SESSIONAL PAPER NO. 4 OF 1997 ON AIDS IN KENYA

MINISTRY OF HEALTH

THE NATIONAL AIDS AND STDS CONTROL PROGRAMME OF KENYA (NASCOP)

STATEMENT OF THE PROBLEM

The Ministry of Health estimates that *200, 000 Kenyans died of AIDS* between 1984 and 1995. If AMS prevention and control measures are not pursed more aggressively and Kenyans change their sexual behaviour in order to reduce the number of new infections, up to one million men, women and children may die of AIDS by the year 2000. In 1995, AIDS was reported to be the leading killer of men and women aged 15-39 years in sub-Saharan Africa. The incidence of deaths due to AIDS is still increasing because of the existence of a large pool of people with MV infection. It is projected that the number of deaths due to AIDS among people aged 15-39 years in Kenya during the period 1995-2000 may be three times the number of deaths due to all other diseases combined. *AIDS affects development and security.*

AIDS kills young economically productive people, brings hardship to families, increases expenditure on health care and adversely affects the country's development. By depriving the economy of 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 ofhealth care, AIDS poses a great challenge to Kenya's development. The loss of skilled uniformed officers has security implications.

In order to overcome these challenges, *a strong political commitment at the highest level*, implementation of a *multi-sectoral AIDS prevention and control strategy* with priority focus on young people, mobilisation of resources for financing HIV prevention, care and support, and establishment of *National AIDS Council* to provide leadership at the highest level possible are critical.

AIDS is a new disease. The first case was reported in the United States of America in 1981. It is caused by Human Immunodeficiency Virus (EW). EW is transmitted through sexual contact, infected blood and from an infected mother to a child. By the end of June 1996, the World Health Organisation estimated 28 million people world-wide to have been infected with EW and 5 million dead due to AIDS.

It is projected that by the year 2000, the cumulative number of people infected will be 30-40 million. Ninety percent of these people win be in developing countries. Analysis of HIV infections by geographic
distribution reveals that the highest concentration of the epidemic is in the sub- Saharan Affica accounting for approximately 70% ofall HIV infections world-wide. Kenya is one of the countries in this region most affected by this epidemic. The main reasons for the rapid spread of AIDS in Affica are not clearly understood. However, ignorance, poverty, high incidence of sexually transmitted diseases, socio-cultural beliefs and practices, civil war and deficient public health inflastructure are the main factors.
In Kenya, AIDS was first recognised in 1984. The number of new AIDS cases reported in one year has been on average 12,000 since 1990. However, due to under reporting, missed diagnosis and delays in reporting, reported cases only represent the tip of the iceberg. The valid estimate may be three times what is reported. Men and women are infected in equal proportions. 80% of the cases occur in the age-group 15 to 49 years while 10% are children under the age of 5 years. The epidemic is more advanced in Nyanza, Western and parts of Rift Valley provinces where IRV prevalence rates among pregnant women are 15% to 30%. It is estimated that if current infection rates continue, the number of people infected will increase from 1.1 million in 1995 to 1.7 million by the turn of the century. Sexual contact accounts for up to 90% of AIDS cases in Kenya. Heterosexual contact is the main mode oftransmission. However, bisexual contact has been reported in some parts ofthe country particularly Coast Province, and among confined groups like Prisoners. Homosexual contact has not been reported in Kenya. Mother to child transmission is growing in importance because of the high HIV infection rates among young women. This mode of transmission together with exposure to infected blood accounts for about 10-20% of AIDS cases in Kenya.

Exposure to infected blood occurs through transfusion ofblood and blood products, injections, traditional surgical practices, and skin-piercing where instruments are shared.

