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Aspects of the gender dimension of HIV/AIDS in Kenya

1 HIV/AIDS is a gender issue

While HIV/AIDS is a health issue, the epidemic is more of a gender issue. Statistics prove that both the spread and impact of HIV and AIDS is not random. Gender inequality is particularly pronounced in sub-Saharan Africa and indeed, the epidemic is clearly gendered: with 57% throughout Sub-Saharan Africa it affects more women than men and women at a younger age than their male counterparts. At the beginning of the pandemic, women and girls were at the periphery; today they are at the centre.

According to **UNAIDS** statistics the highest prevalence of HIV/AIDS in pregnant women is between 20 to 30 percent in *Southern Africa*, as in *Botswana* and *South Africa*, *Swaziland* and *Lesotho*. With 5 to 10 percent it is less prevalent in *West Africa* and *Eastern Africa*. A downward trend was detectable in Uganda[1] (5 – 6%) and in Kenya where the prevalence has dropped from 13.6% in 1997/1998 to 9.4% in 2002 and then staying largely unchanged in 2003 (UNAIDS 2004 : 26). The latest representative data collection at national level, the **Kenyan Demographic and Health Survey 2003 (KDHS)** reported 6.7% prevalence (CBS 2004).

In the beginning of 2005 UNAIDS recognized the decline in HIV prevalence in Kenya. Peter Piot acknowledged the efforts of the Kenyan Government in reducing the country's HIV prevalence rate from nearly 14 percent in 1997 to about 7 percent in 2004; but he also reminded that it is not enough being done to help women and the increasing number of orphans.[2] Undoubtedly, poverty is the main responsible factor for the spread of HIV/AIDS in Africa, and in all its dimensions women are worst off.

[1] The causes are not yet clear. In Uganda three main factors have been identified: 1. A delay of first sexual intercourse; 2. considerable increase in condom use; 3. drop of nearly 50% in the proportion exchanging sex for money; Kaleeba et.al., Open Secret. People facing to HIV and AIDS in Uganda. Strategies for Hope, Series, No 15. ACTIONAID 2000.

[2] http://allafrica.com/stories/printable/20501190683.html, accessed 7 February 2005.

HIV/AIDS prevalence in Kenya in 2003:

The latest representative data collection at national level, the **Kenyan Demographic and Health Survey 2003 (KDHS)**, reported 6.7% HIV prevalence (CBS 2004). The survey collected information from 8,561 households on demographic and health issues interviewing 8,195 woman aged 15 - 49 and 3,578 men aged 15 - 54 (total response rate: 85.5%). Furthermore, the survey offered voluntary HIV testing. According to the survey HIV prevalence among women (age 15-49) was nearly 9 percent, while for men (age 15-54), it was under 5 percent. The peak prevalence among women is to be found in the age group 25-29, with men at age 40-44 (CBS 2004 : 221):

Table 1: Percentage of HIV positive among women age 15-49 and men age 15-54 who were tested, by age, Kenya 2003:

	Women		**Men**		**Total**	
Age	% HIV+	Number	% HIV+	Number	% HIV+	Number
15-19	3.0	711	0.4	745	1.6	1,456
20-24	9.0	658	2.4	566	6.0	1.224
25-29	**12.9**	522	7.3	428	10.4	950
30-34	11.7	438	6.6	368	9.4	806
35-39	11.8	345	8.4	321	10.1	666
40-44	9.5	276	**8.8**	260	9.1	535
45-49	3.9	202	5.2	163	4.4	364
50-54	not applicable	not applicable	5.7	193	not applicable	not applicable
Total	**8.7**	3,151	**4.6**	2,851	**6.7**	6,001

Source: Kenya Demographic and Health Survey 2003, CBS 2004 : 222; emphasis added B.T.

Projections that have been made earlier predicted a continuous increase of HIV/AIDS and the Kenyan Ministry of Health expected 14% prevalence by 2005 (Ministry of Health 2001). Therefore a **prevalence of 6.7%** is remarkable. Nevertheless 6.7% is a prevalence that is still of "serious concern" and which "can hardly be dismissed as 'only' 6.7 percent" (Barnett 2004 : 2). However, data suggests that western Kenya as opposed to the whole of Kenya may have reduced the prevalence level. And yet, Barnett assumes "that this is probably only a point on an ascending curve, with worse to follow" (ibid. : 2).

