

**HIV/AIDS IN THE SLUMS OF KENYA: INTERVENING THROUGH EFFECTIVELY  
UTILIZING VOLUNTEERS**

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# **HIV/AIDS IN THE SLUMS OF KENYA: INTERVENING THROUGH EFFECTIVELY UTILIZING VOLUNTEERS**

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HIV/AIDS affects millions of people globally and has significantly impacted public health for decades. In Kenya, the effects of HIV/AIDS are widespread, but slum areas have an adult HIV prevalence rate twice as high as the national rate. Slums are characterized by scarce resources, making HIV prevention efforts extremely challenging. Many believe that the voluntary sector is best suited for the role of spearheading efforts to address HIV/AIDS through prevention programs. International volunteerism is growing in popularity, but the various projects that volunteers work on are sustainable and impactful only if the volunteers are properly trained. To examine this process, the author travelled to Kenya to work with Fadhili Community, a local NGO involved in HIV/AIDS prevention programs within Kibera and other slums. The objectives of this research study were to assess current volunteer HIV/AIDS programs, determine gaps in knowledge and skills among volunteers, and develop an HIV/AIDS training manual for incoming volunteers. The author, utilizing participant observation, visited eight volunteer HIV/AIDS programs in different regions of Kenya to assess them for organizational capacity to utilize volunteers. The author discovered widespread assumptions prevalent among HIV programs and international volunteers that prevented effective utilization of volunteers. To address the gaps in knowledge common among volunteers and to address the expectations of HIV programs, the author created and introduced a HIV/AIDS manual to Fadhili Community volunteers. Educating and training international volunteers in a concise yet effective way will positively impact HIV/AIDS programs in Kibera.

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## **PREFACE**

I would like to extend my deepest gratitude to every member of Fadhili Community for embracing me as a part of your family and allowing me to share in your tireless work to improve the lives of those suffering from HIV/AIDS in Kenya. Asante sana.

## **1.0 INTRODUCTION**

Since its emergence, HIV/AIDS has disrupted and destroyed millions of lives throughout the world. Sub-Saharan Africa is the region of the world where this devastation has been the most severe. For decades, the global community has responded to the HIV/AIDS epidemic in sub-Saharan Africa through donations, innovations, and human service. In fact, international volunteerism focusing on HIV/AIDS is extremely popular among young people and has become an integral piece in the fight against HIV/AIDS. Kenya has embraced international volunteerism as a part of its vast tourism industry and attempted to utilize the hundreds of international volunteers in order to combat HIV/AIDS. International volunteers are often inclined to focus their efforts on the neediest areas of Kenya, such as the slums.

This paper focuses on Fadhili Community, a Kenyan organization that fosters partnerships between international volunteers and HIV/AIDS programs throughout the country. The author travelled to Kenya in order to examine both sides of the volunteer process, the HIV/AIDS programs and the volunteers. The objectives of this research study were to assess current volunteer HIV/AIDS programs, determine gaps in knowledge and skills prevalent among volunteers, and develop an HIV/AIDS training manual for incoming volunteers. Based on emergent themes from the HIV/AIDS programs' expectations and limited knowledge and skills from volunteers, the HIV/AIDS manual is now utilized by Fadhili Community and its



international volunteers. The expectation is that educating volunteers will increase the effectiveness and viability of HIV/AIDS programs within Kenyan slums.

In the following pages, the author discusses both the history and current state of HIV/AIDS in sub-Saharan Africa with a focus on Kenya. Chapter 3 highlights the need for a special focus on slums, particularly Kibera. Chapter 4 discusses private, state, and voluntary partnerships as they relate to HIV/AIDS programming. In Chapter 5, the author discusses international volunteering and its increased popularity within Kenya. Chapter 6 explains the participant observation research in Kenya and outlines the objectives, methods, and results of this research. In Chapter 7, the author addresses the research limitations and makes recommendations for future research. Finally, Chapter 8 offers a conclusion from the research and discusses the implications for global health.

## **2.0 HIV/AIDS IN SUB-SAHARAN AFRICA**

Sub-Saharan Africa is a term used to classify all African nations that are located either partially or fully south of the Sahara desert. The population of this region is over 900,000 million (UNAIDS, 2010). There are only six nations in Africa not classified as sub-Saharan. Sub-Saharan Africa is home to 22.5 million people living with HIV/AIDS (PLWHA) as of 2009. This is nearly two thirds of the global total of PLWHA (UNAIDS, 2010). The notable spread of HIV started in sub-Saharan Africa in the late 1970s, as indicated by most of the available epidemiological data (UNAIDS, 2003). The first case of what was later identified as AIDS was officially reported in Africa in 1982 (Kates & Carbaugh, 2006).

### **2.1 HISTORY OF HIV/AIDS IN KENYA**

Kenya, nestled in the heart of Sub-Saharan Africa, has a population of 39 million and is one of the regions hit hardest by the HIV/AIDS epidemic. As the HIV epidemic spread across sub-Saharan Africa and into Kenya, 26 cases of AIDS were reported between 1983 and 1985 (NAS COP & Ministry of Health, 2006). The first group affected was sex workers, according to the Bureau of Hygiene and Tropical Diseases (1986). By 1987, a total of 287 cases had been reported. In subsequent years, adult HIV prevalence rose from 5.1% in 1990 to 13.4% in 2000 (NAS COP & Ministry of Health, 2006).

The Kenyan government has been widely criticized since the onset of the HIV epidemic. Unlike its neighbors, Kenya historically has not responded as aggressively to the epidemic in terms of condom promotion, education, and preventative measures. The government's response to the epidemic was delayed and muddled. It was not until 1999 that Kenyan President Daniel Arap Moi declared AIDS a national disaster and called for the creation of a National AIDS Control Council (AIDS Analysis Africa, 2000). The prevalence rate has been declining steadily since 2000 from 13.4% in 2000 to 6.9% in 2006, likely a result of increased awareness and preventative interventions (NASCOF & Ministry of Health, 2006). Another notable cause for the decline in HIV prevalence between 2000 and 2006 is the large number of people dying from AIDS in Kenya. In 2001 alone, an estimated 190,000 people died from AIDS (Central Intelligence Agency, 2011).

## **2.2 THE CURRENT HIV/AIDS SITUATION IN KENYA**

Currently, Kenya has an estimated 1.5 million PLWHA: 180,000 of them are children (UNAIDS, 2010). The adult HIV prevalence rate is 6.3%, which is 5.2% higher than the overall global HIV adult prevalence rate of 1.1% (Kates & Carbaugh, 2006). Among young people (15-24), Kenya's HIV prevalence rate is 2.9% (UNICEF, 2010).

The HIV epidemic in Kenya is categorized as generalized, which means that HIV affects people across all sectors of the population. Of course, HIV does not affect all groups equally. Its effects depend on gender, education, location, age, and many other factors. Some groups in Kenya are disproportionately affected by HIV/AIDS and these include commercial sex workers,

injecting drug users, men who have sex with men (MSM), women, truck drivers, and cross border mobile populations (Kefa, 2011). It is difficult to identify the effect that HIV has had on Kenya's homosexual population, as homosexuality is illegal in Kenya and is punishable by law up to 14 years in prison (Human Rights Watch, 2010). Therefore, accurate data on this marginalized group are unavailable.

### **2.2.1 Women and HIV/AIDS**

Women in Kenya are disproportionately affected by HIV. In particular, young women are victims of an apparent disparity. As of 2009, young males had an HIV prevalence rate of 1.8%, whereas females had an HIV prevalence rate of 4.1% (UNICEF, 2010). This rate is more than double that for males, as males have a higher rate of comprehensive HIV knowledge (55% males, 48% females).

Women, especially those under 24, are much more likely to experience high rates of violent sexual contact than men. According to the 2003 Kenya Demographic Health Survey, 13% of women aged 20-29 years had experienced sexual violence in the previous year (Government of Kenya, 2004). In fact, nearly half of Kenyan women report being victims of sexual violence. Victims of violent sexual encounters are particularly vulnerable to HIV transmission during the act because of genital trauma, multiple perpetrators, and the associated risk of STIs (Royce et al., 1997). This is a likely contributor to higher rates of HIV in this population.

Rape of young women is common in Kenya. Widespread myths about sex with virgins perpetuate the rape of young women countrywide. In a 2003 National Survey, nearly one quarter

of women ages 12-24 reported a loss of their virginity by force (UNGASS, 2008). Many HIV positive men in Kenya believe that sexual intercourse with a virgin will reduce their viral load, and this belief contributes to the occurrence of incest between fathers and daughters (Amuyunzu-Nyamongo, Okeng'o, Wagura, & Mwenzwa, 2007). Another common scenario in Kenya is young mothers sending out their very young daughters (age five and above) to work in prostitution, in an effort to raise money to assist with the cost of HIV medication as well as food and other necessities for the family (Kefa, 2011). Females in Kenya from very young ages are placed in compromising situations that increase their likelihood to acquire HIV.

