# "HIV/AIDS AND HUMAN RIGHTS IN KENYA"

**BY**

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## DECLARATION

**THIS DISSERTATION IS MY ORIGINAL WORK AND HAS NOT BEEN SUBMITTED FOR A DEGREE IN ANY OTHER UNIVERSITY**

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**THIS DISSERTATION HAS BEEN SUBMITTED FOR EXAMINATION WITH MY APPROVAL AS A UNIVERSITY SUPERVISOR.**

**SIGN:** _____ **DATE** 4/11/03

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## DEDICATION

My efforts to the dissertation are dedicated to my husband Owen K. N. Makuu and children Muithi Kimeu and Awena Kalekye. Without your encouragement, love perseverance and prayers, this work would not have been possible. Thank you for believing in me and supporting me all the way.



## IN MEMORY

**PAMELLA PAULINE AWITI JAGONGO (LADY JOHN)**
**(1922 – 2003)**

Maa, you told me that, had you been in my place, you would have gone to the moon. I will not go to the moon, but I will try to live your dream. Thank you for making me know that education is the key. Rest in peace Lady.

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## ABSTRACT

This study investigates the impact of HIV/AIDS scourge in Kenya. It examines the relationship between HIV/AIDS and lack of respect for human rights. It also examines the role played by HIV/AIDS in undermining the realisation of human rights, as well as the effects of HIV/AIDS on the socio-economic and cultural rights in Kenya.

This study has utilised both documentary and survey data. Interviews were conducted through questionnaires formulated for people living with HIV, employers and implementers of policies from various organisations.

The central assumption is that those infected by HIV/AIDS are prone to human rights violations, hence the study examines how Kenya is implementing the international standards set by the United Nations in upholding the rights of those infected with the virus.

The study has found out that though positive HIV/AIDS status leads to human rights violations, there are several other factors which go hand in hand with it, for example the status of a person in society, and the sex of the person. This therefore makes those persons whose other human rights are already violated more vulnerable to further infection with HIV/AIDS and violation of their rights.

The study makes the case that poverty and underdevelopment are major components in the spread of HIV/AIDS, by denying persons access to treatment,

care, preventive interventions and education. It concludes that if people's rights to health, work and non-discrimination are honoured, then the trend in the impact of HIV/AIDS would be reversed.

The study established that those living with HIV/AIDS, to a large extent believe that their human rights are being violated, while the employers believe that those infected with the virus are being treated like the rest. The study has also highlighted the fact that due to the level of socio – economic development in Kenya, most of the people do not understand the complexities of human rights violations.

## LIST OF ABBREVIATIONS

**AIDS**.....Acquired Immuno Deficiency Syndrome

**ARV**.....Anti-Retroviral

**BCC**.....Behaviour Change Communication

**CBO**.....Community Based Organization

**FHI**.....Family Healthy International

**GNP**.....Global Network of People Living with HIV/AIDS

**HAART**.....Highly active Anti-Retroviral Therapy

**HBC**.....Home Based Care

**HIV**.....Human Immuno Deficiency Virus

**ICCPR**.....International Covenant for Civil and Political Rights

**ICW**.....International Community of PLWHA

**IEC**.....Information, Education, Communication

**ILO**.....International Labour Organization

**KANCO**.....Kenya AIDS NGOs Consortium

**KHRC**.....Kenya Human Rights Commission

**MMWR**.....Morbidity and Mortality Weekly Review

**MTCT**.....Mother To Child Transmission

**NACC**.....National AIDS Control Council

**NASCOP**.....National AIDS and STD Control Programme

**NGO**.....Non – Governmental Organisation

**OI**.....Opportunistic Infections

**PLWHA**.....People living with HIV and AIDS

**PTCT**.....Parent To Child Transmission

**PWA**.....People With AIDS

**PWH**.....People With HIV

**STDs**.....Sexual Transmitted Diseases

**TM**.....Traditional Medicine

**UDHR**.....Universal Declaration of Human Rights

**UN**.....United Nations

**UNAIDS**.....United Nations AIDS Programme

**VCT**.....Voluntary Counselling and Testing

**WHO**.....World Health Organization

**WID**.....Women in Development

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# CHAPTER ONE

# HIV/AIDS AND HUMAN RIGHTS

## 1.0 Introduction

HIV continues to spread throughout the world, shadowed by the increasing challenges to human rights, at both national and global levels. The virus continues to be marked by discrimination against population groups: those who live in the fringes of society or who are assumed to be at risk of infection because of behaviours, race, ethnicity, sexual orientation, gender, or social characteristics that are stigmatised in a particular society. In most of the world, discrimination also jeopardises equitable distribution of access to HIV-related goods for prevention and care, including drugs needed for HIV/AIDS care and development of vaccines to respond to the specific needs of all populations, in both the North and South. As the number of people living with HIV and with AIDS continues to grow in nations with different economies, social structures, and legal systems, HIV/AIDS-related human rights issues are not only becoming more apparent, but also becoming increasingly diverse.[1]

This is a study examining the interactions and dynamics of HIV/AIDS infection and the human rights in Kenya. The study bases its arguments on the International covenant on Economic Social and Cultural Rights.

The study examines the types and scope of the experiences of HIV/AIDS infected persons in order to derive from them the various types, forms and the format the

perceived violations take. It is hypothesized that in Kenya, those infected by HIV are prone to human rights violations.

The fact that HIV/AIDS was declared a national disaster in 1999 implies that the disease not only poses grave danger to Kenyans, but is indicative of the fact that more needs to be done to control and prevent it. Secondly, one of this study's premises is that there are legal and social dimensions and dynamics of HIV/AIDS not yet fully understood, and ones which are believed to violate human rights of the infected person makes the study even more compelling and urgent.

Available data reveals that people infected with HIV/AIDS suffer untold amount of human rights violations. A significant number do not access adequate care and support as the antiretroviral drugs are inaccessible due to the costs and cumbersome treatment protocols involved.

All these elements are a direct violation of all the fundamental human rights including the right to good health and life, the right to gainful employment, and the freedom from fear and discrimination. People living with AIDS are often psychologically and emotionally traumatized because they are looked at awkwardly and labelled. Issues related to HIV/AIDS in the work place include termination of employment. Yet, no one fully understands the depths of these vulnerabilities of persons infected by the virus.

Clearly, there is need to deepen our understanding in order to generate more proactive and responsive actions. The perspectives on the relationship between HIV/AIDS and lack of respect for human rights as well as the role played by HIV/AIDS in the reversal of the progress and realisation of human rights in Kenya, needs to be investigated.

The origin of HIV/AIDS is shrouded in mystery, coupled with the increasing recognition that public health often provides an added and compelling justification for safeguarding Human Rights several, guidelines have been put in place by the United Nations office of the High Commissioner for Human Rights and the joint United Nations programme on HIV/AIDS (UNAIDS).

## 1.1 Statement of the problem

Violations of Human rights fuel the spread and exacerbates the impact of the disease, while at the same time HIV/AIDS undermines progress in the realization of Human Rights. This link is evident in the disproportionate incidence and spread of the disease among certain groups especially those living in poverty. It is further apparent in the fact that the overwhelming burden of the epidemic today is borne by developing countries, where the disease threatens to reverse vital achievements in human development. AIDS and poverty are now mutually reinforcing negative forces in many developing countries.

UNAIDS has established HIV/AIDS and Human Rights International Guidelines which was adopted at the second International consultation on HIV/AIDS and Human Rights, held in Geneva from 23 to 25 September 1996, to assist states in creating a positive, rights-based response to HIV/AIDS that is effective in reducing the transmission and impact of HIV/AIDS and consistent with human rights and fundamental freedoms. In 2001/2002, Kenya formed a task force to look into the legal issues relating to HIV and AIDS, translating into HIV and AIDS control Bill 2003. These guidelines however need to be looked into for assessment of their implementation.[2]

The paper focuses on HIV/AIDS and human rights based on the International covenant on economic, social and cultural rights, which in the context of International human rights are generally distinguished from civil and political rights. Specifically the paper will look at the rights against discrimination based on sex and health status. The right to work which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts. The right to social security, including social insurance. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

## 1.2 Objectives of the study

The objective of the study is to investigate the impact of HIV/AIDS on the Human rights of those infected by the HIV/AIDS scourge in Kenya, establish the interplay of factors between that relationship, draw correlates that help in pointing to

explanations. This will fill important information gaps in existing policy and programme options.

**Specific objectives**

(1) To critically examine how Human rights can be reshaped and re-interpreted to accommodate the emerging HIV/AIDS and Human rights issues which were not prevalent when the resolutions were formulated.

(2) To examine how Kenya is implementing the Guidelines on HIV/AIDS and Human rights as set by The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the office of the UN High Commissioner on human rights in September 1996.

**1.3 Justification of the study**

With seven hundred persons dying per day (3 per minute) in Kenya, HIV/AIDS has been declared a national disaster and a priority area of concern to the government, individuals and families of Kenya. There are critical information gaps, which compromises efficient response to this compelling problem.[3]

Prevailing efforts in combating HIV/AIDS are mostly concentrated on prevention and treatment. They do so to the total occlusion of human rights. In Kenya, most literature on HIV/AIDS touching on human rights merely state the facts as they are

without addressing issues of policy, human rights, law enforcement mechanisms and the specific roles of the government and individuals, and if they do, it is not exhaustive. Yet, the human rights approach to development has been established as both an important value in itself and also as a key strategy in achieving desired results. For example, positive correlates have been drawn between the decrease in the prevalence of STIs and HIV/AIDS where issues of equality and women's empowerment have been improved.

In addition to killing seven hundred persons per day, HIV/AIDS has generated some nine hundred thousand orphans and other children made vulnerable due to HIV/AIDS. This is despite the fact Kenya has ratified the United Nations Convention on the rights of the child and domesticated it through its own Children's ACT No.8 of 2001. Given this high rate of orphan-hood due to HIV/AIDS, one wonders how this ACT should be interpreted. Many questions abide about the enforcement mechanisms and with no tangible results.[4]

Clearly, there are many abiding questions and very few answers. The study will generate and provide vital data and information which will enhance policy formulation on human rights approaches to HIV/AIDS after endeavouring to find out why there is no behaviour change despite the amount of effort and worldwide campaign against HIV/AIDS. The study will confirm whether or not those infected by HIV/AIDS have joined the unending list of vulnerable groups whose human rights are trampled on.

At very senior levels, people are getting a way with human rights violations especially as pertains to language. The media is using derogatory terms in referring to people living with HIV/AIDS. Language is an important tool which can be used correctly in the fight against HIV/AIDS with a human rights approach. There is a gap in the type of language to be used in the face of HIV/AIDS.

Culture especially in sub-Saharan Africa has been evoked in the fight against HIV/AIDS. Culture is not static and can be moulded to fight HIV/AIDS with a human rights approach.

## 1.4 Review of literature

HIV/AIDS is about two decades old in the world. As such, it is a recent phenomenon. However, due to its devastating nature a lot of literature has been generated and documented on it from various angles. Most of the literature however is concerned with the trends therein, its socio-economic and health implications and how to deal with prevention and treatment of the disease.

Most of the literature on Human Rights is on its nature in a legal and political context as well as their substance and means of protection[5], therefore leaving a vacuum on how human rights relates with emerging issues like HIV/AIDS.

To Mann J., and Tarantola D., HIV/AIDS is such a major world issue that cannot be dealt with through the traditional health approach, even when organized and applied

with all the vigour and creativity, and that the health approach lacks sufficient power to combat the pandemic and to mitigate the impact. They therefore feel that the multi sectoral approach would be the most suitable way in dealing with HIV/AIDS issues[6].

Konotey-Ahulu concentrates on the clinical features of HIV/AIDS and how it is acquired, and also touches on the best approaches to prevention especially in the African context[7]. Reid E. bases her book HIV/AIDS on the desire to stimulate people to think of the ways in which HIV the epidemic might affect their lives, their work and their communities in the years to come is the major concern.[8]Most of the writings on HIV/AIDS are in forms of journals, annual reports of NGOs and medical bulletins. Originally they were concerned with the clinical aspects of HIV/AIDS, but now, with the setting in of multi-sectoral approach to the scourge, they have moved into prevention, advocacy, care and support. The majority of Kenyan people are still illiterate and are not able to access and benefit from the available information on HIV/AIDS.

Viljoen compares the contributions made by individuals and NGOs in the judicial process especially the European and International American courts. They cite the fact that the African court has the benefit of history and therefore should emulate both courts in order to enhance its own capacity to resolve human rights disputes that will come before it in future[9]. This citation gives room for HIV/AIDS disputes should there be legislation to that effect in future.

Okoth-Obbo sets out to find out if African Customary Humanitarian Law exists, and especially to test the real usefulness of professor Bello's book to humanitarian law scholarship in Africa. This book mainly looks at the relationship between Western Human rights laws, and what the African human rights law should entail.[10]

Naldi Gino J. is interested in examining the issue of the interim measures in the African human rights system. This system is recent in origin, and the least developed of the regional systems and is currently faced with several challenges including HIV/AIDS. This paper is mainly concerned with the African commission on Human and Peoples Rights, its merits and demerits[11].

Cobbah, A. M. is concerned mainly with whether human rights is an entirely western concept and how the rest of the world especially Africa can deal with it. He claims that despite the discussion of human rights in Africa, very little exists in the form of literature that approaches human rights from an African perspective. The paper insists that we should talk about rights with a cultural context and that Africentric conception of human dignity is presented as a valid worldview which should inform the cross-cultural fertilization of ideas[12]. Attempts have been made in various forums to link Human Rights to HIV/AIDS. The UNDP organised a Law, Ethics and HIV consultation in 1993 in Cebu, Phillipnes[13]. The aim of the meeting was to provide a forum for the exchange of experience amongst experts from countries in the region of Asia and the Pacific, therefore contributions show the variety of the legal regimes which are in force and the religious and cultural traditions which influence the

responses of the countries represented, to the sudden peril presented by the HIV/AIDS epidemic[14].

