MONITORING SEXUAL REPRODUCTIVE HEALTH 2008 UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON AIDS (UNGASS) TARGETS IN KENYA.

BY

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A RESEARCH REPORT SUBMITTED TO GESTOS BRAZIL FOR UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON AIDS (UNGASS)
ACKNOWLEDGEMENT

First we thank our almighty God for making this study a success. We are indeed grateful to United Nations General Assembly Special Session on AIDS (UNGASS) and Gestos Brazil for choosing Kenya to participate in this important research study in efforts to fight HIV and AIDS pandemic. Our gratitude also goes to the Ministry of Science and technology for granting us permission to carry out this study in various organizations and government ministries and departments in Kenya. We sincerely thank all the individuals, government and non-governmental organizations that consented to participate in this study without whom this study would not have been a success. Many thanks to all research assistants and every one who participated in one way or another in this study, your efforts were of great value.
ACRONYMS and ABBREVIATIONS

AIDS-Acquired Immune deficiency Syndrome
ANC-Ante natal Care
ARV-Anti-retroviral
ART-Anti-retroviral therapy
CHIACSO-K-Coalition of HIV Infected and Affected Community Service Organization of Kenya.
CSO-Civil Society Organization
FAWE-Forum for African Women Educationalist
FAWEK- Forum for African Women Educationalist-Kenya
HIV-Human Immune Virus
IEC –Information, Education and Communication
IGA- Income Generating Activities
KNCHR-Kenya National Commission on Human Rights
NACC-National AIDS Control Council
NASCOP-National AIDS and STDs Control Programme
NCGD-National Commission on Gender and Development
NGO-Non-Governmental Organization
RTI-Reproductive Tract Infections
STI-Sexually Transmitted Infections
UNGASS-United Nations General Assembly Special Session on HIV and AIDS
ABSTRACT

The main objective of the study was to collect information on reproductive health and AIDS for 2008 UNGASS targets in Kenya. A cross sectional descriptive study was used. Both quantitative and qualitative methods were used during data collection. Data was collected using structured questionnaires, key informant interview guide and observation guide. A sample of 82 respondents were interviewed who included representatives of non-governmental and government ministries and departments. The collected data was cleaned, coded and entered into the computer and analyzed using SPSS version 11.50 and Excel software. Descriptive statistics such as percentages and frequencies were used to summarize data. Data was presented using charts, graphs and frequency tables. The study found that the government and other stakeholders had put great efforts in fight against HIV and AIDS. The results showed that women who were HIV positive could access health care services from dispensary level 32.9% to provincial level 8.5%. The coverage of ARV treatment was high with some respondents saying the coverage was 90%. Fifty five percent said that nutritional package was available during pre-natal and postnatal care. Prevention of Mother to Child Transmission of HIV services were available and the highest coverage mentioned by respondents was 40% and 90%. There were policies to guide prevention, diagnosis and treatment of STIs/RTIs and there laws put in place to protect women and girls from sexual violence and against women trafficking. Human rights were protected even in prisons. Majority of respondents 45% said that many women could not access information on health care. It was clear that more AIDS patients are put on ARV treatment; others on prophylactic treatment and pregnant women could access PMTCT services. It was also realized that although government and other stakeholders had put great efforts in war against HIV and AIDS more resources are needed to meet a huge challenge of treating ever increasing number of AIDS patients who require ARV treatment, prevention and care services. The government and other stakeholders have put policies to ensure gender balance in HIV and AIDS education program and have set laws to protect women from trafficking and sexual violence to reduce vulnerability to HIV infection. The government and stake holders however had not fully involved women and girls who are more vulnerable in formulation and evaluation of HIV and AIDS curriculum in schools. The government and other stakeholders should set aside more resources to maximize strategies in HIV infection preventive measures such public awareness on female condom to enhance acceptability, intensify fight against female genital mutilation (FGM) which is a sexual violence against women and a risk to HIV infection, fight stigma which is still a big obstacle to success of treatment and care services especially among the youth and women who are more vulnerable. The government should focus on capacity building of Health care providers and teachers success of sexual reproductive health and HIV and AIDS education in schools. The government should distribute Specialist like gynecologist and psychologist to Dispensary level and decentralize decision making to community level.
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CHAPTER ONE: INTRODUCTION

1.1 Background

In June 2001, Heads of State and Government Representatives of 189 nations gathered at the first-ever Special Session of the United Nations General Assembly on HIV/AIDS. At this United Nations General Assembly Special Session (UNGASS), the gathered nations unanimously adopted the Declaration of Commitment on HIV/AIDS, acknowledging that the AIDS epidemic constitutes a "global emergency and one of the most formidable challenges to human life and dignity." The Declaration of Commitment on HIV/AIDS covers 10 priorities, from prevention to treatment to funding, and these reflect a global consensus on a comprehensive framework to achieve the Millennium Development Goal of halting and beginning to reverse the spread of HIV/AIDS by 2015. For a complete copy of the UNGASS Declaration of Commitment on HIV/AIDS, please visit: (UNAIDS 2001) http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf. Recognizing the need for multi-sectoral action on a range of fronts, the Declaration of Commitment addresses global, regional and country-level responses to prevent new HIV infections, expand healthcare access and mitigate the epidemic's impact. Although it was governments that initially endorsed the Declaration of Commitment, the document's vision extends far beyond the governmental sector - to private industry and labour groups, faith-based organizations, non-governmental organizations and other parts of civil-society, including organizations of people living with HIV. Under the terms of the Declaration of Commitment, success in the response to AIDS is measured by the achievement of concrete, time-sensitive targets. The Declaration calls for careful
monitoring of progress in implementing agreed upon commitments. In 2002, the Joint
United Nations Programme on HIV/AIDS (UNAIDS) Secretariat collaborated with
UNAIDS co-sponsors and other partners to develop a series of core indicators to measure
progress in implementing the Declaration of Commitment. These core indicators were
further refined in 2005. For more information on the Joint United Nations Programme on

Kenyan HIV/AIDS Situation.

The first case of AIDS in Kenya was recognized in 1984. Since then, the human
immunodeficiency virus (HIV) has spread through the entire country. With over one
million Kenyans infected with the virus and another 1.5 million who have died from this
disease, AIDS has had a major socio-demographic and economic impact on the country.
Life expectancy has dropped by almost twenty years since the onset of this epidemic and
more than 1 million children under the age of 15 years are orphans due to HIV/AIDS.
Economic status has declined and poverty has increased. As a result HIV/AIDS was
declared a disaster in 1999. All Kenyans have been affected by this epidemic. Awareness
concerning HIV/AIDS is almost universal among adults and knowledge of correct
methods of prevention of HIV is high (Guidelines for HIV testing in Clinical Settings,
2006). Women in Kenya, have been shown to have the highest prevalence of HIV as
compared to men (NACC, 2005) Therefore, issues like micro finance credit, participation
in decision making, consideration in research, natural history of AIDS in the female body
and AIDS education for girls, if addressed will help reduce the vulnerability of women.
1.2 Statement of the problem

The need to monitor government fulfillment of its commitment to achieve the requirement of the declaration as agreed at UNGASS New York in 2005 is paramount. In June 2001, Heads of State and Representatives of Governments met at the United Nations General Assembly Special Session dedicated to HIV/AIDS. The meeting was a major milestone in the AIDS response. It was recognized that the AIDS epidemic had caused untold suffering and death worldwide. The UN Special Session also served to remind the world that there was hope. With sufficient will and resources, communities and countries could change the epidemic’s deadly course. The theme global crisis requiring global action served to underline the need for urgent attention. At the meeting, Heads of State and Representatives of Governments issued the Declaration of Commitment on HIV/AIDS. The Declaration remains a powerful tool that is helping to guide and secure action, commitment, support and resources for the AIDS response (UNAIDS 2005). HIV and AIDS is real challenge whose affect are felt now and will be felt in decades to come. Countries like Uganda that had shown remarkable success in their fight against AIDS epidemic are now showing signs of falling back to dangers of the spread of the epidemic. The HIV epidemic in Kenya has resulted in a 30% increase in mortality among infants and children. Among children living with HIV, the vast majority (~80%) acquired infection through mother to child transmission (NACC, 2005). Promoting and Monitoring PMTCT is important as a commitment to the declaration. Cases of gender violence against women, girl as well as boy child have been reported in Kenya. Gender based violence cuts across all social, cultural, ethnical, racial, economic, political and religious contexts, carrying out investigations on gender based rights and
violations and forwarding recommendations to the relevant authorities is the key role of the Kenya National Commission on Human rights (KNCHR, 2006).

1.3 Study Justification.

The 2006 follow-up meeting on the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS took place from 31 May – 2nd June 2006 at the United Nations in New York, USA (UNAIDS 2006). However it was noted that despite the committeemen by head of states of the member countries to fight the spread of the HIV/AIDS epidemic, the disease is still spreading and killing many people around the world. Therefore there is a strong need to carry out this study whose findings and the findings of other related studies in other member countries will provide the information that will help United Nations General Assembly Special Session on AIDS (UNGASS) that will meet in June 2008 to assess performance of each member country in the war against HIV and AIDS.

1.4 Research Questions

1) What Health care services do pregnant women access in the health care facilities in relation to HIV and AIDS care?

2) Are there policies that address gender inequalities in order for success of educational programs for HIV prevention as a human right?.

3) What is the government initiative to address gender based violence and its consequences like sexual violence against women and girls to safe guard human rights?
4) What is the role of the government and non-governmental organizations in repressing women trafficking in order to reduce vulnerability to HIV infection?

5) What measures does the government and Non-governmental organizations take to involve the vulnerable people like women and girls in effort to fight HIV/AIDS?

