

2008 National Youth Shadow Report

Progress Made on the 2001 UNGASS
Declaration of Commitment on HIV/AIDS



KENYA



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Preface¹

In just two years, the world will evaluate ten years of work toward “Universal Access by 2010” to HIV and AIDS prevention, care and treatment. While progress has been made in several areas of the AIDS response, the targets laid out so ambitiously for youth in the 2001 Declaration of Commitment on HIV/AIDS (DoC) will be unmet by drastic margins; indeed, 7 years later, few governments even bother to collect data specifically on youth.

Globally, 1.7 billion young people aged 10-24 make up one quarter of the world’s population. Approximately 40% of all new HIV infections occur among young people between 15-24 years of age,² and there are 5.4 million young people living with HIV.³ Young people are the face of HIV. We are at higher risk of HIV infection because we lack access to the crucial information, education, and services to protect ourselves. However, our needs are often ignored when data is collected and strategies on HIV and AIDS are drafted, policies developed, and budgets allocated. Successful programs often lose funding as interests shift toward other, less controversial topics, or young leaders “age out” and others with similar potential are not empowered. This is especially tragic, because we, as young people, are statistically more likely than adults to adopt and maintain safe behaviors.⁴

Ignoring us in policies, programs, and resource allocation is a main contributing reason to the further spread of the HIV epidemic. Our particular vulnerability to HIV infection draws attention to societal inequities that few want to speak of, let alone address, such as sexual violence, injecting drug use, same-sex relationships, and sex work. Evidence clearly displays that the longer governments, stakeholders and health care providers continue to ignore the unpleasant realities faced by many young people, the more our peers and siblings will be infected with HIV.

In June 2001, heads of State and government representatives convened for the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). At the first UNGASS on HIV/AIDS, 189 countries signed the Declaration of Commitments (DoC) as a pledge to halt and begin to reverse the spread of the AIDS epidemic through international, regional and country-level partnerships and with the support of civil society. Progress is measured through intermittent reviews.

Despite DoC commitments to work in full partnership with youth, governments still treat us as beneficiaries of programmes and services rather than crucial stakeholders and key actors in achieving the DoC targets and goals.⁵ The impact of this exclusionary attitude will manifest shortly in a lack of leadership and an even greater shortage of health care workers. As we come of age to adulthood, we must be trained and empowered today as a cadre of young leaders.

The DoC states that by 2005, at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 will have access to the information, education, skills and services to protect themselves from HIV infection. **However, as of 2007, only 40% of young men**

Notably, the DoC recognizes young people’s higher risk to HIV infection and established time-bound targets for action:

- (Paragraph 37) By 2003, ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS that (...) involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people (...)
- (Paragraph 47) By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal: to reduce, by, 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent.
 - To reduce, by 2010, HIV prevalence among young men and women aged 15-24 globally.
 - To intensify efforts to achieve these targets as well as to challenge gender stereotypes, attitudes, and inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys.
- (Paragraph 53) By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV/AIDS education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers.
 - Expanding good-quality, youth-friendly information and sexual health education and counseling services;
 - Strengthening reproductive and sexual health programs; and
 - Involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programs.

¹ Adapted from GYCA and Global Youth Partners, “Our Voice, Our Future: Young People Report on Progress Made on the UNGASS Declaration of Commitment on HIV/AIDS.” UNFPA, 2005. <http://www.youthaidscoalition.org/resources.html>

² UNAIDS (2007) AIDS epidemic update: Core slides: Global Summary of the HIV and AIDS epidemic. UNAIDS, Geneva. http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/epi_slides.asp

³ UNAIDS (2007) AIDS Epidemic Update

⁴ UNICEF/UNAIDS/WHO (2004) Young People and HIV/AIDS, Opportunity in Crisis. UNICEF, UNAIDS & WHO, 2004.

and 36% of young women had accurate HIV knowledge on transmission and prevention.⁶

The needs of young people are not homogenous or universal. Young people are mothers, students and sex workers. They are injection drug users and prison inmates. Young people have varying sexualities, lifestyles and definitions of the family. Young people living with HIV are studying, working, having sex and planning families. Young advocates are best positioned to design policies and programs that are most relevant and effective at addressing our varying needs.

