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Politics, Etiquette, and the Fight Against HIV/AIDS in Kenya: Negotiating for a Common Front

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Abstract

HIV/AIDS is the single most serious socio-economic and health problem affecting Kenya presently. The rapid spread of the epidemic resulted from the failure of government to recognise it as a problem early enough and institute necessary measures to counter it. Today, there are efforts from various stakeholders to slow down the spread of the epidemic. Some of these efforts have caused much debate and controversy, sometimes taking a political angle. Hardly any agreed steps are accepted by national institutions and even individuals on how to tackle the epidemic. This diversity of views and standpoints may be healthy especially when it comes to finding concrete solutions to the problem. However, this is only so if unity in diversity is achieved within a certain time-frame before the problem gets out of hand. This paper tries to assess the efforts and methods suggested in the fight against HIV/AIDS in Kenya and the resultant controversies, debates and chances for unity in diversity.

Résumé

Le VIH/SIDA est le problème socio-économique et sanitaire le plus aigu auquel le Kenya est actuellement confronté. La vitesse de développement de cette épidémie est due au refus du gouvernement de l'identifier assez tôt comme étant un problème à part entière et d'adopter les mesures nécessaires à son éradication. Aujourd'hui, les différentes parties prenantes déploient tous leurs efforts pour ralentir la prolifération de l'épidémie. Certains de ces efforts ont provoqué un certain nombre de débats, ainsi qu'une grande controverse, sur le plan politique, notamment. Pratiquement aucune mesure approuvée relative aux moyens de combattre cette épidémie, n'a été acceptée par les institutions nationales et les personnes concernées. Cette diversité d'opinions est en soi, de bon aloi,

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particulièrement en ce qui concerne la recherche de solutions concrètes à ce problème. Mais cela ne peut être de bon aloi que si l'on arrive à réaliser l'unité dans la diversité, dans un certain délai, pour éviter que le problème ne prenne d'énormes proportions. Cette contribution tente d'évaluer les efforts et les méthodes proposées dans le cadre de la lutte contre le VIH/SIDA au Kenya, les controverses et débats qui en résultent, ainsi que les chances de réaliser l'unité dans la diversité.

Introduction

HIV/AIDS is the single most serious problem that has been carried forward from the last millennium into the current one. The epidemic has taken advantage of how people express their sexuality and puts a premium on a limited number of sexual partners for any individual. It is clear that for many people to restrict themselves to only one lifetime sexual partner is not necessarily possible or even desirable, but it is something everybody must take seriously in order to live in the current world bedevilled by HIV/AIDS.

The HIV/AIDS epidemic is nowhere worse than sub-Saharan Africa. Statistics show that out of the world's 40 million people living with HIV/AIDS, 75 percent are from sub-Saharan Africa (Price 2002). Last year alone, 2.2 million people died of AIDS in sub-Saharan Africa and many more were infected. Given these facts of HIV/AIDS in Africa in comparison to other continents such as Europe, North America and Asia, it is no longer tenable to claim that the disease 'knows no boundary'. It is evidently visible that HIV/AIDS thrives within certain socio-economic boundaries such as those found in sub-Saharan Africa. Currently, of the 40 million people living with HIV/AIDS worldwide, about 730,000 are receiving antiretroviral treatment. Out of this, over 500,000 or 68 percent live in the high-income countries of North America, Europe and Asia.

Similarly, of 2.2 million people who died of AIDS last year (2001) in sub-Saharan Africa, only 30,000 or less than 2 percent received treatment (Price 2002). The lesson to learn from all these statistics is that HIV/AIDS is prevalent in poor economies where money cannot be raised for prevention campaigns and treatment by antiretrovirals. In this case, therefore, HIV/AIDS knows, and indeed, respects economic boundaries which in most cases coincide with political boundaries. In fact, the over-estimation of the number of people who had HIV/AIDS in Africa before the mid-1980s and the rapid spread of the virus in the region after that led many from the west to allege that HIV came from Africa (Schoepf 1993). This baseless allegation was meant not only to revitalise racism and discrimination against Africans, but also cause heightened denial and delayed acknowledgement that HIV/AIDS is a global problem requiring global efforts to fight it.

Kenya, like other sub-Saharan African countries has inherited a huge HIV/AIDS problem from the last millennium. Sero-prevalence levels have risen from 2 percent in 1985 to well over 14 percent in the year 2000 (NASCOP 2001). In fact, it is now estimated that one in every eight adults in Kenya is HIV-positive and that at least 700 people die from AIDS or AIDS-related ailments every day. At independence in 1963, Kenya pledged to fight three common enemies namely: poverty, ignorance and disease. In respect to this, Kenya rightly views good health for its citizens as the basis of socio-economic development. However, this expectation is threatened by high prevalence of HIV/AIDS that places a very heavy socio-economic burden in the country.

