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STIGMA AND DISCRIMINATION AS IMPEDIMENTS TO THE IMPLEMENTATION OF TEACHERS SERVICE COMMISSION HIV AND AIDS SUB–SECTOR POLICY AMONG PUBLIC SECONDARY SCHOOL TEACHERS IN NAIROBI COUNTY, KENYA

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Abstract: *The objective of the study was to analyze how stigma and discrimination manifest as barriers to effective implementation of the Teachers Service Commission (TSC) HIV and AIDS sub–sector policy among public secondary school teachers in Nairobi County, Kenya. A mixed method approach was used to collect data from public secondary teachers, Kenya Network for Positive Teachers (KENEPOTE) officials in Nairobi County and TSC officials involved in the implementation of the policy. A structured questionnaire and semi–structured interview guide were used to collect data from 202 respondents. Data was analyzed by use of descriptive statistics and formation of themes and categories. The results from the data showed that stigma and discrimination are at high levels among the secondary school teachers. As a result, HIV positive teachers have been pushed to silence. Implementation of the TSC HIV and AIDS policy has not impacted on the stigma and discrimination levels among public secondary teachers. The study recommends that 'AIDS talk' should encouraged among teachers by principals so as to demystify the disease hence reduce stigma and discrimination. Principals should be trained on how to handle HIV matters in schools through capacity building workshops organized by TSC.*

Key Words*: stigma, discrimination, Teachers Service Commission, HIV and AIDS sub–sector policy*

1.1 Background of the Study

The increase of HIV related knowledge and the significant change of attitude and public policies over the past thirty years since the disease was discovered, have not contributed to stigma reduction among individuals, communities and society at large (Cataldo, 2013). There is still an inherent stigma attached to HIV and AIDS that often affects individuals' ability to work in everyday environment. Stigma and discrimination have been associated with the fight against HIV and AIDS hence its relation with implementation of policies which aim at eradicating HIV among the populace. This study therefore presents the HIV related stigma and discrimination and how it has affected the implementation of the TSC HIV and AIDS sub–sector policy.

1.2 Empirical Review of Literature

HIV related discourse is in agreement that stigma remains a formidable barrier to HIV prevention and care (Ansari & Gaestel, 2010; Cheung, 2014; Chan, Alexander & Tsai, 2016; Jain, Sinha1, Kar, Yadav, 2017). It is therefore paramount in this study to understand the concept of stigma and its origin. Stigma is a Greek term which explained a mark that was cut or burned into a person's skin to identify them as criminal, slave or traitor (Cataldo, 2013). The mark would warn the public to take caution when interacting with such a person which led to obvious discrimination. Similarly, in the era of HIV and AIDS, HIV related stigma has been constructed and perpetuated in societies and communities to embrace acts of social prejudice and self–unworthy like gossip, moral judgement, rejection and in some cases violence has been meted on people living with HIV (PLWHIV) (Kalichman, 2014; Ojikutu, Pathak, Srithanaviboonchai, Limbada, Friedman, Li, et al. 2016; UNAIDS, 2017). The situation has caused more infections by those not yet infected by HIV intimately associating with HIV positive ones who have been silenced by acts of discrimination hence, have not been receiving medication to reduce their viral load (Jain, et al. 2017).

In an attempt to describe stigma discourse, Cheung (2014) stated that, "Stigma affects two kinds of people, the person who is being inflicted upon by stigma and the person who is inflicting stigma. People shoot to hurt someone else out of fear, ignorance, blame, and judgement, but they are still impacted by what they're shooting at." Subscribing to similar views, Onyebuch–Iwudibia and Brown (2014) added that depression was positively linked to HIV–related stigma thus affecting the quality of life of those infected and affected by the disease. Stigma therefore has far reaching effects in societies that practice it.

