



# An Investigation into Policy Factors Influencing the Effective Participation of Men in HIV/AIDS Campaigns: A Case of Selected Government Ministries Based in Nairobi Kenya

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## ABSTRACT

Since its discovery more than thirty years ago, HIV/AIDS has remained one of the devastating infections globally. It is the fourth most common causes of premature deaths in the world and the leading cause of death in Africa. The fight against HIV/AIDS is of public concern because the epidemic could undermine the collective development effort. In staging this effort, the participation of both men and women is critical in combating the scourge. HIV/AIDS is emerging as the paramount threat to investment in Kenya and subverts efforts to lift people out of poverty; thus calling for an urgent and sustained participation of both genders. Various interventions have been put in place by various stakeholders including government agencies, NGOs, the media, religious organizations among others. However, it is evident that the participation of men has been wanting since their presence in the various interventions is glaringly absent. This paper is based on a study that was carried out in Nairobi, Kenya, to establish the non-participation of men in the HIV/AIDS prevention initiatives. The main objective of this study was to establish factors influencing affective participation of men in HIV/AIDS campaigns within government ministries in Nairobi, Kenya. The study adopted an explanatory research design to collect quantitative data. The study utilized both primary and secondary data. The study administered questionnaires to a total of 59 respondents who were obtained from the selected government ministries in Nairobi, Kenya. Stratified random sampling was used to select respondents from the target population. Secondary data was gathered from various authoritative sources including books, articles, published and on-line journals. Data was analyzed using the statistical package for social sciences (SPSS). Statistical mean and standard deviation as well as percentages was used in interpretations to determine data characteristics, Cronbach's alpha test was used to establish the reliability of the study variables as well as multiple regression analysis used to determine the predictive power of the study model. From the study findings, it was established that policy factors had significant influence on effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi, Kenya. The study therefore recommended that mechanisms be devised that address the problem of lack of information, advocacy, counsel and support services among men and boys to enable them take an active role in HIV prevention. There was also need for a framework that has in-built mechanisms of gender equity integration in HIV/AIDS campaigns; that a policy is devised to ensure that all employees are persuaded and coerced to participate in HIV/AIDS campaigns in each department of the ministries that were sampled for the study and finally, policy guidelines be provided to guide HIV/AIDS key areas such as awareness, prevention and response. Finally, adequate budgetary allocations be considered to help create capacity that encompass relevant areas both in terms of infrastructure and management among other recommendations.

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## 1. Introduction

Kenya is home to one of the world's harshest HIV and AIDS epidemic. An estimated 1.5 million people are living with HIV; around 1.2 million children have been orphaned by AIDS; and in 2009 80,000 people died from AIDS related illnesses (UNAIDS, 2010). Kenya's HIV preference peaked during 2000 and, according to the latest figures, has

dramatically reduced to around 6.3 percent. This decline is thought to be partially due to an increase in education and awareness, and high death rates. (UNGASS, 2010). Many people in Kenya are still not being reached with HIV prevention and treatment services. Only 1 in 3 children needing treatment are receiving it (UNAIDS, 2010).

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This demonstrates Kenya still has a long way to go in providing universal access to HIV treatment, prevention and care.

Between 1983 and 1985, 26 cases of AIDS were reported in Kenya. Sex workers were the first group to be affected. This is according to a study from 1985 report on an HIV prevalence indicating a 59 percent effect amongst a group of sex workers in Nairobi. Towards the end of 1986 there was an average of four new AIDS cases being reported to the World Health Organization each month, (AIDS 1986).

One of the Kenyan government's first responses to the epidemic was to publish informative articles in the press and to launch a poster campaign urging people to use condoms and avoid indiscriminate sex. A year later in 1987, the Minister of Health announced a year-long health and education programme, funded by a £2 million donation from Western countries, (AIDS 1986).

By 1987 HIV appeared to be spreading rapidly among the population and an estimated 1-2 percent of adults in Nairobi were infected with the virus (AIDS Newsletter, 1986), and between 1989 and 1991 HIV prevalence among pregnant women in the capital had increased from 6.5 percent to a staggering 13 percent (The New York Times, 1993).

The government was criticised for not responding aggressively to the emerging epidemic, unlike governments in its neighbouring countries, such as Uganda where much was being done to reduce the incidences of HIV/AIDS. The government was also accused of playing down the threat of AIDS because of the damage it could do to Kenya's tourism industry. By 1994 an estimated 100,000 people had already died from AIDS and around one in ten adults were infected with HIV (AIDS Newsletter 1994). In a speech at an AIDS awareness symposium in 1999, Kenyan President Daniel Arap Moi declared the AIDS epidemic a national disaster and announced that a National AIDS Control Council would be established imminently to respond to the threat posed by the epidemic. Critics argued that in the speech the President failed to promote the use of condoms as a preventative measure and a way forward for tackling the epidemic.

Kenya's HIV epidemic has been categorized as generalized – meaning that HIV affects all sectors of the population. Nearly half of all new infections were transmitted during heterosexual sex whilst in a relationship and 20 percent during casual heterosexual sex. HIV prevalence is higher amongst specific groups and tends to differ according to location, gender and age. Various studies have revealed high HIV prevalence amongst a number of key affected groups, including sex workers, injecting drug users (IDUs), men who have sex with men (MSM), truck drivers and cross-border mobile populations, (UNGASS 2010).

Some of these groups are marginalized within society – for example, homosexuality is illegal in Kenya and punishable by up to 14 years in prison. Therefore these groups are difficult to reach with HIV prevention, treatment and care messages and the extent to which HIV is affecting these groups has not been fully explored. Up to one third of new infections in 2008 were within these 'most at risk populations' (UNGASS 2010).

In 2008, an estimated 3.8 percent of new HIV infections were among IDUs and in the capital, Nairobi, 5.8 percent of new infections were among IDUs (Strathdee, 2010). Laws prohibiting harm reduction services, such as needle and syringe exchanges, significantly hindered the prevention of

new infections among IDUs. HIV infections are easily prevented in health care settings, nevertheless, 2.5 percent of new HIV infections occurred in health facilities during 2008 in Kenya (UNGASS, 2010). It is interesting to note that these groups of people, mostly affected by HIV/AIDS are hard to reach and do not want to come out in the open to discuss their sexual orientation habits and hence their non-participation in the HIV prevention efforts and hence the focus of this study.

