

HIV and AIDS in Kenya: Forty Years Later

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Abstract

About forty years ago, the first case of HIV was identified in Kenya. Since then the government, civil society organisations and other stakeholders have taken various initiatives to combat the spread of the scourge and to mitigate its negative consequences. This paper analyses the trends of HIV in Kenya, the strategies adopted in a bid to eradicate its spread and the existing gaps. Secondary data from published and unpublished sources on HIV and AIDS in Kenya were used and an anthropological approach of data analysis and presentation adopted to tell the story of HIV in Kenya. Results indicate that in Kenya, 40 years of concentrated anti-HIV campaigns and programs have had mixed results. That is, they succeeded in some areas and failed in others. Where HIV strategies have succeeded, it generated benefits such as reduced infection rates and changes in sexual lifestyles leading to positive outcomes. Where HIV initiatives failed, inadequate access to information, inadequate group-specific strategies, socio-cultural and economic barriers were cited as some the key contributing factors. These findings therefore conclude that despite all these efforts, there is need to address existing gaps through investing in sexual behaviour change, more HIV and AIDS awareness creation, and scaling up HIV prevention programmes in all populations.

Introduction

The Human Immuno-Deficiency Virus (HIV) was first diagnosed in 1983 and it remains a global sore in the twenty-first century. Over the past 40 years, HIV and AIDS has become a pandemic killing an estimated 23 million people and the number of HIV infected people continues to increase at an average of rate of 5,000 new infections per day and an estimated 45 million people in the world today live with HIV (UNAIDS, 2016). Despite great efforts, no cure has yet been found. HIV and AIDS therefore remain a major developmental and public health problem in many developing countries. Global analyses of HIV and AIDS indicate that more than half of the people infected and affected by the disease are found in the developing countries in Africa, Asia and Latin America (WHO, 2017). In Sub-Saharan Africa (SSA) HIV and AIDS are the leading causes of morbidity and mortality. SSA accounts for between 25 and 28.2 million of people living with HIV and AIDS (PLWHA) in the world. It also accounts for two thirds of all new infections and more than 12 of the 14 million related orphans in the world. Despite, the prevalent view that HIV and AIDS is predominantly a problem of the developing countries, the reality is that even in the industrialized nations, there are pockets of people infected and affected by the disease.

HIV and AIDS prevention has been a priority for years in the international development discourse since the early 1980s when HIV was first acknowledged in America by the US Centres for Disease Control and Prevention (CDC) as a new disease. Multilateral Organizations including the World Health Organization (WHO), United Nations Development Programme (UNDP), World Bank (WB), International Monetary Fund; national governments, NGOS, Community Based Organizations (CBOs), Faith Based Organizations (FBOs), scholars, researchers and other stakeholders have directed enormous amounts of resources, efforts, attention and time towards HIV prevention and treatment. To affirm global commitment to defeat HIV and AIDS, the United Nations Programme on HIV and AIDS (UNAIDS) was formed to spearhead the fight against the scourge. Combating HIV

Citation: Casmir, E. N; Ondicho, T. G & Ongolly, F. K (2018). HIV and AIDS in Kenya: Forty Years Later. *Journal of African Interdisciplinary Studies*. 2(5), 91-99

was also declared as one of the central themes of the Millennium Development Goals (MDGs) and now the Sustainable Development Goals (SDGs) which inform development work internationally. Despite these efforts, the number of PLWHA not only remains unacceptably high but also appears to be increasing in some parts of the world including Kenya.

Kenya is one of the countries in SSA that is greatly affected by HIV and AIDS. It accounts for nearly 1.5 million of all PLWHA in the world and new infections are being reported daily (UNAIDS, 2017). HIV/AIDS, in particular, represents a major source of suffering and death among the infected persons. The pandemic has reached a stage where high prevalence levels threaten all aspects of national development. As a result, the government of Kenya has put in place a number of strategies and programmes to prevent the spread of the disease and mitigate its negative impacts. For example, in 1999, the government of Kenya declared HIV/AIDS a national disaster and called upon all stakeholders to join hands in the fight against the scourge. A multisectoral approach bringing together both the public and private sectors in mainstreaming HIV and AIDS into their core functions was adopted. As part of this effort, the government of Kenya has put in place different strategies, policies, programmes and activities to tackle HIV and AIDS.