1.1 Government response to AIDS
When the first case of AIDS was recognised in Kenya, the Government responded by taking the following measures:

a) *Establishment of National AIDS Committee and the development of strategic plans*
The National AIDS Committee was established in 1985 to advise the Government on all matters related to the prevention and control of AIDS. AIDS Programme Secretariat (APS) was established in the office of the Director of Medical Services to co-ordinate programme activities. These steps led to the establishment ofKenya National AIDS Control Programme in 1987 which was then followed by the development of a five year strategic plan, Medium Term Plan (1987-91). This plan enphasised creation ofawareness about AIDS, blood safety, clinical management ofAIDS opportunistic infections and capacity building for management ofAIDS control programme at national level. The main strategies pursued were the prevention of sexual transmission, prevention of transmission through blood, prevention of mother to child transmission and disease surveillance. Second Medium TermPlan (1992-96) continued to pursue the same strategies but in addition emphasised the need to involve an sectors in HIV prevention in order to mobilise broader National response against the epidemic. The new plan also emphasised the need to provide care and social support to people infected with HIV, their families and community; the need to reduce the social and economic consequences of HIV/AIDS and the strengthening of national and district capacity to respond to the epidemic.

b) *Recognition ofAIDS as a development issue*
This led to devoting a whole chapter on AIDS hi the Seventh National Development Plan and the Fifth District Development Plans.

c) *Recognition of STD control as a priority intervention*
The recognition that Sexually Transmitted Diseases facilitate the spread of EW led to integration of STD control into AILD S Control thus establishing NASCOP in 1992.

d) *Resource mobilisation*
The Government received considerable support from multilateral and bilateral donors in the financing ofAIDS control activities during the first half of the first MTP. However, it became apparent to the Government that while the epidemic was getting worse, funding from donors was rapidly declining. In 1993, the Government approached the World Bank for a credit to help finance HIV prevention and care. The World Bank approved a credit of US$ 40 million from the International Development Association (IDA) in 1995 for Sexually Transmitted Infections. The Government appeals to donor agencies for assistance towards EW prevention and care. The annual requirement for HIV prevention alone is estimated to be 40 million Kenya Pounds. This excludes the cost of care. Cost benefit analysis in Kenya has shown that for every shilling invested in HIV prevention, there are thirty shillings net savings in benefits. Effective resource mobilisation and use of these resources require that an appropriate policy framework be put in place to guide programme implementation, particularly where many actors including Non-Governmental Organisations, Community Based Organisations and the private sector are involved. Hence the preparation of this paper.

1.2 Major achievements
Evaluation of the impact of interventions undertaken in Kenya since HIV was first recognised has identified the following areas of major achievements:

a) *High Level of awareness attained*
National Survey in 1993 revealed that 90% of men and women (15-49 years), were aware of sexual transmission of AIDS irrespective ofurban-rural residence, level of education or province of residence. However, misconceptions about the modes of transmission of HIV, particularly mosquito bites and kissing, were very high (50% of respondents). There is still need to intensify AIDS awareness particularly among young people and people living in rural areas.

b) *Safe blood transfusion*
Infrastructure for screening of blood for HIV has been established. This includes the availability of ERV blood screening facilities in most district, provincial, mission and private hospitals, supply of HIV testing reagents, maintenance of HIV screening machines, training of laboratory personnel and education of blood donors. This has ensured that 98% of blood for transfusion is screened for HIV in Kenya. However, the maintenance of this infrastructure to make it responsive to the rapidly changing technology in HIV screening has put considerable strain on the National AIDS Programme due to resource limitations. *Kenya Pounds 10 million is required every year to maintain an effective HIV blood screening programme.*

c) *Advocacy*
The National AIDS Programme has been instrumental in advocacy on critical issues pertaining to law, ethics, culture, vulnerability of women, and youth among others. The programme has developed partnerships with NG0s, Community Based Organisations and international agencies working in the area of AIDS, human rights and development.

d) *HIV Surveillance*
Surveillance systems for monitoring the trend of HIV epidemic and AIDS cases is established. Kenya is one of the few countries in the World with an efective HIV sentinel surveillance, AIDS case surveillance programme and reliable epidemiological database on AIDS. District capacity to implement HIV prevention has been realised through the establishment of District Inter-sectoral AIDS co-ordinating Committees which bring together representatives of Government departments, NG0s and Community Based Organisations. The Ministry of Health has since 1995 decentralised AIDS activities to the districts by issuing authority to incur expenditure to District Medical Officers for AIDS control.

e) *NG0s participation*
Many NG0s and Community Based Organisations are involved in HIV prevention and care activities. A consortium ofNG0s working in HIV prevention and care exists.