There are three types of HIV related stigmas which permeate the society: enacted, perceived and anticipated stigmas. Enacted stigma comes from experiences of discrimination, either by oneself or seeing other people facing acts of mistreatment and discrimination by others (Reinius, 2018). Kalichman (2014) and Reinius (2018) explain perceived or felt community stigma as fear of such mistreatment which results to PLWHIV anticipate stigma in societies where they live. Enacted stigma leads to perceptions of community stigma which consequently makes PLWHIV anticipate stigma (Cataldo, 2013; Kalichman, 2014). In such a scenario, then the assumption that stigma starts with the society and not an individual, make sense. It is the three types of stigma which culminate to self–stigma (Katieno, Odundo & Ojwang, 2016) causing feelings of shame, guilt, depression, low self–esteem and desire to conceal one's HIV status (Churcher, 2013; Reif, Wilson & McAldaster, 2017; Caliari, Teles, Reis & Gir, 2017).

More literature has established that enacted, perceived and anticipated HIV related stigma, have

affected HIV infected people in the society negatively leading to lack of disclosure, poor ARVs and follow–up clinic adherence and loneliness (Chi, Li, Zhao & Zhao 201; Ojikutu, Pathak, Srithanaviboonchai, Limbada, Friedman, Li, et al. 2016; Katieno, Odundo & Ojwang 2016; Kay, Rice, Kaylee, Crockett, Ghislaine, Atkins, et al. 2018). Chi, Li, Zhao and Zhao (2013) concluded that increased perceived or enacted stigma led to increase of depression symptoms among children affected by HIV and AIDS in China. In their study on association between perceived stigma and HIV disclosure, Li, Chenc and Yuc (2016) found out that perceived stigma was negatively associated with attitudes, intention and behavior of HIV disclosure. It means that where there is high levels of perceived HIV related stigma, there is low levels of disclosure. Non–disclosure can fuel HIV new infection by not only contributing to late initiation of ARVs resulting to detectable load but also lack of neonatal prophylaxi (Jasseron, 2013).

The three types of stigma in this discussion may manifest in different measures and in different situations either one of them distinctly or all in a group of people causing various effects. A survey conducted by Jain, Sinha, Kar, & Yadav (2017) on one hundred healthy individuals in India using self–designed semi‐structured questionnaire showed that there was more perceived stigma as compared to enacted stigma. In this research, nearly 46% of the individuals felt that HIV‐infected persons should be blamed for their illness and 41% individuals felt that they would have felt ashamed if they had HIV. Earlier, Olley, Ogunde, Oso and Ishola (2016) in their study on HIV related stigma and self–disclosure in Nigeria found out that anticipated discrimination may impact HIV related stigma to reduce self–disclosure among the population of study. On other hand, Turan, Budhwani, Fazeli, Browning, Raper, Mugavero et al. (2017) confirmed an association between perceived community stigma and interpersonal outcomes like lack of social support, and mistrust in physicians which were mediated by internalized stigma and anticipated stigma

Further interrogation of researched works revealed that anticipated stigma in general population in Sub–Saharan Africa was still high despite ART scale–up during 2000–2013 (Cataldo, 2013). Other studies still in Sub–Saharan Africa found perceived community HIV related stigma has persisted despite the ART scale–up since people have been resistant in changing their opinions towards PLWHIV (UNAIDS, 2008; Chan & Tsai, 2016). What had significantly reduced was the social distance towards people living with HIV and AIDS. These findings were similar to those of Reinius (2018) whose study held that there was increased perceived community stigma and reduced enacted stigma in era of efficient treatment in Sweden. The impact of the perceived stigma has been experienced the same as in the other parts of the world with reports of low ART and follow–up clinic adherence being the commonest.

In South Africa, despite the high levels of awareness, a survey research by Zuma et al. (2016) among school educators showed very low levels of disclosure, something attributed to self–stigma which is a direct product of enacted stigma (Cataldo, 2013). Previous research by UNAIDS (2008) had reported significant teacher HIV related stigma and discrimination in African countries which resulted in poor VCT uptake, an argument corroborated by Tsheko (2010) in the Botswana study on teacher management in a context of HIV and AIDS. Fundamentally therefore, teachers face the full brunt of stigma just as the general population despite their status.

