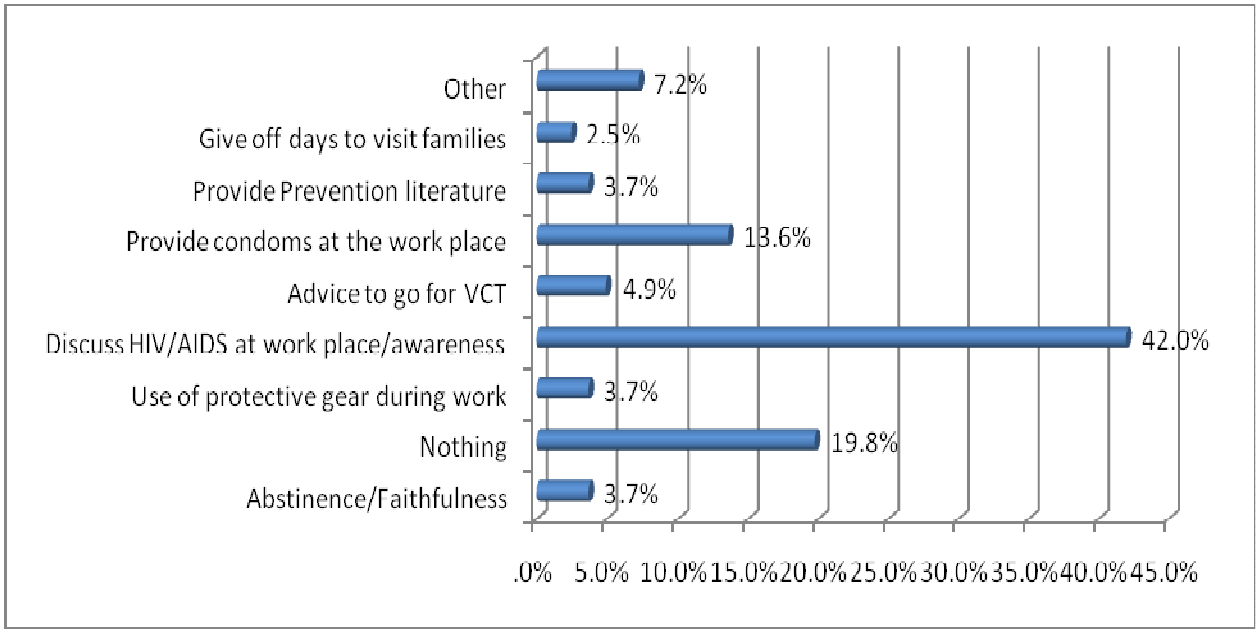

Figure 198: Measures taken to decrease the risk of staff exposure to HIV infection

4.5.3 Impact of HIV&AIDS on the Capacity of Informal Sector

About half (50.8%) of the organizations indicated that they have a shortage of staff due to frequent or prolonged sick leave and absenteeism from duty while 42.4% said there was an increase of costs from health care provision to staff related to HIV & AIDS. Further, respondents from 76 (62.3%) of the organizations perceived a decline in work performance due to the HIV epidemic and 85 (70.2%) of the respondents said there was frequent staff absenteeism to attend funerals for their colleagues, family members, and friends.

Regarding direct financial costs, 33 (27.5%) of the organizations indicated that there was an increase in overtime payments in bid to compensate for positions left vacant due to HIV-related illness and death, 29 (24.4%) indicated that there is an increase in premiums of medical cover/health insurance resulting from HIV&AIDS and 40 (33.3%) indicated that there was an increase in expenses (costs) related to hiring new staff.

Other impacts included co-workers getting demoralized and/or depressed about the illness and/or death of their colleagues due to suspected AIDS-related illnesses which was affirmed by 76 (62.8%) of the organizations while 65 (55.6%) of the respondents said there was low morale due to stigma and discrimination of staff openly living with HIV and/or AIDS. These impacts are depicted in Table 30 below.

Table 18: Impact of HIV at the workplace

	# (%) responded Yes	**Percent rating effect as:**			
		Great	Moderate	Minimal	None
Have a shortage of staff due to frequent/ prolonged sick leave and absenteeism from duty	63 (50.8)	14 (22.2%)	21 (33.3%)	22 (34.9%)	5 (7.9%)
There an increase of costs from health care provision to staff related to HIV and AIDS	50 (42.4)	18 (36.7%)	15 (30.6%)	6 (12.2%)	6 (12.2%)
Perceive a decline in work performance due to the HIV epidemic	76 (62.3)	23 (30.3%)	27 (35.5%)	16 (21.1%)	9 (11.8%)
There is frequent staff absenteeism to attend funerals for their colleagues, family members, and friends	85 (70.2)	23 (27.4%)	35 (41.7%)	17 (20.2%)	7 (8.3%)
There is an increase in overtime payments in bid to compensate for positions left vacant due to HIV-related illness and death	33 (27.5)	5 (15.2%)	8 (24.2%)	15 (15.2%)	10 (30.3%)
There is an increase in premiums of medical cover/health insurance resulting from HIV&AIDS	29 (24.4)	9 (32.1)	1 (3.6%)	10 (35.7%)	8 (28.6%)
Co-workers are demoralized and/or	76 (62.8)	29	21	14	4

depressed about the illness and/or death of their colleagues due to suspected AIDS-related illnesses		(38.7%)	(28%)	(18.7%)	(5.3%)
There is a loss of skilled staff and institutional memory due to suspected HIV and AIDS-related illnesses and deaths	67 (56.3)	23 (34.3%)	19 (28.4%)	12 (17.9%)	8 (11.9%)
There is an increase in expenses (costs) related to hiring new staff	40 (33.3)	11 (27.5%)	9 (22.5%)	6 (15%)	11 (27.5%)
There is low morale due to stigma and discrimination of staff openly living with HIV and/or AIDS	65 (55.6)	16 (25%)	21 (32.8%)	14 (21.9)	6 (9.4%)

Impacts that were rated by many organizations as having a great or moderate effect on the organization performance included increased costs from health care provision to staff related to HIV and AIDS, decline in work performance due to the HIV epidemic, frequent staff, co-workers demoralized/depressed about the illness/death of their colleagues due to suspected AIDS-related illnesses and absenteeism to attend funerals for their colleagues, family members, and friends, all rated great/moderate by over 60% of the organizations, as seen in Table 30.

Respondents identified other organizations in the informal sector. The organizations identified by the institutional respondents are given in Annex 10 and those identified by the individual respondents are given in Annex 11.

CHAPTER FIVE: DISCUSSION, LESSONS LEARNT, CONCLUSIONS AND RECOMMENDATIONS

5.1 Discussion

5.1.1 HIV&AIDS Interventions

The findings of this study reveal that HIV&AIDS-related services are almost non-existent at the workplaces of most informal sector workers. Both quantitative and qualitative data point to the fact that informal sector workers access HIV&AIDS services at facilities outside their workplaces. In fact, results from the survey indicated that only 16.6% of the respondents reported that their workplace had VCT services. It came out in one FGD with jua kali wokers in Kisumu that they travel far to access the HIV&AIDS related services. Also supporting this fact is the discussions that were held at various sites.

> *"Our drivers work for 24 hours, they can't easily go for referrals, thanks to the site VCTs but there should be more of such along the transport routes where they could access ART and TB treatment"* - Long distance/truck drivers FGD at Mlolongo.

According to a key informants in Eldoret East District and Kakamega the workplace did not provide employees with information on where they could receive HIV counseling and antibody testing, nor did they have on-site or nearby facilities for HIV prevention services. Nevertheless, it emerged from most key informants that most workplaces provided employees with information on where they could receive HIV counseling and antibody testing.

Where services were offered, these included HIV&AIDS testing, distribution of condoms and counselling, all at no cost. Treatment of opportunistic infections to employees who were infected with HIV and AIDS was also offered. This was true for Kisumu East District and Kakamega as indicated by key informants there.

Workplace policies and programmes were said to be non-existent, according to participants in all the FGDs that were conducted. The trend is similar in the survey where about a third (29.0%) of the organization respondents were aware of any workforce policies related to HIV and AIDS in the sector.

Key informants from Eldoret East District and Kisumu East District reported that there were workplace HIV&AIDS policies for workers in the informal sector in their respective regions, incorporating preventive programmes such as education on abstinence, use of condoms, counselling and prevention.

It is worth noting that even where HIV&AIDS services were provided by various players, the main deterrent to utilization was mentioned as fear of being stigmatized. Interviews with organizations revealed that the most common cited reasons for staff not requesting VCT services was fear of stigma and discrimination at work (46.9%) and fear of breach of confidentiality at work (31.7%). Similarly, in the FGDs, stigma was seen as a major holdback to utilization of services.

"The stigmatization that comes with being seen in the queues waiting for ARVs is just unbearable; we are therefore forced to go for ARVs in places where we are not known." - FGD participant in Kisumu.

"Many of us fear queuing for the services because every one might just know that I have the HIV virus" - traders in Mombasa FGD.

From discussions with jua kali workers, long distance/truck drivers and traders in Kisumu, Mlolongo and Mombasa respectively, it emerged that social support was not provided to PLWHA and those affected. In the FGD at Mlolongo, long distance/truck drivers reported that PLWA among us do not get social support and medicines from government health facilities, recommending that the existing VCT sites should provide comprehensive care. In Mombasa, participants reported that even those who have already tested positive do not get post test support because post test clubs are non-existent.

Results also show that in cases where the services existed they were mainly provided by NGOs and CBOs working in the area, with the Government providing 28.9% of the services. This finding is corroborated by views expressed by participants in all the FGDs, as follows:

"The programmes started by the government have not reached the informal sector adequately, a lot still needs to be done. The government should channel funds through the already existing groups directly for maximum impact on HIV and AIDs intervention" " - Long distance/truck drivers FGD at Mlolongo.

"The government should come up with policies that directly influences HIV&AIDS related activities in the informal sector. it should build a clinic or a VCT centre around the Jua Kali sheds, where the informal workers could access ARVs, HIV testing and social support. Apart from condom provision, it should also give training and funds for HIV&AIDS activities" – FGD with Jua Kali sector workers in Kisumu.

Almost all the key informants indicated that there were healthcare facilities/services that provided HIV and AIDS services in the region. In Kisumu, these were run by the Government through the Ministry, NGOs, Public sector and Municipal Council health centres. In Kisumu and Kakamega, these facilities provided health care services such as counselling, VCT, provision of ARVs and provision of nutritional food (porridge).

In Eldoret, these facilities/services that provided HIV and AIDS services in the region included AMPATH, AU Dispensaries, District hospitals, Moi Teaching and Referral Hospital, and VCT centres. The type of health care services provided in these health facilities include treatment, testing, counselling and guidance. It was clarified that AMPATH provided ARVs, counselling services, treatment of opportunistic infection, nutritional support and home based care; while the Government-run facilities also provided ARVs, counselling and treatment of opportunistic infections and home based care.

Key informants mentioned a myriad constraints experienced by the informal workers in accessing health services. These were stigma, breach of confidentiality, lack of social and

financial support, gender inequality, lack of awareness on HIV&AIDS, negative attitude due to lack of information, stock-outs in ARVs, stock-outs in HIVs/AIDs kits, staff shortage and infrastructural challenges.

When asked how the existing health facilities could be made to serve the community better, key informants suggested increase of health care personnel, improvement of technology at the facilities, capacity building of facility staff, integration of services and consistent supply of medical commodities.

5.1.2 HIV&AIDS Needs and Extent to which they are Met

From both qualitative and quantitative findings, it is clear that condom provision is the single most common service provided by the Government and CBOs/NGOs alike.

Survey findings indicate that workers in the informal sectos are exposed to risk of HIV infection due to the nature of their work. This was put at almost half (43.5%) of the respondents. This fact also emerged in the various discussions that were conducted, as follows:

> *"The very skilled workers are the most affected. They earn good money and even women like them. Generally their level of indulgence is very high."* - Jua Kali sector FGD in Kisumu.

> *"The kiosks where we go to for lunch are the reasons why the prevalence is high. The ladies serving clients there are beautiful, employed there for that work so as to attract customers. In the evening, they meet and even go to bed without knowing each other's status. This has made the infections to go u.p"* - Jua Kali sector FGD in Kisumu

In the FGD at Mlolongo, long distance/truck drivers reported that with very many clubs around Mlolongo with rooms, these are always fully booked by young women for the purposes of commercial sex work, which promotes HIV and AIDS infection.

From all the key informants interviewed, it was reported that the nature of work done by informal sector workers exposed them to HIV infection. In Kisumu, the measures that the organization had taken to minimize the risk of HIV infection among informal sector workers included condom distribution, awareness creation, distribution of educational materials and behaviour change communication.

In Eldoret East District and Kakamega, key informants reported that the main risk factor contributing to staff being infected with the HIV virus in the informal sector was reported as separation of spouses due to working outside the home. Other risk factors were mentioned as sexual harassment, living in single-roomed houses that were shared by different sexes thereby minimizing privacy and travelling to distant places for work-related seminars. It was reported that organization had taken measures to minimize the risk of possible infection at the workplace including creation of awareness, introduction of guidance and counselling and provision of ARVs from for PLWHAs. Others included peer education, condom provision, treatment of STIs, referral services and PEP, albeit at introductory stage.
There was concurrence among all the key informants that certain factors made female workers in

the informal sector more vulnerable to HIV infection than their male counterparts. These included sexual harassment, exploitation through poor pay, threats and termination of work. Others included poverty and unemployment and therefore engagement in commercial sex. It was also reported that owing to gender imbalance and power dynamics, female workers in the informal sector were susceptible to sexual harassment/ wife abuse, wife inheritance, harmful cultural practices and rape.

