HIV/AIDS in Kenya

The Need for Prevention Through Cultural Education

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There is general consensus the world over today that the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) epidemic is a tragedy for humankind. Since it was first diagnosed in the early 1980s the epidemic has had devastating direct and indirect effects on the infected and on their families, communities, and on the economies and demographics of their communities or countries. In the words of the Secretary-General of the United Nations Education and Scientific Organisation (UNESCO),

> In two decades HIV/AIDS has evolved from a medical curiosity to a worldwide human tragedy and international emergency. It is a development disaster and a security crisis with social impacts more devastating than any war. It has reduced life expectancy by 15 years in sub-Saharan Africa and created more than 14 million orphans. Its impact is wide reaching, and even in those parts of the world where the epidemic has been relatively slow to evolve, there are worrying signs of its gathering strength. It has spread nearly everywhere beyond the first so-called high-risk groups, today principally affecting vulnerable populations: the poor, the marginalized, young women and children.[1]

Transmission of HIV/AIDS

Research indicates that HIV/AIDS is transmitted through exchange of body fluids through unprotected sex with an infected person; blood transfusion, where the victim is transfused with blood from an infected person; and sharing of needles by intravenous drug users with an infected person. In Kenya, the major mode of transmission is through heterosexual relations, as a result of which, the epidemic

> … affects young, working age, sexually active adults – people between the ages of 15 and 50. Both women and men become infected in similar numbers, but women tend to become infected at a younger age than men, reflecting the biological and social vulnerability of teenage women.[2]

Although HIV/AIDS was first diagnosed in Kenya in 1984, its devastating nature was not realised until much later, which was also the case elsewhere because of "widespread belief that AIDS was no more serious than other diseases."[3] It is not surprising, therefore, that Government only reacted a year later by establishing the National Aids Council (NAC) under the Ministry of Health. This lacklustre government response appears to have been informed by the assumption originating mainly from the USA that HIV/AIDS was exclusively a problem of homosexual men whose actions constituted sin against the Almighty. To Government, admission that Kenya was affected by HIV/AIDS would have made foreign tourists shun Kenya, thus hurting her economy.[4]

Further Government reaction was witnessed in 1988 with the establishment of the National AIDS/STD Control Programme (NASCP) under the Ministry of Health. The Programme embarked on public education, which, among others, advocated for use of condoms as one of the methods for checking the spread of the disease. Religious leaders, especially the clergy of the Roman Catholic Church, publicly opposed use of condoms. They reasoned that use of condoms would promote promiscuity in society and that HIV/AIDS could only be checked by abstinence from sexual activity. The Church continues to take this position to date in spite of considerable human suffering and loss of human life. To an observer, it is surprising that the Church fails to acknowledge that the majority of Kenyans, who are not Catholic, may not necessarily share this idealism or religious virtue.

Religious leaders and other anti-HIV/AIDS campaigners in Kenya, and in other affected countries, can borrow a leaf from research conducted among the most vulnerable age bracket in Burkina Faso in West Africa concerning their acquisition of knowledge about protecting oneself from infection. The findings indicate that the level of knowledge acquired from religion that abstinence protects oneself from infection is dismal compared to the level of knowledge acquired from the scientific approach that condoms offer protection from infection.[5] Conducting similar studies in Kenya may help us to identify whether both the religious and the scientific approaches are having the desired impact.

Campaigns against Spread of HIV/AIDS

It is now recognised that campaigns aimed at checking the spread of HIV/AIDS require a multi-pronged approach if we are to achieve any meaningful results. As hinted above, this

has traditionally included (i) the scientific or medical approach, which promotes use of condoms and treatment and care of the infected; and (ii) the religious or moral approach, which promotes abstinence from sexual activity. More recently, a third and a fourth front have been added. These are (a) the legal approach, which recognises the rights of the infected and the rights of the uninfected; and (b) prevention education, which aims at bringing about behavioural change and empowering individuals, especially the most vulnerable, to make informed decisions so as to protect themselves against infection.[6]

While these campaigns have undeniably had some significant successes, it is not lost on the keen observer that they have also failed in some cases. Why else would HIV/AIDS remain "a worldwide human tragedy and international emergency"[7] two decades since the campaigns started? If we are to answer this question effectively, it behoves us to systematically evaluate the successes and failures of each of these approaches. Besides helping us to identify the most successful approach, this will bring about significant improvements in those approaches in order to realise the desired results. Since there is as yet no vaccine or cure for HIV/AIDS, the best available strategies to help check the spread of the disease are those that are aimed at bringing about change in sexual behaviour. It is to this that we now turn.

Prevention Education

In the words of the Director-General of UNESCO, prevention education

> …supplies the knowledge and fosters the attitudes and behaviours needed to combat the [HIV/AIDS] epidemic. It is essential in improving the contextual factors that can arrest the epidemic, by broadening access to quality education in general, by changing the environment of gender inequality by valuing diversity and context, and by fostering values of equality, democracy and respect for human rights."[8]

Like other approaches aimed at helping prevent transmission of HIV/AIDS and mitigation of its negative impacts, prevention education requires involvement of individuals, governments, non-governmental organisations, religious organisations, community based organisations, professional associations, the private sector, and any other organised groups. However, for prevention education to achieve the desired results, attempts must be made to understand a people's culture in order to make prevention messages culturally suitable and acceptable to the community concerned.

