RESEARCH DOSSIER:
HIV PREVENTION FOR GIRLS AND YOUNG WOMEN
Kenya

This Research Dossier supports the Report Card on HIV Prevention for Girls and Young Women in Kenya produced by the United Nations Global Coalition on Women and AIDS (GCWA). It documents the detailed research coordinated for the GCWA by the International Planned Parenthood Federation (IPPF), with the support of the United Nations Population Fund (UNFPA), United Nations Program on AIDS (UNAIDS) and Young Positives.

The Report Card provides an ‘at a glance’ summary of the current status of HIV prevention strategies and services for girls and young women in Kenya. It focuses on five cross-cutting prevention components:

1. Legal provision
2. Policy context
3. Availability of services
4. Accessibility of services
5. Participation and rights

The Report Card also includes background information about the HIV epidemic and key policy and programmatic recommendations to improve and increase action on this issue in Kenya.

This Research Report is divided into two sections:

PART 1: DESK RESEARCH: This documents the extensive desk research carried out for the Report Card by IPPF staff and consultants based in the United Kingdom.

PART 2: IN-COUNTRY RESEARCH: This documents the participatory in-country research carried out for the Report Card by a local consultant in Kenya. This involved:

Two focus group discussions with a total of 19 girls and young women aged 15-24 years. The participants included girls and young women who are: living with HIV; in/out-of/school; involved in sex work; living in urban and suburban areas; and working as peer activists.

Five one-to-one interviews with representatives of organisations providing services, advocacy and/or funding for HIV prevention for girls and young women. The stakeholders were: a country representative of an international NGO; a nurse at a national NGO focusing on sexual and reproductive health; a counsellor at an NGO/government voluntary counselling and testing centre; a programme officer of a United Nations agency; and a Technical Adviser of an international donor agency.

Additional fact-finding to address gaps in the desk research.
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Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ARVs</td>
<td>Antiretroviral</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>CIA</td>
<td>Central Intelligence Agency</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>IEC</td>
<td>Information, communication and education</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>MTCT</td>
<td>Mother-to-Child Transmission</td>
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<td>PLHA</td>
<td>People living with HIV</td>
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<td>PLWHA</td>
<td>People living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>STD</td>
<td>Sexually transmitted disease</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>UNADS</td>
<td>United Nations Program on AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VCT</td>
<td>Voluntary, Counseling and Testing</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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PART 1:
DESK RESEARCH
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<th><strong>COUNTRY PROFILE</strong></th>
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<tr>
<td><strong>Population below income poverty line of $1 per day (2006):</strong> 46%</td>
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<tr>
<td><strong>AIDS deaths (adults and children) in 2006:</strong> 140 000 [110 000 – 170 000] (UNAIDS Country Situation Analysis – Kenya, (Date accessed 04/04/07))</td>
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</table>
• **Number of children (0-15) living with HIV (ages 0-14 years, 2006):** 150,000 [55,000 – 290,000] (UNAIDS Country Situation Analysis – Kenya)

• **Estimated number of AIDS orphans (0-17 years):** 1,100,000 (UNICEF Kenya Statistics
  [http://www.unicef.org/infobycountry/kenya_statistics.html](http://www.unicef.org/infobycountry/kenya_statistics.html) (Date accessed 04/04/07))

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### PREVENTION COMPONENT 1: LEGAL PROVISION
(national laws, regulations, etc)

#### Key questions:

1. **What is the minimum legal age for marriage?**

   According to the UN Statistics Division the legal age for both men and women to marry is 18 years for both men and women.

   UN Statistics and Indicators on Women and Men (2003)

2. **What is the minimum legal age for having an HIV test without parental and partner consent?**

   18 years for medical procedures. However, Married or pregnant youth; counselor discretion for 15 to 18; 14 and under counseling only; interview parents to protect child.


3. **What is the minimum legal age for accessing SRH services without parental and partner consent?**

   As above question 2.

4. **What is the minimum legal age for accessing abortions without parental and partner consent?**

   18 years for medical procedures. However, Married or pregnant youth; counselor discretion for 15 to 18; 14 and under counseling only; interview parents to protect child.


**Grounds on which abortion is permitted:**

- To save the life of the woman: Yes
- To preserve physical health: Yes
- To preserve mental health: Yes
- Rape or incest: No
Additional requirements:

An abortion must be performed by a certified physician, with the consent of the woman and her spouse. Two medical opinions, one of which must be from the physician who has treated the woman and the other from a psychiatrist, are required before the abortion is performed. The abortion must also be performed in a hospital.


5. Is HIV testing mandatory for any specific groups (e.g. pregnant women, military, migrant workers, and sex workers)?

Many churches are compelling couples to take HIV tests before they wed, but their members are divided as to whether this will help curb the spread of AIDS or perpetuate stigma.


6. Is there any legislation that specifically addresses gender-based violence?

The Sexual Offences Act 2006 includes:
1. There are 14 new offences including gang rape, deliberate infection with HIV/AIDS, trafficking for sexual exploitation, and child pornography.
2. The introduction of minimum sentences.
3. The setting up of a DNA data bank and a paedophile registry.
4. The criminalization of sexual harassment.

(Legislating against sexual violence: The Kenyan Experience, Interview with Hon. Njoki Ndungu Member of Parliament [http://www.choike.org/nuevo_eng/informes/4717.html](http://www.choike.org/nuevo_eng/informes/4717.html) (date accessed on 05/04/07))

7. Is there an AIDS Law – or equivalent – that legislates on issues such as confidentiality for testing, diagnosis, treatment, care and support?

In January 2004 the Kenyan High Court approved an agreement between the government and the Nyumbani Children's Home whereby the Ministry of Education will admit HIV-positive children to government schools


8. Is there any legislation that protects people living with HIV/AIDS, particularly girls and young women, from stigma and discrimination at home and in the workplace?

9. Are sex workers legally permitted to organise themselves, for example in unions or support groups?

In Kenya, the law penalizes women (or men) for selling sex, but not the client for buying. Sex work in Kenya is thus based on a legal double standard. Sex work in Kenya is also based on a sexual double standard. Sex work is illegal and stigmatized.
10. Are harm reduction methods for injecting drug users (such as needle exchange) legal?

Many IDU share needles and syringes as well as having unprotected sex, and have been identified as a 'bridging population', speeding the spread of HIV to the general population. Heroin injection now appears to be occurring in most large towns of Kenya. A study of 336 heroin users in Nairobi, Kenya found that 44.9% were, or had been, injectors.

In Malindi, possession of used needles and syringes can lead to prosecution. Therefore, weighing up the relative risks of misplacing injecting equipment, another person borrowing it or using it because they mistake it for their own, as opposed to the danger of arrest for its possession, leads many injecting drug users (IDU) to decide not to carry injecting equipment on their person. Few IDU buy new equipment each time they use heroin, but conceal needles and syringes in locations where drugs are consumed.

Discussion questions:

- Which areas of SRH and HIV/AIDS responses are legislated for?
- What are the biggest strengths, weaknesses and gaps in legislation in relation to HIV prevention for girls and young women?
- Is action taken if laws are broken (e.g. if a girl is married below the legal age)?
- Is there any specific legislation for marginalised and vulnerable groups? If yes, is the legislation supportive or punitive? And what difference does it make to people’s behaviours and risk of HIV infection?
- To what extent are ‘qualitative’ issues – such as confidentiality around HIV testing – covered by legislation?
- How much do girls and young women know about relevant legislation and how it relates to them? Are there any initiatives to raise awareness about certain laws?
- Overall, how is relevant legislation applied in practice? What are the ‘real life’ experiences of girls and young women? What difference does it make to their vulnerability to HIV infection?
- How do the effects of legislation vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?

PREVENTION COMPONENT 2: POLICY PROVISION
(national policies, protocols, guidelines, etc)

Key questions:

11. Does the current National AIDS Plan address the full continuum of HIV/AIDS strategies, including prevention, care, support and treatment?

The KNASP 2005/06-2009/10 is founded on a set of core principles, which reflect the common values of all stakeholders in the national response. These core principles determine the priorities of the strategy, the design of interventions, and the approach to implementation. The core principles are explicitly reflected where possible in the results framework for the strategy; and should be implicit in all areas of the national response. The core principles are:

1 Examples include: people living with HIV/AIDS, sex workers, injecting drug users, migrant workers, refugees and displaced people, street children, school drop-outs, lesbians and ethnic minorities.
Multi-sectoral approach, including the development of strategic partnerships and mainstreaming HIV/AIDS in all key sectors;
- Targeting vulnerable groups;
- Focus on gender and youth;
- Maximum engagement of PLWHA in the implementation of the strategy;
- Evidence-based interventions;
- Empowered, participatory approach; and
- Support to regional and international initiatives.

This section describes these core principles, explains why they are important to the KNASP, and sets out how the principles are operationalised

(KNASP 2005/06-2009/10

Kenya implemented the multicultural response to HIV/AIDS through its first multicultural Strategic Plan for years 2000-2005. The priority areas identified were:
- prevention and advocacy;
- treatment, continuum of care, and support;
- mitigation of the socio-economic impact;
- monitoring, evaluation, and research;
- Management and coordination.

The KNASP (Kenya National AIDS Strategic Plan) 2000-2005 also emphasized greater involvement of the civil and private sector organizations. The KNASP 2005/6-2009/10 was developed through participatory and all-inclusive approaches, and its goal is to reduce the spread of HIV, improve the quality of life of those infected and affected, and mitigate the socio-economic impact of the epidemic. Three priority areas will be Prevention of New Infections; Improve the Quality of Life; and, Mitigation of Socio-economic Impact


The mandate of the National AIDS Control Council is:
To provide policy and a strategic framework for mobilizing and coordinating resources for prevention of HIV transmission and provision of care and support to the infected and the affected in Kenya

Strategic Objectives of KNASP 2005/6 – 2009/10 are:
- Prevention of new infection
- Improvement of the quality of life foe the infected and affected
- Mitigation of the socio-economic impact of AIDS
- Provision of support services


Kenya has developed a National HIV/AIDS M&E Framework based upon the 3 ones principles - one agreed AIDS action framework that provides the basis for coordinating the work of all partners, one national AIDS Coordinating authority with a broad-based multisectoral mandate, and one agreed country level Monitoring and Evaluation system. The goal of the National HIV/AIDS Monitoring and Evaluation Framework is, therefore, to guide collection, analysis, use, and dissemination of information that enables the tracking of progress made in response to HIV/AIDS and enhances informed decision-making. The Framework provides an environment for inclusion of new fresh ideas on Monitoring and Evaluation and improvement of indicators in line with efforts done by experts and organizations working on Monitoring and Evaluation of HIV/AIDS.

The National HIV/AIDS M&E Framework provides stakeholders with a tool for well coordinated, interlinked and functional HIV/AIDS M&E systems that allow them to efficiently assess how well HIV/AIDS interventions are contributing to achieving the national programme goals.


12. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of girls and young women?

The Total War Against HIV/AIDS (TOWA) project prioritizes proposals and activities targeting the following vulnerable groups:

- Commercial sex workers
- Orphans and vulnerable children
- Migrant workers
- Women and youth
- Workers in small and medium-sized enterprises, micro-enterprises, and the informal sector
- People living with disabilities

(NACC Restructured to Meet its Mandate, Journal for National AIDS Control Council (Sept-Dec 2005) [http://www.nacc.or.ke/downloads/nacc_restructured.pdf](http://www.nacc.or.ke/downloads/nacc_restructured.pdf) (date accessed on 05/04/07))

KNASP strategies for preventing HIV infection among young people include:

- carefully targeted prevention messages: most young people have heard of HIV/AIDS but, for example, only 53% of young women and 60% of young men aged 15-24 know that condoms reduce the risk of contracting HIV (KDHS 2003);
- youth friendly access to HIV and reproductive health information and other services;
- mobilizing the education system to provide comprehensive prevention and care for youth in school;
- improving girls’ access to education and skills training, and protecting their rights;
- building partnerships with youth-based organisations.


13. Does the National AIDS Plan specifically address the HIV prevention and SRH needs of marginalised and vulnerable groups, including people who are living with HIV/AIDS?

The concept of vulnerability lies at the core of the KNASP strategic approach. The KNASP aims to extend the analysis and understanding of vulnerability to both infection and impact; and engage with and meet the needs of newly identified vulnerable groups in the national response.

**Discordant couples**

Discordant couples are couples in which the HIV status of the two partners is different. The HIV negative partner in a discordant couple is very vulnerable to infection. It is estimated that over 400,000 married couples in Kenya are HIV discordant. The KNASP advocates for couple testing and counseling, and the provision of information and education on reproductive rights and preventing Infection in discordant couples.

**Commercial sex workers (CSW)**

The sex industry is one of the key factors driving the spread of HIV infection. Targeting HIV interventions at commercial sex workers (CSW) and their clients presents several challenges: many CSW have a highly migratory lifestyle which makes targeting difficult; CSW clients operate in secrecy and do not wish to be identified. The KNASP supports the development of HIV/AIDS prevention, treatment and care strategies for CSW and their clients.

**Orphans and vulnerable children (OVC)**

It is estimated that 11% of children under 15 years in Kenya are orphans, defined as having lost one or both parents (KDHS 2003), compared with 9% in 1998. Nationally, 2% of children under 15 are “double orphans”; that is, have lost both natural parents. However, there is considerable regional
variation; the highest rate of double orphans is 6% in Nyanza province, which also has the highest HIV prevalence rate (around double the national average). It is estimated that around half of all orphans in Kenya are attributable to parental AIDS deaths.

Community structures for caring for orphans are over-stretched and cannot adequately absorb the increasing numbers of orphans. The social and economic impact of HIV/AIDS on communities and families further weakens the social system for caring for orphans.

Key issues addressed by KNASP 2005/06-2009/10 include:
- strengthening social mechanisms for orphan care;
- ensuring OVC access to social services – food/nutrition, education, health, shelter and social support;
- strengthening the legal and policy framework for protecting the rights of OVC; and
- strengthening the framework for monitoring and coordinating interventions which support and protect the rights of OVC.

**Migrant workers**
Separation from regular partners make migrant workers vulnerable to contracting HIV by seeking occasional sex from different partners. Workers at high risk include long distance truck drivers and workers in the agricultural, tourism and fishing industries. The KNASP seeks to develop innovative HIV/AIDS prevention, treatment and care strategies for targeting migrant workers; and mainstream HIV/AIDS in the sectors serving migrant workers.

**Uniformed services**
A high proportion of uniformed service personnel (the military, police and similar agencies) are young men living away from their regular partners, often having a higher income than local populations, with many opportunities for casual sex. The KNASP seeks to develop innovative HIV/AIDS prevention, treatment and care strategies for targeting the uniformed services; and mainstream HIV/AIDS in relevant sectors.

**Survivors of rape and sexual violence**
Rape and sexual violence expose both the perpetrators and the victims to the risk of contracting HIV. Key issues addressed under the KNASP 2005/06-2009/10 include:
- strengthening the capacity of the police and health care system, including the private sector, to provide prompt services to victims of rape and sexual violence;
- strengthening the provision of post exposure prophylaxis services in the country;
- developing strategies to fight stigma associated with rape.

**Other vulnerable groups**
Other groups, which have been identified as particularly vulnerable to infection, include injecting drug users (IDUs) and men who have sex with men (MSM). Members of both these groups have a very high risk of becoming infected, and also of passing infection to the general population. The KNASP will develop specific strategies to address the HIV prevention and other HIV-related needs of these groups.

(KNASP 2005/06-2009/10

14. Does the National AIDS Plan emphasise confidentiality within HIV/AIDS services?
Not explicitly but it does state that of the findings of the KNASP 2000-2005 evaluation was that there was a lack of professional counseling at VCT sites and generally that health workers have poor attitudes and are in most cases unhelpful while serving people living with HIV/AIDS.

(KNASP 2005/06-2009/10

15. Does the national policy on VCT address the needs of girls and young women?
Thirty-five MPs are expected to publicly take HIV/AIDS tests to know their status, The Standard has
established. The MPs, under the umbrella of the Kenya Young Parliamentarians Association, are doing this as part of a campaign to encourage the youth to go for voluntary counseling and testing.


One of the findings of the KNASP 2000-2005 evaluation was that there was a lack of professional counseling at VCT sites and generally that health workers have poor attitudes and are in most cases unhelpful while serving people living with HIV/AIDS.

Counselling and testing is a key sexual behaviour change strategy. Individuals who test HIV negative are motivated to guard their sero-status, while those that test HIV positive can be counseled on how to protect their partners from infection, and be referred for ART where appropriate. KNASP 2005/06-2009/10 focuses on scaling up voluntary counselling and testing services in the country as a key HIV infection prevention strategy. The quality of services provided through VCT, including testing, counselling and referral of those testing positive constantly strengthened. Interventions include direct capacity building, such as training and provision of test kits, and the establishment of a national VCT quality assurance framework. KNASP seeks to achieve equity in the provision of VCT services by ensuring that there is at least one VCT centre in each administrative division in the country. The VCT communication strategy plays a key role in ensuring increased VCT uptake. The communication strategy is focused and targeted at those at high risk of contracting HIV. The strategy is used to raise awareness about the issue of discordant couples and encourage couples to seek testing and counselling services. In addition to VCT, the diagnostic testing and counseling policy is meant to lead to an accelerated increase in the number of people tested for HIV in the clinical setting.


16. Does the national protocol for antenatal care include an optional HIV test?

Prevention of mother-to-child transmission (PMCT) services are currently provided in about 400 antenatal clinics (ANC) in Kenya. KNASP 2005/06-2009/10 seeks to expand PMCT services countrywide to increase access to ARV for HIV positive pregnant mothers from 10% to at least 50% and reduce the proportion of HIV positive babies born to HIV positive mothers from 33% to below 23%. Expansion of the PMCT+ programme is meant to ensure that HIV positive mothers continue to receive ARV after giving birth.


17. Does the national protocol for antenatal care include a commitment that any girl or young woman testing HIV positive should be automatically offered PMTCT services?

The PMTCT section of Isiolo’s District Hospital has seen a 10 fold increase in the number of women attending in the last 2 years


Since the Germany based manufacturer, Boehringer Ingelheim, offers nevirapine (brand name: Viramune) free of charge for the indication of PMTCT for a period of five years to all developing countries who meet certain conditions, a collaboration was established.

A comprehensive PMTCT - Project using nevirapine was started in 2001 in selected sites in Kenya, Tanzania and Uganda. The Project includes the implementation of an antiretroviral treatment programme for mothers participating in the PMTCT - Programmes, their children and partners. The PMTCT - Project is meant to assist the partner countries in establishing the necessary infrastructure to offer low-cost measures for reduction of mother-to-child transmission of HIV. The Programmes are strictly integrated into the existing health services. All activities are conducted in accordance with the
national PMTCT strategies and under information exchange with international and national organisations and institutions active in PMTCT interventions.

The main components of the project are:
- Sensitization of the general and the target population
- Continuous support and training of the health personnel
- Improvement of infrastructure in the intervention sites
- Implementation of voluntary counseling and testing services (VCT)
- Procurement of reagents, supplies, test kits, drugs
- Offer of nevirapine, infant feeding counseling and replacement feeding, if wanted.
- HAART for mothers, their children and partners (WHO quality)
- Implementation of a monitoring and evaluation system
- Accompanying research

About 9,000 pregnant women attend antenatal care services of the four sites (that the project covers) annually. The HIV prevalence among pregnant women is about 26%.


One of the findings of the KNASP 2000-2005 evaluation was that PMTCT activities are too confined to big hospitals in urban areas.

Prevention of mother-to-child transmission (PMTCT) services are currently provided in about 400 antenatal clinics (ANC) in Kenya. KNASP 2005/06-2009/10 seeks to expand PMTCT services countrywide to increase access to ARV for HIV positive pregnant mothers from 10% to at least 50% and reduce the proportion of HIV positive babies born to HIV positive mothers from 33% to below 23%. Expansion of the PMCT+ programme is meant to ensure that HIV positive mothers continue to receive ARV after giving birth.


18. Is there a national policy that protects the rights and needs - including HIV prevention, SRH services, employment opportunities and education - of young women or girls at risk or affected by early marriage?

