

# **The Contribution of Culture and Social Capital to Adoption of HIV and AIDS Prevention Measures in Kenya**

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## **Abstract**

The prevalence of HIV in Kenya has increased from 6.7% in 2003 to 7.4% in 2008 despite intensified promotion of prevention measures such as condom use, screening for HIV at Voluntary Counselling and Testing centres and circumcision. Culture has been recognised internationally, in the Millennium Development Goals, as pivotal in preventing HIV infections. The author has attempted to determine, through field research in selected communities in Kenya, how this international concern is played out at the local level in terms of incorporating a cultural dimension into HIV prevention measures and determining how culture influences the adoption of HIV prevention measures. My research was influenced by Social Capital: an understanding that a peoples' culture is full of social resources such as honesty, trust, norms, values, relationships and other networks which facilitate adoption or non adoption of HIV prevention measures. The results indicate that current HIV prevention measures target the youth; with social capital either promoting or hindering the adoption of HIV prevention measures. Many circumcised boys, for example, bond and become a source of encouragement to peers to adopt HIV prevention measures, such as condom use and screening for HIV in groups. Upon maturation, they marry and abandon HIV prevention measures in pursuit of cultural values; such as children and prestige, leading to unprotected sex with multiple sexual partners. Among the Luo of Nyanza Province, the Council of Elders was initially opposed to adoption of circumcision as an HIV prevention measure. Politicians convinced and sought support from the elders prior to adoption of circumcision as a prevention measure. Therefore, in order to change the face of HIV and enhance adoption of HIV prevention measures, the elderly and mature members of communities should be a new focal point instead of only addressing the youth who are already receptive to change.

## **Introduction**

The prevalence of HIV in Kenya has increased from 6.7% in 2003 to 7.4% in 2008 (KAIS, 2008). This increase, reflects, to a great extent, minimal adoption of healthy sex behaviour and prevention measures that are promoted by the international community, Government of Kenya (GoK) and Non-governmental organizations (NGOs), such as Abstinence, Faithfulness to One Sexual Partner, the Use of Condoms (ABC), screening for HIV at Voluntary Counselling and Testing (VCT) centres, prevention of mother to child transmission (PMTCT), early treatment of sexually transmitted infections (STIs) and promotion of male circumcision (UNAIDS/WHO, 2007). A higher proportion of women age 15-64 (8.7%) than men (5.6%) are infected due to a number of economic, cultural, political and gender-specific factors which make them more susceptible to infection than boys and men (UNAIDS/WHO, 2007; NASCOP, 2005). The distribution of HIV infection in Kenya varies depending on geographic location with Nyanza Province at 15.3% having more than double the national prevalence estimate (KAIS,

2008). The challenge of disparities in HIV prevalence along geographic or cultural identities remains.

There has been a debate on the role of culture and social capital in adoption of HIV prevention measures. Some scholars, on one hand, argue that culture and social capital hinder (Igumbor, Pengpid & Obi, 2006), while on the other hand, some scholars perceive the two phenomena as facilitators to adoption of HIV prevention measures (Shapiro & Kapiga; 2002; Kebaabetwa & Norr, 2002; Le Coeur & Lallemand, 2002). Prior to 1980, international policy makers often ignored cultural factors when interventions were introduced to address societal problems resulting to non-adoption (Thomson (1969:5). However, this trend changed since the inception of HIV; with greater reflection on the role of culture and social capital in preventing the spread of the epidemic. Global debates over the driving forces and underlying conditions perpetuating HIV and AIDS in the 1990s have generated greater awareness of how significantly interactions of individuals in a community influence its transmission (United Nations, 2005; <http://www.portal.unesco.org/en/ev>).

The Joint United Nations Programme on HIV/AIDS office (UNAIDS) and World Health Organization (WHO) are currently prioritizing an examination of cultural practices underlying susceptibility of communities to HIV/AIDS (UNAIDS/WHO, 2004). Furthermore, the United Nations (UN) and the World Bank (WB) launched a major collaborative project in May 1998 on the link between health and culture by the United Nations Education Scientific and Cultural Organization (UNESCO) and UNAIDS: *The Cultural Approach to HIV/AIDS Prevention and Care* (<http://portal.unesco.org/en/ev>). Also, the Millennium Development Goals (MDGs) report reiterates that the complex interplay between issues of development and culture must be prioritized if the target of the sixth goal of combating the HIV and AIDS epidemic is to be achieved by 2015 (United Nations, 2005). Therefore, in combating HIV/AIDS, as part of an effort to address the sixth MDG, an understanding and an appreciation of the culture and social resources of affected communities must be integrated in the prevention measures, especially in Sub-Saharan Africa (SSA) which has been heavily hit by the epidemic.

The challenge to researchers is to determine whether and how this international concern is played out at the local level; both in terms of incorporation of culture into HIV

intervention measures and its influence on adoption of prevention measures. Researchers are also recognizing that efforts to combat epidemics must take into account the needs of the society as a whole in planning viable solutions for effective HIV/AIDS programming when they state:

The development of effective HIV prevention programs requires careful and detailed attention to a number of factors, such as cultural and social aspects of people's situations. Good social research will allow us to identify these factors and determine which appropriate approaches will most likely be effective (Fan, Conner and Villarreal, 2005:195).

In Africa, and Kenya in particular, there has been limited empirical research focused on demonstrating how people relate to HIV prevention measures and strategies from a cultural and social perspective. The existing literature has yet to address whether or not the indigenous cultures and social resources of communities are being appropriated in the development and implementation of HIV prevention measures and strategies, and how the influence of these cultures and social resources serve to determine their patterns of adoption. For instance, there is limited data on whether social capital (in particular access to HIV information, participation in ceremonies/rituals, trust of community members, respect of values, norms, power relationships, structures and Afrocentric world view) contributes to determining adoption of HIV prevention measures in Kenya.

This paper helps to clarify the two positions that have dominated debates among scholars: those who argue that culture and social capital hinder and others who argue that they facilitate adoption of HIV prevention measures. Empirical data will shed light on this issue through an examination of the complex interplay between an African cultural context, social resources and the effectiveness of programmes for prevention of HIV put in place by the GoK and some NGOs in Kenya. Our thesis is that culture and social capital are like a double edged sword; they either hinder or enhance adoption of HIV and AIDS prevention measures and strategies in Kenya.

### **Link between Culture, Social Capital and HIV Prevention**

Culture is the sum total of what an individual acquires from his/her society: beliefs, values, customs, artistic norms, food habits and crafts which are acquired through interaction with the past and conveyed by formal or informal education (Shorter, 2001). The inherited cultural "lens" enables an individual to perceive and understand the world, and to learn how to live within it based on a set of guidelines or norms. At a communal

level, culture is perceived as being composed of ideals, values and norms that regulate life within a community. A breach of cultural norms can lead to varied sanctions and punishments

The concept of social capital has been conceptualized differently by scholars depending on areas of emphasis. Putnam, for example, stressed the role of social capital in economic development through civic engagement (Putnam, 1993). Another key scholar, Coleman (1988) focused on the role of social relationships in the creation of human capital. Woolcock (1998) has defined social capital in terms of social networks or institutional relationships. Social capital emphasizes attributes such as trust (Putnam, 2000), reciprocity (Boneham & Sixsmith 2006), information management (Afifi & Weiner 2004) and participation in collective decision making (Beaudoin, et al., 2006). Some scholars argue that social capital presents both positive and negative effects to a community (Kawachi et al. 2004; Kawachi & Berkman, 2000; Stole, 1998; Portes & Landolt, 1996).