The single most important risk factor contributing to informal sector workers being infected with the HIV virus was reported by key informants as mobility, which separated spouses for periods of time. Other risk factors were mentioned as disposable incomes and poverty.

Key informants in the study organizations reported that they had instituted measures that were meant to minimize the risk of possible infection at the workplace, such as raising awareness, prevention through condom distribution, involvement of PLWA in education and counselling services.

5.1.3 Impact of HIV&AIDS

The survey results indicate that financial burden and absenteeism were mentioned by 44% and 23% of the respondents respectively as the main ways in which work is affected. This finding is elaborated further by the following excerpts from discussions held in various sites:

> *"AIDS is real issue, whenever our colleagues fail in health, we have to take care of them yet we also have families. It is very burdensome to us providing food for those who are sick from HIV"* – traders in Mombasa FGD.

One male FGD participant working in the Jua Kali sector in Kisumu reiterated that

> *"when one falls sick, there is reduced productivity at the place of work because the disease puts you down; you can't work every day when you are sick! The hospital bills, fees for children and food in the house for the family then becomes a problem".*

A jua kali worker in Kisumu reported that when HIV&AIDS strikes one's productivity is affected, one loses customers and therefore income goes down. This was also repeated in Mlolongo, where one participant reported that

> *"There are two things that happen in the informal sector; you either work or perish. When an informal worker misses work even for a day or two to seek treatment than (s)he loses the job".*

The issue of loss of job opportunities, manpower and skills was mentioned as a major consequence of HIV&AIDS by. As one FGD participant put it:

> *"We make different goods or products here at the Jua Kali. When one of us is down with HIV&AIDS, there is a big loss of expertise"* – FGD with jua kali workers in Kisumu

"Truck drivers who absent themselves from work to go for referrals sometimes lose their jobs because the employers do not understand; what they want is that their goods are delivered at the intended destinations as required by their clients" - Long distance/truck drivers FGD at Mlolongo.

The survey findings showed that majority (74.8%) of the respondents had a family member or friend or colleague who was infected or affected by HIV and/or AIDS, with 62.4% of those who had an infected family member/friend said that they had ever missed work as a consequence of taking care of them. These findings are backed by responses from FGD participants in all the sites visited. With regard to this, participants expressed the challenges faced while dealing with friends/relatives who are affected/infected:

"HIV&AIDS is such an issue. In the past years most of our people have died from HIV&AIDS leaving children behind. Sometimes we have to provide for children left behind by colleagues who died from HIV&AIDS" - Traders in Mombasa FGD.

"The women are the most affected; they are the people who take care of the orphans and the sick people at home and even in the hospital" - Traders in Mombasa FGD.

"People are dying daily and many children remain as orphans. The problem of stigmatization is also very high, nobody wants to associate freely with PLWA and some people talk about them behind their backs." - FGD participant in Kisumu

5.2 Lessons Learnt

1. Majority (81%) of the respondents did not have access to VCT at their place of work.
2. From the institutional interviews the most common cited reason for staff not requesting VCT services was fear of stigma and discrimination at work (46.9%).
3. Almost all the organizations that indicated that they had HIV&AIDS policies also had HIV&AIDS prevention programmes, meaning that almost always, policy is translated to programme.
4. Where HIV programmes and services existed at the workplace, condom provision and guidance and counselling were the most commonly provided services.
5. In cases where the services existed they were mainly provided by NGOs and CBOs working in the area. The Government provided only 28.9% of the services.
6. Awareness of HIV&AIDS was universal
7. Among the respondents who had had sex in the preceding 12 months, condom use was low (22.8%). This is probably because the most common partner with whom the respondents had had the last sexual intercourse with was the husband or wife (72.8%). Further, casual sex and sex with prostitutes was low at 3.5% and 1.2% respectively.
8. Almost half (43.5%) of the respondents indicated that the nature of their work put them at risk of HIV infection.
9. A higher proportion of truck drivers/touts/boda boda operators reported that the nature of their work put them at risk of HIV infection when compared to respondents from other sectors.

10. Only about one quarter (24.5%) had heard of PEP, with only 25.2% of these reporting that they had access to PEP in case of accidental exposure to HIV.
11. Financial burden and absenteeism were mentioned as the main ways in which work is affected as a result of HIV&AIDS.
12. The main impact of HIV&AIDS on organizational capacity include shortage of staff due to frequent or prolonged sick leave and absenteeism of infected staff from duty – reported by about half (50.8%) of the organizations representatives.
13. 42.4% of organization representatives reported that there was an increase of costs from health care provision to staff as a result of HIV & AIDS.
14. Further, respondents from 76 (62.3%) of the organizations perceived a decline in work performance due to the HIV epidemic and 85 (70.2%) of the respondents said there was frequent staff absenteeism to attend funerals for their colleagues, family members, and friends.

5.3 Conclusions

The results from this study show that the level of workplace interventions in the informal sector was very low. Where they existed, they were limited to only a few services, mainly condom provision and counseling. It was evident that the main providers of HIV&AIDS related services were sector-specific associations, CBOs and NGOs.

There was evidence of access to HIV&AIDS related services. However, the majority of these were not provided at the workplace, and informal sector workers had to be referred or access services from nearby facilities. The range of services offered at these facilities was also limited to VCT, condom provision, and excludes HIV&AIDS comprehensive care services, including PEP and ARV provision.

Workplace policies were nonexistent in most organizations. Nevertheless, it is worth noting that organizations that had workplace policies also had various HIV&AIDS programmes in place. This indicates that more often than not, policies encourage translation to practice. Findings of the study revealed that stigmatization affected utilization of services where programmes existed.

It emerged from the findings of the study that workers were vulnerable to HIV&AIDS owing to the nature of occupation in the informal sector, due to the high levels of disposable incomes.

The impact of HIV&AIDS in the informal sector was reported to be overwhelming, and includes absenteeism; loss of productivity; lowered income due to absenteeism and reduced output, financial and social burden due to support of PLWAs and orphans.

5.4 Recommendations

- VCT services should be provided at the workplace in all the regions and for workers in all categories in the informal sector. Special attention should be given to truck drivers/touts/boda boda operators' category of informal sector workers.

- Pre and post test counselling should be carried out as a part of the VCT process as provided for in the national guidelines. Efforts should be made to build the capacity of providers of VCT service to enhance compliance with provisions of the guidelines.

- The referral system should be strengthened to ensure that VCT clients are provided with information on where one could get follow-up services.

- Concerted efforts should be made to reduce stigma associated with clients accessing VCT services. Workplace HIV&AIDS related services should be provided in accordance with the existing guidelines, and confidentiality maintained

- Formulation and implementation of workplace HIV&AIDS policy for the informal should be done. Results of the study have shown that where policy exists, they are translated to programmes.

- Programmes should be scaled up to include comprehensive HIV&AIDS care and support services, not just VCT and provision of condoms.

- Strengthening the existing CBOs and NGOs to provide HIV&AIDS-related services should be explored as results of the study shows that they are the main service providers.

- Efforts in awareness creation should be enhanced especially for those who are sexually active as the results indicated that most of the respondents did not have accurate knowledge especially in terms of modes of transmission. It should be noted that less than half (47.3%) of the respondents had comprehensive knowledge of HIV based on the questions recommended by UNGASS.

- Sector-specific mitigation measures should be instituted to minimize the risks that expose informal sector workers to HIV&AIDS. Special attention should be given to truck drivers/touts/boda boda operators who reported a proportionately higher risk of contracting HIV infection when compared to respondents from other sectors.

- Raising awareness of PEP should be done across all the regions, and to workers of all informal sectors, as only about a quarter of the respondents were aware of PEP. Access to PEP services should be increased.

- Mitigation of effects of HIV&AIDS at the workplace should be instituted, by way of providing treatment for opportunistic infections, ARVs, social (including orphan care, food and upkeep) and financial support.

- Informal sector workers should be involved in HIV&AIDS workplace programmes, with special attention given to male involvement.

- Further studies should be carried out to determine how to make informal sector workplaces safer especially for women in order to reduce their vulnerability to HIV&AIDS.

- Literature shows that there are partnerships at various levels between the formal and the informal sectors, with examples in Kenya entailing Government involvement in Jua Kali sector; and FKE activities with the informal sector. However, partnerships need to be scaled up to cover HIV and AIDS related services.

- Existing networks in the informal sector need to be strengthened and new ones established for improved coordination of HIV-related services. This will enhance representation and visibility of the informal sector.

- The informal sector is already a vulnerable group, and PLHIV in this sector are even more disadvantaged. There is need for special targeting to encourage formation of networks for PLHIV and strengthen the existing ones, if any.

- Use of the sector as a platform for advocacy and awareness creation should be encouraged, e.g. using matatus to display posters and educative arts on HIV.

- Further research should be carried out to determine innovative techniques for reaching the informal sector.

- A detailed study on impact of HIV (impact assessment) on the informal sector is recommended.

At a Stakeholders Validation Workshop held on July 30th, 2010 the participants agreed on the following additional recommendations:

- Religious leaders should be facilitated to give more information about HIV/AIDS.

- There is need to avail VCT services in different settings for access by people working in the informal sector, such as static VCT sites in high density areas; moonlight VCTs and mobile ones.

- There is also need of incorporating the Ministry of health strategy of provider-initiated testing and counseling.

- There is need for VCT counselors to be picked from amongst the informal sector and be trained by NASCOP to provide the service.

- There is need for issuance of referral cards for those of members of the informal sector on ARVs, which should be recognized by all health institutions.

- There is need for increasing availability of condom dispensers at discreet spots in public places and appointment of caretakers among the informal sector workers to be refilling them.

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ANNEXES

ANNEX 1: LIST OF ENUMERATORS AND STUDY GUIDES

RESEARCH ASSISTANT	STUDY GUIDE	SITE
1. Moses Mwadzoya	Ahmed Omar	Mombasa
2. Edmund Kimutai	Penina Cheserem	Eldoret
3. Chitiavi Juma	Joshua Nyabute	Kakamega
4. Clinton Juma	Geoffrey Njuguna	Nakuru
5. Dancan Odero	Richard Awiti	Kisumu
6. Nancy Kosgey	Charles D. Chigiri	Narok
7. James Munene	Kombo Charo	Mombasa
8. Kevin Kayondo	Richard Makhulo	Busia
9. Emmanuel Kaingu	Peter Mburu	Malindi
10. Grachem Akoth	Joseph Kibe Karanja	Naivasha
11. Laurette Abuya	Judith Gitau	Nairobi
12. Constantine Okoth	Francis Gitungo	Nairobi
13. Joshua Ochola	Salome Midega	Kisumu
14. Muthoni Muriithi	David Mukwanjura	Nairobi

ANNEX 2: INDIVIDUAL QUESTIONNAIRE

MAPPING OF THE INFORMAL SECTOR INTERVENTIONS AND RAPID IMPACT OF HIV&AIDS STUDY IN THE INFORMAL SECTOR

1. QUESTIONNAIRE SERIAL NUMBER _____ Date _____/_____/2010

2. Enumerator's Name: _____Signature _____

IDENTIFICATION				
Site	1	Nairobi and Environs (incl. Thika, Athi River, Ongata Rongai)	6	Naivasha
	2	Mombasa (incl. Ukunda, Mariakani and Mtwapa)	7	Eldoret
	3	Nakuru	8	Kakamega
	4	Kisumu and environs	9	Busia
	5	Narok	10	Malindi
Location of organization				
Sector	1	Agriculture & Rural Development	7	Governance, Law and Order
	2	Trade, Tourism and Industry	8	Public Administration
	3	Physical Infrastructure	9	Special Programs
	4	Environment, Water and Sanitation	10	National Security
	5	Human Resource Development	11	Macro Working Group
	6	Research, Innovation and Technology		
Category of Informal sub-sector	1	Truck drivers	5	Fishing community,
	2	Hawkers	6	Touts & Boda bodas,
	3	Tour guides/travel agents	7	Jua kali artisans
	4	Agricultural Sector,	8	Other(Specify)

Part 1: BACKGROUND AND DEMOGRAPHIC INFORMATION

No.	Question		Coding Category	Skip to
Q101	What is your age in completed years			
Q102	Sex	1	Male	
		2	Female	
Q103	What is your marital status	1	Single	
		2	Married	
		3	Widowed	
		4	Separated	
		5	Divorced	
Q104	What is your highest level of education?	1	None	
		2	Incomplete Primary Education	
		3	Primary Education	
		4	Incomplete Secondary Education	
		5	Secondary	
	ONE RESPONSE ONLY	6	Tertiary	
		7	University	
Q105	Have you ever been trained at a vocational training college/centre?	1	Yes	
		2	No	*Go to Q107*
Q106	After what level of education was the vocational training	1	None	
		2	Primary	
		3	Secondary	
		4	University	
Q107	For how long have you been working in the informal sector?	1	Less than one year	
		2	Between 1 and 2 years	
		3	Between 3 and5 years	
	ONE RESPONSE ONLY	4	More than 5 years	
Q108	Do you earn money doing some other work apart from your current work in	1	Yes	
		2	No	*Go to Q110*
Q109	If yes, in what other sector do you earn a living?	1	Agriculture/livestock	
		2	Trading/Self employed/hawking	
		3	Pastoralism	
	Multiple responses possible	4	Transport /Truckers/	
		5	Fishing	
		6	Industrial/jua kali artisans	
		7	Hotel/restaurant/lodge/washing	
		8	Education	
		9	Other (Specify):	
Q110	On average, approximately how much is your monthly income?	1	Below 2000 per month	
		2	2001-5000 per month	
		3	5001 – 10000 per moth	
		4	10,001 -15,000month	
		5	15001 and above	
Q110	Who do you live with?	1	Spouse	
		2	Children	
		3	Parents	
	Multiple responses possible	4	Friends / Mates	
		5	Relative (s)	
		9	Other (specify):	

Part 2: HIV and AIDS KNOWLEDGE and ATTITUDES

Now I am going to ask you some questions about HIV and AIDS and I would like you to answer YES or NO or don't know depending on what you think.

