Gendered Dimensions of Health

An analysis and strategy for improving health and gender outcomes in Danida’s support to the Kenyan health sector

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1. Introduction and context

The enjoyment of the highest attainable standard of health, including the right to health care services – regardless of sex and age – is one of the fundamental rights of every human being. Yet, socially constructed patterns of behaviour and relations still translate into major health inequities for women and men, girls and boys. These patterns are often gendered.

This health sector gender analysis identifies a number of entry-points and opportunities for strengthening gender mainstreaming during next Danida Health Sector Programme Support (Phase III) to ensure that outcomes are achieved both in terms of better health, and transformed gender relations. This will require moving concepts of gender and health into the sector-specific context of day-to-day operations. It will also require a shift in thinking about gender in the sector to more explicitly include and mainstream also men’s health issues and male involvement as a strategy to improve equitable health outcomes.

The objective of this gender strategy has therefore been identified as:

_**Strengthened ability to continuously analyse and respond to gendered dimensions of health at different levels of health planning and service delivery, thereby getting better and more equitable health and gender outcomes.**_

- **Key indicators of gender mainstreaming performance:**
  - Number of reported changes in key health sector indicator outcomes that can be traced back to applying a gender-transformative approach to addressing the problem (at different levels)
  - Number of staff at different levels who can give one or several concrete examples of how they have adapted their work processes and/or technical work plans to incorporate a gender dimension
  - Number of gendered initiatives in sectors where health outcome is not biologically determined by sex (e.g. in disease prevention, child immunization etc.),
  - Examples of changes in outcomes due to the involvement of men in the areas of maternal and child health
  - Existence of established structures and increased synergies with other ministries to address maternal mortality and morbidity through a multisectoral approach with a joint results monitoring framework.

A matrix is included in Section 7 which with some specific entry points for future Danida health sector programming, as well as suggested indicators.

The objective of the consultancy was to assess how gender issues are currently addressed within the Kenyan health sector, and to identify strategic areas of engagement and support in line with Government of Kenya and the Danish Ministry for Foreign Affairs policies. Recommendations from this analysis will feed into the design and formulation of phase III of the Danish Health Sector Programme Support in Kenya (2012-2017).

The assignment included a review of national policies, strategies and legislation of relevance, as well as a literature review to contrast findings with the current body of knowledge and good practice. Interviews were also conducted with Government representatives (MOPHS and MOMS) as well as other sector stakeholders and development partners. Health facilities in Mwingi and Thika districts were also visited during the period 11-18 May 2010. The analysis further contains:

- An assessment of the systems, capacities and outcomes of initial efforts to put an
institutional framework in place for implementation of gender related issues under the two health ministries – the Kenyan Ministry of Public Health (MOPH) and the Ministry of Medical Services (MOMS),

- An assessment of the capacity to gather, analyze and use sex disaggregated data for decision making and planning at different levels,
- An identification and assessment of some of the gender specific issues that have direct impact on health indicators of relevance to Danish health sector support,
- Assess donors’ efforts in coordination, harmonization and alignment with the government’s efforts in mainstreaming gender issues, as well as other inter- and intra-sector coordination mechanisms between State and non-State actors.

For further details, please refer to the Terms of Reference (Annex I).

2. Policy environment

2.1 Gender policy environment

- **National gender policies, legislation and structures:**

Kenya has committed to gender equality through international law and is party to many key international conventions on the status of women, including the Beijing Platform for Action and the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW). Only some of these commitments have been effectively translated into domestic law and operationalised in practice. Personal law is the area where the most blatant gender inequalities are accepted, through discrimination against women in customary law, which is founded on social, cultural and traditional practices and norms. Most Kenyan cultures still have a very traditional view of gender roles, where issues of family health and reproductive roles are seen to be the responsibilities of women.

Yet, CEDAW’s Article 5, states that “State Parties shall take all appropriate measures: (a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women; and (b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.”

The Social Institutions and Gender Index (SIGI), developed by the OECD Development Centre, examines women’s status in five key areas: (i) family code: early marriage, parental authority, polygamy and inheritance rights; (ii) physical integrity: violence against women and female genital mutilation, (iii) son preference: ‘missing women’; (iv) civil liberties: women’s freedom of movement and dress; (v) ownership rights: women’s access to land, property and credit. Kenya is ranked as 57 out of the 102 non-OECD countries.

There have been policy developments, and enactment of key legislation has been undertaken in the recent past geared at gender equality and protection. The National Policy on Gender and Development (2000) provides a framework and policy mandate to address gender inequality in line with Government commitments based on the Beijing Platform for Action. The Sessional Paper No. 2 2006 on Gender and Development provides a framework for operationalisation of gender mainstreaming into policy, planning and programming. Other important legislation includes the

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1 See TORs which specifies that a selection of some key issues of relevance, rather than a comprehensive mapping is to be done, due to the scope and timing of the assignment.

2 These views were confirmed during interviews undertaken for this analysis.
Sexual Offences Act (2006) which addresses rape, defilement, sexual assault, child trafficking (including child sex tourism and prostitution), trafficking for sexual exploitation and incest. Of importance is also the Children’s Act for protection of the girl child (including prohibition of FGM on minor girls).

The Kenyan government has institutionalized its commitment to addressing gender inequalities by creating a National Commission on Gender and Development (2003), the National Gender and Development Secretariat (NGDS) and the Ministry of Gender, Sports, Culture and Social Services in 2004, as well as initiating Gender Desks in various ministries (gender focal points/divisions), including in the current two health ministries (Ministry of Public Health – MOPH, and the Ministry for Medical Services – MOMS). A Parliamentary Committee on Gender and Development (PCGD) has also been established.

Moreover, there is a Presidential Decree of 30% affirmative action in terms of minimum number of women for formal appointees to public posts and a Women Enterprise and Development Fund has been established as an initiative towards reducing poverty through economic empowerment of women. The Draft Constitution which is to be subjected to a referendum in August 2010 also has extensive provisions on gender equality and women’s rights. Kenya’s Vision 2030 proposes to mainstream gender equity in all aspects of society by making fundamental changes in four key areas, namely: opportunity; empowerment; capabilities; and vulnerabilities as follows (see graph):


- **Opportunities and gaps in the national gender policy framework**

\[3\] However, this law only gives legal protection to girls under 18 years of age, which is why a new bill to be tabled in Parliament on abandonment of FGM is currently being prepared.
Although the recent policy developments are favourable for undertaking gender mainstreaming across government operations, the institutional structures for its operationalisation are weak. An important shift in policy terminology has been to move from the ‘Women’s Bureau’ into the ‘Department of Gender’ in December 2004, and to spell out that gender mainstreaming is about the needs and preferences of both women and men, boys and girls. Even so, the concept of gender equality is still poorly understood and internalized across government departments where ‘gender’ is often equated with ‘women’. This creates the need to establish a more balanced and holistic approach to gender, which in turn could lead to widened buy-in.

A risk associated with the institutional framework in place, however, is that issues can be sidelined as the responsibility of the currently under-staffed and under-resourced gender units/divisions, or seen as an ‘add-on’ to regular practice, rather than being incorporated across operations as a different way of carrying out already existing day-to-day work (see section 4).

Also, whereas existing policy frameworks, based on e.g. the Beijing Platform for Action, is explicit on the issues and inequalities facing women, there is no specific mention in existing policies on how to involve men and boys, both to attain good gender equality outcomes as well as to achieve overall better development results through applying a gender-transformative approach. The recognition of men and boys, both as partners to women, and as actors in their own right is important to do justice to gender mainstreaming concepts. It is also important for increased buy-in among predominantly male policy-makers, and to avoid backlash that could even negate already achieved gender equality gains.

Another risk – and opportunity to refocus future policy orientation – is the current focus on inputs-oriented measures to obtain gender equality, rather than on measuring and influencing outcomes. Recent evaluations have shown that affirmative action through gender quota for the work force – though effective in getting women into male dominated sectors – can also be perceived as limiting or even discriminatory for women unless it is well understood and properly socialized in communities and among stakeholders when introduced. An outcome-oriented focus makes policy provisions both for inputs and desired outputs/outcomes on desired gender equality gains.

2.2 Gender and health

In the NHSSPII (2005-2010) it mentions that gender focus will be mainstreamed, but does not give detailed guidance as to how this will happen and what it means. The MOPHS strategic framework (2008-12) also does not specifically mention gender mainstreaming in its objectives and strategic thrusts, and therefore leaves it open for individual interpretation (see graph).

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4 This was also concluded in the ADB National Gender Profile of Kenya, undertaken in 2007.
5 As noted during the interviews carried out for this health sector analysis.
6 That contributes to a decrease in existing gender inequalities.
7 Such as the minimum 30% quota of women, the number of women on health facility management committees etc., without specifying what the role of these women would be.
8 This refers to findings in a recent evaluation of Swedish development cooperation in the roads sector in Kenya, where the 30% quota for women’s employment in public works on roads was seen as the max ceiling, rather than the minimum participation rate for women in communities. The quota was also being campaigned against by local politicians who felt ‘threatened’ for their local power base. (Byron, G., Ørnemark, C., 2010)
Health policy environment and institutional arrangement

The ongoing comprehensive health sector reforms in Kenya can be traced back to 1994 when the Ministry of Health produced Kenya’s Health Policy Framework (KHPF) which outlined a blueprint for future development in the health sector for next ten years. The policy document was based on a comprehensive situational analysis of the sector and broadly outlined the Agenda for reform for the sector. Two National Health Sector Strategic Plans (NHSSPs) have been developed and implemented deriving from the policy framework. The NHSSP I (1991 – 1994) emphasizes the decentralization of the health care delivery through redistribution of health services to rural areas. NHSSP II (2005 -2010) focuses on the essential key priority packages based on the burden of disease and health services, and the required support systems to deliver these services to the Kenyans.

The Kenyan health sector is currently implementing the final years of the NHSSP II. The plan has been anchored on two major principles (i) reversing the declining health trends and achieving the ambitious targets and priorities defined by the Economic Recovery Strategy 2003–2007 (ERS) of the Government of Kenya (GOK); and (ii) the international Millennium Development Goals (MDGs). It sets five strategic policy objectives for the realization of this purpose:

- Equitable access to health services increased
- The quality and responsiveness of services in the sector improved
- The efficiency and effectiveness of service delivery improved
- The fostering of partnerships enhanced
- The financing of the health sector improved

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A major innovation of NHSSP II in respect to health care service delivery is the definition of the Kenya Essential Package for Health (KEPH) and the re-definition of service delivery levels – most particularly the inclusion of Level 1 services (community level) as part of the service delivery units. In order to deliver the essential health services more effectively.

Kenya’s health sector adopted the development of annual operational plans (AOPs) as a means of ensuring that NHSSP II was implemented as intended. The sector is currently implementing the fifth Annual Operational Plan since its inception. The annual action planning is also informed by the Kenya Vision 2030 and its first Medium Term Plan (MTP) for 2008–2010, along with the Roadmap for Acceleration of Implementation of Interventions to Achieve the Objectives of the NHSSP I.

The first MTP sets out the policies, reform measures, projects and programs to be implemented during the period 2008–2012 in line with Vision 2030. The MTP health sector objectives are to:

- Reduce under-five mortality from 120 to 33 per 1,000 live births;
- Reduce the maternal mortality ratio (MMR) from 410 to 147 per 100,000 live births;
- Increase the proportion of deliveries by skilled personnel from the current 42% to 90%;
- Increase the proportion of immunized children below one year from 71% to 95%;
- Reduce the number of cases of TB from 888 to 444 per 100,000 persons;
- Reduce the proportion of in-patient malaria fatality to 3%; and
- Reduce the national adult HIV prevalence rate to less than 2%.

**Health status in Kenya**

Trends in overall health of the population are best measured by impact indicators particularly those related to mortality indicators such as Adult Mortality Rate (AMR), Maternal Mortality rate (MMR), Under-5 Mortality Rate (UMR), Infant Mortality Rate (IMR) and Neonatal Mortality Rate (NMR). Improvements in the mortality indicators suggest impact of interventions meant to improve the health of the population.

Latest information on impact trends is available from the preliminary report of the 2008 Demographic and Health Survey. This presents partial data, with the more comprehensive information to be released with the final report. The trends in mortality impact indicators during the period of the policy are shown in the figure below.

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The general trend in impact indicators suggests a worsening of the health situation that appears to be on an improving trend. However, during the last ten years, the neonatal and maternal mortality levels indicate decline, while infant, and under 5 mortality trends suggest improvements.

The current 2008 DHS preliminary report doesn’t allow for analysis across key socio economic variables. However, the previous report suggested USMR and IMR are most probably higher in rural areas, as opposed to NMR that was higher in urban areas. Similarly the USMR and IMR were higher in male children, as opposed to female children, with the increases seen driven largely by increased mortality of the males.

- Performance of the health sector

The performance of the Kenyan health sector is ably summarized in the Annual Operational Plan 5 as “Many – if not most of the specific NSSP II service delivery targets are far from being achieved. A variety of factors contributed to these shortfalls, but the fact remains that there is urgent need for everyone to redouble effort to accomplish the goal of good health ‘for all the Kenyans’.”

It further goes on to make this critical observation; “If management of the sector continues ‘as business as usual as was the case in the NHSSP I, it was recognized that the targets will not be achieved”. Therefore NHSSP II focuses on the changing the mindset of the health managers to adopt in the holistic and participatory approach to the sector management, appreciating the involvement and responsibility of other actors, orientation to results than to the processes and procedures and use flexible and learning approaches.

- National health policies (incl. HIV/AIDS) and how gender is framed and catered for in these

Gender differences in health and how well health systems and health care services meet the needs of women and men are well documented. Kenya’s national health statistics show inequalities in health status and access to health services between men and women. Gender differences are pronounced in life expectancy, the risk of mortality and morbidity, health behaviours and in the use of health care

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services, reproductive health, HIV/AIDS incidence and domestic violence. Even the health care administrations are all characterised by significant gender inequality. Promotion of gender equality in other sectors can also influence health status.

Moreover, there is increasing evidence demonstrating the importance of a number of different social determinants of health, and these interact with gender inequalities in ways that can magnify the impact on health. Additionally, there has been an increasing recognition that health policy may exacerbate gender inequalities when it fails to address the needs of either men or women, and that health systems must address gender equity. Despite the now widely recognized gender dimension in the health services utilization and health outcome, efforts towards gender mainstreaming in regards to policy, institutional arrangements and programming in the health sector is still weak and haphazard.

In the NHSSP II, the sector premier policy blueprint document, gender equality is not well articulated as a sector policy or strategic intervention. While acknowledging that wide health inequalities exist, NHSSP II recognizes gender roles, as one of the key drivers of the inequality. But it fails to articulate gender mainstreaming as common thread running across the entire spectrum of health programming. Where it is mentioned, gender related interventions are presented as ‘women’s issues’ or as a specific intervention.

A review of the strategic interventions proposed for the realisation of the five key sector policy objectives, reveal a number of proposed gender related interventions such as:

- Target resources to services for women and children, like reproductive health, safe motherhood
- Humane, compassionate and dignified service provision
- Privacy for women
- Greater gender awareness
- Understanding of the different health needs of men and women
- The human rights approach will be promoted in practical clinical settings
- Services will become more clients-oriented
- Establish youth-friendly services and even special youth clinics where possible
- Enhance service quality by initiating regular clinical audits (in particular for maternal deaths) and building these into the performance management system.
- Encouraging the participation of men in reproductive health services.