Married adolescent girls and young women have higher rates of HIV prevalence than their sexually active unmarried counterparts. Early marriage increases coital frequency, decreases condom use, and virtually eliminates girls’ ability to abstain from sex. Furthermore, husbands tend to be older than partners of single girls, HIV prevalence rates found among the husbands are much higher than those found among the unmarried girls’ partners.

Common HIV prevention messages encourage young girls to abstain from sex, reduce their number of partners, or use condoms, even though for most married girls these strategies are impractical, if not entirely impossible.

Could increasing the age at marriage help delay age of sexual debut and reduce the overall HIV risks for adolescents? Since selection of an HIV-negative spouse is nearly essential for avoiding HIV after marriage, might younger, sexually inexperienced grooms be considered more attractive or might counseling and testing for HIV become part of the marriage process? Can the development of new technologies such as non-contraception microbicides or the promotion of new social behaviors such as delaying the first birth after marriage help resolve the currently conflicting goals of becoming pregnant and avoiding HIV?

(Harris School Working Paper Series 04.06, Early Marriage and HIV Risks in Sub-Saharan Africa, Shelley Clark http://harrisschool.uchicago.edu/about/publications/working-papers/pdf/wp_04_06.pdf (date accessed on 17/04/07))

19. Is HIV prevention within the official national curriculum for both girls and boys?
The Government of Kenya recently implemented its HIV/AIDS Prevention Education curriculum, focusing on prevention education in upper primary and middle schools. It is hoped that the lessons learned will help the adolescents formulate health “best” practices that will keep them free of HIV as become sexually-active adults.

In addition to designing the curriculum and developing textbooks, the Ministry of Education is providing in-service training to teachers on delivering the HIV/AIDS curriculum.

But due to the budget constraints the teacher-training program is being randomly phased-in over several years, creating an opportunity to rigorously evaluate the effectiveness on behavioral change of large-scale school-based AIDS prevention education efforts.

In partnership with the Abdul Latif Jameel Poverty Action Lab at MIT (J-PAL), IPA is conducting an evaluation of the effectiveness of Kenya’s teacher training and curriculum, and to comparing to alternative ways of reducing risky behavior among schoolchildren, notably reducing the cost of education to keep children in school longer, encouraging structured discussions of condoms among peers, and discouraging teenagers from engaging in high-risk partnerships.

In close collaboration with the Ministry of Education and International Child Support Africa, a non-governmental organization based in Kenya, the IPA and J-PAL designed a large-scale impact evaluation involving 351 primary schools in Western Province, Kenya. The evaluation has two main components: First, in 175 randomly chosen schools, the Ministry trained three teachers on (a) how to incorporate the curriculum into their classes and (b) how to run student health clubs (and also provided startup funds for the clubs). Second, in another 174 schools chosen at random (87 from among the 175 schools participating in the HIV training and 87 from among the 176 remaining schools), the program helps girls stay in school longer by paying for their mandatory school uniforms. These cost about US$6, a non-trivial expense in a country where the per capita GDP is US$360, and a substantial part of the population subsists on less than US$1 a day. Overall, more than 20,000 uniforms were distributed.

The evaluation also examines three other school-based interventions: promoting critical thinking and developing life skills among adolescents; awareness campaign on the risks of cross-generational sex; and introducing HIV/AIDS question drop boxes on the school compound, to encourage students to ask questions anonymously.

Data collection efforts has included: 1) self-reported data, collected through focus group discussions and knowledge, attitudes and practices questionnaires administered to students and teachers, and 2) quantitative measurement of risky behaviors in the target population, namely, childbearing rates among teenage girls.

The use of childbearing rates as a proxy for risky sexual behavior was a major innovation, as childbearing rates provide more objective data than self-reported sexual behavior, and data on childbearing can be collected very cheaply and less intrusively than HIV statistics. Overall, IPA and J-PAL team has been successfully following up the schooling progress, self-reported sexual behavior, and childbearing outcomes of more than 70,000 pupils in 328 primary schools.

This study started in July 2002 and will end in July 2006. At the beginning, IPA and J-PAL organized a conference for key stakeholders in the government, civil society, communities and international partners to discuss the purpose, design, content, methodology, and implementation plan of the evaluation and its importance to the government’s HIV/AIDS prevention policy. Every year, IPA and J-PAL prepare interim reports, and holds an operational consultation with representatives from the Kenyan Government, the World Bank, and representatives from NGOs and international organizations engaged in the fight against HIV/AIDS in East Africa. The final results will be ready for publication and dissemination by July 2007. At that time, a major conference will be held in Nairobi.

The IPA and J-PAL team has held an operational consultation after each round of data collection to review the program design and adjust or revise the evaluation tools if needed. This high level of integration ensures that the findings of the evaluation are directly available for policymakers in the Kenyan government. To enable them to truly combine scientific rigor with local knowledge and experience and enhance the quality of the collaboration, IPA and J-PAL trained ICS staff on a day-to-day basis in the methodology of randomized evaluation and the related skills of designing surveys, data collection, data management, and so on, thereby building a local monitoring and evaluation team from the ground by hiring and training locals. The Monitoring and Evaluation Team of International Child Support Africa (ICS) now has 70 members, including operations managers, surveyors, and data quality assurance specialists, whose expertise has been instrumental in the
success of the project.

We found that:
1) After two years, teacher training increased students’ tolerance toward people with HIV/AIDS
2) Girls exposed to the program were more likely to be married to the fathers of their children
3) The program had little other impact on students’ knowledge, attitudes, and behavior, or on the incidence of teen childbearing
4) The condom debates and essays increased practical knowledge and self-reported use of condoms without increasing self-reported sexual activity
4) Reducing the cost of education by paying for school uniforms reduced dropout rates, teen marriage, and childbearing.


20. Is key national data about HIV/AIDS, such as HIV prevalence, routinely disaggregated by age and gender?

Yes.


Discussion questions:

- To what extent are relevant bodies – such as the Ministry of Education, NGO networks, religious organisations, etc – engaged in policy-making around HIV prevention for girls and young women?
- To what extent do those bodies work in partnership or in isolation? What areas of HIV prevention responses (e.g. behaviour change, counselling, treatment, home-based care) have national protocols or guidelines?
- To what extent do those protocols address the needs of girls and young women, including those that are marginalised and vulnerable?
- What does school-based sex education cover? Does it help to build young people’s confidence and skills, as well as knowledge?
- To what extent do policies help to reduce stigma and discrimination? For example, do they encourage people to stop using derogatory language or ‘blaming’ specific groups for HIV/AIDS?
  o To what extent are different areas of policy provision – such as for HIV/AIDS and antenatal care – integrated or isolated?
  o What policy measures exist in relation to consent, approval and confidentiality? For example, can girls and young women access services such as VCT without having to notify their parents and/or partner? And are they informed of their right to confidentiality?
- Overall, how are relevant policies applied in practice? What are the ‘real life’ experiences of girls and young women? How much do they know about them and how they relate to them? What difference do these policies make to their vulnerability to HIV infection?
- How do the effects of policies vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?
## PREVENTION COMPONENT 3: AVAILABILITY OF SERVICES

(number of programmes, scale, range, etc)

<table>
<thead>
<tr>
<th>Key questions:</th>
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<tbody>
<tr>
<td>21. Is there a national database or directory of SRH and HIV/AIDS services for young people?</td>
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</table>

*Integrating STI diagnosis and treatment into relevant health services increases opportunities for case detection and follow up on treatment. Most commonly, clients seeking health care specifically for symptoms of STIs are seen in a general outpatient department (OPD). Less commonly, there are specific STI services including STI screening and treatment or service areas.*


<table>
<thead>
<tr>
<th>22. How many SRH clinics or outlets are there in the country?</th>
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</table>

*Integrating STI diagnosis and treatment into relevant health services increases opportunities for case detection and follow up on treatment. Most commonly, clients seeking health care specifically for symptoms of STIs are seen in a general outpatient Department (OPD). Less commonly there are specific STI services including STI screening and treatment or service areas. Essentially therefore there is no catalogue or Directory specifically for SRH clinics or outlets.*


Nationally there are 20 youth centres that provide adolescent reproductive health services.

(List of Available Youth centres per province, 2007; Division Of Reproductive Health Ministry of Health, Nairobi, Kenya)

<table>
<thead>
<tr>
<th>23. At how many service points is VCT available, including for young women and girls?</th>
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- Integrating family planning and VCT services is expected to allow more comprehensive service provision, expand access to services, and make services more cost-effective.
- Research demonstrating the feasibility of integrating family planning into VCT centers has led the government of Kenya to develop a national integration strategy.
- The new strategy highlights four potential levels of integration, each contingent on available resources at individual facilities.
- Government leadership, an effective task force, and stakeholder commitment have facilitated the development and implementation of the strategy.


One of the constraints on the KNASP 2000-2005 was inadequate VCT sites.

<table>
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<tr>
<th>24. Are male and female condoms available in the country?</th>
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Condom use remains a key methodology for prevention of HIV and other STIs. KNASP continues to

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2 (Refers to the full range of SRH and HIV/AIDS services relevant to girls and young women. These include antenatal care, STI information and treatment, HIV prevention, condoms, VCT and other counseling, positive prevention, treatment of opportunistic infections, care and support, treatment (including ARVs), skills building, economic development, etc.)
promote correct and consistent condom use among the general population and those at higher risk of HIV infection. Social marketing programmes will be expanded to enhance availability and affordability of condoms particularly in high-risk locations. An accelerated condom distribution programme currently implemented in 4 provinces will be expanded to cover all provinces, supported by an IEC strategy targeting vulnerable groups. KNASP also supports the distribution of female condoms as a means of empowering women to choose safer sex.

The target for 2010 is to have 160 million condoms distributed annually. Condom use at most recent high-risk sex in 15-24 age range at least 40% for women, 65% for men At least 85% of women and 85% of men in age range 15-24 correctly identify ways of preventing sexual transmission of HIV/AIDS

(KNASP 2005/06-2009/10

25. Is a free HIV test available to all pregnant girls and young women who wish to have one?

VCT sites located within public health facilities provide testing and counselling services free of charge for anyone willing to be tested. However, an affordable fee can be charged to enhance sustainability of VCT services; but the fees must be approved by the facility management- the District Health Management Board (DHMB) and the District AIDS Committee (DAC) guided by the National policies. Stand alone VCT sites may charge a fee if approved by the agency running the site. The fee must be posted clearly so that clients visiting the site know in advance what they are expected to pay. If a fee is charged measures such as free days should be put in place so that clients who are unable to pay can access service. Counsellors should be able to waive fee is they determine that client is unable to pay, but there will be personal or public health benefit if test is provided. The District Health Management Board and The District AIDS committee should discourage overcharging in such sites.

(Ministry of Health Kenya (MOH), National AIDS and STIs Control Programme (NASCOP); 2001 National Guidelines for Voluntary Counselling and Testing. MOH, NASCOP Nairobi Kenya. Pg. 13. (Date Accessed 6/07/07))

26. At how many service points are PMTCT services (such as nevirapine) available for pregnant ls or young women who are HIV positive?

Mother to child transmission (MTCT) accounts for an estimated 10% of HIV infections in Kenya. Of the 5,170 facilities that provide ANC services, 1,090 include PMTCT services.


There are currently 2,000 access points for PMTCT services in Kenya. They keep on increasing as programmes and facilities expand their programmes.

(National AIDS and STIs Control Programme (NASCOP), 2007 Quarterly Report of PMTCT services)

Prevention of mother-to-child transmission (PMCT) services are currently provided in about 400 antenatal clinics (ANC) in Kenya. KNASP 2005/06-2009/10 seeks to expand PMCT services countrywide to increase access to ARV for HIV positive pregnant mothers from 10% to at least 50% and reduce the proportion of HIV positive babies born to HIV positive mothers from 33% to below 23%. Expansion of the PMCT+ programme is meant to ensure that HIV positive mothers continue to receive ARV after giving birth.

(KNASP 2005/06-2009/10

27. At how many service points are harm reduction services for injecting drug users available?
Currently listed service points on the National Campaign Against Drug Abuse In Kenya (NACADA) website include the following organizations:

ALCOHOLICS ANONYMOUS (AA)
It is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. It is self-supporting group, where the only membership is a desire to stop drinking. It is both a fellowship for alcoholics and a method for treating alcoholism. To its members, it is the first way back to life and then a design for living. To those outside it, it has often been simply a miracle.
AA Helpline: 020-784654

1. REDHILL PLACE, LIMURU
   REDHILL PLACE It provides treatment and counselling services for alcohol and drug dependency. It is a residential treatment centre providing primary and extended care for all addicts. It is situated near Green Acres School, 5km off Limuru Road.
   P.O. Box 8667-00100 Nairobi,
   Tel: 0722-714300, 0733-805510, 0722-837627,(020) 2721498, (020) 2721513
   Website: www.ikenya.ws/redhillplace
   mail:tnngigi2000@yahoo.com.

2. Asumbi Treatment Centres: Homa Bay and Karen (Nairobi)
   ASUMBI Treatment Center is located next to Asumbi Teachers College in Rangwe division, Hama Bay District, Nyanza Province, 24 km from Kisii town and 27 km from Homa Bay town along the murram road of Suneka to Rodi Kopany.
   P.O. Box 40309 Asumbi, Kenya,
   Tel 0733-901657, 0721538141,
   Office - 0733- 443836.
   website:www.asumbitc.org
   Email: asumbitc@yahoo.com

3. MEWA REHAB MOMBASA
   MEWA Located in Mombasa town offering six months in-patients treatment to male heroin addicts only.
   P.O. Box 89427 Mombasa,
   Telephone: 0722448576/0722 796287/0721608980
   email: aswabir@yahoo.com.

4. REACH OUT REHABILITATION CENTRE
   REACH OUT REHABILITATION CENTRE located at Kanamai, Kilifi District. Offers a mandatory six months treatment to male heroin addicts only.
   P.O. Box 34211 Mombasa,
   Telephone: (041) 473599/ 0722-415475
   email: reachout977@yahoo.co.uk

5. BRIGHTSIDE
   BRIGHTSIDE Drug Abuse Treatment and Rehabilitation Center, situated in Kitsuru, Nairobi is a residential facility for detoxification, treatment and rehabilitation for alcohol and substance abuse.
   P.O. BOX 341262 Nairobi,
   Tel 020- 339744, 0722847130.

6. OMARI REHAB MALINDI
   The OMARI PROJECT is a Drug abuse Treatment and Rehabilitation Center for heroin addicts. The centre is located in Malindi town and offers six months mandatory in-patient treatment for male and female clients. A patient is admitted only after he/she has undergone rigorous assessment test.
   P.O. Box 438, Watamu, Tel: (042) 31602 or 0733 59 1434 or 0733 233147
email: theomariproject@yahoo.co.uk

7. MATHARE HOSPITAL
   TEL: 3764644

8. Kenyatta Hospital
   P.O. Box 20723, Nairobi
   254-20-2726300-19

9. REACH OUT REHABILITATION CENTRE
    Located at Kanamai, Kilifi District. Offers a mandatory six months treatment to male heroin
    addicts only.
    P.O. Box 34211 Mombasa
    Tel: 041 - 473599, 0722415475
    Email: reachout977@yahoo.co.uk

10. CHIROMO LANE MEDICAL CENTER (NAIROBI)
    Muthithi / Chiromo Lane
    Tel: 020 – 3749979

(NACADA website - http://www.nacada.go.ke/helpcentres.php (Date accessed 9/07/07))

IDUs are not in the high priority vulnerable groups in Kenya and therefore services are scarce if not
non-existent. However, they do state that other groups, which have been identified as particularly
vulnerable to infection, include injecting drug users (IDUs) and men who have sex with men (MSM). Members of both these groups have a very high risk of becoming infected, and also of passing
infection to the general population. The KNASP will develop specific strategies (no mention of what
these specific strategies are though) to address the HIV prevention and other HIV-related needs of
these groups.

(KNASP 2005/06-2009/10

28. Are there any specific national projects (such as camps, conferences, and training
courses) for boys/girls and young people living with HIV/AIDS?

The Kenya National HIV/AIDS Strategic plan 2005/6 – 2009/10 has set out clear plans for targeting
youth with prevention strategies. To what extent this has been implemented requires more
investigation.

(The Kenya National HIV/AIDS Strategic Plan 2005/6 – 2009/10 A Call on action,
National AIDS Control Council, Nairobi, Kenya. Pg.16)

29. At how many service points are ARVs available to people living with HIV/AIDS?

As part of the (recent) restructuring exercise, NACC has strengthened the role of District Technical
Committee to oversee the implementation of programmes at the community level and provide
technical support to the constituency AIDS control committees.

(NACC Restructured to Meet its Mandate, Journal of national AIDS Control Council (Sept
– Dec 2005) http://www.nacc.or.ke/downloads/nacc_restructured.pdf (date accessed on
13/04/07))

30. Are there specific positive prevention services, including support groups, for young
    women and girls living with HIV/AIDS?

Discussion questions:
What scale and range of HIV prevention services is available for girls and young women? For example, do programmes go beyond ‘ABC’ strategies? Do programmes cover social issues (e.g. early marriage)?

To what extent are SRH, HIV/AIDS and broader community services integrated and able/willing to provide referrals to each other? For example, could most SRH clinics refer a girl testing HIV positive to a support group for people living with HIV/AIDS?

To what extent are HIV prevention services available through ‘non-traditional’ outlets (e.g. religious organisations, youth clubs)?

Are there community programmes on gender awareness/dialogue for girls/boys and young women/men? Do they explore power differences and social ‘norms’ for sexual behaviour? Is there mentoring, peer support and economic development that targets females?

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.

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 harmonize conflicting statements in customary, common and statute laws.


Under KNASP 2000-2005, a Gender and HIV/AIDS Technical Sub-Committee was formed to develop strategies for mainstreaming gender in the national strategy. The committee completed a comprehensive analysis of the gender gaps in the KNASP and developed a strategy for mainstreaming HIV/AIDS in KNASP in 2002. This strategy provides a framework for integrating...
gender sensitivity into the HIV/AIDS response, which is fully applicable to KNASP 2005/06-2009/10:

- ensure all prevention and advocacy strategies and programmes are gender sensitive in order to reduce the vulnerability and risk of women and men;
- promote health and quality of life for women and men infected and affected by HIV/AIDS;
- reduce the negative social and economic impact of HIV/AIDS on women and men;
- measure the success of engaged HIV/AIDS programmes;
- establish gender sensitive policies to ensure that management systems provide an enabling environment for gender mainstreaming; and
- protect the rights of women and men affected and infected by HIV/AIDS.


IPPF’s Male Involvement Project specifically targets men to change men’s attitudes and behaviour so that they will use condoms both for family planning and STI/HIV/AIDS protection, support their partner’s use of family planning, and encourage better communication between husband and wife on SRH issues. A more understanding attitude among men may liberate women to use contraception without fear or shame.

(The Male Involvement Project, Family Planning Association of Kenya (FPAK) http://www.ippf.org/NR/rdonlyres/269F5E8E-CCE3-4280-9133-CFAF671B82FD/0/kenya.pdf (date accessed on 18/04/07))

How available is prevention information and support for girls and young women living with HIV/AIDS?

How available are HIV prevention ‘commodities’ (e.g. condoms)? How are they distributed?

- How much do girls and young women know about the availability of services, such as where to get condoms or ARVs?
- Overall, what does the availability of HIV prevention services mean in practice? What are the ‘real life’ experiences of girls and young women? What difference do these services make to their vulnerability to HIV infection?
- How do the effects of availability vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?

PREVENTION COMPONENT 4: ACCESSIBILITY OF SERVICES
(location, user-friendliness, affordability, etc)

Key questions:

31. Are all government HIV prevention and SRH services equally open to married and unmarried girls and young women?

Anyone 18 years and above should be considered able to give full consent for voluntary counselling and testing for HIV. Young people under 18 years old, married, pregnant, parents, who engage in behaviour that puts them at risk or are child sex workers, should be considered “mature minors” who can give consent for VCT. Counsellors should make an independent judgement of this age category to access VCT services. Testing of minors under 18 years old should be done with the knowledge and full participation of their parents or guardians.

(Ministry of health (MOH), National AIDS and STIs Control Programme (NASCOP); 2001 National Guidelines for Voluntary Counselling and Testing. MOH, NASCOP, Nairobi Kenya. Pg.15 (Date Accessed 6/07/07))

32. Are all government HIV prevention and SRH services equally open to girls and young
women who are HIV positive, negative or untested?