Social capital, with regard to interpersonal relationships (Putnam, 2000) has been identified with positive health outcomes in many studies (Szreter and Wollocock, 2004; Veenstra, 2002; Veenstra, 2000; Putman 2000). For instance, people with increased social capital better cope with stresses and live longer than those with less social capital (Cattell 2001; Kawachi et. al., 1997). Again, rich people with increased social networks are better able to manage health challenges compared to the poor who lack human and economic resources to sustain good health care (Cattell, 2001). Other positive effects of social capital in health care include: positive association between belonging to organizations and self-reported somatic symptoms (Yamaoka, 2007) and maternal social capital and improved child nutrition status (Silva & Harpham, 2006).

Studies further demonstrate that participation in local community groups is often positively associated with psychological and social determinants of safer behavior to avoid HIV infection (Horizon, 2006; Jana *et. al.*, 2004; Gregson, *et al.* 2003). However, there is variation in the ability to forge community groups with informal settings demonstrating greater success in building strong peer education groups for HIV prevention than formal settings (Campbell *et al.*, 2002). Data further show that males in

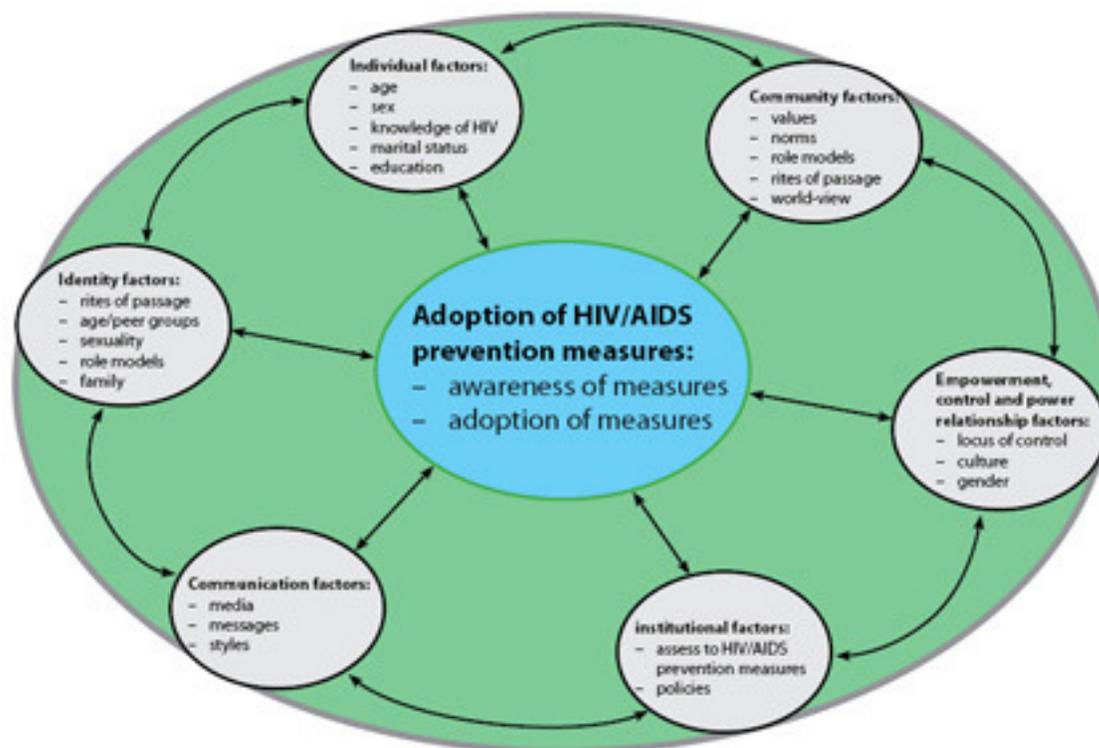
households with greater cognitive social capital have lower HIV prevalence than those in households with less cognitive social capital (Pronyk, *et al.*, 2008).

In view of the apparent relationship between culture, social capital and HIV prevention, critical questions remain unaddressed in Kenya. For instance, is culture and social capital a panacea to acceptability of HIV prevention measures in Kenya? If indeed they are, do programme implementers, researchers and politicians understand the operations and dynamics of these two aspects in influencing HIV prevention measures and strategies? The reality of the matter is that there is need to search deeper in order to comprehend the contribution of culture and social capital in HIV prevention in Kenya. This calls for use of theoretical and conceptual models that can contribute toward a deeper understanding of how culture and social capital interact with HIV prevention measures. This paper adopts perceptions of social capital as measured through structures and relationships (structural social capital) as expounded by Putman (1993) and as crucial resources for survival of a community through trust, reciprocity and social harmony (cognitive social capital) as envisioned by Coleman (1988).

### **Theoretical and Conceptual Perspectives**

A conglomeration of ideas derived from reviewed theories were appropriated in our conceptual model for understanding determinants of culture and social capital in adoption of HIV prevention measures in Kenya as demonstrated in Figure 1. The diagram shows cross-currents of interaction and the influence of culture and social capital on adoption and non-adoption of HIV/AIDS prevention measures. The relationships shown in Figure 1 are complex and rarely strictly linear, reflecting how intertwined are the myriad cultural and social factors influencing people's decisions on whether or not to adopt HIV prevention measures and strategies. Such decisions may be made at a given time ( $T_n$ ), taking into consideration several factors. The two outcome measures for our studies, based on the interaction of these variables, are: the level of awareness of HIV prevention measures and strategies; and the adoption, or non-adoption, of HIV/AIDS prevention measures.

**Fig. 1: Cultural and Social Determinants of Adoption of HIV Prevention Measures and Strategies**



Source: Author’s own conceptualisation

The variables and corresponding measurements for two factors presented in this paper; namely community and power relationships, are shown in Table 1.

**Table 1: Specification of Exposure Variables for our Studies**

Factor	Variable	Measurement
Community	<ul style="list-style-type: none"> <li>• expected values, norms and worldview</li> <li>• availability of role models</li> <li>• positive and negative values</li> <li>• specialist in African traditions like prophets and herbalists</li> <li>• rites of passage</li> <li>• myths and misconceptions</li> <li>• access to relevant information about HIV</li> <li>• sexual taboos</li> <li>• monogamy, polyandry and polygamy</li> <li>• perception of sickness</li> <li>• communal exclusion through violation of norms</li> <li>• excommunication of stigmatized individuals</li> <li>• desire for re-incorporation through rituals.</li> </ul>	<ul style="list-style-type: none"> <li>• rites of passage</li> <li>• African values</li> </ul>

<p><b>Control and power relations</b></p>	<p><b>internal controls:</b></p> <ul style="list-style-type: none"> <li>• perceived ability to control own sexuality</li> </ul> <p><b>External controls:</b></p> <ul style="list-style-type: none"> <li>• vesting sexual decisions in a sexual partner</li> <li>• lack of communication with sexual partner</li> <li>• incidences of rape and sodomy</li> <li>• beliefs of sexual partner</li> <li>• power relations</li> <li>• formal groups</li> <li>• male centeredness and polarization</li> <li>• economic situation</li> <li>• alcohol and drug abuse</li> </ul>	<ul style="list-style-type: none"> <li>• power relationships and their implications on risks for HIV acquisition.</li> </ul>
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Source: author's conceptualisation.

