Gender Audit of the National Response to HIV and AIDS, KENYA

July 2009
Gender Audit of the National Response to HIV and AIDS

Kenya

The Gender Technical sub Committee of the National AIDS Control Council
July 2009

UNFPA – because everyone counts.
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Foreword

The complex challenges caused by HIV and AIDS call for an extraordinary response to the epidemic. Globally, years of engagement with the epidemic have shown that HIV and AIDS programmes that address gender inequality as a central goal maximize their overall effectiveness. However, gender disparities in programming outcomes have remained pertinent as evidenced by recent studies including Kenya AIDS Indicator Survey (KAIS, 2007), Kenya Demographic Health Survey data (KDHS, 2003), and the Kenya Modes of Transmission Study (KMoT, 2008).

The Kenya National AIDS Control Council (NACC) understands the importance of gender integration in programmes. To this end, NACC established a Gender Technical subcommittee in 2001 to ensure that gender dimensions of the HIV and AIDS epidemic are translated into practical tools in decision-making and that programming done promotes gender responsiveness within HIV and AIDS policy formulation and implementation in Kenya. Whereas programming has received primary focus, there has been the lack of engagement with the broader framework, i.e., decision making structures and processes through which programmes and interventions are prioritized, planned, monitored, evaluated and financed.

It is for this reason that NACC secured consultancy services to conduct a gender audit with the aim of understanding to what extent gender is integrated in the structures and processes of the Kenya National Strategic Plan framework. Outcomes of this study would further 1) provide evidence for policy briefs targeted at HIV and AIDS policy makers and programme managers, researchers, implementers, and development partners; and 2) inform the development of guidelines for involved sectors for the systematic and effective integration of gender into the national HIV response. This is, therefore, the first gender audit of the national HIV and AIDS response of its kind to be undertaken in Kenya since it focuses on structures and processes. The findings of this audit have informed the development of KNASP 2009/10–2012/13 including the operational framework and institutional arrangements.

It is hoped that this report will provide in-depth understanding to policy and senior level decision-makers, programme planners and officers, of the linkages between gender dimensions and KNASP framework structures and processes and the identification of appropriate entry points to effectively and systematically integrate gender in HIV and AIDS initiatives.

Lastly, I wish to personally extend my gratitude to all stakeholders who actively participated in the process of this gender audit.

Prof. Alloys S. S. Orago
Director
Acknowledgements

The process of conducting this gender audit of the national HIV and AIDS response in Kenya was highly participatory and it included various stakeholders from the public and private sectors, civil society, Faith-based organizations and international agencies.

Special thanks go to UNFPA, UNAIDS through AMREF/TSF and the Government of Kenya for financial support; NACC Director and the entire Coordination and Support Division for leadership and guidance to the process.


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Many thanks go to all NACC staff especially Dr. Bathsheba Osoro, Ondeng’ Onyango, Dr. Patrick Mureithi and Charles Mwai and Edwin Kimutai for their constant support to the process. We can not forget to thank respondents from the AIDS Control Units in Government Ministries, organizations which represent People Living with HIV and AIDS, Civil Society Organizations, International NGOs, Academia, UN Agencies, Department of Gender and Faith-based organizations without whom, this process would not have been complete. Consultations with representatives of various implementing agencies were held in the regions and we wish to thank all those who participated.

The invaluable support and contribution offered by various organizations, institutions and individuals is greatly acknowledged. A full list of organizations and individuals is provided in Annex 2.

Dr. Sobbie Mulindi
Deputy Director, Coordination and Support
# List of Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>ACU</td>
<td>AIDS Control Unit</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>CACC</td>
<td>Constituency AIDS Control Committee</td>
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<td>CBO</td>
<td>Community Based Organizations</td>
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<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination against Women</td>
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<td>CSO</td>
<td>Civil Society Organizations</td>
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<td>DDO</td>
<td>District Development Officer</td>
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<td>DTC</td>
<td>District Technical Committee</td>
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<td>ERS</td>
<td>Economic Recovery Strategy</td>
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<td>FBO</td>
<td>Faith Based Organizations</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>FY</td>
<td>Financial Year</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>GIPA</td>
<td>Greater Involvement of People living with HIV and AIDS</td>
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<td>GTC</td>
<td>Gender Technical sub-Committee</td>
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<tr>
<td>HBC</td>
<td>Home Based Care</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-Deficiency Virus</td>
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<td>ICASA</td>
<td>International Conference on AIDS and STIs in Africa</td>
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<td>ICC</td>
<td>Inter-Agency Coordinating Committee for HIV and AIDS</td>
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<td>IDU</td>
<td>Injecting Drug Users</td>
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<td>JAPR</td>
<td>Joint Annual HIV and AIDS Programme Review</td>
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<td>KAIS</td>
<td>Kenya AIDS Indicator Survey</td>
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<td>KANCO</td>
<td>Kenya AIDS NGO Consortium</td>
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<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<td>KNASP</td>
<td>Kenya National HIV and AIDS Strategic Plan</td>
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<tr>
<td>M &amp; E</td>
<td>Monitoring &amp; Evaluation</td>
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<td>MARPs</td>
<td>Most at Risk Populations</td>
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<td>MCG</td>
<td>Monitoring Coordinating Groups</td>
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<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<td>NACC</td>
<td>National AIDS Control Council</td>
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<td>NASCOP</td>
<td>National AIDS and STI Control Programme</td>
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<td>NGO</td>
<td>Non-Governmental Organizations</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PLWHA</td>
<td>People living with HIV and AIDS</td>
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<td>PPP</td>
<td>Public-Private Partnerships</td>
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<td>PWD</td>
<td>Persons with Disabilities</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TOWA</td>
<td>Total War against HIV and AIDS</td>
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<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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Glossary of Key Concepts

**Gender**: refers to the socially constructed roles, responsibilities, behaviors and expectations associated with men and women. Gender roles vary depending on the place, time, socio-economic, political and cultural context. Gender analysis is done to reveal and clarify women’s and men’s different social roles, responsibilities behaviour, power relations and expectations. It involves the collection and use of sex disaggregated data to understand crucial HIV and AIDS related issues and inform programmes, policies and legislation that enable women and men to protect themselves and each other from infection.

**Sex differentiated from gender:**
Sex refers to the biological differences between men and women; the biological characteristics that categorize someone as either female or male. Men and women play different roles that are shaped by biological, ideological, historical, religious, economic and social-cultural determinants.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Biological</th>
<th>Born with</th>
<th>Cannot be changed</th>
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<tr>
<td>Gender</td>
<td>Socially constructed</td>
<td>Learned through socialization</td>
<td>Can be changed/dynamic</td>
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**Gender Audit**: the analysis and assessment of policies, programs and institutions based on whether they take into account the different impacts of their activities on women and men

**Gender Analysis**: This diagnoses differences between men and women in conditions, needs, level of participation, access to resources and development, control of assets, decision-making powers etc. within the context of the prescribed gender roles. The analysis demonstrates specific activities, conditions, needs, their access to resources (particularly financial) and possibility of administering them, as well as their access to development assistance and decision-making. Analyses examine these ties and other factors in their broader social, political and economic context and in the context of the environment. A gender analysis presupposes chiefly the gathering of data classified by sex and gender-sensitive information on the relevant population. Gender Analysis can also be described as the systematic gathering and examination of information [using appropriate tools] on the relationships between men and women in terms of access to resources, their activities, and the constraints they face relative to each other. It provides information on the different conditions those women and men face and the effects that policies and programs may have on them because of their situations.

**Gender Planning**
The technical and political processes and procedures necessary to implement a policy which recognizes the different roles, and therefore, different needs of men and women in a given society.

**Gender integration**: ensures gender equality. Both women and men specific concerns are taken into consideration in the design and implementation of structures, processes, programming and financing of HIV responses to ensure that
both women and men benefit equally. Gender integration therefore focuses on the real needs of women and men. Gender Integration as used in this study refers to the process of assessing the implications for women and men of any planned action in the national HIV response. These include the programmes, projects and interventions in the research area. It is a strategy for making women’s as well as men’s concerns and experiences an integral dimension of the activity plans, implementation, monitoring and evaluation of these projects and interventions so that women and men benefit equally and inequality is not perpetuated.

**Empowerment:** The ability of a woman/man to control her/his own destiny. For women to be empowered they must not only have equal capacities and equal access to resources and opportunities but must also have agency to use those rights to make choices and decision provided through leadership opportunities and participation in political institutions. The pillars of empowerment include capacities, resources, opportunities, and security.

**Gender Equality:** This is the absence of discrimination on the basis of a person's sex in opportunities, in the allocation of resources and benefits or in access to services. An attainment of fundamental rights, a situation where men and women are seen to be equal, provided with equal opportunities in the society, enjoying equal benefits and are treated the same before the law. Gender equality cannot come about only through changes in women’s condition – it requires transformation of the structures and systems which lie at the root of women’s subordination and gender inequality. This transformation cannot be induced by external interventions. Women must themselves become active agents of change. Gender equality therefore demands women's and men's empowerment, a process that leads to greater participation in social and political processes, greater decision-making power and to conscious action for social transformation. Gender Equality denotes women having the same opportunities in life as men, including the ability to participate in the public sphere.

**Gender Equity:** This refers to fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes. Gender equity denotes the equivalence in life outcomes for women and men, recognizing their different needs and interests, and requiring a redistribution of power and resources.

**Engender:** The process of ensuring that planning and programming is appreciative of and takes into account the female and male differences and concerns.

**Gender Discrimination:** Prejudicial treatment, restriction or exclusion made on the basis of one’s gender - man or woman, which has an effect of impairing or nullifying the recognition, enjoyment of human rights and fundamental freedoms.

**Gender Issues:** Specific consequence of the inequality of men and women.

**Gender Sensitization:** This is the process of developing people’s awareness, knowledge and skills on gender issues.
**Gender sensitivity**: Awareness of gender issues and gaps, recognition that gender roles are socially constructed and can change over time and that woman and men have equal rights to access to and control over resources, to participation and fair treatment in life and in development programmes.

**Gender responsiveness**: Putting actions/activities in place to address gender-based unfairness and discriminatory treatment to promote equity, empowerment and advancement of both men and women.

**Gender based violence**: This is an umbrella term for any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed (gender) differences between males and females.

**Gender Training**
This refers to a facilitated process of developing awareness and capacity on gender issues, to bring about personal or organizational change for gender equality.

**Practical Gender Needs [PGN]**: Practical gender needs are the needs women identify that do not challenge their socially accepted roles. They include basic living commodities such as shelter, employment and food. They require short-term strategies to realize.

**Strategic Gender Needs [SGN]**: Strategic gender interests challenge those roles in favor of equity for women. They require long-term strategies to realize. Moser (1999) defines SGN as ‘the needs women identify because of their subordinate position to men... relate to gender division of labor, power and control and may include such issues as legal rights, domestic violence, equal wages and women’s control over their bodies’. Meeting SGN helps women to achieve greater equality. It also changes existing roles and therefore challenges women’s subordinate position.

**Gender mainstreaming**: The process of integrating a gender equality perspective into the development process at all stages and levels. Gender mainstreaming is a strategy for the achievement of gender equality.
Executive Summary

Background

Gender reviews of responses to HIV and AIDS have previously focused on programmatic results, intervention levels and activities developed and undertaken. However, gender disparities in programming outcomes have remained pertinent. According to KAIS (2007) about 1.4 million adults in Kenya are living with HIV with 8.7% prevalence among women and 5.6% for men. Young women of age 15-24 are 4 times more likely to be infected than men (6.1% compared to 1.5%). The biological make-up of women enhances their vulnerability to HIV infection and inter-links with gender-related vulnerabilities to escalate their risk to infection, burden of care, access to care and treatment services. On the other hand, due to stigma and prejudice regarding male sexuality, men are less likely to seek medical care, legal or psychosocial support (Jejeebhoy and Boit, 2003) thus increasing danger to HIV infection. All these observations point to the fact that effective integration of gender has not taken place in planning and decision making processes and structures, financing and reporting mechanisms within the national response by all stakeholders including government, implementing and development partners across the national and sub-national levels. There has been the lack of engagement with the broader framework, i.e structures, processes and financing of the national response through which programmes and interventions are prioritized, planned, monitored, evaluated and financed.

Basing on the factors above, NACC, through the Gender Technical Subcommittee, envisaged the need to conduct a gender audit of the national HIV and AIDS response with the aim of understanding to what extent gender is integrated in the national structures and processes through which HIV and AIDS initiatives are prioritized, monitored, evaluated and financed in Kenya.

The audit findings were expected to provide national guidance for effective gender integration in the processes for delivery of results as espoused in the KNASP III. Key outcomes of this report include:

1. Guidelines for each sector for the integration of gender into the national HIV response with a focus on processes, financing, structures and monitoring and evaluation framework
2. A policy briefing targeted at HIV and AIDS policy makers and programme managers, researchers, implementers and development partners in the public and private sectors as well as among the civil society.

Objective

The overall objective of the assignment was to audit the national HIV and AIDS response from a gender-sensitive standpoint. The audit was to be done with special attention inclined to the structures and processes through which programmes and interventions are prioritized, planned, monitored, evaluated and resourced.

Methodology

The services of a consultant were secured to conduct and facilitate the audit. The GTC appointed a 10-member taskforce from within its membership to oversee this process. The assignment entailed review of existing structures, processes, programming and financing mechanisms with the aim of establishing the extent to which gender perspectives are
integrated in HIV and AIDS interventions, constraints and limitations faced and identify
gaps and challenges and subsequently make recommendations for response. This
involved in-depth literature review of relevant documents and collection of empirical data
from stakeholders by administering structured questionnaires to key staff from
implementers in government ministries, members of JAPR and MCG, organizations
representing those living with HIV and AIDS, Civil Society Organizations, private sector
and development partners. Six regional consultative forums were conducted to capture
views from the regional partners. Periodic consultative meetings were held between the
consultant with members of the GTC and NACC staff to share and appraise information
gathered. On completion of the draft report, an experts meeting was convened to
critically review the report and build the consensus on the final document.

Findings

The main findings include:

- Overall, implementation of relevant policies and laws has been slow.
- Gender disparities are pertinent in legal, social, economic and political levels of
  participation in decision making, access to and control of resources, opportunities
  and benefits.
- Weak coordination, harmonization and networking among actors at all levels
- Inadequate resources (human and financial)
- Limited technical capacity and capacity consistency due to deployment / transfers especially in the public sector
- Monitoring and Evaluation (M&E) framework without gender sensitive indicators
- Socio-cultural issues
- Misinterpretation of the concept of gender as women rather than women, men,
  boys and girls
- Lack of gender sensitivity at core sector indicators development and targets
  setting
- Lack of budgetary allocation targeting gender activities at sector levels and
  national budget
- Weak structural linkages at different levels to facilitate translation of commitment
to actions with a sustained momentum.

Recommendations

Given the financial and human resource constraints, an enabling environment and
appropriate institutional frameworks are crucial to ensure that all HIV and AIDS-related
activities are effectively co-coordinated to address gender inequalities. Thus the
following factors are imperative:

- Legal and policy framework that supports advancement of gender equality and equity.
- Political and administrative will and commitment among the highest level at NACC
  Secretariat to gender equality and equity.
- Capacity building for all stakeholders and implementers working in the area of HIV
  and AIDS on gender concepts, gender-responsive planning, analysis and
  programming and the application of gender sensitive indicators for monitoring and
evaluation.
- Women and gender expertise represented at the highest decision making organs.
- Adequate human and financial resources for gender integration.
1.0 Introduction

The Kenya National AIDS Strategic Plan (KNASP) provides the overarching strategy for all HIV and AIDS interventions in Kenya for implementers from all sectors including the public sector, civil society, private sector and development partners. It further provides the framework and context within which sectoral HIV and AIDS strategies, plans and budgets are formulated and monitored. It also provides the framework for annual operational plans that bring together the efforts and contributions of various partners for operationalization of the national responses to HIV and AIDS. KNASP therefore constitutes the One Agreed Action Framework, in line with the internationally agreed “Three Ones Principles” to scale up national AIDS responses: One agreed HIV and AIDS action framework that provides the basis for coordinating the work of all partners; One national AIDS co-coordinating authority with a broad based multi-sectoral mandate and One agreed country level monitoring and evaluation system.

A review of the first Strategic Plan (KNASP 2000 – 2005) in 2001 revealed that there were gender dimensions to HIV and AIDS epidemic. In spite of this, responses in the strategy were not targeted to address these dimensions. This led to the establishment of a Gender Technical sub-Committee (GTC) whose aim was to ensure that gender dimensions of the HIV and AIDS epidemic do not just remain at intellectual level, but instead are translated into practical tools in decision-making and that programming was done to promote gender responsiveness within HIV and AIDS policy formulation and programming in Kenya. The efforts of the GTC in integrating gender in HIV and AIDS responses contributed towards informing the second Strategic Plan (KNASP 2005/06 – 2009/10) which clearly outlines the following strategies towards addressing gender inequalities: Ensure all prevention and advocacy strategies and programmes are gender sensitive in order to reduce vulnerability and risk of women and men; Promote health and quality of life for women and men infected and affected by HIV and AIDS; Reduce the negative social and economic impact of HIV and AIDS on women and men; Measure the success of engendered HIV and AIDS programmes; Establish gender sensitive policies to ensure that management systems provide an enabling environment for gender integration; and Protect the rights of women and men affected and infected by HIV and AIDS.

During the life of this consultancy, NACC begun the process of development of the third Strategic Plan III (KNASP 2009/10 – 2012/13) which was necessitated by new evidence from a population based AIDS indicator survey and mathematical modeling of modes of transmission of HIV in Kenya. Both the review of KNASP 2005/06 – 2009/10 and the development process of KNASP III were informed by findings and recommendations of this audit, although a specific gender programme audit of the achievements of the second strategic plan was undertaken for the purposes of the development of the third KNASP. This report outlines the audit of KNASP 2005/06 – 2009/10 processes and structures, while informing the development of KNASP 2009/10 – 2012/13 including the operational framework, institutional arrangements to the largest possible extent and programming.
1.1 Rationale for Gender Audit

Gender reviews of responses to HIV and AIDS have previously focused on programmatic results, intervention levels and initiatives/activities developed and undertaken. These qualitative and often non-representative studies and documentation have often noted the disparities in the desired results of HIV prevention, treatment and care responses that have been corroborated by national population-based HIV surveys including the Kenya Demographic Health Survey 2003 and the Kenya AIDS Indicator Survey (KAIS) 2007. While gender disparities in programming outcomes have remained pertinent, there has been the lack of engagement with the broader framework, i.e., structures, processes, and financing of the national response through which programmes and interventions are prioritized, planned, monitored, evaluated, and financed. This has meant that the effective integration of gender has not taken place in planning and decision making processes and structures, financing, and reporting mechanisms within the national response by all stakeholders including government, implementing and development partners across the national and sub-national levels.