Anyone 18 years and above should be considered able to give full consent for voluntary counselling and testing for HIV. Young people under 18 years old, married, pregnant, parents, who engage in behaviour that puts them at risk or are child sex workers, should be considered “mature minors” who can give consent for VCT. Counsellors should make an independent judgement of this age category to access VCT services. Testing of minors under 18 years old should be done with the knowledge and full participation of their parents or guardians.

Ministry of health (MOH), National AIDS and STIs Control Programme (NASCOP); 2001 National Guidelines for Voluntary Counselling and Testing. MOH, NASCOP, Nairobi, Kenya. Pg.15 (Date Accessed 6/07/07)

33. Are VCT services free for girls and young women?

VCT sites located within public health facilities provide testing and counselling services free of charge for anyone willing to be tested. However, an affordable fee can be charged to enhance sustainability of VCT services; but the fees must be approved by the facility management - the District Health Management Board (DHMB) and the District AIDS Committee (DAC) guided by the National policies.

Stand-alone VCT sites may charge a fee if approved by the agency running the site. The fee must be posted clearly so that clients visiting the site know in advance what they are expected to pay. If a fee is charged measures such as free days should be put in place so that clients who are unable to pay can access service. Counsellors should be able to waive fee if they determine that client is unable to pay, but there will be personal or public health benefit if test is provided. The District Health Management Board and The District AIDS committee should discourage overcharging in such sites.

(Ministry of Health Kenya (MOH), National AIDS and STIs Control Programme (NASCOP); 2001 National Guidelines for Voluntary Counselling and Testing. MOH, NASCOP Nairobi Kenya. Pg. 13. (Date Accessed 6/07/07))

34. Are approximately equal numbers of females and males accessing VCT services?

There are gender disparities with regard to uptake of VCT services with 56% of clients accessing VCT services over the period between year 2001 and year 2004 being Male. A look at age cohorts shows more men using VCT services. The only age where the gap between males and females is narrow is 15 yrs to 19 yrs which is an encouraging development.

(UNAIDS Kenya, the Global Coalition on Women and AIDS; 2006: Access and Barriers to HIV Information and Services for Girls and Young Women in Kenya, UNAIDS Nairobi, Kenya. pg.19)


35. Are STI treatment and counselling services free for all girls and young women?

Over the years the government has invested heavily in STI prevention and treatment. STI treatment using the syndromic approach is available free is available free of charge in government public health facilities


36. Are condoms free for girls and young women within government SRH services?

Condom social marketing, used to prevent HIV transmission among those who are sexually active, expanded in 2003. Sales of socially marketed condoms grew 12% to almost 20 million, averting an estimated 45,000 new HIV cases and complementing the public sector distribution of almost 64
Condom use remains a key methodology for prevention of HIV and other STIs. KNASP continues to promote correct and consistent condom use among the general population and those at higher risk of HIV infection. Social marketing programmes will be expanded to enhance availability and affordability of condoms particularly in high-risk locations. An accelerated condom distribution programme currently implemented in 4 provinces will be expanded to cover all provinces, supported by an IEC strategy targeting vulnerable groups. KNASP also supports the distribution of female condoms as a means of empowering women to choose safer sex.

(KNASP 2005/06-2009/10
2010_Final_Report.pdf (date accessed on 17/04/07))

37. Are ARVs free for all girls and young women living with HIV/AIDS?

As of June 2006 ARVs are free to everyone that needs them.

(Kenya to provide free Aids drugs http://news.bbc.co.uk/1/hi/world/africa/5040240.stm
(date accessed on 18/04/07))

38. Are issues relating to HIV/AIDS stigma and discrimination included in the training curriculum of key health care workers at SRH clinics?

KNASP 2005/06 – 2009/10 has the aim of 50% of health workers in each health facility trained on PMTCT by June 2006 and 75% of health workers in all health provider institutions sensitised on developing positive attitude towards PLHIV by June 2007.

(KNASP 2005/06-2009/10
2010_Final_Report.pdf (date accessed on 17/04/07))

39. Are issues relating to young people included in the training curriculum of key health care workers at SRH clinics?

KNASP 2005/06 – 2009/10 aims to provide youth friendly access to HIV and reproductive health information and other services.

(KNASP 2005/06-2009/10
2010_Final_Report.pdf (date accessed on 17/04/07))

40. Are there any government media campaigns (e.g. television commercials and newspaper advertisements) about HIV/AIDS that specifically address prevention among girls and young women?

Also in collaboration with the FHI/ Kenya office, Youth Net worked with major television networks Kenya to promote the global HIV Prevention Campaign of Music Television (MTV) called Staying Alive 2002, which Youth Net helped coordinate. This promotion effort resulted in Kenya stations broadcasting the MTV campaign and in one station developing its own youth forum, a two-part show called "Youth in Dilemma." As part of Youth Net's evaluation of the MTV campaign in Kenya, it is conducting focus groups with young people to see how Kenyan youth interpreted the global media messages. A summary of the Kenya campaign appears in a report on the overall Staying Alive 2002 campaign and will be posted here this summer.

In June 2002, the FHI/Kenya office launched the Staying Alive campaign in Kenya at a meeting with representatives from the major television stations, the Ministry of Health, and major
non-governmental agencies working with AIDS Prevention. “We emphasized that the programs would be available rights-free, and therefore available to the broadcasters at no cost,” said Dr. Ndugga Maggwa, of the FHI/ Kenya office, who coordinated the local Campaign, along with consultant Emily Nwankwo.

Among those at the FHI briefing were officials from the Nation media Group, which publishes the largest newspaper in Kenya and operates a major television station. “We need to be pre-emptive with young people,” said Joel Musundi, production manager at Nation Broadcasting. “Youth have so many messages thrown at them, from the media or church or peers.” The Nation group decided to work closely with the campaign and developed the local forum.

(Family Health International http://search.fhi.org/cgi-bin/MsmGo.exe?grab_id=78877770&extra_arg=&page_id=755&host_id=1&query=media+Campaign
(Date Accessed 09/07/07)

Discussion questions:

Are HIV prevention services truly accessible to girls and young women, including those that are marginalised and vulnerable? For example, are they: safe? Affordable? Reachable by public transport? in appropriate languages? Non-stigmatising? open at convenient times?

What are the cultural norms around prioritizing females and males for health care?

To what extent are informed and supportive SRH services accessible for girls or young women living with HIV/AIDS?

What are the client/service provider ratios in different types of HIV prevention services? What is the gender ratio for staff in those services?

Do services make proactive efforts to attract girls and young women? For example, do SRH clinics have separate rooms for young women so that they do not risk seeing family members or familiar adults?

What are the attitudes of service providers to girls and young women, including those who are marginalised and vulnerable? Are they kind, non-judgemental and realistic (for example about young people’s sexual pressures and desires)? Can they encourage girls/boys to assess their risks of HIV infection and change their behaviour? Are attitudes generally getting better or worse?

Do HIV prevention information campaigns, etc, target girls and young women? For example, are they culturally and linguistically appropriate? Are materials distributed through appropriate media and outlets?

Is there a national monitoring and evaluation framework? Does it encourage data to be disaggregated (according to gender and age) – to help assess the extent to which girls and young women are accessing programmes and services?

Are referrals and follow-up provided during HIV/AIDS, SRH and antenatal care services for young women and girls?

Overall, what difference does accessibility to services mean in practice? What are the ‘real life’ experiences of girls and young women? What difference is made to their vulnerability to HIV infection?

How do the effects of accessibility vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?
### Key questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>43. In the National AIDS Council (or equivalent), is there an individual or organisation that represents the interests of girls and young women?</td>
<td>See answer to Q45.</td>
</tr>
<tr>
<td>45. Was the current National AIDS Plan developed through a participatory process, including input from girls and young women?</td>
<td>Following stakeholder validation the KNASP strategy document was formally approved by the NACC Council and submitted for approval by Cabinet and adoption as official policy in readiness for a formal launch in June 2005. (The development of the Kenya National HIV/AIDS Strategic Plan (KNASP) covering the period 2005/06-2009/10 followed a participatory process in which many stakeholders took part. The stakeholders were drawn from a cross-section of public, private, civil society, faith-based organizations and international institutions. The process involved extensive nationwide consultations)</td>
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with stakeholder groups as well as joint HIV/AIDS programme review meetings. The Plan, whose theme is ‘A Call to Action’, operationalises the commitment of the Kenya Government and all stakeholders including development partners and civil society involved in the fight against the HIV/AIDS pandemic.

The following stakeholders who were involved in the development of this strategic plan are acknowledged for having played tremendous individual and collective roles:

- Development partners for having supported the preparation and production of this strategic plan including those who have already pledged to contribute substantial amount of resources towards the implementation of the proposed activities.
- NGOs, civil society Faith Based organizations, CBOs, PLWAs, CACCs, research institutions and the private sector among others are thanked for having taken part in the preparation of this strategic plan including the identification of various problems and prioritization of appropriate interventions. In addition these organisations are acknowledged for participating in the setting of realistic targets during the plan period and for their continued support for various HIV/AIDS activities in the country.
- Various Government ministries and departments are acknowledged for having identified various constraints that need to be addressed and for supporting various sector specific HIV/AIDS activities including coordination of the national effort at all levels.


The government of Kenya has moved quickly to develop and begin implementing a strategy for providing family planning services at all VCT centers in the country. Government leadership, an effective task force, and stakeholder commitment have been key to translating this important research into improved family planning and VCT services for Kenyan clients.


The process of developing the National HIV/AIDS Monitoring and Evaluation Framework has been participatory and all-inclusive with consultations at constituency, provincial, and national levels. It has entailed participatory research to identify monitoring and evaluation approaches, opportunities, and constraints as well as field visits and consensus building around the process of indicator development.


46. Is there any type of group/coalition actively promoting the HIV prevention and SRH needs and rights of girls and young women?

WOFAK (Women Fighting AIDS in Kenya), in the pursuit of its mission of providing care and support services, implements the below programs:

- Individual (one to one) and group therapy counseling.
- Medical care using both conventional and alternative medicines.
- Home and hospital care visits.
- Nutritional support.
- Economic support and empowerment.
- Orphan and other vulnerable children care and support.
- Community education and advocacy.
- Networking and collaboration with other agencies in furtherance of the above programs.

As an organization, we care for and serve women and children made vulnerable by HIV / AIDS
through the following ways:

- Individual and group counseling
- Medical care using both conventional and alternative medicines
- Visiting of our clients at homes and when they are hospitalized
- Economic support through promotion of income generation activities for women, older orphans and foster parents
- Referrals to other support centers for services which are not provided by ourselves
- Nutritional support for the vulnerable children and bedridden clients

(Women Fighting AIDS In Kenya [http://www.wofak.or.ke/linkhome.htm](http://www.wofak.or.ke/linkhome.htm) (date accessed on 13/04/07))

47. Is there any type of national group/coalition advocating for HIV prevention (including positive prevention) for girls and young women?

48. Is the membership of the main network(s) for people living with HIV/AIDS open to young people, including girls and young women?

ARTICLE VI Of the Constitution of (National network for persons living with HIV/AIDS) NEPHAK.

MEMBERSHIP:

SECTION 1:

Any organisation, which is of and by people living with HIV/AIDS in Kenya and which, is registered under the laws of Kenya or under the Ministry for the time being charged with Culture and Social Services may apply to be a Member.

SECTION 2:

Any person living with HIV/AIDS, who voluntarily seeks membership, will be eligible to individual membership with no voting rights.

SECTION 3:

1. Any other registered organisation or individual that has particular interest in HIV/AIDS, either professionally or through working with the NEPHAK, or as a result of association with persons

(NEHPAK Website - [http://www.nephak.org/policies](http://www.nephak.org/policies) (Date accessed 9/07/07))

49. Are there any programmes to build the capacity of people living with HIV/AIDS (e.g. in networking, advocacy, etc)?

No available data

50. Are there any girls or young women living with HIV/AIDS who speak openly about their HIV status (e.g. on television or at conferences)?

No available data

Discussion questions:

- How are international commitments (e.g. CRC, CEDAW, and CCM) applied within the country?
- Is the national response to HIV/AIDS rights-based? For example, does it recognise the
SRH rights of women living with HIV/AIDS?

- Do key decision-making bodies (e.g. the Country Coordinating Mechanism of the Global Fund to Fight AIDS, TB and Malaria) have a set number of seats for civil society? Are any of them specifically for representatives of girls and young women or people living with HIV/AIDS?

- Are HIV prevention programmes generally developed ‘for’ or ‘with’ girls and young women, including those who are marginalised and vulnerable? Are girls and young women seen as ‘implementers’ as well as ‘receivers’ of services?

- To what extent are girls and young women aware of decision-making processes? Are they encouraged to have a voice? Are they seen as an important constituency within committees, management groups, etc?

- How high are issues relating to HIV prevention for girls and young women (e.g. early marriage and stigma) on the agendas of local leaders and decision-making groups (e.g. district AIDS committees)? To what extent do girls and young women participate in those type of bodies?

- To what extent are people living with HIV/AIDS organised, for example in networks? Are girls and young women involved in those bodies?

- How are issues of participation affected by stigma? For example, is it safe for people living with HIV to speak openly about their HIV status?

- Overall, how are participation and rights applied in practice? What are the ‘real life’ experiences of girls and young women? What difference is made to their vulnerability to HIV infection?

- How do the effects of participation and rights vary among different types of girls and young women, such as those in/out of school, married/unmarried, in rural/urban areas, living with HIV/not aware of their HIV status?
PART 2: IN-COUNTRY RESEARCH
Focus group discussion: 15-26 year olds

Age group: 15 - 26 years
Number of participants: 12
Profile of participants: Included some girls and young women who are: peer educators; from rural area; out of school; 3 married and 9 unmarried.
Place: Community resource centre/social hall (rural Area in western part of Kenya)
Date: 06th July 2007.
Start time: 11.23am. End time: 1.45 pm.

1. What sort of HIV prevention services are there for girls and young women in your community? For example, where would you go to get: information? Condoms? Treatment for a sexually transmitted infection (STIs)? An HIV test?

Introduction

There are a number of HIV/AIDS prevention, treatment and care services in the rural areas. The available services include:

- Voluntary Counselling and Testing Centres (VCTs),
- Private health facilities
- Public health facilities
- Condom dispensers placed in strategic places; like public latrines, in corridors in health centres, to encourage people who might be shy to pick them in the open to be able to do so in some privacy.

2. How much do boys and young men know about HIV prevention services in your community? What is their role in supporting HIV prevention for girls and young women?

Most of the boys in villages know about HIV/AIDS.

One respondent explained:

"In my estimation about 90% of young people both male and female know about HIV/AIDS. Although there is information about HIV/AIDS, most young people in the village know that HIV is transmitted through sexual intercourse, very little information is passed to them on other modes of transmission like through sharing of ear piercing equipment, or sharing needles while removing foreign bodies from one’s foot or other parts of the body, or being in contact with blood of an infected person. They mainly identify sexual intercourse as the main mode of transmission".

Some boys do appreciate the need for safe sex but in general, boys do not help girls in supporting prevention against HIV transmission and other STIs.

"Most boys would like to have sex with their girlfriends without using a condom. Boys tell girls that sex is sweet naturally and that using a condom during intercourse is like trying to chew sweets in their wrappers. So they will insist on having sex without any protection."

Men have information about HIV/AIDS and would work towards stopping transmission of disease by using condoms. But those who use condoms also do so only for a while. If a relationship continues for a long time many men will stop using a condom with a girlfriend they have had for a long time. Partners begin to feel that they are more familiar with each other – they become used to each other to the extent that, even without going for testing, they believe they are okay and will have sex without using any protection.

A respondent explained:

"I had a boy friend some time back, when we started the relationship, he would suggest to me that we use condoms, to help prevent pregnancy because we were both in school and
would not take care of a baby; as well as prevent STIs but after about six months we were still together, he made love to me without using any protection. I think he used condoms earlier because we were new to each other, but as the relationship progressed he felt more used to me and felt safe making love to me without using a condom."

It is the men who determine which direction a relationship will go, whether it will progress or whether it will end shortly. They take lead in making decisions on what to do or not to do, so girls have to listen to what they say or agree to their demands.

“You know as a woman you are so much in love with this guy, so you want as much as possible not to loose your boyfriend. So you will try very much not to offend him. If I visit my boyfriend and he decides that we are going to make love, I will agree because, I love him and I feel if I decline to have sex with him, I might offend him and he might quit the relationship. It goes the same way if he asks me to make love to him without using a condom, if he wants it that way, I have no option, I cannot insist, if I do he might go out there and find another woman who will agree to make love to him without using a condom and I might loose him.”

Girls often succumb to pressure to show their love and trust for their boyfriends by agreeing to have sex without protection.

Most Boys have multiple sexual partners.

A respondent explained:

“If they were to actively help girls in preventing transmission, they should ensure that they have only one sexual partner and they must at all times use protection with their partners.”

Another participant explained:

“Boys and young men do not do much to help us prevent HIV transmission. I am a single mother of two children. I am not employed; I sell fish at a local market to support my family. Have to wake up early to buy fish from the fishermen as they get back to the shores early in the morning. There is stiff competition for fish from the fishermen as they get back to the shores all the time and for the fishermen to agree to spare fish for us they ask for sexual favours before they can agree to spare stock for us. Many of us have to agree to have sex with the fishermen for us to get the stock to sell. We desperately need the fish because without it we cannot support our families and they want to have sex without any protection”.
3. What sort of HIV prevention services would you like more of in your community? How would that make a difference to your life?

- Voluntary Counselling and testing services and awareness creation programs. Set up centres specifically providing services for young people. These services should also be widely distributed so that they are easy to reach.
- More outlets for condom distribution for young people. Making sure that dispensers are consistently stocked with condoms.

A participant asserting this point explained:

“There are times when some dispensers do not have condoms. You want to use them, but they are not available. Then you end up making love without using protection putting you at risk.”

- Teach young women about the female condom, and distribute more of female condoms so that young women have an alternative to relying on male condom for prevention.
- Audio visual HIV/AIDS campaigns (through videos and films).
- Sponsored camps and retreats where young people would go to learn about HIV/AIDS in open discussion forums.

Prevention component: Accessibility of services

4. What are your experiences of using HIV prevention services in your community? In what way have those experiences been good or bad?

Most youth have no employment and therefore are not capable of paying for such services as access to contraception or treatment of STIs. The government and Non-governmental organizations have made sure that available services like VCTs are free and everybody has access to them.

Scarcity or and inconsistency in service provision is a bad experience for young people. A participant reiterated:

“In the rural areas, you will find condom dispensers that are empty. They remain without condoms for a long time. They are supposed to be the points at which young people can have access to condoms when they need them, once they lack them they go ahead and have sex without them”

5. What are the main barriers that you have faced when trying to use HIV prevention services in your community? For example, what difference does it make if a service is: expensive? too far away? Unfriendly?

Uncooperative parents and community members is a barrier to young girls and women accessing prevention services.

“There is a very –ve image of persons seeking preventive services like visiting a VCT for testing. If you are seen going to a VCT centre; may be just to pick some information; community members will conclude that you made the visit because you are living with HIV/AIDS or because you know you have engaged in risky behaviour in the recent past (like having sex with many men) and you suspect you have HIV. You can easily be discriminated by family members for suspicion of being infected.”

Parents do not discuss sexual issues with young people.

“The subject of sex is taboo in most communities and it would be difficult for parents to understand a young person’s reasons for example to go for VCT services.”
Confidentiality is a factor. Knowing that privacy is respected and confidentiality can be assured is very important to young people. Young people fear that nurses/doctors or the counsellors are likely to reveal information to other people – their friends, relatives or parents in the neighbourhood. Concern that their status might be revealed to other family/community members may make young persons not access services especially when they are only able to access services nearest to their homes.

“There is a VCT at the shopping centre near my home, but I cannot go there for fear of running into my relatives or for fear that results of my test might be disclosed to other people in my neighbourhood. If I have to use a VCT, I have to go to a place where I am not known.”

In some places the VCTs and health care facilities that provide preventive services and treatment for the infected are far away from home. Lack of money to cater for bus fare to access services is a barrier to many young people.

“In some places VCT services are quite a distance away. One must have bus fare for them to reach the services, as long as they lack bus fare they will not get there even when they need to.”

