



Correcting myths and misconceptions about HIV can empower and protect young people.

PHOTO: Sarah Day

The USAID-funded AIDS, Population and Health Integrated Assistance (APHIA II) North Eastern Province (NEP) project brings together Pathfinder International, IntraHealth International, and Management Sciences for Health under the umbrella of the Extending Service Delivery project to implement an integrated program of assistance through government, private, nongovernmental, and faith-based partners in NEP. APHIA II NEP focuses on HIV and AIDS, tuberculosis, reproductive health, and healthy timing and spacing of pregnancy and supports a wide range of activities addressing prevention, care, treatment, and support for people living with HIV, their families, and communities.

Assessment of Kenyan Sexual Networks:

Collecting evidence for interventions to reduce HIV/STI risk in Garissa, North Eastern Province, and Eastleigh, Nairobi

Historically, the ethnic Somalis that constitute the majority of Kenya’s North Eastern Province (NEP) have been largely isolated from other regions in Kenya, both culturally and geographically. One benefit of this isolation was that their traditional Islamic practices, nomadic pastoral lifestyle, and remote location kept them relatively untouched by the HIV epidemic affecting the rest of the country. But in recent years, new technology such as mobile phones, increasing road traffic between provinces, shifting cultural practices and norms, and population changes are working together to change the way all Kenyans interact, including the residents of NEP.

In 2002, just one bus traveled between Nairobi and Garissa (the capital of NEP) per day. By 2008 that number had increased to 30. Undoubtedly, this increase in communication and interaction between NEP and other areas of Kenya has brought improvements such as increased access to goods and services and even medical care, but it may also be contributing to an increase in HIV prevalence. In 2003, zero cases of HIV were reported in NEP.¹ In 2007 HIV prevalence had increased to 1.3 percent throughout the province.² The rate is likely even higher in urban and peri-urban areas.

The Sexual Networks Assessment

One of the APHIA II NEP program’s goals is to prevent further increases in HIV prevalence by increasing knowledge about HIV/AIDS and reinforcing local religious and societal leaders’ messages about abstinence and faithfulness. To date, little information has existed specific to the NEP context to inform HIV prevention activities. Though anecdotal evidence indicated

THE GARISSA DISTRICT AT A GLANCE

POPULATION: 368,593
YOUTH (15-25): 84,195
% LIVING IN ABSOLUTE POVERTY: 68
RURAL POPULATION: 276,562
URBAN POPULATION: 92,031

that sexual practices were not markedly different in Garissa compared to other urban areas in Kenya, little empirical evidence has existed to that effect. Therefore, between May and July 2008, APHIA II NEP conducted a rapid assessment of sexual networks in Garissa town and Eastleigh, a neighborhood in Nairobi with many NEP immigrants and business and social connections to NEP. The main objectives of the assessment were to evaluate the level of risk behavior among key groups—students, sex workers, miraa (khat) and camel milk sellers, taxi and truck drivers, and civil servants—and identify gaps in HIV knowledge, behavior, and practices that will inform the program’s strategies and messages.

¹ Kenya Demographic and Health Survey 2003, MACRO and GOK, Nairobi.

² Kenya AIDS Indicator Survey, 2007, Preliminary Report, July 2008, NASCOP/MOH/GOK.



Chill Clubs, groups of secondary school students guided by respected youth leaders, are important entry points for teaching youth how to protect themselves from HIV.

PHOTO: Sarah Day

Methods

A two-staged approach to answering study questions was used: in-depth, semi-structured interviews with 70 key informants, and a rapid targeted survey of nearly 1000 individuals. All key informants were over the age of 18, were evenly split between males and females, and included civic and religious leaders, NGO managers, businesspeople—especially those in the miraa or camel milk trade—teachers, and bus drivers, touts, taxi, and truck drivers.

The rapid survey gathered perceptions of risk by sex workers, their clients, and single or married men and women identified by the key informants as potentially engaging in high-risk behaviors, such as concurrent relationships and transactional sex. All respondents were between 18-35 years old, and were split evenly between males and females.

The research team also facilitated group discussions with two groups of secondary school boys and girls in Garissa.

It is important to note that interviewees were selected because they were perceived to belong to a key population at higher risk and therefore these results are not representative of the NEP and Eastleigh populations as a whole.

Results

It is clear from the data gathered in this assessment that the sexual behaviors of key populations in Garissa are comparable to other areas of Kenya and do indeed put them and their sexual partners at risk of contracting HIV. Risky behaviors such as concurrent relationships, commercial sex, transactional sex, intergenerational sex, and drug and alcohol use were reportedly practiced among the groups interviewed.

Analysis of the data showed no particular socioeconomic pattern among the most-at-risk individuals. They are scattered throughout both the urban and peri-urban areas of Garissa and include university graduates and men and women with no education, students, civil servants, business people, day laborers, and the unemployed. The diversity of most-at-risk groups means that they are not isolated or insulated; the virus could pass easily to the general population unless effective behavior change programs target a broad audience.

