

## RESEARCH REPORTS

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### HIV/AIDS in Kenya: Moving beyond policy and rhetoric

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#### 1. Introduction

HIV/AIDS has a profound effect on national development and security. It kills young economically productive people, brings hardship to families, increases expenditure on healthcare and adversely affects the country's development. By depriving the economy of a qualified and productive labour force, restricting the tax base, and raising the demand for social services due to the increased number of orphaned children, widows and the high cost of healthcare, Aids poses a great challenge to Africa's development. Further, the loss of skilled uniformed officers has security implications (World Bank Report 2000, UNAids 2000).

'Aids', as stated by former Zambian President Kenneth Kaunda during the Economic Commission of Africa conference in Addis Ababa, Ethiopia in December 2000, 'is a disease that affects us silently, persistently and destroys us ruthlessly sucking away the life and vitality of our families'. This statement acquires meaning when one looks at some statistics. UNAids (June 2000) estimates that globally there were 36.1 million people living with the virus by the end of 2000, 5.3 million of them became infected in 1999 alone.

An analysis of HIV infections by geographic distribution reveals that the highest concentration of the epidemic is in sub-Saharan Africa accounting for approximately 70 per cent of all infections worldwide (National Aids Control Council, NACC 2000). The region accounts for 85 per cent of the estimated deaths due to HIV/AIDS since the beginning of the epidemic.

The question that remains unanswered is 'why does the prevalence of HIV/AIDS vary greatly in different settings?' Two decades after the disease was discovered, the diverse dynamics of its transmission are still only partly understood (Crauel and Holmes, 2001).

This is particularly true in sub-Saharan Africa where HIV spreads heterosexually in adults and where it has stabilised at 30 per cent in some cities and is showing little or no sign of decline (Ferry et al, 2001). However, the burden of HIV/AIDS epidemic is not equally distributed over the continent: the prevalence of HIV infection is generally higher in East and Southern Africa than in West and Central Africa (UNAids 2000, Auvert et al 2001).

The impact of the pandemic is staggering when viewed country by country. For Kenya, life expectancy has declined to 52.8 for males and 53.4 for females in the years 2000-2005 from the projected 64.1 and 67.5 for males and females, respectively (NACC 2000).

By June 2000, it was estimated that Aids had killed 1.5 million Kenyans since the epidemic started in the early 1980s. It is estimated that the national adult HIV prevalence rates increased from 5.3 per cent in the 1980s to 13.1 per cent in 1999. Prevalence is generally higher in urban areas with an average of 16 per cent to 17 per cent than in rural areas, with an average of 11 per cent to 12 per cent (NACC 2000).

Ignorance, poverty, high incidence of sexually transmitted diseases, socio-cultural beliefs and practices, civil strife and deficient public health care systems are the main factors for HIV/Aids spread in Africa. In addition, lack of resources to finance the implementation of cost-effective interventions is a major source of concern for the sub-Saharan region. HIV/Aids-related discrimination and stigmatisation is widespread and occurs in every sector of the society; in schools, in work places through enforced testing and lay-offs; in the markets through ostracism of the identified trader and within families and communities. The fear, ignorance and lack of open dialogue about HIV/Aids and the difficulty of involving all of society, including families and communities in the search for solutions, has placed tremendous pressure on family bonds.

The main purpose of this paper is to give an insight into the Kenyan scenario with the primary objective of providing an analysis of the impact of the HIV/Aids pandemic and the capacity of health-care systems in the provision of care for those living with the disease. It looks at the national and international policies on HIV/Aids with a view of identifying existing gaps in the current situation, and most important, the paper provides views on critical areas if Kenya is to change the current trends in HIV and Aids.

## **2. What is the impact of HIV/Aids in Kenya?**

The impact of HIV/Aids has been felt across all national sectors and structures including education, health, agriculture and industry. Kenya has a high literacy rate of 76 per cent for males and 67 per cent for females. However, Aids is threatening to reverse enrolment and completion rates.

UNAids (2000:27) states: 'Skilled teachers are a precious commodity in all countries but in many African countries they are leaving schools and dying at an unprecedented and shocking rate'. The HIV/Aids epidemic affects the education sector in at least three major ways: (i) the supply of experienced teachers is reduced by Aids-related illness and deaths; (ii) children are kept out of school if they are needed at home to care for sick family members or to work in the fields; and (iii) children may drop out of school if their families cannot afford school fees due to reduced income as a result of an HIV/Aids death (UNESCO 1995, NACC 2000).

