MINISTRY OF HEALTH

NATIONAL AIDS CONTROL COUNCIL

STRATEGY

ON

MAINSTREAMING DISABILITY AGENDA IN THE NATIONAL AIDS CONTROL COUNCIL AND THE COUNTRY's HIV & AIDS RESPONSE

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Contents

ABBREVIATIONS AND ACRONYMS

ACU	AIDS Control Unit
AIDS	Acquired Immune Deficiency Syndrome
APDK	Association for the Physically Disabled of Kenya
APHIA-PLUS	AIDS, Population, Health Integrated Assistance-People centered Local Leadership, Universal access & Sustainability
ARV	Anti-retroviral Treatment
CACC	Constituency AIDS Control Committee
COBPAR	Community Based Programme Activity Reporting
CSO	Civil Society Organization
CT	Counseling and Testing
GIPA	Greater Involvement of People Living with HIV and AIDS
HCT	HIV Counseling & Testing
HIV	Human Immunodeficiency Virus
IEC	Information, Education & Communication
IGA	Income Generating Activities
JAPR	Joint HIV and AIDS Programme Review
KANCO	Kenya AIDS NGO Consortium
KNAC	Kenya Overall AIDS Commission
KNASP	Kenya Overall HIV&AIDS Strategic Plan
KNBS	Kenya Overall Bureau of Statistics
MACODE	Masaba Community Development
M&E	Monitoring and Evaluation
NACC	Overall AIDS Control Council
NCAPD	Overall Coordinating Agency for Population and Development
PMTCT	Prevention of Mother to Child Transmission of HIV
PwD	Person with Disability

SRH	Sexual and Reproductive Health
TOWA	Total War against HIV and AIDS
VCT	Voluntary Counseling & Testing
UN-CRPD	United Nations Convention on the Rights of Persons With Disability
UPDK	United Disabled Persons of Kenya

FOREWORD

The Government of Kenya recognizes the disability agenda as one of the cross-cutting developing issues to be mainstreamed into sectoral and institutional framework for programming. This is anchored in the Constitution of Kenya (2010), which recognizes fundamental human rights of every citizen as stated in the Bill of Rights. This resonates with UN Convention on the Rights of Persons with Disability which stipulates that disability issues should be addressed from a rights-based perspective.

In line with Kenya's Constitution, the Overall AIDS Control Council (NACC) has developed this Disability Mainstreaming Strategy to guide internal and external mainstreaming in the country's HIV & AIDS response. The need to address gaps existing in programme interventions aimed at enhancing mainstreaming disability in HIV & AIDS interventions forms the basis for developing this strategy. The strategy envisages guiding the mainstreaming of the disability agenda in the core functions of different stakeholders for the country's HIV and AIDS response.

The strategy seeks to give broad guidance on key issues that each sector should prioritize in the HIV & AIDS response. The overall goal is to reduce new infections and offer care and support to those living with HIV among people with disability. NACC therefore calls upon all stakeholders to use this strategy to mainstream issues of disability agenda in HIV response.

Dr. Nduku Kilonzo.
Director, NACC

ACKNOWLEDGEMENTS

This strategy was developed in three phases. Phase one employed a situational analysis to identify relevant disability issues to be mainstreamed in NACC and the country's HIV and AIDS response. In Phase two the results of the situational analysis were used to inform the development of this strategy. Phase three involved developing the strategy's costed Action Plan.

The NACCs Disability Mainstreaming Committee, coordinated the strategy's development process.

We would like to recognize the efforts of all Committee members and NACC Regional Officers for for providing leadership and coordinating data collection and analysis process in Western, Nyanza, Central, Eastern and Nairobi.

We acknowledge the invaluable support of the team from the NACC who supported the various consultative processes and the following persons and organisations: Mathew Ashers *(Proudly Kenyan);* Joseph Njenga, Esther Wairimu and Martin Pepela from *UDPK;* Stephen Ogutu Obama, Phoebe Awidhi Agutu and Njoki Kariuki from *(KANCO);*, Rose Gichanah *(MACODE)*, Major Rose Mbula Musyoka *(Salvation Army)*, who also provided input in the development of the Strategy.

We also thank all those who provided vital information including those interviewed in Western, Nyanza, Central, Eastern and Nairobi regions .

It is my hope that this strategy shall guide disability mainstreaming in the country's HIV response.

John Kamigwi

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Chair, Disability Mainstreaming Committee

DEFINITION OF TERMS

Disability mainstreaming in HIV&AIDS response: This is a strategic process of making disability issues part and parcel of organization's HIV & AIDS response efforts targeting its staff, staff's family members and its clients.

Internal mainstreaming: This refers to establishing policies, guidelines and activities that address HIV & AIDS needs of persons with disability at the workplace in the overall organization's response to HIV and AIDS.