In this regard, NACC, through the GTC, envisaged the need to conduct a gender audit of the national HIV and AIDS response with the main focus on the structures and processes for planning and programming.

1.2 Aim of the Gender Audit

The aim of this gender audit was to understand to what extent gender is integrated in the national structures and processes through which HIV and AIDS initiatives are prioritized, monitored, evaluated, and financed in Kenya.

The findings will provide national guidance for effective gender integration in the processes for delivery of results as espoused in the KNASP III. The expected outcomes of this report include:

1. A policy briefing targeted at HIV and AIDS policy makers and programme managers, researchers, implementers and development partners in the public and private sectors as well as among the civil society.
2. Guidelines for each sector for the integration of gender into the national HIV response with a focus on processes, financing, structures and monitoring and evaluation framework
2.0 Background

2.1 Status of the Epidemic in Kenya
This section is structured based on the priorities as identified in the KNASP 2005/06 – 2009/10 that formed the core basis of this audit.

2.1.1 HIV prevalence
The Kenya AIDS Indicator Survey (KAIS) provides evidence that the national response should be addressing the complexities of gender vulnerabilities to HIV in Kenya in a much more focused manner than has happened to date. 7.4% of Kenyans age 15-64 are infected with HIV. This translates to about 1.4 million adults living with HIV with 8.7% prevalence among women and 5.6% for men. This means 3 out of every 5 HIV-infected Kenyans are female. The data reveals further that HIV infection is higher in women until age 35 after which the ratio of male to female infections start to become equal. Young women of age 15-24 are 4 times more likely to be infected than men (6.1% compared to 1.5%). In the older age group 60-64 prevalence is higher in men than in women. The increase in HIV prevalence among rural males was found to be statistically significant representing 58% increase between the KDHS data (2003) and KAIS (2007).

Further young girls are 5.5 times more likely than young men their age to become infected even though young men tend to be more sexually active. The HIV-negative partner in a discordant relationship, sex workers, those in same-sex relationships especially men, injecting drug users and migrant workers whose higher percentage are males are among the most vulnerable groups to infection. HIV risk of infection has also been seen to rise among married couples. The KAIS revealed that, among married individuals who are HIV-infected, 45% have a partner who is not currently infected. There has also been a shift towards heterosexual transmission as the epidemic has spread. The Kenya Modes of Transmission Study of 2008 indicates that the highest incidences of infection are among partners in casual heterosexual sexual relationships.

Most literature on people with disabilities is from the West. It suggests that the risk of people with disabilities to be sexually violated is between one and a half to three times as high as that of other people. Disability is associated with increased physical and psychological vulnerability to sexual violence. Overprotection and internalized societal expectations of people with disabilities, and the limited opportunities available to learn to set boundaries for physical contact, increases their vulnerability to sexual violence. Sexual violence such as rape directed towards people with disabilities has been reported in association with HIV and AIDS in Africa.

The ‘feminization’ of the epidemic is apparent, with prevalence among women (8.8% for 15-49 and 8.4% for 15-64 age groups) significantly higher than among men (5.5% for 15-49 and 5.4% for 15-64 age groups). While prevention programmes among young people have contributed in delaying sexual debut and increasing risk perception, for young women who are already sexually active, prevention programmes have generally failed to make a difference (KAIS, 2006).
2.1.2 HIV prevention response

Prevention of new infections is a critical part of the national HIV response. The KNASP II had 8 result areas for HIV prevention. A review of KNASP II showed the following results.

- **Counseling and Testing:** only 36% of Kenyan adults know their HIV status; 80% of HIV infected people do not know their status; testing rates show little difference across provinces, despite large geographical variation in prevalence. Knowledge of HIV status is higher among women at 42%.

- **PMTCT:** testing and counseling reaches more than 80% of all pregnant women accessing MCH clinics with HIV CT services, but less than one-third of mothers tested are reached with nevirapine – also no clear evidence to suggest that efforts to-date are leading to HIV-negative babies being born to HIV-positive mothers.

- **Condom promotion:** condom use at last higher-risky sex shows substantial progress for both women (23.9% in 2003 KDHS - 35.0% in 2008 KAIS) and men (46.5% - 51.8%), but procurement and distribution systems remain a major challenge.

- **Voluntary Medical Adult Male Circumcision (VMAMC):** new – at least 16% of Kenyan males not circumcised mainly residing in the highest HIV prevalence areas; policy and rollout plans in support of MC in place; demand of MC at present is high and outstripping supply of services.

- **Transmission in health settings:** 100% of blood supply screened for HIV; 60% of injections by means of disposable syringes; and PEP only available at some VCT and ART sites.

- **Prevention with Positives (PWP):** relatively new area; hardly any coverage to talk about; approx. 250,000 Kenyans are aware of their positive HIV status but few receiving the interventions.

- **BCC –** some changes in risk behavior (e.g. condom use, delay in sexual debut, reduction in number of sexual partners), but not enough to turn off the tap of new infections numbering more than 200 per day.

2.1.3 HIV Care and Treatment

About 38-45% of those in need of HIV related treatment are reached at present. Coverage for children is much less; at about 15%. Up to 300,000 Kenyans are still at the risk of dying because they lack treatment access. Nutritional support programmes for those on ART programmes are not widely implemented in the country. 70% of PLHIV live in rural areas, but services are concentrated in urban and peri-urban areas.

According to KAIS, HIV prevalence among STI patients is declining (from 21.5% in 2005 to 19.1% in 2006); however, overall linkages between STI clinics and CT services remain weak. One-third of Kenyans aged 15-64 years (81% among those with HIV) are infected with HSV-2. Of the Kenyan adults infected with HSV-2, over half of them are female. KAIS reveals that women are more likely to be infected with HSV-2 than males (42 and 26 percent respectively). By age 25, one in every five women is infected with the HSV-2 virus; half of all individuals aged 35 – 64 are infected. Among those with and without HSV-2 prevalence stands at 17% and 2% respectively (KAIS, 2007).

HIV care and treatment was a priority area of the KNASP II. A review showed the following results:
84% of HIV positive Kenyans require contrimoxazole but are not receiving this since they do not know their HIV status. An insignificant 27% of HIV positive and TB patients are on ART despite 80% of TB patients being offered HIV testing and 80% of TB facilities providing HIV testing.

**STI**: HIV prevalence among STI patients is suggested to be declining – 19.1% in 2006 compared with 21.5% in 2005; overall, linkages between STI clinics and CT services remain weak yet, according to KAINS, one-third Kenyans age 15-64 years (81% among those with HIV) are infected with HSV-2; over half of the adult female Kenyans infected with HSV-2.

**Treatment, care and nutrition**: only between 38-45% of those in need of treatment being reached at present (coverage for children much less at about 15%); up to 300,000 Kenyans still at the risk of dying because they lack treatment access; a small percentage of PLHIVs who are on ART receive nutritional support; 70% of PLHIVs live in rural areas, but services are concentrated in urban/peri-urban areas.

**TB-HIV**: despite 80% of TB patients being offered HIV testing and 80% of TB facilities providing HIV testing, only 27% of HIV positive and TB patients are on ART

### 2.1.3.1 Mitigation of socio-economic impacts of HIV

Overall, the impact of HIV and AIDS has negatively affected life expectancy, which was at 54 years in 1975. Life expectancy at birth of women in Kenya is now at 50 years, even lower than that of men at 51 years. This is largely attributed to the morbidity and mortality effects of HIV and AIDS. Kenya’s high infant and under-five mortality rates could be attributed to the HIV and AIDS pandemic, poverty and the general decline in economic well-being.

The mitigation of the socio-economic HIV was a priority area of the KNASP II. A review showed the following results:

- **OVC**: the national cash transfer programme scaled up to cover 37 districts, benefiting some 16,000 households in 2007/08, significantly up from 7,500 households in 2006/07; both OVC Policy and a National Action Plan has been developed and is awaiting operationalization.

There are approximately 2.4 million HIV orphans and vulnerable children in Kenya who require care and support from their extended families and communities. 260,000 adults are in need of ART and 50 – 70% bed occupancy by HIV related cases. (Kenya HIV and AIDS M & E Report; 2006). Many of the PLHIVs are referred back to their communities for HCBC programmes. The impact of the burden of care is greater in resource-poor settings, particularly for rural and grassroots caregivers, and for those that are unlinked to coordinated home-based care programmes.

### 2.2 Gender Vulnerability and HIV and AIDS in Kenya

A range of factors influence vulnerabilities to HIV and AIDS in Kenya. Women are often at an invariably greater disadvantage due to biological, social, economic, political and cultural factors.

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1 Joint United Nations Programme on HIV and AIDS, 2007
2.2.1 Biological vulnerabilities
This biological make-up of women enhances their vulnerability to HIV infection and inter-links with gender-related vulnerabilities to escalate their risk to infection, burden of care, access to care and treatment services.

2.2.2 Gendered vulnerabilities to HIV Infection
In most Kenyan societies, gender relations are characterized by unequal balance of power between women and men. Women do not enjoy equal rights with men. HIV is primarily transmitted sexually. Sexual behaviour is greatly influenced by the individual’s culture, sexual orientation, experience and knowledge. There are great differences in female and male sexual behaviour which often creates unequal power relations. Power to decide on whom to have sex with, how and why often lies with the male leaving the female with little or no choice to negotiate for safe sex. In order for one to understand male and female sexual behaviour, one requires to be aware of the social, economic, political and cultural factors that influence these interactions.

2.2.2.1 Social and Religious Factors
- Unequal power relations prevent women and girls from negotiating for safe or abstain from sex.
- Girls and young women tend to be exposed to sexual activities at an early age precipitated by cultural practices such as FGM and early or forced marriages.
- Limited access and affordability of female condoms limits its use among women.
- Men are expected to be “experts”, widely exposed and experienced in sex and therefore engage in frequent sexual behaviour with multiple partners.
- Criminalization of homosexuality, commercial sex work and drug use in Kenya presents obstacles to effective HIV prevention and care for populations that are most-at-risk to HIV infection.
- Increasing cases of sexual violence, human trafficking and forced prostitution predisposing survivors to infection and/or sexual exploitation.
- Persons with mental and physical disability are prone to sexual abuse exposing them to HIV and STI infection.
- Rejection, disinherition of property and gender discrimination and stigma is inclined more against women and girls.
- Food insecurity threatens gains made in AIDS treatment and care.
- Religion
  - Religious perspective of condom use
  - Different interpretations of female and male sexuality

2.2.2.2 Economic Factors
- Work opportunities take men like truck drivers, civil servants, and teachers away from theirs partner for long periods of time; this is counterproductive because it promotes cross generational sex, multiple sexual partners and casual unprotected sex.
• Domestic labour due to increased poverty and subsequently the diminishing ability of parents to provide for their children has exposed young girls to sexual abuse.
• Limited education and job opportunities for girls coupled with their economic dependency on men exposes women to risk situations such as sex work and unsafe sex.

2.2.2.3 Political Factors

• Refugees and migrants experience some form/s of sexual violence as they flee and may be infected.
  o While fleeing or in the camps during the post-elections violence of 2007/08 in Kenya, many were sexually abused, experienced limited access to ART or other opportunistic infections treatment.

A rapid assessment of gender-based violence during the Post-election violence in Kenya conducted in January – February 2008 (UNIFEM/UNFPA study) indicates that sexual violence is not only occurring as a by-product of the collapse in social order in Kenya brought on by the post-election conflicts, but it is also being used as a tool to terrorize individuals and families and precipitate their expulsion from the communities in which they live. Investigation into sexual violence which occurred during flight yielded anecdotal reports from all regions, but in particular from Mombasa, Nairobi, and parts of the North Rift, of threats of sexual violence being used as a fear-instilling tactic, insofar as women were told they and their children would be raped if they did not vacate their property within a designated timeframe. As is detailed in this report, in many instances these threats of rape and defilement were actualized, sometimes committed by gangs of men and accompanied by physical brutality, such as inserting objects into the victim's genitalia.

2.2.2.4 Cultural Factors

• Culture prevents men from discussing sex with their partners.
• Gender roles assume the responsibility of decision making around sex as the role of the man.
• Further, forced widow inheritance may involve an infected partner.
• Alcohol abuse has also been sighted as a cause of casual unprotected sex. Wife sharing is another risk factor.
• Gender bias and secrecy surrounding sexual violence and rape
• Myths: Emerging myths that sex with young virgins can cleanse sexual assault-perpetrators of the HIV virus have contributed to the rising phenomenon of child rape among Africans (Kim et al, 2003).

2.2.3 Gendered vulnerabilities to HIV Impacts

2.2.3.1 Care giving Roles and Responsibilities

Gender roles tend to confine girls and women to the incessant domestic and subsistence activities and men to commercial activities. (Integrating Gender into KNASP 2000 – 2005). Women and girls provide the primary-care to the sick and orphaned children. The burden of care in the context of HIV and AIDS is inclined mostly against females. In many communities, 50-60% of orphans and vulnerable children (OVC) are left under the care of older persons, mainly older women. Due to the large numbers of orphans, elderly women, mostly widows, are getting more involved in care – giving for OVCs and PLHIV than men. Data from Kenya OVCs cash transfer programme coordinated by the Ministry of Home Affairs indicates that 40% of orphans are being cared for by older carers, mainly women who are over 50 years
of age. However, the chair of the GTC who is also the Head stakeholders coordination at NACC, during a speech delivered to participants of a Workshop at a Nairobi Hotel (24th September, 2007) took cognizance of the fact that KNASP makes minimal reference to the role of older people in HIV and AIDS era and impact of the epidemic on the group.

Women spend active days and nights providing care to bed ridden relatives, coupled with their general domestic chores. Sick females receive care from their female children and female friends. Some of these friends are fellow members in women’s guilds while others are relatives, such as aunts, sisters and mothers. It is not socially permissible for women to leave their homes when their husbands are bedridden. Given such circumstances, young men often migrate to towns in search of opportunities for income leaving women and girls behind to provide care. One study in Western Kenya found out that it takes the work of three females to care for one adult male AIDS patient; usually a multiple team made up of mother, aunt and daughter [Johnson and Ouko 2002].

2.2.3.2 Vulnerability to Stigma and Discrimination

The HIV and AIDS context has also led to stigma and discrimination against both the infected and affected. Often family members level greater blame against mothers and wives when she or the spouse or child is diagnosed as HIV positive. This complicates the process of exposure and link to care and treatment. Stigma and discrimination against care-givers has made the fulfillment of other responsibilities such as provision of food, energy, and income, exceedingly difficult. This implies that women and girls continue to bear the greater burden of care while sharing greater blame, stigma, discrimination and social exclusion in general. Such stigmatization is one of the causes for isolation of women which earns them disinheritance of family property including loss of control of their most important factor of production; land.

Family members of People Living with AIDS [PLWHAs] endure the traumatizing agonies of isolation in the trade and market systems. Stigmatization has secluded afflicted members of the community out of active participation in community activities. They also register decreased levels in the access and control of land, credit, information and other productive resources as well as sale of produce. Eventually, this undermines the economic position of most women and renders them economic dependants

2.2.3.3 Vulnerability to Gender Based Violence

A survey conducted by ActionAid International in Kenya (2006) revealed that gender-based violence is both a cause and a consequence of HIV and AIDS. Gender-based violence is an issue both of social justice and human rights and of health and human welfare. It takes many forms and can include physical, emotional or sexual abuse. While both males and females can suffer from gender-based violence, studies show the women, girls and children of both sexes are most often the victims (UNAIDS, 2001). One in every three women in the world has been beaten, raped, coerced into sex or physically abused in some way, usually by someone she knows (UNFPA, 2001). According to Askew and Ndiovu (2006), 43% of 15 – 49 year old women reported having experienced some form of gender-based violence in their lifetime, with 29% reporting an experience in the previous year; 16% reporting having ever been sexually abused, and for 13%, this had happened last year. According to the World Bank, gender-based violence accounts for more death and ill health among
women aged 15 to 44 worldwide than cancer, traffic injuries and malaria combined (Rose, 2001). The experience of violence, or fear that it might take place, disembowels women in their homes, workplaces and communities and limits their ability to participate in and benefit from initiatives for HIV prevention and AIDS mitigation (Southern African AIDS Training Programme, 2001).

Men most commonly experience sexual violence in the form of receptive anal intercourse; forced masturbation of the perpetrator; receptive oral sex; forced masturbation of the victim (WHO, 2003). Due to stigma and prejudice regarding male sexuality, men are less likely to seek medical care, legal or psychosocial support (Jejeebhoy and Boit, 2003). It has been observed that health-seeking behaviour by men is generally poor especially regarding sexually transmitted infections thus increasing danger to HIV infection.

Published literature reporting gender based violence, and particularly sexual violence in Kenya is limited. No nationally representative data on sexual violence existed until the 2003 Kenya Demographic and Health Survey1. In this survey 29% women reported experiencing sexual violence in the year preceding the survey, and the highest proportion is among women aged 20–29 years. A survey of domestic violence in Kenya by the Federation of Kenya Women Lawyersii showed that 51% of women visiting four antenatal clinics in Nairobi reported having been victims of violence at some point in their lives, 65% from their husbands and 22% from strangers. In a study of 324 HIV positive women in Kenya, 19% had experienced violence from their partneriii. Evidence suggests that adolescent sexual activity is not consensual as is often assumed. A study of 10,000 female secondary school pupils in 1993 found that 24% of the sexually active girls reported experiencing forced sex on their first encounteriv. There is "growing evidence that a large share of new cases of HIV infection is due to gender-based violence in homes, schools, the workplace and other social spheres. Not all young people have sex because they want to. In a nationwide study of women 12 – 24 years old, 25% said they lost their virginity because they had been forcedv. In a study on contraceptive use among high school students, 9% reported not using a method at last intercourse because they had been forced to have sexvi. A countrywide study showed that pressure starts at an early age, with 29 per cent of girls and 20 per cent of boys aged 13 years and below reporting one or more episodes of sexual harassmentvii (Kilonzo, 2007).