In the health sector, the rapid increase in the number of reported cases presents a significant challenge. Indications of a serious strain on the sector include shortage of drugs and patient care supplies. There are also inadequate diagnostic capabilities at various levels including blood screening equipment and their maintenance, overcrowding in the health facilities, irregular supply of testing reagents, high turnover of qualified health personnel making continuity impossible. Further, HIV has caused a major resurgence of tuberculosis, which presents an immense public health problem particularly with the emergence of drug-resistant forms of tubercle bacilli.

HIV/Aids impacts the health sector in three main ways: (i) it increases the number of people seeking healthcare services; (ii) it increases the overall cost of health care in the country; and (iii) there is depletion of human resources including both trained and skilled including doctors, nurses, technologists and other service providers. The Sessional Paper No. 4 of 1997 in Kenya estimates the direct cost of treating a new HIV/Aids patient at KSh34,680 (\$444), while indirect costs amount to KSh538,560 (\$6,904) or a total of KSh573,240 (\$7,349).

The bed occupancy rates due to HIV/Aids, estimated at 50-55 per cent in rural areas and 30 per cent at national hospitals, greatly constrain hospital facilities, undermining other operations (NACC 2000). Further, the quality of health care has worsened, as the number of HIV/Aids patients increases. It has also eroded the health sector budget, thus denying the preventive component of health service delivery its share (NACC 2000).

The agricultural sector has not been spared either. Agriculture is Kenya's primary economic activity, engaging about 80 per cent of the labour force and accounting for 25 per cent of the gross domestic product. The impact of HIV/Aids on this sector is posing a threat to the country's food security. Fertile land remains idle due to shortage of labour as a result of illness, caring for the infected persons and death (World Bank 2000, Cohen 2001). The morbidity and mortality in the agricultural sector leads to loss of skills and experience; increased recruitment and training costs, terminal benefits or pension funds for the dead and funeral costs.

Crop varieties are also declining and changes in cropping patterns are occurring. Cash crops are abandoned in favour of less labour-intensive subsistence crops (Guerry 2000; UNAids 2000; Topouzis 1998; Bollinger et al. 1999; Egal et al, 1999). Livestock production is also affected as animals are sold to generate cash to buy medicine for the ailing and support their families.

HIV/Aids has had adverse effects on the workforce at all levels, including skilled and unskilled labour in both urban and rural areas. The projected labour force loss due to Aids in 2005 in the following countries is: Tanzania – 9.1 per cent; Kenya – 8.5 per cent, Uganda – 16.3 per cent, Ethiopia – 8.3 per cent, Rwanda – 10.7 per cent and Eritrea – 2.8 per cent (ILO, 1998). Analyses of several Kenyan firms show that HIV/Aids will increase labour costs (in terms of

absenteeism, labour turnover, healthcare costs, burial fees, recruitment and retrenchment costs) by 4 per cent by the year 2005. Within the next 10 years, the impact of HIV/Aids is expected to reduce Kenya's Gross Domestic Product (GDP) by 14.5 per cent (NACC 2000, UNAids 2000:3/51).

In addition, the impact of HIV/Aids on the population may cripple effective demand for manufactured products, thus rendering the industrial sector vulnerable (NACC 2000). National economies are clearly at greatest risk when HIV affects the principal foreign exchange earning sectors. Kenya's late development of a National Prevention Policy has been directly linked to the fear of losing its valuable tourism industry (Cohen 1992:1, UNECA, 2000).

The military and police forces have also been hard hit. Throughout the world, soldiers are among the most susceptible people to HIV/Aids because they live away from home and are thus more susceptible to temptations for casual sex. It is important to note that HIV transmission is five to 20 times more likely where other sexually transmitted infections (STIs) occur (Grosskurth et al 1995, Gilson et al, 1997). As a result of such factors, HIV/Aids now represents a direct threat not only to socio-economic integration and political stability but also to national security (NACC 2000). The scenario within the Kenya Police Force (KPF) illustrates how serious the problem is. For instance, anecdotal data indicates that yearly deaths of officers rose from 25 in 1989 to 520 in 1998. Although this may not be purely as a result of HIV/Aids, its role is significant and presents a big challenge to security especially in the current wave of crime in the country (Kenya Police Force, KPF Annual Report, 1999).