Similarly, in Kenya, in spite of awareness of HIV and AIDS being comparatively high, people living with HIV encounter high levels of stigma which leads to the way people are treated

subsequently preventing them from seeking heath care services (UNAIDS, 2017). Previous research has emphasized the existence of the three types of stigmas (enacted, perceived and anticipated stigma) which manifest in HIV positive people in Kenya (Katieno, Odundo &Ojwang 2016). For instance, a study done in rural area in Kenya found out that anticipated stigma was common among pregnant women who perceived fear of HIV related stigma from their partners, lowering their positive attitude towards facility–based child birth (Medema–Wijnveen, Onono, Bukusi, Miller, Cohen & Turan, 2012).

Another study done by Ngugi (2014) took note of existence of stigma perceptions in Kenya. The study was on influence of stigma on treatment failure on HIV patients undergoing treatment at Mbagathi District Hospital. The sample was 155 HIV patients undergoing treatment which was selected using random number tables and 13 staff members of Mbagathi Hospital who dealt with HIV treatment. The research used a semi–structured questionnaire for the patients and interview guide for the staff. The finding concurred with most of the studied literature that people who hold stigmatizing attitudes were less likely to access VCT services and even declare their status, a discovery which was similar to that of Zuma et al. (2016). It also emerged that stigma in the society affected adherence to drugs hence making the fight against the disease an uphill task. However the study did not target teachers and was not based on assessing effectiveness of implementation of TSC sub–sector workplace policy on HIV and AIDS, a subject which was investigated by the current study so as to find out if how the implementation of the workplace policy is reducing stigma amongst teachers.

Discrimination has been described as a manifestation of stigma. In fact discrimination is a by–product of perceived stigma. And on the flipside, discrimination brings about enacted stigma which marks the onset of all other stigmas. Stigma and discrimination are seamless. And as literature revealed, it is due to stigma and discrimination that there is a great deal to the continuation of the AIDS pandemic by creating a culture of silence and denial that makes it difficult to take necessary measures to effectively fight its spread (Esau, 2010; Otieno, 2012; Tombi, 2012). Because of stigma, individuals, families and even whole communities are often discriminated against; others in ways that cause great suffering (Campbell, Nair, Maimane & Sibiya, 2005).

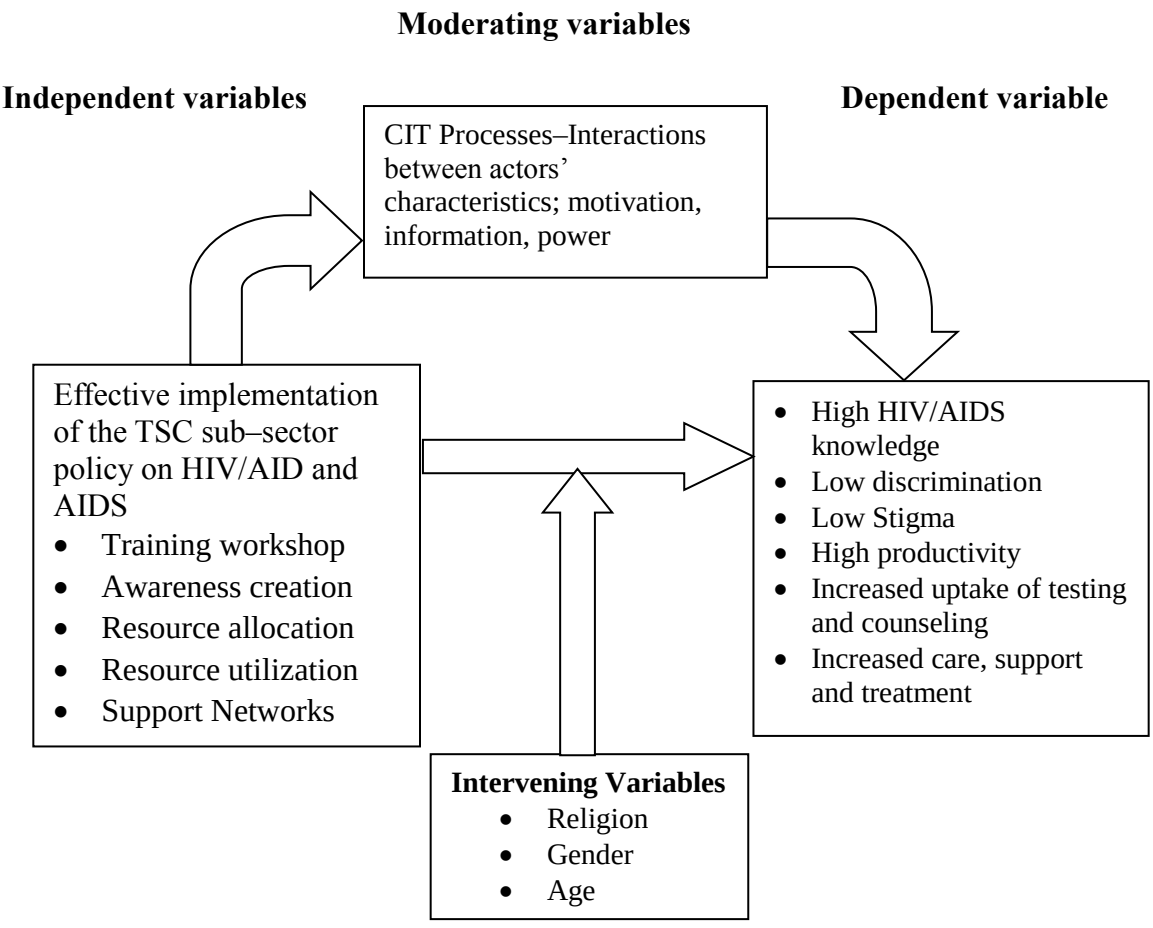
Although discrimination is a violation of the principle of natural justice, it happens often in HIV and AIDS related cases. The right not to be subjected to discrimination is enshrined in Article 2 of Universal Declaration of Human Rights and in many International Legal Texts (UNESCO, 2003). Yet societies practice discrimination with clear knowledge that it is wrong and illegal to do so. A survey UNAIDS (2017) confirms that generally, discriminatory attitudes persist globally with due disregard of the law on discrimination. If stigma and discrimination against PLWHIV can be eliminated, then the battle against the HIV will be successful and the world will be free from HIV.

