AN ABSTRACT OF THE THESIS OF


Abstract approved: Redacted for privacy

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Sunil K. Khanna

From July to September, 2002 I spent ten weeks in Kenya conducting full-time research on the macroeconomic impact of HIV/AIDS and community action towards combating the epidemic in locations dominated by members of the Luo tribe in Nyanza Province, Kenya. Gathering data from both the Ministry of Health and non-governmental organizations, I sought to identify the causations and impact of the HIV/AIDS epidemic from a holistic framework.

Serving as a pilot study for future research and program evaluation, my research primarily focused on four community-based organizations (CBOs) and Ministry of Health offices located in Kisumu, Nyando, Rachuonyo, and Migori Districts. My research objectives were to explore the cultural and economic variables related to the spread of the HIV/AIDS epidemic, identify which sectors of society were negatively impacted by the epidemic, record community action in response to these impacts, investigate obstacles related to implementation of such interventions, and share research and recommendations with the Ministry of Health and CBOs in Nyanza Province in a way that was meaningful and useful to them.
Several qualitative and ethnographic methods were utilized. Participant observation was the principal method used and consisted of a wide range of activities. Additionally, I conducted sixteen formal semi-structured interviews, approximately thirty informal unstructured interviews, and one focus group discussion with nine youth.

I found that community-based organizations and the Ministry of Health engaged in a wide variety of activities in response to the HIV/AIDS epidemic including providing Home Based Care to the sick and dying through trained community health workers; training individuals in income-generating activities to provide support for the organizations, the infected and affected, and as a means of prevention of new infections; and providing education to the communities at large.

The Ministry of Health and non-governmental organizations also engaged in a significant level of collaborative work to assist each other with their programs and ensure there was no duplication of services.

Despite considerable organizational efforts by both the governmental and non-profit sectors, these groups faced a number of different obstacles in their mobilization efforts including limited funding, transportation obstacles in visiting HIV/AIDS clients, and difficulties in convincing individuals to change their behaviors. Individuals interviewed cited a number of factors related to the spread of HIV/AIDS including wife inheritance, wife cleansing, poverty, commercial sex work, and distance marriages. Limited access to voluntary counseling and testing (VCT) services was also an obstacle in a number of communities. Additionally, I found a positive association between access to VCT services, perceptions of people living with
HIV/AIDS, and social support for the infected.

Based on my findings I concluded that individuals’ behavior resulting in the transmission of HIV/AIDS is not solely related to lack of knowledge. Circumstances, especially related to poverty, lead to actions such as exchanging sex for money, distance marriages, early marriages for females, and wife inheritance. In order for HIV/AIDS prevalence to be reduced in Kenya, there must be active participation at all levels and from all sectors of society, including from community members themselves, community-based organizations, the Government of Kenya, and international governmental and non-governmental assistance organizations.

Among my recommendations I propose the expansion of voluntary counseling and testing services to make it easier for individuals in rural areas to know their HIV status. I also advocate for a holistic and multisectoral response to HIV/AIDS prevention and support for the infected and affected, including through Home Based Care and social support for the infected, support for AIDS orphans, prevention of mother-to-child transmission, effective HIV/AIDS education, reducing poverty through income-generating activities, making school educations accessible for all children, and improving the overall state of health and access to health facilities for all individuals.
The Grassroots Response to HIV/AIDS in Nyanza Province, Kenya: An Analysis of the Community-Based Approach for Combating the Multisectoral Impact of an Epidemic

by
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A THESIS submitted to Oregon State University in partial fulfillment of the requirements for the degree of Master of Arts

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

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Becky A. Johnson, Author
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stay there.

I also would especially like to thank my parents, Gary and Joyce Johnson for all of the support and encouragement they have given me over the years. I owe a large amount of my accomplishments to them.

I also thank my Kenyan friends, especially Eusevius and Gordon, for the memorable times that we spent together. I wish them the best of luck in all that they do in the future.

I would like to close by offering my thanks to all of the individuals and organizations who welcomed me into their programs and offered their time, experiences, and opinions to me to make this research possible. *Erokamano kuom gik moko duto.* I would especially like to acknowledge all of my HIV-positive friends who have given their lives to this deadly disease. *Safiri salama. Asante sana.*
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<td>ABC</td>
<td>Abstinence, Being faithful, Condom use</td>
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<td>AD</td>
<td>Anno Domini (measure of time in years)</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AMREF</td>
<td>African Medical Research Foundation</td>
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<td>ARRM</td>
<td>AIDS Risk Reduction Model</td>
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<td>AZT</td>
<td>Azidothymidine (anti-retroviral drug)</td>
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<td>BCE</td>
<td>Before Common Era</td>
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<td>BCG</td>
<td>Bacille Calmette-Guérin (tuberculosis vaccine)</td>
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<td>CBO</td>
<td>Community Based Organization</td>
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<td>CORP</td>
<td>Community Own Resource Person</td>
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<td>DACC</td>
<td>District AIDS Control Committee</td>
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<td>DCM</td>
<td>Diakonia Compassionate Ministry</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>ELISA</td>
<td>Enzyme-Linked Immune Sorbent Assay (HIV test)</td>
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<td>FGM</td>
<td>Female Genital Modification</td>
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<td>FORD</td>
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<td>SIV</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TEMAK</td>
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<td>UAC</td>
<td>Uganda AIDS Control Commission</td>
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<td>UNAIDS</td>
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<td>VCT</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>YOFAK</td>
<td>Youth Fighting AIDS in Kenya</td>
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DEDICATION

To Gary and Joyce Johnson
“Only through the concrete understanding of particular worlds of suffering and the way they are shaped by political economy and cultural change can we possibly come to terms with the complex human experiences that undermine health.”

Paul Farmer, 1999
Infections and Inequalities
Between 1985 and 2002 over two million Kenyans became infected with the HIV virus. As the majority of those infected are young adults, this epidemic has had a tremendous impact on multiple sectors of Kenyan society—leaving over one million AIDS orphans and further devastating the economy. In response to Kenyan President Daniel arap Moi declaring AIDS a national disaster, numerous organizations were established throughout the country reaching out to those infected and affected by this disease, as well as aiming to reduce its prevalence in the future. This thesis will specifically examine the approaches to community organization utilized by clubs for HIV-positive individuals and organizations working with orphans and young adults in four unique communities, dominated by members of the Luo ethnic group, in Nyanza Province, Kenya. Founded in the late-1990s, these organizations provide different approaches to combating the multisectoral impact of the HIV/AIDS epidemic by providing social and medical support for the infected, educational and monetary support for those orphaned, and preventative education for the communities at large. Through a holistic approach to community organization, these groups intend to conquer the broader issues perpetuated by the HIV/AIDS epidemic. This thesis attempts to lay the foundation for analyzing and evaluating the successes and failures of such organizations in the future through their attempts to lower HIV prevalence and improve the quality of life for those infected and affected by this disease.
During my field work in 2002, I found that strategies for mobilization varied from community to community. In Oyugis, HIV-positive individuals performed in a choir which sang spiritual and HIV/AIDS awareness songs, attended educational campaigns, and visited homes to care for their fellow members who were in the late stages of AIDS. In Nyatike Division, infected individuals attended community barazas,\(^1\) and with cooperation and a precedent set by the government-appointed local chief, encouraged their fellow community members to go in for counseling and an HIV test, which was paid for by their organization. In both communities, HIV-positive community members had become part of social organizations, engaged in income-generating activities to help ease the burden of chronic poverty, and provided social support to members who had been ostracized by their families. But no matter what the time of day, club members were eager to share their personal testimonies with a *mzungu* anthropologist and express what it meant to them to “live positively.”

In the city of Kisumu the Teenage Mothers and Girls Association of Kenya (TEMAK) provided vocational training to at-risk girls in marketable skills to reduce the burden of poverty and to increase the choices the girls had for income-generating activities. Diakonia Compassionate Ministry provided similar training to both at-risk boys and girls and facilitated an overseas sponsorship program to provide education and medical expenses for AIDS orphans. Both organizations strived to help individuals affected by the HIV/AIDS epidemic and to help at-risk individuals add an

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\(^1\) Words in italics throughout this thesis are either of Kiswahili or Dholuo origin. The English translation for each word is given in the glossary in Appendix One.
Map 1. The African Continent

income to their lives, thereby increasing their chances of successful income-earning and reducing their reliance on at-risk behavior such as commercial sex work.

By examining the processes of community mobilization in Oyugis, Nyatike Division, Nyando District, and Kisumu, Kenya, this thesis addresses the underlying themes of the ongoing grassroots approaches to empowering community members to overcome the HIV/AIDS epidemic. Drawing on testimonies from community and organization leaders, community health workers, HIV-positive club members, and youths living in these communities, I discuss the continuous process of community involvement in organizational proceedings, coalition-building between the Government of Kenya and community-based organizations, national protocols for training community members to provide home-based care for the sick and dying, and the largest concerns of the people living in these communities to accomplish their overall goals of reducing the numbers of infections and assisting those people who are already infected. By presenting these four examples of community-based organizations working to combat the HIV/AIDS epidemic, I create a broader framework for analyzing and evaluating the effectiveness of such programs in the future with the intentions of improving these programs and assisting in building other community-based programs throughout Kenya working with HIV/AIDS clients. Through describing the overall objectives and activities of these programs, I explain how the macroeconomic impact of the HIV/AIDS epidemic is being addressed in these communities. Given the overall pattern of rural habitation in Kenya, I argue that the holistic approach to community organization is an effective tool for mobilizing
individuals in sparsely populated areas.

During ten weeks of fieldwork in from July to September of 2002 I met with location\(^2\) chiefs, Ministry of Health medical personnel, community-based organization leaders, community health workers, individuals living openly with HIV and AIDS, and community members at large. Members from each group expressed many of the same concerns regarding the HIV/AIDS epidemic and agreed that the knowledge of this virus and how it is spread was present, but the necessary behavioral changes were not occurring. Most individuals cited "culture" as the number one cause of HIV/AIDS infections in Western Kenya and provided examples of such practices as wife inheritance, wife cleansing, commercial sex work, and "immorality" as examples of "bad culture." Many of those interviewed, representing a variety of ages and positions in society, provided their own creative solutions to integrating, or even eradicating such cultural traditions to make way for safe behavioral practices that would potentially decrease the number of those at risk and infected with the HIV/AIDS virus.

The objective of this thesis is to draw from my own observations, experiences, and the collective responses of community members in Nyanza Province, Kenya to analyze the impact of such programs on overcoming the multisectoral impact of the HIV/AIDS epidemic. The methodology used to carry out this research is presented in chapter two. Chapter three provides an overview of the HIV/AIDS epidemic in

\(^2\) In Kenya, the ordering of the government from macro- to micro-levels includes nation, province, district, division, location, and sub-location. Chiefs are appointed by the Government of Kenya at the location level. This position is generally a lifetime appointment given to a respected elder from the community.
Kenya, the macroeconomic impact of the epidemic, and the theoretical basis for my research drawn from the literature on HIV/AIDS, community organization, and anthropological and organizational theories. Chapter four provides an historical background of the Luo people and the development of HIV/AIDS in Kenya. Chapter five describes the setting for the community-based organizations studied. Chapter six presents the data gathered from participant observation experiences and interviews. The final chapter provides a discussion on the impact of such community-based programs and focuses on the future of the HIV/AIDS epidemic in western Kenya. Recommendations are also given for potential intervention programs in the future.
CHAPTER TWO

METHODOLOGY

The four case studies presented in this thesis are the results of intensive, full-time fieldwork in Western Kenya from July to September, 2002. In conjunction with a graduate internship in community health, I worked with the Kenyan Ministry of Health in Nyando District and visited a total of ten community-based organizations throughout Nyanza Province working on HIV/AIDS issues. The four primary cases presented here, Oyugis Integrated Project, Nyatike Home Based Care, the Teenage Mothers and Girls Association of Kenya, and Diakonia Compassionate Ministry—Kenya, are the results of my four most in depth studies which involved living and working in these communities.

The data for this thesis were gathered using ethnographic methods. According to Hammersley and Atkinson (1983:2) ethnographic methods foster an in depth analysis as “the ethnographer participates, overtly and covertly, in people’s daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact, collecting whatever data are available to throw light on the issues with which he or she is concerned.” The most dominant method utilized for this study was participant observation. Bernard (1995:136) defines participant observation as “getting close to people and making them feel comfortable enough with your presence so that you can observe and record information about their lives.”

During my attachment with Oyugis Integrated Project (OIP), I visited two different community centers that are gathering places for HIV-positive people, visited
AIDS clients in their homes as part of the Home Based Care program, went into the field with OIP’s agricultural representative to inspect the progress of personal income-generating projects for group members and orphans, assisted in the dispensary, visited the social work office, and attended several HIV/AIDS awareness campaigns at local schools. With Nyatike Home Based Care I attended organizational meetings, visited clients in their homes as part of their Home Based Care program, attended a meeting sponsored by the local Ministry of Health office regarding prevention of mother-to-child transmission of HIV, and visited a number of health facilities in the area. I was also able to attend a portion of a training session for community health workers (CHWs) in Nyando District, which is adjacent to Oyugis and Rachuonyo District. Additionally, I spent a week observing vocational training programs at the Teenage Mothers and Girls Association of Kenya, observed part of a baseline survey on women’s reproductive health conducted by the Ministry of Health in rural Nyando District, assisted with a free medical treatment campaign sponsored by Diakonia Compassionate Ministry, worked as an intern at the Ministry of Health hospital in Ahero, and visited clients in Kisumu District Hospital. My observations from such experiences were recorded in a field notebook. For the majority of my time in Kenya I also lived with a Kenyan family, which allowed me to further immerse myself into the culture. Through a reciprocal agreement with the agencies that I worked with, I assisted them in any way possible during my participant observation experiences. My

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1 The word “client” is preferred over the word “patient” by organizational leaders and members in referring to individuals infected with the HIV/AIDS virus.
assistance was utilized the greatest in the overwhelmed health facilities, as I spent numerous hours taking vital signs for patients and filling prescriptions. Through my attempts to immerse myself into a Kenyan lifestyle and through my willingness to assist the programs with their activities, I believe I was able to establish a greater level of trust with my informants, which aided my fieldwork immensely.

Data collection also consisted of approximately 30 informal unstructured interviews with organizational leaders, Ministry of Health employees, organizational members, and community members and 16 semi-structured open-ended interviews with governmental leaders, organizational leaders and community health workers divided among the participating organizations. In addition, a focus group discussion was held in Nyatike Division with nine youths. All informal interviews were written up in a field notebook and all semi-structured interviews and the focus group discussion were tape-recorded with the permission of all participants and later transcribed. In the event that informants did not speak fluent English, a translator worked with me during interviews. My assistant’s translations were later verified through the use of a bilingual English-Dholuo dictionary. To capture the knowledge, attitudes, and practices of a broad range of members of each community, Ministry of Health personnel, local government officials, organizational leaders, HIV-positive organization members, and community members at large were all interviewed for this study. It should also be noted that this research was approved by Oregon State University’s Institutional Review Board and special permission was granted to use participants who were age 15 and above.
I gained entry into the field and the organizations I studied by first writing letters of introduction to the organizations, which were presented by a Kenyan contact. Additionally, organizations that I worked with wrote letters of support on my behalf to the Institutional Review Board which consented to their involvement in my study and stated that they would assist me in recruiting participants and interviewees. In the field I also worked with a key informant and a field assistant who helped introduce me to new participant observation situations. I also gained acceptance and approval from local chiefs in the communities that I studied.

The four primary organizations discussed in this thesis were chosen through a convenient sample with the intention of representing HIV/AIDS community-based organizations that were among “the most active organizations” (field notes July 6th, 2002) in Nyanza Province. I identified individuals to interview through my key informants, field assistant, and organizational leaders. I followed snowball and convenient sampling techniques. In the event of my focus group discussion and interviews with community health workers, my field assistant recruited a sample from the community that paid particular attention to a broad range of age and gender. Participants in the focus group discussion also equally represented the three sublocations of West Kadem location in Nyatike Division—the rural community that serves as the headquarters for the Nyatike Home Based Care organization. Specific demographic information for focus group participants is highlighted in Table 1 below.
Table 1. Participants in Focus Group Discussion, Nyatike Division

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Occupation</th>
<th>Education Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>22</td>
<td>Selling bicycle parts</td>
<td>Standard VII</td>
</tr>
<tr>
<td>Male</td>
<td>16</td>
<td>Student</td>
<td>Standard VIII</td>
</tr>
<tr>
<td>Male</td>
<td>15</td>
<td>Student</td>
<td>Standard VIII</td>
</tr>
<tr>
<td>Male</td>
<td>15</td>
<td>Student</td>
<td>Form II</td>
</tr>
<tr>
<td>Male</td>
<td>21</td>
<td>Student</td>
<td>Form III</td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
<td>Student</td>
<td>Form III</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>Unemployed</td>
<td>Standard VIII</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>Unemployed</td>
<td>Secondary Completed</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>Student</td>
<td>Form I</td>
</tr>
</tbody>
</table>

Specifically, this research was intended for both instrumental and emancipatory use. My research design was constructed around the interests of a newly-formed community-based organization based out of Kisumu, Kenya to investigate current trends in community organization strategies used for HIV/AIDS prevention, education, and outreach to clients. Connections were established with assistance from the Ministry of Health and other organizational leaders with the intentions of sharing practices, obstacles, and testimonies with a larger population base. This research is also emancipatory in that it is grounded in advocacy and seeks to improve already existing structures and integrate cultural customs to promote positive health outcomes. Additionally, portions of this research were also used as a

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2 In the Kenyan educational system Standards I through VIII represent primary schooling and Forms I through IV represent secondary schooling.
needs assessment and served as the basis of a grant proposal to establish a permanent voluntary counseling and testing center and the foundation for an HIV-positive club in an area that lacked these facilities.

Grounded in applied anthropological theory and practice, the ideas presented in this thesis are drawn from and intended for both theoretical and applied use, or praxis. Praxis is a construct that bridges the gap between theory and practice.

According to Warry (1992:157):

A praxis approach in applied anthropology requires the development of methodology that is ethical and emancipatory—methods that engage research participants in action and theoretical discussion. A praxis anthropology requires analysis of the way in which value, perception, and belief mediate the translation of theory into strategic action. Praxis investigations would focus attention on cooperative activities that assist individuals to make decisions and assume responsibility for planned change, rather than conceding that task to the experts.

My research design is representative of praxis, as it is grounded in anthropological theory and is designed as the result of collaborative input from the participating organizations and Ministry of Health offices. I therefore intended for the results of this research to have meaningful uses by all parties involved. The concept of praxis will be discussed in further detail in the theoretical foundations section of chapter three.

The themes examined consist of organizations' sources of funding, financial sustainability through income-generating activities, collaborative work with the government of Kenya and other non-governmental organizations and community-based organizations, recruitment of new members through voluntary counseling and
testing services, educational programs designed to reduce future prevalence, obstacles that organizations have faced, and sociocultural issues linked to the high numbers of infection. From a broader perspective, my research also sought to examine the interrelationships between poverty, behavior, and the high prevalence of HIV/AIDS.

Questionnaires were highly qualitative and designed around Rothman’s models of community organization (Rothman and Tropman 1987), the AIDS Risk Reduction Model (ARRM) (Catania et al. 1990), and Critical Medical Anthropology (Baer et al. 1986). The specific components of each theory will be discussed in further detail in my literature review in chapter three.

Questions for government officials and community-based organization leaders focused on organizational history, sources of funding, inter- and intra- relationships and collaborative endeavors between the government and non-profit organizations, programs offered, community knowledge levels, perceptions of people living with HIV/AIDS, prevention activities, the proximity and barriers of voluntary counseling and testing services, economic and sociocultural barriers, and future plans. Informal interviews with HIV-positive clients were more phenomenological and focused on individual testimonies of how individuals believed they became infected and came to be tested, lived experiences associated with their HIV status, and the impact that involvement in HIV-positive organizations has had on their lives. Interviews with community health workers focused on motivation for work, general knowledge of HIV/AIDS and opportunistic infections, training programs, roles in communities and services provided, communication with host organizations, economic and
sociocultural barriers, perceptions of people who are HIV-positive, and overall lived experiences as community health workers. The focus group discussion was centered around the knowledge, attitudes, and practices of participants. Questionnaires for semi-structured interviews and the focus group discussion are included in Appendices Two through Four.