1.5 Objectives of UNGASS 2008

i) Strengthening national activities by monitoring SRH& R public policies

ii) Increasing CSO participation in SRH&R programs

iii) Strengthening SRH & R in HIV/AIDS issues

iv) Encouraging political agenda input in UNGASS at national and international level.

1.5.1 Specific Objectives

1) To assess the health care services that pregnant women access in both private and public health care facilities in relation to HIV and AIDS care

2) To determine whether there are policies that address gender inequalities in order for success of educational programs for HIV Prevention as a human right.

3) To identify the government initiative to address gender based violence and its consequences like sexual violence against women and girls to safe guard human rights

4) To examine the role of the government and Non-governmental organization in repressing women trafficking in order to reduce vulnerability to HIV infection

5) To identify measures that the government and Non-governmental organizations have taken to involve the vulnerable people like women and girls in effort to fight HIV/AIDS.
2.0 CHAPTER TWO: LITERATURE REVIEW

2.1 Global HIV/AIDS Situation

A total of approximately 39.5 million people were living with HIV in 2006 that is about 2.6 million more than in 2004. There are 24.5 million HIV infected people in Sub-Saharan Africa and an estimated 12 million AIDS orphans. Some two million people died of AIDS related conditions in 2005. That 2.7 million were also newly infected in 2005 points to the need for unprecedented action to stem the tide (UNAIDS 2006 Report on the Global HIV/AIDS Epidemic).

2.2 Kenyan Situation

HIV prevalence in Kenya had fallen to 7% in 2003 from a peak of 10% in adults in the mid 1990s (Ministry of Health, 2005); this is only the second time in more than two decades that a sustained decline in national HIV infection levels has been seen in a sub-Saharan African country (AIDS Epidemic Update, UNAIDS / WHO 2005). More recent sentinel surveillance data indicates that adult prevalence has fallen even further to 6.1% as at end 2004 (Kenya HIV and AIDS Data Booklet, NACC 2005). Evidence suggests that this dramatic turn around is the result of a combination of factors which include higher death rates, lower incidence, and behaviour change. Though behavior change is only one factor which may affect a prevalence decline, in the case of Kenya, evidence suggests that significant numbers of Kenyans have adopted safer sexual behaviors in recent years, including increased condom use, delay in first sexual experience and reduction of partners (AIDS Epidemic Update, UNAIDS/WHO 2005). Following widespread initial reluctance to tackle the epidemic in the early 1980s, there is now strong political will to
reverse the spread of HIV and AIDS in Kenya, and to take constructive steps toward mitigating the effects of the epidemic. The fight has public support and leadership from President Mwai Kibaki and from many senior political leaders. The active and collaborative involvement of a wide range of partners—including government entities, civil society organizations, the faith-based community, the private sector and development partners, all working under the coordination of the National AIDS Control Council (NACC)—is also undoubtedly a factor in Kenya’s success to date.

Kenya’s response to the epidemic is based upon the “Three Ones” principles: one national strategic action plan, one national coordinating authority, and one national M&E system. The new *Kenya National AIDS Strategic Plan (KNASP) 2005/6 - 2009/10* were developed in a broad-based and highly participatory fashion, and thus enjoys broad ownership among stakeholders. The KNASP is evidence-based and results oriented, and its progress is reviewed each year in the annual Joint AIDS Programme Review (JAPR). The national M&E framework was developed in a similar way, and progress in developing the systems needed to implement the framework effectively is monitored by a newly-reconstituted M&E Working Group. Both of these vital strategic documents were developed under the leadership of the NACC, which is recognized by all stakeholders as the one national coordinating authority on AIDS in this country. Given that these critical “Three Ones” building blocks are in place, the challenge for Kenya now is to build upon our successes, safeguard against complacency and re-double our efforts to tackle the many challenges that still remain. Kenya must use its strategic documents, its technical capacities, the goodwill and energy of the stakeholder community, and the significant new resources available, to assure that all available resources (human,
technical and financial) are used efficiently and effectively to dramatically scale-up the national response towards our aim of universal access to prevention, treatment and care for all Kenyans in need by 2010.

Kenya is acknowledged as one of the few countries that have succeeded in changing the course of the HIV/AIDS Epidemic. According to UNAIDS, nationwide HIV prevalence presently stands at 6.1 percent among adults ages 15-49 years (UNAIDS 2006). HIV surveillance data over the last 15 years provide strong evidence that there has also been a decline in incidence. The number of new cases appears to have peaked at 200,000 annually in the early 1990s and fell to 86,000 in 2003. The sad news however, is that AIDS related deaths now exceed new infections and an estimated 150,000 adults died in 2003 (Ministry of Health 2005).

Almost nine out of ten Kenyan adults do not know their HIV status (Central Bureau of Statistics 2004). According to the 2003 Kenya Demographic and Health Survey (KDHS) only 14 percent of men and 13 percent of women ages 15-49 have ever rested for HIV. (Kenya Health Workers Survey 2005).

2.2.1 HIV Prevalence by Age and Residence

The age specific HIV prevalence rate among ANC respondents were analyzed and showed that the 25-29 age group had the highest prevalence 8.2% for rural and 40-44 age group for urban 17.8%. This was followed by the 30-34 age group 7.4% for rural and 11.1% for urban. The HIV prevalence amongst the adolescents (15-19) was 5.1% rural
and 7.3% urban. The age group 15 to 24 years is used as an impact assessment indicator for establishing infection rate amongst the young population and monitoring achievements towards United Nation General Assembly Special Session on HIV/AIDS (UNGASS) targets. The HIV prevalence among this group was 5.4% (95% CL, 4.7-6.2%) 7.6% (95% CL 6.7%-8.7%) for rural and urban respectively. (Sentinel Surveillance of HIV and STDs in Kenya Report 2005).

2.2.2 Current HIV and AIDS Information

The national HIV and AIDS programmes have registered significant progress in the last one year. The current data shows an estimated adult HIV prevalence of 5.1% (4.6%-5.8%) in 2006, compared to 5.9% registered in 2005. The current estimate of urban prevalence is about 8.3% (7.3%-9.1%) while rural prevalence is 4.0% (3.3%-4.7%). The annual number of adults AIDS deaths; in Kenya reached a peak of about 120,000 in 2003. It would have stayed at that level for the next three years were it not for the increasing number of people receiving anti-retroviral therapy (ART). Treatment has reduced the annual number of AIDS deaths to about 85,000 in 2006. In 2006 the number of deaths averted due to treatment is estimated at 57,000 since 2001(National AIDS and STDs Control Program, 2006)

Between 2002 and September 2005 there has been a dramatic increase in the number of patients assessing ARV therapy from an estimated 3,000 in 2002 to 54000 patients at the end of the 3rd quarter of 2005 with over 70,000 patients in clinical (non ARV treatment) are (Guidelines for antiretroviral organization therapy in Kenya 3rd-ed 2005). Currently
250,000 Kenyans need ART immediately, 90,000 patients are in ART and 7,000 children are on ART (Children and HIV Basic Facts, A Guide for Health Workers 2007). Another progress realized is the drop in new infections incidences were estimated at 55,000 in 2006, a drop from 60,000 in 2005. Most of the new infections are occurring among young people (National AIDS and STDs Control Programm, 2006).

Table 2.1 The National HIV estimates for 2006

<table>
<thead>
<tr>
<th></th>
<th>Prevalence</th>
<th>Number HIV positive (+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults 15-49 years old</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total range</td>
<td>5.1</td>
<td>934,000</td>
</tr>
<tr>
<td>Range</td>
<td>(4.6-5.8)</td>
<td>(700,000-1,200,000)</td>
</tr>
<tr>
<td>Male</td>
<td>3.5</td>
<td>320,000</td>
</tr>
<tr>
<td>Female</td>
<td>6.7</td>
<td>614,000</td>
</tr>
<tr>
<td>Urban</td>
<td>8.3</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Adult 50+ years</td>
<td></td>
<td>55,000</td>
</tr>
<tr>
<td>Children 0-14 years old</td>
<td></td>
<td>103,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>1,091,000</td>
</tr>
</tbody>
</table>
Table 2.2 Estimated Adult HIV prevalence by province in 2006

<table>
<thead>
<tr>
<th>Province</th>
<th>Number HIV+</th>
<th>Prevalence</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nairobi</td>
<td>197,000</td>
<td>10.1%</td>
<td>8.0%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Central</td>
<td>96,000</td>
<td>4.1%</td>
<td>1.7%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Coast</td>
<td>93,000</td>
<td>5.9%</td>
<td>5.0%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Eastern</td>
<td>72,000</td>
<td>2.8%</td>
<td>1.1%</td>
<td>4.4%</td>
</tr>
<tr>
<td>North Eastern</td>
<td>9,000</td>
<td>1.4%</td>
<td>0.9%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Nyanza</td>
<td>183,000</td>
<td>7.8%</td>
<td>6.1%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Rift Valley</td>
<td>171,000</td>
<td>3.8%</td>
<td>2.6%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Western</td>
<td>112,000</td>
<td>5.3%</td>
<td>4.2%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Total</td>
<td>934,000</td>
<td>5.1%</td>
<td>3.5%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

These figures illustrate the magnitude of the task to provide prevention, care and treatment and support services for all who need them. The result derived from estimation indicate that; 1.5 million pregnant women need counseling and testing each year to determine their status, 68,000 need treatment to prevent mother to child transmission of HIV, 23,000 children need ART and 200,000 need cotrimoxazole prophylaxis, 430,000 adults need ART and 2.4 million orphans need care and support from their extended families and communities (National AIDS and STDs Control Programm, 2006).
2.2.3 HIV/AIDS Mother to Child Transmission rate

An estimated 630,000 children worldwide become infected with HIV in 2003. Most through MTCT. In other words out of 100 infants born to women with HIV/AIDS and without intervention, 60-75 of them will not be infected of the one third who become infected about 5-10 babies will be infected during pregnancy, 25 during labor and delivery and 5-15 during breastfeeding largely dependent on breast feeding practices and duration. In 2003, nearly 500,000 died of AIDS related causes. Most children born with HIV die before they reach their fifth birthday with most not surviving even two years. The high rate of MTCT in developing countries compared to much lower rates in richer countries, illustrate growing inequalities in global health. In most wealthy countries the rate of MTCT is less than 2% because of widespread access of anti-retroviral therapy (ART), planned cesarean sections, and the means to safety formula feeds and access to quality medical services. In poorer countries like Kenya; there is a 30-40% chance that an HIV positive breastfeeding mother will pass HIV to her child in the absence of these services. Young women are more vulnerable in Kenya than men as evidenced by nearly 9% prevalence rate among women and fewer than 5% among men. At least 50,000 to 60,000 infants in Kenya are thought to become infected with HIV as a result of MTCT each year. (KDHS 2003, NASCOP (2002).

