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A Field Experience

ASSESSMENT OF HIV/AIDS BEHAVIOUR CHANGE COMMUNICATION STRATEGIES EMPLOYED BY NGOs IN KAKUMA REFUGEE CAMP

KENYA

Health & Community Development Section
Division of Operational Support

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This document forms part of a series of publications that document field experiences in the areas of community services, education, food, health, HIV/AIDS and nutrition. The mission and report was undertaken by Professor Elizabeth Ngugi, Nairobi University, Kenya

These are intended to share experiences among practitioners and program managers in various refugee situations and thereby strengthen responses to needs of refugees and other persons of concern.

Should you have any questions about this document, please contact the UNHCR office in Kenya (e-mail: KENNA@unhcr.org), or the Health and Community Development Section at UNHCR Geneva (e-mail: HQTS∅∅@unhcr.org).

Other titles in the Field Experience series:

Assessing Refugee Perceptions of Health Care Services, Tanzania (September 2002)

Worm Control Activities in Refugee Camps, Tanzania (November 2001)

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FOREWORD

Qualitative assessments are imperative to direct HIV/AIDS prevention and care programs and to influence the implementation of qualitative surveys. Dr. Ngugi's use of qualitative methods in Kakuma refugee camp is a model of how to effectively evaluate and make practical recommendations that will greatly improve the HIV/AIDS programs among that population.

Professor Ngugi studied not only humanitarian workers and various members of the refugee and local community, but also the hard to reach and high risk populations, such as commercial sex workers among the refugees. She astutely observed differences in attitudes among the various ethnic and religious groups in Kakuma camp and tailored her recommendations accordingly. Her comprehensive analysis included all sectors and emphasised capacity building, integration, and co-ordination.

Behaviour change and communication (BCC) is an essential element of HIV/AIDS prevention and care. A generic, one-size fits all BCC strategy does not work. Populations must be studied, the various and disparate groups analysed, and a diverse and targeted approach implemented. I hope this Field Experience will serve as a template for other organisations in the field to modify and utilise accordingly.

Paul B. Spiegel MD, MPH
Snr. HIV/AIDS Technical Officer,
HCDS, DOS, UNHCR, Geneva
February 15, 2003

LIST OF ABBREVIATIONS

ABC	Abstain, Be faithful, Condom
AIDS	Acquired Immuno Deficiency Syndrome
ACU	AIDS Control Unit
ARV	Anti Retroviral
ANC	Ante-natal Clinic
BCC	Behaviour Change Communication
CDC	Centre for Disease Control
CSW	Commercial Sex Worker
DB	Don Bosco
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FP	Family Planning
GOK	Government of Kenya
GTZ	German Technical Co-operation
GUD	Genital Ulcer Disease
HBC	Home Based Care
HIV	Human Immuno-deficiency Virus
IGA	Income Generating Activity
IEC	Information, Education, Communication
INS	Immigration and Naturalisation Service
IRC	International Rescue Committee
JRS	Jesuit Refugee Services
LWF	Lutheran World Federation
MCH	Maternal Child Health
MOE	Ministry of Education
MOH	Ministry of Health
NCCK	National Council of Churches of Kenya
NGO	Non-governmental Organisation
OA	Olympic Aid
PID	Pelvic Inflammatory Disease
PLWA	People Living with AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UD	Urethral Discharge
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
USA	United States of America
USRP	United States Resettlement Program
VD	Vaginal Discharge
VCT	Voluntary Counselling and Testing
WCT	Windle Charitable Trust
WFP	World Food Program
WVK/J	World Vision Kenya/Japan

EXECUTIVE SUMMARY

This study used qualitative methods including key informant interviews, focus group discussions, participatory observation and field visits. Data was collected between 11 November and 3 December 2002.

Quite consistently, HIV/AIDS has not been taken at a personal level by refugees in Kakuma refugee camp. Abstinence and remaining faithful to one partner are acceptable, but by the same breath, the communities of different ethnicities conceded that it is difficult for men to refrain from sex and that they do have premarital and extramarital sex. It was a consensus that due to women's subordinate role and their strict upbringing, they are much more unlikely to engage in sex before marriage or extramarital sex than men.

The major difficulty that emerged throughout this study lies in condom availability, promotion and use. Condoms are viewed by the Sudanese and Somalis as going against religion and culture.

The Sudanese are a polygamous society and their wealth dictates how many wives they can have. A sex industry exists in the camp but is "ignored" and these women are subject to a lot of stigma and human rights abuses.

Targeted HIV/AIDS educational materials that are cultural, religious, age and gender specific are missing as are the curricula including that of schools produced by the Kenyan Ministry of Education (MoE).

The flowchart for the treatment of sexually transmitted infections (STIs) is not being fully followed. The omitted areas are compliance, counselling, condom use and contact treatment. This is the main behavioural change communication (BCC) in STI patient care. Voluntary counselling services have started at two sites in Kakuma and they are of a good standard.

Capacity building regarding STI/HIV/AIDS and networking is a necessity and upgrading should be considered once a year.

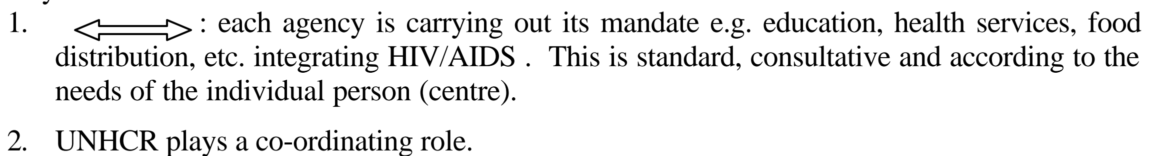
Pages 16 and 19 of the report show specific gaps and recommendations made based on the findings. Figure 1 captures the recommended integrated approach. The suggested work plan for Kakuma is contained on page 22.

There are 16 recommendations that should be implemented together with UNHCR's Strategic Plan 2002-2004. Furthermore, it is necessary to have HIV/AIDS focal points in both Dadaab and Kakuma UNHCR offices as well as at partner level.

Figure 1
Summarising HIV/AIDS Integrated Approach

Agency
Agency
CENTRE OF ANALYSIS
Agency
Agency
HUMAN NEEDS
Agency
Agency
UNHCR Coordinating
HIV/AIDS prevention, control, care & support

Key:

1.  : each agency is carrying out its mandate e.g. education, health services, food distribution, etc. integrating HIV/AIDS . This is standard, consultative and according to the needs of the individual person (centre).
2. UNHCR plays a co-ordinating role.

INTRODUCTION

HIV/AIDS remains a global security threat, particularly in Africa where 75% of the 40 million people infected globally lives. There are cultural and religious beliefs relating to sex, sexuality, and condom use - and some of these are prohibitive to HIV/AIDS preventive behaviour in these communities. Since interactive processes take place between them, they can influence one another either positively or negatively in the area of HIV/AIDS.

BACKGROUND

The exploratory mission report in June 2002 carried out in both Kenya and Tanzania by UNHCR recognised that a number of innovative initiatives had been undertaken in these sites. However, the need for UNHCR to become more involved in HIV/AIDS policies and programs was recognised. It was further emphasised that this could be achieved by participating in the United Nations (UN) theme groups and technical committees. This would lead to inclusion - in particular - in national/regional planning and programs such as the Great Lakes Initiative for AIDS which include Kenya and Tanzania as well as the Global Fund for HIV/AIDS, tuberculosis (TB) and malaria.

According to the same report, there is a high turnover of trained staff for a variety of reasons and the need for more training is real, thus making the in-service education continuous and appropriate to needs.[1]

The same report suggests that the partner organisations do not have sufficient capacity (i.e. human, financial and material) to respond appropriately to HIV/AIDS prevention, control, care and support initiatives.[2]

It is against this background that this mission was commissioned in order to move forward and plan the next steps.

RATIONALE

The rationale is that these refugee camps are in Kenya where HIV transmission and the AIDS impact is high. Notwithstanding, the estimated lower prevalence in refugee camps i.e. 2-10%[3] is no reason for complacency since HIV is already present in these camps. The stage is set for the spread of the virus in the absence of appropriate interventions. It is also appreciated that when people live in camps, the sexual network is increased and not always with protection. This exposes such populations to increased incidence of STIs which are a marker for HIV transmission. The other reason that makes this study important is the interaction between the refugee and local population.

Such a study as this will identify gaps and make suggestions for HIV/AIDS preventive and supportive interventions.

[1] UNHCR Mission Report: HIV/AIDS in Kenya and Tanzania Refugee Camps, June 2002.

[2] *Idem.*

[3] *Idem.*

OBJECTIVES

1. To assess the current behavioural change and communication (BCC) strategies employed by the various non-governmental organisations (NGOs) including:
   - The different strategies and messages for different groups - especially adolescents and young women and including commercial sex workers (CSWs).
   - The various mediums for reaching the groups, including printed materials and posters, youth groups, theatres, etc.
2. Examine co-ordination between the various NGOs working on BCC programs in the camps.
3. Examine the various interactions between the host and refugee communities and how this affects BCC communication.
4. Assess the potential barriers to implementing BCC (e.g. religious or community leaders, host community regulations, etc.)