Significantly, the **prevalence rate of women** is almost double as high as that of men. It is an alarming fact that the majority of new infections occur among young women aged 15 to 29. Female Kenyans of this age group are more than thrice likely to be infected as men in the same age group. Under the gender lens the success of the Kenya National Strategic Plan is rather restricted.

Background

In 1999, former President Daniel arap Moi described the HIV/AIDS situation in Kenya as a national disaster and created the **Kenyan National AIDS Control Council (NACC)**.

One of its first tasks was to formulate the Kenya National HIV/AIDS Strategic Plan 2000 - 2005, which was published in December 2000. Despite the vast evidence that the prevalence of HIV/AIDS among women was appalling no explicit strategies on gender were included in the plan.

But in 2001, the **National AIDS Control Council** established **The Gender and HIV/AIDS Technical Sub-Committee** in order to mainstream gender in the **National HIV/AIDS Strategic Plan**. It was agreed that the best approach would be to engender the existing Strategic Plan because it is the key document that guides and co-ordinates all responses to HIV/AIDS in Kenya. The plan identified **five priority areas** to address the gender dimensions of HIV/AIDS in Kenya:

- Gender relations governed by customs and cultural practices
- Education
- Economic conditions
- Traditional and modern laws
- Political representations.

The gender analysis and mainstreaming strategies are contained in the Gender and HIV/AIDS documents that were published in October 2001 and May 2002 by NACC. The reports reveal how different attributes and roles have been assigned to males and females by society and how these profoundly affect their ability to protect themselves against HIV/AIDS and to cope with its impact. Examples ranged from the gender issues that render both men and women vulnerable to HIV infection to the ways in which gender influences men and women's responsibility for, and access to, treatment, care and support. The findings from the field studies[3] and the resulting gender analyses illustrated that

[3] Two sets of community field studies were completed during the research phase of this document to investigate some of the more complex determinants of gender vulnerability to HIV/AIDS. In October 2001 NACC commissioned the first study to be carried out in Kisumu, Thika and Narok. These three communities presented different cultural perspectives that have critical gender-based implications for the HIV/AIDS epidemic and all had varying HIV prevalence rates: Kisumu – a very high prevalence area; Thika - a moderately high prevalence area; and Narok - a mild prevalence area. Another study was commissioned in May 2002 to ensure a wider geographical coverage. The second study was carried out in Mombasa, Meru South and Kajiado districts. Each district represents a cross section of community groups in Kenya. Mombasa represents the Muslim community, Meru the agricultural/sedentary communities and Kajiado the pastoralist community.

gender roles and relations powerfully influence the course and impact of the HIV/AIDS epidemic; gender-related factors shape the extent to which men, women, boys and girls are vulnerable to HIV infection, as well as the ways in which AIDS affects them, and the kinds of responses that are feasible in different communities and societies. It was concluded that the control of the spread of HIV/AIDS is dependent on the recognition of women's rights in all spheres of life and therefore, women's empowerment is an important tool in the fight against HIV/AIDS (The Gender and HIV /AIDS Technical Sub-Committee of the National AIDS Control Council 2002).

The current president of Kenya, Mwai Kibaki, has encouraged open discussion of HIV/AIDS in Kenya, provision of anti-retroviral treatment for People Living With HIV/AIDS, and favours the suggestion that Kenyans must discard certain cultural beliefs that contribute to the spread of AIDS.

1.1 Why are women often at greater risk for HIV/AIDS?

Transmission of HIV comes mainly through heterosexual intercourse, while unsafe sex remains the main cause of infection. Many unprotected sex appears to be the norm in many societies, even when multiple partners are involved. Women are at risk for different reasons than men and there is a direct link between women's low status, the violation of their human rights and HIV transmission. Compounding women's vulnerability are social norms that deny women sexual health knowledge and practices that prevent them from controlling their bodies. Gender-based violence is one of the leading factors in the increased rates of HIV infection among women. Women's restricted sexual autonomy and men's expanded sexual freedom are reflected in all studies of factors which increase women's and men's risk and vulnerability to HIV as well as several violent elements in sexual relationships. There is growing evidence that a large share of new cases of HIV infection is due to gender-based violence in homes, schools, the workplace and other social spheres. Abuses are many and occur as sexual violence, coercion or rape, female genital mutilation or unequal property and inheritance rights. What the HIV/AIDS epidemic brings to light is a certain aspect of the gender relation: extremely coercive sexual relations based on rigid gender norms. Yet, the sexual oppression of women is one of the major causes for the rapid spread of HIV/AIDS on the African continent.

