



**HIV/AIDS**  
**and the community**  
**with reference**  
**to Kenya**

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Review Paper

# HIV/AIDS and the community with reference to Kenya

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**In spite of the increased awareness on HIV/AIDS the prevalence rates is increasing in Kenya and in other countries in Sub-Saharan Africa. Statistics on prevalence rates show diversities in gender and across the countries and regions. Among the vulnerable groups are the youth and females for obvious reasons ranging from biological, social-economic and drugs abuse. The impact of the pandemic has caused a major concern at the family and communities levels and has affected government's spending and the development process at all levels. The most vulnerable groups including youth need special targeting in HIV and AIDS programming. In this endeavor, particular emphasis needs to be provision of appropriate information and change of sexual behavior.**

**Key words:** HIV, AIDS, Community and Kenya

## INTRODUCTION

HIV stands for Human Immuno-Deficiency Virus. A Virus is a tiny particle that attaches itself to a cell of another creature and uses it to multiply. There are many types of viruses, which attack different selected cells and in different living things. Some viruses can only affect [plants, others animals and others human beings. Some can affect both animals and humans beings, while others can be harmless to animals and harmful to human beings. Many diseases in animals and human beings are caused by viruses. Some of the viruses are not very harmful, for example those that cause mild illnesses such as common cold while others are haemful such as those that causes ebola, yellow fever and polio, Wanjama, Kimani and Lodiaga (2008). Within the family of viruses are the retroviruses, found in mammals and birds, and which cause different diseases. They for example cause leukemia in cattle, anaemia in horses, arthritis and brain diseases in goats and AIDS in human beings, Mungai (2000).

The Human Immuno-Deficiency Virus (HIV), as its name suggests, affects the human immune system, making it less efficient in protecting the body against infections. The result is that the body's immune system is so suppresses to the extent that it is in a state of a lack of immunity, then referred to as the *Acquired Immuno-Deficiency Syndrome (AIDS)*. When the body is in this state it is vulnerable to being attacked by diseases and

therefore needs special protection, and medicine to boost its immunity. HIV enters the body through either the body's mucus membrane or the blood. HIV only attacks parts of the white blood cells, although there are other components of the blood, namely, plasma, red blood cells and platelets. The white blood cells are a collection of different types of cells that work together to guard the body against virus, bacteria and germs that cause diseases. The specific type of white blood cells that are attacked and eventually destroyed by the HIV are the *cluster Differential 4 (CD4) of the T cells*. The HIV locks itself on the CD4 cell. While inside the cell it starts to reproduce other viruses, eventually destroying the host cell. The destruction takes place on several CD4 cells simultaneously, depending on the number of Human-Immuno Deficiency viruses launched in the body at any one given moment.

The normal range of the CD4 cells in an adult is about 400-1800 per cubic millilitre of the blood volume. The number of the CD4 cells for the children vary, depending on the level of the maturity of the blood system. The highest concentration of the CD4 cells is in the blood, semen and vaginal fluid. As more and more CD4 cells are attacked and destroyed by the HIV, a person's defence system is weakened and therefore the body is less able to defend itself against infections and diseases. For an adult, if the number of the CD4 cells falls below

200 per cubic millilitre of the blood volume, the person is thus diagnosed as being in a state of immune-deficiency and has thus acquired immune-deficiency Syndrome (AIDS). Human Immunodeficiency Virus (HIV), responsible for causing Acquired Immuno-Deficiency Syndrome (AIDS) is currently one of the world's most serious threats to the survival of humanity.

AIDS therefore stand for *Acquired Immune Deficiency Syndrome*, caused by the HIV, through the progression destruction of body's defense cells of the white blood. HIV stands for *Human immuno-deficiency Virus*, the virus that causes AIDS. It is caused by the HIV through the progression destruction of body's defense cells (Cd4 T-Cells of the White Blood Cells). The body becomes liable to frequent attacks of bacteria, virus or disease, unless the person is protected from situations of such attacks by use of Anti Retro-Viro Therapy. This is a combination of management therapy which includes medication, counseling, healthy eating habits, responsible sexual behavior and personal care on day to day basis.

### **How people get infected with HIV**

The HIV must get into the blood system to be able to attack the CD4 cells of the White blood cells. Since the virus is concentrated in the blood, semen and vagina fluid, the easiest way to contact the virus is through direct contact with infected blood or sexual intercourse with an infected partner. Most HIV transmission in Kenya occurs through sexual intercourse with infected partners, which can be through the vagina, anus or the mouth (oral sex). The risk of infection is heightened if one or both partners have sores in their genitalia. Besides HIV unprotected sexual intercourse can cause to other sexually transmitted infections (STIs).

WHO, (2003) define STIs as communicable diseases, mainly transmitted through sexual intercourse with an infected partner. Common STIs are gonorrhea, syphilis, and non-gonococcus urethritis. Getting infected with STIs makes one more vulnerable to HIV infection because they cause sores in the genitalia make it easy for HIV to get into the blood. Moreover people infected with STIs could be as a result of indulging in risky sexual behavior with multiple partners. It is also true that people with HIV may be vulnerable to STIs due to the suppressed immunity.

