



OFFICE OF THE PRESIDENT

**MAINSTREAMING GENDER INTO THE
KENYA NATIONAL
HIV/AIDS STRATEGIC PLAN
2000-2005**



The Gender and HIV/AIDS Technical Sub-Committee
of the
National AIDS Control Council
November 2002

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Special recognition should be given to the editorial committee members who freely gave of their own time to craft a multitude of issues into a coherent and readable document.

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ABBREVIATIONS / ACRONYMS

ACU	AIDS Control Units
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral Therapy
BCC	Behavioural Change Communication
CACC	Constituency AIDS Control Committee
CBO	Community Based Organisation
DACC	District AIDS Control Committee
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
IGAs	Income Generating Activities
MTCT	Mother to Child Transmission
NACC	National AIDS Control Council
NGO	Non-Governmental Organisation
KNASP	Kenya National HIV/AIDS Strategic Plan for 2000-2005
OVC	Orphans and Vulnerable Children
PACC	Provincial AIDS Control Committee
PLWHA	People Living with HIV/AIDS
PTCT	Parent to Child Transmission
STI	Sexually Transmitted Infection
TSG	Technical Subcommittee on Gender and HIV/AIDS
UNAIDS	United Nations Program on AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WID	Women In Development

EXECUTIVE SUMMARY

In 1999, President Daniel arap Moi described the HIV/AIDS situation in Kenya as a national disaster and created the National AIDS Control Council. One of its first tasks was to formulate the Kenya National HIV/AIDS Strategic Plan, which was published in December 2000. At that time, the adult HIV + prevalence rate was 13.1% and the optimistic thinking was that the situation might stabilise at 14%, or even decline with effective implementation of the strategic plan. Yet by the end of 2001 an estimated 13.5% of Kenyan adults were HIV positive and the latest UNAIDS Epidemiological Fact Sheet reports a figure of 15%.¹ If a natural HIV prevalence limit does exist, it is considerably higher than most people originally thought.

During the process of formulating the Kenya National HIV/AIDS Strategic Plan, some of the gender dimensions of the epidemic had been recognised. It was noted that a striking feature of the epidemic was its impact on women as compared to men; the incidence of HIV/AIDS among women was rising at a shocking rate and women were being infected at an earlier age than men were. However, explicit strategies that focused specifically on gender issues were not included in the development of policies or programmes under the five priority areas.

In 2001, as the gender aspects of the epidemic became clearer and it was recognised that gender was playing a crucial role in the dynamics of the HIV/AIDS pandemic, the National AIDS Control Council established a Technical Sub-Committee on Gender and HIV/AIDS Task Force. It was agreed that the best approach would be to engender the existing Kenya National HIV/AIDS Strategic Plan because it is the key document that guides and co-ordinates all responses to HIV/AIDS in Kenya.

The Technical Sub-Committee's mandate was to formulate guidelines and create a strategic framework through which gender concerns could be integrated into the analyses, formulation and monitoring of policies and programmes relating to the five priority areas of the Kenya National HIV/AIDS Strategic Plan so as to ensure that the beneficial outcomes are shared equitably by all – women, men, boys and girls.

The gender analysis and mainstreaming strategies contained in this document are centrally informed by two National AIDS Control Council commissioned field studies carried out in October 2001 and May 2002. The findings of the field studies illustrate how different attributes and roles societies assign to males and females profoundly affect their ability to protect themselves against HIV/AIDS and cope with its impact. Examples range from the gender issues that render both men and women vulnerable to HIV infection to the ways in which gender influences men and women's responsibility for, and access to, treatment, care and support.

The findings from the field studies and the resulting gender analyses illustrate that gender roles and relations powerfully influence the course and impact of the HIV/AIDS epidemic. Gender-related factors shape the extent to which men, women, boys and girls are vulnerable to HIV infection, the ways in which AIDS affects them, and the kinds of responses that are feasible in different communities and societies. The control of the spread of HIV/AIDS is dependent on the recognition of women's rights in all spheres of life and therefore, women's empowerment is an important tool in the fight against HIV/AIDS.

Because the HIV/AIDS pandemic is fuelled by gender inequalities, a proactive engendered response is required to minimise its impact. It is through this document that the Technical Sub-Committee on Gender hopes to ensure that the gender dimension of the HIV/AIDS epidemic does not remain just an intellectual idea, but through the identified strategies becomes a practical tool for guiding policy decisions and programming for all activities under the umbrella of the Kenya National HIV/AIDS Strategic Plan for 2000 - 2005.

¹ Report on the Global HIV/AIDS Epidemic 2002 UNAIDS. July 2002.

1.0 BACKGROUND

1.1 Introduction

One of the striking features of HIV/AIDS is its impact on women. At the beginning of the pandemic, women and girls were at the periphery; today they are at the centre. Globally, the incidence of HIV/AIDS among women has risen at a shocking rate. In 1997, 41 per cent of HIV infected adults were women, but this figure rose to 49.8 per cent in 2001². An estimated 15 million women carried the virus, compared to 10.9 million men, in sub-Saharan Africa at the end of 2001.³ The latest data for Kenya estimates 1.4 million women in the age bracket from 15-49 years compared to .9 million men in the same category.⁴

Table 1: Estimates of People Living with HIV/AIDS: 1999 and 2001

		Total Adults and Children	Adults (15-49)	Women (15-49)	Men (15-49)	Children (0-14)
Global Millions	End 1999	34.3	33.0	15.7	17.3	1.3
	End 2001	40.0	37.1	18.5	18.6	3.0
Sub-Saharan Africa Millions	End 1999	24.4	23.4	12.0	11.4	1.0
	End 2001	28.5	25.9			2.6
Kenya Millions	End 1999	2.1	2.0	1.1	0.9	0.078
	End 2001	2.5	2.3	1.4	0.9	0.22

Source: Reports of the Global HIV/AIDS Epidemic and UNAIDS Assessment of the Epidemiological Situation in Kenya, 2002.

Women are also infected at an earlier age than men are. For example, in 1998 most HIV+ women in Namibia were in their 20s, while most men carrying the virus were in their 30s.⁵ In Kenya HIV prevalence by age and sex has been well documented and it is generally accepted that the infection levels for women are higher than for men. One study found that in the 15-19 age group, infection rates for women are five times that of men. In the 20-24 age group, infection rates for women are three times that of men.⁶

² Report on the Global HIV/AIDS Epidemic 2002 UNAIDS. July 2002.

³ UN Special Session on HIV/AIDS Fact Sheet 2001.

⁴ Report on the Global HIV/AIDS Epidemic 2002 UNAIDS. July 2002.

⁵ UN Special Session on HIV/AIDS Fact Sheet 2001.

⁶ WHO 1997 Multi-centre Study. Kisumu, Kenya.

Table 2: HIV Prevalence in Kisumu District by age and sex, 1997

Distribution	Age-groups - years					Total
	15-19	20-24	25-29	30-39	40-49	
Men	4.2%	13.4%	29.4%	34.0%	29.9%	21.0%
Women	22.3%	39.0%	38.6%	31.7%	19.4%	30.9%
Ratio	5.3	2.9	1.3	0.9	0.6	1.5

Source: HIV/AIDS in Kenya: Situation Analysis for National HIV/AIDS/STD Control Programme, September 1998.