Methodology

With only two years left to achieve the UNGASS goals and targets, young people are actively participating in the tracking and reporting of UNGASS commitments. In 2008, these young people have produced 10 UNGASS Youth Shadow Reports to present at the UNGASS, in its seven-year review. Young researchers from Egypt, Jamaica, Viet Nam, Nepal, India, Kenya, Zimbabwe, Senegal, Nigeria and the United States of America tracked and monitored progress on the UNGASS commitments to young people in their own countries and made recommendations for moving forward. Their research, findings and analysis will set the tone for needs and priorities that must be taken into account during the high level meetings. On 10-11 June 2008, 30 young leaders will advocate to decision-makers by sharing knowledge of their country's national response and identifying major gaps and barriers to success.

Since 2005 GYCA has facilitated the production of 34 UNGASS National Youth Shadow Reports.⁷ GYCA members from 17 countries volunteered to research and produce shadow reports, and assembled national teams of young people from various networks to take part. For several of researchers, this report was the first of such an undertaking. Seven reports address findings at the community level, and will be available shortly on GYCA's website. Researchers used a range of methods to conduct their research and collect relevant information. They gathered inputs from young people, including young people living with HIV (YPLHIV) in their countries through focus group discussions, in-depth interviews and workshops.

Young people were asked to make recommendations for strategies to ensure that their country would meet the UNGASS targets for young people. This qualitative information was supplemented by reviews of national policies, laws and documents, as well as academic literature. Young people also consulted representatives from national and local governments and national AIDS programs when available, as well as various stakeholders such as service providers, representatives from NGOs, international and bilateral organizations. The final reports were reviewed and edited by GYCA staff, preserving original content, tone, and perspectives as much as possible.

A guide was developed by young people with the technical assistance of adult allies to assist youth researchers in gathering information and reporting on their country's progress.⁸ A number of questions, based on the indicators suggested by the UNAIDS National AIDS Programs - A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programs for young people,⁹ were suggested to guide their research. Data collection and analysis focused on four main areas:

- 1) Political Commitment
- 2) Financial Commitment
- 3) Access to Information Services
- 4) Youth Participation

Country's progress on collecting youth-specific, disaggregated data was also evaluated. This report details the findings of the young researchers, and their recommendations and vision for the way to move forward.

⁶ UNGASS (2008). Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to Millenium Development Goal.

⁷ The first twelve reports were compiled into GYCA & GYP's "Our Voice, Our Future", UNFPA 2005. In 2006, six independent reports were produced, and in 2008, this report is one of 17- 10 national reports and 7 community level reports.

⁸ The research guide is available upon request, and is loosely based on UNDESA's 2004 "Making Commitments Matter: A toolkit for young people to evaluate national youth policy."

⁹ UNAIDS (2004) National AIDS Programs - A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programs for young people.

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About the Global Youth Coalition on HIV/AIDS (GYCA)

GYCA is a youth-led global network of over 4,000 young leaders and adult allies fighting the spread of HIV and AIDS in over 150 countries worldwide. GYCA, supported by UNFPA and UNAIDS, was established in 2004 and is based in New York and Accra, Ghana. GYCA empowers young leaders with the knowledge, skills, opportunities and resources they need to be effective agents of change in their communities. For more information please visit <http://www.youthaidscoalition.org>, or write to info@youthaidscoalition.org.

Portrait of Kenya in Numbers	
Total population	36.9 million (2007) ¹⁰
Population aged 10-24	12.2 million - 33% of total population (2006) ¹¹
Gross national income in purchasing power parity (GNI PPP) per person /or GDP	1,300 USD per person (2005) ¹²
Per capita total expenditure on health	\$95 USD (2005) ¹³
Secondary school enrollment rate	29.3% (2005) ¹⁴
Estimated number of people ages 15+ living with HIV	1.2 million (2005) ¹⁵
HIV prevalence among people ages 15-49	5.1% (2006) ¹⁶
HIV prevalence among young people ages 15-24	5.7% (2006) ¹⁷
Median age of first intercourse	Female 17.8 (2003) ¹⁸
Median age of first marriage	Female 19.9 (2003) ¹⁹
Young people ages 15-24 who have had sex before age 15	Female 17.1% (03-05) Male 20.4% (03-05) ²⁰
Young people ages 15-24 reporting higher-risk sex in the last year (%)	Female 8.6% (2003-2005) Male 15.5% (2003-2005) ²¹
Young people ages 15-24 reporting using a condom the last time they had sexual intercourse with a non-regular partner	25.2% (2000-2005) ²²
Contraceptive prevalence rate young people ages 15-24	Female 58.6 (2003) Male 68.3% (2003) ²³