From the 1995 National Council for International Health (NCIH) HIV/AIDS workshop held in Virginia[15], it transpired that most restrictive actions by government in the context of HIV/AIDS have been justified on Public Health grounds. All Human rights are not absolute. Governments can restrict many rights if they can justify these actions as necessary in order to achieve an overriding public good. Given the importance of health, it is not surprising that Public Health is recognised as a valid reason for restricting rights under certain circumstances.

However, when a government limits the exercise or enjoyment of a right, this action must be a last resort, carefully assessed on a case by case basis and can only be permitted if certain specific criteria are met including being carried out according to law, in the interest of a legitimate general interest, to achieve the public good, must be least intrusive means of achieving the desired goal and must not be imposed arbitrarily[16]. Christian Lund looks at dualism of legal systems in the third world, as well as the heavy influence of the West on the development of human rights in these societies. He also brings in the issue of universal rights versus the culturally embedded rights and concludes that universalism is superior because they are deduced from the fundamental ideas of what is to be human[17].

Lund further elaborates on the modification of rights by changing historical circumstances, and the continuing new additions to the list of human rights, and

cites the recent additions e.g., the right to live in an unpolluted environment, the right to personal privacy and the right to one's own genetic heritage., The development of this cluster of rights illustrates that rights develop in historical contexts, and it suggests that the creation of rights accelerates with the transformation of society[18] This gives room for the inclusion of HIV/AIDS rights related issues in future. Most of the literature reviewed on the topic tends to deal with symptoms of the human rights violations arising from HIV/AIDS status rather than the causes.

Koch, I.E.[19] seeks to get closer to an understanding of the legal implications of the nation of the indivisibility of human rights as distinct from the philosophical implication. The article deals with the notion of indivisibility in a general way by discussing possible interpretations and legal principles for pursuing an integrated human rights approach. It also deals with indivisibility in the concrete context of deprivation of liberty for medical or social reasons. The article emphasises the close connection between the existence of treatment and the duration of confinement, and further argues that the fulfilment of the civil right to personal liberty is dependant on recognition of the interdependence between social rights and civil rights. Even though social and civil rights have been separated into two conventions, it should be noted that the social right to treatment ought to be considered on integrated component of the civil right to personal liberty.

Brigit Toebe's[20] concentrates on distinguishing the applicability of the two distinguishable human rights namely, economic social and cultural rights as opposed

to civil and political rights. It brings out the problems of definitions, codification and implementation of the various rights

Goldstein J.S[21] focuses on the nature of HIV and AIDS. He claims that AIDS is a worldwide epidemic in which the failure of one state to control it's the spread makes it more likely that people in other states will eventually become affected as well. AIDS spreads internationally, through travel, reflecting the interdependence of states, and therefore the epidemic cannot be stopped in one country until it is stopped in all.

The Canadian HIV/AIDS legal network states that the goal of legal, ethical and human rights activities must be to ensure that laws, policies and programmes respect and promote the rights of people with HIV/AIDS and promote and facilitate rather than hinder prevention efforts, and provide care, support and treatment to people with HIV/AIDS.[22]

To date, no cure for HIV/AIDS is in sight and therefore it makes sense to make management of HIV/AIDS an issue. This study will endeavour to bring out the salient features of HIV/AIDS as it relates to Human Rights, taking Kenya as a case study.

## 1.5 Theoretical framework

Theory is a worldview referring to a set of assumptions of relationships. In a study theory is important as it explains the reason why things are the way they are. HIV/AIDS knows no boundaries and therefore will need a multi-dimensional approach. Human rights conventions are issues of ideology primed on principles such as the natural laws and universality of human rights and equality. This study will rely heavily on the natural law approach and the universality of human rights theory.

The natural law approach begins with the assumption that there are natural laws, both theological and metaphysical, which confer certain particular rights upon individual human beings.[23] This law constitutes a higher law which is the ultimate standard of fitness of all positive law whether national or international.

The great historic contribution of the natural law emphasis has been in the affording of this appeal from the realities of naked power to higher authority which is asserted to require the protection of individual rights. The proponents of this approach like C.Becker and D. Ritchie assume the observational standpoint of identification with the whole of humanity[24]. A principal emphasis has been upon a common human nature that implies comparable rights and equality for all.

For many centuries the natural law approach has been an unfailing source of articulated demand and of theoretical justification for human rights. Its contribution to both constitutional and international law and especially to the protection of individual rights has been well recorded[25].The two decades old HIV/AIDS would therefore find justification for its human rights requirements in this approach.

The theories of natural rights were challenged in the 19th century by legal positivism, initiated by Jeremy Bentham, the founder of utilitarianism in Britain. Positivism was further developed by John Austin, who in his "the province of Juris prudence determined" published in 1832, sought to clarify the distinction between law and morality, which he considered to be blurred by doctrines of natural rights. Austin elaborated his definition of law as species of command from a sovereign accompanied by a threat of punishment (the 'sanctum') for disobedience[26].

The early conceptions of natural rights were criticised as narrow and non-responsive to the needs of a complex society that was quickly evolving in the process of industrialisation[27]. They were accused of vagueness and ambiguous mandate. Legal positivism reigned supreme in most western societies from the beginning of the 19th century until the end of World War II, but were mostly challenged by the consequences of unmitigated positivism experience during the Nazi era. From the Nazi experience the notions of inherent rights get a tremendous revival at the end of world war II, this time with a much broader and inclusive scope than those of the 17th and 18th centuries.

The values of natural human rights have been bequeathed to us by all the great democratic movements of human kind and which are being expressed in the common demands and expectations of people everywhere[28]. These rights have been projected in the 1948 universal declaration of human rights. The study will especially benefit from the international covenant on economic, social and cultural rights, and narrow it down on how Kenya is applying it to the HIV/AIDS issue.

International human rights derive from natural rights theories and systems, harking back through English, American, and French constitutionalism to John Locke, and earlier natural rights and natural law theory[29].

An international law of human rights strives for universality regardless of historical and cultural differences[30]. This brings in the theory of universalism the philosophy of universal rights is based on the idea that all humans are equally worthy of respect,[31] suffice to say including those suffering from HIV and AIDS. This idea is based on a conception of natural rights in which the potential of the individual human being deserves protection.

Universalists argue that we need a set of fundamental moral standards in order to distinguish between good and evil. A number of proponents of the idea of individual natural rights argue that these principles are superior to culturally embedded rights because they are neither culture-bound, nor is their genesis fixed in history[32].

The natural law approach has received criticism from various writers, who claim that its assumptions, intellectual procedures and modalities of justification can be employed equally by the proponents of human dignity and those of human indignity in support of diametrically opposed empirical specifications of rights, and neither set of proponents has at its disposal any means of continuing the one claim or at discontinuing the other[33].

The idea of universalism of human rights too has received a lot of criticism based on the argument that rights are not static and keep on being modified as well as changing with historical circumstances, and therefore as new rights acquire significance, the old once take back stage. Norberto Bobbio[34] argues that we have to come to terms with rights as socially and historically established claims which in a more or less successful process of universalisation can be variable, heterogeneous and at times contradictory.

This century and the latter half of the last century has seen universal acceptance of human rights in principle and general agreement on its content. Philosophical as well as political objectives to the idea of individual rights have subsided or become irrelevant. HIV/AIDS due to its very nature of respecting no boundaries or person and therefore impacting on human rights worldwide stands to benefit both from the natural law approach and universal rights approach.

## 1.6 Operationalisation of concepts

*HIV*

*Human Immune Deficiency virus* is a virus that causes AIDS, which is found mainly in bodily fluids e.g. blood, semen, vaginal secretion and breast milk. People are said to be HIV positive when antibodies are detected in their blood, the antibodies are created when the immune system is trying to fight off the virus whose failure then leads to the positive status[35].

HIV acts by gradually destroying the immune system. In a period of between five to fifteen years an infected person's body becomes so weak/deficient that it cannot fight off infections. This makes the body prone to opportunistic infections e.g. T.B, skin cancer, pneumonia, diarrhoea, fungal infections[36].

HIV in this study will therefore refer to the above described stage of the infection when the immune system is trying to fight off the virus through the use of antibodies

*AIDS*

This concept will also be used in the study. *AIDS* is the name for a combination of illnesses caused by a virus that can break down the body's immune system and lead to fatal infections and some form of cancer.

In areas where *CD4* counts and viral loads can be measured, people are regarded as having AIDS when their CD count falls below 200. In most settings, however, the capacity to carry out such sophisticated tests does not exist. So AIDS is then defined clinically, i.e. by examining the patient and making an assessment of his/her condition[37].

In the study therefore AIDS will refer mostly to the stage where the immune system of a person has broken down, and a number of opportunistic infections are taking an advantage of its depletion e.g. T.B, pneumonia etc.

*AIDS* refers to the Acquired Immune Deficiency Syndrome. Acquired means something gotten not inherited, Immune System which defends the body from diseases, Deficiency means becoming weakened by a virus. Syndrome means the body shows a variety of symptoms.

*Human Rights*

In this study *human rights* will refer to the human rights as envisaged in the International Bill of rights, as declared in the Universal Declaration of Human Rights and adopted by the General assembly of the United Nations on 10th December 1948.

*Human rights* are, literally, the rights that one enjoys simply as a human being. As such they are equal rights, because we are equally human beings. They are also inalienable rights because no matter how inhumanly we act or are treated we cannot become other than human beings.[38]

The idea of *human rights* assumes that all human beings have some basic commonly shared characteristics, and as a result they should be viewed and judged as members of the human race rather than as members of a particular group. The recognition of these shared qualities gives rise to a principal of equality which requires that all persons be treated with equal respect[39].

It is against this background that conventions and laws have been created to protect these rights for individual or groups. Some of the most important characteristics for rights are.

- They are founded on respect for the dignity and worth of each person
- They are universal, and apply equally to all people, without any discrimination whatsoever
- They are inalienable-no person can have his or her rights taken away except in very specific situations, the right to liberty, for example, can be restricted if a person is convicted of a crime, in a proper court.
- They are indivisible, interrelated and interdependent- if one right is violated, that may well affect respect, for the rights.

All human possess all these rights, regardless of race, colour, sex, language, religion, political or other beliefs, national or social origin, birth, age or other status, including real or perceived HIV status.

## 1.7 Hypothesis

The central assumption of the study is that those infected by HIV/AIDS are prone to Human rights violations, therefore the study will endeavour to examine how Kenya is implementing the international standards set by the United Nations in upholding the rights of those infected with the virus.

(1) Those infected and affected by HIV/AIDS are prone to Human Rights violations.

(2) Violations of human rights fuel the spread and exacerbates the impact of HIV/AIDS.

(3) HIV/AIDS undermines progress in the realisation of human rights.

## 1.8 Methodology

The study applies both qualitative and quantitative methods. Valuable and lasting people's and institutional empowerment comes from popular participation in which people control and own their experiences and perceptions. To the extent that this study seeks to draw from and understand the views and experiences from three tiers (Individual, government and civil society) on the issue of HIV/AIDS and Human rights.

Data collection was achieved at two levels. Primary data was collected through questionnaires and interviews with various stake- holders in the field where face-to-face surveys were conducted. In the survey data collection, information was gathered through direct interviews with people living with HIV/AIDS, policy makers and implementers.

Secondary data was gathered via review and analysis of documented data as well as through the inter-net. Documentary data was collected from published and unpublished academic papers and others on HIV/AIDS and Human rights worldwide. Tools for interviews and discussions were developed for different categories of people.

Taking into account the fact that Kenya as yet has no legislation on HIV/AIDS, the study examined the recently established Human rights, Office at the Attorney General's Chambers, as well as the HIV/AIDS prevention and control bill 2003.The study covered the period from the early 1980s when the first HIV/AIDS case was diagnosed in Kenya to-date. The study concentrated in Nairobi and its environs and a few selected areas.

### 1.9 Chapter outline

The study comprises five (5) chapters and Chapter One is the Introduction. Chapter two provides the historical background and situational Analysis of HIV/AIDS, Chapter Three deals with human rights conventions and the Kenya human rights situation.

Chapter Four deals with case studies, several case studies were carried out to show the situation as it is on the ground, followed by the analysis of the findings. This chapter relied heavily on people living with the virus as well as the employers and health care providers.

Chapter Five is the summary, conclusions and policy recommendations. This chapter also brings out research issues.

## End Notes

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# CHAPTER TWO

# HISTORICAL BACKGROUND AND SITUATIONAL ANALYSIS OF HIV/AIDS

## 2.0 Introduction

The AIDS epidemic, first known in the early 1980s, has wiped out more than twenty million lives and left forty-two million people living with HIV at the close of 2002.[1] In the same year, five million people were infected by the HIV virus and more than three million died from AIDS. This is an epidemic that is globally widespread and in its impact more devastating than the Black Death, which seven hundred years ago changed the course of development and history in Europe by killing one third of the population at the time some twenty-five million people.

Although HIV continues to affect people throughout the world, ninety five per cent of new HIV infections are among people in developing countries. In 2002, five million people were newly infected with HIV and three million people died.[2]

The HIV/AIDS epidemic has been termed as one of the greatest challenges facing humanity in the twentieth century. In the current situation, where a cure continues to elude researches, and where infection results in death, curing the spread of HIV/AIDS through prevention, and managing the infection through care and support have been the focus of efforts all over the world.

## 2.1 Origin of HIV/AIDS

The issue of the origin of HIV/AIDS has been contentious and has been answered by hypothesis rather than by fact, and because these hypothesis are propounded by acknowledged scientists they have been elevated to the status of fact.

The African origin hypothesis led by Dr. Robert Gallo in 1981 claimed that AIDS probably originated in central Africa in the 1950s, and from there spread to the Caribbean then USA and then Europe. However this hypothesis has been discounted by several scholars who do not understand how then the first case of HIV/AIDS was discovered in the USA. While Robert Biggar says that "there is no conclusive evidence that the AIDS virus originated in Africa, since the epidemic seemed to start approximately the same time as in America and Europe"[3].

