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Effectiveness of HIV and AIDS Intervention in the Kenya Police Service

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Abstract

An estimated 2.7 million new infections were recorded worldwide in 2008 with over 6800 new infections on a daily basis. The HIV prevalence among ages 25 to 34 years is expected to be 45% by the year 2015 and majority of police officers are within this age bracket and are key in dealing with the HIV vulnerable populations. The objective of the study is to determine the effectiveness of HIV intervention measures in the Kenya Police Service. A total of 405 police officers took part in the survey and majority were males with 99% having secondary education and above. Majority of the respondents have know their HIV status and with a prevalence rate of 7% there exist many misconceptions about the pandemic in the Kenya Police Service making more officers vulnerable due to the nature of their duty and very little support extended to the infected. The study recommend support programmes be initiated for the officers and their immediate families to avoid misconceptions and reduce stigma and social exclusion.

Keywords: HIV and AIDS, Kenya Police Service, Vulnerability and Interventions

Introduction

In 2008 an estimated 2.7 million new infections occurred worldwide and over 2 million people died from Acquired Immune Deficiency Syndrome (AIDS) related illnesses, mostly because of inadequate access to HIV prevention and treatment services (UNAIDS/WHO, 2009). By 2030, HIV and AIDS may appear to be main cause of diseases and deaths at 12% given that every day over 6800 people become infected with Human Immunodeficiency Virus (HIV) (Meyrowitsch and Bygbjerg, 2007). In adults aged 15 years to 49 years HIV prevalence ranges from 4.6% to 5.5% (Figure1). Over thirty million people worldwide now live with HIV and AIDS out of which 22.4 million are from Sub-Saharan Africa (UNAIDS/WHO, 2009), which still has the heaviest burden of dealing with the pandemic. According to South African Police Service (SAPS), a maximum of 8% to 10% functional Police officers might be infected with HIV in South Africa.

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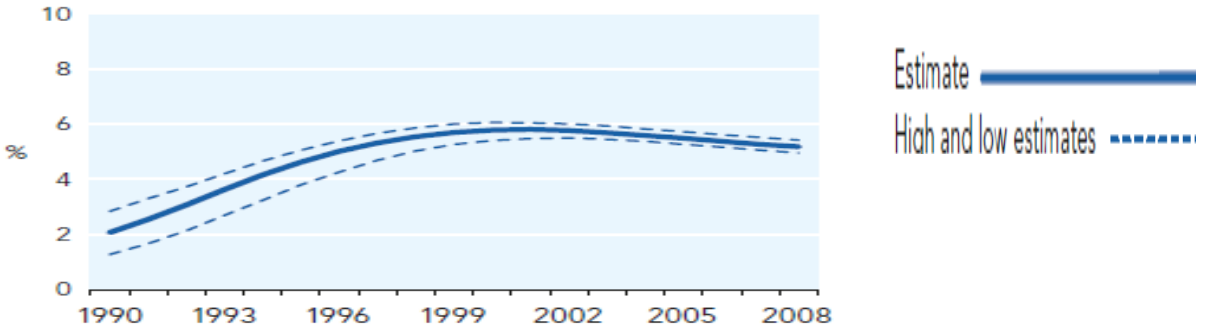


Figure 1: Estimated adult (15-49) HIV prevalence % in Sub-Saharan Africa, 1990 – 2008, **Source***: UNAIDS/WHO, 2009*.

Age specific prevalence projections indicate that HIV prevalence amongst people aged between 25 and 29 years and between 30 and 34 years is expected to increase from 17% in 2000, to approximately 35% and 45% respectively by 2015. While not all deaths and discharge due to ill health in the department are related to HIV and AIDS, the significant increase over this period is quite high (Schönteich, 2003). A survey of the Ethiopian Police officers in the year 2000 reported an infection rate of 7% whereas in 2004, a survey of their wives revealed an infection rate of almost 30% (Avert, 2007). In the year 2002, the HIV prevalence rate in Kenya was found to be 14.3% in urban areas and 6.3% in other areas (WB, 2004). The highest prevalence rate of 35% was reported in Suba, while in Bamba, Kalulumo and Kilifi the rate was 4%. Among women aged between 15 and 19 years, HIV prevalence was 23%, compared to 3.5% among men of the same age.