Why are women often at greater risk for HIV/AIDS?

A variety of factors increase the vulnerability of women and girls to HIV including their limited access to economic and educational opportunities and the multiple household and community roles they are responsible for. Compounding women's vulnerability are social norms that deny women sexual health knowledge and practices that prevent them from controlling their bodies.

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 to 24 years old, 25% said they lost their virginity because they had been forced.⁷ A recent Nairobi study indicated that 4% of HIV infections in the adolescent 13 - 19 year age group were a consequence of rape.⁸

Unwilling sex with an infected partner carries a higher risk of infection, especially for girls. Since force is used, abrasions and cuts are more likely and the virus can more easily find its way into the bloodstream. What's more, condom use is unlikely in such situations.

Research has shown that in up to 80% of cases where women in long-term stable relationships are HIV-positive, they acquired the virus from their partners (who had become infected through their sexual activities outside the relationship or through drug use).⁹

Women also find themselves discriminated against when trying to access care and support when they are HIV-positive. In many countries, men are more likely than women to be admitted to health facilities. Family resources are more likely to be devoted to buying medication and arranging care for ill males than females.

Men, and especially young boys, are vulnerable too. Social norms reinforce their lack of understanding of sexual health issues and at the same time celebrate promiscuity. This vulnerability is further increased by the likelihood of engaging in substance abuse (such as alcohol and other drugs) and of opting for types of work that can entail mobility and family disruption (such as migrant labour or the military).

While HIV/AIDS is a health issue, the epidemic is a gender issue. Statistics prove that both the spread and impact of HIV and AIDS is not random. It disproportionately affects women and adolescent girls who are socially, culturally, biologically and economically more vulnerable at the same time.

⁷ AIDS In Kenya. 2001.

⁸ Violence and Abuse of Women and Girls in Kenya. Research study by PCA and NCWK, 2002

⁹ UN Special Session on HIV/AIDS Fact Sheet 2001.

In Kenya the impact of HIV/AIDS is felt at all levels. As the country loses young productive people, the effects have an influence on all sectors. Households fall into deeper poverty, economies stumble and women are invariably left bearing even bigger burdens-as workers, educators, mothers and, ultimately as caregivers, as the burden of caring for ill family members is made to rest with women and girls. A recent study found 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. Girls are often removed from school, not to specifically care for the sick and dying, but to take up “home duties” that release older women in the family for “care duties”. In some standard eight classrooms in south Nyanza, there are no girls enrolled in this grade.¹⁰

Of HIV+ pregnant women in Kenya, 30% give birth to HIV+ babies who are likely to die before age five.¹¹ It is projected that between 2000 and 2020, 55 million Africans will die earlier than they would have in the absence of AIDS. (These projections are based on the assumption that prevention, treatment and care programmes will have a modest effect on the growth and impact of the epidemic in the next two decades.)¹² In many sub-Saharan African countries, including Kenya, AIDS is erasing decades of progress in life expectancy. Currently at 47 years, it would have been 62 without AIDS.¹³

1.2 The Technical Sub-Committee on Gender and HIV/AIDS

Most HIV infections are transmitted through sexual intercourse, and heterosexual intercourse accounts for the largest proportion of infections. Therefore, gender and sexuality are significant factors that determine the spread of HIV. They also influence availability, access to and quality of treatment, care and support. The National AIDS Control Council (NACC) realised that gender-related vulnerability factors mentioned above could not be ignored when designing and implementing strategies aimed at curbing the spread of the HIV/AIDS epidemic and at mitigating its impact on both men and women. Therefore, it was proposed that a sub-committee be formed to develop modalities for this process to ensure that the outcomes could be shared equitably by all – women, men, boys and girls.

The NACC established the Technical Sub-Committee on Gender and HIV/AIDS (TSG) in April 2001 to develop strategies for mainstreaming gender in the Kenya National HIV/AIDS Strategic Plan for 2000-2005 (KNASP). The TSG was charged with the responsibility of identifying the gender gaps in the KNASP, analysing the gender issues arising from the field research, formulating guidelines and creating a strategic framework through which gender concerns could be integrated into the analyses, formulation and monitoring of policies and programmes relating to the five priority areas of the Kenya National HIV/AIDS Strategic Plan.¹⁴

Support for and participation in this committee has been widespread and comes from a broad cross-section of organisations and sectors. At least 36 organisations have participated in this committee. These have included the Government of Kenya, multi-lateral organisations, NGOs, PLWHAs groups, faith-based organisations, policy groups, donor groups and donor-funded projects. See Annex 2 for the complete list of participant organisations.

¹⁰ Johnson, T. and Ouko G. AIDS Orphans in School. Population Communication Africa, 2002

¹¹ Women Fighting AIDS in Kenya, The Communication Initiative Website, 2001

¹² UNAIDS Fact Sheet 2002

¹³ UNAIDS Fact Sheet 2002

1.3 Identifying the Gaps in Priority Areas

A review of the KNASP by the TSG in 2001 revealed that minimal attempts had been made to develop policies and strategies within the five identified priority areas to address the gender dimensions of HIV/AIDS in Kenya. Gender relations governed by customs and cultural practices, education, economic conditions, traditional and modern laws and political representations were either not adequately addressed or were omitted. Please note that since the publication of the KNASP some progress has been made to address some of the weaknesses that are highlighted below. However, the overall plan can be strengthened by reflecting on the identified gaps and addressing them through policy recommendation, programme priorities, strategies and resource allowances.

Two general comments apply to all the priority areas:

- The KNASP falls short of using gender disaggregated data to analyse the underlying causes of vulnerabilities and risks for men, women, girls and boys. Gender disaggregated data could greatly enhance the KNASP's gender dimensions.
- The roles and functions of Government, NGOs, CBOs, faith-based communities, private sector and international development partners were not defined in addressing the institutional responses to gender-related issues of the HIV/AIDS epidemic.

Comments that apply to the specific priority areas:

Prevention and advocacy gender-related gaps

- Availability, accessibility and affordability of the female condom has not been ensured.
- Lack of specific engendered strategies to address the needs of difficult to-reach groups such as people with disabilities, prisoners, homosexuals, street children, street families, substance abusers and sex workers.
- Inadequate emphasis on gender-based violence including rape of women and girls and child sexual abuse, including incest.
- Lack of appropriate address regarding different modes of sexual contact other than vaginal intercourse, such as anal and oral sexual activity.
- Lack of specific strategies to address stigma, discrimination and human rights issues pertaining to marginalized groups, including PLWHA.
- Shortage of appropriate IEC materials to address gender stereotyping and different age groups.
- Lack of recognition and strategies to address the issue of cross-generational sexual relationships.
- Lack of strategies to address the implementation of equitable inheritance rights.
- Lack of specific interventions to address single-female-parent headed households in terms of property ownership and inheritance.
- Lack of specific interventions to address orphans and vulnerable children (OVCs) in terms of property ownership and inheritance.

¹⁴ TSG TOR 2001

- Lack of specific interventions to address education, employment opportunities and land ownership.