No disease or phenomenon since 1960s has brought about such a negative and devastating transformation on Kenya's socio-economic landscape as has HIV/AIDS. The disease has nearly held economic development in the country at ransom and torn apart the social structures and networks of the entire population. The epidemic has physically attacked and disabled people at their prime time of productivity and reproductivity (between 15 and 45 years). Although both the urban and rural population is affected by the epidemic, the worst hit is the urban population (UNDP 2001). This has meant low production due to absenteeism, high expenditure on settling medical bills, and a budget set aside for prevention campaigns (Hancock et al. 1996). In this regard, the epidemic is actually compounding the poor status of health in the country. Consequently, it is projected that the fight against HIV/AIDS will cost the country Ksh. 5.5 billion in the next two years (*Kenya Times* 13/7/2002).

Basically, the fight against HIV/AIDS in Kenya has gone through four broad phases. In the first phase between 1984–1987, the disease was not considered as a serious problem for the country and was described in the press and by policy makers simply as a 'disease for westerners'. The attitude changed when it became apparent that the epidemic was affecting tourism, one of Kenya's leading foreign exchange earning sectors. For instance, in early 1987, the British army prohibited its soldiers from taking leave in Mombasa citing the threat of HIV among the commercial sex workers in the city. Following the HIV/AIDS scare, tourism drastically dropped as the tourists opted for other holiday destinations. This marked the beginning of the second phase between 1988–1991 when political leaders started giving AIDS a more realistic appraisal as a potentially harmful health issue. Even then the responsibility of managing the disease only remained with the Ministry of Health and as such, the public did not respond positively by changing their personal behaviour.

The third phase, 1992–1998, marked another significant change in Kenya's policy in that for the first time data on HIV/AIDS were released, and in April 1993 the first national conference on AIDS was held to deliberate on the problem. The Ministry of Health took the onus on itself to declare that HIV/AIDS had become a national crisis. This, coupled with rising number of illnesses and death from AIDS across all population groups, provoked pressure from business, the media, NGOs and professional societies for clear policy directions from the government. The government was forced in a number of its subsequent policy documents, for instance the Development Plan 1994–1997 and in Sessional Paper No. 4 of 1997, to address the issue of HIV/AIDS in terms of its impact and setting out of general statements to guide the future action. However, this seemed to be a public relations gimmick since no tangible efforts were visible on the ground. For example, no backups accompanied the various proposals in the documents. The Ministry of Health's budgetary allocation remained more or less the same.

The fourth phase (1999–2002), witnessed the President declare HIV/AIDS a national disaster and appeal officially to the international community, local organisations and individuals to assist in the fight against the disease. This created a stage for action from a host of players that ranged from institutional research, NGO interventions to individual efforts. Various initiatives, suggestions and approaches taken by these players in the fight of the epidemic have brought many issues for debate in terms of their effectiveness, legal, policy, ethical and human rights concerns. These debates have centred on a wide range of issues, among them importation and use of condoms, introduction of sex education in formal schooling system, HIV testing and confidentiality of the results, criminalising the spread of HIV, and the efficacy of certain drugs e.g. *the Pearl Omega* of Prof. Arthur Obel and *Polyatomic Apheresis* of Dr. Basil Wainwright.

In all these debates, the hand of politics has been quite conspicuous thereby greatly shaping people's response to these issues. Political utterances on some of the interventions suggested have resulted in a strong undercurrent of scepticism or downright opposition by the public without due consideration of the facts available. The conceptual basis for the fight against HIV/AIDS in Kenya leans toward concept of unity in diversity. It is basically a good gesture for people within a nation (stakeholders) to let their views and fears about a particular phenomenon be known. Freedom for stakeholders to air their opinions and doubts gives rise to divergent views which need to be accommodated and properly assessed with the aim of coming up with common solutions that are practical. Unity in diversity in the fight against HIV/AIDS in Kenya is a hallmark for success for the struggle. As such, whatever suggestion, view, disagreement and contradiction that stakeholders put across about the process,

needs to be appropriately assessed in the light of others so that a common fighting front can be formed. The questions, then, that this paper attempts to answer are: What has characterised the fight against HIV/AIDS in Kenya? How have Kenyans reacted to various initiatives, approaches and suggestions on the fight against HIV/AIDS?

The fight against HIV/AIDS in Kenya

The fight against HIV/AIDS in Kenya has been characterised by much controversy around the methods used and approaches taken. Every method suggested has met heated debates from various quarters with hardly any compromise being reached. Sometimes what seems to be entirely the prerogative of experts to comment on has been, in many instances, taken up by lay people, thereby politicising the issue. The delay by the government to issue policy guidelines on the fight against HIV/AIDS early on gave room for the emergence of conflicting views and suggestions. However, in the situation of a national crisis everybody's contribution counts. Institutions and individuals charged with spearheading the fight need to put in place a properly functioning screening mechanism to harmonise various views and suggestions that come in.

The use of condoms in preventing the spread of HIV/AIDS

There have been wide-ranging debates and controversies on the use of condoms to fight the spread of HIV/AIDS. The main battle has been between the Catholic Church together with some Muslim groups, on one hand, and the government on the other. The argument from the Catholic Church has been that promoting use of condoms would encourage promiscuity among the youth. They, instead, advocate creating awareness and understanding among the youth on the dangers of sexually transmitted diseases including HIV/AIDS and the need to abstain from sex. Although this method is morally good, it does not give an alternative to those who cannot abstain and want to have a chance to live. Hence, religious groups opposed to the use of condoms have always been on the war path with politicians and other organisations and individuals who believe strongly that the use of condoms can help save lives that would, unnecessarily, be lost through AIDS.

