THE IMPACT OF HIV AND AIDS ON SERVICE DELIVERY IN THE KENYA POLICE

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DECLARATION

STUDENT

This thesis is my original work and has not been presented by any other person to any other university for the award of any degree. No part of this work may be reproduced in any form without prior permission of the author and/ or Masinde Muliro University of Science and Technology.

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ABSTRACT

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) are not simply a health issue but a substantial threat to security and socio-economic development, imposing a heavy burden on families, communities, economies and governments. HIV and AIDS affect people mainly in their prime ages, between 15 and 49 years. The majority of the Kenya Police are under 45 years and falls in the most sexually active years. In Kenya, 75% of all Police deaths in 1999 were attributed to HIV and AIDS. Studies on HIV and AIDS have not addressed the Kenya Police, yet they are in the frontline, dealing with key groups that are vulnerable to high level of HIV. These groups include commercial female sex workers (FSWs), trafficked women and children, children living and working on the streets, detainees, intravenous drug users (IDUs), illegal immigrants, stigmatized groups such as men having sex with men (MSM) and People living with HIV/AIDS (PLWHA). The objective of the study is to determine the impact of HIV and AIDS on service delivery in the Kenya Police and involves the determination of relationship between an explanatory variable (the prevalence of HIV and AIDS) and a response variable (service delivery in the Kenya Police). Two main methods, questionnaires (structured and unstructured) and key informant interviews were used in data collection. An updated nominal roll of the stratified sampled Police stations was ascertained. Weighted criteria was used to ensure that selected stations were apportioned the right number of officers for interview based on the station strength. The study employed simple random sampling method to select the respondents at the station level. Secondary data were obtained from libraries at Police headquarters, Regional Aids Training Network (RATN) and African Medical Research Foundation (AMREF) among other sources. Ethical issues such as confidentiality of the respondents were adequately addressed by seeking their consent. Data were coded, entered into database and analysed using Microsoft Excel and SPSS software. Continuous variables were analysed by Chi- Square Tests and $p\ values < 0.05$ were considered significant. Majority of the officers (354) were in the age range 18 – 45 years. Out of 295 who had tested to know their HIV status, 27(7%) was HIV positive. About 53.8% officers indicated that service delivery is compromised when on duty with an infected colleague while 66.7% of the infected indicating poor performance. To improve on the quality of service delivered, the Police need to put up own hospital to manage the healthcare support of officers and obtain better data on the epidemiology of HIV and AIDS among Police officers. These will enhance control and prevention measures and not just treatment.

DEDICATION

I wish to dedicate this thesis to my beloved parents Mrs. Dorothy A. Ochieng and the late Mr. Thomas Ochieng Mbaria; my late grandparents Mzee Simeon Mbaria Ochieng and Mama Rachel Achola Mbaria; my darling wife Norah Achieng, son Thomas Odhiambo and daughter Tertia Mary Adhiambo.

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Be blessed abundantly

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ACRONYMS AND ABBREVIATIONS

ACU	-	AIDS Control Unit, Police Headquarters
AIDS	-	Acquired Immune Deficiency Syndrome
AMREF	-	African Medical Research Foundation
ART	-	Anti-Retroviral Therapy
ASTU	-	Anti Stock Theft Police Unit
ATPU	-	Anti Terrorism Police Unit
AWSE	-	African Women in Science and Engineering
BBC	-	British Broadcasting Cooperation
CDC	-	Centre for Disease Control and Prevention, United States
CDMHA	-	Centre for Disaster Management and Humanitarian Assistance
CHRI	-	Commonwealth Human Rights Initiative
CID	-	Criminal Investigation Department
CIL	-	Compare InfoBase Limited
FHI	-	Family Health International
FSO	-	Force Standing Order
FSW	-	Female Sex Worker
GOK	-	Government of Kenya
GSU	-	General Service Unit
HAART	-	Highly Active Antiretroviral Therapy
HIV	-	Human Immunodeficiency Virus
ICRAF	-	International Centre for Research in Agro-Forestry, Kenya
IDU	-	Intravenous Drug Users

IFRC	-	International Federation of Red Cross and Red Crescent Society
KAIS	-	Kenya AIDS Indicator Survey
KAPU	-	Kenya Airport Police Unit
KAWI	-	Kenya AIDS Watch Institute
KHFF	-	Kaiser Henry Family Foundation
KPC	-	Kenya Police College
KPF	-	Kenya Police Force
KPR	-	Kenya Police Reserve
KPS	-	Kenya Police Service
MMUST	-	Masinde Muliro University of Science and Technology
MOH	-	Ministry of Health, Kenya
MRC	-	Medical Research Council, United Kingdom
MSM	-	Men having Sex with Men
NACC	-	National AIDS Control Council, Kenya
NASCOP	-	National AIDS and STI Control Programme
OCPD	-	Officer Commanding Police Division
OCS	-	Officer Commanding Police Station
PEPFAR	-	Presidential Emergency Plan for AIDS Relief
PLWHA	-	People Living with HIV and AIDS
PPO	-	Provincial Police Officer
RATN	-	Regional AIDS Training Network
SAPS	-	South African Police Service
SIV	-	Simian Immunodeficiency Virus

SPSS	-	Statistical Package for Social Scientist
STI	-	Sexually Transmitted Infection
TPU	-	Tourist Police Unit
UN	-	United Nations
UNAIDS	-	Joint United Nations Programme on HIV and AIDS
UNDP	-	United Nations Development Programme
UNESCO	-	United Nations Educational and Cultural Organization
UNICEF	-	United Nations Children Fund
USA	-	United States of America
USAID	-	United States Agency for International Development
VCT	-	Voluntary Counselling and Testing
WB	-	World Bank
WHO	-	World Health Organization

OPERATIONAL TERMS

Attrition The process through which employees leave employment. The loss of labour either voluntarily or involuntarily through death. Attrition amounts to loss of labour. It also includes dismissal, redundancy, resignation and retirement.

Dangerousness Means bringing or involving the chances of loss or injury, or exposing or involving one to risk (as of loss or harm).

Disaster A serious disruption of the functioning of the society causing widespread human, material or environmental damage and losses which exceed the ability of the affected community to cope using their own resources.

Mitigation Short and long term actions, programmes or policies implemented in advance of a natural hazard or in its early stages, to reduce the degree of risk to the people, property, and productivity capacity.

Pandemic Disease occurring over a whole country or world.

Risk Is the probability of harmful consequences or loss resulting from the interaction between natural or human made hazards and vulnerable conditions of property and people.

Stigma Is the prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV at the individual, group or communities with which they are associated.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter presents the background to the study by looking at HIV and AIDS from the global to national perspective with a brief history of the Kenya Police, the study justification, problem statement, objectives, hypotheses, assumptions and the scope and limitations to the study.

1.1 Background to the study

The scale of the HIV and AIDS pandemic has exceeded all expectations since it's identification in the United States of America (USA) in 1981 (Boer, 2008). Globally, an estimated 33.4 million (31.1 million – 35.8 million) people are currently living with HIV (see Figure 1.1) and approximately 4.0 million people are receiving antiretroviral therapy. An estimated 2.7 million (2.4 million- 3.0 million) new infections and 2 million (1.7 million – 2.4 million) deaths due to AIDS related illnesses occurred in 2008 (UNAIDS/WHO, 2009). Some 25 million people in the world have already died of AIDS since 1981, with the worst of the pandemic centred on Sub-Saharan Africa (UNAIDS/WHO, 2006).

In Sub-Saharan Africa, the region of the world is worst affected by the AIDS pandemic, HIV and AIDS has caused vast amounts of human suffering. Here AIDS remains a leading cause of death. Nearly two-thirds (67%), of all HIV positive people worldwide live in this area, although it contains little more than 10% of the world's population

(UNAIDS, 2006a). According to UNAIDS/WHO (2009) an estimated 1.4 million (1.1 million – 1.7 million) AIDS related deaths occurred in Sub – Saharan Africa. Since the beginning of the pandemic, more than 15 million Africans have died from AIDS related illnesses (UNAIDS, 2006a). In 2007 alone, 72% of all AIDS deaths in the world was recorded in Sub-Saharan Africa (UNAIDS, 2008)

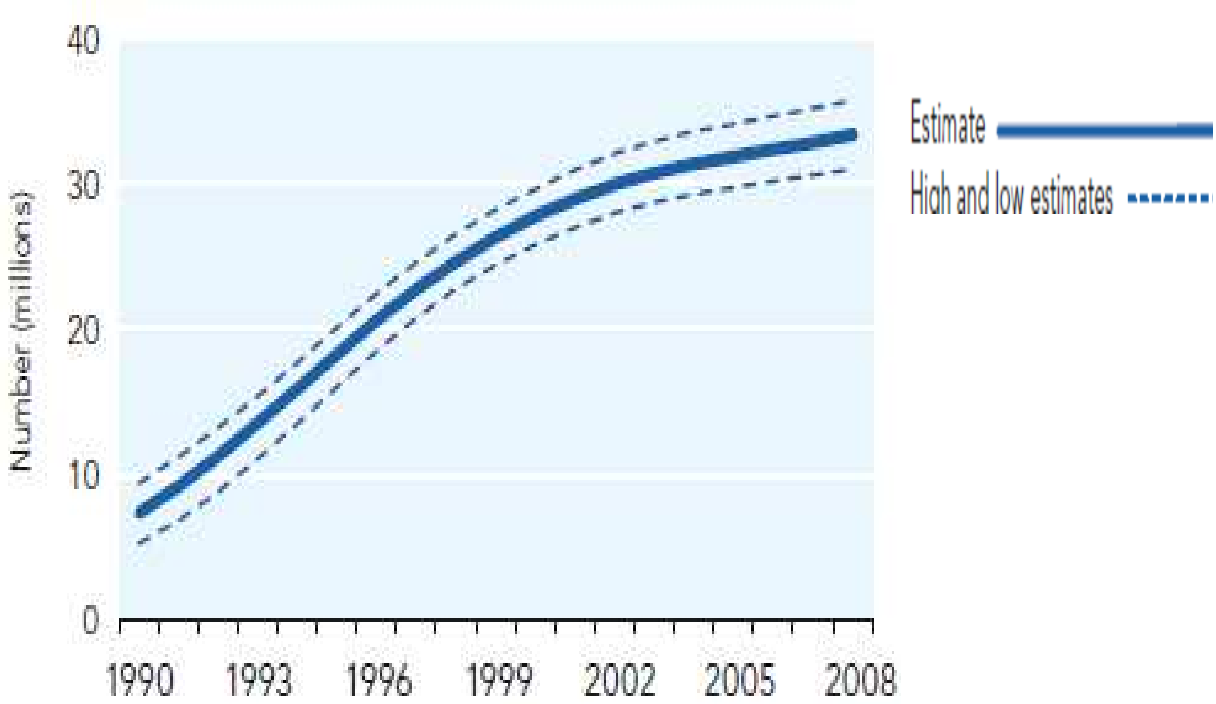

Figure 1.1: Estimated number of people living with HIV globally 1990 – 2008
Source: UNAIDS/WHO, 2009.

In Kenya, the first case of HIV was diagnosed in 1984 (GoK/UNICEF, 2000). The trend from 1990 to 2005 suggested that adult HIV prevalence in Kenya increased to about 14% per year and then stabilized at that level. The number of infected people in the population increased from about 2.2 million in 2000 to 2.6 million by 2005 and was projected to rise to 2.9 million by 2010 (GoK, 2001). National adult HIV prevalence fell from 10% in the late 1990's to about 7% in 2003, to just 5% in 2006 (GoK, 2005a;

UNAIDS, 2006b). However, according to 2007 Kenya AIDS Indicator Survey (KAIS), the National HIV prevalence rate had increased to 7.4% (NASCOP, 2008).

The pandemic has become one of the leading challenges to socio-economic well being of the country. More than one half of the reported HIV and AIDS cases occur among the economically active and productive segments of the population. According to NASCOP (2008), Nyanza province inhabited by the Luo, Kisii, Kuria, Suba and other smaller tribes is leading in the prevalence of the scourge by 15.3% with the most infected being the Luo. In spite of the high awareness, behaviour change is desperately lagging behind. This can be traced to Luos' retrogressive cultural practices like wife inheritance, non-circumcision of males among other factors. According to Odundo and Owino (2004), sex is so deeply entrenched in the cultural framework of the Luo that it can not be studied in isolation.

Compared to other sectors of the national population in Kenya, military and other uniformed services personnel have HIV infection rates two to five times higher than the general population (USAID, 2005). They are highly vulnerable groups to sexually transmitted infections (STIs) mainly due to their work environment, mobility, age and other facilitating factors that expose them to higher risk of HIV. Approximately 75% of all Kenya Police deaths in 1999 were attributed to HIV and AIDS and many resources have been diverted to address the problem (UNDP, 2006a).

1.1.1 History of the Kenya Police Force

The Kenya Police had its humble beginnings in the period between 1887 – 1902, tracing its foundation to the Imperial British East Africa Company (I.B.E.A.C), and a businessman Sir William McKinnon, who in the interest of his business, found it necessary to provide some form of protection (security) for his stores along the coastline of Kenya (Kenya Police, 2004). It was from this origin that the concept of constituting a real Police Service was conceived in Mombasa in 1896 (CHRI, 2006). Generally, Police activities centred on protection of the business of the I.B.E.A. Company where the strength was mainly of Indian origin with a skeleton staff of some Africans otherwise referred to as "Askaris" (*Kiswahili word which means Policemen/women/guard*) as Police duties were negligible (Kenya Police, 2004).

The construction of the Kenya - Uganda railway lines provided for the growth of this infant Force into the inland from Kenya coastline. By 1902, Police Service units existed at Mombasa, Nairobi and Kisumu for the purpose of safeguarding the railways property and materials as well as the manpower engaged in constructing the Railways (CHRI, 2006). The laws in force were from India including the Indian Criminal Procedure Code, the Indian Evidence Act and the Indian Police Ordinance (Kenya police, 2004). In 1906, the Kenya Police was legally constituted by a Police Ordinance. Up to 1907, the Kenya Police was organized along military lines and the training was military in nature (CHRI, 2006).

After the end of the First World War in 1918, the Police Service began to be reorganized (CHRI, 2006). Schools were established for African Education, thereby improving literacy in the Force and the name changed to Kenya Police Force (Kenya Police, 2004). In 1926, the Criminal Intelligence Unit was established with the sole responsibility of collecting, tabulating and recording the history and data of criminals, undesirable and suspicious persons (Moseley and Onwundiwe, 2008).

There continued to be signs of development of the Police as an investigative body, with the establishment of the Criminal Investigation Department (CID) and education classes provided for lower ranks. Special sections like Fingerprint Bureau were created, starting with a skeleton staff composed of former Police officers from Britain and South Africa (CHRI, 2006). This was the foundation of today's Kenya Police Force (KPF). In the same year, the Railway Police Unit was also established to deal specifically with prevention and detection of offences in the Railways from the coast to Kisumu, including Kilindini Harbour and branch lines (Kenya Police, 2004). As the years progressed, the scope of Police activities increased and it was called upon to deal with traffic problems such as accidents and parking. The Police were also called upon to deal with cattle rustling in the countryside (Moseley and Onwundiwe, 2008).

The Kenya Police Service (KPS) was placed under the office of the Attorney General in 1946 (Kenya Police, 2004). The Police officers' powers were increased, and to cope with the new development, a new Police Training Depot was opened in Maseno in 1946. In 1948, several important developments were made in the Force. To improve the

effectiveness of crime control, a dog section was also introduced in 1948 and the General Service Unit established and deployed in troubled areas in emergency situations (CHRI, 2006).

In 1949, the Police Airwing was formed to carry out duties like communication and evacuation of sick persons to hospitals and was made part of the permanent Police Service in January 1953. After the declaration of the state of emergency in 1952, there was an immediate increase in personnel to cope with the situation and in response to the Mau Mau insurgency (Kenya Police, 2004).

In 1957, the Police headquarters building (Vigilance House, Harambee Avenue) in Nairobi was opened and in 1958 the Force was integrated within the Ministry of Defence (Kenya Police, 2004). In the period prior to independence, the Kenya Police was greatly involved in the maintenance of law and order during political meetings and at the height of the independence election period.

After Kenya gained her independence from Britain on 12th December 1963, the Force realized tremendous achievements in various fields of operation (Moseley and Onwundiwe, 2008). In line with the Police resolve to effectively deal with security threats and to bring down crime to minimal levels, various specialized units were formed. They included the Anti-Stock Theft Unit (ASTU), Tourism Police Unit (TPU), the Anti-Corruption Police Unit (ACPU), Presidential Escort Unit (PEU), Anti-Terrorism Police Unit (ATPU) and the Anti-Motor Vehicle Theft Unit (CHRI, 2006).

1.1.2 Challenges facing the Kenya Police

The KPS was established under provisions of an Act of Parliament known as the Police Act, Chapter 84 of the Laws of Kenya (GOK, 1988). The Police Act provides for the functions, organization and discipline of the KPS and the Kenya Police Reserve (KPR) and for matters incidental thereto. In addition to the Police Act, the Force is also guided by the Force Standing Orders (FSO). According to section 14 of the Act (GOK, 1988), the KPS is established in the Republic of Kenya to perform the following functions:

(a) Maintenance of law and order;

(b) The preservation of peace;

(c) The protection of life and property;

(d) The prevention and detection of crime;

(e) The apprehension of offenders;

(f) The enforcement of all laws and regulations with which it is charged.

The Kenya Police today faces numerous difficulties, most of which are linked to inadequate funding. These difficulties undermine the Police efforts to live up to its mandate. Some of these include additional personnel which the Police needs to improve quality of its service delivery, poor housing which makes officers not live together with families and be predisposed to HIV infection and low wages. The increase in administrative units in the country has necessitated the establishment of additional Police commands and units, including housing for officers, equipments, arms and motor vehicles to back this rapid expansion. There has also been the upsurge of terrorists and terror gangs which call for a Police Force that is well equipped and

trained to cope with these new security demands. Forensic analysis and research on crime and other security concerns are still lacking in the Kenya Police (CHRI, 2005).

1.1.3 Vulnerability of the Kenya Police to HIV

Under the provisions of section 108 of the Constitution of Kenya, the Kenya Police Force is under the command, superintendence and direction of the Commissioner of Police, who is responsible to the President of the Republic of Kenya, for the efficient administration and governance of the Police Force (Kenya Police, 1997). For the purpose of Police administration the Force is divided into Provinces and Formations. These are further subdivided into Divisions/Sections, Stations, Post and Patrol Bases depending on their specializations (Kenya Police, 2004).

Police officers spend lengthy periods away from home on special duties. As a result, some Police officers are tempted to look for ways to relieve loneliness, boredom, stress and the build up of sexual tension (CHRI, 2006). The urge to relieve loneliness is also brought about by the lack of adequate housing where officers do not bring spouses to live with them (AMREF, 2006). Moreover, many officers are in high risk age group for HIV infection, the sexually active age group of 25 to 35 years. Relatively low levels of maturity combined with high levels of testosterone among this age group boost aggression and the willingness to take risks. These traits are further enhanced by the paramilitary culture that still pervades several sections of the Police (Schönteich, 2003).

Officers, particularly those stationed in rural areas, often have more disposable income than most of the local population. This provides officers with the financial means to purchase sex on a going concern basis as officers frequently interact with sex workers. The nature of work also exposes Police officers to risk of infection not involving sexual intercourse. During the course of arrest an officer could be injured, bitten or come into contact with the other person's body fluid, which lead to the transmission of the HIV virus. An indication of the risk Police officers face can be gleaned from the high numbers who are injured and killed every year on duty (Schönteich, 2003).

The recruits enlisted in the Police do not get enough information on HIV and AIDS to facilitate behaviour change during their training and are likely to practice unsafe sexual behaviour. Recruits training in the Police colleges are normally very restricted in their movement outside the colleges, but on occasions where the opportunity presents itself, many engage in casual sex, often with commercial sex workers in the vicinity of the colleges (Kimotho, 2005).

1.2 Study justification

Studies on HIV and AIDS have not addressed the Police Force, yet they are in the frontline, dealing with key groups that are vulnerable to high level of HIV. According to Bayre and Bazergan (2007), these groups include commercial female sex workers (FSWs), trafficked women and children, children living and working on the streets, detainees, intravenous drug users (IDUs), illegal immigrants, stigmatized groups such

as men having sex with men (MSM) and People living with HIV/AIDS (Schneider and Moodie, 2002).

This study will thus help policy makers and planners appreciate the level of prevalence of the pandemic in the Kenya Police for the uniformed staff and determine the extent of resource allocation to the force, besides intervention measures to reduce the impact. The findings of this study will enable the Kenya Police to adopt appropriate strategies and interventions to mitigate the impact of the epidemic on productivity as there is neither HIV testing on recruitment nor subsequently (Kimotho, 2005).

1.3 Problem statement

The rapid spread of HIV and AIDS is likely to adversely affect the operations and efficiency of Police department. Prolonged HIV and AIDS related cases tend to affect the staff in their ability to work, causing high staff turnover, high recruitment and training cost to replace the deceased officers or those affected, expensive medical care and funeral expenses (Kenya Police, 2006a). The low numbers of officers in the Kenya Police in relation to the increasing population they are supposed to serve make it difficult to respond to the ever expanding policing needs.

Most of the officers are vulnerable to the pandemic due to various factors. Among them is the age of officers (AMREF, 2006). Each year approximately 2000 new officers are recruited to join the Police Force. These officers, apart from increasing the strength, are

meant to replace those who die, retire, resign or are removed from the Force. Some of these recruits are already infected with the virus before joining the Police.

HIV affects people mainly in their prime ages, between 15 and 49 years. The majority of officers in the Kenya Police are under 45 years and are in the most sexually active periods. Recruits tend to be between the ages of 18 and 30 years and have just left school and other academic institutions and are not different from other young people in the country (UNAIDS, 2003).

The nature of duty of the officers dictates that they attend to scenes of crime and accident and in most cases with very little protective gear. Female suspects who are arrested offer sex on the way to station so as to be released. Housing problem also separates families. Sharing of rooms is a common practice and this make it difficult for a spouse to visit or if a spouse visits, the room mate is forced to look for an alternative accommodation which might lead to casual sexual relationship with a sex worker (AMREF, 2006). These increase the risk of infection to the officers.

In response to the national policy on the prevention and management of the epidemic, AIDS Control Unit (ACU) was established at Police headquarters to provide guidance and counselling services, collect and disseminate routine information on absenteeism, morbidity and mortality for the purpose of human resource planning, mainstreaming HIV and AIDS into core functions and work plan of the Police (Kenya Police, 2006a).

1.4 Study objectives

The main objective of the study was to determine the impact of HIV and AIDS on service delivery in the Kenya Police.

The specific objectives were to:

(a) Determine the prevalence of HIV and AIDS in the Kenya Police;

(b) Establish the effect of HIV and AIDS on duty allocation among the Police officers and how HIV/AIDS status affects performance of duty;

(c) Investigate the effectiveness of intervention measures within the Police Force;

1.5 Study hypotheses

(a) Service delivery in the Kenya Police is not affected by the prevalence of HIV/AIDS.