Treatment, continuum of care and support of the infected and affected gender-related gaps

- Lack of direction for treatment of opportunistic infections and the access to and use of anti-retroviral (ARV) drugs targeting specific vulnerable groups such as PLWHAs, commercial sex workers and prisoners.
- Lack of credit for income-generating activities for vulnerable HIV positive women and men and child-headed households.
- Lack of rape/incest crisis centres for counselling and post-rape STI/HIV prophylaxes.
- Lack of strategies to address the health and nutritional status of men and women infected with HIV/AIDS.
- Failure to put in place modalities for counselling close relatives of women who stop breast-feeding and who may be stigmatised due to their HIV serological status.
- Failure to ensure that voluntary counselling and testing (VCT) and parent-to-child transmission (PTCT) or mother-to-child-transmission (MTCT) services are provided in a gender sensitive manner.
- Failure to target women who are disproportionately responsible for the care of those infected without information about their sero-positive status.

Mitigation of the socio-economic impact gender-related gaps

- Lack of strategies to address property rights and inheritance for girls, widows and orphans.
- Lack of appropriate guidelines for marriage, separation, divorce and ownership of property.
- Failure to outline measures to eliminate female circumcision and other harmful cultural practices such as wife inheritance.
- No provision of alternatives to female circumcision, widow inheritance and wife sharing.
- Lack of gender sensitive and responsive programs for children.
- Lack of adequate consideration given to policy and legal issues concerning the sexual rights of women and girls.
- Failure to address programme activities that ensure women's equal participation in all facets of the response to the pandemic at the local, national, regional, and international levels.

Monitoring, evaluation and research gender-related gaps

- Lack of gender sensitive indicators for tracking gender vulnerability impacts and progress of responses and implementation.
- Failure to use disaggregated male and female epidemiological data in monitoring and evaluation instruments.
- Lack of a gender-sensitive surveillance system, data collection, processing and dissemination

- No guarantee of the rights and benefits of women and men participating in research work, especially related to AIDS vaccine testing.

Management and co-ordination gender-related gaps

- No direction for gender training for NACC and other entities.
- Lack of mechanisms for collaboration with other partners to share information on effective responses to gender-related HIV/AIDS issues.
- Failure to engender NACC budgets.
- No allocation of specific funds for gender programme components.
- Lack of a gender and HIV/AIDS curriculum for formal and informal education.
- No provision for participation with NACC secretariat.

2.0 FIELD STUDIES

Two sets of community field studies were completed during the research phase of this document to investigate some of the more complex determinants of gender vulnerability to HIV/AIDS. In October 2001 NACC commissioned the first study to be carried out in Kisumu, Thika and Narok. These three communities presented different cultural perspectives that have critical gender-based implications for the HIV/AIDS epidemic and all had varying HIV prevalence rates: Kisumu – a very high prevalence area, Thika - a moderately high prevalence area, and Narok - a mild prevalence area.

Another study was commissioned in May 2002 to ensure a wider geographical coverage. The second study was carried out in Mombasa, Meru South and Kajiado districts. Each district represents a cross section of community groups in Kenya. Mombasa represents the Muslim community, Meru the agricultural/sedentary communities and Kajiado the pastoralist community. Nevertheless, groups outside the stipulated communities also provided information, especially in Mombasa and Kajiado.

The findings from both studies have been fully integrated into the gender analysis in Section 3 of this document, but this section details the findings of the latter study that was carried out in Mombasa, Kajiado and Meru South. Particular importance was attached to the criteria for choosing each target area in order to ensure that information pertaining to that criterion was obtained. Participatory methodologies were used to gather information from the communities including large group and focus-group discussions as well as individual interviews with key informants in the community such as leaders of local CBOs, women's, men's and youth groups. Discussions were led according to the groups' interest in relation to the HIV/AIDS crisis. The study included the following groups:

- Women's groups including organised groups from the Christian and Muslim faiths, and community and self-help organisations. Two groups of sex workers were also interviewed.
- Community groups composed of both men and women. These groups were sometimes divided in male/female sub-groups to elicit their views.
- Youth groups including both in-school and out-of-school male and female youth.
- Local leadership who were mainly male.
- CBOs whose membership consisted of men and women, but whose leadership was mainly male with token female representation.

Contact organisations that had projects on the ground were utilised to identify the groups and to organise the field logistics. These were the Society for Women and AIDS (SWAK) in Mombasa, Chogoria Hospital in Meru South and the Intermediate Technology Group (ITDG) in Kajiado.

Many similarities existed in each of the three target areas. Of concern across the board were poverty, stigma, sex work, subordination of women and issues relating to care and support. However, the following issues carried more weight in specific areas as shown below:

Particular Areas of Concern for Each District		
Mombasa	Kajiado	Meru South
<ul style="list-style-type: none"> • AIDS orphans • Lack of VCT before polygamous unions • Female condom 	<ul style="list-style-type: none"> • Wife Sharing • Moranism • Lack of VCT before polygamous unions • Traditional medicine • Misconceptions about the male condom • Early marriage 	<ul style="list-style-type: none"> • Role modelling for male youth • Female condom • Misconceptins about the male condoms

Specific Notes from Field Studies

Gender roles and responsibilities

- Gender roles tend to confine girls and women to domestic and subsistence activities and men to commercial activities creating socio-economic disparities and vulnerability to HIV infection.
- Men and boys have the first priority to move to urban settlements in search of employment and better education. This leads to family separation and vulnerability to HIV/AIDS.
- Because of the male movement to urban areas, some women also move to the cities to provide domestic labour and sexual services.
- Males are perceived to be and often are preferentially assigned the more economically productive roles leading to male control of family resources.
- Homes headed by orphaned girls are easily pushed into sex in order to ensure a livelihood for themselves and their siblings.
- The gender division of labour keeps men away from their wives for long periods leading to promiscuity and the spread of HIV.

Access and control of resources

- Loss of gainful employment by men because of getting sick from HIV/AIDS reduces their capacity to provide for their families and thus impoverishes the whole family and imperils their opportunities.
- Loss of family property in the event of illness and death of the husband/father increases the vulnerability of widows and orphans to HIV infection.
- The low economic status of women drives them into sex work.

- Women tolerate unprotected sex because of poverty while men engage in unprotected sex because of affluence – men are willing to pay more to have sex without condoms.
- Women are unable to protect themselves because of issues related to accessibility, affordability and convenience of female condoms. On the other hand, some men do not know how to use male condoms correctly.