External mainstreaming: Adapting the organization's response to HIV & AIDS among the target population it serves to address the HIV & AIDS needs of persons with disability.

Disability: Disability includes any physical, sensory, mental, psychological or other impairment, condition or illness that has, or is perceived by significant sectors of the community to have, a substantial or long-term effect on an individual's ability to carry out ordinary day-to-day activities. (Article 260 of the Constitution of Kenya, 2010).

1.0: INTRODUCTION

1.1 About the disability mainstreaming strategy

The disability agenda has been identified by the Government of Kenya as one of the cross-cutting developing issues to be mainstreamed into sectoral institutional framework and programming mandate. In keeping with this policy, the Overall AIDS Control Council (NACC) has developed this strategy to guide the process of internal mainstreaming of disability agenda as well as mainstreaming into the country's HIV and AIDS response efforts.

1.2 Strategy organization

This strategy is organized into the following main sections;

Introduction: It presents information on the disability strategy including its purpose, content, organization and use.

Background information: This section provides information on the disability situation in the country.

The concept of disability mainstreaming: Both internal disability and external disability mainstreaming concepts are explained to help the reader understand the contextual meaning of disability mainstreaming.

Rationale for mainstreaming disability in NACC and Country's HIV & AIDS response:
The justification for mainstreaming disability in country's HIV & AIDS response is provided in this section. The disability mainstreaming is anchored in the government's policy that identifies disability as a development issue that must be addressed in all development sectors. This resonates with the United Nations Convention on the Rights of Persons with Disability (UN-CRPD) which stipulates that disability issues should be addressed from a rights-based perspective. The need to address gaps existing in programme interventions aimed at enhancing mainstreaming disability in HIV & AIDS interventions formed the basis for developing this strategy. Section 1.4 clarifies the said programme gaps.

Principles underpinning disability mainstreaming: These principles are meant to ensure that mainstreaming is founded on rights-based approaches.

Mainstreaming disability in National AIDS Control Council: This section presents mainstreaming of disability agenda in NACC through internal and external mechanisms.

Mainstreaming disability into the country's HIV&AIDS response: This section identifies various broad mainstreaming themes that shall guide the process of mainstreaming disability agenda in the country's HIV and AIDS response.

Implementation of strategy: This section explains how the disability mainstreaming strategy shall be implemented

1.3 Aim of the strategy

The disability mainstreaming strategy is the blue-print that shall guide NACC in ensuring that disability agenda is mainstreamed within NACC and in the overall HIV & AIDS response.

1.4 Strategy Development Process

This strategy development was based on the findings of the rapid assessment carried out to determine the status of disability mainstreaming in Kenya. The assessment involved primary data collection from the HIV & AIDS stakeholders in the public and private sectors, the civil society and development partners; field visits in Nyanza, Western, Nairobi, Central and Eastern as well as literature review of disability and HIV & AIDS information in Kenya and other parts of the world.

The assessment established the following as some of the issues influencing focus on disability agenda in country's HIV & AIDS response effort:

- ***Communication***: despite communication being the main thrust of HIV and AIDS prevention efforts, PwD face communication challenges since information on HIV and AIDS is not available in formats that they would facilitate access such as braille, sign language, audio CDs among others. Consequently, most PwD are not informed about critical HIV and AIDS issues including prevention, care, support and treatment.
- ***Physical access to health facilities***: some of the facilities where HIV and AIDS information and services are provided are not accessible to persons with physical disabilities due to absence of assistive devices such as ramps and infrastructure.
- ***Stigma and discrimination***: PwD are heavily stigmatized as they are perceived to be sexually inactive. Those living with HIV positive bear double stigma since health workers tend to hold them in low esteem. This makes some PwD avoid seeking HIV and AIDS services.
- ***Low technical capacity among health professionals and AIDS service providers:*** Many health professionals do not know how to handle some forms of disabilities such as the HIV and AIDS related needs of persons with mental disabilities. This greatly hampers service provision to PwD.
- ***PwD are ignored***: Many HIV&AIDS programmes ignore the HIV and AIDS needs of PwD as some believe that providing information to this population segment would render them more vulnerable to HIV and AIDS. Many agencies involved do not know the rights of PwD.