The biological warfare generic engineering experiment hypothesis that has been put forward to explain the origin of the AIDS virus. According to this theory scientists were able to tinker with some viruses, cut them up and fuse the end of one virus (retrovirus HTLV-1) to the other end of another virus (brain-damaging sheep VISNA virus), to their surprise the manufactured virus lived, and escaped from the laboratory into the human population. Another version of the theory is that the manufactured product was tried on male long term prisoners, a high portion of whom were homosexuals. In this theory it has been suggested though not confirmed, that the virus has been man-made in the Soviet Union or United States as a weapon of biological warfare[4]

Dr. Noireau claims that the virus got from monkey to man, writing from Congo Brazzaville he says "the isolation from monkeys of retroviruses closely related to HIV strongly suggested a simian origin for this virus". This theory was based on a cultural practice along the Great Lakes region where in order to stimulate a man or woman and induce them to active sexual intense, the blood of a male monkey was inoculated directly into the pubic area, thighs and back of a man and that of a female monkey into the same regions of a woman, after which Dr. Noireau concludes that "these magic practices would therefore constitute an efficient experimental transmission model and could be responsible for the emergence of AIDS in man[5].

Rainwater, outer space, smallpox vaccination and biting insects like mosquitoes and bedbugs, African swine, fever virus, have been quoted as agents in connection with origin and transmission of the AIDS virus. All have been discounted by the world health organisation. Mosquitoes especially cannot spread HIV in Africa because all age groups bitten by the mosquito are not infected by the AIDS virus, and babies not bitten by the mosquito are infected. Children between infancy and middle teens are usually AIDS free unless they had been transfused with blood or had injections with un-sterilised needles[6].

## 2.2 Historical development of HIV/AIDS

Between 1978 and 1980 doctors in the United States began to observe clusters of diseases which previously had been extremely rare. These include a type of

pneumonia spread by birds (pneumocytis carinii) and cancer called Karposis Sacoma. The first public record of the pneumonia was contained in the morbidity and mortality weekly report (MMWR) of 5 June 1982, a widely circulated report on infectious diseases and deaths produced by the Centres for Disease Control in the US The MMWR recorded five cases of pneumocystis carinii. Later on 3 July, the MMWR reported a clustering of cases of karposis sarcoma in New York. Subsequently, the number of cases of both diseaseS which were mainly centred around New York and San Francisco rose rapidly, and scientists realised that they were dealing with a new phenomenon[7].

Once the new syndrome had been identified, various scientific and epidemiological activities followed. By 1983 the virus that caused AIDS had been identified by a French scientist, Luc Motagmer, and later by an American scientist Robert Gallo. The virus was named the Human Immunodeficiency Virus or HIV[8].

In 1985, a second immunodeficiency virus labelled HIV-2 was identified in humans. HIV-2 is a slower-acting virus, which appears to be found mainly in West Africa, but has now diffused to other parts of the world. It was during this same year when the first report of the transmission of the virus from mother to child through breastfeeding came out, and by the end of the year twenty thousand three hundred and three cases of AIDS had been reported to the world health organisation (WHO) [9].

Between 1986 and 1989 there were several developments as regards HIV/AIDS. A dramatic progress in the provision of medical treatment of AIDS emerged when early results of clinical tests showed that a drug called azidothymidine (AZT) slowed down the attack of the AIDS virus.

Worldwide leaders started taking the lead in public education and awareness. The U.K. Secretary of State for Social Services Norman Fouler, in a widely publicised trip to San Francisco U.S., shook hands with an AIDS patient this was soon followed by Princess Diana doing the same. In 1987 in Africa president Kenneth Kaunda of Zambia went public that his son had died of AIDS and sent a passionate appeal to the International community that AIDS be treated as a worldwide problem. It is in the same year that the WHO global programme on AIDS developed a global AIDS strategy with clear objectives to prevent and control HIV/AIDS worldwide. It included the need for every country to have a supportive and non-discriminatory social environment. By December over seventy thousand AIDS cases were reported to the WHO with the greatest number of cases from the USA followed by France, Uganda, Brazil, Tanzania, Germany, Canada, U.K, and Italy in that order[10].

As the global mobilization against AIDS continued, a world summit of health ministers was held in London in 1988 to discuss a common AIDS strategy focusing on programmes for AIDS prevention. One outcome of the meeting was the London declaration on AIDS prevention which emphasises education, free exchange of information and experience, and the need to protect human rights and dignity. The

WHO also agreed to promote an annual world AIDS day that was first celebrated on December 1st 1988[11].

In 1990[12] the U.S banned HIV positive people from entering the country, and though this was amended after criticism from the international AIDS society (IAS) and their statement that no further IAS sponsored conference would be held in the country, and actually non has been held in the U.S since 1990. By the end of 1990 over three hundred thousand AIDS cases had been officially reported to the WHO. The estimate of the number of people with HIV worldwide was eight to ten million whom about five million were men and three million women.

Table 2.0

| Area | Estimated HIV | Reported AIDS | Estimated AIDS |
|---|---|---|---|
| Africa | >5,500,000 | 77,043 | >650,000 |
| N America | 1,000,000 | 156,658 | 200,000 |
| S America | 1,000,000 | 28,937 | 90,000 |
| Asia | 500,000 | 843 | 2,000 |
| Europe | 500,000 | 41,564 | 50,000 |
| Oceania | 30,000 | 2,334 | 2,700 |
| Total | <9,000,000 | 307,379 | <1,000,000 |

Source: UNAIDS (2002) 'The Global HIV/AIDS epidemic' June 2002

The estimated three million HIV positive women are also estimated to have between them given birth to about three million infants whom over seven hundred thousand were estimated to become infected with HIV.

In 1991 the red ribbon became an international symbol of AIDS awareness. The visual AIDS organisation in the U.S together with Broadways cares and equity fights AIDS established the wearing of the Red Ribbon as something that signified support for people living with HIV/AIDS[13].By 1995 eighteen million adults and 1.5 million children were estimated to have been infected with HIV since the beginning of the epidemic, and the same year first annual AIDS conference was held in Cape Town South Africa, and it was revealed that eight hundred and fifty thousand persons were believed to be HIV positive in South Africa, representing twenty one per cent of the forty million HIV positive persons.

In 1996 the new joint United Nations (UN) programme on AIDS (UNAIDS) brought together six agencies affiliated with the UN system WHO, UNDP, UNICEF, UNFPA, UNESCO, and the world bank into the fight. By the end of this year UNAIDS reported that three million people mostly in the age bracket of 21 – 29 had become newly infected with the virus bringing to nearly twenty-three million the total number of infected people worldwide. In addition an estimated 6.4 million people, five million adults and 1.4 million children had already died from the virus[14]. By 1999 most of the new HIV infections were in sub-Saharan Africa, according to the world health report and AIDS had become the fourth killer worldwide.

## 2.3 An overview of HIV/AIDS situation in Africa

Sub-Saharan Africa is the region of the world that is most affected by HIV/AIDS. An estimated 29.4 million people are living with HIV/AIDS and approximately 3.5 million new infections occurred in sub-Saharan Africa in 2002. In just the past year the epidemic has claimed the lives of an estimated 2.4 million Africans[15].

Ten million young people (aged 15-24) and almost 3 million children under 15 are living with HIV. An estimated eleven million children have been orphaned by AIDS in sub-Saharan Africa. The extent of the epidemic is now becoming clear in many African countries, as increasing numbers of people with HIV are becoming ill. In the absence of expansive prevention, treatment and care efforts, the AIDS death toll on the continent is expected to continue rising before peaking around the end of the decade.

This means that the worst of the epidemics impact on these societies will be felt in the course of the next ten years and beyond. Its social and economic consequences are already being felt widely not only in health but in education, industry, agriculture, transport, human resources and economy in general.

Large variations exist between individual countries. In some African countries, the epidemic is still growing despite its severity. Others face a growing danger of explosive growth. The sharp rise in HIV prevalence among pregnant women in

Cameroon more than doubling to over 11 % among those aged 20-24 between 1998 and 2000 shows how suddenly the epidemic can surge.

National HIV prevalence rates vary greatly between countries. In Somalia and Gambia the prevalence is under 2% of the adult population, whereas in South Africa and Zambia around 20% of the adult population is infected. In four southern African countries, the national adult HIV prevalence rate has risen higher than was thought possible and now exceeds 30%. These countries are Botswana (38.8%), Lesotho (31.5%), Swaziland (33.4%) and Zimbabwe (33.7%) [16]. West Africa is relatively affected by HIV infection, but prevalence rates in some countries are creeping up. In west and central Africa HIV prevalence is estimated to 5% in eight countries including Cameroon (11.8%), Central African republic (12.9%), Cote d'Ivoire (9.7%) and Nigeria (5.8%).

Until recently the national prevalence rate has remained relatively low in Nigeria, the most populous country in sub-Saharan Africa. The rate has grown slowly from 1.9% in 1993 to 5.8% in 2001. But some states in Nigeria are already experiencing HIV prevalence rates as high as those now found in Cameroon. Already more than three million Nigerians are estimated to be living with HIV/AIDS. HIV infection in Eastern Africa varies between adult prevalence rates of 1% in Somalia to 15% in neighbouring Kenya. In Uganda the country prevalence among the adult population is 5%, but recent HIV infections appear to be on the decline in several parts of the country[17].

Over and above the personal suffering that accompanies HIV infection wherever it strikes, HIV in sub-Saharan Africa threatens to devastate whole communities, rolling back decades of progress towards a healthier and more prosperous future. The

impact of HIV/AIDS is severe in many countries of Sub-Saharan Africa, AIDS is erasing decades of progress made in extending life expectancy. Millions of adults are dying young or in early middle age. Average life expectancy in Sub-Saharan Africa is now 47 years, when it could have been 62 without AIDS.

The toll of HIV/AIDS on households can be very severe. Many families are losing their income earners and the families of those that die have to find money to pay for their funerals. Many of those dying have surviving partners who are themselves infected and in need of care. They leave behind children grieving and struggling to survive without parental care. HIV/AIDS strips the family assets further impoverishing the poor. In many cases, the presence of AIDS means that the household eventually dissolves, as the parents die and children are sent to relatives for care and upbringing. In all affected countries, the HIV/AIDS epidemic is bringing additional pressure to bear on the health sector. As the epidemic matures, the demand for care for those living with HIV/AIDS rises, as does the toll amongst health workers. Health-care services face different levels of strain, depending on the number of people who seek services, the nature of their need, and the capacity to deliver that care.

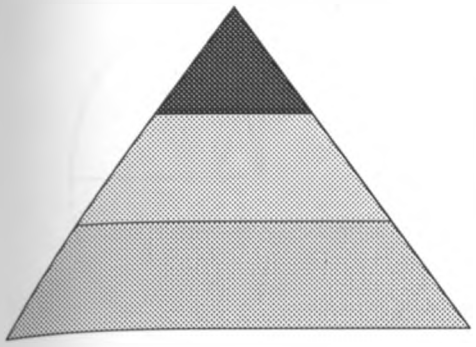
## 2.4 Situational Analysis of HIV/AIDS in Kenya

AIDS was first reported in Kenya in 1984. By the year 2001 a cumulative total of 105,601 cases had been reported to the National AIDS and sexually transmitted disease control programme (NASCOP). Due to under reporting, delayed reporting and missed diagnosis the reported cases are grossly underestimated. NASCOP

estimates that 2.2 million people have actually developed AIDS since the epidemic started and over 1.5 million died.[18]

Men and women have been infected in about equal portions, implying heterosexual contact. Seventy per cent of these cases have occurred among people in the age group 15-49 years with children under five contributing between eight to ten percent. Because AIDS is a sexually transmitted disease, it mainly strikes adolescents, young adults and people in early middle ages, the very people whom the society relies on for production and reproduction. These are men and women who raise the young and care for the old. When they die of AIDS, the elderly are left without support and their children become orphans. Coast, Nyanza, Rift valley and Nairobi provinces account for about seventy percent of the reported AIDS cases. On average the annual incidence of AIDS cases is about 150,000 new AIDS cases each year.[19]

Figure 2.0



105,601 reported AIDS cases (June 2001)

1,060,000 Actual AIDS cases

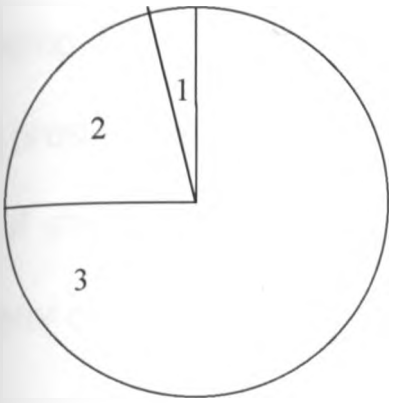
2.2 million Additional HIV infections (2000 estimate)

Source: NASCOP 2002

**Modes of transmission**

Sexual intercourse accounts for over seventy five percent of all new HIV infections. HIV can also be transmitted from an HIV-infected women to her foetus or infant before, during or shortly after birth and through breast milk. Transmission also occurs through HIV-infected blood, blood products or transplanted organs or tissues. For example it can be transmitted by direct blood transfusion through the use of improperly sterilised needles, syringes and other skin piercing instruments that have been in contact with infected blood.[32]

Figure 2.1




1 Transfusion

2 Prenatal

3 Sexual transmissions

Source: NASCOP 2002

**2. 4. 1 Major causes of HIV in Kenya**

**Poverty**

Due to HIV/AIDS the number of poor people in Kenya has risen in recent years and poverty is acquiring an increasingly permanent quality. The poor constitute slightly more than half the population of Kenya with women constituting the majority. More than three-quarters of the poor are in rural areas. The bulk of the poor are located in districts within a belt stretching South-to-South East from the shores of lake Victoria to the coast and straddling the rail and road corridors. Many children

whose parents have died of AIDS lack the basic necessities for survival, including food, shelter and clothing. The girl orphaned child is forced into prostitution at an early age which in turn exposes her to the HIV, and if she becomes the bread winner of her family, the vicious cycle of poverty continues.