Cultural practices, attitudes and stereotypes

- Traditional cultural practices and the patriarchal behaviour of men and boys make women and girls subservient and more vulnerable to HIV infection.
- Practices such as widow inheritance, in which widowers remarry without having a HIV test, contribute to the spread of the epidemic.
- The rigid implementation of traditional practices such as dowry payments make women men's property. These women have no rights over their own sexual behaviour.
- Female genital mutilation, wife inheritance, high levels of girls dropping out of school and sex to obtain favours from males also contribute to the spread of HIV.
- Gender-based cultural expectations assign sexual prowess to males and sexual subservience to females. It is prestigious for males to have multiple sexual partners. This exposes both males and females to HIV infection.
- Male youth have been cultured to believe it is a sign of manhood to be able to control relationships. Females are brought up to believe that males are superior in all spheres of life and should be the masters in sexual relationships.
- Some communities in Mombasa district, and especially Muslims communities, expect girls to remain virgins until marriage. There are rewards for conformity and penalties for nonconformity. Parents prefer their daughters to be ignorant concerning sexual issues.
- Polygamous marriages and the lack of men's sensitivity to the plight of women fuel the spread of HIV. Most men uphold polygamy as a religious obligation whereas women see it as increasing the risk of contracting HIV/AIDS.
- Female and male circumcision is still practised in the traditional way whereby traditional surgeons use a common knife on their clients.
- Wife sharing is practised in some communities. There is a common belief that women who refuse will be cursed.
- Teenage pregnancy for girls who are still in their parents' homes is taboo. Consequently, girls who become pregnant are married off to any man to avoid shame to the family. Early marriage is encouraged as a means of deterring sexual adventures.
- Moranism continues to be practised, leading to the withdrawal of boys from school. Because of idleness, they engage in sexual relationships with the young wives of older men.

Stigma

- HIV/AIDS stigma and discrimination is widespread. This is demonstrated, for example, by the common belief that there should be specific hospitals for AIDS patients just as there are mental hospitals. People believe that confining AIDS patients in such hospitals would ensure that they don't infect other patients and would also ensure that the community would find out who was HIV positive.

- Maasais often ask, “Why do doctors cover up those who are infected? We want to know them for sure so that we can avoid them.” The implication of this question is that the infected should be abandoned to die.
- Women who are HIV infected are divorced even when their husbands had infected them. This is a particularly painful experience for women who have known wives who have taken care of their infected husbands until they died.
- Sex workers are stigmatised as spreaders of HIV/AIDS.
- Among the Maasai the association of HIV/AIDS with immediate death is a major roadblock to addressing the epidemic.
- Men and women have different reactions to life when they learn they are infected with HIV. Men lose hope and believe that life is no longer worth living, but the women want to live as long as possible so that their children will be older. One mother said, “I pray everyday that God may give me another five years so that my son will be 18 and be through with high school. I am sure he will manage by himself after that.”

Care and support

- Elderly grandparents, often women, are burdened with caring for orphans.
- Women have a higher biological risk for HIV and STIs. STIs are often asymptomatic in women. Women have a high rate of obstetric complications due to limited access to often poor quality health services.
- Some women and girls who are caregivers do not know that the people they are caring for are infected. Women fear that they may become infected because they know nothing about standard infection control practices.
- Most HIV/AIDS female patients are poor and are rejected by their husbands and family. They cannot afford basic drugs for opportunistic infections, let alone antiretroviral drugs. One hospital in Meru South district admitted two women patients. Hospital staff believed that the women’s husbands could afford to pay for ARV therapy, but they had not responded to the hospital’s advice. The women themselves could make no decisions about their own care because they had no income.
- Although pregnant women are tested routinely for HIV as part of antenatal surveillance, their male partners and spouses do not receive any attention.

Behaviour and attitude change

- Early childhood disempowerment of the girls renders them sexual subordinates. They are unable to negotiate for safer sex.
- Cross-generational sex involving younger girls and older men and younger boys and older women is increasing. Girls are taken advantage of by older men who give them food items in exchange for sex.
- People are unaware that anal and oral sex can transmit HIV infection.
- Many young men believe that condoms carry the HIV virus. In Meru South district there is a specific need to address male youth who are neglected in terms of counselling.
- HIV-infected women are more stigmatised than infected men are. Many infected men are in denial of their status.

- Poverty has become a major concern and is cited as one of the major factors driving women to sex work. Survival is particularly difficult in the urban areas where social support is very limited. It is common to hear sex workers say, “You die faster from hunger than from AIDS.”

Legal concerns

- The law is lenient on rapists who are likely to infect young girls and sex workers.
- Sex workers have difficulties obtaining justice when their clients assault them. For example, law enforcement officers often demand sex in exchange for providing any assistance.

Access to information

- The low level of literacy among women means that they have little access to HIV information.
- Awareness of HIV/AIDS is lower among girls than among boys due to high levels of illiteracy, domestic responsibilities and parents’ concern for the security of their daughters outside the homes.
- Young people, even those who practise high-risk behaviour, are afraid of being tested for HIV. They argue, “The test will not change anything. If anything, should it be positive, it will just hasten the time of death.”
- Some men who have tested positive continue to be in denial and therefore continue to spread the virus. This is especially alarming when the myth continues to spread that the cure for HIV/AIDS is to have sexual intercourse with a young girl.
- The boys discussed condoms and the fact that, although the community condemned their use, the elders are not teaching them how to handle their sexuality. The boys particularly condemned their fathers who never discuss “manly” ideas with them.
- Some out-of-school youth have a fatalistic attitude. They believe, “If it is your turn to get HIV, you will. You can’t avoid it.”

Participation in decision-making

- In Mombasa, women’s representation in governance structures is very low. Of the 33 councillors in the district, only two are women. Of the six Members of Parliament who represent the district, only one is female.
- There is a low level of women’s representation in the District AIDS Committees (DACs) and the Constituency AIDS Committees (CACs). These committees do not understand the gender dimensions of the HIV/AIDS epidemic.

3.0 GENDER ANALYSIS

3.1 Key Concepts of Gender and Sexuality

The interconnection between gender and HIV/AIDS cannot be understood without understanding the key concepts of gender and sexuality.

Gender is defined as the set of characteristics, roles and behaviour patterns that distinguish women from men socially and culturally. Gender is a social and culture-specific construct that differentiates women from men and defines the ways in which women and men interact. Gender is learned, and therefore can be unlearned. Unlike gender, sex is biologically determined; it is received, universal, and cannot be changed.

The concept of gender refers not only to the roles and characteristics of women and men but also to the power relations between them. Typically, men are responsible for the productive activities outside the home while the domain of women are the reproductive and productive activities within the home. In most societies women have limited access to income, land, credit and education, and have limited control over these resources.

Sexuality is the totality of the human being – of maleness and femaleness. In other words, it is the awareness of being a female or a male and the capacity to experience and to express oneself sexually. Unlike gender that is a culture-specific construct, sexuality starts at conception and develops throughout life. It is only at birth that a gender is assigned to the child – boy or girl, depending on the appearance of the external genitals.

Sexuality is distinct from gender, yet it is intimately linked to it. Power is fundamental to both sexuality and gender. The power underlying any sexual interaction, heterosexual or homosexual, determines how sexuality is expressed and experienced. Power determines whose pleasure is given priority and when, where, how, and with who sex takes place. There is an unequal power balance in gender relations that favours men. This translates into an unequal balance of power in heterosexual interactions.

Male pleasure has priority over female pleasure, and men have greater control than women over when and how sex takes place. An understanding of male and female sexual behaviour requires an awareness of how gender and sexuality are constructed by a complex interplay of social, cultural, and economic forces that affects the distribution of power. These concepts are important in discussion and in formulating effective programme responses to HIV/AIDS.