No.	Question		Coding Category	Skip to
Q201	Have you ever heard of an illness called HIV&AIDS?	1	Yes	
		2	No	*Go to Q301*
Q202	If Yes, how did you get to know about HIV and AIDS	1	Mass media/radio	
		2	Religious leaders	
		3	Information brochures	
		4	Awareness forums	
		5	Friends/Family	
		6	Electronic media (TV)	
		7	School	
		8	No response	
		9	Other (Specify):	
Q203	Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	1	Yes	
		2	No	
		3	Don't Know	
		4	No response	
Q204	Can a person reduce the risk of getting HIV by using a condom every time they have sex?	1	Yes	
		2	No	
		3	Don't Know	
		4	No response	
Q203	Can a person get HIV&AIDS from mosquitoes or other insects?	1	Yes	
		2	No	
		3	Don't Know	
		4	No response	
Q204	Can a person get HIV&AIDS by sharing a meal with someone who is infected with HIV?	1	Yes	
		2	No	
		3	Don't Know	
		4	No Response	
Q205	Is it possible for a healthy looking person to have HIV, the virus that causes AIDS?	1	Yes	
		2	No	
		3	Don't Know	
		4	No response	
Q206	Is it possible for woman infected with HIV to give birth to a child who is not infected with HIV?	1	Yes	
		2	No	
		3	Don't Know	
		4	No response	
Q207	If a person has HIV, should he or she be allowed to continue working or attend school?	1	Yes	
		2	No	
		3	Don't know	
		4	No response	
Q208	If a member of your family became sick with AIDS, would you be willing to take care of him or her?	1	Yes	
		2	No	
		3	Don't know	
		4	No response	

Q209	Do you think that HIV&AIDS is a punishment from God/Allah?	1	Yes	
		2	No	
		3	Don't know	
		4	No response	
Q210	Do you think that people who have HIV&AIDS deserve compassion or support?	1	Yes	
		2	No	
		3	Don't know	
		4	No response	

Part 3: RISK OF INFECTION WITH HIV IN THE INFORMAL SECTOR

	Question		**Coding Category**	**Skip to**
Q301	Does the nature of your work put you at risk of HIV infection?	1	Yes	
		2	No	*Go to Q303*
		3	Don't Know	*Go to Q303*
		4	No response	
Q302	Does the nature of your work expose you to HIV infection?	1	Yes	
		2	No	
		3	Don't Know	
		4	No response	
Q303	If yes to Q301 or Q302, please explain the nature of risk:			
Q304	If no to Q301 or Q302, why do you think you are not at risk of HIV infection? (***Many responses possible)***			*Go to Q401*
Q305	What precautions if any do you take to ensure that you are not infected with HIV&AIDS while in the course of your work?			
Q306	Do you know about PEP	1	Yes	
		2	No	*Go to Q401*
Q307	In cases of accidental exposure to HIV&AIDS virus, do you have access to Post Exposure Prophylaxis (PEP) on site?	1	Yes	*Go to Q401*
		2	No	
		3	Don't Know	
Q308	If no, where do you have access to PEP?	1	Nearby health centre	
		2	Nearby private clinic	
		3	Nearby district/mission/church clinic & hospitals	

PART 4. VOLUNTARY COUNSELLING AND TESTING (VCT)

	Question		**Coding Category**	**Skip to**
Q 401	Does your workplace/environment have VCT services?	1	Yes	Go to Q403
		2	No	

	Question		Coding Category	Skip to
		3	Do not know	
Q402	If NO, where can you and your colleagues access VCT services? ***Many responses possible.***	1	Nearby health centres	
		2	Nearby private clinics	
		3	Nearby district/mission/church clinic & hospitals	
		4	Available at provincial level	
		5	Mobile /Moonlight VCT	
		6	Don't know	
		7	No Place	
		9	Other (Specify):	
Q403	Have you ever had an HIV test?	1	Yes	
		2	No	*Go to Q408*
Q404	Was pre and post test counselling provided as a part of the VCT processes?	1	Yes	
		2	No	
Q405	Was information on where one could get follow up services (referral) provided at the VCT?	1	Yes	
		2	No	
Q406	In the last one year (12 months), how many times have you tested for HIV	1	Once	
		2	Twice	
		3	Three times	
		4	More than three times	
		5	None	Go to Q408
Q407	Did you collect the results of your test?	1	Yes	
		2	No	
Q 408	Would you like to take an HIV test in the future?	1	Yes	*Go to Q501*
		2	No	
Q 409	Why don't you want to have an HIV test? ***Many responses possible.***	1	Am afraid of knowing my status	
		2	I'm faithful and so don't need one	
		3	Cultural/Religious barriers	
		4	Do not know how to manage the shock and stress of knowing my status	
		5	Don't see the importance of the test as there is still no cure	
		6	Don't know where to take the test	
		7	Don't have the resources to take the test	
		8	Don't trust confidentiality	
		9	Other (Specify):	

Part 5: HIV PROGRAMS, ACTIVITIES AND INTEVERVENTIONS IN THE SECTOR

- To assess current HIV & AIDS interventions in the informal private sector by undertaking a mapping exercise of the sector in selected geographical areas

Q 501	At your workplace, do you have any operational HIV and AIDS program and services?	1	Yes	
		2	No	Go to 507
		3	Don't know	Go to 507
Q502	If Yes, What HIV and AIDS programs/ services are available to you in the informal sector? M*any responses possible.*	1	Condom provision	
		2	Clinic/hospital/medical check up	
		3	Guidance and counselling	
		4	Health education	
		5	Peer education	
		9	Other (Specify):	
Q503	If Yes, who is the provider of the services **Multiple Responses**	1	Government	
		2	Faith based	
		3	Community members	
		4	NGOs/CBOs	
		5	Private	
		6	Traditional	
		7	Other (Specify):	
Q504	How do you feel about the quality of services provided by your service provider	1	Excellent	
		2	Good	
		3	Fair	
		4	Poor	
		5	No Response	
Q505	Does the sub sector (Jua kali, Hawkers, fishers, truckers) you operate in provide you with any specific HIV and AIDS related programmes and services	1	Yes	
		2	No	
Q506	If yes, please specify the nature of on going programs and support:			

Q507. What can be done differently to improve the quality of HIV and AIDS prevention, care and support and treatment programs and interventions in the informal sector?

.....

.....

.....

IMPACT OF HIV AND AIDS ON THE SECTOR

Q601	Have you ever had a family member/friend/colleague who is infected/affected by HIV and /or AIDS	1	Yes	
		2	No	Go to Q607
		3	Do not know	
		4	No response	
Q602	If yes, have you ever missed work because of a family member/friend/colleague who is infected/affected by HIV and AIDS?	1	Yes	
		2	No	Go to Q604
Q603	If YES, approximately how many days per month do you think you have missed due to the illness of family member/friend/colleague?	1	None	
		2	Less than 5 days	
		3	5 – 10 days	
		4	More than 10 days	
Q604	Do you support the Infected /affected family members/ friends/colleagues	1	Yes	
		2	No	Go to Q607
Q605	How do you support the infected or affected family member/friend/colleagues (multiple answers permissible)	1	Lives with relative	
		2	Provides for treatment and medication	
		3	Provides food and upkeep	
		4	Takes care of the orphans	
		5	Takes care of the widow	
		6	Provides financial support	
		7	None	
		9	Others (Specify)	
Q606	In what ways does the support you provide affect you and your work (multiple answers permissible)	1	Attendance/absenteeism from work	
		2	Performance/Productivity at work	
		3	Financial burden	
		4	Psycho social stress/burden	
		5	Do not know	
		9	Other (specify)	

Q607. What could be done differently to reduce the impact of HIV and AIDS in the informal sector?

.....

.....

.....

AWARENESS OF OTHER ORGANIZATIONS
1. Are you aware of other small or medium organizations carrying out business similar or related to yours? 1.Yes _____ 2.No _____ If yes, name them: Type of organization (if known):

1. _____ _____

2. _____ _____

3. _____ _____

Any other comments

.....

.....

……

Thank you

Annex 3: INSTITUTIONAL QUESTIONNAIRE

MAPPING OF THE INFORMAL SECTOR INTERVENTIONS AND RAPID IMPACT OF HIV&AIDS STUDY IN THE INFORMAL SECTOR
SURVEY QUESTIONNAIRE – Institutional

3. QUESTIONNAIRE SERIAL NUMBER _____ Date _____/_____/2010

4. Enumerator's Name: _____ Signature _____

IDENTIFICATION					
Organization Name:					
Site	1	Nairobi and Environs (incl. Thika, Athi River, Ongata Rongai)	6	Naivasha	
	2	Mombasa (incl. Ukunda, Mariakani and Mtwapa)	7	Eldoret	
	3	Nakuru	8	Kakamega	
	4	Kisumu and environs	9	Busia	
	5	Narok	10	Malindi	
Location of organization					
Sector	1	Agriculture & Rural Development	7	Governance, Law and Order	
	2	Trade, Tourism and Industry	8	Public Administration	
	3	Physical Infrastructure	9	Special Programs	
	4	Environment, Water and Sanitation	10	National Security	
	5	Human Resource Development	11	Macro Working Group	
	6	Research, Innovation and Technology			
Category of Informal sub-sector	1	Truck drivers	5	Fishing community,	
	2	Hawkers	6	Touts & Boda bodas,	
	3	Tour guides/travel agents	7	Jua kali artisans	
	4	Agricultural Sector,	8	Other(Specify)	

Location (Physical Address):	
P.O. Box Number	
Telephone	
Email	
Organization's Focal Person/ Contact:	
Name Of Interviewee:	

Designation Of Interviewee:	

ORGANIZATION PROFILE	
Year Started operating	
Core Business	
Is a Member of (Association/Umbrella organization)	
Geographic coverage of operations	
Number of employees:	Male..... Female.....
No of Staff with health related duties	
No of staff with specific HIV prevention/treatment/care duties	

PART I - WORKPLACE HIV&AIDS POLICIES AND PROGRAMMES

No	Question	Coding categories		Skip to
101	Does the workplace have an HIV&AIDS policy?	1	Yes	
		2	No	Go to Q103
		3	Don't know	
102	If yes, does the workplace provide HIV&AIDS prevention programmes to employees?	1	Yes	
		2	No	
		3	Don't know	
103	Are employees required to take an HIV antibody test prior to employment?	1	Yes	
		2	No	
		3	Don't know	
104	Has the workplace had a prevention programme within the last 3 months?	1	Yes	
		2	No	
		3	Don't know	
105	Does the workplace provide employees with information on where they can receive HIV counselling and antibody testing?	1	Yes	
		2	No	
		3	Don't know	
106	Does the workplace provide on-site or nearby peer education on HIV prevention?	1	Yes	
		2	No	
		3	Don't know	
107	Is there a workplace sponsored clinic on-site or nearby for employees	1	Yes	
		2	No	
		3	Don't know	
108	Does the clinic provide HIV counselling and antibody testing to employees	1	Yes	
		2	No	
		3	Don't know	
109	Does the clinic provide antiretrovirals	1	Yes	

	for HIV&AIDS treatment to employees	2	No	
		3	Don't know	
110	Does the clinic provide treatment* of opportunistic infections to employees	1	Yes	
		2	No	
		3	Don't know	
111	Does the clinic provide referral services to clinics where employees can receive care for STIs including HIV&AIDS	1	Yes	
		2	No	
		3	Don't know	

PART II: IMPACT OF HIV&AIDS IMPACT ON INFORMAL SECTOR Organisations

(A) **IMPACT OF HIV&AIDS ON STAFF -*(Vulnerability, Susceptibility & Effects of HIV&AIDS Infection)***

No.	Question	Coding Categories		Skip to
201	Is it mandatory for your staff to take HIV tests?	1	Yes	
		2	No	
		9	Do Not Know	
202	Does the nature of work in your institution/organization expose staff to HIV infection?	1	Yes	
		2	No	Go to Q208
		9	Do not know	
203	Describe the nature of work that is potential to HIV exposure in your workplace/organization. *(Multiple answers are permissible)*	1	Contact with body fluids	
		2	Contact with blood	
		3	Trauma and injuries	
		4	Contact with injection needles	
		5	Handling of contagious specimens (evidence/exhibits)	
		8	Do not know	
		9	Other (specify):	
204	What measures has your organization/institution taken to decrease the risk of staff exposure to HIV infection? *(Multiple answers are permissible)*	1	Provision of protective equipment such as gloves, goggles and gowns	
		2	Prevention education literature	
		3	Post exposure prophylaxis (PEP)	
		4	Condoms	
		8	Do not know	
		9	Other, please list:	