## **II. Effective participation of men in HIV/AIDS campaigns**

The current work with men and boys for gender equality is part of a paradigm shift which came to the fore in the mid-eighties in the continued struggle to seek more effective strategies to achieve the goals of equality, development and peace, which the world has pursued the last three decades. For those who have followed the evolution of the global movement for gender equality since the First World Conference on Women in Mexico City in 1975, it has been a decade after decade review, with the same general agreement that while some progress had been made, there were still major obstacles. It has also been a continuous acceptance, decade after decade, that overall, the situation of the majority of women was getting worse. So, the question has always been, what are we not doing right, what else could be done or done differently?

The shift from the women in development approach to the gender and development approach was proposed after the Nairobi Conference (1985). This approach was embraced with enthusiasm because it seemed to offer yet another hope for the achievement of deeply valued and yet ever elusive goals. The initial stage of embracing and understanding the approach was controversial within the women's movement. Many women felt that it was a dilution or selling out of the women's struggle, while others felt that the new approach was a sound strategy for advancing the women's empowerment and gender equality goal. The gender approach entailed the shift from meeting women's basic needs to the focus on power relations between females and males in society (FIDA, 2011).

Many women today feel strongly that working with men and boys is diluting, diverting and even trivializing women struggle. Many hold the view that because men and boys are the beneficiaries of male privilege and the discrimination against women and girls, they can never fully understand the women's struggle. Many doubt that men and boys can be fully committed to a change that would mean them losing a lot of the privileges they enjoy, and which is bestowed upon them by the society. Traditionally, men and boys have leverage over girls and women. As the understanding of gender dynamics, their social construction, masculinities, femininity and their impact on all groups in society deepens, it becomes clearer that males have many reasons to want to change, and that gender equality would have benefits for them, but for one reason or the other, they have failed to participate in the change initiatives.

## **III. Policy factors**

The troubled political context in Kenya through the late 1980s and 1990s also forms a key part of the story. The policymaking and implementation functions of the policy process were characterized by pervasive corruption. Internally, this meant that the policy response to HIV/AIDS was ineffective. Externally, it meant there were problematic relations with international donors and aid was withheld. The future remains tricky. The new government must deal with a

legacy of mismanagement, and concerns remain about how quickly it can improve governance in an overall sense.

Given the rapidly evolving AIDS situation with ARVs, it will take time for the political system to review the policy and legal frameworks. There are likely to be major challenges at the implementation level as regards system and infrastructure. (Mundy, 2003)

The sad situation about Kenya is that various institutions responsible for HIV did pull together strategies based on evidence – really from the mid-1980s onwards. For example, the five-year plan launched in 1987 by the National AIDS Control Programme emphasised the key areas of awareness, prevention and response that might have made a difference if adopted. It included, for example, four prevention priority areas: sexual transmission; blood transmission; mother to child transmission; and disease surveillance. The second five-year plan reinforced these and included the need to broaden the national response. The Ministry of Health produced a series of policy documents that highlighted the background to the disease, the impacts, interventions and policies. These were evidence rich – in particular, the AIDS in Kenya publications that were prepared since 1993.

However, it was only since the mid-1990s that AIDS was taken seriously as a development issue in Kenya. This led to the inclusion in the Seventh National Development Plan (1997) of a whole chapter on AIDS. In the same year, Parliament passed Sessional Paper No. 4 on AIDS, which stressed the importance of advocacy and policy development an HIV/AIDS policy framework within which AIDS control activities were to be undertaken for the next 15 years (1997-2012).

The future for Kenya and bridging research and policy looks favorable however. Kenya has a larger research community in most disciplines compared with most other African countries, including six public and 13 private universities, and several prominent regional research institutions also headquartered in Nairobi (Tostensen, 2004). The other interesting aspect is that there appears to have been a renaissance for policy analysis and research. This has been reflected in the recent development of a number of autonomous public, quasi-public and private research institutions, both broad and sector-specific in their mandate. Some new bodies are consulting companies employing professionals with research backgrounds; others work as policy think-tanks for government.

Tostensen (2004) highlights that these institutions are effectively situated, and act as a linking mechanism, between academic research and policy making centres ‘While maintaining high standards of professionalism they cultivate relations with decision makers (civil servants and politicians alike), venture into policy discussion and put forward policy options underpinned by their research findings’. There are several reasons for this. There is a perceived disproportionate balance of foreign researchers and consultants in the policy field: since 1995, a wide range of research conducted and data generated– from randomised clinical trials to perceptions surveys – has arisen from collaboration between the University of Manitoba and the University of Nairobi.

Tostensen (2004) further suggests the renaissance stems from the ‘new opening for transparent debate after years of repression and executive dominance in policy formulation’, and partly from the recognition by the research community of the need to move from the academic sphere to contribute more

actively to policy debate. Since the new government came into power in 2003, it has completed the most authoritative assessment of HIV incidence in the country (GoK, 2004); however, as yet there are few studies of the policy process as it unfolds in Kenya specifically.

#### **IV. Statement of the problem**

Recent estimates peg the total number of people infected with HIV at around 40 million globally. Of these, an estimated two-thirds live in sub-Saharan Africa (CHGA, 2011). In the struggle to combat the spread of HIV/AIDS in Africa, working with men and boys presents one possible approach but a challenge, given the dominance of patriarchal ideologies and systems and the relationship between the low status of women and the spread of HIV/AIDS.

Working with men and boys is a new approach and experiences with it are recent, sketchy and much less tested. But the need for finding solutions is urgent and therefore all possible solutions must be employed to combat this life threatening situation. This is not the only way to go, but it is a definite way of getting some solutions.

Both practitioners and academicians acknowledge that men’s involvement in HIV/AIDS related activities is low compared to that of women both globally and locally. In addition, no archival evidence is available to indicate what could be the cause of this low involvement. There is no significant relationship between policy factors and effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi. The purpose of this study was therefore to establish policy factors that influence effective participation of men particularly in HIV/AIDS campaigns in Kenya.