The pervasiveness of certain cultural practices such as **female circumcision, polygyny, widow inheritance and widow cleansing, and dry sex as well as physical and sexual abuse of women and children** fuel the epidemic most

significantly (Society for Women and AIDS in Kenya & The Panos Institute 2002).

Female circumcision: According to the KHDS 32 percent of the surveyed women in Kenya were circumcised. The proportion of women circumcised increases with age from 20 percent aged 15-19 to 48 percent of those aged 45-49. Thus, there has been a decline in the practice of female circumcision over the past two decades. A higher proportion of rural women (36%) than urban women (21%) have been circumcised, with a great variance among ethnic groups. It is nearly universal among Somali, Kisii, and Maasai women and almost nonexistent among Luhya and Luo women. There is a strong relationship between educational level and circumcision status (CBS 2004 : 250-251).

Polygyny: 16 percent of currently married women in Kenya lived in polygynous unions. Older women are more likely to be in polygynous unions, and it is more prevalent in rural (18%) than in urban (12%) areas. 11.6 percent of those living in polygynous unions are reported to be HIV positive (11.4% women, 11.6% men) (CBS 2004 : 90-92).

Widow inheritance and widow cleansing: Women who are widowed, divorced, or separated have significantly higher HIV prevalence than married women (in Kenya 30 % and 21 % versus 8 %; CBS 2004 : 224).

Dry sex: In order to enhance men's sexual pleasure women dry out their vaginas with herbs or other means that swell the soft tissues of the vagina. Research has shown that dry sex causes vaginal lacerations and suppresses the natural bacteria, both of which increase the risk of HIV infection. Although dry sex hurts women continue with the practice to enhance men's sexual pleasure.

"Young women are likely to encounter difficulty in resisting the demands of young men and to ensure safety in the context of sexual relationships. Women are more likely to empathise with men and to downplay their own wishes. They are usually self-effacing about their own sexual desires. The differentiated norms for men and women mutually reinforce one another, preventing open communication about needs, risks and protection." (Jobson 2004 : 325).

Power is fundamental to both sexuality and gender. The power underlying any sexual interaction determines when, where, how, and with who sex takes place. There is an unequal power balance in gender relations that favours men. This translates into an unequal balance of power in heterosexual interactions. Male pleasure has priority over female pleasure, and men have greater control than women over sexual interaction. The prevailing gender order and the expectations of masculinity (in contrast to femininity) make women more

vulnerable to HIV infection. Social norms give more power and freedom to men, who then exert power and control over women.

1.1.1 HIV/AIDS, sexuality and violence against women

Although HIV/AIDS affects both men and women, women are more vulnerable because of sexual violence. Violence against women is a worldwide phenomenon and is common in practically all societies and a major cause of death. Gender violence is defined as any act of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (United Nations Assembly, Declaration on the Elimination of Violence Against Women 1993).

Violence against women is supported and in turn serves to reinforce discrimination against and subordination of women. Worldwide, there exists an environment for violence against women, a tolerance surrounded by a culture of silence. For many women, the threat of violence that permeates their everyday lives exacerbates their vulnerability to HIV. Abuses existed for a long time and many have been life-threatening. With HIV/AIDS abuses are lethal on a massive scale. AIDS prevalence in Africa is a direct result of human rights abuses that women and girls suffer. In Kenya as elsewhere youth is disproportionately affected by HIV. Evidence is given that quite a considerable percentage of sex among youth may result from coercion. Therefore the social context of adolescent sexual activity particularly the influence that gender relations and power imbalances have should be looked at. For instance, there is a serious problem of sexual exploitation of schoolgirls by male teachers. Many girls report that the first abuse in their lives occurred in childhood and adolescence (Johnson 2002).

Survey: In a large population-based survey conducted in 2001 in Central Province, Nyeri, Kenya a special module on sexual coercion was included in order to explore the prevalence and patterns of sexual coercion among married and unmarried males and females aged 10–24 (Erulkar 2004). African programs for young people, which tend to emphasize abstinence, usually overlook early experiences of violence and coerced sex. The message in these programs, which is often directed at young women, advises them to “just say no” to young men’s advances. However, as the study shows, many young women do not have a choice on whether to have sex. The sample for the study consisted of 1,753 young men and women aged 10 to 24.