RECOMMENDATIONS

1. Provide specific and concrete recommendations on how to adopt current BCC programs to target different groups using appropriate media.
2. Provide a detailed Plan of Action and budget for the remainder of 2002 and 2003.

STUDY AREA

Kakuma

Kakuma refugee camp (Kakuma I, II III and IV) is located in the Northwest of Kenya in the Turkana District (Rift Valley province) close to the borders of Sudan, Ethiopia and Uganda. The camp was established in July 1992 by UNHCR initially to provide protection and assistance to some 16,000 teenage Sudanese refugees who had earlier sought refuge in Ethiopia, but later forced to flee through Southern Sudan to the present location owing to political changes in Addis Ababa. It would also provide assistance for 10,000 or so other Sudanese refugees.

Kakuma covers a total area of approximately 25Km^2 and is home to 82,000 refugees of 9 different nationalities and 20 ethnic groups. The large majority (66%) are Sudanese, followed by Somali and Ethiopians. The refugees are mostly Christians of various denominations, followed by Muslims.

UNHCR has the responsibility of providing international protection to the refugees with the Government of Kenya (GoK) providing physical security. This includes the respect of international conventions governing refugees in general, women at risk, child protection and prevention of harmful practices.

When applicable, UNHCR promotes voluntary repatriation and/or resettlement. At present, civil wars and political instability keep plaguing the countries of origin of Kakuma refugees. Therefore, the hopes and dreams of thousands of refugees confined in the camps for more than a decade is a far cry from becoming a reality.

Since voluntary repatriation is not conducive at the moment, great expectations are raised for resettlement. The recipient countries being USA, Canada, Australia and New Zealand.

In December 2001, UNHCR undertook the Somali Bantu Operation through a verification and documentation exercise on behalf of United States Resettlement Program (USRP). The exercise was completed and the Somali Bantus have since been relocated to Kakuma for resettlement to the USA. JVA and the Immigration and Naturalisation Service (INS) are currently processing 11,800 candidates.

The resettlement program has since benefited 3,936 individuals including the now famous "lost boys of Sudan". Ironically, the Sudanese girls numbering about 3,000 who went through the same ordeal as the boys "could not benefit from the program, not because of gender discrimination but because they did not satisfy the selection criteria/status i.e. to be single without a child and less than 18 years". The majority are now over 18 and married since in the Sudanese community girls marry at 15 years.

UNHCR also provides material assistance to refugees. By its mandate, the UNHCR assistance program is implemented through NGOs. In Kakuma, the multi-sectoral assistance program covers logistics, food, water, shelter, medicine, sanitation, education, environment and community services. These activities are implemented by four major NGOs namely: the Lutheran World Federation (LWF), the International Rescue Committee (IRC), World Vision Kenya/Japan (WVK/J) and the German Technical Co-operation (GTZ). These are complemented by the Jesuit Refugee Services (JRS), the Windle Charitable Trust (WCT), the National Council of Churches of Kenya (NCCK), Right to Play and Don Bosco (DB). The World Food Program (WFP) - is the major supplier of basic food items in the district.

METHODS

Literature review was carried out and information analysed and documented as necessary.

Focus group discussion (FGD) and group discussion guides were developed and administered to each of these groups of 4-17 people in attendance: youth group (male and female) boys, girls, men, women and sex workers.

A key informant interview tool was developed and administered to stakeholders and UNHCR partners including government institutions, donors, as well as international and local NGOs. These comprised of UNHCR, the Kakuma District Officer, JRS, Kakuma Mission Hospital, DB, NCCK, IRC, WFP, GTZ, LWF, WVK and WCT (see Annex 1).

Also used was participatory observation at sites likely to have sex networks (bars and the market).

Field visits to health facilities and communities were also carried out.

Survey instruments used are included in Annex II.

RESULTS

Kakuma (82,120 pop.) is served by one IRC hospital and five post clinics. The staffing pattern is shown in Tables 1 and 2. Patients needing specialised care are referred to Kakuma Mission Hospital. The refugees do not pay for services but IRC does based on the memorandum of understanding between, IRC, UNHCR and the Kakuma Mission Hospital. Other referral centres include Lodwar District Hospital, Lokichoggio (Lopiding Trauma Centre) and various centres in Nairobi as necessary following established procedures.

Table 1
Number of hospital staff in the Kakuma IRC Hospital

Staff	Number
Doctors	3
Clinical officers	4
Nurses	11
Medical assistants	4
Midwives	2
Lab technicians	3
Pharmacy dispensers	5
Physiotherapists	1
Nutritional managers	2

Source: IRC data - November 2002

Table 2
Number of staff in the Kakuma IRC clinics

Staff	Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5	Total
Clinical officers	1	1	1	1	1	5
Medical assistants	2	2	2	2	2	10
Lab assistants	1	1	-	1	1	4
Dispensers	2	2	2	2	2	10
Family planning	2	2	2	2	2	10
ANC nurses	4	4	4	4	4	20
Vaccinators	3	3	3	3	3	15

Source: IRC data - November 2002

Key informant interviews

Seventeen key informant interviews were carried out with the UNHCR Head of Sub Office, the Kakuma District Officer, NCCK, IRC, WFP, GTZ, JRS, DB, the Kakuma Mission Hospital, LWF, WVK and WCT.

The head of mission laid the foundation when he said *"gaps are very wide in BCC. The initial approach to HIV/AIDS was not good. It was preached like religion, that if you have it, you are going to die. Communication is very important but if you put fear in people they will not come out even for HIV testing".*

Stigma is also a barrier and this is demonstrated in the case of a young laundry boy who was almost beaten because of mixing laundry with that of a person suspected to be HIV+. The people thought that HIV could be transmitted simply by mixing garments for laundry. This shows a high level of ignorance and stigma.

BCC should not be seen as for refugees alone but for staff as well so that they can participate in HIV prevention and destigmatisation.

Another respondent who started health services in Kakuma in 1992 is carrying out HIV sentinel surveillance and although this is at its infancy, sero-prevalence is so far 2%. The IRC does not produce any information, education, communication (IEC) materials but depends on the Ministry of Health (MoH) to share what they have - either targeted or not – which is scarce.

The voluntary counselling and testing (VCT) community centres have been established. The MoH protocol is being properly operationalised. The centre sees 2-8 clients per day. Although the proportion of men to women is greater in the former, the number of women coming for VCT is few. Measures must be taken to reach out to women. They should also be protected from battering, abandonment and other types of human rights violations.

The criteria for food supplements for those found HIV+ is rather strict as one respondent said *"we wait until the person is malnourished before starting him/her on food supplements"*. The second thing is that the VCT centre needs to facilitate the creation of a HIV/AIDS support group and thirdly those HIV+ need consideration for income generating activities (IGA). However, it is recognised that the VCT centre only started in April 2002 and what it has so far achieved is commendable.

Preparation for prevention of mother to child transmission (PMCT) interventions has started and already over 400 pregnant women have been counselled and screened. Of these, four were found to be HIV+.

VCT sites at Kakuma have made a good start. However, individuals should be provided with information regarding income generating activities and connected to a food supplement system. Also, plans should be considered to provide anti-retrovirals (ARVs) whose price has been reduced tremendously, i.e. Ksh. 3,000-3,500 per month.

Plans to establish home based care (HBC) is underway and this is progressive for the reasons normally advanced i.e. strengthens BCC care and support.

GTZ started its energy conservation operation and has 57 extension officers who could be trained to provide focused HIV/AIDS education as they carry out their main work. However, it was reported that they lack targeted educational materials. The respondent said that *"what is available is inconsistent and inadequate"*.

Barriers regarding HIV/AIDS and Sudanese and Somali communities are many and varied, stemming from religion to culture. In particular, the use of condoms is *"forbidden by religion"*.

It was suggested that the best way to roll out HIV/AIDS activities is to have a focal point *"every organisation should be mandated to integrate HIV/AIDS activities into their programs with a focal point"*.

The mandate of NCCK is to promote reproductive health (RH) services focusing on women of reproductive age, men and youth. A general curriculum is used. This does not target any group but is said to be adjusted at the point of teaching. Community motivators are given one and a half day course on HIV/AIDS during their two-week training. According to this respondent *"UNHCR has tried to streamline programs but there is a lot of overlap. Therefore, there should be co-ordination and cohesive support"*.

The NCCK shows videos on RH and HIV/AIDS. Some of these are:

1. *Silent epidemic.*
2. *Bush fire* – demonstrating how peer pressure can mould or destroy the youth.
3. *Life at stake* – shows a story of a man living reckless life, with risky behaviour that resulted in HIV infection.
4. *Like any other lover* – shows a couple who are infected, but are not blaming each other, and are living positively with HIV/AIDS.