The biggest limitation that I faced in the field was the amount of time I had to spend with each organization. Given that I was only in Kenya for a total period of ten weeks, I was only able to spend an average of two weeks with each organization; therefore I was not able to see and experience as much as would have been possible with a more lengthy period of time. However, I believe that I managed my time in Kenya in a productive way, and through my attempts to fully immerse myself into Kenyan culture and learn as much as possible about the HIV/AIDS situation, in large part I believe I never left the field from the time I set foot in Kenya until the time of my departure.

The biggest preconceived notion that I brought to this study that turned out to be incorrect was that a majority of people would go in for an HIV test and then share their results with me (initially, I had planned to do a more quantitative study and focus on the relationship between the practice of wife inheritance and the high prevalence of HIV/AIDS). When I arrived in the field, I realized that there were greater underlying problems that had led people to avoid HIV testing and to believe that HIV/AIDS could not infect them. After learning this information, I tried to formulate new questions that asked why people were not being tested and whether or not people felt vulnerable
to HIV/AIDS infection. It is still a possibility that my initial research design could be incorporated into future studies if the number of people going in for voluntary counseling and testing were to increase.

Another limitation was that my research experience and attachments with organizations were largely shaped by connections established by a few Kenyan individuals. Not being too familiar with western Kenyan communities and organizations before embarking on this research, I was appreciative that these individuals helped me to establish these connections, but at the same time worried that I would only observe a selected portion of the Luo experience. Additionally, my research with community-based organizations predominately represented registered self-help groups\(^3\) working with large client and population bases. However, once my research started, I also had opportunities to have short visits and meetings with other organizations and I learned quite a bit from observations and informal conversations in my day-to-day life in Kenya. Therefore, I attempted to observe and learn from a wide variety of individuals and experiences, an aspect that allowed me to see the overall picture of the HIV/AIDS epidemic and alternate variables from the multiple perspectives that these experiences warranted.

Because registered CBOs throughout Kenya face the same rules and regulations, the data collected from this research specifically related to organizational strategies in response to the HIV/AIDS epidemic may be applied to community-based

\(^3\) A self-help group is a community-based organization formally recognized as a non-profit organization by the Ministry of Culture.
organizations working throughout Kenya. Due to the distinct cultural characteristics of the Luo ethnic group, data on the sociocultural factors related to the spread of HIV/AIDS may only be applied to Luo-dominant areas of Nyanza Province. However, given the fact that poverty is a leading factor in the transmission of HIV/AIDS in a number of cultures and nations worldwide, conclusions and recommendations drawn from this study may be applied to such cases as well.
CHAPTER THREE

LITERATURE REVIEW

This chapter provides an overview of the HIV/AIDS epidemic in Kenya, the macroeconomic impact of the epidemic, and the theoretical basis for my research drawn from the literature on HIV/AIDS, community organization, and anthropological and organizational theories.

At the time of this study, data suggested that over 2.2 million Kenyans were living with the HIV/AIDS virus (Ministry of Health 2001; Centers for Disease Control 2001; UNAIDS 2001). Given that fewer than one percent of all Kenyans had actually undergone an HIV test (Centers for Disease Control 2001), the Ministry of Health has established sentinel surveillance sites in twelve urban and eight peri-urban or rural areas throughout the country measuring the HIV/AIDS prevalence in pregnant women seen at antenatal clinics. Through random testing of pregnant women, and predictions made from previous surveys examining HIV/AIDS prevalence in Kenyan men, it was estimated that the overall prevalence of HIV/AIDS infection for the entire nation was 13.5 percent. The highest prevalence of urban infection had consistently been in Kenya’s third-largest city, Kisumu, with 2000 estimates topping 35 percent. Additionally, the provincial host to Kisumu, Nyanza Province, had an overall estimated prevalence of 22 percent (Ministry of Health 2001). Specific data for HIV/AIDS prevalence for each district of Nyanza Province are indicated in Table 2 below:
Table 2. HIV/AIDS Prevalence in Each District of Nyanza Province

<table>
<thead>
<tr>
<th>District</th>
<th>Total Number Infected</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bondo</td>
<td>32,062</td>
<td>27</td>
</tr>
<tr>
<td>Gucha</td>
<td>26,452</td>
<td>11</td>
</tr>
<tr>
<td>Homa Bay</td>
<td>39,614</td>
<td>27</td>
</tr>
<tr>
<td>Kisii Central</td>
<td>27,763</td>
<td>11</td>
</tr>
<tr>
<td>Kisumu</td>
<td>70,077</td>
<td>28</td>
</tr>
<tr>
<td>Kuria</td>
<td>20,692</td>
<td>27</td>
</tr>
<tr>
<td>Migori</td>
<td>70,380</td>
<td>27</td>
</tr>
<tr>
<td>North Kisii</td>
<td>28,505</td>
<td>11</td>
</tr>
<tr>
<td>Nyando</td>
<td>41,626</td>
<td>28</td>
</tr>
<tr>
<td>Rachuonyo</td>
<td>41,929</td>
<td>27</td>
</tr>
<tr>
<td>Siaya</td>
<td>64,393</td>
<td>27</td>
</tr>
<tr>
<td>Suba</td>
<td>21,237</td>
<td>27</td>
</tr>
</tbody>
</table>


The majority of new HIV cases were acquired via sexual contact with an infected person, although estimates reported that at least 100,000 newborns had been infected through mother-to-child transmission, and a small number of cases occurred due to blood transfusions and contact with infected blood. Those individuals particularly at risk of this type of infection included health workers, traditional birth attendants, and traditional male and female circumcisers (Ministry of Health 2001).

Other groups of individuals who are at an increased risk of HIV/AIDS infection include youth, commercial sex workers, long distance truck drivers, the armed forces, and individuals involved in distance marriages. Additionally, more than 75 percent of AIDS cases occur in adults between the ages of 20 and 45. Individuals engaging in sexual relations with multiple partners also put themselves at an increased risk of contracting HIV/AIDS (Ministry of Health 2001).
Definitions

Human Immunodeficiency Virus (HIV) is a virus that slowly breaks down the body’s ability to fight infections and eventually leads to the development of the AIDS syndrome (Centers for Disease Control 2003). HIV/AIDS is spread via unprotected sexual intercourse, tainted blood transfusions, sharing of needles or piercing instruments from an infected person, from a mother to child during birth, or through breast milk. HIV/AIDS cannot be spread through casual contact and there is no evidence that the virus is spread from mosquitoes (Ministry of Health 2001). A person with HIV is said to be HIV-positive and may not show any signs and symptoms of the disease, but is still able to transmit the disease to others. Generally in Kenya, an HIV-positive person will live seven to ten years after initial infection before the virus develops into full-blown AIDS (Ministry of Health 2001).

Acquired Immune Deficiency Syndrome (AIDS) is a fatal disease defined by an infected individual possessing a CD4 helper cell count below 200, which destroys the body’s ability to fight infection. Signs and symptoms of AIDS include fatigue, weight loss, hair loss, loss of appetite, nausea, and diarrhea (Centers for Disease Control 2003). The individual also becomes prone to opportunistic infections such as tuberculosis, herpes zoster, oral thrush, and common infectious diseases such as pneumonia, malaria, and typhoid. Due to limited access to anti-retroviral drugs in Kenya, a person with full-blown AIDS will generally live less than one year after the virus has progressed to this stage (Ministry of Health 2001).

According to the World Health Organization (WHO 2001) an HIV/AIDS
orphan is any child who has lost a mother due to HIV/AIDS and is below 15 years of age. The designation of partial orphan is given to a child who has lost a father as a result of HIV/AIDS.

The Macroeconomic Impact of HIV/AIDS in Kenya

It has been argued that the HIV/AIDS epidemic has had a tremendous negative macroeconomic impact on Kenyan society. Numerous studies have been carried out to measure the impact of HIV/AIDS on the Kenyan economy. In one study conducted by researchers from the World Bank, an actual model was developed by the researchers to potentially be used as an intervention guideline that predicts an increase in the Gross Domestic Product (GDP) in Kenya by decreasing the prevalence of HIV/AIDS (Robalino et al. 2002).

In an article discussing this model, David Robalino et al. (2002:196) write that “the HIV/AIDS epidemic has been a major threat to economic development... HIV/AIDS is expected to have serious impacts in the size and productivity of the labor force and through this channel, economic growth.” To that end, a stochastic model, one based on random variables, was created to evaluate the macroeconomic impacts of the HIV/AIDS epidemic in Kenya and project future impacts the epidemic may cause on the GDP given different scenarios with dissimilar prevalences. Given that the HIV/AIDS epidemic primarily affects the 15-49 year old population in Kenya (Ministry of Health 2001), the population which is the most economically active, the model predicts that a reduction in HIV/AIDS prevalence would ultimately lead to an increase in the GDP, and hence improve the overall economic situation in Kenya
(Robalino et al. 2002).

The results of this model indicate that if HIV/AIDS prevalence continued to grow, the GDP during the 2000-2020 time period would decrease by an estimated 20 to 30 percent. As an increase in GDP reflects a decrease in prevalence, the authors recommend stabilization of current prevalence within the next five years, followed by reduction. The authors also suggest that condom distribution is the most cost-effective intervention.

Indeed, Nab and Aoko (1994) estimated that by the year 2015, the GDP in Kenya would be 14.5 percent lower than baseline estimates without the HIV/AIDS epidemic due to projections that 80 percent of HIV infections occur in the 15-49 year old population, the population which is the most economically active. This has led to reductions in the size and experience of the labor force, increased health care expenditures, rises in the cost of labor, a decline in productivity, and reductions in savings and investments (Ministry of Health 2001). Arguably, the greatest impact has been on commercial and small-scale agriculture, which accounts for approximately 30 percent of the GDP and 70 percent of export earnings (Rugalema, et al. 1999).

The distribution of the US$18.4 billion spent on HIV/AIDS worldwide in 1993 allocated 63 percent of monies on care, 23 percent on research, and only 14 percent on prevention. Additionally, an estimated 8 percent of the total allocation was spent in “low income” countries, where 95 percent of all HIV cases occur (Turkon 2003:1).

The HIV/AIDS epidemic in Kenya has had a negative impact on multiple sectors of Kenyan society. Among those most affected include health care, education,
the military, transport, and agriculture.

Health Care. The health care sector is responsible for providing care to the sick and dying. Because of HIV/AIDS, the health care sector is receiving demands beyond their capacity to help. It is estimated that HIV/AIDS patients occupy up to 70 percent of hospital beds in the Kisumu District Hospital (Ministry of Health 2001). Because of the increased number of patients requiring hospital care, many patients are forced to share a single bed with another individual or even sleep on the floor. It is estimated that as the number of HIV/AIDS cases continues to grow, an increasing number of demands will be placed on the health care sector and will affect health services to all individuals (Ministry of Health 2001).

Education. As Kenya has nearly one million AIDS orphans, many of these children cannot afford to go to school and receive an education, which has drastic implications on the future of Kenyan society. Education is not free in Kenya, and each pupil must pay up to US$300 each year to cover enrollment expenses, school uniforms, textbooks, and stationery. Additionally, many teachers are dying from HIV/AIDS complications. Education is also seen as part of the solution for reducing the prevalence of HIV/AIDS infection and improving the well-being of orphaned children (Ministry of Health 2001).

Military. HIV/AIDS prevalence tends to be high among military soldiers stationed in various countries around the world. This has negative consequences on the defense and military strength of Kenya (Ministry of Health 2001).

Transport. Long distance truck drivers are another group of individuals who
possess a high HIV/AIDS prevalence. These individuals are more likely to engage in sexual intercourse with commercial sex workers, which facilitates the spread of HIV/AIDS in their home communities when they return (Ministry of Health 2001). To that end, an intervention program utilizing highway billboard signs on major highways has been designed to target the long distance truck driver audience.

**Agriculture.** Because HIV/AIDS is infecting both small-scale and commercial farmers, this has led to a loss of workers, decline in labor productivity, and loss of income for those individuals dying of AIDS-related complications and their families (Ministry of Health 2001). This has also led to a decrease in Kenya’s Gross Domestic Product.

**Mother-to-Child Transmission of HIV/AIDS**

In the year 2000, approximately 600,000 infants became infected with HIV/AIDS. Approximately 90 percent of these cases resulted from mother-to-child transmission (MTCT) and approximately 90 percent of these cases occurred in sub-Saharan Africa, where over two-thirds of all worldwide HIV/AIDS cases occur. It is estimated that between 15 percent and 30 percent of infants born to HIV-positive mothers acquire the virus from their mothers (WHO 2001). The question remains as to why the prevalence of MTCT is overwhelmingly abundant in sub-Saharan Africa compared to the total distribution of HIV/AIDS worldwide. This is in large part due to the political and economic situations in many African nations, which makes it extremely difficult for HIV-positive mothers to have access to AIDS drugs and other preventative measures, as well as the relatively low number of HIV-positive...
individuals who have actually received an HIV test.

The World Health Organization and the United Nations Committee on AIDS currently recommend voluntary counseling and testing services, antiretroviral therapies, safe delivery practices, and education on the availability of alternatives to breastfeeding (WHO/UNAIDS 2002). These practices have proven to significantly reduce MTCT in the United States and in countries in western Europe (Avert 2002). According to the World Health Organization, much of the problem is attributed to the fact that “nine out of ten new mothers in developing countries do not even know they are infected” (WHO/UNAIDS 2002).

Clinical trials in the United States have shown that HIV transmission from a mother to her baby can be reduced from 25 percent to 8 percent if an HIV-positive pregnant woman takes AZT, an anti-retroviral drug, throughout her pregnancy and her baby is given AZT drops for six weeks after birth. Additionally, in a clinical trial at San Francisco General Hospital involving the combination of AZT and protease inhibitors, 0 out of 71 HIV positive mothers transmitted HIV to their infants (Valley AIDS Information Network 2001). While this evidence has overwhelmingly supported the administration of antiretroviral drugs to pregnant women to prevent MTCT, the tremendous cost of these drugs has made it increasingly difficult for most women to obtain them. For example, a course of treatment on the drug AZT ranges from US$1,000 to US$2,000, depending on what point in the pregnancy the treatment was begun (Avert 2002). In the United States, this cost is often covered by medical insurance companies. In low-income nations, this is an overwhelming amount of
money for a young woman to pay out of her own pocket, especially when this amount exceeds her annual income.

This has led pharmaceutical companies to develop an alternative drug to prevent MTCT, Nevirapine, which has a market price of only US$3. Due to its low cost, this has quickly become the drug of choice in low-income countries, but access to it is still rather difficult. A clinical trial in Uganda found that administering Nevirapine to an HIV-positive mother at delivery and to her infant within the first three days of life could reduce HIV transmission to 13.1 percent (Valley AIDS Information Network 2001). Although it has not been proven to be as effective as AZT in preventing MTCT, Nevirapine is far more affordable and does not require nearly as long of a treatment regimen.

Other factors that have proven to be effective in reducing MTCT include avoiding breastfeeding, undergoing an elective Caesarean section, and avoiding amniocentesis. Research has shown that transmission rates can be as high as 24 percent to 30 percent for babies who are breastfed. The Centers for Disease Control and World Health Organization currently recommend the use of formula as an alternative to breastfeeding with HIV-positive mothers only when access to clean water facilities is available for formula preparation (CDC 2001; WHO 2002). The most dangerous combination is a mixture of breast and formula feeding. However, serious ethical concerns are raised in situations when HIV-positive mothers do not have access to a clean water supply and are not able to afford costly formula. Further considerations need to occur in regards to risking starvation of an infant due to lack of
nourishment through withholding breast milk or risking the one in four chance that the infant will become infected with HIV through his or her mother's breast milk.

Impact of HIV/AIDS on the Household

David Turkon (2003:2) describes the relationship between poverty and the HIV/AIDS epidemic as "bi-directional;" he states that poverty is a leading factor in the transmission of the virus and that poverty is also increased by the impact of the epidemic. Women, who account for an estimated 55 percent of the HIV-positive adult population in sub-Saharan Africa, are especially affected by the implications of poverty. Because of HIV/AIDS, women's workloads have been increased, as women have traditionally served as the primary caregivers for their sick or dying relatives. According to Brown (2000), women whose husbands are suffering from AIDS and opportunistic infections spend up to sixty percent less time farming than they would without having the added burden of care giving. Workloads have also increased for children, especially females, who are frequently removed from school to save money on educational costs and to assist with household labor (Collins and Rau 2002). This also has future implications on the children, who do not receive an education and additional information on HIV/AIDS prevention (World Bank 2002:20); these children also will have an increased difficulty in finding employment due to illiteracy (Rugalema 2000:542). According to Turkon (2003:7):

AIDS has the potential to exacerbate disparities in wealth that already exist. By spreading the burden of care-giving across a broad spectrum of the population, what equalized distributions of wealth exist could perhaps at least be sustained. This would have the benefit of strengthening communities, instilling a sense of hope in community members, and even countering any
trends toward hopelessness and acceptance of shorter life-spans.

Turkon suggests that the focus of economic planning in rural African communities should include hybrid ideologies that incorporate African belief systems surrounding coping strategies, social capital, and the extended family (Turkon 2003:7). Above all, argues Turkon, this shift in economic planning and action will not be possible without assistance from governments and NGOs. If this does not occur, families infected and affected by HIV/AIDS will face depleted resources and chronic poverty and will be doomed to pass their economic hardships onto future generations (Turkon 2003:8).

Governmental Response

In 1997 the Government of Kenya issued *Sessional Paper Number Four* to establish a national multisectoral framework for utilization by the government and non-governmental organizations to combat the HIV/AIDS epidemic in Kenya (Ministry of Health 1997). The objectives as outlined by this paper included establishing:

- a strong political commitment at the highest level, implementation of a multisectoral prevention and control strategy with priority focus on young people, mobilization of resources for financing HIV prevention, care and support, and establishment of a National AIDS Council to provide leadership at the highest level possible (Ministry of Health 2001:26).

National protocols were thus established for community based programs such as Home Based Care and for monitoring organizations for duplication of services, both of which are monitored at the district and community levels (NACC 2000).

The goals outlined by the Government of Kenya in *Sessional Paper Number*
Four include: (1) strategies on how to deal with controversial issues and socio-cultural factors related to the spread and prevention of HIV/AIDS; (2) challenging the Government of Kenya to take an active role in controlling the HIV/AIDS epidemic from multiple sectors of society and to encourage active participation through a number of different governmental departments; and (3) recommendations for an appropriate protocol of HIV/AIDS programs and activities, including education and Home Based Care programs (Ministry of Health 1997).

Despite the acknowledgment of the serious threat of the HIV/AIDS epidemic and the policies laid out to combat it, very little activity has been carried out by the Government of Kenya since the time this decree was issued (Pisani 2002). Given that over two-thirds of Kenyans are practicing Christians, including a number of political leaders (Pisani 2002), many governmental, religious, and organizational leaders are not eager to promote and distribute condoms (AIDS Weekly 2002b; East African Standard 2000; Pisani 2002). With respect to condom usage, numerous comparisons have been drawn between the HIV/AIDS epidemic in Kenya and Uganda. At the time of writing, Uganda was the only sub-Saharan African nation that had shown a decrease in HIV/AIDS infection, and was the first African country to publicly recognize the posed threat of this epidemic. Previously possessing a nationwide prevalence of over 25 percent, Uganda’s rate of infection has dropped to below 10 percent (UNAIDS 2000). Arguably, this was in part due to the Ugandan governmental response to the epidemic beginning with President Yoweri Musevani speaking openly about sexual behavior and cultural norms beginning in 1986 (Pisani 2002). However,
data suggest that although the prevalence of HIV/AIDS had declined, condom use had not increased (Leclerc-Madlala 2002). This suggests that abstinence education might be a successful culturally appropriate strategy for combating HIV/AIDS.

At present, the most popular HIV/AIDS educational model taught in Kenya follows the “ABC” approach. Under this model: (1) abstinence is encouraged as the best way to prevent HIV/AIDS infection; (2) being faithful to one partner is encouraged for those individuals who do not abstain from sexual intercourse; (3) condom usage is encouraged as a last resort, for those individuals who have more than one sexual partner (field notes July 16th, 2002).