### **3. Are there members of the society who are more vulnerable to HIV/Aids?**

There are a number of groups and categories of people whose vulnerability to HIV/Aids and its impact is higher than other members of the community. These include children, the youth, women and the disabled. According to the UNAids December 1998 report, Aids orphans (defined as children who have lost one or both parents to Aids before the age of 15 years) number 8.2 million to date and 95 per cent of them live in Africa. Before the onset of Aids, about 2 per cent of children in the developing countries were orphans. By 1997, Aids orphans accounted for 11 per cent of all children in Africa (UNAids, 2000).

The capacity of the extended families to absorb such children has been stretched to the limit, resulting in children-headed households with little supervision and parental guidance as they grow up. Also, child-labour among the orphans who have dropped out of school is common. And because of lack of parental supervision, such children are likely to be delinquent (African Development Forum, ADF 2000).

The number of HIV/Aids orphans in Kenya is projected to exceed 1.5 million by the year 2005. These children are at greater risk of malnutrition, illness, abuse, sexual exploitation, stigma, discrimination and school dropout. Several

studies in Africa have shown that uninfected children of HIV seropositive women have a much higher mortality than children of uninfected women living in the same environment.

Another vulnerable group comprises the youth who are key to the future course of the HIV/Aids epidemic. Young people, between the ages 10 and 24 years, account for more than 50 per cent of new post-infancy infections worldwide. This age group constitutes more than 30 per cent of all people in the developing world, where the epidemic is concentrated and in Kenya 60 per cent of the population is under age 20 (UNAids 1999:27). Youth vulnerability to HIV infections is increased by such factors as early sexuality due to cultural, economic and media influence.

The problem is worsened by the inability of parents, leaders and teachers to discuss sexual matters with young people (Amuyunzu 1997). Various questions still present when assessing youth in relation to HIV/Aids (United Nations Economic Commission for Africa, UNECA 2000: p1416) include: What is the changing socio-economic and political context for youth? What cults and organisations exist among young people themselves? What do we know about risk taking and orientation towards the future? What do we know about youth cultures of resistance? If Kenya desires to preserve its future leaders, these issues should be addressed through the implementation of targeted and timely interventions.

Gender differences and biases have become more accentuated, as infected women bear the brunt of rejection in higher proportions than their male counterparts. Women are also disproportionately responsible for the care of those infected with HIV/Aids, often without sufficient information, medication and support.

There is evidence of discrimination against widows and children from inheritance of family property of the deceased spouse (NACC 2000). It has been established that in sub-Saharan Africa over 20 per cent more women than men are living with HIV. A number of gender elements have been identified by UNECA (2000: 5-7) as needing attention if there is to be a realistic chance of containing the pandemic. These include sexual violence and economic pressures on women that contribute to a high rate of commercial sexual activity. Other factors are stigmatisation and powerlessness of women with respect to use of condoms; lack of privacy; domestic violence; polygamy, early marriages and sexual activity for girls, and illiteracy.

People with disability form another category of vulnerable groups yet they are rarely considered in reproductive health discourses. The vulnerability of these members of the society emanates from their inability to access services such as education, health and career development. In many communities sexual abuse and rape is common as established by a study conducted by the African Medical and Research Foundation in 1999. The researchers found that sexual abuse of people with mental disability was high and yet the abusers were

never apprehended. The Kenyan law refers to people with disability as idiots and imbeciles. Consequently, they cannot defend themselves in court and the abuses go on unabated (AMREF, Unpublished).

The vulnerability of children, youth and women is doubled when they have a disability. Focus has to be shifted towards understanding the conditions and needs of people with disabilities, both the infected and affected (see also the PRSP, June 2001). The elderly are also a forgotten segment in terms of HIV/Aids and they are only recognised as care givers to Aids orphans but not as people at risk of HIV infection.

#### **4. What are the main predisposing factors to HIV infection?**

There are several situations that present risks to HIV/Aids among any given population. These include poverty, STIs, drug and alcohol abuse, cultural influence and civil conflicts. The poor are defined as those members of the society who are unable to afford minimum basic human needs comprising of food and non-food items. The poor constitute slightly more than half the population of Kenya. Women constitute the majority of the poor and also the absolute majority of Kenyans (IPRSP 2000).