(b) There is no relationship between HIV/AIDS and performance of duty among Police officers.

(c) There are no effective intervention measures put in place by the Police to reduce vulnerability of the officers to HIV/AIDS at the workplace.

1.6 Assumptions

The study was informed by the following assumptions:

(a) That quality of service is affected by the HIV and AIDS pandemic and if infections are minimised the Police can deliver quality service;

(b) That the responders are fairly knowledgeable about cause of HIV and AIDS, transmission modes, symptoms and effects on duty performance. As a consequence,

they are able to give an informed response during discussions and interviews and suggest appropriate policies to improve service delivery;

(c) That the officers are honest in indicating their HIV status and that death from certain causes or symptoms within the age group of 18 to 45 years are AIDS related.

1.7 Scope and limitations

1.7.1 Scope

The study covered the Kenya Police. Given the lack of time series data and accurate trends, impact assessment was generally based on three scenarios: (a) infected, (b) not infected, and (c) don't know. The inclusion criterion was; all Police officers randomly selected in the sampled station that were present and willing to participate in the study. The exclusion criterion was: Any Police officer not selected in the sample including any other person, not a Police officer whether an employee of the Police department or a relative to a Police officer who was willing to participate in the study.

1.7.2 Limitations

One of the limitations was that some of those officers who were infected or affected could have chosen not to respond appropriately and conducting full analysis would be very demanding in terms of expertise, permission, data requirements and time. Difficulties were also experienced in getting information from some of the commanders due to the sensitive nature of the study. This was only overcome after thorough explanation on the confidentiality involved as to no direct mention of source.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents a review of literature on HIV and AIDS and captures the origin, infection, myths and beliefs associated with the pandemic, prevalence, impacts on various sectors and a conceptual framework of the study.

2.1 HIV and AIDS

HIV and AIDS were first recognized in the early 1980's and have grown to become a devastating global pandemic. HIV infection progressively weakens the immune system, reducing the capacity to fight other infections and certain cancers and eventually leads to AIDS (MRC, 2007). HIV is a lentivirus, and like all viruses of this type, it attacks the immune system. Lentiviruses are in turn part of a larger group of viruses known as retroviruses. Lentivirus means "slow virus" because they take such a long time to produce adverse effects in the body (Boer, 2008).

AIDS is a syndrome that is characterized by a complex of diseases and symptoms arising from immune deficiency. It is caused by the HIV and has no specific symptoms, but manifests itself through different illnesses (Ndeda, 2000). People with AIDS are prone to a range of life threatening illnesses, many of which do not usually affect healthy people, and if untreated the victims usually die of AIDS related illness within 12 years of contacting HIV (MRC, 2007). What makes HIV and AIDS different from other epidemics is the fact that there are two curves, namely one for HIV and one for

AIDS. This pattern followed by the illness makes this disease very dangerous, as people tend to forget about the AIDS curve that follows the HIV curve a few years later.

2.2 Origin of HIV and AIDS

The origin of HIV and AIDS has been widely speculated and debated. The global HIV and AIDS pandemic consists of many separate epidemics each with its own distinct origin in terms of geography and population groups affected, and each involving different types and frequencies of risky behaviours and practices. The precise origin and natural history of HIV is still contentious and no one knows exactly where it came from. Some say it came from the Vervet African Green monkey in central Africa, others say it was laboratory experimentation gone awry, while others say it was a punishment from God (AWSE, 2001). Theories explaining the origin of the virus include among others:

2.2.1 Vervet African monkey theory

The earliest known case of HIV-1 plasma specimen dates to 1959, found in serum of a Congolese person. An analysis of this serum in 2008 by Worobey and others, suggested that the first case of HIV-1 infection occurred between 1884 and 1924, much earlier than previous estimates (Boer, 2008).

2.2.2 Hunter theory

Most Western scientists argue that HIV was probably first transmitted to humans in Africa, through contact with Chimpanzees and or other African monkeys which harbour very similar viruses. No one is, however, certain exactly when and how this might have occurred. The hunter theory indicates that Simian Immunodeficiency Virus (SIV), a virus similar to HIV that infects primates was transferred when humans killed chimpanzees for food during the late 19th and early 20th century (AWSE, 2001).

The Western scientists argue that this could have happened more than once in the past through ingestion or by getting infected chimpanzee blood into their own blood system through open wounds. The current epidemic is due to social changes during the 20th century, for example decolonization, mass migration, urbanization and sexual liberalization, which allowed the virus to spread rapidly around the world through heterosexual contacts (Ndeda, 2000; Robertson, 2008). According to Boer (2008), there are evidences which show how retroviral transfers from primates to hunters are still occurring today.

2.2.3 Polio vaccine theory

Another line of thought is that polio vaccines, widely given in central Africa in the 1950s and 1960s using monkey serum called chat, could have been contaminated with SIVs which were not detected those days but could have been rapidly passed on to thousands of humans through vaccination (Jackson, 2002). The use of the vaccine was traced to the Congo, Rwanda and Uganda in the 1950's. This oral polio was cultured in

the laboratory in kidney cells taken from chimpanzees and the vaccine used was grown in SIV infected cells (Robertson, 2008).

2.2.4 Visna conspiracy theory

The other theory regarding origin of HIV is the Visna conspiracy theory, which posits that USA perfected an inconclusive process started by Nazi Germany of creating the HIV (Ndeda, 2000). That they unleashed the Nazi holocaust on human kind, initially targeting the black nations, black Americans and homosexuals but it backfired to engulf the whole human kind, although Africa remains the epicentre. The process started as far back as 1920s when German researchers began to work on an offensive and biological host called the Visna programme.

According to scientists, the genetic origin of the early HIV viral strains bears a direct correlation to those early German Visna viral agents (Katrak, 2006). The theory is that the virus was developed by the United States of America Federal Special Cancer Virus Program and spread using the smallpox and hepatitis B vaccines performed on gay and bisexual men in the early 1970s (Robertson, 2008). However, historical and scientific evidence do not support this theory since HIV has been traced back as far as 1958, 23 years before Hepatitis B vaccine was developed (Boer, 2008).

2.2.5 Colonialism theory

The colonialism theory was first proposed by Moore (2000). The colonial rule was particularly harsh and many Africans were forced into labour camps where sanitation

was poor, food scarce and physical demands were extreme. These factors alone could have been sufficient to create poor health, so SIV could easily have infiltrated the labour force and taken advantage of their weakened immune system to become HIV. A stray and perhaps chimpanzees with SIV could have made a welcome extra source of food for the workers. One final factor Moore uses to support his theory is the fact that the labour camps were set up around the time that HIV is first believed to have passed into humans - the early part of the 20th century (Katrak, 2006).

2.2.6 Contaminated needle theory

The contaminated needle theory is an extension of the original hunter theory. In the 1950's, the use of disposable plastic syringe became commonplace around the world as cheap and a sterile way to administer medicines (Katrak, 2006). However, to African healthcare professionals working on inoculation and other medical programmes, the huge quantities of syringes needed were very costly. One single syringe would have been used to inject multiple patients without any sterilization in between. This rapidly transferred any viral particles, creating huge potential for mutation and replication in new individuals (Boer, 2008).

2.2.7 Homosexuals and wrath of God theory

In the United States of America, HIV and AIDS were first recognized and described clinically by doctors from a previously unseen syndrome in a community of male homosexuals in 1981. Between 1980 and 1981, five young men were treated for a disease called Pneumocystis Carinii, a disease usually found in older people. These

cases were reported to and investigated by CDC. The number of cases increased and soon scientists identified this to be a different illness and named it AIDS. In 1986 the World Health Organization accepted HIV as an international designation (Barnett and Rugalema, 2001). When the HIV was first isolated among a group of gay men in 1981, the question was whether AIDS is God's judgement against homosexuality (Noden, 2007). From the natural law perspective, man had deviated from that which he was created to do and the consequence of that disobedience has fallen upon him. In other words, this is a third way in which God often judge people: through the consequences of their actions that go against His intended order. There are others who believe that HIV came as a cosmic debris as part of the tail of a comet (Katrak, 2006).

Other scientists argue that the disease was sent to Haiti by the Americans who wanted to get rid of Haitians because too many had immigrated to the USA to work and jobs were running low. The virus entered Haiti via American gay tourists who had sex with young male sex workers, forced to perform this act due to abject poverty (Wikipedia, 2008).

Given the evidence we have already looked at, it seems highly that Africa is the continent where the transfer of HIV to humans first occurred. Monkeys from Asia and South America have never been found to have SIV that could cause HIV in humans. Chimpanzees found in Africa are likely the origin of both the pandemic Group M of HIV-1 and the far rarer Group N principally affecting people living in South-Central Cameroon. The exact origins of Group O however, remain unknown. It is likely that we

will never know who the first person was to be infected with HIV, or exactly how it spread from that initial person.

Scientists investigating the possibilities often become very attached to their individual 'pet' theories and insist that theirs is the only true answer, but the spread of AIDS could quite conceivably have been induced by a combination of many different events. Whether through injections, travel, wars, colonial practices or genetic engineering, the realities of the 20th Century have undoubtedly had a major role to play. Nevertheless, perhaps a more pressing concern for scientists today should not be how the AIDS pandemic originated, but how those it affects can be treated, how the further spread of HIV can be prevented and the world be changed to ensure a similar pandemic never occurs again.

2.3 HIV infection

HIV is found to belong to an unusual group of viruses in humans, cats, cattle and some other animals. More specifically, HIV is found to be related to SIVs, which mutate easily. The HIV mutates significantly, even in one human being during the progression of infection and the person develops many slightly different strains of the virus over the years (Ndeda, 2000).

There are two main types of HIV; HIV-1 and HIV-2. Infection with either of them causes AIDS, but compared to HIV-1, HIV-2 infections produces fewer viruses in the body fluids, spreads between people less easily and is slower to cause AIDS (MRC,

2007). The HIV attaches itself to the cells which are responsible for coordinating and activating the body's immune system; CD_4 (T_4 helper cells) and CD_8 receptor cells. It also invades white blood cells called dendritic cells that alert the CD_4 cells on the presence of infectious material. Immunity is partly lost through HIV infection, mainly cell-mediated immunity because of the gradual loss of CD_4 cells. The HIV viruses multiply and kill the cells, creating room for opportunistic diseases such as typhoid, malaria, meningitis, among others (WHO, 2002).

As well as creating risk of opportunistic diseases, HIV can enter brain cells and cause multiple problems. These range from mild memory loss and mood changes to AIDS dementia, with complete mental breakdown (Ndeda, 2000). The Centre for Disease Control and Prevention (CDC) of the USA, states that people are diagnosed as having AIDS if CD_4 cell count below 200, even if they don't have opportunistic infection. AIDS may also be diagnosed if a person develops one of the numerous infections and cancers that occur with HIV infection (Zugar, 2006).

HIV infection is not spread by casual contact such as hugging, touching items previously touched by a person infected with the virus, during participation in sports or through mosquito bites. Almost all people infected with HIV, if not treated, will develop AIDS. There is a small group of patients who develops AIDS very slowly, or never at all. These are non-progressors, and may seem to have a genetic difference that prevents the virus from damaging the immune system (Zugar, 2006). The time from infection to AIDS varies between individuals and depends on many factors like age and

body immune system. The onset of AIDS can be checked by antiviral therapy and balanced nutrition. The viral development occurs in three phases namely window, asymptomatic and symptomatic phases.

2.3.1 Window phase

This is the period at which a person becomes infected with HIV, and the time antibodies are detected. The infected person do not immediately become "HIV Positive" but there is a time lapse before the body reacts to the presence of this virus by producing antibodies that can be found in the blood through laboratory testing. This phase is the most infectious stage and occurs in the first three months (UNAIDS, 2003). Initial HIV infection can produce no symptoms. Some people however, do experience flu like symptoms with fever, rash, sore throat, and swollen lymph nodes, usually two weeks after contracting the virus. Some people with HIV infection remain without symptoms for years between the time they are exposed to the virus and when they develop AIDS (Zugar, 2006).

2.3.2 Asymptomatic phase

After infection with HIV, there is usually no change in a person's health for quite a few years and the person feels well, showing no signs or symptoms of being sick. This period varies from a few years to as many as 12 years. However, individuals experience initial sickness at about five years or less after infection (UNAIDS, 2003).

2.3.3 Symptomatic phase

AIDS is a collection of conditions that, taken together, makes a diagnosis of AIDS. Most of the conditions that start to appear are “opportunistic infections” caused by bacteria or virus that do not cause illness in a person with a strong immune system (UNAIDS, 2003). People who are infected with AIDS have their immune system depleted by HIV and are very susceptible to these opportunistic infections. Common symptoms are fever, sweats (particularly at night), swollen glands, chills, weakness, and weight loss. These infections include diarrhoea, tuberculosis, pneumonia, skin rush, weight loss, among others. Rapid mutation and resultant variants keep the virus one step ahead of the immune system (Zugar, 2006).

2.4 HIV transmission

HIV is carried in blood and other body fluids, including breast milk. Approximately 70% to 80% of HIV cases are spread through unprotected penetrative sex with an infected partner. Other significant infection routes are transmission from an infected mother to child during pregnancy, at birth or during breast feeding accounting for between 5% and 10% (Kiragu, 2001). Infected blood transfusion constitutes 5% to 10%. Donated organ transplants, sharing of hypodermic injections, needle prick accidents, congenital transmission and other traditional invasive practices such as tooth extraction, circumcision, skin piercing, scarification and blood letting operations are some of the methods through which infection takes place though insignificant in relation to heterosexual activities (Ndeda, 2000).

The time from infection to AIDS varies between individuals and depends on many factors like age and body immune system. The HIV and AIDS satisfy the model given by the equation 1:

$$\text{Disaster } R = f(D, E, V) \quad \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (1)$$

Where R = Risk is a function of D, E, V

D = Dangerousness,

E = Exposure and

V = Vulnerability of a person or community

Western scientists have found that African-Americans and Africans could be much more susceptible to HIV due to a genetic trait only found in people of African descent (Gathura, 2008a). A study published by Avert (2008) suggests that this trait could be an answer as to why Africa is the continent hardest hit by the epidemic. A genetic trait found in 60% of African-Americans and in 90% of Africans makes HIV infection 40% more likely among this group. This trait is virtually non-existent in whites. It evolved to protect Africans against a form of malaria that no longer exists, and is now unfortunately making people of African descent particularly susceptible to HIV. This increased susceptibility accounts for millions of extra cases of HIV. People who have this particular genetic trait are able, on average, to live extra two years longer than others if they become infected with the virus. However at the end of the day "behaviour change" among Africans would assist in the fight against HIV and AIDS despite the genetical trait as claimed by Avert (2008).

2.5 Cure for HIV and AIDS

There is no cure for HIV and AIDS at this moment in time. However, a variety of treatments are available that can help keep symptoms at bay and improve the quality of life of those who have already developed symptoms (Zugar, 2006). Antiretroviral therapy offers an opportunity to improve the prognosis and quality of life of people living with HIV and AIDS by suppressing the replication of the HIV virus in the body. A combination of several antiretroviral agents, termed Highly Active Antiretroviral Therapy (HAART), has been highly effective in reducing the number of HIV particles in the blood stream, as measured by a blood test called the viral load. It is not a cure for HIV, and people with suppressed levels of HIV can still transmit the virus to others through sex or other modes. HIV may become resistant to HAART in patients who do not take their medications on schedule everyday (Zugar, 2006). Scientists have also developed a pill to be taken before sex that stops transmission of HIV and is already being prescribed to a limited number of patients although studies are still on going (Gathura, 2008b).

Normally ART treatment consists of drugs that have to be taken every day for the rest of a patient's life. The ART drug gradually reduces the viral load and improves the CD4-lymphocyte count, helping the immune system to recover and preventing the development of opportunistic infections. As with any drugs there may be problems with intolerance, side effects, resistance and toxicity. According to KAWI (2010), there are four main groups of anti-HIV drugs. Each of these groups attacks HIV in a different.

(a) Nucleoside Reverse Transcriptase Inhibitors (AZT- Zidovudine, Retovir, d4T – Zerit, Stavudine, Ddl – Videx, didanosine, 3TC – Epivir, lamivudine, Abacavir – Ziagen, 1592, ABC, Ddc – Hivid, Zalcitabine, Combivir –AZT/3TC together, Trieivir – AZT/3TC/Abacavir together)

(b) Non-Nucleoside Reverse Transcriptase Inhibitors (NVP – nevirapine, viramune, EFZ – efavirenz, sustiva)

(c) Protease Inhibitors (IDV – Indinavir, crixivan, NFV – nelfinavir, viracept, LPV/r – lopinavir, ritonavir/norvir)

The fourth group is still under going trials in the United Kingdom and USA.

(d) Fusion Entry Inhibitors (T-20 – Pentafuside)

2.6 Myths and beliefs of HIV and AIDS

Many Africans continue to view HIV and AIDS as a witchcraft phenomenon brought about by women who become infected and are blamed and frequently ostracized by their families (CDC, 2007). Social religious and cultural practices have exacerbated the African pandemic. Some people see themselves above getting infection because of the superiority of their religion or an irrational perception of their righteousness, hindering communication about safe sex. Some believe that a man with HIV can rid himself of the disease by having sex with a virgin girl (Zugar, 2006).

In South West Nigeria, some people still do not believe that there is AIDS. The reason being that they have not seen an AIDS victim before or that they knew the danger posted by HIV with fatalism, arguing that one will eventually “die of something”, and

so is not prepared to change their sexual behaviour simply because of the threat of HIV. The belief in Nigeria has it that AIDS is a “white man” disease; AIDS is a plot to control population growth in Africa; AIDS is spread by casual social contact such as living and eating together with an infected person, hugging the victim and donating blood (Osinubi and Amaghionyeodiwe, 2005).

Among the Luo of Nyanza Province in Western Kenya, it was long believed that death by AIDS was a curse or “chira” (*Luo belief of a curse which befalls people who are seen to have gone against the customs and traditions of the society characterised by wasting away with signs and symptoms similar to full blown AIDS and may lead to death*), which was brought about by witchcraft, malicious behaviour, unpaid debts, or a host of other reasons. The Luo thought it was witchcraft or that some people did not follow the traditional laid down ways of living and so when one fell sick traditional medicines were administered or seek the cultural causes of the disease and were still in denial. This belief has since changed (ICRAF, 2003).

Some of the misconceptions about HIV and AIDS include the notion that HIV is a disease that only homosexuals and drug users can get; there is a cure for HIV and AIDS; HIV and AIDS mean one is going to die; people with TB have HIV and AIDS. Other beliefs are that someone cannot get HIV by having sex for the first time; or only has sex with a person once; HIV can be transmitted through mosquito bite, sharing a drinking glass, being around someone who suffers from AIDS and he/she coughs, among others. All these are untrue and transmission of HIV can only occur if someone

is exposed to blood, semen, vaginal fluid or mothers milk (Zugar, 2006). However, exclusive breastfeeding where there is no food or other liquids significantly reduces the risk of infection when the breastfeeding is stopped at six months (Highleyman, 2008).

2.7 Prevalence of HIV and AIDS

Everyday over 6800 people become infected with HIV. In 2008, an estimated 2.7 million (2.4 million – 3.0 million) new infections occurred world wide, see Figure 2.1, and over 2 million (1.7 million – 2.4 million) people died from AIDS related illnesses, mostly because of inadequate access to HIV prevention and treatment services. (UNAIDS/WHO, 2009). In 2005, 3.1 million people died of AIDS related illness, of these more than 500,000 were children. In Asia the number of people living with HIV and AIDS rose from 7.1 million to 8.3 million in 2005 (UNAIDS, 2006c; UNDP, 2006b).

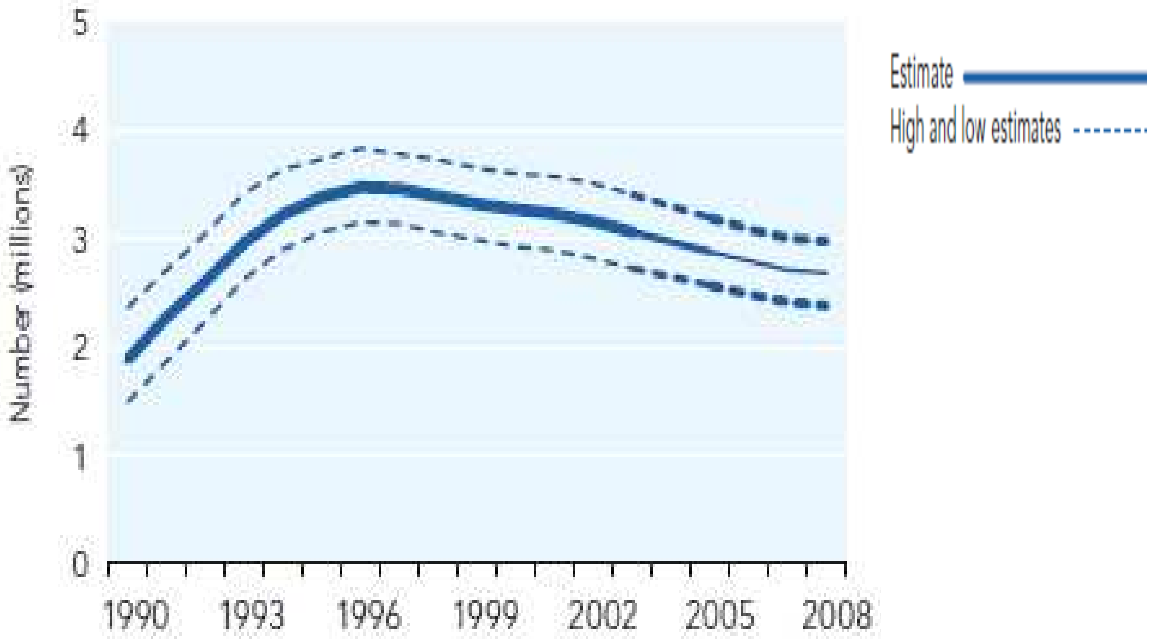

Figure 2.1: Number of people newly infected with HIV 1990-2008
Source: UNAIDS/WHO, 2009.

Close to 5 million people were newly infected with the virus in 2005 (UNAIDS/WHO, 2005). By 2030, HIV and AIDS may appear to be main cause of diseases and deaths at 12% (Meyrowitsch and Bygbjerg, 2007).