2.2.4 Incidence values and predomination of other STD and congenital syphilis.

The epidemiology of reproductive tract infections (RTI) is poorly understood due to an inadequate reporting system in our health institutions with adoption of the syndromic
approach in the country, the prevalence of STIs/RTIs should be reported in syndromes. Data available from NASCOP on genital ulcer disease (GUD), vaginal and urethral discharge reveals that STI/RTIs are common in the population. During 1990-2000 the prevalence of vaginal discharge and genital ulcer disease was between 11-28% and 20-37% respectively.

Most of studies conducted in urban areas especially in Nairobi and Mombassa mostly involving either women attending ante natal clinics, female sex workers or men working as long distance drivers show estimates for the prevalence rates for gonorrhea to be 4.9% with a range of 3.6- 11 %, trichomoniasis 11.2% with a range of 2-29.4%, bacterial vaginosis is 29% with a range of 9-49% and syphilis 5.8% with a range of 2-9.5%. (Natunal Guidelines for reproductive tract infections services 2006)

Most STIs/RTIs can affect both man and women although the consequences in women are more common and more severe than in men. In fact STIs/RTIs and their complications are among the most important causes of illness and death of women in poor regions of the world. Infections complications of pregnancy (Post abortion and post partum infections) alone are estimated to cause about one third of the 414 maternal deaths per 100,000 live births that occur in Kenya each year (KDHS 2003)

2.2.5 Prevention of STIs / RTIs

The best approach to preventing RTIs including HIV is to avoid exposure. STIs are transmitted from person to person primarily through specific preventable behaviors such
as having many sexual partners, changing sex partners frequently, having sex with casual partners, clients of commercial sex workers or commercial sex workers, sexual practices such as anal sex and not using condoms or incorrect use of condoms and delay in getting STI treatment. Failure to bring in sexual contacts for treatment and not taking treatment for STIs. Condoms are the most reliable method available for situations where people want to protect themselves or their partner from any risk of STIs. Both male and female condoms offer almost the same protection although female condom is more expensive. Some studies have shown that the female and male condom is acceptable to both women and their male partners (National Guidelines for Reproductive Tract Infections Services, 2006).

Adolescent sexuality in most of Sub-Saharan Africa has raised a lot of eyebrows in view of contraceptive use, unplanned pregnancies and sexually transmitted infections including HIV/AIDS. Except in Ghana current contraceptive use is much higher among adolescent males than females. For males, it ranges from 7.2% in Ghana to 24.5% in Kenya. In general, use of modern methods is higher than that of traditional methods. Among females, the predominant contraceptive method in Ghana and Zambia is the Condom, while in Kenya and Tanzania it is the pill. The most predominant method used by males in all the four countries is condom (Tawiah E.O, 2002)

In Kenya the ministry of health has a division of reproductive health (DHR). The goal of DRH in the ministry of health is the ‘Provision of a Comprehensive and integrated system of reproductive health care that offers a full range of services by the government, NGOs and the private Sector, as outlined in the National population policy framework of

The division of reproductive health (DRH) is currently undergoing reforms. These reforms in the health sector generally, began in 2006. It was thought, this would help DHR to coordinate programs better and partners interested in reproductive health agenda, thereby getting best value for money and most importantly, better reproductive health (RH) services for Kenyans.

DRH forum is a newsletter launched to ensure wide sharing of information, provision of widespread technical leadership and information, provision of necessary communication required to ensure an efficient and high quality reproductive health (RH) care system, which is accessible, equitable and affordable to all Kenyans and further ensure high quality, integrated, promotion, curative and rehabilitation (RH) services to all Kenyans. Contribution to the newsletter is open to the public, mission, private sector and stakeholders.

Besides the newsletter there is a website www.drh.go.ke which was launched in 2003 to be used by staff and reproductive health care stakeholders to strengthen DRH projects and research management by coordinating and providing reproductive health information, tools and guidelines to the public health institutions and individuals.

Within DRH, there is the program of gender, sexual and reproductive rights. The program is headed by a program manager and 3 program officers.
Gender issues cut across all other program and involve elements as male participate in RH, reproductive health cancer, infertility, adolescents, youth activities and safe motherhood.

The program of gender, sexual and reproductive rights has the following activities: Development of guidelines; Manuals and curriculum and management of sexual violence; Female genital mutilation; Coordination of gender activities with provincial teams and stake holders; Support establishment of post rape management services in the provinces and districts; Collaborate with other ministries and partners on FGM and sexual violence management; Support training of TOTS on gender mainstreaming and sexual violence management; Conduct support super vision gender; Sexual and reproduction health rights services; Carry out research activities on gender; Sexual and reproductive health rights; Conduct monitoring and evaluation on gender.

Within DRH, there is the adolescent sexual reproduction health (ASRH). It is headed by a program manager and three program officers. The activities of the program are as follows: Policy formulation and development and reviews of guidelines and training materials Coordination of ASHR activities; Training of TOT’S on ASRH services on; Conduct support supervision on ASRH services; Carry out research activities on ASRH services; Resources mobilization; Advocacy; Conduct monitoring and evaluation of ASRH services;

Involved in activities pertaining to reproductive tract cancers-cervical cancer prevention; plan, reproductive tract cancer training under the program of human rights education and
training, the issues concerning the education of men against violence against women should be addressed.

There is also family planning /RTI/HIV/AIDS program headed by a program manager and three program officers. The activities of the programme include: Formulation of policies, development of standards, guidelines, manuals, curriculum in family planning, ensuring adherence to the above documents dictates; ensuring contraceptives security fund raising, projection and forecasting logistics management Information Systems;(LMIS) addresses family planning services provision concerns/issues, change in methods, side effects, methods choice, data on contraceptives prevalence support training and updates in FP services delivery points. The programme also works closely with NASCOP on STI / HIV and PMCT activities, addressing issues on infertility.

Finally, there is safe motherhood and childhood survival programme headed by a program manager and three programme officers. The activities include Ensuring that policies around, safe motherhood are clear, evidence based and are known by RH place , support activities in forecast Ante-natal care(FAMC) malaria in pregnancy(MIP) Obstetrics, fistula training targeted post –part um care, community reproductive health and essential obstetrics care, support supervision, capacity building for provision reproductive health and training teams(DRH Forum,2006)
2.2.6 Human rights

The Forum for African Women Educationalist (FAWE) is a Pan-African non-government organization founded in 1992 whose goal is to increase access, improve retention and enhance the quality of education for girls, women in Africa. In Kenya the outcry through lobbying and advocacy led to the passing of the sexual offences bill into law on 31st May 2006. Through its Kenyan National Chapter –FAWEK-FAWE joined the ranks of an array of lobbyists advocating for passage of the bill as sexual abuses are among the most cited constrains for girls education. The president has since signed it into law showing the government commitment in making a policy towards the achievement of Education for All (EFA) ensuring that girls will not be sexually harassed within or outside the school environment (FAWE 2006).

The National Commission on Gender and Development was established by an ACT of parliament in December 2003 and was launched on 24th November 2004. The object and purpose for which the commission was established is to coordinate, implement and facilitate gender mainstreaming in national development and to advice the government on all aspects there of.

The national commission on gender and development has a mission to co-ordinate, implement and facilitate gender mainstreaming in nation development through to the government and stakeholder, participation in policy formulation, advocacy, research, education, investigation of gender based violation, establishment of partnership, monitoring and evaluation in order to achieve to gender equity and equality.

The mandate of the commission therefore, is to advice the government on policy, options and legal reforms on gender in order to ensure development and implementation of
gender responsive national policies, programmes, plans and legal reforms. The commission has provided leadership, strategic advice, expertise and training to the government to the following policy, programmes and legal reforms. It also provides advice to the government on measures necessary to comply with its international human rights obligation.

It also aims to be the leading national institutions central to the realization of gender equality and equity in all aspects of developments for affair and just society.

As a result of commitment of the national commission on gender and development (Charter) to provide high standards of service, the following have benefited: Men and women, boys and girls, women organization, Non Governmental Organizations, Government ministries, Individuals who conduct or use the services provided as a result of the charter, donors, and community based organizations.