Protection against HIV and other STIs for the unmarried is to abstain from sexual intercourse until the marriage to one uninfected partner. This thus means that the marrying couple must get tested for HIV before marriage. After marriage the way to remain uninfected is to be faithful to the marriage partner. Due to the high rates of infection among the married and unmarried couples, there is a wide advocacy on the use of condom, which reduces the risks of getting infected with the HIV and other sexually transmitted infections. Condoms are made of latex or polyurethane which provides effective

protection against infection and pregnancy as the virus, bacteria or sperms cannot pass through during the sexual intercourse. Thus, when properly inserted and consistently used the uninfected partner is protected against infection. However, latex can easily be damaged by heat and light and so condoms need proper storage and care. They also need to be opened and inserted with care to avoid compromised protection through tear. Although there are both male and female condoms the former are more readily available. This may be a disadvantage to the female sexual partners, who then may not have control on their male partner's use of the condom.

HIV infection can happen during blood transfusion with infected blood or in any situation which allows blood contact with infected blood. Risks of infection during the transfusion are reduced when by thorough screening. HIV infection can also happen during child delivery if the mother is infected and care is not taken to avoid Mother to Child Transmission (MTCT). MTCT remains a significant contribution to HIV burden in Kenya accounting for between 5-10% of all infected people living with HIV (MoH report 2010). Kenya has been able to control mother to child transmission of HIV through a combination of interventions including good antenatal follow up of pregnant women (with highly active Anti Retro-Viral drugs or prophylaxis) depending on eligibility and safe hospital deliveries.

Other modes of HIV infection through the contact with infected blood can be through fights, tattooing, body piercing, and circumcision ceremonies if the instruments are not sterilized and the sharing of used needles and other skin cutting instruments. These however account for a small fraction of infection. If the person infected with HIV has sores in the mouth, the saliva may contain HIV. In this case oral sex and deep kissing can cause infection. The same would also happen with the sharing of tooth brush. Thus the way to avoid HIV infection is to ensure that there is no exchange of fresh blood and that all body cutting and piercing instruments are not only sterile but are used only once and not shared.

Occupational exposure may be also another mode of HIV infection. This is specifically the risks of infection in the call of duty, mainly for health workers, traditional birth attendants, first aid providers, Home Based Care Providers and police officers as they handle the dead and the injured. To avoid HIV in these occupations it is advised to use protective devices such as gloves when handling people who have sores and cuts.

It is however important to note that while HIV is not transmitted through witchcraft and curse, it is neither transmitted through living together and specifically in sharing food, a bath, touching each other, shaking hands, hugging, playing, working together, coughing or sneezing. It is neither transmitted through sharing hair combs, beddings, towels, clothes, toilets and latrines.

**Table 1:** HIV Prevalence rates by regions in Kenya

Region	Prevalence %
Nyanza	13.5
Nairobi	7.0
Western	6.6
Rift Valley	4.7
Central	4.6
Coast	4.2
Eastern	3.5
North Eastern	3.5
North Eastern	0.9

Source: Kenya National Aids Council (2012)

Mosquitoes, bed bugs or any other insects that bite human beings do not transmit HIV infection.

### AN OVERVIEW OF HIV STATUS IN KENYA

HIV is a Global concern since its discovery in early 1980s. Globally the number of people living with HIV has risen from 8 million in 1989 to over 34 million in 2011. It is a worse situation for Africa in that over 65 % of the infected are in Sub-Saharan Africa, UNAIDS Report (2011). According to Kenya Demographics Profile 2012, HIV/AIDS - adult prevalence

According to the National Aids Control Council, (2012), Kenya is ranked fourth in the world amongst countries with the highest HIV prevalence rate stands at 6.3%, People Living with HIV/AIDS are 1.5 million, deaths due to AIDS are 80,000 and New HIV cases are about 118,000 per year. In Kenya, of the People Living with HIV (PLHIV), 8 % are women and 4% are men. The prevalence rate for women aged 20-24 prevalence is 6.4%, men aged, while that of men within the same age cohort is 1.5%. Rural prevalence rate is 7.2%, while that one of urban is 6.0%. There are also regional diversities in prevalence rates as shown in table 1.

According to the National Aids Control Council, (2012), Kenya is ranked fourth in the world amongst countries with the highest HIV prevalence rate at 6.3 %. South Africa tops the list with Nigeria and India coming in second and third. South Africa has a population of 5.6 million PLHIV, 3.3 million PLHIV in Nigeria and India with a population of 2.6 million PLHIV. Nearly 30 years into the epidemic, however, there are many countries in which negative legal environments undermine HIV responses and punish, rather than protect, people in need.