During a one-week symposium of Members of Parliament (MPs) at the Continental Resort in Mombasa, MPs described the Catholic Church as being an impediment in the fight against HIV/AIDS and other sexually transmitted diseases in Kenya. They stated that 'The Catholic Church is undermining every effort being made by those fighting HIV and we want to know what the church stands to gain when millions of Kenyans are dying' (*Daily Nation* 27/11/1999).

Arguably, those who advocate the use of condoms and those that argue instead for upholding moral standards and abstinence from sex are all fighting against HIV/AIDS but on different fronts. All they need is to harmonise their efforts, focussed on the common goal. Former president Daniel Moi himself underwent an impressive transition from advocating the fight against HIV/AIDS from purely a moral perspective to a combination of morality and the use of condoms. When Moi started talking about HIV/AIDS openly in public, he was a strong believer in the school of thought of fighting HIV/AIDS from a moral standpoint by people abstaining from sex (*Kenya Times* 27/12/1998). At one point he even made a passionate appeal for Kenyans to abstain from sexual activities for at least two years to save their lives and save money spent on the importation of condoms (*Kenya Times* 16/7/2001). However, in reaction to this appeal on one of the FM radio stations call-in-session, a caller described Moi's appeal as a joke because according to the caller if Kenyans abstained from sex for even a week, they would all go blind. These sentiments may be taken as a joke but they actually stand for what the majority of Kenyans believe. Therefore, the fight against the epidemic in Kenya needs to move away from the use of a one method approach to one that will use a composite of methods.

Daniel Moi as head of state was very concerned about the spread of HIV/AIDS among the populace. This explains his quick change of stance on how to fight the epidemic as the situation got worse. Moi came out strongly in support of the use of condoms while officiating the 27th Graduation Ceremony of the University of Nairobi, describing the practice as inevitable in fighting HIV/AIDS. He argued that in today's world, condoms are a must to save the precious lives of young people being lost due to the epidemic. Moi's open support of the use of condoms led to the importation of 300 million condoms worth over Ksh.1.5 billion (*East African Standard* 13/7/2001). The statement aroused much controversy. The argument was why import condoms worth that much when people were dying of hunger, hospitals had no drugs and the economy was on its knees. However, what the critics of the move failed to take note of was the fact that 700 Kenyans were dying every single day, 30,000-40,000 children were being born HIV positive and that there were 1.1 million orphans as a result of HIV/AIDS (*Kenya Times* 16/4/1998). These concomitant effects, obviously, were costing the economy more money that what was spent on importing condoms.

Many times, the church has been strongly blamed for not doing enough in the fight against HIV/AIDS yet it is rightly argued that nobody or organisation is in touch with the people like the church. It is only the church that commands audiences of the people at least once a week every week. In Moi's address to the nation when he arrived from the UN Summit on AIDS in New York, he

accused the church of not doing enough to prevent their followers from falling victim to the HIV/AIDS scourge. He illustrated the church's lax in tackling the epidemic by pointing out that although 80 percent of Kenyans are Christians, the spread of HIV/AIDS was continuing unabated contrary to Christian ideals. His challenge to the church was that they should play their role by preaching abstinence and fighting to change people's attitudes and beliefs. The church for its part accused Moi of behaving like a proverbial man who pursued a rat from a burning house forgetting his immediate aim of salvaging his belongings. The urgent issue in the fight against HIV/AIDS in Kenya is for all stakeholders (government, church, NGOs and people) to work together to eradicate the spread of the epidemic before they start evaluating who did the most and who did the least.

It is not only the church that is opposed to and campaign against the use of condoms. Some anti-condom lobby groups dismiss the use of condoms, not on the grounds of morality, but because they doubt their effectiveness in preventing HIV/AIDS infection. The lobby groups argue that the HIV virus is smaller than the pores on the condoms and, therefore, there are high chances of the virus passing through the condom. But according to efficacy studies carried out by the Centres for Disease Control and Prevention (CDC) based in Atlanta, USA, condoms reduce the transmission of AIDS by about 85 percent (KEMRI 2001). Condoms, which are made of latex, if not damaged or degraded, are impermeable to the HIV virus. One indication is if a condom does not leak water, it cannot possibly allow the transmission of HIV virus unless damaged. In fact, the point made by the anti-condom lobby that condom pores are larger than the HIV virus is true. However, what is important to note is that the virus does not walk or fly across a condom but has to be carried in a fluid media (blood, vaginal secretions, semen etc) or a cellular medium such as blood cells. In this regard, therefore, the exchange of body fluids and not the virus size is the most important determinant of viral passage through latex.

The use of condoms is, so far, the only known effective way of preventing the transmission of the HIV virus. However, their use in Kenya like many other African countries is hampered by perceived discomfort, culture and superstition (Nasirumbi 2000). There are people who find wearing a condom during sexual encounters uncomfortable to the extent that their pleasure is compromised. This explains why some people would wear a condom during the first sexual act and forget about it altogether during subsequent acts. As mentioned earlier, sex in many African cultures is treated as taboo and an act that cannot be talked about in the open. As such, many people fear buying condoms across the counter where many people might see them. Efforts aimed

at finding a solution to this has seen the introduction of condom-dispensing machines where rather than a person buying condoms across the counter, he simply inserts appropriate coin in the machine and it dispenses condoms equivalent to the amount inserted (*Daily Nation* 25/11/1999). The machines were supposed to be strategically placed near social places such as bars, nightclubs, discotheques, brothels and even in colleges. Unfortunately, this innovation is yet to take root in Kenya.