3.2 Gender, Sexuality and Vulnerability to HIV Infection.¹⁵

In sub-Saharan Africa, HIV is primarily a sexually transmitted disease. The most effective methods of HIV prevention are partner dependent – abstinence, faithfulness and condom use. The extent to which sexual partners are free to negotiate safer sex and to protect themselves and their partners is greatly influenced by the gendered aspects of sexual behaviour. Sexual behaviour in turn is greatly influenced by a person's understanding of sexuality, broadly understood as the social construction of a biological drive. Whom one has sex with, in what ways, why, under what circumstances, and

¹⁵ This section on Gender, Sexuality and HIV/AIDS is based on Dr. Geeta Rao Gupta's plenary address at the 12th International AIDS Conference, Durban, South Africa, July 12, 2000. Her talk was entitled "Gender, Sexuality, and HIV/AIDS: The What, the When, and the How."

with what outcomes defines one's sexuality. In addition, a person's sexuality is in turn defined by gender, age, economic status, ethnicity, etc. Therefore, gender and sexuality are at the heart of any understanding of the dynamics of HIV transmission. Examples of how gender and sexuality render females vulnerable to HIV transmission include the norm of virginity for unmarried girls that increases a young girl's risk of HIV infection because the virginity norm inhibits young women from seeking information about sex. This virginity norm and the silence surrounding sex also stigmatise women seeking treatment for sexually transmitted diseases. Males are vulnerable to HIV infection through masculinity norms that expect them to be knowledgeable about sex. Such norms make it difficult for males to admit lack of knowledge or to seek information about sex. In many cultures, multiple partners for men is believed to be essential to men's nature and for sexual release. Such beliefs challenge messages such as partner faithfulness or reduction in the number of partners. Further elaboration is provided in the sections below.

3.3 Gender Vulnerability Factors

The following determinants of gender vulnerability were identified by the TSG during gender analysis discussions.

Social

- Social construction of gender and the socialisation process.
- Myths regarding masculinity and femininity.
- Peer pressure to engage in sexual activity is higher among men than in women
- Lack of positive role models.
- Lack of gender sensitivity in social institutions, including families.
- Lack of education for girls results in low exposure to HIV/AIDS education messages due to low literacy rates.
- Age differentials in who has sex with who.
- Lack of gender disaggregated data.
- Women are more prone to stigma of STIs, especially HIV/AIDS.

Cultural

- Female subordination.
- Age of marriage and assumptions of maturity/adulthood.
- Circumcision and purification.
- Wife inheritance.
- Unquestioned assumptions about female and male sexuality.
- Gender bias regarding issues of sexual violence and rape.
- Weak laws against sexual violence.

Economic

- Lack of education for girls results in poverty and economic dependence on men.

- Few opportunities for girls/women to access job/career opportunities.
- Limited access to media.

Religion

- Religious perspective of condom use.
- Different perspective and interpretation of male and female sexual behaviour.
- Stigma on sex as sinful.

3.4 Determinants of Gender-related Vulnerability to HIV/AIDS

The following determinants of gender-related vulnerability to HIV/AIDS were identified by the TSG during gender analysis discussions.

Global determinants

- Unquestioned sexual roles and sexual behaviours.
- The social construction of gender and socialisation of men and women.
- The cultural expectations for men and women.
- Control of resources vis-à-vis men and women.
- Myths regarding masculinity and femininity.
- Lack of gender sensitivity in social institutions, including families.
- Lack of positive alternative role models.
- Lack of gender disaggregated data.
- Lack of integration of religious values.
- Secrecy versus confidentiality.
- Stigma/discrimination.

Male-related determinants

- Relationships between men and men – men who have sex with men.
- General expectations and peer pressure among men to have many sexual partners.
- Cross generational sexual behaviour – older men having sex with younger women.
- “Predatory” view of male sexuality.
- Men deny their vulnerability to HIV/AIDS and in consequence endanger their lives and sexual partners.

Female-related determinants

- Women’s biological vulnerability.
- Low education levels and low economic status cause women to be dependent on men.
- Low economic status leading to women engaging in commercial sex work.

- Cultural female subordination reflected in the age of marriage, circumcision, wife inheritance and gender-based violence.
- Virginity norm prevents women from openly seeking reproductive health information.
- Polygamy.
- Weak laws against sexual violence.
- Low representation of women in decision-making at all levels.
- Health services delivery systems are gender-biased e.g. availability and affordability of male condoms as opposed to female condoms.

3.5 Women, sexuality and HIV/AIDS

It is a women's right to be in a position to protect herself from HIV or other sexually transmitted infections. She has a right to limit the number of sexual partners, to delay the age of her first sexual encounter, to say "no" to sex with an infected partner, regardless of her legal marital status, or to insist that a condom be used (even with her husband). However, the reality is that in many societies women are unable to exercise their sexual rights. Economic factors, social expectations, cultural taboos, and religious values all operate in such a way as to increase the barriers to a women's sexual autonomy.

Even where women have a degree of economic autonomy, social and cultural expectations may make it extremely difficult for them to set the terms of sexual encounters. Examples of double standards in male and female behaviour abound. Producing children gives status to a family, but childlessness in a woman is regarded as a reason for rejection and divorce. Women are expected to be faithful, but multiple sexual relationships are acceptable and even encouraged for men. Women are not free to negotiate the use of condoms without the fear of negative consequences, including violence. Willing submission is part of the gender-construction of being a woman and often it is a woman's most intimate relationship that is the most threatening. Some examples of barriers to women's sexual autonomy are:

- Women are objects of reproduction.
- Childbearing and sexually satisfying her husband are the key expectations for a wife.
- Women are not expected to discuss, make decisions about, or enjoy sex.
- Unmarried women are generally expected to be abstinent.
- Ignorance about sex is viewed as a sign of purity; too much knowledge is considered a sign of immorality.
- Women may be pressured into having sex as a proof of love and obedience.
- Women can not negotiate condom use; insistence on condom use invites violence and the suspicion of infidelity.
- It is socially acceptable for men to have multiple partners.
- Men may seek younger partners to avoid infection; sex with a female virgin is believed to cure AIDS.

3.6 Men, sexuality and HIV/AIDS

Sexual prowess, multiple partners and control over sexual interactions define masculinity. Taking the lead in sexual activity is part of the gender-construction of being male. Men normally take the initiative and decide where, when and how sexual relations take place. Men tend to have more sexual partners than women and are prone to take risks by having unprotected sex.

Factors in men's sexuality that predispose them to risky sexual behaviours include:

- Masculine norms make it difficult for men to admit any lack of knowledge in the sexual arena.
- Access to and control of resources is profoundly gender-related in both the private and public domain.
- Alcohol use and drunkenness is socially sanctioned for men and is common and widespread.
- Bars, clubs and drinking establishments abound and are closely associated with reduced inhibition and casual sex.
- Stigma with regard to same sex relationships means that men who have sex with men have secret relationships, are difficult to reach with safe sex messages and at the same time marry due to social pressure.

3.7 Conclusion

The above analysis of women's and men's sexuality and HIV/AIDS portrays them as prisoners of gender roles within any given society. However, the most effective strategy for breaking out of these roles is for men and women to form a partnership of responsibility.