#### **V. Literature review**

In mid-2004, an estimated 42 million people were living with HIV or AIDS; in 2003, almost five million people became newly infected with HIV, the greatest number in any one year since the beginning of the epidemic (UNAIDS, 2002). However, many issues related to HIV/AIDS and how to respond to the disease remain contested. HIV/AIDS is an issue where the gaps between research and policy have devastating implications. Preventing and responding to HIV/AIDS in developing countries is one of the challenges of our time.

Fighting HIV/AIDS is a priority for the international development community and there have been sustained international efforts towards this. HIV/AIDS was a priority in the UN Millennium Declaration, signed by virtually all world leaders in 2000, and halting and reversing HIV is one of the Millennium Development Goals (MDGs). A new United Nations organisation, UNAIDS, was set up in 1995 to help coordinate the fight against the disease. Major discussions have been held at the UN Security Council. At the UN General Assembly Special Session dedicated to HIV/AIDS held in June 2001, participating heads of state and representatives of government issued the Declaration of Commitment on HIV/AIDS, which forms the basis of international commitment to fighting the epidemic today. Yet, the response of policymakers in developing countries has been extremely mixed (UNAIDS, 2003). Some have given massive priority to responding to the disease instead of preventing it. Thailand, Uganda, Brazil, the Philippines and Senegal have made progress after mainstreaming a response to the disease. In many other countries, HIV has spread and the crisis deepened owing to the reluctance of governments to respond adequately to the disease.

Today, a growing literature proves that better utilization of research and evidence in development policy and practice can help save lives and improve the quality of life. A recent study by the UK Department for International Development (DFID) catalogues the value of research for development (Surr *et al.*, 2002). Although there has been extensive study of HIV/AIDS, surprisingly little is from a research-policy perspective. Yet, HIV/AIDS presents a particular challenge in terms of bridging research and policy. Although HIV/AIDS is a terminal disease and takes several years to become full blown for the infected, policy cycles addressing the problem tend to be very short. For policy makers, this poses many problems, and makes it difficult both to gauge the success of initiatives and to balance short and long-term needs. The problem is extremely complex; it requires an understanding not only of the biomedical aspects of the disease, but also of sexual behaviour, politics, economics and culture, (Surr *et al.*, 2002).

Although evidence clearly matters, there has been very limited systematic understanding of when, how and why evidence informs policy. While there is extensive literature on the research-policy links in OECD countries, from disciplines as varied as economics, political science, sociology, anthropology, international relations and management, there has been much less emphasis on research-policy links in developing countries. The massive diversity of cultural, economic and political contexts makes it especially difficult to draw valid generalizations and lessons from existing experience and theory. In addition, international actors have an exaggerated impact on research and policy processes in developing contexts, (Surr *et al.*, 2002).

The Research and Policy in Development (RAPID) programme at the Overseas Development Institute (ODI) aims to develop a better understanding of how research can contribute to pro-poor policies, hoping that this will lead to improved use of research and evidence in development policy and practice. RAPID has developed a framework for understanding research-policy links based on an extensive literature review (de Vibe *et al.*, 2002), conceptual synthesis (Crewe and Young, 2002), and testing in both research projects and practical activities (Court and Young, 2003; Court *et al.*, 2005).

## **VI. Health Research and Policy Linkages in Developing Countries**

While the literature on HIV/AIDS has grown massively in recent years, very little is from a bridging research and policy perspective. This section draws on the findings of two annotated bibliographies prepared for the project, which reviewed over 150 research articles and books on the topic of HIV/AIDS that are particularly relevant to the topic of this report. Lush and Walt (1999) provide one of the best studies of issues relating to research-policy linkages. They argue that the relationship between research and health policy is far from rational, and that in fact it is based on the interplay of context, personalities and political expediency. Research and policymaking proceed along different trajectories, and efforts to engineer better links between these trajectories are rare. Nevertheless, they argue that such efforts have the potential to be highly effective.

The work by Philpott, *et al.* (2002) and Philpott (1999) focuses on one of the best known case studies of research-policy linkages – the ‘Mwanza’ case study in Tanzania. The analysis showed that the policy shift was a cumulative but

non-linear process. The evidence from the Mwanza trial played a crucial role in both boosting and confirming existing policy positions. It highlighted the facts that changing political contexts do affect receptivity to research, and also that key moments of communication tend to involve personal contact.

A key aspect was the use of a ‘magic bullet’ statement as a motivating force for policy change. Ultimately, the case study showed that context has a crucial influence over whether or not policymakers choose to consider research.

## **VII. Health Research and Policy Linkages in Kenya**

External influences have had some impact on policy within Kenya. International media attention ensured that policymakers were aware of it. The donor community also supported many research initiatives at various points from 1985 onwards. The role of donors was constrained through the 1990s by their reluctance to engage more generally with the government of Kenya owing to governance concerns. In the early 1990s, the paradox was that even though the epidemic was getting worse, donor funding was rapidly declining. That said, most donors did disburse significant funding through CSOs.

With the declaration in 1999 of HIV as a national disaster in Kenya, donors became more able to support the fight against HIV. This engagement increased since the new government came into play from 2003. The new emphasis on Kenyan policies towards HIV has been pushed substantially by international actors. The 3x5 Initiative has been important in setting a policy agenda. The US in particular has provided substantial funds to expand ART in Kenya.

Generally, the policy context has not provided an enabling environment in which research relating to HIV and men participation could be translated into policy. Even when HIV featured on the political agenda, and research was forthcoming, the research-policy gap was not bridged; even where there was evidence, the resulting policy was based more on ideological factors (only abstinence), as a result of a lack of genuine leadership. Today, the implementation of evidence-based policy remains difficult in the context of weak institutional structures, a legacy of mismanagement and weak infrastructure.

Despite the role CSOs have played in the delivery of HIV services, the lack of political leadership and the uninviting political context has meant that civil society has not been strategically harnessed or motivated to act as a linking mechanism. This has been exemplified by the non-consistent and un-integrated role of FBOs. However, it is encouraging that government is now harnessing the influence of religious-based groups and the need to reach boys and boys. The international arena has been important in putting HIV on the Kenya national agenda.