Recently, Kenya experienced an intense period of post-election violence following the 2007 presidential elections. During this time period, women were at a much higher risk for gender based sexual violence than in times of peace. Amongst the turmoil of post-electoral violence, women were victims of rape, gang rape, attempted assault, sexual slavery, and sexual exploitation. Over 650 cases of gender based sexual violence were reported at Nairobi Women's Hospital during the crisis (Siebert, 2009). This large number, combined with the large number of cases that went unreported, highlights the burden of gender based sexual violence contributing to HIV prevalence in Kenya.

### **3.0 THE FOCUS ON SLUMS**

The annual population growth rate in Kenya between 2000 and 2009 was 2.9%, which places it 29<sup>th</sup> globally. Considering this and the total fertility rate of 4.9 children per woman, Kenya has a large number of people and limited physical space (UNICEF, 2010). Approximately 35% of Kenya's population lives in urban areas and more than half of urban residents are living in slums (UN-Habitat 2007). It is expected that the percentage of the population living in urban areas will increase by 50% by 2015, and as a result, the nation is facing the pressure of increased urbanization (UN-Habitat 2007).

Approximately 50% of Kenyans live below the poverty line, living on less than \$1/day (Central Intelligence Agency, 2011). Residents of slum areas are in this category. Slums are characterized by severe overcrowding in low quality housing and a lack of general infrastructure including sanitation, drainage, and a clean water supply. Slum residents have deplorable housing conditions. Structures are made of corrugated iron sheets that serve as both the walls and roof. There is usually no permanent flooring in place. When it rains, the floors turn to mud, and the structural integrity of the home is compromised. Most residents lack secure tenure in their housing (UN-Habitat, 2011). Landlords are ever-changing and corruption abounds among them. Residents can be forced from their homes at any time, without explanation (UN-Habitat, 2011).

Clean water is limited and most residents do not have access to it. Without this, residents are at a high risk for waterborne diseases (Mulama, 2007). Sanitation issues are extensive in

slums, as human waste runs throughout the settlements in open sewers. The drainage systems in place lack the capacity to serve the large population and its waste (UN-Habitat, 2011). Poor sanitation and population congestion contribute to negative health outcomes for slum residents. These include infectious diseases, malnutrition, and diarrheal diseases (Zulu et al., 2011).

Slum residents experience high levels of unemployment, poor social and environmental issues, and high levels of crime (Mulama, 2007). Secure tenure in a residence is generally considered to be a prerequisite for access to social and economic opportunities (UN-Habitat, 2011). Slum residents lacking secure tenure also lack credit, public services, and livelihood opportunities (UN-Habitat, 2007). Additionally, educational institutions within slums are limited and ill-equipped for the demand for education. Without education and socioeconomic opportunities, the poverty cycle within slums continues and the problems compound over time (UN-Habitat, 2011).

There are over 100 areas in Kenya that are classified as slum areas. Nairobi, the capital city, has 1.5 million slum residents (Mitullah, 2003). Such areas have existed within and around Nairobi since the city's founding in 1899 (United Nations Environment Programme, 2011). During this time, Africans were kept out of the residential areas in the central business district, which were designated for Asians and Europeans. Forced to establish their own residential areas, Africans created informal settlements located outside the central business district, yet close enough to be able to travel to work there (Amnesty International, 2009). Informal settlements were built entirely on government owned land, though to this day the Kenyan government does not formally recognize the settlements. For slum residents, this means that the government does not provide basic services including schools, clinics, running water, or lavatories (Mutisya &

Yarime, 2011). Any services that do exist in these categories are privately owned and operated (Amnesty International, 2009).

### **3.1 KIBERA**

Kibera is Nairobi's largest informal settlement, with an estimated population of more than 500,000 people. Organizations such as the United Nations and Kenya's government report drastically different population estimates. UN-Habitat estimates the population to be between 500,000 and 700,000 (UN-Habitat, 2007), whereas Kenya's government claims the population is around 200,000 (KNBS, 2009). Kibera is located approximately five kilometers southwest from central Nairobi and stands on 2.5 square kilometers (Mutisya, & Yarime, 2011). Fourteen recognized distinct villages that are characterized by their ethnic and tribal differences comprise Kibera slums. This can pose an extreme challenge when attempting to collect accurate census data, as residents are constantly forced from their homes by members of other tribes and relocate to other villages in the slum.

Because the government provides no services, daily life is plagued with many challenges and is complicated by the presence of human refuse, garbage, soot, dust and other waste. Open sewers run throughout the entirety of Kibera slums, overflowing with both human and animal feces due to the lack of basic drainage systems. Residents lack access to latrines and therefore resort to "flying toilets," which are plastic bags used as latrines and thrown into the streets (Mutisya, & Yarime, 2011).

Kibera slum residents suffer from poverty that is difficult to escape due to a lack of governmental intervention and infrastructure. Residents are likely to experience unemployment,



overcrowding, involvement in risky sexual practices, and social fragmentation (Amuyunzu-Nyamongo, Okeng'o, Wagura & Mwenzwa, 2007). This environment is highly conducive to the rapid spread of illness and disease, exacerbated by risky behaviors such as high alcohol consumption, unsafe sex, and substance abuse (Kyobutungi, Ziraba, Ezah & Ye, 2008). Negative health outcomes associated with these behaviors, "...in the short and medium term...may lead to higher mortality from external causes and communicable diseases such as HIV/AIDS, and in the long term – to higher risk of non-communicable diseases" (Kyobutungi, Ziraba, Ezah & Ye, 2008, p. 2).

### **3.1.1 HIV/AIDS in Kibera**

It is impossible to know the true HIV prevalence rate among Kibera residents because it is impossible to collect accurate census data. The population in this slum area is transient (Amnesty International, 2009); therefore, the HIV prevalence rate is likely to fluctuate greatly. However, it is known that HIV rates are drastically higher within slums. Some sources estimate the adult HIV prevalence rate in Kibera is around 14%, significantly higher than in the rest of Kenya (Umande Trust, 2007).

### **3.1.2 The Barriers to HIV/AIDS Prevention in Kibera**

The main barriers that inhibit HIV/AIDS prevention efforts in Kibera are unsuccessful antiretroviral medication programs, prohibitive social stigmas, and unsatisfactory education. Many research efforts have been devoted to understanding why antiretroviral medication programs have not successfully deterred the rising HIV/AIDS rate within Kibera (Izugbara &

Wekesa, 2011). Despite low-cost or free medications, the people of Kibera have numerous cultural and personal beliefs that hinder the success of these programs. Some residents attribute a family member's death to ART, not considering the complications of HIV/AIDS (Unge et al., 2008). Similarly, social stigmas prevent those living with HIV/AIDS from becoming economically productive members of society (Amuyunzu-Nyamongo, Okeng'o, Wagura & Mwenzwa, 2007). These stigmas are attributed to misinformation, unsatisfactory education, and cultural beliefs (O'Hara, Murdock, Lutchmiah & Mkhize, 2003). Factors that contribute to these hindrances are largely caused by a lack of resources. Interventions are not designed to tackle the economic despair in Kibera, but rather are designed to improve conditions despite the scarce resources.

Those living with HIV/AIDS in industrialized nations benefit from highly active antiretroviral therapy (ART). The developing world has followed in these efforts, increasing the numbers of those who have access to ART with great success (Kyobutungi et al., 2008). Sub-Saharan Africa has by and large shared in this success, though there have not been significant numbers of interventions focused specifically on resource-poor areas such as Kibera. The constraints of underlying poverty, fractured infrastructure, and limited staff and health workers contribute to the shortcomings of ART programs (Undie, Ziraba, Madise, Kebaso & Kimani-Murage, 2009).

One study interviewed 69 Kibera inhabitants with the purpose of determining why they did not accept ART, despite its availability to them. Unge et al. (2008) state that the six main reasons found in the qualitative analysis were:

- a) fear of taking medication on an empty stomach due to lack of food; b) fear that side-effects associated with ART would make one more ill; c) fear of disclosure and its possible negative repercussions; d) concern for continuity of treatment and care; e) conflicting information from religious leaders and community, and seeking

alternative care (e.g. traditional medicine); f) illiteracy making patients unable to understand the information given by health worker (p. 147).

For those residents who overcome these obstacles and are actively enrolled in ART, there is still a significant problem with drop outs. The dropout rate from ART in Kibera is 23 per 100 persons (Kyobutungi, et al., 2008). In order to minimize the risk of dropout, researchers suggest offering intensified patient support (Unge, Johansson, Zachariah, Some, Van Engelgem & Ekstrom, 2008). The lack of support that contributes to dropouts also contributes to non-compliance with ART. In a quantitative study, researchers found that over 25% of patients had overall compliance below 95% with prescribed ART regimens (Unge, Södergård, Thorson, et al., 2009). Those living in Kibera are 11 times more likely to be non-compliant or drop out from ART treatment than those living outside the slum (Unge et al., 2008).