Such knowledge would also help us to arrest beliefs, superstitions, misconceptions and cultural attitudes that fuel the spread of infection. Members of some communities in Kenya, for example, reason that HIV/AIDS is a curse or a consequence of witchcraft. Therefore, according to them, the disease can be countered by stronger witchcraft; appeasing one's ancestral spirits through animal sacrifices and pouring of libation; or 'cleansed' by having sex with a minor or a virgin.

The so-called 'wife inheritance' has also been identified as a crucial factor in the spread of the epidemic in some communities in Kenya and elsewhere. Although this practice was widespread about a century or so ago, it is now frowned on whenever it occurs. While rigorous campaigns have been waged against this custom for over a decade, especially by religious organisations and non-governmental organisations, the practice continues to appeal to members of the communities concerned. This can be attributed to the campaigners' failure to appreciate the cultures of those communities as well as their failure to recognise the traditional economic role that this practice entailed. Instead of couching their messages in culturally acceptable language, the campaigners have tended to employ language that passes judgement and condemns (e.g. the expression 'wife inheritance') on those communities. This, has, in turn, made those who engage in the practice to popularise it in the guise of championing *their* culture.

It is also important to note that sex between women and men, which is the main mode of transmission of HIV/AIDS in Kenya, is an important aspect of ritual in some communities. As such, the sexual act must precede important economic activities like farm preparation, sowing, weeding, harvesting, or social activities like burial. Where one's wife or husband is away and a farm must be prepared for sowing because the rains are due, the individual concerned seeks out a sexual partner other than his/her regular partner. If one of them is infected the scourge is passed on. As is the case with the custom of the so-called 'wife inheritance', failure to understand the cultural nuances involved here makes the campaigners to deliver their well-intentioned messages in a manner that is culturally unacceptable to those communities. The end result has been to make the communities feel they are under siege, thus turning them into *cultural warriors*. Needless to add, the behaviour of such warriors only makes the situation worse, which can be averted by culturally customising the messages and delivering those messages in a manner and through messengers who are culturally acceptable.[9]

Further, while most of the people infected with HIV/AIDS do not know they are infected because of lack of medical facilities for testing and others because of fear of stigmatisation and discrimination, there are those who spread HIV/AIDS unknowingly because their knowledge about the disease is faulty.[10] In addition, there are those who also spread the disease unknowingly because their communities' cultural attitudes, beliefs, or superstitions discourage them from medical examination, lest they 'invite' death. These and other cultural issues hampering prevention campaigns call for an urgent study of what I will characterise here as the "the anthro-

pology of HIV/AIDS." The need for such an undertaking is also demonstrated by a recent scientific study involving male circumcision in South Africa, to which we now turn.

Male Circumcision and HIV/AIDS Prevention

In the recent past it has been suggested that male circumcision can serve as a method of preventing female-male transmission of HIV/AIDS. This suggestion is based on the South African study titled "The impact of male circumcision on the female-male transmission of HIV: results of the intervention trial: ANRS 1265" by Auvert *et al.*[11] as well as on similar studies conducted previously in Kenya and Uganda.

While the studies concerned appear to have promising results, it is my contention that it is premature to promote male circumcision as a method of preventing oneself against HIV/\/AIDS infection for several reasons. To begin with, although the South African study appears scientifically sound, it fails to take cognisance of the fact that humans are not only biological beings, but also cultural beings and, therefore engage in sexual behaviour that is deeply rooted in culture and history.

Second, the study does not provide data on the sexual behaviour of the uncircumcised group of young men or that of the circumcised group prior to circumcision. Third, it fails to provide any data on the sexual partners of the young men belonging to the two groups: (a) the control group, which was made up of uncircumcised young men; and (b) the experimental group, consisting of circumcised young men. Fourth, the study does not tell us how the circumcised young men's post-circumcision sexual behaviour compares to their pre-circumcision sexual behaviour. That all the young men were initially HIV negative may have been a reflection of their cautious sexual behaviour in a country with a very high prevalence. If correct, it is reasonable to assume that circumcision did not alter the young men's cautious behaviour, which may explain their low rate of infection.

Fifth, the study does not provide information on socio-cultural or psychological impact of circumcision, if any, on the young men. For example, were the young men informed about the reasons for their circumcision? If so, did this not intensify their awareness of HIV/AIDS, thus making them cautious in their sexual lives? What did circumcision mean to the young men? Was it simply a surgical procedure or did they, or at least some of them, attach some socio-cultural or ritualistic meaning to it? If yes, how did this impact on their sexual behaviour after circumcision? Did the young men come from areas where some or all of their neighbours circumcise? If yes, weren't the young men likely to adopt real or construed meanings of circumcision from those neighbours, thus altering their sexual behaviour accordingly?