1.3 Major Constraints
The major constraints that plague AIDS control in Kenya include the slow pace of change of sexual behaviour, resource limitations, poverty, harsh effects of structural adjustment programmes on the vulnerable groups particularly widows and orphans, rapid increase in the number ofpeople developing AIDS and needing medical care and social support, overburdened NASCOP, and lack of a clear policy framework to guide implementing agencies.

Although remarkable efforts have been made in Kenya to control the spread of WV and to reduce the impact ofAIDS on individuals, families, communities and the Nation as a whole, the epidemic remains powerful and dynamic, evolving with changing and unpredictable patterns in diffierent communities. In communities where the epidemic is advanced and appears to be levelling in the general population, infection rates are increasing among young women. Within these communities, a new epidemic of orphaned children and widows has emerged.

Objectives of Sessional Paper on AIDS
The aim of the Sessional Paper on AIDS is to provide apolicy_framework within which AIDS prevention and control efflorts will be undertaken for the next 15 years and beyond. Specifically:

a) The SPA will give direction on how to handle controversial issues 6 while taking into account prevailing circumstances and the socialcultural environment.

b) It will enable the government to play its leadership role in AIDS prevention and control activities. Challenges posed by AIDS call for a multi-sectoral approach thus bringing a diversity of actors together. Their roles will be harmonised within the framework of this SPA.

c) SPA will recommend an appropriate institutional framework for effiective management and coordination ofMV/AIDS programme activities.

AIDS CHALLENGES
AIDS is a major development and health problem. If affects socioeconomic and cultural aspects of life. It destroys young members of the population who are economically productive thus disrupting development. Behaviour change which is critical for effiective prevention and control measures takes a longtime to be realized because issues related to sexuality are taboo, private and intimate.

2.1 Economic Impact
AIDS has significant effects on demographic composition of the population, and on social and economic structures of the country. The disease has negative effects on life expectancy, infant mortality, adult mortality, and dependency ratios. At the micro level, AIDS brings hardships to the family by reducing the capacity to cam income. It adversely affects health care expenditures as well as the overall development of the country at macro-economic level. Thus, AIDS has adverse economic repercussions given its negative impact on population trends, labour productivity and overall social costs.

2.2. Morbidity and mortality
Most Kenyans with HIV infection look healthy and have no symptoms. This is due to the long incubation period ofAIDS. Because up to 80% of people infected are in the age-group 15-49 years, effective labour force for the country is threatened. The number of deaths arising from fix blown AIDS remains a small proportion of the HIV positive population but is growing steadily. It is estimated that whereas 16,000 people died of the disease by 1989, and 200,000 by 1995, the cumulative figure is projected to increase to 1 million by the year 2000.

The economic consequences of increasing deaths particularly in the rural areas will be the deprivation ofthe agricultural sector ofits required labour force, noting that 74% of Kenya's labour force is engaged in small scale farming.

Increasing deaths due to AIDS results in higher child and adult dependency ratios, which imply greater demand for health and education services. More single parents especially mothers and AIDS orphans win raise the demand for social services. Because it is the duty of the Government to provide these social services, the implications of this will be the diversion of investment funds to meet the increased demands for social services. In addition, the country will have a restricted tax base thus reducing the Government's ability to meet the demand for social services.

2.3 Costs to the economy
The direct and indirect costs oftreating AIDS patients can be quantified. Direct costs include the cost of drugs, laboratory tests, radiology and hospital overhead costs. Indirect costs involve the average productive life-yearslost. Surveys in Kenya indicate that a productive person can be defined to be one aged between 15 and 65 years. An adult therefore has 50 years available for work. On average, a Kenyan is employed for 36 years. Combining productive life-years lost with the age of those who develop AIDS, each new AIDS case results in a total loss of 22 years of productivelife. The average direct cost per new AIDS case is estimated to be Kshs. 34,680 assuming that 55 per cent of AIDS patients receive hospital treatment plus an estimated indirect cost ofKshs. 538,560 in lost wages. This gives the combined cost ofAIDS to be Kshs. 573,240. These costs are very high for a young economy like that of Kenya.

