KENYA

THE CHALLENGE

Although HIV prevalence in Kenya has been steadily declining since its peak of 30 percent in the early 1990s, population based surveys undertaken in the last 10 years show that HIV prevalence among women and men aged 15–49 years ranged from 6.7 percent in 2003 to 5.6 percent in 2012.[1]

Women are disproportionately affected, representing 58 percent of those infected and young women and girls are especially at risk.[2] Indeed, young women aged 15–24 are 60 percent more likely to be HIV positive than young men of the same age.[3]

Kenya's HIV epidemic is largely driven by sexual transmission, which accounts for 93 percent of new HIV infections.[4] Heterosexual intercourse in a union or primary relationship represents 44 percent of new infections, with HIV prevalence exceeding 18 percent among both men who have sex with men and people who inject drugs and 29 percent of female sex workers.[5]

Gender-based violence and its link to HIV infection remain a serious challenge. Women's unequal social status limits their ability to negotiate safe sex with their husbands or intimate partners and increases their vulnerability to violence. Twelve percent of women reported that their first episode of sexual intercourse was against their will; this figure rose to 22 percent among females who became sexually active before age 15.[6] Harmful gender norms and attitudes deriving from pervasive gender inequality underscore the problem.[7]

THE POLICY ENVIRONMENT

The 2010 Constitution guarantees the equal rights of women and men. Vision 2030, the chief development strategy, also contains strong provisions related to gender equality. Additionally, the country has ratified major international and regional human rights frameworks, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The Kenya National AIDS Strategic Plan III 2009/10 – 2012/13 (KNASP III) demonstrates the country's commitment to addressing the gender and human rights dimensions of HIV and AIDS by including a strong

1 *Kenya AIDS Response Progress Report*, 2014, p. 3.
2 Calculation based on estimates provided in UNAIDS, 2014, *Gap Report*, A27, A33.
3 Ibid., p. A15
4 *The Kenya AIDS Epidemic: Update 2011*. National AIDS Control Council and National AIDS and STI Control Programme, Nairobi, 2011.
5 Ibid.
6 Kenya National Bureau of Statistics, 2010.
7 UNAIDS, 2010, *Report on the Global AIDS Epidemic.*

gender focus and explicitly acknowledging the ways that gender inequality helps drive the epidemic.

Since 2001, the National AIDS Control Council (NACC) has had a Gender Technical Committee (GTC) to coordinate and strengthen gender mainstreaming as part of the HIV response. Its efforts have contributed towards identifying gender gaps and concerns and prioritizing actions targeted at women. In 2011, the NACC launched its 'National Action Plan 2009/2010 – 2012/2013: Mainstreaming gender in HIV responses in Kenya' (hereinafter 'Gender Action Plan') that is aligned with the KNASP III. Its chief goal is to accelerate and monitor the implementation of gender priorities.

> "This Gender Action Plan is a deliberate effort towards the realization of the KNASP III approach that emphasizes that 'Human rights, gender equality and responsiveness' issues must be addressed across all aspects of the strategic plan."
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> —Professor Alloys S.S Orago (Director, NACC).[8]

Two grassroots community organizations, the Kenya Network of Women with AIDS (KENWA) and Women Fighting AIDS in Kenya (WOFAK), have trained advocacy teams to lobby policy makers to enact laws that consider the needs of women living with HIV (WLHIV). Nonetheless, overall participation and representation by WLHIV in the national response has been lacking.

PROGRAMME RESPONSE

Supporting Gender Equality in the Context of HIV/AIDS (2009-2012) addressed these challenges with the goal of integrating gender equality and human rights into HIV policies. The programme had two main elements: promoting the participation of women living with HIV in networks that influence HIV policies, and strengthening national commitment to gender equality in the HIV response.

8 National AIDS Control Council, 'The National Action Plan 2009/2010–2012/2013: Mainstreaming gender in HIV responses in Kenya.' p.3.