This paper therefore seeks to bring to the fore the manner in which stigma and discrimination manifest among teachers as impediments to the implementation of TSC HIV and AIDS sub–sector policy among public secondary school teachers in Nairobi County, Kenya. This will allow corrective measures to be undertaken leading to effective implementation of the policy and healthy teachers who can deliver education service effectively. The conceptual framework in this study shows relationship of variables of policy implementation and the activities which take place as

interaction between actors occur. Effective implementation of the TSC sub–sector policy on HIV and AIDS is the independent variable which can directly influence teachers' HIV and AIDS knowledge, level of HIV related stigma and discrimination, rate of uptake testing and counseling, level of care, support and treatment and productivity of the teacher. The implementation of the TSC sub–sector policy on HIV and AIDS has several interacting factors. The factors motivation, information and power/collaboration are inherent in any policy implementation (Spratt, 2009). These are the factors discussed in the Contextual Interaction Theory which is the guiding concept of this research.

The researcher was to find out how effective HIV related stigma and discrimination are being achieved through interactions of motivation, information and power. Key activities in the implementation process are allocation and utilization of resources, awareness creation and training workshops of TSC officials and heads of public secondary schools involved in the implementation process. If the policy is implemented effectively, new infections of the disease can be halted, the effects mitigated, hence ensuring a high productive teaching workforce with high level of HIV and AIDS knowledge, low HIV stigma level, low HIV discrimination level, and high uptake of voluntary testing and counseling and increased care, support and treatment. However the research anticipates intervening variables religion, gender and age which may also have some influence in the outcomes of the policy implementation. Figure 1 gives a diagram on how the theory has been conceptualized.

1.3 Conceptual framework



***Source**: Researcher, 2019*

1.4 Research Methodology

The study used mixed research paradigm, a combination of both qualitative and quantitative approaches. Specifically, convergent parallel research design was adopted. The study population was all TSC wellness unit officials at the headquarter involved in the implementation of the TSC sub–sector HIV and AIDS policy, all principals, teachers in public secondary schools and Kenya Network for Positive Teachers (KENEPOTE), a social support group for HIV positive officials in Nairobi County. These TSC officials have the mandate to ensure that TSC sub–sector policy on HIV and AIDS is effectively implemented. The officials therefore were in a position to provide relevant data on how implementation of the policy is going on citing achievements and any impediments encountered.