### Methods and Data Sets

This paper is based on five studies conducted by the author in selected communities in Kenya using both quantitative and qualitative methods (Table 2). Ethical clearances were obtained from relevant institutions and written informed consents were administered to study participants. Additional consent was sought in cases of minors who accepted to participate in some of the studies. Data collection comprised three phases. First, focus group discussions (FGDs) were carried out in local languages prior to developing open ended questionnaires to ensure the appropriateness of the sub-ethnic communities' language and content. Moderators used FGD guides as two note takers took notes and tape recorded the proceedings. Transcription and translation of the data from vernacular to English were undertaken prior to analysis using N-Vivo 6 computer soft ware.

Second, surveys were administered to participants who were selected randomly. Open ended questionnaires were used and trained research assistants administered the questionnaires to participants who were randomly selected at health facilities and social places such as market centres. The data were edited, coded, cleaned and entered into the SPSS for analysis. Third, in-depth interviews (IDIs) were conducted with key respondents to clarify unclear issues. Content analysis was used to analyse IDIs.

**Table 2: Data and Methods Used in Studies by the Author**

Author	Objective	Research Questions	Ethnic Community(ies)
Ambasa-Shisanya, 2009	Assessment of adoption of HIV prevention measures in Western	To what extent have HIV measures such as	Luo (Nyanza Province) and

	Kenya	ABC, PMTCT, VCT, screening for STIs, Circumcision and use of PEP been adopted?	Abaluhya (Western Province)
Ambasa-Shisanya, 2006	Comparison of HIV prevention and Care Interventions between the Roman Catholic and Quaker Church in Kibera Informal Settlement -What is the magnitude of adoption of HIV prevention measures and why?	-Do church structures and ideologies influence their responses to HIV prevention and care interventions? -Which church structures promote better management of HIV prevention and care programs and why? -Do the interventions increase or reduce HIV related stigma?	Kibera Informal Setting with varied ethnic compositions
Ambasa-Shisanya, 2005	Assess reasons for continuity of widow cleansing ritual that makes participants susceptible to HIV infection.	-Are condoms used in the ritual? -How is the HIV prevention measure of faithfulness to one sexual partner construed by the Luo?	Luo, (Nyanza Province)
Ambasa-Shisanya, 2004	Analysis of cultural and socio-economic conditions of widows in the era of HIV	-Are condoms used? -Are widow inheritance? -Do people screen for HIV?	Abalogoli, (Nairobi and Western Provinces)
Ambasa-Shisanya, 2002a	Assess how culture and religion influence women's reproductive health	-Who determines sexual issues and how? -Are condoms used? -Is Abstinence and faithfulness model applicable? -Are different knives used during rites of passage? -Is VCT accepted?	Kikuyu (Central Province), Tharaka (Eastern Province) and Luo (Nyanza Province)

## Instrumentation

We assumed that respondents who are knowledgeable about modes of HIV transmission and interventions are better able to adopt HIV prevention measures. Thus, the questions enquired whether respondents had heard about HIV and AIDS, sources of their information, definition of HIV and AIDS, whether they know someone living with HIV and AIDS, whether they think culture makes girls and women vulnerable to HIV and AIDS, identification of HIV prevention measures in their communities; whether they have ever used HIV prevention measures and identification of methods used.

## Results

Quantitative results of the most recent study (Ambasa-Shisanya, 2009) are presented. Additionally, qualitative results from previous studies are highlighted to demonstrate how culture and social capital either enhance or hinder adoption of HIV prevention measures among the Abaluhya, Agikuyu, Luo and Tharaka of Kenya. Social capital and culture are analyzed through lenses of two factors; namely, the community and power relationships.

### General Knowledge about HIV and AIDS

The level of general knowledge about HIV and AIDS was high, with 395 (98.3%) out of 402 respondents indicating that they had heard of the epidemic. Most respondents heard about HIV/AIDS from sick relatives and/or at funerals of relatives (135, 33.5%) showing how devastating HIV/AIDS is on the institution of the family. The radio and media (print and electronic) also served as important channels of communication about the epidemic for many respondents (115, 28.6%). Others learned about HIV/AIDS from teachers in schools (74, 18.4%), churches, nurses, chief's meetings and peers. Men mostly accessed HIV information through the media and chiefs' meetings, while women did so through health centres and nursing of patients. One woman said, "*I first heard about HIV from a nurse at the antenatal clinic.*" (IDI with a woman, Ambasa-Shisanya, 2005) Respondents had a good understanding of what was meant by the words HIV and AIDS. Others defined the epidemic using their cultural worldview, *Ayaki* a Luo term that is synonymous with AIDS (9, 2.2%). The majority 330 (82.1%) had seen someone living with HIV and AIDS. A small proportion of respondents (7, 1.7%) were ignorant of the epidemic. An elderly man observed,

In this area, the major disease is cultural impurity, *chira*, which afflicts those who disregard the laid down procedures. *Chira* leads to extreme thinning of the body, followed by death. Some young people disregard the Luo cultural practices and die due to *chira* if they fail to have their impure state neutralized by a herbalist using traditional herbs called *manyasi*. (IDI with an elderly man, Ambasa-Shisanya, 2009)

Culture was identified as a reason for susceptibility of girls and women to HIV infections 273 (67.9%) through polygamy, sharing of ritual instruments, male prowess and desire for procreation as shown in the following excerpts:

In the Luo community, tradition allows men to be polygamous. Since many people do not screen for HIV before a second or third marriage, it is possible for the senior wife to be infected with HIV if an additional wife or wives are HIV positive. (FGD with women living with HIV, Ambasa-Shisanya, 2009)

When my husband joined the Legio Maria Church, one plier was used to extract the teeth of all members who joined the church with him. When I heard from a nurse that HIV/AIDS could infect someone through sharing of such instruments, I got very worried. (Female FGD, Ambasa-Shisanya, 2005)

Our husbands sometimes engage in extra-marital affairs yet the Roman Catholic Church prohibits the use of condoms. If one tries to express desire for protection, she can easily be beaten for suggesting that a husband is immoral. So, many of us [married women] just accept to have unprotected sex with our husbands. (Female FGD, Ambasa-Shisanya, 2002)

A girl could abstain from sex before marriage or use condoms to prevent infections when still single. However, upon marriage, she is expected to procreate. (FGD, girls in boarding school, Ambasa-Shisanya, 2009)

### Knowledge of HIV Prevention Measures

Respondents were asked about HIV prevention measures in their communities. The use of condoms (329, 81.8%) and abstinence (230, 57.2%) are perceived as more important HIV prevention measures than faithfulness 164 (40.8%). (Table 3)

**Table 3: Respondents' Knowledge of HIV Preventive Measures**

Knowledge of prevention measures	Frequency (%)		Chi-square test	DF	Significance
	Yes	No			
contaminated blood	11* (2.7)**	391 (97.3)	359.204	1	0.000
condom use	329 (81.8)	73 (18.2)	163.025	1	0.000
VCT visit	65 (16.2)	337 (83.8)	184.040	1	0.000
PMTCT	7 (1)	395 (99)	374.488	1	0.000
prompt treatment of STIs	4 (1)	398 (99)	386.159	1	0.000
faithfulness	164 (40.8)	238 (59.2)	13.622	1	0.000
abstinence	230 (57.2)	172 (42.8)	8.368	1	0.004
not sharing unsterilized sharp objects	53 (13.2)	349 (87)	217.950	1	0.000
overall	377 (93.8)	25 (6.2)	661.448	2	0.000