- ***Poverty:*** In general most PwD are among the poorest members of the population. Consequently, many of them tend to engage in risky sexually behavior such as commercial sex.
- ***Disability as a vulnerability factor***: Most PwD are sexually abused (raped and defiled) due to reduced capacity to defend themselves. Many of them also engage in risky sexual behavior such as unprotected sex because of low capacity to negotiate for safe sex. The PwD have sexual feelings like able-bodied persons. However, they may take long to find sexual partners. This may lower the capacity for negotiating for safe sex.
- ***Low literacy levels***: Many PwD are illiterate. This is because many parents do not prioritize the educational needs of their children with disability. The high illiteracy levels hamper HIV and AIDS sensitization among PwD.
- ***Inadequate information on the linkage between HIV&AIDS and disability***: There is a dearth of information on HIV and AIDS and disability. At overall level, periodic surveys such as the Kenya Demographic and Health Surveys and the Kenya AIDS Indicator surveys do not place emphasis on HIV and AIDS situation among the PwD. This has potential negative impact on planning and resource allocation for HIV and AIDS programmes targeting PwD.

The findings summarized as the thematic issues herein, informed identification of the strategic goals and recommended mainstreaming actions of the strategy.

NACC reviewed the final draft of the strategy and subsequently, developed a costed action plan through a stakeholders' consultative process. The stakeholders thereafter validated the strategy.

2.0: BACKGROUND INFORMATION

2.1. Disability situation in Kenya

Kenya has not had accurate data on the number of persons with disability. In 1989, a disability module was included in the Overall Population and Housing Census but the data collected was not analyzed. However, in 2008, the Overall Council for Population and Development (NCPD), the Kenya National Bureau of Statistics (KNBS) and partners conducted a survey on persons with disability in Kenya. The survey was designed to provide up-to-date information for planning, monitoring and evaluation of the various activities, programmes, and projects intended to improve the wellbeing of persons with disabilities. The following is a summary of key findings:

Table 1: Summary of prevalence of disabilities in Kenya

- Prevalence of disability in Kenya is 4.6%
- Prevalence is highest in Nyanza (7%), Coast (5%) and Central (5%). It is lowest in North Eastern (3%), Rift Valley (3%) and Western (3%)
- The most prevalent forms of disability are visual (30%), hearing (12%) and mental (11%)
- Visual disability is highest in Nairobi (53%), Coast (35%) and Eastern (30%)
- More females (55%) than males (45%) experience visual difficulties.
- Physical impairment is highest in Central (39%), Western (34%), Nyanza (31%) and Rift Valley (30%)
- More males (54%) than females (46%) suffered from mental disabilities
- Most disabilities were caused by diseases (19%), congenital disorders (14%) and accidents (12%)
- Different programmes targeting these groups of PwD need to be developed by Government and other stakeholders

Source: Report on Overall Survey for persons with disabilities (2008)

2.2 Disability dimension in the HIV and AIDS response

Disability is intricately associated with HIV and AIDS with one enhancing chances of occurrence of the other. Despite this realization, HIV and AIDS issues are largely ignored in populations of persons with disability in many parts of the world. Certain forms of disability such as physical and mental disabilities may enhance vulnerability to HIV infection. Cases of sexual abuse of persons with physical and mental disability are known. Moreover, reports from organizations of persons with disability indicate that some of the targets of extra-marital sexual relationships are persons with hearing and speech impairment.

Reports from some agencies working with PwDs indicate that HIV and AIDS treatment has also contributed to temporary and/or permanent disabilities among some previously non-disabled

individuals. For instance, cases of blindness due to side effects of ARV treatment have been reported in some patients.

These scenarios underscore the centrality of disability issues in the overall HIV and AIDS response which falls within the prevention, care, treatment, and socio-economic impact mitigation domains. Currently, efforts to respond to the HIV and AIDS intervention needs of the persons with disability are underway albeit on a minimal scale.

The Kenya National Survey for Persons with Disabilities carried out in 2008 indicates that nine (*9)* out of ten (*10)* persons with disability are aware of HIV and AIDS. The PwD in rural areas (64%) have less access to HIV and AIDS information and services than those in urban areas (82%). Only one (1) in five (5) PwD had ever tested for HIV, with more in urban areas than rural ones. The PwD aged 35-54 years had the highest proportion of those who had been tested for HIV (47%), followed by age-group 23-34 years (22%) and 15-24 years (19%). In terms of marital status, those who were single had less information on preventive measures (58%) than did PwD who have or had a marital relationship (81% of married PwD and 70% of separated/divorced)

The government of Kenya has identified disability issues as one of the cross-cutting development issues, to be addressed by all sectors. A disability policy has been formulated to guide, among other issues, response to disability needs in HIV and AIDS response programmes.

3.0: THE CONCEPT OF DISABILITY MAINSTREAMING

Disability mainstreaming in HIV&AIDS response: This is a strategic process of making disability issues central to the way an institution involved in response to HIV and AIDS organizes itself, treats its staff and clients, and delivers its services. In developing HIV and AIDS work place and client centered programmes, the institutions take into consideration the needs of persons with disabilities without necessarily losing focus of its core mandate. Disability mainstreaming shall be carried out by all organizations involved in the overall HIV and AIDS response in the internal and external mainstreaming domains.