¹⁰ Population Reference Bureau (PRB). "Kenya Statistics," <http://www.prb.org/Countries/Kenya.aspx>

¹¹ Ibid

¹² Ibid

¹³ WHO. (2005) "Kenya," <http://www.who.int/countries/ken/en>

¹⁴ Bureau of Democracy, Human Rights, and Labor. (2005) "Country Reports on Human Rights Practices," <http://www.state.gov/g/drl/rls/hrrpt/2007/100487.htm>

¹⁵ "UNGASS 2006 Country Report Kenya," http://data.unaids.org/pub/Report/2006/2006_country_progress_report_kenya_en.pdf

¹⁶ Ibid

¹⁷ Ibid

¹⁸ Center for Health and Gender Equity. "Risk and Reality: U.S. Funding of HIV Prevention Programs in Kenya," <http://www.genderhealth.org/pubs/KenyaAtAGlance.pdf>

¹⁹ Ibid

²⁰ 2008 UNGASS Country Progress Report

²¹ Ibid

²² Ibid

²³ KDHS 2003 Survey

http://www.cbs.go.ke/downloads/pdf/Kenya_Demographic_and_Health_Survey_2003_Preliminary_Report.pdf

Number of births per 1,000 young women ages 15-19	114 (2003) ²⁴
Young people ages 15-24 who can identify two prevention methods and reject three misconceptions about HIV	Female 58.3% (2003-2005) Male 79.5% (2003-2005) ²⁵
Schools with teachers trained in life-skills-based HIV education who taught it during the last academic year	60% of Primary Schools (2005) 50% of Secondary Schools (2005) ²⁶
Number of physicians per 100,000 people	14 ²⁷

* Please note that the majority of the data were not updated for the 2008 UNGASS Country Report in part due to political turmoil.

I. Introduction

In May 2006, the African Civil Society Coalition stated that African countries have failed to meet prevention targets agreed upon in UNGASS. The statement noted that no African country has met the UNGASS goals of reducing HIV prevalence among young people by 25 percent or ensuring 90% access to HIV AND AIDS information and education by 2005.

In May 2008, the African Civil Society Coalition met in Nairobi to review the 2008 UNGASS country progress reports. They have made a call to UNGASS delegations to governments to scale up investments in youth empowerment and education around HIV; to collect disaggregated data on young people, and promote economic empowerment of young people. We, the Kenyan youth, hold our leaders accountable.

The available data confirm that overall, the rate of progress in expanding access to all services is failing to keep pace with the UNGASS goals or the continuing vulnerability of Kenyan youth to HIV infection. The Shadow Report team will be monitoring the progress of the Kenyan National AIDS Strategy Plan (KNASP) aims, among other policies that have been put into place, including the Male Circumcision Task Force and the Kenya National Youth Council.

Youth and HIV

In the face of post-election violence in Kenya, the government still managed to submit their 2008 UNGASS country report on time. Kenya's commitment to the UNGASS targets and goals remains steadfast. However, the number of young people made further vulnerable to HIV infection through political turmoil has yet to be quantified. With prevalence among young people ages 15-24 at 5.7%,²⁸ the barriers to access persist in the scarcity of condoms, inadequate health services, the hidden costs of treatment, and lack of antiretroviral medication in the private boarding schools where most children and young people live and study.²⁹ Thankfully the Government of Kenya (GoK) has worked tirelessly to instate comprehensive policies that support young people in their right to universal access to prevention, treatment, support and care. However, while there have been great advancements in policy-making, implementation and impact-monitoring is rare.