\*Means frequency

\*\* Means percentage

Source: Field work Ambasa-Shisanya, 2009

Such attitudes were also revealed in separate FGDs with male and female respondents, as illustrated in the following excerpts:

Male condoms are the most common and sure way to protect oneself from HIV infection. The government provides free samples at health facilities and some of us, especially those

whose spouses are HIV negative, have found condoms very useful in protecting them from infections. (FGD, Men living with HIV, Ambasa-Shisanya, 2009)

The best way for a girl to avoid HIV infection is to abstain from sex. It is impossible to know the level of faithfulness of men since the Luo culture allows them to befriend and also marry many wives so as to earn respect in the community. (FGD, girls primary boarding school, Ambasa-Shisanya, 2009)

The data were disaggregated based on socio-economic characteristics. Respondents in the Siaya district were more knowledgeable (194, 51.5%) about HIV prevention measures, in comparison with those in the Busia district (183, 48.5%). A chi-square test (chi-square=573.796,  $p<0.0001$ ) indicated a significant difference in the respondents' level of knowledge of HIV prevention measures between the two districts. More females (227, 60.2%) than males (150, 39.8%) were knowledgeable about HIV prevention measures, probably due to the greater level of interaction of females with health-care facilities and service providers, with such interactions taking place at family planning clinics, ante and post-natal clinics and VCT centres where information about HIV is disseminated.

Levels of education could be correlated with levels of knowledge about HIV prevention measures. Respondents with a primary level of education and above were more knowledgeable compared with those without any formal schooling. Respondents who had attained university level education were the most knowledgeable about HIV prevention measures. A chi-square test statistic (23.910,  $p<0.000$ ) revealed that the differences observed based on the level of education were significant.

A chi-square test statistic (chi-square =661.448) shows that the difference noted in the respondents' level of knowledge is highly significant ( $p<0.000$ ), indicating that social factors, among others, are key in determining access to HIV and AIDS prevention information. The lowest test statistics for Abstinence, Faithfulness and Condom Use (ABC), show that most respondents were more aware of these three measures, in comparison with other HIV interventions (chi-square = 8.368, 13.622 and 163.025 respectively). The high proportion of respondents who failed to mention other HIV prevention measures, such as PMTCT and PEP, indicates a very low level of awareness of the interventions that could lead to HIV transmission out of ignorance.

## Adoption of HIV Prevention Measures

Our research findings indicate a variation in the influence of culture and social capital in adoption of HIV prevention measures by either enhancing or hindering adoption of the measures in selected communities in Kenya. Respondents had adopted HIV prevention measures as indicated in Table 4.

**Table 4: Adoption of HIV Preventive Measures**

Adoption of Measures	Frequency (%)		Chi-square test	DF	Significance
	Yes	No			
Male condom-vaginal	244* (60.7)**	158 (39.3)	223.940	2	0.000
Male condom oral	8 (2)	394 (98)	745.254	2	0.000
Male condom anal	10 (2.5)	392 (97.5)	739.657	2	0.000
Female condom	50 (12.4)	352 (87.6)	800.747	3	0.000
VCT before marriage	120 (30)	282 (70)	488.806	3	0.000
VCT after marriage	101 (25)	301 (75)	302.642	2	0.000
Decline to breast-feed	8 (2)95	394 (98)	959.214	3	0.000
Prompt treatment of STIs	56 (14)	346 (86)	779.711	3	0.000
Use of Nevirapine	12 (3)	390 (97)	930.796	3	0.000
PEP	8 (2)	394 (98)	694.075	2	0.000

\*Means frequency

\*\* Means percentage

Source: Field work, Ambasa-Shisanya, 2009

### *Condom Use*

The use of condoms for vaginal sex is high 244 (60.7%) compared to its use for other sexual orientations; anal sex: 10 (2.5%) respondents; oral 8 (2%) respondents; and female condoms 50 (12%) respondents. Differentials in the pattern of adoption were noted with most adoptors (233, 95.5%) being less than 40 years of age. The majority of the adopters (114, 46.7%) were in the 21-30 year age bracket, while there were no respondents who had adopted the use of condoms in the age brackets 51-60 years, and 61

years and above. The data were subjected to a chi-square test and a test statistic (chi-square=395.129,  $p<0.000$ ) revealed a significant difference in the pattern of adoption of condoms based on the age of respondents. The majority of respondents with university education, 13 (92.9 %) out of 14 respondents, had adopted the use of condoms while only 1 (7.1%) had not done so.

With regard to gender, more women, (138, 56.6%), than men, (106, 43.4%), had adopted the use of condoms for vaginal sex. In our studies, the majority of women who reported having used condoms were either single or were more likely to have used condoms before marriage. A girl reiterated, *“Many girls in the Agikuyu community insist on using condoms to avoid pregnancy and STI, but the situation changes after marriage”* (FGD with youth, Ambasa-Shisanya, 2006). This view was supported, in different studies, by respondents who observed:

When I was in college, I always insisted on using condoms to avoid sexually transmitted infections, HIV and pregnancy. My wedding night marked my first sexual encounter without a condom because I was now a married woman. (IDI with a young woman, Ambasa-Shisanya, 2009)

We [men] pay bride wealth before acquiring wives in the Tharaka community. They [wives] are like our property and we can engage in sex or beat them at will when we want to do so. (Male FGD, Ambasa-Shisanya, 2002)

Condoms are for use with young girls, commercial sex workers and casual female friends but not with wives. Sex should be “skin to skin” to demonstrate trust, love and procreate. (FGD with married men, Ambasa-Shisanya, 2002)

In a different study, a large proportion of men (206, 76.1%), out of 271 respondents, was unwilling to use condoms compared to (65, 23.9%), which did not mind using them (Ambasa-Shisanya, 2002). Reasons given for failure to use condoms included, *“They [condoms] reduce sexual pleasure.”* (IDI with a married man, 2002); *“They [condoms] stick in the vagina.”* (FGD with married women, 2005); *“The Roman Catholic Church prohibits the use of condoms since they kill lives and promote promiscuity.”*(FGD with married men, Ambasa-Shisanya, 2006); *“Condoms are laced with a lubricant that causes AIDS.”* (FGD with men, Ambasa-Shisanya, 2005)

Results showed that condoms are not used correctly and consistently due to community factors, like development of trust between sexual partners, night discos at funerals, drug abuse and economic inhibitions. Some participants noted,

Condoms are used at the beginning of relationships but are dropped after two or three sexual encounters to facilitate more enjoyment. Again, some girls and women believe that using condoms means lack of trust; yet they would like to be trusted and married by the men. (FGD, married men, Ambasa-Shisanya, 2009)

Some boys purchase condoms in preparation for the funeral discos where they meet with their girl friends for sexual relationships. Unfortunately, they forget to wear them especially after taking alcohol. Furthermore, it is difficult to wear condoms in darkness [the bush] unless someone can afford a torch and batteries. (FGD, young men, Ambasa-Shisanya, 2009)

The use of female condoms for protection against HIV increases with the level of education: 3 (6%) for those without any formal education; 10 (20%) for those with a primary-school education; and 17 (34%) for those with secondary-school education. Women who belong to the POTAWA support group mentioned adoption of female condoms irrespective of their education background. A husband to one of the women observed, *“I do not like male condoms; but my wife uses female condoms because she would like me to take care of our three children in case she dies.”* (IDI with man, Ambasa-Shisanya, 2009) The data were subjected to a test statistic and the test result (chi-square= 231.910,  $p < 0.000$ ) shows a significant difference in the pattern of adoption of condoms based on the level of education.