There are also a number of superstitions concerning condoms. The popular one is that the condoms are treated with chemicals capable of making the user impotent or sterile. This claim is often illustrated by the fact that condoms are given free of charge in health institutions, local administration offices, quasi-brothels and in bars and other leisure joints. It is the nature of Kenyans always to become suspicious of items and services given free in an environment where almost everything is paid for in the name of cost sharing. For instance, people would not understand why they pay to get malaria treatment in a health centre and be given free condoms in the same institution. This, to them, looks ridiculous, hence the room for much speculation.

HIV/AIDS medical research and the efficacy of new drugs

Since the diagnosis of the HIV virus, many research projects have been going on in search of a cure and/or vaccine, not only in Kenya, but throughout the world. A number of candidate drugs and vaccines have been tried since the first injection of an experimental HIV/AIDS vaccine in 1987 in United States, but none at all has been found to cure and/or immunise against HIV/AIDS. Some of the prominent drugs and/or vaccines that have been tried include:

- AZT drug therapy which reduces mother to baby transmission by about 51 percent;
- Virodene PO58, described as a wonder drug;
- Nevirapine, an antiretroviral drug;
- T20 that prevents the HIV virus from getting into immune cells;
- Kemron, developed by Kenya Medical Research Institute (KEMRI);
- Pearl Omega developed by Prof. Arthur Obel;
- Hydroxyurea (not new) used together with other anti-HIV drugs, a cocktail developed by Research Institute of Genetic and Human Therapy (RIGHT);
- Triple-drug cocktail of protease inhibition that sends the HIV virus into a quiescent state in cells;
- Cotrimoxazole, an antiretroviral drug recommended for Africa by UNAIDS and the World Health Organisation (WHO);
- Polyatomic apheresis (Oxygen therapy) of Dr. Basil Wainwright.

At the local level, Kenyan scientists, sometimes in collaboration with scientists from other countries, have been fully involved in research for HIV/AIDS cure and/or vaccine. Some of the drugs/vaccines have caused some controversy in terms of their efficacy. For instance, research on Kemron that had proved quite promising in its initial stages ended up failing in meeting efficacy tests. A point worth noting about Kemron research is that the last stages of the research coincided with the time Kenyans were preparing to celebrate a decade of *Nyayo* Era (president Moi's rule). During the celebration, every sector was struggling to put something on the table to show the achievements of the era. A number of achievements were publicised, including the *Nyayo* bus, the *Nyayo* car, the 8-4-4 system of education, Nyayo tea zones, and even the Kemron drug. However, eyebrows were raised by some scientists to the effect that the research on the drug was hurried through its final stages against the protocol guiding the research. Even if the drug would have failed efficacy requirements, the hurry to list it as among the achievements of a decade of *Nyayo* Era was ethically and procedurally wrong. Although the celebration organisers achieved their aim of using the drug to give political mileage to the *Nyayo* Era politicians, especially as the country was preparing for general elections, the act was not friendly to the course of medical research, and more specifically HIV/AIDS research in the country.

Kenyans still remember well the debate and controversies that surrounded polyatomic apheresis that was developed and administered by Dr. Basil Wainwright. Polyatomic apheresis treatment involved passing rays of atmospheric oxygen through the body of a patient. Dr. Wainwright claimed this could treat cancer, HIV/AIDS and a host of other diseases. In a letter dated 30th of July 1996, Dr. Wainwright was cleared by the then Director of Medical Services Dr. James Mwanzia, to set up a Polyatomic apheresis Treatment Centre. The letter in part read:

> It has been wonderful meeting with you and discussing early stages of what is likely to be a medical breakthrough in Kenya and indeed East African region. The setting up of a polyatomic apheresis treatment centre in Nairobi is greatly appreciated by the government of the Republic of Kenya. I would like to assure you of continued government support in assisting our fight against the many new, emerging and re-emerging diseases such as HIV/AIDS, Yellow fever etc (*East African Standard* 19/7/1998:12).

Although Dr. Manzia had authorised Dr. Wainwright to set up a polyatomic apheresis treatment centre in Nairobi, the Medical Practitioners and Dentists' Board was totally opposed to the administration of polyatomic apheresis to patients. In search of support for their stand, the board had written to those in authority both at international and local levels. Following these efforts, the

United States Food and Drug Administration (FDA) wrote to the government of the Republic of Kenya cautioning it that polyatomic apheresis was not medically approved in the US (where Dr. Wainwright was before coming to Kenya) for the treatment of HIV/AIDS and that Dr. Wainwright was a fugitive on probation violation. Consequently, about a year later in 1997, Dr. Wainwright was banned from administering polyatomic apheresis anywhere in Kenya. In correspondence dated 24th September 1997, the same Dr. Mwanzia after one year banned the administration of polyatomic apheresis noting that the government had information that Dr. Wainwright was a conman. In part the letter read:

> In view of the fact the unsuspecting public is being or is likely to be exploited, I have instructed the C.I.D. and Chief Drug Inspector to close down and seal all loopholes being used by Dr. Wainwright and take action on any criminal activities (*East African Standard* 19/7/1998:12).

