GENDER, HEALTH AND DEVELOPMENT ISSUES : THE PLACE OF WOMEN GNOS IN AIDS PREVENTION AND CONTROL IN KISUMU, NYANZA PROVINCE, KENYA

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Introduction

Over the past few years, the incidence of AIDS in Kenya has been on the increase, particularly in major urban centres such as Nairobi, Kisumu, Mombasa, Eldoret, Nyeri, and Nakuru (*cf.* Obudho & Awino, 1992). According to the Kenya National AIDS control Programme (NACP, Sentinel surveillance report), the total cumulative reported AIDS cases in Kenya as of April, 1991 were 17,260 out of which 10,426 were male and 6,834 were female. In 1993, it is estimated that there were about 760,000 people infected with HIV. This includes about 730,000 adults and 30,000 children. The peak ages for AIDS cases is 25-34 for both men and women, indicating that infection occurs during adolescence and early adulthood (*cf.* NACP, 1996).

The adult HIV prevalence was 3.5% in 1990, 4.5% in 1991, 5.3% in 1992, 5.7% in 1993, 7% in 1995 ; with a 13-14% in urban areas and in Kisumu prevalence was quite high estimated at 30%. There are currently over 1.2 million estimated infections in Kenya, although many cases are said to remain unreported and many people do not know their sero-status. The epidemic continues to be powerful and dynamic ; evolving with changing and unpredictable patterns in the communities (*cf.* AIDSCAP/FHI, 1996). This has led to the recognition of the AIDS epidemic as a national dilemma hence its inclusion in the 8th National Development Plan of 1996 to 2000 and in the 6th edition of the District Development Plans, 1996. The Sessional Paper No. 4 of 1997 confirms further the Government of Kenya's commitment in containing the epidemic through the policy direction and implementation (*cf.* Min. of Health, 1997).

Kisumu is Kenya's third largest town. It lies on the shores of Lake Victoria, in Nyanza province. The topographical conditions of Kisumu are not favorable ; the northern part is covered by the lake and swamps, and in the lake shore areas there is a sharp decline of rainfall, usually unpredictable and variable. Due to this, the area is compounded by various problems, some of them directly related and others indirectly, which have greatly affected the people's social welfare. These include inadequate food security, chronic safe water shortages, high levels of malnutrition (ranging between 30-45%), endemic poverty, poor environmental sanitation, increased rate of communicable diseases, poor access to health facilities, high prevalence of illiteracy (particularly among women 30%) and high infant and child mortality

rate estimated at 123 and 199 per 1,000 live-births respectively and this is said to be higher in slums (*cf.* Gov. of Kenya, 1995).

In addition to all these social problems, the National AIDS/STDs Control Programme (NACOP), 1989, showed that Nyanza province had the second highest rate of HIV prevalence in Kenya. Results also from HIV screening of 4,481 in-patients at the Nyanza provincial Hospital showed 1,088 or 24.3% sero-positivity for HIV. Of this, 47% were males and 53% females. The Kenya National AIDS Control Programme (NACP), 1995, surveillance data showed that Nyanza province had 112,166 cases (15+) and out of that Kisumu had 74,060 cases. In the same year, it also indicated that 23.7% of pregnant women attending ante-natal clinics in Kisumu had tested positive and in certain areas of Kisumu, HIV/AIDS had reached alarming proportions, where prevalence was said to be about 50%.

Countrywide the prevalence rates had lowered by October, 1997. However, NACP showed that Nyanza province (which comprises of 4 districts: South Nyanza, Kisumu, Siaya and Kisii) had now the highest number of HIV/AIDS cases (12,284) ; followed by Coast province with 10,296 cases ; Eastern province with 9,723 cases ; Rift Valley province with 9,302 cases ; Nairobi province, with 8,959 cases ; Western province with 4,121 cases and North Eastern province with 282 cases. Mombasa, Kisumu, South Nyanza and Nakuru were now cited as areas with highest prevalence rates in Kenya (*cf.* NACP, 1997).

According to the Kisumu District Development Plan (1995), the major cause for the increased spread of the disease in the district remains unprotected sex with infected persons. The spread of AIDS can further be attributed to practices such as widow or widower inheritance, sexual cleansing, polygamy, post-partum relations, extra-marital but discrete sexual networking systems of accepting relationships between females and males before marriage, multiple sexual partnerships, cultural definitions of maleness, high levels of illiteracy. High levels of untreated STDs which compound female vulnerability to the infection have also been identified as being responsible for the HIV spread.