### *VCT Uptake*

120 (30%) of the respondents had adopted the use of VCT before marriage. The majority of adopters were female (74, 61.7%) in comparison to the male respondents (46, 38.3%). Most adopters of VCT before marriage were below 40 years of age (115, 95.7%), with a half of the adopters belonging to the 21-30 age group (60, 50%). Only 3 (2.5%) of the respondents without any formal education had adopted VCT, but the number increased to 27 (22.5%) among those who had a primary-school level of education and increased further to 60 (50%) among respondents who had attained a secondary-school. Group support for VCT counselling exists in the areas of study. Commenting on this aspect, a university student reiterated:

My fellow comrades suggested that we may support each other emotionally and go for HIV screening. We were afraid that we could have contracted the deadly virus but encouraged each in order to make informed choices about our health options. Our group had seven members. Four of them had been circumcised jointly in an indigenous ceremony that is observed by some sub-ethnic groups within the broader Abaluhya community. The strong bond among the “four brothers”, as they referred to themselves, and the desire to support

each, other irrespective of the VCT results, gave us courage to proceed with the HIV screening. (IDI with a young man, Ambasa-Shisanya, 2009)

Only 101 (25%) of the respondents had adopted the use of VCT after marriage. More females (68, 67.3%) than males (33, 37.7%) had adopted this HIV preventive measure because of the mandatory screening during visits to antenatal clinics. In a respondent's own words:

These days, the health service providers demand that expectant mothers be screened for HIV at VCT when they seek for antenatal care. If a person refuses to comply with this requirement, then she is likely not to receive appropriate care during delivery. (Female respondent, FGD with married women, Ambasa-Shisanya, 2009)

Some of the reasons given for non-adoption of VCT after marriage include fear of disclosure, stigma and physical violence. A girl and woman observed,

Despite having been faithful to my husband in marriage, I fear to visit a VCT because he could beat and divorce me if found HIV positive. I would rather live in ignorance than initiate a process that will lead to suffering (FGD with married women, Ambasa-Shisanya, 2005).

I do not know what will befall me if found HIV positive. I am afraid of being deserted by my marital partner, friends and relatives (Girl, Ambasa-Shisanya, 2006).

The data in Table 4 were subjected to a chi-square and the test statistic (chi-square =302.642,  $p < 0.000$ ) revealed that the differences in the pattern of adoption among respondents were significant.

### *PMTCT*

Only 12 (3.0%) of the respondents had adopted the use of nevirapine before delivery with the majority among them (8, 66.7%) belonging to the 21-30 year age group. Only 5 (41.7%) respondents who had attained a primary level education had adopted this HIV prevention measure, the number increased to 7 (58.3%) among those who had attained a secondary school education. Most adaptors of the nevirapine intervention (8, 66.6%) had between 1-3 children implying that they visit antenatal clinics. More respondents in Busia District (8, 66.7%) had adopted the use of nevirapine to PMTCT, in comparison with the Siaya District (4, 33.3%). Few respondents 8 (2%) reported declining to breastfeed after delivery compared with 394 (98%) that had not adopted the method. The majority of the adaptors (7, 87.5%) were below 40 years of age, from a

young portion of the population that is receptive to new innovations, in comparison with older respondent who might, in any case, also be past the childbearing age.

When asked whether or not PMTCT preventive measures are undertaken at antenatal clinics, respondents observed that a few women accept being injected to prevent transmitting the virus to their babies, while the majority decline treatment, fearing possible discrimination from service providers or deformity of their offspring. In the respondents' own words:

If found HIV positive, intensive counselling is offered before the concerned woman is treated with an injection to prevent infecting the baby. However, some women refrain from the treatment and stop attending the antenatal clinics altogether. (FGD with women living with HIV, Ambasa-Shisanya, 2006)

Some women fear that their babies could be deformed if they were to be injected to prevent transmitting HIV to their children. While others fear the possibility of being stigmatized by service providers and, hence, prefer to visit TBAs instead. (FGD with women, Ambasa-Shisanya, 2005)

When respondents in FGDs were asked reasons for non-adoption of declining to breastfeed to PMTCT of HIV, some indicated the fear of discrimination and the influence of mothers-in-laws as shown in the following excerpts,

When a woman fails to breast feed, people in the village begin spreading rumours about the persons' positive HIV status. This leads to discrimination in accessing social amenities such as drawing water from the well. The fear of being discriminated against by members of the community compels many women to continue breastfeeding even when aware of the danger of possible transmission of the HIV to their babies (FDG with women, Ambasa-Shisanya, 2009)

I delivered a baby boy who was HIV negative. The nurse instructed me to breastfeed exclusively for six months. My mother-in-law started feeding the baby on porridge and water because she argued that baby boys require more food than girls. Right now, I am afraid of visiting the post-natal care clinic because my baby has put on too much weight that might make the nurse suspect that I ignored her rule of exclusive feeding. (FDG with women, Ambasa-Shisanya, 2009)

More respondents from the Busia District (5, 62.5%) had declined to breast feed to PMTCT compared with the Siaya district (3, 37.5%). The data on declining breastfeeding to PMTCT were subjected to a chi-square (Table 4) and the test statistic (chi-square =959.214,  $p < 0.000$ ), reveal that the differences in the pattern of adoption of the prevention measure were significant.

### *The Use of PEP*

The results in Table 4 show that only 8 (2.0%) respondents had adopted PEP compared with 394 (98%) non-adopters. An equal number of males (4, 50%) and females (4, 50%) had adopted the preventive measure suggesting that both genders are at risk of HIV infection. A greater number in Busia (7, 87.5%) were exposed to PEP than in Siaya (1, 12.5%). The data were subjected to a chi-square test and the test statistic (chi-square = 694.075,  $p < 0.001$ ), was found to be significant, revealing variations in the adoption of PEP by respondents in the Busia and Siaya districts. When asked in FGDs whether or not PEP is used in the area, respondents observed that silence after rape ordeals and lack of knowledge about the HIV prevention measure could be contributing to its low uptake. Some respondents observed,

Cases of rape occur in families but silence is maintained to avoid stigmatizing the girls, men involved and their families. Few parents take their daughters to the Busia District Hospital for medical attention after rape ordeals. (FGD with male respondents, Ambasa-Shisanya, 2009)

Many people do not know that they could be saved from infection if they rush to hospitals immediately after exposure to the HIV because the information has not been disseminated to the public. The majority of people in this area only get to know about the intervention when they take their daughters to hospital after rape. Surprising, some people even rape young boys as well. (FGD with male respondents, Ambasa-Shisanya, 2009)

### *Prompt Treatment of STIs*

The results in Table 4 reveal that 56 (14%) respondents sought prompt treatment for STIs and STDs, compared with the large proportion of respondents 346 (88%) that had not. The majority of respondents (50, 89.3%), who had sought prompt treatment for STIs and STDs were below 40 years of age. More females (37, 66.1%) than males (19, 33.9%) had sought the prompt treatment for STIs and STDs. The result implies that females are more vulnerable to STI and STD infections, which could be attributed to many factors, including their lesser ability to negotiate with male partners for safe sex.