According to evidence of health status, the prevalence and incidence of sickness are similar for both the poor and non-poor. However, their response to sickness is markedly different. An overwhelming majority of the poor cannot afford private health care (76 per cent rural and 81 per cent urban) and rely on public health facilities. However, 20 per cent of the urban poor and 8 per cent of the rural poor have found even public health charges unaffordable. Furthermore, 58 per cent of the urban and 56 per cent of the rural poor reported that they do not seek public health care because of the unavailability of drugs (IPRSP). If you add HIV/Aids to this scenario then you have a real catastrophe.

UNECA (2000:16-18) links poverty to many of the characteristics prevailing in the developing world. Poverty often means lack of information; entails the inability to manage risk and it drives women to unprotected sex. Poverty contributes to migration, which is a major risk factor for HIV. Poverty is closely associated with factors such as malnutrition, susceptibility to other diseases, and risk of harmful traditional practices such as early marriages (see also Zulu et al, 2000 and Magadi et al, 2001). The retrenchment of civil servants does not take into consideration the care of orphans and the health needs of the people infected and affected. As a result people are poorer and as stated by Kenneth Kaunda during the ADF meeting in Addis Ababa (2000): 'Poverty is a fertile ground for Aids and Aids feeds on poverty'.

Another predisposing factor to HIV is sexually transmitted infections (STIs), which have a direct linkage to HIV transmission. It is reported that individuals with ulcerative STIs have an increased risk of transfer of HIV infection by factors of two to four times. Research conducted by the London School of Hygiene and Tropical Medicine and AMREF in Mwanza, Tanzania, showed

that a modest syndromic management approach to STIs reduced the prevalence of HIV by 40 per cent (Grosskurth et al 1995, Gilson et al 1997). Barriers to effective management of STIs include inadequacy of essential supplies and drugs; lack of trained personnel; inadequate management of STIs; limited contact tracing and poor referral system; inadequate health seeking behaviour; limited sensitivity and specificity of syndromic approach; and reluctance of the private sector to accept the syndromic approach (NACC 2000).

The abuse of alcohol and other substances is becoming a serious risk factor to HIV infections for Kenyan youth (Amuyunzu et al 1999, Johnston 2000). Substance abuse inhibits the ability of the individual to make rational decisions. The need to provide for their addictions inclines the abusers to crime and sexual activities that expose them to the risk of sexually transmitted infections including HIV/Aids. In a study conducted by Johnston (2000) it was concluded that young people who experiment over time with beer and cigarettes particularly are more prone to contracting an STI than those who never experiment with those substances. Injecting drug use directly exposes the abusers to HIV although at the moment there are no data to suggest that it is a big problem in Kenya.

Culture and religion have a big role to play not only because HIV/Aids has been moralised in the region but because culturally prescribed roles disadvantage some segments of the communities and increase their vulnerability to HIV and other STIs. In Kenya, it has been reported that young women in the age group 15-24 years are two to three times likely to be infected as males in the same age group (Okeyo et al 1998:12). In some situations, HIV/Aids related symptoms are given cultural relevance far removed from biomedicine such as curses, taboos and breaking of societal norms. These beliefs may hinder people from seeking appropriate care and using proper preventive measures. Furthermore, certain religious doctrines and practices forbid the use of preventive and protective measures. For instance, the Catholic and Muslim opposition to the use of condoms is one barrier in the face of HIV/Aids (Amuyunzu et al, 1999). Misconceptions regarding sexual and reproductive health information also act as barriers. Many adults in Kenya are wary of their children being given sex education because of the unfounded fear that it will encourage them to be 'promiscuous' (Fugelsang 1997, Amuyunzu 1997).

The marriage institution has also contributed due to the obligations that are socially and culturally instilled. Some women continue bearing children with the knowledge of their HIV positive status because that is what is required of them or due to their innate need to leave behind an offspring to propagate their lineage. Widow inheritance and the overall subservient nature of women put them at risk. Lack of male circumcision has also been related to increased risk to infection (Carael and Holmes, 2001).

Political conflict within the country and across the borders also predisposes people to HIV/Aids because it leads to displacement that exposes the victims to

harm. Such conflicts are accompanied by rape of women. Even if not forced, the women use sex as the only means of survival and escape. The civil strife in Somalia, Sudan, Ethiopia, the Democratic Republic of Congo, Rwanda and Burundi has led to mobility of displaced people, which has contributed to the spread of HIV infection and the resulting consequences. The refugee communities suffer even more due to the trauma and abuse they endure.