Men are in a unique position to positively determine the outcome of the epidemic. They must learn to evaluate gender definitions, grasp how traditional views of masculinity have contributed to the transmission of infection, and take responsibility for change. As principal decision-makers, they can use their greater economic, political and social powers for preventative behaviour.

Because of the prevailing socio-economic dynamics that make women unable to negotiate safer sex, as well as a female's biological vulnerability, the overall impact is that women are contracting HIV at a faster rate than men. The economic and social empowerment of women is therefore essential if women are to protect themselves, and share responsibility for the containment of HIV.

4.0 GENDER MAINSTREAMING AS A STRATEGY IN HIV/AIDS RESPONSE

4.1 Concept of Gender Mainstreaming

Gender mainstreaming seeks to address the differential impacts of HIV/AIDS on women, men, boys and girls that are described in this report. Gender mainstreaming also seeks to promote social justice by reducing gender inequality. It uses gender analysis as the framework to describe the current power relationships between women and men and their differential authority to decide on people's access to and control over the use of resources. Gender analysis identifies the multiple ways in which policies and programmes differentially affect men and women at all levels, and especially at the household level. Gender mainstreaming ensures that gender inequalities are addressed in the design, planning, implementation, monitoring and evaluation of programs, and ensures that the beneficial outcomes are shared equitably by all – women, men, boys and girls.

In gender mainstreaming, all gender biases are removed and everyone plans with the concerns of women, men, boys and girls in mind and how the intended activity affects them differently. Where there is disparity, a deliberate trade-off is made to bring about gender equality. Mainstreaming addresses both practical gender needs and strategic interests.

4.2 Rationale for Mainstreaming

The main criticism of Women in Development (WID) policies is that they continue to define women themselves as 'the problem', as passive victims who need welfare and special treatment if their circumstances are to be improved. Consequently, the reasons for women's plight remain largely unexplored. No explanation is given for the systematic devaluing of their work or the continuing constraints on their access to resources. In an attempt to fill this gap in the analysis, the focus of many planners and policy-makers is now shifting from women themselves to the social divisions between the sexes - in other words gender relations.

It is now clear that most dimensions of economic and social life are characterised by a pattern of inequalities between women and men that routinely value what is 'male' over what is 'female'. Until these divisions are addressed seriously, policies designed to benefit women will offer only limited and often short-term solutions. Many development agencies and other organisations, therefore, now adopt the 'gender and development' or GAD approach as a more appropriate methodology for tackling the massive inequalities that limit the potential of most women around the world.

4.3 Institutional Mechanisms required for Mainstreaming

Given the financial and human resource constraints, an appropriate institutional framework is crucial to ensure that all HIV/AIDS-related activities addressing gender are co-ordinated, and provide the best value for money. The following institutional reforms are recommended in order to effectively mainstream gender within the national response to HIV/AIDS:

- NACC must assume prime responsibility for ensuring that its policies are gender responsive and that gender is incorporated in all HIV/AIDS related activities.

- NACC and all implementing agencies must develop appropriate gender responsive objectives and indicators and collect disaggregated data to monitor progress.
- Capacity building: All institutions (NACC, line ministries, NGOs, CBOs, FBOs and ASOs) should review their priorities and budgets to ensure that gender audits and staff training in gender-responsive planning and programming are adequately funded. Additional resources, both financial and skilled staff, should be provided as required.
- Legal and policy reforms: The Government of Kenya should repeal or harmonise conflicting statements in customary, common and statute laws.

4.4 Process of Gender Mainstreaming

In all societies, men and women experience different vulnerabilities and have different capacities because of their gendered roles. Sometimes these roles are very different and rigid; sometimes they are overlapping and fluid. In either case, the failure to identify gendered roles and to formulate policies and plan programmes with them consciously in mind can result in the inequitable delivery of assistance, and inadequate attention to the potential long-term outcomes of short-term interventions. The tool of gender analysis is a powerful one for accurately diagnosing opportunities and constraints in any programme situation, and for identifying more effective strategies for developing and implementing interventions that make a difference.

Gender must be taken into account during each step of the programme cycle including defining the problems/issues; formulating a strategy; identifying the target group; establishing/strengthening the institutional framework; specifying objectives and indicators for success; defining outputs, activities and inputs and specifying monitoring and evaluation procedures.

How does gender analysis help us understand vulnerability? Gender is not the only determining factor of vulnerability. However, an understanding of vulnerability and the development of strategies for overcoming it can be advanced through gender analysis. There are several design options for planning within a gendered context including women-specific projects, women's component in a general project and a general project with gender mainstreamed into it. Conducting a gender analysis consists of several steps and a concise example is included in Annex 1. Becoming familiar with this tool should be a must for all readers.

5.0 GUIDELINES AND STRATEGIES

5.1 Goal

To reduce the vulnerability and risk of both men and women, boys and girls to HIV/AIDS infection and to provide comprehensive treatment, care and support programmes to all people infected and affected by HIV/AIDS.

5.2 Objectives

5.2.1 Overall Objectives

To establish an institutional policy framework for integrating gender into all HIV/AIDS policies and programmes.

To create a gender responsive legal framework for HIV/AIDS prevention, treatment and care.

To ensure that adequate human and financial resources are available for gender responsive HIV/AIDS programming.

5.2.2 Specific Objectives

To identify the biological, epidemiological, socio-economic, cultural and religious issues within urban and rural Kenyan communities as they relate to the vulnerability and risk to males and females to HIV infection.

To use a rights-based approach, including the right to be healthy and free of disease, unwanted pregnancy, coercion or violence, with the values of respect and decency rooted in all programmes and activities.

To state what an engendered HIV/AIDS programme would incorporate.

To address HIV/AIDS challenges in a gender sensitive and responsive manner to ensure the sustainability of AIDS prevention, treatment, care, support, monitoring and evaluation systems.

To undertake gender and HIV/AIDS analyses prior to programme development to identify relevant components and initiatives for gender mainstreaming.

To engender the technical components of HIV prevention, e.g., syndromic management of STI, VCT, condom promotion, i.e., promote both the male and female condom, HIV prevention with youth, hard to reach groups such as truckers, sex workers and men who act as the bridge population between casual sex partners and their wives, partners or girlfriends.

To develop HIV prevention strategies to empower all women, including married women, and men to protect themselves from HIV infection.

To build capacity among decision-makers and donors regarding the gendered dimensions of HIV infection, prevention, treatment, care and support.

To build the capability of all implementing agencies and institutions at all levels to integrate gender into all HIV/AIDS policies and programmes and support all sectors of society to develop appropriate strategies for the prevention and mitigation of HIV/AIDS.

To create structures and opportunities that will enable women to participate in decision making in all communities and institutions.

To integrate gender into all HIV/AIDS research, M&E and analyses by designing gender sensitive objectives and indicators, and collecting disaggregated data.

To ensure that national planning and budgetary processes are engendered in order that adequate expertise and funds are available for implementation of gender sensitive policies and programmes.

To ensure that the benefits and resources of all programmes are shared equitably by both men and women.