Poverty then becomes a factor not only in the impact of HIV, but also in the spread. It deprives people of access to health facilities, schools and media. It denies most people the right to information, education and communication materials about HIV. Poverty pushes whole communities and families who are often unaware of the risks, to send their children into the workforce far away from home. The children then end up in forced labour and sexual abuse which exposes them to HIV.[21]

HIV is intertwined with poverty as it leads to decline in individual and family welfare, and these are families marginalised even before the onset of HIV/AIDS. Household resources are eroded quickly, as adults become care givers for sick family members, then they get sick themselves. At the same time they are the people who take in orphaned children of relatives, neighbours and friends. Poor families that are already struggling to make ends meet are even more vulnerable to the consequences of HIV/AIDS. Ordinarily, it is a woman's duty to care for the sick family members or relatives and for children. This obligation forces women to neglect subsistence crop production or activities that generate income for the household as have been

observed in many rural Kenya settings. Labour diverted from the essential activities lead to food insecurity.

Overall, for most households, issues related to poverty subsume the other effects of HIV/AIDS, which exacerbates a household's poverty. The women and girls are more likely to engage in commercial sex work to earn much needed income. This drastically increases their risks of contracting and spreading HIV/AIDS and STIs. The onset of Structural Adjustment Programmes in Kenya in the nineteen nineties, further complicated the issue of HIV/AIDS, as many retrenched persons and their families soon joined the ever swelling poverty stricken Kenyans.

**Culture**

To Prof. G.E.M. Ogutu, in Kenya culture is the central variable in explaining different patterns of change and essential determinant of sustainable transformation. Culture shapes all the thinking, imaging and behaviour of the Kenyan people. Cultures are neither isolated nor static, but interact and evolve, that is, transform. It is for this reason that Javier Perez de cuellar, former UN Secretary General, said "development efforts have often failed because the importance of human factor, that complex web of relationships, beliefs, values and motivations, which lie at the very heart of culture, had been underestimated in many development projects".[22]

Against the above background several Kenyan cultures have been quoted as fuel the spread of HIV. The culture of female circumcision which has of late been referred to as Genital Female Mutilation (FGM) is common among, the Maasai and Kalenjin of

the Rift valley as well as the Kisii of Nyanza and Meru of Eastern province. When the circumcision is carried out in a traditional setting, where the same knife is used on several girls, chances of infection are high. Though several NGOs are educating the populace on the dangers therein, cases have been reported even of forced circumcision.

Marrying off young girls whose genitalia are not fully developed exposes them to HIV, as they are more likely to tear and get bruised during sexual intercourse. The culture of child brides is common among the Miji Kenda in the Coast, the Maasai in the Rift valley and the Kuria in Nyanza province. Though the government has put machineries in motion to curb this practice, it has not been eliminated and this fuels the spread of HIV/AIDS.

Traditional male circumcision where knives are shared among age mates is a sure avenue of HIV infection. Though most communities in Kenya today take their young men to hospital for circumcision, there are pockets who still insist on carrying out this activity in the villages for example the Bukusu a sub tribe of the Luhya community of western Kenya.

The culture of remarrying a brother of a deceased husband, or 'wife inheritance' as it is popularly known in Kenya fuels the spread of the HIV. This practice is common amongst most communities, though the Luo and Luhya of western Kenya have been specifically identified with it, if a person dies of HIV, logic dictates that the spouse would be infected too, and if she remarries chances of spreading the virus are high.

The culture of wife sharing among the maasai of the Rift Valley has been cited as a major cause of the spread of HIV. In this practice age mates are free to sleep with each others wives by planting spears outside a hut as a symbol of the presence of a man in the house.

Among most of the Bantu communities of Kenya especially the Kikuyu and Kamba, woman to woman marriages were encouraged in case of barrenness. If a woman could not have children of her own she could 'marry' a younger woman who could then bear children for her with a man of the bride's choice, this practice has not totally died out and can be a cause of the spread of HIV.

HIV/AIDS is a sex problem and sex is central to people's culture, beliefs and practices. In Kenya HIV is mostly spread through heterosexual sexual relationships, and therefore culture is one of the causes of the spread of HIV/AIDS in Kenya[23]. Most of the above cited cultural practices are rigid, and apart from spreading HIV they also interfere with individual human rights.

## 2.4. 2 Prevention and management mechanisms

### Voluntary counselling and testing

Voluntary counselling and testing is being promoted as one of the prevention methods in Kenya. This service is offered freely to those who wish to know their HIV status, and a team of qualified and experienced counsellors take them through this. It is an effective prevention method as those who know their status are in a better position to decide either to stay negative, or live positively with the virus. VCT is an effective entry point to prevention of mother to child transmission and home based care.

### Behaviour change communication through information, education and communication (IEC)

Public health education programme in Kenya has raised the awareness of Kenyans about the nature and transmission modes of the HIV/AIDS epidemic to over ninety-five percent. However, this high awareness level has not been translated into behaviour change. The rapid spread of HIV/AIDS, and the incidence of sexually transmitted disease pose a daunting challenge to behaviour change promotion and advocacy.

The incubation period of HIV can lead to increased infection. The interval between infection with HIV to the onset of the disease AIDS is between three and ten years.

During this period the infected person may not have any symptoms. Under these circumstances promiscuity continues and this hinders prevention and control of HIV.

**Prevention of mother to child transmission.**

Due to the high sero-prevalence among women of childbearing age, there is a high frequency of mother to child transmission (MTCT), this usually occurs during pregnancy, at delivery or breast feeding. These mechanisms account for 35-40 percent of infections of children born to HIV sero-positive mothers and represent a major cause of morbidity and mortality among young children. MTCT transmission of HIV is now largely preventable through anti-retroviral therapy in late pregnancy.[25]

Effectiveness of zidovudine (AZT) and Nevirapine in reducing MTCT requires widespread institution or extension of services that involves among other things provision of voluntary counselling and testing (VCT) and provision of alternative baby feeds to non-breast feeding HIV positive women. These interventions are partially relevant in many of the developing countries where infectious diseases and malnutrition are the leading causes of infant mortality and where artificial feeding may be hazardous as well as prohibitively expensive.[26]

Abstinence especially among the youth has been encouraged as a preventive measure. The leading proponent of this approach has been the Catholic Church followed by other Faith-based organisations. Mostly for the married, being faithful to one uninfected partner has been encouraged, and taking into account the human nature, those not able to follow the above two alternatives have been advised to use

condoms, proper use of condoms has been identified as a preventive measure. Finally, those already infected are encouraged to live positively to prolong their lives.

### 2.4.3 Treatment and control of HIV

The high level of HIV infection means that large numbers of people require treatment, care and support services. It is estimated that, patients suffering from HIV/AIDS related diseases, occupy over 50% of hospital beds in medical wards in Kenya and this is expected to rise. To care for the large number of persons with HIV/AIDS has involved many sectors. In the National HIV/AIDS strategic plan it is suggested that treatment, care and support structure should attempt to link medical facilities and services within the community including home care.

Currently, formal government health and social services are partially meeting the needs of PLWHAS. Communities and NGOs have generated innovative responses to help people infected and affected to cope with HIV and improve their quality of life. PLWHAS have a big role to play in care and support and their visibility ensures that planning for care programmes is based on reality rather than speculation.

Clinical care aims to reduce suffering by treatment and preventing opportunistic infections. Quality of care is however, compromised by lack of basic supplies such as drugs for some opportunistic infections, gloves and antiseptics. It is desirable that treatment of opportunistic infections be integrated into the primary health care sector. This allows better access to treatment and early diagnosis of infections[29]

Nursing care involves attending to the personal needs and maintaining dignity of the patient, preventing transmission of infections and administering prescribed medications to ensure patient compliance. Nursing care also takes into consideration patient's comfort and nutritional needs. In Kenya nursing care is offered to PLWHAS in hospitals and at home where necessary. Sometimes nursing care is provided by family members who have been trained.

Home based care includes the care given to the sick and affected in their own home, and care extended from the hospital or health facility to their homes through family participation and community involvement. This is a collaborative effort between hospital, family and community. It includes components such as physical, physiological and spiritual support. Some people have turned to alternative medicine in form of herbs. This is especially as pertains to opportunistic infections. Herbalists prescribe various types of herbs for different types of ailments. The herbalists have formed an association that regulates the various operations. Nutrition, dubbed eating for health, specifies mainly unrefined foods as best for people living with the virus, and this has been viewed by many as alternative treatment. Highly active anti-retroviral therapy (HAART) has received much International publicity in recent years. HAART uses combination of drugs and can inhibit the spread of HIV within a person's body. For some HIV-infected persons, HAART has been an effective way to prevent the onset of AIDS and prolong life. However to others the effect of the drugs and the combination therapy treatments are not helpful. The rigorous

conditions of taking the drug is also too difficult for some patients, and most importantly the cost of these drugs are prohibitively high for most patients in Kenya.

The social support from the community is crucial for people living with the virus. Some NGOs/CBOs and social service organisations sometimes provide material assistance. Support groups run by and for people infected and affected by HIV/AIDS provide material, emotional and mutual moral support. Support groups are essential in that they enhance the profile and visibility of people living with HIV/AIDS, and help reduce stigma directed at the infected and affected. Legal support is also an essential service that PLWHAS require enabling them to deal with such issues as writing of wills and helping the affected to enforce such wills so as to inherit what is legally theirs. In addition support assistance to orphans in the form of psychological support, education, health care and nutrition helps in alleviating the impact of HIV/AIDS in the household[32]

### 2.4.4 Government of Kenya's response to HIV/AIDS

When the first case of AIDS was recognised in Kenya in 1984, the government responded by establishing the National AIDS committee in 1985. In 1987 the government established the National AIDS control programme within the ministry of health, and this was followed by the development of a five year strategic plan known as medium term plan (1987-1991), closely followed by the second medium term plan developed (1992-1996).[33]

In 1992, the government recognised that sexually transmitted diseases facilitate the spread of HIV/AIDS, and thus integrated STD control into AIDS control programme thus resulting in the establishment of the National AIDS and STD control programme (NASCOP). A policy framework paper, the sessional paper no. 4 of 1997 was developed to give direction on how to handle the various challenges posed by the epidemic.[34]

In 1999 AIDS was declared a national disaster and followed by the creation of the National AIDS control council (NACC) to provide policy and strategic framework for mobilizing and coordinating resources for prevention of HIV infection and provision of care and support to the infected and affected people in Kenya.

In 2003 the government formed the cabinet committee on National campaign against HIV/AIDS, under the chairmanship of the president. Its mandate is to provide National leadership, policy coordination and sustainability of the fight against HIV/AIDS as a national priority, to mobilize resources and to oversee their efficient utilization in the prevention and management of HIV/AIDS and to give impetus to the National AIDS control council.

The five priority areas identified in combating HIV/AIDS are: Prevention and advocacy, treatment, continuum of care and support, mitigation of the socio-economic impact, monitoring evaluation and research, and management and coordination.

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# CHAPTER THREE

# HUMAN RIGHTS CONVENTIONS AND THE KENYA HUMAN RIGHTS SITUATION

## 3.0 Introduction

The concept of right was first systematically developed in Rome, which was also the first western society to develop the concept of the private realm and to insist on its relative inviolability and equality with the public realm. For the Roman jurists, right, law and justice were inseparable, and the term *jus* was used to refer to them all[1]. Rights were created by the law, and the law was an articulation of the community's conception of justice.

The declarations of human and civil rights in the late eighteenth century were preceded by a long chain of events extending back into classical and medieval times. Classical antiquity created the intellectual preconditions for reflecting on political rule in terms of human rights. Later Christianity attributed to this meta-political legitimacy authority of human order, in a fundamental relation to human nature and to each concrete individual specimen of human life[2].

In its path to universality the development of human rights has gone through milestones. The declaration of rights of June 21, 1776 in Virginia USA became the first declaration of human rights in the history of the world to be adopted as a constitutional principle by a freely elected parliament[3].

On August 16,1789 human rights entered into European constitutional history when the French national assembly proclaimed its *'Declaration des droits de l'homme et du citoyen'* on December 10, 1948 a giant step was taken towards true universality extending beyond the boundaries of western cultures, when the United Nations declarations was signed[4].

Prior to 1945, International law was generally not concerned with how states treated individuals within their own boundaries. Such matters were regarded as being within the jurisdiction of each state. Exceptions did exist in the cases of slavery, humanitarian intervention, the treatment of aliens, minorities and the laws of war, but they were spasmodic, limited in scope, and largely political rather than idealistic in motivation[5]. Following the 2nd World War, however, the international human rights movement was born. As a reaction to events prior to and during the second world war, the allies and later the International community as a whole, came to the belief that the establishment of the new world order should be based upon a commitment to the protection of human rights and fundamental freedoms. Accordingly the protection of human rights was declared to be one of the purposes of the United Nations (UN), and the UN charter imposed certain obligations upon member states to that end.

The scope of human rights has broadened. Initially, the concerns included personal integrity, due process and fair trial and freedom of religion, expression and information. Later the scope expanded to include more wide-ranging rights to association, assembly and political activity, over which there were more struggles

throughout the 19th century, leading to major victories in parts of the world. In other parts, progress was recorded only in the 20th century, particularly in the 1980s and 1990s, but is still far from complete[6].

The declarations root itself in the principle that violations of human rights upset international order and in fact the UN charter commits states to respect fundamental freedoms. The declarations proclaim that 'all human beings are born free and equal' without regard to race, sex, language, religion, political affiliation, or the status on the territory on which they were born. It goes on to promote norms in a wide variety of areas, from banning torture to guaranteeing religious and political freedom to the right to economic well being[7].

Geographically, the recognition and application of human rights has expanded. From their origins in the triangle of Britain, the North American colonies (U.S) and France in the 17th and 18th centuries they expanded to wider European and Latin American acceptance in the 19th and early 20th centuries. They never the less endured tenuous circumstances and frequent and severe reversals, including the fascist regimes in Europe between the two world wars. Despite setbacks such as the military dictatorships in Latin America in the 1960s and 1970s, they finally became a universal concern after world war II through the charter of the U.N. since only 59 states were members of the U.N. in 1948, the truly universal acceptance took place only at the world conference on Human Rights held in Vienna in 1993, where nearly 180 governments expressed their commitment to universal human rights[8].

One important aspect of the process of geographical diffusion as a contribution to the universalisation of human rights has been the emergence of regional human rights mechanisms that build on universal rights but apply them in their regional context. Such instruments have so far been adopted in Europe, the Americas, and in Africa. The substance of rights is closely modelled on the universal declaration, but some of them go beyond it to include duties. In the case of Africa, collective and solidarity rights have also been included.