Sixth, the study does not provide data/information on the female sexual partners of either the circumcised or the uncircumcised young men. For example, were those women, or some of them, sexual partners of the young men prior to circumcision? Did some or all of the sexual relations with those women continue into the post-circumcision period? If yes, how did this impact on the results of the study? What was the women's HIV/AIDS status prior to and after the circumcision of the young men? Did they have other sexual partners besides those involved in the study? How did this impact on the results of the study? What was the women's sexual behaviour prior to and after the circumcision of the young men and how did this impact on the results of the study?

Thus, while male circumcision may turn out to be a useful method of curtailing the spread of HIV/AIDS, it is important that such studies involve multi-disciplinary approaches. Inclusion of anthropologists, for example, would have addressed the social and cultural issues raised above in several ways for no society or member thereof exists in a social or cultural vacuum.

Once the scientific efficacy of circumcision is established, the next step should probably be to make it safe, especially where it occurs *en masse*, as is the case among the Bukusu and among the Maa-speakers in East Africa. Ensuring the procedure takes place under hygienic conditions and that the cutting instruments are properly sterilised or not recycled could do this. This would, in turn, ensure that adoption of male circumcision as one of several methods to prevent the spread of HIV/AIDS, when (and if) it happens in future, does not end up harming society by inadvertently spreading the disease.

Experience from campaigns against female circumcision that have been going on in Kenya for close to a century now inform that serious opposition is likely to be encountered in the advocacy of male circumcision. There is, therefore, a need for social scientists to collect data that will help us establish the nature and forms of resistance that are likely to be encountered from communities that do not circumcise.

All this will enable us to educate those involved in the advocacy of male circumcision about the social and cultural practices and nuances of the communities concerned for effective transmission of their messages. For example, it would help ensure that advocacy teams appreciate that adoption of circumcision by communities that do not traditionally circumcise boys is not predicated on the assumption that their culture is inferior to that of neighbouring groups who circumcise. In so doing the teams are likely to carry the communities along in their work.

Conclusion

It is about 20 or so years since campaigns against the spread of HIV/AIDS were launched. While the campaigns have succeeded in some areas

and among some communities, they are yet to yield desirable results in other areas/among other communities. As an anthropologist, I feel the shortcoming is attributable to the failure to appreciate the centrality of culture in our lives. HIV/AIDS is not simply a *moral* problem (hence the involvement of religions in 'fighting' it) or a *health* problem (hence the scientific/medical approach), but also a *cultural* problem. For example, in some communities sexual intercourse is at the centre of virtually all their rituals. When an occasion to perform such rituals arises, the man/woman concerned must engage in sexual intercourse, either with his/her regular partner or with a stranger. To these cultural warriors, culture reigns supreme. They would rather die but ensure 'their' culture remains intact!

What did circumcision mean to the young men?

As demanding as cultural studies are likely to be because of the existence of varied cultural practices in East Africa, there is an urgent need to incorporate them in dealing with the HIV/AIDS problem. It may also be necessary to rethink the language that we employ in our campaigns against the HIV/AIDS disease. For example, when we state that HIV/AIDS is an *enemy*, aren't we labelling those who are infected as enemies of the un-infected? By definition, enemies fight or fight back. Are some of the infected people not likely to fight the un-infected by spreading the scourge quietly?

No doubt, some individuals, organisations and/or governments may reason that what people need is scientific education, which is factual, rather than vast expenditure on social science research, which is not likely to guarantee protective behavioural change. This notwithstanding, it cannot be denied that preventive education, as advocated by UNESCO,[12] can help lessen vulnerability to infection by reducing misconceptions and superstitions about HIV/AIDS. In any case, any monies saved today for failure to conduct research that will facilitate a multi-pronged approach, will certainly translate into major losses for our country/countries in the future when we lose relatives, friends and colleagues at the prime of life and suffer undesirable socio-economic consequences.

Notes

1 UNESCO. *UNESCO's Strategy for HIV/AIDS Prevention Education*. Paris: International Institute for Education Planning, 2004, p. 5.

2 B. Rau, S. Forsythe and T.M. Okeyo. An introduction to Kenya's epidemic, Chapter 1 in *Aids in Kenya: socio-economic impact and policy implications*, edited by Steven Forsythe and Bill Rau, Washington, DC: Family Health International/AIDSCAP, 1996, p. 3.

3 *Ibid.,* p. 4.

4 UNESCO, *op. cit.*

5 UNESCO, *op. cit.*, p. 23.

6 UNESCO, *op. cit.*

7 UNESCO, *op. cit.*, p. 5.

8 UNESCO, *op. cit.* p. 6.

9 UNESCO, *op. cit.*

10 UNESCO, *op. cit.*

11 B. Auvert *et al* "The impact of male circumcision on the female-male transmission of HIV: results of the intervention trial: ANRS 1265." Paper presented at the International AIDS Society Conference, Rio de Janeiro, 26 July 2005.

12 UNESCO, *op. cit.*

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