Uganda: A Case Comparison for Governmental Response

Uganda is a unique example in sub-Saharan Africa because, at the time of writing, it was the only sub-Saharan African nation where HIV/AIDS prevalence and incidence had declined. The case of Uganda also makes for an interesting comparison with Kenya because of the close proximity between the two nations and the fact that both nations are a part of the East African Union.\footnote{In addition to Kenya and Uganda, the East African Union also includes Tanzania.}

Data from sentinel surveillance sites within Uganda have shown a decline in HIV/AIDS prevalence among pregnant women from as high as 30 percent in the city of Kampala in 1992 to below 10 percent in 2000 (Uganda Ministry of Health 2001). Although the specific reason for this decline cannot positively be ascertained, there are several factors that could possibly account for such a decline.
In 1986, Ugandan President Yoweri Musevani publicly addressed the impact of the HIV/AIDS epidemic in his country, warned Ugandans that “you either abstain, be faithful, or die” (as quoted in Wendo 2002:1), stressed the importance of a “patriotic duty” to fight against the disease, and helped establish a multisectoral response for combating the HIV/AIDS epidemic. In 1992, the government of Uganda established the Uganda AIDS Commission (UAC) to coordinate and monitor HIV/AIDS prevention and intervention activities in multiple sectors of Ugandan society. The multisectoral response to the epidemic in Uganda also included active participation from over 700 agencies, both governmental and non-governmental. Uganda also became one of the first nations in the world to use voluntary counseling and testing (VCT) as a prevention strategy (Green et al. 2002:4).

In Uganda, the target audience in the behavior change campaign has included both at risk populations and the general population. Thousands of individuals were trained as community-based AIDS counselors, health educators, and peer educators to disseminate prevention education. As Green et al. note:

Led by their leaders’ examples, the general population in both urban and rural areas eagerly joined the fight against AIDS, so that it became a “patriotic duty” to support the effort. Spreading the word involved not just “information and education” but rather a fundamental behavior change-based approach to communicating and motivating. Decentralization itself was actually a type of local empowerment that involved local allocation of resources—in itself a motivating force (Green et al. 2002:4).

In regards to non-governmental support, an enormous amount of action has been taken by religious leaders and faith-based organizations in response to the HIV/AIDS epidemic. The involvement from both Christian and Muslim religious
communities has included both prevention education programs and support for the infected and affected; these programs have been among the most respected and well-received programs among the Ugandan people. For example, a program created by the Islamic Medical Association of Uganda (IMAU) to train religious leaders and lay community members as educators and community health workers has been selected by UNAIDS as a “Best Practice Case Study” (Green et al. 2002).

As in Kenya, the model of HIV/AIDS education in Uganda has been the “ABC Approach,” an HIV/AIDS education model which promotes abstinence, being faithful to one partner, and condom use. In Kenya, abstinence and being faithful to one partner are promoted more aggressively than condom use; however, it has been argued that in Uganda all three components of the model are promoted equally. In response to implementation of the ABC campaign, data from the African Medical Research Foundation (AMREF) revealed a delayed sexual debut among 13-16 year olds following information, education, and communication (IEC) compared to data from the early- and mid-1990s (AMREF 2001).

Condom distribution and use also increased, especially among commercial sex workers and those reporting sexual intercourse with non-regular partners. However, given that consistent condom use has not increased significantly in the general population, it can be argued that condom distribution was not synonymous with the decline in HIV/AIDS prevalence and incidence (Green et al. 2002). For example, demographic surveys have reported that among Ugandan women, only 1 percent had ever used a condom in 1989, compared to 6 percent in 1995 and 16 percent in 2000.
Among men, figures rose from 16 percent in 1995 to 40 percent in 2000 (Wendo 2002).

Arguably, according to Green et al. (2002:9), "the most important determinant of the reduction in HIV incidence in Uganda appears to be a decrease in multiple sexual partnerships and networks." For example, compared to 15-19 year old males in Kenya, Zambia, and Malawi, AMREF studies found that Ugandan youth were less likely to have sex outside of marriage and less likely to have multiple sexual partners, especially if never married. The success of Uganda's ABC model has been dubbed a "social vaccine" for Africa and as Green et al. (2002:12) conclude:

Although we may never fully know "what really happened in Uganda," the experience there and in other countries that have achieved some success suggests that a comprehensive behavior change-based strategy, ideally involving high level political commitment and a diverse spectrum of community-based participation, may be the most effective prevention approach.

**Wife Inheritance and Wife Cleansing**

The vast majority of research and commentary on the HIV/AIDS epidemic in Kenya contends that cultural and socioeconomic factors are the main causations for the high prevalence of this virus. Traditionally, the male is the sole breadwinner in the family and, depending on his economic status, may have two or more wives (Parkin 1978). Upon the death of the husband, his wife or wives are inherited by his brothers or other close relatives in order for the woman to be guaranteed continued financial support for herself and for her children. Before the ritual of wife inheritance is complete, each wife must undergo a cleansing ritual, in which she is required to
have sex with a stranger (Lovgren 1999). If either the widow or the wife cleanser is infected with HIV/AIDS, his or her sexual partner may thus become infected with the virus, and the disease is then spread throughout the woman’s new compound or other women with whom the wife cleanser has sexual relations.

Historically, the practice of wife inheritance (known as ter in the Dholuo language) served the purpose of providing economic and social protection to widows. Because women were prohibited from inheriting property on their own, wife inheritance was a way for women to access land. The purpose of the inheritor was to support the woman and her children. While the terms “wife inheritance” and “wife cleansing” are oftentimes used interchangeably, wife inheritance “generally refers to the long-term union of a widow and a male relative of the deceased, and cleansing typically refers to a short-term or one-time sexual encounter with a man paid to have sex with a widow” (Walsh 2003:12). The underlying meaning behind such practices has been linked to the belief that “women cannot be trusted to own property and the belief that widows are contaminated with evil spirits when their husbands die” (Walsh 2003:12).

There are four different types of wife inheritance and wife cleansing rituals. First is non-sexual wife inheritance, or symbolic inheritance, in which an inheritor places a coat in the widow’s homestead to symbolically cleanse her. This has historically occurred for widows who are past childbearing age. Second is inheritance with long-term sexual relations, whereby the brother of the deceased forms a union with the widow in what is the equivalent to marriage in customary law. The third type
involves both cleansing and inheritance, in which the widow is first required to have sexual intercourse with a "wife cleanser" (known as a jater in the Dholuo language), who is oftentimes a social outcast and paid for this deed by the widow’s in-laws. This ritual act serves the purpose of cleansing the woman of her husband’s spirits before she is inherited. The fourth type involves cleansing alone, whereby the widow is required to have sex with a jater, but is not inherited on a permanent basis (Walsh 2003:12).

Commercial Sex Work

Additional data suggest that the majority of Kenyan individuals engage in multiple sexual relations throughout their lifetimes both inside and outside of marriage. In one study with women in Kisumu, two-fifths of HIV-positive women interviewed had had sexual relations with an HIV-positive partner prior to marriage (Glynn 2000). It is likely that many young people are infected with this disease prior to marriage.

Commercial sex work has played a significant role in the transmission of the HIV/AIDS epidemic in Nyanza Province, Kenya. A study conducted by anthropologists and public health professionals from Kenya and the Netherlands examined the relationship between commercial sex work and the transmission of HIV/AIDS (Voeten et al. 2002). Data were collected from the city of Kisumu and the rural districts of Siaya and Bondo, which are both areas that are primarily inhabited by members of the Luo tribe. The article reported that the majority of clients of female sex workers (FSWs) are married and have sexual relations with three to five FSWs per
year. Of the clients interviewed, over forty percent admitted that they rarely or never used condoms with FSWs. Of those who did use condoms, it was discovered that condoms were used during the first several sexual encounters with FSWs; after this the clients believed they had established a level of trust with their partners and no longer needed to use a condom (Voeten et al. 2002).

As seventy-percent of clients involved in this study were married, and as the clients had had an average of 6.2 sexual partners in the previous year, data suggests that because of sexual encounters with commercial sex workers, “clients in Nyanza province can be regarded as an important core group in the transmission of HIV/STDs and not just as a bridge population that connects FSWs with the low-risk group of wives” (Voeten et al. 2002:450). The authors thus recommend intervention programs that target condom use between FSWs and their clients and suggest that men who work in places frequented by clients might serve as educators in the educational campaign. Having free condoms available in the rooms of lodges that are routinely used by FSWs and their clients is also discussed (Voeten et al. 2002).

Additionally, Kenyan anthropologist A.B.C. Ocholla-Ayayo (1997) found that the number one reason that girls engage in sexual intercourse is for economic motivations. A number of Kenyan girls exchange sex for money on occasion as a means to earn an income for themselves. Economic motivations for sexual intercourse exceeded both motivations based out of pleasure or love. Specific results of Ocholla-Ayayo’s study are indicated in Table 3 below:
Table 3. Reasons Give by Respondents for Girls Having Sex with Men in Their Communities

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Number of Cases</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money (economic)</td>
<td>4,635</td>
<td>44.8</td>
</tr>
<tr>
<td>Gifts (economic)</td>
<td>989</td>
<td>9.6</td>
</tr>
<tr>
<td>Sexual Experience</td>
<td>818</td>
<td>7.9</td>
</tr>
<tr>
<td>Leisure (social)</td>
<td>1,128</td>
<td>10.9</td>
</tr>
<tr>
<td>Love (psycho-social)</td>
<td>1,010</td>
<td>9.8</td>
</tr>
<tr>
<td>Sociocultural Motive</td>
<td>751</td>
<td>7.2</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>1,009</td>
<td>9.8</td>
</tr>
</tbody>
</table>


Violations of Women’s Property Rights

In a report released by Human Rights Watch, a New York-based organization, in March, 2003 (Walsh 2003), violations of women’s property rights and the implications of those violations on the health and economic sustainability of the women are discussed. According to the report, there are a number of cultural, legal, and social factors that are related to these violations. In Kenya, practices are often dictated by customary laws, which are largely unwritten, but highly influential on the actions of individuals within cultural groups. According to this report:

Past practices permeate contemporary customs that deprive women of property rights and silence them when those rights are infringed. Kenya’s constitution prohibits discrimination on the basis of sex, but undermines this protection by condoning discrimination under personal and customary law....Sexist attitudes are infused in Kenyan society...men interviewed said that women are untrustworthy, incapable of handling property, and in need of male protection. The guise of male “protection” does not obscure the fact that stripping women of their property is a way of asserting control over women’s autonomy, bodies, and labor—and enriches their “protectors” (Walsh 2003:2).
Women who refuse to be inherited or to undergo the cleansing ritual are often denied property rights. Before marriage, the husband’s family acquires the wife from her family by exchanging a dowry, which thereby signifies that the woman becomes the property of her husband and his family. The family of the husband keeps the dowry and the only way for the woman to separate from this family is if the dowry is returned to her family. If the husband dies, the widow’s in-laws often force the woman to be cleansed and inherited; if the woman refuses, she is often greeted by death threats and has her property removed from her homestead. In order for a woman to go to the police to report such offenses, she must have enough money to pay for a bribe. Therefore, many women are forced into persistent poverty and homelessness because of denial of property rights (Walsh 2003).

Denying women their property rights has serious implications on the women that often results in persistent poverty, homelessness, and an increased vulnerability to infectious disease and violence for both the women and their children (Walsh 2003). This also has a direct relationship with the HIV/AIDS epidemic because an increasing number of women are widowed at an early age and denied their property rights. Additionally, women who give in to practices such as wife inheritance and wife cleansing are at an increased risk of sexually transmitted infections, including HIV/AIDS. As cited by Walsh (2003:31), “because women do not own property as such, men have more say over them. They can’t negotiate safer sex, and this increases infection.” Women with HIV/AIDS who have been denied property rights are likely to die sooner, as they have been denied the basic shelter and resources essential to
their survival, including the necessary resources to afford medical treatment (Walsh 2003).

Women’s property rights violations also have serious consequences on the overall economic state in Kenya. Insecure property rights for women have also been linked to low agricultural production, food shortages, underemployment, and rural poverty. More than half of all Kenyans live in poverty; the agricultural sector accounts for one quarter of Kenya’s gross domestic product; and women make up over one half of the agricultural work force. “If Kenya is to meet its development aims, it must address the property inequalities that hold women back” (Walsh 2003:2).

In the 1990s, a number of governmental aid organizations, such as the World Bank and the International Monetary Fund, reduced aid to Kenya and cited corruption and mismanagement as the primary reasons. Funding instead was given to non-governmental organizations, some of which were working in favor of women’s property rights. After the outcome of the 2002 presidential election, a number of governmental organizations, including the International Monetary Fund, the World Bank, the United Kingdom, the United States, Italy, and the European Union, have re-pledged their support (Walsh 2003:15).

Questions Surrounding Voluntary Counseling and Testing

At the time of writing, the Kenyan government had recently implemented a program to encourage pregnant women to undergo voluntary counseling and testing for HIV/AIDS in order to take appropriate measures to protect their fetuses. While interventions such as administration of the drug Nevirapine, Caesarean section, and
feeding the newborn only through breastfeeding (or entirely without breastfeeding), may reduce the chances of a newborn contracting the HIV/AIDS virus from the mother, the sexual partners of the expectant mothers still are at risk of contracting the disease via sexual intercourse, especially as HIV-positive mothers are often reluctant to reveal their status to others, including spouses and other sexual partners (field notes July 26th, 2002).

An article published in Reuters Health (Woodman 2002) suggests that the partners of expectant mothers who are HIV-positive should also be tested for the virus. In a recent study in Britain, it was discovered that a significant number of pregnant women who tested positive for HIV did not report their status to the fathers of the fetuses. The majority of HIV-positive women in this study were of African origin and many chose not to reveal their status to their partners due to fear of breakup, domestic violence, and homelessness. This article addresses issues beyond HIV testing and also reveals some of the societal stigmas associated with HIV, especially in Africa where the disease is the most rampant. It also raises questions regarding the right to privacy for a person to be able to choose whether to reveal his or her HIV status to others.

**Theoretical Foundations**

**Medical Anthropology**

Medical anthropology is “the application of anthropological theories and methods to questions of health, illness, medicine, and healing” (Brown et al. 1998:10). Broadly construed, medical anthropology consists of five distinct approaches: (1) biological, (2) ecological, (3) ethnomedical, (4) critical, and (5) applied; these
approaches often overlap one another. The goal of medical anthropological research is to expand knowledge of health and healing systems. The aim of applied research is to solve specific problems related to the health of a population or community (Brown et al. 1998). The following pages will only describe the approaches which are most relevant to my research design and analysis.

**Ethnomedical Approaches to Medical Anthropology**

The ethnomedical perspective has been defined as “the study of how members of different cultures think about disease and organize themselves toward medical treatment and the social organization of treatment itself” (Fabrega 1975:969). Within the ethnomedical perspective itself, there are five major areas of research: (1) ethnographic descriptions of health and healing practices; (2) comparisons of ethnomedical models and systems; (3) explanatory models of sickness and health; (4) health-related behaviors; and (5) the efficacy of ethnomedical systems (Brown et al. 1998:14). All ethnomedical systems include theories of illness causation, methods of diagnosis, and theories regarding appropriate treatment strategies (Brown et al. 1998:15).

Part of the ethnomedical perspective, explanatory models include an individual’s own cultural interpretations of disease etiologies, treatment, and sick roles (Brown et al. 1997). Like culture itself, explanatory models are often based upon learned cultural behaviors. Generally, explanatory models are either personalistic or naturalistic. Personalistic belief systems “explain sickness as the result of supernatural forces directed at a patient, either by a sorcerer or by an angry
spirit” (Brown et al. 1998:15). Naturalistic belief systems “explain sickness in terms of natural forces, such as the germ theory of contagion in Western biomedicine or the imbalance of humors in many forms of Chinese, Indian, and Mediterranean systems” (Brown et al. 1998:15). According to Brown et al. (1998), differences in explanatory models between patients and healers often result in miscommunication and noncompliance of treatment regimens.

Critical Medical Anthropology

Critical medical anthropology (CMA), also known as the political economy of health, “emphasizes the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness experience, and health care” (Singer and Baer 1995:5). Based on the theoretical models outlined by Karl Marx and Frederick Engels, a CMA approach examines the challenges of health care systems and disease prevention created by human-made socioeconomic arrangements.

The CMA model includes multiple levels of analysis, based on “macrosocial” and “microsocial” models. The macrosocial model focuses on national and international political and economic systems while the microsocial system focuses on factors at an individual level and possibly related to health provider-patient interactions, sufferers’ social networks, and individual psychobiology (Singer and Baer 1995:63).

In his book Infections and Inequalities: The Modern Plagues, Paul Farmer uses a critical medical anthropological approach in examining the issues of poverty and inequality as a leading causality of infectious disease outcomes worldwide,
particularly in relation to HIV/AIDS and tuberculosis. He states that "the histories of both anthropology and medicine show these disciplines to be notable for their lack of attention, respectively, to oppression (and, perhaps, to human suffering in general) and the sicknesses of the poor" (Farmer 1999:6). Farmer challenges the reader to examine the reality that infectious emerging and reemerging diseases are infecting low-income populations at drastic rates.

Throughout the world, HIV/AIDS infection is far more prevalent in populations living in poverty where there is limited access to health care and education. Among the reasons Farmer cites for the spread of HIV/AIDS are "deepening poverty, gender inequality, lack of timely response by public health authorities, and lack of culturally appropriate prevention tools" (Farmer 1999:146). But despite the startling data the Farmer provides to confirm these reasons, the victims are the ones often blamed for their disease for their inappropriate cultural and behavioral practices.

**Applied Approaches in Medical Anthropology**

Applied anthropology "emphasizes the direct application of anthropological theory and method to particular social problems" (Brown et al. 1998:16). There are two main applied approaches in medical anthropology, those which target clinical settings and those which target public health programs. Clinically applied anthropology "focuses on health care within biomedical settings and analyzes the effects of cultural and socioeconomic factors on doctor-patient interaction, adherence to treatment, and the experience of healing" (Brown et al. 1998:16).
Also cornerstone to applied anthropological theory is the notion of praxis. Praxis bridges the gap between theory and practice and is defined and discussed briefly in chapter two. In praxis centered work “applied anthropologists… engage in theoretical discussion in the context of actual practice with their research subjects, clients, and collaborators, who are not anthropologists, at the point of intervention—the community or the organization as it directly applies to the problem at hand” (Ervin 2000:9). Thus collaboration is a central component of applied anthropological work, as key informants are stakeholders in the data collected and help to guide the research design.

In an article on critical medical anthropology, Merrill Singer (1998) debates whether the concept of praxis can be combined with the CMA approach. Singer (1998:235) argues that:

Concern with social relations as a determinant force in social life directs critical attention to the alignment of forces in practical work. In an effort to offset the imbalance in social power across class, race, or other social divisions, critical praxis emphasizes collaboration and coalition building. Central to critical praxis is the forging of collaborative relations across social segments that heretofore have been subject to divide and conquer tactics.

Linking theory, practice, and critical medical anthropology is an item that will be discussed in further detail in subsequent chapters.

Rothman’s Models of Community Organization

Rothman’s models of community organization consist of three distinct typologies for organizing communities: locality development, social planning, and social action (Rothman and Tropman 1987). The locality development model is
largely process oriented and focuses on consensus-building and cooperation with the purpose of “building group identity and a sense of community” (Minkler and Wallerstein 1997:35). In comparison, the social planning model is largely task oriented and focuses on a “rational-empirical problem-solving” (Minkler and Wallerstein 1997:35) ideology that is facilitated by an outside expert. The social action model is both process and task oriented. Under this model, the focus is on “increasing the problem-solving ability of the community with achieving concrete changes to redress imbalances of power and privilege between an oppressed or a disadvantaged group and the larger society” (Minkler and Wallerstein 1997:35).

Historically, most systems of community organization fell under one of these three categories; however, Rothman and Tropman have since argued in favor of the “mixing and phasing” of these models in which two or more models are utilized in a single community organization program (Rothman and Tropman 1987).

For nearly twenty years, Rothman’s models of community organization have been the dominant framework within community organization theory. However, these models have recently been criticized for their limitations. One criticism is that the term “locality development” is restrictive in that it does not consider the organization of communities on “nongeographic lines” (Minkler and Wallerstein 1997:35). A second criticism is that social planning is not a true model of community organization because it relies heavily on outside assistance, which keeps the focus away from the problem-solving abilities of the community members themselves (Minkler and Wallerstein 1997). Additionally,
The fact that this typology is problem based and organizer centered, rather than strength based and community centered, constitutes a philosophical and practical limitation that may be particularly problematic as organizing increasingly occurs in multicultural contexts (Minkler and Wallerstein 1997:35).