## 3.1 Social, economic and cultural rights

The study intends to benefit from the economic, social and cultural rights whose distinct historical origin has been used to explain its identification as a discrete category of human rights. They are usually termed as 'second generation'[9] rights, deriving from the growth of socialist ideals in the late 19th century and early 20th centuries and the rise of the labour movement in Europe. They contrast with the 'first generation' civil and political rights associated with the 18th century declarations on the rights of man, and the 'third generation'[9] rights that encompass the rights of 'peoples or groups', such as the right to self-determination and the right to development.

The reason for making a distinction between first and second generation rights could be more accurately put down to the ideological conflict between east and west pursued in the arena of human right during the drafting of the covenants. The soviet states, on the one hand, championed the cause of economic, social and cultural

rights, The United States on the other hand, asserted the priority of civil and political rights as being the foundation of[18] liberty and democracy in the free world. The conflict was such that during the drafting of the international bill of rights the intended treaty was divided into two separate instruments, which were later to become the ICCPR and the ICESCR.

Although within the UN there is now almost universal acceptance of the theoretical 'indivisible and interdependent' nature of the two sets of rights, the reality in practice is that economic, social and cultural rights remain largely ignored. As the committee on economic, social and cultural rights has pointed out, the reality is that: 'The international community as a whole continue to tolerate all too often breaks of economic, social and cultural rights which, if they occurred in relation to civil and political rights, would provoke expressions of horror and outrage and would lead to concerted calls for immediate remedial action. In effect, despite the rhetoric, violations of civil and political rights continue to be treated as though they were far more serious, and more patently intolerable, than massive and direct denials of economic, social and cultural right'.

The international covenant on economic and social and cultural rights (ICESCR) entered into force on 3 January 1976, following the deposit of the 35th instrument of ratification. Together with the international covenant on civil and political rights (ICCPR) and the universal declaration on Human Rights (UDHR) it forms part of the international bill of rights which was intended to form the basis of freedom, justice, and world peace following the Second World War. Despite the ambition of the United

Nations to secure the foundations of the new world order upon a respect for human rights, it took nearly twenty years to finalise the rest of the covenant. A further decade lapsed before the covenant entered into force and yet another before the covenant was provided with a supervisory body that was worth of the name[11].

Despite its age, the covenant should be looked upon as 'new', it was not until 1986, the creation of the U.N. committee on economic, social and cultural rights, that the covenant got a meaningful system of generating a wider understanding of its terms.

The greatest innovation made by the universal declaration is the inclusion of economic, social and cultural rights. (*Article 22)* refers to the economic, social and cultural rights 'indispensable for one's dignity and free development of one's personality' and to 'the right to social security', which entitles everyone to access to welfare state provisions. It precedes five subsequent articles which declare the right to work (*article23*), to rest and leisure (*article 24*), to an adequate standard of living (*article25),* to education (*article26)*, and to participate freely in cultural life of the community (*article 27).*[12]

### 3.1.1 Right of everyone to the enjoyment of the highest attainable standard of physical and mental health (*part III article 12*)

The right to health is firmly embedded in a considerable number of international human rights instruments. The right to health as laid down in the preamble to the constitution of the world health organisation (WHO) constitutes the point of

departure on which most of the provisions in these instruments are based. The preamble formulates the 'highest attainable standard of health as a fundamental right of everyone, and defines health as a 'state of complete physical, mental and social well-being and not merely the absence of disease and infirmity'[13].

In the same vein, most treaty provisions stipulate a right to the highest attainable standard of (physical and mental health) and include a number of government obligations as well. These government undertakings usually include commitment regarding healthcare and also mention a number of underlying preconditions for health such as occupational health, clean drinking water, and adequate sanitation.

In addition to specific treaty provisions addressing the right to health, there are a number of general treaty provisions that stipulate that there is a universal right to health. The most well known and influential of these is *Article 12* of the international covenant on Economic, Social and Cultural rights (ICESCR). In addition to this article there are a number of other treaty provisions that stipulate a right to health for particular vulnerable groups, such as women, children, racial minorities, prisoners, migrant workers, indigenous populations and more recently people living with HIV/AIDS.

The documents produced during several UN world conferences, including the Vienna Declaration, the programme of Action, of the Cairo conference, and the Beijing Declaration, the programme of Action, have also elaborated on the meaning and scope of the international human right to health and of international health issues generally[14].

The problem with the right to health is not so much a lack of codification, but rather an absence of a consistent implementation practice through reporting procedures and before judicial and quasi-judicial bodies, as well as lack of conceptual clarity. These problems are interrelated; a lack of understanding of the meaning and scope of aright makes it difficult to implement, and the absence of a frequent practice of implementation in turn hampers the possibility of obtaining a greater understanding of its meaning and scope.

The committee of economic, social and cultural rights as far as provision of healthcare services is concerned, a distinction between availability, accessibility, affordability, and quality of health care services prove useful in order to scrutinise the committees approach. With regard to the availability of health care services, the committee assesses the aggregate of hospital beds and the population per nurse per doctor. In order to guarantee the availability of health care facilities, the committee notes that state parties should encourage health personnel to stay and practice in their countries of origin.

Regarding the accessibility of health care services, the committee focuses on the most vulnerable groups, who are generally minority and indigenous populations, women, children, the elderly, disabled persons, and persons with HIV/AIDS. In addition, the committee expresses its concern about the accessibility of healthcare facilities in remote, rural areas. State parties are to make efforts to institute rural

health sub centres and to stimulate doctors and nurses to set up practice in rural areas.

An important aspect of the accessibility of healthcare facilities is the affordability of the available services. State parties are to ensure that healthcare services are affordable for the economically underprivileged in general and for the elderly and low income women in particular. As part of the affordability requirement, state parties must make sure that privatisation does not constitute a threat to the affordability of health care facilities. Finally, state parties must ensure that the available healthcare services are of good quality. This requires that doctors and nurses are skilled and that equipment and drugs are adequate.

When it comes to underlying preconditions for health there is some overlap with other rights. In particular, there is overlap with those rights contained in *article 11* of the ICESCR: food, housing, and clothing of these, the most explicitly health related are food related issues. Additional preconditions for health that are not covered by other rights but are disused within the framework of *article 12* are access to safe water and the provision of adequate sanitary facilities, environmental hygiene, occupational hygiene, and health education. State parties have to make sure that their population has sufficient access to safe water and adequate sanitation. In particular, they have to ensure that people living in remote, rural areas have sufficient access to these facilities[16].

Still another area of concern for the committee is HIV/AIDS. State parties are urged to take measures to reduce the spread of HIV/AIDS, to set up information campaigns, to adopt laws to prevent discrimination against HIV/AIDS positive persons, and to endeavour to avoid measures that discriminate against people with HIV/AIDS. These measures, including transit restrictions to minimize the risk of the spread of AIDS, mandatory testing, and control of prostitution[17].

Regarding drug abuse, state parties are to remain vigilant on the question of human rights violations and the means used to punish abusers. It has been observed that drug problem cannot be solved solely by resorting to repressive measures without recognising either serious problems, such as extreme poverty or inequality for example, drug addicts should not necessarily be regarded as delinquents but rather as patients. Finally state parties are to take measures to combat alcoholism and to discourage minors from having access to alcoholic beverages and tobacco products.

The committee members disapprove of coercive policies relating to health of the population. Forcing people to undergo certain treatment, such as psychiatric treatment, treatment of drug addiction, HIV/AIDS testing, or forcing indigenous populations to abandon traditional healing, is generally rejected by the committee which emphasises the adverse effects that such policies may have. Committee members have expressed concern that these practices give rise to violations of economic, social and cultural rights, as well as violations of civil and political rights. In this regard, it is note worthy to observe that some of the issues addressed by the

committee within the framework of the right to health overlap with civil and political rights.

With regard to healthcare, a 1992 Colombian case that concerned the terminal illness of an AIDS patient is worth mentioning. In that case the Colombian supreme court ruled that the state was required, by the right to health in *Article 13* of the Colombian constitution, to provide special protection when the lack of economic resources prevents a person from decreasing the suffering, discrimination, and social risk involved in being afflicted by a terminal, transmissible and incurable illness[18] To this end, the court decided that the hospital was required to provide the AIDS patient the necessary services.

It will take a long time for economic, social and cultural rights to obtain the same status and impact as civil and political rights. States will continue to fear the financial commitments of guaranteeing such rights.

As for the right to health, it has become clear that it concerns a broad right that is difficult to pinpoint, therefore, the adoption of health in *article12* of the ICESCR is of the utmost importance. It is also important that reliable indications be developed to measure sates progress in the field of health and that states, U.N. specialised agencies, and NGOs make efforts and cooperate in this reagrd[19]. Especially in regard to HIV/AIDS where the healthcare system has been overstretched and the drugs overpriced.

## 3. 1.2 The right to work *(part III article 6)*

All human communities depend for their existence on the work done by their members. Rarely, however, is this simple fact expressed as cogently as in the Italian constitution of 1948 which states in its very first article, paragraph 1:
'Italy is a democratic republic founded on labour'[20].

The first legal document on a world-wide scale in which a right to work is openly proclaimed is the universal declaration of Human Rights, adopted by the U.N. general assemble on 10 December 1948, *article 23*, paragraph 1, of the declaration which reads as follows: 'Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and protection against unemployment'.

The social foundations of right to work, a good place to start is the Bible 'In the sweat of thy face shalt thou eat bread' (Genesis 3:19)[21].

These words provide a clear reference to labour as the means of ensuring mans existence, his survival in a world that does not provide him with a natural habitat. Normally, in order to earn a living, a person must work.
Whoever is denied the opportunity to work lacks important possibilities to broaden his or her experience of the world. It is through work that a human being defines and develops his or her specific personality, gains ad insight into the life of the nation. However there are those who are unable to work, and this does not make

them lose their dignity, and therefore whoever is able to work, enjoys a great privilege which should be made full use of for his or her personal benefit as well as for the benefit of the communities to which he or she belongs.

The right to work requires states not to prevent human beings from working. Normally, no government is interested in establishing such prohibitions. The life and the wellbeing of a nation have their foundations in the labour which its citizens are able to perform. But legal impediments may derive from discriminatory practices, or affect the individual as a consequence of regimes, which combine the right to work with a duty to work.

Right to work like all the other human rights clauses is characterized by the element of non-discrimination. Discrimination is banned under article 1 of the ILO convention (no. 111) concerning discrimination in respect of employment and occupation[22]. Special emphasis has been placed in the international convention on the elimination of all forms of racial discrimination of 1965 (*article 5 (e) (1)*) as well as in the convention on the elimination of all forms of discrimination against women of 1979 (*Article II*) on committing states parties to combat and do away with any kind of discrimination in employment. Finally the concluding document of the 1989 Vienna CSCE conference also stresses (Principle 13.7) that the enjoyment of all human rights and fundamental freedoms shall be ensured to everyone 'without discrimination of any kind'[23] listing the forbidden grounds of discrimination by literally reproducing the words employment by the two conventions of 1996.

Most employment opportunities exist in the private sector. Giving effect to right work requires the state, *inter alia* to prohibit policies of discrimination on the part of private employers[24]. In order to enjoy the social rights (*article 25*) there is also need to enjoy certain economic rights. These are the right to property (*article 17*), the right to work and other work-related rights (*article 23 and 24)* and the right to social security (*article 22 and 25*).

The combination of economic and social rights serves the dual function of freedom and equality. The right to property, which had a prominent place in the early theory of natural rights, serves as a basis for entitlements which can ensure an adequate standard of living, and this is also a basis of independence and hence, of freedom. But property in the traditional understanding of the world cannot be enjoyed on an equal basis by all. It has to be supplemented, therefore, by the right to work that can provide an income commensurate with an adequate standard of living, and by the right to social security that can supplement, and where necessary fully substitute, insufficient income derived from property or from work. The right to work is also a basis of independence, provided the work is freely chosen by the person concerned, that sufficient income is obtained from it, and that workers can protect their interests through free trade unions and collective bargaining.

The work related rights in *article 23* consolidate a development that had started at the beginning of the 20th century and been promoted through the international labour organisation (ILO), which was formed in 1919. The right to form and join trade unions (freedom of association) without interference from the state was

included as a basic principle of the constitution of the ILO[50]. It presented a victory over the very restrictive economic liberalism of the 19th century when legislation had prohibited or made redundant all agreements between employers and employees for advancing the latter's wages or working conditions Of similar importance is the principle included in *article 23* that everyone shall have equal pay for equal work. Lower pay for women was and still is a deeply entrenched practice in many societies. By including this principle, the declaration provided a basis for action that in most parts of the world has led to considerate equalisation of rates of pay between Women and men, though much remains to be done.

**ILO standards and HIV/AIDS**

While there is no international labour convention that specifically addresses the issue of HIV/AIDS in the work place, many instruments exist which cover both protection against discrimination and prevention against infection that can be, and have been used. The conventions that are particularly relevant to promoting respect for human rights in the context of HIV/AIDS at work include:

Termination of employment convention, 1982 (no.102)

Vocational rehabilitation and employment (Disabled persons) convention, 1983 (no.159)

Social security (Minimum standards) convention, 1952 (no.102)

Occupational safety and health convention, 1981 (no.155)

Labour inspection convention, 1947 (no.81) and labour inspection (Agriculture) convention, 1969 (no.129)

The eight fundamental conventions, especially the discrimination (Employment and Occupation) convention, 1958(no.111) have to be respected by states even if they have not ratified the conventions concerned.

### 3.1.3 Right to non-discrimination and equality.

*Based on article 2(2) and article 3.*

This covenant is based upon the idea of the 'equal and inalienable rights of all members of the human family'[25]. The ICESCR identifies 10 prohibited grounds for discrimination (race, colour, sex, language, religion, national or social origin, property, birth or other status).