## **VIII. Effective participation of men in HIV/AIDS campaigns**

The current work with men and boys for gender equality is part of a paradigm shift which came in the decade of the mid-eighties in the continued struggle to seek more effective strategies to achieve the goals of equality, development and peace, which the world has pursued the last three decades. For those who have followed the evolution of the global movement for gender equality since the First World Conference on Women in Mexico City in 1975, it has been a decade after decade review, with the same general agreement that while some progress had been made, there were still major obstacles. It has also been a continuous acceptance,

decade after decade, that overall, the situation of the majority of women was getting worse.

The work with men is a strategy to multiply the number of men who will defy, confront and transform society and move society out of cultural, social and economic bondage. In the struggle against gender based violence and the spread of HIV/AIDS, which now pose a threat of a magnitude that is unprecedented in the history of our world, women have been and continue to be the greater victims relative to men. Many programmes target women with messages, advocacy, and counsel and support services. Still the problems continue to escalate unabated, causing the continuous and almost desperate search for solutions and answers (KENWA, 2010).

Gender analysis became a key tool for the unearthing of the unequal gender and power relations as the root cause of many of the social and economic ills facing society, that was affecting men's voluntary participation in HIV/AIDS prevention.. The unequal impact of the HIV/AIDS pandemic on females relative to males is a crucial revelation from gender analysis. The powerlessness of women and girls to change their own situations is one of the obstacles that must be addressed. The power dynamics demand that men and boys must become key agents of change and transformation. With this shift of thinking, attention is gradually being turned to men and boys as partners to women and girls, as part of the solution to combating the scourge. Although this approach is still in its infancy, compared to other approaches, indications are that it holds a promise,, and that is what informed the current study.

#### **IX. Masculinity, Men and HIV/AIDS**

The concept of masculinity differs from one society to the other, depending on the socio-cultural situation. It is defined as a set of attributes, values, functions and behaviors that are considered normal conditions of men in a given culture. In most societies masculinity is culturally constructed as essentially into a dominant person who discriminates against and subordinates women and other men, especially those who do not conform to similar behaviour. Boys are socialized and modeled along this pattern from birth and through the life cycle. Social systems ensure compliance to this behaviour. Men who deviate from the defined behaviour are ostracized and assumed to take the side of women. The fear of being labeled as women keeps many men and boys from supporting gender equality and defending the rights of women (KENWA, 2010).

The socialization of boys and men regarding sexuality is one of the areas of masculinities that are of major concern to day, in face of the HIV/AIDS, especially in Africa. Most men and boys are socialized to believe that they are entitled to have sex and that it is natural to have many partners. Boys and men are socialized to believe that sex is their right and that they are entitled to it whenever they want it. Girls are socialized to be submissive, service oriented and self-sacrificial. They grow up believing it is their duty to serve and satisfy men. Some women believe the lie that it is natural for men to have many partners or to exercise power over them. Even when they know their partners are involved in risky behaviour, they lack the power to negotiate safe sex and to say no to irresponsible men (KENWA, 2010). This negatively affects the participation of men and boys from participating in HIV/AIDS prevention initiatives especially those spearheaded by women. That is why this study set out to investigate the policy implications and their effect on men participation.

It is evident that men, women and children are at risk of HIV/AIDS. Men's vulnerability is made higher by their patterns of behaviour, modes of socialization, peer pressure, prevailing concepts of masculinity, alcohol and drug abuse, violence, hostile environments, cultural practices and norms. Men have significant control over women's sexual lives. Many use violence, psychological, economic or social pressure to insist on sex with their partners. Further they use the same advantages to have many sex partners. Even when aware of their own vulnerability, most women have little opportunity or power to protect themselves from HIV and other sexually transmitted infections (STIs). Men are placed at risk by masculine values, which discourage them from protecting themselves. In a recent consultation with some men in Nairobi, they traced the risky behaviour many of them indulge in to the way they were socialised and brought up to show masculine prowess and power over women and girls (FIDA, 2011).

Building partnerships between women and men and transforming socialization processes is the key strategy for addressing one of the root causes of the spread of the pandemic, the unequal gender power relations. The fight against the HIV/AIDS pandemic requires the efforts of everybody in society, especially men who hold the power of decision-making at every level of, from the bedroom to the Statehouses and other power bases of policy, politics and resources. Innovative, bold and rigorous approaches to HIV/AIDS prevention and care of those affected are urgently required and men are critical players at all these levels, (KENWA, 2010).

The Kenya Men's Network has added a new dimension in the fight against gender based violence just by the fact of them being men. In the communities they send the message that perpetrators of violence against women and girls are not fighting against helpless victims but a force comprising women, men and organizations, which will stop at nothing until justice is done. In the courts they stand with the survivors and their families to provide legal counsel, moral support and show much needed solidarity, in situations where too often perpetrators are allowed to get away with such lenient sentences that they make mockery of justice. With law enforcement officers, community leaders and service providers, they use their skills, clout and knowledge to persuade them to act effectively and urgently, (WHO 2003).

Visionary men who have recognized that gender equality is the answer to many of the ills that have bedeviled society are to be found even in the most patriarchal societies. These include village elders who have seen generations of women and men play different roles in society and recognized the equal value of contributions of women and men; also recognizing the complementary nature of such roles. These men of vision also see the dangers of oppressing and subordinating one group of people in society and are the voice of reason in discussions with peers, in counselling younger people, in fighting for the rights of the oppressed and marginalized and in calling society to order. In the fight against HIV/AIDS and gender based violence these men have included prominent men in society as well as men living with HIV/AIDS (WHO 2003).

#### **X. Theoretical Framework**

The study was guided by the AIDS Risk Reduction Model (ARRM), theory. Introduced in 1990, the theory provides a framework for explaining and predicting the behaviour change

efforts of individuals specifically in relation to the sexual transmission of HIV/ AIDS. A three-stage model, the ARRM incorporates several variables from other behaviour change theories, including the Health Belief Model, "efficacy" theory, emotional influences, and interpersonal processes. The stages, as well as the hypothesized factors that influence the successful completion of each stage are as follows (Catania, Kegeles and Coates, 1990).