205. What risk factors contribute to staff being infected with the HIV in your institution/organization? *Probe to get factors specific to: (i) junior and senior staff (ii) staff mobility (travel & transfers) (iii) housing (iv) distance from family(partners and spouses separated).*

_____
_____
_____
_____
_____
_____

206. Are there any specific factors that make women staff in the informal sector more vulnerable to HIV infection? *List and explain. (Please probe on issues of sexual harassment, abuse and exploitation).*

_____
_____
_____
_____

207. What has your organisation done to ensure that the risk of possible infection at the workplace is minimised?

_____
_____
_____
_____
_____

208	Do you know of any staff member who is openly HIV +?	1	Yes	
		2	No	Go to Q301
		9	Do Not Know	
209	If YES to Q208 does the HIV+ staff experience opportunistic infections?	1	Yes	
		2	N0	Go to Q211
210	If YES to Q209, has the HIV+ staff been missing work due to illness?	1	Yes	
		2	No	
211	If YES to Q208, has the HIV+ staff been missing work to travel/access HIV&AIDS related medical services?	1	Yes	
		2	No	
212	If YES to Q208, do HIV+ staffs miss any opportunities for promotion and training because of their status?	1	Yes	
		2	No	
		9	Do not know	
213	For staffs who are HIV+, what factors are contributing to their getting to the AIDS/ FULL BLOWN stage and /or DEATH stage?	1	Risky sexual behaviour (being repeated exposed of the virus	
		2	Staff not testing early to know their status	
		3	HIV+ staff not taking care of their health as expected	

		4	Staff not getting appropriate health care and support services	
		5	Inadequate institutional support to infected staff	
		6	Stigma and discrimination of infected staff	
		29	Other, please list:	

214. Please describe any other issues related to how HIV and/or AIDS impacts on your organisations staffs that has not been mentioned so far:

_____
_____
_____
_____
_____
_____

215. What should be done differently in order to mitigate the impact of HIV and AIDS on staff in your institution and organization?

_____
_____
_____

PART III- **ACCESS TO QUALITY HEALTH CARE & SUPPORT PROVISION TO STAFF – (*Preventive, Promotion & Treatment)***

No.	**Question**	**Coding Categories**		**Skip to**
301	Does your organisation provide VCT services for staff?	1	Yes	Go to Q305
		2	No	
302	Are your staffs asking the organisation to assist them access to HIV counselling and testing services (VCT)?	1	Yes	Go to Q305
		2	No	
		3	Do Not Know	
303	If NO to Q302, give reasons why are staff are not asking for VCT services?	1	Absence of VCT facilities at workplace	
		2	Absence of a workplace HIV awareness and prevention programme	
		3	Fear of stigma and discrimination	

			at work	
		4	Fear of breach of confidentiality at work	
		5	Ignorance on importance of knowing ones' status	
		6	Ignorance on provisions of workplace policy and programs on HIV&AIDS	
		7	Other, please list:	
304	If NO to Q302, does the employer provide referral services for VCT?	1	Yes	Go to Q308
		2	No	
		9	Do Not Know	
305	If YES to Q301, is pre-test counselling provided to those taking the HIV test within the institution/organization?	1	Yes	
		2	No	
		9	Do Not Know	
306	If YES to Q301, is post-test counselling provided before giving the results of an HIV test to staff?	1	Yes	
		2	No	
		9	Do Not Know	
307	Does the pre and post test counselling services explain to staff the nature of health care and support (comprehensive care) services available to infected and affected staff?	1	Yes	
		2	No	
		3	Do Not Know	
308	Are condoms provided at the VCT centre?	1	Yes	
		2	No	
		If YES, Male condoms……. (mark x) Female condoms……. (mark x)		
309	If YES to Q307, is information about referral services for better health care and support **(comprehensive health care) provided**?	1	Yes	
		2	No	
		9	Do Not Know	

310	Does your organisation provide healthcare facilities/services on-site?	1	Yes	
		2	No	
		9	Do Not Know	

311	If yes to Q310, are the health care facilities available in all workstations?	1	Yes	
		2	No	
		9	Do Not Know	
312	If YES to Q310, describe the healthcare facilities/services situated within your organization. *(Multiple answers are permissible)*	1	Health centre	
		2	Dispensary	
		3	Staff clinic	
		4	VCT centre	
		5	Psychosocial support/counselling services	
		6	Do not know	
		Other, Please list:		
313	Describe the type of staff working in the health care facility described in Q312. *(Multiple answers are permissible)*	1	Doctor(s)	
		2	Nurses	
		3	Laboratory technicians	
		4	Support staff	
		5	Clinical officers	
		6	Public health technicians	
		7	Counsellors	
		8	PLWHAs support staff	
		9	Pharmacist	
		10	Do not know	
		Other, Please list:		
314	Give details of type of health care services provided in the health facility described in Q312. *(Multiple answers are permissible)*	1	HIV prevention information	
		2	Male condoms	
		3	Female condoms	
		4	Spermicides/microbicides	
		5	Psychosocial support/counselling	
		6	VCT services	
		7	STI treatment	
		8	Treatment for opportunistic infections	
		9	ARVs/ART	
		10	Treatment for TB	
		11	Laboratory and diagnostic services	
		12	Harm reduction (injectable drugs)	
		13	Prevention of mother-to-child transmission (PMTCT) services	
		14	Referral to other services Please list_____	
		15	Do not know	

		Other Please list_____		
315	Describe the factors that affect/influence staff use of health services described above in Q314. *(Multiple answers are permissible)*	<u>Positive:</u>		
		1	Staff friendly and supportive	
		2	Staff punctual and present during working hours	
		3	Drugs and medical supplies always available	
		4	Patient privacy and confidentiality is respected	
		5	Facility is clean and welcoming	
		<u>Negative:</u>		
		6	Staff are rude and unfriendly	
		7	Staff are late to report on duty	
		8	Staff are absent during opening hours	
		9	Staff are judgmental and not sensitive to HIV-related issues (stigma	
		10	Drugs, medical supplies, and condoms are sometimes out of stock	
		11	Patient privacy and confidentiality is not respected	
		12	Facility is not clean and welcoming	
		13	Do not know	
		Other Please list:		
316	Does your organisation provide access to HIV-related referral services <u>off-site?</u>	1	YES	
		2	NO	
		9	Do not know	
317	Are the above mentioned health care services in Q314 provided free?	1	YES	
		2	NO	
		9	Do not know	
318	If NO to Q317, give examples of services for which staff mostly pay for.			
319	Do staff have a health/medical cover?	1	YES	
		2	NO	Go to Q401
320	If yes to Q319, does the health/medical cover include HIV&AIDS related illnesses?	1	YES	
		2	NO	
		9	DO NOT KNOW	
321	If YES to Q319, describe the type of health/medical	1	Medical coverage under NHIF(by employer)	
		2	Private medical coverage (by employer)	

	insurance coverage that staff have. *(Multiple answers allowable)*	3	Private medical coverage paid by staff member	
		4	Do not now	
		Other Please list_____		
322	If YES to Q320, indicate the type of health facilities and health services that the coverage enables staff to use (for HIV&AIDS related illnesses)?	1	Prevention services (VCT, counselling, etc.)	
		2	ARV/ART	
		3	Viral load monitoring/CD4	
		4	Private hospital outpatient and inpatient (full coverage)	
		5	Palliative are	
		6	Private nursing homes inpatient and outpatient (full coverage	
		7	Private clinics (outpatient consultation, tests and drugs	
		8	Psychosocial services/counselling	
		9	STI treatment	
		10	Prevention of mother-to-child transmission (PMTCT) services	
		11	Do not know	
		Other Please list_____		
323	What details have been given to staff on the type of medical/insurance coverage they are entitled to as an employee?	1	HIV workplace policy information	
		2	ART/ARV benefits	
		3	Ex-gratia services	
		4	Medical coverage for HIV- related illness	
		5	None	
		6	Do not know	
		7	Other support provided to PLWHA staff Please list_____	
		Other Please list:		
324	Are there referral services for HIV-related illnesses provided by your organization for staff to public and private health institutions?	1	YES	
		2	NO	Go to Q326
		9	Do not know	
325	If YES to Q324, describe the	1	Provides transport to health facility	

	referral services provided by your organization? *(Multiple answers are permissible)*	2	Gives referral letter to GOK health facilities in the proximity (Public	
		3	Gives referral letter to private health facilities in the proximity	
		4	Referred to Uniformed Services health facility (i.e. Military, Administration, Police	
		5	Do not know	
		Other Please list_____		
326	Does your organization offer medical insurance coverage and HIV-related health care services to members of staff's immediate family?	1	YES	
		2	NO	
		9	Do not know	

PART IV- IMPACT OF HIV&AIDS ON THE CAPACITY OF INFORMAL SECTOR TO PROVIDE SERVICES ACCORDING TO ITS CORE MANDATES

Negative impact has the HIV epidemic had on your organisations capability to deliver services?

Please rate the effects accordingly using the given scale: **greatest = 1; moderate = 2; Minimal = 3; none = 4; and don't know=99**

	Impact Questions	**Yes**	**No**	If YES, define the negative effect: ***Great =1*** ***Moderate =2*** ***Minimal =3*** ***None = 4*** ***Don't know =5***
401	a) Do you have a shortage of staff due to frequent/ prolonged sick leave and absenteeism from duty?			
402	b) Is there an increase of costs from health care provision to staff related to HIV and AIDS?			
403	c) Do you perceive a decline in work performance due to the HIV epidemic?			
404	d) Is there frequent staff absenteeism to attend funerals for their colleagues, family members, and friends?			
405	e) Is there an increase in overtime payments in bid to compensate for positions left vacant due to HIV-related illness and death?			
	f) Is there Increase in premiums of medical			

406	cover/health insurance resulting from HIV&AIDS?			
407	g) Do you think co-workers are demoralized and/or depressed about the illness and/or death of their colleagues due to suspected AIDS-related illnesses?			
408	h) Do you think there is a loss of skilled staff and institutional memory due to suspected HIV and AIDS-related illnesses and deaths?			
409	i) Is there an increase in expenses (costs) related to hiring new staff?			
410	j) Do you know if there is low morale due to stigma and discrimination of staff openly living with HIV and/or AIDS?			

PART V- CURRENT RESPONSES TO HIV&AIDS IN THE INFORMAL SECTOR

(A) INSTITUTIONAL & LEGAL RESPONSES IN PLACE *(Policies, Laws and Services)*

501	Are you aware of the private Sector Workplace Policy on HIV&AIDS	1	Yes	If **NO**, Go to Q504
		2	No	
		9	Do Not Know	
502	If YES to Q501, were the staff in your organization sensitised/inducted on it's the provisions of the Policy?			
503	If YES to Q501, what aspects of the Policy have the staffs been inducted /sensitised on?			
504	Are you aware of the new HIV and AIDS Prevention and Control Bill passed by Parliament in 2006?	1	Yes	
		2	No	
505	Are you aware of any workforce policies related to HIV and AIDS in your sector? *(According to this Bill, the Government must ensure the provision of basic information and instruction on HIV and AIDS prevention and control).*	1	Yes	
		2	No	

506. What resources and/or mechanisms are available to support the provision of HIV&AIDS services in your organization?

(*Multiple responses allowable)*

a) Line Ministry ACU staff [ ]
b) Staff specifically assigned with HIV-related responsibilities [ ]
c) Funds allocated for HIV and AIDS related workplace activities [ ]
d) Umbrella association Annual Work Plans [ ]

e) Other, please describe:----------

---

f)

AWARENESS OF OTHER ORGANIZATIONS
1. Are you aware of other small or medium organizations carrying out business similar or related to yours? 1.Yes _____ 2.No _____ If yes, name them: Type of organization (if known): 4. _____ _____ 5. _____ _____ 6. _____ _____

Any other comments

.....
.....

Thank you

ANNEX 4: KEY INFORMANT INTERVIEW

MAPPING OF THE INFORMAL SECTOR INTERVENTIONS AND RAPID IMPACT OF HIV&AIDS STUDY IN THE INFORMAL SECTOR

KEY INFORMANT INTERVIEW
Introduction

Hello, my name is _____. I am a researcher commissioned by National AIDS Control Council and the Kenya Private Sector Advisory Network to undertake a mapping of the informal sector HIV&AIDS services in Kenya. We are undertaking a situational analysis of HIV and AIDS response within the informal sector. As a professional in the relevant area, you have been selected randomly to participate in the survey.
I would like to confirm to you that all the responses you give was treated with confidentiality and will only be used for the purpose of the study. Your responses was recorded but your name will not be written to ensure confidentiality.

I would like to ask you some questions relating to this exercise. The interview will take about 30 minutes.

Name:	Date:	Region
Designation	Time discussion started:	Time discussion ended:
Profession:	Female/Male:	Name of interviewer:
How long have you worked here.....		

PART I - WORKPLACE HIV&AIDS POLICIES AND PROGRAMMES

Is there any workplace HIV&AIDS policy for workers in the informal sector in this region?

If yes, does the workplace provide HIV&AIDS prevention programmes to workers in the informal sector?

Does the workplace provide employees with information on where they can receive HIV counselling and antibody testing?