The national response to HIV/ AIDS in Kenya has focused mainly on research and surveillance; information, education and communication; awareness creation; community mobilisation for prevention through the promotion of faithfulness, abstinence and condom use; counselling and testing, advocacy on access to affordable treatment targeted at medicine producers and international trade bodies; and work to 'mainstream' support to AIDS affected individuals and communities, and currently test and treat strategy as well as establishing linkages to care facilities. However, it has been widely demonstrated in the literature and in numerous studies that many policies and strategies for HIV prevention are based on unclear understanding of the social, economic, political dynamics. Consequently, the formulation and implementation of such policies and programmes mostly fail to improve the lives of the infected and affected people. Most programmes and policies have focused on women and youth and assume that everybody will benefit equally. As such they ignore men and fail to address the specific needs of men living with HIV. Consequently, they reinforce the feminization of HIV.

The adoption of various HIV prevention measures in the last 40 years raises several questions about their achievements. That is how much has actually been achieved by the government and other stakeholders in the fight against HIV in Kenya. Often the achievements are over or understated. It is important also to ask why HIV and AIDS prevalence in Kenya remains high in spite of international and local efforts to defeat it. These questions about the performance of anti-HIV initiatives are also relevant for evaluating the success of policies, strategies, and programme to combat HIV in Kenya. Kenya is faced with high prevalence of HIV which threatens livelihoods and the gains made in national development. It is from this perspective that HIV prevention strategies in Kenya are analysed to determine whether they have made significant contributions to HIV prevention over the last 40 years.

Research Methodology

In this paper we reviewed existing literature on HIV in Kenya from both published and unpublished documents. Historical literature review method was used to guide the synthesis of the information used in the paper. The purpose of this method was to put literature in a historical context in order to show the state of development of HIV in Kenya over a period of 40 years, to identify the existing gaps, and come up with recommendations to inform future

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strategies. An anthropological approach of data presentation was adopted to tell the story of HIV in Kenya from the time the first case was reported. In the analysis, we focused on the following thematic areas:

Trends of HIV in Kenya: HIV in Kenya in the early Years (1980-1990s), HIV in Kenya in the early 2000s, HIV in Kenya 2008 and beyond.

HIV prevention strategies in Kenya over years and Gaps in HIV prevention in Kenya

Results and Discussion

HIV Trends in Kenya

Early years (1970-1990s)

In the late 1970s, HIV first reached Kenya suspected to have come through Uganda and Tanzania from the Western Equatorial region. In 1980 tests done among sex workers showed zero prevalence but retrospective tests in 1981 showed a prevalence of 4%. At this time it was believed to be a disease for mostly sex workers and gay men. Later in 1982 Vertical transmission from mother to child during pregnancy and heterosexual transmission was recognized as a means of HIV transmission and HIV was then agreed to affect even the general population. In 1984 AIDS was later renamed to HIV by WHO during which the first case of was reported in Kenya and triggered the establishment of the National AIDS Committee in 1985 (Hivikenya, 2018).

In 1987 the ministry of Health in Kenya issued a directive that people tested should be told their HIV status. Two years later (1989), it is reported that the president by then ordered the quarantining of people with HIV/AIDS, however the order was ignored. Worldwide, 7.5 million people were reported to be living with HIV in 1990, though Kenyan numbers of infection was not very clear due to lack of proper documentation. Early 1990s data reported a substantial number of people infected with HIV in the world (up to 17.5 million people living with the virus). During this time, the number of new infections per year in Kenya peaked to 2%, specifically; Rift valley province reported prevalence of 14% and later on in 1994 Western province reported 17% prevalence prompting the government of the time to recognize HIV as a serious issue.

A year later (1995), the prevalence in Nairobi shot to 17% and 14% nationally but still the Kenyan government was unshaken with HIV as an epidemic. New technology in managing HIV was introduced in 1996 after the development of Highly Active Anti-Retroviral Therapy (HAART). During this time, condom use was encouraged across the country as a working strategy to reduce new infections however with lots of resistance from the Christian fraternity more specifically the clergy which triggered HIV prevalence to peak. A 15 year national AIDS policy was approved by the Kenyan parliament and the National AIDS Control Council is formed in 1997. At this time, religious leaders also join the government (Avert, 2018). In 1998, HIV prevalence in Northern Kenya is reported at 6% which was relatively low compared to other regions in the country. A lot of HIV/AIDS related deaths were reported among employees in the Kenyan public sector and within the same time the Great Lakes Initiative on AIDS (GLIA) is established. This is the same year when AIDS was declared a national disaster in Kenya but still with a lot of reluctance to come up with immediate interventions despite the fact that the National AIDS Control Council was in full operation.

