An Examination of How political Factors Have Influenced the Effective Participation of Men in HIV/AIDS Prevention Campaigns in Kenya: A Case Study of Selected Government Ministries in Nairobi Kenya

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ABSTRACT: HIV/ AIDS is the fourth most common causes of premature deaths in the world and the leading cause of deaths in Africa. The fight against HIV/AIDS is of public concern because the epidemic could undermine the collective development effort. In staging this effort, the participation of both men and women is critical in combating the scourge. However, it is evident that the participation of men in Kenya has been minimal or non-existent in the various intervention strategies. This paper is based on a study that was carried out in Nairobi, Kenya, to establish the reasons of non-participation of men in the HIV/AIDS prevention initiatives. The main objective of the study was to establish political factors, among other issues, that influenced effective male participation in the HIV/AIDS campaigns within government ministries based in Nairobi. The study adopted an explanatory research design to collect quantitative data. A sample size of 59 respondents who were obtained from the selected government ministries in Nairobi, Kenya. Simple random sampling was used to select respondents from the target population. Secondary data was gathered from various authoritative sources including books, government records, published and on-line journals. Data was analysed using the statistical package for social sciences (SPSS). Statistical mean and standard deviation as well as percentages was used in interpretations to determine data characteristics, Cronbach's alpha test was also used to establish the reliability of the study variables as well as multiple regression analysis used to determine the predictive power of the study model. From the study findings, it was established that political factors had significant influence on effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi, Kenya. The study therefore recommended that adequate budgetary allocations be considered by the political class to help create capacity that encompasses relevant aids both in terms of infrastructure and management through adequate funding of HIV/AIDS activities as well as gender integration approaches. Issues like corruption and mismanagement be adequately addressed through proper monitoring and evaluation of HIV/AIDS activities across the ministries departments and sections. This can be reinforced through regular audits on HIV/AIDS resource provision and use.

I.   INTRODUCTION

An estimated 1.5 million people are living with HIV\AIDS in Kenya; around 1.2 million children have been orphaned by AIDS; and in 2009 80,000 people died from AIDS related illnesses (UNAIDS, 2010). Kenya's HIV preference peaked during 2000 and, according to the latest figures, it has dramatically reduced to around 6.3 percent. This decline is thought to be partially due to an increase in education and awareness, and high death rates. (UNGASS, 2010). Many people in Kenya are still not being reached with HIV prevention and treatment services. Only 1 in 3 children needing treatment are receiving it (UNAIDS, 2010). This demonstrates that Kenya still has a long way to go in providing universal access to HIV treatment, prevention and care.

One of the Kenyan government's first responses to the epidemic was to publish informative articles in the press and to launch a poster campaign urging people to use condoms and avoid indiscriminate sex as a way of preventing HIV/AIDS. In 1987, the Minister of Health announced a year-long health and education programme, funded by a £2 million donation from Western countries, (AIDS 1986).

By 1987 HIV/AIDS appeared to be spreading rapidly among the population and an estimated 1-2 percent of adults in Nairobi were infected with the virus (AIDS Newsletter, 1986), and between 1989 and 1991 HIV prevalence among pregnant women in the capital had increased from 6.5 percent to a staggering 13 percent (The New York Times, 1993).

The government was criticised for not responding aggressively to the emerging epidemic, unlike governments in its neighbouring countries, such as Uganda where much was being done to reduce the incidences of HIV/AIDS. The government was also accused of playing down the threat of AIDS because of the damage it could do to Kenya's tourism industry. By 1994 an estimated 100,000 people had already died from AIDS and 1 in 10 adults were infected with HIV (AIDS Newsletter 1994). In a speech at an AIDS awareness symposium in 1999, the then Kenyan President Daniel Arap Moi declared the HIV/AIDS epidemic a national disaster and National AIDS Control Council (NACC) was established to respond to the threat posed by the epidemic. Critics argued that in his speech, the President failed to promote the use of male condoms as a preventive measure and one effective way of tackling the epidemic especially among men because, it was reported that they were the ones who demanded for unprotected sex from women who depended on them for economic support.

Kenya's HIV epidemic has been categorized as generalized – meaning that HIV affects all sectors of the population. Nearly half of all new infections were transmitted during heterosexual sex whilst in a relationship and 20 percent during casual heterosexual sex. HIV prevalence is higher amongst specific groups and tends to differ according to location, gender and age. Various studies have revealed high HIV prevalence amongst a number of key affected groups, including sex workers, injecting drug users (IDUs), men who have sex with men (MSM), truck drivers and cross-border mobile populations, (UNGASS 2010).Some of these groups are marginalized within society – for example, homosexuality is illegal in Kenya and punishable by up to 14 years in prison according to the Kenyan Constitution.

Therefore these groups are difficult to reach with HIV prevention, treatment and care messages and the extent to which HIV is affecting these groups has not been fully explored. Up to one third of new infections in 2008 were within these 'most at risk populations' (UNGASS 2010).

In 2008, an estimated 3.8 percent of new HIV infections were among IDUs and in the capital, Nairobi, 5.8 percent of new infections were among IDUs (Strathdee, 2010). Laws prohibiting harm reduction services, such as needle and syringe exchanges, significantly hindered the prevention of new infections among IDUs. HIV infections are easily prevented in health care settings, nevertheless, 2.5 percent of new HIV infections occurred in health facilities during 2008 in Kenya (UNGASS, 2010). It is interesting to note that these groups of people, mostly affected by HIV/AIDS were difficult to reach with messages on prevention and do not want to come out in the open to discuss their sexual orientation habits and hence their non-participation in the HIV prevention efforts and hence the focus of this study.