**The AIDS Risk Reduction Model (ARRM)**

The AIDS Risk Reduction Model (ARRM) outlines a framework that focuses on levels of behavior change in relation to the knowledge, attitudes, and practices concerning the transmission of HIV/AIDS via sexual intercourse (Catania et al. 1990). The ARRM incorporates several constructs from other theoretical models such as self-efficacy, perceived susceptibility, and perceived barriers from the Health Belief Model (Janz and Becker 1984). The ARRM has also drawn from Stages of Change Theory in that it has created a process of three stages in which an individual at high risk of HIV/AIDS infection changes his or her behavior. These processes include identifying one’s behavior as high risk, deciding to change high risk behavior and focus on low risk activities, and taking action (Ulin et al. 2002). Depending on the individual and his or her situation, the stages may be occurring simultaneously or skipped altogether.

According to the ARRM, there are several variables that affect an individual’s movement through the behavior change continuum. These factors include: (1) an individual’s knowledge of what HIV/AIDS is and how it is transmitted, (2) perceived susceptibility, (3) the belief that HIV/AIDS is an undesirable disease, (4) costs associated with behavior change, (5) perceived benefits, (6) self-efficacy, (7) social networks and social support, (8) open dialogue with sexual partner(s) regarding sexual matters, and (9) behaviors and beliefs of sexual partners (Ulin et al. 2002).
Additionally, the influences of prevention education, informal social support networks, and reactions from watching other individuals suffering from HIV/AIDS, serve as cues to action under the ARRM (Ullin et al. 2002). The ARRM has been applied to numerous and varied populations over a period of the last ten years. Specifically related to Africa, a study conducted in Zaire (now the Democratic Republic of Congo) found that women engaging in high risk behavior did not label their behavior as such and only one-third of these women believed they were at any risk of contracting the HIV/AIDS virus (Bertrand et al. 1992).

Culture of Poverty Theory

The notion of a culture of poverty is something that has been debated in anthropological theory for decades. In the early 1960s, Oscar Lewis coined the term “culture of poverty” and distinguished it from the general definition of poverty. To Lewis, poverty was defined as low wages, chronic unemployment, and lack of adequate housing and food supplies. People could be living in poverty but not necessarily be consumed by the culture of poverty. Like culture in general, the culture of poverty is a set of acquired characteristics that are passed down from generation to generation. The people living in the culture of poverty are often illiterate, display feelings of hopelessness, and are highly marginalized from middle- and upper-class societies (Lewis 1965:235). By being born into the culture of poverty, people are often bound by their situation and it is nearly impossible for them to escape their fate.

Lewis asserts that it is easier to eliminate the culture of poverty than poverty itself. He uses the United States as an example of working toward the elimination of
poverty by suggesting that society is slowly working towards raising the standard of living and incorporating impoverished people into the middle class\textsuperscript{2}. Lewis also suggests that:

in the underdeveloped countries... by creating basic structural changes in society, by redistributing wealth, by organizing the poor and giving them a sense of belonging, of power, and of leadership, revolutions frequently succeed in abolishing some of the basic characteristics of the culture of poverty even when they do not succeed in abolishing poverty itself (Lewis 1965:240).

Social Support Theory

Social support can be defined and measured in a number of different ways. House (1981) defines social support as the functional content of relationships and categorizes support systems into four broad categories: emotional support, instrumental support, informational support, and appraisal support. Emotional support consists of empathy, love, trust, and caring shown to another person. Instrumental support involves the distribution of material aid and services that are designed to help persons in need. Informational support includes the dissemination of knowledge, information, and advice that is designed to address particular problems that one might face. Appraisal support includes constructive feedback that is helpful to a person on an individual level (Heaney and Israel 2002).

Social support has been shown to have a positive relationship to human health by helping people to meet the “basic human needs for companionship, intimacy, a sense of belonging, and reassurance of one’s worth as a person; supportive ties may

\textsuperscript{2} This article was written in 1965, amidst a different socioeconomic situation in the United States and political action taken to alleviate poverty, such as President Lyndon Johnson’s proposed Great Society.
enhance well-being and health regardless of stress levels” (Heaney and Israel 2002:189). According to Heaney and Israel (2002:190), social networks and social support have a direct impact on physical, mental, and social health. They influence individual health behaviors through targeting behavioral risk factors, preventive health practices, and illness behaviors. Participation in social support programs have a positive influence on individual coping resources by improving an individual’s problem-solving abilities, access to new contacts and information, and perceived control. These social networks also have an impact at the community level by increasing community empowerment and community competence (Heaney and Israel 2002:190).
CHAPTER FOUR

HISTORY

The Republic of Kenya, formerly British East Africa, lies on the equator and is bordered by Sudan, Ethiopia, Somalia, Tanzania, Uganda, Lake Victoria, and the Indian Ocean (See Map 1 and Map 2). A country with a landmass twice the size of the state of Nevada, Kenya is known worldwide for its wildlife and is a popular destination for tourists and safaris. However, Kenya also possesses immense human history and diversity, being the home to several of the oldest hominid fossils ever discovered and presently serving as the home of forty-two ethnic groups. With a population exceeding 31 million inhabitants in 2001, each ethnic group or tribe embraces its own unique history, language, and cultural traditions. The following pages discuss the history of cultural migration and political and economic forces that have led to present-day tensions between the Luo and Kikuyu and an uneven distribution of wealth across Kenya and in Nyanza Province especially. Background information on the Luo and their customs and a brief history of HIV/AIDS globally and in Kenya are also discussed.

Pre-history

Fossil remains in Kenya have yielded a vast pool of information regarding the evolution of the human species. In western Kenya, deposits have been found that date back over 20 million years. Also in western Kenya, primate fossils have been discovered dating back approximately 2 to 14 million years ago, which have provided important insight into the development of the hominoid superfamily and the hominid
family. At Lake Turkana in northern Kenya, 2.6 million year old fossils of an extinct australopithecine species have been discovered. Additionally, skeletal remains have been found for several other archaic species from the *Homo* genus. Less information is known about the pre-history of *Homo sapiens* habitation in Kenya. Remains from the stone industry, dating back to 16,000 BCE, have been discovered, which is possibly linked to an archaic *Homo sapiens* sub-species (Kaplan et al. 1976).

Archaeological findings indicate that Kenya's lakeshores have continuously been occupied since around 8000 BCE primarily by fishing populations. Skeletal remains dating to around 3000 BCE have been found that have been linked to Cushitic-speaking peoples who now occupy regions on the Horn of Africa. The Cushitic peoples appear to have lived sympatrically with populations living along the lakeshores. Additionally, a third group of humans also inhabited the area of present-day Kenya at about the same time. These individuals are thought to have been Nilo-Saharan and lived around Lake Victoria and in the Rift Valley (Kaplan et al. 1976).

Bantu speakers began to arrive in Kenya between 500 BCE and AD 500 from West Africa, evolving into numerous tribes including the Gusii, Kikuyu, Akamba, and Meru (MacPhee 1968). The Luos are believed to have evolved from the Nilotes of present-day Sudan, a group that existed over one thousand years ago. According to Ogot (1967:41):

most authorities seem to agree that 1000 A.D. is the most likely date by which the Nilotes had evolved as a distinct group, and were living as a small backward group in the open grass plains of the present eastern Equatoria and the eastern parts of the Bahr-el-Ghazal Provinces of the Republic of Sudan.
It is believed that the Nilotes began to migrate shortly after this time due to overpopulation. The Luo migrated following the Nile to what is present-day Kenya (DuPré 1968). Nilo-Hamitic tribes arrived from the Nile Valley and formed the present-day tribes of the Kalenjin, Maasai, Samburu, and Turkana. Muslims from the Arabian Peninsula and Shirazis from Persia settled along the East African coast beginning in the eighth century AD (MacPhee 1968) and established the ports of Mombasa and Malindi. The intermixing of indigenous inhabitants and Arab settlers formed the Swahili culture and language. During this time period principal trading items were slaves and ivory (Uwechue 1996).

It is thought that the Luo settled at Ramogi Hill in Kadimo, Central Nyanza between the years 1490 and 1600. The Luo remained clustered in the Ramogi Hill region until the early seventeenth century, when they began to disperse to land along the eastern shores of Lake Victoria. As documented by Ogot (1967), there were three separate waves of Luo migration following the first at the end of the nineteenth century; as a result, present day Luo settlement patterns emerged. Ogot writes (1967:154):

Between six and seven generations ago, South Nyanza was invaded; and then the process was completed when the Luo finally abandoned their traditional habitat and invaded the higher areas of Gem, North Ugenya, Kisumo, and North Seme about two or three generations ago.¹

**European Colonization**

In search of spices and wealth, the Portuguese began to explore Africa in the

¹ To Ogot, a generation was approximately 26.5 years (DuPré 1968).
fifteenth century. Following the western coast of Africa, Vasco de Gama rounded the Cape of Good Hope and continued up the eastern coastline in 1497. In 1505, the Portuguese began their colonization of the region. By the sixteenth century, the majority of Swahili trading towns, including Mombasa, had been seized by the Portuguese, marking the end of Arab domination of Indian Ocean trade. In 1593, the Portuguese built Fort Jesus in Mombasa, which became the main port for Portuguese trading vessels. Despite control of the coastal region, the Portuguese faced constant resistance from Omani Arabs and the Goa of India (MacPhee 1968). The Omani Arabs captured Fort Jesus in 1698 and reclaimed control of the East African coast (Uwechue 1996).

In the mid-nineteenth century, Christian missionaries, explorers, and traders from Britain and Germany began their colonization of the inland of the East African region (MacPhee 1968). The first Europeans to reach the interior of present-day Kenya were Reverend Johann Krapf and Reverend Johannes Rebmann, both missionaries of the Anglican Church Missionary Society. Krapf reached Mount Kenya in 1849. Joseph Thompson, a traveler from Britain, became the first European to have contact with the Maasai. Both Britain and Germany battled for control of Maasailand, which resulted in an 1890 agreement to divide the land between the two of them. According to this agreement, the British claimed control of the area north of the Umba river, the region which comprises Kenya and Uganda. The British Government gave this designated land to the British East Africa Company, a trade organization which had been given a royal charter to operate in the East Africa region
By the time East Africa was declared a British protectorate in 1895, the Luo of western Kenya had established several sub-tribes, each with well defined boundaries and chieftainships. Despite the arrival of German and English settlers in western Kenya as early as 1884, Luoland was not colonized until 1900. According to DuPré (1968:16), “the routes over which the trading caravans had rumbled were to the north and south of Luo territory, and it was only by accident that a Luo saw a white man.” Before this time, the Luo had engaged in intertribal warfare with the neighboring Kipsigis and Nandi (DuPré 1968), sub-tribes of the Kalenjin.

At the time Kenya was declared a British protectorate in 1895, C.W. Hobley was sent to the Kavirondo region in western Kenya to act as sub-commissioner of that province. As DuPré (1968:16) writes, “it was his job to make Kavirondo safe for travelers and settlers.” The settlers faced resistance from a number of Kavirondo tribes, but the Luo were not among these (DuPré 1968).

Britain established the administration for Nyanza province between the years 1900 and 1914. The administrators stopped the progress of tribal migration and created boundaries that were equivalent to the boundaries established by sub-tribes. The units established from these boundaries became known as administrative locations. Chiefs were appointed in each location to collect taxes and to serve as mediators between the government and the local people. The British government
made no distinction between the Luo and Luhya\textsuperscript{2} tribes in the administration of the protectorate, despite the unique languages and customs of the two tribes. The British government appointed Mumias-no’s, a Luhya chief, the Paramount Chief of Nyanza province and “conscripted people of Nyanza indiscriminately to serve as guards to Mumias-no’s and his sub-chiefs” (DuPré 1968:16). The Luo complied with this arrangement, but faced a number of consequences as a result.

The command that the Luo people must serve the chief of a rival tribe was damaging to the Luo’s pride, but the selection of two Luo chiefs to represent the entire tribe in the government was even more wounding to the Luo people. Historically, the Luo had not had a chief leader serving over their entire tribe; each sub-tribe had its own appointed chief (DuPré 1968). However, the administration established by the British protectorate abolished this system and “the system settled down to an acceptable compromise between the stereotype of the British administrators and the system that the tribe itself followed” (Whisson 1964:112).

The Struggle for Independence

The native peoples of British East Africa became outraged by European domination and began to organize to overthrow the British protectorate shortly after World War I. In 1921, when European employers attempted to cut the wages of indigenous workers, the workers staged massive protests and demonstrations. Outraged workers met in a Nairobi suburb and formed the Young Kikuyu Association,

\textsuperscript{2} The Luhya are a Bantu people presently inhabiting the Kakamega region of Western province, along the Nzoia River.
the first all-African political organization in Kenya (The Economist Intelligence Unit 1998). Harry Thuku, a member of the Kikuyu tribe and an early leader of the resistance movement, was jailed by the British in 1922 (MacPhee 1968). His successor in the fight against the British was Johnstone Kamau Ngengi (later known as Jomo Kenyatta), who reorganized the Young Kikuyu Association into the Kikuyu Central Association (KCA) in 1928 and became the newly-formed organization’s first general-secretary (The Economist Intelligence Unit 1998).

The Kenya Africa Union (KAU), formed in 1944, grew as a resistance to colonial rule. Jomo Kenyatta, back from expulsion in Britain, became the leader of the KAU in 1946 and was elected to the organization’s presidency in 1947. Kenyatta sought to create ethnic unity among the various tribes of the area and thus brought Oginga Odinga, from Kenya’s second-largest tribe, the Luo, to be part of KAU leadership in 1950. By 1951 the KAU had approximately 150,000 members spread throughout Kenya (The Economist Intelligence Unit 1998).

Another resistance organization, the Mau Mau, comprised primarily of a faction of Kikuyu that was angry about the British seizure of Kikuyu lands, began a violent and aggressive attack on colonization between the years 1952 and 1956 (The Economist Intelligence Unit 1998). In 1956, the Mau Mau led an uprising against the British protectorate and all Africans who supported the British government; 13,547 Africans including Mau Mau guerillas, civilians, and troops, and 100 European settlers were killed in subsequent attacks (MacPhee 1968). The interpretation of the Mau Mau has been portrayed differently depending on the ethnicity of the historian.
In the words of a Luo:

This struggle has been distorted as the savage activities of primitive murdering gangs, the Mau Mau. Persons better qualified than I have argued that this word is unknown in the Kikuyu language, that those who participated in the struggle never called themselves ‘Mau Mau,’ that this became a term of abuse against every Kikuyu who did not volunteer for the government’s security forces and give proof of his loyalty to the government... The poor were the Mau Mau (Odinga 1967:120).

The true intentions of the Mau Mau are difficult to ascertain from historical records.

According to a British historian (MacPhee 1968:112):

Mau Mau was neither a manifestation of poverty and other causes of social discontent; nor was it some evil reaction to the pressures of a white civilisation on an ignorant, primitive people. It was a movement which used every weapon it could to enslave the mass of the Kikuyu people to the ideals of African nationalism and to the campaign to free Kenya from alien rule... the methods used by Mau Mau were undoubtedly primitive and evil; but terrorism as a political weapon knows no bounds in Africa or in any other continent.

As a result of the Mau Mau Rebellion, the governor of the British protectorate, Sir Evelyn Baring, broadcast a speech declaring a state of emergency and implementing martial law. That same day, the British government, in Operation Jock Scott, arrested and detained thousands of Kikuyu (The Economist Intelligence Unit 1998), including ninety-nine KAU leaders who had no affiliation with the Mau Mau, one of which was Jomo Kenyatta (MacPhee 1968).

With the absence of Kikuyu in the KAU organization, members of other tribes, including the Luo, assumed leadership positions. Beginning in 1957, the British permitted Africans to be members of the Legislative Council with restricted privileges. The Africans appointed to these posts, led by Luo trade unionist Tom Mboya, refused to accept their official duties as appointed by the British government.
Early in 1960, a constitutional conference was held in London, establishing a transitional constitution which led to the legalization of political parties and an African majority in the Legislative Council. The Kenya African National Union (KANU) was thus formed with Mboya and James Gichuru accepting leadership roles for the imprisoned Kenyatta (The Economist Intelligence Unit 1998). Kenyatta was freed in 1961 and subsequently became the leader of KANU (Odinga 1967). Kenya declared its independence from Britain on December 12, 1963, and Kenyatta became the nation’s first president.

The cornerstone of Kenyatta’s political ideology became the slogan *Harambee*, which soon became the national motto of Kenya and a symbol of national unity for the newly formed country. “It stood for one country, one destination, one Africa, one party, one policy, the unity of all tribes and peoples for a united free country” (Odinga 1967:238). Today, the concept of *Harambee* calls the citizens of Kenya to voluntary action in assistance towards one another.

Early in Kenya’s independence, Kenyatta and his Luo vice president, Oginga Odinga, formed the Lumumba Institute³, “to define, teach and popularize African socialism in the context of universally accepted principles and practices of socialism to instil [sic] the spirit of *harambee*, nationalism and patriotism” (Odinga 1967:271). The Luo Tom Mboya was appointed to the post of Secretary-General in the KANU

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³ The name ‘Lumumba Institute’ commemorates Patrice Lumumba, first prime minister of the Republic of Zaire, who was assassinated for his involvement with the socialist movement. The involvement of the United States’ Central Intelligence Agency (CIA), in installing a replacement to Lumumba, has been debated.
government.

Around this same time, tension began to develop between Kenyatta, Odinga, and Mboya. Historical accounts on the reasons for such tension vary. According to Odinga himself (1967:275-278):

During 1963 and 1964 I was becoming increasingly uneasy that forces were at work trying to drive a wedge between Kenyatta and myself... The campaign of slander and undermining was only a taste of what was to come... During 1964 there were two disturbing sets of tendencies... The first was that the Cabinet did not seem to be its own master... The second thing that disturbed me was that I seemed repeatedly to be the victim of manipulation from forces within our country whose tactics, if not planned in conjunction with external, neo-colonial forces, nevertheless managed, with astonishing accuracy, to coincide in intention and effect... Suddenly I found myself the so-called evil genius of a ruthless plot to overthrow the government.

In 1966, Odinga resigned from his position as vice president and formed the Kenya People’s Union (KPU), an action which commenced a multi-party system in Kenya (The Economist Intelligence Unit 1998). In 1969, KANU’s secretary-general, Tom Mboya, was assassinated by a Kikuyu under circumstances which have never been positively ascertained. The Luo saw the assassination as an ethnic and political attack on their entire tribe and tension between the Luo and Kikuyu escalated in succeeding months. In October of 1969, the KPU party was banned and seven of the party’s leaders, including Oginga Odinga, were imprisoned (The Economist Intelligence Unit 1998). Odinga remained in prison until he re-pledged his allegiance to KANU (MacPhee 1968). Kenyatta remained President of Kenya until his death in August, 1978, at which time he was succeeded by Vice President Daniel arap Moi, a member of the Kalenjin tribe. Moi won the
national election for presidency in 1979, running as the sole candidate (The Economist Intelligence Unit 1998).

**The Moi Presidential Era**

Moi's presidential era was wrought with controversy and accusations of unfair elections and political systems. The Kenyan National Assembly declared KANU the sole legal party in June, 1982. As a result, a Kenyan Air Force-led coup attempted to overthrow Moi's government in August of that year. Odinga was linked to the coup and later placed under house arrest. In the ensuing years, dissidence grew against Moi's government and limited action was taken by the government to remedy these tensions. Beginning in 1984:

- The government felt threatened by the rise of a left-wing opposition group, Mwakenya. Many parliament members were arrested beginning in March, 1986, and accused of being connected with Mwakenya. The right to a secret ballot was overturned in 1986 and replaced by "line-up" voting in preliminary elections. Presidential power was further strengthened in December, 1986, when parliament passed a constitutional amendment that increased the president's power over the civil service and the judiciary that extended to the power to dismiss the Attorney General without recourse...In February, 1988, Moi dismissed preliminary public elections and was summarily re-elected president (University of Pennsylvania 2003:4).

- In 1991, President Moi finally conceded to immense pressure and allowed Kenya to become a multi-party nation. By 1992, a number of political parties had emerged, including Mwai Kibaki's Democratic Party, Oginga Odinga's Forum for Restoration of Democracy (FORD), the Social Democratic Party, the Kenya National Democratic Alliance, the People's Union of Justice and New Order, and the Islamic Party of Kenya (University of Pennsylvania 2003).
In 1992, the FORD party staged Kenya’s first legal protest rally in 22 years, which led to civil unrest between Kalenjin warriors and Kisii tea farmers. In the following two years, “outbreaks of violence continued to mount… seeming to confirm the government’s predictions that multi-party politics would exacerbate ethnic tension and eventually splinter the country along tribal lines” (University of Pennsylvania 2003:5). The protests claimed 2,300 lives and displaced 25,000 individuals. Riots also took place in Nairobi, Kisumu, and Homa Bay, in Nyanza Province. To add to the political climate in Kenya, the riots took place at the same time the Kenyan government was dealing with the ramifications of the wars in Somalia and Sudan, including the migration of thousands of refugees into northern Kenya (University of Pennsylvania 2003).