The theory looks at three major stages of behaviour change:

**Recognition and labelling of one's behaviour as high risk** The theory hypothesized Influences: knowledge of sexual activities associated with HIV transmission; believing that one is personally susceptible to contracting HIV; believing that having AIDS is undesirable as well as social norms and networking.

**Making a commitment to reduce high-risk sexual contacts and to increase low-risk activities**

Hypothesized Influences: cost and benefits; enjoyment; response; self-efficacy; knowledge of the health utility and enjoy ability of a sexual practice, as well as social factors are believed to influence an individual's cost and benefit and self efficacy beliefs.

**Taking action**

This stage is broken down into three phases: Information seeking; obtaining remedies as well as enacting solutions. Depending on the individual, phases may occur concurrently or phases may be skipped.

This theory was relevant to this study in that it tries to explain why people take action towards the prevention of an occurrence or reasons why they fail to do so. The study was to establish why men participation in HIV/AIDS prevention initiatives. The need for awareness creation coupled with policy enforcement will go a long way in involving m/AIDS.

## XI. Research design and methodology

The target population of this study was the 23,550 employees working in government Ministries in Nairobi (PSC, 2011). But the proportion of the population that had the characteristic to be measured are those employees who deal with HIV/AIDS related issues and are members of HIV/AIDS committees in each ministry. There are 942 employees in such committees in Nairobi.

For this study a total sample size of 59 was considered adequate. Since 59 was the total sample size required, this was picked as a proportion of 942 using stratified random sampling.

## XII. Target Population

Target population in statistics is the specific population about which information is desired. The target population of this study was the 23,550 employees working in government Ministries in Nairobi (PSC, 2011). Mugenda and Mugenda (2003) define a population as an entire group of individuals, events or objects having a common observable characteristic and therefore based on that the study. A sample size of 59 was considered adequate based on proportion of 942 calculated using the following formula:

$$n = (1.96)^2 \cdot (0.04) \cdot (0.96) / (0.05)^2 = 59(\text{approx})$$

## XIII. Data collection and analysis

Data was collected by use of questionnaire method. The researcher used descriptive statistics to analyze data. This included frequency distribution tables, percentages, mean, modes, median and standard deviation. SPSS and Microsoft excel software was be used to generate the data and other measure of central tendencies and standard deviation.

## Age of respondents

On age, the study found out that generally the respondents were below 50 years of age. 21.2% of the respondents were found to be below 30 years of age, 36.4% of the respondents between 30 and 39 years of age and 21.2% of the respondents between 40 and 49 years of age. Over 21.2% of the respondents were above 50 years of age. See table 4.3.2 for findings.

### Age distribution of respondents

| No | Description | Percentages    |             |             |             |             | Statistics |                    |
|----|-------------|----------------|-------------|-------------|-------------|-------------|------------|--------------------|
|    |             | Below 30 years | 30-39 years | 40-49 years | 50-59 years | 60-69 years | Mean       | Standard deviation |
| 2  | Age         | 21.2           | 36.4        | 21.2        | 18.2        | 3.0         | 3.8547     | 0.9012             |

Source: Survey data (2011)

### Respondents' level of education

The study found out that 8.6% of the respondents were secondary school graduates while 40% of the respondents were found to be undergraduates. 42.4% of the respondents were found to possess tertiary colleges' certificates as 8.6% of the respondents were found to be postgraduates. This partly explains that the respondents were adequately knowledgeable and were capable of giving information with high degree of relevance. See table 4.3.4 for findings.

### Respondents' level of education

| No | Description        | Percentages |               |                  |              |       | Statistics |                    |
|----|--------------------|-------------|---------------|------------------|--------------|-------|------------|--------------------|
|    |                    | Secondary   | Undergraduate | Tertiary college | Postgraduate | Other | Mean       | Standard deviation |
| 4  | Level of education | 8.6         | 40.0          | 42.4             | 8.6          | 0.00  | 3.7560     | 0.8201             |

Source: Survey data (2011)

## XIV. Effective participation of men in HIV/AIDS campaigns

The respondents were asked to rate the extent to which there was effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi on effective participation measures on a five point likert scale. The range was strongly agree (5) to strongly disagree (1). The scores of strongly disagree and disagree were taken to present a component that had an impact to a small extent (S.E) equivalent to a mean score of 0 to 2.5 on a continuous likert scale; ( $0 \leq S.E \leq 2.4$ ). Scores of neutral were taken to represent a component that had an impact of a moderate extent (M.E) equivalent to a mean score of 2.5 to 3.4 on the continuous likert scale: ( $2.5 \leq M.E \leq 3.4$ ).

## XV. Discussion of Results

The respondents were asked to rate the extent to which policy factors influenced effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi on policy measures on a five point likert scale. The range was strongly agree (5) to strongly disagree (1). The scores of strongly disagree and disagree were taken to present a component that had an impact to a small extent (S.E) equivalent to a mean score of 0 to 2.5 on a continuous likert scale; ( $0 \leq S.E \leq 2.4$ ). Scores of neutral were taken to represent a component that had an impact of a moderate extent (M.E) equivalent to a mean score of 2.5 to 3.4 on the continuous likert scale: ( $2.5 \leq M.E \leq 3.4$ ).

The scores for both agree and strongly agree were taken to represent a variable which had an impact to a large extent (L.E) equivalent to a mean score of 3.5 to 5 on a

continuous likert scale; ( $3.5 \leq L.E \leq 5.0$ ). A standard deviation of 1.5 implied a significant difference on the impact of the component among respondents.

From the respondent's views, the study found that lack of policy in key areas such as awareness, prevention and response (mean: 4.0714) had the greatest impact on effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi. Others that had similar great impact on men's participation included: Lack of relevant reviews of policy and legal frameworks (mean: 3.8000); corruption within policy making and implementation functions of government policy processes (mean: 3.7571) as well as the legacy of mismanagement impeding good governance within government policy functions.