5. *Sio rahisi* – a Kiswahili show featuring a young girl caring for her HIV infected boyfriend, and teaches the community that caring for a HIV infected persons does not mean that you can get infected. Also teaches the community that HIV infected persons need love and care just like any other person.
6. *Watoto wa karate* – a Kiswahili cartoon for children, teaching how HIV is transmitted, and preventive measures that one should take.
7. *Yellow card* – also features an African football team, some of the players have risky sexual behaviour and get infected. Also, showing how peer influence can mould or destroy youth.
8. *Rita* – shows the influence of peer pressure and how one can resist the negative aspects of peer influence.
9. *Living positively with AIDS* – a Ugandan play featuring counselling positive cases and encouraging them to live positively.

Another point that emerged from NCCK is that people do not want to talk about sex workers. They say that there are no sex workers in Kakuma yet 30 have been identified and there are more. Some of those already identified are willing to change and have been referred to DB for IGA. The pattern of their organisation is different, that is, the Sudanese are spread throughout the camp but the Somali sex workers are in one cluster. This is because their community regards them as outcasts. NCCK who does a lot more work in HIV/AIDS education than other partners concedes that Ugandans, Ethiopians and Zaireans are much more accommodative compared to Somalis and Sudanese.

The mandate of WV is shelter, relief and development services. More specifically, they support education by constructing schools, labs, food stores and toilets. The respondent said of AIDS *"we do not have a HIV/AIDS program or mandate, but our judgement is that it could be a problem in the camps".* To strengthen this point further, it was stated that *"wives lost their husbands during the war and therefore they engaged in sexual relationships here".* The refugee cultural practices are facilitative to HIV transmission. These include polygamy and frequent divorce.

In order to address the HIV/AIDS situation, people's attitudes and values must be addressed. In particular, any positive ones encouraged and those facilitative to HIV/AIDS discarded through targeted education.

The respondent confirmed that the organisation intends to be more involved in HIV/AIDS activities through "Hope Initiative" which is going to come on board next year (2003). However, *"we would like to avoid duplication".* This is one of the reasons that strengthens the notion that UNHCR can take the co-ordinating role.

LWF concerns itself with schools and educational services. There are 6,000 pupils in pre-primary, 21,000 in primary and 3,300 in secondary schools. There is also a special school with 600 pupils (girls) who would have dropped out for various reasons. The teachers are both Kenyan and from the refugee community. The enrolment of boys versus girls is 2:1 in primary schools and this reduces in secondary school. This means there will be fewer females receiving HIV/AIDS education while at school than boys, which is a disempowerment and a gender issue.

Although 40 teachers were sensitised in HIV/AIDS this year, they neither have the MoE HIV/AIDS curricula nor the skills to implement the same. The co-ordinator was connected with the MoE AIDS Control Unit (ACU) and the Kenya Institute of Mass Education where the curriculum can be ordered. The respondent said that *"there are many partners here but the teachers have not been trained".* He further stressed that parents should also receive HIV/AIDS education so that they can support their children at home.

Gender

Emerging issues throughout key informants was gender violence including rape. Although rape is not as frequent as it used to be, it is still reported at the rate of about one every month. This can be a source of HIV infection, other STIs and unwanted pregnancy besides pure mental and physical trauma.

There was consensus that culture is a crosscutting barrier issue. For example, when Baraza (general meetings) are called to discuss HIV/AIDS, women - and in particular girl child - participation is low. The Muslim faith limits women's participation too. It was stressed that Muslims do not want to talk about AIDS. Also, *"when men and women are in the same Baraza to talk about sexual issues, it is unacceptable"*. Notwithstanding, *"we also lack targeted material including posters"*. The respondent finished by suggesting that *"a mandated focal point for HIV/AIDS be identified for greater commitment to the issue at hand"*.

Gender and education was seen as a barrier because girls enrol in school and then drop out to get married at 14-16 years of age. It was said that the Sudanese girls are not allowed to socialise. They are "restricted" given that they are not allowed to eat before their brothers. The boys can move freely and are therefore much more likely to be exposed to HIV/AIDS IEC.

The respondents stressed forced inheritance for both men and women, but more in women. This means the spouse of the deceased is forcibly “married” off to either a relative or a person chosen by the clan. Notwithstanding, the man will still marry another wife - *"his"*. There is a ghost or shadow marriage too where the dead man's brother marries for him and gets children who belong to the dead brother. The woman does not even know about this until the "husband" decides to marry this time for himself. The Sudanese women too do not seem to question why their husbands are going out of their marriage because they are “disempowered”. Lastly, in this area, polygamy is allowed in Sudanese culture. However, dowry or bride price is valued and is hefty i.e. something as high as one million shillings equivalent to 100 cows. Quite instructively, even after paying any amount of money, the man is still required to provide cows". So the wealthier the man the more wives he can marry. Should a father of a girl who has no money wish to marry or get a wife for his son, he simply marries off his less that 15 year old daughter to get dowry to use for either purposes.

Condoms

Some of the refugees have never seen a condom let alone use one. There are incidents where *"condoms are stolen and destroyed"* the reason being *"the health staff are spoiling our girls by promoting condoms. They are alerting our girls to sex"*. The dispensers are also sometimes destroyed by the community. At any rate these incidents are few.

Activities for condom promotion were said to be *"disorganised"*. For example *"several departments are dealing with this issue and there is no co-ordination"*. The female condom is unavailable causing a gender equity problem. However, the introduction and education of female condoms should be done stagewise and systematically, given that the male condom is not the norm yet.

The RH motivators are predominantly male and this is another barrier. Culturally sensitive messages need be participatory developed and introduced slowly and systematically for this multi-ethnic community. The respondent then concluded this point by saying *"we are not trained in BCC but we hope to be trained"*. This needs funding and technical support.

There are also myths surrounding condoms with the Sudanese community saying that *"condoms are plastic and therefore not good and cannot be used by humans"*. The Catholics forbid

condom use saying it is goes against procreation. At this sitting, the Muslims insisted that HIV/AIDS should not be talked about within the context of condoms because they prevent conception.

The RH program reports increasing acceptance of condoms although the motivators do not take them into the community during their promotional visits. So as concerns religious inhibitions about condom use, cultural beliefs and values will have to be addressed with all the sensitivity they deserve.

Another point that emerged consistently is that the MoH educational materials are not culturally/religiously based and this anomaly needs to be corrected. They are also few and the only place that has sufficient numbers is the VCT centre at Kakuma I. These do not address the Somali community who dress differently.

Stigma

Again, here this is a crosscutting issue. HIV/AIDS patients are pointed at, discriminated and isolated by the community. However, the acceptance level of Sudanese people is better compared to the Somalis and Congolese, some insisting that they cannot get AIDS because their religion protects them.

To demonstrate the high level of stigma particularly among Somalis, one Somali woman who contracted HIV in 2001 had to be relocated to Nairobi. People made her life unbearable.

When it comes to the Sudanese, they blame it on the Kenyans and Sudanese who speak Kiswahili and interact with them.

The hospital which is situated in Kakuma I provides the curative services including STIs. The flowchart for the treatment of STIs is placed at the right place for clinicians to consult, but the 'C' for condoms of the "ABCs" is still not emphasised. Besides, there was no penile model for condom demonstration - one of the barriers to condom use is lack of skill in putting it on and disposing of correctly. There was a condom dispenser placed at the outpatient clinic and was full with condoms. Consideration should be given to additional dispensers in more strategic and less obvious areas.

Surveillance of HIV in TB patients started in July 2002, and 53 clients have been tested showing a 28.3% sero-prevalence. They receive counselling and food supplements.

The hospital had only one poster about HIV in one of the wards and there were no other BCC materials. TB patients were found HIV+ at comparable levels to other areas in Kenya and Africa.

Data management on STI/HIV/AIDS, ante-natal clinic (ANC)/family planning (FP) and TB screening is being organised. What has been collated is shown in Table 3. The raw data on other STIs is shown in Annex III. The gender/age segregated data is not yet available. Suffice to say that HIV is an explosive situation and needs comparable response.

A visit to one health clinic showed an average of 5 patients sought treatment for a variety of STIs daily, mostly urethral and vaginal discharges. The community does not seem to stigmatise STIs. For example, they say loudly that they have syphilis. This phenomena was found in Dadaab refugee camps in Kenya as well.

Table 3
Estimated HIV Prevalence in Kakuma Refugee Camp among Various Groups
(February - October 2002)

	Percentage and *n*
Blood donor	3.9% (101)
ANC (HIV)	5% (400)
Genital Ulcer Disease (GUD)	7% (649)
VCT clients	2% (206)
TB patients (HIV)	28.3% (335)

Source: IRC, October 2002

The Provincial Administration Officer in charge of Kakuma is keen to operationalise the Presidential Declaration that HIV/AIDS is a national disaster. He is therefore ready to participate in any activities that advance BCC. He further stated that in view of the many people who come and go seeking all manner of services and residents at the compound, a condom dispenser (which he does not have) will go a long way to advance the course of the fight against HIV/AIDS.