In addition, Kisumu is a major stop along the trucking line to Uganda and Tanzania and is frequently used by the long distance truck drivers and travellers. According to Brokensha (1988), these truck drivers have been known to spread the HIV virus into Kenya, especially from Uganda and Tanzania. And by virtue of its position ; being along these two borders, Kisumu has been highly affected by the epidemic, and cross-border migrations can be cited as a relevant attribute.

The town also has so much to offer in terms of business and relaxation ; it is the centre of various commercial activities, industries and employment ; has numerous night spots, discos, bars and other socially tempting venues and as such the town has attracted a great deal of tourists, migrants, businessmen, visitors and consequently, sex workers. Some of the parts, for instance, Nyalenda, Obunga and Kondele are densely populated and social interaction, coupled with poverty and low educational levels leading to unemployment is a fertile ground for commercial sex work.

The peri-urban and rural areas for their part are deeply entrenched in their cultural beliefs and practices ; some of which are harmful and tend to spread HIV unnoticed. A combination of the traditional and modern practices is what one would call a culturally-propelled and urban-propelled life ; with both contributing to the spread of HIV/AIDS in Kisumu (*cf.* Ocholla, 1995). Majority of the residents are Luo, and ethnic attributes are still associated with ethnic loyalties and therefore their culture is an attribute relevant to the research question. Institutions such as the extended family and the attitude patterns associated with them, have severally been blamed for the increase in the number of HIV cases and the general lack of dynamism in society.

Poverty and its series of inter-related problems is a major problem in Kisumu and in Kenya as a whole. According to the Kenya Poverty Assessment (March 1995), 30% of the population were below the poverty line. Ownership of land is a critical factor. Married women enjoy unsurfructuary rights to land but widowhood brings uncertainty and upon separation, many assets including land becomes the sole property of the man. A third of the homesteads are female-headed and as many as 60% of them have no male support. Being destitute most of these women often migrate to urban slums where they try to earn an income. Lack of education or little education is another factor. Girls are as likely to enrol in primary schools as boys but drop or are pulled out more often. The main economic opportunities available for them include housework, selling vegetables, food stuffs, secondhand clothes or illegal brew (changaa), which provides little income. For some, the temptation is to enter into selling sex in order to have a better economic life.

The people of Luo, Kisumu are trapped and this has left them vulnerable especially in health and development issues. They cannot cope because many important decisions which directly affect their lives are made outside the area. For example, the Lake Victoria fishermen have little say in the marketing of their catch, the sugar farmer is at the mercy of the unreliable factories and the cotton industry is virtually dead because the farmer has no say over pricing. The people must be empowered to develop new coping strategies because the old ones have clearly failed e.g. in decision-making, who decides for whom ? NGOs, politicians, administrators and interest groups need to establish the real needs of the community and work on the creative response to challenges of their social reality and augment their trickle-down effect assumption, which in practice is found to be minimal and wanting.

Position of women as a risk factor for STDs/HIV/AIDS

The manner in which health is perceived, defined, experienced and practiced by society is largely a gender question. To address the issue of women's sexual behavior underscores the call for an investigation of the AIDS-related health knowledge possessed by the society. For a proper grasp of the problem, focus was directed at the perceptions of women in relation to the frustrating socio-cultural, physical and economic environments. How has this situation, especially in light of the lack of barriers or other options that women can use and control, predisposed them to the risk of HIV infection ? Is this risk due to conservative or modernistic values or is it a combination of both ?

HIV/AIDS prevalence in Kisumu is still increasing among women. Poverty and social inequality still prevail. According to statistics, a third of the households are female-headed. However, the definition of a female-headed household is not clear ; but was assumed that the household is female-headed when a woman has no husband or has a husband residing in a different place from her. As the epidemic continues to rise, it continues to evolve among those who are at the highest risk i.e. women. Thus HIV/AIDS affects the disenfranchised and poor. However, awareness of AIDS (over 96%), was essentially universal in this population ; but the actual knowledge of AIDS appeared to be lacking since 32% of the respondents associated the disease with other forms of " curses " such as *chira*[1].

The question of power relations within general relations is very central to the Luo, and all this stem from the differing social construction of male and female sexuality. This forms the basis for prevalent double standards in the Luo society with regard to reproductive issues, inside and outside marriage and continues to put the women at risk of STDs and HIV infection. To begin with, male dominance still pervades the structural framework ; men are the acknowledged heads of household. Men own the land and women only get access to land through marriage. The Luo in Kisumu, do not think that females have a lower reasoning capacity, but rather that a man's main superior position is due to his physical attributes ; they do not seem to give women the recognition that they deserve in society, such as in making decisions that affect their " health and their daily life ". As such, their social relationships are emphasised on the concept of " hierarchical relations " based mainly on age and other status positions, with women and children at the bottom.