Many HIV/AIDS prevention interventions in Kibera begin with a focus on reducing sexually transmitted infections (Kaul et al., 2004). The main target for these interventions is female commercial sex workers, who are at a high risk of acquiring HIV due to the nature of their work. One intervention undertook a qualitative assessment of the potential acceptability of intravaginal rings (IVRs), current HIV prevention methods, and common behavioral practices among female sex workers (Smith, Wakasiaka, Hoang, Bwayo, del Rio & Priddy, 2008). This study used six focus group discussions to gain insight. IVRs were explained as possible vehicles for microbicidal compounds and are in development for HIV prevention. Women expressed interest in IVR use, as it is well documented that men prefer skin-to-skin contact during sexual intercourse and are therefore reluctant to use condoms (Arthur, Nduba, Forsythe, Mutemi, Odhiambo & Gilks, 2007). One woman stated, “If it [the IVR] is inserted inside, even if you meet someone, you will not worry about whether or not he will wear a condom because you are

already protected” (Smith, et al., 2008, p. 1030). There were many other positive reactions toward the IVR as a potential HIV prevention method among women in slum areas.

Negative responses in the focus groups were about losing male customers due to IVR use. Many women felt that if a man discovered the ring during intercourse, he would no longer be willing to pay for sex and could potentially ruin a woman’s reputation, limiting her clientele. There were no concerns about a loss of sexual pleasure, as one woman stated, “You know as a woman, I don’t care about pleasure. All I want is money” (Smith, et al., 2008, p. 1031).

Women, especially mothers, are of particular concern when considering the barriers to HIV prevention services within Kibera slums. Maternal health is a focus area for HIV prevention programs in Kibera as HIV/AIDS contributes to 20% of maternal deaths (Ziraba, Madise, Mills, Kyobutungi & Ezeh, 2009). Therefore, addressing maternal health in slum areas of Kenya is critical in the fight against both HIV/AIDS and maternal mortality.

Maternal health interventions in Kibera often focus on providing/improving antenatal care. Fosto et al. (2008) state that, “the potential of the antenatal period as an entry point for HIV prevention and care, in particular for the prevention of HIV transmission from mother to child, has led to renewed interest in access to and use of ANC services” (p. 430). For resource poor areas such as Kibera, the availability of proper antenatal care is limited, as most health care facilities are in areas with more resources. Fewer than 40% of expecting women in Kibera visit a health care provider for the recommended number of visits for antenatal care (Fosto et al., 2008). Inadequate antenatal care contributes to unhealthy pregnancies as well as women not being aware of their HIV status. For HIV positive women, receiving consistent quality antenatal care could mean the difference between transmitting HIV to their fetus and preventing transmission. One intervention suggests that the government of Kenya should implement a two-pronged

strategy to improve maternal health in slum areas: 1. The government should regulate private health facilities operating in urban slum settlements to ensure that the services they offer meet the acceptable minimum standards of obstetric care. 2. “Good” facilities should be given technical support and supplied with drugs and equipment (Ziraba et al., 2009). Providing ART therapy to pregnant women can reduce the risk of mother-to-child transmission by 43% (Suksomboon, 2007). Reducing the number of vertical transmissions of HIV from mother to child will combat HIV/AIDS in Kibera (Otieno et al., 2010).

HIV/AIDS is a topic that is widely known yet vastly misunderstood within Kibera (Izugbara & Wekesa, 2011). Just as there is a stigma attached to HIV/AIDS in the United States, so there is in Kibera. Many factors heighten the social stigma of HIV, despite its prevalence (Kyobutungi et al., 2009). One study had an objective to understand the social stigma of HIV in Kibera by surveying 1,331 persons. Researchers sought to determine the level of awareness of available HIV services among residents. They found that 90% of respondents were aware of HIV/AIDS prevention and control programs in their communities, whereas 8.9% of respondents were aware of none (Odindo & Mwanthi, 2008). However, 40% of respondents stated that there are stigma and discrimination associated with seeking services from these programs (Odindo & Mwanthi, 2008).

For those respondents who were PLWHA, 75% stated that they had experienced stigma and discrimination, primarily in the form of segregation and separation. Sixty-four percent of respondents stated that because of their positive HIV status, they were confined to certain sitting or sleeping areas and were sometimes forced to use separate eating utensils from the rest of the household (Odindo & Mwanthi, 2008). Daily living is also an issue for PLWHA, as respondents

reported that they experience rejection, loneliness, inadequate food, inadequate finances, and lack proper housing.

These challenges are especially present for women living with AIDS (WLWA). Women often endure most of the burden of HIV/AIDS within family settings as they are frequently accused of bringing it into the family (Amuyunzu-Nyamongo et al., 2007). WLWA are often ejected from their households, left to fend for themselves on the streets. Therefore, they have insufficient access to food and have poor diets. These women rarely engage in positive income generating activity, succumbing to the occupation of commercial sex work (Odindo & Mwanthi, 2008). Those who are not ejected from their families are expected to hide their HIV status from the public. This is particularly challenging for pregnant women or new mothers, who often turn to breast feeding as a method of concealing their status and avoiding public discrimination (Amuyunzu-Nyamongo et al., 2007), even though about 15% of children who are breastfed by HIV positive mothers will become infected (UNICEF, 2011). When this happens, another generation is plagued with the burdens of HIV/AIDS coupled with the hardships of living in the slum.

WLWA are the most targeted group for HIV discrimination in Kibera. One way that men shame HIV positive women is through rape. Rape is widespread, and often the children of WLWA are also rape victims (Amuyunzu-Nyamongo et al., 2007). The emotional trauma from this situation takes a severe toll on the entire family. As it is in the rest of Kenya, many HIV positive men in Kibera believe that raping a child or a virgin will reduce their own viral load. Despite the presence of external NGOs and outside support organizations, rape victims suffer silently because of the fear of repercussions for seeking support (O'Hara, Murdock, Lutchmiah & Mkhize, 2003).

The barriers to HIV prevention in slums are numerous and convoluted. The particularly challenging circumstances of resource poor Kibera cause more barriers to effective HIV prevention programming. In order to begin to intervene successfully, state, voluntary, and private sector partnerships must be in place.

#### **4.0 STATE, VOLUNTARY, AND PRIVATE SECTOR PARTNERSHIPS**

Due to the rapid urbanization of Kenya, the demand for affordable, low-income housing and basic services has grown significantly in recent years (UN-Habitat, 2007). This demand has given rise to many possible strategies for solutions, particularly in slum areas. Many researchers believe that the triad of state, voluntary and private sector partnerships offers the most promising solution to this dilemma (Otiso, 2003).

Each member of the partnerships has its own strengths and weaknesses. In African nations such as Kenya, the state plays a crucial role in efforts to upgrade housing in slums. However, ambivalent governments and poor urban planning have limited the success of housing upgrade programs in the slums in Kenya (UN-Habitat, 2011). Limited by financial restrictions, governments often overlook informal settlements because slum upgrading does not offer an attractive finished piece for political display (Syagga & Kiamba, 1992). When state, voluntary and private sector partnerships struggle to provide housing to the residents of informal settlements, the partnerships struggle also to find solutions for the immediate need for delivery of basic services, such as health care.

Kenya, like other African nations, has a legal and social contract to provide services in return for political support (Syagga & Kiamba, 1992). While this contract remains unfulfilled, the state still has the potential to deliver these services to slum residents. The Kenyan government has the capacity to assemble the financial, administrative, and technical resources to



undertake large scale projects such as slum upgrading (Otiso, 2003). Moreover, the government of Kenya has the ability to influence housing and service providers to achieve its upgrading goals (Syagga & Kiamba, 1992).

The state sector also has some weaknesses. These include an inflexible administrative structure that is often out of touch with the unique needs of the urban poor, corruption that leads to misallocation of resources, inability to effectively communicate with informal groups, and political dominance exerted over elite groups at the expense of the poor (Otiso., 2003). Due to corruption on many levels, the government of Kenya does not have the ability alone to effect the provision of health services within its informal settlements.

The formal private sector presents its own unique strengths and weaknesses. Service providers such as waste management companies, health care clinics, and various development corporations are included in the formal private sector. When the private sector is well developed in a region, it ensures profits for its members. Additionally, the formal private sector has the financial stability to subsidize poor consumers. Nevertheless, the formal private sector rarely involves itself with informal settlements due to the extremely low income rates and the general inability of residents to pay for private services (Otiso, 2003).

Another division of the private sector is the informal. These are the small, unregistered and unregulated service providers functioning primarily in slum areas. Home health workers, peer counselors, and natural medicine providers are included in this group. A major strength of the informal private sector is that it is comprised primarily of community residents who are aware of the community's needs (Otiso, 2003). Informal private service providers are limited by a lack of capital, professional skills, and equipment, which prevents them from affecting the availability of quality health services in slum areas. They provide services only to those able to

pay for them, which generally excludes the poorest residents in slums who are often the most in need of services (Werna, 1998). Often times even the informal private sector focuses on the most profitable services such as water vending and recyclables and avoids the essential (but not as profitable) services such as waste management and health services (Syagga & Kiamba, 1992). Because the demand for private sector services is so high and the supply is limited to those provided by informal providers, slum residents receive inferior services for an inflated cost that often exceeds the cost for the same services provided to the rich by the state (Otiso, 2003).