“Sexual matters are matters of secrecy in our communities. It is seen as immoral to discuss them. It is a taboo subject. It is therefore difficult to openly buy or pick condoms from dispensers especially those near home for fear of being perceived as an immoral person.”

Religion is a barrier in accessing prevention services. The catholic faith does not encourage the use of condoms.

A participant explained:

“I am a catholic faithful and in my church they do not encourage use of condoms or accept the fact that young persons get involved in sexual activities because the bible teaching is that sex is only allowed in marriage. Many young Catholics going by these teachings might avoid using condom distribution services.”

Although there are various HIV prevention services, it is not easy for girls to use them because most of girls live with their parents and have to ask for permission whenever they want to leave home to go anywhere. It is not easy for girls to ask for permission to use preventive services. Parents will be taken aback – that their daughters are getting involved in sex cannot take things like condoms home.

A participant explained:

“I respect my parents. I cannot let them know that I am going for VCT or to attend reproductive health clinic. They will have to know why I need to attend clinic and if they discover it is about contraception, I fear that my parents will see me as immoral if they knew.”

There are myths associated with contraceptives use.

A participant explained:

“There is a belief among young people that condom use might result into infertility. That if condoms are used during intercourse it might result in a woman not having children in future. That it is possible that either the female or the male condom might get into the vagina fail to come out and lead infertility.”

“It is also believed that condom use can cause some allergic reactions in the genitals that might cause complications in fertility.”
Where subsidised user fees is charged for services, young people might find it difficult to access services.

A peer educator putting up with a sister living with HIV explained:

“At district health centre, my sister is expected to pay for CD4 cell count services. When she cannot afford a shilling to pay for that service she misses her test and has to wait till we have some money in our hands to pay for the test.”

6. In what way are HIV prevention services easier or harder for particular types of girls and young women to use? For example, what difference does it make if you are: unmarried? out of school? HIV positive?

Some participants (3 married young women) said it is difficult for married women to use the preventive services because they have to seek permission from their husbands to use preventive services. When they do not agree you will not use them.

One explained:

“Because of certain side effects when using contraceptive pills for family planning, I opted for regular condom use with my husband, when I tried discussing that with him, he felt I was beginning to cheat on him. He asked me to explain why I would want to use condoms yet we had not been using them once we were married, I was going to lose his trust, I had to stop the discussion.”

Another participant (not married) said that it is harder for the girls living with their parents to use these services:

“I must get permission from my mother, father or an elder sister or brother before I leave home. When I was coming to this meeting,( referring to leaving home to attend the FGD session), I had to explain to my parents that I would be away to attend a discussion, tell me how to explain to an older person that, I am going to visit a VCT or to pick condoms or pills, what will they think about me?”

HIV +ve persons only face the fear of being discriminated by community members once they get to know their status. That might make it hard for them to access treatment. Sometimes young girls will find it difficult to attend clinic for fear of being judged negatively in case they are infected with HIV.

Prevention component: Participation and rights

7. Have there been any projects in your community to bring together girls and boys or young women and young men to talk about HIV prevention? If yes, what did they involve and what did they achieve?

Local NGOs and churches conduct HIV/AIDS awareness campaigns that bring young men and women together. These forums are useful but, should be made more interesting to attract the attention of young people.

A peer educator explained:

“Such forums should have concerts/drama and music that appeal to young people. It would work better if games like football, netball, scrabble and others are included so that it is more of fun to get involved while at the same time getting education on the pertinent HIV/AIDS information. ”

8. What would encourage you to get more involved in HIV prevention in your community?

“Being able to access up to date information in a regular basis will be a great encouragement. There are many myths about HIV/AIDS, a lot of cultural beliefs and
definition of disease that need to be worked on to make people know that HIV/AIDS is just a
disease like any other and can be prevented. If pamphlets, brochures, and posters could be
designed that would facilitate information dissemination.”

Small incomes or allowances would go a long way to support volunteers do HIV prevention
work. A participant peer educator asserted:

A peer educator explained:

“Sometimes I need to visit a place to speak with young people about HIV/AIDS and I have
no money for bus fare neither do I have an alternative means of transport. If I can get
some allowances or a small income to facilitate movement that will motivate and
encourage me more to participate in HIV prevention activities.

“We need bicycles to ease our movement between villages as we do HIV prevention work.”

Prevention component: Legal provision

9. What do you know about laws in Kenya that might affect how girls or young women can
protect themselves from HIV? For example, do you know about any laws that: allow girls
to get married at a young age? do not allow girls or young women to have abortions?
Prevent girls from using services unless they have the consent of their parents?

Women are allowed to get married at least at the age of 18. The law states that marriage
should be at adulthood. In Kenya you are an adult once you attain the age of 18 years

A participant explained:

“There are girls who have dropped out of school due to lack of school levies, they get idle
doing nothing at home if they opt to get married at whatever age they will get on; one
cannot be stopped if they wanted to get married at an earlier age”.

Abortion is illegal in Kenya. Young girls who get pregnant and cannot carry pregnancy to
term or because they fear being sent away from home depend on abortions done in hiding.
Some old women help them procure abortions in the villages.

A peer educator explained:

“There are cases where young girls have resorted to using crude means to procure abortion
like overdosing with anti-malaria drugs or taking strong toxic herbs to kill the foetus. This kind
of practice has resulted in many deaths”.

Sex work is illegal in Kenya.

VCT guidelines require that minors seek consent of their parents to use the services.

“Young people below 18 years of age have to seek parents’ consent to use VCT services.
What that means is that young persons who are sexually active do not use the services.”

Prevention component: Policy provision:

10. What type of education have you received about issues such as relationships, sex and
AIDS? For example, what have you been taught about your sexual and reproductive
health in school?

Under the subject of Social Ethics HIV/AIDS, male and female reproductive organs,
unwanted pregnancies and effects of procuring abortion are taught. The subject covers a
few issues; it is shallow and inadequate.

There is no official sex education in schools in Kenya.
11. What could the government of Kenya do to fight fear about AIDS in your community?

- There should be more awareness campaigns as well as legislative framework to support the infected people. Communities need to receive information that will help reduce the stigma and discrimination.

Summary of discussion

12. What are the 2-3 most important changes that could be made – for example by the government or community leaders – to help girls and young women in Kenya to protect them from HIV?

- The government should pass laws that protect young girls from early marriages.
- Strengthen awareness campaigns and make them more consistent and persistent so that people do not forget the information passed.

"Awareness campaigns are not consistent in the villages, they are done once in a while, it takes time before they are repeated and people tend to forget. If they are repeated at short intervals then people will not forget what they have been taught".

- Sex education should be introduced in schools so that young people learn life skills which will go a long way to prevent infections.
Focus group discussion: 15- 24 year olds

Age group: 16 - 25 years
Number of participants: 12
Profile of participants: Included some boys and young men who are: out-of-school; peer educators; from urban areas/informal settlements in Nairobi; Married and unmarried.
Place: Social Hall, Eastleigh
Date: 11th June 2007
Start time: 2.15 pm. End time: 3.45pm.

Introduction

The participants were given the background of the study by the in-country IPPF consultant. They were briefed on the importance of the study that it is being carried out in other African countries as well. They were told to contribute freely as most of the information would be kept confidential and the responses be used only for the purpose of the study.
All the participants could communicate fluently in English but Kiswahili translations were put in place to aid clarity and meaning in the local context.

4. What sort of HIV prevention services are there for girls and young women in your community? For example, where would you go to get: information? Condoms? Treatment for a sexually transmitted infection (STIs)? An HIV test?

There are several VCTs and a youth information centres in Nairobi where one can get testing and treatment services for HIV and other STIs. In most health centres, disco clubs, restaurants and public toilet facilities, there are condom dispensers in strategic places that make it easy to access male condoms.

5. How much do boys and young men know about HIV prevention services in your community? What is their role in supporting HIV prevention for girls and young women?

Boys and young men know enough about HIV prevention services. There are brochures and pamphlets in schools that talk about HIV/AIDS. Information is all over town in bill - boards, on television many advertisements are aired that talk about prevention. There is a lot of information.

Young men do not help young women much in the prevention against HIV.

“Although some boys use condoms most of them insist on sex without condoms to test if their girl friends are faithful, trust and love them.

Certain beliefs may also make young men not help much in preventing infection among young girls and young women. A participant explained:

“There is a myth among us young guys that when one takes an antiretroviral tablet before sex then they become immune to HIV infection – that ARV acts as a vaccine against HIV infection”.

Boys also prefer their girlfriends using the ‘morning after pill’ to use of condoms. Participant explained:

“Only about two out of ten boys will use protection while most use self diagnosis rhetoric such “niko poa sija konda” (I am okay am not growing thin…..am healthy) to console themselves despite the risk”.
Drug use among boys and young men is in the increase and is another reason why boys put their girl friends at risk of infection.

Participant explained:

“Boys and young men abuse drugs and other substances like alcohol thus making them vulnerable to unsafe sex. Once they get drunk, they might not be able to put on condoms properly.”

Another participant explaining why he believes young men and boys do not play a major role in prevention:

“Boys feel their age mates (girls) abandon them for older men. Young men also go for younger women and trick or coerce them into sex. Sometimes without any form of protection”.

Boys therefore do not play a big role in preventing HIV transmission among young girls and young women.

One participant believed that it goes the same way for both gender so boys and young men are not the only ones to blame in lack of HIV prevention:

“Some older women also go for young boys and young men” they are referred to as Sugar Mummies. They will bring all sorts of goodies for young boys and men to lure them to engage in sex with them. Some of them will encourage the young men to engage in sex without condoms.”

6. What sort of HIV prevention services would you like more of in your community? How would that make a difference to your life?

“There are so many campaigns and services but the effect is not being felt as such”.

More innovative ways of passing information to young people should be adopted. Most services are not tailored to suit the needs of young people. HIV prevention services are distinctly set up differently from other health facilities.

“Voluntary Counselling and Testing services should be integrated with other services so that they are not seen as places where only HIV infected people go”.

“The idea of the local youth Centres is very good because one can access many services at the same place therefore it is not only associated with HIV infection and treatment and the young people are free to walk in without fear of being seen. If they are made more accessible to young people, they will be able to access relevant up to date information regarding HIV and this will help in curbing transmission”.

Prevention component: Accessibility of services

7. What are your experiences of using HIV prevention services in your community? In what way have those experiences been good or bad?

It is still not easy to access these preventive services despite their availability. The society still associates these services with sexual immorality. That if you are going to use a condom then you must be an immoral person.

One of the participants reiterated:

“‘I cannot ask a shopkeeper for a condom in front of other shoppers. If I want to buy condoms I have to go to a different neighbourhood where nobody knows me’.”
“Visiting a VCT centre still means suspicion of infection and can lead to seclusion given that once you have been posted at a VCT many think that you are infected. There are no VCT centres that are particularly set up to serve the youth. We find it hard to go for services where other older people go for them.”

For treatment of STIs, it is difficult to access treatment among the young people. Nurses and doctors do not receive young people well.

Participant explained:

“Some doctors and nurses rebuke young people for getting themselves infected with STIs they judge them negatively”.

8. What are the main barriers that you have faced when trying to use HIV prevention services in your community? For example, what difference does it make if a service is: expensive? too far away? Unfriendly?

The attitude of health providers towards young people is a barrier to access services. One participant narrated his experience while attending clinic for treatment of an STI:

“One of the nurses walked up to where we were sitting and said; If you have gonorrhoea move to this line... pointing at where he wanted people coming for STI treatment to stand”.

This is an example of how young people are addressed and treated at some public health facilities that treat STIs. The staffers in most facilities are either rude to the youth or too old to listen to and understand the youth. The young people are not free to talk to older people including their parents at home about sexuality or issues related to relationships with the opposite sex.

The environment is not friendly and therefore most young people stay away and suffer in silence.

A participant explained:
“There is nothing for the youth without the youth”.

The youth are more comfortable talking to their fellow youth. Most young people have no source of income and cannot ask for money from their parents to pay for STI treatment services most of which are not free.

Access to most of the centres that provide these prevention and treatment services is also a big barrier for the youth.
A participant explained his experience while attempting to access services from a facility:

“You have to identify yourself and state clearly what your mission is first to the watchmen manning the gates of such facility and several other people before you can reach a counsellor or a nurse”.

This keeps young people away from these facilities and services.

Location of facility is a barrier to many young people:

“The youth are mostly unemployed and will not be able to reach a facility that is far away from home for lack of money to meet the transport costs. This is mainly in the rural areas where services are a distance from home. But even in town if services are near home they will not use them. They want to use services that are away from their neighbourhood. It is still an impediment given that they will need to meet cost of transport to the facility away from their neighbourhood”.

Certain myths do exist that might deter young people from using services.
One Participant explained: “There is a belief among young people that condoms are laced with HIV virus and if used might then lead to infection.”

Within informal settlements (slums) some private practitioners sell condom packs meant for free distribution. This makes it difficult for young men living in these areas to access them. A participant from informal settlement (slum) in Nairobi explained:

“Condoms in white packs labelled GOK (government of Kenya not for sale) are sold in some outlets in the slums. You have pay Ksh.10 to get a pack of three condoms. The choice is difficult you are a young unemployed person, you have ten shillings, you would rather buy food with that money than buy condom meant to be distributed free of charge.........you see what I mean.”

9. In what way are HIV prevention services easier or harder for particular types of girls and young women to use? For example, what difference does it make if you are: unmarried? Out of school? HIV positive?

“Sex is a taboo subject in most of our families. It is not easy for young girls to even discuss going to a VCT with their parents. Girls living with their parents have more difficulty in accessing these services”

The situation is confusing among older adolescents in school,

A participant explained:

“While programmes targeting youth teach about prevention by use of contraceptives, if teachers find students with condoms in school might mean being discontinued from school as a disciplinary measure”.

Prevention component: Participation and rights

9. Have there been any projects in your community to bring together girls and boys or young women and young men to talk about HIV prevention? If yes, what did they involve and what did they achieve?

There are projects that bring young people together but young girls often do not participate actively because parents are very protective of the girls. During the weekends when young people attend camps for training, fewer girls are allowed by their parents to attend.

A participant explained:

“Information is very important and these free discussion forums should be encouraged more”.

10. What would encourage you to get more involved in HIV prevention in your community?

   a. Programmes supporting peer educators should budget for some financial allowances that will facilitate their movement and give them motivation.
   b. Refresher trainings for peer educators are needed to equip them with up to date information that can aid them fight myths, stigma and discrimination.

Prevention component: Legal provision

10. What do you know about laws in Kenya that might affect how girls or young women can protect themselves from HIV? For example, do you know about any laws that: allow girls to get married at a young age? do not allow girls or young women to have abortions? Prevent girls from using services unless they have the consent of their parents?
Abortion is illegal in Kenya.
FGD participant explained:

“Young girls and women do abortions, but they have to go to hidden places to do abortions. Some of them end up dying out of complications due to abortion”. VCT centres do not allow minors to get services without the consent of their parents at the same time young girls will not have courage to approach parents for consent to use services.

Early and forced marriages among young girls are still common in many Kenyan communities. These are supported by customary laws which are still recognized by the Kenyan law. Most marriages are still arranged by parents giving girls little or no choice at all. A participant reiterated:

“Religion and culture affect the enforcement of legislation. Use of contraceptives is trapped in this confusion. On one hand programs teach us to use a condom if we have to engage in sexual intercourse, on the other hand, religion does not allow use of condoms among young people they ask us to abstain, abstaining is very difficult”.

Prevention component: Policy provision:

12. What type of education have you received about issues such as relationships, sex and AIDS? For example, what have you been taught about your sexual and reproductive health in school?

Young people are not adequately taught about sexuality both at home and at school. Parents and Churches are opposed to sex education. What is currently being taught in schools about sexuality is under Social Ethics is too shallow to have any meaningful impact on young people. A respondent suggested thus:

“Probably the subject name should be changed to “life skills training” in place of “sex education” to gain acceptance among parents and churches”.

13. What could the government of Kenya do to fight fear about AIDS in your community?

- The government should put in place legislation that protects young people from risks of HIV.
- The youth should be used more to sensitize their fellow youth on dangers of the disease and the importance of using prevention services. New approaches should be adopted. Like aggressively using youth to reach other youth.
- Programs should be redesigned to appeal to young people. For example social and political celebrities should be engaged to help in the awareness campaigns.
- More information and treatment centres should be set up to increase accessibility.
- Government and NGOs are spending more resources on treatment rather than prevention. Awareness campaigns should be given more attention.

Summary of discussion

13. What are the 2-3 most important changes that could be made – for example by the government or community leaders – to help girls and young women in Kenya to protect them from HIV?

- Sex education or life skills as a subject should be introduced in the educational curriculum.
- Community and religious leaders should encourage the use of safe preventive measures to protect young women and girls from the dangers of
contracting HIV instead of sticking to out-dated cultural beliefs and practices.

- The government should also step up rigorous campaigns in all sectors of government.
Focus group discussion: 15- 24 year olds

Age group: 15 - 26 years
Number of participants: 12
Profile of participants: Included some girls and young women who are: peer educators; from urban area; informal settlements; out of school; married and unmarried.
Place: NAIROBI YOUTH CENTER, Eastleigh
Date: 06th June 2007.
Start time: 10.00am. End time: 11.45 pm.

The participants were exposed to the background of the study and their consent (to participate, was sort by the IPPF in-country consultant. They were briefed on the importance of the study including the fact that it is being carried out in other African countries. They were asked to contribute freely as most of the information would be kept confidential and only used for the purpose of the study.
All the participants could communicate fluently in English but Kiswahili translations of the FGD guide was put in place to aid clarity and meaning in the local context.

7. What sort of HIV prevention services are there for girls and young women in your community? For example, where would you go to get: information? Condoms? Treatment for a sexually transmitted infection (STIs)? An HIV test?

There are various HIV/AIDS prevention and care services in various parts of the city. These are Voluntary Counselling and Testing Centres (VCTs), youth information centers, private and public clinics.

8. How much do boys and young men know about HIV prevention services in your community? What is their role in supporting HIV prevention for girls and young women?

Boys have information about HIV/AIDS though they do not help girls much in the prevention against HIV and STIs - they are the ones who insist on sex without protection. Some boys use condoms, some abstain.

One respondent asserted:

"Abstinence doesn’t work with many people very few young boys and girls can abstain”

In many relationships, boys and young men stop using condoms with their girlfriends after sometime – they become used to each other to the extent that, even without going for testing will have sex without using any protection .

FGD participant explained:

"Men will use a condom with someone new they have just met, but with the girlfriend they have been relating with for along time, they have trust so they might not use condoms".

"Some men kind of blackmail their girlfriends by threatening to quit their relationships if their girlfriends do not accept to engage in sex without using condom. "It is for most boyfriends a sign of their girlfriends not having trust on them”.

Girls often succumb to pressure to show their love and trust by agreeing to have sex without protection.

"The boys also tend to have multiple sexual partners. It is like fashion among boys to have many girlfriends.”
9. What sort of HIV prevention services would you like more of in your community? How would that make a difference to your life?

- More youth centres equipped with Voluntary Counselling and testing services and awareness creation programs.
- More outlets for condom distribution for young people.
- Audio visual campaigns (through videos and films) are more effective as they are captivating with HIV/AIDS messages passed more vividly. Audio visuals are both informative and entertaining.

"Audio visuals will bring vivid pictures of what HIV does to human bodies and therefore lead to young people taking much care not to be infected".

Prevention component: Accessibility of services

10. What are your experiences of using HIV prevention services in your community? In what way have those experiences been good or bad?

Young people can use HIV prevention services because most of them are free of charge. VCTs are free of charge, in many public restaurants you find free condom dispensers and the youth centres provide services for free for those who seek them. However there are very few youth centres and most public health facilities do not have youth friendly services.

One of the participants explained:

"Many of us find it difficult to go for services in public health facilities because the nurses and some doctors judge young people seeking help negatively. I had a friend of mine who complained of Vaginal discharge with bad odour, I helped her get to a public health centre near our estate, when she explained to a nurse attending to her condition, the nurse reacted with anger telling her that she was young and it was very wrong for her to have contracted a sexually transmitted disease- that she was not supposed to engage in sex. After that we walked out the facility without getting treatment. A friend later helped her raise money to see a private doctor".

11. What are the main barriers that you have faced when trying to use HIV prevention services in your community? For example, what difference does it make if a service is: expensive? too far away? Unfriendly?