For the married woman, there is inequality in power negotiations. The male dominance and the cultural expectation of a " good wife to be submissive " leads to subordination and sexual coercion by her husband. Although she may suspect or even know that he is engaged in risky behavior, she will not dare question him in this regard. This is even worse for the women in the slums because of the education and formational background of their husbands. In this situation of struggle for survival and in fear of being infected with HIV/AIDS, these women are reduced to a state of desperation. Those infected hide their illness for fear of being known, for fear of being judged morally " bad " women and for fear of rejection and abandonment by family, friends and ethnic community- who in many cases, will support the man and blame the woman even though she may be infected by her husband.

The single woman does not have it any easier. In case of infection, she is not accepted by her neighbors and is seen as a " morally bad woman " who deserves her fate. These women are stigmatized, and have the additional worry and anxiety about how these actions of people will affect their children. In any case, whether infected or not, the face of AIDS is too cruel for these women. Their mental anguish is endless.

1 In Luo traditional set-ups, whenever somebody died of a disease which could not be explained it was referred to as witchcraft or the taboo disease `chira,' a traditional curse that befell community members who do socially unacceptable deeds, resulting in extreme loss of weight and suffering from medically undiagnosable ailments such as skin conditions like rashes and finally dying. Only a witchdoctor/herbalist with an antidote could cure it. It has in many occasions been confused with HIV/AIDS symptoms.

Cultural beliefs such as sexual cleansing[1], widow/widower inheritance[2] and practices such as polygamous unions, serial[3] and levirate[4] marriages, multiple sex partnerships are cited as a big handicap to the prevention of HIV/AIDS and a major factor to women's feeling of helplessness. However, these practices do not actually pose any danger, but the rituals and marital demands that go along with it and especially assuming that any of the new partners could have the virus, or the widow/widower is infected. The women argue that in most occasions, it is the husbands or partners who bring such a disease to the homes. This, however, is not to suggest that women do not affect men, they do.

In addition, societal norms, dependence on men for financial and material support and fear of a violent response has influenced their inability to insist on safer sex practices e.g. condom use and many of these women do not believe that they have the right to do so. Some of these women after considering all odds, including the future of her children, arrive at a compromise decision that " as long as the partner or husband provides for her and the children, they do not care what he does out there ".

The spread of modern methods of contraception is a major factor for change in the position of women. However, from the study findings, only (198) 20.6% women said they used family planning, (693) 72.2% said they did not use any method to prevent or delay pregnancy, while (68) 7.1% were pregnant. This figure is low and the very possibility of effective birth control gives women the prospect of greater power over their futures, which these women do not seem to practice — either due to ignorance or lack of decision making power. In addition, the fact that majority of the women had started coitus quite early, they were not using any protective measures against STDs/HIV infection, and are involved with several partners, indicate that the fight against AIDS is far from being won.

Limited economic options and need for money has forced the women into a cycle of dependency, placing them at risk and where their ability to free themselves from their dependent role is further reduced by the day to day reality of coping with the societal norms. For example, sex workers (CSWs) interviewed, point to men when asked how and why they entered the profession. Fathers did not allow them to go to school, or had to drop out, or forced to marry against their wishes. Husbands beat them, deserted them or died, leaving them with the children, *etc.* Of 300 CSWs, 83.3% cited lack of money as their main reason for sex work, which in essence is also their main source of income.

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1 a ritualistic cleansing, whereby a spouse of the dead has sex with a family member inorder to be cleansed or freed of the evil spirit of the deceased. In some cases a man is specifically hired and handsomely rewarded to perform the ritual, loosely referred to as 'chodo kola' in Luo. Some of the men have specialised in this practice and end up performing the ritual on several widows and may lead the 'chord cutter' picking the virus and distributing it to all the subsequent widows he sleeps with or vice versa.

2 Widow inheritance was reported as a type of accepted marital system. Upon the husband's death the wife is usually inherited by a brother-in-law or a close relative to maintain the widow within the family, to limit her sexual movements and thus bringing into the family children of unknown origin and to continue the lineage of her husband by getting children, in case they had not by the time of husband's death, who automatically are considered to be the deceased's and are accorded the right of property inheritance.

3 participation in a sequence of regular partnerships or unions.

4 is where the parents of a dead wife, offers a sister of the deceased to the husband as his wife in 'replacement' of the dead one, to take care of the sister's children and to play the role of wife to the man, also termed as 'widower inheritance.'

In order to stay competitive with other CSWs and to maintain, attract and please more customers they go to great lengths to achieve this, such as unprotected sex and application of special herbs and other agents to tighten and dry the vagina, not knowing that this causes vaginal erosion and tears within, offering easy access for the virus to enter the blood stream. Many do not have enough power to exercise caution, are exposed and are vulnerable to sexual exploitation, manipulation and oppression. Condom use revealed that only 38.4% used condoms on all their clients ; 14.7% on most, 9.5% on about half, 3.9% on a minority and 33.7% said they did not use condoms.