Many senior health managers in the Ministries of Health, while acknowledging the importance of gender considerations in health programming, concurred that gender mainstreaming as presently formulated in the policy documents were rather ambiguous and did not provide clear programming direction for health managers at the district and facility level. 15

**HIV/AIDS policy and gender mainstreaming**

The national HIV & AIDS prevalence is 5.1% and is higher among females (6.7%) compared to males (3.5%). To a larger extent, women are more susceptible than men to infections in any given heterosexual encounter due to physiological reasons and gender norms in many communities allow men to have more than one sexual partner which exposes women to more risks of infection. Gender based violence in many communities also prevent women from negotiating safer sex. The preliminary results of the 2008/2009 Kenya Demographic and Health Survey (KDHS) indicate that

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15 Senior managers interviewed during the Gender analysis study by Danida consultants.
domestic violence is still prevalent in Kenyan society with 39% women reporting having ever been physically or sexually assaulted by their husbands or partners during their lifetime. In one year (April 2007- March 2008) the Gender Violence Recovery Centre based at the Nairobi’s Women Hospital recorded a total of 2,750 survivors of sexual and domestic violence. Sexual and gender based violence was one of the traumatising human rights violations that occurred during the post-election violence in 2007-2008. Women and girls were subjected to rape, gang rapes, sexual assaults and sodomy as a way of punishment by warring ethnic communities. Mending these deep social rifts will take a lot of time and goodwill to heal. This cannot be the responsibility of women alone – men have a crucial role to play in ensuring that this is not repeated again as an ‘accepted’ male behaviour in times of crisis and ethnic conflict.

The HIV/AIDS sector of health is comparatively ahead in embracing and articulating the gender issues in its policy formulation and programming. This can partly be attributed to the rather obvious gender aspects of the HIV/AIDS infections. In 2002, the National Aids Control Council (NACC) produced the “Mainstreaming Gender into the into the Kenya National HIV/AIDS strategic Plan 2000-2005; which set the agenda for Gender Mainstreaming in the HIV/AIDS policy and programming.

According to the Kenya National HIV and AIDS Strategic plans 2009/10 – 2012/13 on the issues of gender dimensions of the epidemic, “feminization’ of the epidemic is apparent with prevalence among women (8.8% among the 15-49 years age group and 8.4% among the 15-64 years age group) significantly higher than among men (5.5% among the 15-49 years age group and 5.4% among the 15-64 years age group”). The strategic plan recognises gender as a programmatic challenge to Universal Access in Kenya and undertakes to ensure that HIV-related dimensions of gender inequalities are prioritized and addressed across all aspects of the plan.

The intentions and desires of the strategic plan have not been actualized in the programming aspects. The few gender interventions undertaken have been limited to specific interventions like procurement of female condoms, scaling up PMCTC, working with most at risk populations (MARPs) and empowering them through micro-financing.

In a nutshell, gender mainstreaming, despite its potential for enormous benefit to the health sector, is not properly articulated and anchored in key policy documents. In addition, many gender related policy desires and interventions are not well understood by all key stakeholders at both national and grassroots level.

**Opportunities for policy articulation and institutional framework**

The sector is currently developing two key policy documents, namely the Second Health Sector Framework and the third National Health Sector Strategic Plan (NHSSP III). These two documents are critical as they will provide the road map for the health sector reform agenda for the next ten and fifteen years. The two documents can provide an opportunity to the sector for a proper articulation of gender mainstreaming as a policy objective and/or strategic intervention. The sector should seize this opportunity to present gender mainstreaming in the policy documents comprehensively in respect to its content, context, process and actors. The policy should identify all key issues

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surrounding gender and health and be well articulated in a manner that can be appreciated by implementing health managers in the district and facilities level.

The health Ministries should also take this opportunity to make gender units more strategically placed within the departments of technical and strategic planning, monitoring & coordination rather than where they are currently placed, in order to gain more strategic inputs to planning and data gathering.

3. Emerging issues related to gender & health

Because of the different biological health needs of women and men, including the exposure of women to higher health risks related to pregnancy and childbirth and HIV/AIDS, gender in the health sector has often been equated with ‘women’s health’\(^{20}\). Other persistent disadvantages in education and economic opportunity also act as barriers to women’s improved health status.\(^{21}\) As a result, many public health interventions have focused on improving women’s health status, rather than addressing biological as well as non-biological gendered dimensions of health – i.e. the socially constructed patterns and behaviours that affect health outcomes for women/girls and men/boys.

Another problem associated with sidelining gender issues in the health sector into the area of reproductive and ‘women’s health’, is that it *isolates the problem from being a cross-ministerial public and political concern* – closely related to infrastructure development and economic integration – to being a *pre-dominantly externally donor funded area* where vertical programmes and service delivery through NGOs and FBOs continue to fill the gaps in spending from the general budget\(^{22}\). Consequently, insufficient public spending to improve maternal health, and to reduce maternal deaths, has fallen off the main public, political and policy agenda.

3.1 Common ‘myths’ and conceptual clarifications

Getting gender concepts across to sector partners (State and Non-State) in political dialogue and in day-to-day implementation is not necessarily easy. Whereas there are a few champions, also at senior Ministry level, many others – even in areas such child health have more preconceived ideas of how to handle it, or that it is a non-issue. Yet even child vaccinations, which of course should be universal for children, could have gender issues attached to it in relation to who of the parents and how children are brought to the clinics.

Numerous gender manuals have been prepared, or were being referred to during interviews for this study. For instance, a generic training manual on gender mainstreaming was produced in 2008 by the Ministry of Gender, Children and Social Development together with UNFPA. Danida also has their own Gender Toolbox which could be made available to gender focal points in the two health ministries. African Development Bank also produced a quite thorough Kenya Gender Profile in 2007 which provides for an important reference point/baseline for some issues. A more health-specific manual for gender mainstreaming prepared by WHO, was also being referred to as a possible tool – yet it may be adopting more of a ‘women’s health’ approach in line with WHO’s institutional position\(^{23}\) compared to Danida’s gender mainstreaming policy (see also section 7).

\(^{20}\) See e.g. WHO, www.who.org

\(^{21}\) Grown, C., Rao Gupta, G., Pande, C., “Taking action to improve women’s health through gender equality and women’s economic empowerment”. The Lancet, 2005

\(^{22}\) Donor investments represent approximately 58% of resources available to the sector in 2009/10, but these are still largely project-based with 88% off-budget.

\(^{23}\) Unfortunately the team did not have access to this manual, as it is not featured on the WHO website.
The Ministry of Gender mainstreaming manual is rich in detail and contains a lot of relevant information and tools. A problem with generic manuals, however, is that they can be seen as quite specialized, decontextualised and difficult to digest. Many (including the Ministry of Gender manual) give the impression that gender mainstreaming is something difficult and unattainable, or something to be delegated to ‘specialists’ to do. Yet, as noticed among interviewees who had attended some gender trainings, most staff other than the gender focal points know the words of gender mainstreaming, but have not internalized the concept or applied it to their own area of work.

During interviews for this study, a number of ‘gender myths’ and misconceptions also surfaced that are indicative of the fact that more emphasis is needed on ‘selling’ and explaining the concept to create an internal demand for gender knowledge and skills within Government structures. Below is a summary of some of these ‘myths’ — directly quoted from interviewees — with some suggestions for ways to address and communicate around them in sector dialogue with partners.

<table>
<thead>
<tr>
<th>Common ‘myths’ encountered about gender &amp; health</th>
<th>Ways to confront/communicate around them</th>
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<tbody>
<tr>
<td>“Gender in the health sector is the same as addressing women’s health issues.”</td>
<td>The fact that women are more likely to die from health issues exclusively affecting women, such as pregnancy-related factors/ maternal health, definitely has a gender dimension to it (as a society we are not taking well enough care of women in fulfilling their reproductive role, or they are forced into risky sexual behaviour due to vulnerabilities, abuse, low socio-economic status etc.). But gender dimensions can be positive or negative and affect men or women, girls or boys. In fact, most health issues have a gender dimension to them that affects outcome.</td>
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<tr>
<td>“It is a ‘luxury problem’ – the sector has so many other problems that are more pressing. Moreover, money could be better used for other things.”</td>
<td>Incorporating gender into the work is not an add-on to what you currently do; it’s about how you do what you do anyway. Adjustments in institutional arrangements, data gathering or work processes will require some time and investments, but once systems and capacities are in place, gender mainstreaming is not costly in itself. Doing things in a gender-responsive manner is a basic requirement for maximizing health outcomes. In that sense prevailing ill health of a population is always much more expensive.</td>
</tr>
<tr>
<td>“We are so under-resourced that we don’t have the time to think about these things [gender]”.</td>
<td>At health facility level, this is definitely true. But even at that level, many practices can be made more gender responsive (such as welcoming/encouraging men to perinatal clinics or for child health clinics). Detailed records and reporting is anyway done from facility level on a regular basis. By just noting the sex of clients more systematically, gendered dimensions of certain diseases or practices that affect health status could become more apparent. Rather than expecting women to pass on health information to men, men can be targeted directly.</td>
</tr>
<tr>
<td>“Women die during child birth because of cultural issues that the Ministry has nothing to do with. Still we get the blame for the high maternal death rate.”</td>
<td>It is easy to ‘push the blame’ elsewhere. But it is also relevant to look at what the health system can do in its interactions with the community to work with and influence cultural or social practices that have negative health consequences. The way the health system interacts with the communities can inadvertently reinforce gender inequalities, e.g. by making pregnancies a ‘women only’ issue. Or it can influence and</td>
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24 E.g. experiences debated by Danida Gender Focal points at a seminar in 2009.
**Common ‘myths’ encountered about gender & health** | **Ways to confront/communicate around them**
---|---
Encourage collective community responsibility for e.g. getting pregnant women to health centres in time for delivery. Family birth preparedness counseling needs to involve the men/husbands, but needs to be made attractive and interesting for men to attend. | There is a strong body of evidence that men and boys can and do change attitudes and behaviour related to sexual and reproductive health, maternal, newborn and child health if targeted and addressed on equal terms and as actors in their own right (not just as partners to women); even in Africa. A problem is usually the isolated nature of such programmes, which are not part of the main health system, but which are typically carried out as small pilot projects by NGOs.

“The African man is like that. He cannot take an interest in women’s issues. It is not done in our culture.” | 30% is not the maximum ceiling; according to affirmative action for employment in the public sector, it is the *minimum* required level of participation by women. Likewise, there could be situations where men are underrepresented and then the minimum 30% should apply to men as well. And it is just a start. Level of participation, knowledge and ability to speak up on issues of importance is equally important. Moreover, gender mainstreaming of the issues does not necessarily happen even with the right team composition in place. It should still be seen and addressed as a joint responsibility.

“If we get 30% women as health workers and in the as participants/committee members we have been successful in gender mainstreaming” | Actually no donor wants gender mainstreaming for the sake of it – but just like Government partners, they do want good health and gender equality outcomes, and these are often related. Gender mainstreaming is a means to achieve this. Donor and partner governments have a mutual commitment to maximize benefits for both women and men in the areas they jointly invest in. There are gendered dimensions to the way health information and services are provided to communities (men and women). There are also gender aspects of most health issues that could be addressed. If these were continuously tracked, analyzed and planned for, we could do a lot better (both in terms of better and more equitable health outcomes, and in getting more gender equality between men and women in the longer term).

“If this is what the Danida wants, we will do it. He who pays the piper calls the tune...” |  

Some of the statements above are also indicative of the fact that there is need for some conceptual clarification on what is possible and strategically relevant to focus on in relation to gender mainstreaming in the health sector.

It calls for a quite drastic shift from *inputs-oriented targets, objectives and indicators to a gender outcome focus*. An example would be to move from ‘counting women on local health committees’ to setting up ways of monitoring whether women’s and men’s interests are well represented and catered for in Committee decisions, and whether they reflect real priorities and needs. This is not to say that the minimum 30% quota representation should be taken away (even though it can have tokenistic effects), but cannot be seen as a not a mainstreaming result in itself.

Another couple of important distinctions for addressing gender in the health sector are:
(1) Even a health issue which is determined by sex (like maternal health) can have clear gender dimensions attached to it which affects the best possible health outcome (e.g. women's lack of nutrition due to lower socio-economic status, male decision-making around pregnancy health risks despite having low levels of awareness).

(2) Health issues with no apparent gender dimension (like malaria prevalence) may very well have gender aspects to be addressed from the viewpoint of service providers (e.g. even if pregnant women get to sleep under the treated malaria net provided by health care providers, an unequal division of labour in the household may mean that she gets up every morning before dawn to carry out household chores).

(3) The way the health system performs and interacts with socially constructed systems (like gender relations) reinforces or mitigates the negative effects of cultural practices, commonly held beliefs, attitudes and behaviours among men and women that affect their health. This interaction can be strategically used to challenge traditional gender roles that are create unequal health outcomes or exposes one group over another to unnecessary risks. (E.g. All health staff interviewed agreed that getting men involved and more interested in their wives' or partners' pregnancies would improve the woman's likelihood to attend antenatal class and to deliver in hospital; yet men are not really 'expected' to show up, and few efforts are made to cater for their information and health needs if they do come to the clinics).

Schematically it is presented in the below graph:

At the one side are the differences in health needs/rights by sex and age (no. I) for which a more clinical approach can be applied, e.g. to cater for different types of health services to women, men, girls and boys in accordance with their physical health needs in the different stages of their lives.
This is an area that the health sector has relatively high degree of control over, but where the focus and resource allocation towards certain services over others, as well as the way in which they are provided, still contain gender dimensions of a more subtle character. E.g. is enough of the overall budget allocated to meet maternal health needs, at which levels are investments made (knowing that most poor women attend lower levels health facilities), are there any clinics to address reproductive health needs of men (like infertility), or any other predominantly ‘male’ health issues (like alcohol consumption, drug abuse etc.).

At the other side are the socio-cultural constructs that contribute to gendered health inequalities (no. II), but where the health system in itself has limited reach or level of influence. These are typically practices or behaviours that are reinforced by communities, culture, traditional belief and attitudes, but with influence over gendered patterns of health outcomes. These can be harmful cultural practices like FGM and wife inheritance, sexual assault and gender-based violence, but also malnutrition and anemia among pregnant women due to poor food intake (being expected to eat last or take less of the meats than male family members), or men’s traditional lack of acceptance of family planning methods. These are all areas where the clinical approach is less suitable and where community-based approaches may have more impact to change the root causes of inequalities. It should, however, be noted that these socio-cultural constructs that contribute to gendered health inequalities can vary greatly even from one community to the next and that they are largely influenced by the attitudes of leaders and Chiefs of that community. Any blue-print model in this area would therefore not be appropriate. It is also easy for health service providers (as observed in this study) to ‘write off’ this area as too complex, impossible to change, and ‘not the job of health personnel to address’.

Finally, and interestingly, is the intersection where these two domains overlap in the gendered dimensions of health outcomes. As indicated above, this is the effects of the way the health system performs and interacts with socially constructed systems (like gender relations) and where good health and gender equality outcomes overlap. In other words, it is where there are actionable programmatic opportunities to influence gender outcomes as well as getting better health outcomes. Although it is not entirely within the control of health systems actors, this is an area where a gendered approach to health can have a longer term influence, and where good practice can be monitored and institutionalised. Adopting this approach would also help to move interventions from being (at best) gender-sensitive (recognizing the specific needs and realities of men and women based on the social construction of gender roles), to also being gender-transformative (aimed at more gender-equitable relationships between men and women, reflected in attitudes, norms and institutional practices.