The results showed that educational levels in the region were relatively high. Virtually all respondents had been to school, with roughly one-third having

reached the secondary level. There was no significant difference in educational attainment between males and females. Fewer than 6% of males had been married, compared with 30% of females. Sexually experienced respondents (337 males and 462 females), who made up almost half of the sample, were the focus of analyses. Among the sexually experienced respondents, 21% of females and 11% of males had experienced sex under coercive conditions. Most of the perpetrators were intimate partners, including boyfriends, girlfriends and husbands. In a multivariate logistic regression, females who had ever been married and those who did not live with a parent or spouse had a significantly elevated risk of sexual coercion (odds ratios, 2.6 and 3.1 respectively); sexual coercion was associated with having had multiple sexual partners and with having had a reproductive tract infection (2.2 and 2.5). Males who had been coerced into sex were significantly more likely than those who had not to have had a first partner who was older by at least five years (82.9) (ibid. : 185).

Among young people who had been coerced, the majority reported having been deceived or tricked into having sex, and many reported partner insistence or "not taking NO for an answer." In a finding consistent with previous research suggesting that respondents may consider forced sex different from rape, 5% of sexually experienced females reported having been physically forced into sex, and 3% reported having been raped (see Table 2):

- For young women, intimate partners - boyfriends and husbands - were the most common perpetrators of sexual coercion, followed by acquaintances. Of the coerced young women who were married, 45% had been coerced by their husbands, 33% by someone else and 22% by both their husband and someone else. Among males who had been coerced, the most common perpetrator was a girlfriend, followed by an acquaintance. Few respondents reported having been coerced by a relative, teacher or employer; this figure, however, is probably an underestimate, given the stigma attached to incest and the disapproval of intimate relationships between young people and their teachers, employers or relatives.
- Seventeen percent of young women who had ever been coerced had had sex before age 15, compared with 10% of those who had not.
- Among young women, those who had ever been married had significantly elevated odds of having experienced sexual coercion (odds ratio 2.6), a finding that suggests a high prevalence of coercion within marriage.
- There is a sizeable proportion of young women on the continent who marry during adolescence.[4]

[4] In the Demographic and Health Survey more than half of all women entered marriage before their 20th birthday but only 11 percent of all men, about half of all men married before age 25; CBS 2004 : 92.

Table 2: Percentage of sexually experienced young people who had ever been coerced into sex, by type of coercion, according to gender, in %

Type	Males (N= 337)	Females (N= 462)
Any	11.0	20.8
Deception/trickery	6.0	11.9
Threats	0.6	3.7
Insistence/not taking no for an answer	4.2	7.6
Locked in a room	1.5	3.0
Physical force	1.2	5.0
Rape	0.9	3.2

Note: Respondents could indicate more than one type of coercion.
Source: Erulkar 2004 : 185.

The study findings reveal that non-consensual sex is a common feature of the early sexual experiences of the country's young women and men. More than one in five sexually experienced young women and one in ten sexually experienced young men had had non-consensual sex. The perpetrators were often the young people's intimate partners - their boyfriends, girlfriends and husbands. The results also suggest that marriage may increase the risk of sexual violence, and other research indicates that it may increase a young woman's risk of HIV infection. Young women who are coerced into sex by their husbands may have fewer options than unmarried women to protect themselves against infection, may find it harder to leave an abusive relationship and may not have recourse to legal protection. In Kenya generally, as well as among the Kikuyu traditionally, husbands cannot be accused of raping their wives because marriage is considered as blanket consent to intercourse. Under Kenya's penal code, rape, attempted rape and other forms of non-consensual sex are crimes punishable by imprisonment. According to Erulkar, however, the law is rarely enforced, and society tends to blame rather than support the victim, which discourages reporting. Moreover, rape is often looked on as a normal and forgivable action by males who cannot control themselves (ibid.).