Female condoms are more expensive and are not easily available.

"Women have to rely on men to use the male condom".

This puts them at a vulnerable position as far as protection is concerned. Sex and sexuality issues are a taboo subject in all Kenyan communities and families. One engaging in such discussions may be perceived immoral or that he/she engages in risky sexual behaviour like sex work. Young women and girls may find it difficult to collect contraceptives like condoms for fear of being perceived by others as being immoral.

FGD participant explained:

"Even when I think of going to pick condoms from the youth centre, it is difficult for me to pick them because I fear that people will question my morality.

Another FGD participant explaining how she accesses contraception explained:

"I prefer to go to clinics or shops away from my neighbourhood to avoid being looked at as immoral".

Confidentiality is another factor. Young people fear that nurses/doctors or the counsellors are likely to reveal information to other people - their friends, relatives or parents in the neighbourhood. Some of the nurses are very old and are arrogant/unfriendly to the youth."
Most of the centres offering prevention, care and treatment services are branded and anybody seen walking in are presumed to be infected........ A visit to a VCT centre; presupposes that one is infected and could lead to discrimination

As one participant said:
“I would not walk into such a branded facility because people will conclude that I am infected with HIV”.

“The service providers should offer other services such as recreational activities and libraries so that the youth can walk in easily without being seen to be ‘victims of HIV infection.’

Religion is also a barrier in accessing prevention services. The Muslim and the catholic faiths do not encourage the use of services like condoms. In Eastleigh (local community) there are very many Muslim faithfuls and the peer educators have a difficult time because Muslim leaders do not support their initiatives.

Although there are various HIV prevention services, it is not easy for girls to use them because most of girls live with their parents and cannot take things like condoms home.

“I have my values; I have to respect my parents’ house...The fear of offending my parents makes me not pick condoms from the youth centre”.

“I cannot talk about a boyfriend or about sex with my parents so how can I even think of mentioning the word condom....”

12. In what way are HIV prevention services easier or harder for particular types of girls and young women to use? For example, what difference does it make if you are: unmarried? out of school? HIV positive?

The response here was varied. A participant (married) said it is more difficult for married women to use the preventive services because they have to seek permission from their husbands to use preventive services.

“It was easier for me to use contraceptive services before I got married; now that I am married I have to first share information with my husband before I can go ahead and use them. My husband does not like using condoms for family planning, the only option I have to avoid getting another baby is to use pills, and he cannot allow me to use pills either, because he feels I am denying him the opportunity to get more children.”

Another participant (not married) said that it is harder for the girls living with their parents to use these services:

“What will my father or mother think of me if they found a condom in my bed room? I cannot even think of keeping a condom or any form of contraceptives at home because there is no privacy”.

Prevention component: Participation and rights

11. Have there been any projects in your community to bring together girls and boys or young women and young men to talk about HIV prevention? If yes, what did they involve and what did they achieve?

Local NGOs and churches conduct awareness campaigns that bring young men and women together to talk about HIV/AIDS. These forums are useful but, should be made more interesting to attract the attention of young people.

“Effective messages can be passed through concerts, Skits and role plays which attract the attention of young people”.

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12. What would encourage you to get more involved in HIV prevention in your community?

“When one is involved actively in these activities they get more information and they benefit more. One’s confidence is also boosted when they have knowledge. This confidence helps them in other areas too”.

Small incomes or allowances would go a long way to support volunteers do HIV prevention work. A participant peer educator asserted:

“When we get some allowances or a small income while participating in these activities, it motivates us to continue doing more prevention activities”.

Prevention component: Legal provision

11. What do you know about laws in Kenya that might affect how girls or young women can protect themselves from HIV? For example, do you know about any laws that: allow girls to get married at a young age? do not allow girls or young women to have abortions? Prevent girls from using services unless they have the consent of their parents?

The law states that marriage should be at the age of 18 years.

“That is the law; one cannot be stopped if they wanted to get married at an earlier age”.

In Kenya women are married at an early age. This exposes young women to dangers of contracting HIV and other STIs.

Older married men, court young women into sex or marriage. This comes from traditions that allowed men to marry girls as young as 12 year olds. There is belief among some men that having intercourse with young girls or virgins is curative.

FGD participant explained:

“There are myths that having sex with young girls or virgins cures HIV infection”.

Young girls and young women get pregnant at early ages. They have no employment, but have children to feed clothe and take to school so they are forced into sex work to earn money to feed their children. There are no laws to protect these girls as they do sex work and sex work is illegal according to the Kenyan law.

Abortion is illegal in Kenya. Young girls who get pregnant and are not ready to carry pregnancy to term or fear being sent away from their parents’ home because of pregnancy out of marriage depend on abortions done in hiding in the backstreets.

FGD participant explained:

“There are secret clinics where young girls and young women go to get abortions done……. they are secret places because the law does not allow abortion. They are risky, many girls and women have lost their lives trying to get an abortion from such clinics.”

When you go to the youth centres, the VCT guidelines require that minors seek the consent of their parents to use the services.

“If you are below 18 years VCT centres will ask for your parents’ consent to be tested. Young girls of this age and who are sexually active will not use the services”.

Prevention component: Policy provision:
14. What type of education have you received about issues such as relationships, sex and AIDS? For example, what have you been taught about your sexual and reproductive health in school?

Relationships, sex and AIDS are taught in school under a subject called Social Ethics. The scope is so shallow and it is not adequate. There is no official sex education in schools in Kenya.

At home, parents do not talk about sex with their children.

15. What could the government of Kenya do to fight fear about AIDS in your community?

- There should be more awareness campaigns as well as legislative framework to support the affected.
  
  “As it is now, infected people are stigmatised and therefore reluctant to come out in the open. People should be encouraged to know their status and live positively without discrimination”.

- Poverty is a major challenge and the government should support poor people improve their living conditions by promoting access to small loans to enable women start small businesses to support their families. Most young girls are coerced into unprotected sex because they have to meet family needs.

A participant living in informal settlement in Nairobi asserted that:

“One participant living in informal settlement:

“In the slum where I live, women must think of ways to bring food on the table. Most of them have no education or skills to earn a living so they have to use what they have… their sexuality”

Summary of discussion

14. What are the 2-3 most important changes that could be made – for example by the government or community leaders – to help girls and young women in Kenya to protect them from HIV?

- Sex education should be introduced in schools at an early age.
- The government should pass laws that protect young girls from early marriages and female genital mutilation (FGM).
- There is confusion as far as abortion is concerned with government, gender activists and Churches pulling in different directions. The government should do something.
- Parents and community leaders should be encouraged to be more accommodative towards sex education. They should shun outdated traditions that are detrimental to the health of young women and girls like female genital Mutilation (FGM).
1. What is your impression about the general situation of HIV prevention for girls and young women in Kenya? Are things getting better or worse … and why?

“My impression of the HIV prevention situation for girls and young women is that currently there is a law on HIV and AIDS but, it is general. It applies to everybody. More specifically HIV prevention response for young girls and young women is a neglected area. There are no programs that target young women and young girls with reproductive health services and HIV/AIDS services.”

Youth centres that are available are mainly located in urban centres and do not specifically target young girls and young women.

**Prevention component 1: Legal provision**

Interview questions:

2. In your opinion, what laws in Kenya are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as:

- Whether girls can get married at an early age?
- Whether sex work is legal?
- Whether girls or young women can have abortions?
- Whether girls and young women can use sexual and reproductive health services without their parents’ consent?

“The new act criminalises wilful transmission of HIV and it is general. It does not make specific reference to young girls and young women. At least there is a law and that law contributes positively towards prevention”.

Sexual offence act makes it illegal for any adult male to engage in sexual relationship with any female under the age of 18 years. But family customary laws allow girls to get married at the age of 16 years.

Sex work is illegal in Kenya.

Abortions can only be allowed if a pregnancy poses a threat to the lives of either the expectant mother or the child she is carrying. It is illegal to procure abortion.

“Young girls are not permitted to have abortions at request. There must be a medical condition that might lead to a doctor recommending an abortion to save life.”

3. How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are:

- In/out of school?
- Married/unmarried?
- In rural/urban areas?
- Living with HIV?

- From marginalised groups (such as sex workers, migrants or orphans)?

Legislation actually has very critical implications on the reproductive health rights and choices that young girls and young women have.
The law is restrictive, abortions are illegal in Kenya therefore girls and young women cannot procure abortions. Most of the abortions that are procured are done in a clandestine manner as young women and girls hide for fear of prosecution and performed by people who are not well trained to handle abortions. This leads to many deaths as a result of complications from abortions.

Generally the new HIV/AIDS act promotes the rights of persons living with HI/AIDS. It makes reference to right to life, right to employment right to good health and access to health services. There is no specific mention or reference to young girls and young women.

“My take is that introducing law on HIV/AIDS might lead to more stigma and discrimination. We have more debilitating ailments like malaria, cholera, and many others and there is no specific law on them. HIV/AIDS will now become a more isolated disease and this will definitely impact negatively on the perceptions regarding HIV/AIDS.”

4. Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

**Prevention component 2: Policy provision**

5. What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in Kenya better or worse?

Government has been working hard to generally promote prevention services in all districts. Voluntary Counselling and Testing as well as PMTCT services are now available in most of the public antenatal clinics. The government has been aggressively promoting condom distribution for prevention of HIV transmission as well as for family planning.

6. Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

Sex education has been resisted. There has been a general mention regarding official sex education in schools. There is no comprehensive sex education in schools in Kenya. Church leaders have not supported sex education in schools.

7. Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

“One key policy that is needed is a policy on comprehensive non-biased sex education in schools. Parents, guardians and church leaders need to be educated on the relevant and critical issues affecting young people so that they can appreciate the role of sex education in alleviating some of the critical reproductive health and HIV/AIDS challenges facing families today”.

There are guidelines for supporting Orphaned and other vulnerable children but, a lot of the activities that should go into specific support for young people who are orphans are not implemented,

**Prevention component 3: Availability of services**

8. What type and scale of HIV prevention services are available for girls and young women in Kenya? For example, to what extent is it possible for them to get:
   * Male and female condoms?
   * Information and treatment for sexually transmitted infections (STIs)?
   * Voluntary counseling and testing?
   * Antiretroviral drugs (for infants, children and adults)?
   * Services and antiretroviral drugs to prevent transmission of HIV from an HIV positive
mother to her children

Condom distribution and VCT services has been promoted in Kenya by the government and other partners. Male condoms are more easily available. The female condom is rare and a lot of times being a new preventive device has not been well received by people of different ages. Again given the role of women and men in sexual relationships it is widely accepted practice that the males take a lead role in deciding what contraception method to use. Because of not understanding the female condom very well a lot of times the male condom has been preferred.

Distribution of such services remain more regular and consistent in urban areas than in rural areas.

"There are no clinics that target young people for access to VCT and ART. Those who need ART have to attend the same clinic with other people. Few VCTs target young people; they do not specifically target young girls and young women. Available youth centres are mainly in urban centres and are not adequate."

The greatest challenge with ART still remains the identification of the proper dosages and formulation for infants. There are few access points for infants and children.

Prevention and support programmes for young girls and young women are lacking. A few programmes exist with Non-governmental organizations are concentrating on this, but are not very consistent.

"Care and support for young girls and young women is terribly lacking, some have been sent away from their homes by parents for being HIV positive".

There are no support groups specifically targeting young girls and young women. This needs to be addressed as it will be a key avenue to prevention of new infections as well as prevention of re-infection among the already infected.

9. What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are:
   * Unmarried?
   * Out of school?
   * Involved in sex work?
   * Orphaned?
   * Injecting drug users?
   * Migrants?
   * Refugees?
   * HIV positive*?

A few NGOs have started identifying and supporting women involved in sex work at a pilot level. Kenya Medical Research Institute (KEMRI)/ Centre for Disease control (CDC) collaboration, The University of Nairobi. "These are isolated projects at a pilot level and cannot be said to do much, because they are still faced with the challenges of acceptance among the groups of women who are involved in sex work.

The government needs to appreciate the level of vulnerability of this group of women and take lead in formulating policies and programmes to support them.

The government has no specific policy on migrants and refugees. A lot of times the support to refugees is emergency response to tackle disease outbreaks- treating diarrhoea epidemics, malaria control and malnutrition are priority areas among refugees while HIV/AIDS prevention and control remains a neglected area among refugees.

"Sexual abuse among young girls and young women is rampant in refugee camps, this evidenced with the high pregnancy rates among young girls and young women. This has definite implications on HIV transmission yet HIV prevention services are lacking".

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10. What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

Services for young people remain general there are no services targeting specific group of young men or young women.

With the realization of high HIV prevalence rates among young girls and young women a lot of focus is now on supporting prevention among young girls and young women and this has began to marginalize young boys and young men with regard to prevention services.

11. Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

There is need for targeted Behaviour change Communication (BCC) for young girls and young women.

Youth friendly clinics should be developed that make available all preventive services:
- Post Exposure Prophylaxis (PEP)
- Treatment for STIs
- Post rape care and treatment
- HIV/AIDS treatment
- Support groups for young girls and young women.

Training is required to enhance capacity of policy makers to develop programmes relevant to young girls and young women.

**Prevention component 4: Accessibility of services**

12. What are the main barriers to girls and young women using HIV prevention services in Kenya? For example, is it:

**The cost of the services?**

Where user fees are required for service delivery, most of the young people cannot afford. Minimal fees charged in some of the health facilities can be an impediment to access and use of services.

Youth in Kenya represent the highest percentage of the unemployed in Kenya. As such programmes offering services for youth are expensive to run because they have to be fully funded because young people are not able to pay for services.

* The location of the services

Much of the services are located in towns. Ones in rural areas are located long distance and the cost of transport is a hindrance to access for young people.

* The lack of privacy at the services?

Youth friendly services are lacking. “Take an example of a fifteen year old girl coming to clinic for treatment of an STI or HIV health care providers might be taken aback- why would such a young person be coming for such services”.

* The hours that the services are open?

To an extent hours for service delivery can be an impediment for example Liverpool VCT in Nairobi requires clients coming for testing services to book appointments this may be a deterrent because young people might not have time to wait for their appointments to be approved to access services.

**The language that the services use?**
Communication component of the services might be a hindrance to access. Most service providers do not know how to communicate with young people. "Nurses rebuke young people when they go for treatment for STIs in health facilities.

* The attitudes of the staff that run the services?

Quality of care is lacking in most public facilities. There is dire need for youth friendly services. The young people have to come to the same clinics where older people are treated. Nurses have judgemental attitude towards the young people - they are rebuked for contracting STIs. "The judgemental attitude drives away young people from seeking health care services form such facilities.

Fear that confidentiality will be breached by the services

Most young people prefer to access reproductive health services or treatment of STIs and HIV/AIDS from clinics away from their residential areas due to fear of information getting to their parents who might be acquainted to their parents.

The attitudes of parents or friends

This is a very key barrier in access to services. Some young women have been sent away from home for being HIV positive. This might determine whether or not young girls and young women will access services.

* Cultural norms, for example that prioritise the health of boys over the health of girls?

13. Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are:
   * Married or unmarried?
   * In school or out of school?
   * HIV positive?

Access to services might be difficult for married adolescents. They have to have the consent of their partners to access contraceptive services. They might have the resources to access services, but their spouses might not allow them to access services.

14. What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

15. Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women

   • Strategy for provision of youth friendly services needs to be put in place.
   • Training of policy makers to understand the needs of young people will enhance prevention services.

Prevention component 5: Participation and rights

16. How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Kenya?

"Kenya is a signatory to these conventions, but they are not translated to actions. The government lacks in capacity to enforce the tenets of such conventions".

17. To what extent is the national response to AIDS ‘rights-based’? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?
The National response to HIV/AIDS does not mention reproductive health rights.

18. To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in:
   * Developing the National AIDS Plan?
   * Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

At the national level the involvement of young people is minimal. "The new Ministry for youth affairs needs to come up with mechanisms for greater involvement of youth in key decision making".

19. Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

There is need to fully translate the National youth policy and the National Adolescent reproductive health policy into action to be able to realise more prevention services.

Summary

Interview question:

20. In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Kenya?
2. What is your impression about the general situation of HIV prevention for girls and young women in Kenya? Are things getting better or worse ... and why?

The situation of HIV prevention among young people has generally improved because there are a number of projects that are now in place to facilitate prevention services by provision of relevant information for the youth with a view to preventing transmission of HIV and other STIs.

"Through such projects it can be seen that it is getting better because young people are getting more up to date information on reproductive health issues as well as HIV/AIDS prevention and care information. This has been done through youth training camps where youth travel for retreat and in the process are involved in discussions relevant to enhance prevention of HIV transmission as well as other STIs."

Prevention component 1: Legal provision

Interview questions:
5. In your opinion, what laws in Kenya are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as:

"There is a new HIV/AIDS law in Kenya passed in parliament towards the end of last year and the law seeks to protect the rights of those who are infected as well as those who are not infected. How this law will affect the different categories of persons in communities still remains to be seen once the enforcement of the law begins”.

Whether girls can get married at an early age?

“Anyone below the age of 18 years is defined as a minor in Kenyan law, as from 18 years old one is regarded an adult. However in certain communities you still find girls getting married at earlier age of 15 years going by the community customary laws. In essence the National constitution seeks to protect young girls and young women from early marriage, but because of the conflicting information given the two laws at play in the country enforcement of the constitution as pertains to early marriage is still lacking”.

Whether sex work is legal?

- “Sex work is illegal in Kenya; women found to engage in the practice are actually criminals for engaging in illegal activity. Many who are engaged in this trade therefore might face many more challenges like abuse by clients seeking services and may not seek redress because they are engaged in illegal activity”.

Whether girls or young women can have abortions?

- “Abortion is illegal in Kenya but it can be allowed if pregnancy poses a threat to mother or the unborn child. Given that it is illegal to procure an abortion many young girls procure abortions in the backstreet and this has led to loss of many lives as a result of complications arising from attempts to procure abortions ”
Whether girls and young women can use sexual and reproductive health services without their parents’ consent?

- “Young people are allowed to have access to reproductive health services without the consent of their parents except for cases of minors where it is recommended that they be given services with consent and in full awareness of their parents”.

6. How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are:

* In/out of school?
* Married/unmarried?
* In rural/urban areas?
* Living with HIV?
* From marginalised groups (such as sex workers, migrants or orphans)?

“The HIV/AIDS law in Kenya has applies generally to the population and does not make specific reference to women of any cadre. Programs and projects to support women should now begin to pick the different clauses and begin to interpret and identify which ones affect positively or negatively prevention of HIV infection among women of various ages”.

7. Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

“There has not been any legislation with regard to prevention of HIV transmission. It would be prudent to see the enforcement of law and begin to see what adjustments may be necessary to make the situation better with regard to improving the situation of HIV/AIDS prevention among women. In addition it is important to note that it is not about laws it is about awareness and commitment by individual persons to protect themselves form infection”.

Prevention component 2: Policy provision

8. What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in Kenya better or worse?

“The government has promoted PMTCT in antenatal care all over the country. This is a deliberate effort by the government to support infected mothers with prevention services so that they do not end up with infected babies and as well help improve the health status of infected mothers. The National AIDS and STIS Control Program together with other partners have been working on new policies to support prevention of HIV/AIDS and other STIs. They have come up with a number of policy documents that target adolescents and youth. There are a number of National guidelines, policies regarding reproductive health, family planning, and HIV/AIDS as well that have been developed”.

9. Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

There is no official sex education in public schools in Kenya as yet. There are on-going discussions regarding introduction of sex education in schools. The ministry of education currently working with other non-governmental organizations to support the development of curriculum for sex education in schools. However even with effort at this level the challenge might be on the capacity of teachers in school to teach the subject in a society where discussing sex is taboo. Teachers and parents have quite not been able to discern what particularly would form the content of the subject in school”.

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10. Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

“It would be nice if the government put in place mechanisms that will help deal with the bigger problem of stigma and discrimination. Stigma and discrimination is a major problem in Kenya. Though it has begun to change a bit in Kenya, we see many people in our group facing challenges while interacting with other people in public. They fear sitting next to you once they learn you are infected. We have supported two young girls who were infected and once the parents learnt they were infected they were sent away from their homes. With our support by way of providing information and encouraging family members they were later accepted back to their families”.