Lack of advocacy on policy development (mean: 3.4118); lack of renaissance for policy analysis and research (mean: 3.3235); challenges in implementation level as regards to systems and infrastructure (mean: 3.0000) as well as lack of policy think-thanks in the government (mean: 2.8182) were also cited as having moderate effects on effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi. Table 4.7 has details.

#### XVII. Policy Factors

The respondents were asked to rate the extent to which policy factors influenced effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi on policy measures on a five point likert scale. The range was strongly agree (5) to strongly disagree (1). The scores of strongly disagree and disagree were taken to present a component that had an impact to a small extent (S.E)

equivalent to a mean score of 0 to 2.5 on a continuous likert scale; ( $0 \leq S.E \leq 2.4$ ). Scores of neutral were taken to represent a component that had an impact of a moderate extent (M.E) equivalent to a mean score of 2.5 to 3.4 on the continuous likert scale: ( $2.5 \leq M.E \leq 3.4$ ).

The scores for both agree and strongly agree were taken to represent a variable which had an impact to a large extent (L.E) equivalent to a mean score of 3.5 to 5 on a continuous likert scale; ( $3.5 \leq L.E \leq 5.0$ ). A standard deviation of 1.5 implied a significant difference on the impact of the component among respondents.

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Lack of advocacy on policy development (mean: 3.4118); lack of renaissance for policy analysis and research (mean: 3.3235); challenges in implementation level as regards to systems and infrastructure (mean: 3.0000) as well as lack of policy think-thanks in the government (mean: 2.8182) were also cited as having moderate effects on effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi as discussed in table 4.7 below:

#### XVI. Effective participation of men in HIV/AIDS campaigns.

| Constructs  | Minimum | Maximum | Mean   | Std. Deviation |
|---|---------|---------|--------|----------------|
| Hindrance of men's participation in HIV/AIDS campaigns due to lack of information, advocacy, counsel and support services       | 1.00    | 5.00    | 4.0714 | 1.09237        |
| Hindrance of men's participation due to unequal impact of HIV/AIDS pandemic between males and females                           | 1.00    | 4.00    | 2.9286 | .97877         |
| Hindrance due to discrimination, subordination and the undervaluing of females  | 1.00    | 5.00    | 3.1857 | 1.27813        |
| Hindrance due to lack of persuasion, coercion, legislation and socialization  | 1.00    | 5.00    | 3.3571 | 1.19171        |
| Hindrance due to poor power relations between females and males in society  | 1.00    | 5.00    | 3.6176 | 1.12181        |
| Hindrance due to lack of understanding by males on gender dynamics, social construction, femininity and their impact on society | 1.00    | 5.00    | 3.8857 | 1.48664        |
| Hindrance due to lack of people integrated approaches   | 1.00    | 5.00    | 3.5571 | 1.39205        |
| Hindrance due to dominance of patriarchal ideologies and systems and the low status of women in society                         | 1.00    | 5.00    | 2.8429 | 1.21129        |
| Hindrance due to lack of gender mainstreaming and transformation within government  | 1.00    | 5.00    | 3.5000 | 1.30609        |

Source: Survey data (2011)

Table 4.5. Policy Factors.

| Constructs   | Minimum | Maximum | Mean   | Std. Deviation |
|--|---------|---------|--------|----------------|
| Hindrance due to corruption within policy making and implementation functions of government policy processes | 1.00    | 5.00    | 3.7571 | 1.46213        |
| Hindrance due to the legacy of mismanagement impeding good governance within government policy functions     | 1.00    | 5.00    | 3.6571 | 1.24482        |
| Hindrance due to lack of relevant reviews of policy and legal frameworks                                     | 1.00    | 5.00    | 3.8000 | 1.05161        |
| Hindrance due to challenges in implementation level as regards to systems and infrastructure                 | 1.00    | 5.00    | 3.0000 | 1.26025        |
| Hindrance due to lack of policy in key areas such as awareness, prevention and response                      | 2.00    | 5.00    | 4.2059 | .91385         |
| Hindrance due to lack of advocacy on policy development  | 1.00    | 5.00    | 3.4118 | 1.32842        |
| Hindrance due to lack of renaissance for policy analysis and research  | 2.00    | 5.00    | 3.3235 | 1.00666        |
| Hindrance due to lack of policy think-thanks in the government   | 1.00    | 5.00    | 2.8182 | 1.26131        |

Source: Survey data (2011)

It was found out that lack of policy in key areas such as awareness, prevention and response; lack of relevant reviews of policy and legal frameworks; corruption within policy making and implementation functions of government policy processes as well as the legacy of mismanagement impeding good governance within government policy functions were also contributors to ineffective participation of men in HIV/AIDS campaigns in that order.

The study found out that lack of advocacy on policy development; lack of renaissance for policy analysis and research; challenges in implementation level as regards to systems and infrastructure as well as lack of policy think-thanks in the government were among the few other factors cited as influencing effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi.

### Conclusion

On a through scrutiny of the findings and as regards to the influence of policy factors on effective participation of men in HIV/AIDS campaigns within government ministries in Kenya, the study concluded that the provision of policy guidelines in such areas as awareness, prevention and response required to be considered urgently. The study concluded that this would assist in improving men's participation in HIV/AIDS campaigns. The study also concluded that this could be the main avenue the government could use to not only address the issues of gender equality and the affirmative action within government, but also as a means of improving the participation of both genders in HIV/AIDS campaigns.

The study also concluded that there was increased need by government to review policy and legal frameworks to support the participation of both genders not only in HIV/AIDS campaigns, but as well in all other spheres of life. As well, the study concluded that corruption and mismanagement required to be nabbed at the bud. The study concluded that continued corruption and mismanagement within the government policy process was not imperative in ineffective participation of both genders in HIV/AIDS campaigns.