The third player in the triad is the voluntary sector. Community-based organizations (CBOs) and non-governmental organizations (NGOs) make up the voluntary sector. NGOs are registered, private, and independent nonprofit organizations generally founded by professionals to contribute to collective wellbeing through poverty reduction and service provision (Copestake, 1993). Like the state and private sectors, the voluntary sector has a wide array of strengths and weaknesses. NGOs are the most capable of articulating poor people's needs to governments and other agencies, due to their constant presence within the communities. Particularly strong in creating and strengthening lines of communication, NGOs are often essential mediators between local communities and businesses, donors, and the local and national governments (Otiso, 2003). Slum residents are most directly connected to NGOs, and are often urged to create CBOs to define and prioritize their needs.

NGOs are resource limited by nature, which restricts them from maximizing their effectiveness within communities. In fact, NGOs constantly receive criticisms that begin with a claim that their successes are often overestimated (Otiso, 2003). Program effectiveness and long term community impacts are rarely measured due to limited funding. As communities articulate their needs to NGOs, the typical response is the creation and implementation of needs-specific,

low-cost and small scale projects that are at times under-financed, of poor quality, insignificant, temporary, and unsustainable (Otiso, 2003). Critics say that NGOs are often victim to the political environment in which they function, despite efforts to remain entirely non-partisan (Copestake, 1993). The socio-political framework in which NGOs must operate often undermines their efforts to change the status quo for the urban poor. Among many other criticisms, \ NGOs are also prone to corruption, as funding is flowing through the organizational administration. Because funding is dependent upon the perceived severity of needs, NGOs tend to flock to areas with highly attractive campaign opportunities rather than focusing on the neediest areas and people (Copestake, 1993).

When state, private and voluntary sectors form partnerships for service provision within informal settlements, they are able to transcend limitations and multiply successes. A Kenyan newspaper writes, "...state efforts are often large-scale but limited in impact, and voluntary sector initiatives have a deep impact within small-scale contexts" (Daily Nation, 1999). State, private and voluntary sectors, despite individual agendas, agree to collaborate for the same reasons: augmenting strengths and overcoming individual weaknesses by capitalizing on the strengths of the other sectors. Naturally, each sector's involvement is guaranteed only when the benefits of partnership exceed the cost of participation. For the state the benefit is often increased political favor; for the private sector it is often increased business opportunity; and for the voluntary sector it is the acquisition of tangible benefits such as money and state support. Most importantly, the informal settlements receive improved services, housing, and infrastructure that would simply be impossible if tri-sector partnerships were not in place (UN-Habitat, 2011). Of course, partnerships are fluid entities that are difficult to maintain in the long term. Differing interests and priorities place strain on the partnerships over time.

When considering health services such as comprehensive HIV clinics within informal settlements, it is necessary to determine which sector is best suited to deal directly with the community in order to maximize benefits to that community. Ultimately, a tri-sector partnership is necessary for long-term successful HIV programming within slums, particularly Kibera (Otiso, 2003). Because NGOs have the aforementioned qualities, many believe that the voluntary sector is best suited for the role of spearheading efforts to meet the urban poor's needs (Otiso, 2003).

## **5.0 INTERNATIONAL VOLUNTEERING**

As the world undergoes mass globalization, international travel and volunteering has increased in popularity, particularly among young people (Lewis, 2006). In America, young people are taking time after high school and college to travel internationally, often times incorporating volunteering into their trips. This has sparked the development of a volunteer tourism sector of the tourism industry. International volunteering and/or volunteer tourism has many appeals: a new cross-cultural experience, the opportunity to serve others, and the chance to see new parts of the world (Hudson & Inkson, 2006). These opportunities are available from many different organizations ranging from travel agencies to online volunteer companies to the Peace Corps. Volunteers can involve themselves in projects that last from one week to multiple years. Typical projects are in the fields of education, youth and community development, health, business, agriculture, HIV/AIDS, and food security, among others (Peace Corps, 2011).

International volunteers have various motivations for embarking on a project in a foreign country. Many want to personally challenge themselves while serving less fortunate people. Others want to have fun while experiencing the world and return home a changed person after their project is complete (Hudson & Inkson, 2006). Most volunteers determine that the experience has been mutually beneficial, for both the volunteer and the local community where he or she worked (Meijs, et al., 2003).

As the trend continues, so do the criticisms of international volunteering. First, many of the volunteer recruiting companies that connect volunteers with local NGOs in different countries are for-profit organizations. One of these companies is International Volunteer Headquarters (IVHQ), which is based in New Zealand. IVHQ places volunteers based on their preferred country and project type, not on their skills or education. An application is required in order to be accepted into one of their programs, though this is merely a formal way of acquiring demographic information. Interestingly enough, IVHQ and other companies recruit volunteers by utilizing the image of poverty (Lewis, 2006). A quick internet search of international volunteering results in hundreds of images of hungry children, makeshift homesteads, and sickly elderly people. These images are powerful and tug at the moral heartstrings of young people. As long as poverty exists, these companies will profit from the volunteers travelling with them. However, if those same volunteers could (hypothetically) find a solution to poverty, the industry would cease to exist. This contradiction has been a concern of critics for years (Hudson & Inkson, 2006).

Critics of international volunteering claim that the volunteer projects are minimal in long term effect, due to the short term nature of volunteering stints. The international volunteer industry has no oversight; therefore, its accountability lies with the volunteers it places. Moreover, most volunteers enter into their projects with little to no prior experience or expertise in their particular areas (Lewis, 2006). This leaves the burden of training and education on the local host organization, most often an in-country NGO. Because volunteers stay for as little as two weeks in some cases, organizations must continually hold orientation sessions for incoming volunteers. This places a high burden on NGOs as well as draining them of time and other resources. Despite this, NGOs persist in their missions by incorporating international volunteers

(Coghlan, 2006). Families are well compensated for serving as hosts, and local communities depend on international volunteers as an income source. In the same way, the projects in which volunteers participate are often funded by volunteer program fees. NGOs provide jobs for locals both in the office and in the field. One concern of locals is that volunteers are serving for free in positions that might otherwise be paid positions for the local community, thereby taking job opportunities away from them (Coghlan, 2006).

In spite of the criticisms, international volunteerism is growing in popularity. People of all ages are excited by the thought of encountering people from around the globe as well as impacting underserved communities worldwide. However, the various projects that volunteers work on are sustainable and impactful only if the volunteers are properly trained.

## **5.1 INTERNATIONAL VOLUNTEERING IN KENYA**

Kenya, like many Third World countries, has a large network of NGOs and CBOs operating in the areas of health, refugees, environment, human rights, education, and other aspects of development and sustainability. NGOs and CBOs are distinct entities in Kenya. Organizations, regardless of origin, size, or revenues can self-identify and register as an NGO in Kenya and are incentivized with tax breaks, training seminars, and coordinating services offered through an NGO board (Brass, 2011). CBOs are different in that they register under a separate ministry of the government and receive little oversight or support. There are over 220,000 CBOs operating throughout Kenya, though there is a cluster of NGOs and CBOs located in and around Nairobi (Brass, 2011). Some highly recognizable organizations operating in Kenya include the

Ford Foundation, Save the Children, World Vision, and Catholic Relief Services. Volunteer organizations that have a specific focus on HIV/AIDS and vulnerable children include Global Volunteer Network, Cross Cultural Solutions, and African Impact.

With regard to HIV/AIDS programs in Kenya, international volunteers and the NGOs and CBOs play an integral role in the Kenya National AIDS Strategic Plan 2009/10. According to the KNASP, Kenya will:

Rely on local contexts and best practices to strengthen the capacity of communities to plan, demand and implement priority HIV interventions. Knowledge, demand and utilisation of services in the formal health system are highly dependent on a strong community-based advocacy and referral system...Focusing interventions at the community level will also ensure that prevention efforts are differentiated by region/area and cause of vulnerability. Interventions at the community level will also ensure that the root causes of vulnerability are addressed at this level...Key interventions will have a socio-cultural dimension, such as the protection of human rights, and the mitigation of HIV effects. The intended programme outcome...is to strengthen community capacity towards achieving Universal Access and social transformation for an AIDS-competent society (p. 24).

The government of Kenya understands the value and potential impact of NGOs and CBOs in the fight against the HIV/AIDS epidemic. By including community based programming in the KNASP, the Kenyan government places a responsibility on the voluntary sector to deliver effective region-specific programming as part of a greater plan.



## **6.0 FADHILI COMMUNITY PARTICIPANT OBSERVATION RESEARCH**

In the summer of 2008, the author traveled to Kenya as an HIV/AIDS volunteer with a local NGO, Fadhili Community. Since its inception in 2007, this organization has been based in Nairobi and has a local Kenyan staff of over ten people. Fadhili Community receives its international volunteers through IVHQ and places them into programs in the following areas: education, orphanage work, sports education, HIV/AIDS work, medical placements, music programs, and women's education programs. Processing over 600 volunteers a year, Fadhili Community is one of Kenya's most popular volunteer organizations (IVHQ, 2011). Volunteers at Fadhili Community come from many different countries, including the United States, England, Ireland, Australia, New Zealand, China, Mexico, Brazil, and Canada. With a wide range of personalities and skills among volunteers, Fadhili Community's local programs are enriched by the presence of such diverse international volunteers.