II. EFFECTIVE PARTICIPATION OF MEN IN HIV/AIDS CAMPAIGNS
The strategy of working with men and boys for gender equality was part of a paradigm shift which came to the fore in the mid-eighties in the continued struggle to seek more effective strategies to achieve the goals of equality, development and peace, which the world has pursued in the last three decades (FIDA, 2011).
In Africa, the most active groups of men for gender equality have been formed by men who have felt left behind by women in organizing for change. They have been formed to fill the gap that men felt as they witnessed women gaining empowerment and providing support to other women in ways that men could never match. The post-Beijing focus on the girl child compared to the boy child proved to be a wake-up call to men, as they started comparing the girl and the boy child, thus recognizing many areas of disparity in the socialization of the boy child. The need for creating new masculinities has become popular as more men seek to understand how to transform male behavior (FIDA, 2011). The shift from the women in development approach to the gender and development approach was proposed after the Nairobi Conference (1985). This approach was embraced with enthusiasm because it seemed to offer yet another hope for the achievement of deeply valued and yet ever elusive goals. The initial stage of embracing and understanding the approach was controversial within the women's movement. Many women felt that it was a dilution or selling out of the women's struggle, while others felt that the new approach was a sound strategy for advancing the women's empowerment and gender equality goal. The gender approach entailed the shift from meeting women's basic needs to the focus on power relations between females and males in society (FIDA, 2011).

Many women today feel strongly that working with men and boys is diluting, diverting and even trivializing women struggle. Many hold the view that because men and boys are the beneficiaries of male privilege and the discrimination against women and girls, they can never fully understand the women's struggle. Many doubt that men and boys can be fully committed to a change that would mean them losing a lot of the privileges they enjoy, and which is bestowed upon them by the society. Traditionally, men and boys have leverage over girls and women. As the understanding of gender dynamics, their social construction,

masculinities, femininity and their impact on all groups in society deepens, it becomes clearer that males have many reasons to want to change, and that gender equality would have benefits for them, but for one reason or the other, they have failed to participate in the change initiatives (FIDA, 2011).

III.   POLITICAL CONTEXT

Political context is the crucial arena affecting research-policy linkages. Indeed, various attempts have been made to explain why certain countries and communities have responded to the crisis better than others. Some of the macro context issues are wealth, income distribution, culture, religion, governance and social cohesion. It is very difficult to analyse the impact of different political systems and governance issues on research-policy links regarding HIV/AIDS. This owes partly to: the absence of information on public sector institutions; the complexity of issues; and the difficulty in comparing data between countries. Nevertheless, for many, it is clear that success or failure in the fight against HIV/AIDS is determined significantly within the realm of politics. Given the sensitivity of the issue, and also the amount of money now involved, HIV/AIDS has become extremely politicized, (Putzel, 2003).

One key aspect of the political context is the degree of freedom, openness and competition within a particular system. Many have emphasised the importance of having an open democracy, but the evidence to support such a claim is mixed. On the one hand, Alan Whiteside, (2002) noted that: 'Condom use and behaviour change messages require a degree of openness in a society which is, unfortunately, not generally present'.The media in many countries has helped raise awareness of the findings of research on HIV/AIDS. However, media freedom is not enough: there are a large number of countries where media freedom exists but the policy response has been muted. The same conclusion applies to competitive politics, where there are success stories in both open societies and those under central control. The diversity of 'success' cases in responding to HIV/AIDS – including Thailand, Senegal, Brazil, Uganda and Cuba – raises interesting questions about what aspects of macro-political context matter. (UNGASS, 2010)

Of particular relevance to this research project, was Putzel, (2003) highlights; the importance of political leadership. This is most clear in the positive cases of Uganda and Senegal and the negative case of South Africa. What is not clear is whether this is a question of luck – or whether there are factors in these countries that make it more likely that those in power will exhibit such qualities.

A general issue is that the incentive structures for both policymakers and researchers are very important. Policymakers need to have more to gain than to lose in taking up the fight on HIV/AIDS. Although governments are increasingly speaking the right language, partly because of external incentives and pressures as well as internal ones, there has still been very little movement on the ground. This raises questions as to whether this is a result of limited real political buy-in or whether it is a question of a problem of implementation capacity (UNAIDS, 2009).

Another key issue affecting research uptake concerns the organization of political authority, (Putzel, (2003) argues that the legitimacy of local leaders and consensus around leadership helps influence the extent to which they listen to the evidence on HIV/AIDS. In particular, the influence of government among traditional or local leaders is crucial to translating policy to action. Putzel, (2003) concludes that we need a better understanding of why it may be legitimate for any leadership NOT to act vigorously on HIV/AIDS prevention. Action could then be taken on the basis of such understanding. A related challenge here is that policy makers often see (or want to see) HIV/AIDS as associated with marginal groups in society – and therefore do not feel pressure to respond. For example, in Eastern Europe and Russia, the major risk groups are drug users and prostitutes while, many politicians in Africa have disparagingly associated the disease with Western homosexuals. The tendency to associate the disease with marginal groups is also occurring in Latin America, (Putzel, 2003).

As highlighted above, implementation agencies and street-level bureaucrats play key roles in research-policy processes. Loewenson and McCoy (2004) outline the challenges for African health systems in this regard. They note the chronic under-resourcing of health systems, the underdevelopment of strategic public health leadership and the attrition of health personnel – issues of concern even before HIV/AIDS hit the agenda. They argue forcefully that health systems responding to HIV cannot be built from a patchwork of non-government, vertical, ad hoc services around a crumbling public sector core. Lack of resources is another key theme affecting the nature of policy response to research findings: funding may not be available to respond adequately. The implementation arena, and lack of implementation capacity, is increasingly recognized as a crucial gap regarding HIV policy. The recent World Bank MAP Interim Review (2004) emphasizes the importance of offering better technical guidance to implementation agencies on good practice, and developing greater technical support capacity especially for scaling up local responses, strategic planning capability, and appropriate national M&E systems to enhance the quality of interventions.

It is important to highlight at the outset the major difficulties with HIV research in developing countries and the major gaps in the data. At the RAPID workshop, Whiteside noted, 'It is very difficult to track

the spread of such a fast developing disease in countries with poor research resources.' Furthermore, data can be highly sensitive; for example, mortality statistics are often contested and denied. In all the main policy arenas – surveillance; prevention; care and treatment; impact mitigation – evidence is missing, unreliable and often politicised. Sue Lucas made the interesting point that the current research agenda is dominated by retrospective input. Often, this is not the most relevant information when thinking about how we should respond next. (UNAIDS, 2010).