Both the District Officer and his chiefs include HIV/AIDS into their barazas, but the information is not standard and educational materials are lacking. However, some of the chiefs have had HIV/AIDS sensitisation workshops. With additional support particularly in training and the provision of educational materials, the local community who interact with the refugees can be reached with the relevant BCC.

It was further revealed that there is a lot of denial and blaming of others by Kenyans who say *"we do not have AIDS - it is for those refugees"*. However, two main risk factors were highlighted pertaining to Turkana community - alcohol (changaa) which they say was brought by the Sudanese, and *busaa* which is another local brew. It was confirmed that khat is chewed by Somalis abundantly.

A visit and an interview with DB revealed a lot of commitment to youth development. However, it was noted that there are more males than females, and a small number of local communities who take a variety of vocational trainings including carpentry, dress-making and masonry.

There are 27 teachers and a population of 560 students who *"do not know much about AIDS, but students and teachers have been shown a video from Ukweli"* (a Catholic communication organisation). He went on to say *"we are not a HIV organisation in Kakuma, it is NCCK which has this mandate"*. Further probing revealed he would be willing to release some teachers and students for training. Since students live in their respective communities, it can be a real powerful ripple effect. The students can also be encouraged to form HIV/AIDS clubs. HIV/AIDS educational materials were said to be lacking and can go a long way to support this group.

He lamented of the marriage pattern *"we cannot tell people to their face to have only one wife… they usually say 'my father had 15 wives and what about me?' So cultually sensitive messages should be used and people slowly educated"*.

He further proposed that communities be educated, i.e. Somalis, Sudanese, Burundians, Rwandese and the locals, and concluded by saying that *"schools too need HIV/AIDS messages"*.

A visit to the Kakuma Mission Hospital which is a referral site for surgical cases for refugee patients revealed a low level of HIV/AIDS BCC. It was confirmed that the hospital does not have any educational materials although diagnostic HIV prevalence is 19.4%. The patients who

can afford are put on ARVs, but the hospital was unaware that the cost has come down from 11,000 shillings per month per person to about 3,000 shillings.

Genital ulcer diseases (GUD) particularly syphilis were reported to be many, but the records were poorly kept and could not give true figures e.g. 99 people had VDRL tests between January and November 2002, but no negative or positive results were shown.

The flowchart (protocol) for the management of STIs is not adhered to. Also, this is a Catholic hospital and therefore does not promote or indeed provide condoms. Clients are asked *"to abstain from sex"* during the counselling sessions. All TB patients, local and otherwise are referred to Kakuma I Hospital for management. The outpatient and MCH have a high turn over of clients/patients who when waiting could be provided with AIDS education, but as was stated before, educational materials are not available.

The JRS has the mandate of providing counselling services to traumatised refugees. They also support 33 single mothers in the camp most of whom are Sudanese and Somali. Victims of rape and other gender based violence, are put in "safe haven" environments for their protection and to aid psychological healing. The organisation has one professional counsellor and 40 assistants who reach out to 500 people per month. Although they want to start a HBC for HIV/AIDS, they shelved the idea when IRC started a HIV counselling program. They have provided *"HIV/AIDS awareness"* to their refugee staff who number 160. It should be noted that the level of HIV/AIDS education provided does not empower staff enough to educate their community.

The Sister in charge of Jesuit social services stated *"I personally have a problem with condom promotion because of the way they are disposed. It increases anxiety especially when you know children will sometimes pick them and blow them like balloons"*. She further expressed another concern saying *"although a lot is being done in collating AIDS awareness, the youth are not listening"*.

It was further revealed that they have an IGA service which is open to all. This respondent's view is that VCT should not be done unless it is also an opportunity to provide ARVs. She was quite categorical too regarding resettlement and said *"people should not be denied resettlement on the basis of HIV status. It should not be an exclusion criteria"*.

<u>Focus Group Discussions (FGD)</u>

Six FGDs were carried out comprised of men, women, youth, young girls, boys and CSWs. The majority of refugees in leadership positions know how HIV is transmitted but preventive knowledge and skills is low. It was the consensus of the various groups that HIV/AIDS knowledge and skills has not reached the general refugee population.

A FGD of youth leaders aged between 19 and 28 years was carried out (9 Sudanese, one Burundian and one Ugandan). They were all Christians and had formal education ranging from form one to form four. They put it squarely when they said that it is very hard to talk about condoms in this community, people say *"condoms encourage sex"*. Therefore, youth pick the condoms secretly from the dispensers which are placed at all youth resource centres. It was also noted that the youth leaders do not distribute condoms in the community.

It was further stated that difficulty lies with the Sudanese culture which say that *"it is embarrassing to use artificial things in sex and those using are prostitutes"*. The youth quipped *"if you use condoms, you are assuming that your partner is sick"*.

The other barrier too is the belief that condoms are a form of family planning and *"since so many people have died in the Sudan war they must be replaced"*. Condom barriers were

collaborated by another Bantu group who said *"condoms reduce pleasure and increase pressure"*. The elder's group was forceful on this and consistently insisted that there can be no pleasure with rubber on and procreation would be reduced. One elder stated and the others agreed *"although I have never seen or used condom, I imagine it is not sweet…it is not enjoyable"*.

Another FGD was conducted with three Somali and one Sudanese woman aged between 27 and 38 years. Two of the participants had adult education, two had no formal education. Except one woman who had no children, the rest had between 3 and 10 children each, and reported having been married only once. One of the women was widowed, two were married, and another was single. The Somali women stated that, and it was a consensus that condoms were for "prostitutes" and cannot be used in marriage. But if you suspect that your husband is having sex outside marriage *"you can use condoms and if he refuses, you just pray to Allah to protect you from the disease"*. This is a high level of helplessness and due to male-female power relations. Also, condoms are not allowed by religion although it is *"not written in the Quran"*. It is God's will to increase the population, why use condoms?

Both Sudanese and Somali cultures do not allow premarital sex. But there is early marriage and the reason is so that the girl can still marry a virgin. However, it was reported that some girls break this norm.

Although Sudanese are Christians and only allowed one wife they revert back to culture saying *"a man with one wife is like a man with one eye"*. The Somalis practice female genital mutilation (FGM) but this was reported to be less. Also, they prefer to send their girls for Madrass education compared to regular education to prevent them from socialisation.

An interesting point emerged from a mixed group of 10 Bantu Somali (the majority) and one Sudanese aged between 20 and 62 years old. All of them were in community leadership positions, and only four had formal education ranging from Standard 7 to Form 4. Except the Sudanese, all the rest were Muslims. They were pushing the idea of early marriage for females saying that *"since they have sexual desires, they should marry at the age of 16-17 years to avoid going from one man to the next. Also if she does not get sexual fulfillment, her egg will go back to her body and give her diseases"*. They recognised that these days both boys and girls have to get education and so *"they should marry young and continue with their education. Their parents should be responsible for supporting them and this is a sure way of stopping AIDS"*.

It was a consensus that STIs (not AIDS) are treatable but some people still practice traditional way of treating HIV/AIDS. Two of these were mentioned, namely *"eating camel meat, milk and resting for 3 months. One gets cured of AIDS*". The respondents gave an example of a man who was refused settlement to USA, had the above treatment, tested HIV negative and went to USA. It can only be deduced that this was a case of false positive in the first place.

STIs are traditionally treated in two ways by Somali Bantu. One is with a root from the "Fongorosinga" tree. This is boiled and drunk in the morning and it is bitter. For gonorrhoea, the patient is asked to *"buy a fat chicken and eat it"*. This will give him/her energy.

The Sudanese community brews and takes alcohol while the Somalis chew miraa. According to women respondents, both drugs create a problem for them. The men come home late, pick a quarrel, may batter them and even force them into sex.

Of alcohol, the respondents said that drunkards cannot make good decisions - *"one can beat and rape"*. For the miraa chewers, they also beat their wives and feel that *"they cannot get sexual satisfaction from their wives and therefore they go with prostitutes and they can bring infection to an innocent wife"*. No other types of drugs were identified.

A FGD with 8 young men aged between 19-24 all Sudanese and Catholic was held. The least education was standard 7 with the rest being high school and excluding two teachers. The mode of transmission was mentioned to be sexual, blood transfusion and mother to child. On prevention, abstinence was said to be good but not easy. However, *"students should concentrate on their studies and keep sex from their mind"*. The consensus was that *"not all young men can abstain so condom education should be provided"*. It was noticed that one young man has never heard or seen a condom and he quipped *"why not remain single and die alone in old age?"*

The respondents demonstrated why people do not want to use condoms, saying, *"one is labelled as promiscuous and word goes round and religion says that condoms are not 100% effective so why use them?* Also, *"young girls and men who use condoms are not trustworthy"*.

Just like the FGD with male leaders, the youth said *"sex with a condom is not sweet, it is like eating sweet with a wrapper on"*. The youth have also heard people saying that *"condoms will remain in the body of the woman and she can be in danger especially if there is no doctor"*. Notwithstanding, one lone young man stated without fear *"use of condoms is a way of caring for one another"*.