### References

Abdool Karim, S. S., Abdool Karim, Q., Preston- Whyte, E., & Sankar, N. (1992) Reasons for Lack of Condom Use among High School Students. *South African Medical Journal*.  
 Abdool Karim SS (2010, 25th February) 'Timing of initiation of antiretroviral drugs during tuberculosis therapy' *New England Journal of Medicine*  
 AEIGS (1999, 3rd December) 'Health-Kenya: President Moi Joins the campaign Against HIV/AIDS'  
 African Press International (2009, 11th November) 'The Global Fund supports 2.3 million people on life- prolonging antiretroviral drugs'  
 AIDS Analysis Africa (20000 'Kenya calls AIDS a national disaster- but vetoes condoms', Feb-Mar:10 (5):10.  
 AIDS Newsletter (1986) 'AIDS in Kenya', Item 265, 31st July  
 AIDS Newsletter (1986) 'Facts and figures from the Paris conference', Item 249, 8th July  
 AIDS Newsletter (1987) 'Africa', Item 181, 23rd March  
 AIDS Newsletter (1987) 'AIDS in East Africa', Item 65, 6th February  
 AIDS Newsletter (1987) 'Kenya', Item 254, 10th April  
 AIDS Newsletter (1987) 'Military service in Kenya: AIDS risk', Item 14, 15th January  
 AIDS Newsletter (1994) 'Economic impact in Kenya', Item 446, 23rd May

Associated Press (2001, 16th July) 'Kenya President shy to talk about condoms as hundreds die daily from AIDS-related illnesses daily'  
 BBC News (2006, 2nd June) 'Kenya to provide free Aids drugs'  
 BBC News (2009, 11th September) 'Kenya bans 'leaky' condom brand'  
 BBC News (2009, 29th October) 'Kenya to launch homosexual census'  
 Business Coalition on AIDS. "Workplace HIV/AIDS Programs: An Action Guide for Managers" produced by FHI works with businesses in more than 60 countries on prevention and management of HIV/AIDS.  
 Business Daily (2010, 9th November) "Calls to reduce HIV risk among health workers"  
 Cantania, J.A SM Keggles and T.J Coates 1990. "Towards Understanding of Risk Behaviour: An AIDS Risk Reduction Model (ARRM) "Health Education Quarterly Spring 1990  
 Capital News (2010, 25th November) 'KSh 240 million campaign to fight paediatric HIV'  
 Cheluget B. (2006) 'Evidence for population level declines in adult HIV prevalence in Kenya', *Sexually Transmitted Infections*, April, 2006  
 Court J. and J. Young (2003) *Bridging Research and Policy: Insights from 50 Case Studies*, Working Paper 213, London: ODI.  
 Court J. and J. Young (2004) 'Bridging Research and Policy in International Development: Context, Evidence and Links' in D. Stone and S. Maxwell, eds, *The Challenge of Transnational Knowledge Networks: Bridging Research and Policy in a Globalizing World*, Abingdon: Routledge.  
 Court, J., I. Hovland and J. Young (2005) *From Development Research to Pro-poor Policy: Evidence and the Change Process*, London: ODI.  
 Crewe, E. and J. Young (2002) *Bridging Research and Policy: Context, Evidence and Links*, Working Paper 173, London: ODI.  
 Daily Nation (2010, 12th February) 'Kenya misses out on AIDS funds'  
 Daily Nation (2010' 12th January) 'Airtime tax to fight AIDS scourge'  
 Daily Nation (2010, 16th February) 'Hitch won't delay AIDS drugs'  
 Daily Nation (2010, 22nd February) 'AIDS patients suffer as ministries tussle for control of donor funds'  
 De Vibe, M., I. Hovland and J. Young (2002) *Bridging Research and Policy: an Annotated Bibliography*, Working Paper 174, and London: ODI.  
 FIDA, (2011). *Building partnerships between women and men. HIV/AIDS working paper NO. 29*  
 Flanagan D, Mahler H. *How to create an effective peer education project: guidelines*  
 Hanney, S.R., M.A. Gonzalez-Block, M.J. Buxton and M. Kogan (2003) 'The Utilization of Health Research in Policymaking: Concepts, Examples and Methods of Assessment', *Health*  
 Health International (FHI) UNAIDS. *The Policy Project of the Futures Group International The World Economic Forum's Global Health Initiative The Global Business Coalition on HIV/AIDS The Corporate Council on Africa Asia*  
 HIV/AIDS Policy Compendium Database that houses most available national HIV/AIDS  
 HIV/AIDS: New York State PWS Leadership Institute. XII International Conference on