Moi was re-elected to a fifth term as president in 1992, with just over one-third of the election votes (University of Pennsylvania 2003). In 2002, Moi announced his retirement and endorsed Uhuru Kenyatta, the son of the late Jomo Kenyatta, as his successor. Again, the campaign for presidency seemed to be focused along ethnic lines, with Oginga Odinga’s son, Raila, also in the running. In a highly contested election in December, 2002, Mwai Kibaki, a Kikuyu representing the National Alliance Rainbow Coalition (NARC), was elected Kenya’s third president. With Kibaki’s inauguration came the optimism of an end to governmental corruption and a renewed sense of activism towards issues of importance to the Kenyan people, including HIV/AIDS, economic development, abolishing primary school fees, and an increased representation of women in Kenyan political positions.
Present Day Kenya

Kenya’s government is presently a republic which operates from a constitution established in 1963. The Kenyan government is led by the president and 22 cabinet ministers who each lead an executive department of the government. The National Assembly, which is the principal lawmaking body within the country, is comprised of 222 members.

For local governmental purposes, Kenya is divided into seven provinces plus the district of Nairobi. Each province is divided into districts, divisions, locations and sub-locations. Districts are headed by a commissioner and a chief is assigned to each location. Each chief is appointed by the District Commissioner and the chief is generally a respected elder from the community. The position of chief is a lifetime appointment and assistant chiefs are often appointed to help with governmental functions at the sub-location level.

Kenya is presently the home to over fifty-one cultural and language groups. A map representing the distribution of these language and cultural groups is included in Map 3 on the following page.

Luo Customs and Lifestyle

According to census data, the Luo comprise 13 percent of Kenya’s total population and are the third largest ethnic group in the nation. The Kikuyu represent the largest tribe with 22 percent of the population and the Luhya rank second at 14 percent (CIA World Factbook 2002).

According to Luo customary law, marriage is exogamous, post-marital
Map 3. Culture and Language Distribution of Kenya

residence is patrilocal, and inheritance is patrilocal (Weinreb 2000). Luo customary marriage has traditionally been arranged when the payment of bridewealth is given by the bride’s parents to the groom’s family. Bridewealth is generally paid in the form of cash, but exchange of livestock or other material commodities may also occur (Parkin 1978). For a divorce to take place, the bridewealth must be returned from the groom’s family to the bride’s family (Walsh 2003). In Luo custom, “marriages are prohibited with a girl of one’s mother’s and mother’s mother’s maximal exogamous lineages [see Evans-Pritchard 1965:213], but it is normally ‘resumed’ with these lineages after these two generations have passed” (Parkin 1978:50-51). Presently, traditional marital customs are weakening as an increasing number of young men and women are cohabitating without the payment of a bridewealth. This has negative implications on the relationship between the husband’s and wife’s families and oftentimes results in marital disputes (Weinreb 2000). The average age for first marriage for males is 25 or 26 years and 17 or 18 years for females (Parkin 1978). Luo custom also allows for a male to have multiple wives. Therefore, in polygynous households, there may be a significant age difference between a husband and his third or fourth wife.

Tribal politics at the local level is administered by a hierarchical council of tribal elders. The elders serve as advisors of local disputes at the sub-clan level. A similar structure also exists at the clan level that deals with interclan issues at the sub-location level. At the location level, representatives from each clan and sub-clan are part of a council that advises the location chief (Weinreb 2000).

Ethnically related to the Dinka of Sudan and the Acholi of Uganda, the Luo
culturally evolved from a pastoralist people. Presently, fishing and agriculture are the primary economic activities of the Luo. Agricultural products grown in the region include maize, tomatoes, papaya, bananas, oranges, tea, and coffee. The main food staples include *ugali* (a cooked dish made from maize meal and water), *sukuma wike* (collard greens), *samaki* (fish, most commonly tilapia), *nyama choma* (goat meat), *chai* (tea with milk), *pawpaw* (papaya), *machunga* (oranges), red beans and rice, and egg whites fried with tomatoes. An occasional slaughter of cattle or chickens is sometimes added to the diet.

It has been argued that because of political tensions between the Luo and Kikuyu as a result of a split in the Kenyatta-Odinga government and the assassination of Tom Mboya, Luoland is among the least “developed” regions of Kenya. Indeed, Luo households are less likely to have running water and Luo children suffer from higher infant and childhood mortality rates and lower childhood vaccination rates. Additionally, in relationship to wage earnings, the Luo possess a smaller proportion of Kenya’s wealth distribution (Weinreb 2000).

**Chira**

*Chira*, roughly translated as a curse or the result of bewitching, has deep roots in the Luo tradition and Bantu cultures as well. Anthropologist David Parkin (1978:14) defines *chira* as “a wasting disease, sometimes culminating in death, which a victim or someone close to the victim has incurred through ignoring (not necessarily consciously) some kind of relationship taboo.” Parkin found that *chira* is acquired when cultural rules are broken or through the improper mixing of distinctly separate
cultural categories (Parkin 1978). Chira thus developed as an explanatory model for a person who experiences severe weight loss and subsequently dies. According to cultural beliefs, a person experiencing these symptoms is believed to have broken cultural norms or to have been bewitched by another person.

In the present, chira is still a powerful explanatory model in Luo culture and there are many taboos associated with the onset of chira. For example, when a person dies, it is taboo for any other person to sleep in that person’s home. If someone does, that person will get chira. Chira causes a person to become thin and die, the same symptoms associated with AIDS. To some extent, that is why many Luo people have refused to accept HIV/AIDS as a sexually transmitted infection, and instead attribute the etiology of the disease to chira (field notes July 26, 2002:38).

George Oduor Ndege (2001:154) provides examples of Luo beliefs regarding the similarities and differences between AIDS and chira. Both diseases exhibit many of the same symptoms including “fatigue, loss of appetite, the wasting away of the body, and eventually death.” However, unlike AIDS, chira is curable. Additionally, Ndege gives examples of how a number of Luo people believe the two diseases are not mutually exclusive; both diseases may be seen as the result of violating cultural taboos. Historically, the onset of chira has been the result of committing a “sin,” and as a number of Luo have adopted Christianity as their religion, these individuals often see the onset of ayaki (AIDS) as the result of sin. Undoubtedly, the association between sin and ayaki has perpetuated an increased stigma towards individuals with HIV/AIDS and has resulted in blaming the victims for acquiring this disease.
A Brief History of HIV/AIDS

The exact origin of HIV/AIDS is unknown to scientists. Genetically, HIV is closely related to Simian Immunodeficiency Virus (SIV), a disease which affects non-human primates (Ministry of Health 2001). A number of scientists believe that HIV was first spread from non-human primates to humans between 1915 and 1941. It is believed among the scientific community that HIV-1, the most widely spread strain of HIV/AIDS infection, crossed over from chimpanzees to humans. HIV-2, a strain that is most prevalent in West Africa, is thought to have originated from sooty mangabey monkeys. Both strains of the HIV virus are believed to have originated on the African continent (Recer 2000).

The African origin model is controversial and many believe that it adds to the stigma associated with the disease and its high prevalence on the African continent. However, a number of factors support the African origin model including: (1) a number of recent emerging diseases have originated in Africa including Ebola, Marburg, and West Nile virus; (2) HIV is related to Simian Immunodeficiency Virus, a disease which has only been found in non-human primates in Africa; and (3) medical records through laboratory tests and stored blood samples indicate that the earliest known HIV/AIDS cases were all from Africa (Kenya AIDS Watch Institute 2003).

In a recent book, “The River” (2000), Edward Hooper theorizes that HIV was first introduced in the Belgian Congo through oral polio vaccines in the 1950’s. According to Hooper, the kidney tissue from non-human primates was used to
weaken the strain of polio in the vaccine. As stated by the Kenya AIDS Watch Institute, “if this theory is true, then, the HIV is of African origin, but was introduced by the West, while trying to control a far less dangerous disease, Polio” (Kenya AIDS Watch Institute 2003:1).

Hooper’s theory has largely been disputed by scientists worldwide. A study conducted by the Los Alamos National Laboratory in New Mexico found that HIV/AIDS most likely crossed over from non-human primates to humans in the early twentieth-century. The researchers involved in this study measured the rate of genetic change in the HIV virus to come to the conclusion that HIV/AIDS most likely originated in southwestern Africa between the years 1915 and 1941. According to the researchers, HIV/AIDS infected a small population base in Africa until African urbanization and global transportation began to increase. Because this theory places HIV/AIDS in human populations in the first half of the twentieth century, Hooper’s theory linking HIV/AIDS to oral polio vaccines in the 1950s appears unlikely (Recer 2000).

Researchers claim that the first proven AIDS-related death occurred in Congo in 1959. By 1978, gay men in Sweden and the United States and heterosexuals in Haiti and Tanzania began to show signs and symptoms of what later became known as AIDS (Aegis 2003). It was originally believed that AIDS was a disease that only affected homosexual males and the disease was thus given the name Gay-Related Immune Deficiency (GRID). In 1982, the acronym AIDS, for Acquired Immune Deficiency Syndrome, was officially adopted (Kenya AIDS Watch Institute 2003).
In the mid-1980s, stories of a disease called Slim\(^4\) in Uganda first began to appear in Kenyan newspapers (Kenya AIDS Watch Institute 2003). In September, 1984, the first confirmed AIDS case was reported in Kenya via an article published in the East African Medical Journal entitled “Acquired Immuno-Deficiency Syndrome is in an African.” The article stated that, “this case is reported to alert medical practitioners to the possibility of AIDS occurring in Africans and to emphasise the point that no race may be exempted from this highly lethal syndrome” (as quoted by Kenya AIDS Watch Institute 2003:1). Shortly thereafter, AIDS began its rapid spread and quickly became the leading cause of death in Kenya.

\(^4\) AIDS was given this name in Uganda because victims of this disease generally experience severe weight loss.
CHAPTER FIVE

SETTING

Oyugis

Oyugis, a peri-urban community in Rachuonyo District, lies along the main north-south road that runs from Kisumu to the Tanzanian border. The main road through town is crowded with people every Friday for market day and the store fronts boast signs of Western technological influences. Many homes have electricity and running water; however, many of the households are lacking these amenities. The countryside surrounding Oyugis is fertile and produces collard greens, maize, and tomatoes; it also provides space for cattle, goats, and chickens. Most people live in one- or two-room mud-slabbed houses with thatched roofs; a few houses have the more expensive iron sheets, which is fortunate to the inhabitants in the rainy season.

The Luo tribe comprises the backbone of Oyugis' population. At best estimates, 41,929 people are infected with the HIV virus in Rachuonyo District, which is approximately 27 percent of the population in this district (Ministry of Health 2001). As one of the largest towns in this district, Oyugis caters to up to one-fifth of the population in this district. Lack of transportation, poverty, and poor road conditions in the rainy season make it difficult for many residents of rural Rachuonyo District to reach Oyugis on a regular basis. The Ministry of Health's district hospital in Oyugis, occupying a small compound, provides treatment for most minor ailments; for major medical procedures patients are referred to larger hospitals in Kisumu or nearby Kisii. Matata Hospital, a small private health facility, also operates in Oyugis.
Map 4. Nyanza Province, Kenya

Source: HIV/AIDS Prevention and Care Program (HAPAC), 2003.
Map 5. Distribution of AIDS Cases

Map 6. Oyugis Integrated Project, Oyugis Town, Rachuonyo District, Kenya

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<th>Main Road</th>
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| Agricultural Projects |
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| Tuvimiliane Center |
| XXXX |
| XXXX |
| XXXX |
| XXXX |

| Ministry of Health Hospital |
| XXXX |

| Shirikisho Center |
| XXXX |
| XXXX |

| Social Work Office/ Agricultural Office |
| XXXX Peanut Butter Shop |
| XXXX |
| XXXX YOFACK Theatre |

| South to Kisii |
| XXXX |
All community-based organizations in Rachuonyo District are monitored by the District AIDS Control Committee and Constituency AIDS Control Committees. Since the late 1990s, the government of Kenya has set aside millions of Kenyan shillings (over US$100,000) for community-based organizations working with HIV/AIDS issues; to date none of this money has been allocated to the actual organizations. According to a high-ranking employee of the Ministry of Health, the National AIDS Control Committee has every intention of allocating the money to CBOs, but when that will actually occur is unknown. Presently, there are several dozen registered CBOs in Rachuonyo District, but according to this same Ministry of Health employee only two have taken noticeable action, Oyugis Integrated Project and an organization based out of Kendu Bay working for the care of AIDS orphans.

In the mid-1990s, Catholic brothers from Kenya and the Netherlands operated a formation house in Oyugis that provided treatment and dressing of wounds. Over time, they noticed that an increasing number of individuals in their community were becoming sick and dying, and they could not afford to go to the hospital. The brothers questioned why so many people were dying and then realized that they were dying because of HIV/AIDS. During that time, the brothers conducted a survey of the community. They visited the homes of community members with the objectives of getting to know the culture better and coming to better understand the problems that were facing the people. In 1996, with financial assistance from the Catholic Church in the Netherlands, Oyugis Integrated Project (OIP) was formed with the intentions of working with people who are living with HIV/AIDS and also assisting AIDS orphans.
In the beginning, the project director established a close relationship with six HIV-positive people, who formed the charter membership of the group. Getting these people to become part of the group in the beginning was not easy, as they feared that the brothers had created a plot to murder these HIV-positive people. Over time, more and more people became aware of OIP and voluntarily went in for an HIV test; over the past six years, membership has swelled to over one hundred people.

Nyatike Division

At the Matoso Clinic in Nyatike Division, patrons flock from the surrounding rural areas and even northern Tanzania to be seen for the flat fee of two hundred shillings (US$2.60), which includes consultation, prescription, and follow-up care. An American physician volunteering at the clinic noted that many patients seen at the clinic show signs and symptoms of HIV/AIDS, but a relatively small number consent to be tested. Of those who have tested positive, there is still a considerable level of personal denial. Once, this physician took a group of clients in the advanced stages of AIDS to the Medico Sans Frontiers (MSF) office in Homa Bay to receive free anti-retroviral drugs to help fight opportunistic infections and prolong their lives. Upon arriving at the MSF office and seeing all of the other people devastated with the AIDS virus, these individuals denied that they were even HIV-positive.

Nyatike Division, consisting of a population of over 65,000 people, is a rural area that lies in Migori District. The inhabitants of this division are primarily Luo, with a small number of representatives from the Kisii, Kalenjin, Luhya, and Meru tribes (Ooko 2002). Lying on the shores of Lake Victoria several kilometers from the
Tanzanian border, Nyatike Division has one of the driest climates in Nyanza Province. Limited rainfall makes agriculture productivity more difficult, with cassava, maize, sorghum, and cow peas being the most reliable crops grown. The principal economic activity in this division is by far fishing, as fishermen pull in dozens of nets of tilapia, perch, and *omena*, which is hauled off to other areas of Kenya each morning. Arguably, the greatest natural resource in Migori District in the past has been mining. However, Kenyans did not profit immensely from this mineral wealth, as colonists from Britain and India pillaged the land long ago, leaving the polluted tailings as the only evidence that this mineral wealth ever existed. It has been estimated that the poverty level in this district is as high as 70 percent, considerably higher than the national average of 54 percent (Ooko 2002).

The most recent estimates of HIV/AIDS prevalence in Migori District list approximately 67,866 individuals infected with the HIV/AIDS virus, roughly 27 percent of the population (Ministry of Health 2001). In Nyatike Division, health facilities consist of nine government dispensaries, five private, non-profit dispensaries, and one health center (Ooko 2002). The services offered at these facilities include diagnosis and treatment of common ailments, maternal child health care, family planning, and health education. When a patient requires a major medical procedure, he or she is referred to larger health facilities in Kurungu or Migori, larger towns in this district. Given the rural composition of this district, the Ministry of Health and NGOs/CBOs have trained Community Health Workers (CHWs), Traditional Birth Attendants (TBAs), and Community Own Resource Persons (CORPs) to provide home
Map 7. Nyatike Division, Migori District

Lake Victoria

To Homa Bay

Nyatike Home Based Care Office

Macalder Health Dispensary

Macalder Mines

Nyatike Home Based Care Office

Office of the Chief

Matoso Clinic

To Tanzania
based care services to individuals who cannot reach these health facilities.

In 1999, the Catholic Diocese of Homa Bay conducted a community needs assessment in Nyatike Division. When conducting this needs assessment, it was discovered that many people in this community were sick and dying, could not afford treatment, and that the HIV/AIDS prevalence was high. Because of this, Nyatike Home Based Care was created out of the Catholic Diocese of Homa Bay that same year. The initial objective of this organization, as the name suggests, was to provide home based care to those people who were suffering from HIV/AIDS and who were in the end stages of their lives. However, in the recent past, following a needs assessment of orphan care and support, it was discovered that this was another major problem in Nyatike Division. To this end, Nyatike Home Based Care has recently decided to provide assistance such as food, medical care, and educational expenses to orphans as another component of their activities during their next funding period.

Unlike Oyugis Integrated Project, Nyatike Home Based Care currently caters to over five hundred HIV/AIDS clients. As part of the goals set when the organization was first established, Nyatike Home Based Care would like to assist at least one thousand clients in a four year period; as of August, 2002 they had already provided care to 683 clients, which suggests the organization will reach their goal. However, the assistance that Nyatike Home Based Care provides is more geared toward providing material support, instead of focusing on psychosocial support, such as the case with OIP.

In both Oyugis Integrated Project and Nyatike Home Based care, the primary
source of funding is from Catholic churches abroad, in the Netherlands and in the United States, respectively. This religious affiliation has had a significant impact on how these HIV/AIDS programs are organized, although neither organization discriminates against a client because of religious beliefs or requires a client to later accept a certain faith. Leaders of both groups have also strayed from mainstream Vatican teachings by distributing condoms and providing education about birth control and family planning methods while simultaneously encouraging abstinence. The leaders of these organizations are themselves Kenyans, and admit that they stray from their religion’s teachings in this matter because they do not like to see their fellow country people die on account of something that could have been prevented. Despite outwardly-displayed similarities in organizational affiliation, Oyugis Integrated Project and Nyatike Home Based Care differ in many other respects related to services offered, organizational objectives, and plans for the future. Although only one hundred kilometers in distance away, and members of the same tribe, residents of Oyugis and Nyatike Division differ in many of their beliefs and practices concerning HIV/AIDS.

**Nyando District**

Carved out of Kisumu District in 1997, Nyando District boasts a population of approximately 300,000 people. Administratively, Nyando District is divided into five divisions, with approximately 60,000 individuals residing in each district. The Ministry of Health district hospital is situated in the small town of Ahero, a thirty minute *matatu* ride from the city of Kisumu. Smaller health clinics and dispensaries
are also located throughout the district; however, as a result of the rural composition of the district, a large number of individuals do not have easy access to health facilities on a regular basis due to distance, lack of transportation, and financial reasons.

Ministry of Health data estimate that a total of 41,626 individuals are infected with the HIV virus in Nyando District, which translates into a prevalence of 28 percent (Ministry of Health 2001). Possessing one of the highest percentages of infection of all districts in Kenya, it could be argued that this is due to the district’s close proximity to the city of Kisumu and that prevalence tends to be higher in urban environments. However, residents of Nyando District do not have access to Voluntary Counseling and Testing (VCT) services on a regular basis and must travel to the Centers for Disease Control VCT center in Kisumu if they wish to know their HIV status.

Parents in this district are advised to bring their children to the Ministry of Health centers for a series of immunizations at birth, four months of age, and nine months of age. The immunizations given include BCG, polio, a combination of diphtheria and hepatitis b, and measles. Most mothers bring their children in for the first two series of shots, but by the time the children are nine months old and require a measles shot, compliance declines, as mothers forget or find it difficult to travel the distance to the health centers. For this reason, measles is one of the leading infectious diseases affecting children in this region.