HIV in the new millennium

In 2000, an estimated 27.5 million people are living with AIDS globally and Kenya develops a five year National AIDS Strategic plan on AIDS education targeting creating awareness for

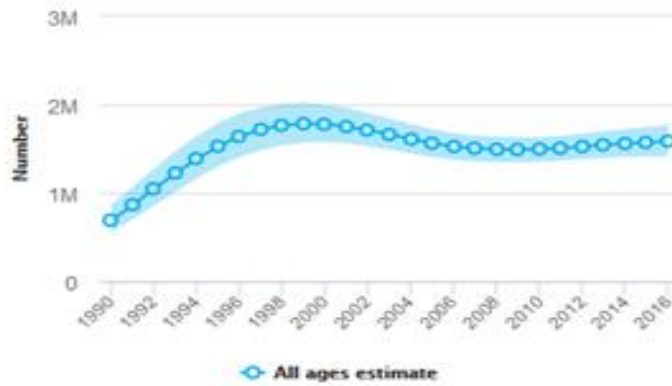
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all schools and colleges (NACC, 2018). By 2001, condoms were proven to be a good strategy in the fight against HIV. However, since this was a year prior to the national elections the Kenyan government still showed some reluctance in spending public funds on HIV prevention strategies such as condoms, and abstinence promoted which was highly supported by religious leaders out of their concerns that condoms will increase immorality in the community. In 2002, a new government regime is elected and the president then declares total war against AIDS in the country with the slogan “*Pamoja Tuangamize Ukimwi*” which led to a drop of Kenya’s HIV prevalence up to 6.7% a year later (2003), however HIV and AIDS related deaths shot to 120000 per year. In the year 2003, results from the Kenya Demographic and Health Survey indicated that women between the ages of 15-49 were more affected with a HIV prevalence of 8.7% as compared to men who registered 4.6%; this ratio of 1.9 to 1 was higher than what other African countries had reported (KDHS, 2003). Later in 2005, the government adopts a five year strategic plan 2005-2010 which saw a drop of prevalence to 6.1% and thereafter 5.1% in the following year (2006). During this period, the country struggles with proper documentation on HIV and AIDS despite the fact that reporting was very critical to understand how to manage the infected and prevent new infections. In 2006, data had indicated that the Kenyan national prevalence dropped to 5.1% but 2007 reported 7.8% which was suspected to be rising from 2004 due to the poor documentation and lack of proper reporting tools in the previous years. There is no much improvement in the following year (2008) and a higher prevalence was even reported (Soft Kenya, 2018)..

HIV in 2008 and beyond

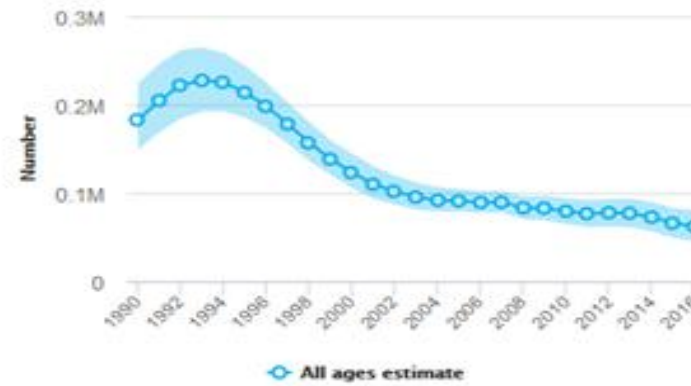
From 2008, there was a recorded reduction trend in numbers of HIV infections as a result of the implementation of Voluntary Medical Male Circumcision (VMMC) as a HIV prevention strategy. This strategy was successful and saw up to 92.6% of men circumcised by the year 2016 (UNAIDS, 2017). According to the estimates by UNAIDS 2017, there was a decrease in the number of new HIV infections and AIDS-related deaths as a result of the increase in ART uptake across all ages between 2010 and 2016 (Fig.1). Within this period, the government adopted the WHO strategy in 2015 to ensure that people who test HIV+ are linked to treatment immediately (UNAIDS, 2016) this saw an improvement of the retention on people on ART from 70% in 2013 to 81% in 2015 (MOH/NACC, 2016). With all the strategies that were adopted by the government within this period (2008-2016) saw a decrease in prevalence from 7.8% in 2007 to 5.4% in 2016 (UNAIDS, 2017).