On the other hand, many of these women are shielded from rapid change in urban areas than their husbands are. First of all, discrimination in education means a considerable educational gap between most spouses. Second, women, tied as they are to the home because of child rearing and household chores, tend to be more restricted to their neighborhood than men. This is especially true if they have no occupational or other roles outside the neighborhood. Finally, the interchange between spouses that might compensate for unequal exposure to change tends to be limited. The husband and wife spend little leisure time together, even in elite families ; because they are separated for long periods or days by work.

Lastly, the overall inequality between the sexes would seem to stand in the way of conjugal equality. Reasons- the statuses assigned to men and women in the society at large presumably have a bearing on their relative position within the family. Educated men usually marry women with less or no formal education and the general theme of male dominance is reinforced by the fact that most women get married quite young to men who are several years their elders. Unless these women are offered some solution to the underlying problem, warnings about the risks involved, other than by increasing women's anxiety about HIV, will not in themselves lead to any actual reduction in the risk.

Part of the challenge in Kisumu today is what can be done to stimulate community active participation in health decision-making while they remain true to their cultural and environmental needs. What practical methods, tools and incentives can these NGOs evolve to address these needs ? What methods should these NGOs adopt to accerelate community and individual attitudinal change towards condom use, care for PLWH/As, and health care in general.

The place of Women NGOs in the fight against AIDS

There are numerous registered NGOs and CBOs working within Kisumu Municipality (KM), some of their projects are mainly or only for women ; others include various categories of people, but show an awareness of gender issues. The women NGOs have an important and on-going role to play in spearheading the AIDS fight. They are recognized for their leading role in promoting the empowerment of women in the field of family planning, sexual and reproductive health and to advocate on issues that directly affect women such as unsafe abortion, teenage pregnancy, risks of STDs/AIDS, violence against women, couple relationships, family planning, infertility and female genital mutilation among others. And the field experience acquired through their community managing roles, create the right profile for their work.

The NGOs/CBOs are involved in various aspects of HIV/AIDS work in Kisumu such as IEC and awareness creation, condom promotion, advocacy, IGA, research and education. They further deal with adequate training programmes and training support materials, empowerment of women by providing relevant training and extension advice, strengthening of traditional coping mechanisms and the promotion of cost-effective survivor assistance programmes for orphans, widows/widowers and community. Each of these organizations share in common the fact that they are largely supported financially by local and outside donors.

They aim at building self-sustaining grassroots rural organizations by promoting groups of the rural poor and by influencing service delivery agencies to direct more of their resources through these organizations to the poor. This is meant to help groups reach a point of self-sustainability and no longer require special assistance from the mother NGO. On the other hand, the women in the community have organized themselves into a variety of groups (women NGOs, market associations, advocacy and religious bodies). These have provided a rich source of ideas and models for action, and show just how much women can and are achieving at the grassroots in terms of political aspirations, health and material needs.

Before tackling this, we need to know a little about the activities of women's groups. Do women have to act as a group to be recognized and what are the reasons that draw them together ? Does participation of such organizations in HAPAC[1] activities and gender issues enabled these women to change prevailing patterns of decision-making or provided them with a power base from where problems affecting them can effectively be tackled, or challenged or are these groups only survival strategies ?

I will agree that the great economic transformations which have occurred in Luo society, particularly since the turn of this century, have fundamentally changed the ties women establish among themselves at the local level, outside the closest family and the household. Women groups have adequately played an important role in the development process in Kenya since the mid-1970s and are today seen as development initiatives. The tradition of women groups gives the actions of women a certain legitimacy. These women have joined together unofficially into self-supporting groups, some of which are not registered. Nevertheless, these 'informal groups[2]' have been involved in various activities such as creation of a financial base that the members can resort to at times of difficulties ; form a revolving fund (usually called a *merry-go-round*), help in chores, visit ill members and bring little gifts of food or money.

These women groups also act as a forum where the members can converge, identify their common problems or needs and devise strategies for improving their lives. This can be seen in this quotation by Mary, the leader of Magina Kodiem women's group : « If you work alone you can fill your stomach, by working together you can buy thing of value or you can take action against an aspect in your life that is detrimental to your wellbeing ». Emma, a group member, adds that the group has become a source of satisfaction, happiness and given her a

1 HIV/AIDS Prevention and Control

2 These could either be the numerous unofficial/unregistered women's groups in the area or the traditionally-oriented support networks. These networks fulfil functions which can neither be assumed by hired laborers, nor by men such as helping and taking care of a woman who has given birth, the sick, participating in functions, plastering the house, subsistence production of food crops...etc. work done together with other women.

sense of family. In addition, acting as a group was said to be their first step in fighting for recognition and empowerment.