Internal mainstreaming: This concerns the institution's workplace, mainly the employees and internal procedures. It is related to HIV and AIDS policies, guidelines and activities addressing HIV and AIDS and disability among employees and immediate family members. Internal mainstreaming is effected when an agency puts in place HIV and AIDS work place policies that address needs of able-bodied persons as well as persons with disabilities. The HIV and AIDS work place policies must take into consideration the HIV and AIDS intervention needs of different disabilities. The work place policies provide strategies and work plans through which actual HIV and AIDS activities are implemented targeting employees and family members. Internal mainstreaming is considered as an entry point for mainstreaming in the external domain.

External mainstreaming: This means adapting core functions of an institution to respond to HIV and AIDS related needs of PwDs through responsive targets, policies and strategies. The external domain is the organization's mandate and routine work that focuses on the population it serves.

4.0: RATIONALE FOR MAINSTREAMING DISABILITY IN NACC AND OVERALL HIV and AIDS RESPONSE

Disability affects all aspects of the society and the country's development. The Government recognizes the challenges posed by the combined effect of disability and HIV and AIDS. Although

the extent to which HIV and AIDS has infected or affected PwDs has not been determined, they suffer same level of prevalence as the rest of the population. The combined effects of HIV and AIDS and disability on a person or group of persons present the Government with a situation of extreme challenge.

4.1 Human rights basis for disability mainstreaming

The disability agenda has received enormous attention through international, regional and overall policy and legislative frameworks. The United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD) adopted in 2007 raises the profile of persons with disabilities through encouraging the creation of legal structures to advance their rights to protection, participation and public freedom. This shift in focus means viewing people with disabilities as holders of rights that should be upheld and observed, just as in the case of non-disabled people, in order to eliminate the often-felt injustices and isolation.

The letter and spirit of the UN-CRPD is reflected in the Bill of Rights in Constitution which spells out a comprehensive array of rights for all population segments including persons with disabilities. To actualize the rights of persons with disabilities, the Persons with Disabilities Act was enacted in 2003. It provides for the establishment of the Overall Council of Persons with Disabilities whose role is, among others, to formulate and develop measures and policies to deal with disability issues. Despite the availability of the Act, services towards persons with disabilities reach a small proportion of them and are unequally distributed between and among various disabilities. This service gaps necessitated policy action leading to formulation of a draft Overall Policy on Disability. The policy aims to eliminate disparities in service provision and to ensure that services are available to all citizens with disabilities.

4.2 Responding to HIV & AIDS programmatic needs of Persons with Disabilities

The results of the disability mainstreaming assessment indicate that there are numerous gaps in the HIV & AIDS response targeting PwD. These include the unmet information needs by the PwD owing to inadequate production and packaging of IEC materials in formats that are accessible by them; stigma and discrimination directed to PwD by health service providers due to inadequate capacity and misconceptions about disabilities; inaccessibility of physical facilities where PwD seek HIV & AIDS services; low literacy levels among PwD as well as prevalent poverty, both of which have negative impacts on adoption of positive behavior with respect to HIV infection. There is also a tendency by many HIV & AIDS agencies to ignore PwD in their programme work. Yet, available information indicates that the problem of HIV & AIDS among PwD could be more serious than among the able-bodied persons. For instance, a US survey[1] reported an HIV infection rate among deaf individuals being twice that of the surrounding hearing population.

[1] *Van Biema, D. (1994). Deafness and AIDS. Time Magazine. 143:14:76-78.*

This strategy shall guide NACC in its coordinating efforts to ensure that the HIV & AIDS needs of persons with different forms of disabilities are addressed in the overall response efforts by stakeholder and partners. Specifically, this strategy identifies structural issues (policies and strategic frameworks through which disability issues are articulated), disability agenda (specific disability issues that need to be addressed) and strategic linkages among HIV & AIDS stakeholders all of which must interplay to contribute to realization of the goal of effective integration of the HIV & AIDS intervention needs of PwD in the overall response to HIV and AIDS.

5.0: PRINCIPLES UNDERPINNING DISABILITY MAINSTREAMING

Mainstreaming disability in overall HIV & AIDS response aims to contribute to the achievement of the overarching goal of addressing disability as a development issue. The following principles elucidated in the Overall Disability Policy 2006, shall underpin disability mainstreaming:

i. **Equalization of opportunities**: measures provided in the policy are to ensure that persons with disabilities are accorded opportunities on an equal basis with able-bodied persons through affirmative action.
ii. **Human rights approach to the disability agenda**: The principle underscores the conscious departure from the ethos of charity to the articulation of human rights and development approach to disability concerns. Hence, the approach provides for protection from discrimination based on real or apparent grounds.
iii. **Mainstreaming**: Persons with disabilities are members of the society hence; their needs should be addressed within their communities and not in isolated service delivery settings.
iv. **Accessibility**: Accessibility should remain an underlying consideration in the built environment, information and services.
v. **Gender**: Disability mainstreaming should be beneficial to men, women, boys and girls with disabilities alike.