Young people living with HIV (YPHIV) are particularly marginalised by pervasive stigma and fear that at times deprives them of services and leads to many YPLHIV dropping out of school. The recent case of a suicide by a young man who found out his diagnosis in May 2008 highlights the

²⁴ FHI. "Assessment of Youth Reproductive Health and HIV/AIDS Programs in Kenya," <http://www.fhi.org/NR/rdonlyres/eqq6kkdzkcliypnsqhtvvhqzz2vm3nwaq7vskqn25b3pko7eohfn5axzcw6ssqka5crgmlufabh/youthRHKenya.pdf>

²⁵ UNGASS 2006 Country Report Kenya

²⁶ Ibid

²⁷ UNDP. (2007/2008) Human Development Report. <http://hdrstats.undp.org/indicators/58.html>

²⁸ 2008 UNGASS Country Progress Report.

http://data.unaids.org/pub/Report/2008/kenya_2008_country_progress_report_en.pdf

²⁹ Presentation by Veronicah Omunga, young Kenyan woman living with HIV. 'Informal Briefing on Young People Living with HIV.' May 21, 2008, organized by UNFPA, GYCA, UNAIDS and the Government of Jamaica, UN Secretariat, New York, NY.

lack of supportive counseling available and the widespread discrimination that still ostracizes those living with HIV.³⁰

Young people are at higher risk of HIV infection for a number of reasons. The feminization of HIV persists across the country. In much of Sub-Saharan Africa, as many as three young females are infected for every male.³¹ In some reports as many as 21% of Kenyan young women have experienced some form of sexual coercion.³² Young sex workers, injection drug users (IDUs) and men who have sex with men (MSM) are marginalised to the point of invisibility which only pushes unsafe sexual behaviour further underground and out of reach of public health interventions. While youth friendly services are well established in most urban areas, the larger population of young people living in rural areas is still neglected.

Therefore, young people need to be placed in sustainable positions of leadership in order to effectively advise and collaborate with decision-makers to prioritize the most marginalised. This report endeavours to lead the way towards further integration of Kenya's future leaders in the national response to HIV.

Key Findings and Recommendations:

- Health centres still do not accommodate the needs of young people in rural areas. With only 19% of the population in urban areas,³³ there is a desperate need for comprehensive sexual and reproductive health services in conjunction with HIV services outside of the cities.
- Many YPLHIV face stigma and discrimination in boarding schools. Drop out rates among YPLHIV is increasing. In boarding schools, health care providers, administrations, teachers and fellow classmates must be trained and educated on the needs of YPLHIV in order to better mainstream them into society.
- The hidden costs of treatment serve as a massive barrier for YPLHIV. The costs of CD4 count and viral load tests are out of many young people's financial reach and yet most ART programs require regular tests to receive medication. These costs must be subsidized by government programs in order to make treatment truly accessible for young people.

About this Report

The report was based on a cross-sectional review of policies, commitments and laws in place aimed at reducing HIV Infection, with four groups of respondents: civil society, government ministries, UN agencies, and the Kenyan youth population.

Data was obtained from Kenya Demographic Health Survey, National AIDS Control Council, UNAIDS, University of California San Francisco (HIVInsight) and through the media. Interviews were also carried out specifically with youth in Nairobi and Nanyuki. In-depth, open-ended and priority interviews were also conducted with a range of government ministry representatives, students, care givers, and media representatives. Please reference the GYCA 2006 Kenya Shadow report for data and findings prior to 2006.³⁴

II. Political Commitment

³⁰ IRIN (28 May 2008) "Boy's suicide reveals gaps in HIV education.

<http://www.plusnews.org/Report.aspx?ReportId=78456>

³¹ UNAIDS (2006) Global Report on the Epidemic. <http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/>

³² Annabel S. Erulkar (2004) 'The Experience of Sexual Coercion Among Young People in Kenya.' International Family Planning Perspectives. Vol.30 (4) <http://www.guttmacher.org/pubs/journals/3018204.html>

³³ PRB (2007)

³⁴ "National Youth Shadow Report: Kenya", <http://www.youthaidscoalition.org/docs/Kenya.pdf>

President Mwai Kibaki's political response to AIDS has provided an example that is being followed by politicians and bureaucrats. His face adorns a country-wide HIV awareness poster campaign, and he has signed and supported the KNASP 2005-2010. The first lady, Lucy Kibaki, sponsors an AIDS run for women to show her support.