Non-discrimination characterises, most of the human rights clauses, and although most of the social, economic and cultural covenant generally contains only promotional obligations, this characterisation is not true when it comes to the prohibition of discrimination. Although states are not placed under a strict obligation fully to realise all the aims listed in the provisions of the covenant as individual rights, they must refrain from practising any kind of forbidden discrimination if and when they take measures for the fulfilment of their duties. The rationale underlying the 'soft' character of the bulk of these duties does not apply here. Sates may not have the financial means to set up a mechanism of social security, but they are always in a position to refrain from discriminatory practises[26].

Nothing illustrates the global impact of discrimination and intolerance better than the global AIDS epidemic, which has become one of the greatest tragedies and challenges to our time. HIV-related stigma and discrimination are immense barriers to effective responses to the epidemic. HIV stigma comes from the powerful combination of shame and fear. HIV is transmitted through sex and so is surrounded by taboo and moral judgement. But we do not need to be prisoners of shame and fear. The AIDS epidemic can be turned back, and to do so, we must defeat HIV-related stigma and discrimination[27].

HIV is a mystery like death and there is nobody who is not afraid of death, and the introduction of HIV was bad, it was said to be a disease of prostitutes, drug users and homosexuals.

Although in many African languages in general and Kenya in particular there is no specific word for stigma, HIV-related stigma is real or perceived negative response to persons by individuals, communities or societies. It is characterised by rejection, denial, discrediting and disregarding, especially in regard to women and children. Stigma frequently leads to discrimination, and the violation of human rights. Stigma occurs because HIV and AIDS has long been associated with sex, blood, death, disease and behaviours that may be illegal or perceived as immoral such as sex, sex-work, men having sex with men and injecting drug use[28].

Human rights underpin meaningful and sustainable approaches to addressing discrimination arising from stigma in many contexts. Stigma and discrimination within the family or directed toward the affected family often poses one of the greatest challenges for those living with HIV and AIDS. As it is the most subtle and the hardest to address. Stigmas, just as prejudice, morals and beliefs have been instilled in us from the time that we were born. It is even more difficult for us to remove stigma from HIV, as it deals with two things that we as society are scared to talk about sex and death/dying.

Non-discrimination is crosscutting and has been dealt with in the international covenant on civil and political rights, the international covenant on economic, social and cultural rights, the international convention on the elimination of all forms of racial discrimination against women. While certain aspects have been provisionally defined in preliminary efforts to draft a convention on the elimination of all forms of religious intolerance, other agreement deal with slavery, genocide, apartheid, and various practices which are peculiar manifestations of discrimination. Specialised agencies, such as the international labour organisation (ILO) and the United Nations educational, scientific, and cultural organisation (UNESCO) have promulgated structures against discrimination. More recently UNAIDS has joined the list[29].

### 3.1.4 International guidelines on HIV/AIDS and human rights

Initial responses to the HIV scourge were often reactionary and invoked in the name of public health and frequently at the expense of human rights. In some countries

strong walls were built separating 'the healthy' from 'the infected' and discriminating treatment of people with HIV/AIDS was common on the grounds of protecting the greater society from contagion.

There has been a rapid growth in the number and scope of international human rights instruments, in the establishment of judicial and non-judicial supervisory organs and procedures designed to secure respect for human rights, in the scholarly literature on human rights and humanitarian norms and in the interest shown by decision makers, the media, and the public at large in the international protects of such rights[30].

During the second international consultation on HIV/AIDS and Human Rights, organised jointly by the United Nations office of the High Commissioner for Human Rights and the joint United Nations programme on HIV/AIDS (UNAIDS), held in Geneva from 23 to 25 September 1996, guidelines were adopted to assist states in creating a positive, rights-based response to HIV/AIDS that is effective in reducing the transmission and impact of HIV/AIDS and consistent with human rights and fundamental freedoms.

The international guidelines state that although the states have primary responsibility for implementing strategies that protect human rights and public health, United Nations bodies, agencies and programmes, regional intergovernmental bodies and non-governmental organisations, including networks of people living with HIV/AIDS, play critical roles in this regard[31].

According to the international guidelines, states should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted disease are not inappropriately applied to HIV/AIDS, and that they are consistent with international human rights obligations.

States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation, and provide for speedy and effective administrative remedies.

States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and safe effective medication at an affordable price.

States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatisation associated with HIV/AIDS to understanding and acceptance[66]. Cooperation through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues is encouraged and states should ensure

effective mechanisms to protect human rights in the context of HIV/AIDS at international level[33].

The history of the recognition of the importance of human rights in the context of HIV/AIDS goes back to 1988 when the world health organisation (WHO) held an international consultation on health legislation and ethics in the field of HIV/AIDS in Oslo. It advocated bringing down barriers between individual and the virus. In the same year the world Health Assembly passed a resolution entitled 'Avoidance of discrimination in relation to, HIV infected people and people with AIDS', which underlined how vital respect for human rights was for the success of national AIDS prevention and control programmes and urged member states to avoid discriminatory action in the provision of services, employment and travel.

In 1989, the first international consultation on AIDS and human rights was organised by the then United Nations centre for human rights, in cooperation with the world health organisation/WHO. The report of the consultation highlighted the human rights issues raised in the context of HIV/AIDS and proposed the elaboration of guidelines. In 1990, the WHO conducted regional workshops on the legal and ethical aspects of HIV/AIDS at Seoul, Brazzaville and New Delhi. The first of these workshops developed guidelines to evaluate current and elaborate future legal measures for the control of HIV/AIDS to be used as a checklist by countries considering legal policy issues[34].

### 3.1.5 Proposed guidelines on HIV/AIDS and human rights in Kenya

Law reform programmes focusing on human rights have been ongoing in countries such as Australia, Canada, the United States and Kenya where this culminated into the formation of a task force on legal issues relating to HIV and AIDS, and enactment of the HIV/AIDS bill 2002.

Therefore Kenya as yet has no legislation in place to deal with HIV/AIDS issues as relates to human rights. However, several guidelines have been recommended in the draft bill, including the fact that the constitution must make reference to a category which upon construction will extend to protect persons with HIV and AIDS e.g. it should outlaw discrimination on the basis of 'health status'[35].

Among the recommendations is a need for policy directions that regulate the conduct of health care workers towards patients with HIV and AIDS and which should emphasis the necessity of a non-discriminative approach that upholds the human rights of patients. It is further recommended that there is need to build the capacity of People living with HIV/AIDS (PLWHAS) to enable them to influence their own treatment and access to healthcare. In this regard, PLWHAS must be considered key players and key determinants in issues regarding access to essential drugs, treatment, care and support. The legal task force recommended the implementation of the provisions of the industrial property Act (2001), to make accessibility to essential drugs and services easier for PLWHAS[36].

At the workplace the Federation of Kenya employers (FKE) has been committed to the fight against HIV/AIDS, and among its objectives are the protection of human rights and dignity of HIV/AIDS infected employees, as well as avoidance of discrimination against those employees infected with HIV/AIDS virus[37].

FKE identifies lack of access to medical treatment because of low incomes amongst the majority of the working population, unaffordable anti-retroviral drugs as among the factors hampering the fight against HIV/AIDS at the workplace. It recommends that any employment screening for HIV/AIDS should be in compliance with the ILO convention no.111 on discrimination (employment and occupation) 1958 and the principles development by the ILO/WHO consultation on HIV/AIDS in the workplace held in Geneva from 26th to 29th June 1988[38].

It further states that HIV/AIDS pre-employment screening as part of the assessment of fitness may not be required, and that sentinel surveillance testing must be kept confidential and may only be used anonymously for statistical purposes.

Further, FKE states that employees and their families should have access to information and education programme on HIV/AIDS, as well as to relevant counselling, voluntary testing and appropriate referrals, and HIV-infected employees should not be discriminated against, including access to and receipt of standard pension, medical insurance or provident fund benefits and occupationally related benefits

On continuation of employment relationships, HIV infection is not a cause for termination of employment. As with many other illnesses, persons with HIV-related illnesses should be able to work as long as medically fit for available, appropriate work or until declared unfit to work by a registered practitioner[39].

The government of Kenya has developed guidelines to antiretroviral drug therapy in Kenya, and it recognises the fact that the mainstay of managing HIV/AIDS epidemic is prevention and advocating for behaviour change. Despite the fact that Kenya hospitals continue to offer care to many patients who occupy beds for long with recurrent HIV/AIDS related complications, availability of antiretroviral drugs to Kenyans who need them is the subject of debate but no doubt the government will soon put in place the legal framework to increase access to these drugs[40].

**Conclusion**

Though we live in a period of civilisation when human rights have received recognition through universal instruments and national constitutions, the truth is that humans without rights are on the increase, and people living with HIV/AIDS have recently joined the list. Though the Government of Kenya has put several human rights mechanisms in place,the strategies need to be implemented and enforced.

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[40] Republic of Kenya, *Guidelines to Antiretroviral Drug Therapy in Kenya*, the Republic of Kenya, NASCOP, Nairobi 2001 p. 12

# CHAPTER 4

# AN OVERVIEW OF THE IMPLEMENTATION OR NON – IMPLEMENTATION OF HUMAN RIGHTS GUIDELINES ON HIV /AIDS IN KENYA: CASE STUDIES

## 4.0 Introduction

The first three chapters looked at the origin and historical development of HIV/AIDS and human rights. We have also looked at their relationship, and what the International community has put into place to counter the negative effects. In particular we looked at both the International and Kenyan proposed guidelines on HIV/AIDS and Human Rights.

We realized that while results of remedying acts of discrimination against individuals and of violation of civil and political rights can be measured immediately, fulfilment of economics, social and cultural rights primarily depend on political will and initiatives and on long-term investments. The matter in this area is therefore more difficult to evaluate.

However, an empirical overview of violations of human rights of persons due to their HIV status can only be done by looking at specific cases, where the individuals have complained or the perpetrators have discriminating policies in place.

In this chapter, we shall look at specific cases of people living with HIV/AIDS, how their rights as pertains to work, Health, Insurance and non-discrimination is affected.

We shall also look at the policies and implementation of the same as relates to HIV in these sectors.

These case studies will help us have a clear insight into the relationship between HIV/AIDS and human rights violations. This chapter is central in helping us to determine whether HIV/AIDS impacts on Human Rights in Kenya and vice versa as postulated in this study.

As relates to the state, the paper is especially going to pay attention to the three forms of state obligations as pertains to human rights. The obligation to respect which requires the state to abstain from interference with the freedom of the individual. The obligation to protect which expects the state to prevent other individuals from interference with the rights of the individual and finally the obligation to fulfil which requires the state to take the necessary measures to ensure the satisfaction of the needs of the individual that cannot be secured by the personal efforts of that individual.

The first part of this chapter looks at the documented evidence of specific cases where the human rights of persons have been violated due to their HIV/AIDS status, and the second part concentrates on the results of the case studies carried out in Nairobi and its environs.

Two different types of questioners have been used in the study. One for the individual members of the public, this paid attention to HIV/AIDS and Human rights issue relating to work, health, insurance and discrimination and equality. The

second questionnaire referred to as the employers' tool was used to collect data from various employers.

## 4.1 HIV/ AIDS and the right to work

The international guidelines on HIV/AIDS and human rights recommend that:

- A national policy on HIV/AIDS and the workplace should be agreed upon in a tripartite body
- There should be freedom from HIV screening for employment, promotion, training or benefits
- There should be confidentiality regarding all medical information, including HIV /AIDS status and
- There should be employment security for workers living with HIV until they are no longer able to work, including reasonable alternative working arrangements[1].

The Kenya recommendations contained in the HIV and AIDS prevention and control Bill, 2003 states that the Government shall ensure the provision of basic information and instruction on HIV and AIDS prevention and control to:-

Employees of all Government Ministries, Departments, Authorities and other agencies and to employees of private and informal sectors.

The information provided under this section shall cover issues such as confidentiality in the work place and attitudes towards infected employees and workers.

A total of twenty employers were interviewed and eighteen of them confirmed that they require medical records of their prospective employees. This they justified was not specifically for HIV/AIDS status, but a requirement, which existed long before the advent of HIV/AIDS. They confirmed that they definitely would not employ an HIV/ AIDS positive person, though the screening is not specifically for HIV. The two companies which do not carry out medical screening had no medical benefits for employees and their employment was based on a renewable two years contract.

As regard confidentiality regarding medical information of employees, the twenty companies interviewed responded that they respected this clause. Seventeen of the Companies interviewed had in house medical officers or were accredited to established hospitals and they confirmed confidentiality. However, when requested for purposes of manpower planning they could break into gender and grades those who had passed or failed the medical examination but not the diagnosis.

On the issue for employment security for people living with HIV/AIDS, seventeen out of twenty Companies interviewed claimed that they would not fire any employee based on HIV status, but on HIV related issues e.g. non-performance, absenteeism, lack of punctuality, or inability to co-operate with colleagues.

The Public Service Commission confirmed in the interview that they treat people living with HIV like other employees, by giving them three months paid medical leave, another three months on half pay then they convene a medical board on whose recommendations they can retire employees on medical grounds HIV positive

or not. On the ground, it emerged from the interviews that as recommended in the HIV and AIDS prevention and control Bill 2003, the Kenya Government has established a National Aids Control Council in the Office of the President as a coordinating body, at the same time, it has established AIDS Control Units in Government Ministries.

The National Aids Control Council is also working in corporation with the Civil Society, the Non-Governmental Organizations and the faith-based organizations. The major mandates of these Organizations is to provide information on HIV/AIDS covering issues such as confidentiality in the work place and attitudes towards infected employees and workers.

From the interviews, it emerged that nineteen out of the twenty Companies interviewed carried out pre-employment testing. The Public Service Commission of Kenya also carried out pre-employment testing. They were all however quick to add that this is not to ascertain the individual's HIV/AIDS status, but their overall fitness in relation to the work being offered, and they confirmed that medical examinations have always been done.

All the interviewed employers revealed that their employment policies never learn of HIV status of their prospective employees, as the doctors don't reveal this to them, but only inform them if an individual has failed or passed the medical examination, and failing can depend on several other factors of diagnosis. Failure of Medical examination determines employment depending on the type of job being interviewed

for, example for Kenya Civil Aviation Authority, an Aeronautical Officer would fail due to sight defects whereas for Kenya Ports Authority diabetes or hypertension could disqualify one from handling cranes, and therefore doctors though not at liberty to disclose the diagnosis would be able to determine fitness or otherwise.