The functions and mandates include: To participate in the formulation of national development policies, responsible for matters relating to gender, exercise general supervision over the implementation of the National policy on gender and development, together with the ministry of culture and social services, to initiate lobby and advocate for legal reforms on issues affecting women and to formulate laws, practices and policies that eliminate all forms of discrimination against women and all institution, practices and customs that are detrimental to their dignity; to initiate proposals and advice on strengthening of institutions mechanisms which promote gender equity and equality in all spheres of life and in particular, access to and benefits in education and health care, nutrition, shelter, employment and control of economic and national resources; to determine strategic priorities in all social-economic, political and development policies of
the government an advice the government on their implementation; to plan, supervise and co-ordinate education programmes to create public awareness and support for gender issues; to evaluate aid policies to determine their impact on women in Kenya; to conduct and co-ordinate research activities on gender issues, to carry out investigations on gender based rights and violations and forward them to the relevant authorities; to receive and evaluate reports by government ministries and other sectors on gender.

The commission strives to protect the dignity, potential worth and rights of every human being (women, men, girls and boys), to mention but one of the core values.

Gender based violations cuts across all social, cultural, ethnical, racial, economic, political and religious contexts, carrying out investigations on gender based rights and violations and forwarding recommendations to the relevant authorities is the key role of the commission. The national commission on gender and development acknowledges the fact that women and young girls are vulnerable group, as far as HIV/AIDS is concerned. Though it does not exclude vulnerability of other groups.

In order to have accurate knowledge of the gender equality work, of the line ministries and to fulfill its mandate, the commission has conducted gender research to gather information in its effort of gender mainstreaming across line ministries. On its mandate of gender research, the commission has achieved the following: conduct of desk survey on gender issues in Kenya in order to identify gender gaps; conduct of baseline survey on customer satisfaction; establishment of resource centre on gender and development; conduct of desk survey on gender based violence.
Concerning education, one of the functions and mandate of the gender commission is to plan supervise and coordinate education programmes to create public awareness and support for the gender issues.

The commission does help orphans and vulnerable children. In order to support national interventions on HIV/AIDS work, the commission has developed a film that brings into attention the often ignored care giving work of grandmothers and elderly women to HIV/AIDS orphans. The film will be an advocacy and education tool to raise policy issues regarding the need for support mechanisms and social safety needs, given the increased burden of work upon women as a result of HIV/AIDS. The commission has a contribution towards HIV/AIDS. It conducts baseline HIV/AIDS survey among its staff. It also conducts Baseline Survey on HIV/AIDS among the commission staff. It also produces documentary on Care Givers to HIV/AIDS orphans and prints materials on HIV/AIDS leaflets to educate people (National Commission on Gender and Development, 2005).

In Kenya also there is Kenya National Commission on Human Rights (KNHCR) which is a Government watch dog organization that works to enhance the realization of human rights. It works closely with Kenya rights human commission, which is an NGO whose head office is located at valley arcade in Nairobi.

The national commission’s work is organized according to the strategic objectives. This is a scene in the key program areas which are: investigating complains and providing redress; campaigns and advocacy; research; policy and legislations; economic, Social
and cultural rights; human rights; education and capacity building; institutional straightening; fund raising; media and communication.

Female genital mutilation, wife beating and forced marriage are not new in the African continent. Traditionally they are seen as ways of exercising an individual or the community’s cultural rights. Ironically trying to stop such practices may be seen as an interference with human rights particularly the cultural rights and hence an increase instead of reduction of social conflicts.

Other than the realization of economic, social and cultural rights other key activities in this program are: monitoring allocation of public expenditure, training public officials and civil society organizations on monitoring economic, social, cultural rights and budget analysis.

Campaigns for penal and police reforms with a view to enhancing human rights protection is one of the key activities under the campaigns and advocacy: here the national; commission uses data and information for advocacy and in influencing key legislation and national policies on human rights.

The national commission mandated by the constitutive act to visit prisons and places of detention or related facilities with a view to accessing and inspecting the conditions under which in mates are held, and make appropriate recommendations thereon. This is based on the national commissions and uninterrupted access to Kenya's 92 penal institutions.
The rights of women in general and those infected with HIV may be looked at under the complaints and redress program. The program review complaints of violation of human rights in many ways one of which may be to refer the complaint to another Government department or civil society organization that is better placed to deal with it. Lesbians, trans gender and drug users in need of information may be referred to appropriate organizations in this respect.

Under the programme of human rights education and training, the issue concerning the education of men against violence against women should be addressed. In this program, the national commission expects to work towards increasing knowledge and awareness on human rights among policy makers and citizenry also works with key institution of learning to ensure these issues are part of the co-curriculum.

After the inauguration of NARC administration, Hon. Moody Awori who later held the office of the vice president as well was appointed minister for home affairs and immigration services and the prisons service was placed under the control of this ministry. The ministry is in-charge of policy co-ordination and implementation. There have been many reforms since the shift of the service from the ministry of home affairs heritage and sports under whose docket it was prior to the year 2002.

In line with the government policy of intensifying the fight against HIV/AIDS pandemic, the prisons service established an AIDS control unit (ACU) in June 2004. This was for
the purpose of mainstreaming HIV/AIDS prevention and care activities in prison functions. The units spearheads awareness campaigns; training of counselors, ensuring access to diagnosis and treatment for infected members of prisons communities and provides policy guidance. It has so far set about complimenting the above strategies in 21 selected prisons.

At a time when Kenya was experiencing an income slump, the following allocations were made for women prisoners: Kenyan shillings 400,000 and 1.2 million for womens expense in 2000/1 and 2001/2 respectively (for expenditure specific to women especially sanitary pads), which worked out at Kenyan shillings 18.09 and Kenyan shillings 57.0 respectively for female prisoners, 26 was grossly inadequate.

Owing to the open door policy, support in terms of charitable donations from communities living near prisons: the business community; NGO’s; and individuals have donated prisoners supplies, training material, and building materials to prisoners. However, in those stations studied, these donations have not been factored in prisons budget or accounting returns, indicating lack of official recognition of such donations as incomes. For this reason stations do not have a budgetary account on these.

The revenue generated from prisons firms and industries go the large GOK pool instead of being given back prisons to the specific prisons or even the prisons services in general. This destroys incentives for to device revenue generating schemes. This is seen as a major budgetary obstacle. More so, the prisons service has been received with mixed
reactions and support in terms of charitable donations from communities living near prisons.

Finally, among the prisons staff, the ratio of men to women is higher. Women prisoners luck proper representation therefore, by virtue of having too few female staff (Republic of Kenya, KNCHR, 2004)
3.0 CHAPTER THREE: METHODOLOGY

3.1 Introduction
This chapter explains the methodology that was used in the entire study. The chapter looks at study area, study design, target and study populations, sampling techniques, research instruments, ethical considerations, data collection, data quality control, data management and analysis.

3.2 Study Area
Kenya-Data was collected from all areas of the country for example, Nyeri, Embu, Kisumu, Mombassa and other towns Kenya.

3.3 Study Design
The study was a cross-sectional descriptive study, designed to collect information on Reproductive Health and AIDS in Kenya. Both quantitative and qualitative methods were used during the data collection.

3.4 Study variables
Dependent variable is HIV prevalence.
Independent variables are health care services, gender based education programs, and gender based violence, policies for controlling gender based violence and women trafficking.
3.5 Target population

HIV and AIDS patients, particularly women and girls.

3.6 Study population

HIV positive men and women, girls age 15 to 25, NGOs, CBOs Government ministries, Hospitals, schools, prisons and women groups in Kenya

3.7 Sample population

Representatives of Kenyan organizations

3.7.1 Inclusion criteria-

Any organization that gave consent to participate in the study

3.7.2 Exclusion criteria

Organizations that did not consent to participate in the study

3.8 Ethical consideration

Clearance was obtained from the Ministry of Education Science and Technology

3.9 Sampling Methods

The sample was obtained through convenient sampling (snowballing), then using a sampling frame made of NGOs, FBO and CBOs; random sampling was used to identify respondents. The government Ministries and Depart were also randomly selected.
3.10 Sample Size Determination

Using simple random sampling the required sample size of 82 organizations including government Ministries and Departments were selected.

3.11 Methods of data collection

Methods of data collection were Questioning and Observation

3.12 Research Tools

The research tools used were structured questionnaire, Key informant interview guide and observation guide.

3.13 Data Quality Control

To ensure the validity and reliability of responses the research tools were pre-tested prior to the actual study.

The research assistants were thoroughly trained and were supervised throughout the entire study.

Continuous scrutinizing, checking and inspection of the data collection was done to ensure, accuracy, consistency and uniformity of the data collected.

3.14 Data Management and Analysis

The data collected was cleaned, coded and entered into the computer using SPSS version 11.50 software. The data was then analyzed using SPSS and Excel soft wares.
Descriptive statistics such as percentages and frequencies were used to summarize the data. The data was presented using charts, graphs and frequency tables.
4.0 CHAPTER FOUR: FINDINGS AND INTERPRETATIONS

This chapter presents the findings of both qualitative and quantitative part of the study. The data was described and summarized using percentages and frequencies. The results were presented using charts, graphs and frequency tables.

4.1 Prevention

4.1.1 Level of health care service accessible to HIV positive women.

The level of health care service that HIV positive women could access most was dispensary 32.9% followed by health centre 23.2%, district hospital 22% and provincial general hospital 8.5%. This finding showed that majority of HIV positive women could easily access health care service at dispensary and health center level. (Figure 4.1).