The impact of the HIV prevalence in Kenya is profound and an impediment toward the achievement of the *country's blue print guiding the development process, namely the Vision 2030*. For instance, AIDS related infections contribute to 29% of all deaths in Kenya – higher than cancer and malaria." This presents a public health and social economic challenge. Further, the high HIV prevalence rate in Kenya has led to numerous human right abuses against PLHIV and HIV affected families.

### Factors fuelling the spread of hiv in the communities in kenya

There are several factors that fuel the spread of HIV infection. They include biological and socio-cultural and economic factors

#### Biological factors

The biological differences between males and females explain the vulnerability to HIV infection, especially to female sexual partners. For females, the larger surface area of the genitalia makes it more conducive for the HIV to penetrate into female's blood system to attack the CD 4 cells. Further the vaginal surface harbours more seminal fluid than the penis does the vaginal fluid. This means that if the male is the one infected with the virus, the female has higher chances of getting HIV infection than it would be to the male if the female is the one infected.

#### Social-cultural factors

Most important on these factors are those that are pinned on cultural practices and beliefs. The practices that hold women as of lower status and subordinate to men make them unable to negotiate for safe sex from their male partners, even when aware of the risks for infection. Their low status is also known to reduce their participation in decision making processes including those related to sexuality, the how and when to have sex with their male partners. Further cultural practices that glorify women's and girls' ignorance on issues surrounding sex and sexuality and their high illiteracy rates hinder their access to accurate information on HIV, sexuality and reproductive rights.

#### Gender based violence and sexual harassment

Gender Based Violence (GBV) which disproportionately affects women and girls as compared to their male counterparts also contributes to the female vulnerability to HIV infection. GBV is any act of violence against girls, boys, women and men due to their gender, resulting in, physical, sexual or psychological harm or suffering. These include threat of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life. Some cultures encourage some forms of GBV and Sexual harassment.

In many cases women and girls are victims of rape, incest, defilement, indecent assault, forced female circumcision, rape, and domestic violence that lead to HIV and other sexually transmitted infections, trauma, or death. The problem of GBV is acute in war and conflict situations where rape is used as a weapon. Sexual violence on male and female victims result in abrasions and tears in the, which increase the chances of HIV infection. In situations of intimate partner violence, which mostly affect women, they dare not negotiate for safer sex or even discuss fidelity with their male partners.

Cultural beliefs have not worked to protect men from

**Table 2:** Myths surrounding HIV/AIDS and sexuality

Myths	Facts
Ignorance about sex is viewed as a sign of purity, and too much knowledge as a sign of immorality	Ignorance is not innocence and information is power
Having multiple sexual partners increase men's prestige and social status among peers	Multiple sex partners increase the risk of HIV infection as well as other STIs.
Abstinence causes male impotence	Abstinence does not in any way affect the male or female reproductive system
Sex with a virgin, preferably a child provides a cure for a man infected with HIV	Presently HIV infection has no cure
People infected with HIV need not use condom	People infected with HIV need to use condom to prevent re-infection
HIV infection is a curse	HIV infects the body the same way other viruses infect the body. It is not a curse.

the vulnerability to HIV infection either. This is because the beliefs that encourage men to be sexually promiscuous and polygamous expose them to risky sexual behaviour. Other practices in Kenya that contribute to male's vulnerability to HIV infection are the male circumcision in two ways, one in cases where it is done traditionally with one cutting instruments for many candidates, and two where the circumcised boys are encouraged to engage in early sex to prove their manhood.

#### **Economic factors**

Many families live in poverty, causing the members to seek for money at all cost, including sex commercial work, which affect girls and women most. In other cases, heads of the families migrate to areas with employment opportunities, mainly in urban. Being away from homes may encourage engagement in risky sexual behaviours outside the marriage, exposing them as well as putting their wives also in the line of infection of HIV and other STIs. Also associated with poverty is lack of quality support for the People Living with HIV, especially in terms of health care, nutrition, shelter, safe and clean water and other basic needs. Further for poor families, children are usually likely not to be in school. This may force the girls into commercial sex work or early marriages, which again expose them to risky sexual behaviour.

#### **Drugs and substance abuse**

Drugs and substance abuse play a key role in the spread of HIV. The practice mostly affect the youth in and out of school. Once under the influence of the drugs and/or substances, people lose control over their sexual actions and thus indulge in risky sex which exposes them to possible HIV infection. Other drugs are taken through injections in groups and with shared injections, exposing the users to possibilities of HIV infection.

#### **Myths surrounding HIV/AIDS and sexuality**

There are known myths surrounding HIV/AIDS and sexuality, which have fuelled the spread of infection

(table 2). The holding the myths confuse many people, making them indulge in risky sexual behaviour and therefore become more vulnerable to HIV and other STIs. While different cultures have different myths, others cut across cultures. What is critical is to appreciate that the myths are not true and therefore need to be dismissed with the truth.