The county has 79 public secondary schools hence 79 heads of these schools. The researcher chose public secondary schools so as to bring to light what is happening in secondary schools as far as the implementation of the TSC sub–sector HIV and AIDS policy. Public secondary school teachers are about 1,720 in Nairobi County. The male teachers are 523 and female 1,197. The KENEPOTE officials in Nairobi County were sampled. The County has 8 KENEPOTE officials. KENEPOTE has been working closely with TSC to actualize the sub–sector policy on HIV and AIDS. The data was useful in corroborating that of the TSC Wellness Unit and of the public secondary school teachers.

The study used both non–probability and probability sampling designs. The researcher used multistage sampling to reduce the vast area of study to manageable size of four sub–counties out of nine. These are: Dagoretti, Kamukunji, Embakasi and Westlands. Purposive sampling was used to select five HIV positive teachers, 3 KENEPOTE officials and, 3 TSC wellness officials. Stratified random sampling was used to select eighteen public secondary schools. All the 18 principals from the selected schools were included in the study. 205 (male–61, female–144) were selected using proportionate stratified random sampling. The researcher used a semi–structured interview guide and a structured questionnaire to collect both qualitative and quantitative data simultaneously. A pilot study was done prior to data collection in three schools in Nairobi County, one from each administrative block. A total of 20 participants were selected by proportionate stratified random sampling.

The two types of data (qualitative and quantitative) were analyzed at the same time. Qualitative data analysis follows a general inductive approach where data was allowed to speak for themselves by emergence of conceptual categories and descriptive themes (Merriam, 2009). Data from the questionnaires were coded manually and computed using Statistical Package for Social Sciences (SPSS) computer program for descriptive and inferential statistics.

1.5 Research Findings

Response Rate

The study had sampled 18 schools in Nairobi County to provide respondents for both qualitative and quantitative data. In these schools, the teachers filled a questionnaire and the principals were interviewed. Out of the two hundred and five questionnaires distributed to teachers, 178 were

returned which is 86.8% response rate.

Principals interviewed were 14 which represents a 77.8% response rate. Four principals refused to participate in interviews on issues concerning HIV and AIDS citing lack of time for such interviews. Interviews with HIV infected teachers were done to five teachers as proposed earlier in the sampling. Two staff from the TSC Wellness Unit provided data for the study and three KENEPOTE office bearers were interviewed.

Results And Discussions On Hiv–Related Stigma And Discrimination

Verbatim data from the field confirmed that HIV–related stigma and discrimination has negatively affected implementation course, results which are similar to those revealed by Spratt, (2009), Tsheko, (2010), UNAIDS, (2016). Separately, the TSC staff were in agreement that absence of disclosure and non–adherence to HIV drugs inhibited realization of policy goals. One of them commented

> *I have seen members (meaning teachers) die due to drug resistance syndrome and other related effects that come with HIV. We have seen people die and the number has been worth to mention because HIV positive teachers who were doing well, going to class and delivering just like everyone else, fall sick and within a short while die owing to stigma and discrimination. This is because they go back to their cocoon which sends them to non–drug adherence and depression. Periodically there is a survey on how we are doing on stigma – is it going down or is it going up, the indicator tells that it is going up.* (Interview, TSC 2, November 17th, 2016).

The interviewee implicated the high levels of stigma and discrimination as causing self–stigma (similarly as data in the questionnaire demonstrated) which reverts the HIV positive teachers to silence, non–adherence to drugs and depression and consequently death takes its cause. This report confirms earlier studies which established the presence of non–disclosure due stigma which results to self–stigma with those affected those going quiet about their status being prone to depression (Gabriel, 2011; Zuma et al., 2016). The same sentiments are expressed by the KENEPOTE officials who agreed that teachers may want to disclose their status but fear of discrimination and stigma has silenced them, findings which are similar with those of Kamau, (2013), Spratt, (2009), Reinus (2018) and USAID, (2009). The findings of Otieno's study (2013) likewise as earlier documented in this dissertation, expressed that lack of adherence to HIV drugs was caused by stigma and discrimination. Thus stigma and discrimination jeopardizes the process of policy implementation by making HIV positive teachers go back to their previous state of silence and non–adherence to drugs and probably continue to transmit the disease to unsuspecting health teachers.