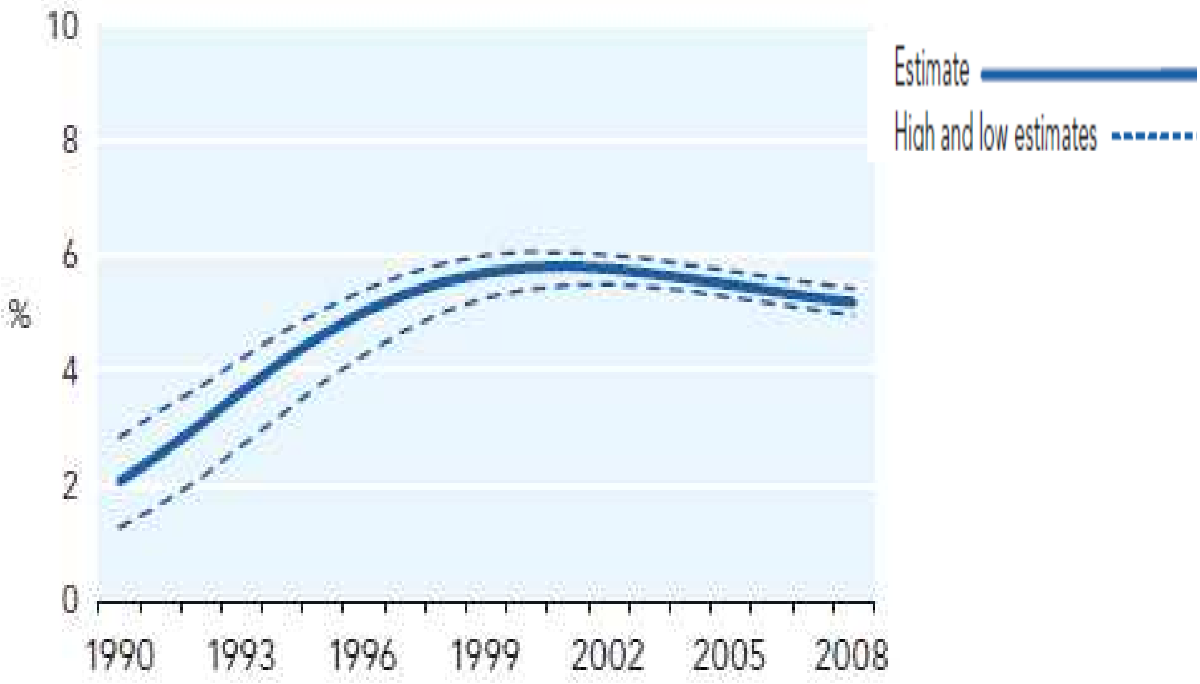

Figure 2.2: Estimated adult (15-49) HIV prevalence % in Sub-Saharan Africa, 1990 – 2008, *Source: UNAIDS/WHO, 2009.*

According to Figure 2.2, HIV prevalence in adults aged 15 years to 49 years range from 4.6% to 5.5%. Over thirty million people worldwide now live with HIV and AIDS out of which 22.4 million (20.8 million – 24.1 million) are from Sub-Saharan Africa (UNAIDS/WHO, 2009). Sub Saharan Africa still has the heaviest burden of dealing with the pandemic (see Table 2.1).

Table 2.1: HIV Statistics. *Source: UNAIDS/WHO, 2009*

Region	Adult (15+) years and Children living with HIV	Adult (15+) years and Children new HIV infection	Adults (15-49) prevalence (%)	Adults (15+) and child death due to AIDS	Number of orphans
Sub-Saharan	22.4 million	2.3 million	5.2	1.4 m	14.1 m
World	33.4 million	2.7 million	0.8	2.0 m	18 m
African Burden	67%	85%		70%	78%

According to South African Police Service (SAPS), a maximum of 8% to 10% functional Police officers might be infected with HIV in South Africa. Age specific prevalence projections indicate that HIV prevalence amongst people aged between 25 and 29 years and between 30 and 34 years is expected to increase from 17% in 2000, to approximately 35% and 45% respectively by 2015. While not all deaths and discharge due to ill health in the department are related to HIV and AIDS, the significant increase over this period is quite high (Schönteich, 2003). A survey of the Ethiopian Police officers in the year 2000 reported an infection rate of 7% whereas in 2004, a survey of their wives revealed an infection rate of almost 30% (Avert, 2007).

In the year 2002, the HIV prevalence rate in Kenya was found to be 14.3% in urban areas and 6.3% in other areas (WB, 2004). The highest prevalence rate of 35% was reported in Suba, while in Bamba, Kalulumo and Kilifi the rate was 4%. Among women aged between 15 and 19 years (see Figure 2.3), HIV prevalence was 23%, compared to 3.5% among men of the same age. As is the case in many African

countries, HIV prevalence in Kenya is higher among women (8.7%), than men at 4.5% (UNAIDS, 2006d).

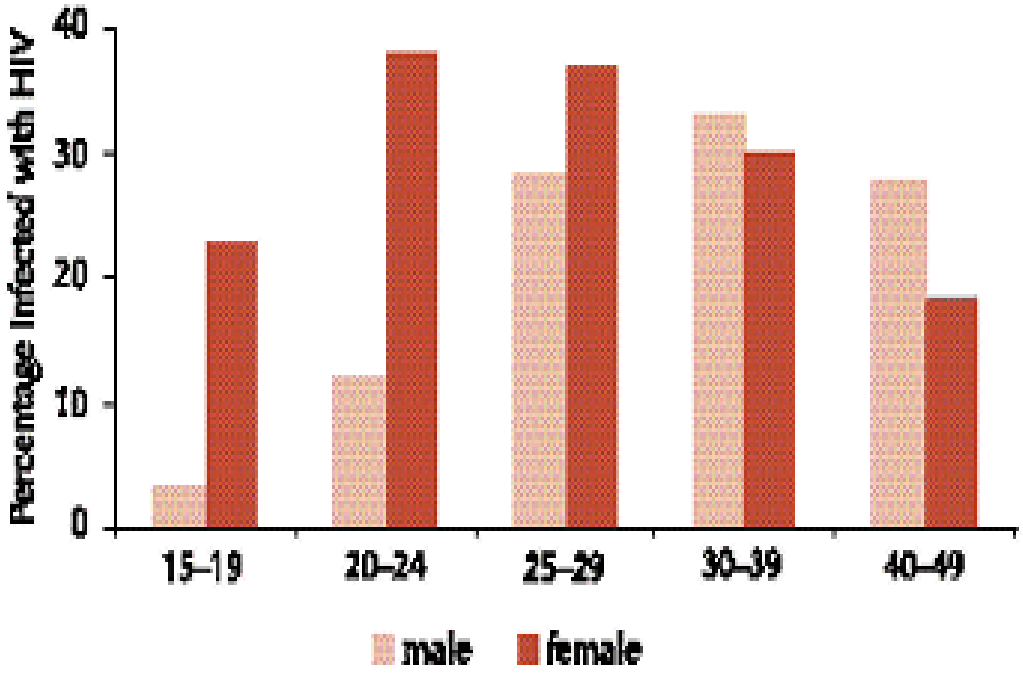

Figure 2.3: Percentage infected with HIV, *Source: GOK, 2001*.

According to 2007 Kenya AIDS Indicator Survey (Figure 2.4), the National HIV prevalence rate is estimated at 7.4% (Mwai, 2008; NASCOP, 2008). Recognizing the pandemic as one of the greatest health challenges of our times, the then USA President George W. Bush announced the emergency plan, to address the disease (PEPFAR, 2004).

The Kenya government declared the pandemic a National disaster in 1999 and developed a National AIDS policy and an institutional framework, intensifying intervention measures for the prevention, management, control and mitigation of socio-economic impact of HIV and AIDS (GOK, 2005b). With 1.4 million people aged

between 15 and 64 years currently living with HIV, Kenya is still contending with a serious AIDS epidemic, as one in ten married couples is HIV infected (Mwai, 2008).

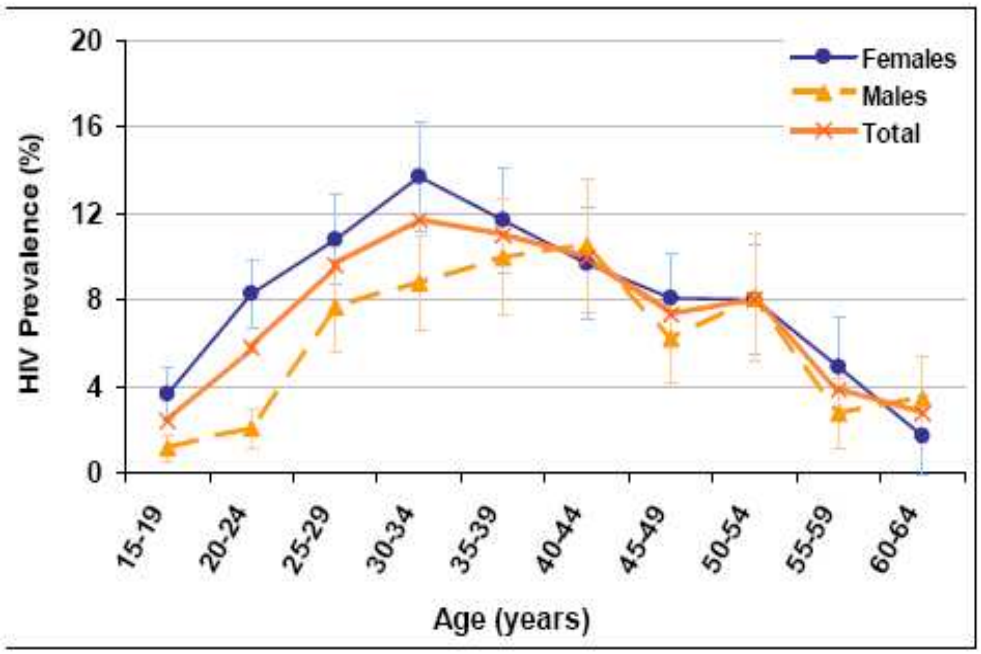

Figure 2.4: Prevalence of HIV among 15 – 64 years old, *Source: NASCOP, 2008.*

2.8 The HIV and AIDS pandemic in the Kenya Police

Kenya Police is one of the uniformed services with a strong network around the country (see appendix E for the organizational structure) and have the most contact with people. Apart from the maintenance of law and order, the Police have to deal with social issues. In carrying out their duties, they interact frequently with vulnerable groups with increased vulnerability to HIV and AIDS such as female sex workers (FSW), intravenous drug users (IDU), men having sex with men (MSM) and prisoners. The Kenya Police not only lack proper modern equipment but also fall far short of the United Nations policing ratio of 1:450 and is operating at the dismal ratio of 1:815 (Kenya Police, 2006a). Policing is both a local and a global activity, a practice within nations and responsibilities shared between them. Every nation has a Police system and

no two Police systems are the same. Every country polices its own territory with distinct methods and judicial procedures, with varying penalties and prison standards, and within unique cultural and historical context that apply specific pressures and pose specific challenges (Martin, 2006).

The Kenya Police has been affected by HIV and AIDS and a number of officers are either infected or affected. In Nairobi, five VCT centres were built in 2005 and approximately 6868 male and 1172 female officers have been tested within the centres. As a result of the pandemic, many experienced and skilled officers have lost their lives. The pandemic has led to loss of skilled and experienced manpower due to deaths, loss of man- hours due to prolonged illness, absenteeism, reduced performance, increased stress, stigma and discrimination (Kenya Police, 2006a).

Police officers are the gatekeepers of the criminal justice system, enforcing the law and arresting offenders. They provide a wide range of services to citizens 24 hours a day. Crime fighting is regarded as the real Police work as it is visible, publicly valued and the most satisfying part of the work for most officers (Martin, 2006). The daily reality of policing is less glamorous as it involves officers with people at their worst when they have been victimised, are injured or helpless, or are guilty and seeking escape. The combination of danger related to unpredictable physical violence, authority to exercise force and organizational pressure for efficiency has resulted in a unique set of behaviours and attitudes. These are termed officers working personality (Martin, 2006).

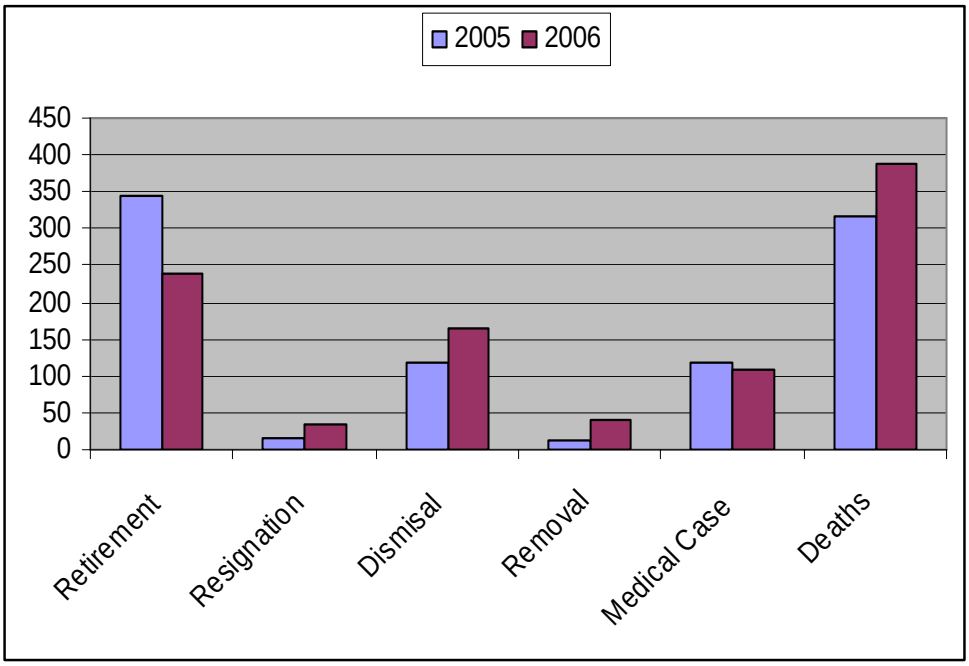

Figure 2.5: Personnel statistic for Kenya Police, *Sources: Kenya Police, 2006b; 2005*.

In the Kenya Police, death is the main cause of attrition followed by retirement as indicated in Figure 2.5 and Appendix D. Dismissal is relatively high considering that the government investment in the initial training of Police officers is high too. Since the Police is a disciplined Force, any act of indiscipline can easily lead to dismissal (Kenya Police, 2006b).

The cause of death in the Kenya Police is usually indicated in the personal files of the dead officer and published in the Force Order. In a large number of cases, the cause of death due to HIV and AIDS is recorded as long illness, tuberculosis, pneumonia among others (Kenya Police, 2006b). This makes it difficult to properly appreciate the relationship between HIV and AIDS and death of Police officers. However, it is estimated that of the deaths, 75% are due to HIV and AIDS. The Kenya Police do not keep information on loss of productivity as a result of absenteeism due to HIV and

AIDS and also do not calculate the cost of HIV and AIDS related morbidity and deaths as HIV testing is voluntary (Kenya Police, 2006a). The Police began to address HIV in a small way in 1986, but initially it was not considered a big problem (Kimotho, 2005).

2.9 Impacts of HIV and AIDS

The HIV and AIDS epidemic has devastating impacts at various levels, from individual and household level to communities and society as a whole, including political and administrative systems. This is particularly the case because the pandemic disproportionately affects young adults, who are central to economy and fulfil important functions as workers, breadwinners, parents, educators, healthcare providers, and so on (UNDP, 2002).

Despite the major strides that have been made to prevent and control HIV and AIDS, the pandemic still has a solid grip in the country and continues to reverse the gains made in key health endeavours and in many sectors of the economy (GOK, 2005a). The HIV and AIDS pandemic have had negative impact on various sectors of the economy. The impact is severely felt in areas where heterosexuality is the dominant mode of transmission and has not only become a serious threat to social and economic development, but also threatens people's very own existence. The impact of HIV and AIDS is here discussed on the demography, households, health, education and agriculture as they are the determinants of good health and economic growth of any nation like Kenya.

2.9.1 Demographic Impact

In many countries of sub-Saharan Africa, AIDS is erasing decades of progress in extending life expectancy. One dramatic impact of AIDS deaths is the decline in life expectancy. A recent study found that the average life expectancy of individuals living in Sub-Saharan Africa has fallen by five years since the early 1990's, mainly because of AIDS (Avert, 2006). In Swaziland it has previously been estimated that life expectancy, which is currently just 33, would be 66 without AIDS (UNDP, 2005).

In Kenya, without AIDS, life expectancy at birth would currently be about 65 years (UNDP, 2006a). However, because of the large number of AIDS deaths, it is actually only about 46 years and may decline to 45 years by 2010. Thus almost 20 years of life expectancy is already lost because of AIDS (GOK, 2001). Over the period 2001-20, HIV and AIDS mortality would reduce population by 5.1 million people. Infant and child mortality rates in Kenya are on an increasing trend, attributed mainly to HIV and AIDS (GOK, 2005a). Demographic impact has an effect on the number of young Kenyans recruited to join the force and how long they live to serve the Police force.

The impact AIDS has had on average life expectancy is partly attributed to child mortality, as increasing number of children are born with HIV due to the fact that their mothers are infected. The biggest increase in deaths, however, has been among adults aged between 20 and 49. This age group now accounts for 60% of all deaths in Sub-Saharan Africa, compared to 20% between 1985 and 1990, when the pandemic was in its early stages. By affecting this age group so heavily, AIDS is hitting adults in their

most economically productive years and removing the very people who could be responding to the crisis (UNAIDS/WHO, 2006).

2.9.2 Impact on households

The toll of HIV and AIDS on households can be very severe. Although no part of the population is unaffected, it is often the poorest sectors of society that are the most vulnerable to the pandemic and for whom the consequences are most severe (Avert, 2006). In many cases, the presence of AIDS means that the household will dissolve, as parents die and children are sent to relatives for care and upbringing. Often both of the parents are HIV positive, consequently more children have been orphaned by AIDS in Africa than elsewhere (Casale and Whiteside, 2006).

In 2008, more than 14.1 million (11.5 million – 17.1 million) children in Sub – Saharan Africa were estimated to have lost one or both parents to AIDS (UNAIDS/WHO, 2009). Many children are now raised by their grandparents or left on their own in child headed households. A study of rural South Africa suggested that households where an adult had died from AIDS were four times more likely to dissolve than those where no deaths had occurred (Avert, 2006). Much happens before this dissolution takes place as AIDS strips families of their assets and income-earners, further impoverishing the poor. In the developed world, people generally are able to save and social welfare and public assistance programmes support the needy (Casale and Whiteside, 2006).

In Botswana it is estimated that, on average, every income earner is likely to acquire one additional dependant over the next ten years due to AIDS pandemic. A dramatic increase in destitute households with no income earners is also expected (UNAIDS/WHO, 2006). Other countries in the region are experiencing the same problem, as individuals who would otherwise provide a household with income are prevented from working by HIV and AIDS either because they are ill themselves or because they are caring for another family member who is ill. Such a situation is likely to have repercussion for every member of the family (Avert, 2006).

Children are forced to abandon their education and in some cases women are forced to become commercial sex work. These lead to a higher risk of HIV transmission, further exacerbating the situation. A study in three countries, Burkina Faso, Rwanda and Uganda, revealed that AIDS will not only reverse progress in poverty reduction, but will increase the percentage of people living in extreme poverty from 45% in 2000 to 51% in 2015 (UNDP, 2003).

A study in South Africa by KHFF (2002) found that already poor households coping with members who are sick from HIV and AIDS were reducing spending on necessities even further. Falling incomes force about 6% of households to reduce the amount they spent on food and almost half of households reported having insufficient food at times. It is estimated that, on average, HIV-related care can absorb one-third of a household's monthly income (Avert, 2006). The financial burden of death can also be considerable,

with some families spending three times their total household monthly income on a funeral (KHFF, 2002).

Caring for a sick person who suffers from AIDS is not only emotionally disturbing for household members, but also a major strain on household resources. Loss of income, additional care related expenses, the reduced ability of caregivers to work, and mounting medical fees push affected households deeper into poverty. One of the more unfortunate responses to a death in poorer households is removing the children especially girls from school. Often the school uniforms and fees become unaffordable for the families and the child's labour and income-generating potential is required in the household (GOK/UNICEF, 2000). Police officers are part and parcel of the larger society and many officers are left to care for relatives whose parents are either sick or dead and this takes much of their attention, compromising their work schedule.

2.9.3 Impact on agriculture

The HIV and AIDS pandemic lead households to divest land and other family assets and spend savings while earning less causing decline in agricultural productivity. Studies in rural Thailand have shown that farm output and income fall by between 52% and 67% in households affected by AIDS (UN, 2004). The economy of many countries that bear the brunt of AIDS epidemic depends on agriculture. Most of these populations in these countries are occupied in agriculture either self employed in subsistence agriculture or large scale agricultural business (Cockcroft, 2002).

A healthy agricultural sector is essential for the well being and food self sufficiency of developing countries. Agriculture accounts for 24% of Africa's domestic product, 45% of foreign exchange and 70% of employment. It is estimated that AIDS will have claimed the lives of one fifth or more of agricultural workers in Southern Africa by 2010 (UNAIDS, 2004). The AIDS pandemic adds to food insecurity in many ways because agricultural work becomes neglected or abandoned due to household illness. In Malawi, where food shortages have had a devastating effect, it has been recognised that HIV and AIDS are fuelling the country's poor agricultural output according to BBC (2005).

A recent study in Kenya published by UNAIDS in 2006 demonstrated that food production in households where the head of the family died of AIDS was affected in different ways depending on the sex of the deceased. As in other Sub-Saharan African countries, it was generally found that the death of a male reduced the production of "cash crops" such as coffee, tea and sugar, while the death of a female reduced the production of grain and other crops necessary for household survival (UNAIDS, 2006e).

The HIV and AIDS pandemic has been found associated with decreased acreage under cultivation, loss of income and increase in food insecurity in smallholder farming in Nyanza and Eastern Provinces (GOK, 2005a). A study in a tea estate in Kenya found that those workers who ultimately died of AIDS had produced roughly one third less tea than other pluckers. They had also used significantly more leave days in the three

years preceding death (UN, 2004). As agricultural production declines, many young adults become idle and engage in petty crimes which could have been avoided when in the farms. The economy of Kenya depends on agriculture and a decline means the government cannot be in a position to equip, house and pay officers as is required.

2.9.4 Impact on education

Globally, AIDS is a significant obstacle to children achieving universal access to primary education (UNAIDS, 2004). It is hard to over-emphasise the trauma and hardship that children affected by HIV and AIDS are forced to bear worldwide. The epidemic not only causes children to lose their parents or guardians, but sometimes their childhood as well. As parents and family members become ill, children take more responsibilities to earn an income, produce food and care for family members. It is harder for these children to access adequate nutrition, basic health care, housing and clothing. Fewer families have the money to send their children to school (WB/UNESCO/UNAIDS, 2002).

The relationship between AIDS and the education sector is circular in that as the epidemic worsens; the education sector is damaged, which in turn is likely to increase the incidences of HIV transmission. A decline in school enrolment is one of the most visible effects of the pandemic. This in itself has an effect on HIV prevention, as a good basic education ranks among the most effective and cost-effective means of prevention (WB/UNESCO/UNAIDS, 2002).

At present, there are numerous barriers to school attendance in Africa. Children may be removed from school to care for parents or family members, or they may be living with HIV themselves. Many are unable to afford school fees and other such expenses. This is particularly a problem among children who have lost their parents to AIDS, who often struggle to generate income (Avert, 2006). Young people with little or no education may be 2.2 times more likely to contact HIV compared to those who have completed primary education. In this context, the devastating effect that AIDS is having on school enrolment is a big concern. In Swaziland and the Central African Republic, it has been found that school enrolment has fallen by between 25% and 30% due to AIDS (UNAIDS, 2002).