In this process of change, women's indigenous ways of associating have developed to be associations with government and other " NGO " support. There are currently about 300 registered women groups and associations. The organizational structure of these groups is hierarchical (with a chairwoman, a secretary, an accountant etc.), however, a few groups had men leaders. One of the reasons given on why these men are important, in such a women's group, is that the activities of the group often require skills which men have, but which these women seldom possess, e.g. marketing skills and book-keeping. It is unclear to which degree " assisting " husbands also control the income generated through the groups' various activities. However, men, and in particular husbands are sometimes drawn into women's groups.

Their advantage as a registered group, is that they are recognized by the government and other donors and are usually the first to be considered when financial and other support is available. However, due to the large number of associations, not all of them can be supported and many have had to look for their own means of support. For instance, in 1997, about a third of the registered groups in KM benefited during the National Women Trust Fund drive, carried out by the President. This money was disbursed by the local government machinery to women groups in every district to enhance their projects.

This is one way the government and the grassroots population keep in contact and gives them a certain legitimacy. On a national level, this is the ideology of *harambee*[1] meaning *let us unite (in* Luo *konyir kende*). Essentially, this ideology states that the individual should place the interest of the community before his or her own, emphasizing the importance of mutual social responsibility (*cf.* Mbithi & Rasmusson, 1977). The collective nature of Harambee is operationalized in its use of indigenous group forms and principles of mutual self-assistance, giving women the opportunity to unite en masse to initiate " self help " projects.

These groups usually undertake varying activities according to the resource base of the group and/or the level of affluence of the donor. Although membership includes all socio-economic strata within the community, these groups are particularly attractive and useful to women in low-income households. However, a huge number of women still do not participate in any women group. When I asked some of the young women why they did not join any group, they said that they could not raise the money needed for membership, and/or they did not have the time to participate.

Many of these associations have already explored the possibility of using their group support and power as a mechanism to protect themselves from HIV infection and to educate the community. In Kisumu, where AIDS has been the most sensitive and controversial health issue upto today, most of the NGOs have had to integrate it into their activities. Other NGOs have arisen specifically to fight the AIDS threat. For others, community members have had to come together, in friendship and solidarity, for economic gain and to help themselves fight this problem. For instance, a member of Widows group says discussing it among friends has

1 This was a common man's movement which took form with its declaration by the president of Kenya and the publication of Sessional paper No. 10 in 1965.

helped them look for any possibility to face it in a human way, especially how to assist people affected and how to avoid the spreading of the disease.

In regard to economic independence, many groups have assumed more important roles such as acting as lobbies for women empowerment and dealing in local produce and investing their profits in small and large scale business opportunities (such as grinding mills, residential houses, revolving savings-cum-credit systems, kiosks (shops), transport vehicles, fish market, making and marketing handicrafts, clothes, second hand clothes (locally known as *mitumba*), sale of vegetable and other crops). Through these economic opportunities, the group members are able to find a measure of economic independence, as they have a means of earning their livelihood, support their children and this has given many a chance to avoid or discontinue with sexual lifestyles which expose them to infections and even the spread of HIV/AIDS.

In addition, the success of these IGAs has boosted them to provide beneficial activities such as opening day care centres for young orphaned children, where they get meals, clothing and love, they also help families earn more money through giving manual jobs within their group activities. Others have found it very enterprising to create revolving loans, IGAs and investment opportunities for their members, many of whom are affected or infected by the epidemic. For example, these women associations have encouraged self-sustaining activities for widows and sick women, who produce different kinds of hand work: table cloths, pots, mats, blankets for babies etc. They sell their produce to the public and the profits shared among members of group, while a part of it is used to acquire the material needed to continue the production. However, the amount of assistance such groups can provide, is small and limited.

These women NGOs also enable women and community members to share visions and experiences where they can start doing something with their talents e.g. in care, support, counselling skills, time management, changing attitudes and practices, helping affected and infected families, and in home based care. They sometimes perform vocational duties and educational campaigns on volunteer bases. For example, the support groups address the needs of the poor, the single women, the teenage mothers, the widows/widowers, the orphans and PLWA[1] in managing their households under such difficult circumstances. Mainly they are more concerned in immediate and pragmatic concerns affecting each and every household, which stem from the needs and interests of the family. They are offering the members ways to save money, providing access to extra-labor at critical times, and other kinds of support such as funeral arrangements, feeding the family, caring for the sick (nursing care), paying school fees, *etc.*

Other groups act as channels for rural development and social behavior change. The progress of these groups can be seen in how they regularly hold meetings and level of member attendance ; shared leadership and member participation in group decision making ; continuous growth in group savings which indicates profitability of group activity ; high rates of loan repayment ; group problem solving and effective links with development services. However, in many groups, this is far from being achieved.