A report by **Amnesty International** on "Rape – the invisible crime" (2002) gives an account of the hidden nature of rape in Kenya as well as evidence of women's experiences and suffer and the ignorance of a system which often protects the perpetrators rather than the rape victim. In Kenya, marital rape is

not recognised as a crime or criminal offence "because of the presumption, especially in customary law, that consent to sexual intercourse is given by the act of marriage" (ibid. : 8). Sexual violence in the home remains largely unreported, only few women report an incidence to the police. Women who seek police intervention are often embarrassed, ridiculed, or verbally abused by the policemen. Even worse, sexual violence is also perpetrated by law enforcement officials. In the report's conclusion Amnesty International blames the Kenyan government for failing in its human rights obligations:

"It is a failure of the state to take action against such abuses, whether they are committed by state officials or private individuals, that allows them to continue. The state has a responsibility to take action in order to protect women from continuing violence. Under international human right law the state has a responsibility to ensure adequate protection for its citizen's human rights. By enacting national legislation and ratifying international and regional human rights instruments, particularly CEDAW, and the African Charter on Human and Peoples' Rights, the Kenyan government is obliged to ensure that the rights of both men and women are protected, respected and fulfilled. However, violence against women continues while the Kenyan government consistently fails to ensure that perpetrators of these abuses are brought to justice" (ibid. : 28-29).

The Kenyan Demographic and Health Survey measured gender violence, in particular spousal violence or violence by other since age 15, and the results confirm those sentiments from Amnesty International:

Table 3: Gender violence since age 15:

	since age 15 (%)	past 12 months (%)	number of women
Age			
15-19	41.8	26.3	1,335
20-29	49.8	25.2	2,197
30-39	53.0	26.2	1,424
40-49	49.4	21.8	922
Marital status			
In union	52.9	31.0	3,508
Separated/divorced	64.4	19.6	348
Widowed	29.5	2.9	260
Never married	40.1	17.7	1,762
Residence			
Urban	48.1	18.1	1,423
rural	48.9	27.3	4,455
Total	48.7	25.1	5,878

Source: Kenya Demographic and Health Survey 2003, CBS 2004 :.242.

The level of gender-based violence is alarmingly high, with no rural-urban differential. Almost half of nearly 5,878 women reported having experienced

violence since age 15, and one quarter in the past 12 months. In particular, married women are exposed to marital violence with three in ten affected during the year preceding the survey.

The main perpetrators of violence were: husbands (57.8%), mothers (23.8%), fathers (14.5%), and teachers (25.7%) (CBS 2004 : 243). The survey also found that "domestic violence is not related to socioeconomic status" (ibid. : 243). The women report emotional, physical and/or sexual violence. The experience of all forms of spousal violence rose with age. The survey also asked married, divorced or separated women about violence committed by women and results show that three percent initiated violence against their husbands. However, this result is certainly underreported, "women find it difficult to admit that they themselves initiate violence." (ibid. : 248).

1.1.2 Cross-generational relationships

A second major cause why women are at greater risk than their male counterparts in younger age groups is having sexual relationships with older male partners. Younger women tend to have their first sex with older men.

A **PSI[5] study** of cross-generational relationships[6] (Longfield, Glick, Waithaka, Berman 2003) revealed that most participants underestimate the risk of sexually transmitted diseases and HIV and couples rarely use condoms. Data were collected in June 2000 as part of a behaviour change communication strategy for young women in Kenya that addressed cross-generational relationships and their risk for STIs and HIV/AIDS. Eight focus groups were conducted with women aged 15-19 and 28 in-depth interviews were carried out with men aged 30 years and older in Nairobi, Mombassa, Kisumu and Meru. Participants discussed motivations for entering into cross-generational relationships, perceived risks and relationship dynamics. Young women identified financial gain as the

[5] PSI: Population Services International, Washington and London.

[6] This study attempted to understand women's and men's motivations for entering into cross-generational relationships and examined how these relationships affect STI/HIV risk perception and condom use. Recommendations include behaviour communication campaigns to educate men and women on the increased risk of STI/HIV associated with cross-generational relationships and long-term interventions to improve women's access to educational and career opportunities while working with communities to change social norms concerning the acceptability of cross-generational relationships; Kim Longfield, Anne Glick, Margraret Waithaka, and John Berman: Cross-Generational Relationships in Kenya: Couples' Motivations, Risk Perception for STIs/HIV and Condom Use, 2003.

biggest incentive to have relationships with older men. Young women actively seek partners who are willing to spend money on them and often initiate relationships with older men. Moreover, peer pressure to "fit in" and family pressure to obtain financial support can compel women to engage in these relationships. Sexual gratification was the major incentive for older men for pursuing younger partners. 25% of young women's partners were 10 or more years older. Some of the young women are often unable to negotiate condom use with their older, more dominant partners who may not want to wear condoms. Some females explained that older men sometimes accuse younger partners of not trusting them and threaten to abandon the relationship if they insist on using condoms. Rather than lose the benefits of these relationships, most women give in to the demands of their older partners. Most participants, both male and female, said that men dislike condoms and believe they reduce sexual pleasure. Even if men recognized the risks associated with these relationships, they believe, the men often refuse condoms in order to maintain the perceived pleasure.