### **5. Is the health care system capable of addressing HIV/Aids?**

The capacity of the healthcare establishment to effectively address HIV/Aids depends on the government and international policies. Internationally, governments are expected to provide healthcare for their citizens. However, the International Monetary Fund (IMF) and World Bank Policies of Structural Adjustment applied to developing countries unable to repay loans may promote the spread of HIV/Aids (Lurie et al. 1994). These policies require governments to reduce spending on health and social services such as education, increase personal tax and ensure currency devaluation. These conditions often-times reduce the buying capacity of individuals, thereby rendering them poorer.

The annual requirement for HIV prevention alone in Kenya is estimated at 40 million Kenyan Pounds (\$1,025,641) excluding the cost of care. An effective approach to the containment of HIV/Aids requires an active voluntary counselling and testing programme. The question that has to be addressed is whether there is adequate capacity for government and private health facilities to provide adequate reliable testing facilities. The current dire situation of the health facilities characterised by lack of drugs and other supplies, inadequate facilities and limited staff, depicts a system that cannot cope with the demand for services (NACC 2000).

Hospitals with the ability and mandate to perform HIV testing are oftentimes scattered and inaccessible to a large segment of the population. The Kenya Government is yet to put in place a system that enables those who have tested HIV positive to live with access to long-term counselling, antiretroviral drugs and treatment for opportunistic infections.

Policies related to medical insurance and social security have to be looked into because they determine to a large extent the decision whether one should be tested or not. For instance, if an individual needs a mortgage, should he be tested? If this implies that if found positive he does not get the loan, why should he bother? Hence, an assessment of whether the health establishment can cope requires a thorough analysis of other closely related issues and national as well as international policies on HIV/Aids.

The Ministry of Health (MOH) strategic plan 1999-2004 is expected to catalyse the implementation of priorities contained in Sessional Paper No. 4 of 1997 on Aids in Kenya. This paper signalled the intention of the government to support HIV/Aids interventions, protect the rights of the affected and provide

care for the infected and affected. It recognised that responding effectively to the crisis requires 'a strong political commitment at the highest level and the implementation of a multisectoral prevention and control strategy'. The Kenyan President, Daniel arap Moi, declared Aids a national disaster in December 1999. Although 15 years late, the declaration has created a favourable environment for mitigation against the HIV/Aids scourge.

The Interim Poverty Reduction Strategy Paper (IPRSP) 2000-2003 identifies people as the most precious resource because of their potential to work for the betterment of the nation. In article 9.12 it is noted: 'control of HIV/Aids is central to an effective poverty reduction strategy' (p 20). The IPRSP presents four main strategies on HIV/Aids namely blood screening, promotion of condom use, development of a national communication strategy and management of STIs (p72). It is interesting to note that care for the infected has been included in the proposed strategies.

Another policy document is the National Aids Control Council (NACC) Strategic Plan of 2000-2005 in which five priority areas have been identified. These are prevention and advocacy; treatment, continuum of care and support; mitigation of the socio-economic impact; monitoring, evaluation and research; and management and co-ordination. Within the priority areas, a variety of interventions and activities have been identified for implementation in order to achieve defined objectives for each. In the absence of a cure for HIV/Aids, the plan allocates most resources to preventive activities, which focus on the youth and community mobilisation to achieve the desired social change in sexual behaviour.

At the international policy level the joint United Nations Programme on HIV/Aids (UNAids) has the main task of identifying practices around the world that work in responding to the HIV/Aids epidemic, and to examine how and why they work. One important international focus has been the development of a vaccine which is seen as the only way, apart from behaviour change, to fight HIV/Aids.

Leadership is a crucial aspect at all levels. The African Consensus and Plan of Action drawn during the ADF Addis Ababa meeting (December 2000) looked at the role of leadership in combating Aids. Leadership is viewed at different levels: personal, community, national, regional and international.

Personal leadership involves individuals' need to break the silence and adopt positive behaviour change. Community leadership involves respect for the rights of people living with Aids and caring for Aids orphans and increasing access to information and treatment for all community members. National leadership is mobilisation of resources; increasing access to quality care and strengthening HIV/Aids control councils.

Regional leadership involves learning from other countries, creation of regional partnerships and ensuring peace within the region while international partnership involves reduction in the cost of antiretroviral drugs, stepping up

research on HIV/Aids, debt relief and providing coordinated, transparent and accountable international support.