The below example on maternal mortality and morbidity illustrates:

<table>
<thead>
<tr>
<th>I. Health needs by sex and age</th>
<th>II. Gendered dimensions of health outcomes</th>
<th>III. Socio-cultural constructs that contribute to gendered health inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Up-grading of health centres to include more delivery beds and emergency theatres for C-sections</td>
<td>- At policy level, reframe issue as a societal problem, a rights issue, not to be solved only by women, or by the ministry of health alone. Instead collective response and male involvement to be stressed and spelled out through strengthened legal and policy framework.</td>
<td>- Identify community-specific attitudes and cultural practices around ‘birth’ and the process of ‘delivery’ that may affect health outcomes of mothers and infants</td>
</tr>
<tr>
<td>- Training of Clinical Officers to enable them to carry out emergency C-sections</td>
<td></td>
<td>- Work out tailored approaches on how to get key local decision-makers to champion issues around male involvement and collective</td>
</tr>
<tr>
<td>- Address obstacles to timely availability of the necessary medical supplies and delivery kits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25 E.g. many referred to attitudes and cultural practices of ‘the African man’ as an obstacle to be worked around, rather than something to work with and try to influence.
### I. Health needs by sex and age

- Upscale maintenance budget of health facilities to improve on cleanliness for reduced risks of post-partum infections
- Initiate inter-ministerial working group on joint efforts to plan for reduced maternal mortality and morbidity in remote areas/areas with highest prevalence rates

### II. Gendered dimensions of health outcomes

- Sensitisation of health workers’ attitudes towards pregnant women (especially teenage pregnancies) to encourage assisted delivery in health facility as opposed to delivery at home
- Setting up of male groups of partners/husbands for ‘birth preparedness counseling’ (to change attitudes/level of involvement/understanding and detection of pregnancy-related health risks)
- In areas where the burying of the placenta on own land is an issue, introduce a system where they can carry the placenta with them to their natal home after delivery
- Create incentives for female nurses and clinical officers to go to remote areas where the sex of the health worker/mid-wife affects cultural choices on whether women deliver in hospitals or at home.

### III. Socio-cultural constructs that contribute to gendered health inequalities

- Needs of women during pregnancy and for postnatal care
- Cultural practices of women and men that affect health
- Gender norms and expectations
- Access to health care services

### Another example of the need for this kind of gendered analysis and approach can be found in the area of malaria prevention. Kenya Demographic and Health Survey (KDHS) findings from 2008/2009 found that 61% of households in Kenya report owning one mosquito net (treated or untreated), while 54% report owning at least one treated net. Some 51% of children under five years and 53 percent of pregnant women were also reported to have slept under a mosquito net the night prior to the interview. Yet the same survey reported indicates that 9 in 10 mothers (96% in urban areas, 90% in rural areas) visited a health professional at least once for antenatal care for the most recent birth in the five-year period before the survey.

There are gendered patterns of use of bed nets that could be relevant in order to fully understand the discrepancy between the high rate of people attending antenatal care, and the – in comparison relatively low number of pregnant women sleeping under bed-nets. While pregnant mothers and children under 5 are targeted for subsidized or free bed-nets, there are questions as to what happens to the older children or the rest of the family if only one free/subsidized net is given out per pregnancy.

It has been noted that a body of research knowledge is lacking and/or underutilized in relation to gender, socio-economic status and health systems in strategies to prevent malaria. It has been estimated, that given equal exposure, adult men and women are equally vulnerable to malaria infection, except for pregnant women who are at greater risk of severe malaria in most areas. Yet,

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26 Kenya Demographic and Health Survey 2008/09  
27 Malaria Research in Africa: Multilateral Initiative on Malaria, Vol. 95, Issue 3, 2007  
28 Gender Health and Malaria, WHO info sheet.
as indicated above, some of the gender norms and value that could influence health outcomes related to malaria are:

- **Division of labour**: Women (including pregnant women) in especially rural parts of Kenya tend to get up before dawn to perform household chores when there is still risk of being bitten thereby possibly negating the effects of sleeping under the treated bed net since it increases their risks of being bitten; male infection, or infection of over-5 children in the household (not targeted for bed nets) may lead to heavier workload for women in the home since women are viewed as main care givers. The potentially positive effects of sleeping under the bed net could be partly negated by unequal division of labour in the home.

- **Sleeping patterns**: Pregnant women may sleep with the smallest children separately from the husband and/or older children giving limited overall family protection. It indicates that health facilities should distribute minimum two, instead of just one treated bed net/pregnancy since studies show that if a household only has one bed net, priority may be given to the male head of the household to sleep under it. Bed nets may also ‘disappear’ or be given away by husbands to their first wives where he himself sleeps; men in some areas may sleep outdoors thereby increasing their risk of infection.

- **Treatment-seeking behaviour**: Pregnant adolescent girls may face difficulties in (or shy away from) accessing health services, thus not getting timely prevention messages or treatment associated with the ‘shame’ of being pregnant; men tend not to seek treatment until they are very ill which affects the health outcome.

- **Household decision-making**: Men are frequently the main decision-makers on health related expenses, but also have a lower treatment-seeking behaviour themselves, which could result in money being withheld from women for going to seek health care.

- **Programmatic responses**: Data on the disease (as on all disease patterns) are not routinely sex disaggregated when reported upwards in the system. At health facility level no gender analysis of records are being carried out (neither at district or national levels).

### 3.2 Men’s health and male involvement

As previously referred to, most Government of Kenya and donor-funded programmes concerned with family planning, sexual and reproductive health and rights, as well as maternal and neonatal care have traditionally targeted primarily women. The evidence is the lack of men both as clients and as health workers at lower levels in preventive or primary care. Men are also poorly catered for in health prevention and early detection of e.g. HIV/AIDS infection, where women testing positive in connection to pregnancy has the main responsibility of telling and bringing her partner to the health facility for testing and treatment.

With few formal contacts between the primary health care system and men, women who attend antenatal and mother-child health (MCH) clinics also become the main channel for sensitising the men on relevant health issues affecting the child’s health and development. Given that women are often in a disadvantaged and unequal power position in the household to begin with, this strategy is unlikely to be successful, especially when it comes to making informed family decisions on health expenditure. This does not only have a potentially negative effect on women’s and children’s health outcomes by placing an excessive burden and responsibility on women in health prevention. As
recently illustrated in other sectors, it could also lead to *male backlash, negative male health gains,* or *male behaviour that potentially negates women’s health gains*\(^\text{29}\).

<table>
<thead>
<tr>
<th>Concepts around male gender issues in health:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Male backlash</strong> – refers to situations where special focus and targeting of women is perceived to give women preferential treatment, leading to reactions of outrage or even violence among male groups who feel sidelined or threatened. Examples are instances where targeting of women for economic empowerment has led to an increase in domestic violence, or where male politicians have campaigned for a lowering of the 30% quota for women’s participation in public works(^\text{30}).</td>
</tr>
<tr>
<td>• <strong>Negative male health gains</strong> – Positive health gains from one intervention – such as increased income from working on rural roads, and increased access particularly for pregnant women to rural health facilities through improvement of the roads network (mainly benefitting women) – can have unforeseen negative health gains for men through increase in alcohol consumption and drugs. This was noted in a case where women’s and men’s access to income from unskilled roads works alleviated men from being in charge of household expenses. Increased access and local commerce from the improved roads network also had a negative impact on their health through an increase in consumption of illicit alcohol brews, and riskier health behaviours. Yet few interventions target male health issues. It can also have a detrimental effect on their wives and families (see below).(^\text{31}).</td>
</tr>
<tr>
<td>• <strong>Male behaviour that potentially negates women’s health gains</strong> – Men can be the main drivers of certain epidemics in some communities, like HIV/AIDS, due to more frequently having multiple sexual partners, and adopting a lifestyle that contains higher health risks associated with drugs, alcohol consumption, tobacco use, which can make them more susceptible e.g. to upper respiratory tract infections that can be passed on to women and children.</td>
</tr>
</tbody>
</table>

The *failure to reach men* by the formal health system and in primary health care interventions is therefore an urgent issue to be addressed. It also symbolises an important shift in previous gender targeting (involving mostly women).

Timing for this is also good, as this has been acknowledged both by the Gender Division at the Ministry of Gender and Social Development, and senior officials in both of the health ministries. The community health strategy launched three years ago offers a comprehensive framework to addressing health issues including family planning, and spells out the participation of men. Implementation has, however, been patchy and ad hoc with few lessons being identified as good practice or being mainstreamed into larger scale roll out. According to a non-state actor representative, “all think it is a good idea, but nobody knows how to do it”.

Other, more recent initiatives include the development of new GoK guidelines for *Acceleration of Maternal, Newborn and Family health: Interventions for the Achievement of MDGs and Vision 2030.* Operationalising these guidelines and building a body of knowledge of best practice on male priorities and incentives for involvement will be key in the coming years, and an area which could be supported under the new Danida health support programme. Important, however, will be to address male issues in a holistic manner and across operations – including addressing men’s own health

\(^{29}\) In a recent evaluation of gender equality in Swedish development cooperation (Byron, G., Ørnemark, C., et al 2010), affirmative action for women in the Kenyan roads sector was sometimes being used by men as a political argument to limit women’s participation. Women’s temporary economic empowerment through income from unskilled labour on the roads also led to negative health gains for men who picked up increased alcohol consumption as a result of having less household expenses and school fees to cater for (now covered by their wives). In the long term this could also lead to an increase in gender-based violence when the responsibilities for household expenditure are transferred back to the men, conflicting with their increased drinking habits.

\(^{30}\) See Evaluation of Gender Equality in Swedish Development Cooperation: Kenya case study.

\(^{31}\) As above.
needs and concerns – and not just to target men as partners to women in reproductive health issues. After all, why would men want to come to health clinics just to attend family planning sessions, if the same facilities don’t usually cater for their health concerns?

### Men to play bigger role in family health

“Men are to play a bigger role in a new campaign to promote healthier families. Besides being actively involved in family planning, men will be encouraged to attend both ante- and post-natal clinics together with their spouses... The minister [Mugo] said the lifetime risk of dying due to a pregnancy related condition in Kenya is one for every 20 pregnancies. ... The situation is aggregated by the low number of gynaecologists in public health facilities. Out of the 290 registered gynaecologists, only 84 of them work in government facilities...”

*Extract from Daily Nation news article, Friday April 23, 2010*

However, it may be unrealistic to expect a bigger role of men in reproductive health, if their own health needs are not being catered for first. It will therefore be important to treat men’s health issues and male involvement as a mainstreaming issue across all health sector operations as part of the overall gender mainstreaming effort, and not to single out just one health area for male involvement. It is also important to avoid a “mass migration” of opportunistic gender CSOs to shift all focus on stand-alone components addressing men. A WHO report reviewing evidence from programme interventions that engage men and boys in changing gender-based inequity in health also concludes, that while such programmes have been effective, the main weakness is that they have so far only been undertaken as small, isolated pilot projects rather than having been gradually up-scaled and incorporated in the wider health sector response strategies.

Yet, to date, there is an alarming lack of systematic gathering of sex disaggregated data and use of such data in the Kenyan health systems to discern and respond to gendered health patterns for both women and men. The WHO report acknowledges that most programmes involving men to date have focused on sexual and reproductive health; HIV prevention, treatment and care and support; maternal, newborn and child health; fatherhood and gender based violence.

This view was confirmed by this study as there seemed to be limited resources available for community mobilisation to pass on health information to a wider group than those who turn up at the out-patients clinics (and where men usually turn up during later stages of the illness than women). Work on health prevention related to men’s health and risk behaviours, and male participation in reproductive/family health should be seen as two important sides of the same coin – but still be treated separately.

For the latter (male participation in reproductive/ family health), efforts to involve men at lower levels of health service provision were observed as part of this study. This included sending home invitation cards with women attending antenatal care for their partners to attend the following session. “Sometimes they come, but most often they don’t”, was the comment of the nurse-in-charge of the facility. In relation to bringing in children for vaccinations and check-ups, men who bring their child can ‘jump the queue’ and get served first, which works relatively well as an incentive for men to come.

Although there is some merit in this approach, it could be refined further as it still gives a ‘mixed message’ to community members about men being more important than women, which could

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33 As above.
34 At the day of the visit to the Mwingi health centre, there were around 20-30 mothers waiting with their children, and with one man being served first as he brought the child instead of the mother.
reinforce existing gender stereotypes. Likewise, the explanation is that men – as the main breadwinner – cannot afford to lose valuable time while waiting in line to be served. Yet, this implies indirectly that women’s time is less valuable, even though they are most often the ones in charge of all household and food preparation chores, and often also engage in additional income-generating activities. By being served first, men also miss out on the mini-talks on preventive health practices that are usually carried out for women while they wait for their turn.

More detailed analysis and gathering of best practice (both from Kenya and elsewhere) should be considered in the design of incentive structures for men’s engagement in family health. It will be important that strategies are context-sensitive, using existing culture and natural meeting points for men as possible entry-points for engagement in addition to making the health clinics more ‘male friendly’. Suggestions in this area include:

- Having special ‘male clinics’ (where both male health issues, family health and health preventive information can be distributed)
- Instead of asking men to come to the clinic, take ‘the clinic’ to natural meeting points for men,
- Sensitising facility staff to a more gender-sensitive use of language and how to make men who turn up at ante- and post-natal clinics feel more ‘comfortable’ (with issues and the environment)
- Having designated male waiting rooms/areas inside clinic facilities where health information tailored to men can be distributed and where small health-talks can be conducted among the waiting men (currently there are no such areas, and men tend to wait in the parking lots instead of entering the facilities).

It would also be good to add to the health card of the child, or in the new “Mother and Child Health Booklet” whether the mother was accompanied to the ante-/post-natal clinic by her partner, or whether it is the mother, father (or both) who brings the children to the clinics for immunization and check-ups. This could then be monitored and correlated with use of different techniques for getting family health messages across to men.

However both men and women need to be sensitised about the advantages of having men present. The perception still prevails, that if a man walks into the health clinic, he has HIV/AIDS, a sexually transmitted disease or has been left by his wife... “Women in the community would gossip,” was the sense among men who generally shy away from this environment.

In addition to encouraging men to attend clinics with their wives or partners, other forms of outreach to men’s groups should be explored, e.g. to set up birth/fatherhood counselling support, or assist couples in drawing up pregnancy plans and budgets to specify coping mechanisms for dealing with the pregnancy, delivery and post-partum period.

Communications strategies to motivate male involvement to family health should also be evidence-based and carefully crafted to avoid depicting men just as partners to women (designed from a women’s perspective) or as potentially violent perpetrators of sexual violence and discrimination. A

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35 For example, the Marie Stopes Clinic in Kisumu is targeting men and boys at their favourite pastimes. The clinic has begun organising football, boat and bicycle riding competitions, where officials take advantage of the opportunity to disseminate family planning information.
36 The booklet was launched on April 23, 2010 with the intention of putting together records of services offered to both mother and child. It forms linkage between the pregnancy, delivery of the baby and continued care of both mother and child.
more effective way would be to craft messages around what motivates men, acknowledging also their own health rights and potential health vulnerabilities.37

Beyond silver bullets – a lesson in gender complexity from South Africa
“What kind of man are you?” The question pounded its challenge from a highway billboard in southern Johannesburg in the summer of 2002. The sign spelled out its meaning a few centimetres below: “Violence against women hurt us all”.

At first glance, it did not take much to connect the dots: women were victimised by men; all it took was a ‘real man’ to stop turning the wheel. This assumption would soon be proven wrong, however, when a national survey showed that half of the South African schoolgirls questioned agreed that “when a woman says ‘no’, she really means ‘yes’”. In certain parts of the country seven out of 10 schoolgirls believed that “it is not sexual violence to force sex with someone you know”.

No single billboard, no creative advertising punch line could summarise and shock as the South African Youth themselves, in rich neighbourhoods, rural villages and run-down informal settlements. And it was not only – as many would have presumed – girls who were forced into having sex; it was boys and girls alike who were at risk... And the family members, teachers and neighbours were among the likely perpetrators, while a silent chorus of prejudice gave passive social consent. (...

Extract from Introduction to Evidence-based Communication – Socialising evidence for participatory action, Centre for International Epidemiological Technologies (CIET), Andersson, N., www.ciet.org

3.3 Sexual and reproductive health and rights (SRHR) & maternal health

The importance of reframing sexual and reproductive health and rights (SRHR) as issues of broad societal concern, rather than those of a small group of ‘lobbying feminists’ has been alluded to in this study – especially considering the 3,000 to 6,000 annual pregnancy-related deaths in Kenya38.