HIV and AIDS do not only affect pupils but teachers as well. In the early stages of African pandemic, teachers were at a higher risk of becoming infected than the general population because of their relatively high socio-economic status and a lack of understanding about how the virus is transmitted (Boler and Jellema, 2005). In Kenya the impact of HIV and AIDS on education is evident on both the supply and demand of teachers and pupils. Teachers' participation and performance in the learning process is reported as being affected adversely by HIV and AIDS when they absent themselves from class (GOK/UNICEF, 2000). The Police force requires educated personnel to meet the ever challenging policing needs. With very few educated Kenyans, the workforce will be adversely affected in terms of specialized units.

2.9.5 Impact on health sector

The pandemic has created a need for a robust, flexible health system at a time when many affected countries have been reducing public service spending to repay debt and conform to international finance institutions requirements (UNAIDS, 2004). In all affected countries, the AIDS pandemic is bringing additional pressure to bear on the health sector. As the pandemic matures, the demand for care for those living with HIV rises, as does the toll among health workers. In Sub-Saharan Africa, the direct medical costs of AIDS excluding ART is estimated at about US$30 per year for every person infected, at a time when overall public health spending is less than US$10 per year for most African countries (UNAIDS, 2002).

In Sub-Saharan Africa, people with HIV-related diseases occupy more than half of the hospital beds (UNAIDS, 2006e). On average HIV positive patients stay in hospital four times longer than other patients. While AIDS is causing an increased demand for health services, large numbers of health care professionals are being affected by the pandemic. In Africa between 19% and 53% of all government health employees deaths is caused by AIDS (UNAIDS, 2004). Botswana, for example, lost 17% of her healthcare workforce due to AIDS between 1999 and 2005. A study in one region of Zambia found that 40% of midwives were HIV positive (UNAIDS, 2006a). The major cause of attrition of health workers in Africa are death and leaving the service. In Kenya where the nurses are the most affected, the main cause of attrition is HIV and AIDS-related death (Tawfik and Kinoti, 2006).

The increased demand for health services due to the number of infected persons has increased constraints on the health sector in Kenya. More health resources and work force are diverted to HIV and AIDS treatment, creating shortages for health care needs (GOK, 2005a) as indicated in Figure 2.6. Kenya required about Ksh. 25.7 billion in 2005/6 financial year increasing to Ksh.48.8 billion in 2009/10 to implement various HIV and AIDS interventions. Prevention, treatment and care of those infected with HIV and AIDS required Ksh.13 billion in 2005/6 increasing to Ksh.19.7 billion in the 2009/10 financial year (GOK, 2005c). As many officers become infected, they require medical attention as any other Kenyan. The constraint on the health sector affect the Police force in that as officers seek these services or take their relatives for treatment, they take a longer time out of work and are not properly attended to.

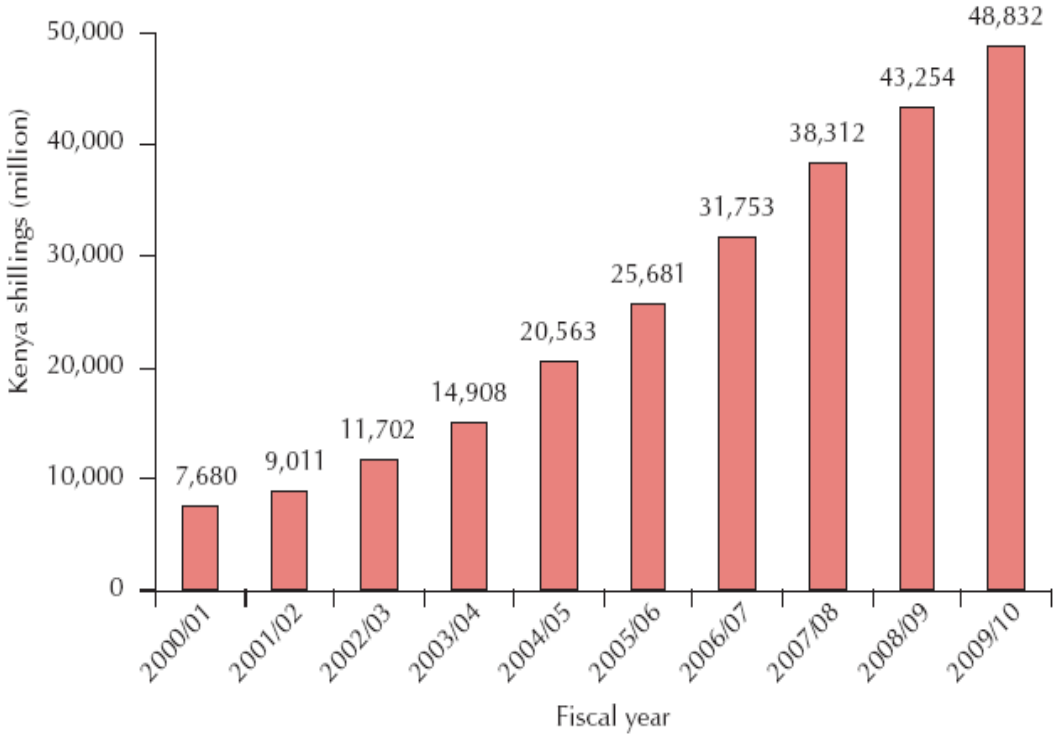

Figure 2.6: Total resource requirement for HIV/AIDS interventions and related activities, 2005–2010, *Source: GOK 2005a*.

2.10 Conceptual framework

The Kenya Police is a critical part of the executive arm of the government. It plays a critical role in governance and facilitates economic and social development. In a liberalised economy like Kenya, the private sector is increasingly looked at as the engine for economic growth. The efficiency and effectiveness of the Police in providing the necessary services are critical for the enhancement of productivity and under performance by the police will adversely affect the development process.

Through its impact on the human resources, HIV and AIDS impact negatively on all functional capacities of the Kenya Police resulting in increased morbidity and mortality. The extent of attrition is an indication of the overall health of the Kenya Police. While attrition cannot always be stopped, it is necessary for the Kenya Police to determine the types and levels of attrition that are required and what types and levels should be avoided for the Police to achieve its mandate. The figure illustrating conceptual framework of the study is given below.

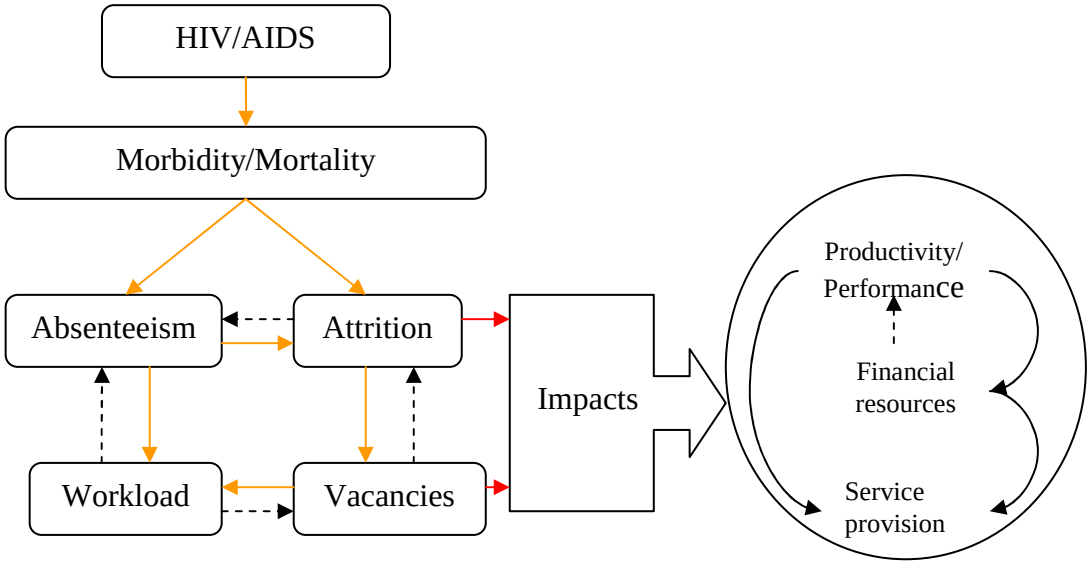

Figure 2.7: Conceptual framework

As indicated in Figure 2.7, attrition leads to vacancies and reflects a shortfall in the authorised staff establishment, which is a standard staff mix to achieve the objectives at any particular time. Any vacancy that occurs disrupts certain activities and will have adverse effects on the overall performance of the Kenya Police. Increased morbidity leads to increased absenteeism which is absence from work for unofficial reasons, and eventually results in possible attrition. Increased morbidity and mortality in the society, amongst relatives of officers lead to higher rates of absenteeism, when employees look after the sick or attend funerals. Both absenteeism and vacancies result in a greater workload for other officers. The dotted arrows depict the reinforcing trend of these impacts: for instance, if vacancies are high and workload is severe, more people are likely to stay away from work or leave the Police Force for better work environments.

The erosion of human resource capacity negatively impacts on the productivity and performance of individual officers and the Police Force as a whole. Furthermore, it has significant financial implications related to recruitment and training, medical benefits, funeral costs and death benefits, amongst others. Overall, the erosion of human resource capacity will negatively affect the core functions of the Kenya Police and impede service provision. Again, these factors are mutually enforcing. For example, to cope with the organisational impacts of HIV and AIDS, financial resources are likely to be diverted away from service delivery, thereby further thwarting the quality and quantity of services. Similarly, a depletion of financial resources will further undermine the overall performance of the Kenya Police.

2.11 Conclusion

The literature reviewed has shown that the HIV and AIDS are global disasters. Sub-Saharan Africa is the most hit area, with the pandemic. Currently the prevalence rate has increased in Kenya; however, death rates remain low due to the availability of ART drugs. With almost one in five adults living with HIV and AIDS, the pandemic has reached alarming proportions. The nature, manifestation and impacts of HIV and AIDS in Kenya is similar to heterosexually transmitted HIV and AIDS pandemic elsewhere in the world. Certain social groups, particularly poor people, the Police, young adults, women, and increasingly children, show a disproportionately high level of vulnerability to HIV infection and to the devastating impacts of HIV and AIDS. This poses a serious challenge to the government of Kenya, to improve the quality of life of all and to promote development.

CHAPTER THREE

MATERIALS AND METHODS

3.0 Introduction

This chapter discusses the research study area, design, target population, sampling techniques and procedures, research instruments, data collection procedures, data analysis, the study variables and ethical considerations.

3.1 Study area

The Republic of Kenya is a country in Eastern Africa and lies astride the equator between longitudes 34° 00' E and 41° 58´ E and latitudes 05° 13´ N and 04° 30´ S, and at an altitude rising from 0ft mean sea level at the Indian Ocean to the highest peak of Mt. Kenya 17,056ft (5,199m) above mean sea level (Figure 3.1). With an area of 582, 650 km^2, the approximated population was 36,913,721 people as at June 2007 (Library of Congress, 2007). Kenya's coastline extends for 536 kilometres which includes the strategically-important harbour of Mombasa, the largest cargo-handling port on the continent's East coast, North of South Africa's Richard's Bay.

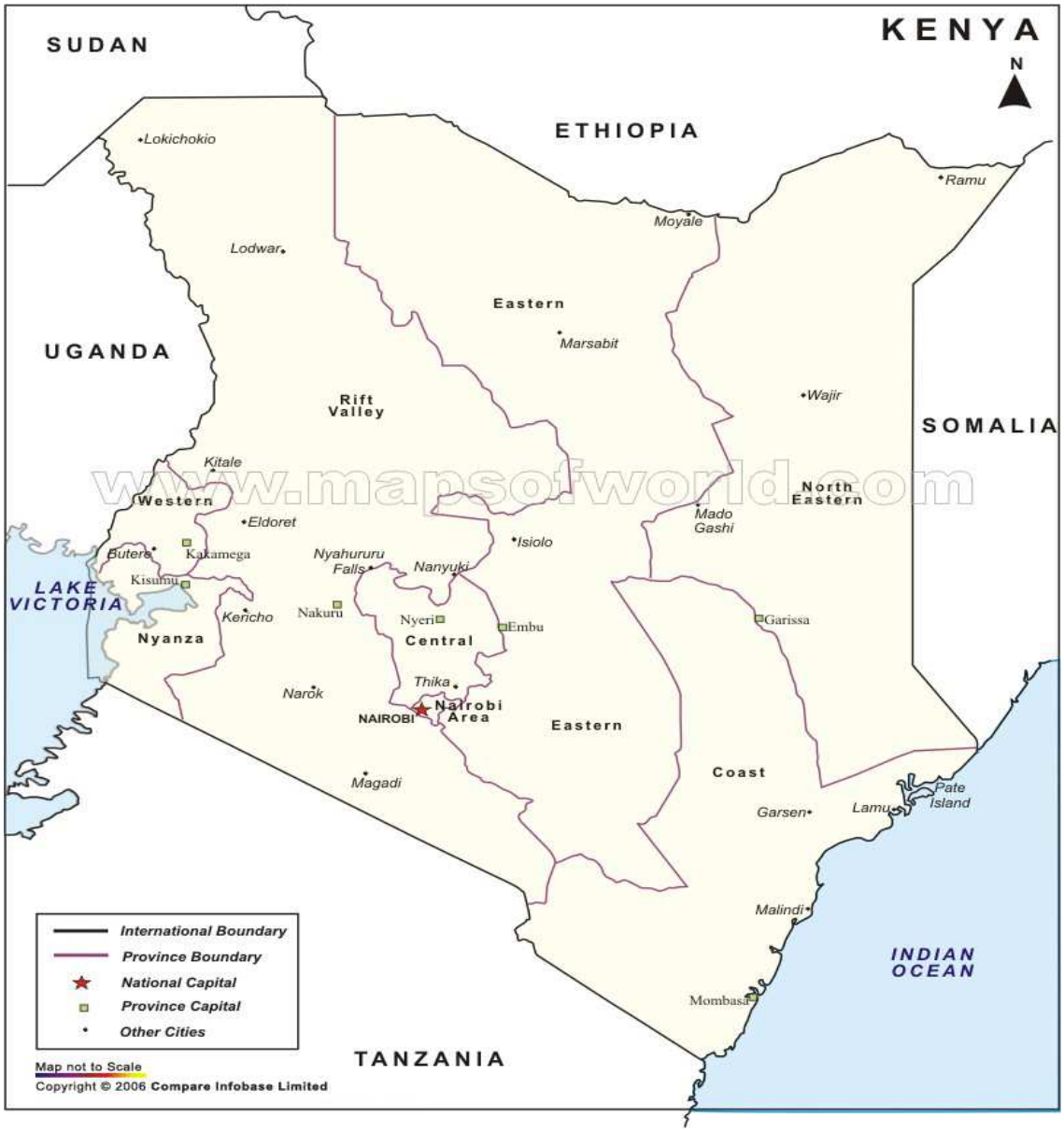

Figure 3.1: Map of the Republic of Kenya, with its provincial capitals where the Provincial Police Officers are based, *Source: CIL, 2006.*

3.2 Study population

The target population for the study to which the results was generalised is the 40,000 Kenya Police officers stationed in various parts of the Republic of Kenya.

3.3 Research design

This is a descriptive survey, and involves the determination of relationship between an explanatory variable (the prevalence of HIV and AIDS) and a response variable (service delivery in the Kenya Police). Two main methods, questionnaires (structured and unstructured) and key informant interviews were used in data collection. The interviews were carried out with the heads of operation sections of various divisions and also the in-charge VCT centres under the Police, while questionnaires were given to the sample Police officers at the station level to fill. The information gathered in the interviews supplemented the data from questionnaires and provided additional perspective on understanding the Police as a vulnerable group.

3.3.1 Sample frame

The Police Department is administered from the Police Headquarters at Vigilance House in Nairobi. There are eight Provinces, fourteen Formations and various Sections at Police Headquarters headed by Provincial/Formation Commanders and Section Directors including the Officer Commanding AIDS Control Unit. Within the Provinces/Formations there are Divisions headed by Officer Commanding Police Division (OCPD), Stations headed by Officer Commanding Police Station (OCS), Police post headed by Officer Commanding Police Post (OCPP) and patrol base headed by Officer Commanding Patrol Base (OCPB). There are also companies, platoons and sections within General Service Unit (GSU) and Anti Stock Theft Unit (ASTU).

The Provinces with the provincial headquarters are Nairobi Area, Nyanza, Western, Rift Valley, Central, Eastern, Coast and North Eastern. The Formations include Airwing, Railways, Traffic, General Service Unit (G.S.U), Anti Stock Theft Unit (ASTU), Kenya Airport Police Unit (KAPU), Kenya Police College (KPC), Diplomatic Police Unit (DPU), Presidential Escort Unit (PEU), Anti Terrorist Police Unit (ATPU), Tourist Police Unit (TPU), Maritime Police Unit, Criminal Investigation Department (CID) and Police Dog Unit (Kenya Police, 2005).

3.4 Sampling method

A pre-determined minimum sample size of 384 officers was applied to the study sampling process from a statistically significant sample of an estimated population of 40,000 Police officers. An updated nominal roll of the stratified sampled Police stationed was ascertained. Weighted criteria was used to ensure that selected stations were apportioned the right number of officers for interview based on the station strength. The study employed simple random sampling method to select the respondents at the station level. The commander of the sampled station and the VCT centre within also qualified for selection. The Police station at the provincial/formation headquarters was selected to cater for the senior officers. This gave a representative sample of the Kenya Police population. In liaison with the Officer Commanding AIDS Control Unit at Police headquarters, the sampled formations and stations were given a time schedule for the data collection and thus organized for the availability of the selected respondents. In case where an officer was selected and was not available (e.g.

not willing) then the replacement occurred by selecting another officer through simple random sampling.

3.4.1 Sample size determination

The sample size for the population was determined using a statistical Equation 2 for larger proportions (Mugenda and Mugenda, 1999).

$$n = \frac{z^2 pq}{d^2} \quad \text{..... (2)}$$

Where

n = the desired sample size (if target population is greater than 10,000);

z = the standard normal deviation (= 1.96) at the required confidence level;

P = the proportion in the target population estimated to have characteristics being measured;

q = 1-p thus (1-0.5) = 0.5;

d = the level of statistical significance set (accuracy = 0.05 level desired).

Because there was no estimate available of the proportion in the target population assumed to have the characteristic of interest, 50% or 0.5 was used in Equation 3.

Thus
$$n = \frac{(1.96)^2 \times (0.50) \times 0.50}{0.05^2} \quad \text{..... (3)}$$
$$n = 384$$

Stratified and simple random sampling procedures were applied to ensure that a proportionate sample size of 384 officers was proportionately distributed among the

40,000 Police officers throughout the Republic of Kenya. A total of 415 Police officers were interviewed. This Figure surpassed the minimum sample size of 384 by 31 officers (+8.1%). However, due to incomplete response rates in data completion, a total of 405 officers response were finally utilized (+5.2% of the intended sample size) as indicated in Table 3.1.

Table 3.1: Officers sample coverage by province and formation

Province/Formation	**Male**		**Female**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
Nairobi Area	39	9.6	9	2.2	**48**	**11.8**
Rift Valley	32	7.9	10	2.5	**42**	**10.4**
Nyanza	22	5.4	15	3.7	**37**	**9.1**
Coast	25	6.1	8	2.0	**33**	**8.1**
Central	23	5.7	7	1.7	**30**	**7.4**
Western	21	5.2	9	2.2	**30**	**7.4**
Eastern	14	3.5	7	1.7	**21**	**5.2**
KAPU	28	6.9	13	3.2	**41**	**10.1**
KPC	22	5.4	8	2.0	**30**	**7.4**
PEU	23	5.7	1	0.3	**24**	**6.0**
Police Airwing	6	1.5	4	1.0	**10**	**2.5**
DPU	7	1.7	3	0.8	**10**	**2.5**
TPU	9	2.2	1	0.3	**10**	**2.5**
Police Headquarters (Operations)	8	2.0	1	0.3	**9**	**2.2**
GSU Headquarters	6	1.5	3	0.7	**9**	**2.2**
ASTU Headquarters	7	1.7	1	0.3	**8**	**2.0**
CID Headquarters	5	1.2	2	0.5	**7**	**1.7**
Railway and Port Police	5	1.2	1	0.3	**6**	**1.5**
Total	**302**	**74.6**	**103**	**25.4**	**405**	**100.0**

3.5 Data collection method

The respondents were requested to fill a questionnaire (see Appendix B). Participation was done at individual level to maintain confidentiality as stigma and discrimination was still high in the Kenya Police. The research assistant who was a qualified social worker was trained and deployed to assist in data collection. For those sampled, the purpose of the study was explained. Items in the questionnaire comprised structured questions which measured the objective responses and unstructured questions which measured the subjective responses. The main variables of the study were the prevalence of HIV and AIDS, the performance of duty and intervention measures in the Kenya Police. The responses enhanced formulation of useful recommendations to the study. Document analysis and key informant interviews were used in the study to corroborate responses given in the questionnaires.

3.5.1 Pilot testing

A pilot study was conducted on a few officers of Kenya Police Airwing based at Wilson Airport to measure the validity and reliability of the research instrument. Those selected for piloting, were not part of the main study sample.

3.5.2 Validity

The researcher sought expert opinion in assessing the validity of the instrument. The questionnaires of the pilot study were assessed and weaknesses identified for example few blank spaces, inaccurate responses and inconsistencies on the instrument. The instrument was modified accordingly. This also ensured accurate determination of the

attitude although it entirely depended on the respondent's honesty and as well maintained privacy, confidentiality and trust with the respondents. The questionnaires were pre-tested and subjects who were not the actual sample were encouraged to write comments and suggestions concerning instructions, clarity, and relevance of the statements.

3.5.3 Reliability

Reliability is the consistency of the instrument or the degree to which it gives similar results for the same individuals at different times. To attest reliability, test-retest reliability was used. The scores were computed to establish Pearson Product Moment Correlation Coefficient. The calculated value was $r = 0.6$ which was relatively higher than the set value of 0.5. This showed high reliability.

3.5.4 Data collection procedure

The respondents were requested and assisted to fill a pre-structured questionnaire. Participation was done at individual level to maintain confidentiality due to stigma and discrimination in the Police Force. The researcher made introductions to the officers and this made it easier to administer the questionnaires and also carryout the key informant interviews. All officers who were eligible for the study were enrolled consequently. The environment was made conducive for the participants when the researcher informed the participants that the study was purely academic. The data were collected over a period of twelve weeks.

3.5.4 Secondary data

Secondary data were obtained from libraries at Police headquarters, RATN, AMREF and Universities within the capital city Nairobi and its environs. These corroborated the information received from Police officers, commanders, in-charge VCT centres and the key informants.