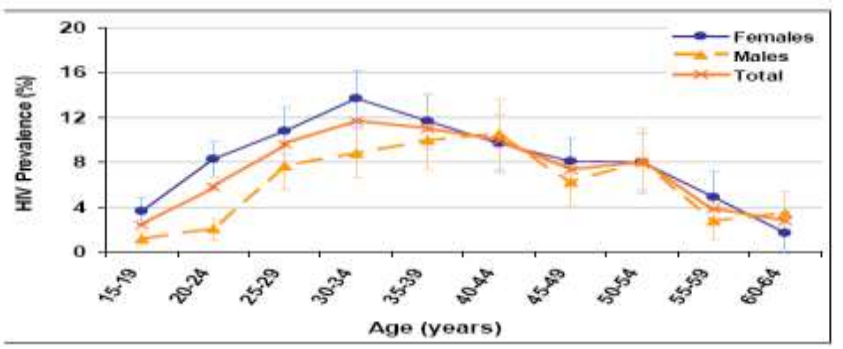


Figure 2: Prevalence of HIV among 15 – 64 years old, **Source***: NASCOP, 2008.*

As is the case in many African countries, HIV prevalence in Kenya is higher among women (8.7%), than men at 4.5% (UNAIDS, 2006). According to 2007 Kenya AIDS Indicator Survey (Figure 2), the National HIV prevalence rate is estimated at 7.4% (Mwai, 2008; NASCOP, 2008). Recognizing the pandemic as one of the greatest health challenges of our times, the then USA President George W. Bush announced the emergency plan, to address the disease (PEPFAR, 2004). The Kenya government declared the pandemic a National disaster in 1999 and developed a National AIDS policy and an institutional framework, intensifying intervention measures for the prevention, management, control and mitigation of socio-

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economic impact of HIV and AIDS (GOK, 2005). With 1.4 million people aged between 15 and 64 years currently living with HIV, Kenya is still contending with a serious AIDS epidemic, as one in ten married couples is HIV infected (Mwai, 2008).

Theoretical Basis of Research

Studies on HIV and AIDS have not addressed the Kenya Police Service (KPS), yet they are in the frontline, dealing with key groups that are vulnerable to high level of HIV. According to Bayre and Bazergan (2007), these groups include commercial female sex workers (FSW's), trafficked women and children, children living and working on the streets, detainees, intravenous drug users (IDUs), illegal immigrants, stigmatized groups such as men having sex with men (MSM) and People living with HIV and AIDS (Schneider and Moodie, 2002). Prolonged HIV and AIDS related cases tend to affect the staff in their ability to work, causing high staff turnover, high recruitment and training cost to replace the deceased officers or those affected, expensive medical care and funeral expenses (Kenya Police, 2006). Each year approximately 2000 new officers are recruited to join the KPS. These officers, apart from increasing the strength, are meant to replace those who die, retire, resign or are removed from the service. The recruits are between the ages of 18 and 30 years and have just left school and other academic institutions and are not different from other young people in the country (UNAIDS, 2003). Some of these recruits are already infected with the virus before joining the KPS. In response to the national policy on the prevention and management of the epidemic, AIDS Control Unit (ACU) was established at KPS headquarters to provide guidance and counselling services, collect and disseminate routine information on absenteeism, morbidity and mortality for the purpose of human resource planning, mainstreaming HIV and AIDS into core functions and work plan of the KPS (Kenya Police, 2006) and the objective of the study is to determine the effectiveness of the HIV intervention measures in the KPS.

Research Background

Challenges Facing the Kenya Police Service

The KPS was established by the constitution of Kenya Article 243 and under provisions of an Act of Parliament known as the National Police Service Act 2011 (GoK, 2012). The Police Act provides for the functions, organization and discipline of the KPS and the Kenya Police Reserve (KPR) and for matters incidental thereto. In addition to the Act, the KPS is also guided by the Service Standing Orders (SSO). The functions of the KPS as set out in Section 24 of the National Police Service Act, 2011 are:- Provision of the assistance to the public when in need; Maintenance of law and order; Preservation of peace; Protection of life and property; Investigation of crimes; Collection of criminal intelligence; Prevention of detection of crimes; Apprehension of offenders; Enforcement of all laws and regulation with which it is charged; and Performance of any other duties that may be prescribed by the Inspector General of Police under this act or any other written law from time to time.