The results show that STIs are more prevalent in Busia District (45, 80.4%) than in Siaya District (11, 19.6%). Regarding ethnicity, the Abaluhya (31, 55.4%) had sought prompt treatment of STIs with greater frequency, in comparison with the Luo (16, 28.6%). In a different study, Siaya District, with (126, 46.6%), out of 271 male respondents, and ( 63, 22.8%) out of 276 female respondents, was ahead of Tharaka and

Kiambu districts which reported relatively low incidences of itching of genitals, six months prior to the study (Ambasa-Shisanya, 2002). Cases of preference for indigenous medication could explain the low uptake of this intervention measure (prompt treatment of STIs) among the Luo. A man observed,

When I started feeling itchy, I knew that it was punishment for breaking a cultural norm that prohibits incest. A herbalist gave me medication, *manyasi* to neutralize the cultural impurity *chira*. (IDI, Ambasa-Shisanya, 2002)

Results from our five studies demonstrate that cultural rituals, norms and structures regulating sex encourage infections with STIs. In one of the studies, (514, 94%) of the 547 respondents had had between one and four sexual partners six months prior to the study (Ambasa-Shisanya, 2002). Respondents identified increased sexual encounters as facilitators to infections with STIs as shown in the following excerpts,

Our Abaluhya community expects mature boys to construct cottages, *esimba* so that they can lead independent lives rather than sleep under the same roofs with their fathers as if they were children. When in the cottage, young men are expected to invite their girl friends and experiment on sexual life. Such sexual experiences require skin to skin sex so that the girls can appreciate the performance. (FGD with young men, Ambasa-Shisanya, 2002)

Among the Luo, we have many cultural practices that require sexual rituals. Sex precedes almost all socio-economic activities: preparing the land, planting, weeding, harvesting, construction of houses, moving to new homesteads, cleansing of widows and many other practices. These practices can only be real if a man ejaculates in a woman. In this case, barriers such as condoms cannot be utilized. (FGD with married men, Ambasa-Shisanya, 2005)

The importance of the rite [excision of the clitoris among the Tharaka] is to prevent immorality among women. But today, the situation has changed because girls who are circumcised tend to be more immoral. (Female FGD, Ambasa-Shisanya, 2002)

Circumcision among the Agikuyu boys and girls prepared them to engage in sexual matters. Even today, the majority initiate sex after the rite of passage. (IDI with a male respondent, Ambasa-Shisanya, 2002)

Therefore, the cultural sleeping arrangements that allow teenagers to experiment with their sexuality; beliefs that ritual sex should be unprotected; perception that initiation is a licence to sex; demonstration of male prowess through many sexual partners; contribute to the risk of STI and HIV infections in the areas of study. The survey data (Table 4) were subjected to a chi-square test and the test statistic (chi-square =779.711,  $p < 0.001$ ) revealed a significant difference in the pattern of adoption of this HIV prevention measure.

## Discussion

### *Relationships and Structures in the Community as Facilitators and Barriers to Transmission of HIV Information*

Our studies investigated whether culture and social capital contribute to HIV knowledge and adoption of HIV prevention measures in selected communities in Kenya. We expected a variation in the level of knowledge and adoption of HIV prevention measures due to differences in cultural and social contexts among the Abaluhya, Agikuyu, Luo and Tharaka ethnic communities of Kenya. The findings showed that the level of knowledge about HIV influenced adoption of HIV prevention measures; with the highly educated having more information and adoption of HIV measures than the less educated. Indeed, knowledge about a phenomenon determines the level of response to the challenge at hand (Catania, Kegeles and Coates, 1990; Rosenstock, Stretcher and Becker, 1994; Bandura, 1989).

Our five studies demonstrate that different aspects of social capital are pivotal for achieving different goals in HIV interventions. Bridging, bonding and linking (see Szreter & Woolcock, 2004) are all instrumental in transmitting HIV and AIDS information in the areas of study. Bonding of family members, for example, enable people to learn about HIV and AIDS as they care for ailing relatives or during funerals ceremonies. Funerals are mandatory socio-religious functions through which relatives bond as they participate in related rituals such as eating beef from a bull or cow that are slaughtered to symbolize manhood and womanhood, respectively (Ambasa-Shisanya, 2004; Genep, 1960).

The bridging aspect of social capital that focuses on relationships between people who are aware of their social differences (Szreter & Woolcock, 2004) enable people in the areas of study to receive information about HIV and AIDS through the print and electronic media. HIV and AIDS information that is transmitted through the media is intended to reach many people in varied contexts. Usually, emphasis is put on the need for people, irrespective of geographic and socio-economic differences, to adopt HIV prevention measures such as condoms, PMTCT and VCT. Such information is diversified and rich in content, especially when health professionals address varied aspects of the

epidemic. Consequently, individuals who access HIV and AIDS information through the print and electronic media tend to be more knowledgeable, about HIV transmission and prevention measures, than people who rely on relatives and peers as their only sources of information.

The linking aspect of social capital where people differ in social spheres but interact within institutional roles (Szreter & Woolcock, 2004) is also crucial in disseminating HIV information in the areas of study through institutions such as schools, clinics, churches, NGOs and the chief's meetings. Nurses disseminate information about VCT and PMTCT at antenatal and postnatal clinics while clinicians disseminate information about PEP at the Causality Department. A priest, for example, disseminates HIV information to members of St. Monica Women's Group and performs religious and cultural rituals instead of letting widows to re-marry and get exposed to HIV transmission (Ambasa-Shisanya, 2007; 2005).

Sometimes, social values and worldview enhance an understanding of the epidemic in some communities. Some respondents defined the epidemic using their cultural worldview by referring to *ayaki*, a cultural impurity among the Luo that is believed to lead to thinning and death. The Abaluhya defined HIV by comparing it to execution by electricity or a cow swallowing a nylon paper that leads to thinness and death (Ambasa-Shisanya, 2009; 2004; 2002). Such a cultural re-definition of HIV and AIDS is significant because it reveals a process of appropriation by community of the epidemic, instead of a perception of it as a foreign disease. When a community identifies and perceives a problem as being a threat to its survival, it takes initiatives to prevent the problem as stated in the AIDS Risk Reduction Model.

Results of our studies also underscore the importance of cultural beliefs, rituals and indigenous specialists as barriers to proper knowledge about HIV and subsequent uptake of preventive measures. The Luo belief in cultural impurity, *chira*, whose symptoms are similar to those of AIDS, seems to confuse some people who fail to draw a clear distinction between the two phenomena leading to transmission of HIV out of ignorance. Again, the cultural belief of impurity and witchcraft could hinder people living with HIV and AIDS (PLWHAs) to seek early treatment and care. The gender roles, that keep women at home as men listen to information at meetings hosted by chiefs, could

make females to lag behind in acquiring information about HIV and AIDS in the areas of study.