Prevention component 3: Availability of services

12. What type and scale of HIV prevention services are available for girls and young women in Kenya? For example, to what extent is it possible for them to get:

Access to Male and female condoms

The government through NASCOP has promoted condom distribution – mainly the male condom and has clear guidelines on access to enhance prevention of HIV transmission. Access to female condoms is still low given the difficulty in acceptance.

“There is conflicting information regarding the use given the different information that is disseminated by churches some of which do not allow the use of condoms. The Catholic Church does not allow followers to use condoms while social marketers encourage use of condoms for protection. These conflicting messages still send mixed and confusing messages to the public. Distribution of condoms is inconsistent. Many dispensers are empty due to no refilling especially in the rural areas”.
Information and treatment for sexually transmitted infections (STIs)

Throughout the country adolescent reproductive health and HIV/AIDS programme try as much as possible to target young people to access the relevant information they need to prevent transmission as well as treatment of STIs including HIV/AIDS. Youth centres that are coming up coordinate clinics and camps where young people get to learn sexuality issues and about sexually transmitted infections.

Voluntary counselling and testing

There is free access to VCT services throughout the country.

Antiretroviral drugs (for infants, children and adults)

The government policy on antiretroviral treatment is those who need treatment should access treatment free of charge from the public health facilities. However in rural areas, patients are asked to pay user fees for such services as CD4 count tests. Young people who are unemployed might not be able to access services due to lack of money to access services.

Services and antiretroviral drugs to prevent transmission of HIV from an HIV positive mother to her children.

"PMTCT services for mothers who need them are available in most public health facilities in Kenya. In most maternity hospitals in Kenya today, if a mother goes for antenatal care it is mandatory that they are counselled and tested for HIV".

13. What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are:

* Unmarried?
  * Out of school?
  * Migrants?
  * Refugees?
  * HIV positive*

Reproductive health service programmes for adolescents and youth target them as a group and is not specific to any category of persons. There are no specific programmes for young women and young men.

Involved in sex work

"Sex work is illegal in Kenya that makes it difficult to find programmes that target sex workers".

Orphaned
Injecting drug users

Only recently, programmes have started to come up to try and support drug users to access information about the risk of HIV infection through sharing of needles and syringes.

14. What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

Young people have been targeted as a group or rather category of young people rather than targeting them separately as boys and girls. For examples Youth Support centres are not specific for either males or females but both genders are supported with services and information at the centres.

15. Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

Voluntary Counselling and Testing centres which are well equipped with testing kits and trained counsellors who can support young girls and young women access information on how to protect themselves from infection and in case they are infected how to prevent re-infection including how to access PMTCT services.

There is need to develop youth friendly services that target young girls and young women with various reproductive health services and information.

Prevention component 4: Accessibility of services

14. What are the main barriers to girls and young women using HIV prevention services in Kenya? For example, is it:

The cost of the services?

There are some facilities that charge minimal user fees for services provided. Majority of young people will shy away from using services due to lack of money.

The location of the services

Where the location of the services is far from home, it becomes difficult for young people to access services. In many rural areas people have to travel along distance to access services. Young persons lack money to facilitate travel to facilities far from home.

The lack of privacy at the services

Most of the health care workers in the public hospitals may not know how to receive adolescents and youth in public health facilities. Many times they will find themselves being rebuked for contracting an STI. Services are also provided together with other older persons that they may fear seeing them in the health facility for treatment of STIs.

The hours that the services are open

The language that the services use

The attitudes of the staff that run the services

Public health workers have judgemental attitude towards young people and this keeps them from accessing services from these facilities.

“Young people have to come to the same clinics where older people are treated. Nurses have judgemental attitude towards the young people- they are rebuked for contracting..."
Fear that confidentiality will be breached by the services

The attitudes of parents or friends

Cultural norms, for example that prioritises the health of boys over the health of girls?

15. Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are:

Married or unmarried

“Access to services might be difficult for married adolescents. They have to have the consent of their partners to access contraceptive services. They might have the resources to access services, but their spouses might not allow them to access services.”.

In school or out of school

HIV positive

It may be difficult for a young woman to access services due to distance to facility. This is mainly in the rural areas where most facilities are far away from home and young girls and women may lack cost of transport.

“The stigma that goes with infection could be the main barrier here. Fear of being discriminated against once relatives and friends get to know the HIV (positive results of a person might make it very difficult for that person to access the services”).

16. What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

17. Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women

- Scale up voluntary Counselling and testing services countrywide. Most of the VCT services are situated in urban and Peri-urban areas.
- The government needs to put in place policies to support provision of services particularly to young girls and young women as a special category of vulnerable persons with regard to HIV infection.
- Strategy for provision of youth friendly services needs to be put in place.
- Training of policy makers to understand the needs of young people will enhance prevention services.

Prevention component 5: Participation and rights

20. How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Kenya?

Kenya is a signatory to the international Convention on the rights of the child as well as the convention on elimination of all forms of discrimination against women. The government signed these conventions but the enforcement is lacking.
21. To what extent is the national response to AIDS ‘rights-based’? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

The government has not had focus on reproductive health rights for women and as such it has no specific policies on reproductive health rights for women. The new HIV/AIDS act has general tenets that do not specifically relate to women’s reproductive health and rights.

22. To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in:
   * Developing the National AIDS Plan?
   * Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

The youth are not consistently represented in key decision making about HIV/AIDS programs in the country. Boards of directors and the top management of the different government departments always meet, make decisions and pass them for implementation. The youth are not adequately involved in decision making.

23. Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

   a. The government should encourage youth representation in key decision making forums to be able to appreciate the needs of young people and plan for them with these issues in mind.
   b. There is need to educate policy makers on the need for representation of youth in key decision making processes in Kenya.
   c. The government needs to set aside a budget to support the development of youth friendly reproductive health services countrywide.
Summary

21. In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Kenya?
3. What is your impression about the general situation of HIV prevention for girls and young women in Kenya? Are things getting better or worse ... and why?

“There has been an improved appreciation of the role of gender in prevention initiatives which as improved the general situation of HIV prevention for girls and women. Services are not yet adequate but at least there is effort being put in that direction”.

Prevention component 1: Legal provision

8. In your opinion, what laws in Kenya are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as:

Whether girls can get married at an early age?

“While the law is clear that marriage below the age of 18yrs is illegal, there is often conflict between the law and cultural practices which makes enforcement difficult. This has therefore not contributed as it should in addressing the plight of girls as it should”.

Whether sex work is legal?

Sex work is illegal in Kenya. Programs targeting this group of individuals are therefore faced with significant challenges in provision of HIV prevention for a group of individuals who are engaged in illegal activity.

Whether girls or young women can have abortions?

“Abortion is illegal in Kenya as defined by law. There has been therefore a lot of backstreet unsafe abortion which has contributed to worsening the HIV situation for young women and girls and has claimed many lives as a result of complications from abortions done with unqualified practitioners”.

Whether girls and young women can use sexual and reproductive health services without their parents’ consent?

“There is a serious impendent to HIV prevention in cases where parental consent must be sought to provide SRH services to Minors. This is a requirement for certain SRH services in Kenya”.

9. How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are:
   * In/out of school?
   * Married/unmarried?
   * In rural/urban areas?
   * Living with HIV?
   * From marginalised groups (such as sex workers, migrants or orphans)?

“In my opinion Kenyan legislation on HIV is crosscutting and does not make reference to the various groups independently”.

10. Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?
“There is need to review laws on abortion and sex work to be able to enhance prevention among sex workers by facilitating deliberate targeted effort to reach them. The law on abortion should be reviewed to accommodate the feelings and choice of young people as well as consider what other circumstances and contexts may define need for abortion for young girls and young women in Kenya”.

**Prevention component 2: Policy provision**

11. What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in Kenya better or worse?

“For HIV testing, the requirement for parental consent for minors is an impediment to accessing services by this group. Policies do not allow for instance condom use demonstration in up to secondary schools.”

12. Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

“There is no official sex education in schools at the moment. There has been a debate on introduction of sex education, any time it has been suggested, the churches, and parents have not agreed to it.”

13. Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?
   a. There is need to review laws that restrict access to information and services in the area of Sexual and reproductive health for minors.
   b. There is need for school-based curriculum that is age specific for schools.

**Prevention component 3: Availability of services**

16. What type and scale of HIV prevention services are available for girls and young women in Kenya? For example, to what extent is it possible for them to get:
   * Male and female condoms?
     Male condoms are easily accessible while there is a persistent shortage of female condoms reducing accessibility.
   * Information and treatment for sexually transmitted infections (STIs)?
     This service is available in most medical facilities the impediment to access is perhaps the stigmatization that goes with it. “Many young people avoid going to public health facilities for treatment of STIs for fear of being judged negatively for getting involved in sexual intercourse and contracting an STI”.
   * Voluntary counseling and testing
     “There has been significant progress in expanding access to this service country wide. In areas where there are no established facilities, mobile outreach services are being provided, but there are no clinics particularly targeting young girls and young women independently.”
   * Antiretroviral drugs (for infants, children and adults)
     “The cost of drugs have come down and in government facilitates the drugs are dispensed free of charge, however still a significant portion of those who need ARVs have no access to them.”
Services and antiretroviral drugs to prevent transmission of HIV from an HIV positive mother to her children.

"Again while significant strides have been made in provision of PMTCT services, this remains an area of need for scale-up."

17. What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are:
   - Unmarried?
   - Out of school?
   - Involved in sex work?
   - Orphaned?
   - Injecting drug users?
   - Migrants?
   - Refugees?
   - "HIV positive"?

Policies and protocols and perceived needs is what varies but prevention services are available for all groups.

"It may however a challenge to support sex workers because sex work is defined by law as illegal."

18. What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

"Well, available services target the general population and not specific gender a few prevention services do exist within youth centres. But these are not adequate. There are a few cites mostly located in the urban areas. The rural areas are not well resourced with youth centres".

What types of services most urgently need to be increased to improve HIV prevention for girls and young women?

- Provision of life skills programmes to build the capacity of young girls and young women to be able to take Sexual and reproductive health decisions appropriately.
- Scaling up access to a wide range of SRH services e.g. information and access to VCT services

Prevention component 4: Accessibility of services

Interview questions:

16. What are the main barriers to girls and young women using HIV prevention services in Kenya? For example, is it:
   - The cost of the services?
   - The location of the services?
   - The lack of privacy at the services?
   - The hours that the services are open?
   - The language that the services use?
   - The attitudes of the staff that run the services?
   - Fear that confidentiality will be breached by the services?
   - The attitudes of parents or friends?
   - Cultural norms, for example that prioritise the health of boys over the health of girls?

"All the above listed factors have an effect on HIV prevention services. They however vary from one place to another and in sometimes there are variations within the same areas depending with who is providing the services."

"Many young people avoid going to public health facilities for treatment of STIs for fear of being judged negatively for getting involved in sexual intercourse and contracting an STI."
17. Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are:
   Married or unmarried

   “It is difficult to say, a number of factors come to play once one is married. Issues to do with consent of spouse the choice of use or non-use of contraceptives might be a challenging one. It depends on the choice and communication among spouses. It might be difficult to determine for couples what services or methods of prevention they need to make use of.”

In school or out of school

   “Access to prevention services might be easier for out of school youth. Parents might not really appreciate the need to provide prevention services for in-school youth. Information might be disseminated freely, but distribution of condoms among this group is hard.”

HIV positive?

   “Access to services for HIV positive young girls and young women might be harder mainly as a result of stigma but this is fast changing”.

18. What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

   “Kenya is largely a patriarchal society which means that men control wealth and take lead in decision making; in many cases without consulting women. From this perspective, men and boys hold the key to improving HIV prevention for women and girls. There is need for programmes targeted at young boys and young girls to make them realise more the need to protect girls and women”.

19. Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

   “Scaling up health promotion efforts, expanding services in terms of range, distribution and consistency and addressing cultural barriers including gender imbalance will go along way to improve prevention efforts in Kenya”.

Prevention component 5: Participation and rights

24. How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Kenya?

   Kenya is a signatory to these commitments and has made effort to institutionalize the same and domesticate them to suit the Kenyan context.

   “However, enforcement of the same commitments have been problematic hence the discord between the law and practice”.

25. To what extent is the national response to AIDS ‘rights-based’? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

   There are gaps in this area emanating from the common trend of addressing HIV/AIDS and Sexual reproductive health services as separate components. Currently however, there is recognition of the need for integration of services.

26. To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in:
   * Developing the National AIDS Plan?
* Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

There is very little involvement of young people in key decision making in Kenya. “However, there are deliberate efforts by the government for youth representation by establishment of a new youth ministry and youth fund”.

27. Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

There is need for budgetary allocation for young people in order to address reproductive heath needs as well as HIV/AIDS prevention.
Summary

22. In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Kenya?

   a. Scaling up health promotion efforts,
   b. Expanding services in terms of range and distribution,
   c. Addressing cultural barriers including gender imbalance,
   d. Reviewing and enforcement of favourable laws and integration of HIV/AIDS and Sexual and reproductive health response.
4. What is your impression about the general situation of HIV prevention for girls and young women in Kenya? Are things getting better or worse ... and why?

The situation of HIV prevention among youth in and out of school has generally been improving because there are more programmes that are now being implemented in Kenya that target this particular group with a view to preventing transmission of HIV and for those who are already infected to access information on treatment and prevention of re-infection as well as prevention of HIV to those who are not infected.

“The Muslim community through the mosques has set up The Family Resource centre under which the adolescent Reproductive health and HIV/AIDS Prevention programme. The family resource centre offers training to peer educators, supports a number of families with HIV +ve members with Care and treatment services including supporting their dietary needs and helping them set up income generating activities (IGAs).

“Through such programmes it can be seen that it is getting better because young people are getting more up to date information on reproductive health issues as well as HIV/AIDS prevention and care information”.

The Youth programme mainly targets youth ages 14-25.

“Please note that the Muslim community is very sensitive when people have to mix. I.e. if males and females have to mix. In which case the male youth and female youth are targeted separately. If training is to be done on various sexuality and reproductive health topics then the males will be taught in a different session from the females. They cannot be taught together”.

Training that is done targets imparting life skills on various reproductive health topics most importantly the understanding of how the male and the female reproductive organs function the risks of contracting disease and most importantly HIV transmission.

Training is done by directly visiting schools and organising sessions where this information is disseminated to them. Teachers are now being trained to disseminate sexual reproductive health information to students/pupils in school. Training is also organized to target out of school youth by organising clinics/camps where youth go and they are trained.

The training on in school youth is targeted at both Christian and Muslim schools, but it is important to note that this programme deliberately targets Muslim schools.

“We make a deliberate effort to go to Muslim schools” the information disseminated is first shared with the School principals through the trained project facilitators before they organize and plan sessions for training.

Training covers:
- HIV transmission prevention
- Other STIs
- Issues to do with masturbation
- Homosexuality
- Rape how to handle rape including issues on post exposure treatment.

“Information that is disseminated during our training sessions is specifically tailored to be in line with the teachings of the Koran”.

Prevention component 1: Legal provision
Interview questions:
11. In your opinion, what laws in Kenya are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as:

“It is important to note that there are two sets of laws in Kenya the government laws Contained in the National constitution and the family customary laws. It is important to note though, that the HIV/AIDS Act was passed by parliament late 2006 and was just gazetted on 2nd January 2007. It will only be clear how these laws affect the various categories of women in Kenya once the full implementation begins. Many projects and programmes targeting women in the fight against HIV/AIDS still need to put in place the necessary mechanisms for full enforcement. Once that happens, then it will be possible to see how the laws affect women and the gaps that are there that probably need to be addressed”

Whether girls can get married at an early age?

In Kenyan law a 15 year old person is regarded as a minor. As from 18 years old one is regarded an adult.

- “The Muslim laws allow women to be married from the age of 15 years as long as the girl is not forced to get married. If a girl aged 15 consents to get married then the Muslim law does allow marriage at this age. This is the minimum age at which a woman can get married according to the Muslim laws”. Looking at the risks involved with regard to HIV transmission then, one might argue that when a girl is allowed to get married at this early age they are likely to get exposed to HIV virus given that reproductive organs are not yet well developed at this age and given that may be at this age the girls do not have sufficient life skills with regard to reproductive health information they need to have to protect themselves from HIV infection.

Whether sex work is legal?

- “Of course sex work is illegal in Kenya, but this law is discriminatory in the manner in which it applies in Kenya. It is one sided in that it supports the punishment of women who do sex work, but does not support the punishment of the men who buy the sex services. This then raises the debate of whether sex work should or should not be legalised in Kenya.

Whether girls or young women can have abortions?

- “According to the teachings of the Koran, abortion is illegal, but it can be allowed if pregnancy poses a threat to mother or the child. In addition, before abortion is recommended one has to take into consideration the stage at which the pregnancy is. For instance the Muslim law will not allow abortion to be done at the third stage of the pregnancy whether or not it poses a threat to the life of the mother or that of the baby. The Koran stipulates that abortion can only be done before 120 days of the pregnancy.”

Whether girls and young women can use sexual and reproductive health services without their parents’ consent?

- “Young women and even young men are allowed to have access to reproductive health services without the consent of their parents, but this access is guided by religious tenets- hereby referring to the guidelines or simply put, the teachings of the Koran. For instance the Koran allows the use of Condoms only among married
couples, because sex is sacred and is only allowed between married couples therefore it will depend on what type of services we are referring to here. If they are going to be allowed to access condoms for example the Muslim law demands that this be done in consent with a spouse in which case both husband and wife must be present at the time. If we were to allow the distribution of condoms among unmarried young people then we will be going against the teaching of the Koran which says that sex is only allowed among married couples”

12. How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are:

- In/out of school?
- Married/unmarried?
- In rural/urban areas?
- Living with HIV?
- From marginalised groups (such as sex workers, migrants or orphans)?

The implementation or rather the enforcement of the laws regarding prevention of HIV transmission in Kenya has a much more general outlook and does not have a specific focus on women alone. Programs and projects to support women should now begin to pick the different clauses and begin to see which ones support or inhibit prevention of HIV infection among women of various ages.

"What is evident is that the HIV/AIDS act has been passed. The translation of this act into actual practice will take a while. It is difficult to be able to discern how the various clauses will affect the different categories of women”.

13. Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

"Again in Kenya there has not been proper legislation with regard to prevention of HIV. Let us first settle down with the implementation process of the new law then we will be able to see what gaps emerge once we begin to delve more into the law by implementing it”. The act that has been passed

Prevention component 2: Policy provision

14. What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in Kenya better or worse?

The multi-sectoral approach to HIV/AIDS in Kenya by the government through the National AIDS control council (NACC) and National STIs and AIDS Control Programme (NASCOP) together with other partners, have been working on policies to support prevention of HIV/ and AIDS and have developed a number of policy documents that particularly target adolescents and youth. There are a number of National guidelines, policies regarding reproductive health, family planning, and HIV/AIDS.

All these documents highlight the key areas of focus and the means to improve prevention of HIV/AIDS in various aspects.

"I have not read them in detail, but my conviction is that a lot of the policies and Protocols as well as the guidelines are meant to improve prevention of HIV/AIDS.”

15. Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?
There is no official sex education in public schools in Kenya as yet. There has been debate on whether to bring it to schools or not to do so. But with the advent of HIV/AIDS it is imperative that information is passed to young people in good time to expose them to various issues in sexuality and HIV/AIDS. As such there is need to train teachers on what information they need to share with students in school and how that information should be disseminated. There has been a big debate between parents and schools on whether to teach sex education in schools or not. It has been generally agreed that programmes to support youth and adolescents be put in place that will help impart life skills to young people so that they are aware of these issues and be able to protect themselves from HIV infection as well as other STIs.

Much of the information that is taught in school today is by way of mentioning shallowly about reproductive health. Any time the need to introduce sex education in schools is brought up, parents resist. The bigger question is in regard to what should be the content of the subject of sex education in school.

“The family resource centre has come up with life skills training programme where issues to do with sexuality is covered. Knowledge about sexuality is taught, this includes exposing young people to how male and female reproductive organs function, risks in premarital sex, good grooming, sexually transmitted infections including HIV/AIDS. Behaviour change communication is a main focus”.

16. Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

The government needs to put in place a sex education policy so that mechanisms can be put in place to specifically target the youth with the relevant information that they need as well as the services that will enhance prevention of HIV among the young people.

Prevention component 3: Availability of services

19. What type and scale of HIV prevention services are available for girls and young women in Kenya? For example, to what extent is it possible for them to get:

Access to Male and female condoms

Access to condoms is as per the Muslim guidelines.