2.2.3.4 Vulnerability to Poverty

80% of Kenyans depend on the rural agricultural economy where 80% of women derive livelihoods and where 7 out of every 10 HIV infected persons live. A study by Rugalema et al. (1999) showed that morbidity and mortality from AIDS leads to decrease in acreage put under farming, loss of income, increase in the dependence ratio, and general increase in food insecurity. Studies in Kenya show that farming systems are changing due to the impacts of the epidemic. Due to decreasing farm labor force and diversion of resources into medication for the care of ailing family members, farm processes are delayed coupled with low investment into farming resulting in poor harvests. In many afflicted families attention towards cash crops has declined and more is directed into the cultivation of food crops. On the whole, household income for many households, especially female headed and child-headed, food insecurity has increased due to low productivity, low production and reduced amounts of disposable incomes at household level.
3.0 Existing Machinery for Gender and HIV and AIDS Response

3.1 International instruments for HIV and AIDS and Gender Responses

Kenya has signed and ratified some of the following international instruments:


United Nations Millennium Declaration explicitly recognized that the equal rights and opportunities of women and men must be assured by setting Millennium Development Goals (MDGs). MDG No. 3 is committed to the promotion of gender equality and empowerment of women as an effective way to combat poverty, hunger and disease and to stimulate development that is truly sustainable. MDG 6 (Combat HIV and AIDS, malaria and other diseases) establishes the value of anti-violence efforts in HIV prevention, highlighting the evidence that violence against women undermines HIV prevention and care efforts and conversely that preventing this violence contributes to the prevention of HIV. In addition, gender equality is recognized as key in achieving all eight Goals.

3.1.2 Convention on the Elimination of all forms of Discrimination against Women:

CEDAW (1979) recommends that State Parties:

- Make information more widely available to increase public awareness of the risk and effects of HIV infection and AIDS, especially to women and children; and communities.
- Ensure that AIDS programmes give special attention to the rights and needs of women and children, and to the ways in which the reproductive role of women and their subordinate position in some societies makes them especially vulnerable to HIV infection;
- Take measures to ensure the active participation of women in primary health care and to enhance their role as care providers, health workers and educators in the prevention of infection with HIV.

3.1.3 UN declaration on the Elimination of Violence against Women (1993): The General Assembly resolution 48/104 of 20 December 1993 recognizes the urgent need for the universal application to women of the rights and principles with regard to equality, security, liberty, integrity and dignity of all human beings; notes that those rights and principles are enshrined in international instruments; and recognizes that effective implementation of the Convention on the Elimination of All Forms of Discrimination against Women would contribute to the elimination of violence against women.

3.1.4 Greater Involvement of People Living with HIV and AIDS (GIPA, 1994)

The idea that the personal experiences of people living with HIV could and should be translated into helping to shape a response to the AIDS epidemic was first voiced in 1983 at a national AIDS conference in the USA. It was formally adopted as a principle at the Paris AIDS Summit in 1994, where 42 countries declared the Greater Involvement of People Living with HIV and AIDS (GIPA) to be critical to ethical and effective national responses to the epidemic.
3.1.5 Commission on the Status of Women
The Commission on the Status of Women, a non-partisan state agency, works in a culturally inclusive manner to promote equality and justice for all women and girls by advocating on their behalf with the Governor, the Legislature and other public policymakers, and by educating the public in the areas of economic equity including educational equity, access to health care including reproductive choice, violence against women and other key issue areas identified by the Commission as significantly affecting women and girls.

3.1.6 UN Guidelines on HIV-related Human Rights
The Guidelines resulted from a request made many years ago by the Commission on Human Rights which underlined the need and the imperative to provide guidance to States on how to take concrete steps to protect human rights in the context of HIV. As the epidemic has evolved, the lessons learned from it confirm that the protection of human rights in the context of HIV reduces suffering, saves lives, protects the public health, and provides for an effective response to HIV.

3.1.7 Beijing Platform for Action (PFA)
The Beijing Declaration and Platform for Action, Fourth World Conference on Women (1995) identifies five strategic objectives in the area of health, under each of which governments from Commonwealth countries agreed to take a number of actions. Objective C3 calls for gender-sensitive initiatives that address STIs, HIV and AIDS, and sexual and reproductive health issues. It calls upon governments to take measures to prevent and eliminate violence against women. At a review of the Beijing PFA in 2000 (Beijing +5), the UN General Assembly, at a special session in 2000, reaffirmed its commitment to eradicate violence against women.

- At the regional level, the Protocol to the African (Banjul) Charter on Human and People’s Rights adopted in 1981, on the Rights of Women in Africa, condemns violence against women and the girl child.

3.1.8 Declaration of Commitment on HIV and AIDS (UNGASS 2001)
A Special Session of the UN General Assembly (UNGASS) on the problem of HIV and AIDS in all its Aspects dubbed ‘Global Crisis – Global Action’ was held in June 2001 in order to intensify international action to fight the HIV and AIDS epidemic and to mobilize the resources needed. Governments unanimously agreed on a Declaration of Commitment to reduce infection rates by 25 per cent by 2005, end discrimination by challenging ‘gender stereotypes and attitudes’ and inequalities between men and women worldwide, and provide AIDS education to 90 per cent of young people by 2005. Poverty, women’s rights and funding issues were also addressed as a part of the solution to combat HIV/AIDS.

3.1.9 Commonwealth Plan of Action on Gender and Development (1995)
The 1995 Commonwealth Plan of Action on Gender and Development and its Update are a blueprint for Commonwealth action to achieve gender equality states as its vision that the Commonwealth works towards a world in which women and men have equal rights and opportunities at all stages of their lives to express their creativity in all fields of human endeavor.
While various international and regional instruments have been put in place to protect women’s human rights in cognizance of the pervasive nature of gender-based violence various authors note that challenges in turning these instruments into policy and further challenges of implementation. Kilonzo, 2005 notes that Government responses have ranged from the use of women’s machineries or special units within governments and organizations to adopting an approach of integrating gender concerns into every aspect of an organizations priorities and procedures referred to as ‘gender mainstreaming’. A potential weakness of the mainstreaming approach is in its focus on analysis with policy statements remaining at the national level on paper and may not get to implementation levels. National commitments therefore disappear in what Derbyshire (2001) refers to as ‘policy evaporation’. Moser (1993) identifies the lack of technical capabilities and simplified tools for planners to use in gender mainstreaming efforts.

3.2 National Gender and HIV and AIDS Legal and Policy Framework

3.2.1 National Policy framework

On pages 22 and 23 gender imbalance is cited as a key factor which is propagating poverty. The document asserts that lack of ownership and control over productive assets are contributing to poverty in agriculture and reaffirms the commitment of the government to address gender issues by providing an engendered poverty diagnosis.

3.2.1.2 The Poverty Reduction Strategy Paper (PRSP)²
The government took cognizance of the fact that the vulnerability factors for HIV infection which included those related to poverty, gender, discrimination, educational attainment and socio-cultural factors were diverse and complex and could only be implemented through a strengthened and comprehensive multi-sectoral national strategy. The strategy included institutional, legal and programmatic reforms which included the establishment of a cabinet sub-committee on HIV and AIDS, chaired by the President, and promulgation of the Bill on HIV and AIDS.

Further, the government implemented a new policy on decentralization to focus attention on the need to strengthen action at the community level, with the Constituencies serving as the focal points. There were plans to intensify advocacy campaigns and education to mitigate stigma and discrimination, prevent new infections and improve the quality of life of all affected and infected.

The government has reformulated its partnership plan by the commitment to maintain an open and productive dialogue with all stakeholders including modalities for stakeholder participation in the planning and operationalization of new policies.

3.2.1.3 The Economic Recovery Strategy (ERS 2003-2007)

The Investment Programme for ERS (IP-ERS) which facilitated the implementation, monitoring and evaluation of ERS provided an opportunity for engendering the outcome indicators of the objectives stipulated in the strategy which were to halt and reduce the spread of HIV and AIDS. The ERS further recognized that women and men have differential needs, constraints, options, incentives and expectations regarding the outcomes and impacts on macro-economic management. The ERS adopted the approach of addressing the socio-economic agenda and equity concerns. Successful expiry of the Economic Recovery Strategy for Wealth Creation and Employment (ERS) in 2007 set the stage for Vision 2030.

3.2.1.4 Vision 2030

The aim of Vision 2030 is “the globally competitive and prosperous country with a high quality of life by 2030.” Kenya’s Vision 2030 for health is to provide “equitable and affordable health care at the highest affordable standard” to Kenyan citizens. The vision has outlined various strategies that are aimed at responses to HIV and AIDS:

- Structural change that will be achieved through an enhanced private sector participation and greater community involvement in service management including reforms through improved governance, decentralization of health facility management, emphasis on preventive services,
- Revitalization of health infrastructure
- Strengthening of Health Service Delivery through decentralization and operationalization of health care management to the facility level,
- Developing Equitable Financing Mechanisms to make health care accessible to all.

The Vision 2030 explicitly acknowledges that cases of GBV - cases of assault and battery, as well as rape and/or attempted rape, are on the increase.

The Vision 2030 document lays out various strategies to reduce gender disparities and address vulnerabilities: These are:

- Reducing gender based violence
- Providing financial support to women to raise their incomes and reduce the gap in estimated earned incomes between men and women;
- Increasing the number of women in Parliament;
- Giving priority to female employees in the public sector in order to attain at least 30 per cent representation in recruitment, promotion and appointment of women to all decision making levels;
- Increasing the proportion of women using family planning methods from 39 per cent to 70 per cent;
- Reducing the rate of high-risk sex through increased access to safe sex methods e.g. use of condoms for men and women from 47 per cent and 25 per cent respectively to 70 per cent;

The central implementation instrument for the Vision 2030 is the Medium Term Plan of the Kenya Vision 2030 (MTP 2008-2012) which recognizes the need to introduce gender indicators in the macro framework and encourages a paradigm shift in resource allocation mechanisms.

3.2.1.5 HIV and AIDS Sessional Paper No. 4 of 1997

3.2.1.6 National Gender and Development Policy (January, 2004)

The overall objective is “...to ensure women’s empowerment and the mainstreaming needs of women, men, girls and boys in all sectors of development ...” one of the
Gender Audit of national response to HIV and AIDS, Kenya

objectives within the Kenya National Gender and Development Policy is to enhance HIV and AIDS awareness programmes with special emphasis to the vulnerability of women. It aims at continuing to create awareness and initiate programmes/activities that include community-based specific interventions on dangers of risky sexual behaviour, protective measures, prevention of mother-to-child HIV transmission and community-based care and support for people infected and affected by AIDS. The policy states that women are at greater risk than men due to illiteracy, cultural emphasis on reproduction, economic deprivation, submissiveness and biological factors making them more susceptible to heterosexual transmission. It also takes cognizance of the burden of care disproportionately shouldered by women more than men through taking care of family members with HIV related illnesses. The situation is far much worse, the policy states, when the woman is infected and has an HIV positive infant.

3.2.2 National Legal framework

3.2.2.1 The Constitution of Kenya
A general principle of gender equality is found in Section 70 of the Constitution which lays out the fundamental rights and freedoms of persons. It states inter alia that:

"...Every person in Kenya is entitled to the fundamental rights and freedoms of the individual, that is to say, whatever his creed... or sex...”

Section 82 of the Kenyan Constitution lays out the fundamental principle of non-discrimination. Section 82 (3) defines the term discriminatory as follows:

"...affording different treatment to different persons attributable wholly or mainly to their respective descriptions by race, tribe, place of origin or residence or other local connexion, political opinions, colour, creed or sex whereby persons of one such description are not made subject or are accorded privileges or advantages which are not accorded persons of another such description.”

The above provisions clearly set out the framework for equal treatment of both women and men under the Constitution and ordinary statute law as well as by virtue of any administrative procedure that may be applied by both public and private institutions.

3.2.2.2 HIV and AIDS Prevention and Control Act (2006):
This Act checks irresponsible sexual behaviour that would lead to HIV infection. This in due course protects both men and women, especially women who comprise about 70% of survivors of SGBV (2007 statistics from Nairobi women’s Hospital).

3.2.2.3 The Sexual Offences Act, (SOA, 2006)
The Sexual Offenses Act deals comprehensively with sexual offences. The Act domesticates the provisions on sexual and gender based violence of the following international instruments:

- United Nations Convention on the Elimination of all Forms of Discrimination against Women,
- The United Nations Convention on the Rights of the Child and

This Act prohibits various forms of sexual violence including rape, defilement, sexual harassment, gang rapes and child pornography and trafficking. The Act is also a bold step against the practice of early child marriages which have continued to undermine
the rights of the girl-child and contribute indirectly to the infection rates and impacts of the epidemic.

3.2.2.4 The Children Act (2000)
The Children Act provides for the protection of child sexual violence survivors. This is in section 20 that requires that a child survivor be removed from the custody of a parent or guardian that violated them. The same law criminalizes FGM for girls below 18.

3.2.2.5 Other Legal and policy Reforms and Initiatives at National and Sectoral Levels
- Taskforce on review of laws relating to women (1993)
- Domestic Violence Bill (Family Protection Bill) (2002)
- Equal Opportunity Bill (2001),
- Matrimonial Property Bill (2007)
- Gender and Education Policy (2007)
- Trafficking of Persons Bill
- The 2005 Policy Framework for the Implementation of Post-Rape Care Services which ensures the inclusion of sexual violence as a key issue within the Reproductive Health Policy and sets the development of standards for post rape care service delivery as part of development of the Output Based Approach (this includes the use of a pre-paid voucher system by district hospitals to provide essential health services to vulnerable groups). Post-rape care is now captured as one of the services offered by the Government in addition to safe motherhood.
- National Guidelines for VCT published by the Ministry of Health give guidance on service Provision (NASCOP 2001)
- The Ministry of Health has produced guidelines and policy on the treatment and management of sexually transmitted infections (STIs)
- National Guidelines Medical Management of Rape/Sexual Violence.

3.3 National Machineries
There exist a range of national machineries for responding to gender issues in Kenya. These include the Department of Gender, the Ministry of Gender, Children and Social Development, the National Commission of Gender and Development and gender focal points in government departments, institutions and parastatals.

3.3.1 The Department of Gender
The Department of Gender in the Ministry of Gender, Children and Social Development which is mandated as follows:
- To promote gender integration in national development processes, and to engender the national budget.
- To co-ordinate the development, review and implementation of gender responsive policies and programmes.
- To promote women’s rights and economic empowerment.
- To promote interventions for the reduction of sexual and gender-based violence
- To promote the generation of sex-disaggregated data to guide interventions.

### 3.3.2 The National Commission on Gender and Development (NCGD)

NCGD falls under the Ministry of Gender whose objective and purpose is the coordination, implementation, and facilitation of gender integration in national development and to advise the Government on all aspects relating to these objectives. The Gender Commission has taken charge to provide a national GBV framework to guide all implementers in the process of responding to all forms of GBV issues including those that are HIV related.

### 3.3.3 Gender Focal Points

Gender focal points exist across government ministries, parastatals, and institutions in response to government directive. Their primary role is to mainstream gender in policies, plans, and programmes. They are expected to specifically undertake the following:

- Identify gender concerns, needs, priorities, constraints, and opportunities within the sector on the promotion of gender equality.
- Ensure that gender needs, concerns, and priorities are integrated in the design, implementation, and monitoring and evaluation of sector policies and programmes at all levels.
- Conduct gender analysis to assess the development impact on men and women and design strategies to mitigate the negative development on women.
- Coordinate the collection, analysis, and updating of relevant sex-disaggregated data with the sector for development planning and programming.
- Develop gender-sensitive development indicators to monitor the progress of gender equality and women empowerment.
- Identify capacity needs and design appropriate sector-specific capacity building programmes.
- Establish public/private partnerships to support gender mainstreaming efforts.
- Develop annual work plans for gender mainstreaming in line with Ministries Strategic plan, policies, and programmes.
- Develop monitoring and evaluation tools to assess the progress and impact of gender mainstreaming and prepare progress reports on a quarterly basis to the Ministry of Gender, Sports, culture, and Social Services.
- Actively participate in sector-based budget processes to ensure adequate resources are allocated for gender mainstreaming work.

In addition to the mandate spelt out in the Sessional Paper No. 2, 2006, and the TOR as spelt above it is recommended that the gender officer undertakes the following:

- Harmonize implementation schedules with other sectors.
- Build coalitions with other stakeholders for implementation especially with Civil Society Organizations and the Private Sector.

### 3.3.4 Gender Sector Coordination Group (GSCG)

This Kenya Joint Assistance Strategy (KJAS) is a statement of 17 development partners, on how to carry forward the Rome and Paris declaration on development aid effectiveness (March 2007) by working with the Government and the people of Kenya to consolidate and scale up the gains that have been made.
by ERS with one overarching tangible result of achieving MDGs targets, The
partners aim at strengthening networking and linkages among relevant processes
and structures. Subsequently, a Gender Sector Coordination Group (GSCG) with
membership from development partners, Department of Gender and other relevant
government agencies and institutions, CSO and private sector representatives exist.
The overall objective of the GSCG is to coordinate the support for Gender equality to
the government of Kenya and non-state actors, aligned in support of the
government’s Vision 2030, its medium-term implementation plan, the National Policy
on Gender and development and other agreed development priorities.

3.4 Structures and systems for the HIV and AIDS response
The Government of Kenya (GoK) declared HIV and AIDS a National Disaster in 1999
and subsequently established the National AIDS Control Council (NACC) through
Legal Notice No. 170 under the State Corporations Act.

3.4.1 The National AIDS Control Council (NACC)
The Sessional Paper No. 4 of 1997 recognizes the need for NACC to:

- Identify the policy issues; draw the attention of the appropriate bodies and
  organizations;
- Discuss and agree on the policies to be put in place so as to guide the
  national response to HIV and AIDS.

Thus NACC is specifically mandated to provide policy and strategic framework,
mobilize resources and coordinate stakeholders in the implementation, monitoring,
evaluation and review of the National Response. Within the context of the 3 ones
responses, NACC facilitates the development of the Kenya National HIV and AIDS
Strategic Plan (KNASP) which provides the action framework and the context in
which all stakeholders develop their specific strategies, plans and budgets to make
multi-sectoral responses to the epidemic. Other than providing governance and
coordination for the implementing the KNASP, NACC also mobilizes financial
resources for funding of innovative programs in support of the KNASP. This reflects
the dual role of the NACC, as a coordinating body and a funding agency. This dual
role is reflected in the results framework and its indicators.

3.4.1.1 The NACC structure
The National AIDS Control Council is a semi autonomous government agency located
within the Ministry of Special Programmes in the Office of the President. At the
National Level are the board/council and the secretariat as shown in Figure 1. Mem-
bership of NACC Council includes a Chairperson, a Director, four Permanent
Secretaries from Ministries of Health, Education, Home Affairs and Directorate of
Personnel Management, the Attorney General, Directors of Medical Services and
Women Fighting AIDS in Kenya, Commissioner-General Kenya Revenue Authority,
the Chairmen of: Kenya Medical Association, KANCO, Maendeleo ya Wanawake,
Kenya Episcopal Conference, Supreme Council of Kenya Muslims, National Council of
Churches of Kenya, Kenya Federation of Employers, and Kenya Association of
Manufacturers and up to three persons appointed by the Minister. The council links
directly with the cabinet subcommittee on HIV and AIDS and the Consultative
Steering Committee.
3.4.1.2 Decentralized Structures of NACC

The national secretariat is decentralized into nine regional offices, District Technical committees (DTC) and up to the implementation unit which is the Constituency AIDS Control Committee. It is expected that all levels of government departments and institutions establish AIDS Control Units. This also applies for private sector organizations.