It was confirmed that medical examinations are also carried out for promotion and training purposes and here too, HIV cases are not handled differently, though three out of twenty Companies said that they have been deploying HIV positive persons to less strenuous and less sensitive areas. All the twenty Companies interviewed and the Public Service Commission confirmed that they do not retire people on their HIV/AIDS status, but on medical grounds, which is general.

A questionnaire dubbed individual's tool was formulated and utilized in interviewing people living with HIV/AIDS. The method of non-probability sampling was used, and twenty five persons living with HIV/AIDS of mixed gender were interviewed. Twenty two out of twenty five persons claimed that they have been denied employment or failed job interviews due to their HIV/AIDS status or related complications.

On being denied job promotion, twenty out of twenty five persons interviewed claimed that they had been denied promotion due to their status while; twenty-three claimed that they have been denied job-oriented training due to their HIV status.

Twenty persons living with HIV out of twenty-five who were interviewed stated that they were fired from their jobs due to their HIV status. Out of the twenty five were adequately compensated.

All the twenty five persons interviewed claimed that colleagues at work had been disrespectful to them due to their HIV status, by refusing to share work tools with them or talking ill of those infected in their presence. All those interviewed said that they had been denied certain benefits at work due to their HIV status.

It was therefore observed that in relation to work, while the employers felt and suggested that human rights of those infected with HIV was not violated, the people living with the virus felt tat their rights had been violated. It was further observed that the existing human rights resolutions are HIV/AIDS friendly, however it is the implementers who need to be educated and sensitised to accommodate the emerging HIV/AIDS and human rights issues.

As regards the HIV and human rights issues guidelines pertaining to work, both the implementation and enforcement is lacking as brought out by the people living with HIV, while the Government and employers who were interviewed would want to believe that the guidelines are being implemented.

From the interviews carried out it emerges that those infected by HIV/AIDS are prone to Human Rights violations as hypothesized.

## 4.2 HIV/AIDS and the right to health

The international guidelines on HIV/AIDS and Human Rights on Health recommend that:

- States should review and reform public health legislation to ensure that they adequately address the public health issues, raised by HIV/AIDS, and that they are consistent with International Human Rights Obligations.
- Public health law should fund and empower public health authorities to provide a comprehensive range of services for the prevention and treatment of HIV /AIDS, including relevant information and education, access to voluntary testing and counselling, STD and Sexual reproductive health services for men and women, and clean injection materials, as well as adequate treatment for HIV/AIDS related illness[2].

A part from surveillance testing and other unlinked testing done for epidemiological purposes, public health legislation should ensure that HIV testing of individuals should only be performed with the specific informed consent of that individual. Exceptions to voluntary testing would need specific judicial authorization, granted only after due evaluation of the important consideration involved in terms of privacy and liberty.[3]

Public health legislation should ensure that information relative to the HIV status of an individual be protected from unauthorized collection, use or disclose in the

health-care and other settings and that the use of HIV related information requires informed consent.

Public health legislation should authorise, but not require, that health-care professionals decide, on the basis of each individual case and ethical consideration whether to inform their patients' sexual partners of the HIV status of their patient. Public health legislation should require that health care workers undergo a minimum of ethics and human rights training in order to be licensed to practise and should encourage professional societies of health care workers to develop and enforce codes of conduct based on human rights and ethics, including HIV related issues such as confidentiality and the duty to provide treatment.

The Kenya guidelines on HIV/AIDS and human rights pertaining to health, have concentrated on safe practises and procedures, stating that a person who offers to donate any tissue shall immediately before such donation undergo an HIV test. Any blood tested which is found to be HIV positive shall de disposed of in accordance with the prescribed guidelines on the disposal of medical waste as soon as reasonably practicable after such result is obtained. The government shall ensure the provision of protective equipment such as gloves, goggles and gowns to all healthcare providers and other personnel exposed to the risk of HIV infection.

Interviews were carried out with ten selected health care providers in Nairobi, and in all of them the patient can be given specific care after the initial contact. After

identification the patient can choose whether to be cared for under the patient support centre (HIV/AIDS care) or not.

The decision to start therapy (anti retroviral drugs) should be made after considering the patient's acceptance or readiness and the probability of adherence. The strength of recommendation is dependent on the prognosis as determined by clinical state, CD4 cell count and viral load.

All the health care providers interviewed said that HIV/AIDS is different from other terminal illnesses due to the stigma attached to it and the symptoms it exhibits. They also confirmed that the way HIV/AIDS is acquired determines to a large extent why it is viewed differently from other terminal illnesses.

The ten hospitals interviewed confirmed that a patient has to pay for treatment before he can be treated unless in an emergency situation. They said that this was not based on the HIV status of a patient and further stated that unless one has full blown AIDS, it is usually not easy to know the HIV status of a patient. All the health care providers interviewed said that they would like their interests to be taken into account when dealing with HIV patients, in terms of protective gear, and they assured us that it is not discriminative as the protection is two way, since there are health care providers who are HIV positive, and could infect the patients if protective gears are not used.

A group of individuals living with HIV were interviewed on health issues pertaining to

denial or access to health services. All of them confirmed that they have never been denied attention due to their HIV status, but due to lack of funds, however, they quoted several occasions when they were treated differently from other patients by being delayed in queues, and rude remarks being made towards them, being looked at badly or openly being treated in a disrespectful manner, one person claimed that when he asked why nobody was attending to him, he was told that he was going to die anyway.

The people living with the virus interviewed cited several occasions when healthcare providers refused to give them personalised attention due to their status, especially where there were shortages of gloves. Of the twenty-five people living with the virus who were interviewed, only five were on anti-retroviral drugs. Two of them were purchasing the drugs on their own and two were being assisted by donors, and one was under a trial programme. Those not on anti retroviral were twenty and eighteen cited lack of funds for not being on anti retroviral, while two cited fear of side effects. The monthly costs of most of the anti retroviral drugs were quoted to be from four thousand to ten thousand Kenya Shillings.

Most of the health institutions interviewed said that they were putting HIV positive pregnant women on Nevirapine, (NVP), on the thirty- fourth week of pregnancy, since most patients deliver before forty weeks of gestation. From the interviews it emerged that those living with the virus felt that the human rights as pertains to right to health were being violated at various levels: by the state, in not being able to provide them with the much needed anti retroviral drugs for free or at highly

subsidised prices, by the health care providers in not being sensitive enough to those who are HIV positive in terms of the language and demeanour towards them.

A few of the health care providers interviewed felt that we risked overprotecting those who are HIV positive. They felt that despite the history of HIV/AIDS, it needs to be treated just like any other terminal ailment, and claimed that what were being cited, as human rights violations had existed with other terminal ailments long before the advent of HIV/AIDS. They cited leprosy, cancer, sickle cell anaemia. They claimed that they worked within the medical ethics, which had guided medical practitioners from time immemorial.

### 4.3. HIV/AIDS and the right to insurance and social security

The International Guidelines on HIV/AIDS and human rights does not dwell much on the right to Insurance, however, under its guidelines on anti discrimination and protective laws it recommends protection for social security and other benefits for workers living with HIV, including life insurance, pension, health insurance, termination and death benefits.

In the HIV and AIDS Prevention and Control Bill, 2003 it is recommended that no person shall be compelled to undergo HIV test or to disclose his HIV status for the purpose only of gaining access to any credit or loan services, medical, accident or life insurance or the extension or continuation of any such services[5].

Most of the insurance companies interviewed randomly, were tight lipped on their policies, but those ready to talk said that they do not insure HIV positive persons at a higher premium because it is a high-risk venture. On medical insurance they confirmed that the high premiums take care of the several opportunistic infections, which are associated with HIV positive persons. All the insurance companies interviewed said that they would not give life insurance to HIV positive persons. Asked on how they handle other terminal illnesses like cancer, they confirmed that when disclosed then each individual case is determined on its own merit, however, should a person not disclose and its existence is discovered during the course of treatment, then in most cases they end up not paying or in court.

In total twenty-five people living with the virus were interviewed as concerns insurance policies and HIV. Twenty-one confirmed that they had sought medical insurance and were turned down on the pretext that they had failed to meet the insurance conditionalities. They all said that despite the nice wordings they knew they had been turned down due to their HIV status. Asked whether they thought that the insurance regulations and conditionalities violated their rights, they all answered in the affirmative. As concerns the insurance policies, HIV/AIDS impacts directly onto the human rights of those infected by the virus.

### 4.4. HIV/AIDS and the right to non-discrimination and equality

The International Guidelines on HIV and AIDS recommends that states should enact or strengthen anti discrimination and other protective laws that protect vulnerable

groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation and provide for speedy and effective administrative and civil remedies[6].

It further recommends that general anti-discrimination laws should be enacted or revised to cover people living with a symptomatic HIV infection, people living with AIDS and those merely suspected of HIV or AIDS. Such laws should also protect groups made vulnerable to HIV/AIDS due to the discrimination they face. Disability laws should also be enacted or revised to include HIV/AIDS in their definition or disability.

The HIV and AIDS Prevention and Control Bill, 2003 cites that there should be no discriminatory acts and policies pertaining to HIV/AIDS at the workplace, in schools, nor restriction on travel and habitation, inhibition from public service, exclusion from credit and insurance services, discrimination in health institutions, and denial of burial services[7].

The interviews on HIV/AIDS and discrimination were personal and were carried out within the twenty earlier identified companies. Purposive sampling was used on identified ten people with university education, ten people of middle level education and ten people of lower cadre. The first question posed was how one would react if their spouses were diagnosed with HIV. The more educated respondents answered that though they would not desert their spouses immediately, they would have no

intimate relationships with them. Most of the middle cadre personnel said that they would not be intimate with their spouses and would consider separation. The lower cadre interviewees said that they would stay with their HIV positive spouses because surviving on their own might prove more difficult.

When it came to how one would react when their friends were diagnosed with HIV, the more educated persons were more tolerant and said they would maintain the relationship, while nine out of the ten lower cadre persons said they would have nothing to do with their friends if they tested HIV positive. When asked if they understood what human rights were, the college degree holders and the middle level persons were more familiar with the civil and political rights, and had very little knowledge of their economic, social and cultural rights while the lower cadre personnel had very little or no knowledge at all of their rights or those of others.

Of the thirty persons interviewed, twenty six said that people who are HIV positive are different from the rest of the people and that they should not have families as they are going to die anyway. The other four were indifferent saying that if people who are HIV positive want to have families it is their business.

All the twenty-five persons living with HIV said that they had been discriminated against at the family level due to their HIV status. The discrimination range from being moved to a separate bedroom to being given separate plates for eating, basins for washing clothes, to being called a disgrace to the family.

At the community level also all the interviewees said that their neighbours had shunned them, avoided them or called them names. Half of them claimed that their children had been hounded out of schools by negative remarks and taunts from both teachers and pupils.

When asked whether they felt that discrimination of any form whether at home or in the community due to HIV/AIDS status is a violation of their rights, twenty of the interviewees thought it was, while the remaining five thought that they deserved what they got as it was their fault that they are HIV positive.

On discrimination, the interviewees living with HIV cited the language used to be very important. They said that the words used for example HIV/AIDS victims usually distances them from the rest of the population, and makes them feel different and alone. Most of them cited the use of language as a source of discrimination. The other word they felt uncomfortable with is 'AIDS sufferers' claiming that this is usually the last stage and most of them are basically still just HIV positive.

One of the objectives of the study was to examine how Kenya is implementing the guidelines on HIV/AIDS and Human Rights as set out by Joint United Nations programme on HIV/AIDS (UNAIDS) and the office of the UN High Commission on Human Rights. To ascertain this, the researcher carried out an interview with the National AIDS Control Council (NACC) legal section. They cited the development of the Five-year Strategic Plan (2000-2005), which sets out to meet the National Framework guideline, the guideline on supporting Community Partnership, and the

Public Health legislation guideline. They also cited the HIV and AIDS Prevention and Control Bill, 2003 as success stories in the implementation of the guidelines.

A part from the above, NACC praised the part being played by Non Governmental Organisations (NGOs) and Community Based Organisations (CBOs) in implementing the guidelines. They in particular singled out Kenya AIDS NGOs Consortium (KANCO), Women Fighting AIDS in Kenya (WOFAK) and Network of People Living With HIV/AIDS in Kenya (NEPHAK) as playing a major role in implementing the guidelines as set out.

NACC further informed the interviewer that the Faith-Based Organisations have also joined the implementation of the guidelines by introducing AIDS Control Units within their organisations to fight stigma and discrimination.

## End Notes

[1]United Nations, *HIV/AIDS and Human Rights, International Guidelines*, United Nations, New York and Geneva 1998 p.16
[2]Ibid., p. 12
[3]Ibid., p. 13
[4]Republic of Kenya, *Guidelines to Anti-retroviral Therapy in Kenya*, Government of Kenya, Nairobi, 2001 p.5
[5] Republic of Kenya, *The HIV and AIDS Prevention and Control Bill 2003*, Nairobi, 2003 p. 822
[6]United Nations, *HIV/AIDS and Human Rights, International Guidelines*, Op. Cit., p. 15
[7] Republic of Kenya, *The HIV and AIDS Prevention and Control Bill 2003*, Op. Cit. p. 822

## CHAPTER FIVE

## SUMMARY, CONCLUSIONS AND POLICY RECOMMENDATIONS

### 5.0 Summary

This study's objective was to investigate how HIV/AIDS relates to the human rights of those infected by HIV virus in Kenya. The assumption was that those infected by the HIV are prone to human rights violations which in turn fuels the spread and exacerbates the impact of HIV/AIDS. It was further assumed that HIV/AIDS undermines progress in the realisation of human rights. Drawing from both the natural rights theory and that of universalism, the study narrowed on the social, economic, and cultural rights which it emerged from the literature review, are considered positive resource demanding, and difficult to measure. The universality theory helps in explaining the broadening at the scope of human rights socially and geographically, to everyone throughout the world, including the recent emerging issues related to HIV/AIDS.

In the methodology, we stated that the study would rely on both primary and secondary sources. We also mentioned that both questionnaires would be formulated for those living with the virus, and those making policies and implementing programs on HIV/AIDS.