6.0: DISABILITY MAINSTREAMING

6.1 General approach to mainstreaming

Disability mainstreaming will be done at two levels - in NACC (internal level) and at the country's HIV & AIDS response level (external mainstreaming). Mainstreaming process targets institutional policies, strategic plans and programme/project components at planning, budgeting, implementation and monitoring & evaluation levels.

In this strategy, the broad mainstreaming areas identified from analysis of situation assessment are presented as thematic areas with corresponding strategic mainstreaming goals. Each strategic goal has a corresponding section on status/situation analysis and recommended mainstreaming actions. Mainstreaming disability into NACC and overall HIV & AIDS response shall be effected in three broad areas namely:

a) **At the work place**: This involves making changes to the internal institutional management structures, policies, practices and operations with a view to preventing new HIV infections, improving quality of life of the infected, mitigating the impacts of AIDS on employees with disability and their work, immediate family members, clients and surrounding communities.

b) **Strategy and programming**: Adapting core functions, structures, policies, strategies, programmes, projects and activities to take into account the causes of HIV infection and consequences of AIDS among PwD.

c) **Strategic linkages and partnerships**: with relevant stakeholders for a more focused, targeted and comprehensive HIV & AIDS interventions targeting PwD.

Taking into account the three broad areas above, this strategy specifically addresses the following mainstreaming issues:

- **Structural issues**: these are proposed policies, guidelines and strategies that should be in place to enable mainstreaming of disability agenda;
- **Disability agenda**: these are specific disability issues that should be addressed to contribute to the achievement of a defined mainstreaming goal;
- **Strategic partnership and linkages**: these are collaborative relationships that need to be established to effectively address disability agenda.

7.0 DISABILITY MAINSTREAMING IN THE NATIONAL AIDS CONTROL COUNCIL

7.1 Introduction

NACC's main role is policy and strategy formulation and coordination of the overall HIV & AIDS response. Coordination by NACC entails coordinating multi-stakeholder response to HIV and AIDS at national and county level. Facilitating mainstreaming of disability in the country's response to HIV & AIDS requires that disability agenda is first mainstreamed in NACC at the internal and external levels.

7.2 Internal disability mainstreaming

Strategic Goal: Strengthen internal disability mainstreaming

Situation

NACC has in place structural issues that would support internal disability mainstreaming. These include work place policies and strategic frameworks on HIV & AIDS. However, there are some gaps in communication, mobility and accessibility that are not adequately addressed.

Recommended mainstreaming actions

i. NACC to establish disability focal person who is well versed with disability issues.

ii. NACC to package IEC materials and other documents it produces in accessible formats and technologies for PWD.

iii. Ensure that job advertisements are sent to NCPWD, organizations for PwD and other communication channels.

iv. Maintain a disaggregated database of PwD that are beneficiaries of NACC Services.

v. Put in place HIV & AIDS programme for staff (*both able-bodied and those with disabilities),* covering HIV and AIDS prevention, care and support and responding appropriately to different disability needs.

vi. Build the capacity of staff with disabilities in HIV & AIDS issues and use them in peer-education activities on HIV and AIDS programme for NACC.

vii. Carry out annual review of internal policies and strategies to respond appropriately to changing disability issues in the organization.

viii. Conduct periodic assessment of progress in addressing HIV and AIDS needs of staff members who have disabilities.

7.3 External disability mainstreaming

Strategic Goal 1: Improve communication with persons with disabilities

Situation

On the external mainstreaming front, NACC still faces challenges relating to communication with PwD. For instance, persons with speech and sight disabilities who have formed a community group to respond to HIV and AIDS have to seek the assistance of persons without disability to develop proposals for them to submit to devolved committees for funding. Such groups would prefer to develop proposals in braille and sign language respectively. Thus the committees that review proposals need to consider co-opting as members, persons with disability particularly speech and sight disabilities. This would greatly enhance appreciation of the inclusion efforts in decision-making on funding towards HIV & AIDS programmes/projects by persons with disability.

Similarly, some of the HIV and AIDS focused messages disseminated through national TV stations are not disability friendly. For example, the common message on HIV prevention among youth through abstinence, packaged as "*tumechill"*,[2] would be interpreted to mean young people are ready for sex in sign language. Moreover, most of the TV messages do not have simultaneous sign language versions.