Individuals' risk of contracting HIV is influenced by their behaviors, knowledge, and self perceptions of risk. The assessment's findings in these areas are outlined below.

HIV KNOWLEDGE AND PERCEPTIONS

Transmission

"Ladies who are more informed and exposed than others discuss HIV/AIDS with the rest of us, although sometimes they may not tell you the truth...like they might tell you that a needle prick is more risky than indulging in sex."
—NEP Girls high school

Knowledge regarding HIV transmission is mixed in Garissa. Though 52 percent of the total sample named unprotected sex as a transmission route, over 80 percent of those respondents also named an incorrect transmission route such as sharing utensils or kissing, mosquito bites, or punishment from God. Over 25 percent named kissing and road accidents as HIV transmission routes. Just 23 percent of the sample only reported correct transmission routes when asked how HIV could be transmitted.

RESPONDENTS' SOCIOECONOMIC CHARACTERISTICS

MEAN AGE: 24 in Garissa, 25 in Eastleigh

EDUCATION: 25% of all respondents had only some primary school or no education at all

MARITAL STATUS: About 50% of the total sample was single; 40% married; 9% other (including separated, widowed, and divorced)

RELIGION: 78% Muslim in Garissa; 66% Muslim in Eastleigh

POSSESSIONS: 80% in Garissa and 90% in Nairobi own a cell phone; 74% of all own a radio; 12% a bicycle; and 3% a car or motorbike

Prevention

"I don't talk about condoms. It is spreading HIV because an infected person could claim to use a condom but in fact damage it to deliberately infect the sexual partner. So as a Christian, I can't talk about condoms. I just tell the people to live a holy life so that they will be blessed." —Male 66, Church Pastor

In Garissa, 56 percent of men and 42 percent of women reported abstinence as a prevention strategy. About a third of the men and a quarter of the women reported consistent use of condoms as a way to prevent HIV transmission. Eleven percent of women say requiring a partner to take a test is a strategy. Over 50 percent of women knew that having only one partner is effective but only 39 percent of men reported fidelity as a prevention strategy.

Condom Use

"I personally don't believe in condoms. They smell bad and are sinful to use." —Male student

Use of condoms is a sensitive issue, particularly among the local population in Garissa.

Nearly 30 percent of men surveyed in Garissa say they used a condom at last sex; 20 percent of women say their partners did. This is a common dissonance in sexual behavior surveys. Only 15 percent of men and 10 percent of women said they used condoms with all partners. Among those who had more than one

partner at the time of the survey, 46 percent used a condom the last time they had sex.

Fifty-three percent of women and 67 percent of men in the total sample stated that condoms prevent disease. However, 20 percent of men and 15 percent of women thought condoms themselves carry disease.

Risk Perception

"The level of ignorance is high among youth because there is a perception that the disease (HIV) is not for Somalis. It is associated with people from other parts of Kenya. So once they establish a relationship with a Somali girl, they don't feel at risk." —Male 31, High school teacher

There remain several disparities between the respondents' perceptions of others' risks and their own, or between their knowledge of prevention methods and their use of them. There may also be a question of reporting bias in this section, especially in relation to the testing behavior of this group.

Almost 60 percent of respondents in Garissa think their friends are at high or moderate risk of infection, but only about 10 percent believe they are themselves at moderate or high risk of becoming infected. When asked their reasons for their responses, the men largely felt they were at little or no risk as they either abstain (22 percent), have only one partner (24 percent), or always use a condom (18 percent). Women gave the same reasons in similar proportions, but slightly more of them believe they are at no risk because their partner is faithful (12 percent). Two percent of men and one percent of women in both Nairobi and Garissa believe that "it cannot happen to me."

Among those who see themselves high risk, the reasons given either relate to knowing they have an infected partner, that they have unprotected sex, or that they have multiple partners. A few respondents self-identified as already infected.

High Risk Behavior

"A friend can ask you to have a "puff"—a brief sex session—with the lady he is pushing with. Such puffs become frequent and the lady ends up having many sexual partners at the same time." —GHS Students

Twenty-two percent of the men in Garissa have practiced transactional sex (given something or received something in exchange for sex, not necessarily money), as have 35 percent of the women. Nine percent of male respondents and 14 percent of female respondents report having been forced to have sex.

There is relatively low reporting of alcohol use (probably an under reporting) but over half the men and eight percent of the women in Garissa reported having chewed miraa. Fourteen percent of men but only two percent of women have used other drugs.

Analysis of the 77 students interviewed showed that many appear to be at high risk in terms of knowledge, perception of risk, and behavior. Over half of youth interviewed reported having multiple sexual partners and engaging in transactional sex to acquire cell phones or air time, clothing, and jewelry, behaviors that they consider "modern."

Though a quarter of this group said they are virgins, some later claimed to have had concurrent partners. About 22 percent of those that have one partner, also had a second partner at the time of the survey. Among those with a regular sexual partner (and none of these are married) 41 percent said they never use condoms.