As for stigma, HIV/AIDS persons are discriminated against. For example, they are thrown out of shelter by those they live with. Sometimes they practice self isolation and even move away where people do not know their status. It was consensus that the community is ignorant and they are scared of getting AIDS. They agreed they would *"preach hope for tomorrow as Christians"*. The respondents had seen people with AIDS in their community, except two.

Another FGD in a different location of the camp took place. There were six girls aged between 15 and 20 years old, one Somali Muslim and the rest Sudanese and Christians. Half of them were in primary school and the rest in high school. STIs are not well understood and HIV even less so by half of the respondents. Those who know mentioned the three ABC (abstinence, be faithful, condom). All had seen a case of AIDS except one (the Somali) back from Sudan and Uganda where they passed through.

There was consensus that girls should be advised *"not to have sex as one might get disease and die young; people say sex is bad"*. They are not really taught anything positive about sex *"we are just told to obey our parents"* (both Somali and Sudanese).

No negotiation skills for safe or safer sex practices are taught and the girls are not checked to establish whether they are still virgins according to them. It was a consensus that when a girl says "no", she means "yes" according to the boys and this is confusing. The respondents were aware of who are having unprotected pre-marital sex and who their sexual partners are *"young and old men"*. The respondents reported to have seen a condom, but none except one knew how they are used. They agreed that condoms should be available at the clinics.

Stigma regarding HIV/AIDS was demonstrated by a few when they said that they would not eat together with an HIV/AIDS person. They went further to say that if a person has TB and drank water from a cup in their house, they would throw it away.

Alcohol including *busaa* and *changaa* are abundant in the community and this has a negative influence on behaviour among the Sudanese community. The group further elaborated that miraa is rampant in the Somali community and this too was said to interfere with behaviour. *"Those seeking marriage should seek HIV tests so that they can make a decision on the basis of the report. Women should insist on this because men will just walk away having brought a disease"*. All people need HIV/AIDS education which encourages them to abstain, use

condoms or go for STI treatment as the case maybe. The young women wanted to know what a female condom looked like and whether it could be left inside a woman. This was clarified by use of an illustration.

Another FGD was carried out with 16 CSWs (12 Sudanese and 4 Somalis). Except for three, the group was illiterate and the push factor towards sex work was poverty. They have on average 1-7 children and their age ranged from 23-30 years. They started sex work when they were 15 years old except for one who started at 20 years.

They stated they are sometimes raped by clients and occasionally deprived of payment. Although the Sudanese are stigmatised, the Somalis are even more so and they are labelled outcasts. For this reason, community leaders refuse them goods that have been donated by agents. They do not feel they are as well protected, for example, when raped. For some of them even shelter is a problem - when they establish one, they are chased away *"because we are prostitutes and we will teach their daughters the trade".* People even chase them from water points.

The respondents went further to say *"when people see us going to NCCK workshops, they say malaya (prostitutes) are going there to collect condoms".* They also have lovers and one of the respondents said *"I got this baby for love. I am a Somali but my boyfriend is Eritrean. In this case the question of condom use is out".*

The charges were said to be 10-50 shillings and *"sometimes you may meet a rich man who gives you 1,000 shillings".* The clients for the Somali are from the local community, refugees from different ethnic groups. The Sudanese said their clients were Sudanese only.

The CSWs have been in the sex industry for 4-7 years and with a sense of hopelessness, one said *"I don't care to count, I have never had a husband in my life. I was raped for two years and now I really just do not care".*

Although these CSWs try to use condoms, it is not consistent and the environment not conducive. They are experiencing discrimination and human rights violations from other refugees including the community leaders who are expected to respect the rights of those they serve - including CSWs.

They further lamented that the agencies do not believe that there are sex workers in the camps and this was re-affirmed by community leaders saying that *“these women must have husbands since they have children".* At any rate *"why are you giving them shelter? They are prostitutes…we do not even know the father of their children, they do not belong to this community".*

HIV/AIDS is stigmatised by these communities who have never had an opportunity to hear self testimony from a HIV infected person (of their own). A few of the respondents have seen somebody with AIDS. Accordingly, HIV/AIDS *"brings shame to the family"* and since it is seen as a disease of the prostitutes, people point at the family saying *"that is a family of prostitutes".* Due to ignorance people also say that they cannot eat with a person with AIDS in case they get HIV. The respondents further stated that the community points their finger at anybody loosing weight saying *"he/she has AIDS."* Also when two people pick a fight in the community, they insult each other by saying *"you have AIDS".* TB is also stigmatised in this community. If a TB person takes water in somebody's house, the cup is thrown away.

Another important result in this study is that two separate FGD uniformly suggested that all agencies should collaborate with each other in matters pertaining to HIV/AIDS. One group

went further and suggested that *"since there are many agencies working on our problems, UNHCR should get a special agent to work on HIV/AIDS"*.

The majority of the FGDs confirmed that some people knew the modes of HIV transmission: sexual contact, blood, contaminated instruments and MTCT. But even among these leaders, some have little knowledge. The main barriers are culture and religion. Prevention runs into grave problems as concerns condom use. Although men state that they cannot refrain from sex, some of them categorically state condom use is against their culture and religion. The women on the other hand, while some would like to use them when they know their husbands are having extra-marital sex *"will leave it to Allah to protect them from disease"* since they do not have the power to force their husbands to use condoms or even negotiate.

Prevention messages i.e. ABC are known by some. They go on to say that 'A' is difficult, 'B' perhaps possible and 'C' not allowed by culture and religion although *"some people use secretly particularly the youth and prostitutes"*.

Participatory Observation

It was reported that there are *"many bars"* in Kakuma refugee camps but nobody knows the number. There are 7 in Kakuma town and 2 or so lodgings. An evening visit to one of these (Kakuma town) called the White House demonstrated characteristics of most bars in Kenya. For example, there were more men than women. These men were both locals and refugees, and according to the bar attendant *"it usually is a mixture of ethnic groups"*. There were two female waitresses and a man with loud music playing. People mixed freely. It can also be hypothesised that some of these interactions may end up in unprotected commercial sex. A condom dispenser was placed in a corner but was empty.

A golden opportunity exists to provide condoms consistently – someone needs to be responsible i.e. the public health technologist/technician. As for the other bars at Kakuma camps there were no condom distributors yet these would have the potential to reduce HIV transmission and subsequently the impact of AIDS.

World AIDS Day

World AIDS Day was celebrated at Kakuma with important messages on prevention i.e. stop indiscriminate sex, use condoms and reduce stigma. These were in the languages of people represented namely Sudanese, Somali, Arabic, Turkana, English and Kiswahili. The actors were all refugees and the audience was 50-50 children and adults.

Since the information retention level of humans is not always comparable to what they hear and translation into activities even less, the same messages in different ways should be reinforced and targeted throughout the year.

Debriefing

The debriefing provided concrete suggestions that there has been other HIV/AIDS studies in Kakuma before this one. The time to operationalise the recommendations is now. Specific funding should be set aside for HIV prevention, control, care and support that includes availability of ARVs. This will *"definitely be a strong motivation for seeking VCT services"*. The Head of Mission went further to say *"let us move away from the notion of prevention only and introduce ARVs"*.

SUMMARY OF GAPS

1. The refugees both Christians (mostly Sudanese) and Muslims (mostly Somalis) are from different ethnic groups. However, they have cultural and religious barriers to condom promotion, care and support of those infected with HIV/AIDS.
2. NCCK and IRC provide some HIV/AIDS education but other partners say *"they do not have a mandate to do so"*. The material used could be targeted better.
3. Syndromic or even indeed laboratory based management of STIs places more emphasis on medication and not so the 4Cs – counselling, compliance, condom use and contact treatment. This was observed at both refugee health services and the Kakuma Mission Hospital.
4. Condom dispensers are few and boxes of trust condoms remain empty for days. Partners who provide condoms stated they do not have enough financial support.
5. There are no peer systems for HIV/AIDS education and counselling, just peer leaders whose groups and zones are not demarcated.
6. Condoms are stigmatised and are seen as anti-culture and anti-religion. They are not even available at Kakuma camp bars which are said to be many in number.
7. Denial of existence of HIV/AIDS among the refugees is high. It transpired that those affected can be isolated and abandoned. The Somalis were strong on this point while others were mid-point.
8. It seems that demand for IGA is higher than the funds available.
9. NCCK and IRC include HIV/AIDS components in their respective RH programs. Here again demand is higher than resource. All the educational materials are not targeted either culturally, religiously, age or gender wise. The majority of HIV/AIDS posters are at the VCT centre. They are not visible in other areas. Although NCCK said they have translated its RH brochure which has a section on STI/HIV/AIDS into the Somali language, this was not produced, but was seen in Dadaab. There are no Sudanese materials available.
10. The MoE's HIV/AIDS curricula is not being used and the partner dealing with education did not seem to be aware that these exist for both primary and secondary schools.
11. VCT services are going well. However, efforts should be made to link up the HIV+ people with IGA.
12. A post-test club has been formed but female participation is low. Subsequently those who are HIV+ and have special needs may wish to form their own club and they should be supported to do so.
13. HIV/AIDS HBC is not being carried out
14. It was not clear whether those positive are given prophylaxis for TB and pneumonia as appropriate.
15. Any person from a HIV+ support group who wishes to disclose their status needs protection due to high stigmatisation.
16. Given the 28.3% HIV sero prevalence in those patients with TB, 2% in VCT clients, 5% in ante-natal women and 4% in blood donors, the programming to reduce the transmission and impact should be deliberate. To expand this point further, the UNHCR staff have not integrated HIV/AIDS in their specific areas e.g. women and children, gender, security, human rights and others.
17. Health care workers lack the capacity to respond appropriately to prevention, control, care and support of STI/HIV/AIDS.