HIV/AIDS programs are popular volunteer choices, as the epidemic is highly publicized worldwide. According to the IVHQ website, Fadhili's HIV/AIDS programs

...are aimed at giving care and support to the HIV infected and also creating awareness to vulnerable groups about the dangers of HIV/AIDS through HIV/AIDS outreach programs. These outreach programs are generally done through schools and community groups while work consists of: visiting patients in their homes, helping with medical care and food, conducting lessons to educate people on the dangers of HIV and how to prevent themselves from getting infected. Our programs are organized in collaboration with Government institutions, NGOs, and CBOs who are working very closely with the communities and HIV/AIDS patients (2011).

During the summer of 2008, the author arrived in Nairobi and attended the volunteer orientation session. Fadhili staff educated volunteers on basic cultural competencies, some common Swahili phrases, and personal safety while in Kenya. A quick lesson in Kenyan history was followed by an introduction to Kenyan food. Next, a brief overview covered the risks of malaria, dengue fever, and yellow fever, but there was no mention of HIV/AIDS.

The author was escorted to the home stay and program placement in a small town, Kitengela, outside of Nairobi. Kitengela Medical Center was the program site for the HIV/AIDS project. However, Kitengela Medical Center had no formal HIV/AIDS program in place and dealt with HIV only when patients came in for other reasons and were tested. Not only did the Kitengela Medical Center lack the capacity to utilize an incoming volunteer, but the author lacked the knowledge and training required to initiate or participate in a functioning HIV/AIDS program.

This experience fostered an interest in the role that international volunteers have in HIV/AIDS programs in Kenya. Clearly, there were gaps in orientation, training, and education. This presents potential health hazards to both international volunteers and the local citizens with whom they interact. Understanding that Fadhili Community processes over 600 volunteers annually, the author decided to return to Kenya to research this process in an attempt to observe and interpret the current process.

## **6.1 OBJECTIVES**

The objectives of this research study were to assess current volunteer HIV/AIDS programs for their capacity to utilize volunteers, determine gaps in knowledge and skills

prevalent among volunteers, and develop an HIV/AIDS training manual for incoming volunteers. For the purpose of this research, the author defined an organization's capacity to utilize volunteers by the number of feasible opportunities for volunteers, the number of staff available to guide volunteers, and the integration process between volunteers and programs. The author set out to uncover the common assumptions surrounding the international volunteer experience. Kibera was selected as the main site for research, as Fadhili Community has multiple functioning HIV/AIDS programs located within this area. Furthermore, Kibera is home to the poorest, most underserved population in Kenya, making HIV/AIDS programming within the slum crucial. Most programs within Kibera have a small primary staff of local residents supplemented by large numbers of international volunteers, offering an ideal opportunity to increase effectiveness among HIV/AIDS programs through the utilization of trained volunteers.

## **6.2 METHODS**

Fadhili connects volunteers with multiple HIV/AIDS programs within Kibera. These include the Women's Empowerment Equality Project (WEEP) Center, Olympic Primary School, and several informal feeding and medication distribution programs. Through participant observation, eight volunteer HIV/AIDS programs located in different regions of Kenya were assessed for organizational capacity to utilize volunteers.

### **The WEEP Center**

...commits to providing medical care, nutrition, vitamins, rent assistance and access to ARV drugs; it also assures that their children have school uniform and other necessary resources to attend school. Once physically stable, the mother is taught a trade at a WEEP

center where she becomes self sufficient and breaks through the impoverished cycle (African Heart, 2011).

The author observed for a total of three days at the WEEP center. Several unique features of the WEEP center contribute to its success within Kibera including its central location, the provision of childcare and education, and its respected history within the community. Women attendees of WEEP center are taught to sew shirts, bags, and other articles as an income generating activity. They are also taught beadwork, and create necklaces, earrings, bracelets, rings and small decorative pieces. These goods are sold to volunteers, community members, and visitors. Acquiring new skills and working together to generate income, the women form a social support network to help them cope with HIV/AIDS in their lives. The WEEP Center provides a safe space for women to share their experiences, hardships, and triumphs while improving their lives economically and socially.

The Olympic Primary School is known for being one of the most successful slum schools in Kibera. With a high attendance rate and successful alumni, the Olympic Primary School offers HIV/AIDS education in the classroom. Another distinctive feature of Olympic is that it offers a feeding program of two meals per day to over 3,000 students. This is a basic need of children, most of whom would not eat otherwise. The author visited the Olympic primary school on two occasions. During these observations, some volunteers were engaging in outdoor sport activities with children while others were talking to them in small groups about the experience of HIV/AIDS in their families.

Many informal feeding and medication distribution programs are staffed by Fadhili volunteers. While the majority of these programs are religious initiatives, some of them are managed by groups of HIV positive community members seeking to better the community at large. Volunteer initiated feeding programs are encouraged by Fadhili. Volunteers placed in

Kibera frequently spearhead feeding programs by making personal connections with community members to determine areas of need and recruiting volunteers from other disciplines (education, orphanages, and music) to donate funding and time to these projects. One of these initiatives, “A Walk through Kibera,” was observed over the course of several days. The author walked through Kibera numerous times. It is important to note that Kibera is an extremely harsh environment for outsiders to enter. Kibera has dangers around every corner, ranging from mounds of broken glass to piles of human feces. If the weather is poor, the hilly ground becomes a muddy mix of dirt and human waste that many volunteers struggle to navigate. Children either embrace visitors by physically clinging to them or reject them by screaming and throwing various objects at them. Unattended dogs covered in flies and open sores growl at and occasionally attack unknown visitors. Kibera residents often view visitors as a potential source of money, so volunteers must travel with a well known resident of Kibera or in large groups for protection. Sometimes volunteers view the journey to the program site through Kibera as the hardest part of the job. Fadhili volunteers paid 1,000 Kenyan shillings (about \$9 as of June, 2011) to have a guided tour through Kibera and the opportunity to distribute food and medication to needy families. The author observed this program during 19 home visits, when volunteers distributed life-sustaining maize and beans and/or HIV medication.

The author travelled with volunteers to five HIV/AIDS programs in other slum areas throughout Kenya. Gioto Garbage Slum, located in Nakuru, is the dumping site for Nakuru’s garbage; it is also home to over 500 people. Residents of Gioto find food, shelter, and clothing exclusively in the garbage dump. The HIV prevalence rate in Gioto is estimated to be well over 50%, as determined by doctors and volunteers during free medical camps provided to residents periodically by volunteers. Medical camps are full day events where tents are set up to provide

basic medical services such as HIV testing, child growth monitoring, family planning, and pharmacy services. Garbage Slum residents lack access to these services unless volunteers provide a medical camp. Volunteers initiated this programming at Gioto and have made it sustainable by training incoming peers.

Other areas of Kenya with HIV/AIDS programs supported through Fadhili Volunteers include the KCC slum project located in Naivasha, school HIV education programs located in Kawangware slums near Nairobi, and women and children's HIV education programs located in Maasailand. These other projects were observed for their capacity to utilize volunteers but were not the focus of this research.

### **6.3 RESULTS**

Excluding the volunteer initiated HIV/AIDS programs in Gioto Garbage Slum and the KCC slum project in Naivasha, all of the programs that Fadhili supports through international volunteers lacked the organizational capacity to utilize volunteers. This means that they could not use volunteers to serve as HIV testers, counselors, or group facilitators. Programs directors attributed this to the fact that volunteers did not come to the programs trained or educated in HIV/AIDS. With limited resources, local programs cannot stop daily routines to teach volunteers how to accomplish these tasks or start a new program. Therefore, volunteers were functioning as extra hands for dish washing, child supervision, and general cleaning. While helpful, this is not the most effective use of volunteers who want to impact the HIV/AIDS epidemic in Kenya.

As a local CBO, the WEEP Center had a limited capacity to utilize volunteers in the area of HIV prevention and education. The women involved at the WEEP Center must be HIV

positive in order to participate in the program. Therefore, volunteers placed at the WEEP Center serve in the areas of social support for the women and product development. Most of the time, the women at the WEEP Center are practicing their trade; volunteers could participate in this activity or help the women expand their initiatives. However, most volunteers at the WEEP Center became frustrated after a few days of watching women sew and requested a new placement. Many attributed this frustration to feeling useless and in the way, rather than helpful and productive. While the women at the WEEP Center enjoy having volunteers there to share time with them, there are no opportunities for volunteers to participate in HIV/AIDS prevention.

At the Olympic Primary School, volunteers were present for the in-class HIV/AIDS educational programming. In this case, the function of the volunteer was primarily child supervision and entertainment while the local teachers educated the children about HIV/AIDS. Volunteers were certainly functional, but not in the area of HIV/AIDS education. Volunteers experienced similar misallocation of their time in Kawangware slum schools. There, volunteers also served as care givers for students rather than educators. In Maasailand, volunteers were often told to engage in sports activities with the children during their placements. For volunteers, this meant that while the children were in school there was no work to do in this extremely remote location. Volunteer frustrations escalated as they simply waited all day until the children were finished with school so that they could play soccer with them. Schools in Maasailand claimed that there was a large need for HIV/AIDS volunteers to serve as educators and support systems for school-aged children; however, these schools failed to utilize volunteers for these purposes.