*Relationships, Structures and Power Control as Facilitators and Barriers to Adoption of Condom Use Among the Abaluhya, Agikuyu, Luo and Tharaka*

Relationships and structures as well as power relationships were found to either promote or hinder adoption of HIV prevention measures in the areas of study. The cultures of the four communities emphasize procreation; hence, sex is expected to be heterosexual, and genital (Ambasa-Shisanya, 2002; Ocholla-Ayayo, 1996; Kenyatta, 1932). This cultural norm (of vaginal sex) partly explains the receptiveness of male condoms by the youth in the areas of study. This finding corroborates the diffusion theory which states that the worldview and expectations of a social system, to a great extent, determine the pattern of adoption of new innovations (Airhihenbuwa, 1989; Rodgers, 1985).

However, the patriarchal structure among the Abaluhya, Luo and Tharaka allows men to control all matters including sexual relationships (Bem, 1993). This cultural expectation is reinforced through the payment of bride wealth that transfers the sexual rights of brides in Africa from fathers and brothers to spouses (Oduyoye, 1995). Marital relationships, therefore, render the use of condoms problematic. An introduction of condoms arouses suspicion because they are associated with prostitution and often result to physical violence and divorce (United Nations, 2006; KDHS, 2003; Bauni & Jarabi, 2000).

Sometimes, social networks in matrilineal communities, like the Agikuyu, provide a provision for women to partly control their sexuality through economic empowerment (Ambasa-Shisanya, 2004; Kenyatta, 1932). Agikuyu girls are not pressurized to get married and often inherit land and other material resources unlike among the Abaluhya, Luo and Tharaka. The economic empowerment enables Agikuyu women to negotiate for safe sex through use of female condoms, unlike their counterparts in the other three communities who rely on men for economic support and control over their sexual matters.

Some aspects of social capital, such as trust and respect in relationships, were found to hinder consistent use of condoms in the areas of study. Girls and women were reported as the most trusting and respecting; hence, continued use of condoms is tantamount to mistrust and disrespect to sexual partners. Yet unprotected sex increases the susceptibility of girls and women to infection with HIV (KDHS, 2003). Another negative effect of social capital is manifested in socio-cultural ceremonies, like funerals, that create opportunities for taking of drugs which inhibit correct and consistent use of condoms in the areas of study.

#### *Age-sets and Indigenous Practices Surrounding Motherhood as Supportive Structures for Adoption of VCT*

Some scholars argue that integration into a social system can serve to inspire participants to behave in a manner prompting positive outcomes (Putnam, 2000). Results show that some circumcised Abaluhya boys bond and become a source of encouragement to peers to adopt HIV prevention measures, such as condom use and screening for HIV. Such a strategy is encouraging, more supportive and based on the communal life of the Afrocentric world view unlike an individualistic approach that is advocated for at VCT centres that was modelled along an Eurocentric world view. There is a disconnect between HIV prevention measures and the communal way of life of the communities discussed in this study. This finding corroborates with the finding that the African world view remains the framework that informs the response toward the pandemic in many parts of Africa (Dube, 2006).

Social capital is further manifested through the structure of ante-natal care, which enables many women to screen for HIV in the areas of study. The bonding aspect (Szreter & Woolcock, 2004) that exists among women at such clinics is coupled with the linking aspect of social capital through service providers, to encourage mothers to screen for HIV and adopt PMTCT, if found HIV sero-positive. The cultural practice that encourages nursing mothers to consult herbalists and traditional birth attendants (TBA) contributes towards acceptability of antenatal clinics in the areas of study. The face-to-face interaction of expectant women with service providers builds trust and subsequent adoption of HIV prevention measures, such as screening for HIV at VCT centres and

adoption of PMTCT measures, to improve the lives of mothers and off-spring. This finding corroborates with the finding of other scholars that ties with formal institutions improves the lives of those in poorer communities (Szreter & Woolcock, 2004).

Further assessment of social capital shows that its structures and relationships equally hinder adoption of VCT among the Abaluhya, Agikuyu, Luo and Tharaka of Kenya. For instance, the power imbalance between men and women sometimes leads to physical violence and divorce, in case the latter are found to be HIV sero-positive (Ambasa-Shisanya, 2009; 2006, 2005, 2002). This finding corroborates with findings from other studies (Masenya, 2002; Oduyoye, 1995) that most women in Africa are subjected to untold suffering if they are found to be HIV positive.

The situation is worsened by lack of economic power that compels girls and women to seek economic support from men through marriage institutions. Consequently, some women fear to screen for HIV prior to and after marriage to avoid losing their spouses. By so doing, many girls and women in the four communities make themselves vulnerable to HIV infections. Indeed, the current dynamics of power governing relations between men and women, deeply rooted in the traditional culture, could well be denying many girls and women the opportunity to negotiate for safe sexual relations and be rendering them highly susceptible to HIV infection (NAS COP, 2005).

*Preference for Traditional Birth Attendants (TBAs), Herbalists and Respect of Mothers-in-law as Barriers to Adoption of PMTCT, PEP and Delayed Treatment of STIs*

It has been suggested that high levels of social capital and community cohesiveness might be protective and facilitate more effective collective responses to the epidemic (Pronyk, et al., 2008). However, our results show the contrary since community cohesiveness, trust and preference for TBAs denies opportunities for adoption of PMTCT in the areas of study. This finding corroborates with findings of other studies that many children get infected at the time of birth due to preference for TBAs who do not practice PMTCT (Le-Coeur and Lallemand, 2002).

Cognitive social capital, in search of family ties and harmony, sometimes compels HIV positive mothers to adhere to the advice of their mothers-in-law to introduce other

foods rather than obey instructions of health providers of exclusive breastfeeding for six months with a view to PMTCT. Mothers-in-law are highly respected by daughters-in-law as a way of maintaining harmony in marriages in the areas of study. To this end, the Afrocentric communal involvement of major stakeholders, such as mothers-in-law and close relatives, could enhance the success of PMTCT rather than the current practice of counselling nursing mothers alone that is centred on Eurocentric individualistic approach to life.

Results from our five studies showed preference for herbalists due to belief in witchcraft in the areas of study (Ambasa-Shisanya, 2009; 2006; 2005; 2004; 2002). Yet in cases of STI infections, herbalists could lack required equipment for screening or administer low dose leading to continued presence of STIs that predispose people to HIV infections. However, the use of herbalists could equally yield positive results in HIV prevention and management; especially if they are trained to play this role. The proximity of TBAs and herbalists to people and the trust that the community has in them could play a crucial role in the uptake of HIV prevention measures. Need arises to educate indigenous healers on how they could serve as access points for HIV prevention, care and treatment as was attempted by in Kwazulu Natal. Results of the study indicated that traditional healers had improved and retained their knowledge of HIV/AIDS/TB, even seven to nine months after their training. They reduced their HIV risk practices and played an important role in giving culturally acceptable STI and HIV/AIDS assessment, counselling and community education (Mngqundaniso, 2006).

#### *Involvement of the Luo Council of Elders and Politicians Created Awareness and Adoption of Male Circumcision*

None of the respondents in our five studies identified male circumcision as a preventive measure for HIV. This happened despite the closeness of the researches to some research sites of the male circumcision randomized single-blinded controlled trial (RCT) and the publicity about its results. The study on the Orange Farm in South Africa showed a 60% protective effect of male circumcision (Auvert, 2005); the Bondo/Kisumu study, conducted in Nyanza Province (53-59% protective effect) and the Rakai study, conducted in Uganda (51% protective effect) (Evert, 2006). Discussions on the efficacy

of male circumcision to prevent HIV infection seems to have been limited to scholars and medical personnel until 2008 when researchers and the Ministry of Health invited the Luo Council of Elders and politicians to persuade the Luo to adopt the measure with a view to reducing the high prevalence of the epidemic in Nyanza Province. The elders opposed the measure, initially, and perceived it as an insult to their cultural values that do not advocate for the rite (Ocholla-Ayayo, 1996). By so doing, social capital served as a barrier to adoption of male circumcision as a prevention measure.