Each June and July the Ministry of Health sponsors National Immunization
Map 8. Nyando District

Lake Victoria

Kisumu

Ahero

Awasi

Upper Nyakach

Sondu

To Oyugis

Muhoroni

Miwani

↓
Week with the aim of vaccinating all children against a certain infectious disease. Past campaigns have bore catchy phrases such as “Kick Polio Out of Kenya.”

The focus for 2002 was measles and maternal-child tetanus. In conjunction with my internship attachment at the Ministry of Health, I had the opportunity to visit the rural community of Angora Ponge’, near Awasi location, during the July immunization campaign. Because of its remote location, the community of Angora Ponge’ is not accessible by road. The trek from Ahero requires a minimum one hour motorbike ride, or up to a day’s trek by foot. For this reason, members of this community seldom visit health centers and have found that when they do, the facilities have often run out of the necessary drugs to treat their ailments. Instead, members of this community rely on traditional healers and “bush doctors” (discussed in Chapter 6) for their health-related needs. Also because of distance, members of this community have never had access to Voluntary Counseling and Testing services, even though a village elder asserts that quite a number of the “middle generation” have died of late and that the number of orphans is significantly increasing.

Kisumu

With a population of nearly 300,000 individuals, Kisumu is the third-largest urban area in Kenya, behind Nairobi and Mombasa. Despite its one hundred year existence, Kisumu was just declared a city by the Kenyan government in January, 2002. Kisumu boasts an urban HIV prevalence of 29.8 percent (Ministry of Health 2001). Urban prevalence is especially high among women under the age of 25, with estimates topping 35 percent.
Kisumu began to develop as an urban center shortly after British colonization. Situated on Lake Victoria in northern Nyanza Province, Kisumu has an active fishing industry and serves as a market and trading center for people from all over western Kenya. Although the Luo comprise the largest ethnic group in Kisumu, the majority of Kenyan tribes are present in this city as well as a substantial Indian population.

Attracted by potential employment opportunities in an urban environment, hundreds of men migrate to Kisumu each year seeking wage-labor and leaving their families in the rural communities. Additionally, Kisumu is on the main highway from Uganda to Nairobi, making it a frequent stop for long distance truck drivers. With an influx of men distanced from their wives, commercial sex work has become a growing industry.

The Teenage Mothers and Girls Association of Kenya (TEMAK) is situated near the Obunga slums, east of the city center. Founded in 1992, the mission of TEMAK is to provide training to at-risk young women in marketable skills through a one year program and to assist these girls in finding employment or starting their own businesses after completion of the program. TEMAK also sponsors a non-formal school for children, a skin treatment clinic, and a small business loan program for young women and widows (discussed in Chapter 6).

Diakonia Compassionate Ministry—Kenya (DCM) is based out of Nyamasaria, a neighborhood in south Kisumu, and operates in both the city of Kisumu and rural Rachuonyo District. Founded in 1999, DCM has largely focused on providing support for AIDS orphans, but has recently expanded their projects to include providing free medical treatment to individuals who could otherwise not
afford medical care. In 2003, DCM began planning for an integrated support center.

This center has begun to train orphans in marketable skills and intends to add a Voluntary Counseling and Testing center and social support for HIV-positive individuals in the future.
CHAPTER SIX

FINDINGS

The following data are the result of participant observation experiences, sixteen formal semi-structured interviews, approximately thirty informal unstructured interviews, and a focus group discussion. The following sections are divided by themes, or major concepts, that emerged from the data based on organizational structure and programming, obstacles, collaborative work, and socio-cultural and socio-economic factors cited in relationship to the high prevalence of HIV/AIDS.

The General State of Health in Western Kenya

Among all government leaders, Ministry of Health employees, organizational leaders, people living with HIV/AIDS, youths, and community members at large, one hundred percent of respondents listed HIV/AIDS as the most serious contemporary health concern in western Kenya. Other common responses included childhood diseases such as measles, pneumonia, diarrhea, malnutrition, and sexually transmitted infections (STIs).¹ The most common reason for listing HIV/AIDS as the most serious health concern was the fact that it has a one hundred percent mortality rate.

Community Outreach Programs Serving the Infected and Affected

Each community based organization provides a range of activities to assist the infected and affected. Background information regarding the primary organizations studied is included in the table below and the specific programs offered by each

¹ Generally respondents placed sexually transmitted infections (STIs) in a separate category from HIV/AIDS.
organization are discussed in further detail in the following section.

Table 4. Background Information on Primary Community-Based Organizations Studied

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Location</th>
<th>Activities Offered</th>
<th>Main Source of Funding</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oyugis Integrated Project</td>
<td>Oyugis, Rachuonyo District</td>
<td>Social support</td>
<td>Catholic Archdiocese from the Netherlands</td>
<td>Approximately 100 HIV-positive members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dispensary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HBC, IGA Prevention Ed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nyatike Home Based Care</td>
<td>Nyatike Division, Migori District</td>
<td>HBC IGA Prevention Ed VCT</td>
<td>Catholic Archdiocese of Baltimore, USA</td>
<td>Approximately 500 HIV-positive members</td>
</tr>
<tr>
<td>Teenage Mothers and Girls Association of Kenya</td>
<td>City of Kisumu, Kisumu District</td>
<td>IGA Training NF School Health Center Prevention Ed Social support</td>
<td>Income-Generating Activities</td>
<td>Approximately 60 at-risk girls per year</td>
</tr>
<tr>
<td>Diakonia Compassionate Ministry</td>
<td>Kisumu City and rural Rachuonyo District</td>
<td>Orphan support IGA Training Health Care</td>
<td>Donations from individual sponsors</td>
<td>Approximately 75 AIDS orphans</td>
</tr>
</tbody>
</table>

HBC=Home Based Care; IGA=Income-Generating Activities, VCT=Voluntary Counseling and Testing; NF=Non-formal

Community Health Workers and Home Based Care

In the case of both Oyugis Integrated Project and Nyatike Home Based Care, the principal objective they share is to provide care for sick and dying HIV-positive clients in their homes. The Home Based Care program itself is a nationwide program that consists of a process of eight components: community mobilization, community support through sustainable income-generating activities, training of community
health workers, client identification, training of primary caregivers, implementation, monitoring, and evaluation.

Community health workers (CHWs) are usually laypeople from the community who undergo a one- or two-week training program. In these training sessions, the CHWs learn facts about HIV/AIDS, methods of prevention, and care and management of the sick and dying. Working as volunteers, the CHWs are usually responsible for finding their own HIV/AIDS clients, which is not too difficult for them given the high prevalence of infection in proportion to the number of CHWs. Although unpaid and given very little tangible incentives, the majority of CHWs interviewed expressed their satisfaction with the work they were doing and noted their desire to become a CHW was rooted deeply in altruism. The spirit of *harambee* was a driving factor, and as one CHW from Nyando District explained, he liked to “help people voluntarily so the deadly disease would not finish them.” Despite this, the majority of CHWs themselves live in poverty and complained that their biggest obstacles in providing home based care was lack of transportation for clients living great distances away and lack of tangible incentives. Volunteers typically receive free meals at training sessions and tokens such as free t-shirts, but as their CHW work takes up a significant portion of their time, they long to receive incentives such as a monetary stipend, food, and bicycles to make transportation easier.

In the July, 2002, Oyugis Integrated Project sponsored the training of over fifty new CHWs. Home Based Care activities are also conducted by nurses affiliated with the OIP dispensary and members of YOFAK theatre group (discussed further in the
following sections). The average home based care visit in Oyugis lasted approximately thirty minutes. During this time the CHW visits with the clients, prepares meals, assists with household chores, gives medications to treat opportunistic infections, and conducts a needs assessment to consider what supplies may be needed on the next visit. The most common opportunistic infections that HIV/AIDS clients suffer from in Kenya are tuberculosis, malaria, typhoid, pneumonia, Kaposi’s sarcoma, herpes zoster, oral thrush, and skin conditions (field notes from CHW training session, July 18th, 2002). The typical CHW visited a client an average of one time per week, more often in cases where the client needed a drug urgently, and less often when the case load was too immense or transportation was difficult. Especially during the rainy season when roads become muddy and difficult to navigate, the CHWs found it difficult to reach clients’ homesteads in rural areas.

One of the primary roles of community health workers (CHWs) affiliated with Nyatike Home Based Care is to provide HIV/AIDS education to their communities. In large part, their education efforts have helped to shape a positive perception towards HIV-positive individuals. However, educating certain groups of people, particularly older men, still continues to be an obstacle for these CHWs.

As of August, 2002, Nyatike Home Based Care had trained a total of sixty CHWs. In addition to their educational responsibilities, these CHWs have provided

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2 Currently, the majority of the population in Kenya does not have access to anti-retroviral drugs and the drugs being dispensed were to treat opportunistic infections and common infectious diseases such as malaria and typhoid. In June, 2002, the Ministry of Health began offering the drug Nevirapine at no cost to HIV-positive pregnant women to reduce the incidence of mother-to-child transmission of HIV.
care to a total of 683 HIV/AIDS clients over a period of three years; during this time over two hundred clients have died. To become a CHW, an individual must be nominated by the community, a process which takes place at the chief's weekly meetings, known as barazas. The nominated individuals then receive a letter from the chief's office inviting them to become a CHW and attend a one-week training program.

Community health workers interviewed found their educational efforts in the community to be largely successful “because the community members are able to accept the teaching and they become flexible and willing to be taught.” The CHWs also counsel widows on the ramifications of inheritance, and as one CHW suggested, the widows are listening. To illustrate his point this CHW told me, “when I go to a home and find a widow, and I discuss issues about HIV and AIDS, these women become careful not to be inherited. They prefer to have the test done before being inherited.”

As most community health workers are themselves volunteers, many desire to receive some compensation for the work that they do. In Nyatike Division, the trainers of CHWs have each received a bicycle as an incentive. One CHW suggested that it would be beneficial for all CHWs to receive a bicycle as “they may be able to visit the clients in their homes more easily.” The bicycle incentive would help extend the Home Based Care service to more individuals.

Voluntary Counseling and Testing Services

An additional component of Nyatike Home Based Care is voluntary counseling
and testing (VCT) services. As part of their funding package, Nyatike Home Based Care provides free rapid HIV testing to the members of the communities they serve. Two tests are given simultaneously, which yields a nearly ninety percent accuracy rate. When there is doubt regarding results, the individual is sent to a health center for an ELISA test for confirmation. Additionally, because the testing procedure is “rapid,” an individual may know his or her status fifteen minutes after taking the test.

Before blood samples are drawn, the individual must attend pre-test counseling by a trained counselor. At this time the client is asked the questions, “how do you feel if you’ve tested positive or how do you feel if you’ve tested negative?” It is the responsibility of the counselor to determine if the individual is ready to have an HIV test and if he or she is prepared to handle his or her results. After the results are read to the client there is also a time of support counseling. The role of the counselor here is to guide the client through any issues that might have arisen as a result of his or her test results.

An employee of Nyatike Home Based Care stated that the number of people going in for an HIV test had increased since the program had been implemented and asserted that this was the reason why they had been successful in enrolling people into the Home Based Care program. According to this individual, as a result of VCT services in this community, “people have come out openly. They are now asking and demanding for the services because the mobilization has been well done. So the community’s been very, very responsive to issues around HIV and AIDS.”

Access to VCT services and community support services for those who test
positive has shaped individuals’ willingness to receive a test. According to one CHW affiliated with Nyatike Home Based Care, “now we are encouraging everybody to go for testing so that they know their status even if they are well.” The number of openly HIV-positive clients in this program is indicative of the success of the VCT program. Another CHW stressed the importance that anybody could be HIV-positive and that one of their roles as a CHW was to prove that point. She stated, “people normally want to know if the community health workers have been tested because when they provide counseling services, the assumption is that they have also been tested. I am an example to the community because I have already gone through counseling and been tested.”

The director of Oyugis Integrated Project affirmed that because of the social support network that their program offers, “mostly we don’t encourage people to go for an HIV test. People have seen what we are doing and they come by themselves.” However, the director asserted that getting to that point was not an easy process and only through the public success of their program were people willing to consent for an HIV test.

Social Support

Both Oyugis Integrated Project and Nyatike Home Based Care provide social support for their clients, but their programs for providing such support are significantly different. For the clients of Nyatike Home Based Care, the organization provides monetary assistance in acquiring basic needs such as adequate shelter, food, and medication. In the case with OIP, providing social support is the backbone of the
project. Clients gather at community centers twice a week for free meals, make crafts to sell as an income-generating activity, socialize, and provide social support to one another. As one client explained, when he first tested positive for HIV after the death of his wife:

My first feeling was that of surprise. I didn’t think the disease could affect me. I thought of committing suicide. Next, was a feeling of despair. I felt despaired because I am the only child in my mother’s house. I didn’t want people to know my new situation because they would make fun of me...And to tell the truth, I am not at peace because, as an African, not getting second-married after a wife’s sickness or having sickness makes me very sad. (July 24th, 2002 interview)

Often ostracized by their families, and requiring social acceptance and support, HIV-positive members of OIP acquire these social needs through their fellow members and contend that “living positively means living longer.”

Brother Balthasar Musyoki, the director of Oyugis Integrated Project, utilizes his training in counseling to provide social and emotional support to HIV/AIDS clients and AIDS orphans. Individuals line up outside his office daily to ask for his advice and support, both emotionally and materially.

Elizabeth, an HIV-positive woman in her early-twenties from Rachunoyo District, visited Brother Balthasar one Friday afternoon when I was on attachment with OIP to ask for financial support and to get formula to feed her infant daughter, who is not HIV-positive. Realizing that Elizabeth was clearly pregnant with her second child, Brother Balthasar questioned her about how she had gotten pregnant in a

3 Pseudonyms are used for all interviewees whose positions in society do not reveal their identities.
joking manner by telling her, “The person who gave you the baby is supposed to help you, not me. So you want me to feed the baby and there is another person who gave you the baby…Did the baby come from the Holy Spirit?”

Brother Balthasar stated that he maintains a “joking” attitude with his clients at most times because of the serious nature of the clients’ problems and because there was otherwise not much to joke about. Becoming conscious that this woman was pregnant, and therefore not using condoms to protect herself, Brother Balthasar went to his storage closet and withdrew a box of one hundred condoms. Despite the fact that Elizabeth knew that her HIV status was positive, she still feared the consequences of revealing her HIV status to her sexual partners because of the stigmatization associated with this disease. Additionally, in spite of Brother Balthasar’s affiliation with the Catholic faith and the Vatican stance on “protected” sex, he asserted that he believes he must distribute free condoms to his clients because he does not like to watch his fellow country people die.

**Monetary Support**

Cash is also distributed to members of Oyugis Integrated Project. At the social work office, members and orphans line up to plead their cases to social workers and to ask for monetary assistance. According to a social worker affiliated with OIP, cash is sometimes the best option to helping these individuals, when other options such as personal income-generation have been exhausted, or when the individuals are too young or to ill to earn an income for themselves.

Discretionary funds to assist the infected and affected on an individual basis
were a common trait among organizations studied. For example, Diakonia Compassionate Ministry (DCM) used cash from their discretionary fund to save the life of a one-year-old AIDS orphan, Grace, who was present at a clothing drive the organization sponsored. By providing cash from this fund, DCM was able to pay for Grace’s medical treatment and meals, as she was suffering from severe malnutrition and malaria. DCM also followed up with Grace’s designated guardian on her care until her untimely death in February, 2003.

**Income-Generating Activities**

Not only do group members gain a sense of community and social acceptance, they also acquire the necessary monetary and social support essential for their survival. Members of Tupendane Center, one of OIP’s two community centers, engage in agricultural activities by growing maize, beans, potatoes, and onions, cultivate fish in a small fish pond, and practice beekeeping to produce honey. Members of OIP’s other center, Tuvimiliane, operate a small store in Oyugis which sells peanut butter, honey, potato crisps, and soy beans. This money is used by OIP to help operate their programs and also give back to the group members as financial support.

Among the goals of Nyatike Home Based Care is to help establish microfinance projects for at least two hundred clients in a period of four years. This component had not been aggressively pursued, but as of August, 2002, the organization was in the process of identifying those clients who will participate in this project. As for the CHWs, one form of income generating activity they are
considering is selling essential drugs to the clients. The proceeds would then be divided between the organization, the CHWs, and given back to the clients through helping to maintain the Home Based Care program. As one CHW, who is also HIV-positive explained:

One problem that I see is that the project is sometimes slow in its implementation of issues. You know, we have to keep up the pace with the community. So I suggest that we need to scale up our activities to reach as many people as possible. Our funding period comes to an end in March of next year. If the project should be extended another three to five years from next year, that should give them the chance to test the issue of sustainability.

Creating successful income-generating activities to sustain these programs from within Kenya and evaluating the success of already established programs in the future are two issues that will become increasingly important for these two organizations to address in the future. To address their current needs, Oyugis Integrated Project not only relies on funding from the Catholic church, but also has established relationships with other non-profit organizations as well. As the director of OIP, reflecting on their relationship with Heifer Project International, recalled:

Heifer International—they have done great work. That is one of the organizations which we are working hand-in-hand together because they are providing animals to the dying patients so that the orphans, they can continue their lives...And they are helping so many people. That is the most very important project within our area, which is helping so many people in a positive way.

Through collaborative work with Heifer Project International, OIP is able to provide cattle and goats to HIV-positive individuals and AIDS orphans; the manure, milk, and meat produced from these animals are sold as an income-generating activity. The project is monitored by both Heifer Project employees from the United States who are
stationed in Kenya and a Kenyan agricultural extension agent who is affiliated with OIP.

For the Teenage Mothers and Girls Association of Kenya (TEMAK) the primary focus has been on training at-risk young women in vocational skills with the objective of helping them develop income-generating activities for themselves. The TEMAK school offers courses in tailoring, computer skills, hairdressing, and craft making. After completing a one-year training program, TEMAK assists the girls in starting their own businesses or finding employment in the community.

The craft making program also serves as an income-generating activity for TEMAK themselves. From their earliest days TEMAK’s plan was for “this organization to be a self-reliant organization where [they] would generate [their] own income around [their] own businesses as usual.” In Kisumu, TEMAK operates a small gift shop in the Kondele neighborhood and sells crafts to tourists at the Imperial Hotel, Kisumu’s largest and most expensive hotel. Seventy-five percent of the profit goes directly to the girls as an income and to help them pay for their supplies and twenty-five percent returns to TEMAK to help sustain their activities.

TEMAK has also developed a small business loan program to assist women in the community. These loans are given to women who are HIV-positive, widows living in poverty, or women who have taken in orphans. The loans possess a low interest rate so that the focus is kept on the woman keeping the majority of her profits. According to the director of TEMAK, keeping the interest rate low is “good for developing the woman.”
From a broader perspective the income-generating focus of TEMAK is attempting to overcome a number of factors in the community related to poverty including girls dropping out of school, teen pregnancy, child prostitution, and HIV/AIDS. By enabling these girls to sustain themselves financially, TEMAK is working to ensure “value in that kind of a girl.”

Diakonia Compassionate Ministry (DCM) had also recently begun to address the issue of poverty and its relationship to HIV/AIDS by establishing a vocational training program similar to TEMAK’s in the Nyamasaria neighborhood of Kisumu. DCM’s vocational training program began in a small workshop designed to train teenage boys in carpentry skills. In visits to area schools as part of the orphan support program the director of DCM noticed that a number of pupils were forced to sit on the floor or on logs due to an inadequate number of desks. To respond to this need, DCM commissioned the carpentry students at the workshop to construct desks to be distributed at the school. According to DCM’s director, the desk program was responding to two community needs: donating much-needed desks to schools and providing an income-generating activity to male youth.

Realizing that TEMAK’s facilities were only accessible to a small geographic location within the city of Kisumu, DCM’s director decided to add a vocational training program for female youth at the Nyamasaria workshop. In February, 2003, DCM began a tailoring and dressmaking training program for girls in the Nyamasaria neighborhood. After completing the six-month training program, each girl is given a sewing machine to assist her in starting her own income-generating activity. To assist
with the costs of the program, DCM has created a sponsorship program for American donors, whereby US$300 may train the girl for the six-month period and purchase her necessary supplies.

**Orphan Support**

As education is not free in Kenya, AIDS orphans are often left without the opportunity to attend school. To respond to this, OIP began addressing the needs of orphan care as another component of their project. With respect to this problem, the director of OIP stated:

> Our future plan is that we channel our help to the orphans because they are more increasing. And the reason for this is that if we don’t channel our help towards the orphans, after five or ten years, it will be very hard for you to stay in the house because everyone will be thugs. These orphans, they miss education. They miss good background to grow in a positive way. So they will grow like thugs.