Figure 4.1 level of health care that HIV positive women could access

4.1.1.1 Coverage of health care service accessible to HIV positive women

Thirty seven percent of respondents said that the coverage of health care service available to HIV positive women was 90%, seven percent of respondents said the coverage was
80% while five percent said that the coverage was 10%. This finding indicated that the coverage of health care service that was available to HIV positive women was high (80% and 90% mostly) (Table 4.1)

Table 4.1 Coverage of health care services available to HIV positive women

<table>
<thead>
<tr>
<th>Coverage of health care services available to HIV positive women</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>4</td>
<td>4.9</td>
</tr>
<tr>
<td>20%</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>30%</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>50%</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>60%</td>
<td>3</td>
<td>3.7</td>
</tr>
<tr>
<td>70%</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>80%</td>
<td>6</td>
<td>7.3</td>
</tr>
<tr>
<td>90%</td>
<td>30</td>
<td>36.6</td>
</tr>
<tr>
<td>Total</td>
<td>49</td>
<td>59.8</td>
</tr>
<tr>
<td>Missing</td>
<td>33</td>
<td>40.2</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>100</td>
</tr>
</tbody>
</table>

4.1.2 Nutritional Support during pre-natal and postnatal care

Fifty nine percent said that nutritional support was part of the package provided during prenatal and postnatal care. Twenty three percent said that nutritional support was not provided during pre and postnatal care while 9% said that they did not know whether nutritional support was provided during pre and postnatal care. This finding suggests that most prenatal and postnatal mothers were provided with nutritional support (Figure 4.2)
Figure 4.2 whether nutritional support was provided during pre and post natal care

4.1.2.1 Coverage of nutritional support provided during pre-natal and post natal care.

Eleven percent said that the coverage of nutritional support during pre and postnatal care was 90%, another eleven percent said the coverage was 40%, four percent said the coverage was 80%. This finding showed that where there was nutritional support during pre and postnatal care the coverage ranged from average to as high as 90% (Table 4.2)

Table 4.2 Coverage of nutritional support provided during pre and postnatal care

<table>
<thead>
<tr>
<th>Coverage of Nutritional Support</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>20%</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>30%</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>40%</td>
<td>11</td>
<td>13.4</td>
</tr>
<tr>
<td>50%</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>70%</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>80%</td>
<td>4</td>
<td>4.9</td>
</tr>
<tr>
<td>90%</td>
<td>11</td>
<td>13.4</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>41.5</td>
</tr>
<tr>
<td>Missing</td>
<td>48</td>
<td>58.5</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>100</td>
</tr>
</tbody>
</table>
4.1.3 Prevention of Mother to Child Transmission (PMTCT) of HIV

Eighty five percent said that PMTCT services were available at a given level of health care, 7% said PMTCT services were not available and 2% said they did not know whether PMTCT services were available. This finding suggests that most of respondents were informed about PMTCT services (Figure 4.3).

Figure 4.3 Whether PMTCT services were available at a given level of health care

This finding was supported by a report by MOH/NASCOP 2007 that for HIV positive pregnant and postpartum women, the government promotes routine offer of HIV testing and counseling, ARVs (Zidovudine+ Nevirapine or Single dose Nevirapine) for the woman and single dose NVP with Zidovudine for the infant and ART for women who are eligible for treatment, exclusive breastfeeding for six months with rapid cessation for women who opt to breast feed (Children and HIV, A Guide for Health Workers, 2007)
4.1.4 Availability of ARVs for HIV positive babies and mothers

Eighty one percent said that ARVs were available for HIV positive babies and mothers. Nine percent said that ARVs were not available while 5% said that they didn’t know whether ARVs were available for HIV positive mothers and babies. This finding showed that most of HIV positive babies and mothers were getting ARV treatment for AIDS (Figure 4.4)

**Figure 4.4 whether ARVs were available for HIV positive babies and mothers**

![Bar chart showing percentage of respondents by whether there is ARVs or not](chart)

This finding was supported by a report by ministry of health that at the end of the 3rd quarter of 2005, 54,000 patients were on ARVs (Guidelines for ARV therapy in Kenya, 2005) and by 2007, more than 90,000 patients and 7,000 children were on ART (Guide for Health Workers 2007). However according to NASCOP 2006 there is a huge challenge because about 68,000 pregnant women need ARV treatment to prevent mother to child transmission, about 23,000 children are in need of ART and about 430,000 adults urgently need ARV therapy.
4.1.4.1 Coverage of ARV treatment available for HIV positive babies and mothers

Thirty three percent said that coverage of HIV positive babies and mothers who had access to ARV treatment was 90%, ten percent said that the coverage was 80%, five percent said that the coverage was 70%, four percent said the coverage was 40% and 50% while one percent said that coverage was 30% and 60%. This finding indicated that where ARV treatment was available for HIV positive babies and mothers the coverage ranged from as low as 30 % to as high as 90%. (Table 4.3)

<table>
<thead>
<tr>
<th>Coverage of HIV positive babies and mothers who access ARVs treatment</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>40%</td>
<td>3</td>
<td>3.7</td>
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<td>50%</td>
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<tr>
<td>60%</td>
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<td>1.2</td>
</tr>
<tr>
<td>70%</td>
<td>4</td>
<td>4.9</td>
</tr>
<tr>
<td>80%</td>
<td>8</td>
<td>9.8</td>
</tr>
<tr>
<td>90%</td>
<td>27</td>
<td>32.9</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>57.3</td>
</tr>
<tr>
<td>Missing</td>
<td>35</td>
<td>42.7</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>100</td>
</tr>
</tbody>
</table>

4.1.5 Pre-test and HIV counseling during pre-natal services

Seventy seven percent said that there was pre-test counseling and HIV screening services during pre-natal care, sixteen percent said there was no counseling and testing services during pre-natal care while two percent said that they didn’t know whether pre-test counseling and HIV screening services were offered during pre-natal care. This finding showed that most pre-natal mothers were counseled and screened for HIV.
4.1.5.1 Coverage of pre-test counseling and HIV screening services.

Sixteen percent said that the coverage of pre-test counseling and HIV screening during pre-natal services was 90%, thirteen percent said the coverage was 40%, six percent said the coverage was 50% and 80%. This finding indicated that where pre-test counseling and HIV-screening services were available during prenatal care the coverage varied from 10% to 90% (Table 4.4)

Table 4.4 Coverage of pre-test counseling and HIV screening during pre-natal services

<table>
<thead>
<tr>
<th>Coverage of pre-test counseling and HIV screening during pre-natal services</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>2</td>
<td>2.4%</td>
</tr>
<tr>
<td>20%</td>
<td>3</td>
<td>3.7%</td>
</tr>
<tr>
<td>40%</td>
<td>11</td>
<td>13.4%</td>
</tr>
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<td>50%</td>
<td>5</td>
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<td>1.2%</td>
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<td>70%</td>
<td>3</td>
<td>3.7%</td>
</tr>
<tr>
<td>80%</td>
<td>5</td>
<td>6.1%</td>
</tr>
<tr>
<td>90%</td>
<td>13</td>
<td>15.9%</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>52.4%</td>
</tr>
<tr>
<td>Missing</td>
<td>39</td>
<td>47.6%</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>100%</td>
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</tbody>
</table>

This finding was supported by the data on Sentinel Surveillance of HIV and STDs in Kenya which showed that due to wider coverage of pre-test counseling and HIV screening during prenatal services the HIV prevalence in both STD and ANC patients had significantly declined over the years with exception of 2005 STD. The data also revealed that people with STDs have twice the risk of infection to other sexually active groups of the population (Sentinel Surveillance of HIV and STDs in Kenya, NASCOP, 2005)
4.1.6 Screening for syphilis and treatment during pregnancy

Fifty six percent said that there was screening for syphilis and treatment during pregnancy, twenty seven said that there was no screening for syphilis and treatment during pregnancy while ten percent said that they didn’t know whether such services were offered during pregnancy (Figure 4.5)

Figure 4.5 whether there was screening for syphilis and treatment during pregnancy

This finding about STIs was supported by studies conducted in urban areas especially in
Nairobi and Mombassa mostly involving either women attending ante natal clinics, female sex workers or men working as long distance drivers show estimates for the prevalence rates for gonorrhea to be 4.9% with a range of 3.6- 11 %, trichomoniasis 11.2% with a range of 2-29.4%, bacterial vaginosis is 29% with a range of 9-49% and syphilis 5.8% with a range of 2-9.5%. (National Guidelines for reproductive tract infections services 2006)

4.1.6.1 Coverage of patients screened and treated for syphilis during pregnancy

Eleven percent said that the coverage in terms of patients screened for syphilis and treated during pregnancy was 90%, five percent said that the coverage was 10% while four percent said that the coverage was 50%. This finding suggests that the coverage in terms of patients screened for syphilis and treated during pregnancy is low (Table 4.5)

<table>
<thead>
<tr>
<th>Coverage of patients screened and treated for syphilis during pregnancy</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>4</td>
<td>4.9%</td>
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<td>20%</td>
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<td>40%</td>
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<td>2.4%</td>
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<td>3.7%</td>
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<td>2.4%</td>
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<td>70%</td>
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<td>80%</td>
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<td>2.4%</td>
</tr>
<tr>
<td>90%</td>
<td>9</td>
<td>11.0%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>31.7%</td>
</tr>
<tr>
<td>Missing</td>
<td>56</td>
<td>68.3%</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>100%</td>
</tr>
</tbody>
</table>
4.1.7 Gynecologist and Psychologist trained to attend women living with HIV

Twenty nine percent said that there were gynecologists and psychologists who were trained to attend to women living with HIV, fifty two percent said that there was none while 12% said that they didn’t know whether there were such specialists to HIV positive women. This finding suggests that there was an acute shortage of gynecologists and psychologists who were trained to attend to women living with HIV (Figure 4.6)
Figure 4.6 Whether gynecologist and psychologist were trained to attend to HIV positive women

Percentage of respondents according to whether they knew gynecologist and psychologist who were trained to attend to HIV positive women

- Yes: 29%
- No: 52%
- Don't Know: 12%
4.1.7.1 Coverage of health care services with gynecologists and psychologist

Nine percent said that where health care service had gynecologist and psychologist trained to attend to women living with HIV the coverage was 10%. This finding indicates that there is a serious problem of shortage of staff with required training to attend to women living with HIV (Table 4.6)

Table 4.6 Coverage of healthcare services with trained gynecologists and psychologist

<table>
<thead>
<tr>
<th>Coverage of Health Care services with trained Gynecologist and Psychologist</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>7</td>
<td>8.5%</td>
</tr>
<tr>
<td>20%</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>40%</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>60%</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>70%</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>80%</td>
<td>1</td>
<td>1.2%</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>14.6%</td>
</tr>
<tr>
<td>Missing</td>
<td>70</td>
<td>85.4%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>82</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

4.1.8 Gynecologist and psychologist trained to attend to women

Twenty six percent said that there were gynecologist and psychologist trained to attend to women in health care service, forty six percent said there were no gynecologist and psychologist in the health care service while fifty percent said that they did not now whether there were such care providers to attend to women in the health care. This finding similarly showed a shortage of trained gynecologist and psychologist in health care service.
4.8.1.1 Coverage of Gynecologist and Psychologist trained to attend women.