Dr. Wainwright saw the hand of politics and corruption in the ban on his polyatomic treatment. He argued that it was the same Director of Medical Services who had allowed the administration of polyatomic apheresis who was now banning it hardly a year later. In the whole saga of polyatomic apheresis treatment, the lack of clear government policy to guide medical research in HIV/AIDS and its enforcement was an impediment in the fight against the epidemic. For instance, a decision granting Dr. Wainwright permission to carry out research on human beings and stopping it within a year on the pretext that he was not a medical doctor and was a fugitive was self-defeating. One would have imagined that before clearing Dr. Wainwright to practice in Kenya, the authority would have sought information on his background.

Pearl Omega invented by Prof. Arthur Obel is another HIV/AIDS candidate drug that took Kenyans by storm. Its ban met with a lot of criticisms from the public and some members of medical fraternity. According to Prof. Arthur Obel, since 1989 when he started administering the drug, more than 77,000 patients had used it, out of which 53,000 were Kenyans (*Kenya Times* 25/4/1997). Prof. Obel argued that since he started administering the drug to patients, many had reverted to HIV negative and nobody was injured or killed by the drug. In indirect support of these facts, the then Assistant Minister of Health Mr. Basil Criticos noted that the government did not dispute the drug's efficacy since no death had been reported. In addition, the government was also aware of patients who were wasting away but after having been on pearl omega, regained weight. However, these facts notwithstanding, the Pharmacy and Poisons Board went ahead and banned the manufacture and administration of the drug, arguing that 'Prof. Obel's behaviour has been unorthodox and

against all protocol and etiquette in a field where the rules are clear cut and heterodox procedure is not expected of researchers' (*Daily Nation* 16/2/1997).

One of the unorthodox behaviours for which Prof. Obel was dismissed was discussing his medical findings in newspapers instead of academic journals and conferences both locally and internationally. To crown this, he refused completely to disclose Pearl Omega's formula and its beneficiaries as required by the government.

In what seemed to be the support of government's stand on the ban of Pearl Omega, the Kenya AIDS Society went to court to seek injunction to stop Prof. Obel from manufacturing, distributing and administering the drug. The society claimed that the drug was ineffective and that Prof. Obel was out to con HIV/AIDS sufferers. However, the court in its wisdom ruled that the society had no prima facie case and, therefore, it was dismissed with costs (*Daily Nation* 17/5/1997). Prof. Obel strongly believed that the government was out to frustrate his efforts, observing that 'This is an intrigue at its pinnacle which is part and parcel of the power game to those who are initiated. The system has given me the opportunity to work as an industrialist in and outside the country' (*East African Standard* 9/2/1997).

According to Prof. Obel, it was the end that was important and not the means. For the simple reason that the drug was in some instances effective, it was argued that the government should have looked for an alternative method to establish its formula and trace its beneficiaries rather than banning it altogether. The then Vice-chairman of Pharmaceutical Society of Kenya, Mt. Kenya branch, Dr. Edward Kamamia and a leading psychiatrist Dr. David Ndetei, came out to criticise the way the government had handled the Pearl Omega issue. They argued that the manner in which the drug was banned was unprocedural and unscientific and was likely to ruin Kenya's possibility of ever discovering a cure for the disease (*Daily Nation* 12/2/1997). They accused the government of politicising the Pearl Omega issue, observing that it was unethical for a doctor to disclose the identity of his or her patients as the government demanded. HIV/AIDS patients also protested the ban of the drug. They argued that the drug was their only hope and gave the analogy of a drowning man who tries to hold on everything in an effort to save his life and in the process he gets saved.

Although Prof. Obel was fully aware of the statutory requirement under the Pharmacy and Poison's Act that the contents and formula of drug be known before registered for use, he feared for his patent and intellectual rights. This made him dismiss both the act and research protocol arguing that what was the standard approach to carrying out research yesterday may be totally obsolete today. Issues of protecting patent and intellectual rights that

Prof. Obel held to so dearly have, in the recent past, been of great concern in HIV/AIDS research in Kenya. The best example for this is the on-going collaborative HIV/AIDS vaccine trials on commercial sex workers in Majengo between researchers from Oxford University, United Kingdom, and University of Nairobi. Kenyan researchers on the team had been, technically, excluded from the list of beneficiaries of the proceeds of the research results. The researchers had to stand firm to be included on the list, with the result being that all the three partners would share equally research proceeds (*East African Standard* 13/8/2002).

After debates, accusations and counter accusations about Pearl Omega certain issues remain obscure. Among these issues is why the drug was allowed on the market for quite some time yet it was never registered under the Pharmacy and Poisons Act. Prof. Obel in this regard defied all laid down rules in medical research with impunity yet the government allowed the sale of an unregistered drug for years. By the time Prof. Obel invented the drug, he was designated as chief government scientist (although the post was never gazetted) drawing his salary from the exchequer (*Daily Nation* 16/2/1997). As such, it is not clear whether the KShs. 2 billion estimated to have been collected from sale of the drug went to the Exchequer or to Prof. Obel since he was an employee of the government.