**Constituency AIDS Control Committee (CACC):** NACC has established 210 CACCs to coordinate and supervise community level activities on HIV and AIDS. CACC members are selected from among private sector, CSOs, youth, PLWHAs, women, trade unions, FBOs, teacher’s organization, councilors and government representatives.

**District Technical Committees (DTCs):** The DTCs are the technical arm of the District Development agenda on HIV and AIDS programmes. This ensures HIV and AIDS is mainstreamed in the district development programs. The District Development Officer (DDO) who is the secretary to the DTC is a key figure at this level. He/she is expected to liaise closely with all departmental head and report to NACC all multisectoral information on HIV and AIDS.
Regional Offices: There are nine NACC field offices occupied by one regional officer and one M & E officer each. Among their main functions is to provide technical support to CACCs, DTCs and sub-ACUs and implementing agencies and M & E activities. Thus the field offices are expected to enhance technical capacity of the decentralized structures in the regions and monitor and report on progress made.

AIDS Control Units (ACUs): The main roles of ACUs are: ensuring HIV and AIDS mainstreaming in core functions of the organization; collecting sectoral data; mobilization of resources through MTEF; promoting linkage, collaboration and networking with other ACUs and NACC; and developing relevant guidelines. Given its central role of supporting the expansion of HIV and AIDS-related prevention, care, and treatment services, the Ministries of Medical Services and Public Health and Sanitation are prioritized ministries under the KNASP. The KNASP’s non-health priority sectors include the following: Ministry of Education, Science and Technology (including the Teacher Service Commission and Commission for Higher Education), the Ministry of Agriculture (including the Ministry of Livestock fisheries and the Ministry of Cooperatives), the Ministry of Transport, and the Governance, Justice, Law, and Order Sector— including Justice, Law and Order, the Kenya Police and Administration Police and the Directorate of Personnel Management (internal mainstreaming). Thus linkage with these departments at all levels is desirable.

HIV and AIDS Implementing Organizations: The private sector, faith-based organizations, CSOs, NGOs and community based organizations (CBO), youth organizations PLWHA organizations compliment government efforts to implement HIV and AIDS programmes in Kenya. Development partners including the UN system, on the other hand, provide the necessary technical assistance and financial and material support. The implementing organizations are expected to mobilize resources, implement relevant programmes and monitor and evaluate their activities. Networks of the youth, women groups, PLWHA, people with disabilities, sex workers, pastoralists, and groups representing refugees exist with structures emanating from either national or regional levels to the community level. Support to Civil Society Organizations includes financial resources mobilized by NACC and it is done through a ‘Call for Proposals’ process.

3.4.2 Coordination of the National Response
The National response in line with KNASP 2005/06 – 2009/10 is organized in 4 priority areas 1) Prevention, 2) Improvement of the Quality of Life of people infected and affected by HIV; 3) Mitigation of the socio-economic impact of HIV and; 4) Support services. Four multi-sectoral monitoring and coordination groups (MCG) aligned according to these priorities oversee planning, prioritization and reporting of the progress of the priority areas. Each Group has several sub-groups/themes based on the result areas as identified in the KNASP 2005/06 – 2009/10 as illustrated in Figure 2 and also outlined in details below:

3.4.2.1 MCG 1: Prevention of New Infections
- Counseling and testing
- Condom promotion
- Sexually transmitted infections
- Prevention of mother to child transmission
- Behavior change communications
- Blood safety
3.4.2.2 MCG II: Improvement of quality of life of people infected and affected by HIV and AIDS
- Care and support
- Protection of human rights

3.4.2.3 MCG III: Mitigation of the socio-economic impact of HIV and AIDS
- Advocacy
- Mitigation policy
- Livelihoods and social security
- Targeted mitigation programmes
- Community empowerment
- Human resources planning

3.4.2.4 MCG IV: Support Services
- Monitoring and evaluation
- *Gender
- Research
- Financing and Procurement
- Communication, Networking and Coordination

*Gender is housed in MCG IV as a cross cutting theme and not necessarily as a support service. Below is an illustration of the coordination of stakeholders – fig. 2:

### 3.4.1 Stakeholder coordination processes

#### 3.4.1.1 The Inter-agency Coordinating Committee (SC-ICC)

The Inter-Agency Coordinating Committee was established in 2006 to address the need for stakeholder inclusiveness and efficiency while building consensus around policy, strategy and operation issues. It provides an effective HIV and AIDS stakeholder coordination mechanism. The ICC provides high-level technical coordination of the KNASP, including coordination of the annual JAPR process. The ICC is chaired by the Director of NACC and includes senior representatives with HIV and AIDS responsibility from Government, civil society, the private sector and development partners. The ICC receives reports from MCGs and reviews progress with the KNASP on a quarterly basis. The forum provides appropriate forums for the engagement and coordination of key stakeholder groups and key sectors in the national response. The membership and sub-committee structures of ICC are reviewed and amended as necessary, to ensure that it is fully able to fulfill its KNASP coordination mandate. An Ad-Hoc committee of the ICC is a multi-sectoral forum constituted by the Steering Committee to ensure that all Calls for Proposals (CFP) are in-line with the priority areas of the KNASP and that they address the priority interventions. The committee develops Calls for Proposals and guidelines for evaluating CFP for Total War against HIV and AIDS (TOWA) project and other projects at different levels. The drafts take into account priorities and gaps identified in the JAPR process and subsequently forward the recommendations to the ICC – HIV and AIDS through its Advisory Committee.
3.4.1.2 **Advisory Committee of the ICC for HIV and AIDS**

The Advisory Committee oversees not only TOWA Project but also all programmes within the KNASP and advises NACC on the overall implementation of KNASP. It provides for coordinated approval of annual reports, work programmes and budgets funded by Development Partners including World Bank and DFID; and assist NACC to address challenges encountered during implementation.

3.4.2 **National planning and prioritization processes for the HIV response**

3.4.2.1 **Monitoring and Coordination Groups**

MCGs are programmed to hold quarterly meetings to review progress of the national response. Reports generated from such meetings are consolidated annually and used to inform the national JAPR, alongside information synthesized from consultations held at district and regional levels.

3.4.2.2 **Joint AIDS Programme Review Process**

JAPR and MCGs are part of the process of collecting results for the country. The Joint AIDS Programme Review (JAPR) process is an annual event since 2002 and its purpose is to bring together stakeholders to review progress made in the fight
against HIV and AIDS. The process is the operational forum in which members of the Monitoring and Coordination Groups illustrated in figure 3 come together. During JAPR, stakeholders outline the achievements made in the fight against the pandemic, identify gaps in HIV and AIDS interventions, identify major challenges/emerging issues, make recommendations/key actions and identify lead agencies to implement the recommendations. During inception in 2002, JAPR was conducted at national level only. However, the process has progressively been decentralised, and in 2008, consultations were held in 71 districts in which various stakeholders participated in identifying issues, challenges and gaps and the priority issues that needed to be addressed. The district consultations results were utilized to develop regional reports, and the regional reports were then discussed during the meeting with the field officers whose output was a synthesized regional report which was then presented during the national JAPR. The methodology and approach adopted are highly participatory as this entails wide consultations at all levels. The process takes place in June – August, a deliberate timing in order to link up with the district and national prioritization, planning and government MTEF processes.

In 2008, national MCG summits were held during which plenary presentation according to thematic areas were made prior to the national JAPR forum. Members of GTC prepared thematic presentations in all the four summits being informed by various sources as specified in the section below.

3.4.2.2.1 Priority Setting

JAPR marks the starting point in setting the annual priorities for implementing the KNASP. The documentation from this broad based forum is used to select the priority areas for all HIV and AIDS interventions based on the experience from implementation during the previous year. This is followed by the selection of priority areas for the next financial year, which is accomplished through the following interrelated activities:

1. The documentation of results in the consolidated Results Framework from the JAPR which is submitted by the JAPR Task Force to the Advisory Committee of the ICC-HIV and AIDS.

2. The Advisory Committee assigns the MCGs the task to select priority areas and expected results/target areas in the Results Framework.

3. Based on the proposals from the MCGs, the Advisory Committee allocates budget ceilings to priority areas for the civil society/private sector and for the public sector respectively. This is documented in the Consolidated Budget Ceilings, which reflects all the contributions to HIV and /AIDS interventions for the year and the expected results (result areas) towards which the Budget ceilings are allocated. These consolidated budget ceilings are to be presented to and adopted by the ICC- HIV and /AIDS. The actual budgets are expected to be reflected in the respective work plans for different organizations.

4. The consolidated work plan is presented to the ICC Advisory Committee for review and endorsement by the ICC before July. The consolidated Work plan is finally presented to the Council for approval – see figure 4.
3.4.3 The Monitoring and Evaluation framework for the response to HIV and AIDS in Kenya 2005/06–2009/10 has been done through the Performance M&E Systems and the Effectiveness M&E Systems as listed below.

3.4.3.1 Performance M&E Systems
1. Monthly Programme Activity Report generated by NGOs, CBOs, ACUs and private organizations
2. Quarterly Programme Reports generated by health facilities
3. Financial Management reports generated from financial monitoring exercises
4. Kenya Service Provision Survey conducted by the National Council for Population and Development
5. National Blood Transfusion Center Reports generated quarterly
7. HIS – MoH

3.4.3.2 Effectiveness M & E Systems
Evaluation of achievements/impact of the response in Kenya is done through the following tools:
1. DHS+ which is a population based survey conducted by Central Bureau of Statistics with assistance from NACC and other institutions.
2. Sentinel Surveillance conducted by National AIDS and STI Control Programme (NASCOP)
3. Behavioral Sexual Surveillance is carried out biannually on selected HIV high risk populations
4. Lot Quality Assurance Sampling is applied by NACC for purposes of estimating coverage at various implementation levels and determination of priority areas by CACCs that are potential areas for funding through Community Initiative Activities proposals.
5. Incidence studies and
6. Demographic Surveillance Surveys that complement incidence surveys and done through commissioned studies by interested groups.

Data flow and linkages at national, provincial, district and constituency is illustrated in figure 4 below:
The role of NACC in the implementation of the M & E strategy is to coordinate all national initiatives by ensuring overall management and implementation of the framework through its M & E division. The implementers which include line ministries, CSOs and private organizations report on programmatic activities and outputs through relevant. The development partners, on the other hand, is to provide technical and financials support to ensure that the monitoring systems are functional.

3.4.4 Financing of the national HIV response
In KNASP 2005/06 – 2009/10, NACC managed to mobilize resources, in a first step towards pooled HIV & AIDS funding. The Total War against AIDS mechanism that pools funding from the World Bank, DfID and Government of Kenya, is a case in point. As a board member of Global Fund Country Coordinating Mechanism (CCM), NACC advised in some of the processes that led to better implementation oversight and in the mobilization of over US $ 130 million in Global Fund Grants to the country’s HIV & AIDS response. Some of the systems set up within NACC, such as the Interagency Coordinating Committee (ICC) have been an integral part of Global Fund processes in the country.
3.5 Gender integration within the national HIV response

In 2001, a review of the first national strategic plan (KNASP 2000 – 2005) revealed that there were gender dimensions to the HIV and AIDS epidemic. Consequently, a Gender Technical sub-committee (GTC) was established by NACC in April 2001. The GTC is a sub-committee of the Monitoring and Coordination Group IV.

The GTC comprises 32 members from the civil society, government ministries – education, agriculture, the UN agencies coordinated by UNAIDS; academic institutions and private organizations. The mandate of the GTC is outlined below:

- Identify critical gender and HIV and AIDS issues for Kenya
- Review strategic plan and Monitoring and Evaluation framework accordingly: identifying gaps and strengths
- Engendering the implementation of strategic plan and inclusion of gender in the M&E framework
- Contribute/advice on the development of a Gender and HIV and AIDS national strategy document
- Develop strategies for integration the national strategy and advice on new advocacy areas/issues for gender inclusion.

The GTC meets quarterly under the chairmanship of the Head of Stakeholder Coordination at NACC.

The GTC developed and launched the document “Integration Gender into the Kenya National HIV and AIDS Strategic Plan 2000 – 2005” as an additional tool for practical use in planning gender sensitive strategies and interventions. The committee also developed a toolkit intended for the training policy and senior decision-makers on HIV and AIDS and Gender. The Task force is also credited for the envisioned recommendation that saw the establishment of a Gender Focal point at the NACC secretariat that is currently occupied by a UNFPA/UNV. Further, the GTC recommended the development and dissemination of practical guidelines for mainstreaming gender into HIV and AIDS Programmes. These efforts were aimed at ensuring that gender dimensions of the HIV and AIDS epidemic do not just remain an intellectual idea, instead they were translated into practical tools in decision-making and programming to promote Gender Integration in HIV and AIDS responses in Kenya in order to alleviate the epidemic’s vulnerability and impacts. This would accelerate progress towards the vision of NACC.

3.5.1 Review of Gender Integration in National Response

The GTC is scheduled to meet quarterly to review, consult, plan and strategize their engagement with the national HIV response forums towards a systematic integration of gender. The GTC is informed by members who belong to organizations, structures and institutions that support gender integration in the health sector, viz

- Department of Gender in the Ministry of Gender, Children and Social Development;
- National Commission on Gender and Development

- Women movements and organizations like Maendeleo ya Wanawake and NEPHAK
- Development agencies and both International and national NGOs that finance and/or implement and monitor and evaluate gendered programmes and projects in HIV and AIDS and have projects and structures to the grassroots i.e. that finance studies and programmes on gendered projects i.e. Canadian International Development Agency (CIDA), Action AID International, African Medical Research Foundation (AMREF) and Liverpool VCT, Health Policy Initiative, Open Society Initiative – East Africa.
- Departments in Academic Institutions: Socio-economic department of University of Nairobi and Gender department of Kenyatta University. Taskforce for review of laws relating to women
- Gender Sector Coordination Group
- Sexuality Taskforce
- GBV Sub cluster of the humanitarian response in Kenya
- UN Coordination Group on Gender and Human Rights
- Taskforce that reviews and reports on: Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)
- Taskforce that reviews and reports on United Nations General Assembly Special Session on HIV and AIDS.
- Coalition for Women Won’t Wait Campaign
- Taskforce that reviews and reports: Commission on the Status of Women (CSW)
- Taskforce for the implementation of Sexual Offenses Act (2006)
- GoK ACUs; representatives of the following departments are consistent members of the GTC: Health (DRH), Education, Agriculture, Gender, Livestock and Teachers Service Commission
- UNAIDS and its co-sponsors who have greater capacity on Gender (i.e. UNIFEM, UNFPA, WHO, World Bank).
- Forums/committees that develop survey tools for Demographic Health Surveys, National Population & Housing Census

During 2008 JAPR the Gender Advisor at NACC secretariat reviewed the draft Results Framework to ascertain that it collects sex and age disaggregated data. Besides, the Gender Advisor attended the district forums in Nyanza as well the two regional forums in Nyanza and Western to get an overview of gender issues cited in the consultations. As mentioned earlier, MCG summits preceded the 2008 national JAPR. Gender presentations during these summits were informed by the following sources:
- Quarterly consultations during GTC meetings
- Experiences and evidence from studies gained by members of the GTC
- Outstanding issues analyzed from the district and regional reports
4.0 Methodology

4.1 Objective
The overall objective of this assignment was to audit the national HIV and AIDS response from a gender-sensitive standpoint. A specific objective required the assignment to provide guidance for effective integration of gender into the national response. The audit was to be done with special attention inclined to the structures and processes through which programmes and interventions are prioritized, planned, monitored, evaluated and resourced. In brief, this document highlights gender issues and oversights of the broader framework of the national HIV and AIDS response that limit the realization of gender responsiveness in programming and propose guidelines on how to effectively institutionalize gender dimensions.

4.2 The Process
The services of a consultant were secured to conduct and facilitate the audit. The GTC appointed a 10-member taskforce from within its membership to oversee this process. The assignment entailed review of existing structures, processes, programming and financing mechanisms with the aim of establishing the extent to which gender perspectives are integrated in HIV and AIDS interventions, constraints and limitations faced and identify gaps and challenges and subsequently make recommendations for response.

4.2.1 Literature Review
This involved in-depth literature review of relevant documents such as the current Kenya National HIV and AIDS Strategic Plan (KNASP 2005/06 – 2009/10); operational plans national and regional initiatives on HIV programmes (including TOWA and GLIA), KNASP Monitoring and Evaluation framework and HIV and AIDS legislation and policies. These documents provided insight on previous and current HIV and AIDS interventions. The literature review also looked at priority setting mechanisms, implementation plans and reports, reporting mechanisms with the aim of establishing the extent to which gender dimensions were addressed.

4.2.2 Interviews
Interviews and administration of questionnaires was conducted among NACC staff, selected key HIV and AIDS implementers from government ministries, members of JAPR and MCG, organizations representing those living with HIV and AIDS, Civil Society Organizations, private sector, development partners and representatives of key implementing partners in the nine regions in the country.

4.2.3 Consultative meetings
Periodic consultative meetings were held between the consultant and members of the GTC and NACC staff to share and appraise information obtained from the field work and literature review. On completion of the draft report, an experts meeting was convened to critically review the report and build consensus before completing the document.
5.0 Findings

5.1 International/national policy and legal frameworks
Lessons learnt form ERS suggested that efforts should be directed towards; improving accessibility to ARVs; Strengthening home based care; setting up of comprehensive care centers in the provincial and district hospitals; create a “one-stop shopping” for HIV and AIDS services; offer nutritional education and counseling at health facilities; quantify the impact of HIV and AIDS on key sectors of the economy; scale up and strengthen government institutions at all levels to lead to the implementation of HIV and AIDS activities.

Vision 2030 pledges to increase finances to the health sector and ensuring that they are utilized more efficiently. This will in turn increase finances allocated to HIV and AIDS responses and translate to financial support that is gender integrated.