Nine percent said that where there were trained gynecologist and psychologist in the health care service the coverage was 10%. This finding also indicated a serious shortage of trained gynecologist and psychologist to attend to women in the health care service.

4.1.9 Women access to information on health care

Thirty eight percent said that women access information on health care, forty five percent said women do not access information on health care while seven percent said that they didn’t know whether women access information on health care (Figure 4.7)

Figure 4.7 Whether women access information on health care

This finding was supported by a report that the National Commission on Gender and Development produces documentary on caregivers to HIV and AIDS orphans and prints materials such leaflets which women can access (NCGD 2005)
4.1.9.1 Coverage of women who access information on health care

Four percent said that the coverage of women who access information on healthcare was 50%, three percent said the coverage was 40% and 2% said the coverage was 10%, 70%, 80% and 90%. This finding indicated that women are less informed about health care.

4.2.0 Level of health care where women access information on sexuality and contraceptives

Sixteen percent said that women access information on sexuality and contraceptives, 10% said access this information at health centers while 4% said that women access information on sexuality and contraceptives at district hospitals. This finding showed that women are less informed about sexuality and contraceptives (Figure 4.8).

Figure 4.8 Level of healthcare where women access information on sexuality and contraceptives

![Pie chart showing percentage of women accessing information on sexuality and contraceptives at different healthcare levels: Dispensary (16%), Health centre (10%), District Hospital (4%), and others (4%).]
4.2.1 Gender based education programs

Twenty one percent of respondents said that there were gender based education programs for girls in the age 15-18 years. Fifty five percent said there were no such programs while 14 % said that they did not know whether such programs were offered. This finding was supported by a report by Forum for African Women Educationalist (FAWE 2006) that Kenyan government has put in place policies to ensure education and protection of the girl child (Figure 4.9)

Figure 4.9 whether there were gender based education programs for girls aged 15-18 years

4.2.2 Coverage of gender based education programs for girls aged 15-18 years

The coverage of gender based education programs for girls aged 15-18 years was not high. The highest coverage reported was 50% followed by 20% and 10 %.
4.2.3 Gender based education programs for girls aged 18-25 years

Twenty three percent of respondents said that there was gender based education program for girls aged 18-25 years. Fifty percent said there was no such program and 14% said they were not aware of such a program.

The coverage for gender based education program for girls aged 18-25 years was high. The highest coverage reported was 90% followed by 50% and 10%. However the 10% coverage was the one widely reported.

4.2.4 IEC Materials for Supporting Sexual Rights for Girls age 15-18 years

Twenty one percent of respondents said that there were IEC materials for supporting sexual rights for girls aged 15-18 years. Fifty four percent said there were no IEC materials for supporting sexual rights for girls and 16% percent said they did not know whether there were such materials (Figure 4.10)

Figure 4.10 Whether there are IEC materials for supporting sexual rights for girls age 15- 18
The coverage of IEC materials for supporting sexual rights for girls age 15-18 was not high. Five percent of respondents reported coverage of 20%, two percent reported coverage of 10% and other two percent reported coverage of 50%.

### 4.2.5 IEC Materials for Supporting Sexual Rights for Girls age 18-25 years

Twenty two percent said that there were IEC materials for supporting sexual rights for girls aged 18-25 years, fifty five percent said there were no such materials and 17 percent said they did not know whether there were such materials. This finding is supported by the fact that FAWE and other lobbyists’ advocacy led to passing of sexual offences bill into law. This ensures that girls’ sexual rights are not violated by anybody (FAWE 2006).

The National Commission for Gender and Development (NCGD) also plays a role in advising the government on policy options and legal forms on gender in order to ensure development and implementation of gender responsive national policies, programmes, plans and legal reforms (National Commission on Gender and Development, 2005). The National Commission on Gender and Development is also an active member of Advisory Board for HIV and AIDS vaccines research in which it provides overall guidance on gender concerns in HIV vaccine research.

The coverage of IEC materials for supporting sexual rights for girls aged 18-25 years was not very high, four percent of respondents said that the coverage of IEC materials was 30%, two percent said that the coverage of IEC was 90%, two percent said the coverage of IEC was 20% and another two percent said the coverage of IEC was 10%.
4.2.6 Public System for Collecting and Publishing Data about Violence against Women and Girls

Sixteen percent of the respondents said that there was a public system for collecting and publishing data about violence against women and girls. Sixty three percent said that there was no public system for collecting and publishing data about violence against women and girls while thirteen percent said that they did not know whether there was such a system. The sixteen percent said Nairobi Women Hospital and National Commission for Gender and Development were such public systems where data about violence against women is collected and published. This finding was supported by NCGD 2005 report that the commission carries out investigations on gender based rights and violations and forwards recommendations to the relevant authorities.

4.2.7 Coverage of Post Exposure Prophylaxis (PEP)

Five percent of respondents said that coverage for post exposure prophylaxis against HIV infection was 10%, two percent said coverage was 205 and other two percent said that coverage was 60%. This finding was supported by another study by ministry of health on health workers where 60% of them said that they could not access PEP (Kenya Health Workers Survey 2005). The finding was also supported by another study by ministry of health on sexually transmitted diseases (STIs) that PEP is no widely available (National Guidelines for Reproductive Tract Infection Services, Ministry of Health 2006).
4.2.8 Income Generating Activities (IGA) targeting Women and Girls

Twenty percent of respondents said there were income-generating activities targeting women and girls. Fifty two percent said that there were no IGA targeting women and girls while 18% said they did not know whether there were IGA targeting women and girls (Figure 4.11).

Figure 4.11 Whether there were IGA Targeting Women and Girls

Coverage of IGA targeting women and girls was not high. One percent said the coverage of IGA was 10%, another one percent said the coverage of IGA was 80% while six percent said that the coverage of IGA was 20%.

4.2.9 Micro Finance Credits for Women and Girls

Twenty seven percent said that there was microfinance credit for women and girls, fifty one percent said there was no microfinance credit for women and girls and twelve percent
said they did not know whether there was micro finance credit for women and girls (figure 4.12)

**Figure 4.12 Whether there was Micro Finance Credit for Women and Girls**

The coverage of micro finance credit for women and girls was limited. Six percent said the coverage was 20%, one percent said the coverage was 60%, one percent also said the coverage was 50%, another one said that the coverage was 40%, 30% and 10%

**4.3.0 Laws against Women Trafficking**

Sixteen percent said there were laws against women trafficking, 54% said there were no laws against women trafficking and twenty one percent said they did not know whether there were laws against women trafficking. This finding was supported by a report by National Commission on Gender and Development that there are laws protecting women against human trafficking and these laws are in accordance to government’s obligation to comply with its international human rights obligations (NCGD 2005)
4.3.1 Monitoring Programs for Women and Girls Trafficking

Eleven percent said that there were monitoring programs for women and girls trafficking. Fifty one percent said there were no monitoring programs for women and girls trafficking and 26% said they did not know whether there were monitoring programs for women and girls trafficking (Figure 4.13)

Figure 4.13 Whether there were Monitoring Programs for Women and Girls Trafficking

Two percent said that there were clear indicators of monitoring programs for women and girls, fifty one percent said there were no clear indicators and 22% said that they did not know whether there were clear indicators of monitoring programs for women and girls
**4.3.2 Family Life Education in schools**

Thirty four percent said family life education is offered in schools, 495 said family life education is not offered in schools and 5% said they did not know whether family life education is offered in schools.

Twenty nine percent said that the education system is religion tolerant, 60% said the education system is not religion tolerant and 9% said that they did not know whether the education system is religion tolerant.

Eleven percent said that there was emergency social support for HIV infected girls, 71% said there was no emergency social support for HIV infected girls and 10% said they did not know whether there was emergency social support for HIV infected girls.

Thirty percent said there was HIV and AIDS curriculum in schools, 56% said there was no HIV and AIDS curriculum in schools and 9% said they did not know there was HIV and AIDS Curriculum in schools.

Majority 77% said that the HIV and AIDS curriculum in schools is not examinable, 4% said the curriculum is examinable and 9% said that they did not know whether the HIV and AIDS curriculum in schools is examinable.

Thirty one percent said that there were textbooks with HIV and AIDS information in schools, 56% said there were no textbooks with HIV and AIDS information in schools and 7% said they did not know whether there were textbooks with HIV and AIDS information in schools.