People living with HIV (all ages)



Source: UNAIDS Estimates 2017

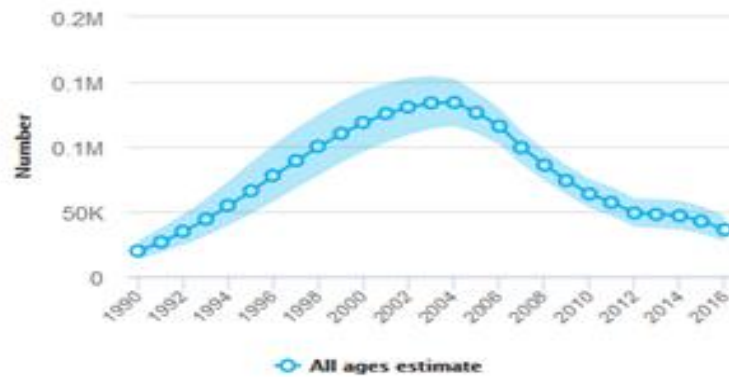
New HIV infections (all ages)



Source: UNAIDS Estimates 2017

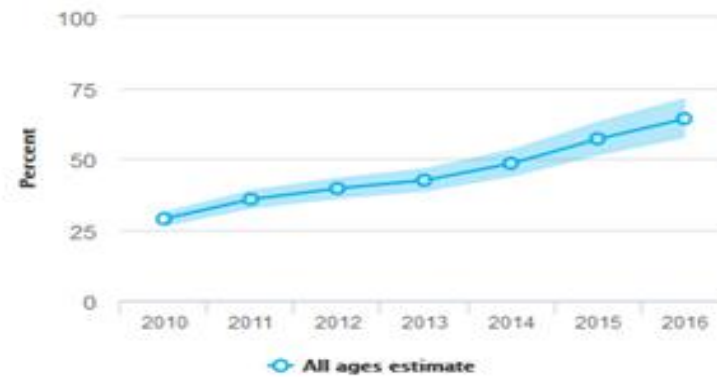
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AIDS-related deaths (all ages)



Source: UNAIDS Estimates 2017

Coverage of people receiving ART (all ages)



Source: UNAIDS Estimates 2017

Figure 1: HIV Trends in Kenya from 1990 to 2016

Strategies towards HIV Prevention and Treatment in Kenya

In the past years, Kenya has made huge strides in tackling its HIV epidemic and has been pioneering the provision of HIV treatment and prevention using different strategies including the following:

Year	Strategy	Description
2000-2005	The establishment of the National Aids Control Council (NACC).	To develop strategies, policies and guidelines relevant to the prevention and control of HIV and Aids in Kenya. Has up to date led the national response by coordinating and implementing various strategic plans covering the periods 2000 to date
2005/6-2009/10	Government-led development of ‘Three ones’ principles approach comprising of 1. One Coordinating Agency, 2. One Agreed Action Framework, and 3. One Agreed M&E system.	It led to tremendous gains in HIV and AIDS programming in the country However the lifespan of this strategic plan was cut short due to emerging trends from research on new sources of HIV infections which mostly occur in couples who engage in heterosexual activity within a union or a regular relationship accounting to 44% of all the infections. Men and women who engage in casual sex contributed 20% of new infections, while sex workers and their clients contributed 14%. Men who have sex with Men (MSM) and prison populations contributed 15% of new infections, and injecting drug users accounted for 3.8% while health facility-related infections contributed 2.5% of new cases.
2009/10 to 2012/13	Developed a vision of having ‘ <i>An HIV Free Society</i> ’	Emphasized on effectively responding to the evidence base information in order to provide a coordinated, comprehensive, and high quality combination prevention, treatment and care services.

2014/15-2018/19	Kenya AIDS Strategic Framework -KASF 2014/15- 2018/19	Aims at universal access to comprehensive HIV Prevention, treatment and care with a vision of: <i>A Kenya Free of HIV infections, stigma and AIDS related deaths.</i> In line to this the Ministry of Health published the Kenya HIV Prevention Revolution Road Map in 2014 outlining different/new approaches to drastically reduce new HIV infections that is “evidence-informed, rights-based and gender sensitive” with a goal to bring HIV infections to “near zero” by 2030 through combining interventions targeted towards the different needs of key populations and geographical locations.
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Source: Author

Citation: Ismail, J. H. (2018). Re-thinking Linguistic Universals in Phonology: Evidence from Phonological Processes Affecting Vowels in Tanzanian Bantu. *Journal of African Interdisciplinary Studies*. 2(4), 88 - 103.