Antiretroviral drugs

The politics of antiretroviral (ARV) drugs is of concern to many people in developing countries. Since their discovery in mid 1990s, antiretroviral drugs have proved highly effective at combating the voracious growth of HIV within the human body (Kuadey 2001). The drugs are specifically important in controlling opportunistic diseases that come as a result of the breakdown in the body's immune system, and in reducing mother-to-child transmission. When the HIV virus is not checked with medication (ARVs), it replicates with a fury, producing 10 billion copies each day. Even though ARV drugs are important in preventing virus replication, accessing these drugs, which are mainly the product of the large pharmaceutical companies such as Glaxo Smithkline, and Boehringer Ingelheim, is a big problem in terms of price to the poor majority. For instance, the cost of AZT treatment for mother and baby is about $1000. This is way beyond the purse strings of developing countries with health budgets of less than $10 per capita. As a result, multinational pharmaceutical corporations have been dangling these drugs before developing countries with a set of conditions such as having exclusive rights of supplying affected country with all or a majority of its drug requirements.

In Kenya, there have been debates on how to make generic antiretroviral drugs accessible to AIDS patients. Efforts contrary to achieving this end have

greatly been criticised by the public. For instance, the then Minister for Health Prof. Sam Ongeri and the then Chairman of Parliamentary Select Committee on Housing and Health Dr. Newton Kulundu were widely criticised by the public for refusing free HIV/AIDS drugs offered by Boehringer Ingelheim of Germany. The Minister explained the circumstances behind his refusal of the drugs on the basis of exclusivity rights with which the drugs were attached. He consequently warned that politicians should stop politicising the issue of AIDS drugs noting that the government was ready to receive free drugs offered without conditions (*Kenya Times* 3/7/2001). The Minister argued that if he was to accept the drugs with conditions of exclusivity attached, he could be left unable to act when another company offered drugs because his hands would be tied.

The country's commitment of availing its citizens with cheap generics of antiretroviral drugs was demonstrated when parliament passed the Industrial Property Bill amidst lobbying and canvassing against the Bill. Unfortunately, the end result was an Act without an essential clause allowing the importation and/or local manufacture of cheap antiretroviral drugs (*East African Standard* 7/8/2002), which had been mysteriously removed. The interesting thing was that shortly after the enactment, an anonymous MP emerged with a miscellaneous amendment to the Act, not knowing the clause he wanted to amend had mysteriously disappeared. The amendment was to effectively bar Kenyans from importing cheap antiretroviral generics except by express permission from the original patent holder (*East African Standard* 12/8/2002). However, it is common knowledge that no patent holder would willingly allow another person to import mimics of his drug that are cheaper. At the same time, Article 31 of the World Trade Organisation Agreement on trade related intellectual property rights allows a country on declaring a national state of emergency to produce cheaper generic versions of any drug (Kuadey 2001). This agreement, therefore, allows Kenya to produce cheaper drugs to treat its citizens. According to Dr. Kulundu, the aim of the anonymous MP was corruptly to give a certain manufacturing company the right to manufacture antiretroviral drugs.

Introducting family life education in schools

A proposal to introduce family life education in schools by the government contained in Sessional Paper No. 4 of 1997 met with resistance from a number of church organisations. The most outstanding opposing force came from the Catholic Church. The argument of the church was that the government was using the AIDS epidemic as a pretext of promoting the use of contraceptives such as condoms among the youth. The church, up to today, is adamant against the use of condoms claiming that they enhance promiscuity among the youth.

After constant negotiations with other stakeholders, the church agreed to reconsider its decision and, therefore, allow the introduction of family life education in the schooling system on condition that it was not used as a pretext of promoting the use of contraceptives.

The government in collaboration with the World Bank and UNICEF was finally able to launch the programme and integrate it into the school curriculum. The programme aimed to teach the youth about HIV/AIDS and the prevention of STDs. This initiative resulted from the concern about the high numbers of adolescent youth who were contracting HIV/AIDS and STDs (*East African Standard* 16/11/1998). Apart from teaching the youth in classrooms, the programme also exposed them to films, poems and drama containing messages about safe sex, the control of contracting HIV/AIDS and other STDs.

Ethical and legal issues in the fight against HIV/AIDS

As is the case with any epidemic, the reaction to the outbreak of HIV/AIDS has been, in most cases, highly emotional. In panic, governments and organizations have instituted measures that are affront to human rights and the law (Rachier 1996). Some responses have tended to disrespect confidentiality requirements and acted as a loophole for discrimination in employment and educational institutions. Kenya's reaction to HIV/AIDS epidemic has tended to be greatly influenced by emotions rather than decisive steps to fight the epidemic. Moi on at least two occasions directed that deliberately infecting others with HIV virus be made a criminal offence. The first instance was in his speech declaring HIV/AIDS a national disaster and the second when he arrived from a UN summit on HIV/AIDS in New York. The most conspicuous was the second occasion, when he directed that people who infected others with the virus should be hanged and rapists jailed for life. He stated that 'We (Kenyans) have to make laws that restrict those who deliberately infect others because young girls cannot protect themselves from such criminals' (*Daily Nation* 21/7/2001).