#### **Youth, sexuality and HIV/AIDS**

The United Nations Population Fund (UNPF, 2003) observes that half of the 5 million new cases of HIV infections occur in youth aged 15 to 24 years. Venier and Ross (2010) in their study in South Africa found out that in communities with high sero-prevalence rates, most new HIV/AIDS infections occur during adolescence. For young women between the ages of 15 and 24, HIV sero-prevalence is estimated to be between 23% and 27%. For young men of this same age group, sero-prevalence is believed to be between 8% and 15% (UNAIDS, 2008). This high rates of HIV infections in young people point to the urgency of fighting HIV/ AIDS among the youth.

In such situation, it is important that an understanding of youth sexual culture and the context of high risk sexual activity be developed. Such understanding should provide the basis upon which programmes aimed at promoting safer sex practices are based. One of the main obstacles to reducing the spread of HIV/ AIDS has been cultural norms regarding gender roles that impact on sexual behaviour. This challenge is particularly relevant for our youth, who inherit these views from their cultural environment, act upon these beliefs with often disastrous health consequences and transmit these beliefs to their own off-springs; perpetuating a cycle of gender inequality and related sexual behaviour. This chapter addresses the challenges of cultural gender-related beliefs that are fundamental to combating the spread of HIV/AIDS among the youth.

The recent Kenya Demographic and Health Survey report outlines the latest information about Kenya's young people age 15 to 24. This report says that almost half of

young women have sex by the time they turn 18, and more than one in ten (13%) have sex by the time they are 15. Young men start having sex at an earlier age. Sixty per cent had sex by age 18 and quarter had sex by age 15. The report also continues that almost a quarter of young Kenyan women (age 15-19) are either pregnant with the first child or already mothers. The rate of teenage pregnancy/motherhood is highest in North Eastern, Coast and Rift Valley.

Adolescent is a period of turbulence and an adolescent is a person in crisis (Kamaara, 2005:3). Some views and theories on human sexuality, as well forms of sexual behaviour are common among young people in Africa. Various authors point out that human sexuality cannot be explained by one theory alone, but by a synthesis of various theories. Other views are that the meaning behind the multiple sexual partnerships of young men in their efforts to seek fulfil their ego is influenced by strong peer pressure and social norms that condone sexual violence and impede safer sex practices. Disparities between AIDs awareness and functional knowledge about the disease and sexuality also lead to the increment of the infections.

Factors such as female sexual submissiveness, entrenched convictions of male dominance, high levels of sexual violence, social acceptance of the 'sugar daddy' phenomenon, and the fear of HIV/AIDS leading men to seek relations with a pool of increasingly younger women and girls have all been identified by the above authors as unique features of the African setting, and which influence the high rates of HIV/AIDS. Gage (1998) provides an analysis of the 'rational' way in which adolescents make 'irrational' decisions. The use of contraceptives, including the condom, and decisions on whether and when to engage in sex, are seen by Gage as comprising a complex cost-benefit analysis that influences adolescent sexual decision-making.

Traditionally, in most of the Kenyan communities, there is a strong association between condoms and the notions of unfaithfulness, lack of love, and disease that are incompatible with manliness. A young girl seen with a condom is perceived as a prostitute and a young man seen with condoms is not a man. All these perceptions continue to provide barriers against safer sex practices. Then there are the plethora of sexual myths (as outlined above) held by young people and the loss of traditional means of sex education that have left Kenyan youth vulnerable and confused when negotiating sexuality in the context of HIV/AIDS

A descriptive study of HIV –related issues among Kenyan adolescents has been provided by Nzyoko et al.(1997). Here, the behaviour of young people at popular truck stops was examined with regard to the expected implications for HIV transmission. What came out here was that these young girls who present themselves to truck drivers without taking precaution are driven by

poverty. This is because of economic factors as already mentioned above. The need to survive makes these young girls take that high risk.

It has also to be noted that traditionally, in most of the Kenyan communities, there is a strong association between condoms and the notions of unfaithfulness, lack of love, and disease that are incompatible with manliness. A young girl seen with a condom is perceived as a prostitute and a young man seen with condoms is not a man. All these perceptions continue to provide barriers against safer sex practices. Then there are the plethora of sexual myths (as outlined above) held by young people and the loss of traditional means of sex education that have left Kenyan youth vulnerable and confused when negotiating sexuality in the context of HIV/AIDS

Focusing on southern Africa, Kalunde (997) examined the behaviour of youth in Zambia, noting how HIV/AIDS was not perceived as a personal threat to the lives of young people, despite very high sero-prevalence rates in that country. Such beliefs compounded by abject poverty seem to prevail throughout the subcontinent. Starting in the early 1990s, a number of variables represented in that population's high- risk profile awareness of condoms and knowledge of AIDS (Kapiga et al., 1991; Klepp et al., 1994; Mnyika et al, 1995; Lugoe et al., 1996). These studies represent quantifiable variables that are discerned but largely de-contextualized; however, contemporary sexual culture through an analysis of past and present modes of sex that should form the basis of education in various African countries. There is currently a growing number of post graduate theses by African students based on primary research of youth sexuality and HIV/AD and these theses will no doubt increase as the epidemic grows and changes.