Another proposed approach is increased involvement of men in family planning and perinatal and family health (see Section 5.2) with the aim to increase male understanding of pregnancy-related health risks and perinatal care and to address some of the gendered attitudes and behaviours that can severely affect health outcomes. Those quoted or observed in relation to this analysis included:

(i) Family planning:

- Still largely seen as ‘the woman’s problem’ if she gets pregnant
- Lack of male acceptance of family planning methods to reduce the family size. Some women have to access contraceptives in secret, and hide evidence of contraceptive use in the home, which means they may not be prescribed the most suitable option. Though some change was seen during the drought in affected areas, where feeding a large number of children was a constraint.

37 Many initiatives targeting men to date frame men ‘as partners’ or ‘men as champions’ to change gender inequalities – see e.g. Kenya Country Report on Reproductive Health and Reproductive Rights, which mentions “information and education materials urging men to encourage and support their spouses/partners in reproductive health”. There are fewer examples of programmes working with men as men, addressing their own priorities and interests, both in terms of their own health concerns as well as sensitising them on the added value of risk reducing behaviour for themselves and their families.

38 Statistic from MOPHS, quoted in the Nation, 23 April 2010.
- Lack of reach of health services for those most in need of the service – such as young women, school drop-outs, the illiterate (evidenced by correlation between education level and fertility rate).
- Health service providers also have limited means of reaching those who do not actively seek out the service by coming to the clinic. Evidence of women using the excuse of “having to take the child for a check-up” to access regular contraceptive shot, but this does not help girls who have been married off at a very young age before having the first child.
- Faith-based health service providers are an obstacle to increased acceptance and uptake of family planning. A well-developed referral system to GoK structures should be mandatory.
- Demand of family planning services and contraceptives larger than the supply
- Lack of data on men’s attitudes and perceptions for local, evidence-based interventions that includes men.
- There is mention of involvement of men in family planning and reproductive health in the NHSSP III. It is however not stated how that would be done.

In the 2003 Kenya Demographic Health Survey, contraceptive prevalence of women aged 15-49 years was 39.3%. This figure may be lower than reality due to a reporting bias among women who access family planning services in secret. It captures women who are practicing or whose sexual partners are practicing any form of contraception. It is usually measured for married women in fertile age. The indicator, though indicative of overall scope of the problem, does not segregate by sex (it covers both women and their partners), which unfortunately makes any monitoring of male practice, use and perceptions in this area more difficult.

It would be important to break this indicator down to male vs. female use of contraceptives to be able to track a shift in gendered patterns in this field over time. In addition to the overall prevalence rate (which is expected to rise if men are sensitised/involved), this would be useful to tell whether behaviour shifts in terms of chosen/preferred methods with more responsibility also placed on men.

(ii) SRHR:

- Many of the issues encountered are similar to those related to family planning, such as male / societal perceptions and attitudes.
- Despite comprehensive policies and guidelines, the concept of gender equality often gets conflated with women’s health issues and SRHR.
- Sexual and reproductive rights of the LGBT (lesbian, gay bisexual and transsexual) community are not legally recognized, which means that it is more difficult to address specific health needs, or risk behaviour patterns to e.g. HIV/AIDS infection of MSMs (men who have sex with men).
- There may be a need for a strengthened legal framework in this area, depending also on the adoption of the new Draft Constitution (August 2010).

(iii) Maternal health: (see also section 5.1)

There is momentum to try to tackle some of the prevailing problems in this field from a new / different angle, given that it is the area that is lagging the most behind for MDG achievement by 2015. (Possible interventions in the area of maternal health have also been previously mentioned in Section 5.1).

One of the key indicators in the area of maternal health is the percentage of women deliveries attended by skilled health personnel, which according to KDHS 2008/09 was around half of all deliveries in Kenya (50%).
According to recent WHO research on global patterns of social determinants of health, the percentage of births with skilled attendance in each country is quite closely correlated with the Human Development Index\(^{39}\) and with its Gender Development Index\(^{40}\). Lower maternal health costs, lower total and adolescent fertility rates, increase in use of contraception and higher proportions of females at all levels of education were all associated with access to skilled birth attendance. Factors (other than health expenditure) such as women’s participation in government and politics, women’s income equality with men and the overall level of income inequality as measured by the Gini index were however *not* correlated with access to skilled birth attendance.\(^{41}\)

Although there might be country-specific variances, this finding indicates that targeting women’s economic and political empowerment alone will not necessarily move outcomes measured by the indicator unless it also affects household decision-making in the areas of health expenditure, fertility rate, and acceptance of use of contraception. In other words, even if women’s public role (participation in politics and in income-generating activities) is strengthened, it tends to be the decision-making in the private sphere that will determine health outcome in relation to having skilled attendance present at birth; it is not up to women alone.

This supports broadening the scope of antenatal care, to involve men and the community which influences social norms and gender relations. To make this happen, it is not only the men, women or local cultural norms that need to change, but also the health system, in order to be more accommodating to this approach.

Another key determinant for maternal death is *access to emergency obstetric care* (EmOC) in the case of pregnancy-related complications. According to a study on availability and use of emergency obstetric services across several countries in East Africa, shortage of trained staff especially mid-level providers, poor basic infrastructure such as lack of electricity and water supplies, inadequate supply of drugs and essential equipment, poor working conditions and staff morale, lack of communication and referral facilities, cost of treatment, and lack of accountability and proper management were identified as the main obstacles in providing EmOC services especially in remote and rural areas.\(^{42}\) These findings were broadly reflected in the much more limited interviews and observations carried out during this study. According to 2003 statistics, women at the poorest wealth status had 9 times less access to C-section compared to their richest counterparts.

Interviewees for this study pointed out the need to make EmOC services available at lower levels of health service provision by training assistant medical officers to carry out obstetrical surgery. Five countries in sub-Saharan Africa use non-physicians to perform major emergency obstetrical surgery, of which Tanzania is one. Assistant medical officers carry out most of this surgery outside of major cities. Other African countries have hesitated to follow this example due to questions raised about the quality of surgery by non-physicians. However, according to a study carried out of 1,134 complicated deliveries and 1,072 major obstetrical operations in Tanzania, there were no significant

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\(^{39}\) Kenya’s 2009 HDI ranking is 147 of 182 countries.

\(^{40}\) Which is the HDI adjusted downwards to capture inequalities between men and women.


differences detected between assistant medical officers and medical officers in outcomes, risk indicators, or quality.\textsuperscript{43}

In Kenya, however, there is still reluctance—primarily from the medical profession\textsuperscript{44}—to introduce this practice even though it would potentially double the number of medical professionals who could perform obstetric surgery within a relatively short time period, making services more easily accessible, especially in remote rural areas.

Even access to obstetric surgery has clear gender dimensions, however, since women often refuse to sign the necessary paperwork for having a C-section carried out on the grounds that her husband has to sign in her place. However, husbands are rarely present or readily available, so this could severely delay much needed urgent emergency care. Instances were also referred to, when the husband did not see the need for the surgery, and refused to sign, thereby severely putting the woman’s life in danger. On the part of the health service provider, there are no clear guidelines as to handle such cases.

\textquote{Women are often not in a position to make any major decisions relating to the pregnancy, leaving such decisions to their husbands. If the husbands were present and understood the health risks, it would help a lot.} (District level health worker)

Another challenge and constraint in this area, highlighted by a coalition of Kenyan women’s organisations, is the practice of detention of women in healthcare facilities for inability to pay. According to a CSO report reviewing Beijing + 15 progress in Kenya\textsuperscript{45}, this occurs both in public and private healthcare facilities. According to the report, women who have just delivered, and who are detained for inability to pay, endure severe mistreatment including being forced to sleep on the floor, being denied sufficient nutrition even though they are breastfeeding, and are verbally abused. With word of mouth getting around that this happens, it can serve as a disincentive especially for poor segments of the population/adolescent women (first time mothers) to seek professional maternal health services. This, in turn, can counteract efforts to reduce maternal mortality and morbidity rates. It would be important to substantiate this practice with evidence, both from health facilities and through perception surveys in order to establish guidelines on practice and to defuse ‘fears’ that could spread.

3.4 Gender dimensions of the AIDS epidemic

Increasingly, HIV/AIDS is striking women more than men. In Kenya, studies have shown that the burden of HIV is higher on women than men, with 60% of those infected being female. Women and girls face a range of HIV-related risk factors and vulnerabilities that men and boys do not; many of which are embedded in the social relations and economic realities of their societies.

This includes the discrimination and violence they face and their relative powerlessness to refuse sex or negotiate safe sex, especially in the context of marriage. This means that most women, including faithful wives, are unable to negotiate for safer sex even with partners they suspect of infidelity. Research has shown that in up to 80% of cases where women in long-term stable relationships are HIV-positive, they acquired the virus from their partners (who had become infected through their

\textsuperscript{43} The quality of emergency obstetrical surgery by assistant medical officers in Tanzanian District Hospitals, Journal of Health Affairs, Vol. 28, No. 5, w.876-w885. McCord, C, Mbaruku, G., Pereira, C., Nzabuhakwa, C., Bergström, S., Published online 6 August 2009

\textsuperscript{44} Based on views recorded during interviews for this study, undertaken in May 2010.

\textsuperscript{45} Beijing + 15: How far have we come, how far to go?: Assessing the implementation of the Beijing Platform for Action in Kenya, Nov. 2009
sexual activities outside the relationship or through drug use). Further risk factors affecting women include:

- Poverty and the low economic status of many women force many of them to engage in transactional sex that also increases their exposure to infections.
- Many cultural practices may increase women’s risk of HIV infection. These practices include dry sex, polygamy, widow inheritance, son preference, child marriages and culturally condoned abuses such as FGM.
- Physiologically, women are more susceptible to HIV infection than men are. Transmission during sexual intercourse is almost twice as likely to lead to female infection as to male infection.

Gender disparities in HIV/AIDS infections Kenya are high: prevalence among adolescent girls aged 15-19 is six times that of men (3% of all young women in that age group, as compared to less than 0.5% of young men). Interventions targeting girls are inadequate. Although condom use at last higher-risk sex shows substantial progress for both women (23.9 percent in 2004 KDHS- 35.0 percent in 2008 KAIS) and men (46.5 percent – 51.8 percent), this level of uptake is too low to lower transmission of HIV.

Women are also infected at an earlier age than men. In Kenya HIV prevalence by age and sex has been well documented and it is generally accepted that the infection levels for women are higher than for men. One study found that in the 15-19 age groups, infection rates for women are five times that of men. In the 20-24 age group, infection rates for women are three times that of men.

Targeting specific to high risk of HIV Infection includes:

- Young boys and girls
- Men in the armed forces
- Boys and men in prison
- Male and female street children
- Men who have sex with men (MSMs)
- Truck drivers and migrant workers (or "men on the move"), who may engage in unprotected sex with multiple partners
- Commercial sex worker
- Widows
- Young boys and girls
- Prisoners
- Injecting drug users
- Alcohol abusers
- Fishing communities (in relation to practice of ‘sex for fish’)

Although the HIV/AIDS strategic plan outlines an array of policy intervention to protect the most at risk populations and vulnerable groups, there was no evidence of a concerted effort or strategy in place to do that.

The Kenya National Aids Programme (implemented by NASCOP) is working with a number of the high risk groups in a targeted small pilot. This includes commercial sex workers in Nairobi and long distance truck drivers at Mlolongo – a major long haul trucks parking bay 30 km outside Nairobi. There are about 7000 prostitutes in the program. The prevalence rate among them is 35%. This is significant because there is 65% who are not infected, and it is important to work with them to prevent infection. The prevention interventions include:

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46 UN Special Session on HIV/AIDS Fact Sheet 2001.
• Helping commercial sex workers to demand 100 percent condom use from all clients;
• Assist them to transition into other income-generating activities (however, there has been some challenges due to general lack of inertia and lack of social skill by many of the women)
• Educating women and girls on negotiating safe sex, and the rights of both men and women to request condom use, or to say “no” to unwanted or unsafe sex.
• Provision of female condom.

For long distance track drivers, roads side clinics for testing and counselling have been developed, and peer educators have been trained to talk to them. These pilots now need to be scaled up. However, a weak evidence-base was identified as an impediment to effective and gender-sensitive prevention programming. There is need for regularized surveys to address specific issues, and to provide more in-depth understanding of issues.

An array of interventions has been used in prevention initiatives, but efforts have not been maximized because gender disaggregated data to analyze the underlying causes of vulnerabilities and risks for men, women, girls and boys have not been consistently collected and used. In addition, the roles and functions of Government, NGOs, CBOs, faith-based communities, private sector and international development partners, are not clearly defined in addressing the institutional responses to gender-related issues of the HIV/AIDS epidemic.48

• Involvement of men

As the HIV/AIDS epidemic continues to advance in Kenya, many responses to control the scourge have failed to address men’s role. Most campaigns in HIV/AIDS in the country have concentrated on women and children, leaving a gap as far as reaching out to men are concerned. Some traditional and cultural practices in the communities encourage men to engage in multiple sexual relations that promote HIV/AIDS spread. Gender inequality and economic advantages of men have also been linked to the spread of the epidemic.

Men have also been reluctant to seek information on HIV/AIDS or reproductive health. For example, men test for HIV and access ARV treatment in significantly smaller numbers than do women. Enlisting men in the fight against HIV is imperative to lowering vulnerability to the virus for both sexes. There is urgent need to promote HIV/AIDS prevention measures that target men to understand their issues and take the right position to avoid HIV infection, protect their partners and families and take a leadership role in HIV/AIDS prevention, care and support initiatives.49 Research linking gender, gender-based violence and HIV has also resulted in the emergence of programmes specifically targeting men.

There is also a lack of detailed data on men who have sex with men (MSM), among which prevalence rates are very high. Since homosexuality is outlawed, and MSM also suffer from serious stigmatisation, including harassment and violence, most also have sex with women. This means that high infection rates among MSM can also drive the infection rates up also among women.50

Both the National Health Sector Strategic Plan (NHSSP II) and the Kenya National Aids Strategic Plan 2009/10 – 2012/13 have identified gender mainstreaming in health programming as a strategic intervention in improving outcomes, particularly in areas where one gender has been disadvantaged in access and utilization of services. According to the HIV/AIDS strategic plan –“Human rights, gender

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equality and responsiveness will be emphasized, ensuring that these issues are addressed across all aspects of the plan."

An obstacle to male involvement is the fact that most community work related to HIV & AIDS is carried out by women volunteers and to engage men at grassroots level is essential. However, as a Sida report points out: “To make more men willing to engage in collective responses to AIDS requires that debate is opened about men and gender ...”

<table>
<thead>
<tr>
<th>Gender Sensitive HIV/AIDS Indicators</th>
</tr>
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<tbody>
<tr>
<td><strong>Impact indicators (overall measurable HIV/AIDS impacts, especially reduced transmission and prevalence):</strong></td>
</tr>
<tr>
<td>Prevalence among 15-24 year olds, by sex (including pregnant women)</td>
</tr>
<tr>
<td>Rate of mother-to-child transmission</td>
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<tr>
<td>Life expectancy by sex</td>
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</table>

| **Outcome indicators (e.g., changes in behaviour or skills needed to achieve outcomes)** |
| No. of women and men who know at least two methods of protection against HIV/AIDS |
| No. of women who report using a condom with all partners [during the last 12 months] |
| Proportion of sex workers (male and female) who report condom use with last client |
| No. of women and men using referral systems between VCT, health care services and community-based organizations |

| **Input indicators (the people, training, equipment and resources needed to achieve outputs).** |
| Percentage of HIV/AIDS budget targeting gender-sensitive measures |
| Sectoral ministries that have incorporated gender-sensitive HIV/AIDS issues in annual plans |
| No. of gender-HIV/AIDS training sessions for govt. staff and peer educators |
| % of line ministry staff by sex who are active in HIV/AIDS programs |

| **Output indicators (activities and services delivered to achieve outcome)** |
| Participation of women’s organizations in HIV/AIDS policy development, implementation & monitoring |
| No. of programs or orgs. providing skills to women and men and alternative life skills to sex workers |
| No. of gender-sensitive HIV/AIDS prevention programs integrated into school curricula |
| No. of stigma reduction activities, and % of males and females enrolled |

### 4. Sex disaggregated data

Sex disaggregated statistical data – as well as capacities to use it for planning and community-based outreach – are essential to effective gender mainstreaming. Local and contextually relevant data, collected routinely and analysed in a timely manner, can be used both to come up with response strategies, to craft prevention campaigns, and to spur a dialogue on health priorities among men and women in the communities.