Does the workplace provide on-site or nearby peer education on HIV prevention?

Is there a workplace sponsored clinic on-site or nearby for informal sector employees in this area? How accessible are these clinics to the worker?

What HIV and AIDS services are offered to the workers? At what cost? Who meets the cost?

Are there treatment of opportunistic infections to employees who are infected by HIV and AIDS

PART II. ACCESS TO QUALITY HEALTH CARE & SUPPORT PROVISION TO INFORMAL SECTOR WORKERS'

i. Are there healthcare facilities/services that provide HIV and AIDS services in the region?

ii. If YES describe the healthcare facilities/services situated within your region (probe for Health centre, Dispensary, Staff clinic, VCT centre etc)

iii. Give details of type of health care services provided in the health facility described in above

iv. What are some of the constraints experienced by the informal workers in access to health services? why?

v. How can the existing health facilities be made to serve the community better?

vi. Who are the main stakeholders involved in health service provision in the area?

PART III: IMPACT OF HIV&AIDS IMPACT ON INFORMAL SECTOR

organisations

i. Does the nature of work by informal sector workers expose staff to HIV infection?

ii. What measures have your department/institution taken to decrease the risk of HIV infection among informal sector players? (probe for Provision of protective equipment such as gloves, goggles and gowns, Post exposure prophylaxis (PEP), condoms etc)

iii. Are there any specific factors that make women staff in the informal sector more vulnerable to HIV infection? *List and explain. (Please probe on issues of sexual harassment, abuse and exploitation).*

iv. What risk factors contribute to staff being infected with the HIV virus in the informal sector? *Probe to get factors specific to: (i) junior and senior staff (ii) staff mobility (travel & transfers) (iii) housing (iv) distance from family(partners and spouses separated).*

v. What socio-cultural practices negatively increase the risk of HIV Infection among informal sector workers?

vi. What has your organization done to ensure that the risk of possible infection at the workplace is minimized?

vii. Please describe any other issues related to how HIV and/or AIDS impacts on your organizations staff that have not been mentioned so far:

viii. What should be done differently in order to mitigate the impact of HIV and AIDS on staff in your institution and department?

PART IV- CURRENT RESPONSES TO HIV&AIDS IN THE INFORMAL SECTOR

i. Are you aware of the private Sector Workplace Policy on HIV&AIDS

ii. Were the informal sector workers in these regions sensitized/inducted on it's the provisions of the Policy?

iii. What aspects of the Policy have the informal sector workers been inducted /sensitized on?

ANNEX 5: FOCUS GROUP DISCUSSION GUIDE

MAPPING OF THE INFORMAL SECTOR INTERVENTIONS AND RAPID IMPACT OF HIV&AIDS STUDY IN THE INFORMAL SECTOR

FOCUS GROUP DISCUSSION (FGD) FOR WORKERS

Requirements

• Participants per FGD (6 -8)
• Adults (= or >18 years, men and women separately
• One moderator, one note -taker (*and* use of tape recorder)
• Neutral venue in the region
• Two FGDs per region (one with men and one with women)

Short introductory remarks

• Introduction of researchers and participants
• Thank participants for agreeing to participate, all share that they are workers in the informal sector
• Explain purpose of study, purpose of this discussion, reassurance about confidentiality, agree on rules.

TOPICS FOR DISCUSSION

1. What HIV interventions are available in these areas?
2. What treatments do you know to be available for treating HIV? What is your opinion about these? (E.g. ARVs; herbs; traditional medicines; spiritual healing; prayers; and perceived benefit (s) of treatment).
3. Do you know any of your colleagues currently on ART? (probe about adherence, adverse effects, pill burden, lack of food, lifestyle issues).
4. How do you think you are being treated (handled) by the health care workers (probe: privacy, confidentiality, respect, being listened to, time spent with patient, waiting time, integration with other services). What is the quality of care provided by health care workers?
5. What do you think about the counselling that you receive? (probe especially on importance of adherence effectiveness of counselling). What support are you given by the health workers to help you adhere better to your medications? Have you disclosed?
6. What support is available for you in the community, in the family, in the workplace? (Probe about discrimination, stigma). Probe differences in perceived availability of social support versus social networks? Any negative social support? Any stress exacerbation?
7. What do you think could be done to help people who are living with HIV in this area? What do you think are the key reasons for lack of support? What are the sources of motivation to come out and fight HIV in this sector?

ANNEX 6: SAMPLE SIZE CALCULATION FOR THE STUDY

The desired sample size (n) is calculated using the following formula and specifications:

$$n = Z^2_{1-\frac{\alpha}{2}} \frac{p\,(1-p)}{d^2} \mathbf{D}$$

Where,
n = the desired sample size

Z = the standard normal deviate, (1.96) which corresponds to the 1-α/2 (95%) confidence level

p = the proportion of the target population estimated to have a particular characteristic (p=estimated proportion of organizations with comprehensive workplace policies, here unknown so 0.5 was used);

D = the design effect, used to compensate for non-simple random sampling, here taken as 1.5;

d = the degree of accuracy, which is 0.05

Thus n = $\frac{1.96^2 \text{ X } 0.5 \text{ X } 0.5 \text{ X } 1.5}{0.05^2}$

576 respondents

ANNEX 7: ORGANIZATIONS/GROUPS THAT WERE INTERVIEWED

KENYA PRIVATE SECTOR ADVISORY NETWORK (KPSAN)
... Fighting H.I.V. and AIDS

	Site	Organisation Name	P.O. Box No.	Telephone Number	Email Address	Organisation Focal Person Contact	Name of Interviewee	Designation of Interviewee
1	Kakamega	Jua Kali Phase II				0720687097	Shem	Chairman/Lady
2	Kakamega	Innocent Hotel Group		0726409087		0726409087	Judy Kageha	Chairman/Lady
3	Naivasha	Narok Line	119 Naivasha	502020744			James Njunguna	Chairman/Lady
4	Naivasha	Kavete United Services	647Naivasha				Peter Mwangi	Treasurer
5	Naivasha	Kinungi	367 Naivasha	0722914506			Joseph Mwaura	Chairman/Lady
6	Naivasha	Satima Sacco	238 South Kinangop	0724326527			Samuel Thogo	Coordinator
7	Naivasha	Mai Mahiu Line	111 Naivasha	0722810964			Andrew Karanja	Secretary General
8	Naivasha	Tobacco Self Help Group	51 Naivasha	0726271483			James Mwangi	Chairman/Lady
9	Nairobi	Umoja Mlolongo	441 Athi River	0728828525		0728828525	Peter Maina	Chairman/Lady
10	Nairobi	Boresha Maisha Youth Foundation	7-00519	0726836443	shalom@yahoo.com	0726836443	Kamau Maina	Chairman/Lady
11	Nairobi	Neighbourhood Youth Group	7-00519	0721323416	george@yahoo.com	0721323476	Julius Kilasi	Chairman/Lady
12	Nairobi	Jitegeme Support Group	49531-Nairobi	601881			Celestine Kanyira	Chairman/Lady
13	Nairobi	Kenya Highway Youth Foundation	7-00519 Mlolongo	0752711712	kenyahighway@yahoo.com	0722464068	Daniel Mburu	Director
14	Nairobi	Sex Workers Club		0728393269		0728393269	Faith Njoki	Chairman/Lady
15	Nairobi	Mlolongo Hope and Union	3048-Nairobi	0721114907		0721114907	David Kariuki	Chairman/Lady
16	Nairobi	Njiru Business Traders	Njiri	0722305206		0722305200	Elijah Seka	Secretary General
17	Busia	Busia Jua Kali Artisans Association	330 Busia	0770747919		0723538286	William Odthiambo	Chairman/Lady

18	Busia	Busia Clearing and Forwarding	54 Busia		0722994037			Moses Ochieng	Chairman/Lady
19	Busia	Busia Boda Boda Association		300	0729493595	organizationcommunit@yahoo.com		Eric Makoha	Chairman/Lady
20	Busia	Busia Community Development	223-50410-Victoria		0728094900	bucoseu@yahoo.com	0721313637	Pascal Were	Community Development Facilitator
21	Busia	One World Foundation	501-Busia		0208028398	worldfoundation@yahoo.com	0721619006	John Kwoba	Director
22	Busia	Chamber of Commerce Busia			0715341155		0710974300	Nelson Mukanda	Committee/ Member
23	Busia	Kenya Orphans Rural Development	244 Busia		0725013100	kordp@elubiinternet.co.ke	0725013100	Waziri Awili Omar	Program Officer
24	Busia	Busia Joint Committee		167	0713672059	birfbo@yahoo.com	0717224202	Bishop Juma	Chairman/Lady
25	Busia	Busia Residents Association	232 Nambale		0726920337			Alutia	Founder
26	Busia	Busia Council of Elders	762-Busia		0715341155		0710974300	Nelson Ouma	Committee/ Member
27	Busia	Jua kali Busia	Private Bag		0735976762		0735976762	Obiero	Committee/ Member
28	Narok	Irmeshiki Menyamal Women Group	641-Narok		0726635036			Esther	Secretary General
29	Narok	Esirit SACCO	520-Narok		020603060		0722880462	Merus Ole Sagana	Chairman/Lady
30	Narok	Tumaini Support Group			0716843682			Nyakundi	Chairman/Lady
31	Narok	Narok Line	176 Narok		0725537806			Antony	Secretary General
32	Narok	Narok Jua Kali	755 Narok		0722953862			Nyaberi	Committee/ Member
33	Narok		505 Narok		0733576381				Chairman/Lady
34	Narok	Uprising Self Help Group	355 Narok		0722649206			Munene	Chairman/Lady
35	Narok	Narok Express Services			0712559133			John Kariuki	Chairman/Lady
36	Narok	Narok Matatu Group	136 Narok		0720215792			Karuru	Chairman/Lady
37	Eldoret	Jua kali Highway Self Help Group	2556 Eldoret		0733484351			Joseph	Secretary General
38	Eldoret	Mkokoteni Group	140 Eldoret					Erick	Chairman/Lady

39	Eldoret	Tool Box Self Help	3087 Eldoret	0734164465			Norman Omondi	Chairman/Lady
40	Eldoret	Barngetuny Motor Cycle Group		0726624930			Ibrahim	Chairman/Lady
41	Eldoret	UGBT Uasin Gishu Bicycle Transport		0710656626			Tonny Ekiru	Chairman/Lady
42	Eldoret	Upendo Self Help Group	5076 Eldoret	0724474988			George	Secretary General
43	Eldoret	Kinda Self Help Group	7913 Eldoret	0710648673			Zacheus Odthiambo	Secretary General
44	Eldoret	Jango Self Help Group	4754 Eldoret	0727560706		0721724527	John Odthiambo	Secretary General
45	Eldoret	Gikomba Jasho Jua Kali	3948 Eldoret	0724231393			Victor Onyango	Secretary General
46	Nakuru	Kenya Rabbit Farmers	13547 Nakuru	0825231188			Tabitha Nyaga	Chairman/Lady
47	Kisumu		19602	572025657			Isaiah Kadier	Secretary General
48	Kisumu		6737 Kisumu	0722932125			Mary Onyango	Coordinator
49	Kisumu		25018 Kisumu	0770662358			John Onyango	Chairman/Lady
50	Kisumu						John	.
51	Kisumu		679 Kisumu	0729171529			Edward Hongo	Chairman/Lady
52	Kisumu		1173 Kisumu				Richard Aduol	Chairman/Lady
53	Kisumu		800-Homabay	0724727023			Joseph Amollo	Secretary General
54	Kisumu		757 Homabay	0710307583			Jane Anyango	Chairman/Lady
55	Kisumu	Kondele Jua kali Association	4853 Kondele	0722479058			Richard Ondijo	Proprietor
56	Kisumu	Kibos Market Disaster Management	4266-40103 Kondele	0714294048			Steven Omondi	Chairman/Lady
57	Kisumu	Victoria Boda Boda SACCO	1331-40100 Kisumu	0723381738			Nelson Ochieng	Chairman/Lady
58	Kisumu	New Slay Jua kali	585 Siaya	0722257188		0717620305	Charles Odima	Manager
59	Kisumu	Friends Garage	4 Bondo	0735237720			Shadrack Ochieng	Treasurer
60	Kisumu	Kocholla Fabrications	4525 Kisumu	0715369041			Barnaba Omollo	Proprietor

61	Nairobi	Comrade Welfare	22797-00100 Nairobi	0727153234			Frances Irungu	Manager
62	Nairobi	Nairobi Shoe Shinners	7415-00200 Nairobi	0720399332			Zakaria	Chairman/Lady
63	Nairobi	Thika Jua kali Welfare Association	3020 Thika				David Muiruri	Chairman/Lady
64	Nairobi	Mitero HIV&AIDS Care Control	2221 Thika				Shadrack Kangiri	Chairman/Lady
65	Nairobi	Stadium Wall Workers Self Help Group	BOX 577				Julius Mwangi	Committee/ Member
66	Nairobi	Seven Stars SHG	2111 Thika	0723917325	tymerent@yahoo.com		Livingstone Mugane	Chairman/Lady
67	Nairobi	Chania Travellers SACCO	906 Thika	21126	chaniasacco@yahoo.com		Peter Ndungu	Manager
68	Mombasa	South Coast Curio Vendors				0738031617	Suleiman Ali	Chairman/Lady
69	Mombasa	Rurva Support Group	95015 Mombasa	0733666872	fruwa@yahoo.com		Francis Ruwa	Chairman/Lady
70	Mombasa	Kilifi Jua kali Association	570 Kilifi	0733370597		0733370597	Samson Tsuma	Chairman/Lady
71	Malindi	Kilifi Fishing	686	0712981720			Kassim Shally	.
72	Mombasa	Rartma Express Welfare Association	88297 Mombasa	0722916104			Ahmed Anwar	Chairman/Lady
73	Mombasa	Macknon Market Workers	40436 Mombasa	0727763079			Mwangi Kinyanjui	Chairman/Lady
74	Mombasa	Mariakani Jua kali Association		0729539947			Samuel Charao	Chairman/Lady
75	Nakuru	Wakward Women Union	7022 Nakuru	0724228054	mary-mbugua@yahoo.com		Mary Mbugua	Chairman/Lady
76	Mombasa	Mtwapa Boda Boda		0727904087			Christopher Kombe	Chairman/Lady
77	Eldoret	Transformer SHG	1480 Eldoret	0770986833			Charles Abwao	Chairman/Lady
78	Naivasha	Sera Value Silver Service	604 Naivasha	0725209100			Peter Patrick Wanjohi	Treasurer
79	Kakamega	Kinda Self Help Group	176-50100	0723643710		0723643710		Chairman/Lady
80	Naivasha	L. Naivasha Motor Bije Association	187 Naivasha	0724352704			James Mburu Kiruthi	.