The KPS today faces numerous challenges, most of which are linked to inadequate funding. These challenges undermine the KPS efforts to live up to its mandate. Some of these include additional personnel which the KPS needs to improve quality of its service, poor housing which makes officers not live together with families and be predisposed to HIV infection and low wages. The increase in

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administrative units in the country has necessitated the establishment of additional Police commands and units, including housing for officers, equipment, arms and motor vehicles to back this rapid expansion. There has also been the upsurge of terrorists and terror gangs which call for a Police Service that is well equipped and trained to cope with these new security demands given that forensic analysis and research on crime and other security concerns are still lacking in the KPS (CHRI, 2005).

HIV Transmission

The HIV is carried in blood and other body fluids, including breast milk. Approximately 75% of HIV cases are spread through unprotected penetrative sex with an infected partner. Other significant infection routes are transmission from an infected mother to child during pregnancy, at birth or during breast feeding accounting for between 5% and 10% (Kiragu, 2001). Infected blood transfusion constitutes 5% to 10%. Donated organ transplants, sharing of hypodermic injections, needle prick accidents, congenital transmission and other traditional invasive practices such as tooth extraction, circumcision, skin piercing, scarification and bloodletting operations are some of the methods through which infection takes place though insignificant in relation to heterosexual activities (Ndeda, 2000). The time from infection to AIDS varies between individuals and depends on many factors like age and body immune system. The HIV and AIDS satisfy the disaster model given by the equation 1:

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

Where R = Risk is a function of D, E, V
D = Dangerousness,
E = Exposure and
V = Vulnerability of a person or community

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

Cure for HIV and AIDS

There is no cure for HIV and AIDS at this moment in time. However, a variety of treatments are available that can help keep symptoms at bay and improve the quality of life of those who have already developed symptoms (Zugar, 2006). Antiretroviral therapy offers an opportunity to improve the prognosis and quality of life of people living with HIV and AIDS by suppressing the replication of the HIV virus in the body. A combination of several antiretroviral agents, termed Highly Active Antiretroviral Therapy (HAART), has been highly effective in reducing the number of HIV particles in the blood stream, as

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measured by a blood test called the viral load. It is not a cure for HIV, and people with suppressed levels of HIV can still transmit the virus to others through sex or other modes and Zugar (2006) is of the opinion that HIV may become resistant to HAART in patients who do not take their medications on schedule every day. Scientists have also developed a pill to be taken before sex that stops transmission of HIV and is already being prescribed to a limited number of patients although studies are still ongoing (Gathura, 2008b).

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

(a) Nucleoside Reverse Transcriptase Inhibitors (AZT- Zidovudine, Retovir, d4T-Zerit, Stavudine, Ddl-Videx, didanosine, 3TC-Epivir, lamivudine, Abacavir-Ziagen, 1592, ABC, Ddc-Hivid, Zalcitabine, Combivir-AZT/3TC together, Trieivir-AZT/3TC/Abacavir together)
(b) Non-Nucleoside Reverse Transcriptase Inhibitors (NVP-nevirapine, viramune, EFZ-efavirenz, sustiva)
(c) Protease Inhibitors (IDV-Indinavir, crixivan, NFV-nelfinavir, viracept, LPV/r-lopinavir, ritonavir/norvir)

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

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

Myths and Beliefs of HIV and AIDS

Many Africans continue to view HIV and AIDS as a witchcraft phenomenon brought about by women who become infected and are blamed and frequently ostracized by their families (CDC, 2007). Social religious and cultural practices have exacerbated the African pandemic. Some people see themselves above getting infection because of the superiority of their religion or an irrational perception of their righteousness, hindering communication about safe sex. Some believe that a man with HIV can rid himself of the disease by having sex with a virgin girl (Zugar, 2006). In South West Nigeria, some people still do not believe that there is AIDS. The reason being that they have not seen an AIDS victim before or that they knew the danger posted by HIV with fatalism, arguing that one will eventually "die of something", and so is not prepared to change their sexual behaviour simply because of the threat of HIV. The belief in Nigeria has it that AIDS is a "white man" disease; AIDS is a plot to control population growth in Africa; AIDS is spread by casual social contact such as living and eating together with an infected person, hugging the victim and donating blood (Osinubi and Amaghionyeodiwe, 2005).