- Hogle, J.A. (2000). Declining HIV Prevalence, Behavior Change, and the National Response. International Development Contract Number HRN-C-00-99-00005-00.
- Human Rights Watch (2008) 'A question of life or death'
- Human Rights Watch (2009, 14th December) 'Letter to Kenyan Minister of Public Health and Sanitation concerning Home-based HIV testing and Counselling'
- Inter Press Service (2000, 21st February) 'Kenya to produce condoms locally'
- International Treatment Preparedness Coalition (2007, December) 'International Treatment Preparedness Coalition (2007, December) Missing the target #5: Improving AIDS drug access and advancing health care for all'
- IRIN (2001, 12th July) 'Condoms to play key role in HIV/AIDS campaign'
- IRIN (2007, 17th September) 'Muslim opposition to condoms limits distribution'
- IRIN (2008, 22nd October) 'Kenya: Fear of HIV testing keeps pregnant women at home'
- IRIN (2009, 23rd January) 'Kenya: Food shortages threaten ARV adherence'
- IRIN (2009, 28th August) 'Kenya: New PMTCT guidelines to save moms and babies'
- IRIN (2009, 9th March) 'Kenya: Female condom shortage'
- Irin/Plus News (2010, 20th August) 'Kenya: TB patients with HIV miss out on ARVs'
- Irin/Plus news (2011, 29th March) 'Kenya: Condom recycling highlights gaps in HIV prevention programming'
- KAIS Collaborating Institutions (2009, September) 'Kenya AIDS Indicator Survey 2007'
- Kashi Vidapeeth, Varanasi, during February 4-6, 2007.
- KENWA, (2010). Gender relations and HIV/AIDS. HIV/AIDS working paper NO. 11
- Kenya National AIDS Control Council (2009) 'Kenya- HIV Prevention Response and Modes of Transmission Analysis'
- Kenya National Bureau of Statistics (2009, 5th November) 'Official launch of 2008/2009 Kenya Demographic and Health Survey Preliminary Report'
- Kitala, J.M. (2011). A study on the impact of HIV/AIDS peer education program on the management of HIV and AIDS at the Kenya Ports Authority.
- Lee, K. and H. Goodman (2002) 'Global Policy Networks: the Propagation of Healthcare Financing Reform since the 1980s', in S. Fustukian *Health Policy in a Globalizing World*, Cambridge: Cambridge University Press.
- LifeSiteNews.com (2006, 23rd May) 'Kenya First Lady: Condom 'is causing the spread of AIDS in this country'
- Maclaren-Ross S, Baker H. 'A training program for HIV/AIDS peer support counsellors.
- Marum, E (2008) 'Using mass media campaigns to promote voluntary counselling and HIV testing services in Kenya', *AIDS* 2008
- McCoy, D., M. Besser, R. Visser and T. Doherty (2002) *Interim Findings of the National PMTCT Pilot Sites: Summary of Lessons and Recommendations*, Durban: Health Systems Trust.
- Merson, M. (2000) 'Effectiveness of HIV Prevention Interventions in Developing Countries', *AIDS* 14 (supp 2)
- Misra, P. & Agarwal, N. (2005) *HIV/AIDS education in India and teacher education*, Staff
- Moran, D. and Jordaan, J.A (2007). *HIV/AIDS in Russia: determinants of regional prevalence*. *International Journal of Health Geographics* 2007, 6:22
- Moszynski, P (2008) 'Kenyan clerics decide to fight against use of condoms', *BMJ*, 24th May, 336;7654
- Mugenda, O.M and Mugenda, A.G (2003) *Research Methods: Quantitative and Qualitative Approaches*. ACTS Press, Nairobi, Kenya.
- NACC (2009, November) 'Kenya National AIDS Strategic Plan 2009/10-2012/13: Delivering on Universal Access to Services'
- NASCOP & Ministry of Health (2006) 'Sentinel surveillance of HIV and STDs in Kenya'
- National AIDS Control Council 'Kenya National HIV and AIDS Strategic Plan 2005-2009/10
- National AIDS Control Council 'Kenya National HIV and AIDS Strategic Plan 2009/10-2012/13
- National AIDS/STD Control Programme (2008) *Policy on male circumcision in Kenya*, Ministry of Health, Republic of Kenya
- Njue, C (2009) 'If you don't abstain you will die of AIDS': *AIDS Education and Prevention*, 2009 April;21(2):169-79.
- Nyaga, R.K., Kimani D.N., Kimen, M.S. and Mwabu, G. (2004). *HIV/AIDS in Kenya: A Review of Research and Policy Issues*. Paper No. 38
- Ogden J. (2003) 'The Politics of "Branding" in Policy Transfer: the Case of DOTS for Tuberculosis Control', *Soc Sci Med* 57(1):179-88.
- Papo, J K. (2011) 'Exploring the condom gap: Is supply or demand the limiting factor' *AIDS*, 25(2): 247-255
- PEPFAR (2009, December) 'Fiscal year 2009: PEPFAR operation plan'
- Philpott, A. (1999) 'Twists in the Mwanza Tale: Did One HIV Research Study Shift Global Policy?', *Development Research Insights* 32, December.
- Philpott, A. (2002) 'Translating HIV/AIDS Research Findings into Policy: Lessons from a Case Study of "The Mwanza Trial"', *Health Policy and Planning* 17(2): 96-201.
- Plus News (2010, 28th May) 'Kenya: Putting HIV positive people at the centre of prevention'
- Plus News (2008, 23rd December) 'Kenya: Nomadic Maasai missing out on treatment'
- Plus News (2010, 18th March) 'ARV woes push universal access off-track'
- Putzel, J. (2003) 'Institutionalizing an Emergency Response: HIV/AIDS and Governance in Uganda and Senegal', Report submitted to DFID, May.
- Strathdee, S A. (2010, 20th July) 'HIV and risk environment for injecting drug users: the past, present and future' *The Lancet* 6736 (10)
- Surr, M. (2002) 'Research for Poverty Reduction', DFID Research Policy Paper, London.
- Sutton, R. (1999). *The Policy Process: an Overview*, ODI Working Paper 118, London: ODI.
- Temmerman, M (1992) 'Rapid increase of both HIV/AIDS', *Oct; 6 (10):1181-5*.
- Temmerman, (1992) 'Rapid increase of both HIV-1 infection and syphilis among pregnant women in Nairobi, Kenya', *AIDS*,
- The Global Fund: Grant Portfolio 'Kenya and the Global Fund'
- The New York Times (1993, 18th December) 'After years of ignoring AIDS epidemic, Kenya has begun facing up to it'
- Trostle, J., M. Bronfman and A. Langer (1999) 'How do Researchers Influence Decision-makers? Cases Studies of Mexican Policies', *Health Policy and Planning* 14(2): 103-14.
- UNAIDS (2004) 'Kenya epidemiological fact sheets'

UNAIDS (2009) 'Kenya HIV prevention response and modes of transmission analysis'  
UNAIDS (2010) 'UNAIDS report on the global AIDS epidemic'  
UNGASS (2006) 'Country progress report- Kenya'  
UNGASS (2008) 'Country progress report- Kenya'  
UNGASS (2008) 'Country report- Kenya', Kenya Office of the President, Ministry of Special Programmes'  
UNGASS (2010) 'Country progress report- Kenya'  
UNICEF (2010) 'Kenya: PMTCT'  
USAID (2007, July) 'Measuring the degree of S&D in Kenya: An index for HIV/AIDS facilities and providers'.

WHO/UNAIDS/UNICEF (2007) 'Towards universal access: Scaling up priority HIV/AIDS intervention in the Health Sector'  
WHO/UNAIDS/UNICEF (2009) 'Towards universal access: Scaling up priority HIV/AIDS intervention in the Health Sector'  
WHO/UNAIDS/UNICEF (2010) 'Towards universal access: Scaling up priority HIV/AIDS intervention in the Health Sector'  
XII International Conference on AIDS, Geneva, 1998.