81	Naivasha	Jua kali Busia	71 Naivasha			Teresa Njeri	Secretary General
82	Nakuru	Neil Tuk Tuk SHG	3134 Nakuru	0722964907		Gibson Githiru	Chairman/Lady
83	Mombasa	Kisulisuli SHG	3134 Nakuru	0722210234		Gladys Wanjiku	Chairman/Lady
84	Kakamega	Highway Bicycle	424-50106 Kakamega	0734222119	0734222119	Ahmed	Chairman/Lady
85	Kakamega	Jua kali Muungano SHG		0724334528	0724334528	Tom	Secretary General
86	Kakamega	Mweleleo Self Help Group	176 Kakamega	0721410455	0721410455	Benard	Chairman/Lady
87	Kakamega	UGBT Uasin Gishu Bicycle Transport	424-50100 Kakamega	0734222119	0734222119	Albio	Secretary General
88	Kakamega	Tushauriane Post Test Club	454-50100	0722484733	0722484733	Sammy	Chairman/Lady
89	Kakamega	Juakie Hybrid	1507-50100 Kakamega	0729585915		Stanley Murunga	Chairman/Lady
90	Kakamega	Mwangolo Self Help Group	176-50100	0725951705		Aggrey Shiramba	Chairman/Lady
91	Kakamega	Kanco		0726285617	0726285617	Moss Mohammed	Secretary General
92	Naivasha	Nairobi Naivasha United Services (NNUS)	1875 Naivasha	0722797386		Paul Musia	Chairman/Lady
93	Nairobi	Kiaringi Women Group	113 Kaimoni			Salome Njeri	Chairman/Lady
94	Busia	Family Bank	329 Busia	0722658881	0712076049	Kenneth Mabuno	Manager
95	Kisumu	ATP Technical Training Institute	2653 Kisumu 40100	572027152	0722755275	Agalla	Head of Department
96	Kisumu	Asumbi Enterprises	19010 Kisumu	0727983689		Michael Juma	Proprietor
97	Kisumu	Asumba Tailoring	6056 Kondele	0721395629		Rose Asimba	Proprietor
98	Malindi	Unions Magnet Theatre	986 Malindi	0422120171	0726263538	Goeffrey Gona	Chairman/Lady
99	Malindi	Malindi Tourists Market	1109 Malindi		071307008	Thomas Mutondi	Chairman/Lady
100	Malindi	Malindi Artisans Jua kali	802 Malindi		0723555540	Silvester Njiru	Secretary General
101	Malindi	Faulu Malindi SACCO	1158 Malindi		0733428411	James Kimani	Chairman/Lady
102	Malindi	Kiamuma Self Help	5288 Malindi			Paul Njoroge	Chairman/Lady

103	Malindi	Wachuuzi Waungae Group	5288 Malindi			0723926476	Peter Mburu	Chairman/Lady
104	Nakuru	Nakuru Youth Hawkers	1108 Nakuru	0720070742	mumnao2003@yahoo.com		Naomi Mumbi Kamau	Chairman/Lady
105	Malindi	Tool Box Self Help	221 Malindi	0208095589	info@malindihandicrafts.co.ke	0725711531	Edson Kaingu	Manager
106	Malindi	Kambu Traders Group	110 Malindi	0711766999			Richard Oloo Akumu	Chairman/Lady
107	Malindi	Soko Mpya Group	5548 Malindi			0721522377	Valeria Ayuma	Chairman/Lady
108	Nakuru	Wholesaler	13063 Nakuru	0720912191			Henary Ndogo Bibia	Chairman/Lady
109	Nakuru	Kenapt SHG	3942 Nakuru	0733899272	jimmedjim@yahoo.com		James Ngugi Njuguna	Chairman/Lady
110	Malindi	Malindi Youth Hawkers	6288 Malindi			0721919123	Anthony Ndungu	Chairman/Lady
111	Mombasa	South Coast Boat Operators	216 Ukunda	0711602398			Salim Juma	Chairman/Lady
112	Mombasa	Ukunda Posta Taxi	209 Ukunda	0722860804			Kassim Hamisi	Chairman/Lady
113	Mombasa	Coast Car		0720249581		0729249581	Chrispus Njoroge	Chairman/Lady
114	Mombasa	Old Town Tourist Guide	82412-080100	0722854472	faridi talla@yahoo.com		Faridi Mohammed	Chairman/Lady
115	Nakuru	Patriotic Rescue International	7078-20100	0728885949	kefeshao8@yahoo.com		Ben Gikonyo	Chairman/Lady
116	Nakuru	Kenyatta Moving Hawkers	13613 Nakuru	0725409271			Jane Wambui Njuguna	Chairman/Lady
117	Nakuru	Masco SHG	13613 Nakuru	0724835902			Teresia Wanjiku	Chairman/Lady
118	Nakuru	Njoro Boda Boda Bikes SHG	13613 Nakuru	0725273862			Nancy W. Njuguna	Chairman/Lady
119	Nairobi	Masai Market Traders		0733232353			Kanini Ndungu	Chairman/Lady
120	Nairobi	Route Jua kali Association		0715391699			Njoroge	Chairman/Lady
121	Nairobi	Kirim HIV&AIDS Program		0721255925			Mwefa Elijah	Chairman/Lady
122	Nairobi	Kanga Jua kali Association		0721255925			Mwega	Chairman/Lady
123	Nairobi	Route Jua kali Association		0715391699			Njoroge	Chairman/Lady
124	Nairobi	Taa ya Kushona Association		0724879103			Nduku	Chairman/Lady

125	Nairobi	Kamukunji Jua kali Association	78558-00507	0724709887		Fredrick Dawa	Secretary General
126	Kakamega	Kanco	135-50100 Kakamega	0722858103			Volunteer

ANNEX 8: KNOWLEDGE OF HIV (NUMBER AND PERCENT OF RESPONDENTS WHO ANSWERED 'YES')

Knowledge Question	Male		Female		Total	
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	369	90.2%	151	91.5%	520	90.6%
Can a person get HIV&AIDS from mosquitoes or other insects?	83	20.5%	27	16.4%	110	19.3%
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	300	72.8%	140	85.9%	440	76.5%
Can a person get HIV&AIDS by sharing a meal with someone who s infected with HIV?	40	9.8%	18	10.9%	58	10.1%
Is it possible for a healthy looking person to have HIV, the virus that causes AIDS?	377	92.0%	159	97.0%	536	93.4%
Is it possible for woman infected with HIV to give birth to a child who is not infected with HIV?	317	77.7%	143	86.7%	460	80.3%
If a person has HIV, should he or she be allowed to continue working or attend school?	383	93.2%	160	97.6%	543	94.4%
If a member of your family became sick with AIDS, would you be willing to take care of him or her?	398	96.6%	161	98.2%	559	97.0%
Do you think that HIV&AIDS is a punishment from God/Allah?	171	41.5%	56	34.1%	227	39.4%
Do you think that people who have HIV&AIDS deserve compassion or support?	404	98.3%	164	100.0%	568	98.8%

ANNEX 9: GUIDELINES FOR CONSTRUCTION OF KNOWLEDGE INDICATOR

KNOWLEDGE, ATTITUDE, PRACTICE AND BEHAVIOUR

Percentage of women and men aged 15-49 who both correctly identify ways of preventing the transmission of HIV and who reject major misconceptions of about HIV&AIDS (By rural & urban)

REFERENCE: 5
INDICATOR LEVEL: OUTCOME
FREQUENCY OF COLLECTION & REPORTING: BIENNIAL
UTILIZATION: STATE & FEDERAL LEVEL

RATIONALE:

Sound knowledge about HIV and AIDS is an essential pre-requisite for adoption of behaviours that reduce the risk of HIV transmission. This indicator combines the measures of knowledge of HIV transmission and prevention with the prevalence of most common misconceptions about HIV. It provides programme managers with a measure of the overall knowledge that people have of avoiding HIV.

DEFINITION:

Percentage of women and men aged 15-49 who both correctly identify ways of preventing the transmission of HIV and who reject major misconceptions about HIV&AIDS disaggregated by rural and urban areas.

MEASUREMENT:

This indicator is constructed from responses to the following set of questions:
1. Can the risk of HIV transmission be reduced by having sex with only faithful, un-infected partner?
2. Can the risk of HIV transmission be reduced by using condoms?
3. Can a healthy looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with some one who is infected?

Item 1 and 2 measure the correct knowledge for preventing HIV transmission. Item 3 measure a common misconception that healthy- looking people do not have HIV infection. This wide spread misconception among people regardless their age or sex, and it can result in unprotected sex with an infected partner. Item 4 and 5 refer to two other misconceptions about HIV transmission.

Base on the 5 components which construct the indicator, it can be measured as follows:

Numerator:
Number of respondents (age 15-49) who gave **correct** answers to all five questions relating to transmission of HIV and misconceptions about HIV.

Denominator:
Number of respondents (age 15-49) who gave answers (including do not know) to all five questions.

This indicator should be presented as percentage separately for men and women disaggregated by age in the following groups: 15-19, 20-24, 25-34, and 35-45. In addition, this particular indicator should also be presented for the 15-24 age group, as the Millennium Development Goals and the UNGASS HIV goals are specified for this age group in particular.

ANNEX 10: LIST OF ORGANIZATIONS IDENTIFIED BY INSTITUTIONAL RESPONDENTS

	Name of Organization	Type			Name of Organization	Type
1	NNOS	Transport		**106**	Beba Group	Transport
2	NNOS	Transport		**107**	Jua kali Highway SHG	
3	Kasese	Transport		**108**	Jool Box SHG	
4	South Lake Travellers	Transport		**109**	Umbrella SHG	Artisans Jua kali
5	Harmony	Self Help Group		**110**	Transformer SHG	Artisans Jua kali
6	Jua Kali Association			**111**	Kondele JKA	Artisans Jua kali
7	Makoko Environment Group			**112**	Sije Ngware Transport	Transport
8	Tap Work Athi river	CBO		**113**	Uyugis JKA	
9	Mlolongo Youth Development Group			**114**	Kibuye JKA	Artisans Jua kali
10	Neighbourhood Youth Group	Self Help Group		**115**	Kibuye Hawkers	Hawkers
11	Njiru Self Help group	Self Help Group		**116**	Citu Engineering	Smith/Metal works
12	Busia Fish Mongers			**117**	Kenaha	
13	Busia Jua Kali			**118**	Tura Wendo	
14	Baba Foundation	CBO		**119**	Thika Road SACCO	
15	Appropriate Rural Agriculture	NGO		**120**	Mtwapa Jua Kali	
16	KEHASO			**121**	Mwambao Community	Fishing
17	Busia Boda Boda	CBO		**122**	Jiheshimu SHG	
18	Busia Boda Boda	CBO		**123**	Mombasa JKA	
19	PUAN Sacco	Micro finance		**124**	Majengo Boda Boda	
20	Heart in Love			**125**	Gikomba SHG	
21	Jool Box SHG			**126**	Naivasha-Nakuru Stage	
22	Tracadero Mkokoteni	Transport		**127**	Soko Huru	Transport
23	Upende SHG			**128**	MASKA	
24	Mkokoteni	Transport		**129**	Ingo Bicycle Transport	
25	Kinda SHG			**130**	Ingo Bicycle Transport	
26	Upende SHG			**131**	Shivere HBC	
27	UAL KONDENI SHG	Artisans Jua kali		**132**	Pioneer Players Group	