The schools have been unable to fight stigma and discrimination effectively as data exposed and teachers have been left in a dilemma. Reports of stigma and discrimination by principals and teachers were heard from the interviewed key informants and the KENEPOTE officials. One of the officials recounted,

> *I have experienced stigma and discrimination from my boss. When I discussed my status with a principal in my former station, things were rough on me. There is a time I arrived in school late because I woke up not feeling well. The principal wrote me a letter of which, when the other teachers learned about it, they were shocked why he had to do it and yet I was not a perpetual absentee. I felt my status betrayed me and I remember after that I went into depression and missed school for two*

weeks with a letter from the doctor (KENEPOTE 3, February 15, 2017).

The teacher's predicament is a representation of the Siyam'kela (2003) report which explained that the management in organizations practiced stigma and discrimination which eroded employees trust and contributed to non–disclosure and low VCT and drug uptake. The outcome has been lack of performance from the infected teachers. Sometimes, when the sick teachers are not able to work, there might be friction between them and the principals who are struggling to meet the demands of new policy and at the same time attain schools' academic excellence as described by Honig (2006) who saw policy implementers as persons who were trying to reconcile their workplace demands with and their professional and personal world views.

Describing how HIV–related stigma and discrimination frustrates the implementation efforts of TSC subsector policy on HIV and AIDS, a KENEPOTE interviewee alleged,

> *It is very sad to find that teachers are still discriminating their colleagues who are positive without caring. Nowadays the disclosure incidents are so isolated considering the big number of teachers. We need to be very aggressive in the fight against stigma and discrimination if we have to make any progressive milestone. I remember that it was courage and determination to live which persuaded me to come out in the open. We know many teachers who are perceived to be HIV positive but they are not ready to declare their status because of fear of stigma and discrimination. The sad thing is that they continue to spread the disease to those who are not aware* (KENEPOTE 3, February 15, 2017).

The above extract is an evidence that there are quite a number of teachers who are suffering silently since they have not disclosed their status for fear of stigma and discrimination from their colleagues and presumably the society at large due to their status, with similar findings a study done in Kenya among teachers by USAID (2009). When expressing his opinion, TSC staff decried the slow growth of KENEPOTE membership compared to the national teacher prevalence rates,

> *"The rate at which teachers are becoming members of KENEPOTE compared to the number of teachers nationally is slow and we are aware that teachers are infected. The membership should grow much more"* (Interview, TSC 2, November 17th, 2016).

The excerpts highlight a very desperate situation in the teaching fraternity. Separately, the key informants expressed their determination to live positively but only one of them was a KENEPOTE member. Two had disclosed to the employer but were not willing to disclose to their principals for fear of lack of confidentiality and discrimination. The fear of lack of confidentiality from management and colleagues has been noted as impediment to policy implementation by past scholarly works (Scott et al., 2013; Tombi, 2012). Another teacher disclosed to her principal and a few colleagues. The fifth one had only talked to a KENEPOTE official but was not willing to become a member of this social group. The current environment has therefore not been favorable for speedy and effective implementation of the TSC subsector workplace policy on HIV and AIDS due to high levels of stigma and discrimination.

Still on HIV and AIDS stigma, a very remarkable scenario was narrated by one of the principals,

> *The short time I came near that (HIV positive teacher) was a time I requested TSC to transfer a teacher. I did not know the teacher was HIV positive but the teacher was not*

> *performing up to standard. I was new in this school and according to me, I expected everybody to perform according to set standards. This particular teacher was a negative influence to the other teachers, whom I don't think the rest of the teachers knew that she was HIV positive. She never worked as I expected and would be absent from school so frequently without permission. Can you imagine she would come to school sometimes to just seat and not go to class? If I would call her to enquire the reasons of her absence she would be very rude. I found her behavior strange. So when I recommended her transfer and of course she was an excess because that department had many teachers, I was called to the TSC offices and told that the transfer had made her CD4 to go up and I replied, 'I am not aware, I didn't know that this teacher was HIV positive and if that is the situation, I am not requesting for her transfer because she is HIV, I am just looking at the work performance.' That experience made me learn that HIV positive people can stigmatize themselves and keep blaming others* (Principal 5, May 4 th, 2016).