Moi was supported on his stand by among others Council of Imams and Preachers of Kenya (CIPK), and the Federation of Women Lawyers (FIDA), Kenyan Chapter. While it is necessary to pass down tough sentences to those who deliberately infect others with the HIV virus, such decisions need to be made with sober minds and not based on emotions. Emotional directives that are in contravention of the constitution are likely, in the long run, not to be implemented. The scale which the epidemic has reached in the country can no longer accommodate time wasting on things that are not practical.

According to medical practitioners, the principle of doctor-to-patient confidentiality has been their biggest dilemma. In this regard, there have

been a lot of debates on the issue of doctors disclosing the nature of illness of their patients to relatives or people who are likely to be affected. Some doctors have strongly advocated the repeal of the legal and ethical guidelines prohibiting them from revealing their patients' HIV/AIDS status (*Daily Nation* 12/5/2001). For instance, Dr. Rosemary Okeyo who was then Kisumu Medical Officer of Health, in an area badly hit by the HIV/AIDS epidemic, constantly advocated the relaxation of legal and ethical guidelines prohibiting doctors from revealing nature of illness of their patients. The argument has been that once the section is repealed, doctors would be free to disclose to people who are likely to be affected by the HIV status of their patients. They believe that once this is achieved the malicious spread of the virus would significantly be reduced. Even the chairman of the National AIDS Control Council (NACC) is on record as saying that one of the major frustrations they face as a Council in tackling the HIV/AIDS epidemic over the years is the legal constraint in respect of doctor-to-patient confidentiality (*East African Standard* 13/8/2002). A task force on legal issues relating to HIV/AIDS formed by the Attorney General and chaired by Ambrose Rachier came up with a solid report that was to be eventually turned into a bill and enacted by parliament. Among the things the task force recommended were:

- The outlawing of mandatory HIV testing before employment, being given an insurance cover/mortgages or being granted refugee status;
- The establishment of an Employment Equity Tribunal and Trust Fund to cater for the interests of people infected with HIV/AIDS;
- The general argument was made that most of the people seeking employment are youths between the ages of 15 and 45 years and unfortunately, they are the same ones most affected by HIV/AIDS. Discriminating against them raises issues of stigmatisation and feeling of social rejection. In addition, they require access to antiretroviral drugs and need public trustees to intervene in cases of inheritance by or for orphans. The task force in its report argued that if these issues were not addressed it might promote the further spread of the disease hence creating a sort of vicious circle.

Traditional and spiritual claims for the cure of HIV/AIDS

Apart from efforts to get an HIV/AIDS cure and/or vaccine from modern medicine, there have been claims by traditional medicine practitioners and spiritual leaders of the ability to cure the disease. By their nature, these claims have lacked scientific backup. In Kenya, many claims regarding HIV/AIDS cures have been announced by herbalists. The most widely known is that made by Mr. S.K. Maingi. He claimed to have completed research on the

drug he calls Blue Computer Drug (BCD) that is able to treat among other diseases HIV/AIDS, cancer and diabetes. According to Mr. Maingi, Patients take the drug for only one week and they are cured (*Kenya Times* 14/8/1999). Similarly, there have been claims across the country of HIV/AIDS cures by spiritual power. The most publicised in Kenya is the open air healing mass at the Holy Ghost Catholic Cathedral in Mombasa. Many people claimed to have been cured by prayers from Sr. Brioge McKenna, a Catholic nun believed to have powers to cure AIDS patients (*East African Standard* 5/2/1997).

Claims such as these are not unique to Kenya alone but are found across Africa. For instance, Nigeria has experienced quite a number of these claims including those made by people like Dr. Paul Amanya and Prophet Temitope Balogun Joshua (Udo and Aimiemwona 2000). Dr. Paul Amanya who claims to be a holder of Ph.D. degrees in traditional Chinese medicine and pharmacology from Shanghai College of Traditional Chinese Medicine and Pharmacology claims to cure HIV/AIDS by his drug Kasa boom boom. He strongly believes that the jinx about AIDS has been broken except in the minds of those benefiting from huge grants for phoney AIDS research. This is the same case with Prophet Temitope Balogun Joshua of the Synagogue Church of All Nations, Ikotun-Egbe, who claims to cure HIV/AIDS patients by prayer. A known fact about HIV/AIDS epidemic is that many people across the world and more so in Africa are suffering. As a result, they are ready to spend any amount of money to improve their health. Quack medical practitioners capitalise on this scenario to exploit the public. This explains the reason why there are individuals and even institutions coming up with unfounded claims of certain concoctions being able to cure the disease.