28	Jua kali Highway SHG	Artisans Jua kali		**133**	Centre Stage	
29	Logistical & Developmental Agency	NGO		**134**	South Lake	Transport
30	Nyamamatia Jua kali	Artisans Jua kali		**135**	Funyula Financial Services Association	
31	Nyalenda Ngware Transport	Transport		**136**	KITC	Training Organisation
32	Muhoroni JKA			**137**	Wateule Malindi	Artisans Jua kali
33	Kisumu JKA	Artisans Jua kali		**138**	Muungano Handicraft	
34	Kondele Hawkers	Hawkers		**139**	Muungano Handicraft	
35	Ndhiwa JKA	Artisans Jua kali		**140**	Tabasamu	
36	Rongo Women Association	Trading		**141**	Wateule Malindi	
37	Kondele Coffin makers	Carpentry		**142**	Muungano Handicraft	
38	Gombe Engineering	Smith/Metal works		**143**	Malindi Tourist	
39	Osrepe Group	Smith/Metal works		**144**	Makadara Grounds Car Wash	CBO
40	Gorofani Self Help Group			**145**	Poultry Farming Association	Vegetable Wholesalers
41	Wananchi Hawkers			**146**	Nuru ya Jamii	
42	Jamhuri Welfare			**147**	Ring Road JKA	Transport
43	Tinawira Organisation			**148**	Aberdares	Transport
44	Thika Town Services			**149**	Aberdares	Transport
45	Diana Aino Vendors			**150**	Nuclear	Transport
46	Afya Bora Support Group	Support Group		**151**	Don Bosco Life Choice Program	
47	Mariakani Jua Kali			**152**	Mlolongo Youth Promising Investment	Artisans Jua kali
48	Kilifi Central	Fishing		**153**	Busia Soko Posta Association	
49	Winners SHG			**154**	Chemoha Uzira	CBO
50	Kaloleni Jua kali			**155**	YMCA	CBO
51	Shanzu Boda Boda Association			**156**	Busia Jua kali	CBO
52	Jool Box SHG			**157**	Stage Mkokoteni	Transport
53	Kubura			**158**	Kinda SHG	
54	For NT	Transport		**159**	Trocadero SHG	
55	Boda Boda	Self Help Group		**160**	Gikomba SHG	
56	Nakuru Youth			**161**	Trocadero SHG	Artisans Jua kali

57	Kakamega Bicycle Transport			**162**	Dunga Ngware Transport	Transport
58	Kakamega Jua kali Association			**163**	Kisii JKA	
59	Kakamega Bicycle Transport			**164**	Upende SHG	Artisans Jua kali
60	Tuungane Support Group			**165**	Nairobi Rail	
61	Tushirikiane Plot Kericho			**166**	2NK SACCO	
62	Jua kali Muungano			**167**	Chonyi Jua kali	
63	Karote	Transport		**168**	Kilifi Creek	Fishing
64	Ecobank			**169**	Voi JKA	
65	RIAT	Training Organisation		**170**	Saga Boda Boda	
66	Wachuuzi Tuungane	Artisans Jua kali		**171**	NSS	Transport
67	MEDA Women Tailoring	Textile		**172**	Moving Hawkers	
68	Malindi Youth Hawkers			**173**	Jipagie Magnet Group	
69	Muyeye			**174**	Mwelekeo	
70	Akamba Handicraft			**175**	Kinangop	Transport
71	Mwembe kuku			**176**	Akamba Handicraft	
72	Wachuuzi Tuungane			**177**	Bidii	
73	Malindi Youth Hawkers			**178**	Malindi Youth Hawkers	
74	Muungano Handicraft	Sculptures		**179**	Malindi Tourist	
75	Jua kali Association			**180**	Kenya Livestock Producers	Vegetable Whole-salers
76	Taveta Group	Vegetable whole salers		**181**	Kayole JKA	Manufacturing
77	South Coast Boat			**182**	Western HIV&AIDS Network	
78	Splendid Hotel Car Wash	CBO		**183**	NNOS	Transport
79	Asante Tours	Tours		**184**	Pamoja Youth Group	
80	Kenya Federation SHG	Training Organisation		**185**	APAB	CBO
81	Patriotic Rescue Team			**186**	Township HBC SHG	CBO
82	Kenyatta Moving Hawkers			**187**	Jua kali Highway SHG	
83	Matatu Welfare Association	Kenya National Hawkers Association		**188**	Onage SHG	
84	September	CBO		**189**	Jua kali Highway SHG	

85	September	Transport		**190**	UGBT SHG	Artisans Jua kali
86	Ziwani JKA	Transport		**191**	Chiga Ngware Transport	Transport
87	Indangalasia HIV&AIDS Community			**192**	Migori JKA	
88	South Lake Travellers	Transport		**193**	Muhoroni JKA	Artisans Jua kali
89	Karote	Transport		**194**	Moses	
90	TKK	Transport		**195**	Nuclear Investment	
91	Karakata Travellers	Transport		**196**	Kaloleni Jua kali	
92	New Life Support Group	Support Group		**197**	Mangrove	Fishing
93	Mlolongo Hope and Vision			**198**	Kikambala Boda Boda	
94	Boresha Maisha	Artisans Jua kali		**199**	Boda Boda	
95	Njiru Sport Youth Group	Self Help Group		**200**	Nakuru-Nyahururu bondo	Transport
96	Busia Jua kali			**201**	KSM Ndogo Youth Association	
97	Busia Fish Mongers			**202**	Pambazuko	
98	Budalangi Theatre	CBO		**203**	Akamba Handicraft	
99	Rural Enterprise Program	NGO		**204**	Kariokor JKA	Manufacturing
100	ADEO	CBO		**205**	Gilgil Travellers	Transport
101	Busia Council of Elders	CBO		**206**	Budalangi Welfare SHG	CBO
102	Busia Fish Mongers	CBO		**207**	Compassionate Women SHG	.
103	Transformer SHG			**208**	Transformer SHG	
104	West Mkokoteni	Transport		**209**	Otonglo JKA	Artisans jua kali
105	Khwambane SHG			**210**	Shimanzi Jua kali	
				211	Kilifi Boda Boda	

ANNEX 11: LIST OF ORGANIZATIONS IDENTIFIED BY INDIVIDUAL RESPONDENTS

	Name of organization	Type		Name of organization	Type
1	Kakamega transporters	.	311	Women group	.
2	Jitegemee group	Support self help group	312	Faulu malindi association	.
3	KREP	.	313	Wachuuzi tuungane	.
4	Busia fish mongers	.	314	Mololine	Transport sector
5	Busia fish mongers	.	315	Mololine	.
6	Kisulisuli SHG	Support self help group	316	GNT	Transport sector
7	Njoro noda noda	Boda Boda Ass.	317	NAGIL	Transport sector
8	Nakuru SHG	Support self help group	318	Mololine	Transport sector
9	Jua kali	.	319	AK Stage	.
10	Kazi mbele youth group	.	320	Equity	.
11	UGBT	Transport sector	321	KUDA boda boda	.
12	Kidiwa group	.	322	Highway SHG	Jua Kali
13	Bins landlord	Waste collectors	323	Berngetuny mot cycle	.
14	Mlolongo	Support self help group	324	Busia joint religious group	.
15	New life support group	Support self help group	325	Tourist MRK Ass	.
16	New life support group	Support self help group	326	Yallo SHG	Jua Kali
17	Majengo boda boda ass	.	327	Highway SHG	.
18	Saga boda boda	.	328	Upendo SHG	.
19	Shanzu boda boda ass	.	329	Ukombozi engineers	Artisan
20	Pau centre	Empowering the community	330	Kadenge Engineers	Artisan
21	Sunsiro group	.	331	Stage mkokoteni	Transport sector
22	UGBT SHG	.	332	Nuclear stage	Transport sector
23	Khwambane SHG	.	333	Kubwa	.
24	Red Cross	.	334	Kenya HIV support group	.
25	Kemaka Youth Group	Support self help group	335	Chemsha uzima	.
26	Manyani environmental group	Environmental issues	336	Baba foundation	CBO
27	Matatu Welfare Ass.	.	337	Budalangi	CBO
28	Kenya Woemn	.	338	Budalangi	.

29	Youth groups	.	339	KEHASO HIV support group	.
30	Kisuli SHG	.	340	Bidii	.
31	Patriotic group	.	341	Highway SHG	.
32	Youth groups	.	342	Onaji SHG	.
33	Women group	.	343	Highway SHG	Jua Kali
34	Youth groups	.	344	Miyako motor bike	Transport sector
35	Busia joint religious group	.	345	Miyako motor bike	.
36	Busia fish mongers	.	346	Busia taxi drivers	.
37	Muungana akamba handcraft	.	347	Nuclear	Transport sector
38	Kumbu traders	.	348	Mololine	Transport sector
39	Red Cross	.	349	NUS	Transport sector
40	Muyeye facric	.	350	Nyambuni	Transport sector
41	Kakamega transporters	.	351	Muguani	Transport sector
42	Malindi/Taveta traders	.	352	Nuclear	.
43	Fruit/vegetable group	.	353	Naivasha national footwear	Small scale shop
44	Kiamuma association	.	354	Watch repair	.
45	Muungana akamba handcraft	.	355	Naivas Kubwa	Transport sector
46	Muungana akamba handcraft	.	356	Silver diplomal	.
47	Mabatini hawkers	Hawking	357	Assembly	.
48	Nuclear	Transport sector	358	Kanu stage	.
49	Kasese	.	359	Mololine	Transport sector
50	Mololine	Transport sector	360	Nuclear stage	.
51	GNT	Transport sector	361	Nakuru	Transport sector
52	Nuclear	Transport sector	362	South lake travellers	.
53	Total stage	.	363	Kondele riders	Transport sector
54	Sweet Banana	.	364	magandi fish mongers	Hand crafts
55	Tumainin duty wiomen group	.	365	Kondele fish mongers	Fish trading
56	Kiunda SHG	Jua Kali	366	Uhanya	.
57	KUDA boda boda	.	367	One in need	CBO
58	Kibuye fish mongers	Fish trading	368	Visions theatre	.

59	Kibuye engineers	Hard ware	369	Muungana akamba handcraft	.
60	Bulso Fev	.	370	Sondu Jua Kali	Artisan
61	Kijambi	Transport sector	371	Rongo jua kali	Artisan
62	Kakamega transporters	.	372	Nyambuni	Transport sector
63	Muungano	.	373	Busia joint religious group	.
64	Christian SHG	Jua Kali	374	Kubwa	.
65	Kiunda SHG	.	375	Upendo SHG	Jua Kali
66	Khwambane SHG	.	376	Bagdad SHG	Jua Kali
67	Rock engine	Artisan	377	Onaji SHG	.
68	Ukombozi engineers	Artisan	378	Khwambane SHG	.
69	Kondele riders	Boda Boda Ass.	379	Malindi Hawkers Ass	.
70	Traccodero SHG	Transport sector	380	Upendo SHG	.
71	Silver diplomal	Transport sector	381	Onaji SHG	Jua Kali
72	Silver diplomal	.	382	Kiunda SHG	.
73	Chania motor bike	.	383	Onaji SHG	.
74	Makadara group	.	384	Jikaze SHG	.
75	RIAT	Training	385	UBBT	Transport sector
76	Mama, oprhan childrens home	.	386	Jua kali	.
77	194. Kenya chamber of commerce Busia chapter	CBO	387	caltex	.
78	194. Kenya chamber of commerce Busia chapter	.	388	Sweet Banana	.
79	YMCA Busia	.	389	Kondele JKA	Carpenters
80	APAB	.	390	Diani beach boy association	.
81	Chemsha uzima	CBO	391	Asante tour	Tours
82	APAB	CBO	392	Sije Ngware Riders	Boda Boda Ass.
83	KAP	AIDS Care	393	Onaji SHG	.
84	Kenya rural orphans Ass	.	394	Kibuye jua kali	Carpenters
85	Township HBC	.	395	New life support group	Support self help group
86	Malindi tourists market	Co-op	396	Shanzu boda boda ass	Boda Boda Ass.
87	Faulu malindi association	.	397	Traccodero SHG	.
88	Transformer SHG	.	398	Total stage	.
89	Upendo SHG	.	399	AK Stage	.
90	Transformer SHG	Jua Kali	400	Funyula FSA	.
91	Afar SHG	Transport sector	401	Makadara grounds carwash	CBO

92	Afar SHG	.	402	New life support group	NGO
93	Kiunda SHG	.	403	Liverpool VCT	VCT
94	Kasese	Transport sector	404	Majengo boda boda ass	.
95	GNT	Transport sector	405	Saga boda boda	.
96	Kasese	Transport sector	406	Majengo boda boda ass	.
97	Karate	Transport sector	407	Jacky's salon	.
98	Kinangop	Transport sector	408	Pendo salon	.
99	Young youth group empowernment	.	409	Ukunda jua kali	.
100	Salima sacco	.	410	Mazeras jua kali	.
101	Paula	Small scale shop	411	Void Jua Kali Ass	.
102	Nairobi shoe makers	.	412	Soko huru	Transport sector
103	Silver diplomal	Transport sector	413	GNT	Transport sector
104	Mathanji stage	.	414	Niva Lake	Transport sector
105	Bright	.	415	Muungano	.
106	Ndogo branchu	.	416	Tivoli hawkers	Hawking
107	Kasese	Transport sector	417	Old posta youth group	.
108	Muungana akamba handcraft	.	418	Jubilee dry fish	Fish trading
109	Light	.	419	Muungano	.
110	Naivas Kubwa	.	420	Muungano	.
111	Kasese	Transport sector	421	Muungano	.
112	Kasese	.	422	Muungana akamba handcraft	.
113	Kiboye jua kali	Carpenters	423	Muungano	.
114	Manyata Boda	Transport sector	424	Kondele JKA	Artisan
115	Nyalenda fish mongers	Hand crafts	425	Tuokadew SHG	.
116	Obunga fish mongers	Fish trading	426	Busia taxi drivers	.
117	Dunga beaches	Trading	427	Busia fish mongers	.
118	Jitegemee group	CBO	428	128. Busia masonary	.
119	Narok Jua Kali	Support self help group	429	Busia Boda boda	.
120	Wachuuzi	.	430	Utulivu sacco	.
121	Muungano	.	431	Onaji SHG	Jua Kali
122	Uhanya	.	432	Nuclear	Transport sector
123	Boda Boda cycle ass	Transport sector	433	Nuclear	Transport sector
124	Kisumu Jua Kali	Transport sector	434	Corner taxi operators	.
125	Awasi Jua Kali	Artisan	435	Muungano	.
126	Mbita jua kali	Artisan	436	Tourist MRK Ass	.