Among the Luo of Nyanza Province in Western Kenya, it was long believed that death by AIDS was a curse or "*chira*" (*Luo belief of a curse which befalls people who are seen to have gone against the customs and traditions of the society characterised by wasting away with signs and symptoms similar to full blown AIDS and may lead to death*), which was brought about by witchcraft, malicious behaviour, unpaid debts, or a host of other reasons. The Luo thought it was witchcraft or that some people did not

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follow the traditional laid down ways of living and so when one fell sick traditional medicines were administered or seek the cultural causes of the disease and were still in denial. This belief has since changed (ICRAF, 2003).

Some of the misconceptions about the pandemic include the notion that HIV is a disease that only homosexuals and drug users can get; there is a cure for HIV and AIDS; HIV and AIDS mean one is going to die; people with TB have HIV and AIDS. Other beliefs are that someone cannot get HIV by having sex for the first time; or only has sex with a person once; HIV can be transmitted through mosquito bite, sharing a drinking glass, being around someone who suffers from AIDS and he/she coughs, among others. All these are untrue and transmission of HIV can only occur if someone is exposed to blood, semen, vaginal fluid or mother's milk (Zugar, 2006). However, exclusive breastfeeding where there is no food or other liquids significantly reduces the risk of infection when the breastfeeding is stopped at six months (Highleyman, 2008).

Research Methodology

The population, sample and sampling

The study was carried in Kenya and the target population for the study to which the results was generalised is the 40,000 KPS officers stationed in various stations in Kenya. Stratified and simple random sampling procedures were applied to ensure that a proportionate sample size of 405 officers was proportionately distributed among the 40,000 Police officers throughout the Republic of Kenya.

Research Tools

This is a descriptive survey and involves the determination of the effect of HIV and AIDS on KPS officers' performance of duty. Two main methods, questionnaire (structured questions which measured the objective responses and unstructured questions which measured the subjective responses) and key informant interviews were used in data collection (Creswell, 2003). The interviews were carried out with the heads of operation sections of various divisions and also the in-charge Voluntary Counselling and Testing (VCT) centres under the KPS, while questionnaires were filled by the sampled respondents. Participation was done at individual level to maintain confidentiality as stigma and discrimination is still high in the KPS. For those sampled, the purpose of the study was explained.

Ethical Considerations

Ethical authorization was sought from the participants. The study was conducted with ethical requirements as stipulated by the Ministry of Health. This included consideration of the following: methods used were not intrusive, either by question or procedure to embarrass the respondent, personal data were handled and stored with confidentiality to avoid traumatizing the respondent and data collected were used for the said study only (Creswell, 2003). The confidentiality of the respondents was protected in that no names or personal information were required in the questionnaire or during key informant interview and measures were taken to ensure no coercion or undue influence was exercised by the

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commanders on the selected responders to participate and this ensured that they gave their best (Mugenda and Mugenda, 2003).

The Analysis of Data

We have used Descriptive statistics and inferential statistics for analyzing data.

Research Findings

A total of 405 Police officers took part in the study. In terms of gender breakdown, 302(75%) were male officers and 103(25%) were female officers. Majority 354(87%) of the officers ages ranged between 18 and 45 years (Table 1). The mean age of the officers is 35 years which means most officers are in their prime ages. These are the ages when most officers are sexually active and physically fit.

Table 1: Age Category of Officers

Age Category	**Frequency**				**Total**
	Male		**Female**		
	n	**%**	***n***	**%**	***n* (%)**
18-24	17	4	23	5	40(9)
25-35	126	31	45	11	171(42)
36-45	116	29	27	7	143(36)
46 and Above	43	11	8	2	51(13)
Total	**302**	**75**	**103**	**25**	**405(100)**

Source: Field data

The level of education of the Police officers was assessed. Given that 401(99%) of the officers have secondary school level of education and above, they can access and even disseminate information among themselves about HIV and AIDS as high illiteracy causes inaccessibility to accurate and reliable information about the pandemic. However, knowledge about personal HIV status declines as level of education increases. The highly educated officers are afraid of knowing their status for fear of stigmatization, as majority of them happen to be highly placed within the KPS command.