HIV/AIDS as a national disaster

It took the government of the Republic of Kenya 15 years to recognise the devastating impact of HIV/AIDS and consequently declare it a national disaster. Moi declared HIV/AIDS a national disaster on 25 November 1999 during a national symposium for members of parliament in Mombasa. While addressing MPs, he noted that HIV/AIDS was not just a serious threat to social and economic development, but also to the very existence of people of Kenya and, therefore, every effort needed to be made to bring the problem under control (*Daily Nation* 26/11/1999). As a consequence, Moi ordered a number of measures to be taken. These measures included:

- The immediate setting up of a National AIDS Control Council to coordinate the fight against the epidemic;
- The education of children regarding the threat of HIV/AIDS, with special lessons to begin in schools and colleges;

- The setting up of constituency AIDS committees chaired by the respective MPs to coordinate the fight against the epidemic at constituency/divisional level;
- The formation of committees of elders by Chiefs and Assistant Chiefs to produce solutions to cultural practices and beliefs that help the spread of the disease;
- The age of consent marriage and maturity be harmonised to 18 years to protect young girls from infection by the older men;
- The criminalisation of any one making any public announcements of HIV/AIDS cures or treatment without formal authority of the National AIDS Control Council;
- The National AIDS Control Council to regulate all biomedical research involving human subjects;
- Making it a crime for anyone to deliberately or knowingly infect another person with HIV virus;
- Making it mandatory for all health workers to inform family members of HIV/AIDS diagnosis and record the same in the death certificate.

Despite the declaration of HIV/AIDS as a national disaster and ordering of the above measures and programmes, tangible results are yet to be felt on the ground. The process of implementation of the measures is too slow, badly managed and in some instances non-existent altogether. Although Moi recognised the vital role of MPs in turning around attitudes and mobilising people to play their role more vigorously in preventing the spread of HIV/AIDS as heads of constituency AIDS committees (*East African Standard* 26/11/1999), their actual action has been more of seeking political supremacy than coordinating the fight against the epidemic. This has resulted in constituency AIDS committees formed to tackle the epidemic at constituency/divisional level being poorly managed to the extent that there have been calls for their disbandment. For instance, local council leaders from Machakos District and District Officers and social workers from Kisumu District have, separately, argued that constituency AIDS committees have been rendered useless because MPs were using them for their own political mileage and not to fight the epidemic. The local leaders claimed that the MPs appoint their stooges to the committees instead of more competent individuals at the expense of the noble work of the committees (*Daily Nation* 11/5.2001).

Although antiretroviral drugs are important in the fight against HIV/AIDS in reducing mother-to-child transmission and prolonging patients lives, the casual manner in which the government handled the process of making them available at a reasonable price is worrying not only to HIV/AIDS patients but to all Kenyans. This, to a large extent, gives validity to claims by the then

chairman of Parliamentary Select Committee on Health, Housing, Labour and Social Welfare Dr. Newton Kulundu that the government was dragging its feet on the issue of antiretroviral drugs to allow a few favoured individuals to invest in the sector while 700 Kenyans die every day (*East African Standard* 12/8/2002). The amount of time the government took to operationalise the Industrial Property Act that was supposed to include a clause on the importation and/or manufacture of cheap generics of antiretroviral drugs was too long for tackling a disease that had been declared a national disaster. The Act was passed on 29 May 2001 only to wait until 31 December 2001 to receive presidential assent and to further wait until 1 April 2002 to be effective, mysteriously missing a clause on importation and/or manufacture of cheap generics of antiretroviral drugs. The Kenyan constitution stipulates that in times of emergency, people shall be allowed to ignore rules in the process of resolving the crisis or disaster (Rachier 1996). Nobody seemed to notice the presence of this clause in the constitution and to use it appropriately.

Even with the legal permission to import and/or manufacture cheap generics of antiretroviral drugs, the staff and equipment of National Drug Quality Control Laboratory is ill-equipped to be able to test their efficacy so that the concerned companies do not fill the market with placebos of the drugs. According to the National Drug Quality Control Laboratory Board chairman Prof. Gilbert Kokwaro, Kenya has no capacity to test AIDS drugs. The incapacity results from the fact that there are no chemical reagents for testing efficacy and toxicity levels when the Industrial Property Act is fully implemented (*Daily Nation* 12/5/2001).The problem is squarely due to budgetary constraints, because, out of the total amount requested from the Ministry of Health to purchase chemical reagents and other equipment, they only received about 32 percent. As a result, the Laboratory has a huge backlog of untested ordinary drugs in store and this situation is likely to be compounded further by the requirement to test antiretroviral drugs. This shows that although there are measures and programmes to suppress the spread of HIV/AIDS, they only exist in government documents with hardly anything on the ground.

Conclusion

The cases and rate of HIV/AIDS infection in Kenya are still very high. The high number of cases of the epidemic resulted from the government's delay in instituting decisive measures to control its spread when the first case was identified in 1984. Until 1999 when the government declared HIV/AIDS a national disaster, there had been no clear policy guidelines on how to tackle the epidemic. This meant disjointed efforts by various stakeholders in the fight against the epidemic, such as education and creating awareness, advo-

cacy of the use of condoms, HIV/AIDS medical research, criminalising the deliberate spread of HIV/AIDS, and the introduction of family life education in schools. Much controversy has erupted in the process. The implementation of the measures and programmes to fight HIV/AIDS is of concern to everyone and is not supposed to be left to the government alone. However, the government has the task of leading and coordinating the activities of other stakeholder, in the fight. This is definitely not the time to apportion blame or to pursue an escaping rat from a burning house. What is important nonetheless is to agree on a common front to pursue a common enemy – HIV/AIDS.

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