## **6. Can Kenya learn from others?**

Kenya can learn from her neighbour Uganda which has brought estimated HIV prevalence rate down to about 8 per cent from a peak of over 20 per cent in the early 1990s with strong prevention campaigns. Uganda was the first government on the continent to recognise the danger of HIV/Aids to national development. Acknowledging this fact, President Yoweri Museveni took active steps through action by the government and other groups in society, including religious leaders and community development organisations (UNAids June 2000).

Kaleeba et al (2000) identify three main factors that have contributed to the reduction of HIV infections in Uganda: (i) a two-year delay in the onset of sexual intercourse among youths aged 15-24 years. Among girls the median age at first sexual intercourse increased to 16.6 years and among boys to 17.4 years; (ii) sharp increases in condom use from 15.4 per cent to 55.2 per cent among men, and from 5.8 per cent to 38.7 per cent among women; and (iii) a drop of nearly 50 per cent in the proportion of men and women exchanging sex for money and a 9 per cent decrease in casual sex among the young people (males aged 15-24 years).

Community-based organisations have come together to provide support and care to the infected and affected. Succession planning has been implemented to ensure that children are well prepared for the death of their parent(s) and are adequately cared for thereafter. Uganda is one of the few countries in the world that have active participation of soldiers in the HIV/Aids campaign and care (Uganda People's Defence Forces Post-Test Club, 2000).

Another good example is Senegal, which has maintained a low HIV prevalence at 5 per cent due to various reasons. The leadership of the National Aids Control Programme has been consistent which allows the office holders to strategise and oversee the implementation of the priority activities. The country has also embarked on a vigorous HIV/Aids campaign that has actively involved Christian and Muslim religious leaders who use their gatherings as dissemination forums for HIV/Aids information. The one most important action by the government has been not to wait for the problem to reach epidemic levels. This is one area, unfortunately, where Kenya failed from the very beginning.

## **7. Success stories in Kenya**

The UNAids Best Practice Collection (Issue 1, 1999) cites two Kenyan cases which the country can adapt or scale up. The first focuses on children and young people namely the Mathare Youth Sports Association (MYSA). The second is a community mobilisation project: the Diocese of Kitui HIV/Aids programme. The MYSA programme, which started in 1994, is implemented in

Mathare, the largest slum in Nairobi. The project's objective is to fight HIV/Aids by promoting healthy living, teamwork and involvement in community-improvement activities. The main activities have involved training footballers to be peer educators on HIV/Aids. The adolescents stress abstinence from sex; but for those who are sexually active, they emphasise the importance of using condoms and staying faithful to one partner.

The programme is estimated to have reached some 20,000 young people between 1994 and 1997. In 1997, 25 girls and 26 boys completed advanced courses in peer education, while 25 girls and 25 boys completed the basic course. The project has demonstrated that adolescents and other young people can be effective peer educators for HIV prevention, and that their mobilisation is a useful strategy for prevention and attitudinal change. However, adequate training and materials are essential to support the work of peer educators and to help maintain their motivation. These materials need not be of high cost, but the support must be ongoing and secure.

The Diocese of Kitui HIV/Aids programme is implemented in Kitui and Mwingi districts in eastern Kenya. These districts are within the semi-arid belt and most of the people depend on small-scale farming and livestock. Poverty is widespread and there has been a marked migration of men between the ages of 16 and 50 to larger Kenyan towns in search of employment. The HIV/Aids programme started in 1992 with two main objectives: to reduce the prevalence of HIV infection; and to enable people infected and affected by Aids to live positively.

The main activities include pre- and post-test counselling, home visits to families affected by HIV/Aids, group counselling sessions with people living with HIV/Aids (PLWHAs), community education, services for people with STIs and preparing people for death. Other services include encouraging economic activities for PLWHAs, and providing simple curative medicines and basic support for needy clients. The programme has taken into account the diverse needs of specific groups of PLWHAs and has devised effective strategies for each. The different groups include PLWHAs with HIV-relevant medical conditions such as TB and STIs, sero-positive or potentially sero-positive infants, elderly caregivers, and people who are in the terminal stages of Aids. The success of this programme has illustrated that PLWHAs are a major resource that should be used in the fight against HIV/Aids.