There is for instance evidence of changes in male behaviour when studies pointing to the correlation between women’s workload during pregnancy and the health outcome for the child have been taken to male focus groups for discussion. In addition to the routinely collected data, more targeted perception surveys can help to get deeper into the underlying attitudes and behaviours that affect a certain health outcome. These are often gendered.

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51. Sida & Lund University 2007 (ibid)
52. This was observed in different programmes in Pakistan (www.ciet.org) or in Ethiopia, see www.sida.se
The Health Management Information systems division (HMIS) – the information and data arm of the Ministry of Health – is responsible for the collection, analysis and dissemination of information. The division, in addition to the staff in headquarters, has statistical staff based in the provinces and districts to coordinate the collection and submission of data to headquarters. Hospitals have health information units that collect data in-house and submit to Nairobi. Information routinely collected by the HMIS division is mainly service data (morbidity and mortality for both inpatient and outpatients).

There are tools (forms and books) that are used for collecting data in hospitals, health centre and dispensaries. At the facility level, A3 size forms bounded into book are used for collecting data. Although the data is disaggregated at the point of collection, summary tools used for consolidating that data eliminates the disaggregation. For instance, at a facility patients seen for malaria or any other ailments are recorded by sex and it is therefore possible to tell how many people were seen in the facility by disease and sex. However when the same data is transferred to summary tools, the sex is merged and one can only tell the number of people seen for malaria and not how many were men or women. Therefore most information (in particular outpatient data) transmitted to HMIS in Nairobi is not disaggregated by sex. This is significant because this is the information that is available to key decision makers and planner in the sector. This seriously compromises the capacity of the decision makers to:

- Identify gender difference and inequality specific to certain disease patterns or health-seeking behaviours
- Make the case for taking gender issues seriously from a planning/health outcome perspective
- Design policies and plans that meet women’s and men’s different needs for curative or preventive interventions;
- Monitor the differential impact of policy, project and budget commitments on women and men
- The category ‘sexual assault’ is not categorised by gender, but is ‘assumed’ to affect women. However, in certain parts of Kenya, this could also affect boys. However, there would be no way of telling from existing data gathering tools.

In addition, the reliability of HMIS data is in question due to the very low reporting rates. In some cases some indicators presented for a region represent less than 60% of the facilities in that region.

There is also no regular practice, and low levels of capacity, for routinely analysing collected data at sub-national levels where trends and patterns are most relevant for a timely and adapted response.

Currently there is a need to strengthen the capacity to collect and analyze sex disaggregated data at different levels. This also includes carrying out additional information and studies if needed to include all social groups, not just those who have access to public services. Other underlying principles should be:

- Community participation in fact-finding (with separate focus groups of male and female community members),
- Dialogue and participation in the search for solutions based on the evidence, and in the interpretation of results,
- Community-informed development of intervention strategies.

Up-scaling and mainstreaming some innovative experiences of AMREF to train and involve Community Health Workers in ongoing fact-finding could be explored in this regard, since the HIMS does not have the capacity to reach beyond the health system. Other ways of strengthening the evidence-base for linking gender more firmly to health outcomes (as well as gendered district planning targets) through a larger scale gender baseline for the health sector would also be
interesting to look into jointly with other donors, such as the World Bank which will be involved in HSSF together with Danida during the next programming phase.

KYETHANI HEALTH CENTRE – MWINGI DISTRICT
INFORMATION COLLECTION AND UTILISATION AND REPORTING.

Kyethani Health Centre is one of the busy health centers in Mwingi District, about 200 km from Nairobi. The centre is manned by two nurses and has a monthly patient attendance of about 1200. Services provided at the centre include curative services, family planning, deliveries and antenatal services. The centre has seen a big increase in the uptake of family planning services due to what the nursing officer attributed mainly to the difficulties of raising many children as a result of persistent hunger in the region. Many women still come for family planning services in secrecy so that their husbands don’t come to know. This has led to situations where women opt for not the best method to keep it secret. Women normally come to family planning clinics on their own, but in situations where major decisions have to be made around delivery, they may come with their husbands.

Poor nutrition status is common in women and children coming for services at the centre. Once again this is attributed to high poverty levels in the area and persistent droughts. Women and children are most affected because they are normally left behind when the men go looking for jobs in urban areas of Mwingi, Thika and Nairobi. The centre has a nutrition program that supports such families with nutrition supplements. The centre is supported by a network of 35 voluntary community health workers (mostly female) who play an important role of linking the centre with the community, identifying health problems in the communities and bringing the same to the attention of the health worker at the centre.

Like all other health facilities, Kyethani Health Centre collects and records information on all patients and services they provide. This is done in an A3 size records keeping book that provides columns for entry of information such as Name; Sex; Address; Symptoms/Danger Signs; Diagnosis; Nutrition status; HIV (whether tested or not); Follow up remarks; Charges (amount paid); and remarks.

The health centre submits its data to the district office for onwards transmission to Nairobi on monthly basis. To do that, the data in the big book is transferred in a summary tool. The tool by design does not capture all the categorizations of data in each record. For instance, the form can only take aggregate number of people seen for various ailments such as malaria, ulcer etc. killing the sex disaggregation of the people seen. Therefore, someone looking at malaria data for the whole country can tell how many people were affected but cannot tell how many were men and how many are women, or whether there were any pronounced difference in gender patterns in rich vs. poor areas, in were. Disease surveillance was however found to keep the sex disaggregation in the summary data submission form. The data retains sex and age until it reaches the Disease Outbreak Monitoring Unit (DOMU).

The District office receiving data from the health centre does not provide any feedback on any aspect of the data submitted to them. Data submission to the district office has therefore become a routine exercise devoid of any feedback systems. There was evidence of rudimentary use of data collected by the centre for its local planning. The data is used for projection and ordering of supplies. A case was explained to us by the Nursing officer in charge of a period when data on malaria cases went up in an unprecedented manner prompting her to notify the public health officer to investigate the source of the infections.

Gender based violence against women is rampant but is not normally brought out in the open. The centre uses its community health workers to identify such cases so that they get medical treatment. Local traditional structures are also used to resolve cases of violence. There was no support program or safe house for women under threat of further violence, which occasionally occurs if the woman goes to the police.

The centre recognizes the important role men can play in improving health outcomes and has made efforts to encourage men to accompany their wives to the clinic or to bring their children to the clinic. Presently, men bringing their children to the facility for treatment of immunization are given priority in getting services.
5. Systems, capacities and institutional frameworks

5.1 Government systems and institutional frameworks

The two Ministries of Health currently have focal persons in charge of gender issues in the Ministries. Although efforts are being made to allocate more staff to these units, they lack the capacity, skill stature to spearhead the gender mainstreaming agenda. The gender unit are below the level of divisions and are very low in the organisational structures of the ministries to have real impact. In the Ministry of Public Health and Sanitation, the gender Unit is domiciled with the reproductive health program, further aggravating the stereotype that gender is limited to women’s issues. At provincial and district level, no structure exists within the health sector with the mandate to drive gender mainstreaming issues, relying on skills being built among existing staff.

The technical capacity for gender analysis and mainstreaming is also lacking in the two ministries in respect to both number of people qualified and levels of technical competencies. Except for the teams of the two focal units, the two ministries lack the critical mass of gender professionals to move the agenda forward.

The concept of gender and gender mainstreaming in the Kenyan health sector is still in its infant stages in terms of being institutionalised across operations, and in terms of being internalised into staff perceptions and work processes. Reviewing the main policies and strategic documents, the terminology has been accepted (and is even written into the Permanent Secretary’s performance contract) but the levels of understanding of how to translate this into practice can generally be considered as low. Internal guidance in terms of revised work processes and sub-sector policies also seem to be missing.

“The role of the Gender Division, Ministry of Gender

The Division of Gender in the Ministry of Gender and Social Development is assigned the responsibility to integrate gender dimensions in policy formulation, planning and implementation with its four key functions being:

(i) formulate and review gender responsive policies across sectors for the integration of women, men, girls and boys into the development process;
(ii) facilitate domestication and implementation of resolutions made at international and regional levels;
(iii) coordinate and harmonize implementation of the national policy on gender & development as well as other gender responsive interventions implemented by GOK and its stakeholders;

A very clinical understanding of gender tends to be applied, largely associated with women’s health issues. This is in line with international commitments on women and the MDGs, but it has also been acknowledged that the global focus on addressing women’s empowerment in the MDG commitments (notably MDG3 and MDG5) represent a narrow focus that sidelines other gender-specific risks and vulnerabilities, roles and responsibilities and power dynamics, particularly since the indicators for the other MDG goals are gender blind. This gives the impression, of gender equality being a separate and stand-alone issue, instead of a mainstreaming issue across and within sectors.

53 Ministry of Medical Services and Ministry Public health and Sanitation

(iv) lobby and advocate for gender mainstreaming in the development process, and engendering of the national budget; and
(v) promote the generation of sex disaggregated data/information on gender equality indicators.

It also fulfils a regular liaison role with Ministries’ Gender Focal Points (GFPs), and there is good evidence that they have a good working relationship with the gender focal points in the health sector. As such they could play an important role in terms of technical support and coordination, especially if gender focal points in the line ministries assume the role of ‘internal advisor’ and ‘catalyst’ rather than being tempted to implement separate and externally funded programmes themselves, for which they do not have the necessary human resource capacity.

In that regard, the lack of GoK’s own budget allocations to operationalise technical gender mainstreaming across Ministry operations is a challenge. In other sectors, gender focal points have been reported to ‘lobby’ for allocation of resources, or been obliged to apply for external and projectised donor funding. Activities of the gender focal point in the MOPHS are for instance largely being funded by off-budget programme money from GTZ which supports the work of the reproductive health unit.

The Division of Gender in the Ministry of Gender and Social Development has recently engaged in regional fora hosted by UNFPA to share lessons and come up with a common framework for working with men and boys for the promotion of gender equality and reproductive health. So far, the few initiatives that target male involvement (see Section 6) do so on a short-term and stand-alone basis. Frequently they address men as a means of achieving certain objectives and outcomes for women, rather than treating men as actors in their own right. There is international evidence that male involvement in family planning and reproductive health is very important for better outcomes. Since this is largely new and untested in Kenya, it is worthwhile to explore further, and the Gender Division could have important inputs in this process.

**The role of Gender focal points**

Gender Units or Gender Focal Points (GFPs) have recently been established across all Ministries. In the Ministry of Medical Services, this is a division in its own right, whereas in the Ministry of Public Health and Sanitation, the gender focal point is located in the reproductive health division under the Family Health department. This represents in itself a fractured approach due to the current split into two separate health Ministries, with challenges of coordination. Other challenges include the lack of substantial budgets to make these units operational and to ensure that allocated staff receives the required training (staff members describe themselves as ‘self-taught’, or have ‘a past in the women’s movement’).

It is also notable that all staff members in the two ministries’ gender teams are exclusively women. This may reinforce the faulty but prevailing perception (especially in the health sector) that gender is all about ‘women’s issues’. One of the big challenges for good and holistic mainstreaming to take place is exactly this view, coupled with low levels of internalization of gender as a concept by Ministry staff.

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55 This would only reinforce ‘gender’ being sidelined as an issue that is separate, rather than integrated, in day-to-day operations and goals. Moreover, neither the gender focal points, nor the Division of Gender at the Ministry of Gender and Social Development would have the necessary human resource capacities and budgets to undertake programme implementation.

56 Lessons from gender mainstreaming in the agriculture sector in Kenya is an example, documented in a research study undertaken by Wageningen University (Netherlands) in 2008.
At the time of this analysis, no gender sensitization had been carried out at sub-national levels and district level officials. This is not surprising, given the reasons explained above. But as an effect, district level officials, along with lower level health service providers had difficulties grasping the concept of ‘gender’ (beyond ‘treatment of women’ or ‘women’s health’) or seeing the value added to their work of centralised gender structures, even though they did see the value of ongoing gender analysis to their practical work.

Many donor evaluations and research studies have debated ‘value-added’ and potential for system change through the appointment of gender focal points\textsuperscript{57}. There are no clear-cut answers. However, the view is generally held that unless there is staff with designated responsibilities in this field, gender equality easily becomes “mainstreamed out of existence”\textsuperscript{58}. At the same time, gender focal points will rarely be the ones to move the agenda on their own, given their relative lack of political clout and/or strategic placement within organisations (often lacking time, resources and authority). Top management support is critical, and successful outcomes of gender mainstreaming efforts are largely dependent on this.

\textbf{• Recommendations on GoK Gender Focal Points (GFPs) & gender mainstreaming}

GFPs should act as advisors, catalysts, information access points, and as sources of knowledge to support gender mainstreaming, not as implementers of the gender mainstreaming agenda. A strategic placement within the Technical Planning and Strategic Development Departments would be more useful than where they are currently located. It would ensure a more technical (rather than emotive) approach, and create a critical bridge between planning, use of sex disaggregated data and policy directions for the future.

The recognition that gender mainstreaming does not happen ‘automatically’ but – like any new practice or change in operations – has a price tag attached to it, is important. This will take time. A World Bank study in 2005 concluded that the large majority of ministries had “neither budget nor staff” to take up gender mainstreaming. The split of many of the ministries in 2008 has not made the situation better.

A pitfall in this regard would be for donors to fund the gender mainstreaming machinery separately as a stand-alone component, which would further sideline gender issues to a ‘stand-alone’ add-on, rather than making it an integrated part of day-to-day operations. A better approach would be to work directly with the technical services and departments (especially with planning capacities and functions at different levels) to practically insert a gender perspective into operations through the provision of technical advisory services, gathering of relevant data etc., which in turn would increase the internal demand for the services and ongoing advise of the gender units.

Another pitfall would be to fund general, externalized and decontextualised gender mainstreaming trainings, using general training manuals (like WHO, UNDP etc.), organized by the gender divisions/focal points. This approach was tested in 2006, when an external consultant together with the Division of Reproductive Health (MOPHS) organized external workshops for GoK Ministry of Health staff, funded by GTZ, using general manuals and an introduce gender concepts and definitions. Heads of Departments did however not attend but usually delegated attendance to lower level staff. As a consequence, the more practical exercise of incorporating gender into one’s own operations were never taken forward at the end of the training since participants lacked the necessary decision-making authority to change very fixed strategies and work plans. The one-off workshop, held outside Ministry premises, was never followed-up on due to lack of funds and is

\textsuperscript{57} See e.g. Sida publications 2003, 2007, 2010.

\textsuperscript{58} Anyoni, R. \textit{The role of Gender Unites a Catalysts for Gender Mainstreaming...}” Wageningen University (Netherlands), 2008.
unlikely to have had much effect on operations. The solution is not to do more of the same, but to try a different approach.

Finally, there is always the danger of GFPs/Gender Units becoming ‘gate-keepers’ of information and contacts rather than to assume the roles of catalysts and facilitators of organisational (health system) change in how to deal with gender. This particularly the case if they are seen by Ministry personnel to be the ones in charge of mainstreaming, not just facilitating gender mainstreaming across operations. Placing too much emphasis on the GFP units alone would therefore be unwise as opposed to adopting a more holistic and multi-pronged approach, in collaboration with GFPs, to ensure that gender is mainstreamed and incorporated into existing practice and priorities across operations at different levels.