In making this claim, the director is referring to the street children living in Kisumu who cannot afford to attend school and spend much of their time scavenging for food on the beaches of Lake Victoria. Most AIDS orphans are in fact taken in by extended family members of other people in the community. But due to educational costs, and given that their own children must be provided for, AIDS orphans are not able to attend school in most situations.

Nyatike Home Based Care has also recently begun to take notice of the needs of AIDS orphans. How to support these orphans was not an issue that was addressed in their initial needs assessment; as a result the organization does not have the funding to address the orphan crisis at the moment. However, in Nyatike Division an
organization affiliated with Lamla Clinic in Matoso is presently working to address these needs by sponsoring a home for orphan care. But given the overwhelming number of orphans in this division, the majority of orphans are still receiving very little assistance.

The Teenage Mothers and Girls Association of Kenya (TEMAK) operates a “non-formal” school for AIDS orphans on their compound. A non-formal school is one that does not follow the curriculum and structure for formal education as prescribed by the government of Kenya. Because of the large number of children who have been forced to drop out of school, especially AIDS orphans, TEMAK formed their non-formal school to target children who could not otherwise afford a school education.

The non-formal school teaches children academic subjects including Kiswahili language, writing, and science. However, the non-formal school also focuses on teaching the children marketable and vocational skills, because, as the director of TEMAK explained, “at the end of the day you want to see that this child is capable of doing something useful, not just academic.” The children in TEMAK’s non-formal school engage in a craft-making program where they make mioto dolls. These dolls are then sold at TEMAK’s craft store as an income-generating activity. The nutritional needs of the children at the non-formal school have also been a concern, and for this reason TEMAK serves porridge to all children once a week. At present, the government of Kenya does not recognize curricular programs of non-formal schools, but as the director of TEMAK stated, because non-formal schools are
becoming increasingly popular throughout Kenya, the government is seeking to standardize a curriculum and guidelines for national exams for such schools in the future.

Diakonia Compassionate Ministry (DCM) has also instituted a sponsorship program to provide orphaned children with educational and medical expenses. Through a needs assessment in 2001, DCM identified 450 orphans in Kisumu and Rachuonyo Districts that cannot afford a school education and lack medical care and proper nutrition. A partnership was formed with Lutheran church congregations in the United States to find “sponsors” for the orphaned children. DCM requests that sponsors pay $30 each month, which covers educational, nutritional, and basic medical expenses for the orphaned children. As of May, 2003, over 75 orphans receive financial support from overseas sponsors.

Condom Use

In Kenya, the HIV/AIDS education model utilized by most organizations and endorsed by many Ministry of Health officials is the “ABC Model.” Under this model, the principal method of preventing HIV/AIDS that is promoted is abstinence; being faithful to one partner and condom use follow behind abstinence as less desirable forms of behavior. According to a Ministry of Health official, project organizers, and youth, if a person asks for condoms it is assumed that he or she cannot abstain from sexual relations or be faithful to one partner. In the past there have been machines at health centers that dispense free condoms, but people have been afraid to take them due to fear of stereotypes that may be placed upon them. Also, because
they are free, people believe they are of a lesser quality or are laced with the HIV/AIDS virus. Other common beliefs were that condom use causes abdominal pain and suggesting that a partner use a condom implies that person is unfaithful in the relationship. Even the motto of Tupendane Center, affiliated with Oyugis Integrated Project, is “abstain from sex, then AIDS will go away.” One member of the center asserted:

With the abstinence it is difficult for people to understand, but some people are understanding. And then we have the—we usually have programs which are given free. So those people would like to use the condoms, which are given here freely. Widow inheritance is also prohibited. We don’t want to inherit women.

Sociocultural and Socioeconomic Factors Linked to HIV/AIDS

In discussing what social and behavioral factors are associated with the high prevalence of HIV/AIDS in their communities, those interviewed often cited the behaviors they believed to be linked to contracting the disease as “bad culture” and desirable behaviors such as abstinence and being faithful to one partner as “good culture.” Although what was termed “bad culture” varied somewhat from community to community, members from both Oyugis and Nyatike Division agreed that wife inheritance, wife cleansing, having sexual relations outside of marriage, and exchanging sex for money were all examples of “bad culture.” According to one member of Oyugis Integrated Project:

We Africans, the only thing which is making us to get this disease is our customs. There are some traditions which we still follow. You can talk to these elder mzees but they don’t understand. So I think the customary laws, they’ll go with time. This may mean that my brother has died. I don’t know if he has died from this disease, but I go to inherit his wife. So it is a problem.
Traditions are very big problems.

It must be noted that, at the time of this writing, there is no conclusive evidence that links wife inheritance and wife cleansing to a higher prevalence of HIV/AIDS. Discussion regarding that matter here is related to HIV-positive clients’ personal testimonies of how they believe they contracted this disease.

In contrast, a number of elder men from the Luo culture believe wife inheritance is the best alternative to preventing the rapid spread of HIV/AIDS. According to one individual:

They can spread this disease more than they can be inherited. Because if the wife is alone, she can move from here to there... But if she is under the husband, she cannot move easily. So you see why the woman, the wife cannot stay alone... once the woman is alone, she can easily move. And that one can infect a large number.

Another cultural factor cited for the high prevalence of HIV/AIDS was the presence of “bush doctors” in rural areas. Bush doctors are individuals who do not have formal training in biomedical procedures, but because of access to drugs and medical supplies, accept the role of a “doctor” in communities that do not have access to medical facilities. That individual may use the same needle to give injections to multiple patients, which may facilitate the transmission of the HIV/AIDS virus. It must also be noted that this information was gathered from informant interviewees and no epidemiological data exist to support this claim.

In Nyatike Division, community members expressed their beliefs that the hotter climate along Lake Victoria was linked to a higher prevalence of HIV/AIDS in their community. According to these individuals, in regions that possess a warmer
climate, people engage in sexual intercourse more frequently because they believe it cools them down. As the story goes, because people engage in sexual intercourse more often and have a greater number of sexual partners, the HIV/AIDS virus is spread more rapidly from person to person. Even a high ranking government official from Nyatike Division contended that it was a “biological fact” that in warmer climates, there are higher rates of sexual intercourse.

A number of people in each community also cited poverty as a social factor linked to a high prevalence of HIV/AIDS. Because of poverty, husbands are forced to leave their wives at their rural homes and travel to the city to find jobs and earn incomes to support their families. Even Wilson (2000) argues that inhabitants of rural low-income communities who seek wage labor in urban areas away from home are at a greater risk for HIV infection. For example, when they are away from their wives, they may take advantage of a relationship with a commercial sex worker. The wives are left without money at home, and may therefore exchange sex for money. According to one member of Oyugis Integrated Project, this is what separates knowledge from behavior change:

Because this word denial is with the human beings. People, they deny until they see the person die, then they accept the person as being HIV-positive. And also the poverty plays a great role in behavior change. You can’t tell a young woman to be faithful, and yet she cannot afford to get food. She will be tempted and she will try to use her body to get food. Also, to use her body to get protection. So it is very hard for behavior change to take place...People, they know AIDS is there. They have knowledge. Behavior change is a long process, because of the way of the culture, the communities are.

Acknowledging poverty as fodder for a higher prevalence of HIV/AIDS in
Nyanza province was a sentiment shared by two Ministry of Health officers. Although baseline surveys have indicated knowledge of HIV/AIDS and its transmission factors above ninety percent, the officers noted there is a considerable level of separation between knowledge and behavior change. Because of economic constraints orphans and widows often end up in situations where they exchange sex for money. To illustrate this point, one Ministry of Health officer stated:

> Due to poverty, you find people go in for cheap sex, they want to make ends meet. So the whole thing revolves around empowerment, poverty, and culture. That’s why you find small school girls give into their teachers because they want to make a bit of money. So the young women go in for older men simply to make ends meet.

Another Ministry of Health officer described situations in Rachuonyo District where women were forced to exchange sex for money to make ends meet:

> It is true that if somebody loses a mother at the age of sixteen... for the next two years, without a mother and a father—you see she’s doing prostitution because that is the only way she can survive. And through that way she has a problem in getting HIV. The other one is that women whose husbands have died, they have no other way of survival. So instead they will go for even some small money to make them continue living, and they don’t know who they’re going to... Because of low economic income people go for commercial sex... The female orphans are bound to suffer because they have no means of survival.

The two statements support Ocholla-Ayayo’s (1997) findings that the number one reason females engage in sexual intercourse is for economic motives. Women engage in “survival sex” because they see it as their best option for earning an income to meet the basic need for themselves and their children.

### Community Perceptions of People Living With HIV/AIDS

Perceptions of people living with HIV/AIDS varied from community to
community. Of those interviewed, Nyando District possessed the most negative stigma toward people living with HIV/AIDS. For example, one young adult from Ahero suggested, “the government should enclose HIV-positive people in one area” to prevent the spread of the disease.

Community health workers in Nyatike Division believed that the education they provided to the communities had helped to create a more positive perception of people living with AIDS. As one community health worker explained, “at first people were afraid of the disease and those who were infected, but through education, through information and communication, through the program, then people have tried to know what it is and to see HIV and AIDS just as one of the diseases.”

Mixed reactions were present in Oyugis. To some individuals, people living with HIV/AIDS were perceived with a lot of sympathy. However, several members of Oyugis Integrated Project had been ostracized by their families after revealing their HIV status. These people had abandoned their families’ homesteads and taken up new residences at Shirikisho, Tuvimiliane, and Tupendane, the social centers affiliated with Oyugis Integrated Project.

Perceptions of people living with HIV/AIDS also varied across generations. In all communities, those interviewed asserted that the older generation, and particularly older men, were the most difficult to educate and to change their perceptions. In contrast, Joab, the director of TEMAK, described his experiences working with a mixture of HIV-positive and HIV-negative girls in his vocational training program. One-third of TEMAK’s girls have confirmed a positive HIV status for themselves.
Joab described the initial responses of TEMAK’s girls towards their openly HIV-positive classmates. “Initially when we started it was tough. For the girls that we started with it was tough. You could see them sitting in one corner and the others sitting in the other corner. It was like ‘don’t get involved.’” Despite the initial negative perceptions towards these girls, attitudes began to change as the girls began to spend time together at TEMAK’s center. Joab told how in 2001 three girls developed full-blown AIDS while attending TEMAK’s center:

While they were here, you could see how the other girls cared for them... Everybody was around them asking them, ‘Do you want water? Do you want this? How are you feeling today? Did you get your medication?’ And when they were in the hospital, the girls organized to stay with them in the hospital in turns—taking care of them, washing them, eating with them. I mean that is something that we have never seen before... One of them died while the rest were standing around her. They were singing together and she was so strong and they were telling her, ‘Don’t worry. Just keep on. Just take care.’ And it’s something to see somebody die and the rest are just standing there like they want to cry... And it was something that even surprised the doctors and the nurses... The emotion, the crying.

Collaborative Work

In large part, the Government of Kenya and NGOs/CBOs rely on one another and collaborate in their attempts to help individuals infected and affected by HIV/AIDS and in prevention programs. Because the Ministry of Health has a limited budget, they rely on the NGOs/CBOs to carry out programs that they could otherwise not afford to have in place.

One CBO working in Nyando District is Omega Foundation. At the time of this study Omega Foundation was sponsoring the training of approximately forty community health workers. This organization had hired personnel from the Ministry
of Health to conduct the training program because of their expertise in medical
treatment programs and HIV/AIDS issues. At the same time, the Ministry of Health
was relying on these CHWs, who were affiliated with the CBO, to provide Home
Based Care service to the dying in rural communities where individuals did not have
access to health facilities.

The Ministry of Health and NGOs/CBOs also meet together quarterly to
discuss programs that each is doing and ensure that there is no duplication of services.
By using this system of checks and balances, the District AIDS Control Committee
(DACC) can be more careful in monitoring the programs being conducted in all of the
communities within a district.

While at the time of writing, the Government of Kenya had allocated no
money to NGOs/CBOs for HIV/AIDS-related programs, the Ministry of Health was
working with a European organization called Hapac to distribute money to these
organizations to assist them with their programs. Under this program, the Ministry of
Health identified NGOs/CBOs who were in need of additional funding and Hapac
provided the needed funds. Together, the District AIDS Control Committee and
Hapac monitored and evaluated the programs receiving grant funds to ensure that the
money was being used in the intended areas.

In Nyatike Division of Migori District community health workers affiliated
with community-based organizations such as Nyatike Home Based Care provide
HIV/AIDS education and encourage community members to have an HIV test at the
chief's weekly meetings, called barazas. Respected members of the community such
as the chief, assistant chief, and councilor have also been trained as community health workers to provide HIV/AIDS education and care to the HIV-infected in their communities. These individuals have also set a precedence in their communities by routinely going for an HIV test to set a public example to community members that anyone can be infected with the HIV virus and all should be tested so that they might know their status.

The Teenage Mothers and Girls Association of Kenya (TEMAK), located in the city of Kisumu, also has maintained a number of ties with the Government of Kenya. Because the girls enrolled in TEMAK’s vocational training program are school dropouts, and through a partnership with the Ministry of Labor, a teacher has come to TEMAK’s center to provide literacy training for the girls. TEMAK also operates a small health clinic which specializes in the treatment of skin infections; the nearby governmental health facilities often refer patients with complicated skin conditions to TEMAK’s facilities because of TEMAK’s reputation for handling such cases. Additionally, because of TEMAK’s history and reputation within the community, they often work with and serve as a mentor for other organizations in helping them to establish programs. TEMAK’s main focus is on self-sustainability through income-generating activities, and in that respect, they have worked to guide other organizations and women living in the surrounding communities in establishing successful income-generating activities for themselves.

Diakonia Compassionate Ministry, a community-based organization based out of the city of Kisumu and also working in rural Rachuonyo District, also established a
collaborative relationship with the Ministry of Health in a free medical treatment health campaign carried out in August, 2002. The goal of this campaign was to provide free medical consultation and treatment to individuals living in rural areas that did not have access to health care on a regular basis or who could not afford such services. The health campaign was funded by a $10,000 grant from a university in the United States which paid for lab supplies, prescription drugs purchased in Kenya, transportation, and a small stipend for personnel. For this health campaign the Ministry of Health provided personnel and use of the Ministry of Health van for transportation.

**Obstacles**

Among the obstacles that organizations face in mobilization efforts for HIV/AIDS education and outreach, the most common response cited by all interviewees was limited funds. To varying degrees, each organization relied on funding from foreign sources for the implementation of their programs. For example, Nyatike Home Based Care is funded by the Diocese of Homa Bay, which is funded by a grant from the Archdiocese of Maryland in the United States. The initial funding period is four years and has been designed to provide training of community health workers, HIV/AIDS educational materials, Home Based Care services, medication, counselors, and rapid testing kits. However, the organization could not afford to provide care and support for orphaned children due to limited financial resources.

Each organization emphasized the fact that the need far exceeds the financial capabilities of each organization. Diakonia Compassionate Ministry could only
support a small percentage of their orphaned children due to limited funding. And because of lack of financial resources TEMAK was forced to rent their facilities; because of this they had to abide by their landlord's rules and were not able to provide training for a larger number of girls.

Community health workers also cited difficulties in transport to visit clients as a significant obstacle. The majority of community health workers did not own bicycles, and thus could only visit a limited number of clients in a day and could not reach clients who were great distances away. Oyugis Integrated Project only owned one bicycle for all CHWs' use which only allowed for one CHW to visit distanced clients each day. Additionally, transportation difficulties were increased during the rainy seasons, as routes became flooded and filled with mud, which made it difficult to navigate.

Another obstacle described by several interviewees was the notion of "Kenyan time." As one CHW, affiliated with Nytike Home Based Care explained, "one problem that I see is that the project is sometimes slow in its implementation of issues." By western standards, governmental officers and employees were routinely late for meetings and, as a result, were slow to accomplish the intended actions. However, the notion of "Kenyan time" is a deeply embedded element of Luo culture and several organizations were integrating this cultural fact into the implementation of their programs.

Two popular Kenyan phrases are "pole pole" (slowly, slowly) and "kidogo kidogo" (a little, a little). The director of TEMAK told me these had become
unofficial mottos for the implementation of TEMAK's programs. Since its founding in 1992, TEMAK has slowly built on their programs offered to the community. In 1992 TEMAK began with one sewing machine and "four, five, six girls crowding around this machine just to learn a skill." Throughout the next decade, TEMAK began to add additional training programs and serve an increasing number of girls. TEMAK has also occasionally applied for grants to fund new projects, such as their skin infections clinic, their non-formal school, and the purchasing of computers for their vocational training program.

The pole pole model also serves as a means of self-evaluation for the organizations. If the programs offered have proven to be successful and there is an increase in funding, the organizations will expand the services offered to the communities. This has been the trend for all community-based organizations participating in the study.

Community Members' Suggestions for the Future

A number of individuals interviewed offered their own creative solutions for combating the HIV/AIDS epidemic in their communities. Emphasis was placed on HIV/AIDS education and advocacy especially directed towards the youths. Many saw the younger generation as those who could "save" Kenyans by changing their behavior. As one individual explained, "now we are dealing with youths because without youths is a country without future." The youths participating in the focus group discussion, however, believed they had no control over the HIV/AIDS epidemic and it was the responsibility of community health workers, government
administrators, doctors, and other health professionals. In spite of this, the youth believed that it was their generation that would end the practice of wife inheritance. The custom of wife inheritance was often criticized by the youths in a joking manner, including through skits performed by Youth Fighting AIDS in Kenya (YOFAK—discussed in greater detail in Chapter 7).

Another suggestion was that “the insecurity about women, the treatment about women, widows, women who have been divorced from their husbands, needs to be addressed so strongly.” Elder men were frequently criticized for their unwillingness to accept HIV/AIDS and modify cultural traditions. Women were left with little choice regarding wife cleansing, wife inheritance, and sexual encounters. Despite Luo women’s growing interest in family planning and contraception, these women found it difficult to convince their husbands to use protection. Additionally, violations of women’s property rights led to an increase in poverty among women, thus limiting their choices and forcing many women into exchanging sex for money. Other suggestions from community members included, “effective education,” bicycles for community health workers to make transport easier, more incentives for community health workers, an increased openness for talking about HIV and AIDS, and “machines for blood tests so people don’t have to walk long distances to look for places where they can be tested.” These suggestions addressed further obstacles that the organizations were facing and the desires to remedy the situation in the future.

Although the specifics of their programs differed, organizations participating in this research share common objectives in serving the needs of HIV/AIDS clients in
their communities and exhibit many of the same plans for the future. All organizations place the needs of the infected and affected as their number one priority and address prevention of further infections as a secondary priority. Given that the primary tribe in each location was the Luo, each organization is facing many of the same cultural beliefs and traditions that are oftentimes linked to HIV/AIDS. What these organizations are presently doing in terms of prevention of new HIV/AIDS cases is discussed further in the following chapter.
CHAPTER SEVEN

CONCLUSION

This chapter examines organizational strategies to prevent further infection, discusses my findings in relationship to past studies represented in the literature, and provides recommendations for the organizations, the Government of Kenya, and international bodies for future programming related to HIV/AIDS.

HIV/AIDS Education

Youth Fighting AIDS in Kenya (YOFAK) is a group of young people under the age of twenty-eight who perform skits about HIV/AIDS and other social issues for pupils attending schools and at awareness campaigns. Although its members are not HIV-positive, YOFAK is affiliated with Oyugis Integrated Project and relies on them for the majority of their funding. In their awareness campaigns, they perform skits in English, Kiswahili, and Dholuo that often make fun of their cultural traditions in a humorous way. Always popular with the younger crowds, YOFAK has won several national awards for their theatrical performances. They often perform with Tuvimiliane Choir, a group of HIV-positive individuals affiliated with one of Oyugis Integrated Project's community centers that sings HIV/AIDS awareness songs in English and Kiswahili. YOFAK also operates a small theatre house and recreational center in Oyugis that shows popular Nigerian movies to area young people. In between movies, educational videos about HIV/AIDS, sexually transmitted infections, and drug abuse are shown that utilize fear message tactics (see Witte and Berkowitz 1998). Since its time of opening, the theatre house has become increasingly popular
with area youth. A small fee is charged for movie showings, which helps offset the cost of the building's maintenance (field notes August 2nd, 2002).