IV.   STATEMENT OF THE PROBLEM

Recent estimates peg the total number of people infected with HIV at around 40 million globally. Of these, an estimated two-thirds live in sub-Saharan Africa. In the struggle to combat the spread of HIV/AIDS in Africa, working with men and boys presents one possible approach, given the dominance of patriarchal ideologies and systems and the relationship between the low status of women and the spread of HIV/AIDS, (CHGA, 2011).

Working with men and boys is a new approach and experiences with it are recent, sketchy and much less tested. But the need for finding solutions is urgent and therefore all possible solutions must be employed to combat this life threatening situation. This is not the only way to go, but it is a definite way of getting some solutions.

Research has shown that men's involvement in HIV/AIDS related activities is low compared to that of women not just in Kenya but the world over. In addition, no archival evidence is available to indicate what could be the cause of this low involvement.

V.   OBJECTIVE OF THE STUDY

It is evident that in Kenya, men have not participated in the fight against HIV/AIDS for various factors such as culture, gender issues, policy and political factors. It is been argued that the Kenyan government has not paid enough attention to the HIV/AIDS epidemic prevention but instead given more budgetary allocation to areas such as the military, political parties and infrastructure, travel and so on, (KENWA, 2010). It is in this background that this study sought to establish and document factors that influence effective participation of men in HIV/AIDS campaigns in Kenya (Author, 2011). The study therefore sought to establish political factors that influence men participation in HIV/AIDS prevention strategies (FIDA, 2011).

VI.   LITERATURE REVIEW

The study looked at the literature that related to main objective of the study and that was to establish why men and boys' participation in HIV/AIDS prevention initiatives was minimal and what hindered their participation. The work with men and boys for gender equality is only one of the many strategies and approaches that must be combined to tackle the ever growing problem of inequality, injustice and oppression. The problem is so large, threatening and daunting, that different strategies must be devised to tackle it. The strategies must include women's empowerment, promoting gender equality, gender mainstreaming, the transformation of men and boys from the cultural inhibitions that hinder their participation in useful health habits including HIV/AIDS prevention. This must be done using integrated, people oriented approaches, ensuring sustainable livelihoods and a diversity of other approaches tried and tested in decades of the struggle towards a more equal and just society. (KENWA, 2010)

It is not one or the other, but often the combination of what is most appropriate, relevant or effective in given circumstances. For example, in the struggle to combat the spread of HIV/AIDS in Africa, working with men and boys presents one possible approach, given the dominance of patriarchal ideologies and systems and the relationship between the low status of women and the spread of HIV/AIDS. Working with men and boys is a new approach and experiences with it are recent, sketchy and much less tested. But the need for finding solutions is urgent and therefore all possible solutions must be employed to combat this life threatening situation. This is not the only way to go, but it is a definite way of getting some solutions. (CGHA, 2011)

There are many compelling reasons for involving men and boys in the struggle for gender equality. For a start, whether or not, justly, legally legitimately, fairly or appropriately most men hold the power, authority, control and privileges that are the contention for the gender equality struggle. They must be engaged as they will have to give (up, in, to, away, etc) something for the struggle to be won. Whether this is to be achieved through persuasion, coercion, political struggle, divine intervention, legislation, socialization, policy, social revolution or whatever means, they have to be involved. (FIDA, 2011).

Gender sensitive men as partners, fathers, sons, brothers, judges, magistrates, police officers, permanent secretaries, ministers and heads of state make significant difference because they believe in women and in their empowerment. The men for gender equality approach are a way of recognizing and deliberately mobilizing such men to be part of the solution. They are there in their thousands, and will actively participate in the struggle once the strategy to involve them is explicit and deliberate. (KENWA, 2010).

The work with men is a strategy to multiply the number of men who will defy, confront and transform society and move society out of cultural, social and economic bondage. In the struggle against gender based violence and the spread of HIV/AIDS, which now pose a threat of a magnitude that is unprecedented in the history of our world, women have been and continue to be the greater victims relative to men. Many programmes target women with messages, advocacy, and counsel and support services. Still the problems continue to escalate unabated, causing the continuous and almost desperate search for solutions and answers (KENWA, 2010).

Gender analysis became a key tool for the unearthing of the unequal gender and power relations as the root cause of many of the social and economic ills facing society. The unequal impact of the HIV/AIDS pandemic on females relative to males is a crucial revelation from gender analysis. The powerlessness of women and girls to change their own situations is one of the obstacles that must be addressed. The power dynamics demand that men and boys must become key agents of change and transformation. With this shift of thinking, attention is gradually being turned to men and boys as partners to women and girls, as part of the solution to combating the scourge. Although this approach is still in its infancy, compared to other approaches, indications are that it holds a promise. (KENWA, 2010).

There is now evidence that in Africa more females are affected and infected by HIV/AIDS. However, most interventions have not addressed critical gender issues, for example, gendered and unfair division of labour, unequal access to resources including health care and services, women's powerlessness, low social worth and inability to make decisions even about their bodies. The HIV/AIDS has added burdens to an already over-burdened, powerless, victimized, oppressed and under-valued group. African villages are now overflowing with women victims of HIV/AIDS who contracted the virus in their bedrooms or because they were victims of rape, marital rape, polygamous relationships, incest, economic hardship and despair that drove them to commercial sex work, exploitation by relatives and a myriad of other factors whose root cause is gender inequality (KENWA, 2010).