Recommended mainstreaming actions

i. Provide technical support towards the development of proposals on HIV and AIDS funding in accessible communication formats for PwD.
ii. Develop HIV and AIDS funding guidelines that address specific needs of PwD.
iii. Have a sign language version for HIV and AIDS messages on TV for deaf persons.
iv. Involve PwD in developing and disseminating TV-based HIV and AIDS messages.
v. Involve PwD at the stages of development and review of funding proposals that respond to HIV and AIDS in the general population.

Strategic Goal 2: Enhance mainstreaming of HIV & AIDS in Overall HIV response

Situation

[2] "tumechill" is a Kiswahili slang word for 'we are abstaining from sex'

Opportunities for mainstreaming disability in HIV & AIDS programmes exist but are untapped due to weaknesses in HIV & AIDS response efforts. In instances where such weaknesses exist, disability mainstreaming will be equally weak. Hence, in agencies, particularly public sector organizations, where disability mainstreaming is mandatory, it is important that effective mainstreaming of HIV and AIDS is carried out as a foundation for building upon disability mainstreaming.

Recommended mainstreaming actions

i. NACC to support agencies implementing HIV & AIDS responses to address HIV and AIDS intervention needs of PwD.

ii. NACC to monitor and evaluate effectiveness of HIV & AIDS programmes in public sector agencies with regard to addressing needs of PwD.

Strategic Goal 3: Raise visibility of the disability agenda in NACC events/ fora.

Situation

NACC takes part in many events and fora at national and international levels. Some of the events are about showcasing best practices or sharing lessons learnt on response to HIV & AIDS. It has been noted that in all these fora, the disability agenda remains obscure. Moreover, there is minimal participation by the PwD as NACC's representatives in such fora despite this being an important way of demonstrating NACC's commitment to the disability agenda in its efforts to respond to HIV & AIDS.

Recommended mainstreaming actions

i. Facilitate participation of organizations working with PwD in events such as the World AIDS Day.
ii. Maintain the disability agenda in all Joint HIV and AIDS Programme Reviews (JAPR) meetings.
iii. Facilitate involvement of organizations working with PwD in national and international experience sharing and best practice showcasing fora on HIV and AIDS.

8.0 DISABILITY MAINSTREAMING IN THE COUNTRY'S HIV & AIDS RESPONSE

8.1 Introduction:

Mainstreaming disability in the country's HIV & AIDS response is done through internal and external disability mainstreaming of agencies involved in the response. There are a number of strategic goals to be realized under internal disability mainstreaming. Similarly, external mainstreaming is organized into thematic areas that correspond to the summary of findings that inform disability mainstreaming *(see section 1.4).*

8.2 Internal disability mainstreaming

Strategic Goal 1: Enhance internal disability mainstreaming in agencies involved in HIV & AIDS response

Situation

Most agencies do not have standard operating policies including HIV & AIDS work place policies; yet, these are the basis for internal mainstreaming. In cases where agencies have internal policies, they do not address the disability agenda. This is partly because most of these agencies neither have PwD as staff members nor as their clients. It is important that such policies are established to guide internal disability mainstreaming processes.

Recommended mainstreaming actions

i. Agencies to conduct regular assessment of the HIV & AIDS intervention needs of their staff.
ii. Agencies to develop HIV & AIDS work place policies that address intervention needs of PwD.
iii. Agencies to establish disability mainstreaming mechanisms to oversee successful mainstreaming process.
iv. Agencies to allocate funds for disability mainstreaming in their HIV & AIDS response programmes.

8.3 External disability mainstreaming

8.3.1 HIV&AIDS Testing, Treatment and Information Access

Strategic Goal 1: Enhance HIV counseling and testing by PwD

Situation

Access to HIV counseling and testing (HCT) is crucial for persons with disability. However, there are factors that hinder access to these vital services by persons with disability. Notable among them is unavailability of disability-friendly counseling and testing centers. There are few such centers with personnel proficient in sign language that are able to handle persons with speech disability.

Similar challenges face the blind and those with intellectual disability. In events where they need a test, there is the challenge of ownership since they have to rely on information from the counselor. In some cases, the blind client may deny results owing to the fact that they have not seen the results. At best they would need to call in their relatives to confirm. This too erodes confidentiality. Their case may be relatively easier to handle since there are guidelines anchored in law on how to deal with blind clients who seek HCT services.

Besides the constraint of communication at the HCT facility, PwDs also face the challenge of inaccessibility of HCT facilities. Some facilities are located on high floors of buildings that do not have provisions to enhance mobility such as ramps for physically disabled persons. Other facilities are a distance away from physically challenged persons.