**Recommendations for working with GoK health sector structures**

Gender mainstreaming should be promoted and woven into all existing training programmes for staff in order to make is an integral part to health decisions and interventions; it should touch on staffing, procedures and programs and should forms part of the responsibility of all staff. It should be noted that gender mainstreaming does not preclude targeting of women. It merely shifts focus from women as a target group, to gender equality as a goal. It can provide support to women-only (or men-only) interventions if they are designed as strategic interventions to ‘level the playing field’ and address a unique aspect of gender inequality.

1. **Develop a shared vision, gain political will and explicit consensus on gender equality objectives, with a focus on women and men:** Ownership of objectives and approaches is more likely to be shared if there is a clear link to policies and commitments that the decision makers already made on gender equality. As alluded to above, there is also a need to more explicitly spell out what gender mainstreaming refers to in the health sector in the revised policy framework. Internal sensitisation, and coaching of key individuals in the Ministries will be needed, also so they know what and how to ask for assistance for its operationalisation in its relations with donor partners.

2. In addition, gender mainstreaming must be supported by the political leadership in the ministry, for which conceptual clarity and awareness is a pre-condition. Hands-on technical support, and clear links to improved results (linking gender more explicitly to health outcomes) can help create such political leadership.

3. **Development of evidence-base and comprehensive in-house knowledge on gender.** Even with efficient HMIS systems, not all knowledge can be generated from routinely collected data within the sector. Additional surveys, assessments and researches need to be routinely undertaken to provide further information. Conducting gender analytical research will require well-developed social and gender analytical skills, with the necessary in-house or sourced expertise to provide this.

4. **Collection, analysis and utilization of sex disaggregated data and gender analytical information, and development of gender sensitive indicators.** By fairly simple means, routine data collecting tools can be adapted to capture the gender dimension. Incentives for staff to do so will also need to be addressed (e.g. training and support to local planners to use this data in planning). Moreover the following issues that are affecting the capacity of the HMIS division to work effectively should ideally be addressed:

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59 Gender Mainstreaming; Conceptual Framework, methodology and presentation of Good practices: Final report of Activities of the group of specialists on Mainstreaming: pg 21
• Begin implementing in earnest the HMIS Strategic Plan  2009 -2014
• Revive all the data summary tool to ensure that it retain the sex aggregation of data
• Harmonization of data collection tools to remove unnecessary data.
• Address the issue of staff shortages according to the HMIS strategic Plan, the entire HMIS has only 582 staff country wide against a required establishment of 5356\textsuperscript{60}
• Institute a clear data submission procedures and strict supervision to ensure compliance.
• Train senior HMIS staff on data analysis and M&E skills.
• Train HMIS staff on gender equality and the importance of gender sensitive data, and hoe to develop and collect such data
• Carry out regular integrated data quality assessment \textsuperscript{61}

5. **A clear and comprehensive understanding of the gender equality and mainstreaming concept by key decision makers in the sector.** Since you can only promote an agenda you understand, it is critical that the whole idea of gender equality and mainstreaming is clearly understood – especially the fact that gender is not just about women – but that it is about maximising health outcomes for women and men, boys and girls. The Ministry of Health should in the long run gear towards having all health workers have this as part of their regular job descriptions to avoid it being drien by a handful of ’gender experts’. On-the-job training and mentorship should be emphasized as opposed to the popular workshop/ seminar methodology (which has not worked well in this field in the past).

6. **Develop a comprehensive national health policy framework encompassing gender equality.** The Ministry of Health should take the opportunity to include a comprehensive and well articulated policy commitment on gender equality, in the second National Health Sector Framework document and the third National health sector Strategic plan (NHSSP III).

7. **Promoting the involvement of women as well as men in decision-making at all levels:** Women have traditionally been disadvantaged in gender blind health programming, and there are encouraging signs established to change this (e.g. the 30% presidential decree on public appointments). However, participation needs to go beyond ‘counting number of women on committees’ to institutionalise mechanisms for meaningful participation.

8. **Engaging and getting commitment from all key stakeholders to addressing gender as a critical health determinant.** In the longer term, the ministry should within the existing coordination mechanisms involve all stakeholders who can play a key role in rolling out a ‘gendered’ focus across health operations. However, it will be critical to first have a shared common vision and strategy in place within the Ministries of Public Health and Medical Services to avoid getting side-tracked by too many conflicting views that are theoretical, rather than practical, in nature too early on in the process.

5.2 **Non-State Actors**

• *Faith-based organisations (FBOs)*
Faith based organisation play an important role in the provision of health services in the country. Their important role is further emphasised by the fact that most of their facilities are located in remote and disadvantaged areas not served by government and private health providers. Two major faith based organisation involved in the provision of health care are; Christian Health Association of Kenya (CHAK), -an umbrella organisation of church health facilities and programs affiliated to the

\textsuperscript{60} The HMIS Strategic Plan 2009 -2014 - MOH
\textsuperscript{61} This were the recommendations made by Dr. Nzioka, head of HMIS during our interview with him
Protestant Churches. And Kenya Episcopal Conference, umbrella body of catholic bishops of Kenya who coordinate Catholic Church managed health facilities. The Supreme Council of Kenya Muslims (SUPKEM) also operates a number of health facilities. CHAK membership consists of 548 facilities and KEC “owns” 445 health facilities. The Church based Health Services provide approximately 30% of health care in the entire country. However, in the Arid and Semi-Arid Lands (ASAL), the percentage is almost 50-60%.

CHAK and KEC are not directly involved in policy implementation and service provision in the member health facilities. They, particularly KEC, have great influence on the health facilities in respect to governance, policy formulation and types of services to be provide. This has partly related to the Catholic’ church organisational structure and position regarding some issues related to sexual and reproductive health and family planning. Some of protestant churches affiliated to CHAK also have ‘limitations’ on issues of women, and some of the services provided to them.

Both CHAK and KEC have strategic plans which have a mission of providing member health facilities with the necessary support to enable them function effectively. The strategic plans do not directly deal with the day to day operations of their member health facilities. However given their important position CHAK and KEC have a great potential to influence and direct how their member health facilities do business.

Many faith-based organisations have been divided on issues of sexual and reproductive health and rights including family planning. In some cases, church doctrines have actually been detrimental to improve outcome in areas like HIV/AIDS prevention, family planning and reproductive health. According to CHAK, “there a serious gap in the area of gender mainstreaming in our member health facilities... there is no deliberate action that has been made to institute and move forward the gender agenda. However many issues related to gender mainstreaming such as condom uses, family planning, contraception etc should be well accommodated within the protestant member hospitals that are generally liberal in those matters”

**MOU with Government**

On the 16th October 2008, the government of Kenya signed a memorandum of understanding with CHAK, KEC, and SUPKEM. The MOU defined the collaboration and support the government will accord the FBO facilities. It was argued that FBOs provided a big chunk of health care to citizen yet they did not get any support from public funds. It was argued that if they are to contribute to better national health outcome, they should also be supported by public funds. The areas and categories of collaboration and support include:

1. **Health service delivery** - FBO facilities will be expected to provide health care per the NHSSP II (2005/2010), and in compliance with existing national health standards, guidelines and protocols as envisaged by the Kenya Health Quality Model (KHQM). They shall also promote community linkages for outreach health services, disease prevention, home based care and health promotion service

2. **Policy dialogue and collaboration** - As signatories to the 2007 Kenya Health Sector Wide Approach strategy (SWAps) and Code of Conduct, CHAK, KEC, and SUPKEM shall be involved in policy development and dialogue with the Government and FBO health facilities shall be represented in existing governance and coordinating structures at all levels of the health sector.

**Opportunities**

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62 Interview with Mr. Peter Ngure; HIV/AIDS program Manager CHAK on the 4th June 2010
This memorandum of understanding provides a great opportunity and entry point for the MOH to open dialogue and influence the direction the FBOs take in respect to many gender related aspect of health care provision. For instance,

1. **Compliance with government policy and plans:** Continued government support to FBO facilities can be linked to fulfilment of some minimum threshold of the health policy and plans in areas of family planning, reproductive health, HIV/AIDS etc.

2. **Access to the very disadvantaged:** It should also be noted that FBO health facilities operate mainly in rural and very remote and disadvantaged areas. These also the areas where many socially and economically disadvantaged women live. Therefore government support to these facilities that could improvement in access to and utilisation of, services will be critical in improving health outcomes in the long run.

3. **Advocacy and knowledge creation:** Another area of opportunity is to use CHAK, KEC, and SUPKEM to advocate the issues of gender equality among its member health facilities. Lack of information and knowledge could be partly contributing to the present situation in many FBO facilities.

4. **Referral points:** FBOs that don’t handle some issues can be used in the provision of accurate information to patients if they cannot provide a particular service, and referring patients to other facilities that can provide those services.

5. **Engaging Church leadership:** the MOU provides a good foundation for engaging the church leadership in the country on some of these important issues related to gender equality. Given the serious magnitude of issue like HIV epidemic, the high maternal mortalities, they are bound to be accommodative on some of the issues.

**NGOs and private foundations**

NGOs active in the sector are organised in the Health NGO Network (HENNET) with around 60 active members containing faith-based organisations, international NGOs, national/community-based CSOs and private foundations like the Aga Khan foundation. The network is well structured and represented in all relevant sector working groups (such as the Health Sector Coordinating Committee, co-chaired by the PSs of MOMS and MOPHS, and containing main sector partners). Given the fact that Non-State Actors fill important service delivery gaps, the collaboration between State and non-State actors is largely non-conflictual and depoliticised.

Recently, there is an increasing interest for gender mainstreaming among specialised NGOs, but capacities are generally low among those specialising in health service delivery. Very few are active on health rights whereas most apply more ‘traditional’ health service delivery approaches. Some innovative practices have been noted and recorded in relation to community involvement, and working with health community workers to gather relevant data for local health planning. Few of HENNET member initiatives have a pronounced gender focus, however, or have been incorporating gender issues from the planning stages of programme design. It was noted that “a few contribute significantly to gender mainstreaming, whereas others face the same challenges as the Ministry of Health” in this field.

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63 With the exception of a new organisation called HERAF who has this as its area of expertise.
64 Carried out by AMREF.
65 Quote from NSA interviewee.
Some innovative attempts to work more directly with men have been carried out among non-state actors and CSOs (see example in the box below). It will be important to more systematically harvest and incorporate lessons from these into mainstream health sector planning, as some documented shortfalls with most initiatives targeting men and male involvement to date is their short duration, the ‘pilot character’ of interventions with limited scope and beneficiaries, and the fact that they are treated as stand-alone components rather than integrated into main practice and health systems service delivery.\(^6^6\)

**Young Men as Equal Partners**

This project involves young men as change agents, beneficiaries and target clients. The initiative seeks to strategically expand young peoples’ knowledge, skills and a sense of responsibility for making informed choices that are in their best interests, while respecting the rights of others. This strengthens the case for SRH/HIV interests to target men especially young men as primary clients. This project is funded by SIDA through Swedish Sexuality Education organisation, RFSU and is implemented in four countries Kenya, Uganda, Zambia and Tanzania. One of the key pillars of the project is partnership with the Government particularly MOH and Ministry of Education in the project sites. Source: [http://www.fhok.org/](http://www.fhok.org/)

The fact that many of the faith-based charities and NGOs active in service provision are important HENNET members also limits its potential for raising and advocating for some of the more controversial health issues with clear gender dimensions (like abortion, family planning, condom use). In fact, many non-state actors active in health sector service delivery – of which many are faith based organisations – often take a more conservative stand than what is enshrined in government policies on issues related to family health and sexual and reproductive health and rights. In other sectors (like the governance and justice sector) government authorities are regularly challenged and monitored by advocates in the non-governmental field. This means that the government has an even more important role in spearheading behavioural and attitude changes in the health sector that affect health outcomes – including addressing gendered dimensions of health.

Some of the key questions that the sector is grappling with – which is indicative of a fairly low level of internalisation of gender as a critical dimension to health – are summarised in the quote below:

> “How do you move gender mainstreaming beyond just counting women in committees? What will be the role of the women on health facility committees? Will ‘gender’ now be their responsibility? What about the men?” (Interviewee)

- **The role of the ‘women’s movement’**

While women’s rights organisations have been vocal in raising the debate on women’s unequal health burden, they have not engaged in supporting the technical aspects of mainstreaming gender into day-to-day health sector operations – such as analysing gendered dimensions of disease or health prevention patterns, or getting involved in detailed auditing of how to make health services and facilities more gender responsive for both women and men\(^6^7\). Instead, many women’s organisations/CSOs working with advocacy a national level have used their work as a political


\(^6^7\) Observations based on interviews with NSA representatives and gender experts from the Kenyan women’s movement.
In general, division along political party lines among women’s groups have negatively affected their collective impact and credibility.

Service-delivery oriented health NGOs therefore observe that they have “not been helped by the women’s movement” in moving the gender agenda into the practical realities of health systems strengthening and health service delivery. According to organisations like FEMNET, this will be an increasing area of concern of many women’s organisations in the future. Others are more sceptical, stressing the fact that donors and government institutions alike have unrealistic expectations on ‘women’s organisations’ as the ones in charge of “fixing the problem” of gender mainstreaming. Instead, very specific technical work, rather than an emotive advocacy response is what is needed.

At the grassroots level, women’s groups are traditionally collective self-help groups that work at a very practical level to cater for women’s day-to-day needs and economic assistance through informal saving and credit groups (‘merry-go-rounds’). They rarely work at a more strategic level of challenging or questioning traditional gender roles, or to ‘claim space’ for women’s local participation. Many are also aligned with political interests or belong to a particular church or faith network (of which many promote more traditional family values, and where family planning as well as sexual health and rights are taboo topics).

The fact that many women are organised into groups can help in outreach and feedback. For instance, a female member of a Health Facility Management Committee in one district said she would feed back Committee decisions to her group members, and would use her group “to know what women in the village prioritise”. Yet, the poorest or most needy are still unlikely to be members of these groups where you have to collectively contribute to a common pool. There is also no equivalent for men.

- **Parliamentarians**
  Past lessons have shown that sensitisation of Parliamentarians before tabling gender-related bills is critical to get them through. In Kenya, where gender stereo-types are deep-rooted and largely discriminatory to women, there are numerous examples where issues related women’s rights cause polemical debate when introduced in the public domain. Gender issues are also generally poorly understood, sparking strong emotions rather than factual debate, unless preceded by a rigorous process of sensitisation. Debates around the Sexual Offences Bill, when introduced in Parliament quickly deteriorated into what was called a ‘tug of war between men and women’ by the then Minister of Justice Martha Karua. Kenya has also at numerous occasions failed to adopt a domestic violence and family protection bill.

There are also important lessons to be learned from the unsuccessful introduction of the Draft Reproductive Health and Rights Bill, which was drafted and advocated for by the Federation of Women Lawyers (FIDA) and the Coalition on Violence Against Women in June 2008. Even though much of its contents had to do with access to contraceptives and family planning, safe motherhood, female genital mutilation (FGM) and the reproductive health of adolescents, it was rejected on

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68 Many of the female leaders of women’s and children’s organisations acquired government positions or nominated seats in Parliament in connection with the last elections; but are not necessarily pursuing the same agendas from the inside.

69 Quote from interviewee.

70 Based on separate interview with FEMNET Exec. Dir. Carried out in April 10.

71 See upcoming evaluation Danida report on support to African women’s organisations (2010).

72 In 2005, some 1,333,135 women’s groups were registered, with a total membership of around 5 million.

73 Interviews during field work carried out in Mwingi and Thika Central during the period 10-18 May 2010.
grounds of being ‘pro-abortion’ with churches dismissing it as “the ideas of some feminist lobbyists”. This debate has now again come to life in relation to the new Draft Constitution.