Assumptions about volunteers' HIV/AIDS knowledge and skills are widespread among Kenyan HIV/AIDS programs. While visiting the various HIV/AIDS programs through Kibera

and other slums, the author heard over and over again a wide array of assumptions. Kenyans who work with international volunteers assume that all international volunteers are comprehensively educated in HIV. They believe that, whether volunteers come from the United States, Europe, China, or Australia, they understand the following aspects of HIV: prevention, transmission, treatment, and mother to child transmission. Furthermore, Kenyans respect and trust the words of visitors, so the expectation among Kenyans is that international volunteers are entirely prepared to initiate HIV/AIDS programming within slum areas. These assumptions are a barrier to effectively utilizing volunteers.

As international volunteers are extremely diverse, so is their education. The author discovered through conversations with volunteers during orientation that volunteers expect and assume that Fadhili Community will place them in a functioning program that has a pressing need for assistance. During orientation, volunteers assume that they will receive all of the necessary information to be able to perform well at their project site. This means that volunteers assume that Fadhili Community provides comprehensive HIV/AIDS information, basic training in the areas of testing and counseling, and a short discussion about creating new programs.

This research uncovered these assumptions and exposed them as fallacies. There is a wide range of HIV/AIDS knowledge among international volunteers. Many international volunteers are undereducated on the topic of HIV/AIDS, despite many of them travelling to participate in those programs specifically. During this research, multiple volunteers asked how HIV can be transmitted and prevented, even though they were already involved with HIV programs. The danger of this lack of knowledge will most often affect the Kenyans who are seeking guidance and support and who instead receive incomplete or incorrect information from international volunteers.



As a result of the lack of knowledge of HIV/AIDS among international volunteers, the author worked with Fadhili and its programs and volunteers to create a comprehensive HIV/AIDS manual for incoming volunteers. The process began while assessing the HIV/AIDS programs, understanding their needs and expectations of volunteers. Through conversations with program directors, the author discovered that programs located in Kibera that partnered with Fadhili expected international volunteers to understand the basic facts about HIV: transmission, protection, prevention, and living with HIV/AIDS. Furthermore, program directors expected that volunteers would be providing monetary support as well as spearheading initiatives to further their program's success. These initiatives could develop in different directions, but one common expectation was that volunteers would be able to begin some type of feeding program for PLWHA in Kibera. Next, program leadership expected that volunteers would be comfortable with testing and counseling patients. Volunteers were expected to know how to discuss next steps with people receiving the results of HIV tests. That is, volunteers were expected to know how to tell a PLWHA how to access, initiate, and maintain a medication regimen. Social and emotional aspects of dealing with a new HIV diagnosis are complex, yet volunteers were expected to counsel people through this stressful time. Finally, volunteers were expected to guide program participants in HIV prevention.

Fadhili Community holds an orientation two times per month to accommodate the constant influx of volunteers. As stated earlier, prior to this research Fadhili offered no information to volunteers during orientation regarding HIV/AIDS. The author conducted several meetings with the staff with the intention of highlighting the importance of providing this information to each volunteer, regardless of their preferred program placement. The first of these meetings was with Joe Gichuki, National Director of Fadhili Community. The purpose of this

meeting was to discuss the need for some form of HIV/AIDS education for volunteers. Mr. Gichuki and the author reviewed the current orientation packet and noted the lack of HIV/AIDS information. The author suggested including HIV/AIDS educational material in orientation in some manner; Mr. Gichuki agreed and scheduled a meeting with the rest of his staff to determine the best format for this material.

Next, the author met with Fadhili Community staff members, including two field workers, the office manager, the accountant, and Mr. Gichuki. The author and Mr. Gichuki reviewed the outcome of the last meeting, which led to a discussion about the best method for delivering HIV/AIDS information to incoming volunteers. Fadhili Community staff had not considered that all volunteers face the risk of acquiring HIV while in Kenya. Many volunteers are working with small children who are entirely unaware of their HIV status; for example, if an HIV positive child scraped his or her knee a volunteer might instinctively come to the aid of that child without considering the risk involved in this HIV endemic nation. Countless scenarios were discussed during the initial staff meeting, and ultimately the decision of Fadhili Community was to invite the author to create a single page insert for orientation containing the most necessary and basic HIV/AIDS information.

Concerned that this would be insufficient for volunteers focusing on HIV/AIDS, the author requested another staff meeting to discuss the possibility of an HIV/AIDS manual. During this meeting, the author suggested the creation of a brief HIV/AIDS manual for volunteers that would be distributed during orientation. Limited by a lack of resources, the staff raised concerns about the replication costs of a manual. It was agreed that the author would provide ten bound copies of the manual to Fadhili Community, as well as the digital version of the manual for further replication. Fadhili staff decided that the manuals would be kept in the office and

available upon request to any volunteer. Furthermore, the staff would encourage HIV/AIDS volunteers to review the manual prior to program involvement.

For those volunteers who are in Kenya to focus their efforts on HIV/AIDS programming, the author created a ten page packet of information. The information presented in this manual is the result of the collaboration among the author, Fadhili National Director, and several Fadhili staff members. During subsequent staff meetings, each party offered ideas as to what information needed to be included in the manual. The author used information gathered from each participant observation experience and shared the needs of the programs with Fadhili. Similarly, Fadhili shared information about its specific goals regarding its HIV/AIDS program and the future of these programs. The mutual sharing of ideas and information served as the basis for the outline of the manual. From there, the author gathered HIV/AIDS information from UNICEF and WHO to supplement the information gathered from Fadhili and the participant observation experiences. Fadhili and the author reviewed and edited several drafts of the manual before both parties agreed upon the final revision. The author printed ten bound copies for Fadhili's use. HIV/AIDS volunteers are able to access and review these manuals in the Fadhili office.

Integrating the HIV/AIDS manual into Fadhili Community's orientation process was challenging, yet rewarding. It created a forum for Fadhili staff to talk more openly with the author and with one another about the topic of HIV. Mutually sharing ideas, expectations, reservations, and excitement surrounding this project was beneficial for everyone involved. Fadhili Community staff openly welcomed the addition of the HIV/AIDS manual into their orientation and education processes. The author and Fadhili agreed that a digital version of the manual would be maintained so that future editing and reproduction would be possible. Additionally, the author and staff concluded that the single HIV/AIDS information page would

be distributed to every incoming volunteer, whereas the manual would be presented to those volunteers focusing specifically on HIV/AIDS.

The manual provides essential information for volunteers regarding HIV/AIDS basics, interpersonal skills, and volunteer tips. HIV/AIDS basics include: “What is HIV?,” “How Does HIV/AIDS Spread?,” “How is HIV/AIDS Transmitted?,” and “HIV/AIDS in Kenya.” The information is presented in a straightforward manner, and takes into account the wide variety of English comprehension levels among volunteers.

Other sections of the manual offer specific information about women, men, children, high risk groups, and those infected also with tuberculosis. This is in accordance with the specific needs of Fadhili programs. Volunteers are given information in this manual about the importance of food as it relates to compliance with ART, taking into account the expectations of programs for volunteers to initiate feeding programs.

One of the most challenging situations for a volunteer is a scenario where that volunteer is expected to counsel a Kenyan person after he or she receives an HIV test. Social workers complete years of training before they are trusted in this situation, whereas volunteers have been thrust into this position completely unprepared. Surely, no volunteer will ever be fully equipped to handle this scenario, but there was an opportunity to better prepare them. The author, with Fadhili staff, discussed the importance of educating volunteers about the social stigma and discrimination that occur against PLWHA in Kenya.

Volunteer initiative was the most common expectation among programs. After this recurring theme emerged at each program site, the author and Fadhili staff concluded that a section of the manual should address this concept.

The manual states:

“You can contribute to HIV prevention and treatment in Kenya in many ways:

1. Be knowledgeable about HIV/AIDS so that you can raise education and awareness at your placement.
2. Answer questions honestly and with confidence. If you don't know, ask. Never give someone incorrect information.
3. Encourage HIV testing.
4. Encourage everyone to practice correct and consistent condom use.
5. Practice nonjudgmental communication. Be open and honest.
6. Have an open mind. Understand that there are often many unspoken challenges that people face.
7. Take initiative—if you see a need that you can fill, do it. If you need help, ask.
8. Engage in conversations. Listen when people share their stories with you.
9. Be respectful of privacy and dignity” (p. 9).

The intention of this section of the manual was to increase the self-efficacy of volunteers. If volunteers are presented with this information at the beginning of orientation, they will begin to conceptualize the possibilities for their placements. The first volunteers to receive the information and manual arrived in Kenya during June 2011. At this time, Fadhili welcomed 55 volunteers from across the globe and distributed the information to each one of them. The reaction was positive, and the interruption of the former orientation routine was minimal. Volunteers were encouraged by an excited Fadhili staff to discuss this project with the author. Several volunteers involved in HIV/AIDS programs in Kibera approached the author regarding the manual. Each of these volunteers had different questions and/or comments regarding methods of taking initiative.