3.6 Data analysis and presentation

The twenty two questions for the officers, twenty one for commanders and six for the in-charge of VCT centres within police areas of command were categorized into the following sub-headings: Age Category, Level of Education, Length of service, Marital status, HIV status of officers interviewed, Performance while on duty with an infected colleague, Performance of duty by an infected officer, How performance was affected, Tested for HIV, Reasons for having HIV test, Modes of HIV Transmission, Chances of contracting HIV, Knowledge of HIV positive colleague and his/her marital status and Support to HIV positive officers.

Cross tabulation was also done to show correlation between some of the variables. Level of education was cross tabulated with knowledge about personal HIV status and Length of Service cross tabulated with knowledge about HIV status. The qualitative data were verified before coding manually. The quantitative data were processed and analysed using Microsoft Excel and Statistical Package for Social Sciences.

Both univariate and bivariate analysis was done using chi-square test to compare proportions of categorical variables and any associations and/or relationship. The results were considered significant when the 2-sided *P-value* was less than 0.05 at 95% confidence interval. The frequencies of responses were also calculated to determine the means of responses. The results were presented in tables, graphs and charts to enable us test the hypotheses.

3.7 Ethical considerations

Ethical authorization was sought from the participants. The study was conducted with ethical requirements as stipulated by the Ministry of Health. This included consideration of the following: methods used were not intrusive, either by question or procedure to embarrass the respondent, personal data were handled and stored with confidentiality to avoid traumatizing the respondent and data collected were used for the said study only.

The confidentiality of the respondents was protected in that no names or personal information were required in the questionnaire or during key informant interview and measures were taken to ensure no coercion or undue influence was exercised by the commanders on the selected responders to participate. This ensured that they gave their best (Mugenda and Mugenda, 1999). The responders were advised on the purpose of the data collection and how the information was to help improve or design programmes relevant to their performance of duty, and were free to withdraw from the survey any time one so wished (FHI, 2007).

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents analysed results of the research conducted on the Kenya Police. A total of 405 Police officers participated in the study. The results are presented in form of bar graphs, pie charts and tables under the three specific objectives.

4.1 Prevalence of HIV and AIDS in the Kenya Police

4.1.1 Age category of officers

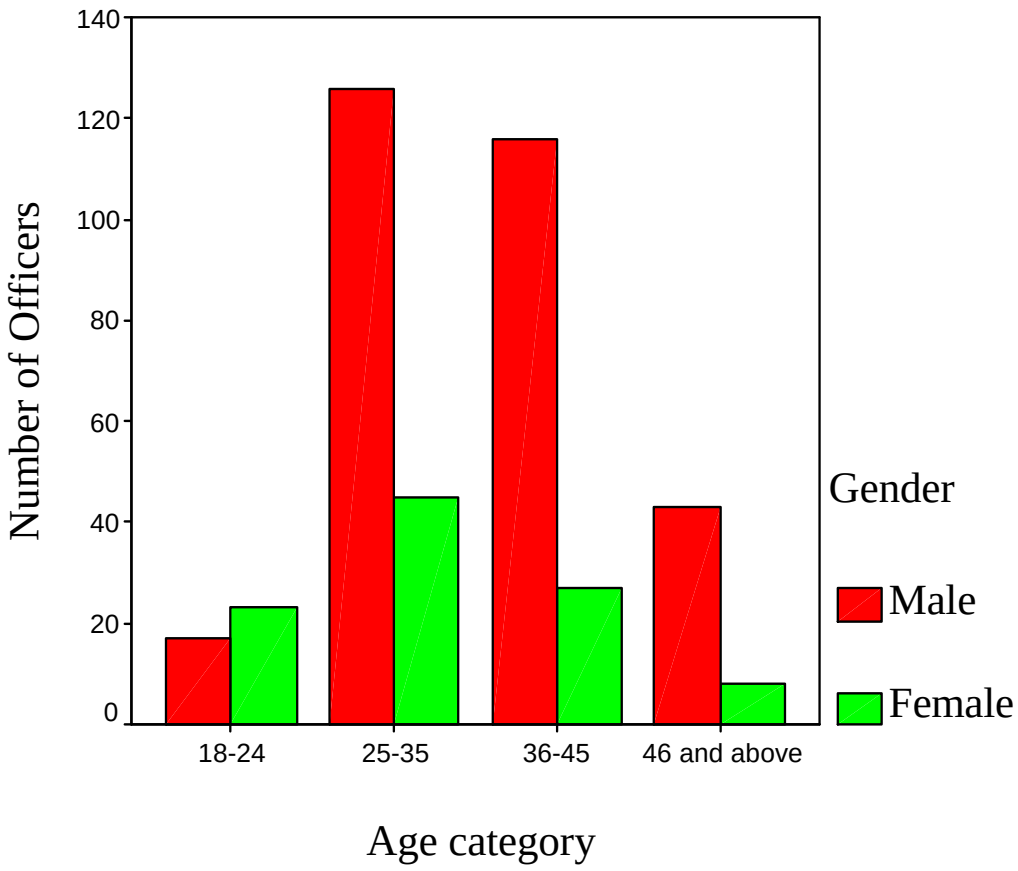

Figure 4.1: Age category of officers

A total of 405 Police officers took part in the study. In terms of gender breakdown, 74.6% were male officers and 25.4% were female officers. The age distribution of the sampled staff is indicated in Figure 4.1. The age group of officers in the study was assessed and the results showed that majority (354) of the 405 officers were in the range 18 years to 45 years. Officers in the age range fourty six and above were few in number (51) see Table 4.1.

Table 4.1: Age category of officers

Age Category	**Male**		**Female**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
18 – 24	17	4.2	23	5.7	**40**	**9.9**
25 – 35	126	31.1	45	11.1	**171**	**42.2**
36 – 45	116	28.6	27	6.7	**143**	**35.3**
46 and Above	43	10.6	8	2.0	**51**	**12.6**
Total	**302**	**74.6**	**103**	**25.4**	**405**	**100.0**

4.1.2 Level of Education

The level of education of the Police officers was assessed and it is noted that the highest number of respondents have secondary school education (71%) followed by college education (23%), university education (5%) and primary school leavers (1%) as shown in Figure 4.2. The university category included those with graduate degrees while those in the primary school category have served the Police Force for more than 20 years.

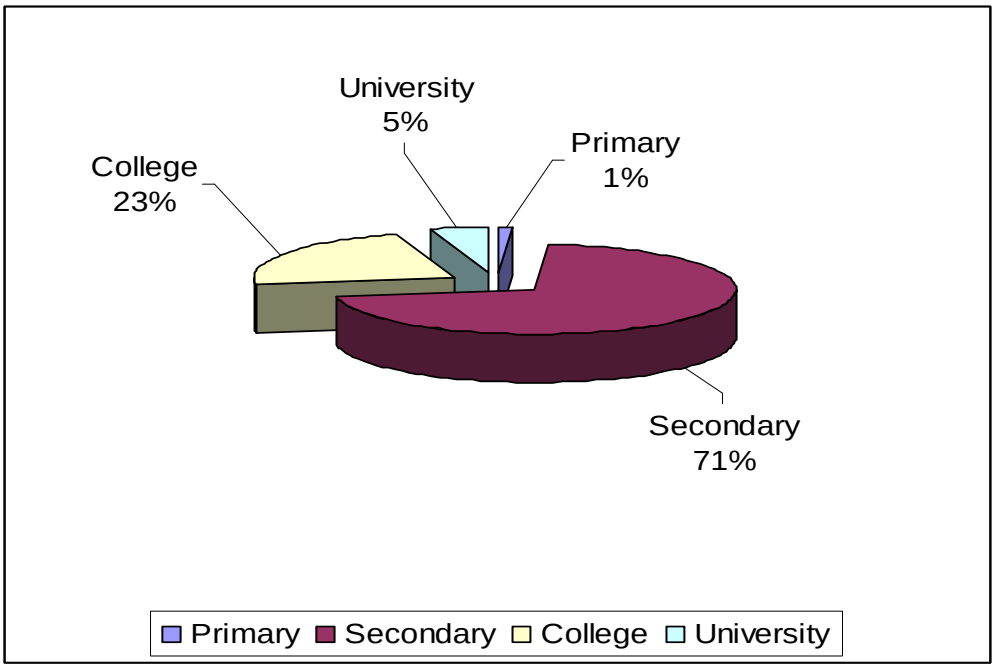

Figure 4.2: Level of education

4.1.3 Length of service

The length of service of officers was assessed. The longer the service the more experienced an officer is in terms of Police work, and the more the police has invested on skill development. Majority of officers who have worked for more than six years in the force have also been deployed in more than two provinces or formations. A total of 156 officers have worked for between 10 and 20 years in the Police, 93 between 6 and 10 years, 84 for over 20 years with a small number of 72 officers having been in the Police Force for less than 5 years (see Figure 4.3).

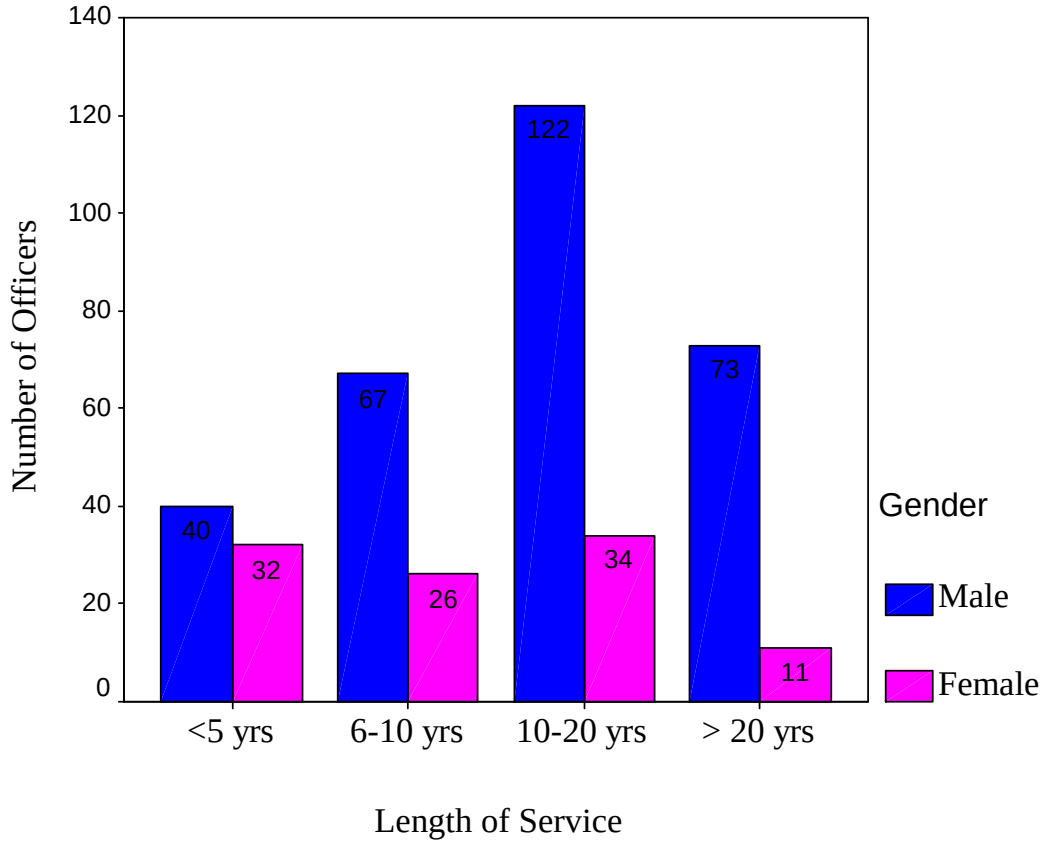

Figure 4.3: Length of service of officers

4.1.4 Marital status

The marital status of officers was assessed. Results revealed that majority of the officers (79%) were married. Only 17% of the officers were single with a small proportion (4%) being divorced, widowed or separated (see Figure 4.4). Married couples are over 50% more vulnerable to HIV and AIDS compared to other groups. This is attributed to the trust married partners have for each other, hence they do not use protection assuming that once in marriage, the spouse does not have other sexual partners.

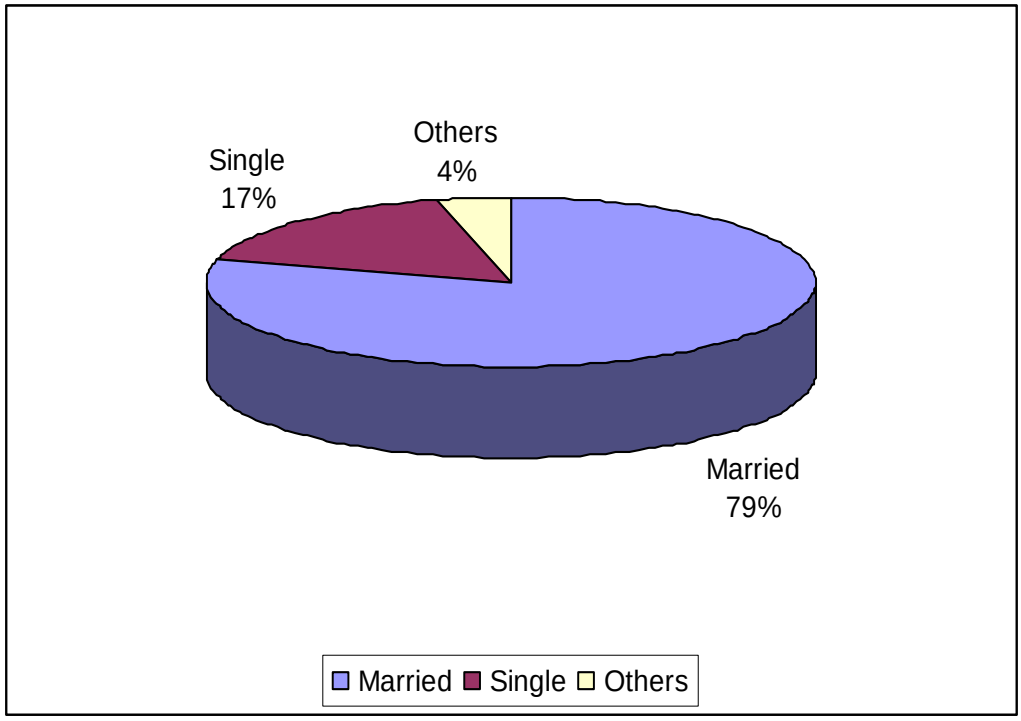

Figure 4.4: Marital status of officers interviewed

4.1.5 Level of Education versus knowledge about HIV status

Assessment was done to establish knowledge of personal HIV status and whether there was a relationship between the level of education and knowledge of HIV status. Results showed that 100% of the respondents were aware of HIV and AIDS, out of which approximately 73% knew their HIV status, having had the test in a VCT centre. Knowledge about personal HIV status progressively declined from officers with primary school education to those with college or university education (see Table 4.2a).

Table 4.2a: Level of education versus knowledge about HIV status

Level of Education		**Knowledge about HIV Status**		**Total**
		Knows	**Don't Know**	
Primary	Count	1	4	**5**
	% of Total	0.3%	1%	**1.3%**
Secondary	Count	200	87	**287**
	% of Total	49.4%	21.5%	**70.9%**
College	Count	79	15	**94**
	% of Total	19.5%	3.7%	**23.3%**
University	Count	15	4	**19**
	% of Total	3.7%	1%	**4.7%**
Total	**Count**	**295**	**110**	**405**
	% of Total	**72.8%**	**27.2%**	**100%**

Table 4.2(b): Chi-Square Tests on level of education versus knowledge of HIV status (Cross tabulation)

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.495[a]	6	.001
Likelihood Ratio	22.785	6	.001
Linear-by-Linear Association	2.504	1	.114
N of Valid Cases	405		

a. 4 cells (33.3%) have expected count less than 5. The minimum expected count is .33.

Table 4.2(c): Symmetric Measures on level of education versus knowledge of HIV status (Cross tabulation)

		Value	Asymp. Std. Error(a)	Approx. T[b]	Approx. Sig.
Nominal by Nominal	Phi	0.230			.001
	Cramer's V	0.163			.001
Interval by Interval	Pearson's R	-0.079	0.044	-1.585	0.114[c]
Ordinal by Ordinal	Spearman Correlation	-0.103	0.045	-2.074	0.039[c]
N of Valid Cases		405			

a. Not assuming the null hypothesis.
b. Using the asymptotic standard error assuming the null hypothesis.
c. Based on normal approximation

About 27% of the officers did not know their HIV status and intended to go for voluntary counselling and testing. The two variables had an association (*p value* < *0.05*) although the association was minimal as shown in the statistical tables Spearman correlation R= -0.103 (see Table 4.2b and 4.2c).

4.1.6 HIV status of officers interviewed

The prevalence rate of HIV in the Kenya police was estimated at 5.9% from the VCT centres within Police areas of command, 1.5% below the estimated national prevalence rate of 7.4%. Out of 405 officers interviewed, 110(27%) had not taken the test, 295

(73%) tested for HIV and 27(7%) were positive and 268(66%) were negative (see Figure 4.5).

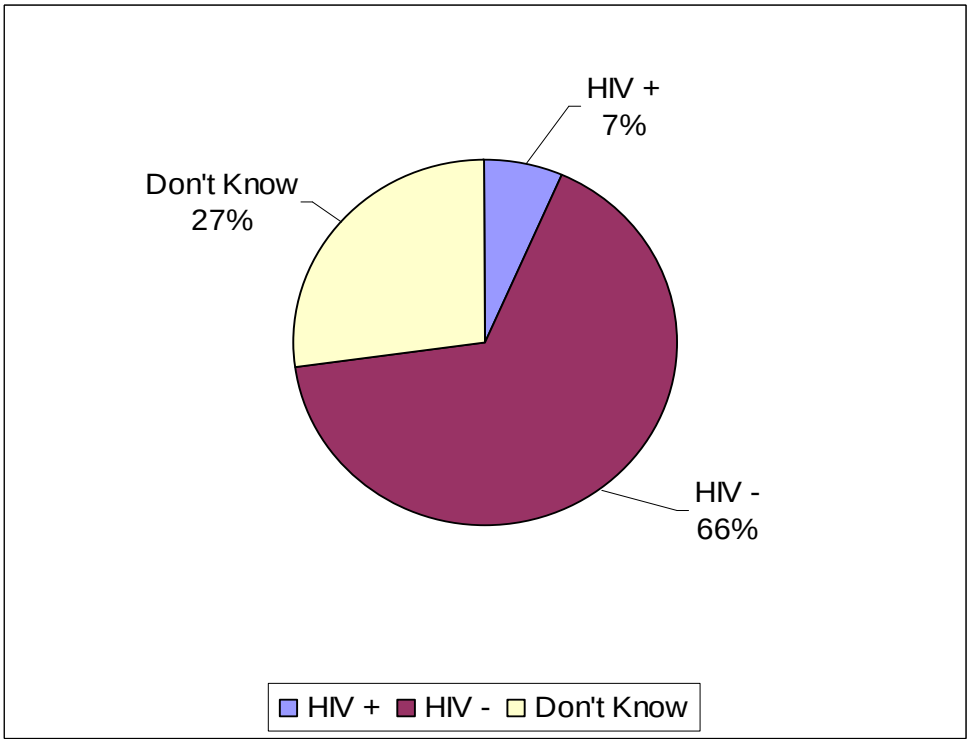

Figure 4.5: HIV status of officers interviewed

4.1.7 Length of service versus HIV status (cross tabulation)

Table 4.3(a): Length of service versus HIV status (cross tabulation)

		HIV Status			
		HIV $^{+}$	**HIV $^{-}$**	**Don't Know**	**Total**
Length of Service	Less than 5 Years	6	51	15	**72**
	6-10 Years	4	73	16	**93**
	10-20 Years	11	101	44	**156**
	More than 20 Years	6	43	35	**84**
Total		**27**	**268**	**110**	**405**

The length of service of officers was assessed to determine the status of the long serving officers who had a lot of experience in the service. Majority of the infected (21) were officers who had served for more than five years. Only 6 of the infected officers had served for less than five years (see Table 4.3a).

The results show that there exists a significant positive relationship between the two variables ($p < 0.05$) as shown in the statistical tables Spearman correlation R= 0.150 (see Table 4.3b and 4.3c).

Table 4.3(b): Chi-Square Tests on Length of service versus HIV status

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.438[a]	6	.008
Likelihood Ratio	17.327	6	.008
Linear-by-Linear Association	7.619	1	.006
N of Valid Cases	405		

a.1 cell (8.3%) has expected count less than 5. The minimum expected count is 4.80.

Table 4.3(c): Symmetric Measures on Length of service versus HIV status

		Value	Asymp. Std. Error [a]	Approx. T[b]	Approx. Sig.
Nominal by Nominal	Phi	0.207			.008
	Cramer's V	0.147			.008
Interval by Interval	Pearson's R	0.137	0.051	2.783	0.006[c]
Ordinal by Ordinal	Spearman Correlation	0.150	0.051	3.052	0.002[c]
N of Valid Cases		405			

a. Not assuming the null hypothesis.
b. Using the asymptotic standard error assuming the null hypothesis.
c. Based on normal approximation

4.2 Duty allocation and performance

4.2.1 Performance of an officer while on duty with an infected colleague

The performance of an officer while on duty with an infected colleague was assessed. The responses were coded. Majority of those interviewed (53.8%) admitted that indeed their performance was compromised. The infected officer can not perform tasks at the same level of competency as the uninfected officer, especially duties that involve use of a lot of energy and physical strength such as riot control and night duties (see Table 4.4). A number of officers (18.3%) indicated that their performance is not reduced irrespective of colleague's HIV status, while 27.9% do not know their colleague's HIV status or how to quantify their output.

Table 4.4: Performance of an officer while on duty with an infected colleague

Performance while on duty with an infected colleague	**No. of responses**	**%**
Performance adversely affected	218	53.8
Performance not affected	74	18.3
I don't know	113	27.7
Total	**405**	**100**

4.2.2 Performance of duty by an infected officer

Officers who indicated their HIV status as positive had their performance of duty assessed by posing the question, how does your status affects your performance of duty? The results show that 66.7% have their performance affected by their HIV status (see Table 4.5). 11.1% do not know whether their performance is in any way affected while 22.2% indicated that they perform their duties normally as any other an uninfected colleague.

Table 4.5: Performance of duty by an infected officer

Performance of duty by an infected officer	**No. of responses**	**%**
Performance adversely affected	18	66.7
Performance not affected	6	22.2
I don't know	3	11.1
Total	**27**	**100**

4.2.3: How performance was affected

The commanders were asked to indicate how performance of duty was affected within their areas of jurisdiction. About 42% of the commanders indicated that absenteeism is a major factor affecting performance, 28% indicated low morale by those who have tested positive for HIV, 19% indicated that man-hours is lost preparing and attending funerals of colleagues while 11% indicated other reasons like decline in general output among others (see Figure 4.6).