This illustrates the need for public sensitisation, as well as sensitisation of Parliamentarian to gradually build broad-based support on these issues. It would also be key to get the other ‘champions’ onboard so that draft bills affecting gender outcomes of health are not just isolated to be a “women’s issue” but rather is introduced and debated as a societal problem. The draft Reproductive Health and Rights Bill itself also contains several omissions, such as the role of men in reproductive health, issues related to ‘fatherhood’, and in framing motherhood as a social function with the recognition of the common responsibility of men and women in the upbringing and development of their children (see CEDAW, paragraph 5). A less controversial introduction of the Bill, which was done through public campaigning of women’s organisations, may also have been a more suitable strategy to get a more moderate but comprehensive Bill through Parliament.

Lessons from a more fruitful approach can be found in relation to the preparation and introduction of the FGM bill and draft law that will be tabled in Parliament shortly and where the Kenyan Women’s Parliamentarians Association (KEWOPA) has done extensive sensitisation with female as well as male Parliamentarians and Parliamentary Committees before a (male) member of Parliament will table it for enactment. A danger and pitfall is, however, to believe that women Parliamentarians automatically will advocate for gender issues. Their previous knowledge and internalisation of gender issues may be equally low to that of men, and it is critical to get men onboard and in the lead on issues that could otherwise be criticised or shot down as issues driven by a small clique of feminist activists (thereby undermining broad-based support).

A strengthened legal framework in relation to family planning, reproductive health and pregnancy/maternal matters could help to institutionalise the rights-based approach to health service delivery. It could possibly also help to take family planning and motherhood out of the individual and personal domain to become an area of societal concern. It was noted during this analysis that there are areas where the legal and procedural framework is unclear, such as incidences when health staff turn away people who cannot pay for delivery costs (or retain people in hospitals unless they settle their bills), in cases of verbal abuse or beating of delivering mothers, or in more rare but nevertheless prevalent cases of children being born with ambiguous genitalia which affects their gender identity and future reproductive possibilities.

A more detailed and targeted study would be needed to determine the need and scope of a strengthened legal framework in the area of reproductive health and rights, including detailed planning for getting maximum acceptance from both the medical profession and other stakeholders (churches, faith-based service delivery providers). However, any attempt to intervene in this area should be done with rigorous technical preparation stressing the gendered dimensions of health outcomes. It should also avoid being launched in connection to key political events to avoid a polemic nature of debates.

**The media**

Gender issues, because of their often controversial and highly emotive character in the Kenyan context, tend to be high-jacked to drive various political or other ‘power dynamic’ agendas, which easily overshadows the true issues at stake. This was particularly the case in relation to women’s

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75 An OB-GYN specialist interviewed commented: “We release these cases with no follow-up, and no information to parents on how to handle the situation and what their rights are to further medical assistance, because there are no established procedures for handling these cases, and no data to refer to.”
right to inherit land during the referendum of the draft constitution in 2005\textsuperscript{76}, and it is currently the case with the ongoing, and raging, debate around abortion in relation to the new Draft Constitution for which a referendum will be held in August 2010.

Key learning points in this field include to use unifying rather than divisive language, to couple public outreach with political and sector-specific dialogue between donors and government parties, and to try to avoid or mitigate political hi-jacking of issues, by e.g. referring to international commitments, joint accountability for outcomes\textsuperscript{77}, and – in the area of health – to discuss gender and health as a cross-cutting prerequisite to achieve all MDGs (including, but not only focusing on MDG3 and MDG5).

One should also keep in mind that there are serious flaws in the current understanding of the root causes of gender inequalities among many key stakeholders in public policy-making, and there is still a tendency to publicly ‘blame’ women. Changing this negative ‘gender culture’ will take time and will need to include unusual champions beyond a few vocal leading women’s activists.

“Why do women in this country or elsewhere want to go ahead and get pregnant, and then procure abortions? Why are we not realizing that the way you can avoid going through the whole problem of abortion is by just not getting pregnant?” National Council of Churches in Kenya (NCCCK), spokesperson interviewed by CNN, 24 March 2010 – responding to the fact that one third of all maternal deaths in Kenya are caused by unsafe, illegal abortions

6. Donor coordination & alignment with GoK in mainstreaming gender

6.1 Health sector coordination & gender

In total donor investments represent approximately 58% of resources available to the sector (2008/09). Most of this (88%) is off-budget, project-based support which is not yet well coordinated or harmonized to most effectively target sector priorities. HIV/AIDS support is estimated to represent close to half of the total health budget in Kenya\textsuperscript{78}.

The main donors are: US (USAID, PEPFAR, CDC), the Global Fund (and other vertical funds), The World Bank, German Development Cooperation, DFID, Japan, UNICEF and WHO. In relation to FGM and other harmful traditional practices, UNFPA has been funding Maendaleo ya Wanawake and the Ministry of Gender to carry out community sensitization and strengthen the legal framework to abandon FGM and other harmful traditional practices.

The main coordination body of health sector development partners is the Joint Interagency Coordinating Committee (JICC), and a common management arrangement monitoring framework has been established between development partners and sector stakeholders. Progress towards joint goals and objectives are reviewed through Joint Annual Reviews (JARs), which serves as a strategic management instrument for GoK and donor partners.

The large degree of off-budget vertical programmes in the health sector, with half of the health budget going to HIV/AIDS, presents huge challenges in terms of coordination and alignment – even for gender mainstreaming with different donors and vertical funding mechanisms coming in with its own set of priorities. Perceptions among some of the government respondents were that they

\textsuperscript{77} As above.
\textsuperscript{78} Health Sector Programme Support to Kenya, Phase 3 (HSPS III): Danida Programme Concept Paper, May 2010
“never heard about gender mainstreaming” from some of the other large disease-specific funding bodies.

This is not surprising, as it is also the conclusion of this study that sex disaggregated data on disease patterns are rarely recorded (or the information disappears at higher levels of aggregation). When and if health outcomes are recorded by sex, these data are only used for clinical purposes, and not to carry out in-depth analysis to come up with gender-transformative ways to address the problem.\(^{79}\)

It has also been recognized that globally, while vertical programming and the influx of external funding has been abundant in relation to specific diseases like HIV/AIDS, malaria and TB over the last decade, funding in the area of reproductive and maternal health has been fairly stagnant\(^{80}\). This fact is further compounded by the fact that many of the UN agencies (UNIFEM, WHO and UNFPA) still have a strong focus on women’s health issues (determined by sex more than gender) in their approach to gender mainstreaming, as opposed to framing issues around gender and gender equality (see also section 5.1).

Donors still have different takes on what is a gender-based approach in the health sector

From WHO’s Info Sheet: What is a gender-based approach to public health: “...In the past, work on women’s health was focused on the health problems of women during pregnancy and childbirth. A gender-based approach has broadened our understanding of women’s health problems and helped identify ways to address them for women of all ages. Cardiovascular disease, for example, is now known to be a major cause of death among women. However, this is not well recognized, leading to delays in treatment-seeking and diagnosis among women. The identification of gender differences in cardiovascular disease has made it possible to develop more effective health promotion and prevention strategies that have improved women’s health in many countries.” Source: “What is a gender-based approach to public health?” www.who.int

UNICEF has a new gender policy as of May 2010, which also recognizes the role of men as partners, and the need to also work on issues of discriminations against boys. Yet, the emphasis is on women’s issues as framed in the Beijing Platform for Action and CEDAW.

<table>
<thead>
<tr>
<th>Strategic objectives in the Beijing Platform for Action:</th>
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<tbody>
<tr>
<td>1. Increase women’s access throughout the life cycle to appropriate, affordable and quality health care, information and related services.</td>
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<tr>
<td>2. Strengthen preventive programmes that promote women’s health.</td>
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<tr>
<td>3. Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues.</td>
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<tr>
<td>4. Promote research and disseminate information on women’s health.</td>
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<tr>
<td>5. Increase resources and monitor follow-up for women’s health.</td>
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Source: Beijing + 15: How far have we come, how far to go? (FEMNET)

Between vertical programming for vaccinations (through GAVI), and for HIV/AIDS, malaria and tuberculosis on the one hand, and for using sparse domestic health resources to invest in areas that affect women’s health on the other, there seems to have been little space for donor coordination around applying a more balanced and sector-wide approach to addressing gender mainstreaming to date. This may be one reason why many gender mainstreaming policies still are in their very infant stages of operationalisation.

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\(^{79}\) This is a problem that has been widely acknowledged also in the literature reviewed as part of this study.

\(^{80}\) Thoraya Obaid, Executive Director of UNFPA’s key-note address at the MDG3 High-level Conference on Women and Employment, Danish Ministry of Foreign Affairs, March 2010.
A sign that this trend is changing, however, is the fact that the World Bank’s health policy recently was changed (2007) from a focus on priority diseases like HIV/AIDS, malaria and tuberculosis and the development of new international initiatives like the Global Fund and GAVI to a focus on strengthening of health systems. Along with Danida, they are one of the partners interested in supporting the GoK’s Health Systems Strengthening Facility (HSSF) with great scope for addressing some of the gender patterns that affect health outcomes at community levels.

6.2 Gender coordination and its links to sector-specific work

A Gender Sector Coordination Group has been created, chaired by the Ministry of Gender, and with all major sector stakeholders and development partners present as members. This is a positive step that has the potential to encourage better integration of gender across development programming, and reflect priorities of the national gender machinery in programme implementation and accountability. Criticisms of the structure are that its operations are slow, that the impact of the gender structures is limited, and that it lacks the sufficient budget to implement some of the recommendations made. It therefore tends to focus on areas where money is specifically allocated towards gender (often from a women’s rights angle), rather than addressing specific gender mainstreaming concerns within or across sectors.

In the area of health, facilitating the establishment of an Inter-ministerial working group on reducing maternal mortality and morbidity could be an important activity for such a group, and ensuring regular monitoring of a cross-ministerial results feeding into a common results framework (including sectors of water, environment & natural resources, roads, gender, culture and national heritage, youth, health & medical services).

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81 Royal Danish Embassy is represented through the Embassy’s Gender Focal Point.
82 Evaluation of Gender Equality in Swedish Development Cooperation: Kenya Case Study. Ørnemark C., Nyamweya P., March 2010
Yet, few donor partners have such a ‘flexible fund’ for targeted support to gender mainstreaming within and across sectors, e.g. to commission a study to create a solid evidence base and institutional analysis on how to gender mainstream practices and introduce indicator in each respective Ministry in order to create a joint results framework for collectively tackling maternal mortality. Rather, sector-specific donor funds tend to be tied up well in advance towards specific sector targets, with the indicators on maternal mortality embedded in the health sector (yet, the contributions from e.g. roads and infrastructure to reduced maternal mortality, if quantified and coordinated, could be substantial).

As a response to the rampant sexual violence that place as a consequence of the 2007 elections, development partners and national structures (via e.g. the Gender Commission and NGOs) were able to use some flexible funding available through GGP (Gender and Governance Programme) to establish a baseline and set up emergency response mechanisms. Such flexible and responsive funding for gender issues is usually not available for more sector-specific obstacles to gender mainstreaming, however. The objectives of GGP are also mostly concerned with the institutional machinery for gender mainstreaming, as well as accountability systems for women’s rights.

Yet, it is still the sector implementers who are in charge of the doing of gender mainstreaming (actual implementation) in the sectors. Yet specific and technical support for fulfilling this role is usually under-funded with few examples of support to cross-sectoral initiatives.  

<table>
<thead>
<tr>
<th><strong>Governance and Gender Programme (GGP)</strong></th>
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<tbody>
<tr>
<td><strong>Impact Objective:</strong> State institutions consistently implement gender-responsive policies and laws</td>
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<tr>
<td><strong>Outcome area 1:</strong> National and local institutions have gender-responsive policy and legal frameworks</td>
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<tr>
<td><strong>Outcome area 2:</strong> Women participate in governance and decision-making processes at national and local levels and actively lobby for women’s issues</td>
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<tr>
<td><strong>Outcome area 3:</strong> Kenyan civil society has a unified voice in articulating women’s needs, demanding and influencing the delivery of equitable services.</td>
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<tr>
<td>Source: GGPIII Programme Document, 2008-2011, UNIFEM</td>
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</table>

The GSCG, through the lead of the World Bank, has tried to come up with a specific Gender Sector Reporting Tool which has been pilot tested among sector partners. The idea is that members of the group have a format for sharing with others their current activities in the field of gender.

The main weakness of the tool, however, is that it is structured by partner, not by sector. It is also puts emphasis at ‘activities’ level, rather than at the level of desired outcomes and results. Achievements to date are noted, but without contrasting and combining different partners’ contributions to national targets and/or international indicators. A sector-by-sector compilation of information would indicate where there are investment gaps in terms of operationalising or addressing sector-specific challenges to gender mainstreaming. It would also make it easier to see where there is further scope for cross-sector collaborations and synergies around specific issues (such as the example of maternal mortality referred to above). However, it concludes that common themes among development partners on gender support are: gender-responsive budgeting, governance (with GGP being the main tool), economic empowerment, gender mainstreaming capacity building, data and strengthening of legal frameworks.

**Recommendations in relation to donor coordination and alignment**

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83 Judging from GSCG minutes available at: www.aideffectivenesskenya.org
84 Harmonization, Alignment and Coordination in the Gender Sector: A Review of a Sector Reporting Tool. Presentation of Asa Torkelsson, World Bank at the Gender Sector Coordination Group Meeting, 24 Feb. 2010.
• Make sure outcomes from gender mainstreaming efforts, in terms of improved health outcomes and transformed gender roles are reviewed as part of the Joint Annual Reviews (JARs), and that a gender-specific results framework is drawn up.

• Strategic alliances between donors active in HIV/AIDS (which is an area that is well-resourced) and those interested in addressing cultural and societal norms of masculinity through gender mainstreaming across operations should be established to undertake more detailed work around men’s health priorities and risk behaviours.

• Establish flexible fund to support emerging technical support or studies to advance gender mainstreaming into technical services and day-to-day operations at different levels of service delivery and planning.

• Fund jointly with other development partners (e.g. World Bank) a larger scale gender baseline for the health sector to link health outcomes more closely to practices, attitudes and behaviours of women/men at HH level. This could be combined with providing capacity building support for planners at different levels to use this data for ongoing gender analysis linked to key sector indicators and targets.

7. Entry-points for addressing gendered dimensions of health in Danida programming

• The overall objective for the Danida health sector gender mainstreaming strategy:

  Strengthened ability to continuously analyze and respond to gendered dimensions of health at different levels of health planning and service delivery, thereby getting better and more equitable health and gender outcomes.

• Key indicators of gender mainstreaming performance:

  • Number of reported changes in key health sector indicator outcomes that can be traced back to applying a gender-transformative approach to addressing the problem (at different levels)
  • Number of staff at different levels who can give one or several concrete examples of how they have adapted their work processes and/or technical work plans to incorporate a gender dimension
  • Number of gendered initiatives in sectors where health outcome is not biologically determined by sex (e.g. in disease prevention, child immunization etc.),
  • Examples of changes in outcomes due to the involvement of men in the areas of maternal and child health
  • Existence of established structures and increased synergies with other ministries to address maternal mortality and morbidity through a multisectoral approach with a joint results monitoring framework.