As a population sub-sector characterized by attitudes and behaviours such as notions of infallibility (*Green et al., 2000*), sexual experimentation and high turnover of sexual partners (*Klrahne and Reiss, 1995; Lear, 1995; Akande, 1997; Varga, 1997*), young people have been of interest to researchers since the start of the HIV/AIDS epidemic in Africa. Richter's (1996) study of age of onset of sexual activity showed that South African youth became sexually active on average between the ages of 13 to 15 years. Such statistics are borne out by information received from provincial hospitals in the greater Durban area, where girls as young as 13 are currently being diagnosed HIV-positive. This age group represents adolescence, the time period in which the development and formation of sexuality is taking place. This developmental period may be constructed and conducted in such a way that enhances vulnerability and makes people prime candidates for new infection.

What is of interest in much of the African research on HIV/AIDS and youth is the conclusion drawn by many researchers that an analysis of the factors propelling or

mitigating the spread of HIV/AIDS. Yet, few local researchers have actually delved into this effusive, complex and highly equivocal arena called 'sexual culture'. Ongoing work by Kelly and his associates (Kelly, 2000,) Kelly and Parker, 2000; Kelly and Nonjeke, 2001) and the current author (Leclerc-Madlala, 1997, 1999, 2001a and b) are examples of South African studies where high risk youth sexuality is conceptualized primarily as an *environmental, social and cultural problem that often and effectively dis-enables youth from transforming safe sex knowledge into functional, health-promoting, safer-sex behaviour*. As such, this genre of research moves beyond the well-worn approach to the problem of HIV/AIDS as being a problem located within the individual, and built around western-derived theories of human behaviour and rational elsewhere have relied upon the assumption that correct information on transmission and prevention would lead to behavioural change (Fishbein, 2000; Muli, 2000; UNAIDS, 1999).

With Africa's HIV/AIDS statistics continuing to sky rocket beyond expectation it seems that for the most part, the agenda for research and intervention have thus far done very little to affect the course of the epidemic. The challenge for future researchers therefore lies in a more detailed analysis of how the various components identified as contributing to the high risk HIV/AIDS profile of youth (i.e. socio-cultural norms of gender equality, sexual violence, multiple partnership for men, lack of sex education, negative attitudes towards the condom, pressure to prove fertility, fatalistic attitudes, dangerous myths etc.) are linked to and maintained by socio-sexual/cultural/context that make behavioural change difficult. On the other hand, the most significant finding to emerge from existing studies of the developed world should have informed the African research agenda early on and directed the attention of researchers to the need for a better understanding of the socio-cultural context of sexual behaviour. As observed by Di Clemente, (1990); Slonim-Nevo et al., (1991) this appeared to have had little impact on intended sexual behaviour of young people.

### **Impact of HIV/AIDS**

HIV/AIDS has spread with ferocious speed. Nearly 34 million people in the world are currently living with HIV/AIDS, one-third of whom are young people between the ages of 10 and 24. The epidemic continues to grow, as 16,000 people worldwide become newly infected each day. AIDS already accounts for 9 per cent of adult deaths from infectious disease in the developing world, a share that is expected to quadruple by 2020 (UNIADS, 2012). Nowhere has the impact of HIV/AIDS been more severe than Sub-Saharan Africa. All but unknown a generation ago, today it poses the foremost threat to development in the region. By any measure, and at all levels, its impact is simply staggering. At the regional level, more than 11 million Africans have already died, and another 22 million

are now living with HIV/AIDS. That is two-thirds of all the cases presently on earth. At the national level, the 21 countries with the highest HIV prevalence are in Africa. In at least 10 other African countries, prevalence rates among adults exceed 10 per cent. At the individual level, the arithmetic of risk is horrific. In many African countries, the lifetime risk of dying of AIDS is greater than one in three.

Tragically, mass killers are nothing new in Africa. Malaria still claims about as many African lives as AIDS, and preventable childhood diseases kill millions of others. What sets AIDS apart, however, is its unprecedented impact on regional development. Because it kills so many adults in the prime of their working and parenting lives, it decimates the workforce, fractures and impoverishes families, orphans millions, and shreds the fabric of communities. The costs it imposes force countries to make heart-breaking choices between today's and future lives, and between health and dozens of other vital investments for development. Given these realities, HIV/AIDS is no longer just a public health problem. It is a development crisis. African governments and their partners must act now to prevent further HIV infections and to care for support the millions of Africans already infected and affected.

HIV/AIDS are transforming the environment in which we live. Major HIV- and AIDS- related changes have occurred and continue to occur in the economic, social, cultural and health situations of families and communities. The numbers we have seen above are not just statistics. They represent Fathers, Mothers, Sisters, Brothers, Relatives and the community at large. HIV/AIDS has negative impact on all sectors of the economy, social and cultural activities. Nationally, severely affected countries record slower economic growth than in an AIDS-free situation. At the business and industrial level, enterprises are experiencing serious losses in the workforce, higher costs, smaller markets, and reduced profitability. Households and families are encountering higher expenditures, reduced incomes, and in many cases increased poverty. As a whole, all levels are being affected by the diversion of resources to health costs, reduced investments and savings, the loss of skills, and fewer economically productive young or middle-aged individuals to support the elderly and the very young.