The National AIDS Control Council (NACC) organised an 'HIV Testing and Counseling Week' prior to the World AIDS Day in 2007. The campaign targeted the general public and key populations at-risk, including youth, and succeeded in counseling 96,300 people, and testing 94% of those. The event was covered by the media and sought to emphasize stigma reduction and positive living.³⁵

There are younger members of parliament who have appeared in similar poster campaigns encouraging youth testing. At times, however, ministers have tested in public, but in Nairobi and not in their home region. The 2008 UNGASS report acknowledges that this will limit the effectiveness of these MPs' efforts.

Gaps



BARAA Mobile VCT, similar set up to where Senator Obama was tested

Meaningful political leadership in the response to HIV has come under scrutiny. Few leaders have taken the bold step in going for a public VCT test. Notably, United States Democratic Party Presidential Candidate Barack Obama (of Kenyan origin) took a public HIV test during his last visit to his paternal village, Kogelo, in rural Western Kenya. However, The VCT site was a trailer that had been imported specifically for occasion and was removed shortly thereafter.³⁶ Kogelo and many rural areas lack adequate access to VCT and other health services. This public health campaign demonstrates the pervasive lack of access and sustainability of numerous attempts to promote HIV testing and awareness in rural areas.

The Government of Kenya (GoK) has been slow to alter laws criminalizing substance users, sex workers and men who have sex with men (MSM). Many youth belong to these subpopulations. Due to stigma, discrimination, persecution and fear, their behaviour shifts further underground and out of reach from prevention and outreach interventions.

With over 350, 000 people displaced in the aftermath of the post-election violence, harsh living conditions and the onset of the cold rainy season have made it increasingly difficult for displaced young people living with HIV (YPLHIV) to stay healthy.³⁷ YPLHIV in internally-displaced people's (IDP) camp are also dealing with the trauma of adjusting to unfamiliar settings, healthcare providers, and whether to disclose their status within their new communities.³⁸

The Ministry of Health (MoH) carried out the Kenya AIDS Survey (KAIS), a nation-wide survey between July and November 2007, with the aim to track the progress toward achieving the GoK's goals and targets of the UNGASS commitments. It is not known exactly which youth indicators will be address by this survey.

Recommendations

³⁵ "2008 Kenya Country Progress Report,"

³⁶ 2008 UNGASS Country Report

³⁷ McKenzie, David. "Thousands remain displaced after Kenyan Violence," <http://www.cnn.com/2008/WORLD/africa/05/16/kenya.displaced/>

³⁸ PlusNews. (2008) "Camp conditions harsh for HIV-positive displaced people," <http://rescuekenya.wordpress.com/2008/04/30/kenya-camp-conditions-harsh-for-hiv-positive-displaced-people/>

There has been a failure on the part of the GoK to confront the realities of HIV. Civil society organisations must hold the GoK accountable to their commitments on universal access. To achieve this goal the Kenyan Government will have to make sure it recognizes and supports at risk populations, particularly youth. The GoK must speed up resettlement for IDPs, and provide adequate services for displaced YPLHIV.

There is a need to develop policies that fully address the needs of women and girls. The policies existing should be reviewed and young men and women must be involved in the process. Their implementation can be guaranteed by enforcing relevant laws like the ban on Trafficking Women and the Sexual Bill Act, which was passed by parliament and signed by President into law.

Despite the political goodwill in terms of policies and public speeches there is still a large gap between commitments and results, as many policies exist only in the ministries, but they are never implemented. The government should require HIV prevention life skills knowledge as part of the tested curricula in both primary and secondary school exams. This will give the proper incentive to both teachers and students to prioritize HIV prevention knowledge.