5.3 Strategic Plan Priority Area Objectives and Strategies

Objective	Strategies
<p>Priority Area 1: Prevention and Advocacy</p> <p>Enlist the support of policy and decision-makers to ensure that all prevention and advocacy strategies are gender sensitive in order to reduce the vulnerability and risk of men and women.</p>	<p>1.1 Develop M&E systems that are sex and age disaggregated on the incidence and severity of STI/HIV (infection) disease to promote gender equity and equality.</p> <p>1.2 Promote the economic independence of women and children through the reform of property rights and inheritance laws.</p> <p>1.3 Advocate for continued reform in family laws by supporting sustained strong political commitment of all decision makers.</p> <p>1.4 Improve economic opportunities for women and children through developing access to IGAs.</p> <p>1.5 Promote female-controlled STI/HIV prevention methods using a mix of initiatives including peer group initiatives such as female condom use among sex workers and other vulnerable groups.</p> <p>1.6 Develop a generic gender-sensitive BCC strategy. In addition, develop BCC materials directed towards specific groups, e.g. truck drivers, prisoners, men having sex with men, young men, young women, urban professional men and women, and rural communities.</p> <p>1.7 Promote specific programmes that address the social and economic vulnerability of young girls and boys.</p>

Objective	Strategies
	<p>1.8 Support girls' education initiatives to close the gap in parity and equality.</p> <p>1.9 Develop public education campaigns regarding issues of cross-generational relationships and vulnerability to HIV infection.</p> <p>1.10 Improve gender equity employment opportunities for youth.</p> <p>1.11 Develop programmes to address gender-based violence and coercive sexual activity.</p> <p>1.12 Encourage recognition of specific high risks groups and take measures to protect them from violence and provide HIV prevention information and treatment without coercion or penalties.</p> <p>1.13 Engender all technical aspects of HIV/AIDS initiatives such as syndromic management of STIs, VCT services, sex worker programmes, etc. One example of an engendered sex work programme would be: Risk reduction to include the following; a) Improve safe sex negotiation and decision-making skills; b) ensure access to the male and female condom; c) work with the clients of sex workers; d) work with male sex workers; and d) reduce police violence and harassment. Vulnerability reduction to include: a) provide economic alternatives; b) promote legal reform of prostitution laws and the human rights of sex workers; c) promote the participation and decision-making of sex workers in sex work programmes.</p>

Objective	Strategies
	<p>1.14 Scale-up VCT to include MTCT and PTCT services.</p> <p>1.15 Engender the HIV/AIDS curriculum at all levels of education and include reproductive health information.</p>
<p>Priority Area 2: Treatment and Support</p> <p>Develop and implement policies to support the provision and access to health services and support systems for all women and men at all levels and localities.</p>	<p>2.1 Develop policies for providing equitable access to prevention prophylaxes, ARVs, and treatment of opportunistic infections and STI with attention to special vulnerabilities of women and children.</p> <p>2.2 Build the capacity of health institutions and communities to ensure that men and women share the burden of quality home-based and community care.</p> <p>2.3 Develop new strategies and support all existing strategies that enable girls to stay in school instead of remaining at home to assist in caring for ill members of the family and extended members of the family (OVCs).</p> <p>2.4 Provide support for micro-finance and IGAs for HIV + women and men and their children.</p> <p>2.5 Support the dissemination of information about rape and incest crisis centres for counselling and post-rape prophylaxes and support the establishment of social institutions to deal with gender-based violence and incest.</p> <p>2.6 Promote gender sensitive VCT and PCT/MTCT programmes, including fully informed consent for HIV testing, ARVs for HIV+ mothers and family counselling for non-breast feeding HIV+ women.</p>

Objective	Strategies
	<p>2.7 Establish monitoring systems to detect any adverse social effects of VCT and PCT/MTCT services, e.g. violence against HIV+ clients who disclose their serostatus to their partners.</p> <p>2.8 Promote couple counselling for VCT and sex disaggregated VCT services (option of male or female counsellor) where required by the client.</p> <p>2.9 Support the capacity of community groups, NGOs and faith-based organisations to provide nutritional support for HIV+ women and men and their families to enhance their health status.</p> <p>2.10 Encourage men to participate in antenatal clinic activities and, in addition, promote the use of these health centres by men to encourage partner notification and treatment of STI.</p> <p>2.11 Support and encourage faith-based organisations to develop gender sensitive HIV/AIDS policies, strategies and support services that are in line with their beliefs.</p>
<p>Priority Area 3: Mitigation of Social and Economic Impacts</p> <p>Ensure the reduction of social and economic impacts of HIV/AIDS on women and men.</p>	<p>3.1 Assess the gender dimensions of discrimination and stigma related and associated with HIV/AIDS and advocate and create awareness to reduce them.</p> <p>3.2 Empower and create awareness among women and men affected and infected by HIV/AIDS on how to improve their welfare.</p> <p>3.3 Support men in their initiatives to mitigate the social and economic impact of the epidemic as they have the power to positively determine its outcome.</p> <p>3.4 Develop an engendered understanding of both the holistic needs of OVCs and the programmes designed to address their psychological, psychosocial, education and welfare needs.</p>

Objective	Strategies
<p>Priority Area 4: Monitoring, Evaluation and Research</p> <p>Ensure that all gender strategies to have gender sensitive indicators.</p>	<p>3.5 Ensure equal participation of men and women in income generating activities designed to reduce poverty to support for men and women living with HIV/AIDS.</p>
	<p>4.1 Develop appropriate gender-sensitive indicators to measure the impact of all HIV/AIDS interventions.</p>
	<p>4.2 Conduct periodic reviews of the progress achieved in implementing gender-sensitive programmes and disseminate the findings.</p>
	<p>4.3 Allocate adequate resources for research into gender and STI/HIV/AIDS.</p>
	<p>4.4 Monitor resource allocation to all HIV/AIDS programs to ensure an equitable distribution of resources to men, women and children.</p>
	<p>4.5 Address the bio-ethical issues that are related to HIV testing, including those that involve women, infants and the welfare of society.</p>
	<p>4.6 Develop protocols to ensure that all participants in all HIV/AIDS related research, especially vulnerable groups of women and children, have given informed consent and know that their rights are protected.</p>
	<p>4.7 Ensure that all members of the community, especially women, children and marginalised groups, benefit from the findings of the research conducted in Kenya.</p>
<p>4.8 Develop and implement a gender-sensitive surveillance system including disaggregated data collection, processing and dissemination. Include men in national surveillance data collection and national calculations.</p>	

Objective	Strategies
<p>Priority Area 5: Management and Co-ordination</p> <p>Establish gender sensitive policies to ensure that management systems provide an enabling environment for gender mainstreaming.</p>	<p>4.9 Conduct regular gender audits of all HIV/AIDS strategies and programmes.</p> <p>5.1 Develop gender responsive policies for the implementation of HIV/AIDS programmes.</p> <p>5.2 Build the capacity of all institutions including the NACC, line ministries, NGOs, CBOs, FBOs and ASOs to engender HIV/AIDS programmes by providing gender training at all levels.</p> <p>5.3 Establish links and identify mechanisms for collaboration with other partners to share information on effective responses to gender-related HIV/AIDS issues.</p> <p>5.4 Create a referral and networking system to allow monitoring of the coverage and quality of the dissemination of information process.</p> <p>5.5 Engender all NACC budgets to ensure equitable resources are available for all HIV/AIDS initiatives.</p> <p>5.6 Develop simple to use and adaptable gender sensitive curriculum for management training to build capacity for all institutions and sectors.</p> <p>5.7 Build the capacity of the NACC Secretariat to ensure it has gender expertise available to support the engendering process.</p> <p>5.8 Develop a range of tools to support the engendering of the NACC secretariat and programme. These include gender audit tools, a gender equity strategy, a sexual harassment policy in the workplace, and the inclusion of gender within all NACC professional's job descriptions.</p>

6.0 THE WAY FORWARD

On a regular basis the TSG will develop and disseminate Kenya specific guidelines, tools, procedures and methods for rapid gender audit and risk analysis for the integration of gender responsive HIV/AIDS activities in the development plans at national, provincial, district and community levels.