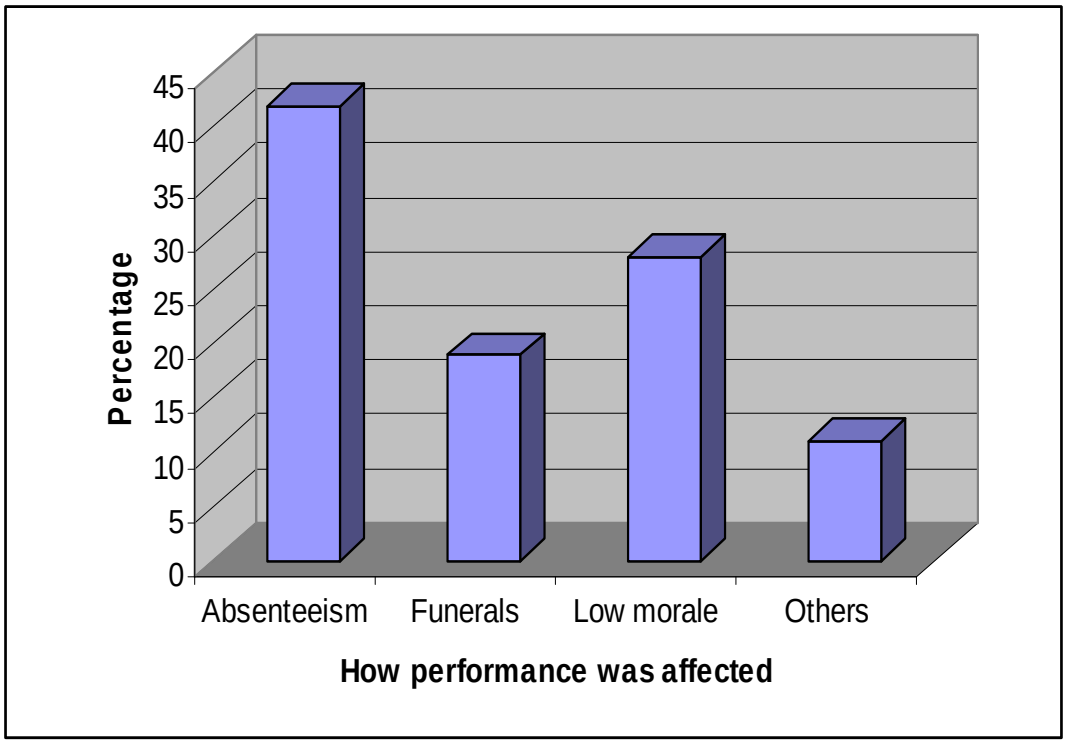

Figure 4.6: How performance was affected

4.3 Effectiveness of intervention measures

4.3.1 Tested for HIV

The number of officers who have tested themselves to their HIV status was assessed. Majority (73%) have gone for the test while (27%) have not tested self for HIV and are thus not aware of their status (see Figure 4.7).

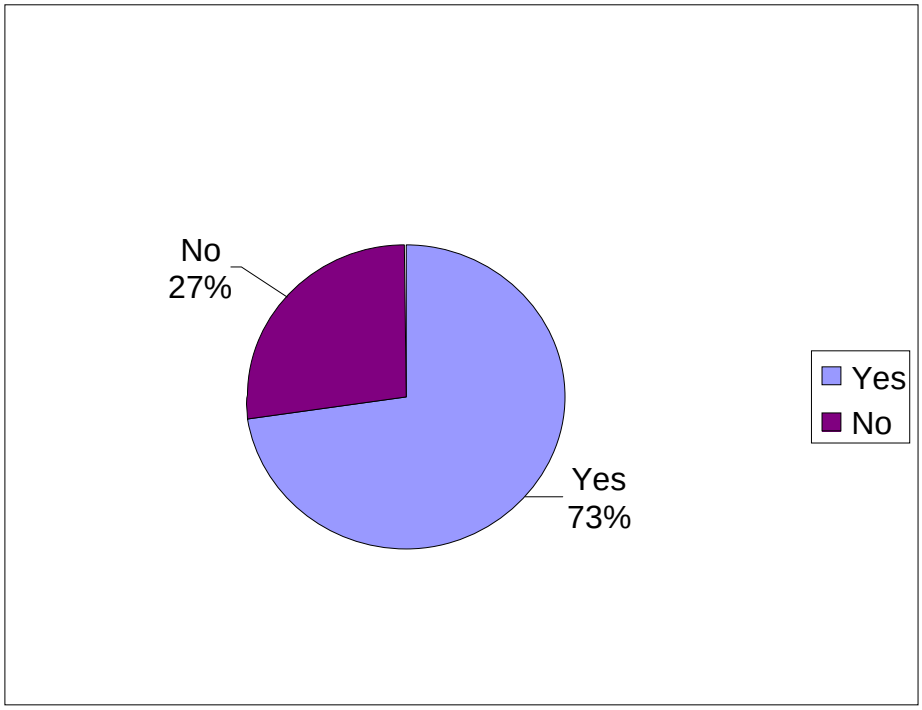

Figure 4.7: Tested self for HIV

It is important to point out here that among those who have not tested, majority (75%) are willing to have the HIV test while 25% are still not willing to have the test, as indicated in Figure 4.8.

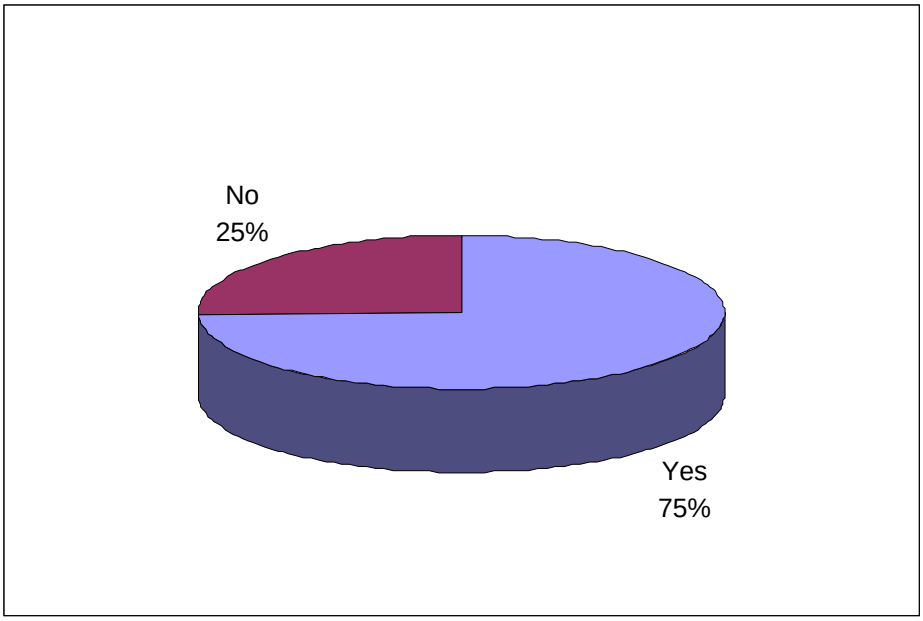

Figure 4.8: Intend to go for HIV testing

4.3.2 Officers reasons for having HIV test

Reasons for having HIV test among Police officers were assessed. Majority of the officers (80%) wanted to know their HIV status, 5% of the officers who are female were expectant, and 2% were donating blood while 13% were either going for peace missions or travelling outside the country (see Figure 4.9).

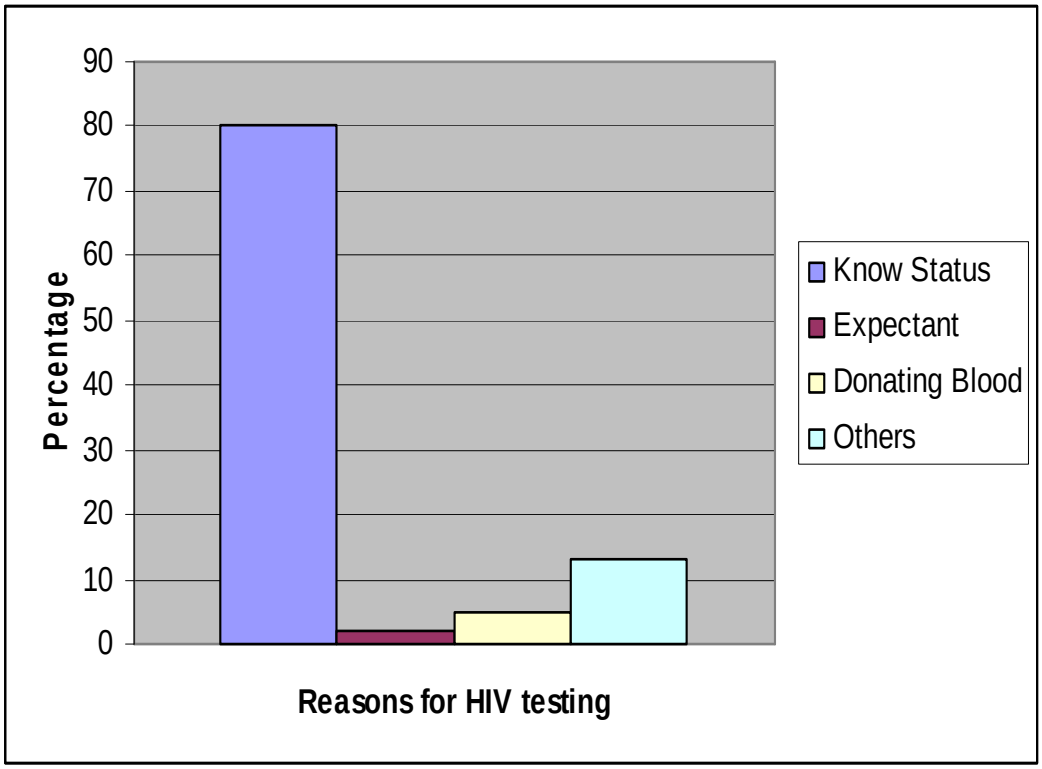

Figure 4.9: Officers reasons for having HIV test

4.3.3 Modes of HIV transmission as provided by officers

Police officers are always at very high risk of contracting HIV. The modes of HIV transmission known to the officers were assessed. The officers identified the modes of HIV transmission indicated in Table 4.6 as the most common. About 98.5% identified unprotected sex with an infected person as the most basic means through which one can be easily infected. Close to 65.7% indicated that one can easily be infected through

transfusion of blood which is not properly screened for the virus. While 25.7% identified sharing of needles and other sharp objects, approximately 19.8% indicated that coming into contact with infected body fluids through open wounds would transmit the virus. Nearly 18.8% indicated mother to child transmission as a mode of HIV transmission.

Table 4.6: Modes of HIV transmission provided by officers

Modes of HIV transmission	**No. of responses**	**%**
Unprotected Sex with an infected	398	98.5
Infected blood transfusion	266	65.7
Contact with an infected body fluids (wounds)	80	19.8
Mother to child transmission	73	18.7
Sharing of needles and other sharp objects	104	25.7

Note: More than one response was possible from a respondent (N = 405)

4.3.4 Chances of contracting HIV provided by officers

The officers' chances of contracting HIV were assessed. Majority (56%) indicated that their chances were relatively high. About 37% of the respondent indicated that their chances of contracting the virus was low and that they take a lot of precaution while 7% indicated that they have no chances at all of contracting the virus as they are faithful to only one partner. This is a misconception among police officers and even the general public (see Figure 4.10).

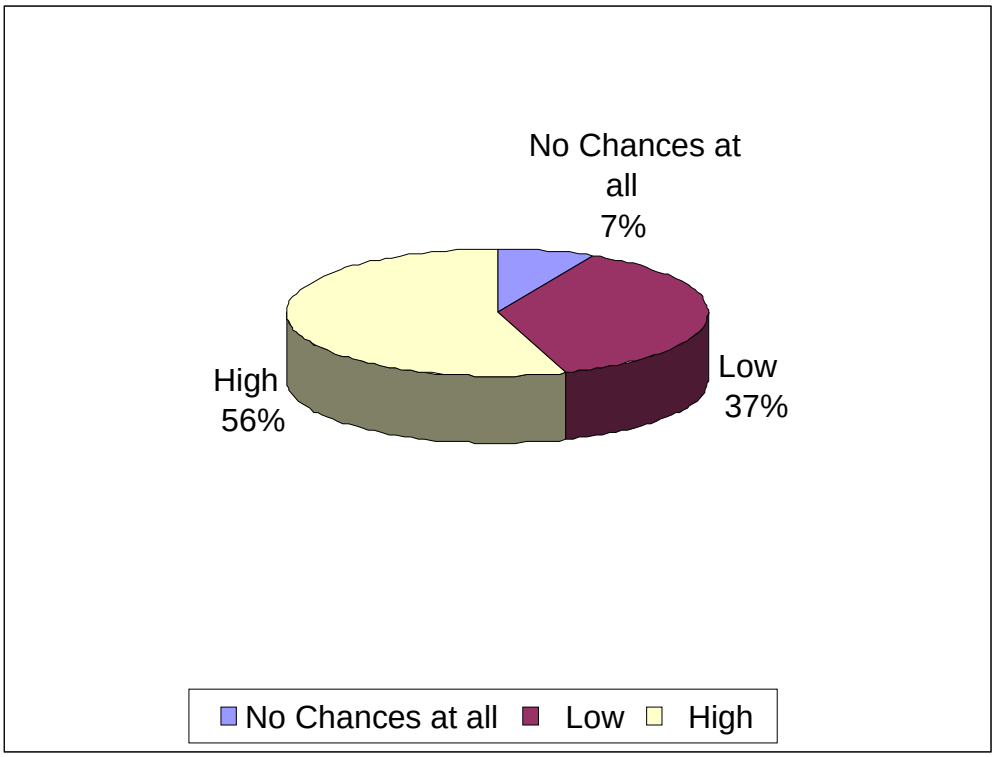

Figure 4.10: Chances of contracting HIV provided by officers

4.3.5 Officers vulnerability to HIV and AIDS

Table 4.7: Officers vulnerability to HIV and AIDS

Reasons for vulnerability	**No. of responses**	**%**
Nature of duty (exposure)	210	52.0
Transfer	89	21.9
Frequent travel	56	13.8
Housing	32	7.9
Don't know	18	4.4
Total	**405**	**100**

The officers' reasons for their perceived chances of contracting HIV were assessed. Close to 52% of the officers indicated that they are more at risk as a result of the kind

of work and the exposure of interaction with many people (see Table 4.7). About 21.9% cited transfers, which in most cases, is to stations where family can not accompany them easily; while 13.8% indicated that the kind of duties allocated to them involve frequent travels and spent nights in market centre lodgings that have commercial sex activities. Approximately 7.9% indicated housing as a major cause while 4.4% did not know what increases their vulnerability.

4.3.6 Knowledge of HIV positive colleague and his/her marital status

Knowledge of any HIV positive colleague and his or her marital status was assessed. The results revealed that many officers (53.6%) were aware of an HIV positive colleague. While 45% knew of the marital status of the HIV positive colleague, 8.6% did not know their marital status. Close to 46.4% did not know the HIV and marital status of their colleagues (see Table 4.8). According to NASCOP (2008), one in ten married couples was HIV infected and nationally steady heterosexual partners are more at risk of infection than any other group.

Table 4.8: Knowledge of HIV positive colleague and his/her marital status

HIV^+ Colleague Marital Status	**Knowledge of HIV^+ colleague**					
	Knows		**Don't Know**		**Total**	
	N	%	N	%	**N**	**%**
Married	142	35.1	-	-	**142**	**35.1**
Single	26	6.4	-	-	**26**	**6.4**
Others	14	3.5	-	-	**14**	**3.5**
Don't Know	35	8.6	188	46.4	**223**	**55**
Total	**217**	**53.6**	**188**	**46.4**	**405**	**100**

4.3.7 Support to HIV positive officers

The support given to HIV positive officers who have indicated their status to the commanders was assessed (Figure 4.11). Many commands indicated that HIV and AIDS programmes have been effectively implemented in their areas. Close to 64% of the commanders indicated that they are given light duties while 30% are allowed to rest when unwell. About 6% of the commanders indicated that the officer continues to work like any other normal officer as there is no policy on duty allocation.

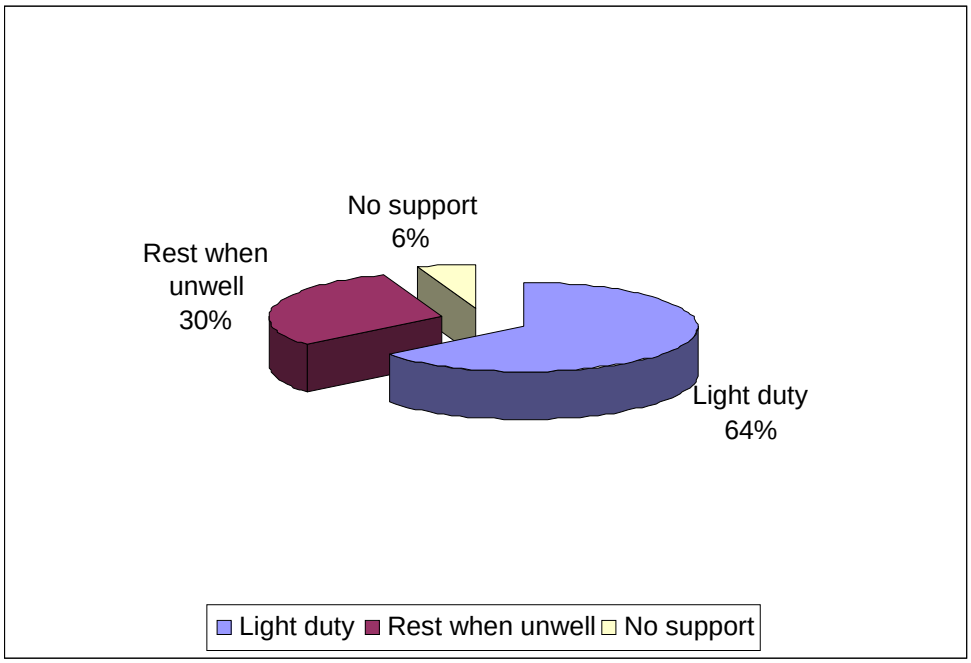

Figure 4.11: Support to HIV positive officers

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter discusses the main findings based on the results presented in chapter four according to the specific objectives of the study.

5.1 Prevalence of HIV and AIDS in the Kenya Police

From the study findings, majority of the officers' (87.4%) ages ranged between 18 and 45 years. The mean age of the officers is 35 years which means most officers are in their prime ages. These are the ages when most people are sexually active and physically fit. The results show that most of the officers in the study were more vulnerable to HIV and AIDS due to the nature of their duty and by being sexually active. The results corroborates the finding of related studies by the ministry of health which indicated that youths were exposed to HIV and AIDS due to being sexually active (MoH, 1997).

There are over 40,000 Police officers majority of who are men under 45 years of age. By virtue of their youth and long periods of absence away from family and mates, the Police are thought to be at special risk for all sexually transmitted diseases. Other risk factors included access to cash and tendency to "buy" sex partners; likelihood to drink heavily or use drugs when off duty; capacity to impose coercive methods to obtain sex, dangerous and stressful work, and general participation in a "macho" culture (*risk taking initiatives; I can do it belief*).

About 99% of the officers have secondary school level of education and above. This means that majority of the officers can access and even disseminate information among themselves about HIV and AIDS. This is in agreement with MoH (1997), which states that high illiteracy causes inaccessibility to accurate and reliable information about HIV and AIDS. However, knowledge about personal HIV status declines as level of education increases (Table 4.2a). Statistical tests showed chi-square value of $p < 0.05$ at 95% confidence interval and Spearman Correlation R= -0.103, indicating that there is minimal association between the level of education and knowledge about HIV status. The highly educated officers are afraid of knowing their status for fear of stigmatization, as majority of them happen to be highly placed within the Police command.

Majority of the officers (156) have worked for between 10 and 20 years (Table 4.3a). The longer the length of service, the more resources the Police have in the long run invested in the skill development of an officer. The statistical tests on the length of service versus HIV status of officers show chi-square value of $p < 0.05$ at 95% confidence interval and Spearman Correlation R=0.150 indicating a significant positive association.

Many of the officers (84) have served the Force for more than 20 years, 93 having served for between 6 to 10 years with only 72 serving less than 5 years. This indicates that most of the infections occur while the officers are in employment and is attributed to the vulnerability of the officers. The Police invest in the training of officers' right

from the initial course and continue to train until retirement. HIV testing is not a prerequisite in staff selection and hence with many years of experience an officer is presumed to have thorough knowledge of Police practical procedure including application of various laws and sections of the law. These knowledge, skills and qualities are eventually lost when an officer die of AIDS, which can be prevented unlike other causes of death while on duty.

About 79% of the officers are married with only 17% being single while a small proportion (4%) are divorced, widowed or separated. This corroborates findings by the MoH (2005). Marriage and other long term monogamous relationships do not protect one from HIV infection. Sexual contact forms part of 70% to 80% of HIV transmission modes (Kiragu, 2001). With over 50% of infection occurring in marriage, the vulnerability of officers to HIV infection increases in marriage due to the fact that partners rarely used any form of protection like condom and are always far separated from one another.

However, awareness and knowledge about HIV and AIDS among Police officers was found to be very high, which is the case generally in Kenya and in most Sub–Saharan countries with similar conditions regarding HIV and AIDS. According to Milkowski (2004), literally everybody in Kenya (89%) has heard about HIV and AIDS and knew that it is mostly a sexually transmitted infection. One hundred percent (100%) of officers interviewed are aware of HIV and AIDS as compared to 99% in MoH (2005). However, of the 27% of officers who do not know their HIV status, 75% are willing to

test for HIV. Many perceive themselves as being at very low risk of contracting the virus by being faithful to one partner when the partner might not be faithful. Quite a number of the Police officers (27%) have not tested themselves for HIV despite having VCT centres near or within selected Police stations.

There is significant variation in HIV prevalence rates across the country (KHFF, 2005). Prevalence rates are much higher among urban, as compared to rural residents. Studies have found that the general awareness of HIV and AIDS in Kenya is high. However, accurate knowledge of HIV is still relatively low and significant misconceptions remains. Some of these include:

(a) The idea that someone can only be infected if one has unprotected sex with an infected partner.

(b) Having only one faithful partner prevent HIV infection.

(c) HIV cannot be transmitted through oral sex.

(d) HIV positive people need not use condom during intercourse.

(e) Showering after intercourse will prevent AIDS among others.

The results indicate that the HIV prevalence rate in the Kenya Police is 7%. However, this could even be higher given that many officers (27%) have not tested themselves for HIV. This corroborates data from key informants' interview which indicates that the HIV prevalence rate in the Kenya Police ranges between 6% and 14% with the likelihood of being even higher.

Officers are vulnerable to HIV and AIDS when they attend to scenes of crime and work far away from family. Those infected and work in remote parts of the republic can not access drugs easily in managing opportunistic infections and they do not live with spouse to care for them. Continuous travel away from duty station usually tempt many into casual sexual relationship as this becomes the best opportunity available while away from the congested and dilapidated Police lines officers live in. For those infected the sanitation and hygiene in the Police lines constitute a problem in the management of the virus.