Status of Implementation
The Strategic Plan for the Ministry of Gender, Children and Social Development acknowledges the following:

- Despite the existence of the policies, legislative reforms, plans and programmes, gender disparities still exists in legal, social, economic and political levels of participation in decision making, access to and control of resources, opportunities and benefits. Overall the implementation of policies and laws has been slow; a situation attributed to gaps in the laws, delayed enactment of gender related legislations and lack of comprehensiveness in content for the same laws e.g. Sexual Offences Act and the Children’s Act.
- Challenges include:
  - Weak coordination, harmonization and networking among actors at all levels
  - Inadequate resources (human and financial)
  - Limited technical capacity and capacity consistency due to deployment / transfers
  - Monitoring and Evaluation (M&E) framework without gender sensitive indicators
  - Socio-cultural issues
  - Misinterpretation of the concept of gender as women rather than women, men, boys and girls
  - Lack of gender sensitivity at core sector indicators development and targets setting
  - Lack of budgetary allocation targeting gender activities at sector levels and national budget
  - Weak structural linkages at different levels (community to parliament) to facilitate translation of commitment to actions with a sustained momentum.

The biggest challenge facing Kenya today is how to create an enabling environment for gender equality and translating commitments into action with concrete strategies to eliminate persistent gender inequality and recognize the roles of women and men in the development of the country. International human rights instruments such as CEDAW, which Kenya is committed to, set benchmarks for achieving gender justice, have not been translated to domestic law. Recommendations from the committee overseeing the Commission for the Status of Women (CSW), to which Kenya reports to periodically are not given significant contemplation nor implemented. The Declaration of Commitment of the 2001 UN General Assembly Special Session on HIV and AIDS recognized that gender inequality and the violation of women's human
rights are critical factors that increase women and girls vulnerability. Its emphasis that by 2005 countries should have developed national strategies to promote the advancement of women, ensure that services for women and girls to enable them protect themselves against HIV and elimination of all forms of discrimination against them is yet to bear fruit. Social, legal and economic factors continue to impede women’s access to vital services and keep them dependent on relationships that put them at risk of infection. Stigma and discrimination, which particularly affect women, persist as key barriers to HIV prevention, treatment and support programmes. Violence against women remains both a significant cause and a consequence of HIV and AIDS.

5.2 National response structures and processes

5.2.1 Gender issues in the national HIV response

Most stakeholders and implementers working in HIV and AIDS do not have basic gender awareness and sensitization. There is also a lot of resistance towards the term ‘gender’ as it is perceived to be championing women’s rights which are seen as a distortion of the social order.

5.2.2 Gender issues in structures

Membership at the NACC council includes two bodies that focus primarily on women related issues. These are Maendeleo Ya Wanawake and Women Fighting AIDS in Kenya. It can be assumed that these two organizations represent women vulnerabilities and advice on appropriate HIV and AIDS responses. At the District Technical Committee level, which is the technical arm, the Gender Officer at the District is not a member of the Technical Committee. This is a gap because the Gender Officer should guide priority setting for HIV and AIDS responses from a gender perspective.

The local planning unit for HIV and AIDS responses is CACC. Within this committee, two slots are reserved for women, one of which must be allocated to the national women’s movement i.e. Maendeleo Ya Wanawake. While their participation and input is critical to the planning process, there is no guarantee that their input translates into gender responsive activities. There is also provision that persons living with HIV and AIDS must have a representative in the committee. This is left open for either men or women and does not explicitly reserve seats specifically for positive women or men. Women and men are affected differently by HIV and AIDS and therefore have different needs.

MCGs are the priority area planning unit. This being the case, gender mainstreaming must be ensured at this level. The gap here is that Gender is considered as an item in MCG 4 which deals with Support Services. This gives the impression that gender is a separate issue and is discussed as a separate unit and hopefully finds its way to the other MCGs. Gender should be discussed within each MCG as this is the only way to ensure gender mainstreaming. Further the MCG planning process is not decentralized to the community level. This means that the real practical gender needs may loose the opportunity of finding their way into this important planning process. In order to ensure that gender is mainstreamed, there is need to ensure that at least one gender expert is a member in each MCG.
Within the job description of ACUs is to ensure HIV and AIDS is mainstreamed in the core functions of the organization, collecting sectoral data and developing relevant guidelines among others. These three areas of work are critical to gender mainstreaming in HIV and AIDS responses yet it is not mentioned. It should not be assumed that gender would be captured and the job description should include that the ACU should carry out their task taking gender into consideration.

It was established that there is limited capacity in gender mainstreaming within the overall NACC structures. Also of concern is that women are under represented in management levels of HIV related organizations such as DTC, CACC and key CSOs. Implementers and policy makers have limited capacity in gender mainstreaming.

Some key issues emerging:
- Priority areas (MCGs) not decentralized to the CACCs level
- Inadequate representation of CACCs at the district level
- Inadequate capacity on gender for representatives at community level
- Lack of definite times for MCG meetings
- Lack of consistent agendas
- Regulations of meeting times not strictly followed
- Meetings are need-based
- Data on results from priority areas not gender disaggregated

5.2.3 Gender issues in stakeholder coordination

The Inter-Agency Coordination Committee provides coordination between HIV and AIDS stakeholders. It also ensures that all calls for proposals are in line with priority areas of KNASP and that they address priority interventions. The ICC therefore plays a very important role in ensuring that HIV and AIDS responses are on course. The ICC can therefore play a critical role in gender mainstreaming if it ensured that all proposals are gender responsive with adequate financial and human resource. The ICC can also ensure that in incorporates stakeholders that have strong gender expertise.

It is evident that there is very limited capacity on gender in general, gender in relation to HIV and AIDS and gender integration in HIV and AIDS responses among implementing civil society organizations and the DTC. Their capacity to synthesize, monitor, validate and analyze data with gender lenses is low. Most programmes are designed and developed to address HIV and AIDS without recognizing the unique differences in the effects of HIV and AIDS to women and men, boys and girls. In some cases, programmes have targeted wrong beneficiary groups because of lack of gender analysis prior to programme planning. This has slowed down the urgently needed positive effects of HIV and AIDS interventions. FOs and M & E officers in the regions cited their incapability to enhance technical capacity on gender and human rights issues since they themselves require this capacity.

There are many NGOs and FBOs and faith based organizations working at the community level on gender issues while others are responding to HIV and AIDS. Whereas these organizations can work together to build on each others strengths, there is no coordination mechanisms in place. This leaves each organization to work in their specialized fields without linkages. There is also weak coordination between NACC and government Ministries. The gender desks are largely non-functional and
have weak linkages with ACUs and/or NACC. Further, there is little coordination between women rights organization, human rights organizations, inter-sectoral and inter-agency. Linkages in as far as targeting gender issues is concerned are weak. The roles of DRH, NASCOP and other stakeholders are not harmonized; such harmonization (in terms of who is responsible for what) is critical for PMTCT programmes. PMTCT and Reproductive Health reporting are not integrated.

5.2.4 Gender issues in Monitoring and Evaluation and Data Collection

Sex disaggregated reporting has been absent in the JAPR through out the response until 2008, when MCGs had gender issues being presented as part of their summits. Where sex disaggregated data was collected within the M & E framework, this quantitative date is not subjected to a gender analysis to examine the factors and opportunities that impact on the ability of women, men, boys and girls to respond to HIV. The analysis therefore does not reveal how affected or infected women and men are impacted on differently. This in turn undermines programming efforts towards gender equality in the access to HIV prevention and quality of life. This therefore leads to the development of programmes that are largely not necessarily gender integrated or responsive.

Despite the obvious gender disparities presented through programme reports in various forums, prioritization at JAPRs which informs the national priorities for the next year remains is lacking. More specifically:

- The rolling results framework did not capture indicators and new programme success measures by gender,
- the budgeting process did not examine funding targeted to gender related vulnerabilities in Kenya.
- The national institutional development plan did not review the capacity of organizations to respond to gender issues at programming levels including prevention targeted at most vulnerable groups such as young females or poor male uptake of testing services, or high burden of care on female orphans.

HIV and AIDS related research and the monitoring tools in place do not generate adequate sex and age disaggregated data. This is due to the fact that monitoring and evaluation tools are deficient on gender sensitive indicators. However, when data is generated, the information does not provide gender analysis to clarify the status and opportunities of women, men, boys and girls. The analysis therefore does not reveal how affected or infected women and men are impacted on differently. The effect gender roles and responsibilities have on response efforts ends up not being clear. This therefore leads to the development of programmes that are largely not necessarily gender integrated or responsive.

In as far as data collection for M&E is concerned, the tendency is to collect quantitative data that reports on number of women, men, boys and girls. M&E should go further to look at the emerging power relations as a result of HIV and AIDS interventions. Although there have been attempts to fill information gaps in the socio-economic dynamics in HIV and AIDS (e.g. National study Commissioned by NACC on FGM and HIV and AIDS in 2008), KNASP still lacks mechanisms to ensure that data collection from implementers would generate information disaggregated by sex and other social economic variables that would inform existing gender based inequalities. It is also not categorical whether deliberate actions would be taken to create a male/female balance in samples targeted in research. The M&E and
research tools should therefore provide for this information to be collected and subsequently make efforts to translate findings to direct policies and programmes.

5.2.4.1 Desegregation of Data
In many instances, the language presents communities as homogeneous groups without taking account of the social, economic, cultural and geographical dynamics that define the uniqueness among men, women, boys and girls. Thus it is noted that:
- Figures of prevalence in terms of gender for the rural areas are not incorporated.
- In terms of AIDS deaths, the ratio of men to women at both global and national levels is not provided.
- Of the 1.7 million orphans, the figures are not segregated on the basis of sex to indicate number of boys against girls.
- No indication of the socio economic effects/impacts of HIV and AIDS from a gender dimension and secondly from an age dimension (i.e boys and girls). It is true that women are the main suppliers of labor especially in the agricultural sector. How the effect of AIDS affects their economic growth is not clear.
- The education and health sectors do not give the ratio of the female to male teachers who have died from HIV – related complications.

5.2.5 Gender issues in the financing of the national response
The National AIDS Control Council is the national legally constituted body in Kenya that takes the lead on the national HIV and AIDS programmes. It oversees, coordinates and monitors the national response to the HIV and AIDS pandemic by bringing together various actors. It is therefore NACC’s responsibility to ensure gender integration in its structure, processes, programmes and financing for all HIV and AIDS interventions. At NACC, there is a gender advisor seconded from UNFPA. The Gender Advisor, supported by the Gender Technical Sub-Committee ensures that gender is enshrined in all national HIV and AIDS initiatives.

**NACC:** NACC’s role should be to ensure that gender is integrated into the national HIV and AIDS action plan; that the plan is aligned to other national development policies and plans – including the country’s national gender policy; and that the gender-responsive AIDS action framework is linked to financial frameworks such as national budgets and medium-term expenditure frameworks for effective mobilization of financial resources and implementation. However, there has been a general lack of adequate financial commitment to mainstream gender within NACC. For, example, there is no specific budget line for Gender under TOWA, the 4-year multi-million World Bank/DFID/GoK funded project.

NACC should also ensure that national AIDS action frameworks include work plans and budgets that are gender-responsive and that address inequalities.

**Government Funding:** The national HIV response in Kenya is highly externally funded: at least 85% from PEPFAR and other donors, most of which is off-budget and largely uncoordinated. To ensure the long-term sustainability of HIV and AIDS programmes, the Kenyan government has made attempts to tie the implementation
of KNASP 2005/6-2009/10 to the government budgetary cycle. This is aimed at enabling ministries to commit and disburse part of their budgets to HIV and AIDS programmes itemized in the KNASP 2005/6-2009/10 results framework. KNASP 2005/6-2009/10 identifies the priorities in responding to the HIV and AIDS epidemic as: preventing new infections, improving the quality of life for infected and affected people (care, treatment and human rights) and mitigating the socio-economic impact of HIV and AIDS. Unfortunately, committed funds are not commensurate to the gravity of the epidemic and have not cascaded effectively to the decentralized levels in most sectors.

**Other Implementers:** Civil Society Organizations and Private Sector are key implementing partners in HIV and AIDS responses at the community level. They write their proposals and submit to CACC. CACC approves and funds proposals of up to Kshs. 350,000/=. Proposals of more than Kshs. 350,000/= to Kshs. 1,000,000/= approved by the District Technical Committee while proposals of more than Kshs. 1 Million are sent to NACC for approval and funding. Looking at a few proposals, it is evident that there is need for strengthening gender budgeting. During subsequent JAPRs, a wide and growing financial and funding gap was observed in almost every target area of KNASP 2005/06 – 2009/10. Most government, civil society and donor groups have found it almost impossible to base any work on such key issues as gender and human rights and therefore, Human rights and gender issues, though key, were not budgeted for. Some donors are not gender receptive and funding of gender issues especially by many international organizations is trivialized. Moreover, women-led organizations that are expected to address disparities facing women are affected by limited fund raising skills.

**5.2.6 Gender Planning and Programming**

Overall, the strategic plan has made commendable effort to ensure that the objectives spell out gender related targets. The core principles of KNASP include focus on gender and youth, maximum engagement of PLWHA in the implementation of the strategy, targeting vulnerable groups and evidence-based interventions. These principles are intended to determine the priorities of the strategy to be applied, the design of interventions, and the approach to implementation. To this end, focus on gender is key in the success of any interventions or action taken. However, understanding of gender is largely limited and to many practitioners it implies the redress of women’s and girls’ issues. This greatly undermines gender responsiveness in all national initiatives.

The comparatively high rate of infection among women and girls is a clear indicator that Kenya still has a long way to go in the attainment of gender equity, equality and women’s empowerment in HIV and AIDS initiatives.

**5.2.7 Lessons Learnt from the KNASP 2005/6-2009/10**

**5.2.7.1 Observations from the core principles of KNASP 2005/06 – 2009/10**

**Integration of HIV and AIDS to support a multi-sectoral approach:** This is an effective approach to KNASP programming in integrating HIV and AIDS. However, the processes undertaken in the multi-sectoral approach are largely gender-blind.
**Targeting vulnerable groups:** the document identifies certain groups as vulnerable with geographical and cultural dimensions that affect the design of interventions. One of the areas of vulnerability is the whole question of gender. One gender group is more vulnerable than the other whether it is among the discordant couples, commercial sex workers or migrant workers. Power relations contribute to the vulnerability of one partner in the relationship. In commercial sex workers for example, many of those involved are women. However, men are part of commercial sex works in the trade. This recognition allows for specific targeting in terms of programmes and finances.

**Orphans and vulnerable children:** Dealing with such children from a gender perspective helps in the kind of programmes put in place to reach them. For example where funding is given to such children, the girls would need more funding because of their extra needs such as sanitary pads. Girls may also have more responsibilities in providing primary care in home based care programmes.

**Uniformed services:** while the programmes are intended to cater for the men who are employed as such and who live away from home; there are no related programmes for two women in the man's life: the regular partner and the casual partner. This is a limited way of looking at the problem and offering solution.

**Focus on gender and youth:** the strategy for integrating HIV and AIDS targets information on gender basis (male and female) across the age spectrum. However, one area missing in this area is lack of ensuring segregation of data on the basis of sex and age group to help in the planning process for any targeted action.

**Empower/Participatory Approach:** the groups specifically mentioned seems to leave out the men as a category of its own. The approach should ensure specific strategy for men and women, boys and girls.

### 5.2.7.2 Observations from KNASP 2005/06 – 2009/10 Priority Areas

#### Priority No. 1: Prevention of New Infections

This priority aims at reducing the number of new infections through decreasing the risk of infection among the general population and decreasing high risk behaviour which make particular groups vulnerable to HIV infection.

Increasing availability and access to counseling and testing: While the provision of VCT services in each administrative unit in the country is a start, the same may not be accessible to many of the vulnerable groups identified that need these services. For women this is not practical as they are far from many of the administrative division. Secondly, the times of operating such centers will determine whether women and the criminalized MARPs (CSWs, IDUs, MSMs) are able to access the same. This is confirmed by the Kenya Aids Indicator survey which indicates that a large number of those who have tested are actually from the urban areas.

**Condom promotion:** Much promotion and focus has been directed towards the male condom which is distributed free of charge. The non availability of women condom may explain why it is not used and therefore the need to change the strategy used

Promoting abstinence, Consistent Safe Sex and Delayed Sex Debut among Young People: what is the targeted number of young women and men and secondly what
proportion of this will be girls? Secondly, this priority seems to suggest that girls only need to stop this behavior. However, this happens with boys who should be specifically targeted to stop having sex and if they do, they have to go for safe sex. The strategies of reaching the groups may in some cases be very specific and would be different.

**HIV testing:** it is important to know the gender that is specifically being targeted in terms of visiting the VCT centers. The same applies to condoms. How many female and how many male condoms will be distributed during this period. Though this information is found under BCC the same should be found in other areas

**STI Management:** The following observations were made:
- Inadequate programs that effectively promote prompt diagnosis, treatment and follow-up of STIs and HIV among (more at risk groups persons) including SWs, fishing communities, male and female prisoners, survivors of rape and sexual violence and Discordant couples
- Few programs that effectively combine STIs diagnosis and treatment with C&T, PEP, EC and testing for pregnancy
- Lack of programs that put emphasis on partner notification upon STI diagnosis
- Youth friendly centers lack capacity to offer STIs services (majority depend on syndromic management);
- There are no programs advocating for STIs Testing in learning institutions e.g. colleges and universities
- Most Disease Testing Centers lack laboratory technology leading to syndromic treatment-women (especially for SWs) are most affected, seeming discriminative

**Priority No. 2: Improvement of the Quality Of Life of People Infected and Affected By HIV/Aids**

This priority area aims at improving the quality of life for those infected and affected with HIV and AIDS. Though gender mainstreaming was envisioned in KNASP II it has neither been infused nor integrated. Due to this, the allocation of resources was not necessarily determined by evidence of the impact of HIV by gender. In determining what is to be done, it would good to have gender dimensions and data to help in the planning. For example in the provision of home based care services, it would be good to know who provides this. In looking at home based care services provided to PLWHA, the information needs to be segregated on who requires this service(those affected), who provides it/carries it out,

**Stigmatization:** Issues of stigma are key and how they affect each gender separately needs to be specific.

**Human rights:** There are continued high levels of discrimination and human rights abuses of people infected and affected with HIV and AIDS. Effective protection of human rights is essential in improving the quality of life of those affected. However, the organizations carrying out this work should be encouraged to use the rights based approach in programming in planning their work. This takes into account the gender question in programming and implementing the programmes.

**Priority No. 3: Mitigation of Social and Economic Impact.**

KNASP aims at initiating impact studies in key sectors with particular reference to women and children. This study should also look at the other gender (men) but to
also look at the young women and men and how they are affected. Such specific studies will determine the strategy to be used, programmes that are initiated to mitigate the problems, determine the type of awareness programmes, call for specific targeted activities and finally will determine the funding requirements. Specific data segregated data is therefore key.