The development of the HIV manual took place in an effort to address and minimize the incorrect assumptions and gaps in knowledge as determined through both formal and informal observations. Its development was a collaborative effort, taking into account the social and cultural distinctions of Kenya, as well as the specified needs of Fadhili Community's current HIV/AIDS projects.

## **7.0 DISCUSSION**

The nature of volunteering is to offer services to underserved people for short period of time; however, the common expectations among local HIV programs are high and in some cases unrealistic. Understanding these expectations and addressing them through training and education was a necessary step in order to better prepare international volunteers for the experience. The introduction of the HIV/AIDS manual into Fadhili Community's volunteer orientation process is an important aspect of training international volunteers effectively in HIV/AIDS programming in the slums, and other areas of Kenya. When volunteers are properly trained and educated, programs in the slums will be more successful in their missions.

### **7.1 VOLUNTEERS ADDRESSING BARRIERS TO HIV PREVENTION**

As the voluntary sector has the most consistent presence within Kibera, intervening to improve health services through the direct contact of volunteers is the most logical and practical option. There are over 200 NGOs present within Kibera, many working to provide HIV services to the neediest people of Kenya (Barcott, 2000). Many of the barriers to providing effective HIV/AIDS services within Kibera can be addressed through prepared and educated volunteers. Empowering Kibera residents in the areas of stigma reduction, comprehensive education, and

accessible health care and medication is vital to successful HIV prevention interventions. The barrier of noncompliance with ART due to hunger can be addressed through feeding program initiatives. These assist Kibera residents by providing food to reduce hunger and encourage adherence to medication and social support to continue the practice. The lack of social support due to stigma can be addressed by volunteers who have the capacity to function as consistent, viable support systems for groups of WLWA like those who gather at the WEEP Center. When international volunteers interact with WLWA in Kibera, the effects of discrimination and isolation are diminished. Programs targeting HIV+ mothers and their children are often staffed by Fadhili Community volunteers. Volunteers facilitate group discussions regarding ways for mothers to protect their children from rape and its effects. Providing a safe space for women to discuss these sensitive issues enables them to leave the worries of community stigma behind and engage in supportive dialogue.

International volunteers are unique in many ways, the most powerful of which is a quality of anonymity (and therefore trustworthiness) with locals. Slum residents generally feel comfortable when working with volunteers from different walks of life. Distrust of organizations, community leaders, and the government that runs deeply in PLWHA is rarely present in terms of their attitude towards volunteers. Attention is most effective when it comes from those with a true dedication to the slum residents as individuals as well as a whole community. Volunteers are a passionate, willing workforce capable of changing the face of HIV services within Kibera and other slums because of their unique qualities and personal motivations. When properly educated, their efforts can be utilized effectively thereby making HIV services more successful.



## 8.0 CONCLUSION

Currently, Kenya has an adult HIV prevalence rate of 6.9%, whereas slum areas have an adult HIV prevalence rate nearly twice that (NASCO & Ministry of Health, 2006). The various barriers to HIV services within slum areas including unsuccessful antiretroviral medication programs, prohibitive social stigmas, and unsatisfactory education were examined and discussed. Kenya is home to thousands of NGOs and CBOs attempting to alleviate the burden of HIV/AIDS. The government of Kenya and many private organizations seek to achieve the same. There is a need for innovative and effective HIV/AIDS programming targeting the slums of Kenya. Kibera, the largest slum in Kenya, presents unique challenges in terms of HIV/AIDS prevention and treatment due to poor infrastructure, widespread poverty, and discrimination. The author examined the use of effectively trained and educated volunteers to tackle the prohibitive barriers to HIV/AIDS alleviation as a part of state, voluntary, and private sector partnerships. Due to the motivations of volunteers and the ability they have to socially and emotionally connect with slum communities and individuals, it can be argued that volunteers could be an effective workforce for future HIV/AIDS interventions in Kenya. However, the author discovered during this research that Fadhili Community volunteers were not adequately educated in the area of HIV/AIDS and often did not receive proper training upon arrival in Kenya. This prohibits the success of many programs by preventing the spread of accurate information and useful services from slum residents.

The author observed eight HIV/AIDS volunteer programs within Kenyan slums that exhibited these weaknesses. To address and combat the assumptions of knowledge and skills, the author developed an HIV/AIDS training manual for use at Fadhili Community. After the development of a culturally appropriate, universally suitable HIV manual for Fadhili Community's international volunteers, the author implemented this manual as a training tool. Volunteers, following the manual implementation, were provided with the knowledge and skills necessary to intervene successfully against the barriers prevalent in Kibera regarding HIV services. Examining NGOs and CBOs in Kenya for volunteer training could expose a widespread weakness that prevents successful HIV/AIDS programming. This is an important next step for NGOs and CBOs to undertake, as they are only successful when their volunteers are prepared to carry out their missions and programs. With the rising popularity of international volunteering and volunteer tourism, addressing this issue on a large scale would provide a skilled public health workforce willing to focus their efforts towards the HIV/AIDS epidemic in Kenya, sub-Saharan Africa, and the globe.

## **8.1 LIMITATIONS**

The goals of this research were to assess the current volunteer HIV/AIDS programs, determine the gaps in knowledge and skills prevalent among volunteers, and develop an HIV/AIDS training manual for incoming volunteers. Programs exclusively supported through Fadhili Community volunteers were observed, leaving a wide range of programs within Kibera unexamined. This may have resulted in bias given that Fadhili Community is managed by religious people who select projects with moral and spiritual goals similar to their own. While

the programs observed were representative of others offered in Kibera, the number of program sites observed was small compared to the number of program sites in total. Therefore, the information gathered about lack of knowledge, assumptions, and expectations cannot be generalized to other programs.

Because international volunteers come from such diverse cultural, religious, social, and political backgrounds, it is unrealistic to categorize them as homogeneous. For the purpose of this research, international volunteers were considered a homogenous group based only on their main motivations for volunteering: to serve the underserved HIV/AIDS population in Kibera.

Lastly, Fadhili Community is not necessarily representative of other international volunteer organizations based in Kenya. It is reasonable to assume that Fadhili Community has missions similar to other comparable volunteer organizations, but its motivations, goals, passions, and interests are distinctly its own. Therefore, this research cannot be generalized to other volunteer organizations, international volunteers, and locations.

## **8.2 FUTURE RESEARCH**

While this research shed light on some of the assumptions that hinder the success of volunteer supported HIV programs within Kibera, it is important to understand the long term impact that volunteers can actually have on these programs. In order to apply this type of intervention in other volunteer organizations, volunteer knowledge about HIV/AIDS and volunteer self-efficacy regarding HIV/AIDS program participation would need to be evaluated both prior to and after the implementation of an HIV/AIDS manual. Further editing of the

manual would be necessary, ultimately creating a comprehensive and universally acceptable edition for this population and its needs. The manual would need to be made available to all incoming volunteers, ideally before their arrival on site. To accomplish this, the manual could be accessible online for volunteers as soon as they are accepted to a program.

Additionally, HIV programs within Kibera would need to be formally evaluated for their organizational capacity to utilize volunteers. Potential measures of organizational capacity could include number of feasible volunteer opportunities, number of local staff available to guide volunteers, and the ways in which organizations integrate volunteers into current programs. Future studies would require the examination these factors over time.

Of course, the ultimate goal of this research would be to reduce HIV incidence and prevalence rates within Kibera through the HIV/AIDS services and programs staffed by international volunteers. Measuring these rates over time after the integration of an HIV/AIDS manual would be an indication of its effectiveness. It is recommended that further research address additional ways in which international volunteers can combat the HIV epidemic in the slums of Kenya.

### **8.3 IMPLICATIONS FOR GLOBAL HEALTH**

International volunteers by the thousands travel the globe annually to make an impact on the most pressing public health issues. While these volunteer experiences are not marketed or packaged as public health work, this is exactly what they are doing. If this research of one volunteer organization in Kenya is any indication of what is happening in other volunteer

organizations globally, then there is a vast unexploited resource in volunteers that has endless possibilities for global health. Examining the actions of one volunteer organization requires a simultaneous focus on the larger volunteer process, whereby volunteers are impacting the health of communities and those communities are changing the perspectives, priorities, and attitudes of international volunteers. This process reinforces the concept of a global community where both international volunteers and the programs in which they participate have an immense responsibility to prepare themselves sufficiently.

Research initiatives exploring the utilization of international volunteers are opening the door of possibility for a universal global health workforce. Young, willing participants are travelling at their own expense to fight poverty, hunger, and disease. Educating and training these volunteers in a concise yet effective way will impact public health in a positive manner wherever volunteers are active. Intervening with a willing workforce is an essential piece in tackling the diseases that plague the globe.

**APPENDIX**

**HIV/AIDS MANUAL**

# HIV/AIDS



# What is HIV?

**HIV** stands for: Human Immunodeficiency Virus.

**HIV** is the virus that leads to AIDS: Acquired Immune Deficiency Syndrome.

**HIV** damages a person's body by destroying specific blood cells, called CD4+ T cells, which are necessary to fight diseases within the body.