For textbooks having HIV and AIDS information, six percent mentioned social sciences text books, seven percent mentioned science text books, 4% mentioned biology text books and other four percent mentioned medical text books.
Sixteen percent said these text books can be found in school libraries, 1% said the text books can be found in health research organization’s libraries, 4% said the text books can be found in book shops and 1% said the text book can be found in hospitals.

4.3.3 Training of Teachers in Sexual Reproductive Health

Twenty three percent said there was training of teachers in sexual reproductive health; forty nine percent said that there was no training of teachers in sexual reproductive health and seventeen percent said that they did not know whether there was training of teachers in sexual reproductive health (Figure 4.14)

Figure 4.14 Whether there was training of teachers in reproductive health
4.3.4 Family Planning Education in Schools

Thirteen percent said there was family planning education in schools, 62% said there was no family planning education in schools and seventeen percent said they did not know whether there was family planning education in schools.

4.3.5 Family consultation in Formulation of HIV and AIDS Curriculum in Schools

Seven percent said that there was family consultation during formulation of HIV and AIDS curriculum in schools, seventy eight percent said that family was not consulted in formulation of HIV and AIDS curriculum in schools and six percent said that they did not know whether family was consulted in formulation of HIV and AIDS curriculum in schools.

4.3.6 Family Consultation in Evaluation of HIV and AIDS Curriculum in Schools

Seven percent said family was consulted in evaluation of HIV and AIDS curriculum in schools, 78% percent said family was not consulted in evaluation and Five percent said they did not know whether family was consulted in evaluation of HIV and AIDS curriculum in schools

4.4 Discussion

The findings of this study showed that HIV infected women widely access health care services at dispensary level. Therefore all services targeting these women like screening for STIs and HIV, ART, nutritional support and PMCTC for pregnant HIV infected
women and health care education should be fully decentralized to dispensary level of health care.

The study also revealed that there is shortage of trained gynecologist and psychologist to generally attend women and specifically HIV infected women. This is dangerous because this shows that with addition of disability due to HIV infection these women pregnancy become more complicated.

There were programs targeted to educate girls on HIV/AIDS and their reproductive health at school and though not many there was a public system to collect and publish data on gender based violence and laws to protect against this violence and trafficking. However, gender based violence was still high, therefore there is need to fully implement policies to reduce this violence and government need to monitor women trafficking abroad. The coverage of post exposure prophylaxis against HIV infection was low. This was mainly because many people including health care providers do not know about the existence of such services and they are offered free of charge. It was also revealed that FGM has died in some communities but it is still rampant in some community like pastrolists in northern Kenya. This is violation against sexual reproductive health rights of girls and it is a risk factor to HIV infection.

Women lacked income-generating activities and lacked enough access to micro finance credit. This reduced their economic power and made them more vulnerable. Families were not involved in formulating and evaluation of HVI/AIDS curriculum in schools. Their lack of involvement made it difficult for practical implementation of the curriculum at school and home level.
5.0 CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

The study findings showed that:

The government and other stakeholders dealing with ADIS epidemic have put more effort to prevent the spread of the disease through ensuring access to quality health care services. However the coverage of ARV treatment is still very low and the coverage of PMTCT services is low. It is clear from the findings that there are policies put in place to ensure that there is reproductive health education for women and girls who are more vulnerable to HIV infection.

The government has been committed to fight gender-based violence by for instance passing sexual offences bill and signing into law so as to protect women and girls against sexual violence although sexual violence against women and girls is still high in the country. The government also has put laws in place to prevent women trafficking to reduce vulnerability to HIV infection.

The government and other stakeholders have taken very little measures to involve vulnerable people like women and girls when coming up and evaluating HIV and AIDS curriculums in schools.

5.2 Recommendations

1) There is need for more resources to ensure that women living with HIV and AIDS access ARV therapy for both PMTCT and self-treatment at all levels of health care to ensure high coverage and reduce transmission of HIV from mother to child.
2) The government in addition to ensuring rule of law is followed to control gender based violence, it should also involve all, men, women, and girls in the fight against sexual violence and women trafficking in order to prevent and reduce vulnerability to HIV infection.

3) Parents, teachers and students should be involved in curriculum development for HIV and AIDS in schools.

### 5.3 Advocacy issues

1) To ensure success of PMTCT program the government and other stakeholders should allocate more resources for sustainability.

2) Men should be involved in the whole process of PMTCT, the community and HIV infected pregnant mothers should be educated to reduce fear of disclosure, stigma and discrimination.

3) For acceptability of MSM in the society, there is need for more awareness to healthcare providers and the community. Their sexual reproductive health and rights should be respected and MSM should be trained as counselors and be involved in offering VCT services especially to their fellow MSM.

4) To improve health care service delivery more health care providers like gynecologist and psychologist need to be trained and be decentralized to dispensary level where majority access health care services.

5) The decision-making should bottom to top approach the ensure the input of the community.
6) The is need for strategies to fight stigma which is a huge obstacle to success of ART program and acceptability of female condom.

7) The society need to be educated more on Post exposure prophylaxis (PEP) and PEP be made available at dispensary level.

8) In formulating and evaluation of HIV and AIDS curriculum in schools the family and the youth and teachers should be consulted to make more comprehensive. More studies on sexual reproductive health among girls in boarding secondary schools and Universities need to be emphasized because these girls are at high risk of HIV infection.

9) Civil society should ensure public policies are implemented, as stipulated.

10) Educating men and involving them and providing alternative rites of passage will win fight against FGM.
6.0 REFERENCES

*Forum for African Women Educationalists: Volume 14 number 1 & 2: 2006*


7.0 APPENDECIS

7.1 Appendix I

UNGASS Kenya Research

QUESTIONNAIRE
UNGASS PARAGRAPH 37 ON LEADERSHIP

1a. Do the women and girls participate in the decision making processes in the HIV/AIDS National program?
Yes_______ No_____ DK (Don’t know) _________

1b. Describe and analyze how women and girls participate in the decision making processes in the HIV/AIDS National program__________________________________________________________
____________________________________________________________________________________

2a. Do the representatives of the women's movement participate in planning and monitoring the actions applied towards HIV vulnerability reduction?
Yes___ No____ DK (Don’t know) _________

2b. How do the representatives of the women's movement participate in planning and monitoring the actions applied towards HIV vulnerability reduction?
____________________________________________________________________________________

2c. When do the representatives of the women's movement participate in planning and monitoring the actions applied towards HIV vulnerability reduction?
____________________________________________________________________________________

2d. Do the representatives of women living with HIV/AIDS participate in planning and monitoring the actions applied towards HIV vulnerability reduction?
Yes_ __ No___ DK (Don’t know) _________

How do the representatives of women living with HIV/AIDS participate in planning and monitoring the actions applied towards HIV vulnerability reduction?
____________________________________________________________________________________
2e. When do the representatives of women living with HIV/AIDS participate in planning and monitoring the actions applied towards HIV vulnerability reduction?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3a. What is the number of women in NAC? __________
3b. What is their average age? ______________________
3c. And what is their HIV status? ____________________

3d. What is the number of women in UNGASS MONITORING ACTION?

3e. What is their average age? ______________________
3f. And what is their HIV status? ____________________

4a. What is the number of women in planning and implementation committees?

4b. What is the HIV status of women in planning and implementation committees?

________________________

UNGASS PARAGRAPH 52 ON PREVENTION

1a. Can girls age 15-18 years access male or female condoms?  
Yes _____ No ____ DK (Don't know) _____
1b. If yes, how can they access them? Through ________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

1c. And where can they access them________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2a. What of age 18-25 years, can they access male female condoms?  
Yes _____ No ____ DK (Don't know) _________
2b. If yes, how can they access them? ____________________________
2c. And where can they access them?

3a. Are there girl-targeted programs? 
Yes __ No _____ DK (Don’t know) __________

3b. If so, where? __________________________

3c. If so, which ones are they? (Please describe them emphasizing on their roles to society)__________

3d. If so how do they operate?

4a. Are there abstinence and faithfulness programs for women aged 15-18 years or 18-25 years? 
Yes ___ No _____ DK (Don’t know) ______

4b. If yes, how many are they? ______________________

4c. If yes, where are they? ______________________

5a. Is there STD diagnosis and treatment at dispensaries for women aged 15-18 years?
Yes _____ No _____ DK (Don’t know) _____

5b. Is there STD diagnosis and treatment at dispensaries for women aged 18-25 years?
Yes _____ No _____ DK (Don’t know) _____

5c. If there is diagnosis and treatment; can these women be referred for HIV screening?
5d. Where can they be referred for HIV screening if found STD positive?

6a. Is there monitoring for STDs?

6b. If yes, where is this STD monitoring done?

6c. And how many STD monitoring units per woman are there, if yes?

UNGASS PARAGRAPH 54 ON PREVENTION

1a. At what level of health service can HIV positive women access care?

1b. What is the coverage of health services available to HIV positive women?

2a. Is nutritional support part of the package provided during prenatal and postnatal care?

2b. If yes, what is the coverage?

3a. Is PMCTC available at that level of health service?

3b. Are ARVs available for HIV positive babies and mothers?