In order for the Government to meet the costs of treating AIDS and related diseases it must adopt a strategy of partnership with the private sector, NGOs, donor agencies and the community in health care financing. Education programmes through the clergy, politicians, provincial administration and community leaders to create awareness among Kenyans in order to curb flu-ther spread of AIDS is a priority

2.4 Social and cultural challenges
Heterosexual relations are primarily determined by psychological and social-cultural factors. It is important to understand the dynamics underlying these factors as they can facilitate and also prevent HIV transmission. Sexual instinct is triggered by both internal and external influences. Psycho-sexual development and socialization of norms and values within the fanilly or conrinunity and the inherent social organizat ion are important instruments in the regulation of sexual behaviour. Control of sexual behaviour is very challenging because sex is a private activity used by individuals and communities to fulfil specific functions.

There is a fairly high degree of awareness about AIDS among Kenyans. However, this level of awareness has not been matched by comparable behaviour change mainly due to diverse social-cultural, and personal factors which are inherent in society and among people. Focus should be made on specific cultural practices that promote positive behaviour and discourage negative practices. EfForts must be made to promote socialcultural norms, values, beliefs and enacted laws that centre around marriage and procreation in order to regulate heterosexual behaviour. Consensus between religious teachings on sexuality and the social-cultural practices must be harmonized through education, advocacy, counselling, persuasion and enforcement of both customary and written law. Implantation of approved norms, beliefs and values of society in relation to future sexual behaviour should start at home and be reinforced in educational institutions and in the society as a whole to lay the foundation on which future social behaviour and relationships are based. Parents, teachers and leaders in society are expected to provide role models to enhance selective attachment with individuals who have positive influence on young people's psychosocial development.

Peer influence plays a significant part in determining the level of involvement in risk practices. In a more traditional society the group may have strong social beliefs which are common to all members, and this is reinforced through peer grouping. Peer education for groups with deviant behaviour will be used to address problems related to adult and adolescent depression, social pressure, early sexual exposure and experiences which may lead to high risk behaviour like commercial sex, bisexuality and drug abuse which in turn make an individual vulnerable to HIV infection. The cultural diversity that exists in Kenyan communities negates uniformity in the application ofmechanisms that would help to regulate sexual behaviour. Furthermore, the norms, values and social-cultural identity are being eroded bywestern influence. No new acceptable social order has been created to replace the old one. Therefore, community counselling will be encouraged in order to revisit customary law which guided marriage, premarital and extramarital sex, separation, divorce and remarriage as a strategy to minimi e deviant sexual behaviour.

2.5 Orphaned children
Orphans are a social burden. Those infected have a double dilemma because AIDS is a stigmatized disease. Social attitude to orphans from single mothers is even more negative because traditional practice scorns such children thereby denying them property rights. Advocacy on the rights of such children will be intensified. Communities will be persuaded to take responsibility, as practised in the traditional sense to care and support these children including those infected with HIV.

2.6 Cultural Issues
The diversity in social-cultural ideologies constitute the diverse andpeculiar elements of sexual practices inherent in Kenyan societies. Culturalbeliefs and practices were usefid in maintaining biological continuity, socialization of young people, maintaining of law and order, defining the meaning of life, and producing and distributing goods and services. These practices also provided the capacity for societies to cope with calamities such as draught and disease outbreaks. With the advent of AIDS, some of these beliefs and practices require re-examination because they promote behaviours which put individuals at risk of contracting or transmitting HIV. These include the different types of marital union like polygamy, woman to woman marriage, reunion, polyandrous, hypodermic, leveretic (widow inheritance) endogamous and exogamous relationships. Nonsexual cultural practices and rites such as circumcision, ear piercing, ritual bathing ofthe dead, scarification and tattooing, if done with contaminated instruments could pose a great danger to practitioners as well as to their clients. Efforts will be made to identify and document traditional norms, beliefs and practices that may promote HIV transmission.

Society will be made to understand the relationship between these practices and HIV transinission. Comniunity involvement hi identifying possible solutions will be undertaken. Advocacy on virtues that lessen the risk of infection and promote collective responsibility in the care and rehabilitation of the infected and the affected will be intensified taking into account that changes in cultural practice take a very long time because they are deeply rooted in society The Government recognizes the important role the social-cultural factors play in transmission and containment of HIV.

