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THE IMPACT OF HIV ON THE SEXUAL HEALTH OF KENYA'S YOUNG GENERATION

BY LAURA LEE

SUMMARY

- Kenyans aged 15-24 have been identified as particularly vulnerable to HIV, sexually transmitted infections and related health issues.
- Over the past two decades, Kenya's Ministry of Health has recognized that reproductive health among youth requires specialized attention, and has worked to develop policies that support youth-friendly sexual and reproductive health services.
- New HIV infections among Kenyan youth continue to be high—despite government-led efforts—and require further action to improve the socioeconomic situation of youth in order to see results on the HIV front.

Sub-Saharan African youth between the ages of 15 and 24 are particularly vulnerable to HIV and other sexually transmitted infections (STIs) (Bankole, Singh, Woog, and Wulf, 2004; Khan and Mishra, 2008), representing 41 percent of all new infections across the continent (UNICEF, 2011b). Globally, it is estimated that 2,500 new infections occur each day among youth, 79 percent of which take place in sub-Saharan Africa (UNICEF, 2011b). Though the World Health Organization defines 'youth' as 10 to 24 years old (NCPD, 2003), the 15 to 24 age group represents the largest risk category in contracting HIV.¹ In addition to HIV and STIs, these youth are prone to early pregnancy and subsequent anaemia, high-risk births, maternal malnutrition and development of obstetric fistulae (Bankole et al., 2004; Hindin and Fatusi, 2009).

¹ It is important to note that as UNICEF (2011a) points out, young adolescents (10 to 14 years old) are in a significant period of behavioural development and it is essential to work with them to create an enabling environment in which they can make choices that benefit their sexual health.

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As Kenya's National Coordinating Agency for Population and Development (NCPD, 2005: 13) states, the "relationship between a nation's development and the health of its adolescents and young people is of paramount concern." With youth populations increasing across the continent, subsequent demands for employment opportunities and social services have been seen as an economic burden (NCPD, 2003), even though youth are a critical resource to African nations and represent an untapped source of creativity and ingenuity (Christiansen, Daniel, and Yamba, 2005). It has been shown that the youth-to-adulthood transition is a key stage in shaping future health decisions, as they tend to be reproduced over time and across generations (Frohlich and Potvin, 2008; Graham, 2002: 2009).

The UN recognized health inequalities across generations and the importance of young people's sexual and reproductive health at the 2001 UN General Assembly Special Session on HIV and AIDS, and pledged to reduce HIV prevalence in young people by 25 percent by the end of 2010. Many countries have worked to meet these targets and make health services and behavioural messages more accessible; but, by 2009, global HIV prevalence among youth had only fallen by 12 percent (UNICEF, 2011b). Another strategy was developed in 2010 by the Joint United Nations Programme on HIV/AIDS (UNAIDS) called 'Getting to Zero.' This new program acknowledged the inadequacy of prevention efforts among youth, and a new goal was introduced: to reduce new infections in young people by 30 percent by 2015 (UNICEF, 2011b).

SEXUAL AND REPRODUCTIVE HEALTH AMONG KENYAN YOUTH

Kenya is a young nation, with 45 percent of its population aged less than 15 years, and 19 percent aged between 15 and 24 (KNBS and Macro, 2010). With a nation-wide HIV prevalence of 7.4 percent, AIDS-related deaths pose a direct threat to young people and have led to mass orphaning throughout the country. UNICEF (2009) estimates that 2.4 million children in Kenya are orphans, 47 percent of whom have lost parents to AIDS-related complications. As orphans or young caregivers to their sick parents, many live in unstable socioeconomic environments, being forced to leave school and earn money for the family (NCPD, 2005). Harmful practices such as female genital cutting (FGC), sexual abuse and forced marriages

present further risks for Kenya's young women and girls (NCAPD, 2005; NCPD, 2003). At present, violence committed against young people is under-reported; it has been shown that only half of victims report their experiences of violence (KNBS and Macro, 2010). The HIV prevalence among young women aged 15 to 24 is four times higher than among young men, demonstrating profound age- and gender-related issues associated with sexual health (KNBS and Macro, 2010).

The violence following Kenya's 2007 presidential elections—where over 1,100 people were killed and another 600,000 displaced—has also affected Kenya's progress in reducing HIV prevalence (Kanyinga, 2011; UNICEF, 2009). Antiretroviral therapy (ART) programs were interrupted, leading to rapid treatment failure (Pyne-Mercier et al., 2011), and increased incidence of rape exposed victims to new infections. Further, internally displaced people (IDPs), living in and out of camps were shown to have been at increased risk of HIV-related death (Feikin et al., 2010).