The length of service of officers was assessed and 156(38%) officers have worked for between 10 and 20 years in the KPS, 93(23%) between 6 and 10 years, 84(21%) for over 20 years with a small number of 72(18%) officers having been in the KPS for less than 5 years. This indicates that most of the infections occur while the officers are in employment and is attributed to the vulnerability of the officers. The marital status of officers was also assessed and the results revealed that majority of the officers 320(79%) were married. Only 69(17%) of the officers were single with a small proportion 16(4%) being divorced, widowed or separated. Married couples are over 50% more vulnerable to HIV and AIDS compared to other groups yet many perceive themselves as being at very low risk of contracting the virus by being faithful to one partner when the partner might not be faithful.

The prevalence rate of HIV in the KPS was estimated at 5.9% from the VCT centres within KPS areas of command, 1.5% below the estimated national prevalence rate of 7.4%. Out of 405 officers interviewed,

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110(27%) had not taken the test, 295(73%) tested for HIV and 27(7%) were positive while 268(66%) were negative. However, awareness and knowledge about HIV and AIDS among Police officers was found to be very high 405(100%), which is the case generally in Kenya and in most Sub–Saharan countries with similar conditions regarding HIV and AIDS as compared to 99% in MoH (2005).

Knowing how long an officer has between the infection, illness and death is important in plotting the effect of the pandemic on the KPS. Quite a number of the Police officers have not tested themselves for HIV despite having VCT centres near or within selected KPS stations. Of those who have not been tested for HIV, 83(75%) are willing to go for the test while 27(25%) are not ready to have the HIV test. The VCT services were initiated in 1995 in the KPS (Kenya Police, 2006) and the workplace HIV testing is an indication of the weak initiatives, which have been put in place by the KPS towards making VCT services available and accessible to Police officers. The numbers of officers who have not tested suggest that the sero-prevalence among the sample population is likely to be much higher than the 7% indicated.

Reasons for Having HIV Test

Reasons for having HIV test among Police officers were assessed. Majority of the officers 324(80%) wanted to know their HIV status and take control of their lives. This response shows that many officers have taken it at a personal level to know their status. There has been a vigorous campaign against HIV and AIDS in the KPS in terms of prevention and management of the already infected. About 20(5%) of the officers who are female were expectant, and 8(2%) were donating blood while 53(13%) were either going for peace missions or travelling outside the country (Figure 3).

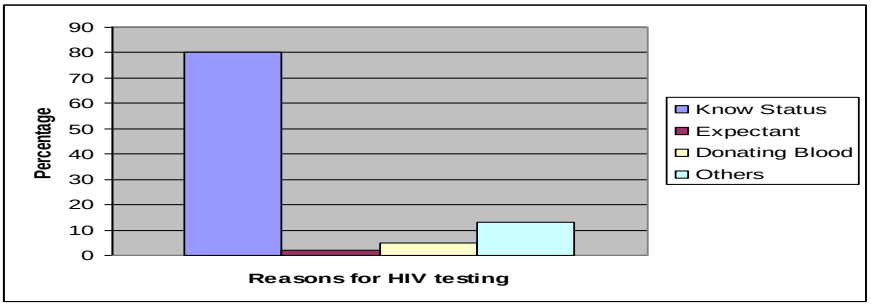


Figure 3: Officers Reasons for having HIV Test
Source: Field data

The HIV and AIDS stigma is a major contributing factor to worsening the plight of most people living with HIV. It prevents people from being tested for HIV, and thus increases the risk of transmission. This corroborates findings by IFRC (2008) in which Police officers gave many reasons as to why they went for the HIV testing.

Modes of HIV Transmission as provided by Officers

Police officers are always at very high risk of contracting HIV. The modes of HIV transmission known to the officers were assessed. The officers identified the modes of HIV transmission indicated in Table 2 as the most common.

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Table 2: Modes of HIV transmission provided by officers

Modes of HIV Transmission	Frequency	Percentage
Unprotected Sex with an Infected	398	98
Infected Blood Transfusion	266	66
Contact with an Infected Body Fluids (Wounds)	80	20
Mother to Child Transmission	73	19
Sharing of Needles and Other Sharp Objects	104	26
Note: More than one response was possible from a respondent (*n* = 405)		

Source: Field data

About 398(98%) identified unprotected sex with an infected person as the most basic means through which one can be easily infected. Close to 266(66%) indicate that one can easily be infected through transfusion of blood which is not properly screened for the virus. While 104(26%) identified sharing of needles and other sharp objects, approximately 80(20%) indicate that coming into contact with infected body fluids through open wounds would transmit the virus. Nearly 73(19%) indicate mother to child transmission as a mode of HIV transmission.