127	Karate	Transport sector	437	Muungano	.
128	Shauri Moya Youth Group	.	438	Muungano	.
129	YMCA Busia	.	439	Tourist MRK Ass	.
130	Bunyala Association	.	440	Tourist MRK Ass	.
131	Mathanji stage	.	441	Tourist MRK Ass	.
132	Pioneer estate women group	Jua Kali	442	EBBT	Transport sector
133	ECO Bank	.	443	Mololine	Transport sector
134	Sarusiro Base	.	444	Corner taxi operators	.
135	Tool Box SHG	Jua Kali	445	Likoni shell beach	.
136	Kiunda SHG	.	446	Mombasa jua kali	.
137	Transformer SHG	.	447	Kinango Jua Kali	.
138	Kigomba SHG	.	448	Kinango Jua Kali	Jua Kali
139	Malindi Education	.	449	Mariakani Jua Kali	.
140	Kigomba SHG	.	450	Mombasa jua kali	.
141	Upendo SHG	.	451	YMCA Busia	CBO
142	Central Kasipul SHG	Jua Kali	452	Ahero Jua Kali	Jua Kali
143	Transformer SHG	.	453	Trade settlers	.
144	Kiunda SHG	.	454	Nyamasaria JKA	Artisan
145	Biashara SHG	.	455	Kibos hard ware	Hard ware
146	EYBT	Transport sector	456	CET	.
147	Muungano	.	457	One in need	CBO
148	Munyoye Co-op	Co-op	458	Void Jua Kali Ass	.
149	Tourists makers	.	459	Void Jua Kali Ass	.
150	Silver diplomal	.	460	Kwale jua kali	.
151	New life support group	Support self help group	461	Uhuru market	Jua Kali
152	New life support group	Support self help group	462	Kikomba market	Jua Kali
153	New life support group	Support self help group	463	Kariobangi market	Jua Kali
154	Total stage	.	464	Othero Market	.
155	Kondele SHG	Carpenters	465	Busia second hand clothes	.
156	.	Trading	466	RBBT	Transport sector
157	Diani tour guides	.	467	Majengo boda boda ass	.
158	Bamburi Beaches	Tours	468	Kikambala boda boda	.
159	Kondele Boda Boda	Boda Boda Ass.	469	Mwangaza group	.
160	Kibuye boda boda	Boda Boda Ass.	470	Kiunda SHG	.
161	Ujamaa SHG	Co-op	471	UNICEF	.
162	Komollo engineering	Black smith	472	GNT	Transport

					sector
163	Kondele JKA	Boda Boda Ass.	473	GNT	.
164	Kisulisuli SHG	.	474	Nuclear	Transport sector
165	Jua kali young tcks	.	475	Soko huru	Transport sector
166	Upendo SHG	Trading	476	Narok liti line	Transport sector
167	Mamboleo	Carpenters	477	Sweet Banana	.
168	New life support group	Support self help group	478	Stage Mau	.
169	New life support group	Support self help group	479	Jua kali young tcks	Jua Kali
170	Tapwak	CBO	480	Upendo SHG	Jua Kali
171	Kikambala boda boda	Boda Boda Ass.	481	Jua kali	.
172	Mulolongo youth promising invesment	Co-op	482	Kiunda SHG	.
173	Boda Boda group	.	483	Malanga engineers	Artisan
174	Agri Financing Corporation	.	484	West Mkokoteni	Transport sector
175	Silver diplomal	Transport sector	485	Walk in stage	Transport sector
176	Silver diplomal	.	486	Ndogo branchu	.
177	Kondele JKA	.	487	Township HBC	.
178	Bumala FSA	.	488	Baba foundation	.
179	Splendid Hotel Car Wash	CBO	489	ADEO	.
180	Mama, oprhan childrens home	CBO	490	Muungano	.
181	Void Jua Kali Ass	.	491	Bandaptai SHG	.
182	Bins landlord	.	492	Highway SHG	.
183	Mlolongo	Support self help group	493	Berngetuny mot cycle	Transport sector
184	Pau centre	VCT	494	KUDA boda boda	.
185	Boresha maisha	.	495	Highway SHG	.
186	Katini youth group	.	496	Mololine	Transport sector
187	Shanzu boda boda ass	.	497	Nuclear	Transport sector
188	Shanzu boda boda ass	.	498	South lake travellers	Transport sector
189	Kikambala boda boda	.	499	Engineer	Transport sector
190	Pendo salon	.	500	GNT	.
191	Jacky's salon	.	501	Nairobi rubber shoe makers	.

192	Void Jua Kali Ass	.	502	Walk in stage	Transport sector
193	Kaloleni jua kali	.	503	Kubwa	.
194	Kaloleni jua kali	.	504	Boma	.
195	Kaloleni jua kali	.	505	Kasese	.
196	Kisulisuli SHG	Support self help group	506	Nuclear	Transport sector
197	Kakamega transporters	.	507	Silver diplomal	.
198	Pirate beaches	.	508	Oserian	Transport sector
199	Malindi tourists market	.	509	Narok liti line	.
200	Jukababa engineers	Artisan	510	Muhoroni Jua Kali	Artisan
201	South lake travellers	Transport sector	511	Kendu Bay Jua Kali	Artisan
202	NUS	Transport sector	512	Ndonyu Njeru	Transport sector
203	Valley cabs	Transport sector	513	Silver diplomal	.
204	Muungana akamba handcraft	.	514	Kiunda SHG	Jua Kali
205	Angawa hawkers	Hawking	515	Highway SHG	.
206	Onane	.	516	Upendo SHG	.
207	Kibuye fish mongers	Fish trading	517	Upendo SHG	Jua Kali
208	Muungana akamba handcraft	.	518	Highway SHG	.
209	Muungana akamba handcraft	.	519	Eldo V. SHG	.
210	Muungana akamba handcraft	.	520	ETBS	Transport sector
211	Muungana akamba handcraft	.	521	Guest in	.
212	Muungano	.	522	Arina Ngware Riders	Boda Boda Ass.
213	Munyoye Co-op	Hand crafts	523	Transformer SHG	.
214	Kibuye jua kali	Artisan	524	Kisumu Jua Kali	Carpenters
215	Khwambane SHG	.	525	Jitegemee group	Support self help group
216	Busia fish mongers	.	526	Majengo boda boda ass	Boda Boda Ass.
217	Busia fish mongers	.	527	Ecsbang	.
218	Busia jua kali	.	528	Saga boda boda	.
219	Busia welders	.	529	Kikambala boda boda	.
220	Busia Boda boda	.	530	Kwale jua kali	.
221	Busia jua kali	.	531	Void Jua Kali Ass	.
222	Busia welders	.	532	Kilifi jua kali	.
223	Busia Boda boda	.	533	GNT	Transport sector

224	Busia welders	.	534	South lake travellers	Transport sector
225	Busia fish mongers	.	535	Mabatini hawkers	Hawking
226	Busia Boda boda	.	536	KingKing youth group	.
227	Pamoja biashara	.	537	Pack traders	Fish trading
228	Highway SHG	Jua Kali	538	Jua kali	.
229	Kadet group	Support self help group	539	Compassionate self help group	.
230	Kasese	Transport sector	540	Busia fish mongers	.
231	GNT	Transport sector	541	Kiunda SHG	Jua Kali
232	Boat and camel	.	542	GNT	Transport sector
233	Coop bank taxi	.	543	South lake travellers	Transport sector
234	Coast general	.	544	Beach operators	.
235	Tourist MRK Ass	.	545	Jua kali	.
236	Shangilia curio - Ukunda	.	546	ETBS	Transport sector
237	Shangilia curio - Ukunda	.	547	NUS	Transport sector
238	Muungano	.	548	Void Jua Kali Ass	.
239	Muungano	.	549	Mombasa jua kali	.
240	Tourist MRK Ass	.	550	Mombasa jua kali	Jua Kali
241	Bombolulu	.	551	Void Jua Kali Ass	.
242	Muungano	.	552	Budalangi	CBO
243	Muungano	.	553	Siaya Jua kali	Jua Kali
244	Muungano	.	554	Heart of love	CBO
245	Muungana akamba handcraft	.	555	Mombasa jua kali	.
246	Mweleleo	.	556	Kilifi jua kali	.
247	Kakamega transporters	.	557	Kariobangi market	Jua Kali
248	Kakamega transporters	.	558	ODM	Transport sector
249	RUBT	Transport sector	559	Highway SHG	.
250	Narok liti line	Transport sector	560	Kasese	Transport sector
251	Nuclear	Transport sector	561	NAGIL	Transport sector
252	Coop bank taxi	.	562	Shuttle group	Transport sector
253	Beat operations	.	563	GNT	Transport sector
254	Ukunda jua kali	.	564	Kasese	.
255	Shangilia curio - Ukunda	.	565	Eldoret main market	.
256	Lunganya Wome Group	.	566	Khwambane SHG	Jua Kali

257	Markman Matatu Ass		.	567	Transformer SHG	.
258	Mariakani Jua Kali		.	568	Othaya night operations	Transport sector
259	Kilifi BMU		.	569	Walk in stage	.
260	Kilifi BMU		.	570	Budalangi	.
261	Kilifi BMU		.	571	YMCA Busia	.
262	Kaloleni jua kali	Jua Kali		572	Khwambane SHG	.
263	Void Jua Kali Ass		.	573	Highway SHG	.
264	Markman Matatu Ass		.	574	Onaji SHG	.
265	Ramza Bus Ass		.	575	2NK	Transport sector
266	Kaloleni jua kali		.	576	Narok liti line	Transport sector
267	Bunyala Ass	CBO		577	Nakuru	Transport sector
268	Kondele JKA	Jua Kali		578	Mololine	.
269	Kingsway HRCS		.	579	Muguani	.
270	Kibuye jua kali	Artisan		580	Boat and camel	.
271	Mini glass	Hard ware		581	Carnnole stage	.
272	Pamoja ni nguvu		.	582	Kinangop	Transport sector
273	ALFA I		.	583	Kirungi	Transport sector
274	Jitegemee group	CBO		584	Khwambane SHG	.
275	Friends meeting		.	585	Ugenya SHG	Jua Kali
276	HAPEP	Youth group		586	Tool Box SHG	.
277	ESIRIT Sacco	Support self help group		587	RUBT	Transport sector
278	ESIRIT Sacco	Co-op		588	Othaya night operations	.
279	Corner taxi operators		.	589	Community VCT centre	VCT
280	Markman Matatu Ass		.	590	Saga boda boda	Boda Boda Ass.
281	Kilifi BMU		.	591	Mazeras jua kali	.
282	Kilifi BMU		.	592	Kwale jua kali	.
283	Mariakani Jua Kali		.	593	Mombasa jua kali	.
284	Kaloleni jua kali		.	594	2NK	Transport sector
285	Kaloleni jua kali		.	595	Kadet group	Transport sector
286	Safari sailers		.	596	Alfa	Hawking
287	Beat operations		.	597	Central youth group	.
288	Safari sailers		.	598	Mkokoteni group	.
289	Corner taxi operators		.	599	Mololine	Transport sector

290	Kamkunji JKA	Jua Kali	600	Kasese	Transport sector
291	Kanakoo market	Jua Kali	601	Kasese	Transport sector
292	Kanakoo market	Jua Kali	602	Chumsha uzima	CBO
293	Kikomba market	Jua Kali	603	Ukunda jua kali	.
294	Uhuru market	Jua Kali	604	Onaji SHG	.
295	Kanakoo market	Jua Kali	605	128. Busia masonary	Transport sector
296	Kawangware amrket	.	606	Soko huru	Transport sector
297	HBC township self help	.	607	Tovi box SHG	.
298	Busia coblers	.	608	Onaji SHG	.
299	UBBT	Transport sector	609	Nuclear stage	.
300	EBBT	.	610	Salima sacco	Transport sector
301	Kikambala boda boda	.	611	Boat and camel	.
302	Shanzu boda boda ass	.	612	Kubwa	.
303	Majengo boda boda ass	.	613	Hunters stage	.
304	Wamangapa group	.	614	Kayole	Transport sector
305	Mkokoteni SHG	.	615	Gikomba SHG	Hawking
306	Holo women grioup	.	616	Khwambane SHG	.
307	AMREF	.	617	Athi River Health Centre	Health centre
308	KREP	.	618	Void Jua Kali Ass	.
309	Kenyatta Hawkers	.	619	Mpeketoni jua kali	.
310	Youth groups	.	620	Njabini	Transport sector
			621	Muungano women group	.

Appreciation

KENYA PRIVATE SECTOR ADVISORY NETWORK (KPSAN)
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