“As I mentioned earlier, the Koran does allow the use of condoms for birth control and the guidelines also state very well that sex is only permitted among married couples. It beats logic to allow adolescent girls to access condoms, if the laws say that they should not have sex and you go ahead and allow them to access condoms, the message you will be communicating to the young person is that they have the right to have sex out of marriage. Condom use is therefore prohibited among young unmarried girls and young unmarried men in the Muslim community.”

“As a result of HIV/AIDS the Muslim community has allowed the use of condoms to prevent transmission, but again the same tenets apply. Condom use will be permitted where a married couple’s intention is about protection against transmission of HIV and birth control”.

Information and treatment for sexually transmitted infections (STIs)

Through the family resource centre and the adolescent reproductive health and HIV/AIDS programme young people can access the relevant information they need to access with regard to transmission and treatment of STIs including HIV/AIDS. The youth centre coordinates clinics and camps where young people get to learn sexuality issues and sexually transmitted diseases. The centre also does school visits where special sessions are organized for training of young people in school in sexuality.

Voluntary counselling and testing
In Kenya today there is free access to VCT services. The only impediment could be the
distance that some young youth need to cover between where they live and where they
go for VCT. Lack of money to access VCT centres can make them not uptake these
services.

Antiretroviral drugs (for infants, children and adults)

The government policy on antiretroviral treatment is that the people who need treatment
should access treatment free of charge from the public health facilities. However in some
cases patients are asked to pay a fee for such services as CD4 count tests. Young people
who form the majority of the unemployed in Kenya might not be able to access such
services due to the user fees they are expected to pay before they get such a service.
It is much easier to get access to antiretroviral drugs for adults. It has been difficult to
determine the right dosage for infected infants

Services and antiretroviral drugs to prevent transmission of HIV from an HIV positive
mother to her children.

PMTCT services for mothers who need them are available in Kenya. What mothers need to
have is the vital information on how and where to access such services. In most maternity
hospitals in Kenya today, if a mother goes for antenatal care it is mandatory that they are
counselled and tested for HIV. If tests turn out to be positive, then referral is made
immediately for PMTCT services. This however does not work well with many women who do
not attend antenatal clinics more so in the rural areas.
Some women will miss to attend antenatal clinics due to lack of information or because the
readily available service at home is that of a traditional birth attendant. They will miss to
know their status and in case of infection risk transmitting HIV to the child. In most rural areas
antenatal clinics are far away from where young mothers live, the cost of transport
between home and hospital may be an impediment therefore leading to lack of uptake of
PMTCT services.

20. What type and scale of HIV prevention services are available for particular types of girls
and young women? For example what services are there for those who are:

  Unmarried?

  * Out of school?

  * Migrants?

  * Refugees?

  *HIV positive*?

Reproductive health service programmes for adolescents and youth target them as a group
of young people. There are no specific programmes for young women and young men
separately. It is just recently with the realization that more girls than boys of the same age
group get infected with HIV that programmes have started targeting specifically group of
girls by setting up special programmes for supporting young girls.

Involved in sex work

“Sex work is illegal in Kenya that makes it difficult to find programmes that target sex workers.
You would basically be supporting persons who engage in criminal activities. There is
deliberate effort to support prevention services among sex workers in Kenya, but I think it is in
a pilot stage with the programmes that have decided to target them as a special group of
vulnerable persons”.

Orphaned
There is no specific programme that target young girls and young women who are migrants even those who are refugees. The government does not have a specific policy on HIV prevention for this category of women.

**Injecting drug users**

Only recently, have programmes come up to try and support drug users to access information about the risk of HIV infection through sharing of needles and syringes. But again drug abuse is illegal in Kenya and the debate is how one supports a group of persons engaged in such criminal activity. Most programmes have come up to attempt rehabilitation of drug users, i.e. supporting them deal with addiction as opposed to safe methods of drug use like supplying them with needles and syringes so that drug users do not share these equipments and reduce the chances of transmission of HIV. But, such intervention faces challenges in that while you may be trying to support prevention of HIV transmission you will on the other hand be supporting drug abuse.”

The Omari project in Coast province has attempted such interventions with a lot of challenges.

21. What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

As mentioned the young people have been targeted as a group or rather category of young people rather than targeting them separately as boys and girls. For examples Youth Support centres that have been set up are not specifically for use by males or females but both genders are supported with services and information in the same centres. Many programmes have come up that target youth with information and services. The national youth policy has also been developed to target the general category of youth. There is no special focus on the young girls and young women or young boys and young men as such.

22. Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

It is important to increase Voluntary Counselling and Testing services well equipped with testing kits and counsellors who can support young girls and young women know how to protect themselves from infection and in case they are infected how to prevent re-infection including how to access PMTCT services.

More specifically there is need to develop youth friendly services that target young girls and young women with various reproductive health services and information.

**Prevention component 4: Accessibility of services**

18. What are the main barriers to girls and young women using HIV prevention services in Kenya? For example, is it:

The cost of the services?

Where minimal user fees is charged for services provided in health facilities the young people who form the majority of the unemployed are not able to afford to pay for the services

The location of the services

Where the location of the services is far away from home, it becomes difficult for young people to access the services. Mainly in the rural areas you will find that they have to travel along way to access services. This is expensive given the time and money that they need to facilitate their travel.
The lack of privacy at the services

Most of the health care workers in the public hospitals may not know how to receive adolescents and youth in public health facilities. Many times they will find themselves being rebuked for contracting an STI. Services are also provided together with other older persons that they may fear seeing them in the health facility for treatment of STIs.

“Youth friendly reproductive health services are lacking in Kenya. There are no reproductive health services that particularly target young girls and young women”.

The hours that the services are open

The language that the services use

The attitudes of the staff that run the services

Public health workers many times have judgemental attitude towards girls and young people and this keeps young girls and young women from going to these facilities.

“For example in some cases you will find reports that service providers will ask young people how come they got infected with an STI yet they are not supposed to engage in premarital sex”.

Fear that confidentiality will be breached by the services

The attitudes of parents or friends

“The key here for parents and friends is the religious guidelines. Therefore parents and friends would not possibly allow young people to access prevention services particularly if they are not married”.

Cultural norms, for example that prioritises the health of boys over the health of girls?

19. Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are:

Married or unmarried

“Particularly harder for young unmarried girls and young women because the religious guidelines do not permit contraceptive use among unmarried young people”.

In school or out of school

Within the Muslim community the only service that in school and out of school youth will find easy to access at any time is information regarding HIV/AIDS. Access to prevention services for example access to condoms is particularly not easy given the Koran law that allows sex on in marriage. If at all one is out of school and they are married then they are allowed to access such prevention services.

HIV positive

It may be difficult for a young woman to access services due to distance to facility. This is mainly in the rural areas where most facilities are far away from home and young girls and women may lack cost of transport.

“Of course if a young unmarried person needs to access prevention services or for that matter a young unmarried person infected with HIV needs to access treatment services , he/she might face challenges given they are not permitted by Muslim guidelines that they must not engage in sexual intercourse.”
20. What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Most probably if there is intensive training targeting young boys on prevention of HIV transmission then this will enable boys and young men to appreciate their role in supporting girls and young women in prevention of transmission of HIV.

21. Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women

- Increase voluntary Counselling and testing services countrywide. Most of the VCT services are situated in urban and Peri-urban areas.
- The government needs to put in place policies to support provision of services that particularly target young girls and young women as a special category of vulnerable persons with regard to HIV infection.

Prevention component 5: Participation and rights

28. How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Kenya?

Kenya is a signatory to the international Convention on the rights of the child as well as the convention on elimination of all forms of discrimination against women. The government ratified these conventions but the enforcement is lacking. There are no mechanisms to ensure tracking of progress in enforcement.

29. To what extent is the national response to AIDS ‘rights-based’? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

The government has not had focus on reproductive health rights for women and as such it has no specific policies on reproductive health rights for women. The new HIV/AIDS act contains in general tenets that do not specifically relate to women’s reproductive health and rights.

30. To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in:

- Developing the National AIDS Plan?
- Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

The youth are beginning to have representation in various fora that work to develop national strategic plans for various interventions. They are not consistently represented in key decision making about HIV/AIDS. Boards of directors and the top management of the different government departments will always meet make decisions and pass them for implementation. The youth are not adequately involved in decision making.

31. Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

a. The government should make a deliberate effort to have representatives of youth in key decision making forums to be able to appreciate the needs of young people and plan for them with these issues in mind.
b. There is need to educate policy makers on the need for representation of youth in key decision making processes in Kenya.
c. The government needs to set aside a budget to support the development of youth friendly reproductive health services countrywide

Summary

23. In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Kenya?

Most probably the very ones I have made in the previous responses will be key in enhancing prevention for young people in Kenya.
5. What is your impression about the general situation of HIV prevention for girls and young women in Kenya? Are things getting better or worse ... and why?

The situation of HIV prevention among young girls and young women is getting better in the sense that there is now recognition of the fact that young girls and young women are the most affected with regard to HIV infection. There is currently recognition from the facts and figures that young women and girls are six times more vulnerable to HIV infection compared to the young boys and young men the same age.

“At the acknowledgement level, Kenya is doing well, but in terms of having tangible responses to enhance prevention of HIV transmission among girls and young women it is not any better. We need to actually do something on the ground”

“For instance Analyses of data collected among young girls and young women show that response to HIV prevention by way of training young people in life skills works better before sexual debut. So in Kenya one tangible action would be to mainstream HIV/AIDS training from an early age probably before the age of 15 years”

Prevention component 1: Legal provision

14. In your opinion, what laws in Kenya are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as:

“It is not about whether the laws are making it better or worse in this case. The HIV/AIDS act has just come to effect with the gazette notice early this year the most important issue is the will and the effective implementation of the law. But the other side of this whole process has to do with the deliberate effort to customise the tenets to suit prevention of HIV/AIDS among young girls and young women”.

There is need to put in place mechanisms that will target young women and girls that is when we will be doing something tangible.

Having the HIV/AIDS act is a step in the right direction, but there is no mechanism to penetrate the different contexts in which these laws would be enforced for example the diverse cultural contexts that put different demands on different members of the society.

One can have laws, but if the laws are not enabled then it is a futile effort.”

For example the sexual offences bill would work well if the environment in which it is being implemented is enabling. In Kenya Sex work is illegal when you get young school going girls getting involved with older men in sex work, the freedom to report victims of rape for instance in the context of sex work becomes difficult.

Whether girls can get married at an early age

Whether sex work is legal

“Sex work is illegal in Kenya. But some young girls and young women engage in sex work and are faced with various difficulties. Some are abused, clients refuse to pay for them and sometimes they are assaulted. It is not possible to report when young girls and women find themselves abused.”
Whether girls or young women can have abortions?

"Abortion is illegal in Kenya and is only permitted in a case where pregnancy poses a threat to the life of the mother or the child she is carrying. But young girls and young women still procure abortions in hiding which makes it much dangerous. There has been debate about whether abortion should be legalised in Kenya or not. It is high time the government came up with a policy to address the issue of abortions in a more effective manner. At least the statistics are there that show the impact of abortions among young girls and young women”.

Whether girls and young women can use sexual and reproductive health services without their parents' consent

Young people can use reproductive health services without the consent of their parents, but there are no youth friendly services in public health facilities that take care of young people’s reproductive health needs. For example when a fourteen year old girl goes to hospital to access treatment for an STI the nurses in the facility would be wondering how come such a young person has STI yet they are not expected to engage in sex. They do not understand how a young girl or a young man can get infected. Sometimes health care workers might report such cases to the parents of the girls.

15. How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are:

In/out of school?

"It is not so much about the government legislation on these issues, but about the stated community or institutions’ responsibility to protect young girls and young women Institutions should be able to enforce laws to protect young girls and young women, on the contrary we have seen in Kenya many young girls get pregnant with the very male teachers who have the responsibility to protect them”.

The question is whether the institutions have the adequate capacity in terms of knowledge and authority to protect young people. Various communities have the responsibility to protect their own young people. It therefore depends on the cultural contexts and the will of community leaders and other community members to do away with harmful cultural practices like Female genital Mutilation (FGM) and early marriages among certain communities in Kenya.

Married/unmarried

"Our experience has been that HIV prevalence among young married women is higher than that of young unmarried girls in Kenya. Again here it is not about legislation, but about family values. One cannot move in with law to control how married couples relate you cannot force these things down people’s throats. Much of it remains the will and commitment to protect each other from HIV infection. For example it very difficult to address voluntary counselling and testing among married couples

In rural/urban areas

A deliberate effort need to be made by the government to make access to information for young girls and young women readily available countrywide. Much of the information dissemination services for example youth centres, are located in town centres. It is easier for young people living in urban centres to access the information and services than in rural areas. There needs to be a stronger government commitment to budget for and set up such centres countrywide

Living with HIV
The new HIV/AIDS act is general in the way it applies. There is no special reference to young girls and young women. The only policy that is closer to give specific attention to Young girls and young women is the adolescent reproductive health Policy, but this also applies to young people not specifically young girls and young women. Deliberate efforts should be made to see how the new laws impact on the special category of women and young girls.

From marginalised groups (such as sex workers, migrants or orphans)

“A lot of effort need to be made to reach the marginalised groups with comprehensive services for prevention of HIV/AIDS. As it is the Northern frontier districts have very scantily distributed services for young people compared to other parts of the country. Perhaps it is also important to take a keen interest in the group of young girls and young women as a special category of the marginalised groups. The government and other partners have come up with National guidelines for the support of orphans and other vulnerable children including provision of information on HIV prevention and treatment of STIs, there is need to see how far implementation of these guidelines has gone since they were developed in 2003”.

Even though sex work is illegal in Kenya a few isolated programmes have began to support this group of women access information and reproductive health services they need. Sex work goes on in Kenya and much more focus on this group of women is needed.

16. Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Voluntary Counselling and Testing in Kenya remains anonymous therefore a futile effort. Once a test is taken the results remain confidential. Moving towards routine HIV testing in hospitals will make a big difference- will increase the threshold for people to be tested.

Prevention component 2: Policy provision

17. What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in Kenya better or worse

The government has in a great way promoted PMTCT in antenatal clinics in Kenya, but there is need to develop special antenatal clinics that target young girls and young women.

Government needs to budget for and develop policies that will enable young unemployed girls and young women to access services more so in the rural areas where minimal user fees still remains a challenge for women.

“The government needs to make a deliberate effort to support access to contraceptives for example; the government does not budget to procure condoms in Kenya, UNAIDS procures condoms and distributes them through the Nations AIDS Control Council (NACC) and The National STIs and AIDS Control Programme (NASCOP). This should be the responsibility of the government not Non-governmental organizations”.

The PMTCT component needs to be integrated with antenatal care services and the communication component needs to be strengthened to disseminate the relevant information on prevention from mother to child.

18. Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

“There is no official sex education in schools in Kenya. Sex education is talked about. There has been a big debate between parents teachers Associations and the churches about introduction of sex education in schools. Any time it has been brought up, it has been shot down. Again if policy on sex education was developed the challenge would be the
capacity of teachers to tackle the subject. The other challenge has to do with interaction between home and school. Parents are always taken aback when they hear that sex education needs to be introduced in schools."

19. Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Prevention component 3: Availability of services

23. What type and scale of HIV prevention services are available for girls and young women in Kenya? For example, to what extent is it possible for them to get:
   * Male and female condoms?
   * Information and treatment for sexually transmitted infections (STIs)?
   * Voluntary counseling and testing?
   * Antiretroviral drugs (for infants, children and adults)?
   * Services and antiretroviral drugs to prevent transmission of HIV from an HIV positive mother to her children

Availability of services depends on the context. In urban areas there are more reproductive health services and HIV prevention services in urban centres than there are in rural centres. Distribution of services can best be described as irregular. Supply of services like Condoms distribution is inconsistent. All options for services are available in some places especially in most urban areas while they are very scanty in the rural areas.

Information and treatment of sexually transmitted infections is more available in urban centres than in rural areas. "There are more bill boards disseminating information about HIV/AIDS prevention in urban centres than in rural areas. VCT services are not adequate in rural areas.

There is access to ART in all district hospitals in Kenya today the challenge has been the testing services for infants and the right ART dosage for infants.

ART access is getting better now, but there is need for strengthening the communication component to be bale to disseminate up to date PMTCT information to young girls and young women.

"The VCT services that are available are not youth friendly. They target the general population of adults and have no specific focus on provision of services to young people. This can be a barrier to uptake of services by young girls and young women".

Integrating HIV treatment programs with other treatment programs to enhance prevention is needed.

24. What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are:
   * Unmarried?
   * Out of school?
   * Involved in sex work?
   * Orphaned?
   * Injecting drug users?
   * Migrants?
   * Refugees?
   * "HIV positive"?

Prevention services like VCT centres do target every body. There are no special services for young people. A few youth centres have been developed, but they are located in towns. Most rural areas have no youth centres.

"Revising policy to target drug injectors is possible. It is still not there".
Refugees too need to be included in the National Policy and strategic plan. They should be included so that they can access services.

25. What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

Services target young people not specifically young men or young women. “Sustained and consistent supply of services is still lacking and need to be strengthened”.

26. Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

Testing and STI treatment targeting young people needs to be scaled up as well as communication and information dissemination that will lead to the uptake of prevention services.

**Prevention component 4: Accessibility of services**

20. What are the main barriers to girls and young women using HIV prevention services in Kenya? For example, is it:
   * The cost of the services?
   * The location of the services?
   * The lack of privacy at the services?
   * The hours that the services are open?
   * The language that the services use?
   * The attitudes of the staff that run the services?
   * Fear that confidentiality will be breached by the services?
   * The attitudes of parents or friends?
   * Cultural norms, for example that prioritises the health of boys over the health of girls?

*Did not respond to this question and issued a document on barriers*

21. Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are:
   * Married or unmarried?
   * In school or out of school?
   * HIV positive?

“Married women may have resources to access services but the enabling environment for use of the same might be lacking. Married young women may have to ask for consent from their husbands before using a service this may be a barrier to use of services”.

22. What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Young boys and young men can play an important role in prevention by
   * Participating in open discussions regarding prevention services like condom use with young girls and young women.
   * Acceptability of use of condoms
   * Accessing services together with their partners is key.

23. Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

**Prevention component 5: Participation and rights**
32. How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Kenya?

Kenya has ratified both conventions; the challenge is the capacity for institutions to enforce them to translate them into tangible actions that can make a difference in the lives of young girls and young women.

33. To what extent is the national response to AIDS ‘rights-based’? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

The National HIV/AIDS policy does not specifically refer to sexual and reproductive Health rights of women and men.

Further analysis of the policy documents is needed to be able to see how the various tenets of the law affect young girls and young women.

There has been a general difficulty in identifying specific groups that need special response strategies. NACC has not been systematically resourced to be bale to respond to the different needs of young people.

34. To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in:
   * Developing the National AIDS Plan?
   * Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

   “There has not been deliberate effort to involve youth in key decision making in Kenya. The first step was the setting up of the Ministry of Youth Affairs. The ministry of Youth affairs needs to coordinate the voice of the young people and let them play a role in decision making especially on issues that affect them”.

35. Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

There is National Youth policy in place. The enforcement of this policy should be key for government to involve young people in key decision making.

Policy makers need to deeply understand the issues that affect different categories of young girls and young women.

There is need for mainstreaming male involvement in prevention of HIV/AIDS.

Summary

24. In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Kenya?

   a. Deliberate effort to set up Youth friendly VCT services which particularly target young girls and young women
   b. The VCT services need to be made available to both urban and rural areas.
   c. Setting up youth centres in both rural and urban centres
d. Community leaders need to be targeted with positive messages and training that will enable them to change cultural practices that inhibit prevention of HIV transmission.

e. Make deliberate effort to train policy makers to understand the reproductive health needs for young girls and young women and mainstream the same in the national strategic plans and budgets.
6. What is your impression about the general situation of HIV prevention for girls and young women in Kenya? Are things getting better or worse … and why?

“The situation of HIV prevention among young girls and young women is not getting better nor is it getting worse. The fact to note here is that HIV/AIDS programming with specific focus on young girls and young women has not been considered. I can say that now there is recognition of the fact that young girls and young women are the most affected with regard to HIV infection. Facts and figures on HIV/AIDS in Kenya show that young women and girls are six times more vulnerable to HIV infection compared to the young boys and young men the same age. With these facts a number of initiatives are beginning to come up to respond specifically to the need for programming for young girls and young women.”