## **8. What are the HIV/Aids challenges for Kenya?**

Several issues need to be addressed if Kenya is to contain the spread of HIV and adequately take care of the infected and affected members of the society (See also Foote and Akukew, 2000). The Ugandan case illustrates the role active leadership can play in bringing down the level of HIV infections. In fact, Peter Piot, the Executive Director of UNAids observes, 'sustainable and systematic alleviation of HIV impact also comes from ways in which resources are

deployed. Social immunity comes when Aids resources are not about short-term projects but instead go across all planning and social sectors through decentralised mechanisms that push funds to district level where they really make a difference'. (ADF 2000).

The success of any intervention will depend on the support received from the government. Access to antiretroviral drugs is currently out of reach of many infected people yet the government can make use of the existing regional and international networks to bargain for reduced costs of these drugs and subsidise the costs. The government, communities and individuals have to actively take a leadership role. Kenyan leadership organs need to go beyond well-written policy documents, position papers, and speeches to steer the country into targeted and committed action. This requires recognition of the needs of different categories of the citizens. There are those who are not infected (who are the majority) whose needs are different from PLWHAs. There are people who are vulnerable such as women, children and people with disabilities whose needs have to be understood and appropriately addressed. For the country to address these needs effectively it would require different strategies and activities for a more comprehensive and integrated approach.

There is no doubt that access to antiretroviral drugs prolongs people's lives and improves the quality of that life. It is sad that only 1 per cent of the 25.3 million Africans living with HIV have access to these drugs. Geeta Gupta, the President of the International Centre for Research on Women (ICRW), observed in 1999: 'we have today therapies and treatments to substantially improve the quality of lives of those living with HIV and Aids in the countries that can afford them'. It is the duty of the government to ensure that these drugs are available to people who need them. Effective management of opportunistic infections should also be implemented in order to alleviate the people's suffering and to prolong their lives. This will effectively change the hopelessness that accompanies an HIV positive result and will re-energise the country's economy that has long been affected by the loss of skilled manpower. Promotion of VCT is pertinent because it will enable individuals to take action early before the depletion of their immune systems.

Prevention has been and continues to be promoted as an important measure of containing the spread of HIV in the region. However, although condom use has been widely promoted in Kenya, its effectiveness has been hampered by inconsistent and improper use and myths/misconceptions regarding its efficacy and role in sexual intercourse (Nyagero et al, 2000, Obiero et al, 2000, Amuyunzu et al, 1999). There is need for increased promotion campaigns that address these misconceptions and focus on the proper use of the condom.

Although there is evidence that many people are aware of HIV (over 80 per cent of the Kenyan population in general) behaviour change lags behind. The main goal of information and education campaign has to be the prevention of new infection, which requires that it has to be targeted while taking care of the

diverse cultural and religious mores of the people. Young people should be used in the formulation of programmes addressing their needs. The MYSAs approach, for example, could be scaled-up in many of the most affected areas, especially in urban slums. The media practitioners should be brought on board and used as important catalysts in the control and management of HIV/Aids.

With Aids orphans projected to hit the 1.5 million mark by 2005, programmes such as the one of the Diocese of Kitui could be scaled-up in order to adequately address the needs of these children. Succession planning has to be adopted as a process of preparing the children and the community for the demise of the infected parent(s). Efforts have to be made to prevent mother-to-child transmission (PMCT) of HIV in order to reduce the number of children born with the infection. While promoting this strategy, long-term treatment has to be considered to prolong the mother's life to reduce the number of children who are orphaned at an early age. A moral question on PMCT hinges on the focus of saving the child and neglecting the mother. What are the chances that the child will survive after the mother's death? Who will care for the baby if the mother's survival is not a central part of the PMCT intervention? Responding to these questions would require the government to plan for the provision of antiretroviral drugs to the women on a long-term basis.

Poverty will continue to influence the patterns and levels of HIV/Aids in Kenya and other parts of the region. The current trends indicate that the poverty levels are on the rise unless specific, community-based measures are put in place. Although the government is currently engaged in the preparation of a full Poverty Reduction Strategy Paper (PRSP), a lot will depend on the implementation of the proposals made therein. A major problem is the reduced expenditure on social services, including health and education (under the prodding and watchful eye of the IMF and the world Bank). In addition, privatisation and retrenchment of civil servants are some of the measures proposed and being implemented for the improvement of the economy. Invariably, these processes are relegating many people into poverty and thereby increasing their susceptibility to HIV infections. For those already infected, a reduction in their access to healthcare implies a quicker progression to Aids. There is a need to consider the needs of orphans and the elderly especially those from poor households.