Cumulatively, these effects result in the availability of fewer financial resources, irrespective of their source, for education. The public sector's investment in education is less than it would be in an AIDS-free situation. The private sector has fewer resources at its disposal. Survival is the first concern of households and families, with educational expenditures not ranking high on their list of priorities. The AIDS epidemic has had, for instance a major impacts on the social climate in which education systems operate. For instance, the composition of

households is changing; more and more households are headed by women or are lacking the presence of an adult. While the epidemic is creating an ever-increasing number of orphans and vulnerable children, the silence, misunderstanding, isolation, stigma and discrimination that surround the epidemic have clouded social relationships with uneasiness and suspicion. Communities feel under pressure to provide support for affected families, especially those that care for the sick. Evidently, a growing burden of childcare is being entrusted to grandparents and the elderly, and as traditional safety nets collapse there is an increase in the mobility of people in search of assistance and employment.

The AIDS epidemic is also bringing changes in a number of cultural areas. Although there is still much reluctance to talk about sexuality, the topic is not as taboo as in the past. One outcome is a heightening of expectations that schools will offer HIV/AIDS and sexuality education to their students. Determined efforts are being made to end practices that favour HIV transmission, such as female genital mutilation, wife inheritance and widow cleansing. Because funerals have become so frequent, that the time and resources spent on them are being reduced, while in some places burial rites have become shorter.

Many of the health impacts are more apparent. In severely affected areas many suffer from extensive, chronic illness, with the situation being made worse in many cases by inadequate healthcare systems. A very high proportion of hospital beds are occupied by patients with AIDS – up to two thirds in many institutions. AIDS-related spending on health services has increased at national and household levels. There is an increasing focus on gaining access to antiretroviral and other life-sustaining drugs. The epidemic is causing a gradual transformation of the entire social environment, affecting all sectors. However, the education sector is unique in the way that it encompasses a vast number of learners and educators, with a great prevalence of young people who, because of their age, are especially vulnerable to HIV infection. It also heightens the need for it to be more responsive to the way the epidemic is changing the context for educational provision.

### **Gender related impact of HIV/AIDS**

Due to the different roles and responsibilities assumed by men and women, AIDS in the family affects men, women, boys and girls differently and the impact also varies on whether it is the man or woman who falls sick. Due to gender disparity in income amongst most Kenyan household, when the man falls ill, there will be a drop in disposable household income. However, in some societies when the woman falls ill there will be a noticeable food security problem. With the current setting of gender in terms of gainful employment, when a man dies from AIDS, his partner is likely to lose her main or

only source of economic and social support; this encourages some cultural practices as wife inheritance that foster the spread of HIV/AIDS. In some societies where these practices are not common, a destitute widow may be forced into exchanging sex for money as a means of survival.

The burden of caring for a sick man usually remains in the hands of the woman and female children, usually resulting in increased school dropout rates for HIV/AIDS affected children. On the other hand, in the case of a woman having AIDS, the burden of care falls on children, especially female children. This is because traditionally, men work out of the home and are not bothered about basic household chores such as cooking, caring for children and the sick. These tasks are often considered gender specific, hence socially and culturally unacceptable for men. This forces most men to re marry in the event of the death of their spouses. These men are likely to be infected thus placing the new spouse at risk of HIV. Children who lose one or both parents from AIDS are likely to be discriminated at school. AIDS orphans are usually cared for by extended female family members and these kids are likely to drop out of school due to lack of finance. Boys and girls are affected differently. Girls are usually forced into earlier marriages with older men, or they turn to commercial sex as a source of income.

### **Youth and HIV/AIDS in Kenya**

In Kenya, the youth represent the most rapidly growing components of new HIV/AIDS infection, with girls outnumbering boys by a substantial factor. As discussed elsewhere in this chapter, there are varied factors for this vulnerability. However the bottom line is that the youth often find it difficult to get accurate and practical information on sexual matters from the parents, teachers or health professionals and are forced to rely on incomplete information circulating in peer groups. To reduce the vulnerability, the youth should be facilitated in a gender responsive manner to participate in programme planning, implementation, monitoring and evaluation that focus on their lives. There is also need to get youth friendly services and centres where they can access information, support and referral, in addition to better parental involvement in giving better communication, guidance and support. Another critical area is promotion of skills-based education about HIV/AIDS as well as protection of girls and women against sexual abuse and exploitation. Communities need a comprehensive programme focusing on the sensitization and education of youth about their sexuality and behaviour. Another strategy would be to scale up the establishment of networks for young people, including those living with HIV/AIDS, for prevention, protection of human rights and promotion of acceptance by society, with an emphasis on taking responsibility in decision-making in matters related to sexual behaviour and peer influence.