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1 People Living with HIV/AIDS

In addition, these vibrant groups are now the source of radical consciousness, for instance, the sex workers have formed groups which help and teach them the need for resistance to exploitation and exposure to diseases and operate as an" active defense " providing help in situations of insecurity, police harassment, illness, beatings by clients, lovers among others, or addressing gender issues in a male dominated society, or by having revolving funds enabling them start IGAs and by doing this, these women are trying to resist economic dependency on their husbands, partners or commercial sex per se. Some do not think they can leave sex work on their own, but within their small community, those who desire have achieved a degree of control over their professional sexual relations, their finances, and their health. Efforts are ongoing to educate them about the seriousness of diseases like AIDS and the usefulness of safer sex practices.

Other organizations have given priority to the prevention of forced marriages, child prostitution, safer sex campaigns to the general public, among the sex workers and their clients if possible, distribution of free condoms, counselling services, the treatment of STDs and minor ailments through their clinics and media support. This has helped establish a personal rapport with the women and allowed for an exchange of views. For instance, Pandipieri and Social Citizen Centres and other community groups run centres for the street children, orphans, PWAs, single and teenage mothers, some of whom maintain the centres and participate in the schedule of activities. These centres should not only be seen as rehabilitation programs, but as broader development initiatives designed to increase the range of options available to these people. The sense of friendship and solidarity, helps them to protect themselves and each other. They have counseling sessions and informal discussions with members. HIV/AIDS is discussed with other health issues, such as eating the right kinds of food, avoiding illegal drugs such as glue sniffing and alcohol, saying " no " to risks and about why they were sometimes doing dangerous things etc.

Church groups also have a large following, and has been a useful entry point for HAPAC activities. The Kenyan people are very religious, prayer and God are part of the social/cultural fabric of people and to disregard the spiritual in the life of a Kenyan is to deny part of who they are as people. Many of the church leaders are involved in community health education activities, they often broach the sensitive issues of sexuality, morality, cultural practices, promote abstinence and fidelity, anti-abortion campaigns and in giving care (physical, psychological, and spiritual). However, not many churches advocate condom use, most are actually against them. Churches in addition, have targeted their women's groups to receive information about AIDS. For example, catholic women's groups have held seminars where women and AIDS is discussed, especially how women could help others work through grief about AIDS deaths if they or family members had AIDS and how they could help reach the youth and other members of society highly at risk.

Some of these church-based women's groups have already taken upon themselves the initiative of being trained in counseling and support skills for people with AIDS. These church groups provide a safe and acceptable environment for these women to receive information if the messages are not blaming or moralizing. These groups are active, and choose amongst themselves who they think would be of good service to the community (male or female). It is a very democratic system, and the leaders are elected by the church community who respect and trust them. These groups members are not people of high education and are volunteers

who have been chosen by their groups as people with the gifts of relating and caring for the sick, the bereaved and the suffering. They see themselves as people of a calling who are called to serve the sick within the community.

The community representatives and peer educators, meet regularly to plan and monitor preventive activities. They visit community members and it is through their service that they come in contact with people infected and affected. Much of the care of PLWAs occur in the home as most sick people prefer to be in their own homes, with family and friends around. They offer basic counseling i.e. listening, asking questions, supporting, giving advice, encouragement, and helping individuals develop personal prevention action plans, as well as specific questions and concerns about HIV/AIDS.

For example, groups in the Catholic church help individuals, orphans and families living with HIV/AIDS within their parishes, to find significance in life and deal with feelings of loss and grief, through discussions and citations from bible passages that reinforce the counseling messages and in facilitating the caring role of families. It is from this dynamic of faith and service that the christian community-based health programmes have developed. They donate food, clothing and money to the affected families and work jointly with hospitals and MCH/family planning services for referrals, testing, special counseling and medical attention.

The initial contact with patients is usually through the patients seeking out assistance themselves, or through their relatives seeking help from them or maybe a neighbor or friend in the area who knows that the person is sick and needs treatment. The volunteer worker thus becomes more than just a person who physically cares for the patient but in many instances a friend and confidant. These women work together with the social workers, the community health workers and pastoral agents to provide different services. This unified effort is said to be a ministry of hope, reconciliation and healing in congregations and communities through prevention, education and care for persons and families.