5.2 Duty allocation and performance

The Kenya Police are the anchors of national internal security, nation building and good governance. The Police are indispensable in national and international humanitarian relief operations as was seen during the 2007 post election violence and in regional and international peace keeping missions. Infected officers are allocated light duties as they can not perform serious operation duties and are low in morale. Many of the HIV positive officers are always on-off duty and when an officer dies, the strength is reduced and performance in the section is generally affected as immediate replacement is never available, hence less meaningful work is performed, reducing the quality of service delivery to the general public within that section.

The result indicates that majority of those officers interviewed (53.8%) have their performance adversely affected while on duty with an infected colleague or one who has developed AIDS. Many officers admitted that they did not expect their infected

colleagues to carry out tasks as is expected of them. This means that while working together, the burden is placed on whoever is not infected. In so trying to cover up for a colleague, the quality of service delivered to the public is reduced. Of the infected Police officers, 66.7% admitted that indeed their performance is affected while on duty and can not perform their work like their healthy colleagues. Officers who are infected but have not developed AIDS have their performance compromised by less severe illnesses and psychological stress. Majority of the infected wants to be assigned certain specific tasks which are less demanding. Stress due to extra work load and fear of HIV infection due to stigma also reduces performance.

While deploying officers, their HIV status, especially those who have indicated in confidence to the command, is considered. The HIV positive officers at some stages, having developed AIDS, are not able to perform other duties adequately such as beat and patrol during the night. This require that they are deployed in areas like report office, or given light duties of supervising those in custody, when carrying out the general cleanliness of the cells and station area. These should be prisoners who are on petty crime charges and the use of firearm is not required in preventing escape from lawful custody in case a prisoner attempts to escape.

The pandemic affects the general operation duties of the Police and subsequently dilute the quality of service delivered to the general public. A whole day riot standby can not be performed by an infected officer. If the riot team consist of a substantial number of infected officers, then the team is definitely not effective should a riot occur. This

obviously means that a gap exists and efficiency is reduced greatly. According to interview conducted for the officers in charge operations at various divisions, it was noted that there is a silent policy of not issuing HIV positive officers with firearm. Instructions are issued from time to time from Police headquarters reminding the station commanders and in-charge armouries that any officer whose status is known to be positive or suspected otherwise is not to be issued with a firearm for whatever reason (see appendix F).

Most officers who have undergone HIV testing on voluntary basis and reported their status in confidence to their commanders makes it easier for the commanders especially when allocating duties. This is because an infected officer is then assigned duties that require no use of firearm. This ensures that the officer do not cause harm to himself, colleagues or to the general public. In some cases as the commanders indicated, HIV positive officers develop hostile attitude towards anybody anytime and are easily provoked when withdrawn due to mood swing. According to an interview by one of the commanders, cases have come up whereby because of stigma, and while drunk, officers abuse one another and such cases end tragically. The effectiveness of the commands is compromised as an infected officer can not perform duties that required the use of firearm, a lot of energy or where the working environment is stressful to cope with. In particular, HIV and AIDS programmes have not been made part and parcel of Police operation duties especially at the division or station level. Such programmes have not been effective in terms of implementation as many officers keep their HIV status in secret unless they are HIV negative.

AIDS is not just a humanitarian crisis, it threatens not just individual citizens, but the very security institutions that define and defend the character of a society (Piot, 2005). The Police readiness to deploy is compromised by HIV and AIDS. Commanders from some stations are worried about being able to deploy effectively on a relatively short notice as a good number of officers are infected (see appendix F). Even when new recruits are posted, readiness and smooth teamwork is compromised when absence is filled in by officers who have not served together previously. Preparedness is also affected as the skills and experience of highly trained individuals are lost due to AIDS and opportunistic infections.

Policing and detective work is largely practical oriented. It required the ability to understand and interpret human behaviour, to think logically, to sum up the demeanour and expression of crime suspects quickly and correctly, and to identify and collect various forms of evidence in such a manner that the prosecution can build up a convincing and coherent case in court (Martin, 2006). Many of these skills can not easily be taught and are acquired and perfected through practice and experience. Good investigation and detection techniques are difficult to teach in a classroom environment, and are usually honed through practical experience in the field. Most Police officers have relatively high skill levels, which are expensive to replace. Once lost, such skills take years to replace. A rapid staff turnover, therefore, undermines the professional capacity of the Kenya Police. Rapid skills drain, brought about by HIV and AIDS, places additional strains on the shrinking number of experienced officers and this

means fewer mentors for new officers and a concomitant increase in the burden placed on the experienced officers. The cost of each HIV infection is likely to be higher.

The efficiency of the Kenya Police at any level depends on the number of officers who "know the ropes" and who have developed their problem solving skills through experience. Absenteeism has been a significant problem in the Kenya Police, although it cannot be clearly quantified or ascribed to AIDS only. Approximately 42% of the commanders interviewed see absenteeism as a serious problem in performance of duty. When absenteeism occurs due to illness of an officer, it can be prolonged and causes significant stress and service disruption. Attendance at funeral of family members or work colleagues is often a social obligatory. These absences have become a significant factor in disrupting work routine.

5.3 Effectiveness of intervention measures

Knowing how long an officer has between with the infection, illness and death is important in plotting the effect of the pandemic on the Kenya Police. The result indicates that 73% of Police officers have been tested for HIV while 27% have not been tested for HIV. Of those who have not been tested for HIV, 75% are willing to go for the test while 25% are not ready to have the HIV test. VCT services were initiated in 1995 in the Kenya police (Kenya Police, 2006a). The workplace HIV testing is an indication of the weak initiatives, which have been put in place by the Police towards making VCT services available and accessible to Police officers. As indicated in Figure 4.7, the numbers of officers who have not tested suggest that the sero-prevalence

among the sample population is likely to be much higher than the 7% indicated in Figure 4.5.

The HIV and AIDS stigma is a major contributing factor to worsening the plight of most people living with HIV. It prevents people from being tested for HIV, and thus increases the risk of transmission. This corroborates findings by IFRC (2008). Officers give many reasons as to why they went for the HIV testing. Almost 80% wanted to know their HIV status and to take control of their lives. This response shows that many officers have taken it at a personal level to know their status. There has been a vigorous campaign against HIV and AIDS in the Kenya Police in terms of prevention and management of the already infected.

Knowledge of modes of transmission of HIV is one of the key determinants of susceptibility of Police officers to the pandemic. The result indicates that Police officers are aware of the various modes through which HIV can be transmitted from one person to another. However, much intervention measures are still required as officers need to understand the other modes of HIV transmission apart from sexual contact. It is important to take precaution especially when dealing with scenes of crimes as only 19.8% indicated this as a mode of transmission. Open wounds constitutes a major source of infection and misconceptions are still large. These findings shows that HIV and AIDS advocacy and awareness campaigns need to put more efforts as more knowledge is required. The HIV and AIDS awareness and prevention campaign programmes need to be regularly updated to facilitate better understanding of credible

research findings, including protecting Police officers against misleading theories about modes of HIV transmission.

Police officers exposure to HIV and AIDS infection, on account of nature and location of the workplace and measures put in place by the Police to counter such exposure, are important indicators of the impact on officers. The public sector workplace policy on HIV and AIDS is clear on measures that need to be addressed to ensure HIV prevention and mitigation of impacts. As shown in Figure 4.10, majority of the officers (56%) indicated that their chances of contracting the virus is high due to exposures while 37% indicated that their chances is low and that they take a lot of precaution during injuries while on duty. Others admitted that while on patrol, commercial sex workers arrested usually offer sex on the way to station to be released and at times one has no condom for protection. This corroborates the view held by AMREF (2006) which states that while on patrol female suspects arrested usually offer sexual favours to officers in order not to be taken to cells or court. This makes officers more vulnerable to the virus than any other group. Due to misconception, some male Police officers (7%) still believe that being faithful to one partner makes them less vulnerable to the pandemic and they consider this a preventive measure yet their partners can be unfaithful.

Majority of the officers interviewed (53.6%) know their HIV positive colleagues and of this 45% know the marital status of those colleagues while 8.6% do not the marital status. About 46.4% of the officers are not aware of any HIV positive colleagues at the workplace. This can increase infection rates among officers. These are indications of

the need to address stigma and discrimination issues and strategic responses for prevention of new infections among the Police officers.

About 64% of the commanders interviewed indicated that officers who are HIV positive and have indicated this in confidence to their superiors are given light duties. Close to 30% indicated that such an officer is allowed to rest when unwell. Approximately 6% indicated that since there is no policy on duty allocation for the HIV positive officers and the fear of stigma, they continue to work as any other normal officer. The mitigation of impact, posed by HIV and AIDS involve adequate investments in human capital, including having a clear legal policy and institutional framework to address critical issues of HIV and AIDS. This study established that many commanders are not aware of the HIV status of their officers. This makes it difficult to deal with the effects of HIV and AIDS, or to enhance evidence based planning and resource allocation towards boosting the capacity of the Kenya Police to respond to the impact of HIV and AIDS on service delivery.

From the results, it can be noted that HIV can be transmitted in three main ways namely sexual transmission, transmission through blood and mother to child transmission. For each route of transmission, there are things that an individual Police officer can do to reduce or eliminate risk. There are also interventions that work at group level. Promoting widespread awareness of HIV through basic HIV and AIDS education is vital for preventing all forms of HIV transmission and this should reach both officers who are at risk and those already infected. Positive prevention is needed

to ensure that those infected do not transmit HIV to others. This can be achieved by encouraging HIV counselling and testing at will.

Mobile populations like the Police have been regarded as vulnerable to HIV infection. Approximately 7% of Police officers are infected with HIV and the primary mode of transmission is heterosexual sex. Sexual behaviour change should be a major focus in the prevention efforts and understanding prevention efforts and changes in behaviour is important for both predicting the future path of the pandemic and the Kenya Police.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the summary, conclusion and recommendations based on the discussions presented in chapter five in line with the research objectives and suggest areas for further studies.

6.1 Summary

The main objective of the study was to determine the impact of HIV and AIDS on service delivery in the Kenya Police. The findings generally confirm trends in existing data, i.e. HIV and AIDS has a negative impact on service delivery in the Kenya Police in much the same way it does to others sectors of the economy. The notion that HIV and AIDS can pose a threat to the nation's internal security has not been a shared view over the course of the pandemic. The vast majority of people living with HIV and AIDS are aged between 18 to 45 years and are in their working lives and most Police officers (87.4%) are in this range. The results reveal that with HIV infection rate estimated at 7%, the Police has a significant role to play in the society as they are generally looked at as role models and are at increased risk of HIV infection because they are more likely to be:-

(a) Young, sexually active, mobile and away from home.

(b) Subjected to periods of stress as well as periods of boredom.

(c) Inclined to risk behaviour, including risky sex and substance abuse.

(d) Deployed where alcohol, drugs and prostitution are easily available.

(e) Often in a position where they have more money and power and more influence than the local population.

With the scourge threatening the Kenya Police, the pandemic is exceptional and the response to it must be equally exceptional. HIV Infected officers are unable to perform the core functions of the Police but only peripheral duties. As many officers die, immediate replacement is not forthcoming. The commands end up with inadequate strength for effective performance. Increase in absence from work and worker attrition is evident as officers fall ill and take, or require time off to care for sick relatives and attend funerals. When an officer dies of AIDS-related illnesses, surviving members are severely affected. This in the long term lead to poor services rendered to members of the public. From the study the prevalence rate of HIV and AIDS in the Kenya Police is estimated at 7%. The pandemic is highly stigmatised in the force, reinforcing officers' unwillingness to admit its reality. One of the formation commanders had this to report: *"I decline to participate in the study due to the nature of operational duties undertaken by members of this unit, but implementation of HIV and AIDS policies are in place within this command"***.**

There is no cure for HIV and AIDS at this point in time. However, there are drugs that can slow the process. The only way to prevent the disease from spreading is for individuals to refrain from behaviours and practices that increase the risk of acquiring HIV and of transmitting to someone else. Thus proper communication of knowledge about the disease, the study and change of social and cultural environment, proper

health care and other factors play an important role in preventing the disease from spreading. There are intervention measures put in place by the Police to reduce vulnerability of the officers. However, these measures are not adequate and have not been rolled down to the station level. Many officers need to know their HIV status and adequate measures put in place to support the infected, prevent infection and reduce stigma in the Police.

6.2 Conclusion

There is ample evidence of the Kenya Police officers' vulnerability to HIV and AIDS. The Chi-square test at 5% level of significance led to the rejection of the null hypothesis of the independence and to the conclusion that quality of service delivery in the Kenya police varied with the prevalence of HIV and AIDS. Majority of officers have worked for between 10 and 20 years while most infection occur to those who have serve the Police Force for more than five years and have develop good skills that are acquired over time. About 79% of the officers are married and this increases their chances of infection. The HIV prevalence rate is estimated at 7% with the possibility of being even higher given that many officers have not tested to know their HIV status. Officers are more vulnerable as they attend to scenes of crime, travel a lot and stay away from family or regular sexual partners.

There is a strong relationship between HIV and AIDS and the allocation and performance of duty in the Kenya Police. Infected officers are allocated light duties even though it is not a policy. Such officers can not perform serious operation duties

and are on-off duty most of the time. The strength of the command is further reduced upon the death of such an officer. The prevalence of HIV and AIDS reduces the readiness to effectively deploy at short notice as certain duties, for example, riot require a lot of physical strength and the use of firearm. There is a silent policy not to issue infected officers with firearm and this determine the kind of duties they are allocated. With sickness and deaths, mentors for new officers are unavailable further compromising the quality of service delivery to the public since Police work is largely practical-oriented and perfected through practice and experience.

There are intervention measures put in place to reduce the prevalence of HIV in the Kenya Police. However, these measures have not been effective. The HIV and AIDS policies have not been fully implemented in many commands. There are weak initiatives at VCT centres. Many centres within Police areas of commands offer HIV counselling and testing only without comprehensive care. Stigma is still very strong in the Police Force and many officers test for HIV status at centres outside Police command. Most commanders are not aware of the HIV status of officers under their commands. This hinder evidence based planning and resource allocation. Misconceptions about HIV and AIDS are still high in the Kenya Police and more knowledge about the pandemic is needed.

6.3 Recommendations

Many existing studies (Schneider and Moodie, 2002; UNAIDS, 2003) comment on the fact that Police forces have a higher than average incidences of HIV and AIDS than the

rest of the population. The Police are highly vulnerable group to STIs mainly due to their work environment, mobility, age and other facilitating factors that exposes them to higher risk of HIV infection. It is difficult to separate vulnerability of society to the impact of HIV and AIDS from specific vulnerabilities of Kenya Police to HIV and AIDS. However HIV and AIDs has a disproportionate negative impact on service deliver in the Kenya Police. The available evidence to date on the links between HIV and AIDS and service delivery in the Kenya Police suggests real, and potential significant, risk to national internal security from the pandemic. The officers are in the sexually active bracket and more vulnerable to HIV and AIDS. Several policy implications were revealed from this study. The following recommendations will go along way into addressing some of these risks.

(a) Better data on the epidemiology of HIV and AIDS among Police officers and the complex relationship between the disease and service delivery are needed. A baseline survey be conducted to find out the prevalence rate in the Police.

(b) Ongoing leadership is required on both the departmental and national levels, which must be transformed from an episodic, crisis management approach to a strategic response that recognizes the need for long term commitment and capacity building, using evidence-informed strategies that address the structural drivers of the pandemic.

(c) Involvement of Police officers in the campaign against the pandemic at the national level and involve experts in the station lectures.

(d) Re-train commanders on the needs of the HIV infected and affected officers. Building human capacity to sustain treatment through training and better use of correct human resources with relevant prevention skills within the Police.

(e) The Police to build her own hospital to effectively manage and improve the healthcare support to Police officers with AIDS and increase training and sensitization for officers to ensure that response to emergencies, whether conflict or disaster are HIV and AIDS competent.

(f) Initiate support programmes for the infected officers and their immediate families. Measures to reduce stigma and social exclusion to be strengthened.

6.4 Suggestion for further study

This study aims at benefiting other scientists who may wish to carry out further or in depth study on the Kenya Police. Many issues relating to the Police and HIV and AIDS have not been explored. Areas of study concern should include among others:

(a) Study to increase understanding of socio-behavioural factors that increase or decrease risk behaviour, hinder or facilitate access to HIV and AIDS interventions.

(b) Study to document the ways in which stigma affects officers, for example, the impact of stigma on their decision to be tested, to engage in risk reduction, to enter medical care and their physical and psychological well being.

(c) The impact of HIV and AIDS on service delivery among the Kenya Military and non military uniformed services, including officers' families and support staff within these organizations.

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APPENDICES

APPENDIX A: Introduction Letter to participants

Dear Sir/Madam,

This study is being conducted by Duncan Ochieng, a postgraduate student at Masinde Muliro University of Science and Technology. I am requesting for your participation during the course of study.

Benefits

By being co-operative to the study, you will be assisting us determine whether HIV and AIDS has an impact on the quality of service delivery by the Kenya Police.

Participation

Your participation is purely voluntary. You are free to decline or accept. The validity of the results depends on obtaining a high response rate, your input is absolutely crucial to the success of the study.

Confidentiality

Your answers will be used for the purpose of the study and for the purpose of improving service delivery in the Kenya Police. Information obtained from you will be treated with strict confidentiality and your personal identity shall not be used in the write up of the research report or on other data that may be linked to any other forums.

Thank you for participating

Duncan Onyango Ochieng
P. O. Box 5999- 00200
NAIROBI
22nd October, 2008

Dear Sir/Madam,

RE: KEY INFORMANT INTERVIEW:

I am a postgraduate student at Masinde Muliro University of Science and Technology and carrying out a research on the impact of HIV and AIDS on service delivery in the Kenya Police and already data have been collected from selected provinces and formations within the Police Force.

To get more in-depth answers and corroborate such data, you have been selected for an interview as a key informant and am requesting for your participation in the survey. Your input will be very much helpful and valued. This will assist us determine whether HIV and AIDS has an impact on the quality of service delivery by the Kenya Police. Your answers will be used for the purpose of the study and for the purpose of improving service delivery in the Police.

Information obtained from you will be treated with strict confidentiality and your personal identity shall not be used in the write up of the research report or on other data that may be linked to any other forums. Thank you for taking your time to participate in this interview.

Yours faithfully

Duncan O. Ochieng

APPENDIX B: Questionnaires

QUESTIONNAIRE 1- Commanders

Prov/Form.……..Div.……..Station.……

Instructions

1. Please respond to all questions and kindly note that all responses are valued
2. For questions where there are no options, you are to answer in own words

Section A: Introduction

1. How many officers are under your command?

   Male [.....] Female […….]
2. Is there a VCT centre nearby? [ ] Yes. [ ] No.
3. How many officers have been tested for HIV?

   Male [.....] Female [……..]
4. How many are HIV positive Male [……...] Female […..….]
5. From your records how many of the infected are on ARV treatment […]
6. Of the infected how many are Married [….] Single […] others […]

Section B: Mitigation Measures

7. How many of the Infected /Affected stay with their families [……..]
8. How does their status affect their performance of duty…….....
9. How many AIDS related deaths of officers were reported in your command within the last one year? [……]

10. Does this affect duty allocation and service delivery in your command

    [ ] YES [ ] NO If yes explain how?……

11. How many officers under your command are on-off hospitals [……] of these how many are due to HIV/AIDS related complications […….]

12. How many officers are admitted in hospitals [……..] Of these how many are due to HIV/AIDS related complications [……]

13. How many officers/support staff are on sick leave [……] of these how many are due to HIV/AIDS related complications [……..]

14. What kinds of duties are allocated to the HIV positive officers? ……

15. How does the officer cope at work? …….....

16. How does this affect your general security operations?…….

17. Does nature of duty increase vulnerability of the officer

    [ ] YES [ ] NO If yes how?.....

18. To perform core functions of the Police how many officers should be under your command on average? [……..]

19. How have you implemented HIV and AIDS policies within your command?.....

20. What can be done to increase the effectiveness of the command?.....

21. Any general observation/comment.……

QUESTIONNAIRE II –Officers

Prov/Form……..Div……..Station……

Instructions

1. Please respond to all questions and kindly note that all responses are valued
2. For questions where there are no options, you are to answer in own words

Section A: Introduction

1. Gender [ ] Male [ ] Female.
2. Age [ ] 18-24 [ ] 25- 35 [ ] 36-45 [ ] 46 and above
3. Marital status [ ] Married [ ] Single [ ] Divorced
   [ ] Separated [ ] Widowed [ ] Others
4. How long have you been in the force?
   [ ] Less than 5 years [ ] 6-10 Years [ ] 10-20 Years [ ] More than 20 Yrs
5. Which parts of the Republic have you served in?……
6. What is your highest level of formal education?
   [ ] Primary [ ] Secondary [ ] College [ ] University

Section B: Mitigation of impact

7. Have you heard of HIV and AIDS [ ] YES [ ] NO
8. How is the virus transmitted……
9. What are the chances that you can contract HIV?
   [ ] No chances at all [ ] Low [ ] High [ ] Has HIV virus
10. Why do you think so?……
11. Have you ever tested yourself for HIV? [ ] YES [ ] NO

12. If YES, What made you have the test……

13. IF NO, do you intent to have the test sometimes? [ ]YES [ ]NO

14. Do you know of any HIV positive officer or of related illness [ ] YES [ ] NO

15. Do you know the marital status of the HIV positive officer

[ ] Married [ ] Single [ ] Others [ ] Don't Know

16. On duty with an infected how is your performance affected?……

17. If you went for the test what was the result [ ]HIV^+ [ ] HIV^-

18. What duties were you performing before you tested for HIV?……

19. Now that you are HIV positive or negative what kind of duties do you perform at present?……...

20. How does your status affect your performance?……

21. What can be done to improve on your performance?……

22. Any general comment or observation.……

QUESTIONNAIRE III – In-Charge VCT Centre

Prov/Form……..Div……..Station……

Section A: Instructions

1. Please respond to all questions and kindly note that all responses are valued

Section B: Demographics

1. When was the VCT centre started? [……]
2. How many people have been tested since inception of the centre?

   [……] Male [……] Female
3. Of the tested how many are Police officers?

   [……] Male [……] Female
4. Of the tested how many are HIV positive?

   [……] Male [……] Female
5. Of the HIV positive how many are Police officers?

   [……] Male [……..] Female
6. Any other comment/observation.……

KEY INFORMANT INTERVIEW

In – Charge Operations*:*

1. How would you describe your overall staffing level?
2. How much staff turnover do you experience and what are the reasons.
3. How deaths have been reported in your command within this year and of those how many are AIDS related.
4. How have you implemented HIV and AIDS policies in your command, is there a policy on duty allocation for those who are HIV infected and if any how does it affect your work.
5. Any comment on how HIV and AIDS impact on service delivery in the Police.