Whilst in the opinion of the principal stood that the teacher had self–stigma, of which the excerpt is demonstrating, the referred teacher's actions are a demonstration of self–denial which HIV positive people use as a defense mechanism to word off anxiety and other threatening emotions (Caliari, Teles, Reis, & Gir, 2017). The self judgement shown in the excerpt is occasioned by enacted stigma in the society (Chi & Li, 2013).

HIV–related stigma is still high among public secondary school teachers with enacted stigma scoring higher. Findings in this research have established that implementation of the TSC HIV and AIDS sub–sector policy has not impacted on stigmatizing tendencies of the secondary school teachers. As a result, teachers who are HIV positive are being discriminated against by their colleagues. The key manifestation of HIV–related discrimination was through gossip and lack of respect of the positive teachers. Third person perspective discrimination was higher among teachers. There were inconsistencies with teachers who will not respect others due to their HIV status but will be comfortable to work with them. Nevertheless, there was no significant relationship between implementation of TSC HIV and AIDS sub–sector policy and HIV–related discrimination level of secondary school teachers hence the policy has been inconsequential as far as reduction of discrimination is concerned. Stigma and discrimination are strongly related. Still, high level of knowledge of HIV would not make one less discriminative.

On average, teachers have at least sought VCT services but not as frequently as expected. Unsure of confidentiality, teachers have kept off the VCT services occasionally held in schools. Findings also reveal lack of relationship between policy implementation and uptake of VCT hence the implementation of the policy has been insignificant in impacting on VCT uptake amongst secondary school teachers. Hypocritically, teachers regard their HIV positive counterparts as productive yet they discriminate them and even suggest that these teachers would be more productive if they had lesser load. The finding confirms the presence of dishonesty surrounding HIV and AIDS which is instigated by high rates of stigma and discrimination predominant in the society.

1.6 Conclusions

Results of this study show that HIV–related stigma and discrimination are still high among public

secondary school teachers. The HIV positive teachers have given narratives on discriminative acts by colleagues which make them feel different sending them to silence about their status. Though the implementation of the TSC HIV and AIDS subsector policy implementation has been ongoing, the stigma and discrimination levels have not been impacted on. As a result, teachers who are HIV positive are being discriminated against by their colleagues. The key manifestation of HIV–related discrimination was through gossip and lack of respect of the HIV positive teachers. Therefore, stigma and discrimination have negatively affected the implementation of the TSC HIV and AIDS subsector policy.

1.7 Recommendations

'AIDS talk' amongst teachers in public secondary schools, similar to that in Uganda as reported by Barnowe–Meyer (2013) should be encouraged by the principals so as to reduce HIV related stigma and discrimination. Since most principals may not be comfortable to talk about HIV in the beginning, they can organize talks for teachers–a strategy common in South African schools (Steyn & Mfusi, 2013) – with speakers who understand HIV and AIDS matters among teachers. The talks can be interactive so as to demystify 'HIV and AIDS talk' in staffrooms. With this taking place, HIV related stigma and discrimination can de reduced and HIV positive teachers can be encouraged to live positively and even to declare their status.

Through capacity building workshops organized by the TSC, public secondary schools' principals can be given tips on how to handle self–declared or perceived HIV positive teachers to avoid stigma and discrimination. They can also be guided on ways of encouraging teachers to declare their status. Further, the principal should be made aware by the employer that once a teacher declares his or her status or is perceived to be HIV positive, it will be his or her responsibility to make such a teacher stays comfortable within the workplace without being stigmatized and discriminated. Advocacy campaigns facilitated by principals should encourage teachers take precaution in intimate relationships, know their status, seek treatment and adhere to drugs for improved health. Such actions will help the principals to reconcile their workplace demands with and their professional and personal world views (Honing, 2006) and at the same time maintain work ethics.

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