III. Financial Commitment

Kenya is one of the 15 focus countries for the US President's Emergency Plan for AIDS Relief (PEPFAR). Under PEPFAR, Kenya received \$368.1 million in 2007 and is expecting to receive over 500 million USD in 2008.³⁹ The actual amount of PEPFAR funds for youth oriented programs is not disclosed, but the funds have largely gone towards abstinence and be faithful programs including peer education and curriculum-based training.⁴⁰

In addition, the World Bank has approved a credit of US \$50 million for Kenya's Total War on AIDS (TOWA) program to expand the coverage of targeted HIV and AIDS interventions to prevent and mitigate the impact of the disease in 2007.⁴¹ Previously, funds were disbursed to Constituency AIDS Control Committee (CACC) through the Kenya HIV and AIDS Disaster Response Project.

TOWA is a new approach to improve accountability and reorganise management by dispersing funds to community-based organisations (CBOs). The goal is to promote a better information flow on needs between communities and national planners and policy makers, and, in turn, strengthen institutional capacity at the grassroots level. The potential for TOWA to impact young people is much greater if funds are allocated transparently and fairly.

With regard to costs of Antiretroviral Therapy (ART), the demand continues to increase and at this point delivery is almost entirely supported by development partners. This raises concerns about the long-term sustainability of ART. The MoH recommends that one of the measures that should be taken to close this gap is to increase health's share of the national budget to 15%⁴² as Kenya committed amongst a host of other African countries at the Abuja Summit in Nigeria in 2001.

Gaps and Recommendations

It is not clear how much the GoK has budgeted for HIV and AIDS services for youth 15–24 years. Kenya has a generalized budget and has refused to commit to hard targets on funding, prevention, care and treatment. Therefore, it is hard to monitor the financial commitment as there is no audit for AIDS expenditures available to the public.

³⁹ "UNGASS 2008 Progress Report

⁴⁰ PEPFAR. (2008) "Kenya: Country Profile," <http://www.pepfar.gov/press/81596.htm>

⁴¹ World Bank Fact Sheet. (2007)

<http://web.worldbank.org/external/projects/main?pagePK=64283627&piPK=73230&theSitePK=40941&menuPK=228424&Projectid=P081712>

⁴² 2008 UNGASS Report

Full disclosure of spending by the GoK and non-governmental PEPFAR recipients is necessary to improve youth services. PEPFAR should change policies to fund life-skills prevention programs that are comprehensive and include condoms, which are much more effective than the abstinence and faithfulness programs currently funded. Clear policies and accountability are essential in financial commitments and needs to be adhered to by the GoK. The government should show commitment by making HIV a priority and move to implement its Total War On AIDS program.

IV. Access to Services

Achievements

A KDHS 2003 survey indicates that awareness of HIV and AIDS is almost universal, with 99% of women and men indicating that they have heard about AIDS. No data have been collected for over three years on how many young people can correctly identify how HIV is transmitted. The last estimates were 58.3% among females 15-24 years old, (2003-2005) and males 79.5% (2003-2005).⁴³ Out of the 3,547 women aged 15–24 interviewed 68.8% indicated that they know someone personally who has AIDS or died of AIDS, while out of the 1,537 men, 68% indicated the same.⁴⁴

Kenya has put in place an Adolescent Reproductive Health and Development (ARH&D) Policy to enhance the implementation and coordination of programmes that address the reproductive health and development needs of young people in the country. Life Skills HIV education is one of these key programs. By 2005, 60% of schools had life skills education in the curriculum. This broke down to just over 60% of primary schools and 50% of secondary schools⁴⁵.

A recent study on the effectiveness of male circumcision in the reduction of HIV transmission among Kenyans aged 18-24 found showed a 60% protective effect compared to the control group. As a result, the Policy on Male Circumcision in Kenya 2008 will integrate voluntary and affordable circumcision services into youth policy for HIV prevention.⁴⁶ The Kenyan government's program needs to take into account ethnic communities in Kenya - including the Luo, Suba and Teso in western Kenya and the Turkana in northwestern Kenya– that do not practice circumcision culturally. Secondly, traditional circumcisers in some communities often use the same blade for several boys, a practice that needs to be eliminated as it increases rate of infection; other traditional circumcisers don't remove the entire foreskin which lessen the prevention benefit.