18. CSWs are highly stigmatised by their own community as well as their leaders. They require special attention so that they can take individual responsibility not to get infected and not spread it through revenge if positive.
19. HIV sero-positivity was said to determine resettlement yet people are known to live for 20 years or so in America and other developed countries because of quality care which includes safer sex practices.
20. Bars in Kakuma camp are not being used as points for condom education and distribution. Some of the 7 bars in Kakuma town have condom dispensers, but condoms are not always available.

DISCUSSION

Again here in Kakuma, just as it was in Dadaab, the centre of analysis are the recipients of the services and religious and cultural patterns that influence their attitude and behaviour in relation to STI/HIV/AIDS. Condom use is seen as anti-religion and anti-culture. The Sudanese went further to explain that *"condoms are a family planning method. How can we use it when we want to replace thousands lost in war in our country?"* The Somali Muslim said that *"sex is sweet and pleasurable without condoms; it is for procreation"*.

In order to make condoms more accessible, distribution should not be limited to health facilities. There should be wide distribution at strategic areas with some level of confidentiality. Limited distribution to only health facilities was also observed in an reproductive health study by UNHCR in June 2001.[4]

Although respondents admitted that abstinence before marriage is HIV protective and it is promoted by culture and religion, it is difficult as boys and girls are having sex before marriage (boys more so).

Although Somalis and Sudanese allow polygamy, men and a few women were said to seek sexual pleasure outside marriage and was also stated that women have no power to negotiate condom use.

Exchange of sex for money exists among Somalis, Sudanese and an Ethiopian. The sex workers are highly stigmatised and their human rights abused by community leaders and the community in general. They are actually seen as outcasts by Somalis.

Besides polygamy, divorce and remarriage is easy in the Muslim community. Age of marriage is low for Somali and Sudanese girls ranging from 14-17 years. In one FGD, they in unison said *"people should marry at an early age to avoid pre-marital sex and diseases like AIDS, and then they can both go on with their education. The parents should take the responsibility to educate them*".

It seems Kakuma refugees' HIV/AIDS knowledge, attitude and skills is low and compares well with how Kiambu was ten years ago. The response to narrow this gap is insufficient. This is in spite of the fact that HIV surveillance data emerging from TB section is high i.e. 28.3% (53) being majority refugees and minority Kenyans. The VCT data also shows a prevalence of 2%.

Targeted materials are lacking at all levels and health personnel who have the mandate to deal with HIV/AIDS have inadequate capacity to cope. The other UNHCR partners stated in unison that HIV/AIDS is not their mandate but would be interested in participating should a standard

[4] Judith o'Heir, UNHCR Reproductive Health Study, June 2001.

HIV/AIDS targeted package be developed. For example, DB has 27 teachers and 550 young men and women from both local and refugee communities. If trained in HIV/AIDS education they could form a critical mass of people with know how and have a sizeable ripple effect. And so would the other partners.

Available Government policies should be available to UNHCR and shared with partners. There exists HIV/AIDS strategic plans from both the MoH and the Office of the President. The Kakuma Mission Hospital, Provincial Administration, the police and others will gain from the HIV/AIDS government directives that are aimed to reducing HIV transmission and AIDS impact.[5]

Also available is a condom policy that provides guidelines on availability, promotion, provision, use and disposal.[6] VCT is another useful policy document that facilitates the process of finding out people's sero-status.[7] HBC guidelines exist to help health care providers decentralise care from hospitals to home and community.[8] The GoK has also produced guidelines regarding use of ARVs as well as PMTCT.[9] The Kenya National Guidelines regarding blood safety is another useful document.[10]

All these guidelines are suggested as a reference point so as not to "re-invent the wheel", thus wasting valuable time and resources.

Blaming AIDS as somebody else's problem was identified. Kenyans in Kakuma said *"AIDS was brought by refugees"* and the Sudanese said *"AIDS is for Kenyans and those refugees who speak Kiswahili and interact with Kenyans"*. It was found that interaction between refugees and locals is real and both communities have low levels of HIV knowledge skills and acceptance and require similar interventions.

The standard protocol for treatment of STIs is not properly followed - in particular counselling, compliance, condom use, contact treatment - thus reducing the capacity to cut the chain of STI transmission. This is both at the camp's health facilities and the Kakuma Mission Hospital.

Sexual networks as demonstrated by polygamy, divorce, remarriage, age of marriage, forced marriage, pre- and extra-marital sex and the sex industry are all facilitative to HIV transmission as is female disempowerment when it comes to the above issues.

Good community structures and others have been established and could be strengthened and empowered to participate in STI/HIV/AIDS prevention, control, care and support.

[5] Office of the President. The Kenya National HIV/AIDS Strategic Plan. Popular Version 2000 – 2002 October.
[6] Republic of Kenya. Ministry of Health: National Condom Policy and Strategy 2001.
[7] Republic of Kenya. Ministry of Health: National AIDS and STI Control Program. Guidelines for Voluntary Counselling and Testing 2001.
[8] Republic of Kenya. Ministry of Health: National Home Based Care Program and Service Guidelines. May 2002.
[9] Republic of Kenya. Ministry of Health: National AIDS Control Program. Use of Antiretrovirals and Prevention of Mother to Child Transmission 2001.
[10] Ministry of Health: Policy Guidelines on Blood Transfusion in Kenya. The National Blood Transfusion Service. November 2001.

RECOMMENDATIONS

Preamble

UNHCR should act as focal point for HIV/AIDS interventions thus taking the lead and playing a catalytic as well as co-ordinating role. This initiative needs a clear HIV/AIDS policy including guidelines. Of the very necessity to adequately serve the less disadvantaged sub-population it will be important to engender the HIV/AIDS activities that embrace age, sex and budget. There are 20 gaps identified and 16 recommendations made to bridge these gaps. The recommendations should be translated into activities systematically and stagewise and not too fast or overloading

Kakuma, compared to Dadaab, is well ahead with VCT services although there are disproportionally more men seeking VCT than women. TB patients and HIV surveillance using pregnant mothers and those seeking family planning services are in progress. All these services need to be monitored and all efforts made to provide support counselling to those found HIV+.

1. Multi-channel communication including print, electronic, traditional (drama, songs, dance, folklore) should be used. The development of materials should be participatory and should be well tested to ensure appropriateness and acceptance by the target population.

2. Participatory development of advocacy packages for abstinence, faithfulness and condom use should be developed. Of the three, condom use is the main one that needs acceptance and needs systematic continuous and targeted advocacy. So do VCT and PMTCT.

3. Both the general population and the refugees need exposure to "personal experience" testimony from a Somali Muslim with HIV/AIDS to remove the notion that HIV/AIDS is not for this community, but for Christians and Sudanese. Subsequently the Sudanese too need to forget the notion that HIV/AIDS is for Kenyans. It is preferred that both genders be represented (in giving testimony).

4. Create a conducive environment that ensures protection of the HIV+ i.e. not blaming or victimisation from any quarter should be consultatively created.

5. UNHCR has adopted a multi-sectoral approach to HIV/AIDS programs. Therefore, the operationalisation of the UNHCR Strategic Plan must be followed critically in the field.[11]

6. It is suggested that UNHCR adopts a multi-sectoral approach in its response to HIV transmission and AIDS impact. More specifically negotiating a minimum HIV/AIDS education package be included in the partners' activities. These sessions should be short (15-25 minutes) and specific.

7. HIV/AIDS should be an integral part of all the other UNHCR programs. In order to achieve this, development of a minimum HIV/AIDS IEC package is suggested. This should be well tested, simple, culturally and religiously sensitive, age and gender specific, and translated into relevant languages. The images/symbols must be similar to those of the audience/recipient to help them identify themselves with the problem and solution.

8. Community education and counselling through peer systems where each group has been mobilised with its own STI/HIV/AIDS peer educators/counsellors is recommended. These would be trained at the ratio of 1:50 ideally, but could be 1:100. The groups

[11] UNHCR: HIV/AIDS Strategic Plan 2002-2004.

should be age, gender, social and cultural specific. This classification would accommodate the sex workers, girl child and women who are more disadvantaged. Comprehensive peer education systems would facilitate wider coverage, use of appropriate media and ownership. Some educational material should be prepared centrally, but in consultation with consumers e.g. STI/HIV/SIDS videos and posters. A peer education system is the pillar for HIV/AIDS community involvement, education and counselling, each sub-group receiving well communicated HIV/AIDS messages with a skills development component, building on all these stagewise.