**HIV** symptoms can include flu-like symptoms, though these are not always present. A person with HIV may feel and appear healthy for many years.

## How does HIV/AIDS Spread?

### Through:



- . Blood
- . Semen
- . Vaginal fluid
- . Breast milk
- . Other body fluids containing blood

### NOT Through:



- . Air or water
- . Saliva
- . Insects
- . Sweat or tears
- . Casual contact (hugging/shaking hands)



# How is HIV/AIDS transmitted?

During unprotected sexual contact.

During pregnancy, childbirth,  
or breastfeeding.

As a result of injection drug use: sharing  
needles, syringes, and other equipment.



# HIV/AIDS in Kenya

## THE FACTS

- In Kenya, an estimated 1.5 million people are living with HIV.
- Around 1.2 million children have been orphaned due to HIV.
- 6.3% of the population is infected with HIV.



## WOMEN

Women are disproportionately affected by HIV in Kenya. They are nearly twice as likely to acquire HIV than men, particularly young women ages 15-24. Young women are often victims of violent sexual contact, which contributes to the higher HIV prevalence. Women are more likely to practice commercial sex work, making them a high risk group for HIV in Kenya.

## MEN

Male truck drivers, men who have sex with men (MSM), and injecting drug users (IDUs) are at a high risk of acquiring HIV in Kenya. IDUs are prevalent in Nairobi, making up 5.8% of new HIV infections. In Kenya, the law prohibits harm reduction programs like needle exchanges, making prevention particularly challenging for this group.

# HIV Prevention

The 2005/06-2009/10 Kenyan National HIV and AIDS Strategic Plan emphasizes the following evidenced based strategies:

- Increasing availability and access to counseling and testing
- Condom promotion
- Strengthening sexually transmitted diseases (STD) and HIV program linkages
- Expanding services for prevention for mother-to-child transmission (PMTCT)
- Ensuring more effective and targeted behavior change communication
- Promoting abstinence, safe sex, and delayed sex debut among young people
- Improve availability of safe blood supplies
- Ensure injection safety and expand access to post exposure prophylaxis and universal precautions
- Ensure mutually supporting prevention and treatment efforts

# HIV Testing

Should we  
still have  
sex if my  
partner has  
HIV?

Discuss this question at a VCT centre near you.

Your nearest VCT Centre is:

- AIDS Resource Centre, Tivoli Centre opposite Kisumu City Hall
- Pandpieri Catholic Centre Integrated VCT Centre, off Nyalenda Ring Rd next to Pandpieri Primary School, Kisumu
- Lumumba Health Centre, Ondiek Estate, off Stadium Rd beside Ondiek Shopping Centre, Kisumu
- Asembo VCT Project, Asembo, Kisumu



What do I do  
if I have HIV?

Discuss this question at a VCT centre near you.



If I'm  
healthy,  
do I still  
need an  
HIV test?

Discuss this question at a VCT centre near you.

Your nearest VCT Centre is:

- AIDS Resource Centre, Tivoli Centre opposite Kisumu City Hall
- Pandpieri Catholic Centre Integrated VCT Centre, off Nyalenda Ring Rd next to Pandpieri Primary School, Kisumu
- Lumumba Health Centre, Ondiek Estate, off Stadium Rd beside Ondiek Shopping Centre, Kisumu
- Asembo VCT Project, Asembo, Kisumu



The most important step in HIV prevention is getting an HIV test. As a volunteer, you should encourage as many people as you can to visit the local VCT (Voluntary Counseling and Testing Center) to get tested.

# HIV and AIDS Treatment

In 2003, only 5% of people needing HIV treatment (antiretroviral therapy or ART) were receiving it. Today, 48% of those requiring ART are receiving it. This is still a low percentage of treatment.



Many people infected with HIV are also infected with tuberculosis (TB). ART is extremely important to those who are dual-infected, but the availability of these services is limited. ART for those with both TB and HIV has been found to improve patient survival, if administered as soon as possible after TB treatment. Most people in this situation are not receiving their required treatment due to lack of resources and access.

## The importance of food...

Those who have access to ART, and those who are currently receiving ART often times are non-adherent to the medication regimen. Sadly, this is due to a lack of food. When receiving ART, a patient must have a balanced and consistent diet to receive maximum benefits. As poverty is rampant in Kenya, often times those with HIV/AIDS are malnourished and ART is not as effective. Without food, those who receive ART may experience severe pain while on medication. Providing food is often the best first step in ART adherence.



# Children and HIV

There are an estimated 180,000 children (ages 0-14) living with HIV in Kenya. Recently, there was an increase in services targeting children with HIV. Despite this, an estimated 68% of children living with HIV requiring treatment do not have access to it. Beyond distance, other barriers to access include caregiver neglect, lack of accurate information regarding treatment requirements, and a lack of resources.

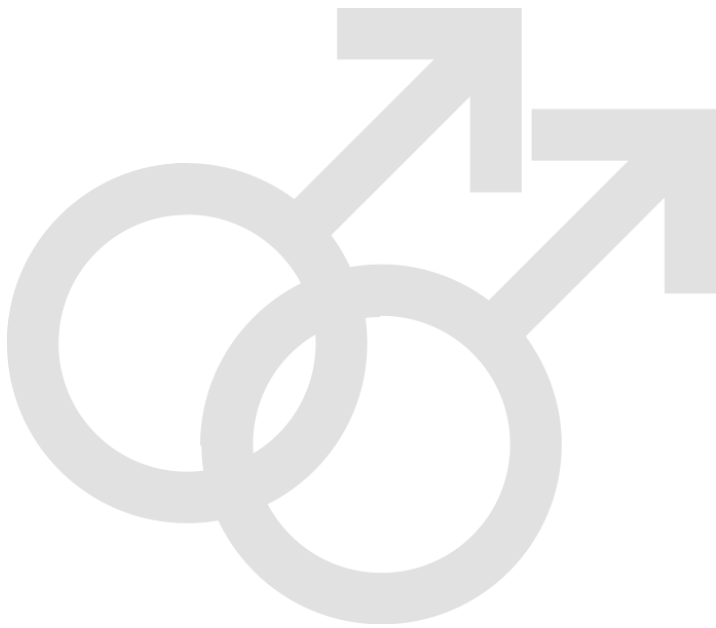
Nomadic tribes such as the Maasai are often unable to obtain antiretroviral drugs for HIV positive children because their livestock requires them to move frequently. This creates non-adherence to a consistent ART routine. While this is harmful for everyone, it affects children most negatively.



Providing comprehensive HIV/AIDS education to children is crucial. AIDS education is a part of the curriculum in both primary and secondary schools, and as a result awareness about HIV/AIDS in Kenya is high. This has not been without difficulty, as some public schools still struggle to implement AIDS education. Some reasons for this include: not enough time in the curriculum, lack of teacher training and support, and reluctance by parents and the government to talk freely about sex and condoms.

# HIV/AIDS stigma and discrimination

Despite the high prevalence and awareness of HIV in Kenya, there is still a huge stigma placed on those who suffer from the virus. Many people fear disclosing their HIV status to their communities, and consequently do not seek much needed medical services.



Homosexuality is illegal in Kenya. Therefore, the high risk group of MSM have an extremely difficult time seeking HIV services. They often face discrimination from their communities and their lifestyle is punishable by up to 14 years in prison. Finding ways to offer HIV services to MSM privately is a way to surpass the stigma.

Women face a particularly high level of discrimination. Many people view HIV as a punishment for immoral behavior. For instance, if a woman is diagnosed as HIV+, she may be accused of having an affair. If this woman denies an affair, she is considered to be a liar and often suffers from violence in the home. This is harmful emotionally, physically, and mentally. The effects of stigma can tear families apart in Kenya. It is important to understand the difficulties women face, as they have suffered much more than they will say.



# As a volunteer...

You can contribute to **HIV prevention and treatment** in Kenya in many ways:

1. Be knowledgeable about HIV/AIDS so that you can raise education and awareness at your placement.
2. Answer questions honestly and with confidence. If you don't know, ask. Never give someone incorrect information.
3. Encourage HIV testing.
4. Encourage everyone to practice correct and consistent condom use .
5. Practice nonjudgmental communication. Be open and honest.
6. Have an open mind. Understand that there are often many unspoken challenges that people face.
7. Take initiative—if you see a need that you can fill, do it. If you need help, ask.
8. Engage in conversations. Listen when people share their stories with you.
9. Be respectful of privacy and dignity.



# As a volunteer...

**Be yourself and enjoy each day!**  
Remember that you are making a difference!  
**Always ask questions!**  
Work as hard as you can for the time that you are here!  
**Change happens because of you!**



When volunteering for the improvement of the HIV/AIDS situation in Kenya, always be aware of your surroundings. Understand the risks and act accordingly. Practice universal precautions when you are at your placement.

The information provided in this booklet is from:  
<http://www.avert.org/hiv-aids-kenya.htm>  
<http://www.unicef.org/infobycountry/kenya.html>  
<http://www.who.int/countries/ken/en/>  
For more information, visit the websites listed above.  
Contact: Hannah Patterson— HP296305@gmail.com



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