“In terms of scaling up i.e. to make the services better data needs to be collected with regard to tracking figures that will give an indication of New infections; number of Injecting drug users being infected; number of commercial sex workers the gay men who have not been considered in Kenya as high risk category; this is in regard to the high risk groups so that one is able to get a clear picture of the real situation on the ground”.

Prevention component 1: Legal provision

17. In your opinion, what laws in Kenya are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as:

“I think it is not about laws. Laws might not help much in efforts to deal with the epidemic and the various dynamics that come with it. Laws might be put in place like the new HIV/AIDS Act gazetted early this year, but enforcement of such laws is a big challenge in Kenya. What is needed is community capacity enhancement and communities moving ahead to take full responsibility to protect themselves from infection. Policy makers need to involve communities at a greater level to be able to help in designing policies and interventions that will be well comprehended by the beneficiary communities”.

Whether girls can get married at an early age

The law permits that girls from the age of 18 years can get married, because at his age they are adults. However there is existence of constitutional law as well as the community customary law. In certain communities early marriage of girls is still practiced as per the customary/community law. Therefore the law against early marriage of young girls is not fully enforced because of the constitutional and family/community law directions that are in play at the same time.
Whether sex work is legal

“Sex work is illegal in Kenya. Some young girls and young women engage in sex work due to the difficult living conditions that many face. In their work they are faced with a lot of challenges. They sometimes find themselves being abused by their clients; some clients will come to them and later decline to pay up; some even assault them. It is not possible for such persons who have been abused to seek redress in laws when they have been abused because they are engaged in illegal business so to speak.”

Whether girls or young women can have abortions?

“Abortion is illegal in Kenya and is only permitted in a case where pregnancy poses a threat to the life of the mother or the child she is carrying. But young girls and young women still procure abortions in hiding which makes it much dangerous. There has been debate about whether abortion should be legalised in Kenya or not. It is high time the government came up with a policy to address the issue of abortions in a more effective manner.”

Whether girls and young women can use sexual and reproductive health services without their parents’ consent

“Young people can use reproductive health services without the consent of their parents, but lack of youth friendly services in public health facilities that take care of young people’s reproductive health needs is a major hurdle in realising this goal”.

18. How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are:

In/out of school?

“For us at UNFPA, it is not about government legislation, but about community responsibility to protect young girls and young women. Communities should take the lead role on protecting them from female genital Cutting, early marriage and many other practices that put them at a greater risk of infection”.

Married/unmarried

In rural/urban areas

A deliberate effort need to be made by the government to make access to information for young girls and young women readily available countrywide. Much of the information dissemination services for example youth centres, are located in town centres. It is easier for young people living in urban centres to access the information and services than in rural areas. There needs to be a stronger government commitment to budget for and set up such centres countrywide

Living with HIV
From marginalised groups (such as sex workers, migrants or orphans)

Generally the new HIV/AIDS act promotes the rights of persons living with HI/AIDS. It makes reference to right to life, right to employment right to good health and access to health services. There is no specific mention or reference to young girls and young women.

19. Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

Prevention component 2: Policy provision

20. What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in Kenya better or worse
The government and other partners have in a great way supported provision of PMTCT in antenatal clinics in Kenya, but there is need to develop special antenatal clinics that would respond to the needs of young girls and young women.

“Government needs to budget for and develop policies that will enable young unemployed girls and young women to access services more so in the rural areas where minimal user fees still remains a challenge for women”.

“The government needs to make a deliberate effort to support access to contraceptives for example; the government does budget for male condoms and when it comes to procurement of female condoms in Kenya, the government says they are too expensive. Gender budgeting is needed here so that an equal volume of female condoms is also budgeted for”.

21. Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

“There is no official sex education in schools in Kenya. Sex education is talked about. There has been a big debate between parents teachers Associations and the churches about introduction of sex education in schools. Any time it has been brought up, it has been shot down. The challenge has been for stakeholders to be able to determine what should be the content of the sex subject in schools and the capacity of teachers to tackle the subject effectively”.

UNFPA, National council for population and Development (NCPD) and other partners have supported the Kenya government to design a sex education package for schools. It has now been piloted and soon they will start working on a final document for implementation.

Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

“There is need for a policy on sex education in schools. Parents, guardians and church leaders need to be educated on the relevant and critical issues affecting young people so that they can appreciate the role of sex education in alleviating some of the critical reproductive health and HIV/AIDS challenges facing families today”.

There are guidelines for supporting Orphaned and other vulnerable children but, activities that should go into specific support for young people who are orphans have not been implemented.

Prevention component 3: Availability of services

27. What type and scale of HIV prevention services are available for girls and young women in Kenya? For example, to what extent is it possible for them to get:
   * Male and female condoms?
   * Information and treatment for sexually transmitted infections (STIs)?
   * Voluntary counseling and testing?
   * Antiretroviral drugs (for infants, children and adults)?
   * Services and antiretroviral drugs to prevent transmission of HIV from an HIV positive mother to her children

Availability of services depends on where one is. In urban areas there are more reproductive health services and HIV prevention services in urban centres than there are in rural centres. Distribution of services can be described as inconsistent. Supply of Condoms is inconsistent.

“Refilling of most condom dispensers in the rural areas is irregular and there is lack of socially marketed condoms that would back the dispensers in public facilities when they run out”.
"The female condoms have not been received positively in Kenya. So they are less distributed as well".

Information and treatment of sexually transmitted infections is more available in urban centres than in rural areas.

There is access to ART in all district hospitals in Kenya today the challenge has been the testing services for infants and the right ART doses for children.

ART access is getting better now, but there is need for strengthening the communication component to be bale to disseminate up to date PMTCT information to young girls and young women.

"VCT services that are available are not youth friendly. They target the general population of adults and have no specific focus on provision of services to young people. This can be a barrier to uptake of services by young girls and young women".

28. What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are:
   * Unmarried?
   * Out of school?
   * Involved in sex work?
   * Orphaned?
   * Injecting drug users?
   * Migrants?
   * Refugees?
   * HIV positive*?

Prevention services like VCT centres do target every body. There are no special services for young people. A few youth centres have been developed, but they are located in towns. Most rural areas have no youth centres.

"Revising policy to target drug injectors would be advantageous".

"UNFPA has programmes through the youth centers for prevention of HIV/AIDS for young girls and young women. The government through the new Ministry of Youth has planned to establish Youth Empowerment Centers where there will be vocational training, entrepreneurship skills and adolescent Reproductive health issues".

29. What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women

Services target young people not specifically young men or young women.

"UNFPA has supported National AIDS Control Council to develop a behaviour change Communication strategy the government should now draw the road map for implementation of the new strategy".

30. Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

Testing and STI treatment targeting young people needs to be scaled up as well as communication and information dissemination that will lead to the uptake of prevention services.

Prevention component 4: Accessibility of services
22. What are the main barriers to girls and young women using HIV prevention services in Kenya? For example, is it:
   * The cost of the services?
   * The location of the services?
   * The lack of privacy at the services?
   * The hours that the services are open?
   * The language that the services use?
   * The attitudes of the staff that run the services?
   * Fear that confidentiality will be breached by the services?
   * The attitudes of parents or friends?
   * Cultural norms, for example that prioritises the health of boys over the health of girls?

“One key barrier is that the services available for treatment of STIs and HIV/AIDS prevention services are not youth friendly. Kenya needs youth friendly services so that the youth are more encouraged to use these services”.

23. Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are:
   * Married or unmarried?
   * In school or out of school?
   * HIV positive?

“HIV/AIDS services are difficult for out of school youth because most of them are not employed and accessing services especially when they live in rural areas where user fees is charged for such services.”

24. What role do boys and young men have in making HIV prevention services easier and better for girls and young women

Young boys and young men can play an important role in prevention by
   * Participating in open discussions regarding prevention services like condom use with young girls and young women.
   * Acceptability of use of condoms both the male and the female condoms.
   * Accessing services together with their partners is key.

25. Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Prevention component 5: Participation and rights

36. How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Kenya?

“Kenya has signed the conventions; the challenge is the capacity for institutions to enforce them to translate into tangible actions that are domesticated to suit local situation and circumstance and that can make a difference in the lives of young girls and young women”.

“Conventions can be signed, but the other side of it is enforcement. In Kenya, the law seeks to protect young girls from female genital cutting but, after a young girl turns 18 and she consents for female genital cutting then it can be done. If a young woman 18 years of age complains of the practice, then law enforcers can take action. This contradiction in law hinders enforcement”.

37. To what extent is the national response to AIDS ‘rights-based’? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?
“The big challenge is that in Kenya, Reproductive health rights have been misconstrued to mean Abortion. And since abortion is not one of the methods of family planning no one wants to give it a thought. Any time it is mentioned policy makers shoot it down thinking that it is a way to legalize abortion. There needs to be more and more sensitization with regard to making people get to understand what reproductive health rights mean”.

38. To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in:

* Developing the National AIDS Plan?
* Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

“There has been an attempt to involve youth in certain activities. For example during the development of the Behaviour Change Communication Strategy (BCC,) UNFPA through the youth centres run under Family Health Options involved quite a number of youth so they could input issues they felt were important for youth. Many times what the youth have been given is mere tokenism so that they can be seen to be represented.”

The ministry of Youth affairs need to coordinate the voice of the young people and let them play a role in decision making especially on issues that affect them”.

39. Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

a. There is National Youth policy in place. The enforcement of this policy should be key for government to involve young people in key decision making.

b. Policy makers need to deeply understand the issues that affect different categories of young girls and young women for better programming.

There is need for mainstreaming male involvement in prevention of HIV/AIDS.

Summary

25. In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Kenya?

a. Make deliberate effort to support economic and livelihood programmes so that young women have options for support and can easily avoid getting into such activities like sex work to support their families.

b. Deliberate effort to set up Youth friendly VCT services which particularly target young girls and young women.

c. The VCT services need to be made available to both urban and rural areas.

d. Setting up youth centres in both rural and urban centres.

e. Community leaders need to be targeted with positive messages and training that will enable them to change cultural practices that inhibit prevention of HIV transmission.

f. Train policy makers to understand the reproductive health needs for young girls and young women and mainstream the same in the national strategic plans and budgets.

g. Gender budgeting;
“The government budgets for male condoms but, when it comes to female condoms they are deemed expensive so just a few are budgeted for. This needs to be corrected to give women an alternative to male condom.”
7. What is your impression about the general situation of HIV prevention for girls and young women in Kenya? Are things getting better or worse ... and why?

The Kenya National demographic and health survey (KDHS) showed that HIV prevalence among young girls and young women is six times higher than that of young boys and young men of the same age.

“Due to such survey results, much attention has been placed on women and girls with regard to HIV prevention efforts without involving males hence the low success rate. Men hold the key and need to be targeted with information to keep the women and girls safe”.

Prevention component 1: Legal provision

Interview questions:
20. In your opinion, what laws in Kenya are making HIV prevention for girls and young women better or worse? For example, what difference is made by legislation relating to issues such as:

Whether girls can get married at an early age?
Whether sex work is legal?
Whether girls or young women can have abortions?
Whether girls and young women can use sexual and reproductive health services without their parents’ consent?

“Legislation in Kenya have done very little to advance prevention of HIV infection among girls and young women. The legislation is rarely disseminated and hardly enforced e.g. the sexual offences Act, the Children’s Act”.

The cultural context in which young girls and young women find themselves also plays a key role in prevention of HIV transmission. There are some cultures in Kenya that still allow early marriage of girls. Some times poverty in families drives parents of young girls to marry them off so that they can earn bride wealth.

“Sex work is illegal in Kenyan law. Therefore, targeting sex workers with prevention, care and treatment interventions still remain a challenge”.

“Where minors need to access reproductive health and care and prevention of HIV/AIDS services, consent of parents has to be sort before they are allowed to use services this is a deterrent to many young people who need these services”.

21. How does legislation affect different types of girls and young women and their vulnerability to HIV? For example how does its effects vary among those that are:

* In/out of school?
* Married/unmarried?
* In rural/urban areas?
* Living with HIV?
* From marginalised groups (such as sex workers, migrants or orphans)?

HIV legislation applies the same way to all categories of people in Kenya. There is no specific relation with young girls and young women.

“Legislation has in a way increased the vulnerability of women to gender based violence and STI/HIV infection e.g. where female sex workers are criminalized for living out of the
proceeds of sex work. They are constantly harassed and violated by law enforcement agents e.g. the police on this account”.

The government does not have a policy on HIV prevention services for refugees and migrants this needs to be put in place.

22. Overall, what laws could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

"It is not about changing or bringing in new legislation but enforcing the ones that are currently there. I am not very familiar with the available pieces of legislation but the war on HIV as it affects women and girls stems from very far away from HIV itself. Land tenure system could be a place to begin. Inheritance and property disposal is another area. Marriage and custody is yet another. There are cultural and family issues that are critical to the well-being of women within various communities in Kenya that need to be reflected upon with much emphasis than even the government legislation."

Prevention component 2: Policy provision

22. What type of government policies or protocols – for example in relation to antenatal care, condoms or voluntary counseling and testing – make HIV prevention for girls and young people in Kenya better or worse?

"Voluntary Counselling and Testing guidelines prohibit provision of prevention services to minors unless they can prove that they are mature minors i.e. married or pregnant by which time they have already exposed themselves to infection while we know with rampant rape cases some perpetrated by the survivors, parents, very young girls are at risk. The p3 form which is a requirement for reporting of violence cases in Kenya is a complex requirement sometimes the offices that should issue it are closed when they are needed, while in rural areas no internet facilities are available to facilitate downloading of the forms. The process of following these protocols itself, at times is very stigmatizing. The family planning protocols define the age at which girls can access contraception that is at the age of 15 years. Below this age, girls will continue to involve themselves in sexual intercourse, and then seek abortion from clandestine sources when they get pregnant - since abortion is also illegal in the country thereby increasing their vulnerability to infection”.

23. Do girls and young women – and also boys and young men - receive any type of official sex education? For example, what are they taught about their sexual and reproductive health and rights while in school?

There is no formal sex education in schools in Kenya. "Sex education is increasingly becoming available for young people through non-governmental organization whereby they are taught gender, functions of male and female reproductive organs, values, sexuality, relationships, pregnancy prevention, STIs and HIV/AIDS etc Reproductive health Rights does not receive much of focus in such programs."

24. Overall, what policies or protocols could the government change, abolish or introduce to bring the greatest improvements to HIV prevention for girls and young women?

"There is need to reduce bureaucratic bottlenecks in access to essential services. The requirement for minors to get parental consent to access prevention services as well as laws on abortion and sex work need to be reviewed to suit the contemporary situation of young girls and young women”.

Prevention component 3: Availability of services

31. What type and scale of HIV prevention services are available for girls and young women in Kenya? For example, to what extent is it possible for them to get:
Male and female condoms.

"Access to condoms is still limited especially in rural areas. Female condoms are hardly available”.

Information and treatment for sexually transmitted infections (STIs)

In formation regarding prevention services is largely available in urban areas but limited in rural areas.

Voluntary counseling and testing?

The government has put a lot of effort in setting up of Voluntary Counselling and Testing services and these services are easily available in almost all parts of the country.

Antiretroviral drugs (for infants, children and adults)?

"There are few access points for infants. Access points for adults are available but still inadequate”.

Services and antiretroviral drugs to prevent transmission of HIV from an HIV positive mother to her children

PMTCT services are quite available in majority of antenatal clinics countrywide.

32. What type and scale of HIV prevention services are available for particular types of girls and young women? For example what services are there for those who are:

Unmarried?
Out of school?

Mainly information is available for unmarried girls. VCT protocols in Kenya still require the consent of parents when minors need to access prevention services.
Involved in sex work?
Information and condoms distribution is available for sex workers.

Orphaned?
There are limited services providing basic needs e.g. education, food, shelter, but there are no specific reproductive health and HIV/AIDS prevention services targeting orphaned and other vulnerable children and youth.

Injecting drug users? Prevention
Information is readily available especially in urban areas, but given that drug abuse is illegal in Kenya, there are critical challenges in targeting interventions for this group.

Migrants?
Refugees?
Migrants and refugees need to be targeted more with prevention information as well as care and treatment services.
“Currently the government does not have a policy on refugees and migrants”.

HIV positive?
VCT, PMTCT and ART access points are not specific to young girls and young women. They are available, but still inadequate especially access to ART is still limited. Majority of people who need them are still not accessing them.

33. What type and extent of HIV prevention services and information are available for boys and young men? How does this affect the situation for girls and young women?

“There is limited incomplete information targeting young boys and young women leading to perpetuation of violence against girls and women for example there is increase of cases of rape of minors among young boys and young men in the hope of riding their bodies of HIV”.

34. Overall, what type of services most urgently need to be increased to improve HIV prevention for girls and young women?

a. There is need for complete accurate information to the men and boys.
b. Proper parenting skills. Improved security (in the residence, at place of work, in marriage, at home etc).
c. Safety nets for girls and women to reduce their dependency on men for example increase opportunities for income generating Activities for young girls out of school and young women.
d. Increased school enrolment and retention.
e. Increased employment opportunities.
f. Improved access to health facilities and improved health service delivery (availability of life saving drugs, safe blood for transfusion.
g. Increase stigma and discrimination activities.

Prevention component 4: Accessibility of services
Interview questions:
24. What are the main barriers to girls and young women using HIV prevention services in Kenya? For example, is it:
   * The cost of the services?
   * The location of the services?
   * The lack of privacy at the services?
   * The hours that the services are open?
   * The language that the services use?
   * The attitudes of the staff that run the services?
   * Fear that confidentiality will be breached by the services?
   * The attitudes of parents or friends?
   * Cultural norms, for example that prioritise the health of boys over the health of girls?
“All of these factors including stigma and discrimination, gender roles and gender based violence inhibit access to services among young girls and young women”.

25. Are HIV prevention services easier or harder for particular types of girls and young women to access? For example, is it easier or harder if they are:
   * Married or unmarried?
   * In school or out of school?
   * HIV positive?

“HIV prevention services more accessible in urban than rural areas by educated employed girls than by uneducated unemployed girls. Information on prevention is more available in school than out of school”.

26. What role do boys and young men have in making HIV prevention services easier and better for girls and young women?

Young boys and young men have not played a major role in HIV prevention for young girls and young women. There is need for prevention interventions that will target them so that they understand their role in prevention of HIV transmission.

27. Overall, what priority actions could be taken to make HIV prevention services more accessible to girls and young women?

Prevention component 5: Participation and rights

40. How are international commitments (such as the Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against Women) applied in Kenya?

“Kenya has ratified all the above conventions. Translating them into action to realise benefits for the targeted groups is still lacking”.

41. To what extent is the national response to AIDS ‘rights-based’? For example, does the National AIDS Policy recognize and address the sexual and reproductive health rights of women living with HIV?

“To a very limited extent is the National response to HIV/AIDS rights based. It is more focussed on provision of care and prevention services. The most explicit rights that are stated in the National response include the right to life, the right to employment and the right to access to services for people living with HIV/AIDS. There is no specific reference to reproductive health rights in the National HIV/AIDS response”.

42. To what extent are girls and young women – including those that are living with HIV - involved in decision-making about AIDS at the national level? For example are they, or the organizations that represent them, involved in:
   * Developing the National AIDS Plan?
   * Participating in the National AIDS Committee or the Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis and Malaria?

The youth in Kenya are not involved in key decision making in Kenya.

“At least the government is working towards the strengthening of representation of youth in key decision making given the establishment of the Ministry of Youth Affairs. This will be the main avenue for representation.”

43. Overall, what priority actions could be taken to support girls and young women to be more involved in national level decision-making about AIDS?

“Get the women interested (culturally a woman’s priority is marriage and child birth anything else is for men), reward the women for their involvement equitably with men, address other barriers to women involvement e.g. stigma and male harassment.”
Summary

26. In summary, what are the 3-4 key actions – for example by the government, donors or community leaders - that would bring the biggest improvements to HIV prevention for girls and young women in Kenya?

a. Good will and true commitment by an informed leadership that does not trivialize women issues is crucial.

b. Participatory and responsible funding by donors is essential so as not to fund counter productive interventions.

c. Effective interventions are those that take into consideration both culture and gender aspects as they predispose both men and women to infection.