Women can and are already doing a lot to cope with the pandemic, but men hold the remaining part of the solution. The predominant patriarchal society insists on control, subordination and the under valuing females, stereotyping males as stronger, better, higher value and leaders of women and society. It creates major problems for females and males of all ages, and nowhere has this been as evident as in the current situation where HIV/AIDS has ravaged humanity, especially in some countries of Africa. On the positive side, increasingly, some male visionaries have become aware that men are beneficiaries of an unfair and untenable system in which everybody eventually becomes a loser. The impact of over thirty years of the global campaign for the rights of women and gender equality is slowly transforming even the most patriarchal societies. The Beijing Conference particularly had such a profound impact on the lives of women and men that even in remote villages and communities; it is not uncommon to hear the name Beijing, correctly associated with the empowerment of women (FIDA, 2011).

In Africa, the most active groups of men for gender equality have been formed by men who have felt left behind by women in organizing for change. They have been formed to fill the gap that men felt as they witnessed women gaining empowerment and providing support to other women in ways that men could never match. The post-Beijing focus on the girl child compared to the boy child proved to be a wake-up call to men, as they started comparing the girl and the boy child, thus recognizing many areas of disparity in the socialization of the boy child. The need for creating new masculinities has become popular as more men seek to understand how to transform male behaviour (UNGASS, 2010)

The pursuit by gender responsive men to transform masculinities is the result of many years of study, analysis and experience. In many countries these male gender activists have observed that while patriarchy confers all the power to the male in society, there is a cost to pay for the things patriarchy has taught and allowed them. For example, male domination over women in matters of sexuality and the abuse of such power is a primary factor behind the HIV/AIDS pandemic. It is not a coincidence that the most patriarchal societies are the same societies where the pandemic is ravaging humanity with the greatest impact. The cost of patriarchal excesses manifests in the presence of more men in prisons, mental hospitals, victims of drug and alcohol abuse, and in gangs; and these conditions are also in turn impacting the spread of the HIV/AIDS and the inevitable end in graves (FIDA, 2011).

This fact has not escaped the notice of the visionary men in societies, in developing and developed countries. Attitudes are gradually changing as more men recognize the value and benefits of societies built on principles of gender equality, justice and freedom. Men who are concerned about the future generation of men are beginning to appreciate the need for constructing new and alternative masculinities, which will among other things inculcate gender equality as a social norm. More men are joining in activities to sensitize men on issues of gender and the dangers posed by such evils as gender based violence and the HIV/AIDS pandemic. Through these interventions men have started rethinking their roles and status regarding other issues such as reproductive health, family responsibility, including the nurturing and care of children. The role of men in socializing boys to

develop new masculinities is one of the areas where programmes for the empowerment of the girl child have motivated men to act to empower the boy child.

ii) Masculinity, Men and HIV/AIDS

The concept of masculinity differs from one society to the other, depending on the socio-cultural situation. It is defined as a set of attributes, values, functions and behaviors that are considered normal conditions of men in a given culture. In most societies masculinity is culturally constructed as essentially into a dominant person who discriminates against and subordinates women and other men, especially those who do not conform to similar behaviour. Boys are socialized and modeled along this pattern from birth and through the life cycle. Social systems ensure compliance to this behaviour. Men who deviate from the defined behaviour are ostracized and assumed to take the side of women. The fear of being labeled as women keeps many men and boys from supporting gender equality and defending the rights of women (KENWA, 2010).

The socialization of boys and men regarding sexuality is one of the areas of masculinities that are of major concern to day, in face of the HIV/AIDS, especially in Africa. Most men and boys are socialized to believe that they are entitled to have sex and that it is natural to have many partners. Boys and men are socialized to believe that sex is their right and that they are entitled to it whenever they want it. Girls are socialized to be submissive, service oriented and self-sacrificial. They grow up believing it is their duty to serve and satisfy men. Some women believe the lie that it is natural for men to have many partners or to exercise power over them. Even when they know their partners are involved in risky behaviour, they lack the power to negotiate safe sex and to say no to irresponsible men (KENWA, 2010).

Polygamy is an accepted norm by both women and men in many societies; and multiple partners are justified as a form of informal polygamy. The informal polygamy is seen as a right to have sex with many women without obligations of fidelity or responsibility to the women or the children conceived in these relations. Widow inheritance, abduction, early marriage, female genital cutting and other cultural practices where men are the beneficiaries have increased the threat of HIV/AIDS for themselves and the women.

Men, women and children are at risk of HIV/AIDS. Men's vulnerability is made higher by their patterns of behaviour, modes of socialization, peer pressure, prevailing concepts of masculinity, alcohol and drug abuse, violence, hostile environments, cultural practices and norms. Men have significant control over women's sexual lives. Many use violence, psychological, economic or social pressure to insist on sex with their partners. Further they use the same advantages to have many sex partners. Even when aware of their own vulnerability, most women have little opportunity or power to protect themselves from HIV and other sexually transmitted infections (STIs). Men are placed at risk by masculine values, which discourage them from protecting themselves. In a recent consultation with some men in Nairobi, they traced the risky behaviour many of them indulge in to the way they were socialized and brought up to show masculine prowess and power over women and girls (FIDA, 2011).

Rape among men in prisons is a common occurrence, which may be through consent, rape or other forms of exploitation. Wars and political instability create refugees persons who are particularly vulnerable to HIV/AIDS because of a multiplicity of factors including inadequate protection, poverty, poor nutrition, inaccessibility to health services, the use of rape as a war weapon and forced transactional sex (FIDA, 2011).

Building partnerships between women and men and transforming socialization processes is the key strategy for addressing one of the root causes of the spread of the pandemic, the unequal gender power relations. The fight against the HIV/AIDS pandemic requires the efforts of everybody in society, especially men who hold the power of decision-making at every level of, from the bedroom to the Statehouses and other power bases of policy, politics and resources. Innovative, bold and rigorous approaches to HIV/AIDS prevention and care of those affected are urgently required and men are critical players at all these levels. Countries like Uganda that have made remarkable strides in halting the spread of the pandemic offer useful lessons, especially on how to mobilize and involve critical male players, including children both boys and girls in schools, young women and men in their peer groups, men in faith based groups, trade union groups, work places and communities. Male political leaders have a particularly important role to play in spreading the message, and as the President of Kenya Hon. Mwai Kibaki tells his fellow men in a continuing advocacy programme against HIV/AIDS, the choice is between life and death and they must choose life (KENWA, 2010).