PROGRAMME PARTNERS

- National AIDS Control Council (NACC)
- Kenya Network of Religious Leaders Living with or Affected by HIV and AIDS
- Kenya Voluntary Women's Rehabilitation Centre (KVOWRC)
- Lean on Me
- National Empowerment Network of People Living with HIV and AIDS in Kenya (NEHPAK)
- WISUVIE Women's Self Help Group
- Women Fighting AIDS in Kenya (WOFAK)

A number of key capacity and needs assessments informed the development of the programme's strategic interventions. A 2008 gender audit found that there was a critical need to strengthen gender responsiveness in the NACC's decentralized structures and that there were significant technical capacity gaps among government stakeholders in terms of how to apply gender analysis and integrate gender concerns in their planning processes, despite their willingness to do so.

The programme therefore placed a senior Gender Advisor at the NACC to provide institutional capacity-building support and technical expertise. She focused on the NACC's approach to gender mainstreaming and human rights, and also served on the taskforce that provided technical support in the development of the country's Gender Action Plan. In addition, she conducted gender-sensitive training for NACC staff, and served on a study team that conducted a desk review to generate baseline data on gender and HIV. As part of the training efforts, more than 80 senior and middle level managers, board members and field staff were sensitized on the importance of gender mainstreaming and the need to promote human rights and gender equality in the HIV response.

A mapping exercise conducted by the programme with WLHIV organizations revealed that, although women were increasingly involved in self-help groups and networks across the country, many of these organizations were small-scale, poorly funded, and unrepresented in any policy or programme level processes. Many WLHIV struggled with discrimination and stigma and lacked the capacity to advocate for their needs and priorities at national or decentralized levels. The programme supported the capacity building of close to 3,000 WLHIV by training, mentoring and supporting them to form self-help groups and networks. WLHIV networks were taught how to identify entry points in the policy-making process, especially at community

level, and how to build their advocacy skills to increase meaningful engagement.

The programme also brought together the government, donors and networks of WLHIV and HIV researchers for the first ever Kenya Women Prevention Symposium in 2010. In 2011, the Gender Advisor and the NACC convened the first National Women Leadership Conference for WLHIV. The conference, which brought together over 200 women and representatives from groups and networks, focused on the rights and access to resources of WLHIV and the development of their advocacy and leadership capacities. It also strongly advocated for mentoring young WLHIV, including building their confidence to confront stigma and discrimination, advocate for their rights and engage more effectively in the national HIV response.

ACHIEVEMENTS

Advocacy and leadership skills training **enhanced the individual and organizational capacity of WLHIV to serve as advocates and leaders in the HIV response.** This has resulted in a cadre of informed and knowledgeable women who are not afraid of declaring their HIV-positive status, many of whom have returned to their families and communities and changed local attitudes towards gender and HIV. These women have also acted as focal points to mentor and mobilize other women living with HIV, including young women, to confront the impacts of HIV and effectively engage in the national response.

Human rights training helped **WLHIV who had been forcibly sterilized at government health facilities to come together to expose the practice as discriminatory and a violation of their constitutional rights.** As the affected women went to the high court for legal redress, the case raised a huge national furor, leading the Minister of Public Health to publicly deny that forced sterilization of WLHIV was government policy and prompted an immediate end to the practice.

Developing a vocal constituency and common agenda enabled WLHIV to inform policy and mobilize funding support. The 2011 Conference and 2012 Symposium brought together women's organizations, including those organized by WLHIV, policy makers and HIV researchers to develop a common understanding. Recommendations from the meetings informed the development of the country's Gender Action Plan. A number of funding proposals were subsequently submitted by community-based WLHIV organizations during the national call for proposals for the World Bank-funded *Total War Against HIV and AIDS Project*, which has a budget of US$115 million.