It is also necessary to stem tribal/clan/border clashes that are oftentimes politically instigated and result in a lot of displacement. Such displacements lead to an increase in poverty and consequently increased susceptibility to HIV and Aids especially for women and young girls. The street people are exposed to a myriad of problems including lack of shelter, food and medical care. Those displaced are oftentimes engaged in sex for survival and sustenance. Other displacements that may exacerbate the level of suffering include evictions of slum dwellers and the perennial land grabbing that often results in many people having no shelter and other means of survival.

The role of research cannot be overstated especially if a local solution to HIV/Aids has to be attained. The Ministry of Health has not been very supportive of Kenyan scientists engaged in HIV/Aids research. There is need for the government to support local scientists in their endeavour to mitigate the HIV/Aids pandemic because there lies hope of getting an affordable and sustainable solution.

The healthcare infrastructure is a central part to the effective control of HIV and for the management of people who are living with the virus. Kenya must reinvent the healthcare system and reposition HIV/Aids as an important national issue. Budgetary allocations to healthcare must reflect the current emergency situation. The country needs to call on international assistance to revamp the public and private healthcare infrastructure, train and re-train health practitioners, and develop effective community-based systems. Efforts should be made to improve healthcare facilities at the local level to provide VCT and follow-up for people who test HIV positive. The current practice is for people who are down with Aids to be taken to the rural areas where the caregivers are least prepared to cater for their physical, medical and emotional needs. The facilities closest to the people (dispensaries, health centres and private owned clinics) should be facilitated to provide back-up services to the rural inhabitants.

Other areas that require sensitisation and advocacy at national and community levels include gender issues and cultural practices especially those that expose individuals to HIV/Aids. Religious conflicts that have characterised the fight against HIV/Aids have oftentimes diminished the gains made and hence, an effort should be proactively made to bring their leadership on board. Controversies on condom use remove focus on the most pertinent issues, which are the reduction of HIV transmission and management for those already infected and affected.

## **Conclusion**

In sub-Saharan Africa, the predominant mode of HIV transmission is sexual intercourse between men and women although there is a large variation in the rate and extent of the spread in different populations. The impact of the pandemic also differs and is dependent on vulnerability to the virus and exposure to the predisposing factors discussed. This paper set out to provide a review of the impact of HIV/Aids in Kenya and it has illustrated the debilitating effect on all sectors of the nation. It is important to acknowledge that HIV/Aids affects both the poor and non-poor members of the society. However, as observed by the World Bank (2000) the pandemic affects the poor more than the non-poor nations and people: 'it may eventually become the disease of the poor'. Given this important distinction, it follows; therefore, that any strategies developed to mitigate the scourge should be sensitive to the different needs and disease patterns.

This paper has illustrated that the high levels of infection among the 15-49 year olds, who account for 80-90 per cent of all infections in the region indicate a depletion of Africa's skilled human resources. This has repercussions on people's survival especially on a continent that has been and continues to be impoverished by poverty, war, preventable communicable diseases, droughts and floods and brain drain to the more developed west. The lack of a properly equipped and managed health sector to deal with simple medical needs adds to the general hopelessness. This partly explains why stigma, shame, despair, and anguish continue to predominate human stories, the media, art and people's views about HIV/Aids.

The paper identifies that the main challenge for Kenya is to prevent infection among the 86 per cent of the adult population not yet infected and to enable the infected 14 per cent to have longer and better quality lives. This is a challenge that can only be met through a multi-sectoral and multi-pronged approach. Policy documents are important but more than that, there is need to implement what is therein. It is only through targeted interventions that Kenya will preserve and retain its people who are the most important resource for achieving sustained development. That is why the country needs to go beyond policy and rhetoric into focused and timely interventions for it to counter the numerous challenges emanating from HIV/Aids.

Although the impact of HIV/Aids is expected to be worse in the next five years before it stabilises, there is a glimmer of hope with the reduced cost of anti-retroviral drugs and the promotion of voluntary counselling and testing (VCT), which enables people to know their status and consequently take action. For this to be realised, political will and well-planned interventions are important prerequisites.

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## **Justice Perceptions in the Workplace: Gender Differences in Kenya**

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