The encounters with the communities lead to the creation of a group known as the "rapid response team" within the network. This team is at hand to support survivors of GBV, most of them young girls and occasionally boys. The team responds by taking survivors to the hospital, getting police and other legal support, counseling survivors and their families and following up on cases in courts to ensure justice is done. The team works in close collaboration with the Coalition Against Violence on Women (COVAW), the Federation of Women Lawyers (FIDA), local leaders, the police, hospitals, media houses and the government administration services to ensure provision of comprehensive services to survivors (UNAIDS, 2010).

Visionary men who have recognized that gender equality is the answer to many of the ills that have bedeviled society are to be found even in the most patriarchal societies. These include village elders who have seen generations of women and men play different roles in society and recognized the equal value of contributions of women and men; also recognizing the complementary nature of such roles. These men of vision also see the dangers of oppressing and subordinating one group of people in society and are the voice of reason in discussions with peers, in counselling younger people, in fighting for the rights of the oppressed and marginalized and in calling society to order. In the fight against HIV/AIDS and gender based violence these men have included prominent men in society as well as men living with HIV/AIDS (FIDA, 2011).

VII. THEORETICAL FRAMEWORK

The study was guided by the AIDS Risk Reduction Model (ARRM), theory. Introduced in 1990, the theory provides a framework for explaining and predicting the behaviour change efforts of individuals specifically in relation to the sexual transmission of HIV/ AIDS.

A three-stage model, the ARRM incorporates several variables from other behaviour change theories, including the Health Belief Model, "efficacy" theory, emotional influences, and interpersonal processes. The stages, as well as the hypothesized factors that influence the successful completion of each stage are as follows (Catania, Kegeles and Coates, 1990).

The theory looks at three major stages of behaviour change:

*Recognition and labelling of one's behaviour as high risk***:** The theory hypothesized Influences*:* knowledge of sexual activities associated with HIV transmission; believing that one is personally susceptible to contracting HIV; believing that having AIDS is undesirable as well as social norms and networking.

*Making a commitment to reduce high-risk sexual contacts and to increase low-risk activities:*Hypothesized Influences*:* cost and benefits; enjoyment; response; self-efficacy; knowledge of the health utility and enjoy ability of a sexual practice, as well as social factors are believed to influence an individual's cost and benefit and self efficacy beliefs.

*Taking action***:** This stage is broken down into three phases: Information seeking; obtaining remedies as well as enacting solutions. Depending on the individual, phases may occur concurrently or phases may be skipped.

This theory was relevant to this study in that it tries to explain why people take action towards the prevention of an occurrence or reasons why they fail to do so. The study was to establish why men participation in HIV/AIDS prevention initiatives was minimal or non- existent. The study also sought to establish the political factors that hindered their participation.

VIII. METHODOLOGY

Study Design

This study employed a triangulation of explanatory and case study research designs that sought to gain an in-depth understanding on the political factors influencing the effective participation of men in HV/AIDS campaigns within government ministries' in Nairobi. Explanatory research will avoid invalid inferences as it focuses on answering the "why" question.

According to Mugenda and Mugenda (2003), a case study is an in-depth investigation of an individual, group, institution or phenomenon. Kombo and Tromp (2006), contend that a case study seeks to describe a unit in detail, in context and holistically. The researcher analyzed in detail the political factors influencing the effective participation of men in HV/AIDS campaigns within government ministries

IX. TARGET POPULATION

Target population in statistics is the specific population about which information is desired. The target population of this study was the 23,550 employees working in government Ministries in Nairobi, Kenya, (PSC, 2011).Mugenda and Mugenda (2003) define a population as an entire group of individuals, events or objects having a common observable characteristic and therefore based on that the study.

The target population of this study was the 23,550 employees working in government ministries in Nairobi (PSC, 2011). But the proportion of the population that had the characteristic to be measured are those employees who deal with HIV/AIDS related issues and weere members of HIV/AIDS committees in each ministry. There are 942 employees in such committees in Nairobi. For this study a total sample size of 59 was considered adequate. Since 59 was the total sample size required, this was picked as a proportion of 942 using stratified random sampling.

A sample size of 59 was considered adequate based on proportion of 942 respondents calculated using the following formula for quantitative data:

$$n \ = \ (1.96)^2 . (0.04) . (0.96) / (0.05)^2 \ = 59 \ (approx)$$

X.   DATA COLLECTION AND ANALYSIS

Data was collected by use of structured questionnaire. The researcher used descriptive statistics to analyze data. This included frequency distribution tables, percentages, mean, modes, median and standard deviation. SPSS and Microsoft excel software was be used to generate the data and other measure of central tendencies and standard deviation.

Age of respondents

Majority of the respondents were below 50 years of age as the distribution below shows: 21.2% of the respondents were found to be below 30 years of age, 36.4% of the respondents between 30 and 39 years of age and 21.2% of the respondents between 40 and 49 years of age.

No	Description	Percentages					Statistics	
2	Age	Below 30 years	30-39 years	40-49 years	50-59 years	60-69 years	Mean	Standard deviation
		21.2	36.4	21.2	18.2	3.0	3.8547	0.9012

Table 1.0 Age distribution of respondents

Source: Survey data (2011)

Respondents' level of education

The study found out that 8.6% of the respondents were secondary school graduates while 40% of the respondents were found to be undergraduates. 42.4% of the respondents were found to possess tertiary colleges' certificates as 8.6%% of the respondents were found to be postgraduates. This partly explains that the respondents were adequately knowledgeable and were capable of giving information with high degree of relevance. See table 4.3.4 for findings.