9. The ABC are some of the known prevention methods and up to and including 'B' the people have less problem. However, there is strong resistance to condom education and use. All attempts should be made to introduce condom use. This can be introduced in peer education systems that embrace culture and religion. Subsequently, it is recommended that condom dispensers be put in public places (local) as well as at the camps when the environment is conducive. It was noted that the government leaders are ready and willing e.g. Provincial Administration to support having condom dispensers in their compound. It is the right of everybody not to be exposed to HIV infection. For this reason, female condoms are suggested so that females can use them when their partner(s) are likely to expose them to HIV risk. In this community, this is particularly important for the sex workers because of the stigma.

10. Prompt and correct treatment of STIs is known globally for reducing the transmission of HIV. It is recommended that besides appropriate medication compliance be emphasised, counselling be undertaken to persuade the client to complete the course of medication and refrain from sexual activity until cured or to use a condom and facilitate the parallel treatment of the sexual partner. O'Heir's report recommended refresher training in this regard as her findings also indicated that *"the skills and ability of workers involved in the treatment of STIs and poor use of syndromic case management affect the quality of care and may contribute to underreporting of STIs"*.[12] The same report also indicated that treatment of sexual partners is poorly implemented and hardly seems to take place putting those who seek treatment at risk of re-infection.[13]

11. VCT centres should consider providing prophylaxis for the HIV+ to prevent TB and pneumonia. Also link the infected and the affected to IGA and at the time when it will be possible ARVs as appropriate.

12. MoE HIV/AIDS curricula for primary and secondary schools should be implemented to provide youths in school with appropriate knowledge, attitudes and skills to prevent and destigmatise HIV/AIDS. In order for this to succeed teachers should be trained not only on HIV/AIDS, but how to use the training materials. Notwithstanding, the teachers are expected to implement the curricula within the cultural value of a given community. A HIV/AIDS youth club should be introduced in schools.

13. It is recommended that HIV behavioural and biological surveys be carried out every 2 years including the Kakuma Mission Health Facility to find out what behaviour has changed and the HIV prevalence. This will then be compared with Bazeyo's BSS of July 2002.[14]

14. Bars in Kakuma camp need special attention. It is suggested that an inventory of all the bars in Kakuma camp should be taken and at least the bar manager and bar attendants be

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[12] Judith O'Heir. UNHCR Reproductive Health Study, June 2001.

[13] *Idem.*

[14] Bazeyo, W. Behavioural Surveillance Survey in Kakuma Refugee Camp. July 2002.

trained in HIV/AIDS communication skills. Condom dispensers and condoms should be provided, and the managers take charge of making sure these are always available.

15. HBC for those with HIV/AIDS and other chronic illnesses is a necessity that will go a long way to improve the quality and quantity of life.

16. The co-ordination recommendation by one of the partners is a welcome idea. A focal point should not only have a health background, but also STI/HIV/AIDS training. In order for these recommendations to be operationalised, it is necessary to have a focal point at the UNHCR Dadaab and Kakuma offices. Partners should have a focal point too.

KAKUMA WORKPLAN

December 2002-December 2003

PERIOD	ACTIVITY	RESP ORG	INDICATOR(S)	BUDGET	
				Particulars	Total (Ksh)
CAPACITY BUILDING					
1ST QUARTER	Current STI/HIV/AIDS and specific roles and responsibilities (a) Sharing the information with agencies who are also partners (b) Participatory planning (Joint) (1 day)	UNHCR	(a) All partners sensitised (b) A plan developed	Lunch and teas 3 participants per agent (30) + 3 Facilitators (33 x Ksh. 335) Facilitator's fee	**9,950**
	Policy makers HIV/AIDS sensitisation workshop. (1/2 day)	UNHCR	All policy makers sensitised	1 per agent x 10 x Ksh.300	**3,000**
	(a) UNHCR staff HIV/AIDS sensitisation training workshop (2 days) (b) Participatory planning	UNHCR	(a) All UNHCR staff sensitised (b) PoA available and operationalised	Tea (20 person) 10 only leave @ Ksh350 x 2 days)	**7,000**
1ST QUARTER	Mobilising and providing sex workers with BCC	NCCK UNHCR Consultant	Capacity building training takes place for CSWs	Mobilisation Capacity building Peer system established Materials preparation	**60,000**
1ST QUARTER	Development or/and adoption of educational materials - culture and religion, age, gender and sex workers specific	UNHCR NCCK Consultant	The material developed adapted/adopted and distributed strategically	Print electronic media (preparation, production, dissemination)	**500,000**
1ST QUARTER	6.Liaise with MoE	LWF	Curricula in primary and secondary schools in place and being used	3 secondary schools 24 primary schools have MoE curricula	***
1ST QUARTER	(a) Discuss with WFP - planning distribution of their food supplement to HIV infected persons (b) Discuss with Don Bosco to include HIV infected persons in their IGA program	UNHCR WFP Don Bosco	(a) Food supplement supplied to HIV/AIDS persons (b) IGA activities in place for HIV infected and affected	No cost 30 HIV/AIDS infected/affected @ 5-10,000 per person	**300,000**
1ST - 4TH QUARTER	HIV Post-test club	CDC Don Bosco	Post-test club formed and number increasing	5,000 per year	**5,000**
2ND- 4TH QUARTER	HIV/AIDS support group	CDC Don Bosco	Support group of PLWA started and getting IGA	10,000 per year	**10,000**
2ND - 4TH QUARTER	General community mobilisation and HIV/AIDS IEC (BCC)	UNHCR IRC	50% reached with BCC messages	Material preparation Dissemination	**500,000**

PERIOD	ACTIVITY	RESP ORG	INDICATOR(S)	BUDGET	
				Particulars	**Total (Ksh)**
CAPACITY BUILDING (cont)					
	Refugee community STI/HIV/AIDS IEC	NCCK IRC	80% reached with BCC messages	Print electronic media (preparation, production, dissemination)	**500,000**
	Peer education system setting - Youth (male), women, men, young women, sex workers.	NCCK / IRC	Peer education established in all sub-groups	Mobilise Form groups BCC Monitoring	**120,000**
	(a) Training of health care workers on STI syndromal management (6 days)	IRC DASCO	At least 15 health workers per site trained and using the flowchart correctly. As far as possible a man and a woman should be trained.	Lunch & teas: (15 health workers x Ksh.350 x 6 days)	**31,500**
	(b) Training of health care workers on HIV/AIDS (6 days)	IRC NCCK UNHCR DASCO	At least 15 health workers per site trained on HIV/AIDS. As far as possible a man and a woman should be trained.	Lunch & teas: (15 health workers x Ksh.350 x 6 days)	**31,500**
3RD QUARTER	Training of health care workers on STI/HIV/AIDS counselling (6 days)	UNHCR Consultant	At least 2 health workers trained per site one of whom is a woman	Lunch & teas: (10 health workers x Ksh.350 x 6 days)	**21,000**
	VCT advocacy at all levels to continue	CDC Don Bosco	(a) Advocacy package prepared and available (b) Support group of HIV positive people formed (c) IGA support provided and working		**100,000**
4TH QUARTER	Health /social workers trained on PMTCT	CDC	(a) Community, all sub-groups, health workers sensitised (b) Advocacy package developed	Advocacy package developed	**50,000**

PERIOD	ACTIVITY	RESP ORG	INDICATOR(S)	BUDGET	
				Particulars	**Total (Ksh)**
SUPPLIES					
1ST-4TH QUARTER	Provision of condom dispensers (male) and later female condoms as well	UNHCR MoH	20 condom dispensers installed	20 dispensers x Ksh. 1,000 each	**20,000**
	Provision of drugs for STI treatment	IRC MoH	Adequate STI drugs supply in all health facilities available	-	**250,000**
	Provision of drugs for treatment of opportunistic infections	IRC MoH	Adequate supply of TB and other opportunistic infections	-	**500,000**
	Provision of drugs for PMTCT (Neverapin)	CDC	Reported to be in stock	-	**-**
1ST- 4TH QUARTER	Prevention of TB in HIV+ people	IRC	Appropriate drugs given to HIV positive persons and taking them	As part of supply of drugs	**-**
	Prevention of pneumonia in HIV+ people.	IRC	Appropriate drugs supplied to HIV+ persons	As part of supply of drugs	**-**
HUMAN RESOURCE					
1ST -4TH QUARTER	(a) Establishment of UNHCR HIV/AIDS focal point (b) Each agency identifies its own focal point	UNHCR All agencies	Staff identified by UNHCR Each agency identifies its own focal point		-
MONITORING AND EVALUATION					
1ST - 4TH QUARTER	(a) Develop monitoring and evaluation system. (b) Develop and implement operations structure i.e. monthly co-ordination meeting. Ensure reporting system is followed.	UNHCR Agencies	Monitoring and evaluation system in place An operations structure which ensures monthly co-ordination meetings in place	No cost implications	**-**
NB: CDC has already put together monitoring and evaluation strategy that is being used by NCCK and IRC. However, what is recommended here is aimed at capturing the implementation level of HIV/AIDS activities that will be carried out by other partners besides NCCK and IRC when they start as recommended in this report.					
GRAND TOTAL					**3,018,950**

BUDGETARY NOTES:

1. Exchange rate: 1 USD = Ksh. 78.00
2. Some of the activities will run parallel.
3. Before any training is started, pre-training questionnaire should be developed and administered. Post-training questionnaire (the same) should be administered at the end of the training and one year down the line.