In addition, several church groups hold retreats and other marriage enrichment activities, and have served as a cornerstone for various efforts. For example, some church groups have been established as an insurance system for funeral ceremony expenses, and have gradually assumed a larger role in community affairs. Most of the associations hope to generate greater support for its activities from parents and other members of the community. These initiatives have struggled to continue their education and care activities, and some have managed to attract funding. Their aim is to create a forum where community members can talk openly and honestly about problems facing them in relation to HIV/AIDS and how to protect themselves and each other.

The PLWA's groups (made up of both infected and non-infected persons) deals with people with HIV/AIDS, with orphans and with needy people in general. They perform various services which extend to the larger reality of needs encountered, like old people, women and orphans. This has meant a widening of the range of activities: home visits, referral to hospitals of PWAs, condom distribution, health education in families, management of domestic needs, advice to PWAs on the risk of pregnancy, of infection and re-infection, of breast-feeding and alternative milk use, and in the distribution of food stuff. Many of these groups have regular monthly meetings for activities that go from adult literacy courses, handicrafts, sewing

activities, health and religious education, together with recreational activities. The main concern of the orphans support programmes is to share with the guardians the responsibility of the orphans (with funds, food and non-food items, beddings, clothing, and orphans' health condition) and to guide them in the correct use of any funds given to them.

These PLWA's groups also try to emphasize the positive value of the different experiences they all bring to the groups, and allow people to talk freely, without fear of being judged or put down for their beliefs or their actions, past or present. Mrs Okumu, a widow, says that her motivation to join the group came from her awareness that there are other women in the same predicament as herself. In order to help these women to accept their illness, counselors are invited to visit them to deal with their different feelings with regards to AIDS, anger, guilt, shame, and stigmatization. Beside individual counseling, group counseling is offered. Through regular group sessions these women share their problems at a very personal level and give each other mutual support. When a member falls ill and is unable to take care of her children, the other group members take turns to care for the children. By visiting and helping each other the groups has become very cohesive.

Like in all other women groups, they have a revolving fund whereby each member contributes a small sum of money. This money is taken in turns by group members for use and in an attempt to empower them economically the women learn different skills such as handcrafts, knitting, crocheting, pottery and tailoring. Those who have a knowledge of these skills teach the other members. Together they make various items which when sold the profit is shared equally and some money kept aside to buy more materials. The women are also encouraged to share freely their fears about their children's future. They are helped to make plans for their children and encouraged to identify a family member who they feel can be able to care for their children. They are helped to explore possible ways of confiding in their family members who they trust.

Through these group activities the women have become more economically independent and thus have an alternative means of earning to support their children, so that they do not continue with sexual lifestyles which expose them to more infections and even the spread of HIV/AIDS. These initiatives have helped those whose illness prevents them from fulfilling their obligations to their dependents as these have been encouraged to support those who are debilitated by AIDS around household services. And through group interactions these women (and men) have become more assertive and they have become more aware of their own personal worth and potential.

Until recently, these women organizations did not really challenge unequal gender relations, cultural practices and obligations, and health issues but have now made it an issue of discussion. Advocacy and civic groups run educational and awareness campaign about rape, forced marriages, female genital mutilation, wife inheritance rights, protection of children's inheritance, cleansing issues, negotiation of risks and other legal rights, are now prioritized topics. They explore myths and misconceptions around them, with the aim of reducing their incidence, try to educate their members in health seeking behavior, encourage them in cases that they cannot handle and in some cases forward them to relevant authorities. They also invite health and political representatives, and other concerned leaders for group meetings, with the hope that some political will may be created and utilized to resolve the problems.

These women's self-help groups may also be seen here as a form of women's resistance or as a response to their pressed situation and is their only means to stress their priorities in the local community in relation to the government policy toward women ; and shows their desire to change the situation of their lives. However, in those cases where profit is actually generated through the project it is usually reinvested in new activities and only occasionally small amounts of money are distributed among the members of the group. Unless these women 'smell' foul play, most of them continue being members ; sometimes, for the friendship and support and usually, work harder in their various activities, with the hope that things will get better.

The organizations encounter several constraints including political lobbying, legal-ethical domains, financial, logistics (due to lack of special training and supervision), collapsing or mismanagement of the association, lack of project sustainability, psychological attributes and socio-cultural aspects, which lead to a great deal of frustration. Some women groups showed how some leaders exploited them by receiving a disproportionate share of the group savings and diverting these resources intended for a project for their own use. This has created a lot of mistrust, disruption of groups, and dying out of many associations, and with group members leaving and joining other groups.