Knowledge of modes of transmission of HIV is one of the key determinants of susceptibility of Police officers to the pandemic. The result indicates that Police officers are aware of the various modes through which HIV can be transmitted from one person to another. However, much intervention measures are still required as officers need to understand the other modes of HIV transmission apart from sexual contact. It is important to take precaution especially when dealing with scenes of crimes as only 80(20%) indicated this as a mode of transmission. Open wounds constitutes a major source of infection and misconceptions are still large. These findings shows that HIV and AIDS advocacy and awareness campaigns need to put more efforts as more knowledge is required. The HIV and AIDS awareness and prevention campaign programmes need to be regularly updated to facilitate better understanding of credible research findings, including protecting Police officers against misleading theories about modes of HIV transmission.

Vulnerability to HIV and AIDS

The officers' chances of contracting HIV were assessed. Majority 227(56%) indicate that their chances were relatively high. About 150(37%) of the respondent indicate that their chances of contracting the virus was low and that they take a lot of precaution while 28(7%) indicate that they have no chances at all of contracting the virus as they are faithful to only one partner and takes precautionary measures while on duty. This is a misconception among police officers and even the general public (Figure 4).

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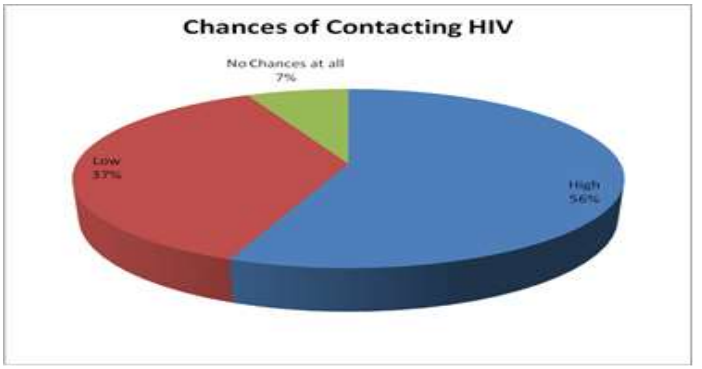


Figure 4: Chances of contracting HIV as provided by officers
Source: Field data

Police officers exposure to HIV and AIDS infection, on account of nature and location of the workplace and measures put in place by the Police to counter such exposure, are important indicators of the impact on officers. The public sector workplace policy on HIV and AIDS is clear on measures that need to be addressed to ensure HIV prevention and mitigation of impacts.

The officers' reasons for their perceived chances of contracting HIV were assessed. Close to 210(52%) of the officers indicate that they are more at risk as a result of the kind of work and the exposure of interaction with many people (Table 3).

Table 3: Officers vulnerability to HIV and AIDS

Reasons for vulnerability	**Frequency**	**Percentage**
Nature of Duty (Exposure)	210	52
Transfer	89	22
Frequent Travel	56	14
Housing	32	8
Don't Know	18	4
Total	**405**	**100**

Source: Field data

About 89(22%) cited transfers, which in most cases, is to a stations where family can not accompany one easily, 56(14%) indicate that the kind of duties allocated to them involve frequent travels and spent nights in market centre lodgings that have commercial sex activities and 32(8%) indicate housing as a major cause while 18(4%) did not know what increases their vulnerability. Police officers admitted that while on patrol, commercial sex workers arrested usually offer sex on the way to station to be released and at times one has no condom for protection. This corroborates the view held by AMREF (2006) which states that while on patrol female suspects arrested usually offer sexual favours to officers in order not to be taken to cells or court. This makes officers more vulnerable to the virus than any other group.

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Knowledge of HIV Positive Colleague and His or Her Marital Status

Knowledge of any HIV positive colleague and his or her marital status was assessed. The results revealed that many officers 217(54%) were aware of an HIV positive colleague. While 182(45%) knew of the marital status of the HIV positive colleague, 35(9%) did not know the marital status of the infected officer. Close to 188(46%) do not know the HIV and marital status of their colleagues (Table 4). According to NASCOP (2008), one in ten married couples was HIV infected and nationally steady heterosexual partners are more at risk of infection than any other group.