**Priority No. 4: Monitoring, Evaluation and Research**

Under this priority area the following observations were registered:

- Inadequate age and sex-disaggregated data during studies, reviews, monitoring and evaluation is generated and this makes it difficult to conduct meaningful data analysis on the basis of social and demographic factors such as age, residence, occupation, migratory patterns and HIV status/discordance to facilitate gender-responsive planning.
- Inadequate utilization of existing KNASP structures and systems for coordination of stakeholders responding to gender issues
- There are too many committees, insufficient coordination and too many meetings without a calendar and this further complicates coordination.
- External mainstreaming of HIV and AIDS not well understood and implemented and this impedes the integration of gender dimensions
- KNASP does not highlight issues of gender balanced representation and participation in research activities.
- The operationalization of the principles of GIPA is presented in a gender-neutral manner. It is not clear how gender equality would be ensured in the participation and capacity building of PLWHA and their organizations and especially when male PLWHAs organizations begin to have a voice.
- KNASP does not stipulate the role of women, girls and elderly women in HIV and AIDS mitigation. Women are affected by HIV and AIDS particularly as care givers. Home based care and nutrition programs should aim to empower women and girls in their roles.
- Results framework often unaligned to research findings
- At decentralized structures, especially at CACC level, logistics are not well defined and therefore scheduled meetings are not well communicated leading to poor attendance
- Policy Environment
  - i. No policy framework to govern Human rights based approaches
  - ii. Limited domestication of international instruments on Human rights
  - iii. Few government departments with workplace policies therefore no gender issues in HIV addressed

**5.2.8 Issues emerging in the KNASP 2009/10 – 20012/13 Development**

Though KNASP 2005/06 – 2009/10 had envisioned gender disparities of the epidemic and focussed on this as one of its core principles, this had not been addressed and attained to have a direct influence on KNASP’s outcomes.

The decision by NACC to develop the third KNASP covering the period 2009/10 – 20012/13 with clear vision, goals and targets was necessitated by two important new sources of information a) Kenya AIDS Indicator Survey KAIS) and b) Modes of HIV Transmission Study (K-MoHT) which became available with significant implications for the current KNASP 2005/06 – 2009/10 (refer to Background Section for gender
dimensions of this evidence). The KNASP 2009/10 – 20012/13 is expected to be underpinned by the best available epidemiological and other evidence. Due to outstanding gender dimensions of the epidemic revealed by the studies, specific actions were undertaken during this process. These included recruiting a gender expert among the consultancy team for the review and development of the new KNASP and ensure considerations for geographic variations, integration of gender and human rights in the programming as one of the guiding principles for development of the new KNASP. Technical multisectoral teams and sub-teams were constituted to drive the process of developing a new KNASP and provide a framework for programmatic response by all implementers. Gender sub-team was placed in the cross cutting pillar which acts as a watchdog for all pillars in ensuring the cross cutting issues are integrated in their write ups. It is also included as distinct performance and accountability areas in the monitoring framework, for which NACC has an oversight function. Below is the proposed structure for KNASP 2009/10 – 20012/13:
Gender Audit of national response to HIV and AIDS, Kenya

Figure 5: Proposed Structure for Kenya National AIDS Strategic Plan 2009/10 - 20012/13

<table>
<thead>
<tr>
<th>Proposed Structure</th>
<th>Kenya National AIDS Strategic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall Policy, coordination, strategic information and accountability</td>
<td>NACC/Ministry of Special Programmes</td>
</tr>
<tr>
<td>· Policy, advocacy and leadership</td>
<td></td>
</tr>
<tr>
<td>· Programme planning, coordination and supervision</td>
<td></td>
</tr>
<tr>
<td>· Resource mobilization, allocation (and grants management)</td>
<td></td>
</tr>
<tr>
<td>· Stakeholder mobilization and partnerships</td>
<td></td>
</tr>
<tr>
<td>· Monitoring, evaluation and research, and reporting</td>
<td></td>
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</tbody>
</table>

2. Facility-based essential HIV-services (Ministry of Health)
- Combination cost-effective prevention – VMAMC, HTC, PMTCT, PwP, Safe Blood
- Treatment and care
- Health systems and procurement/supply
- HIV health sector strategy and coordination ETC.

3. Community-based HIV programmes (NACC)
- AIDS competence
- Treatment literacy
- Social mobilization – risk perception, demand for services including ABC
- Reduced stigma and discrimination
- Hot-spots/area-based special programming
- Support for OVC/widows/PLHIV ETC.

4. Sectoral HIV mainstreaming (Ministry of Planning)
- Vision 2030 Mid-Term Plan, MTEF
- Regional HIV initiatives (e.g. GLIA, IGAD, EAC)
- Public sector strategies and programmes – ACUs
- Private and informal sector
- Social protection and national safety net
- Legislation/PLHIV human rights protection ETC.

Gender issues emerging from the new KNASP development:
- Currently, the structure is at national level only
- Current positioning of gender as a cross cutting issue may not trickle to each and every level - It is currently located on the periphery
- Numbering may introduce the aspect of hierarchy
- The texts on gender should be given prominence
- Not clear where the Ministry of Gender falls within the structure
- It is not too clear as to what exactly is ‘cross cutting issues’
- Proposal to have cross cutting issues as gender, human rights and systems strengthening
- Need to de-link the gender and the youth working group
6.0 Recommendations

In 1999, the Joint United actions Programme on HIV and AIDS (UNAIDS) published a technical paper entitled ‘Taking Stock of Research and Programmes on Gender and HIV/AIDS’ which demonstrated that although limited in scale, HIV and AIDS programmes that address gender inequality as a central goal maximize their overall effectiveness.

Given the financial and human resource constraints, an enabling environment and appropriate institutional frameworks are crucial to ensure that all HIV and AIDS-related activities are effectively coordinated to address gender inequalities. Thus the following factors are imperative:

- Legal and policy framework that supports advancement of gender equality and equity.
- Political and administrative will and commitment among the highest level of leadership at NACC to gender equality and equity.
- Capacity building for all stakeholders and implementers working in the area of HIV and AIDS on gender concepts, gender-responsive planning, analysis and programming and the application of gender sensitive indicators for monitoring and evaluation.
- Women and gender expertise represented at the highest decision making organs.
- Adequate human and financial resources for gender integration.

6.1 Programming

6.1.1 Supportive Legal and Policy environment

6.1.1.1 Domestication of International and Regional Agreements

In order to strengthen gender equality and women’s rights in the one agreed national AIDS action plan, the plan should ensure that commitments made by Government based on human rights instruments to women’s human rights are incorporated. Thus the need to hasten domestication of international and regional instruments on gender mainstreaming in HIV and AIDS programmes.

Further, while coming up with key priority and action areas, space for women’s participation should be intentionally created, particularly those most affected, to ensure that their priorities are incorporated into the formulation and review of the plan. To this end, existing data and research on gender equality and HIV and AIDS form the basis for specific provisions in the plan. Lobbying the government to continually develop gender responsive policies and guidelines for the implementation of HIV and AIDS programmes is crucial. A prerequisite to this is the building of the capacity of the policy-makers and project administrators in the national HIV response (including all implementing organizations) to ensure support for gendered processes in policy-making, planning, financing and programming and establishment of guidelines to ensure that management systems provide an enabling environment for gender-responsiveness. Existing relevant national and sectoral policies and strategies/plan should be reviewed to identify gender-HIV gaps with the aim of filling them. Moreover, all organizations require workplace HIV and AIDS policies;
particularly government departments who should therefore be encouraged to undertake this process.

6.1.1.2 Alignment of NACC’s Action plans with National Policies and Plans

NACC should ensure that the national action plan is aligned to other national development policies and plans – including the country’s national gender policy; and that the gender-responsive AIDS action plan is linked to financial frameworks such as national budgets and medium-term expenditure frameworks for effective implementation. NACC can also ensure that national AIDS action frameworks include work plans and budgets that are gender-responsive and that address inequalities.

6.1.2 Collection and Analysis of Sex Disaggregated Data

There is need for gender analysis to clarify the status and opportunities of women and men, boys and girls before developing HIV and AIDS programmes. The analysis should involve the collection of sex-disaggregated data which reveals how development activities impact differently on women and men and the effect gender roles and responsibilities have on development efforts.

Collecting data for monitoring and evaluation should be based on gender sensitive indicators which are developed using information derived from gender analyzed sex-disaggregated data. Monitoring and evaluation tools in place should be reviewed to ensure that all the targets show the different gender dimensions. It should also be reviewed to ensure that all the targets and indicators reveal the number of women, men, boys and girls reached.

Gender Analysis prior to Programming

NACC should conduct a gender analysis of the emerging priority areas to allow identification of gender related constraints and opportunities for improving outcomes and gender equity by using the Five gender analysis domains listed below:

- Access;
- Knowledge, Beliefs, and perceptions
- practices and participation
- time and space
- Legal.

This would ensure that both men, women, boys and girls have access to treatment; equal participation in programs that ensure quality of life of people infected and affected by HIV and AIDS, address knowledge beliefs and perceptions around gender issues as they relate to care and support.

6.2 Structures and Processes

The two most important strategies towards ensuring the reduction of HIV and AIDS infections and impacts are alleviating gender inequalities and empowering women and girls in order to reduce their vulnerability to infection and improve their access to treatment and care. Women and girls must have more access to information of prevention methods and have power to protect them from infection. In order to achieve this, new synergies, greater coordination and increased resources to integrate gender equality and women’s human rights into national HIV and AIDS policies, programmes, plans and actions are required. Thus the need to enhance the capacity of NACC to mobilize resources and coordinate,
6.2.1.1 Strengthen Capacity of NACC for effective Coordination
NACC being the one national AIDS co-coordinating authority should initiate and strengthen gender integration in institutional arrangements and provide the overall coordination and monitoring for gender integration. It should also play the leading role in coordinating trainings in such areas as basic gender awareness and sensitization, gender analysis, gender planning, the use of gender sensitive indicators, monitoring and evaluation. The training should also include content that helps overcome hostility and negative attitude towards gender and show the relevance of gender in HIV and AIDS responses. Sufficient resources should be provided for coordination of the gender response.

6.2.1.2 Full time Gender Advisor at NACC Secretariat
NACC ought to demonstrate its commitment to gender integration by entrenching the position of gender advisor into a full-time senior managerial level in its hierarchy. This would imply greater influence on funding for evidence-based programming addressing gender dimensions of HIV and AIDS to benefit those most impacted, continuous monitoring and gender analysis of the AIDS pandemic and ensure that stakeholder consultations and forums are inclusive and that both women’s and men’s voices are heard and taken into account.

6.2.2 Enhanced Coordination and Monitoring of Gender integration
The Department of Gender in the Ministry of Gender, Children and Social Development needs to be strengthened to play its role as the key actor in gender integration during the development of the national AIDS action plans. Inclusion of government gender officers and other gender experts at all levels in District Technical Committees and CACC, regional forums and national structures is imperative. Funds are required to increase institutional capacity and technical expertise in order to backstop, monitor and evaluate gender responsiveness. The Ministry should ensure that Gender Officers at the District level are adequately equipped to deliver on ensuring gender is integrated in all programmes including HIV and AIDS responses. They would be charged with extension work to train committees on gender integration and ensure that proposals coming for vetting at the District level are gender integrated. They would be able to do this by assisting those writing proposals at the constituency level to ensure that they are gender integrated. While writing proposals related to all decentralized funds, there is provision to consult government officers for assistance.

There is need to periodically monitor and review the progress of gender integration in HIV and AIDS and share the findings and recommendations with stakeholders through the MCGs and JAPR.

6.2.3 Institutional Technical Capacity
Systematic training on gender issues in HIV and AIDS for all NACC, GoK staff and other stakeholders to enhance sensitivity and response is important in order to promote equal access to prevention, treatment and care. Many CBOs managed by women require both support and capacity building on resource mobilization (literacy levels of women in Kenya is observably low compared to men). The need to build the gender capacity of policy makers and programme planners for example by
supporting gender awareness training for all CCM members, Advisory Committee of the ICC and members of the MCGs must be underscored.

6.2.3.1 **Address Gender Capacity Gaps in Key Decision-making Structures**
Increase representation of women/gender expertise in key decision making bodies e.g. Country Coordinating Mechanism, MCGs, Advisory Committee, DTCs, CACCs

6.2.4 **Improved Stakeholder Capacity and Coordination**
- At the design stage of all HIV and AIDS responses, all activities under each priority area must be specific and time-bound, identifying strategic partnerships for implementation with gender related targets to be achieved. This ensures that both technical skills and finances are resourced in good time and that programme financing is gender responsive.
- Develop criteria to integrate and measure gender responsiveness in funding mechanisms, including grant eligibility, monitoring and evaluation tools for utilization of availed funds.
- Plan and make available resources for an integrated response in each sector, including an analysis of the factors within the sector that contribute to the spread of HIV and AIDS,

6.2.4.1 **Build Partnerships and Strengthen Networking**
NACC extending and deepening strategic partnerships with international and local organizations, NGOs and networks focused on women’s rights and empowerment which is key to developing and implementing health programmes that address gender issues. This should include partnerships with networks of men who have sex with men and other vulnerable groups. Thus the need to map all the Organizations focusing on gendered vulnerabilities and establish forums of networking and establish links and identify mechanisms for collaboration with other partners to share information on effective responses to gender-related HIV and AIDS issues.

6.2.4.2 **Human Resource and Technical Capacity**
The District Gender officers that belong to ministries that coordinate government sectors should participate actively while representing interests of their respective ACUs as ex-officio. In their absence, one or more of the CSO/NGO and women representatives selected should have a good background on gender perspectives. These persons as well as the FOs, M & E at regional offices and DDOs are also key trainees for technical capacity building trainings on gender and HIV and AIDS.

6.2.4.3 **Involvement of People Living with HIV and AIDS**
HIV-positive women and men can provide insights into how living with HIV affects women differently than it does men. This should translate into programmes that address and respond to unique women and men’s needs. The structure should therefore provide explicitly the seats reserved for specifically women and men living with HIV and AIDS at all levels.

6.2.5 **Sustainable financing of Gender Initiatives**
Utilize the meager resources available in the health sector in a cost-effective and equitable way. Action must be taken to ensure that women and girls have adequate access to sexual and reproductive health services and that there is equality in the
provision of drugs for treating HIV and AIDS and opportunistic infections and of care to those infected.

6.2.6 Other Recommendations

- Political and administrative will and commitment at the highest level of government to gender equality and equity is paramount in ensuring effective gender integration in HIV and AIDS responses. This goodwill should be demonstrated by government’s financial commitment through annual budgets, to strengthen institutions capacity to develop, implement monitor and report on programmes from a gender perspective.
- Commitment by stakeholders and implementers to build organizational capacity on the knowledge and skills in gender awareness, gender analysis and planning
- Legislative and constitutional framework that is conducive to advancing gender equality should be put in place
- More representation of women at all levels of decision-making structures. Training on gender, gender and HIV and AIDS and gender integration made mandatory and available for all persons within the structure from CACC, DTC, NACC secretariat, NACC Consultative Steering Committee and the Cabinet Committee on HIV and AIDS
- Provision of adequate human and financial resources.
- During the development and implementation of national strategic plan,
  - Gender experts to be included in structures and processes at all levels of policy making up to the community levels.
  - Involvement of the Ministry of Gender needs to come up very strongly within the structure
  - Need to allocate specific monies for gender
  - Kenyan Human Rights Commission should be put on board so that they can support with the rights-based approach
- The terms of reference of this task should go to all NACC departments so that they each have a deliverable on gender
- In order to attain efficiency in the utilization of funds, NACC will need to include within each objective specific unique needs and responses for women, men, boys and girls including numbers.
- As the government develops financing mechanisms to make health care accessible to all, NACC gender experts and the GTC should ensure that they are included in the process.
- While funding proposals may have elements for responses from men and women, there is need to ensure that financing of projects is engendered.
- Effective monitoring and evaluation should ensure that gender-sensitive indicators are used and sex-disaggregated qualitative and quantitative data are collected.
- One of KNASP’s tasks is not only to use approaches and structures that are available but to influence and ensure the same where they are not engendered.
- Sex disaggregated information should be captured on the access to specific HIV-related services; how many women and men are accessing condoms for example.
- Strengthen monitoring and evaluation framework/tools with gender sensitive indicators; all indicators for monitoring and evaluation must show the results and extent to which an intervention is expected to address the different needs of male, female, adolescents and children as evidence of assessing effectiveness with which gender dynamics of the epidemic are being programmed.
6.3 **Recommended Next Steps**

Drawing from the recommendations outlined above, guidelines are fundamental in order to provide guidance to stakeholders to strengthen initiatives on integration of gender in HIV responses. These guidelines should inform the different categories of stakeholders i.e. NACC, government departments, civil society and private organizations, development partners and research institutions how, where and when to engage the national HIV and AIDS response and monitoring framework more effectively in order to advance gender responsiveness in HIV programmes in Kenya. These guidelines should target at building the capacity of various stakeholders to engage effectively with the broader KNASP response framework in which planning decisions that influence priorities on funding, programming and research are made. Alongside this guidance, indicators to provide a framework for monitoring this progress must be developed. To support this exercise, here below are proposed guidelines and indicators which are primarily based on the findings of this gender audit.

6.3.1 **Guidelines for Stakeholders**

In response to the gender gaps and issues identified in the national response and monitoring frameworks, here are broad national guidelines proposed for the various categories of stakeholders.