A few group leaders also felt that when men get the managerial positions in these associations, they take full command and the women do not feel liberated to do exactly what they want to do, or to air their opinions in a relaxed way or to manage their activities as they would want to. They argued that when male domination infiltrates such a group, they are no longer the actual actors or initiators of the projects, and many problems are not well resolved. Such limiting factors greatly prevent them from fully utilizing their potential for a full and effective participation in the national AIDS control programme.

Conclusion

All these support and self-help groups are concurrent with the general fight to get women's issues on the AIDS agenda, and are integrated and co-ordinated with other initiatives, both HIV and non-HIV related. They have formed strong and effective associations for the protection of their social and commercial interests, for the ventilation of their grievances, are a reflection of the mutual aid spirit *harambee* and now act as useful channels of HIV/AIDS prevention and control activities. They have recognized the need and responded by forming their own support groups. They are using their own resources to help meet the emotional and financial needs of the group members, others have even attempted to incorporate the needs of orphans into their programmes.

These women NGOs work closely with the local government leaders i.e. subchiefs, chiefs, department of Culture and Social Services, health department, through their community health and social workers, who all act as important controllers of " local machinery ". In addition, politicians, companies and other governmental administrators are involved in women's groups initiatives through various activities such as construction of buildings, holding harambees and giving donations. Generally, these NGOs have, to some degree harnessed

resources as well as mobilized manpower in order to build and strengthen their capacity to deal with social and health problems that affect members of their community.

However, the work of these women NGOs is largely sporadic and many of them have duplicated projects, are catering to too many activities, leading to some of them being overdone and others not being tackled effectively. Very few, if any, organisations are able to include all the necessary facets of HIV prevention and care in their projects. Due to financial constraints some are not able to sustain the projects for long and this dashes the members' hope and many of them have reverted to their old ways e.g. sex workers, local brewers, drug abusers, and street children.

Many also lack the required resources, skills, supplies, equipment and other logistical support needed to effectively mitigate against the rapid spread and development implications of HIV/AIDS. Some of these organizations/groups need to have co-ordinated, long term planning, with a clear vision and target on making their clients self reliant for future purposes e.g. by creating and making IGAs which are sustainable ; and by creating cost sharing initiatives such as the Bamako initiatives already being effected in some rural areas of Kenya.

Although Kisumu has many programmes which are educational, most of them skip the question of women empowerment, do not have hard data and concrete strategies for action to be measured in quantifiable terms and many of their objectives are yet to be implemented. Many of the programmes geared towards meeting the minimum needs of the people of Luo, skirt around the real issues that should be tackled. In practice, many of these programmes are engineered by the government, politicians, the church and NGOs.

The government is on its financial knees because of resource mismanagement, the politicians finds underdevelopment a political expediency and most NGOs have been rendered ineffectual by the unmitigated greed of those in charge. Sadly, the government is quickly drifting into a populist approach to development. In Luo, like in all parts of Kenya, the citizenry equate 'development' with being politically correct. But even such politically-induced development are not sustainable as they lack adequate involvement and participation of the community[1].

By supporting organized mobilization of women's groups, primarily through channeling inputs into approved women group projects, national bodies and NGOs have and can help these women to improve their income-earning opportunities, increase their personal power to control one's vulnerability to health issues such as diseases, family planning and other social problems affecting women. In addition, building community support to encourage risk-reducing behavior and to understand their role as local managers of their own health and development process.

We find that these women NGOs have active strategies for adapting to change, especially in their deteriorated economic position vis-à-vis men, and if incorporated further into the AIDS fight could act as an effective entry point for broad-based interventions to address women's and in general, societal needs. However, we should not forget the men who form the other half of the equation, as most strategies to prevent transmission of HIV that are effective (such as condoms or abstinence) are under the control of men. Men should therefore be integrated

1 Population Council, 1997

into the health educational, control and support programmes and every effort made to change their behavior.

Finally, what Kisumu needs are large scale, credible, imaginative, innovative and sustainable HAPAC programmes for any significant change to occur and for risk reducing behavior, especially incorporating local ideas and perceived solutions while policy makers should strengthen advocacy and develop culturally appropriate strategies to address the needs of the society as a whole with respect to HIV/AIDS. The people need to be empowered to develop new strategies because some of the old ones have clearly failed or are not very effective. For instance, Information, education and communication (IEC) promotion and intensive campaigns have not effected behavior change in the community. And if widow inheritance in the area is unfavorable, then how can the situation be improved ?

In a nutshell, all of the HIV prevention and care strategies described are most effective if they are applied under social, political and legal conditions which support them. This is done by gaining the support of those with influence, and all individuals or groups should directly participate in identifying strategies to curb the HIV spread. They need to be accorded the chance to identify local opportunities and offer local solutions to this problem (with the assistance of the developmental and health agencies) and not *vice versa*.

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