In Nyatike Division, HIV/AIDS education is normally conducted in schools, churches, and at the chief's weekly meetings, called *barazas*. The same CHWs who provide home based care services to the clients are responsible for educating the community about HIV/AIDS. Educational efforts are in large part targeted towards youths, and in many cases the CHWs found it difficult to educate certain people, particularly older men:

There are some groups who are not easy to understand it, especially older people. It's like the old men are still very strong about culture and tradition. Some of them don't want to do away with issues like wife inheritance, so they may still maintain a lot of culture. So they have become hard to convince.

According to Ministry of Health Data (2001), HIV/AIDS prevalence is higher among men over the age of thirty than in younger men, the reverse of prevalence patterns in women.

Edward Green (1994) argues that traditional healers should also be included in HIV/AIDS education and outreach. Given that the majority of Kenyan individuals live in rural areas, do not have convenient access to medical facilities, and rely on traditional healers to serve their health needs, it is important that traditional healers be trained in HIV/AIDS education and outreach and become part of the prevention campaign.

**Modification of Cultural Traditions**

Organizations such as Oyugis Integrated Project and Nyatike Home Based
Care are currently working to eradicate the practices of wife inheritance and wife cleansing. Practice of such cultural traditions is highly discouraged among the members of these organizations and the members appeared to comply. However, these practices are also linked to poverty, particularly in women, which is an obstacle that must also be dealt with. But to these organizations, and the people in the community, poverty is something that cannot be easily overcome, as they are relying on other nonprofit organizations from overseas as their main source of funding. Moreover, these customs are ones that the Luo have known and practiced for hundreds of years without having to worry about the threat of diseases like HIV/AIDS. Getting people to change their cultural traditions that have been a part of their cultural heritage for so long is not a process that can be accomplished overnight.

However, modifying cultural traditions is something that has been addressed and accomplished in recent years by other tribes in Kenya. Traditionally, a large number of tribes in Kenya have practiced female genital modification (FGM), with the Luo being one of the few exceptions. But throughout the latter part of the twentieth-century, the prevalence of this practice steadily declined as a result of education and activism. The Luo’s neighboring tribe, the Kalenjin, are one example of a tribe that has seen a dramatic decrease in the prevalence of FGM. A recent study concluded that there was a direct correlation between education and the practice of FGM. Educated women were significantly less likely to have the procedure performed and educated men were less likely to desire a wife who had undergone the procedure (Oboler 2001).
Additionally, a number of social action organizations throughout Kenya, including Maendeleo ya Wanawake have worked to abolish FGM. They have suggested alternate rites of passage, including a ceremony where community members agree to become “godparents” to girls who do not undergo the genital surgery. The role of the godparents includes providing educational expenses for the girls, further emphasizing the link between education and the eradication of FGM. The girls receive gifts and are still accorded the same prestige in society (Oboler 2001). As in the case with FGM, both social action and locality development (see Rothman and Tropman 1987) organizations have taken an active role in eradicating the practices of wife inheritance and wife cleansing. Additionally, alternate rituals have been discussed and implemented in several Luo-dominant areas in Nyanza Province that maintain the principle of providing financial support for the woman, while not requiring her to be inherited or engage in sexual relations as a stipulation of this support.

One such alternate ritual being promoted and implemented in Nyatike Division is the practice of hanging a coat to signify that a woman is already inherited. Under this practice, a man symbolically “inherits” a woman and provides her with financial support; at the same time the woman remains in her old homestead and does not “owe” her symbolic inheritor anything in return. When a coat is hung at the entryway to the woman’s home, the community members then know that the woman is “inherited,” and she is not required to participate in traditional practices of wife inheritance or wife cleansing. The theory behind this practice is that the woman does
not have to worry about being without any form of financial assistance or being stigmatized by her community for not having been inherited, two key concerns among women who are not inherited. Ideally to those who forgo inheritance, HIV/AIDS would be less likely to spread in this situation; by contrast, when wife inheritance and wife cleansing are practiced in their traditional manners, a widow, her cleanser, or her inheritor may be more likely to be infected with the HIV/AIDS virus (August 14th, 2002 interview).

Access to Voluntary Counseling and Testing Services

Another obstacle to potentially reducing the HIV/AIDS prevalence in Nyanza Province is the limited number of voluntary counseling and testing (VCT) facilities in many areas and the reluctance of community members to go in for an HIV test. For example, residents of Nyando District do not have access to VCT services within their district on a regular basis even if they wanted to have an HIV test. Many of these residents would have to travel up to an hour on foot and then another thirty minutes by local transport just to reach the Center for Disease Control’s VCT Center in the city of Kisumu.

In nearby Oyugis, community members may go for an HIV test at the Ministry of Health hospital or at Matata Hospital. Although admitting that encouraging the community to obtain a test several years ago was not an easy task, the director of OIP told me that at the time of this study:

Mostly we don’t encourage people to go for an HIV test. People have seen what we are doing and they come by themselves. They want to do an HIV test... The reason is because we have been very open to them. We socialized
with them. And they know what we are doing... And despite if that person is HIV-positive, we like that person... And the person at home—those who have not been tested—they know they are sick. They are suffering. They want that love. They want that support.

According to Israel (1982), in health intervention programs where there is a strong social support network, individuals are more likely to engage in positive health behaviors. As in the case with Oyugis, it appears that community members who have obtained the knowledge of the signs and symptoms of HIV/AIDS and who believe they might have been at risk for this disease are voluntarily going in for counseling and an HIV test because they see the support system that is in place for them should they test positive. As access to VCT services was found to be linked to perceptions of individuals who were openly HIV-positive, the number of individuals receiving an HIV test, and the social support systems available to those who test positive, it is imperative the voluntary counseling and testing services be readily accessible to individuals in all rural and urban areas on a permanent basis. As was shown in Uganda, VCT may serve as an effective means of prevention as well as help to assist those who are infected to “live positively.”

**Misinformation**

The majority of individuals interviewed, particularly those in leadership positions in the Ministry of Health and community health workers who provide HIV/AIDS education, mistakenly noted that through educational efforts and increased knowledge the HIV/AIDS prevalence is steadily declining. This assertion contradicts data from the National AIDS and STDs Control Programme (2001), the Ministry of
Health (2001), and the World Health Organization (2002). It appears that these leaders and educators are too quick to judge their prevention programs a success, which could potentially harm stepping up the pace of these prevention programs in the future. A common response by those interviewed, and also expressed by a member of Oyugis Integrated Project, was that “the death rate is now decreasing because of the awareness.” In fact, the death rate from HIV/AIDS is increasing and will continue to do so for quite some time, as those who were infected in the mid-1990s are beginning to die of opportunistic infections. It is too soon to tell if these community mobilization efforts are truly reducing the prevalence, as sentinel surveillance data and results from VCT services in years to come will be the best indicators.

Political and Economic Response

As in the case of Uganda, HIV/AIDS prevalence began to decline when “active political support for HIV-related activities and the availability of resources encouraged other sectors of society to become involved in efforts to reduce the spread and impact of HIV” (Pisani 2002:127). By declaring AIDS a national disaster and allocating money for community based organizations fighting the epidemic, the government of Kenya has created a framework that appears suitable for effective action. Given the organizational efforts of CBOs thus far, a number of individuals involved in programs like Oyugis Integrated Project, Nyatike Home Based Care, TEMAK, and Diakonia Compassionate Ministry, including HIV-positive individuals and AIDS orphans, have undoubtedly experienced improvements in the quality of their lives.
Although the prevalence of HIV/AIDS in Nyanza Province has continued to rise over the past two decades, the Government of Kenya, non-governmental organizations, and community-based organizations are taking positive action to overcome the negative macroeconomic implications of the HIV/AIDS epidemic. Such interventions are aimed at reducing poverty through income-generating activities and improving perceptions of HIV-positive people through engaging them in such activities. Through collaborative work between the Government of Kenya, non-governmental organizations, and community-based organizations, multiple sectors of Kenyan society are working together to assist the infected and affected and ensure that there is no duplication of services.

Despite efforts to assist the infected and affected, the Government of Kenya, non-governmental organizations, and community-based organizations have faced a number of different obstacles in their efforts related to HIV/AIDS, the majority of which are related to poverty and limited funding. Individuals' behavior resulting in the transmission of HIV/AIDS is not solely related to lack of knowledge. Circumstances, especially related to poverty, lead to actions such as exchanging sex for money, distance marriages, early marriages for females, and wife inheritance.

AIDS orphans are becoming an issue of increasing importance and their numbers will continue to rise as the mortality of HIV/AIDS clients increases. Many of these orphans lack education, health care, enough food to eat, and even a place to sleep in some cases. It is important that orphan support be addressed in HIV/AIDS policy and programs to prevent poverty among these individuals, thereby improving
their choices and decreasing their risk for contracting HIV/AIDS.

Jackson and Lee (2002) argue that "given the myriad of other issues facing [sub-Saharan Africa], it will be difficult to gain the priority that the pandemic requires and the energy required in our response." But as the high prevalence of HIV/AIDS, high prevalence of other infectious diseases, the number of orphans, poverty, and a potentially devastated economy are all interrelated, by working to solve one problem, one is thereby creating solutions to other problems as well. And as Oyugis Integrated Project, Nyatike Home Based Care, TEMAK, and Diakonia Compassionate Ministry are working on assisting the infected and affected both financially and socially, and increasing the number of people receiving a school education through their orphan support programs, it can be argued that this holistic approach to community organizing is thus simultaneously working to solve a number of other problems that Kenyans are facing.

Advocacy for a Multisectoral Approach

HIV/AIDS has had a negative impact on multiple sectors of Kenyan society, and therefore a multisectoral approach is essential to combat the negative effects of the epidemic and ultimately reduce the prevalence of HIV/AIDS in the future. Former president Daniel arap Moi was often criticized for not taking enough action toward the HIV/AIDS epidemic compared to Ugandan President Yoweri Musevani. It is essential that Kenya's new president, Mwai Kibaki, step up the pace to improve voluntary counseling and testing services, encourage open dialogue of HIV/AIDS, and pass legislation in favor of the rights and protection of women.
HIV/AIDS is part of a cycle caused by sociocultural behaviors and related to poverty. Because the epidemic is mostly infecting the 15 to 49 year old population, the population which is the most economically active, the economy will continue to decline as the death rate increases. It is important that other factors, such as the economy, education, and health care in general, be examined and addressed in future HIV/AIDS-related programs.

Above all, in order for HIV/AIDS prevalence in Kenya to be reduced, there must be active participation from all levels of society, including from community members themselves, community-based organizations, the Government of Kenya, and international governmental and non-governmental assistance organizations. Monetary assistance must extend beyond issues such as care for the infected and affected, prevention of mother-to-child transmission, and HIV/AIDS education and must also focus on reducing poverty, making education accessible for all children, and improving the overall state of health and access to health facilities for all individuals.

In this thesis, I have demonstrated how four community based organizations in Western Kenya have mobilized their communities to support those individuals infected and affected by HIV/AIDS. Although sharing similar objectives, the four organizations utilize different strategies in providing service to their client bases: Oyugis Integrated Project offers social clubs for its one hundred clients, educational assistance to orphans, and agricultural and craft production and sale as an income-generating activity; Nyatike Home Based Care provides medical assistance for nearly five hundred clients and voluntary counseling and testing services to the community,
but is in the process of mobilization and seeking funds for an orphan support program and income-generating activities for clients; the Teenage Mothers and Girls Association of Kenya (TEMAK) provides training to at-risk female youth to reduce the burden of poverty and to decrease their risk for negative health outcomes; Diakonia Compassionate Ministry provides educational, medical, and monetary support to AIDS orphans, vocational training to at-risk youth, and free medical treatment to individuals suffering from a variety of ailments in an attempt to improve the overall state of health in Nyanza Province. Each organization also provides some degree of HIV/AIDS preventative education to their communities.

As Jackson and Lee (2002:216) write, “the scale of the HIV/AIDS pandemic south of the Sahara is such that a massive commitment at all levels and from all sectors is required to promote prevention, ensure care, and work toward effective and appropriate mitigation.” Although the Government of Kenya has declared HIV/AIDS a national disaster, allocated money for fighting this epidemic, and held several major meetings with Ministry of Health and other government officials, they are still in the planning phase of how to control this epidemic. While relying on community based organizations to deliver services, it is important that the government also take an active role in HIV/AIDS prevention and assisting the infected and affected.

The research presented here illustrates the grassroots approach to community organization that these four organizations and four governmental districts have taken to provide HIV/AIDS education and outreach services. As eighty percent of the population of Kenya inhabit rural areas, and as most of these individuals have
difficulty in acquiring transportation to other areas within the country, this grassroots
approach to fighting the HIV/AIDS epidemic is an effective way of reaching members
of the communities they serve. But as community based organizations are struggling
for funding in most communities, hence limiting the services they provide, it is
important that community based organizations working with large client bases, such
as Oyugis Integrated Project, Nyatike Home Based Care, and TEMA, work with
newly formed and struggling organizations to design effective intervention strategies.

This thesis has sought to create a broader framework for evaluating the
successes and obstacles of such community-based organizational programs and
strategies in the future. Programs assisting the infected and affected may be measured
by the number of clients served and the level of services provided to them.
Ultimately, the success of prevention programs will be measured by the prevalence of
HIV/AIDS in future years. In the face of rising death tolls from HIV/AIDS infection
in Kenya, particularly in Nyanza Province, it is essential that action be taken to
overcome the issues associated with this epidemic.

This thesis has shown how the HIV/AIDS epidemic in Kenya has had a
tremendous impact on multiple sectors of society. Guided by critical medical
anthropological theory, this thesis demonstrates how community-based organizations
and the Ministry of Health have mobilized at the grassroots level in response to the
macroeconomic impact of the HIV/AIDS epidemic. Grounded in both theory and
practical applications, the research presented here reveals that critical theory can and
should be combined with multisectoral interventions and health policy in the future
given the interconnectivity between poverty, behavior, and health outcomes highlighted in this thesis.

Medical anthropologist and physician Paul Farmer (1999:281) wrote that “only through the concrete understanding of particular worlds of suffering and the way they are shaped by political economy and cultural change can we possibly come to terms with the complex human experiences that undermine health.” Future social science research in years to come will be vital in determining how these programs have impacted communities and ways these programs may be improved, a factor that may, in due course, help other community based organizations throughout Kenya and sub-Saharan Africa with HIV/AIDS mobilization programs as well.
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APPENDICES
APPENDIX ONE

GLOSSARY

_Ayaki_ (D) AIDS
_Baraza_ (K) a community meeting organized by a chief
_Chai_ (K) tea with milk
_Chira_ (D) a curse or the result of bewitching believed to cause an individual to grow thin and die
_Harambee_ (K) Kenya’s national motto and the cornerstone of Jomo Kenyatta’s political ideology; a symbol of national unity which calls Kenyans together in an altruistic spirit
_Jater_ (D) wife cleanser
_Kidogo, kidogo_ (K) a little, a little
_Matatu_ (K) a passenger van used for public transportation
_Machunga_ (K) oranges
_Mzee_ (K) literally “old person”; generally used to refer to an elder male
_Mzungu_ (K) white person
_Nyama choma_ (K) goat meat
_Omena_ (D) small fish
_Paw paw_ (K) papaya
_Pole pole_ (K) slowly, slowly
_Safari_ (K) literally “journey”; in a Western context generally refers to a wildlife viewing expedition geared towards tourists
_Samaki_ (K) fish
_Shirikisho_ (K) community
_Sukuma wike_ (K) collard greens
_Ter_ (D) the ritual act of wife cleansing
_Tupendane_ (K) love one another
_Twimiliane_ (K) be patient with one another
_Ugali_ (K) a cooked dish made from maize meal and water

K = Kiswahili word
D = Dholuo word
APPENDIX TWO

SAMPLE QUESTIONS USED IN SEMI-STRUCTURED INTERVIEWS WITH INDIVIDUALS/ADMINISTRATORS PRESENTLY SPONSORING HIV/AIDS EDUCATION AND OUTREACH PROGRAMS

1) Please provide me with some information regarding the structure and history of your organization and your organization's mission (also information about when the organization was founded, for what purpose, and how it has grown since its founding).

2) What do you believe to be the greatest health concern in Western Kenya today and why?

3) How has your organization worked with [the government] [NGOs/CBOs] in controlling the HIV/AIDS epidemic?

4) Do you believe that the government and NGOs/CBOs share common objectives in controlling the HIV/AIDS epidemic? Why?

5) Do you believe that the government of Kenya is moving in the right direction to controlling the HIV/AIDS epidemic? Why?

6) Do you believe that NGOs/CBOs are moving in the right direction to controlling the HIV/AIDS epidemic? Why?

7) What sorts of programs has your organization done to help control the HIV/AIDS epidemic?

8) Do you believe these strategies have been effective?

9) How could these programs be improved in the future?

10) How does your organization recruit and train community health care workers?

11) Do you believe that people in Western Kenya generally have a good idea of what HIV/AIDS is and how to prevent it or has this been an obstacle for you? Please explain your reasoning.

12) How are people who have HIV/AIDS generally perceived in your community? How can this perception be improved?
13) Are there certain groups of people who have been more difficult to educate than others? Who are they? What is reasoning behind this?

14) What obstacles has your organization faced in mobilization efforts for HIV/AIDS education and outreach?

15) What social and behavioral factors do you believe are linked to the high rates of HIV and AIDS in this region?

16) Where in this community can a person go for an HIV test?

17) In your opinion, who should be tested?

18) Whose responsibility is it to control the HIV/AIDS epidemic?

19) What programs has your organization planned for the future to help control the HIV/AIDS epidemic?

20) What do you believe separates knowledge from behavior change?

21) Is there anything in particular that you would like me (the student researcher) to examine in this study?
APPENDIX THREE

SAMPLE QUESTIONS USED IN SEMI-STRUCTURED INTERVIEWS WITH COMMUNITY HEALTH WORKERS

1) Please provide me with some information about yourself including your age, [gender], and level of education.

2) Why were you initially interested in becoming a community health worker?

3) What sort of training program did you go through to become a community health worker?

4) Did you find this training program to be helpful? In what way?

5) Is there anything you wished you knew, but didn’t before going into the field? Explain.

6) Do you believe there is a good level of communication between community health workers and their supervisors? How could things be improved?

7) Do you believe that your organization is moving in the right direction to controlling the HIV/AIDS epidemic? Why?

8) What is your role as a community health worker? What sorts of services do you provide?

9) Do you find these services to be effective in mobilizing the community? Why?

10) How could these programs be improved in the future?

11) Do you believe that people in Western Kenya generally have a good idea of what HIV/AIDS is and how to prevent it or has this been an obstacle for you? Please explain your reasoning.

12) How are people with HIV/AIDS generally perceived in your community? How can this perception be improved?

13) Are there certain groups of people who have been more difficult to educate than others? Who are they? What is your reasoning behind this?

14) What obstacles have you faced in mobilizing your community for HIV/AIDS education and outreach?
15) What social and behavioral factors do you believe are linked to the high rate of HIV and AIDS in this region?

16) Whose responsibility is it to control the HIV/AIDS epidemic?
APPENDIX FOUR

SAMPLE TOPICS USED IN FOCUS GROUP DISCUSSION WITH YOUTH

1) Gather demographic information about each participant in private before the discussion begins including age, gender, marital status, occupation, income level, and level of education.

2) What health-related issues are of concern to your community?

3) Please rate the following diseases' level of concern on a scale of 1 to 5 with 1 being of low concern and 5 being of high concern.
   - Cholera-
   - Malaria-
   - Tetanus-
   - Measles-
   - HIV/AIDS-
   - STIs-

4) What can you tell me about HIV?

5) What can you tell me about AIDS?

6) How do you believe that a person becomes infected with this disease?

7) Do you believe that you or anyone you know is at risk of getting HIV/AIDS? Why?

8) Do you know anyone who has HIV/AIDS or who has died from this disease?

9) Are there certain types of behaviors that lead a person to develop HIV/AIDS?

10) How does one know that he/she has HIV/AIDS?

11) Who should be tested?

12) How is a person with HIV/AIDS perceived within your community? What can be done to change these perceptions?

13) What does a person do to manage HIV/AIDS infection?

14) What sorts of changes does that person make in his/her lifestyle?

15) What sorts of changes should that person make in his/her lifestyle?
16) How does one protect himself/herself from getting HIV/AIDS?

17) Do you practice any of these? Which ones?

18) Whose responsibility is it to control the HIV/AIDS epidemic?

19) Have you ever attended an HIV/AIDS education seminar? Who was it sponsored by? Did you find this event to be beneficial?

20) What are some of your suggestions to how HIV/AIDS can be better managed in your community?