## MANAGEMENT OF HIV/AIDS

In Kenya, strategies to reduce HIV infection and management of the infected and affected have been scaling up since the declaration of the pandemic as a National disaster on November 25<sup>th</sup> 1999 and the development of the National HIV/AIDS policy in December 1999. Most remarkable in spearheading the strategies and activities have been the Ministry of Health, National Aids Council, NGOs, CBOs, FBOs, mostly with the support from the government and donor agencies. The efforts have centred around the National strategies whose focus has been on management, care and support for HIV/AIDS, as a result of which many VCTs have been opened country-wide. Since 2000, the ministry of education has integrated issues of HIV and sexuality into the curriculum at primary and secondary education. The media has also been in the forefront in advocacy and awareness raising.

The HIV/AIDS Management and Prevention Act 2003 was passed in 2003. Its main purpose was to manage and provide avenues towards prevention and spread of HIV/AIDS. Its main emphasis is that People living with HIV/AIDS PLWHA have the same rights as everyone else and therefore need protection. The objective of Act are to protect the privacy; liberty and mobility rights of persons infected or affected by HIV/AIDS; provide an atmosphere where persons are encouraged to go in for voluntary testing and post-test counselling and support services; (Section 1); prevention of mandatory HIV testing and safeguarding confidentiality. The Act empowers an affected person to seek redress from the Courts and also allows for penalties to be imposed by the courts of law either through a monetary fine, a jail term or both.

Although the emphasis has been on abstinence, and faithfulness, the condom use has now taken centre stage in the campaign among all sexually active people. Also important has been the discouragement of retrogressive cultural practices that encourage risky sexual behaviour, for example Female Genital Mutilation (FGM) for girls, early marriages, wife inheritance and polygamy, among others. Other strategies that have been scaled up in the campaign have been advocacy and support for girls' education and encouraged male circumcision.

The youth however need a special focus in the campaign to reduce HIV infection. There is therefore need to continue building support of AIDS control among the youth by ensuring that young people become more aware of risks for HIV and the strategies to avoid the infection. Parents/guardians and more Leaders need to speak out about the HIV among the youth. It is also important for education and communication messages must go beyond merely offering information in terms of change of sexual behavior and emphasize on enhancing social-skills for abstinence as well as delay of sexual debut. Girls in particular need to be prepared with survival skills to say no to sexual advances or negotiation

for safe sex with sexual partners. Equally important is to educate parents to provide HIV education to their children early, long before children become sexually active.

Ministry of education need to continue to lobby and support CBOs FBOs and NGOs working with communities to give top priority to funding activities to reduce HIV infection, and enhance efforts to encourage the communities to change social norms as efforts to reduce individual risk taking. The CBOs and FBOs are well placed to campaign on the importance of education for both girls and boys, especially in the communities with low enrollment and transition rates from primary to secondary and secondary to primary. As most programs for the youth are found to work better when the young people help to plan and run them, the same should be done for HIV.

Additionally, HIV programs facilitators must find out more effective ways to reach parents and adults who can influence young peoples' life. The programs need to reach out to vulnerable youth among street children, commercial sex workers, and millions of young people orphaned by AIDS. Youth should be encouraged to use condoms, with an emphasis on the correct and consistent use of the same as they are the only devices that can protect against HIV infection as well as against pregnancy. As such condoms should be widely accessible in strategic places in the community and learning institutions. To serve young people better, health care must do more to make young people feel more welcome and comfortable to access the services. These include treatment of STIs, VCTs reproductive health services for adolescent mothers, anti-natal and referrals.

## CONCLUSION

The most striking feature about HIV/AIDS in Kenya is that individuals and communities have been mobilized and sensitized about it. To this effect, people are not only speaking out but community support groups and local institutions are coming into existence in support of the infected/affected and reduction of the HIV infection. However, given the increased prevalence rates in Kenya, the commitment of community agents of change need to be transformed into active force for change of sexual behavior. For these to happen, there must be a new social contracts and partnerships among men and women, girls and boys. This is because HIV/AIDS and its impact on society can only be overcome if men and women, girls and boys begin to forge true partnerships of mutual respect and trust, and of equitable sharing of the burden of sickness, pain, care and support created by the epidemic. Within the expected partnership, there is need to appreciate that man or woman alone cannot stop the spread of HIV, nor care for the infected and affected. Women alone cannot bear the burden of its psychological, social, and economic impact nor should this be expected of them. Further there is need for to

establish an honest communication about sexuality and sexual behavior to prevent the transmission of HIV.