No	Description	Percentages					Statistics	
4	Level of education	Secondary	Undergraduate	Tertiary college	Postgraduate	Other	Mean	Standard deviation
		8.6	40.0	42.4	8.6	0.00	3.7560	0.8201

Table 2.2 Respondents' level of education

Source: Survey data (2011)

XI.   EFFECTIVE PARTICIPATION OF MEN IN HIV/AIDS CAMPAIGNS

The respondents were asked to rate the extent to which there was effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi on effective participation measures on a five point likert scale. The range was strongly agree (5) to strongly disagree (1). The scores of strongly disagree and disagree were taken to present a component that had an impact to a small extent (S.E) equivalent to a mean score of 0 to 2.5 on a continuous likert scale; (0≤ S.E≤ 2.4). Scores of neutral were taken to represent a component that had an impact of a moderate extent(M.E) equivalent to a mean score of 2.5 to 3.4 on the continuous likert scale: (2.5≤M.E≤ 3.4).

Political factors influencing male participation in the fight against HIV/AIDS

The respondents were asked to rate the extent to which political context influenced effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi on political context measures on a five point likert scale. The results are tabulated in the table 1.4 below:

Constructs	Minimum	Maximum	Mean	Std. Deviation
Effects of political buy in	1.00	5.00	2.8429	1.41302
Effects of lack of implementation capacity	1.00	5.00	3.8429	1.25892
Poor organization of political authority and ineffective participation of men in HIV/AIDS	1.00	5.00	3.6429	1.26358
Effects of chronic under-resourcing of public health systems on participation of men	1.00	5.00	3.5000	1.28338
Effects of underdeveloped strategic public health leadership on participation of men on HIV/AIDS campaigns	1.00	5.00	3.4118	1.21525
Effects of low political freedom and openness	1.00	5.00	2.9857	1.31443

Table 1. 4 Political context

Source: Survey data (2011)

The range was strongly agree (5) to strongly disagree (1). The scores of strongly disagree and disagree were taken to present a component that had an impact to a small extent (S.E) equivalent to a mean score of 0 to 2.5 on a continuous likert scale; ($0 \leq$ S.E$\leq$ 2.4). Scores of neutral were taken to represent a component that had an impact of a moderate extent(M.E) equivalent to a mean score of 2.5 to 3.4 on the continuous likert scale: ($2.5 \leq$M.E$\leq$ 3.4).

The scores for both agree and strongly agree were taken to represent a variable which had an impact to a large extent(L.E) equivalent to a mean score of 3.5 to 5 on a continuous likert scale; ($3.5 \leq$ L.E$\leq$ 5.0). A standard deviation of 1.5 implied a significant difference on the impact of the component among respondents.

From the respondent's views, the study found that lack of implementation capacity (mean: 3.8429) had the greatest impact on the effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi. Other factors that were rated by the respondents as having the greatest impact included: Poor organization of political authority within the ministries (Mean: 3.6429); chronic under-resourcing of public health systems (mean: 3.5000) as well as underdeveloped strategic public health leadership (mean: 3.4118).

Low political freedom and openness (mean: 2.9857) as well as political buy in (2.8429) were found to have a moderate effect on effective participation of men in HIV/AIDS campaigns within government ministries in Nairobi. Table 4.6 has the findings.

XII.   DISCUSSION OF RESULTS

The study found out that political issues were at the centre stage influencing effective of men in HIV/AIDS campaigns. For instance the study pointed at lack of implementation capacity; poor organization of political authority within the ministries; chronic under-resourcing of public health systems as well as underdeveloped strategic public health leadership as epitomizing political impeding effective participation of men in HIV/AIDS campaigns. Low political freedom and openness as well as political buy in were also cited as having varying influences.

The respondents generally acknowledged thatthat lack of proper information, education and communication activities; lack of refresher training, updated information and materials; poor understanding of multiple impacts of HIV/AIDS infection on overall community as well as poor allocation of resources were part of the educational and awareness factors impeding the effective participation of men in HIV/AIDS campaigns. There was also need for the political leadership to support men participation in HIV/AIDS prevention by way of funding such initiatives. As witnessed in Uganda, president Museveni personally got involved in the fight against HIV/AIDS with remarkable positive results. The same spirit should be seen in Kenya by the political leadership which is predominantly male.

XIII.   CONCLUSIONS

The study concluded that there was need to give issues relating to HIV/AIDS campaigns a positive political perspective, lest the pandemic is left to spread and consummate the active economic working class of government employees who were not being encouraged to take the fight of this scourge seriously. To this end, it was concluded that adequate resourcing and strategic leadership were required to take the HIV/AIDS campaigns the next level.

XIV.   RECOMMENDATIONS

This study recommended that the government should build the implementation capacity; ensure that there is proper organization of political authority within the ministries; ensure there are adequate resources in public health systems as well as well developed strategic public health leadership so as to ensure effective participation of men in HIV/AIDS campaigns.

REFERENCES

[1].   Abdool Karim, S. S., Abdool Karim, Q., Preston- Whyte, E., &Sankar, N. (1992) Reasons for Lack of Condom Use among High School Students. South African Medical Journal.
[2].   Abdool Karim SS (2010, 25th February) 'Timing of initiation of antiretroviral drugs during tuberculosis therapy' New England Journal of Medicine
[3].   AEIGS (1999, 3rd December) 'Health-Kenya: President Moi Joins the campaign Against HIV/AIDS'
[4].   African Press International (2009, 11th November) 'The Global Fund supports 2.3 million people on life- prolonging antiretroviral drugs'
[5].   AIDS Analysis Africa (20000 'Kenya calls AIDS a national disaster- but vetoes condoms', Feb-Mar:10 (5):10.
[6].   AIDS Newsletter (1986) 'AIDS in Kenya', Item 265, 31st July
[7].   AIDS Newsletter (1986) 'Facts and figures from the Paris conference', Item 249, 8th July
[8].   AIDS Newsletter (1987) 'Africa', Item 181, 23rd March