  (See matrix for component specific entry-points below).
### Component 1: Support to Primary health Care

<table>
<thead>
<tr>
<th>No.</th>
<th>Result Area</th>
<th>Underlying Principle</th>
<th>Entry Point/Challenges</th>
<th>Management and service delivery Indicators.</th>
<th>Incentive systems</th>
<th>Further Exploration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health Sector Services Fund (HSSF)</td>
<td>Improve funding flow for provision of quality of services at lower levels where majority of socially and economically disadvantaged seek and access.</td>
<td>Ensure women membership in the HFMC is as per the government notice gazette as well as their meaningful participation.</td>
<td>No of decisions of HFMC’s that carer for or respond to concerns of women or men in the community and that has a gendered character.</td>
<td>As incentive, link funding to the number of people attending various services of the clinic (including preventive services and community-based outreach sessions) and the result of patient satisfaction surveys.</td>
<td>Need to look at the criteria that the minister will use to appoint person to the HFMC beyond their sex. The process could be abused for political expediency.</td>
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<tr>
<td>2</td>
<td>Improve access to, and utilization of, quality services for women and men.</td>
<td>Improve linkages with the communities.</td>
<td>Capacity building and knowledge creation in gender equality in health programming at district levels.</td>
<td>No of patients visiting health facility tested for HIV by sex and age.</td>
<td>Reward increase in male attendance in family planning/MCH clinics through special allocation to make clinic ‘male friendly’.</td>
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<tr>
<td>3</td>
<td>Delegation of responsibility of health care provision to communities.</td>
<td>Male clinics to address issues like prostate cancer, infertility, and drug and alcohol abuse. Make sure men have a gendered role.</td>
<td>Gender mainstreaming of District and facility health plans.</td>
<td>No of activities in the health facility plans with gender dimensions.</td>
<td>Introduce principles of gender responsive budgeting, and bonuses for proper banking, management and accounting of funds.</td>
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<td>4</td>
<td>Empower women in decision-making through their role at the HFMCs.</td>
<td>Identify areas where the performance or services of the health clinic has the potential to challenge and influence gendered patterns of behaviour that affect health outcomes (in areas of HH decision-making, nutritional status, division of labour).</td>
<td>No of male patients attending outpatient and/or inpatient services</td>
<td>No of communities with active support for gender transformative health prevention from Chiefs</td>
<td>Unutilized fund reduced from net allocation.</td>
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<td>5</td>
<td>Improve linkages with the communities.</td>
<td>All facility service delivery indicators contained in the AOP5**, with gender dimension added also to capture male involvement in maternal/reproductive health services.</td>
<td>As incentive, link funding to the number of people attending various services of the clinic (including preventive services and community-based outreach sessions) and the result of patient satisfaction surveys.</td>
<td>Data collected is sex disaggregated and is used at the closest point of health service delivery for gender analysis and planning.</td>
<td>The process could be abused for political expediency.</td>
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<td>No.</td>
<td>Result Area</td>
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| 2.  | Essential Medicines and medical supplies (EMMS) | 1. Improve flow and availability of essential drugs and medical supplies in Health Centres and Dispensaries | - Priority given to drugs and supplies related to HIV/AIDS, maternal health, reproductive health and child health.  
- Train and develop capacity to forecast drug needs to support the pull system.  
- Put in place a proper drugs storage with lockable compartment, pellets, with drugs accounting systems, (i.e bin cards)  
- Make sure a sufficient supply of delivery kits are made available for the health facility to pass on to retired nurses that are assisting with deliveries in the remote communities | - % of tracer drugs available  
- No and types of drugs expired.  
- No of drug unused beyond the projected utilization period.  
- % of drugs unaccounted for.  
- % of drugs spoilt (contaminated due to poor handling and storage)  
- No of delivery kits accounted for |  | Improved drugs flow will require a qualified pharmaceutical technician/technologist. Is that possible in all lower level facilities? |
| 3.  | Support to Human Resources for Health           | 1. Increased staff level in lower level facilities  
2. Gender balance among staff to cater for client preference in areas | - Hire staff on permanent basis to lower level health services to address current understaffing  
- Priority be given to women recruits to support reproductive  | - No. of staff taken over and retained by Govt at end of the Danish support  
- Nurse/patient ratio in the facility  
- Clinical officer/patient |  | Build on lessons from HSPSI in terms of setting up a reward system for posting of female nurses to remote areas, and areas where it is culturally |
<table>
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<tr>
<th>No.</th>
<th>Result Area</th>
<th>Underlying Principle</th>
<th>Entry Point/Challenges</th>
<th>Management and service delivery Indicators.</th>
<th>Incentive systems</th>
<th>Further Exploration</th>
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<td></td>
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<td>where it is culturally sensitive for pregnant women to be attended to by male nurses</td>
<td>health, family planning and delivery services • In staff placements, priority be given to facilities in marginalized areas with poor staff attraction and retention. • Develop a health staffing policy strategy to institutionalize incentive system to attract staff, especially women to marginalized areas</td>
<td>ratio in the facility.</td>
<td>sensitive for women to be attended to by a male nurse</td>
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<tr>
<td>1</td>
<td>Planning and Financial Management support to HSSF</td>
<td>1. Gender mainstreaming becomes part of staff work plans and day-to-day operations, and is not led or delegated exclusively to gender focal points/unit.</td>
<td>• Include gender as part of all training manuals, including manuals/ support for financial management (aspects of gender-responsive budgeting)</td>
<td>• No of HFMC decisions that take gender considerations (women and men) into account in deciding on budget allocations</td>
<td>• Establish a reward system for well-performing HFMC’s based on good management criteria, satisfaction surveys among clients, evidence of results from gender-transformative interventions (such as making family health clinics male friendly etc.)</td>
<td>Review and advise (through provision of TA services) how to make all training manuals and planning documents incorporate a gendered approach instead of providing stand-alone gender training</td>
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<td>2</td>
<td>HR Systems Development</td>
<td>1. As above. 2. Explore possibilities of up-scaling technical skills of Assistant Medical Officers to undertake Emergency Obstetrics care (Tanzania model)</td>
<td>• Reinforce capacities of technical planning and strategy development units to use available sex disaggregated data, and to highlight where there are gaps • Create internal ‘demand’ for gender support (from gender unit and external) by</td>
<td>• No of staff at different levels who can give one or several concrete examples of how they have adapted their work processes and/or technical work plans to incorporate a gender dimension • No (or scope of) additional studies and technical support services demanded or sourced directly from technical</td>
<td>• Link staff capacities to operationalise gender mainstreaming to performance contracts at lower levels then PS (e.g. Department heads) • Mainstream gender into internal capacity building /training efforts conducted by the division for regulation and quality assurance</td>
<td>Explore level of skills and investment needed in terms of HR systems development and involvement of Professional Associations for quality assurance to extend availability of EmOC to lower level health facilities</td>
</tr>
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### SWAP support

1. Improve sector coordination and alignment with GoK procedures
2. Apply broad-based and inclusive gender mainstreaming approach across all areas of operations (rather than as stand-alone components or programmes)

**Entry Point/Challenges**
- See section 7

**Management and service delivery Indicators.**
- See section 7

**Incentive systems**
- See section 7

**Further Exploration**
- Donor dialogue around how to be more result-oriented in their approaches to monitoring of outcomes from gender mainstreaming in sectors needed
- Further exploration among donors around ways to include stronger emphasis on male involvement, and to understand male treatment seeking behaviour (without losing focus on women’s rights) is needed.

### AOPS facility service delivery indicators (+ suggested added gender dimension):

- No Women of Reproductive Age (WRA) receiving Family Planning (FP) Commodities; No of men accessing family planning services, No of men accepting family planning for thier partners/wives, No of men undergoing or willing to undergo vasectomy
- No Pregnant women attending at least 4 ANC visits: No of women accompanied by partner/husband for at least 1 ANC visit, No of men reached through community-based birth preparedness counselling/outreach
- No Newborns with Low Birth Weights (LBW) –(less than 2500 grams) – No of mothers with LBW babies whose nutritional status is poor
- No Pregnant women distributed with LLITNs – No of pregnant women receiving two LLITNs to cater for family needs (children older than 5, family sleeping patterns etc)
- No Pregnant women receiving two doses of Intermittent Presumptive Therapy (IPT2)
- No of HIV infected pregnant women who received preventive antiretroviral therapy to reduce the risk of mother-to-child transmission (PMTCT) – Number of HIV infected pregnant women whose husbands / partners are reached for testing and treatment after detection of status
- No of deliveries conducted by skilled health attendants – Ratio of deliveries conducted by skilled health attendants and male involvement in ANC visit or birth preparedness counselling
- No. Maternal Deaths Audited
- No. Fresh still births in the health facility
- %Newborns receiving BCG:
Annex I. Terms of Reference

Terms of Reference for Undertaking a Sector Gender Analysis and Drafting a Gender Mainstreaming Strategy for Danida Health Sector Programme

1. Background information

The Danish Government has supported Health Sector for over 30 years. The support has shifted from projects supporting specific intervention to programmatic mode under the Sector Wide approach (SWAp) mechanism. Currently the sector is supported under the Health Sector Programme Support II (HSPS II) which started in January 2007. The programme sought to support the government’s effort in institutionalising SWAp as the approach to improving health sector services.

HSPS II is guided by the prevailing policy framework and the National Health Strategic plan II. The programme supports systems strengthening focusing mainly on lower levels of the service delivery. The programme lays emphasis on direct funding to facilities, provision of drugs, strengthening health information system, strengthen HIV/AIDS intervention through provision of human resource and pay specific attention to NE special needs. Under the programme, gender issues are addressed as a cross-cutting issue.

The programme comes to an end in December 2011 and the Embassy is in the process of preparing a new phase. To ensure that gender issues are addressed in the new programme, the Embassy plans to undertake an assessment of how gender issues are dealt with by the sector’s national policies and strategies and by the current programme. The assessment will provide lessons on how to mainstream gender issues under the new programme.

2. Objective

The objective of the consultancy is to assess how gender issues are addressed within the health sector and under the current Danida Health Programme Support II and inform the design and formulation of phase III of the Danish Health Sector Programme Support.

3. Scope of Work

The scope of work includes but is not necessarily limited to:

- Review national legislation, policies and strategies on gender
- Review the sector’s policies and strategies, and assess extent to which gender issues are addressed or mainstreamed.
- Assess the systems and institutional framework put in place for implementation of gender related issues under the two ministries.
- Assess capacity and efforts of the Ministries in mainstreaming gender issues within programmatic interventions
- Identify and assess SOME of the gender specific issues that have direct impact on health indicators
- Assess the capacity in the sector to analyze sex disaggregated data and use of the same for decision making
- Assess donors’ efforts in harmonization and alignment with the government’s efforts in
mainstreaming gender issues.

- Assess coordination mechanisms within the sector (including interrelationships between state and non-state partners) in mainstreaming gender issues within programmatic interventions.
- Review gender mainstreaming within Danida current Health Sector Programme Support II
- Develop a strategy that would ensure that gender issues are mainstreamed within Health Sector programme Support III to the health sector (2012-2017) based on lessons learnt from the current programme support
- Identify possible entry points, opportunities, possible results & direct or proxy indicators for gender mainstreaming.

4. Study approach

The analysis will apply the following approach:

- At the beginning, the consultant will be required to provide one page write up on their understanding of the TORs.
- Qualitative & quantitative desk review
- Consultative Meetings
- Debriefing to the Embassy

5. Desk review

The consultant is expected to undertake a desk review of key relevant policy, strategies and programmatic documents, reports & funded interventions in relation to addressing gender equality & mainstreaming within the current RDE programme.

6. Consultative Meetings

The consultant is expected to undertake consultative meetings/interviews with key gender donor agencies, Government representatives and CSOs to attain a national perspective on current challenges & opportunities.

7. Debriefing

A debriefing meeting with Danida to discuss the review and the strategy proposed.

8. Output

- A review report that addresses key issues & challenges being faced in addressing and mainstreaming gender issues within the health sector (refer to the Danida Gender Equality Toolbox-Sector Gender Analysis Guidelines+ attached questionnaire).
- A gender mainstreaming strategy document to be used in the planning of the next programme phase.

9. Qualification

Gender specialist with extensive knowledge and expertise in health and sector programming

10. Timing

The consultancy will take 25 man days and is expected as soon as consultant is the identified.
## Annex II. List of people interviewed

<table>
<thead>
<tr>
<th>NAME</th>
<th>DESIGNATION/POSITION</th>
<th>ORGANISATION</th>
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<tbody>
<tr>
<td>1. Rhodah Njuguna</td>
<td>Programme Officer</td>
<td>Royal Danish Embassy</td>
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<tr>
<td>2. Ole Thonke</td>
<td>Deputy Head of Mission</td>
<td>Royal Danish Embassy</td>
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<tr>
<td>3. Simon Eriiksson</td>
<td>Intern, Health Sector Programme</td>
<td>Royal Danish Embassy</td>
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<tr>
<td>4. Dr. Marianne Ndonga</td>
<td>Gender Focal Person</td>
<td>MoMS</td>
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<td>5. Dr. Margaret Meme</td>
<td>Gender Focal Person</td>
<td>MoPHS</td>
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<tr>
<td>6. Dr. Were</td>
<td>Head: Technical Planning</td>
<td>MoPHS</td>
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<tr>
<td>7. Dr. Simon Mueke</td>
<td>Head: Obstetrics and Gynecology</td>
<td>MoMS</td>
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<tr>
<td>8. Dr. Susan Magada</td>
<td>Health Research, Quality &amp; Standards</td>
<td>MoMS</td>
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<tr>
<td>9. Dr. Nzioka</td>
<td>Head of HMIS</td>
<td>MOH</td>
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<tr>
<td>10. Dr. Isabella Maina</td>
<td>Technical Planning</td>
<td>MoMS</td>
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<tr>
<td>11. Dr. Rachael Nyamae</td>
<td>Head: Division of Peadriatics</td>
<td>MoMS</td>
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<tr>
<td>12. Dr. Willis Akhwale</td>
<td>Head: Dept of Disease Prev. Control</td>
<td>MoPH</td>
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<tr>
<td>13. Dr. Nicholas Muraguri</td>
<td>Head: NASCOP</td>
<td>MoPHS</td>
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<td>14. Anna-Carin Matterson</td>
<td>Head: Policy Advisory Services Comp.</td>
<td>GTZ</td>
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<tr>
<td>15. Ms. Rukia Yassin</td>
<td>Snr. Program Officer GBV</td>
<td>GTZ</td>
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<tr>
<td>16. Prof. Khasiani</td>
<td>Gender Consultant</td>
<td>Family Support Institute</td>
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<tr>
<td>17. Dr. Mutie</td>
<td>District Medical Office of Health</td>
<td>Mwingi District</td>
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<tr>
<td>18. Ms. Alice Ngesa</td>
<td>District public Health Nurse</td>
<td>Mwingi District</td>
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<td>19.</td>
<td>District Health administrative officer</td>
<td>Mwingi District</td>
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<tr>
<td>20. Ms. Hellen Charles</td>
<td>Nursing officer Incharge</td>
<td>Kyethani Health Centre</td>
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<tr>
<td>21. Ms. Mary Wambui</td>
<td>Nursing Officer Incharge</td>
<td>Mbondoni Health Centre</td>
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<tr>
<td>22. Ms. Alice Ngesa</td>
<td>District Public Health Nurse</td>
<td>Mwingi West District</td>
</tr>
<tr>
<td>23. Mr. Wachanga</td>
<td>District Health Administrative Officer</td>
<td>Thika District</td>
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<tr>
<td>24. Mr. Jairus Mbindingo</td>
<td>Clinical Officer Incharge</td>
<td>Ngoliba Health centre, Thika</td>
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<tr>
<td>25. Mr. David Munyao</td>
<td>Chairman; Facility management Comm.</td>
<td>Ngoliba Health Centre</td>
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<tr>
<td>27. Dr. Njoroge</td>
<td>Medical Superintendent</td>
<td>Thika District Hospital</td>
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<td>28. Mr. Protas Onyango</td>
<td>Asst. Director of Social Service, Gender Div.</td>
<td>Ministry of Gender</td>
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<tr>
<td>29. Ms. Maureen Gitonga</td>
<td>Program Officer</td>
<td>KEWOPA (Parliamentarians)</td>
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<td>30. Dr. Kamau Tatu</td>
<td>Ag. Head Family Health</td>
<td>MoPHS</td>
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<td>31. Ms. Anne Gitutu</td>
<td>Maternal Health Program</td>
<td>MoPHS</td>
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</tbody>
</table>
32. Mr. Onyaberi  
   Officer  Gender Program  
   MoPHs

33. Ms. Matte Kjaer  
   Country Director  
   AMREF

34. Peter Ngure of Kenya  
   HIV/AIDS Program Manager  
   Christian Health Association