It will establish a system for sustained provision of technical support for planning, implementation and monitoring of gender responsiveness in HIV/AIDS projects, ensuring the full participation of women, men, girls, boys, the disabled and particularly PLWHA.

A Gender and HIV/AIDS curriculum will be developed to communicate the issues clearly and concisely in an adaptable format. This will support the TSG to build the capacity of all institutions including the NACC, line ministries, NGOs, CBOs, FBOs and ASOs at all levels.

The TSG will advocate for and facilitate the rational allocation of resources to groups with activities involving women, men, girls, boys, mothers, orphans, the disabled and PLWHA at national, district and sub-district levels.

The TSG will create a “Popular Version” of this document that highlights the main ideas. It will break down the priority area strategies into specific action plans that include measurable indicators. This new version will be a tool for policy and decision-makers at all levels to use to make these ideas become a reality in practice.

Finally, to address gaps at agency level the groups and experts in the different domains of gender within the TSG, (and in all organisations, in all sectors), must ask themselves the question, “What does Gender mean to you and your organisation?” The answer can be found by using the tool in Annex 1 to conduct a gender analysis in order to determine just how gender-sensitive a program and its components and services really are.

A Tool For Self-Assessment: How gender sensitive are your HIV/AIDS program interventions?

This continuum is a tool to investigate how gender responsive an organisation's services and programs are to gender issues related to HIV/AIDS interventions within the overall rights-based approach. This rapid assessment of programs and staff can determine where your own programs are in the continuum and which components of your programs and services are either not gender sensitive, somewhat gender-sensitive or ideal gender-sensitive. The ones on the left of the continuum (0 - 1) require substantial overhaul that might require external facilitation. Those in the middle (2 - 3) are moving in the gender-sensitive direction and would benefit from an internal commitment to continue growth in the right direction. Those that fall to the right (4 - 5) are model programs and may be able to produce best practices that can be shared as good experiences.

To calculate your HIV/AIDS gender sensitivity score your services from 0 to 5 of these areas.

Non-Gender Sensitive Program

0

1

- Only identifies and targets risk behaviour of females without considering the role of her partner.
- Advocates and teaches condom use irrespective of the context of the prospective user.
- Explains the factual information of the HIV virus.
- Uses fear as a motivation tool, e.g. medical jargon to promote behaviour change.
- Works exclusively on changing risky behaviour with so called "high-risk" populations e.g. commercial sex workers and ID users.
- Exploits traditional gender roles to convince partner to use a condom e.g. to use passive femininity and tricks to win compliance by partner.
- Assumes that asymptomatic women in long-term relationships do not need STI services; STI-symptomatic women are referred to an STI clinic.
- Counsels HIV positive women not to get pregnant.
- Uses a medical model to treat emotional and physical STI/HIV issues.
- Works exclusively with target populations in isolation from other women's groups.
- Encourages condom use and partner notification without recognising potential negative outcomes, such as the woman being abused as a result of condom proposition or HIV status disclosure.

Somewhat Gender-Sensitive Program

2

3

- Identifies risk behaviour of client as well as perception of partner behaviour, e.g. assesses individual needs and sexual practices based on facts and not assumptions.

- Teaches condom negotiation skills, recognising that women often do not have the power to insist on its use.
- Explains transmission of the HIV virus, including a reference to the fact that partner's behaviour can put one at risk.
- Targets sexually active women in general as an "at risk" population, not just women who are seen as part of a "high-risk group".
- Identifies personal practical needs and practical interests to motivate client.
- Teaches and motivates women to use a variety of positive survival strategies to negotiate safer sex.
- Provides confidential STI services to symptomatic women in a non-designated STI setting, e.g. in a family planning clinic.
- Gives information to women about the dangers of perinatal transmission and stresses the importance of condom use to avoid pregnancy and HIV transmission to partners.
- Individual or group counselling used to address specific STI/HIV issues.
- Works with other women's health organisations to better the condition of women by addressing injustices women suffer due to traditional gender bias.
- Helps women think through different scenarios relating to condom negotiation and HIV status disclosure to ensure that the women are involved in the mainstream of decision-making and assisted in making the final decision.

Ideal Gender-Sensitive Program

4

5

- Identifies a broad range of individual and social determinants of vulnerability to HIV. Helps the client to determine current needs through an objective assessment of all needs and practices.
- Builds decision-making and negotiation skills on sexual relations, including condom use and personal needs.
- Explains transmission of the HIV virus and discusses with client her/his specific sexual practices, preferences and sexual orientation to determine one's own individual risk.
- Recognises the contextual issues that render women and men vulnerable and targets those issues that put women at more risk for intervention. Creates enabling environment to help in reducing vulnerability.
- Uses a rights-based approach (the right to be healthy and free of disease, unwanted pregnancy, coercion or violence) as motivation.
- Helps women and men recognise and overcome gender-based abuses and power imbalances that affect ability to make informed decisions and take actions to protect oneself and partner from HIV infection and its consequences.

- Explores risk of STIs and other RH issues, especially Reproductive Tract Infections (RTIs), with all clients in a confidential manner and provide appropriate remedial measure or treatment.
- Helps women to make fully informed and independent choices about their reproductive and sexual lives regardless of their HIV status.
- Provides opportunities for women to dialogue individually and in groups about the factors, which contribute to STI/HIV transmission such as poverty, violence and dependency.
- Works with other social groups, especially women groups, to better women's lives by challenging social constructs that create gender injustices and inequalities.
- Explores gender-based violence (GBV) with all women who come to the clinic for HIV counselling and testing and offers specific services to those women identified as being victims of GBV. Assesses women's risks not only in terms of STI/HIV, but also mental and physical well-being and other reproductive health outcomes, such as unplanned pregnancies.

Total Score _____

Divide your total score by 11 for your gender sensitive score _____

ANNEX 2 TECHNICAL SUB-COMMITTEE ON GENDER (TSG) MEMBER LIST

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DISCLAIMER

This document does not replace the Kenya National HIV/AIDS Strategic Plan for 2000-2005. It is an additional tool for practical use in planning gender sensitive strategies and interventions and will be reviewed on a regular basis.