3c. If yes, what is the coverage of HIV positive babies and mothers who have access to ARVs?
4a. Is there pre-test counseling and HIV screening during pre-natal services?
Yes_______ No_______ DK_______
4b. If so, what is the coverage of pre-test counseling and HIV screening during pre-natal services?
________________________________________________________________
________________________________________________________________

5a. Is there screening for syphilis and treatment during pregnancy?
Yes_______ No_______ DK_______
5b. If so, what is the coverage in terms of patients screened for syphilis and treated during pregnancy?
________________________________________________________________
________________________________________________________________
________________________________________________________________

6a. Are the gynecologists and psychologists aware and trained to attend to women living with HIV in healthcare service?
Yes_______ No_______ DK_______
6b. If so, Please explain
The health workers working in MCH are trained on PMCT on PMCT
6c. what is the coverage of healthcare services with gynecologists and psychologists who are aware and trained to attend to women living with HIV?
________________________________________________________________
________________________________________________________________

6d. Are the gynecologists and psychologists aware and trained to attend to women in healthcare service? Yes____ No____ DK (Don't know)_______
If so, Please explain
________________________________________________________________
________________________________________________________________
________________________________________________________________

6e. What is the coverage of healthcare services with gynecologists and psychologists who are aware and trained to attend to women healthcare needs?
________________________________________________________________
________________________________________________________________
________________________________________________________________

6f. Do women access information on healthcare? 
_____ No____ DK (Don't know)_______
6g. What is the coverage of women accessing information on healthcare?

6h. At what level of health care do women access information on sexuality and contraceptives?

UNGASS 60 and 61 ON HUMAN RIGHTS
1a. Are there gender based education programs for girls age 15-18?
   Yes____ No___ DK (Don’t Know)
1b. What is the coverage for gender based education programs for girls age 15-18?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

1c Are there gender based education programs for girls age 18-25?
   Yes____ No____ DK (Don’t Know)
1d. What the coverage for gender based programs for girls age 18-25?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2a. Are there IEC materials for supporting sexual rights for girls age 15-18?
   Yes ____No____ DK (Don’t Know)
2b. What is the coverage of IEC materials for Surpoting sexual rights for girls age 15-18?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

2c. Are there IEC materials for supporting sexual rights for girls age 18-25?
   Yes_____NO____ DK (Don’t Know)
2d. What is the coverage of IEC materials for supporting sexual rights for girls age 18-25?

________________________________________________________________________

3a Is there public system for collecting and publicizing the data about violence against women and girls?
Yes____ No____ DK (Don’t Know)
If so, please Explain____________________________
________________________________________________________________________
________________________________________________________________________

4. What is the coverage of PEP (Post Exposure Prophylaxis)?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Observe on site on women attending the clinic and if possible interview client on Effectiveness and appropriateness of the service and record your observation.

RECORD YOUR OBSERVATION BELOW
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

1a. Are there IGA targeting women and girls?
Yes____ No____ DK (Don’t know) __________________

1b. What is the coverage of IGA targeting women and girls?
________________________________________________________________________
________________________________________________________________________
2a. Are there micro finance credits for women and girls?
   Yes______No______ DK (Don’t know) ___________________

2b. what is the coverage of micro finance credits for women and girls?
________________________________________________________________________
________________________________________________________________________
__________________
______________________________________________________
________________________________________________________________________
________________________________________________________________________

3a. Are there laws against women trafficking?
   Yes_____No_____ DK (Don’t know) ______________

3b. If so
   Explain_______________________________________________________
   __________________________________________________________________
   __________________________________________________________________
   ____________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

4. Are there monitoring programs for women and girls trafficking?
   Yes______No______ DK (Don’t Know) ______________

5a. If yes, are there clear indicators?
   Yes_______No_______ DK (Don’t know) ____________

5b. If so, explain your Answer_________________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

6a. Are CSOs represented in committees involving women trafficking?

6b. Were CSOs involved in formulation of these indicators, if there are?
UNGASS PARAGRAPH 63 REDUCTION OF VULNERABILITY

1. Is there family life education in schools?
   Yes_____No_____DK (Don’t know)______________

2. Is the education system religion tolerant?
   Yes_____No_____DK (Don’t) __________________

3. Is there emergency social support for HIV infected girls?
   Yes_____No_____DK (Don’t know) _____________

4a. Is there HIV/AIDS curriculum?
   Yes____No______DK (Don’t know) ______________

4b. If yes, is it examinable?
   Yes____No______DK (Don’t know) ______________

5. Are there text books with HIV/AIDS information?
   Yes_____No_____DK (Don’t know) ______________ (IF YES PROCEED TO 6a and 6b)

6a. What type of text books have HIV/AIDS Information?

6b. Where are these text books Found

7a. Is there training of teachers in sexual reproductive health?
   Yes_____No_____DK (Don’t know) ______________

7b. If yes, how is these training of teachers Conducted?
8a. Is there family planning education in schools?
   Yes   No   DK (Don’t know)
8b. If yes, what is the extent of this kind of Education
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

9a. Is the family consulted in formulation of HIV/AIDS curriculum in schools?
   Yes   No   DK (Don’t know)
9b. Is the family consulted in evaluation of HIV/AIDS curriculum in schools?
   Yes   No   DK (Don’t know)

UNGASS PARAGRAPH 64 REDUCTION OF VULNERABILITY

1a. Does the government have national strategies supported by international initiatives to reduce vulnerability of vulnerable groups?
   Yes   No   DK (Don’t know) (IF YES, CONTINUE TO Q.1b and Q.2)
1b. If so, how is this Conducted?
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

2. If so, have these been formulated through participatory process?
   Yes   No   DK (Don’t know)
3a. Are women who are vulnerable involved in international meeting?
   Yes   No   DK (Don’t know)
3b. If they are what is the coverage?
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

3c. If they are what is the inclusion criteria?
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

4a. Has the government allocated a budget on this project (vulnerability reduction)?
   Yes   No   DK (Don’t know)
4b. How has it varied over the last five years?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

UNGASS PARAGRAPH 65 ON ORPHANS AND VULNERABLE CHILDREN (OVC)

1a. Is there policy or law in place to address OVC?
   Yes____ No____ DK___________

1b. Is there international OVC support program?
   Yes____ No____ DK___________

1c. Are there OVC programs that provide counseling and psychological support?
   Yes____ No____ DK___________

1d. What is the coverage of OVC programs that provide counseling and psychological support?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

1e. Are there OVC programs that provide counseling and schooling?
   Yes____ No____ DK___________

1f. What is the coverage of OVC programs that provide counseling and schooling?
   ____________________________________________________________
   ____________________________________________________________

1g. Are there OVC programs that provide counseling and shelter?
   Yes____ No____ DK___________

   What is the coverage of OVC programs that provide counseling and shelter?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

1h. Are there OVC programs that provide counseling and health?
   Yes____ No____ DK___________

   What is the coverage of OVC programs that provide counseling and health?
   ____________________________________________________________
   ____________________________________________________________
1i. Are there OVC programs that provide counseling and nutrition?

Yes_____ No_____ DK_____________

What is the coverage of OVC programs that provide counseling and nutrition?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

UNGASS PARAGRAPH 72 ON RESEARCH AND DEVELOPMENT

1a. Are there established methods to investigate the efficacy of medicines?
Yes___ NO___ DK_____________

1b. If yes, please cite them
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

1c. Briefly describe each

1d. Are there established methods to investigate the toxicity of medicines?
Yes___No___DK____

1e. If yes, please cite them
________________________________________________________________________
________________________________________________________________________

1f. Briefly describe each

1g. Are there established methods to investigate the side effects of medicines?
Yes___NO____DK___

1h. If yes, please cite them
Through evaluation of patient progress and assessment of CD4 count.
________________________________________________________________________

________________________________________________________________________
1i. Briefly describe each. During the assessment of CD4 count and monitoring of viral load, and the viral load increase and CD4 decrease this is a sign of treatment failure.

1l. While interacting with each other in the human body, are there established methods to investigate:
   Efficacy of medicines? Yes__ No__ DK__
   1j. If yes, please cite them______________________________________________

1k. Briefly describe each

1l. Toxicity of medicines? Yes__ No__ DK__
   1m. If yes, please cite them______________________________________________

1n. Briefly describe each
10. "Side effects" of medicines? Yes___ No___ DK___
   If yes, please cite them_________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

1p. Briefly describe each
   ____________________________________________
   ____________________________________________
   ____________________________________________

2a. How first do you expect health care service providers in the country can respond to resistance effects?
   ____________________________________________
   ____________________________________________
   ____________________________________________

2b. How skilled are health care service providers in responding to resistance effects?
   ____________________________________________
   ____________________________________________
   ____________________________________________

2c. How equipped are health care service providers in terms of resources required to respond to resistance effects appropriately?
   ____________________________________________
   ____________________________________________
   ____________________________________________

2d. If health care service providers are prepared (quick, skilled and resourceful enough) to respond to resistance effects, how do they respond to this resistance effects?
3a. Are there research findings or is there research in progress on the natural history of HIV in the female body?
Yes___NO___DK__________

3b. If yes, please cite them______________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

3c. Briefly describe the study(s)/ finding(s)/program(s) and their role to society______________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

4a. Are women motivated to participate in research?
   Yes___NO___DK__________

4b. If yes, by citing examples, please explain how____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

4c. Are there women involved in research and clinical analysis?
   Yes ___No ___DK__________

4d. If yes, how many____________________

4e. How many of these women involved are HIV positive?____________________________
5a. Are HIV positive women included in Bio ethics Committee?
Yes___ NO ___ DK__________

5b. If yes, please explain how__________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

6a. Are there behavioral studies related to HIV infection, especially in HIV positive women?
Yes___ NO ___ DK_____

6b. If yes, please cite the names of the studies________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

6c. Briefly describe the studies and their role to society________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

7a. Are women participating in research provided with Informed consent?
Yes___ NO ___ DK_____

7b. If yes, please explain how__________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Date of interview…………………………………………………………………………………………...

Name of Interviewer/Data collector…………………………………………………………………………

Signature……………………………………………………………………………………………………
Source/Institution…NASCOP………………………………………………………….

Signature of respondent………………………………………………………………..

AHSANTE SANA
7.2 Appendix I

MAP OF KENYA