## REFERENCES

- Akande A (1997). 'Black South African Adolescents' Attitudes Towards AIDS Precautions.' *School Psychology International*, 18(4): 325-342.
- Gage A (1998). 'Sexual Activity and Contraceptive Use: The Components of the Decision Making Process.' *Students in Family Planning*, 29(2): 154-166.
- Kalunde W (1997). 'HIV/AIDS and Sexual Behaviour Among Youth in Zambia'. *Health Transition Review (Review (Supp.)* 3(7): 91-95.
- Kaamara EK (2005). Gender Youth Sexuality, And HIV/AIDS: A Kenyan Experience. *Gaba Publication*, Limuru, Kenya.
- Kelly K (2000). 'Communication for Action. A Contextual Evaluation of Youth Responses to HIV/AIDS.' *Sentinel Site Monitoring and Evaluation Project Report*. Pretoria: Department of Health.
- Mnyika K, Klepp K, Kvale G, Schreiner A, Seha M (1995). 'Condom Awareness and use in Arusha and Kilimanjaro Regions, Tanzania: A Population-based Study.' *AIDS Education and Prevention*, 7: 403-414.
- Muli A (2000). HIV/AIDS Awareness: What Impact on Behaviour Change? Kenya Partner News (on-line). [http://www.ms-dan.dk/ik.country/ms-ken/partnernews/3\\_2000/hivawareness.htm](http://www.ms-dan.dk/ik.country/ms-ken/partnernews/3_2000/hivawareness.htm).
- Museveni Y (1997). 'AIDS: A Socioeconomic Disease'. *The Pan-Africanist*, 1(2): 39-41. Behaviour Among Students at the University of Natal, Durban', AIDS Committee Project.
- Nzyoko S, Lurie P, McFarland W, Leyden W, Nyamwaya D, Mandel J (1997). 'Adolescent Sexual Behaviour Along the Trans-Africa Highway in Kenya'. *AIDS* 11, 21-26.
- Oliver M (1996). 'Adolescents' Perceptions of Sexuality'. *South African Journal of Education*, 16(1): 5-8.
- Peguegnat W, Stover E (2000). 'Behavioral Prevention is Today's AIDS Vaccine!' *AIDS*, 14 (2): 1-17.
- Perkel A, Strebel A, Joubert G (1991). The Psychology of AIDS Transmission: Issues for Intervention'. *South African Journal of Psychology*, 21(3): 148-152.
- Preston-Whyte E, Zondi M (1991). 'Adolescent Sexuality and its implications for Teenage Pregnancy and AIDS'. *Continuing Medical Education*, 9(11), 1389-1394.
- Preston-Whyte E, Zondi M (1992). 'African Teenage Pregnancy: Whose Problem?' In S. Burman and E. Preston-Whyte (eds). *Questionable Issues: Illegitimacy in South Africa*. Cape Town: Oxford University Press.
- Preston-Whyte E (1994). 'Gender and the Lost Generation: The Dynamics of HIV Transmission Among Black South African Teenagers in KwaZulu-Natal'. *Health Transition Review (Supp.)* 4,241-255.
- Richter L, Swart-Kruger J (1995). 'AIDS-Risk Among Street Children and Implication for Intervention. *South African Journal of Youth Psychology*, 25(1): 31-38.
- Roos J, Pretorius H, Visser M (1995). 'A Proposed Strategy for Changing High-Risk Sexual Behaviour Among Students at Tertiary Institutions. A Qualitative Investigation with a view to Developing a Prevention Programme'. *Journal of Comprehensive Health*, 6(2): 81-89.
- Schwab ZL, Kiragu K (1998). "The Health Consequences of Adolescent Sexual and Fertility Behaviour in Sub-Saharan Africa". *Studies in Family Planning*, 29(2): 201-232.
- Slovin-Nevo V, Ozawa M, Auslander W (1992). 'Knowledge Attitudes and Behaviour Related to AIDS Among Youth in Residential Centres: Results From an Exploratory Study'. *Journal of Adolescence*, 14: 17-33.
- Swart-Kruger J, Richter L (1997). AIDS -Related Knowledge, Attitudes and Behaviour Among South African Street Youth: Reflections on Power, Sexuality and the Autonomous Self'. *Social Science and Medicine*, 45(6): 957-966.
- UNAIDS (2000). *Men and AIDS: A Gendered Approach*. Geneva: United Nations AIDS Programme.
- Varga C, Makubalo A (2000). 'The Forgotten Fifty Percent: "A Review of Sexual and Reproductive Health Literature on Boys and Young Men in Sub-Saharan Africa". Paper Presented at Meeting on Health and Development Needs of Male Adolescents and Young Men, Pretoria.
- Venier J, Ross M (1997). 'HIV/AIDS Related Social Anxieties in Adolescents in Three African Countries'. *Social Science and Medicine*, 46(3): 313-320.
- Wanjama LN, Kimani EN, Lodiaga J. M. *HIV and AIDS: The Pandemic*. Nairobi: The Jommo Kenyatta Foundation.
- Whiteside A, Sunter C (2000). *AIDS: The Challenge for South Africa*. Tafelberg: Human and Rousseau.
- Whiteside A, Stover J (1997). 'The Demographic and Economic Impact of AIDS in Africa'. *AIDS (Supp.)*, 11, 55-61.