Gaps

The Kenya UNGASS 2008 reported that only 24% of women and 46% of men aged 15-24 who had sex with more than one partner in the previous 12 months reported using a condom in their last sexual encounter. Sex with casual partners or sex workers without a condom is also common practice. Out of school youth in particular tend to have sex earlier have the lowest rating for condom use.⁴⁷

Data show that many young people still lack accurate information on reproductive health and sexuality. Some girls still believe that they will not get pregnant if they have sex while standing. Thousands of others think that contraceptives are 'evil' or 'sinful' and should be avoided at all costs. Yet others think that if they use contraceptives, they will not ever be able to have children, and some boys still believe that a condom is an invention to bar them from sexual pleasure. Some even claim that one is in more danger of contracting STIs when using a condom.

Issues voiced by YPLHIV involve non youth-friendly policies requiring young people under the age of 18 to seek consent from parents/guardians before services are provided. Few young people would like their parents to know if they are having pre-marital sex, and thus avoid getting an HIV test or

⁴³ UNGASS 2006 Country Report Kenya

⁴⁴ Kenya DHS (2003) Final Report. http://www.measuredhs.com/pubs/pub_details.cfm?ID=462

⁴⁵ "UNGASS 2006 Country Report Kenya."

⁴⁶ "2008 UNGASS Country Progress Report."

⁴⁷ Kenya DHS (1998) Survey: Behavioural Surveillance Survey: Out-of-School Youth (15-19 females and 20-24 males) http://www.measuredhs.com/hivdata/surveys/survey_detail.cfm?survey_id=323

accessing services. Stigma from the community is ever-present, which hand in hand with discrimination causes most young PLHIV to withhold their status due to fear of rejection. Most notably, young women lack access to condoms for dual protection of pregnancy and for positive prevention. Even with access to condoms, many young women do not have the negotiation skills or status within a relationship to insist on condom use, faithfulness, or to refuse sex.

Limited access to sexuality education is an additional obstacle. There is little discussion of gender or sexual orientation, and MSM youth are often highly stigmatized. There is also a problem of dissemination of information as youth are unaware where to access antenatal and childbirth services, post-partum care and abortion services.

Young PLHIV lack access to comprehensive treatment including cost for CD4 counts. The first line of treatment is available, but the second line is not covered. Although youth friendly services are more visible in urban areas today, they are still very scarce in rural areas and many still neglect the needs of YPLHIV. Ideally, these facilities would be readily available within existing health facilities, creating health care facility where YPLHIV can access services swiftly and easily at one point. Without a central resource, there has been poor uptake of treatment by YPLHIV since it is time consuming and expensive to access services. In order for these facilities to have the optimum impact, health care workers need to be trained to provide information and services for YPLHIV in a sensitive and non-judgmental manner.

According to the 2008 UNAIDS Report, strides have been made to provide more equitable ARV treatments for women; however, treatment for young people has low uptake. No data is collected for youth-specific treatment and services.⁴⁸

Recommendations

The Ministry of Education's School Curriculum on HIV and AIDS needs to be reviewed and formulated again with more input from women and girls, teachers, students and parents. In addition, the gender gap in school enrollment must be addressed. According to the Global campaign for Education, if every child received a primary education, at least 7 million HIV infections could be prevented in one decade.⁴⁹ Primary school is free, and more children are enrolled in school, but there is still a gender gap as more males attend than female, especially secondary school (50% of males compared to 46% of females)⁵⁰. Staying in school will reduce new infections, particularly when life skills are taught.

If the UNGASS Declaration is to be achieved more emphasis needs to be put into the rural areas,' says Anderson Githinji, VCT Manager, BARAA. Mr. Githinji, who runs 7 fixed Voluntary Counseling and Testing (VCT) sites and a rotating Mobile Team, has partnered with other like minded organisation to see an average of 2,100 clients monthly. He notes that 65-70% of his clients are aged 15–24 years.⁵¹

KDHS 2003 notes that knowledge of where to obtain condoms plays an important role in prevention of STI/HIV and unwanted pregnancies. The data suggests that older youth living in urban areas have more knowledge of access to condoms. In addition, according to the NACC, condom shortages have been reported across the country and only exacerbate this problem. Female condoms are not widely distributed and are too costly, as well as not being widely trusted.