Other strategies in use

HIV Education and awareness: This strategy aims at reducing HIV infection through awareness creation and capacity building on HIV transmission, prevention and treatment among people of all ages. In Kenya, this was mostly marketed through the inclusion of HIV in the learning curriculums in a gender sensitive way. This has received with mixed reactions by the public especially when it comes to teaching young people about condoms; a key component in HIV prevention with the argument that this will promote increased sexual activities among young people (Kenya National Bureau of Statistics, 2015).

Condom policy: Condoms have been supported by the Kenyan government as a HIV prevention strategy since early 2000s, although with great resistance from the clergy and some cultures. Condoms have an efficacy of 98% and have proven to be highly effective and are still being used in combination with other strategies. Some of the biggest milestones by the government to increase condom use include ensuring that they are easily available and accessible to the public. This has been achieved through the provision of free condoms in health facilities, institutions of learning and social places among others (Avert, 2018).

HIV testing and counselling: Kenya has adopted the test-and-treat strategy since 2015 whereby people who test HIV+ are linked to HIV care and treatment not more than two weeks after testing. This strategy has proven to be very effective by linking people who test to appropriate HIV services including treatment and prevention services such as risk reduction counselling, offering of ART and PrEP/PEP services among others. Initially, people who tested HIV+ would get lost between testing and initiation of ART leading to increased new HIV infection cases and mortality among people living with HIV. This has worked well, because it has helped people to know their HIV status and enabled those who are infected with HIV to get timely treatment and reduce new infections. Currently, to encourage more people to know their HIV status, the government has adopted HIV self-testing as a strategy. (2016 Kenya National ART Guidelines)

Voluntary Medical Male Circumcision (VMMC): In 2008, the Kenyan government implemented VMMC policy with priority in areas that had high HIV prevalence among the uncircumcised (CDC, 2012). By 2015, the government scaled up this intervention which showed effectiveness in reducing new HIV infection among specifically in western Kenya (UNAIDS, 2016).

Antiretroviral drugs for prevention of mother to child transmission (PMTCT): This strategy is geared towards preventing vertical HIV transmission from mother to the child (Avert, 2018). To achieve the latter, the government recommends that all pregnant women should attend antenatal clinics and get tested for HIV during which services should concentrate on increasing knowledge of PMTCT, increasing male involvement, and provision of ART services to HIV+ women (NACC, 2014)

Treatment as prevention (TASP): This strategy ensures that people living with HIV are put on ART treatment and adhere to in order to achieve viral suppression. According to research virally suppressed HIV infected people are unlikely to transmit the HIV virus to other people in the community. This is commonly known as treatment as prevention and promoted by most health providers (WHO, 2012).

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Pre-Exposure Prophylaxis (PrEP): This strategy was adopted by the government in the year 2016 and promoted at large scale delivery in public health facilities in 2017 both by the government and the private sector. It is whereby ARV drugs are used by HIV- people to prevent themselves from HIV infection before exposure to the HIV virus. Several studies on PrEP in Kenya show high levels of efficacy up to 96% with proper adherence. For the short period that PrEP has been rolled out in the country it has proven effectiveness especially among people in HIV sero-discordant partnerships (UNAIDS, 2016).

Post-Exposure Prophylaxis (PEP): Post exposure prophylaxis is whereby people who have been exposed to HIV virus take antiretroviral drugs (ARVs) as prevention within 72 hours of exposure. This strategy was adopted by the government and has been supported by other NGOs that are geared towards HIV prevention and treatment (NASCOP, 2010).

Conclusion and Recommendation

From literature reviewed in this paper, it is evident that much effort has been put forward in HIV prevention, care and treatment. However, there are notable gaps that need to be addressed including: regional differences in HIV prevention and management, prevention efforts lack integration with other programs, gender differences and inequality in addressing HIV prevention and treatment, insufficient programs targeting the youths, less intensive programs targeting most vulnerable groups, high risk groups, and social-cultural and economic barriers. Therefore to address these gaps, the government needs to adopt a comprehensive and integrated approach in the following ways: Scaling-up HIV testing and treatment programmes aiming at achieving the 90-90-90 across all ages, gender and regions; Investing in HIV prevention and stigma elimination focusing more on youths, adolescents, and most vulnerable groups; Investing in behaviour change among people of all ages; Creating more awareness on HIV and AIDS in the public including reduction of unsafe sexual practices, promotion of biomedical HIV interventions such as PEP, PrEP, HIV-self testing among others; Promoting age and gender-specific sex education programs and addressing socio-cultural and economic barriers that predispose people to HIV infections.

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