Young people living with HIV contract the virus 'vertically' through the mother, 'horizontally' through unprotected sex (including rape and child sexual abuse), or through intravenous drug use (UNICEF, 2011a). The severity of mother-to-child-transmission is often hidden as almost half of children infected at birth die before age two (UNICEF, 2009). With the improvement in prevention of mother-to-child transmission (PMTCT), further infections among young children are being prevented and many who were infected at birth are now approaching their teenage and early adulthood years (UNICEF, 2011a). With high youth fertility rates and HIV prevalence, it is essential that access to health services, including PMCT, continues to improve; in the past decade, the percentage of young people accessing maternal health services in Kenya has only increased slightly, as compared to the general population (KNBS and Macro, 2010).

Though Kenya's National AIDS Control Commission (NACC) was created in 2001, 95 percent of the HIV/AIDS budget is still donor-funded, demonstrating the government's lack of commitment to combating the virus (National AIDS Control Commission, 2010). Tackling governance issues and poor leadership are still in need of close attention in the policies or programs around adolescent reproductive health.

KENYA'S RESPONSE TO YOUNG PEOPLE'S REPRODUCTIVE HEALTH

Momentum on adolescent reproductive health began in 1994 when there was a call to action at the International Conference on Population and Development. It was explicitly stated at the conference that action was needed among youth populations (NCAPD, 2005). In the following years, many countries abolished laws that prohibited young people from accessing health services. When it comes to specific service provision in Kenya, young people and adolescents are still a neglected group, despite their specific psychological and biological needs, high prevalence of sexual abuse and high risk of STIs, HIV and pregnancy (DRH, 2005). The new millennium, however, has brought increased focus to reproductive health with the revised Children's Act promoting children's and young people's rights (NCAPD, 2005). Increased funding has also been provided to meeting the social and health needs of orphans and vulnerable children (OVCs), but such programs only focus on those 18 years and under, leaving out many other young people requiring services (National AIDS Control Commission, 2010; UNICEF, 2009).

The 2003 Kenya Demographic and Health Survey revealed that almost one-quarter of young women aged 15 to 19 were either pregnant or already mothers, and further, that teenage fertility was on an upward trend (NCAPD, 2005). With 50 percent of new HIV infections in Kenya occurring among 15 to 24 year olds, it was recognized that the development of youth-friendly services was imperative (DRH, 2005). As a result, Kenya's Department of Reproductive Health worked to develop the Adolescent Reproductive Health and Development Policy in 2003 (NCPD, 2003) and put together a 'plan of action' for youth from 2005 to 2015 (NCAPD, 2005). The 2003 national policy declares:

The high fertility rate among youth and adolescents is attributed to lack of access to needed reproductive health information and services, perceived hostility of service providers who at any rate lack the appropriate skills for dealing with adolescent reproductive health problems, and a policy structure that is inadequate for the needs of young people (NCPD, 2003: 9).

A study on attitudes of nurse-midwives in Kenya, the core reproductive health care providers for youth, revealed a tendency to disapprove of youth sexual activity and emphasized the need to deal more empathetically with youth sexuality (Warenus et al., 2006). In 2005, the Department of Reproductive Health developed guidelines for youth-friendly services that are available, accessible, affordable and cater specifically for the needs of youth (DRH, 2005).

The resulting Plan of Action, written in 2005, (NCAPD, 2005) recognized “poor enforcement of existing laws and policies that guarantee the rights of adolescents, especially those who find themselves in difficult circumstances” as one of the main challenges affecting health. But even in 2011, with youth-friendly policies and regulations in place, levels of new HIV infections among young people continue to be high. There is also gender inequity shown in the feminization of the epidemic (UNICEF, 2009). In order to reach the goals set for 2015, more needs to be done to curb the epidemic among Kenyan youth and to operationalize the laws that are in place.

BALANCING THE ‘BEHAVIOURAL’: CREATING AN ENABLING SOCIAL ENVIRONMENT FOR YOUTH

The most recent report from the NACC shows a rise in HIV prevalence, and is “raising questions on the effectiveness of the Behaviour Change Communication Strategy” (National AIDS Control Commission, (2010), p. 51). The emphasis on behavioural approaches to youth sexual health, which aims to educate young people about risks and reproductive decision making, is prominent in Kenya (Cho et al., 2011). The Plan of Action recognizes that “improving young people’s reproductive health is therefore key to improving the world’s future economic and social well being” (NCAPD, 2005, p. 12).

Yet resources for adolescent reproductive health in 2005 were largely allocated to the development of youth-friendly support services (86 percent)² and behaviour change communication (10 percent) (NCAPD, 2005). Though socioeconomic factors receive some attention in the Kenyan policy, there is still a need for a more concerted effort on improving the economic situation of youth and creating an enabling social environment. This is critical to improving reproductive health and minimizing the risk of

² Prevention initiatives have tended to be focussed on schools, making them inaccessible to out-of-school youth (National AIDS Control Commission, (2010).

contracting HIV at an early age. Studies have shown that knowledge of HIV/AIDS is not strongly associated with behaviour; rather, factors such as lack of food or land ownership, not living with relatives and being out of school were more influential (Nzyuko et al., 1997; Okal et al., 2011).

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