6.3.1.1 **Guidelines for National AIDS Control Council**

A key factor in ensuring the successful integration of Gender is political and administrative commitment to gender equality and equity at the highest level at NACC. This would ensure a supportive policy environment and representation of women and gender expertise at the highest decision making organs to advocate and coordinate the prioritization of gender dimensions and financial resources to mainstream gender in the national HIV response and broader development processes. The following action points are recommended for NACC:

**Organizational capacity**

- Establish and maintain a Gender unit and managed by a senior officer in NACC to advice and provide enhanced advocacy on gender in agenda-setting, funding, planning, program design and implementation, monitoring and evaluation and coordination.
- Conduct an assessment of the capacity of NACC to mainstream gender and develop and operationalize gender capacity building plan for effective coordination and promotion of gender integration in the national HIV response.
- Strengthen the Resource center at NACC with gender-responsive IEC materials

**Institutionally**

- Identify and advocate for stronger representation of women and human rights organizations and gender experts in decision-making structures of KNASP including Inter-agency Coordinating Committee on HIV and AIDS (ICC), Advisory Board of ICC. (KNHRC, NCGD, Department of Gender, FIDA)
- Establish and continuously update a database on international, national, regional and community organizations and experts involved in addressing human rights and specific vulnerabilities of women and girls, boys and men to HIV; including gender focal points in government, research institutions, media, and Kenya National Bureau of statistics, Maendeleo ya Wanawake, organizations of PLHIV
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(SWAK, NEPHAK and WOFAK) and groups addressing men and masculinities so as to engage them in:
- Strategic planning
- Monitoring and Evaluation processes
- Research agenda setting
- Networking

- Coordinate the development and dissemination of a national Action Plan for gender integration in HIV and AIDS as a gender strategy to guide implementation. The action plan to be in harmony with the current KNASP, National Gender and Development Policy and national Gender Strategy.
- Document best practices and projects on integrating gender in HIV and share the outcome with stakeholders for scale up.
- Develop a training curriculum to sensitize, orientate and provide practical gender training to all NACC staff (including Managers, program and administrative support staff) on gender dimensions in HIV and AIDS. (see existing curricular by WHO)
- Coordinate the development and disseminate training curricula and analysis tools for gender and HIV to ACU programme managers to facilitate the building up of ToTs
- With the support of the members of the GTC, design, develop and disseminate easy to understand IEC materials on gender and HIV and AIDS for service providers and target communities.
- Support/encourage various sectors to develop sector-specific gender-sensitive indicators in HIV and AIDS programming

Strategically
- Coordinate the participation of the integration of gender equality and HIV into broader development processes, including National Development Plans (Sector Reports) and their implementation and review, and adopt HIV and gender as a cross cutting theme for strategy development and review.
- Ensure that national AIDS action frameworks include work plans and budgets that are gender-responsive and that address inequalities.
- Coordinate the participation of all key stakeholders in the review of research protocols to ensure that they are gender responsive and to interact within KARSCOM in setting research agenda
- Coordinate the participation of the review of KNASP Monitoring and Evaluation frameworks and tools to ensure specific gender responsive indicators are captured to generate data that is disaggregated according to sex, age category, marital status, geographical area and socio-economic strata for analysis in order to inform decision-making in financing and programming.
- Engage the national joint programme review process at both sub national and national levels by revising the reviewing tools and coordinating a gender assessment of the epidemic and the national response as regards vulnerabilities to HIV infection and impact and barriers to access of women/girls and men/boys in the general population and in key populations at risk to inform the national JAPR on gender priorities for national programming
- Create operational linkages with national gender equality/women’s development programmes and initiatives in the country for networking and collaborative activities; these include:
  1. Gender Sector Coordination Group
  2. GBV Sub cluster
  3. Kenya Demographic Health Surveys
4. UN Coordination Group on Gender and Human Rights
5. Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)
6. Commission on the Status of Women (CSW)
   • Identify and advocate for the filling of capacity gaps on gender in the focal points for KNASP III, policy and decision making structures within NACC including decentralized levels from amongst stakeholders
   • Develop a sexual harassment strategy at workplace.
   • Engage the media and local celebrities during commemorations and special occasions (including World AIDS Day, International Women’s Day, Mother’s Day etc) to communicate messages on pertinent gender related issues
   • With support of the GTC, hold an annual Gender review to inform national JAPR

Financial commitment
   • Develop a mechanism to facilitate periodical audits of gender responsiveness in NACC funding, policy formulation and programming.
   • Develop criteria to measure and ensure that all funding applications to multilateral and bilateral donors for HIV and AIDS include explicit components on gender equality and equity.
   • Promote networking and sharing of information in JAPR, UNGASS, CEDAW, CSW, and other national and regional forums with stakeholders and networks on HIV related gender dimensions.

Political commitment
   • Coordinate stakeholders to support government in formulating gender responsive HIV and AIDS national sector policies and strategies.
   • Prepare and upload periodic policy briefs and updates on the analysis of pertinent and emerging gender issues in HIV and AIDS from research evidence (KDHS, KAIS, National population & Housing Census and other regional or national research reports) onto NACC website
   • Update toolkit for training policy makers and senior decision-makers on Gender and HIV and AIDS and conduct sensitization workshops in order to increase their appreciation and funding of gender in national development priorities
   • Coordinate the development of simple to use and adaptable gender sensitive curriculum for community training to build technical capacity for community institutions and structures on gender and HIV, targeting to demystify the gender concepts and to curtail resistance so often encountered on the mention of the term ‘gender’.
   • Coordinate the development, testing and validation of gender-integration tools/criteria/checklists and instruments for advocacy towards resource mobilization and facilitate gender integration into the current national and sectoral AIDS policies and plans to enhance and monitor practice, and engender any new policies and plans.
   • Facilitate short capacity building courses of 6–12months and exposure tours on gender analysis, gender planning and programming in HIV and AIDS to officers supporting gender programming at National AIDS Control Council.
   • Among the three open slots in the NACC council to be appointed by the Minister, one should be allocated to the Director of Gender from the Ministry of Gender, Children and Social Development.
6.3.1.2 Government / Public Sector

Many government departments and institutions have established AIDS Control Unit and/or Gender focal points in their organizational hierarchies. Some of the ACUs have built their own gender capacity within the unit, for example, Ministry of Agriculture, Ministry of Education and Ministry of Health. However, in spite of the institutional arrangement in place, government needs to take specific action and mainstream gender into funding, planning and programmes for HIV and AIDS. Below are specific actions for government:

- Conduct studies to determine sectoral risk factors and most vulnerable populations.
- Determination and prioritization of sectoral gender issues in HIV and AIDS for programming and performance contracting.
- Development of sector-specific gender-sensitive indicators in HIV and AIDS programmes to monitor progress respective initiatives.
- Conduct organizational assessment for the organization/department to assess capacity to mainstream HIV programmes and gender and implement proposals.
- Formulation of gender responsive HIV and AIDS national sector policies.
- Government to earmark a realistic figure of funds (10% – 15%) from the national budget to support gender specific dimensions including HIV-related.
- Identify and register participation in Monitoring and Coordinating Groups/KNASP III Pillars in which the organization exerts greater comparative advantage.
- Evaluation of sectoral HIV related plans, polices and laws in terms of their effectiveness in addressing the rights and needs of different age groups of both sexes in the sector and use the results/recommendations to lobby for the roll out, review, enactment or reinforcement of protection from practices that promote HIV infection and impacts for women and girls. Such policies/laws include:
  1. National Gender and Development Policy
  4. HIV and AIDS workplace policy guidelines
- Establish and equip a gender desk within the ACU or establish operational linkages between ACU and the existing gender focal point in the organization to advice and provide enhanced advocacy on gender in research agenda-setting, funding, planning, program design and implementation, monitoring and evaluation.
- Develop specific sectoral strategies relating to HIV needs and issues of men/boys and women/girls.
- Identify and promote increased representation of women and gender experts in decision-making organs pertaining to HIV and AIDS in the sector and in decision-making structures for the development of national priorities, for example gender expert to be positioned at national Secretariat of Vision 2030, Minister of Gender in the Cabinet subcommittee on AIDS, to ensure that gender is integrated into the national priorities, plans and strategies.
- Strengthen linkage/participation between ACU in the organization and GTC to facilitate networking and collaboration (public-private partnerships - PPP).
- Review Sector Reports while adopting HIV and gender as a cross cutting theme for strategy development.
- Adoption of the gender action plan in HIV and AIDS for decision making during planning, research prioritization, policy development, funding and programming.
- Facilitate capacity building courses and tours on gender analysis, gender planning and programming in HIV and AIDS to officers supporting gender programming in national HIV responses.
• Develop a sexual harassment strategy at workplace.
• ACUs and gender units in the organization to support and/or participate in the government budgeting process and JAPR to ensure that funds are committed and disbursed to address gender disparities in HIV and AIDS programmes as prioritized in the KNASP results framework.
• Include targets in the performance contracts

6.3.1.3 Guidelines for CSOs working in HIV and AIDS

Participation of the Civil Society organizations is crucial for the realization of specific strategic outputs of national HIV programmes. In general, Civil Society groups which include international and national NGOs, community based organizations and faith-based organizations should:

- Organize and advocate for consistent engagement of gender expertise in national processes and in funding modalities including KNASP development and operationalization, JAPR, MCGs, advisory board of the ICC/HIV and AIDS, proposal review committees for TOWA at CACC, DTC and national levels etc.
- Identify capacity and funding needs for activities to promote gender equality and equity, and present these to Government, Joint UN team on AIDS (UNAIDS) and other development partners.
- Develop advocacy and social mobilization strategies to ensure that concrete efforts to reduce vulnerability of women and girls and men and boys to HIV are prioritized and included in all the four Pillars of KNASP III and the operational plan (NPO).
- Participate in reporting under the Declaration of Commitment on HIV and AIDS and to human rights treaties on progress towards universal access and adoption of recommendations in terms of gender equality i.e.
  - Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)
  - UNGASS – HIV and AIDS
  - Commission on the Status of Women (CSW) etc.
- Working within alliances, advocate jointly on the importance of reducing stigma and discrimination, and addressing harmful gender norms and gender-based violence in the context of the national HIV response.
- Engage with partners working across the spectrum on development, women’s and girls’ development, and HIV to build synergies and joint strategies and programmes.
- Lobby the government to formulate gender responsive national and sector policies and strategies on HIV and AIDS.
- Establish linkage between organization and GTC to facilitate networking flow by registering the participation of the gender unit in the organization. This will provide the organization with an opportunity to:
  - Participate in the review of KNASP Monitoring and Evaluation frameworks and tools to ensure specific gender responsive indicators are captured to generate data that is disaggregated according to sex, age category, marital status, geographical area and socio-economic strata for analysis in order to inform decision-making in financing and programming.
  - Participate in the review of research protocols to ensure that they are gender responsive
  - Identify and register participation in Monitoring and Coordinating Groups/KNASP III Pillars in which the organization exerts greater comparative advantage.
- Participate in the integration of gender equality and HIV into broader development processes, including National Development Plans (Sector Reports) and their implementation and review, and adopt HIV and gender as a cross cutting theme for strategy development and create operational linkages with national gender equality/women’s development programmes and initiatives in the country for networking and collaborative activities; these include:
  1. GBV Sub cluster
  2. Kenya Demographic Health Surveys
  3. UN Gender Sector Coordination Group
• Facilitate capacity building courses on gender analysis, planning and programming in HIV and AIDS programmes to staff.
• Develop a sexual harassment strategy at workplace.
• Participate in the development of sector-specific gender-sensitive indicators in HIV and AIDS programmes and develop gender-sensitive indicators in HIV and AIDS programmes for organizational projects
• Design, develop and disseminate easy to understand IEC illustrated materials on gender and HIV and AIDS
• Conduct studies to determine risk factors and most vulnerable populations in target groups.
• Support the identification and advocacy for stronger representation of women and gender experts in decision-making organs that are engaged in setting national priorities.
• Adopt HIV and gender as a cross cutting theme for strategy development during the support for review of the Sector Reports
• Adoption of the gender action plan in HIV and AIDS for decision making during planning, research, policies, funding and programming
• Participate in the evaluation of national and sectoral HIV related plans, polices and laws in terms of their effectiveness in addressing the rights and needs of different age groups of both sexes in the sector and use the results/recommendations to lobby for the roll out, review, enactment or reinforcement of protection from practices that promote HIV infection and impacts for women and girls.

6.3.1.4 Guidelines for Private Organizations implementing HIV and AIDS
Private sector is increasingly becoming engaged in the national HIV and AIDS response. Many private sector organizations and enterprises are making efforts to develop HIV and AIDS workplace policies and programmes and policies. Such policies and programmes should reflect gender sensitivity at all levels. Private sector engaged in the national HIV responses should:
• Put in place institutional mechanisms for identifying gender integration opportunities within the organization by:
  - Sensitizing, orientating and providing gender awareness training and its application to all staff
• Participate in the development of sector-specific gender-sensitive indicators in HIV and AIDS programmes to monitor progress respective initiatives
• Identify and register participation in Monitoring and Coordinating Groups/KNASP III Pillars in which the organization exerts greater comparative advantage
• Establish and equip a gender focal point within the organization to advice and provide enhanced advocacy on gender in their social/cooperate responsibilities, monitoring and evaluation of funded projects.
• Document and promote good practices, strategic alliances and information exchange on gender integration with Kenya Private Sector AIDS Network (KPSAN).
• Engage with and support human rights organizations, women’s movements and organizations addressing specific vulnerabilities of women and men in their areas of jurisdiction to advocate for increased budgetary allocation to their programmes and services.
• Strengthen linkage/participation between gender focal point in the organization and GTC to facilitate networking and collaboration (public-private partnerships - PPP)
• Adoption of the gender action plan in HIV and AIDS for decision making during planning, research work, policy development, funding and programming
• Develop a sexual harassment policy/strategy at workplace.

6.3.1.5 Guidelines for Development Partners

• Increase financial assistance to NACC for gender training, recruitment of gender expertise and technical support on gender and HIV.
• Build own capacity on gender and HIV at country level so as to better support Kenya in implementing a gendered response.
• Provide technical assistance and funding for gender and HIV-related activities in key sectors/Ministries to support their engagement in the HIV response (i.e. Health, Education, Agriculture and Ministry of Gender and the National Commission on Gender and Development)
• Participate in the development of KNASP in addition to reviewing own policy and funding guidelines and mechanisms to ensure that they encourage commitment to implementing programmes in national strategic frameworks and operational plans that are gender sensitive, transformative and empowering, including activities implemented by the civil society.
• Conduct a gender technical capacity needs assessment among key implementing partners and share proposal on the effective support on gender programming in the national HIV response.
• Monitor and evaluate own policies, priorities and funding outcomes in terms of positive or negative impact on gender equality and equity and achieving universal access in national HIV responses.
• Support the civil society in the implementation, and engagement in monitoring and evaluation of gender equality and equity.
• Support the development of advocacy messages on the importance of gender equality.
• Review support to national development and gender equality goals to better align these with KNASP and National Gender and Development Policy and Strategy.
• Make gender and HIV an explicit policy and programmatic objective in funding strategies and a review criterion in proposal evaluation.
• Identify areas of technical assistance e.g. vision 2030 secretariat for gender advisor

6.3.1.6 Guidelines for the UN System

• Support the engagement of women’s groups, CSWs, MSMs, IDUs, human rights groups, and gender equality groups in AIDS planning and funding mechanisms
• Within the UNAIDS division of labor, coordinate the support for gender equality in the national HIV response by drawing from the gender expertise and
Gender Audit of national response to HIV and AIDS, Kenya

programming experience of different NCGD Department of Gender Maendeleo ya Wanawake, NEPHAK, KARSCOM and Sector Reports for joint programme review.

- UNAIDS co-sponsors to support concrete national efforts by funding research, planning processes, policy dialogue, technical assistance to NACC and key implementers or through the GTC etc.
- Create formal linkages between the UN Gender Theme Group and the UN Theme Group on AIDS, and or create an HIV and Gender Working Group composed of gender and AIDS focal points in each agency which should then subsequently link up with the GTC.
- Provide technical assistance and catalytic funding for gender and AIDS-related activities in key sectors/ministries including the Health, Education, Agriculture and Ministry of Gender and the National Commission on Gender and Development.
- Build the capacity of national partners to collect disaggregated data (by sex, age, marital status, location, wealth quintile, ethnicity, race, risky practice etc), analyze the data and utilize the data regarding infection and uptake of prevention, treatment, care and support services.
- Support national partners to commission gendered research in hitherto gray areas (FGM/lesbianism vs HIV and AIDS; discordance etc) and determine impediments to access and sustained uptake of prevention, treatment, care and support for men, women, boys and girls in specific communities.
- Support the engagement of the civil society in monitoring and evaluation of gender equality and equity by supporting projects directly or linking them to the PAF and catalytic funds from the Global Coalition on Women and AIDS.
- Support high level engagement on the dialogue on gender and HIV and AIDS.
- Identify areas of technical assistance e.g. vision 2030 secretariat for gender advisor.

6.3.2 Gender Sensitive Indicators

Outlined below are some of the critical gender sensitive indicators to guide in the development of national indicators for the national HIV and AIDS responses.

6.3.2.1 Structures and Processes

- Number of gender experts at each level of the different structures responding, setting the agenda and prioritizing HIV and AIDS issues.
- Number of Ministries and Local Authorities with gender focal point monitoring progress on set indicators on HIV and AIDS responses.
- Number of policies and practices enforced on non discrimination that protect PLWHA.
- No of policies in place that protect workers e.g. sexual harassment and health insurance policies for workers affected or infected with HIV and AIDS.
- No of studies conducted to assess organizational capacity on gender and document best practices.

6.3.2.2 Programmes

- Number of gender and gender integration training conducted for all focal points in Ministries and Local Authorities designing, programming, budgeting and monitoring gender integration in HIV and AIDS responses.
- Number of policies and laws put in place that promote gender quality and reduce gender discrimination as a response strategy to HIV and AIDS pandemic.
• Number of persons sitting at different structures at all levels responsible for HIV and AIDS agenda setting, prioritizing and budgetary decision making trained on gender integration on HIV and AIDS.
• Integration of gender information into priority setting, policy making and implementation.
• Number of research done that use gender analysis tool
• Number of gender experts sitting at all levels of the structure from NACC to CACC responsible for gender awareness, gender analytical skills for policy and programme design, implementation, monitoring and evaluation ensuring that all data collected and analyzed is sex disaggregated.
• Number of lobbying activities to eliminate detrimental gender stereotypes, stigma and unfriendly customary, religious and statutory laws.
• Proposal evaluation guidelines that ensure gender responsive strategies in place
• Number of programmes that influence and reinforce fair and positive social and cultural roles, responsibilities, values and attitudes towards femininity and masculinity.
• Number of sex education programmes in promoting HIV and AIDS prevention of new infections, improving the quality of life of people affected or infected with HIV and AIDS and mitigation of social and economic impact.
• Monitoring tool in place to establish behaviour change and attitudes towards femininity and masculinity.
• Monitoring tool in place to establish the level of reduced stigma and negative attitude towards HIV and AIDS and PLWHA.
• Number of activities and the role they play in changing gender stereotypes

6.3.2.3 Financing
• Number of gender experts at each level of the different structures making budgetary decisions on HIV and AIDS responses.
• Number of programmes with gender integrated budgets
• Extent to which government ensures that financial budgeting and allocation is gender responsive.
• Number of times NACC advises and influences Government on gender responsive financing for HIV and AIDS responses
• Funding requirements in place to ensure gender sensitive response mechanisms from all proposals submitted.
• Gender audit mechanism for application by NACC in place
7.0 Conclusion

Although implementation of HIV and AIDS responses through the implemented strategies achieved positive results, it has been observed that the design, planning, implementation of programmes, monitoring and evaluation was general and did not take into account the gender dimensions. The results described do not show the effects of HIV and AIDS interventions for women, men, boys and girls. By doing so, it would have brought out the lessons learnt to guide the interventions from one government strategy to another. The overall results do not specify the number of women, men, boys and girls beneficiaries. This was as a result of the absence of clear targets for the different groups at the objectives stage.