ANNEX I
INSTITUTIONS AND PERSONNEL INTERVIEWED FOR KEY INFORMATION

INSTITUTION	PERSON (S) INTERVIEWED	POSITION
UNHCR	Kofi Mable	Head of Sub Office
Kakuma Mission Hospital	Sister Regina	Matron
Kakuma Division	J.K. Menju	District Officer
JRS	Christina	Head, Social Services
NCCK	Florence Sayo	RH Trainer
IRC	Dr. Julius Wekesa Esther Mwanyika Dr. David Muriuki Dr. George Mureithi Joseph	Medical Co-ordinator VCT Counsellor Hospital in-charge RH Focal Point Medical Attendant, Clinic 5
WFP	Escala	Program Officer
GTZ	Joseph Kiai	Community Development Officer
LWF	Joel Onyango Lucy Githaiga	Education Co-ordinator Gender Equity Officer
WV	Joshua Nyamai	Project Manager
WCT	Caroline Mbugua	Program Co-ordinator
Don Bosco	Brother Jose	Project Co-ordinator

FGD

1. Men - Kakuma II
2. Women - Kakuma II
3. Youth - Kakuma I
4. Young girls - Kakuma II
5. Boys - Kakuma I
6. Commercial sex workers - Kakuma I

ANNEX II
STUDY INSTRUMENTS

Organisation Questionnaire – Key Informants

Statement for Consent

"Hello, we are (Names) from UNHCR and we are carrying out a survey on BCC and the gaps therein in the area of HIV/AIDS. We have identified you as one of our respondents and we hope that you feel free to discuss with me. All the information that you will provide will be treated in confidence. Your name or information that may identify you as a respondent will not be given to anyone. You are not under obligation to respond to all the questions, and you may withdraw at any time during the interview should you desire to do so. Can I go on? Thank you very much for your time and information".

1. Name of organisation___________________________

2. When did you start?
    1. 1 year ago __________
    2. 5 years ago __________
    3. 10 years ago __________
    4. >10 years ago __________

3. What services do you provide to the general population?
    1. Agriculture __________
    2. Education __________
    3. Administration __________
    4. Police __________
    5. Others __________

4. List the health services provided by your organisation
    1. Curative __________
    2. MCH/FP __________
    3. STD __________
    4. HIV/AIDS __________
    5. Others (specify) __________

5. Do you provide Behaviour Change Communication education?
    Yes
    No

6. (a) Do you have youth activities?
    Yes
    No

    (b) If yes, enumerate ____

7. (a) Do you have a youth-friendly clinic
   Yes
   No

   (c) If yes, describe ________________________________

8. (a) Do you have gender sensitive services?
   Yes
   No

   (b) If yes, describe________________________________

9. (a) In your view, is there HIV/AIDS problem in your intervention area?
   Yes
   No

   (b) If yes, describe________________________________

10. What are the major reasons that facilitate the spread of HIV/AIDS?
____
____
____
____

11. (a) Let us go back to Question 9 and find out whether in your views there are gaps in prevention of HIV spread and impact this has at individual, family and community levels.
   Yes
   No

   (b) If yes, list them
   ____
   ____
   ____

   (c) Describe how these gaps can be narrowed
   ____
   ____
   ____

12. Do you have any other comments?
____
____
____
____

FOCUS GROUP DISCUSSIONS GUIDE

Statement for Consent

"Hello, we are (Names) from UNHCR and we are carrying out a survey on BCC and the gaps therein in the area of HIV/AIDS. We have identified you as one of our respondents and we hope that you feel free to discuss with me. All the information that you will provide will be treated in confidence. Your name or information that may identify you as a respondent will not be given to anyone. You are not under obligation to respond to all the questions, and you may withdraw at any time during the interview should you desire to do so. Can I go on? Thank you very much for your time and information".

KAP on HIV/AIDS

1. Let us discuss HIV/AIDS. How is HIV transmitted?
2. How is HIV prevented?
3. Stigma related to HIV/AIDS
4. Do you have sex workers here?

KAP on STIs

1. What about STIs? Are they transmitted the same way as HIV?
2. Tell me about all the STIs you know.
3. Where would you seek treatment if you contracted an STI?
4. Why would you make this choice?
5. Are STI/HIV/AIDS common in the refugee camp?
6. Which category of people is most affected? Why?
7. If treatment is not sought, what are the reasons given?
8. What is the perception of the community regarding condoms, abstinence and other preventive measures against STI/HIV/AIDS?

Use of alcohol and drugs in relation to sexual behaviour

1. Is drinking a common practice among the (target population)?
2. Do people drink alcohol before sex?
3. What are the facilitators and barriers to practice safe sex?
4. Which intervention approaches do you consider feasible to sexual risk reduction?
5. What opportunities exist for preventive interventions?
6. What types/strategies of protection do people from the target population use?
7. What is the effect of alcohol/drug use on the decision-making about protection against STI/HIV/AIDS/pregnancy?

KEY INFORMANT INTERVIEW

Head of Sub Office, UNHCR Kakuma

Statement for Consent

"Hello, we are (Names) from UNHCR and we are carrying out a survey on BCC and the gaps therein in the area of HIV/AIDS. We have identified you as one of our respondents and we hope that you feel free to discuss with me. All the information that you will provide will be treated in confidence. Your name or information that may identify you as a respondent will not be given to anyone. You are not under obligation to respond to all the questions, and you may withdraw at any time during the interview should you desire to do so. Can I go on? Thank you very much for your time and information".

Preamble

HIV/AIDS in Kenya is a top priority because of its fast spread and impact it is having at all levels of our society and so in December 1999, His Excellency announced that it is a national disaster.

A policy was developed and structure set. This is a good environment for any organisation wishing to participate in HIV prevention, care and support.

UNHCR is thinking of getting more involved in reducing HIV and AIDS devastating effect. As you head sub-office Kakuma, there are several areas I would like to have your views on and these have been found effective.

1. BCC in the camps and the general population that has a systematic skill building element.
2. Condom advocacy - storage, distribution and use. The GoK Health Centre does not even bother to order although the government has made available 300 million male condoms. Abstinence and mutual monogamy should be in the package.
3. VCT centres - this usually helps people make a decision about their sexual behaviour and other types of lifestyles.
4. Treatment of STIs this reduces the risk of getting HIV.
5. PMTCT (ARVs).
6. Provision of ARV to those HIV+.
7. Prompt treatment of STIs.
8. HBC - HIV/AIDS and other chronic illnesses.
9. Support counselling.
10. Collaboration - in order to achieve the above, more comprehensive networking with the Government, NGOs. Equal bases partnership.

This mission is expected to draw work plan and a budget from December 2002 - December 2003. This will be participatory.

KEY INFORMANT INTERVIEWS

Health Care Providers

Statement for Consent

"Hello, we are (Names) from UNHCR and we are carrying out a survey on BCC and the gaps therein in the area of HIV/AIDS. We have identified you as one of our respondents and we hope that you feel free to discuss with me. All the information that you will provide will be treated in confidence. Your name or information that may identify you as a respondent will not be given to anyone. You are not under obligation to respond to all the questions, and you may withdraw at any time during the interview should you desire to do so. Can I go on? Thank you very much for your time and information".

About the health facility
(Check for health educational messages in the hospital)

1. Organisation
2. Services provided
3. Common cases seen

KAP on STIs

1. Knowledge of various STIs – symptoms, signs
2. Common STIs seen
3. Knowledge of syndromal management of STIs
4. About the 4Cs
5. Condom advocacy - distribution, use and attitudes

HIV/AIDS

1. Knowledge on HIV/AIDS - transmission and prevention
2. In your view, is there HIV/AIDS problem in your area of intervention?
3. Facilitating factors to HIV infection in Kakuma
4. Condom advocacy - distribution, use and attitudes
5. Sexual networks - patterns, CSWs, attitudes towards CSWs
6. Feasibility of intervention
7. Recommendations/ addressing gaps

ANNEX III
STI CASES IN KAKUMA REFUGEE CAMP 2002

Month	U.D	V.D	GUD	PID	Total
January	49	104	44	96	293
February	68	132	35	98	333
March	76	134	60	170	440
April	56	89	41	117	303
May	49	109	57	173	388
June	71	140	60	97	368
July	97	174	58	54	383
August	68	192	106	129	495
September	90	186	127	179	582
October	80	196	61	114	451

Source: IRC, October 2002