When asked about high risk behavior, students reported that the "keja" (a local term for rooms that boys rent in their final year of high school for studying) are more likely to be used for parties and sex than academic pursuits. Most alarmingly, students described "retaliation sex," where a girl is gang raped in retaliation for spurning a boy. It is unclear how commonly this occurs, but it must be addressed. It was also unclear

from the focus group discussions how common it is for male students to visit sex workers, but it seems it is not unheard of. In the discussion with high school boys, they argued that the behavior was changing due to HIV campaigns and other factors. One boy reported that the sex workers gave out free condoms but said, "...the boys are so scared that the condom may be expired or damaged that they don't like using it."

Testing

"We Somalis, if someone asks you to go for an HIV test, we see this as an abuse... We even try to use other means of testing our future partner without their knowledge."
—Male taxi driver, Garissa

In general, voluntary HIV testing in Garissa is rare. However, more than half of the Garissa respondents say they have been tested for HIV and they report a 100 percent receipt of the test results. When asked if they would tell their main sexual partners if they tested positive, 75 percent of respondents said yes. Among those who said they wouldn't, the main reasons were stigma related to shame, fear of violence, and fear of losing their partner.

Sources of Information and Communication Preferences

"Somalis are difficult people to inform about HIV. The Imams should be used to reach them through the Mosques. They respect the Imams." —Female 55, Women's Leader

The Nairobi sample reports first learning about HIV at an older age (15 years) than the Garissa group (13 years). More respondents in Nairobi learned about HIV through television or other media, and through school or via a friend. In Garissa, more respondents learned about the virus through religious leaders or family members (mostly parents).

When asked for the preferred source of information on HIV and AIDS, two-thirds of the Garissa sample said radio and a quarter said television. The preferred agents for delivering messages about HIV were nurses (about 40 percent in both places) and religious or other leaders (18 percent of the total sample). Interestingly the proportion who learned about HIV from religious

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MALE TAXI DRIVER, GARISSA



APHIA II NEP supports innovative approaches—such as this “moonlight” VCT—to reach key populations at higher risk in urban areas.

PHOTO: Stephen Ndegwa

leaders was higher in Nairobi (23 percent) than in Garissa (13 percent). About 22 percent of respondents chose “Someone I trust” and “Someone like myself who knows a lot.” The lack of a clear pattern in these answers suggests that careful tailoring of different messages for different groups may be necessary. Almost all respondents indicated a desire to learn more about HIV.

Stigma and Discrimination

“We aren’t sure a teacher who tests positive should be allowed to teach in schools. Some of us will be very scared even to enter the class...students might refuse to attend and some could attend just to see what the person looks like but avoid the front rows for fear that HIV may spread to them through the air.” —NEP Girls

As expected, stigma is higher in Garissa than in Eastleigh, though it is still present in Eastleigh. For example, when asked if it is reasonable to refuse to buy goods from someone who may be HIV positive, about a third of respondents in both places thinks it is reasonable.

Similarly, a quarter of the total sample thinks it is reasonable to refuse to rent a room to someone who is positive.

Much of the stigma reflects a lack of knowledge and the continuing fear of infection through casual contact. These attitudes are relatively easy to change through education. But half the respondents in both Garissa and Eastleigh think that HIV-infected individuals should be ashamed of themselves, and almost 75 percent believe that AIDS is a punishment from God. These attitudes are the more challenging types of stigma to overcome.

Conclusion and Project Response

It is clear from the data gathered in this assessment that HIV prevention messages have reached Garissa, but more must be done to clarify and refine these messages and improve knowledge and behaviors regarding risky sex. Though this sample should not be viewed as representative of the NEP population as a whole, these data can be used by APHIA II NEP to create a targeted, evidence-based prevention strategy. APHIA II NEP plans to work with partners to improve knowledge, attitudes, and practices through a strategic behavior change campaign with the following objectives:

- **Targeting key populations at higher risk**, including miraa and milk vendors, sex workers, out of school youth, taxi drivers, truck drivers and the bus crews (drivers and touts), using an in-depth HIV awareness and prevention program. Emphasize communications on “risky behaviors” as opposed to “risky groups.”
- **Leveraging the endorsement and influence of religious leaders.** Religious leaders in NEP play a central role in social and health-seeking practices and have the potential to be strong allies for positive change, including the prevention of HIV and stigma reduction. Religious leaders have the potential and willingness to play a supportive role in community and home-based care and forge linkages with Comprehensive Care Centers.
- **Projecting familiar social settings and “our face” in all communication materials.** Most residents of NEP would identify readily with the sight of a woman wearing a veil or hijab in a video or on a poster. The lack of such materials has contributed to the impression that AIDS is a foreign disease that does not affect people from NEP. Communications must also emphasize that AIDS is a treatable disease, avoiding fear mongering and scare tactics.
- **Intensifying school-based programs.** Many myths can be dispelled at this level. APHIA II NEP will build on the apparent hunger for more information including more in-depth information about the epidemiology of the disease, more information about prevention strategies, and emphasis on risk in concurrency and transactional sex.



Increased access to goods and services may also be contributing to an increase in HIV prevalence.

PHOTO: Stephen Ndegwa

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