Progressively, the government has shown tremendous political will to deal with HIV and AIDS by committing to structural, policy and legal reform. There has been commitment to increased financing through the government budget and strengthening partnerships with development partners. As the government develops strategies, there should be clear indicators that show impact/results they would like to achieve spelling out the number of women, men, boys and girls. Within the structural reform, there should be emphasis on gender integration in all processes. It is encouraging that the government recognized that gender is one of the vulnerability factors in all the strategies. The government needs to go further at that stage to design deliberate gender interventions that reduce vulnerability within the multi-sectoral approach.

Government commitment to ensure equitable health financing is yet to integrate gender. This is an opportunity.

Since the Government has commitment itself to support HIV and AIDS responses, it should lead in entrenching gender integration in its strategy. This would in turn be used by the different Ministries to develop action plans that are gender integrated in all their HIV and AIDS responses.

To ensure the long-term sustainability of HIV and AIDS programmes, the Kenyan government tied the implementation of KNASP 2005/6-2009/10 to the government budgetary cycle. Since the Medium Term Expenditure Framework (MTEF) Budgeting Process leading to the Financial Year (FY) 2006/07, all Ministries/Departments were expected to mainstream HIV and AIDS in their budgets. This major milestone towards HIV and AIDS mainstreaming in public sector institutions was achieved through increased allocation of resources by Government to Line Ministries for HIV and AIDS mainstreaming.

During this assignment, it emerged that ACUs face enormous capacity challenges related to structural, skills, knowledge, Intra and Inter-departmental linkages in HIV and AIDS and gender integration. As a result, the majority of work plans reflected generic activities such as sensitization of staff members and weak on responses based on sectoral comparative advantage in response to the socio-economic impact of HIV and AIDS from a gender perspective.

Since HIV and AIDS is not only a health issue and affects every aspects of life, it calls for a multi-sectoral response with strong political will from the highest level.
Government takes the lead in fostering a supportive environment and providing a framework for action that works both horizontally (with government, business and civil society organizations) and vertically (at international, national and community levels). HIV transmission and the stage of the epidemic are different in each part of the country, depending on the underlying social, economic, political and cultural context. Sectoral planning should be done taking into consideration the different gender needs.

Integration of gender calls for skills in gender analysis and planning; the capacity to collect and interpret sex disaggregated data; a commitment by government to action to achieve gender equality; and the availability of human, technical and financial resources. Short-term strategies might focus on people’s immediate needs, such as information, support to home-based care and access to treatment for STIs. More long term strategies need to address the underlying social and cultural structures that sustain gender inequality.

Each sector must plan and make available resources for an integrated response, including an analysis of the factors within the sector that contribute to the spread of HIV and AIDS, the impact of the disease on its workforce and products, and the consequences for both the sector and the community. Practical short-term and long-term interventions need to be developed to protect the sector’s workers, to cope with the skills shortages that will arise and to mitigate the adverse effects on society.

For this to take place, stakeholders must engage the broader KNASP response framework in which planning decisions that influences priorities on funding, programming and research are made, monitored and evaluated. Guidance for this process is provided. Proposed indicators to provide a framework for monitoring this progress must be developed.
8.0 Way forward

Following the findings and recommendations of this gender audit, there is need to utilize the guidelines provided and develop practical Guidelines and Indicators for Integrating Gender in the National HIV and AIDS Response in Kenya for all stakeholders. Therefore, NACC with support of the members of the GTC should undertake the following activities:

- Dissemination of the gender audit findings and recommendations to key stakeholders.

- Embark on the process of developing practical Guidelines and Indicators for Integration of Gender in the National HIV and AIDS Response in Kenya.

- Develop an Action Plan for Gender Integration in HIV and AIDS as a gender strategy to guide implementation of KNASP 2009/10 – 2012/13. This will guide sectoral decision making and prioritization of research agenda, funding priorities and programming for gender and HIV and AIDS.
## Annexes

### Annex 1: Indicators for Gender Integration in National HIV Responses Matrix

#### a. Structure

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategic Interventions</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| Inadequate gender integrated within the NACC structure | Gender accountability should be at the second highest level of the NACC structure. | • Number of NACC at high level of the structure tracking gender integration in all structures, processes, programming and financing of HIV and AIDS responses.  
• Number of gender experts each level of the different structures responding, setting the agenda and prioritizing HIV and AIDS issues. |
| PLWHA are not protected at their work places. | Policies in place that protect PLWHA. | • No of policies in place that protect workers e.g. sexual harassment and health insurance policies for workers affected or infected with HIV and AIDS.  
• Number of policies and practices enforced on non discrimination that protect PLWHA. |
| Limited personnel within the structure with gender expertise. | Gender expertise in place within established gender desks in Ministries, NACC and all structures responsible of decision making on HIV AIDS responses.  
Advocate for positioning of gender officers into decision-making structures | • Number of gender experts in place at different levels of the NACC, ICC, JAPR, MCG, CTC and CACC.  
• Proportion of male to female in decision making structures  
• Number of skilled personnel in gender in decision making structures  
• Number of implementing agencies with skilled personnel to mainstream gender. |
| M & E framework and tools do not always generate data by sex-desegregation. | Strengthen M & E framework and tools and to generation of sex and gender-disaggregated data for analysis and planning throughout all M & E performance systems of the national response | • Number of dissemination forums that are studies representative of both gender  
• Gender specific Data collection tools |
### b. Processes

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategic Interventions</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate gender integrated within the NACC processes.</td>
<td>Gender accountability should be at all processes.</td>
<td>• Level of gender integration at all processes.</td>
</tr>
<tr>
<td>Gender blind policies, guidelines and strategies</td>
<td>Review existing policies, guidelines to make them gender responsive</td>
<td>• Number of policies and guidelines reviewed including workplace policies.</td>
</tr>
<tr>
<td></td>
<td>Customized national Gender and Development Policy into HIV response</td>
<td>• Availability of policy guidelines to address gender in HIV response in every sector</td>
</tr>
<tr>
<td>Strategic partnerships for gender integration.</td>
<td>Enhance strategic partnership at international, regional, national and local levels</td>
<td>• Number of organizations addressing gender partnering.</td>
</tr>
</tbody>
</table>

### Programming

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategic Interventions</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender is not given the attention that it deserves in KNASP II</td>
<td>Develop a checklist on gender integration in KNASP</td>
<td>• No. of programmes that are gender responsive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• KNASP reviewed annually on its responsiveness to gender</td>
</tr>
<tr>
<td>Several high risk groups have been left out in the KNASP but appear in MOT study and other references</td>
<td>Ensure that all programmes are gender responsive in order to reduce the vulnerability of women, men, boys, girls and other vulnerabilities</td>
<td>• Number of programmes targeting women and girls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Number of programmes targeting men and boys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Number of different groups reached, disaggregated by sex and other social demographic variables</td>
</tr>
</tbody>
</table>

---

4 Commercial sex workers and their clients, Health workers, Injecting drug users, Long distance drivers, Migratory workers, Males who have sex with males (MSM), Orphans and vulnerable children, Pregnant women, Prison population, Sexually-transmitted infections (STI) clinic, attendees, Teachers, People Living With Disabilities, Tourism workers, Victims/Survivors of GBV, Uniformed personnel, Young girls and boys (adopted from MOT Study 2007 and World Bank 2004)
<table>
<thead>
<tr>
<th>Issue Description</th>
<th>Proposed Action</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>KNASP does not provide adequate data disaggregated by sex and by various</td>
<td>Produce data disaggregated sex data, vulnerabilities and other social demographic variables</td>
<td>• Number of research done that use gender analytical tools</td>
</tr>
<tr>
<td>vulnerable groups</td>
<td></td>
<td>• Data that is disaggregated sex data, vulnerabilities and other social demographic variables</td>
</tr>
<tr>
<td>Inadequate gender integrated M&amp;E tools</td>
<td>Develop, test and validate gender-integration tools. These tools would facilitate tracking of gender</td>
<td>• Number of research done that use gender analysis tools for M&amp;E</td>
</tr>
<tr>
<td></td>
<td>integration in programmes.</td>
<td>• Number of gender integrated M&amp;E tools to monitor gender integration in KNASP.</td>
</tr>
<tr>
<td>Capacity building</td>
<td>Ensure that policy makers and program planners in the national HIV response (including all implementing</td>
<td>• Number of gender and gender integration trainings conducted for all focal points in the public, private and civil society designing, programming, budgeting, monitoring and gender integration</td>
</tr>
<tr>
<td></td>
<td>agencies) are trained on gender and gender integration.</td>
<td>• Number of individuals trained by sex</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Number of persons sitting at different level structures responsible for HIV and AIDS agenda setting, prioritizing and budgetary decision making trained on gender integration on HIV and AIDS.</td>
</tr>
<tr>
<td>Unequal power relations between women, men, boys and girls</td>
<td>Transform harmful gender norms</td>
<td>• Number of programmes targeting the transformation of harmful gender norms.</td>
</tr>
<tr>
<td>Inadequate linkage between gender integration and human rights based approach</td>
<td>Create linkage between gender integration and human rights approach in all HIV and AIDS programmes</td>
<td>• Number of engendered programmes promoting prevention of new infections, improving the quality of life of people affected or infected and mitigating the social and economic impact of HIV and AIDS.</td>
</tr>
</tbody>
</table>
### Limited knowledge on gender and the related terminologies

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategic Interventions</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness creation and sensitization of gender and gender related terms and its social construct.</td>
<td>• Number of training programmes and gender awareness creation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of people trained in gender integration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of institutions participating in gender integration</td>
<td></td>
</tr>
</tbody>
</table>

### Vision 2030 focuses on community based and private sector for service provision.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategic Interventions</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic positioning in order to benefit from government priorities in community based and private sector service delivery.</td>
<td>• Number of interventions that are community based.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of service provision by private sector</td>
<td></td>
</tr>
</tbody>
</table>

### Financing

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategic Interventions</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of adequate financial commitment to mainstream gender within the HIV and AIDS National Response</td>
<td>Ensure that gender responsive budgeting in relation to HIV and AIDS is in place</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of programmes with gender integrated budget</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Extent to which government ensures that financial budgeting is gender responsive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of gender experts engaged in budgetary decisions on HIV and AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Funding requirements in place to ensure gender responsive response mechanisms from all proposals.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strategic Interventions</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision 2030 focuses on increased funding for community based and private sector service delivery</td>
<td>Strategic positioning in order to benefit from government funding in community based and private sector service delivery.</td>
<td>• Number of interventions that are community based due to increased government funding.</td>
</tr>
<tr>
<td></td>
<td>• Number of service provision by private sector due to increased government funding.</td>
<td></td>
</tr>
</tbody>
</table>
| Limited gender responsive budgeting | Gender responsive budgeting | • Proportion of national budget allocated to gender integration in HIV.  
• Participation by public and CSOs in MTEF process. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited gender financial and programme audit.</td>
<td>Process of audit of the national resource allocation, programme priorities, results framework against research findings.</td>
<td>• Annual audit reports</td>
</tr>
</tbody>
</table>
Annex 2: Questionnaire

Respondents Details

1. Name of the Ministry/Government Department/Institution/Organisation:
   ..............................................................................................................................
   ..............................................................................................................................

2. Name of Responding Officer:
   ..............................................................................................................................

3. Position:
   ..............................................................................................................................

4. Email Address:
   ..............................................................................................................................

5. Postal Address:
   ..............................................................................................................................

6. Tel No.:
   ..............................................................................................................................

7. Fax:
   ..............................................................................................................................

Gender Integration

What is your understanding of gender?
   ..............................................................................................................................
   ..............................................................................................................................
   ..............................................................................................................................
   ..............................................................................................................................

What is your understanding of gender integration?
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   ..............................................................................................................................
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   ..............................................................................................................................

What do you understand by the term gender responsive HIV and AIDS responses?
   ..............................................................................................................................
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   (Structures and Process)
Describe who at each level within your Ministry’s organizational structure (from headquarters to the grassroots) is responsible for gender integration in HIV and AIDS?

What are their roles and responsibilities with regards to HIV and AIDS gender integration?

Is there any formal/written documentation for gender integration in HIV and AIDS management, programming and financing within your Ministry/institution/organisation?

At what levels of the organizational structure do you have gender experts/advisors?

Describe the level of participation/representation of women, men, young women and men’s within the structure?

Are there formal requirements of participation/representation at each level? If so, which levels?
Who participates and determines the priority areas of HIV and AIDS responses (at what level and how many women and men are influential in that process?)

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(Programming and Financing)
Are there specific resources (personnel, financing) allocated for implementation of gender integration programmes and targets?

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Are there HIV and AIDS programmes that specifically target women, men, boys and girls? Explain.

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Do you make gender analysis of your HIV and AIDS response budgets? Explain

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In which policy areas have you implemented gender integration for HIV and AIDS responses? Explain why these areas were chosen.

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Are all your statistics collected at all levels disaggregated by sex? Explain

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(Training)
Do you have any gender integration training within your Ministry/organisation/institution? If yes, describe the content of the training.

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17. Who conducts the training?

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For whom and how often is the training conducted?

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(Recommendations)
What measures do you think would further improve gender integration in HIV and AIDS responses?

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Annex 7: Full List of participants

a. Gender Technical Committee and co-opted Members:

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Organization</th>
<th>Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Florence Gachanja</td>
<td>UNFPA</td>
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<td>8</td>
<td>Jane Kabui</td>
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<td>9</td>
<td>Kiara Consolata</td>
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<td>16</td>
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<td>17</td>
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### Gender Audit of national response to HIV and AIDS, Kenya

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**b. Respondents from NACC**

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<td>4</td>
<td>Selina Kibogy</td>
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<tr>
<td>5</td>
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</tr>
</tbody>
</table>
Gender Audit of national response to HIV and AIDS, Kenya

c. Respondents from the Regions

NAIROBI REGION
1. Population Council
2. National Council of Churches in Kenya
3. Catholic Justice and Peace
4. Central Organization of Trade Union (COTU)
5. United Nations Population Fund (UNFPA)
6. United Nations Women Fund (UNIFEM)
7. National Commission on Gender and Development (NCGD)
8. AMREF
9. NEPHAK
10. Ministry of Gender
11. Ministry of Agriculture
12. Mother Child with Aids Support Organization (M.C.A.S.O)
13. National Informal Sector Coalition
14. Haki Self Help Group (HAKISHEP)
15. CACC - Constituency Aids Control Council
16. Roots Mathare Mothers Development Center
17. Kibera Counseling and Feeding For OVCs and Care Givers
18. Bar Hostess Empowerment and Support Programme (BHESP)
20. Aids Orphan Care And Support Programme (AOCASP)
   Community Management And Training East (CMTC/EA)
21. National Aids Control Council (NACC)
22. Discordant Couples of Kenya (DISCOK)
23. Ministry Of Public Health and Sanitation
24. Voice of Women-Mbotela
25. Al Faroud Islamic Center
26. Mungamano Women Group
27. FAIDAK - Women
28. SWAK - Branch
29. Pastrol Aid Programme
30. Provinclal Administration
31. Council of Imam and Preachers of IJARA
32. Ebenezer TB/HIV and Malaria Support Group
33. Ministry of State for Planning, Nation Development and Vision 2030
34. Maendeleo Ya Wanawake Organization
35. Horsed Welfare Society

NYANZA REGION
1. Ministry Of Public Health
2. Wang Neno Youth Group
3. Office of the President
4. Disciples of Mercy
5. Kitero Widows and Orphans Self Help Group
6. MAPAS
7. Shauri Yako Fishmongers Self Help Group
8. Kisumu Town East Constituency Aids Control Council
9. Widows, Widowers Positive Living Support Group (BEWOPOL)
10. Dophil Nursing Home
11. Constituency AIDS Committee Representatives
12. AMREF – Maanisha
14. Victory Post Test Group
15. Ugenya Community against HIV/AIDS (U.G.A.H.A)

**CENTRAL REGION**
1. Ministry of Planning, National Development and Vision 2030
2. P.C.E.A Tumutumu Hospital
3. K.Y.C.E.D Kenya Youth Community and Educational Development
4. A.P.H.I.A lii
5. K.E.N.W.A
6. Constituency AIDS Committee Representatives
8. Mugunda Fighters of Aids (M.U.F.O.A)
9. Ministry Of Agriculture
10. Ruiru Aids Awareness Group
11. Action Aid International-Kenya
12. Life Enhancers Support Group
13. Franciscans HIV/ Aids Control and Resource Center
14. W.E.M Integrated Health Services
15. Local Government Municipal Council of Nyeri
16. Othaya P.L.W.H.A. Support Group
17. International Center For Aids Care And Treatment Programme (I.C.A.P-K) Constituency Aids Control Committee-Mukurweini
18. National Aids Control Council
19. Partner's Link

**RIFT VALLEY REGIONS**
1. Ministry of Planning, National Development and Vision 2030
2. Constituency AIDS Committee Representatives
3. I.C.R.O.S.S- Nakuru International Community for Relief of Starvation and Suffering
5. Samaritan Friends Self Help Group (Seventh Day Adventist)
6. S.A.M.O.F- Community Response to OVCs
7. Advocates for Positive Living
8. L.A.L.A.N.G.A.A Community Based Organization
9. Tracom College
10. Bahai Faith Nakuru
11. Voice of Roses-Kenya
12. Vijana Tugutuke Initiative (Kolbakek)
13. N.E.P.H.A.K
15. Egerton University –Gender Institute
16. C.C.C Deliverance Church Nakuru
17. Kenya Tea Packer's Ltd KETEPA
18. Adventist Development and Relief Agency
19. Newstep to Positive Living
20. Tears Group Kenya

**COAST REGION**
1. M.P.W.D
2. Hope World Wide Kenya
3. Constituency AIDS Committee Representatives
4. Ministry Of Local Government
5. Ministry Of Public Health and Sanitation
6. Maendeleo Ya Wanawake
7. Dawida Health Support Group
8. Shika Adabu Bamako Initiative
9. Mwamko Mpya Women’s Group
10. Dream Achievers
11. Tana Pastoralist’s Forum
12. Mkengie Group For Physically Impaired
13. Likoni Community Development Programme
14. Plam Self Help Group Mwatate
15. Operation Lifeline Mswambueni (O.L.M) Diani Beach Nanas
16. Garden of Hope Support Group
18. Tumaini Letu Group
19. Kenya Sustainable Health Aid
20. Mshikamano Community Based Youth Group
Important References


iii 324 HIV positive women (159)