Table 4: Knowledge of HIV positive colleague and his/her marital status

HIV^+ Colleague Marital Status	**Knowledge of HIV^+ Colleague**					
	Knows		**Don't Know**		**Total**	
	n	*%*	*n*	*%*	*n*	*%*
Married	142	35	-	-	142	35
Single	26	6	-	-	26	6
Others	14	4	-	-	14	4
Don't Know	35	9	188	46	223	55
Total	**217**	**54**	**188**	**46**	**405**	**100**

Source: Field data

Majority of the officers interviewed (54%) know their HIV positive colleagues and of this 45% know the marital status of those colleagues while 9% do not the marital status. About 46% of the officers are not aware of any HIV positive colleagues at the workplace. This can increase infection rates among officers. These are indications of the need to address stigma and discrimination issues and strategic responses for prevention of new infections among the Police officers.

Support to HIV Positive Officers

The support extended to HIV positive officers who have indicated their status to the commanders was assessed (Figure 5).

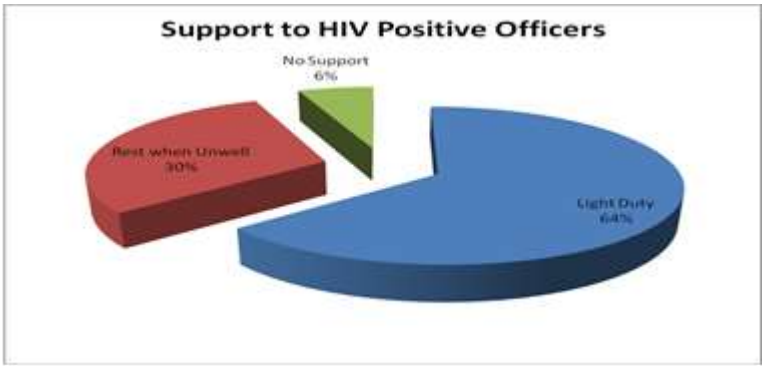


Figure 5: Support to HIV positive officers
Source: Field data

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Many commands indicated that HIV and AIDS programmes have been effectively implemented in their areas. Close to 259(64%) of the commanders indicated that they are given light duties while 122(30%) are allowed to rest when unwell and about 24(6%) of the commanders indicate that the officer continues to work like any other normal officer as there is no policy on duty allocation. Since there is no policy on duty allocation for the HIV positive officers and the fear of stigma, they continue to work as any other normal officer. The mitigation of impact, posed by HIV and AIDS involve adequate investments in human capital, including having a clear legal policy and institutional framework to address critical issues of HIV and AIDS. From the study findings many commanders are not aware of the HIV status of their officers. This makes it difficult to deal with the effects of HIV and AIDS, or to enhance evidence based planning and resource allocation towards boosting the capacity of the Kenya Police to respond to the impact of HIV and AIDS on service delivery.

Conclusion

From the study findings, it can be noted that HIV can be transmitted in three main ways namely sexual transmission, transmission through blood and mother to child transmission. For each route of transmission, there are things that an individual Police officer can do to reduce or eliminate risk. There are also interventions that work at group level. Proper communication of knowledge about the disease, the study and change of social and cultural environment, proper health care and other factors play an important role in preventing the disease from spreading as misconceptions are still high. There are intervention measures put in place by the KPS to reduce vulnerability of the officers. However, these measures are not adequate and have not been rolled down to the station level. Many officers do not know their HIV status and stigma is still high.The HIV and AIDS policies have not been fully implemented in many commands as there are weak initiatives at VCT centres. Many VCT's within KPS areas of commands offer HIV counselling and testing only without comprehensive care and many officers test for HIV status at centres outside KPS command. Most commanders are not aware of the HIV status of officers under their commands. This hinder evidence based planning and resource allocation.

Practical Suggestions

Mobile populations like the Police have been regarded as vulnerable to HIV infection. Approximately 7% of Police officers are infected with HIV and the primary mode of transmission is heterosexual sex. Sexual behaviour change should be a major focus in the prevention efforts and understanding prevention efforts and changes in behaviour is important for both predicting the future path of the pandemic and the KPS. Support programmes should be initiated for the police officers and their immediate families with measures to reduce stigma and social exclusion strengthened.

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