2.7 Legal and ethical challenges
The Government of Kenya has responded to the problem of HIV and AIDS by including a chapter on AIDS in the 7th National Development Plan and the 5th edition of District Development Plan and has developed various manuals and Policy Guidelines on the control and management of HIV/AIDS. However, no specific legal standards have been developed to address the problem.

Although there is no specific statute dealing with EMAIDS in Kenya, some ofthe existing statutes have provisions which are ofdirect relevance to the management ofAIDS epidemic. Other legal positions can be inferred and/or expected from customary law and cultural practices. The issues emanating from these legal positions include:

Human rights: All forms of discrimination against people with AIDS will be outlawed as enshrined in the Constitution.

Testing from HIV: Testing for HIV will be voluntary with informed consent except for authorized research where the protocol has been approved by the National AIDS Committee.

Confidentiality: This must be maintained in fine with existing professional medical ethics. However, health care providers are allowed to disclose the HIV status of their patients to persons considered to be at risk of infection after the individual has been provided enough opportunity to disclose his EW status to those concerned.

Medicalethics: The existing ethical practices will continue to be applicable in the handling AIDS and HIV infection. In the interest of the public an people diagnosed with HIV infection must be informed oftheir status and be encouraged to take precaution for themselves and those with whom they are likely to get into sexual relations.

Employer-employee rights: The employer does not have to know the HIV status of their employees without the consent of the employee.

Research: Co-ordination ofresearch is currently being handled by dilierent departments of Government without legal authority A legal body with a clearly defined mandate will be established to co-ordinate AIDS/HIV/STDs and related research.

Religion and culture: Because ofthe diversity of the Kenyan culture and religion, written law and ethics will be applied within the context of specific communities. Research on these issues will be undertaken to shed more fight on what is involved in each community. Religious and cultural practices and utterances which undermine HIV/AIDS control measures will be censured for public good.

Criminal sanctions: Criminal sanctions against people who deliberately and irresponsibly infect others with MV will be upheld.

Children affected by AIDS: Children infected and affected by HIV/AIIDS will be protected from exploitation and discrimination using existing laws.

Insurance: The Government will work closely with insurance companies to establish guidelines pertaining to policies and benefits for people afected or infected with HIV.

Both medical and legal ethics provide a basis for the protection of some of the rights of persons allected by HIV/AIDS. Provisions governing medical ethics in Kenya are found in the codes of professional conduct and discipfine. The major ethical concerns relate to training, confidentiality, professionaljudgement and the guarantee of safety ofhealth care providers.

2.8 Religion and culture
Kenya consists of many religious communities, and each of them has certain rules and norms, which form part ofthe regulating mechanisms in society Each ethnic community has its traditional customs and laws. Some communities have common cultural practices and these practices have implications for the spread of I-HV These norms are relevant to the social behaviour related to the transmission and spread of HIV/AIIDS . Most religions have a stand on the issues of premarital and extramarital sex, abortion, contraceptives and polygamy in keeping with their beliefs. These in turn have a bearing on the management of the HIV/AIDS epidemic. Many ofthe legal and ethical provisions, and religious and cultural positions reveal various social dilemmas which need careful thought and serious attention in any attempt to resolve them in the formulation of policies and the management and control of HIV/AIDS.

2.9 Health care
The rapid increase in the number of reported cases of AIDS and people with HIV infection presents a significant challenge to the existi health care system The potential to over-stretch existing resources for health care delivery exists.

Provision of health care remains a big challenge to the Government. Shortage of drugs and patient care supplies, inadequate diagnostic capabilities at various levels including blood screening equipment and their maintenance, overcrowding in the health facilities, irregular supply of testing reagents, and high turnover of qualified health personnel making continuity impossible are indications of serious strain on the health sector. HIV has caused a major resurgence of Tuberculosis which presents a major public health problem particularly with the emergence of drug resistant fo of Tubercle bacilli. The cost of treatment is too high. Drugs for treatment of HIV infection cost average 700,000 Kenya Shi person per year. Drugs fo management of opportun are also very expensive.

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