[9].   AIDS Newsletter (1987) 'AIDS in East Africa', Item 65, 6th February
[10].   AIDS Newsletter (1987) 'Kenya', Item 254, 10th April
[11].   AIDS Newsletter (1987) 'Military service in Kenya: AIDS risk', Item 14, 15th January
[12].   AIDS Newsletter (1994) 'Economic impact in Kenya', Item 446, 23rd May
[13].   Alan W. and T. Barnett (2002) AIDS in the Twenty-First century: Disease and globalization 2nd Edition Palgrave Macmillan UK.
[14].   Associated Press (2001, 16th July) 'Kenya President shy to talk about condoms as hundreds die daily from AIDS-related illnesses daily'
[15].   BBC News (2006, 2nd June 'Kenya to provide free Aids drugs'
[16].   BBC News (2009, 11th September) 'Kenya bans 'leaky' condom brand'
[17].   BBC News (2009, 29th October) 'Kenya to launch homosexual census'
[18].   Business Coalition on AIDS. "Workplace HIV/AIDS Programs: An Action Guide for Managers" produced by FHI works with businesses in more than 60 countries on prevention and management of HIV/AIDS.
[19].   Business Daily (2010, 9th November) "Calls to reduce HIV risk among health workers'
[20].   Cantania,J.A SM Keggles and T.J Coates 1990. "Towards Understanding of Risk Behaviour: An AIDS Risk Reduction Model (ARRM) "Health Education Quarterly Spring 1990
[21].   Capital News (2010, 25th November) 'KSh 240 million campaign to fight paediatric HIV'
[22].   Cheluget B. (2006) 'Evidence for population level declines in adult HIV prevalence in Kenya', Sexually Transmitted Infections, April, 2006
[23].   Court J. and J. Young (2003) Bridging Research and Policy: Insights from 50 Case Studies, Working Paper 213, London: ODI.
[24].   Court J. and J. Young (2004) 'Bridging Research and Policy in International Development: Context, Evidence and Links' in D. Stone and S. Maxwell, eds, The Challenge of Transnational Knowledge Networks: Bridging   Research and Policy in a Globalizing World, Abingdon: Routledge.
[25].   Court, J., I. Hovland and J. Young (2005) From Development Research to Pro-poor Policy: Evidence and the Change Process, London: ODI.
[26].   Crewe, E. and J. Young (2002) Bridging Research and Policy: Context, Evidence and Links, Working Paper 173, London: ODI.
[27].   Daily Nation (2010, 12th February) 'Kenya misses out on AIDS funds'
[28].   Daily Nation (2010' 12th January) 'Airtime tax to fight AIDS scourge'
[29].   Daily Nation (2010, 16th February) 'Hitch won't delay AIDS drugs'
[30].   Daily Nation (2010, 22nd February) 'AIDS patients suffer as ministries tussle for control of donor funds'
[31].   De Vibe, M., I. Hovland and J. Young (2002) Bridging Research and Policy: an Annotated Bibliography,Working Paper 174, and London: ODI.
[32].   FIDA, (2011) Building partnerships between women and men. HIV/AIDS working paper NO.29
[33].   Flanagan D, Mahler H. How to create an effective peer education project: guidelines
[34].   Hanney, S.R., M.A. Gonzalez-Block, M.J. Buxton and M. Kogan(2003) 'The Utilization of Health Research in Policymaking: Concepts, Examples and Methods of Assessment', Health
[35].   Health International (FHI) UNAIDS. The Policy Project of the Futures Group International :The World Economic Forum's Global Health Initiative The Global Business Coalition on HIV/AIDS The Corporate Council on Africa Asia
[36].   HIV/AIDS Policy Compendium Database that houses most available national HIV/AIDS
[37].   HIV/AIDS: New York State PWS Leadership Institute. XII International Conference on
[38].   Hogle, J.A. (2000).Declining HIV Prevalence, Behavior Change, and the National Response. International Development Contract Number HRN-C-00-99-00005-00.
[39].   Human Rights Watch (2008) 'A question of life or death'
[40].   Human Rights Watch (2009, 14th December) 'Letter to Kenyan Minister of Public Health and Sanitation concerning Home-based HIV testing and Counselling'
[41].   Inter Press Service (2000, 21st February) 'Kenya to produce condoms locally'
[42].   International Treatment Preparedness Coalition (2007, December) 'International Treatment Preparedness Coalition (2007, December) Missing the target #5: Improving AIDS drug access and advancing health care for all'
[43].   IRIN (2001, 12th July) 'Condoms to play key role in HIV/AIDS campaign'
[44].   IRIN (2007, 17th September) 'Muslim opposition to condoms limits distribution'
[45].   IRIN (2008, 22nd October) 'Kenya: Fear of HIV testing keeps pregnant women at home'
[46].   IRIN (2009, 23rd January) 'Kenya: Food shortages threaten ARV adherence'
[47].   IRIN (2009, 28th August 'Kenya: New PMTCT guidelines to save moms and babies'