Stakeholders continued to re-negotiate with and recognize some members of the Luo Council of Elders, prompting their acceptance of the intervention (Oral interview with a Male Circumcision Consortium Officer, January 2009). In agreement with the diffusion theory (Rodgers, 1985), the early adopters were instrumental in convincing the rest of the elders to accept the intervention. They invited and presided over meetings to discuss the male circumcision intervention instead of researchers and government personnel assuming the roles (Oral interview with a Male Circumcision Consortium Officer, January 2009). After all members of the Council of Luo Elders had accepted male circumcision as a prevention measure, the council invited Luo politicians to a meeting in September 2008, under the leadership of the Prime Minister, to create awareness about the intervention. The politicians encouraged the Luo to adopt male circumcision; and some publicly announced intentions to undergo the rite. Consequently, there is high awareness, trust, support and high up-take of male circumcision to prevent HIV among the Luo. Therefore, social capital (trust of community leaders), coupled with the positive health outcomes of undertaking male circumcision, have contributed to high uptake of the prevention measure. This practice corroborates the findings of other scholars (Catania, Kegelea and Coates, 1990; Skinner, 1998).

The circumcision findings have a flip side in that the Abaluhya, Tharaka and Agikuyu, who traditionally circumcise their males, have equally been hit by HIV/AIDS, despite having circumcised the men. From an emic point of view, circumcision of boys provides a permit to engage in sex (Vincent, 2008; Kenyatta, 1932). Such beliefs, coupled with the message that male circumcision is an HIV prevention measure, could lead to false hopes and hinder males from actually practicing safe sex (Ambasa-Shisanya, 2009). Therefore, gatekeepers of biomedical findings on the effectiveness of male

circumcision in HIV prevention should present the results in a way that encourages a strategy of dual protection, rather than as a single, autonomous measure given that Luo politicians were silent on this matter. Again, the new integrated social capital (a combination of the Luo Council of Elders, politicians, researchers, NGO partners and the Government that work on the Male Circumcision Consortium) should also encourage the Luo to discard life threatening rituals such as widow cleansing and guardianship for easier buy-in (Ambasa-Shisanya, 2009; 2007).

*Abstinence Protects some Youth from HIV Infection among the Abaluhya, Agikuyu, Luo and Tharaka*

Our studies established that abstinence was promoted in the indigenous settings of the Abaluhya, Agikuyu, Tharaka and Luo; through sex education during rites of passage (Ambasa-Shisanya, 2009; 2002). Indigenous structures were discouraged by missionaries thereby limiting options for the youth to be instructed on sexual matters (Ambasa-Shisanya, 1993). Consequently, sexual debut is lower than in the past (KDHS, 2003). However, in cases, of delayed sexual debut, the youth are protected from HIV infection to some extent. This explains why there has been revival of provision of gifts to men and women in the Buganda Kingdom, virginity testing in Kwazulu Natal and observation of the old chastity custom known as *mcwawasho* (Bruce, 2003). The revival of virginity testing has a flipside and has provoked a remarkable debate with human rights activists condemning the practice as a violation of the rights of young girls due to unreliable screening methods. Besides, some girls who are found to be virgins are rendered susceptible to male rapists who believe they could get cleansed through engaging in sex with virgins (Leclerc-Madlala, 2001). This Zulu belief has been internalised by some men in the Abaluhya, Agikuyu, Tharaka and Luo communities of Kenya leading to raping of virgin girls thereby rendering them susceptible to HIV infections.

*Belonging to Organizations as a Facilitator and Barrier to Adoption of Female Condoms, Avoidance of Risky Widow Cleansing Rituals and Uptake of VCT*

Belonging to organizations is associated with increased social capital that leading to either positive or negative effects to a community (Putnam, 2000). In the areas of

study, PLWHAs have united to form an association called TAPWAK that provides psycho-social support to its members (Ambasa-Shisanya, 2009). A women option of the group, POTAWA, encourages members to adopt female condoms to protect themselves from re-infections. Indeed, the majority of the women in the group utilize female condoms since they know the positive health outcomes. Studies show that females are willing to adopt HIV preventive measures that could protect them from HIV transmission (Esu-Williams and Blanchard, 2002)

Furthermore, the results indicated success in building bonding social capital of Luo widows in Siaya District who declined to be cleansed (Ambasa-Shisanya, 2007; 2005). The Luo believe that a widow becomes culturally impure “*okola*” after demise of a spouse. As expected of rites of passage (Gennep, 1960), the impure state is supposed to be neutralized through a ritual sexual intercourse prior to re-incorporation of the widow into the society (Ambasa-Shisanya, 2007; 2005). In the past, widows were placed under guardianship institutions by their brothers-in-law; but the former are reluctant to do so due to fear of contracting HIV. Instead, professional cleansers have sprung up to cleanse widows at a fee; who could act as a bridge to transmission of HIV from widows to the general public. But some Christian women abhor the practice of widow cleansing and have joined a women’s group called St. Monica Widows Group that provides socio-economic support to its members (Ambasa-Shisanya, 2007; 2005).

Results of a study conducted in the Kibera informal settlements of Nairobi equally demonstrated group cohesion and great support among members of the Roman Catholic Church (RCC) as opposed to those of the Quaker church (Ambasa-Shisanya, 2006). This is because the RCC has a vertical power structure with well managed HIV prevention and care programs, such as VCT unlike the Quaker Church with an horizontal church structure that hinders members from presiding over important issues such as prevention and care of HIV. In the absence of support structures, no one in the Quaker Church had publicly declared his or her HIV status in a view to creating awareness about the epidemic. But in the RCC, many youthful members; who are receptive to innovations unlike the elderly (Rodgers, 1985), had screened for HIV at VCT centres owned by the church. Those found to be HIV sero-positive are supported and cared for by the church. In this way, the institution of the RCC has contributed to the uptake of HIV prevention

measures whereas the Quaker Church acts as a barrier to adoption of HIV prevention measures. This finding corroborates findings of other scholars that social capital either yields positive or negative effects to a community (Szreter & Woolcock 2004; Cattell, 2001; Putman 2000).

## **Conclusion**

The studies provide information that can be used to design interventions to prevent HIV transmission in Kenya and among other populations. Given that communities have different cultures, HIV prevention interventions should respond to specific characteristics and needs as appropriate. An Afrocentric model should be utilized to ensure that social capital that comprises cultural values, channels of communication, community leaders, rites of passage, symbols and rituals; are integrated into HIV prevention programs. By so doing, a previous mistake of utilizing individualistic models based on Eurocentric worldview in HIV prevention will be avoided. Again, focus will be put on involving mature members and elders of communities in HIV prevention interventions in agreement with expectations of African culture that perceives the elderly as reservoirs of knowledge and instruction to younger generations. This could translate into more awareness about HIV prevention measures among mature people and the elderly in Kenyan communities and reverse both the current trend of only addressing the youth who are already receptive to change; and also reduce HIV prevalence rates in the country.

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