> "The voice of women living with HIV in Kenya was not commensurate to the HIV burden they bear, it was not quite audible during the development of KNASP 2009/10–2012/13. We need strong WLHIV leadership to ensure visibility of women living with HIV; the momentum created (courtesy of EC-UN Women funding) needs to be sustained."
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> —Eunice Odongi, Senior Programme Officer, NACC.[9]

A mapping exercise for WLHIV organizations highlighted which organizations had gaps in advocacy and leadership skills and organizational/financial management. As a result, **a mapping directory for WLHIV and their organizations for 2010 and 2011 was developed** to inform future decisions and interventions for any partner wanting to work with WLHIV.

A baseline study on gender and HIV was undertaken by the NACC with the support of the Gender Advisor. Although an in-depth analysis is still needed to fill information gaps, the study provides key baseline information for policy, planning and tracking progress on gender dimensions, gender-based violence, sexual reproductive health and HIV.

Through a series of training sessions, **the capacity of NACC staff was enhanced to better apply equality and human rights concepts to increase the gender-responsiveness of the policies, plans and programmes of the national HIV response.** The Management and Information System (MIS) has developed an e-learning portal on the NACC website that incorporates gender, and will be updated continuously to facilitate ongoing learning by both existing and new staff.

The Gender Action Plan has been disseminated to development partners and to all the counties to inform resource allocation and implementation plans at all

9 Interview with NACC Senior Programme Officer, Nairobi, Kenya (UN Women-EC Programme 2009-2013).

levels. This is critical given the two-level system of government (national and county).

A strong partnership emerged between WLHIV organizations and the NACC. The NACC has gained a better understanding of how organizations run by WLHIV can participate in regional and national policy development, and how to effectively collaborate with these organizations. WLHIV organizations have, in turn, learned about entry points into the policy process, and how to engage in programme prioritization and review processes.

The programme has **enabled the NACC to incorporate the input of WLHIV in national policies and plans on HIV and AIDS.** An example is the development of the Gender Action Plan, for which representatives from WLHIV organizations and the Gender Advisor served on the task force that provided relevant technical advice from its conceptualization up to the finalization of the process.

LESSONS LEARNED

Having a gender advisor at the National AIDS Control Council is essential in terms of both provision of technical advice and resource mobilization to sustain attention on gender at decision-making and programme levels and facilitate the participation of WLHIV in these processes. Her involvement was critical, and provided focus and technical support to all national processes and efforts working towards gender equality in the HIV response.

The efforts of WLHIV must be supported with the necessary long-term vision and resources because social transformation takes place in incremental steps. Marginalized constituencies require support to organize and speak as one. When a constituency speaks in one voice, it is much louder and better heard than many disjointed and uncoordinated voices.

Training in leadership and women's rights in the constitution can transform women's thinking and actions. For example, after a training conducted by the programme, WLHIV who had been given treatment that was not appropriate, with a lot of harmful side effects, stood their ground and persuaded the doctor to prescribe a more appropriate treatment.

The alignment and integration of programme interventions to national priorities results in a better response, as well as support for national governments. Capacity building activities under the programme were deemed relevant and useful by NACC officials, who were able to adopt action points that were identified during training sessions as part of the NACC annual plans.

LEADING AT THE LOCAL LEVEL: PARTICIPANT, UN WOMEN-EC ADVOCACY TRAINING FOR WOMEN LIVING WITH HIV

After her husband died of AIDS, Faustina, who lives with HIV, was blamed by her relatives for bringing the disease into her family. She and her four children were chased from their home and all the crops in her farm were destroyed. With nowhere to go, she moved to a slum in Nairobi and was eventually forced into sex work to provide for her family.

Faustina did not give up. She found out about the Kenya Voluntary Women's Rehabilitation Centre and soon enrolled in training on advocacy and leadership skills. In a short time, she became a peer educator and outspoken advocate for other women living with HIV.

With her new confidence and organizational skills, Faustina returned to her community and formed the Tigoi Women's Self Help Group. She also successfully obtained funding from the NACC to run the organization. Today, the community that once rejected her now embraces her, and she is a local leader in the HIV response.