[48]. IRIN (2009, 9th March) 'Kenya: Female condom shortage'
[49]. Irin/Plus News (2010, 20th August) 'Kenya: TB patients with HIV miss out on ARVs'
[50]. Irin/Plus news (2011, 29th March) 'Kenya: Condom recycling highlights gaps in HIV prevention programming'
[51]. KAIS Collaborating Institutions (2009, September) 'Kenya AIDS Indicator Survey 2007'
[52]. KashiVidapeeth, Varanasi, during February 4-6, 2007.
[53]. KENWA, (2010). Gender relations and HIV/AIDS. HIV/AIDS working paper NO. 11
[54]. Kenya National AIDS Control Council (2009) 'Kenya- HIV Prevention Response and Modes of Transmission Analysis'
[55]. Kenya National Bureau of Statistics (2009, 5th November) 'Official launch of 2008/2009 Kenya Demographic and Health Survey Preliminary Report'
[56]. Kitala, J.M. (2011).A study on the impact of HIV/AIDS peer education program on the management of HIV and AIDS at the Kenya Ports Authority.
[57]. Lee, K. and H. Goodman (2002) 'Global Policy Networks: the Propagation of Healthcare Financing Reform since the 1980s', in S. Fustukian Health Policy in a Globalizing World, Cambridge: Cambridge University Press.
[58]. LifeSiteNews.com (2006, 23rd May) 'Kenya First Lady: Condom 'is causing the spread of AIDS in this country'
[59]. Maclaren-Ross S, Baker H. 'A training program for HIV/AIDS peer support counsellors.
[60]. Marum, E (2008) 'Using mass media campaigns to promote voluntary counselling and HIV testing services in Kenya', AIDS 2008
[61]. McCoy, D., M. Besser, R. Visser and T. Doherty (2002) Interim Findings of the National PMTCT Pilot Sites: Summary of Lessons and Recommendations, Durban: Health Systems Trust.
[62]. Merson, M. (2000) 'Effectiveness of HIV Prevention Interventions in Developing Countries, 'AIDS 14 (supp 2)
[63]. Misra, P. & Agarwal, N. (2005) HIV/AIDS education in India and teacher education, Staff
[64]. Moran, D. and Jordaan,J.A (2007). HIV/AIDS in Russia: determinants of regional prevalence. International Journal of Health Geographics 2007, 6:22
[65]. Moszynski, P (2008) 'Kenyan clerics decide to fight against use of condoms', BMJ, 24th May, 336;7654
[66]. Mugenda,O.M and Mugenda , A.G (2003) Research Methods: Quantitative and Qualitative Approaches. ACTS Press, Nairobi, Kenya.
[67]. NACC (2009, November) 'Kenya National AIDS Strategic Plan 2009/10-2012/13: Delivering on Universal Access to Services'
[68]. NASCOP & Ministry of Health (2006) 'Sentinel surveillance of HIV and STDs in Kenya'
[69]. National AIDS Control Council 'Kenya National HIV and AIDS Strategic Plan 2005-2009/10
[70]. National AIDS Control Council 'Kenya National HIV and AIDS Strategic Plan 2009/10-2012/13
[71]. National AIDS/STD Control Programme (2008) Policy on male circumcision in Kenya', Ministry of Health, Republic of Kenya
[72]. Njue, C (2009) ''If you don't abstain' you will die of AIDS': AIDS Education and Prevention, 2009 April;21(2):169-79.
[73]. Nyaga,R.K., Kimani D.N., Kimen,M.S. and Mwabu,G. (2004). HIV/AIDS in Kenya: 'A Review of Research and Policy Issues'. Paper No. 38
[74]. Ogden J. (2003) 'The Politics of "Branding" in Policy Transfer: the Case of DOTS for Tuberculosis Control', SocSci Med 57(1):179-88.
[75]. Papo, J K. (2011) 'Exploring the condom gap: Is supply or demand the limiting factor' AIDS, 25(2): 247-255
[76]. PEPFAR (2009, December) 'Fiscal year 2009: PEPFAR operation plan'
[77]. Philpott, A. (1999) 'Twists in the Mwanza Tale: Did One HIV Research Study Shift Global Policy?', Development Research Insights 32, December.
[78]. Philpott, A. (2002) 'Translating HIV/AIDS Research Findings into Policy: Lessons from a Case Study of "The Mwanza Trial"', Health Policy and Planning 17(2): 96-201.
[79]. Plus News (2010, 28th May) 'Kenya: Putting HIV positive people at the centre of prevention'
[80]. Plus News (2008, 23rd December) 'Kenya: Nomadic Maasai missing out on treatment'
[81]. Plus News (2010, 18th March) 'ARV woes push universal access off-track'
[82]. Putzel, J. (2003) 'Institutionalizing an Emergency Response: HIV/AIDS and Governance in Uganda and Senegal', Report submitted to DFID, May.
[83]. Strathdee, S A. (2010, 20th July) 'HIV and risk environment for injecting drug users: the past, present and future' The Lancet 6736 (10)

[84]. Surr, M. (2002) 'Research for Poverty Reduction', DFID Research Policy Paper, London.
[85]. Sutton, R. (1999). The Policy Process: an Overview, ODI Working Paper 118, London: ODI.
[86]. Temmerman, M (1992) 'Rapid increase of both HIV/AIDS', Oct; 6 (10):1181-5.
[87]. Temmerman, (1992) 'Rapid increase of both HIV-1 infection and syphilis among pregnant women in Nairobi, Kenya', AIDS,
[88]. The Global Fund: Grant Portfolio 'Kenya and the Global Fund'
[89]. The New York Times (1993, 18th December) 'After years of ignoring AIDS epidemic, Kenya has begun facing up to it'
[90]. Trostle, J., M. Bronfman and A. Langer (1999) 'How do Researchers Influence Decision-makers? Cases Studies of Mexican Policies', Health Policy and Planning 14(2): 103-14.
[91]. UNAIDS (2004) 'Kenya epidemiological fact sheets'
[92]. UNAIDS (2009) 'Kenya HIV prevention response and modes of transmission analysis'
[93]. UNAIDS (2010) 'UNAIDS report on the global AIDS epidemic'
[94]. UNGASS (2006) 'Country progress report- Kenya'
[95]. UNGASS (2008) 'Country progress report- Kenya'
[96]. UNGASS (2008) ''Country report- Kenya', Kenya Office of the President, Ministry of Special Programmes'
[97]. UNGASS (2010) ' Country progress report- Kenya'
[98]. UNICEF (2010) 'Kenya: PMTCT'
[99]. USAID (2007, July) 'Measuring the degree of S&D in Kenya: An index for HIV/AIDS facilities and providers'.
[100]. WHO/UNAIDS/UNICEF (2007) 'Towards universal access: Scaling up priority HIV/AIDS intervention in the Health Sector'
[101]. WHO/UNAIDS/UNICEF (2009) 'Towards universal access: Scaling up priority HIV/AIDS intervention in the Health Sector'
[102]. WHO/UNAIDS/UNICEF (2010) 'Towards universal access: Scaling up priority HIV/AIDS intervention in the Health Sector'
[103]. XII International Conference on AIDS, Geneva, 1998.