Recommended mainstreaming actions.

i. Put in place mechanisms to ensure that guidelines for establishing HCT centers are strictly adhered to.
ii. HIV counseling and testing facilities to have counseling and testing personnel who are proficient in sign language for effective communication with deaf persons .
iii. Increase mobile HCT services to reach PwD whose mobility is hampered; particularly persons with physical disabilities.
iv. Revise HCT training curriculum for counselors to cover braille, sign languages and other accessible formats and technologies.
v. Train PwD in HCT to enable them serve as HCT counselors.
vi. Involve PwD in community HIV and AIDS outreach campaigns.
vii. Enforce section of Persons with Disabilities Act 2003 which calls for modification of buildings housing HIV and AIDS services to enhance mobility and accessibility by PwDs.

Strategic Goal 2: Increase uptake of HIV & AIDS treatment services by PwD

Several factors influence accessibility to HIV & AIDS treatment by PwD. These include among others, long distance to health facilities, stigma and discrimination by health professionals as well as communication barrier between health professionals and PwD.

Recommended mainstreaming actions

i. Open inventory of PwD who are on ARVs.
ii. Intensify follow-up on PwD who cannot go to clinic for ARVs.
iii. Introduce mobile services for PwD in need of HIV and AIDS-related treatment.
iv. Conduct regular training for health care workers on HIV and AIDS needs of PwD.

Strategic Goal 3: Enhance visibility of counseling and testing information on disability in health planning and resource allocation processes

Situation

Currently, HIV testing data is disaggregated along disability line in the health facility counseling and testing tool. However, in the summary form on counseling and testing, the disability disaggregation element is not captured. This means that testing results on disability miss at (higher) planning level where the summary data is presented. Since planning, among other issues, determines resource allocation, it means that disability is left out in the main planning process which influences resource allocation for HIV testing.

Recommended mainstreaming actions

i. Capture counseling and testing data on disability in summary records that inform HIV and AIDS programme planning and resource allocation.

Strategic Goal 4: Enhance access to sexual and reproductive health information

HIV and Sexual & Reproductive Health (SRH) are intertwined. SRH information such as management of sexually transmitted infections and family planning through use of condoms helps prevent HIV infection. Available information indicates that very few PwD have access to SRH information. About 17% of women with disabilities reported using some form of family planning methods (Kenya National Survey for Persons with Disabilities, 2008). Moreover, CSOs involved in SRH do not target PwD because of the perception that PwD are sexually inactive hence do not need these services. Research information indicates that PwD are likely to engage in unprotected sex due to lack of information on HIV and AIDS and SRH.

Recommended mainstreaming actions

i. Provide SRH information to PwD to meet the needs of varying forms of disability.
ii. Train PwD to disseminate SRH information through, among others, participatory approaches such as peer education.
iii. Increase self-efficacy skills of PwD in use of reproductive health products such as condoms.

Strategic Goal 5: Respond to HIV & AIDS information needs of PwD to reduce vulnerability

Situation

Available information indicates that most community-based HIV & AIDS programmes do not target PwD. This population segment is left with enormous HIV and AIDS information deficit which in turn predisposes them to HIV infection. Despite the existence of risk factors that are specific to PwD to a greater extent, information on prevention, care and treatment among PwD is low. PwD may take long before finding sexual partners hence the reduced tendency to negotiate for safe sex when an opportunity arises, thus leading to the possibility of unprotected sex. Some of the common beliefs that PwD are sexually inactive and thus, free from HIV attract able-bodied persons to them for casual unprotected sex. This scenario calls for increased sensitization of PwD on HIV and AIDS issues as a basis of promoting prevention of HIV and adoption of positive practices relating to care , treatment and impact mitigation.

Recommended mainstreaming actions

i. Develop HIV & AIDS behavior change messages on vulnerability of PwD to HIV infection through heterosexual and homosexual relationships.
ii. Develop community-based HIV and AIDS interventions that respond to the needs of persons with multiple disabilities such as deafness and physical challenge.
iii. Involve PwD (including PwD living with HIV) in the design and implementation of information programmes/projects that aim to benefit them.
iv. Enhance self-efficacy skills in use of HIV prevention devices such as condoms by PwD.

8.3.2 Poverty among persons with disabilities

Strategic Goal: Address poverty among persons with disabilities

Situation

Poverty leads to sexual exploitation of PwD, in some cases, leading to HIV infection. In some cases, PwD engage in risky behavior such as commercial sex as a survival measure. This militates against efforts to fight HIV and AIDS among the PwD.

Recommended mainstreaming actions

i. Support PwD through social protection programmes.
ii. Capacity building of PwD on Income Generating Activities (IGA) through the disability serving organizations.
iii. Link organizations working with PwD with micro-financing Institution for possible micro-credit support.

8.3.3 Protection of persons with disabilities

Strategic Goal 1: Enhance protection of persons with disabilities against sexual abuse.