All over sub-Saharan Africa women are engaged in "transactional sex" due to the lack of resources. In particular young women see "sugar daddies" as a 'means of survival' for either gaining necessities such as school fees or clothing or luxuries such as cell-phones. Single women in their twenties may have several regular partners who pay for rent, electricity or other bills. Single mothers may use sex as a means of providing for their children if the father abandons them or loses interest. Widows may use sex as a means of survival if their husband's family steals their possessions after his death (Society for Women and AIDS in Kenya & The Panos Institute 2002). In this context, the use of condoms would be life-saving.

1.2 The underusage of condoms

Condoms are currently the best barrier method for prevention of STIs and HIV transmission. Many people have widespread knowledge of condoms but their use remains relatively low. On the one hand there exist some misconceptions and beliefs, which have continued to be barriers to effective condom use. Certain social cultural and religious values discourage the use of condoms in family planning and in protecting oneself from sexually transmitted infections including HIV. On the other hand condoms are not considered part of African culture as they are associated with casual sex. Casual sex is often considered immoral and not part of African culture and so condoms are also associated with immorality. Some people in new sexual relationships opt to use condoms at the beginning but stop to using them later. Men also tend to assume that their wives are faithful to them and so believe them to be free of HIV. Some men refuse to

use condoms while having sex with young girls since they perceive them as safe from HIV (ibid.).

Probably the most powerful obstacle lies in the African concept of sexuality, which is based on a notion of the flow of sexual substance ("flesh-to-flesh contact"), which actually makes condom use more or less impossible. For instance, mine workers in a South African case study made a strong link between sex and masculinity in relation to their general physical and mental health and well-being. Particularly important for health was what was referred to as "the maintenance of a balanced supply of blood in the body. Several people commented that sex played a key role in the regulation of a balanced supply of blood and sperm, and that regular sex was essential for a man's good health." (Campbell 2003: 33). Or else if people used condoms with casual partners they would not use them with their regular partner, a behaviour which Catherine Campbell interprets in the context of and as a symbol for love and trust. In her study on sexual behaviour of mine workers, commercial sex workers and youth in a South African community non-use of condoms was seen as a valued and positive affirmation of trust and faithfulness, and played a key role in maintaining comforting myths of fidelity in a community where there was, in reality, very little fidelity (ibid. : 115).

Over the past few years, there has been a lot of effort by the Kenyan government to promote condom use locally by making them available and accessible to the entire population (see Ministry of Health & National AIDS Control Council 2001). However, in the Kenyan Demographic and Health Survey only one-quarter of women and less than half of men reported the use of condoms at the most recent occurrence of higher-risk sex[7]:

Table 4: Higher-risk sex and condom use at last higher-risk sex

	Women		Men	
	Number of women who had higher-risk sex in past 12 months	% who used condom at last higher-risk sex	Number of men who had higher-risk sex in past 12 months	% who used condom at last higher-risk sex
15-19	289	23.4	250	41.3
20-24	258	27.6	355	50.7
25-29	166	25.8	149	51.8
30-39	184	23.1	142	38.6
40-49	109	14.9	46	50.0
15-24	547	25.4	605	46.8
Total	1,006	23.9	942	46.5

Source: Kenya Demographic and Health Survey 2003, CBS 2004 :.201.

[7] In the context of this survey, higher-risk sex is defined as sex with a non-marital (including pre-marital sex), non-cohabitating partner in the 12 months preceding the survey.

In addition, 3,363 men were asked to agree or disagree to several statements about condoms, amongst other "condoms diminish a man's sexual pleasure"; "condoms protect against disease"; "buying condoms is embarrassing"; "a woman has no right to tell a man to use a condom".

Table 5: Attitudes towards condoms/agreed statements in %:

	"condoms diminish a man's sexual pleasure"	"condoms protect against disease"	"buying condoms is embarrassing"	"a woman has no right to tell a man to use a condom"
Total	45.7	77.9	34.1	27.9

Source: Kenya Demographic and Health Survey 2003, CBS 2004 :.204.