In Chapter II, we looked at the origin and development of HIV/AIDS from 1984 when the first case was diagnosed in Kenya to the present. The main purpose of the Chapter was to trace how HIV/AIDS was first recognised in the country, its

development and the current status as the number one killer in the country. Originally, AIDS was a disease for those with risky sexual lifestyles, and this made it a highly stigmatised disease developing a fertile ground for human rights violations mostly discrimination related. It is this factor which led us to Chapter III where we looked at human rights Conventions, especially the social, economic and cultural rights under which HIV/AIDS scourge smugly fits. Here we singled out the right to health, the right to work, the right to social security and insurance, and the right to non-discrimination and equality around which we moulded our case studies. We went ahead and carried out specific case studies in trying to bring it out. Indeed the rights of those infected with HIV are violated due to their HIV status.

## 5.1 Conclusion

On the basis of the available data as pertains to the first hypothesis we have come to the conclusion that the dependent and independent variables have a positive relationship. Though HIV/AIDS status leads to human rights violations, there are several other factors which go hand in hand with it, for example the status of a person in society, and the sex of the person. This therefore makes those whose human rights are already violated more at risk of being infected with HIV/AIDS and further violation of the rights.

In Kenya the level of development is low and the other human rights are already thoroughly abused. HIV/AIDS have joined the economic, social and cultural rights whose violations are difficult to measure.

The Government of Kenya, its partners in development, the civil society, the general public and the people living with HIV are aware of the fact that those infected are prone to human rights violations, and this has led the Government to put into place various mechanisms to counter this trend. However, the implementation has been slow, more especially because in Kenya even the human rights of those not infected by HIV are being violated, and therefore this makes those infected especially vulnerable.

A major obstacle in Kenya in dealing with human rights violations of those infected by the virus is the level of human rights awareness of the populace. We have come to the conclusion that those infected would be less prone to human rights violations if they were to be more aware of their rights, though from the interview those infected were not happy with the way they are being treated, they accepted the status quo and were not too sure on what alternative there is.

Though the Kenya Government has recognised and addressed the relationship between HIV/AIDS and human rights, the deliberations and action plans so far developed need to be implemented and materialised. We have come to the conclusion that when human rights for people living with HIV/AIDS are defined and protected, fewer people become infected and those living with the ailment and their families can better cope with the scourge.

As pertains to hypothesis two, we have come to the conclusion that dependent and independent variables have a positive relationship. When persons who are HIV

positive are fired from their jobs, the cycle of poverty begins. They are then not able to meet their health care needs, and their conditions worsen as they are not able to check the opportunistic infections. The impact of HIV/AIDS on the family then worsens as children drop out of school, or are forced to be child labourers, who in turn can be infected. Worse still, those who are stigmatised and shunned can decide to hit back at the society by spreading the virus knowingly.

In Kenya, according to the NACC records, AIDS is eroding the development gains of the past forty years and reversing improvements in the life expectancy. Especially, poverty has been identified as bringing out the interrelationship between HIV/AIDS and human rights. AIDS causes individuals and communities to slide into poverty.

Poverty and underdevelopment also fuels AIDS. Poverty reduces an individual's ability to avoid becoming infected. Lack of income leads people to engage in high-risk behaviour, and income-generating activities such as sex work. Sex workers engage in sex without condoms for the sake of higher fees. Poverty is associated with lower education, which results in lower awareness of measures to prevent HIV infection. The poorer individual has no access to treatment, care, preventive interventions and education. The bottom line is that if the right to health work and non-discrimination is adhered to then the above scenario need not arise. This therefore supports the third hypothesis that HIV/AIDS undermines progress in the realisation of human rights.

## 5.2 Recommendations

In this study, we have highlighted that though most of the rights of those infected by HIV are violated, not everybody is in a position to understand the complexities of human rights abuses, because Kenya like most African countries is busy dealing with the scourge in its totality as well as poverty, and human rights issues even those not infected has not been a priority.

The Government needs to ensure that laws, policies and programs respect and promote the rights of people with HIV/AIDS, by promoting and facilitating efforts to provide care, support and treatment to people with HIV/AIDS.

The Government should ensure that activities put in the combat of HIV/AIDS promotes the rights of all people with HIV/AIDS; both those who are able to benefit from improved health associated with advanced care and treatment and those marginalised by the social, economic and other factors.

The Government should ensure that the HIV and AIDS Prevention and Control Bill, 2003 is passed in Parliament, becomes law and is implemented fully. This then would take care of continuance of current activities associated with high priority issues of drug laws, return to work, discrimination, new testing technologies and new drugs.

All the future HIV/AIDS and human rights programmes should take into account the various categories of people who are directly affected by HIV/AIDS. For those who are able to benefit from antiretroviral drugs and new combination therapies, issues such as income protection, insurance and return to work are paramount. Then there is the other group of infected and affected people who are even more marginalised and the access to basic care, treatment and rudimentary support remains a real life and death challenge. This is where the slum dwellers infection drug users, and sex trade workers fall.

Consideration should be given to ways of promoting greater understanding of action on legal and human rights issues associated with HIV/AIDS among Government officials, academics, service providers and others. The same group of people and especially the media should be educated on the right type of language to be used in the fight against HIV/AIDS, since language and the images it evokes shape and influence behaviour and attitudes. Language affects listeners in particular ways. The use of language is an ethical and programmatic issue, and the Government should encourage use of proper language for the fight against HIV and AIDS.

Available statistics show that women are generally more infected and affected by AIDS than men. Most customary and religious laws are biased against women and the constitution recognises them. We wish to recommend that the principles of non-discrimination and equality be entrenched in the constitution.

It is important to recognise the fact that HIV/AIDS brought out the already existing prejudices, which already affect women and by extension children. For every woman disinherited or chased from home due to her HIV status, an average of five children will suffer, therefore the Government should take this opportunity to amend and enforce the law of succession.

Finally, HIV/AIDS exhibits new challenges daily and therefore the approaches must be open to continuous reassessment and adjustment. Any HIV/AIDS action plan created should be based on the principle of flexibility and periodic changes in the priorities attached to human rights.

## 5.3 Issues for research

With seven hundred people dying daily in Kenya, HIV/AIDS has reached pandemic proportions. This calls for more research to be done to find out ways of not only finding the elusive cure, but also softening the effects and impacts of the disease.

This study was based on specific objectives and therefore had limited scope and HIV/AIDS being a current problem which is very topical, many issues are coming up and have to be tackled in different ways. There is need for further study to look into issues arising from HIV/AIDS, and its myriad of problems. The fact that there is no cure for AIDS makes the research for a vaccine very pertinent and timely. The Nairobi/Oxford Research for a vaccine should be carried several steps further.

There has been a lot of talk on HIV/AIDS programs not benefiting those who are suffering from the scourge. A lot of time and money has been put in the fight and the results are not tangible. Research should be done on the best approach in fighting HIV/AIDS as the multi-sectoral approach has produced more talk than action.

Commercial sex work has been quoted as one of the causes of the bush fire spread of HIV/AIDS, yet it is the world's oldest trade which is here to stay. Research should be done on the regulation of this trade in Kenya as a personal service industry focusing on management by mandating universal precautions, for both the sellers and buyers.

Brazil, Malaysia, Thailand and Uganda are being cited as success stories in the fight against HIV/AIDS. Brazil in particular has managed to provide anti-retroviral drugs to its populace, since developing countries are still pressing on the issue of compulsory licensing and parallel imports, a study into the new developments in WTO regulations, especially after the recent meetings in Cancun, Mexico, would show the latest strategies the developing world intends to put in coping with the pandemic which has become a sub-Saharan problem.

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## APPENDIX

### IMPACT OF HIV/AIDS ON SOCIOECONOMIC AND CULTURAL RIGHTS IN KENYA QUESTIONNAIRE

### EMPLOYER'S TOOL

Interview number/code
Interview date
Name of organisation
Type of organisation
How long has organisation
Position of interviewee
How long has interviewee
Sex
Age

| | | | |
|---|---|---|---|
| Language | | | |
| Interview completed | | | |
| Incomplete interview | | | |
| Refusal | | | |
| Start time(enter hour and minutes using the 24 hour system) | | | |
| End time(enter hour and minutes using the 24 hour system) | | | |
| Data entry date | | | |
| | | | |
| **Section 1: Work** | | | |
| 1. Do you carry out pre-employment testing? | | | |
| **If yes explain** | | | |
| | | | |
| 2. What is your employment policy on those found to be HIV positive? | | | |
| | | | |
| | | | |
| **3.** What is your employment policy on those found to be HIV negative? | | | |
| | | | |
| | | | |
| | | | |
| 4. How do you handle your employees who test HIV positive? | | | |
| | | | |
| | | | |

5. Under what condition would you dismiss your employees before their retirement age?

**Section 2: Health**

1. Do you have special units dealing with HIV and AIDS cases?

**Explain**

2. Do you provide Anti Retroviral Drugs?

3. If so, to whom?

**Explain**

4. Is HIV/AIDS different from other terminal illnesses?

**Explain**

5. Do you ever turn any patients away?

1. If so, under what conditions?

7. As a health provider, are there any recommendations you would like to make in relation to handling and treatment of HIV/AIDS positive people? Please list them

**Section 3: Insurance**

1. Do you insure HIV positive persons?

2. If yes, what are the cost implications?

3. If no, why?

4. What is your approach to insuring other terminal illnesses?

**Section 4: Discrimination**

1. How would you react if your spouse was diagnosed HIV positive?

2. When your friend is diagnosed with HIV, how would you react?

3. What is your understanding of human rights?

| 4. Is a person who is HIV positive different from the rest? | |
|---|---|

**Explain**

5. Should HIV positive persons have families?

**Explain.**

5. Have you ever had your insurance premiums raised due to your HIV status or related complications?

**Section 5: Discrimination**

| 1. Have you ever witnessed anyone being discriminated against at the family level due to his/her HIV status or related complications? | |
|---|---|

**Explain**

| 2. Have you ever witnessed anyone being discriminated against at the community level due to his/her HIV status or related complications? | |
|---|---|

**Explain.**

| | |
|---|---|
| 3. How does HIV/AIDS affect an individual's relationship with members of his/her family? | |
| | |
| | |
| | |
| 4. How does HIV/AIDS affect and individual's relationship with members of his/her community? | |
| | |
| | |
| | |
| 5. Do you think that discrimination of any form whether at home or in the community due to one's HIV status is a violation of their rights? | |
| | |

## QUESTIONNAIRE ON HUMAN RIGHTS & HIV/AIDS

***Part A: PLWHA Only***

**General Questions**

1. Name of respondent:
2. Sex of respondent:
3. Age of respondent:
4. Have you ever heard of the term Human Rights?
5. What do you understand by human rights as relates to:

A] Work?

B] Health?

C] Insurance?

6. Have you ever been discriminated against because of your HIV/AIDS status? If yes describe the circumstances.
7. As a PLWA are there any specific rights you feel are violated? If yes please name them?
8. Does the lack of respect/protection of your rights have any impact on the spread of HIV/AIDS? Explain.

**Work**

9. Have you ever been denied employment or failed a job interview due to your HIV status or related complications? Explain.
10. Have you ever been denied a job promotion due to your HIV status or related complications? Explain.
11. Have you ever been denied a job-oriented training due to your HIV status or related complications? Explain.
12. Have you ever been suspended from work due to your HIV status or related complications? Explain.
13. Were you compensated adequately?
14. Has anyone at the workplace been disrespectful to you due to your HIV status or related complications?

15. Have you ever been denied any benefits at work due to your status? Explain.

**Health**

16. Have you ever been denied health services due to your HIV status or related complications?
17. Has any healthcare provider treated you differently due to your HIV status or related complications?
18. Has any healthcare provider refused to touch you or give you personalized attention due to your HIV status or related complications?
19. Are you on Anti Retroviral Drugs? If no why? If yes what is the monthly cost (in kshs)?
20. Do you feel the administration of the Anti Retroviral drugs interferes with your rights in any way? Explain.

**Insurance**

21. Have you ever sought medical, life or education insurance cover?
22. Were you subjected to HIV test before issuance of the cover? Explain.
23. Have you ever had an application for any form of insurance turned down due to your HIV status or related complications? Explain.
24. Do you think the Insurance regulations and conditionalities violate your rights in any way?
25. Have you ever had your insurance premiums raised due to your HIV status or related complications?

**Discrimination**

26. Have you ever been discriminated against at the family level in any way due to your HIV status or related complications? Explain.
27. Have you ever been discriminated against at the community level in any way due to your HIV status or related complications? Explain.
28. How has your HIV/AIDS status affected your relationship wit h members of your family?
29. How has your HIV/AIDS status affected your relationship wit h members of your community?
30. Do you think that discrimination of any form whether at home or in the community due to your HIV/AIDS status is a violation of your rights?

***Part B: Service Providers and Others***

**General Questions**

31. Name of organisation:
32. Position of interviewee:
33. How long has your organization been in operation?

**Work**

34. Do you carry out pre-employment testing?
35. What is your employment policy on those found to be HIV positive?
36. What is your employment policy on those with other terminal ailments?
37. How do you handle your employees who test HIV positive?
38. Under what condition would you dismiss your employees before their retirement age?

**Health**

39. Do you have special units dealing with HIV and AIDs cases?
40. If so, why?
41. Do you provide antiretroviral drugs?
42. If so, to whom?
43. Is HIV/AIDs different from other terminal illnesses? Explain.
44. Do you ever turn any patients away?
45. If so, under what conditions?
46. As a health provider, are there any recommendations you would like to make in relation to handling and treatment of HIV/AIDs positive people? Please list them.

**Insurance**

47. Do you insure HIV positive persons?
48. If yes, what are the cost implications?
49. If no, why?
50. What is your approach to insuring other terminal illnesses?

**Discrimination**

51. How would you react if your spouse was diagnosed HIV positive?
52. When your friend is diagnosed with HIV, how would you react?
53. What is your understanding of human rights?
54. Is a person who is HIV positive different from the rest? Explain.
55. Should HIV positive persons have families? Explain.