Though there is a condom procurement policy, there is no specific policy in place promoting young people's access to condoms nor are there enough youth friendly services. Sexual activity is most frequent in the upper primary and secondary classes in Kenya; unfortunately schools rarely encourage condom use as an option, and in addition no condom dispensers are available in these institutions.

⁴⁸ "2008 UNGASS Country Progress Report."

⁴⁹ Global Education Campaign, June 2004. "Learning to Survive: How Education for all would save millions of young people from HIV/AIDS."

⁵⁰ UNFPA, Kenya Country Profile.

⁵¹ Based on interview.

V. Youth Participation

The government has made room for young people to come together and form youth groups in an institutionalized manner to tackle HIV and its affect on young people. This has caused a rise in youth groups, particularly peer education groups⁵².

The Kenyan National Youth Policy (KNYP) recognizes "the importance of youth to enjoy their youthfulness. Irrespective of social status and sex, the youth have a right to life, meaningful education, good health, marriage after the legal age of consent, protection from sexual exploitation and abuse, meaningful employment, adequate shelter, food and clothing, freedom of speech, expression and association, participation in making decisions that affect their lives,pProtection from social, economic and political manipulation and ownership and protection of property."



Youth participating during the Worlds AIDS Day celebration for 2007 at the KICC

Gaps

Youth still face discrimination when it comes to effective involvement and participation in formulating, implementing and evaluating the HIV/AIDS policies and programs that affect youth. MoH strategies to control the epidemic have only been focused on information, education and communication (IEC) for awareness and risk-reduction, ignoring access to youth friendly services, access to condoms, and availability of treatment.

Kenya lacks adequate rural venues for youth to discuss issues of common concern. There are only a handful of model community youth centers across the country, meaning that only a limited number of youth have the opportunity to meet, interact and discuss topics of interest, especially those related to the spread and prevention of HIV.

YPLHIV cite a lack of representation at the National AIDS Council and at the Ministry of Education to voice their opinions and participate in the issues of young people living with HIV. Although all stakeholders in Kenya agree that YPLHIV should be in the forefront in achieving universal access, the reality is that there is little involvement in the policy decisions effecting YPLHIV. This is partly because there are no defined criteria for appointing or nominating a YPLHIV to a position of leadership.

Recommendations

The GoK needs to fill the communication gap between youth and adults, involving youth in sex education, policy development and implementation as essential components in addressing HIV and AIDS among young people. In addition, the government must establish effective ways to involve rural youth participation in HIV and AIDS.

⁵² "2008 UNGASS Country Progress Report."

VI. Conclusion

The GoK has demonstrated its commitment to UNGASS through developing the KNASP. KNASP, through the joint efforts of more than 100 stakeholders' organisations including GoK Ministries, UN bodies, civil society, etc, aims to:

- Clearly identify priority areas and key strategies for intervention by all stakeholders including GoK, youth-led organisations, civil society, and the private sector and development partners.
- Provide a results framework to be revised annually which guides interventions across all sectors by identifying specific tangible results to be delivered in each priority area and identifying lead agencies and strategic partners responsible for implementation.
- Empower civil society and private sector stakeholders to engage effectively in the national response.

Recommendations

- Kenya has only few good youth-friendly centres concentrated in urban areas; governments and other stakeholders need to set up more youth friendly services in all parts of the country to encourage services uptake by YPLHIV and young people in general.
- The GoK needs to create and implement policies and programs to assist YPLHIV especially in setting up services for boarding school students to avoid dropouts. YPLHIV must be involved in the creation, implementation and evaluation of these policies and programs.
- Kenya has good policies on HIV, reproductive health; the problem is implementation and scaling up of these services, and scaling up coverage to reach young people in rural areas.
- The GoK must fund and build one-stop clinics onto existing services to meet sexual and reproductive health and HIV service needs. This will enhance uptake for family planning, contraception and HIV prevention and treatment.