The table confirms - as indicated above - that there is widespread knowledge of condoms but their use remains relatively low. Unsafe sex remains therefore the predominant cause of infection and finally death in the overall population. A recent survey, however, revealed that male student's attitude towards condom use has changed significantly over the years. A large proportion (42.1%) used a condom every time they have sex (ICL 2004 : 26).

2 Demographic impact

HIV/AIDS in Africa means death on a large scale. People are not "living" with HIV/AIDS, they are dying of HIV/AIDS. Mainly it is adults in their working prime who are victims of the virus. In the absence of treatment the median time from infection with HIV until death is estimated at around three to seven years, with survival time once full-blown HIV/AIDS kicks-in being less than a year. 150,000 people died of HIV/AIDS in 2003, altogether more than one million people have already died due to AIDS in Kenya. This has a severe demographic impact. Life expectancy has dropped to 46 years. Again the Kenya Demographic and Health Survey gives evidence of the gender dimension in terms of mortality:

Table 6: Age specific mortality rates for women and men age 15-49 based on the survivorship of sisters and brothers of survey respondents for the seven-year period preceding the survey, Kenya 2003:

	Women			**Men**		
Age	**Deaths**	**Exposure**	**Mortality rates**	**Deaths**	**Exposure**	**Mortality rates**
15-19	65	23,470	2.76	42	22,865	1.83
20-24	117	25,091	4.67	93	25,142	3.71
25-29	148	22,601	6.56	101	22,448	4.48
30-34	166	18,221	9.11	159	18,811	8.45
35-39	119	13,248	9.02	128	13,862	9.26
40-44	92	8,428	10.94	111	8,543	13.01
45-49	51	4,912	10.34	67	4,775	14.08
15-49	759	115,971	6.57	701	116,446	6.19

Source: Kenya Demographic and Health Survey 2003, CBS 2004 :.235.

For age group 15-34 female mortality exceeds male mortality, with a wider difference at age group 25-29 and almost the same at age group 35-39. Above age 35 male mortality exceeds female mortality. Thus, women die at a younger age than men. Usually it is expected that male mortality typically exceeds female mortality in the age group 15-49 but here female mortality is with 6.6 deaths higher males (6.2). AIDS is now a significant cause of death in Kenya, and its emergence has altered the age and sex pattern of mortality (CBS 2004 : 235). The reasons why have already been described. However, this pattern has a significant impact on national economies, their communities and individual households if one considers the specific contributions of the genders:

"Women in Kenya play such an important role in the economy, and their deaths from AIDS are thus a threat. In many households, women provide labor in the agricultural sector, they work more than 13 hours a day doing household chores, toiling on farms and running small businesses as vendors and hawkers, and they ensure their children go to school, and meals are on the table. When these women become infected with AIDS, it is a tragedy for the whole country." (Eunice Mathu, Journalist, Kenya).

3 Conclusion

The sexual oppression of women is a major cause for the rapid spread of HIV/AIDS on the African continent imbedded in a number of traditional cultural practices which disguise the fact of women's repression. The pervasiveness of certain cultural practices such as female circumcision, polygamy, widow inheritance and widow cleansing, dry sex as well as physical and sexual abuse of women and children fuel the epidemic most powerfully. HIV/AIDS is therefore a gender issue due to rigid gender norms which tolerate extremely coercive sexual relations and disadvantage women in favour of men. The seemingly successful reduction of HIV prevalence in Kenya is worth celebrating but is not balanced between women and men: the infection rate of women (8.7%) is almost as twice as high as that of men (4.6%). The pervasiveness of certain cultural values as well as sexual abuse still fuel the gender dynamic in the epidemic. Evidence is given that a considerable percentage of sex among youth results from coercion. As a large youth survey showed boyfriends and husbands were the most common perpetrators of sexual coercion, and also the Kenya Demographic and Health Survey confirmed high levels of gender-based violence.

Condoms provide the best barrier to HIV prevention and their use would be life-saving, and yet, the majority of men dislike the use of condoms arguing that condoms reduce sexual pleasure. One may easily admit that condoms are not

perceived as part of African culture and undermine the African traditional understanding of sexuality, but what is the alternative if we look at the prize for the reluctance? Until today, in the middle of a pandemic, unsafe sex remains the predominant cause of infection and death. The death of millions of people has severe demographic, economic and social impacts putting a whole continent at risk. All sectors of the economy are affected. Especially those are hit hard where women's (invisible) contributions to communities, households and families, the informal economy and agricultural sector are a major factor for survival. At the household level, the deaths of breadwinners and primary caregivers contribute to deepen poverty. HIV/AIDS is rapidly increasing the number of orphans who have lost at least one parent. AIDS orphans face great predicaments in terms of educational and employment opportunities, housing, nutrition, health and welfare. Many children end up in child-headed households, or as street children, in many cases turning to prostitution and crime to survive. All this contains a high potential of social instability.