In – Charge VCT Centre

1. When was this Centre started and what is the general response from officers.
2. How many patients have received care here within the last one month?
3. What are the general characteristics of your clients i.e. age, gender, e.t.c
4. Do Police officers visit with their spouses?
5. What types of services are offered here and where do patients get HIV medicines prescription filled?
6. What barriers or challenges do you experience in providing care to the infected?
7. What have you observed among your clients especially police officers as the most common modes of HIV transmission?
8. Any comment on the prevalence of HIV and AIDS and how it affects the Police.

APPENDIX C: Sampled Police Commands

Provinces

Nairobi Area, Rift Valley, Coast, Central, Nyanza, Eastern and Western,

Formations:

Police Airwing, Tourist Police Unit, Railways Police Unit, General Service Unit, Kenya Police College, Anti-Stock Theft Unit, Diplomatic Police Unit, Presidential Escort Unit, Police headquarters- operations branch, Kenya Airport Police Unit, Criminal Investigation Department.

Kenya Police Ranks

(a) Gazetted officers

(i) Commissioners

✂ ♉♉	Commissioner of Police	– CP
✂ ◆♉	Senior Deputy Commissioner of Police I	– S/DCP I
✂ ★♉	Senior Deputy Commissioner of Police II	– S/DCP II
✂ ♉	Deputy Commissioner of Police	– DCP
✂ ◆◆	Senior Assistant Commissioner of Police	– S/ACP
✂ ◆	Assistant Commissioner of Police	– ACP

(ii) Superintendents

◆◆♉	Senior Superintendent of Police	– SSP
◆♉	Superintendent of Police	– SP
♉	Acting Superintendent of Police	– Ag.SP

(b) Members of Inspectorate

◆◆◆	Chief Inspector of Police	- C.I
◆◆	Inspector of Police	- IP
◆	Acting Inspector of Police	- Ag.IP

(c) Other Ranks

(i) Non Commissioned Officers (NCO)

🕛	Senior Sergeant of Police	– S/SGT
➢➢➢	Sergeant of Police	– SGT
➢➢	Corporal of Police	– CPL

(ii) Police Constable - PC

Key:

✂ - Crossed spear, ♉- Lion badge, ◆- Military pattern star, ★- Five pointed star,

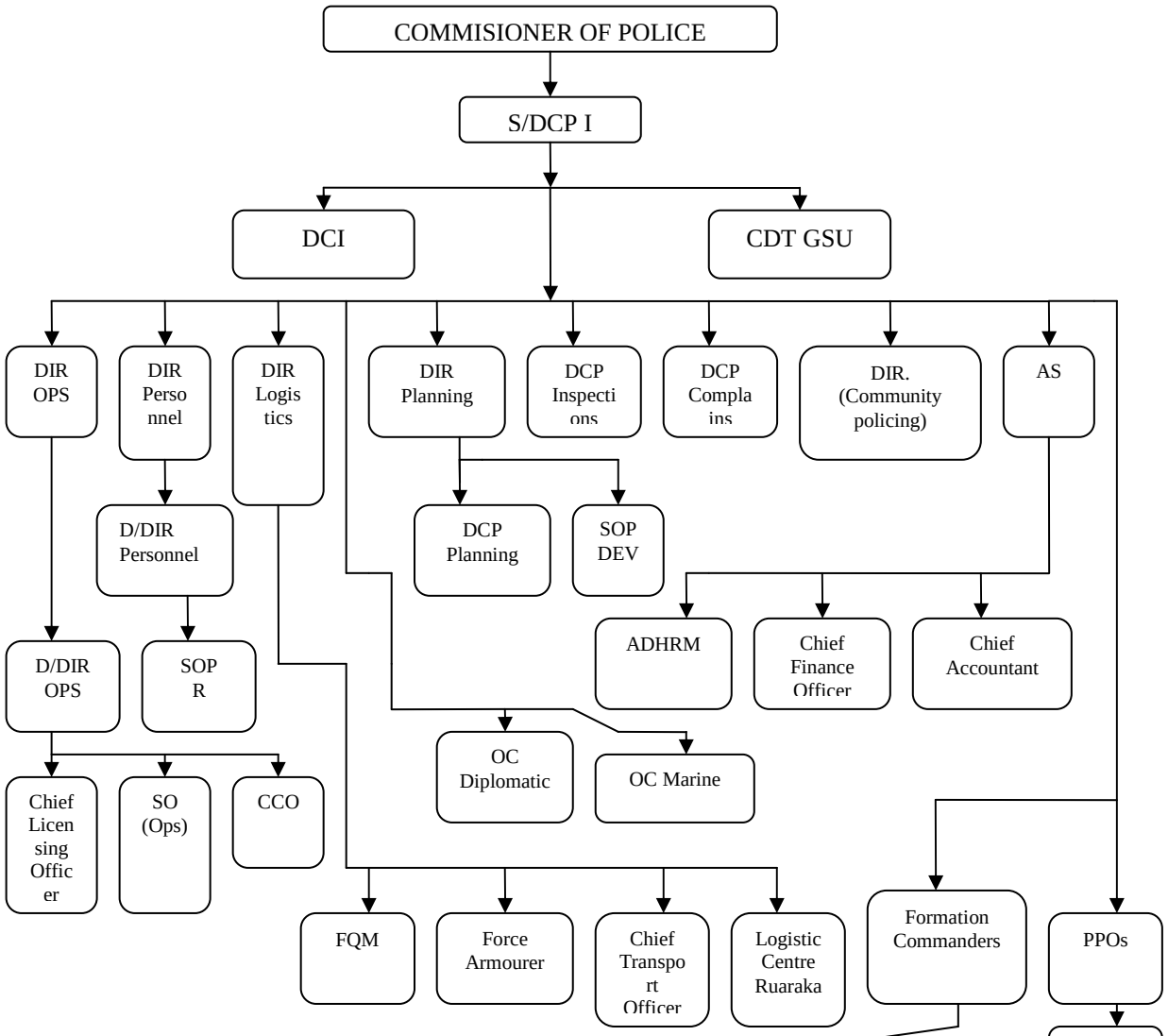
🕛 - Court of arms, ➢➢- Chevrons.

APPENDIX D: Table of statistics from personnel branch
(The annual reports, Kenya Police 2006 and 2005)

	AS AT 31st DECEMBER 2006													
	SDCPI	SDCPII	DCP	SACP	ACP	SSP	SP	CI	IP	SSGT	SGT	CPL	PC	TOTAL
Promotions	-	1	5	11	18	72	108	115	295	55	188	308	-	**1176**
Retirement at 55 years	-	1	2	5	3	11	6	33	25	7	24	16	58	**191**
Retirement under 12-20 year rule	-	-	-	-	-	-	-	-	-	-	3	1	25	**29**
Retirement 50 year rule	-	1	-	-	2	1	1	1	6	1	1	3	3	**20**
Resignation	-	-	-	-	-	1	-	3	11	-	-	4	15	**34**
Dismissal	-	-	-	-	-	-	1	2	4	-	3	13	142	**165**
Removal	-	-	-	-	-	-	1	6	8	-	1	-	21	**37**
Removal on medical	-	-	-	-	-	-	-	-	-	-	-	-	3	**3**
Medical cases	-	-	-	3	4	3	3	2	4	-	6	10	75	**110**
Deaths	-	-	1	-	1	2	3	18	15	1	16	30	300	**387**

	AS AT 31st DECEMBER 2005													
	SDCPI	SDCPII	DCP	SACP	ACP	SSP	SP	CI	IP	SSGT	SGT	CPL	PC	TOTAL
Promotions	-	1	2	3	21	50	99	55	125	117	458	366	-	**1297**
Retirement at 55 years	1	2	2	5	9	19	11	29	60	15	27	40	124	**344**
Retirement under 12-20 year rule	DATA MISSING													
Retirement 50 year rule														
Resignation	-	-	-	-	-	-	-	-	3	-	-	3	11	**17**
Dismissal	-	-	-	-	-	1	1	-	4	-	3	7	102	**118**
Removal	-	-	-	-	-	-	-	-	-	1	-	-	11	**12**
Removal on medical	DATA MISSING													
Medical cases	-	-	-	-	-	6	4	4	5	1	8	12	79	**119**
Deaths	-	-	-	-	-	3	7	8	13	-	10	20	255	**316**

APPENDIX E: ORGANIZATION STRUCTURE OF THE KENYA POLICE



KEY

ADHRM	Assistant Director Human Resources Management
AS	Administrative Secretary
ATPU	Anti-Terrorism Police Unit
CCO	Chief Communications Officer
CDT GSU	Commandant General Service Unit
DCI	Director Criminal Investigation Department (CID)
DIR OPS	Director Operations
FQM	Force Quarter Master
KAPU	Kenya Airport Police Unit
KPC	Kenya Police College
OC	Officer Commanding
OCS	Officer Commanding Police Station
OCPD	Officer Commanding Police Division
OCPP	Officer Commanding Police Post
PPO	Provincial Police Officer
S/DCPI	Senior Deputy Commissioner of Police I
SO- Ops	Staff Officer Operations
SOP (Dev)	Staff Officer Planning (Development/Projects)
SOP (R)	Staff Officer Public Relations

Source: Kenya Police, 2006b

APPENDIX F: SELECTED KEY INFORMANT INTERVIEWS

OPERATIONS

CENTRAL DIVISION – NAIROBI AREA

"This is Central Division of Greater Nairobi Area Province and in this area of command; there are a number of police stations. These include the Central police station, Kamukunji, Parliament and many posts and patrol bases. The division is generally understaffed since officers available for deployment is usually inadequate. This leaves some areas within the command uncovered. Recently, about two and a half months ago, many of our junior officers were deployed and transferred permanently to Mt. Elgon. The replacement has been delayed from the Police Headquarters and this has caused us a lot of work load especially in areas of riot, beats and patrol, bank and premise guard and national events. In the last three years, many officers have been transferred into and out of this command. This has made it not very easy to monitor the staff turnover and in any case, there are no structures and mechanisms in place to monitor this and it is usually done by the personnel branch police headquarters because even us we are subjected to transfers any time to any where throughout the republic. However 4-5 cases of officers' deaths due to AIDS complications known to me were reported. There are no official records to tabulate staff turnover and this leaves the commander with no records but to work with the existing strength.

While deploying officers, their status especially those who have indicated in confidence to the command administration, is usually considered. HIV positive officers at some stages will not perform other duties adequately like beat and patrol especially during the night. This requires that they are deployed in areas like report office, or given light duties of supervising those in custody while they are doing the general cleaning of the cells and station area. These must be prisoners who are on petty crime charges and the use of firearm is not required as such. HIV and AIDS affect the general operation duties in this division and subsequently dilute the quality of service delivered to the general public. A case in point is riot standby. If it is required that you deploy ten officers from your area of command for standby duties for the whole day in town and suppose three or two of these are HIV positive then such a standby team will definitely

not at all be effective should a riot occur. This obviously means that a gap exists and efficiency is reduced greatly.

Besides that, instructions are issued from time to time to remind the in-charge stations and armoury that any officer whose status is known to be positive or suspected should at no time be issued with a firearm. This is because such an officer may cause harm to himself, colleagues or the general public. In most cases HIV positive officers do develop hostile attitude towards anybody anytime and are easily provoked. This again leads to the issue of duty allocation whereby the effectiveness of the command is compromised as such an officer cannot perform duties that require the use of firearm. Suppose almost half of the strength is infected then the command cannot deliver as required. The quality of service delivered by the police is adversely affected by AIDS in that as many officers die, replacement is never forthcoming and the command end up with inadequate strength to perform effectively. Training of new officers and specialized officers is an annual exercise and take long.

The police force should come up with programmes to take care of officers when found to be HIV positive because they get it while on duty as officers are on duty on a 24 hour basis. This will assist their families and not leave the officer to cater for drugs from the meagre pay. This will in one way help psychologically and prevent further spread. But when such an officer takes care of everything from the little pay, he may use his/her powers and privileges to spread the virus even among colleagues. Adequate programme to assist such an officer and his family is very important in boosting their performance and not leave such officers to join national groups for social support".

POLICE HEADQUARTERS

"This section is known as the operations branch and it deals with the day to day running of police activities at police headquarters and includes crime data analysis, general security of police headquarters, scheduling of meetings and events and coordination of operation duties together with other provinces and formations. Currently there is a serious shortage of police constables in this section. This is due to

the fact that a good number of officers under this section were promoted to the rank of corporal to be managers of given sections to head approximately seven to fourteen constables. However when suitable replacements are found, then the issue of understaffing will be sorted out amicably.

The staff turnover has been on the minimal in this section. Over the years, this section, just like any other sections or divisions of the police, lost officers at higher rates especially due to AIDS. However many cases have now been taken care of by the introduction of ART and no deaths from AIDS related complications or from any other cause has been reported within this year. All officers in this section are subjected to normal transfers and suitable replacement found. HIV and AIDS programmes have been made part and parcel of police operation duties in this section. Most officers in this section have undergone HIV testing on voluntary basis and as their in-charge; I have this report in confidence from individual officers. This information is very vital to me especially when allocating duties; we have a silent policy of not issuing HIV positive officers with firearm. This is meant to minimize cases of misuse of firearm. In the past, cases had come up whereby because of stigma, and while drunk, officers abused one another and such cases ended in a tragic manner. Again an infected officer may feel demoralized and withdrawn and end up misusing his or her firearm on himself, colleague or members of the public. This issue of firearm also touches on duty allocation where an officer whose status is known to us to be positive must now be allocated duties in areas that do not require the use of firearm, a lot of energy or the working environment is not stressful to cope with. Hence generally this issue of HIV and AIDS affects the general operation of the police and the nature of response and quality of response delivered in performance of duty.

Many officers who have been tested and found infected have to take care of themselves and family from the little salary they are paid. This again reduces the quality of service delivery because the officer will be so much stressed on duty looking for other sources of income to supplement for drugs and provide for the family upkeep given that in most cases even the spouse is infected and children affected. In most cases, we try very much

especially on the request of the officer to transfer him or her to a police station nearer to home to enable his or her immediate family to take care of the officer especially in administration of drugs and proper diet apart fro social comfort. When such is not possible, I take my own personal initiative to find for such an officer a suitable accommodation where he or she can live with family comfortably and ensures that water and sanitation is available even if it means squeezing out other officers from a house. All this only happen when an officer is open enough to declare to me in confidence his or her HIV status.

This section is however not in a position to monitor the health of officers effectively especially those infected and I strongly recommend that the police should by now have its own hospital where officers can be taken care of medically. This will also help in increasing efficiency because seeking medical services in government hospitals takes longer than expected and the private hospitals charge what officers cannot afford given that the monthly medical allowance is Ksh. 495 for police constables, who are the majority. The police have doctors and nurses to deploy in this hospital. This will ensure that infected officers and family are properly taken care of by the police by managing their condition and this will relieve many of stress and definitely performance will improve. If not properly checked, the scourge might disable the police in the long term. This will not only be a threat to the police as a department of the government but also to the internal security of the nation. This is because officers will not be in a position to perform the core functions of the police but only peripheral duties and this will lead to upsurge of crime and the nation might not stand".

NGONG DIVISION

"Ngong division covers Ongata Rongai, Ngong and Kiserian police stations and other police posts and patrol bases. With the rapid growth of population and structures coming up at an alarming rate, the general strength is low given that we have to cover a very sensitive area in terms of crime as it used to fall under Rift Valley Province but due to high crime rate and with ease of communication it was transferred to Nairobi Area to effectively deal with crime. Some of the duties performed include the night

rounds and beat duties. The night rounds starts as early as 6 – 9 pm and beat from 10 pm – 6am in the morning. We are at the same time required to provide the much needed operation support at the Nairobi Central Business District. On a daily basis we provide 12 constables, 1 Non Commissioned Officer, 1Inspector and a vehicle to maintain law and order. Providing this strength to the city leaves this command with no officers to perform day patrol which is also a very important crime prevention measure.

Within the command, we have no mechanism in place to monitor staff turnover. However at present only 5 officers who were involved in a road accident while on duty are admitted into hospital with multiple fractures and injuries. In the last one year, only one death of officer from pneumonia was reported in this command. There is no work place policy in place to deal with cases of infected officers and as such even the command is not aware of the status of officers and consider this a personal issue which does not require our attention and as such all officers are treated as healthy and capable while allocating duty. What is known to us is that HIV and AIDS is a work place issue and as such we do organize with Police headquarters to give lectures because it reduces the effectiveness and efficiency of an officer thereby reducing on the quality of that officers output".

LANGATA DIVISION

"Langata division covers Langata police station and the estates include south C, Nairobi West, Mugoya, Baraka, Ngei 1 and 2, Otiende, Hardy, Karen and Riruta Satellite. It is within the Nairobi West District of Nairobi Province. The overall strength level is not adequate or sufficient and many more officers are required to be able to deal with the ever changing policing needs of the division as new estates and businesses do sprung up each and every day. The strength level affects operation in this command in that once the available personnel is deployed, other areas seen as less sensitive are left uncovered and when an incident occurs in that area, then we have to move personnel to attend to the incident and as such again leave another area unattended to causing a lot of movement up and down and an upsurge in crime incidences.

The command experienced transfers and replacements are still being awaited. In most cases, replacement is usually from the police college when recruits pass out which will be somewhere in early 2009. The deaths reported of officers within this year were one officer who was sick for a while, one died while on duty and another died a natural death. However none was of HIV complications. Within the command, there is no workplace policy on HIV and AIDS, however out of our own evolution, when an officer is sick, irrespective of the nature of sickness; such an officer is given light duty like radio room duties. Although it is not an official policy, HIV positive officers are also not issued with firearm but instead deployed in areas that require no use of such weapons. An infected officer might not be effective like his or her healthy counterpart in performance of duty especially those that are labour intensive like riot, and in any case such an officer do strain a lot to deliver services to the public especially when suffering from opportunistic infections and this reduces the quality of service delivered to the public".

VCT CENTRES

NAIROBI AREA HEADQUARTERS

"This VCT centre was established in the year 2005. It serves both police officers and members of the public. Based at the provincial headquarters, many officers found this centre very much appropriate to have the test. Of late many have opted to have the test in some other places rather than come to the centre for the test. This is because many female spouses of officers have now taken it upon themselves to have the test here and from the records which we have as at now, the prevalence in the police is approximately 14%. This is actually considered double the national prevalence rate.

Within the last one month alone, we have attended to 165 client's majority of who are female spouses of officers between the ages of 20-35 years. Our client base consists of people of all gender and age with those below 40 years of age being the majority. Police officers are not comfortable coming for the test here but their spouses are very comfortable. Besides that many people who work around here are our frequent customers. In this centre we offer counselling and voluntary testing for HIV, those tested positive are referred for comprehensive care at centres like Kenyatta National

Hospital, Nairobi Hospital, Mbagathi District Hospital or to any centre in Nairobi nearer to the residence of the client for collection of medicines. TB testing is also carried out at this centre.

Some of the challenges we face here is the lack of enough personnel. At this centre, counsellors are police officers. As police officers, they are still bound by the rules and regulations of the force. Training of personnel as counsellors depend on provisions allocated by the police headquarters and not on the demand as required by the centre. As counsellors there is no special provision in terms of allowances but every emolument is just like any other officer including promotion. This is not very much motivating given that we deal with human life in a very special way. Many of our clients who visit this centre admitted that they contracted the virus from unprotected sex with an infected partner. The prevalence rate at present can be approximated to 14% from the number of police officers and their spouses who have visited the centre. This definitely affects the performance of the police adversely given that many who have tested positive cannot perform core police work at the same level with the uninfected".

SOUTH B

"The VCT centre was established in 2005 and has been serving both police officers and members of the public. Generally police officers are the main clients however as it has been noted, many officers prefer to be tested in VCT centres in areas where they are not known than come to us fellow officers who are counsellors for testing. There is still that fear amongst police officers. On average, this month alone we have received 50 clients and they are mostly youths between the ages of 18-30. The majority is usually female and we have realized that female clients are more concerned about knowing their HIV status unlike the male clients who are few in number. This is contrary to even the general population in the police where males are more than female officers unlike the general public where females are the majority.

This centre serves the general public even though it is supported by the police. We do encourage those who come for testing especially married couples to visit together. This

response has been taken positively and even officers do visit with spouses for counselling and testing. At this centre we offer counselling and testing for HIV and those found infected are referred for treatment at comprehensive care centres like Kenyatta National Hospital, Mbagathi District Hospital, Industrial Area Prisons, South B PMCT centre or any other that the client might have in mind depending on where one resides.

There are a number of challenges faced by this centre in provision of services. The test kits are usually never enough. This is because we at times experience an influx of clients and these kits have to be brought from police headquarters ACU that in turn get them from the government supplier. This chain of procurement sometimes delays the items to the centre. On staff morale, we find that most of the work done here as monthly reports or returns are done at the counsellors expenses, besides that we have to file these returns to police headquarters and in Makadara using our own means of transport as no funds have been allocated for such. On career progression, we counsellors are not recognized by the provincial or formation commanders for the purpose of promotion. The ACU police headquarters also leaves this role to these commanders. We feel that a good structure should be put in place to consider counsellors along side other officers for promotion and not look at our work as not being core functions of the police.

Many clients who visit this centre and tested positive admitted that they were infected from unprotected sexual intercourse with an infected partner. This mode of transmission is the most common among our clients. The prevalence of HIV was very high when this centre was started but since then, from our clients we have realized that it has drastically reduced to between 6%-7% especially in the police. This might be attributed to the major campaigns that have been launched to sensitize people on the disease. The ART has also prolonged the lives of many and deaths have reduced. This virus is having a negative impact on the police in that just as it weakens the human body, it also weakens the police as many officers who are infected are not able to perform at per with colleagues who are not infected".

KAPU – EMBAKASI

"This VCT centre was established in August 2008 in response to the fact that the Embakasi airport police line has over 500 police officers and the general public population around this area is large. Many of our clients are police officers, their family members and also members of the public. In the last one month alone a total of approximately 140 clients visited the centre for counselling and testing. Many of them were between the ages of 20-30 years and female clients out weighted their male counterparts in knowing their HIV status.

In most of the cases we have attended to, many clients do not come with spouses especially police officers. Many opt to come for the test alone and the same apply to their spouses. The services we offer here include Voluntary Counselling and Testing, TB clinic and where a client has been infected, then we refer them for comprehensive care centre in Kenyatta National Hospital, Dohnholm, Mukuru Kwa Njenga or any other place for collection of medicine, depending on where the client resides. There are many challenges that we face here at the centre. One is the lack of equipments like the CD4 machine. Once a client has been tested and found positive, then such a client must be referred for specialized diagnosis because we lack the equipments to do that and the capacity to dispense drugs as this require medical doctors when we are only counsellors. This means that we require the training in order to serve our people well. The support we get from the police especially the command under which we fall is not enough. There is not enough recognition of the role we play and this reduces our morale as service providers.

Many of the clients who test positive in this centre admit having contracted the virus through unprotected sexual intercourse with an infected partner. The HIV prevalence is generally high for those who have visited the centre and given for police officers it is on an approximate value of 10%, this affects the general performance of police work e.g. patrols and beat during the night. Such officers cannot perform these tasks in the cold night. This will in the long run reduce the efficiency of the force".