Bibliography

Amnesty International (2002): Kenya: Rape - the invisible crime. AI Index: AFR 32/001/2002.

Amuyunzu-Nyamongo M (2001): HIV/AIDS in Kenya: Moving beyond policy and rhetoric, in: African Sociological Review, Vol. 5, Issue 2.

Ayieko M A (1998): From single parents to child-headed households: The case of children orphaned by AIDS in Kisuma and Siaya Districts (Study Paper No. 7), New York: UNDP.

Barnett T (2004): HIV: A challenge for Anthropology, in: Anthropology Today, August 2004, Vol. 20, No. 4, pp. 2-3.

Barnett T & Whiteside A (2002): AIDS in the twenty-first century, Disease and Globalisation. New York: Palgrave Macmillan.

Campbell C (2003): Letting Them Die: Why HIV/AIDS prevention programmes fail. Indiana University Press/James Currey/Juta Doublestorey.

Central Bureau of Statistics (CBS) (Kenya), Ministry of Health (MOH) (Kenya) and ORC Marco (2004): Kenya Demographic and Health Survey 2003. Calverton, Maryland: CBS, MOH, and ORC Macro.

Desmond, C, Michael, K, Gow J (2000): The Hidden Battle: HIV/AIDS in the Family and Community, Health Economics & HIV/AIDS Research Division (HEARD), University of Natal, Durban (Paper).

Erulkar, A S (2004): The Experience of Sexual Coercion Among Young People in Kenya, in: International Family Planning Perspectives, Vol. 30, No. 4, pp.182–189.

Fox M P, Rosen S, MacLeod W B et. al. (2004): The impact of HIV/AIDS on labour productivity in Kenya, in: Tropical Medicine and International Health, Vol. 9, No. 3, pp. 318-324. March.

Human Rights Watch (2003): Vol. 15, No. 5 (A), III; March; http://www.sarpn.org.za/documents/d0000333/P313_Kenya_Report_Background.pdf; accessed 21 April 2005.

Human Rights Committee (2005): Review of Kenya's Compliance with the ICCPR. New York March 10;

http://hrw.org/english/docs/2005/03/16/kenya10330_txt.htm; accessed 21 April 2005.

Hunter S (2000): Reshaping societies: HIV/AIDS and social change: A resource book for planning, programs and policy making, Glen Falls, NY: Hudson Run Press.

ICL/I Choose Life Kenyatta University Baseline Survey Report (2004): HIV and AIDS knowledge, attitudes and practice (KAP) survey among students. December.

International Labour Organization (2004): HIV/AIDS and work: global estimates, impact and response. Geneva.

Jobson M (2004): The intersection of gender, HIV/AIDS and human rights, in: Welpe I, Thege B, Henderson, S (eds.): The Gender perspective. Innovations in economy, organisations and health in the Southern African Development Community (SADC), Frankfurt am Main: Peter Lang Verlag, pp 314 – 353.

Johnston T (2002): Kenyan men: Violence and abuse. Population Communication Africa, Nairobi: New World Printers.

Longfield K, Glick A, Waithaka M, Berman J (2003): Dangerous Liaisons. People in cross-generational relationships underestimate risk, Population Services International (PSI), Research Brief No. 2, February.

Ministry of Health (2001): AIDS in Kenya. Background, projections, impact, interventions, policy. 6th edition.

Ministry of Health in collaboration with the National AIDS Control Council (2001): National Condom Policy and Strategy 2001 – 2005, September.

Society for Women and AIDS in Kenya & The Panos Institute (2002): Men, HIV and AIDS in Kenya, Panos SWAA Report, October.

The Gender and HIV /AIDS Technical Sub-Committee of the National AIDS Control Council (2002): Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan 2000-2005, November.

UNAIDS (2000): Men make a difference. Men and AIDS – a gendered approach. 2000 World AIDS Campaign, March.

UNAIDS & WHO (2005): AIDS Epidemic Update, December 2005.

UNAIDS, UNFPA, UNIFEM (2004): Women and HIV/AIDS. Confronting the Crisis.