Situation

Persons with disability especially deaf and physically challenged are usually exploited sexually, in some cases, resulting in HIV infection. However, due to communication barriers, deaf persons who survive rape may be discouraged from reporting rape cases to the police. Available information indicates that most individuals with disability have little or no access to the police and legal counsel for protection. And that should sexual abuse occur, individuals with disability have less access to medical information, including psychological and prophylactic care than their non-disabled peers.

Recommended mainstreaming actions

i. Enhance enforcement of Sexual Offences Act and HIV and AIDS Act in cases where survivors (victims) are PwD.
ii. Train police officers in sign language and other forms of communication that would enable them deal effectively with sexual assault cases reported by the persons with various forms of disabilities.
iii. Sensitize the community on the importance of reporting perpetrators of sexual offences to law enforcers.

Strategic Goal 2: Improve physical environment for persons with physical disabilities

Situation

Availability or absence of physical assistive structures in buildings where HIV and AIDS services are being provided determine the level of accessibility to such services especially for persons with physical disabilities.

Section 15(5) of the Persons with Disabilities Act,2003 prohibits discrimination by employers and expressly states that *an employer shall provide such facilities and effect such modifications, whether physical, administrative or otherwise, in the workplace as may reasonably be required to accommodate persons with disabilities*.

Section 21 of the Act on accessibility and mobility provides that *persons with disabilities are entitled to a barrier-free and disability-friendly environment to enable them have access to buildings, roads and other social amenities, and assistive devices and other equipment to promote their mobility.* Similarly, the section on public buildings provides that; *a proprietor of a public building shall adapt it to suit persons with disabilities in such manner as may be specified by the Council.*

The sections of the law cited herein aim to promote mobility and accessibility by the persons with disability. However, most of the public buildings, some of which house HIV and AIDS services, do not comply with theses sections of the law resulting in inability by PwD to access such services.

The Persons with Disabilities Act does not fully address some aspects of discrimination faced by PwD. Given the need for greater specificity on issues such as political participation, social security, social support, workers' compensation as well as transport and building standards; discrimination against persons with disabilities needs to be addressed in mainstream laws that address these issues. The Persons with Disabilities Act is currently under review.

Recommended mainstreaming actions

i. Enhance enforcement of provisions of the Constitution of Kenya 2010 and Persons with Disabilities Act 2003 that promote mobility and accessibility by the persons with disabilities.

8.3.4 Evidence-based HIV and AIDS and disability programming

Strategic Goal: Generate up-to-date information on HIV and AIDS and disability

Situation

Information on prevalence and incidence rates of HIV and AIDS in the general population is produced regularly in Kenya through Kenya Demographic and Health Surveys. However, information on the *linkages* between HIV and AIDS and disability in general, prevalence and incidence rates of HIV and AIDS among persons with disability in particular, are scanty. This hampers planning, development and resourcing of HIV and AIDS programmes targeting this (*persons with disability who are affected and infected with HIV*) population segment.

Recommended mainstreaming actions

i. Include modules on disability in the Kenya Demographic and Health Surveys and other periodic HIV and AIDS studies.
ii. Information to be generated at county level on PwD, infected with HIV, accessing VCT and ARV services from on-going VCT and ARV programmes, and accessing services through on-going social protection programmes.
iii. Studies/researches to be carried out on areas of inter-relationships of HIV and AIDS and disability that are of interest to the government and organizations serving PwD.
iv. Involve PwD in HIV and related research that target to benefit them.

8.3.5 Work place HIV & AIDS programmes for persons with disabilities

Strategic Goal: Include disability in the Principles of National Code of Practice on HIV&AIDS in the workplace.

Situation

The *National code of practice on HIV and AIDS in the work place guiding principles* is expected to be in accord with international convention, national laws, policies, guidelines and regulations. In keeping with UN-Convention on Rights of Persons with Disability which promotes response to the needs of persons with disability from a rights-based approach, the Government of Kenya has identified disability as one of the development issues that must be addressed by all sectors. Moreover, the condition of disability can serve as a risk factor in HIV infection. Despite the aforementioned development importance of the disability agenda, it is not captured in the guiding principles of the National Code of Practice.

Recommended mainstreaming actions

i. Conduct assessment of the HIV and AIDS intervention needs of PwD in the private sector setting to inform review of the National Code of Practice on HIV and AIDS in the workplace.

ii. Review the National Code of Practice on HIV and AIDS in the workplace to capture the disability agenda in the core guiding principles.
iii. Develop a HIV and AIDS work place policy template with a disability component.

8.3.6 HIV & AIDS needs among learners with disability

Strategic Goal: Increase HIV & AIDS programme coverage of learners with disabilities

The education sector has four strategic advantages in contributing to disability mainstreaming in HIV & AIDS response. First, it enhances literacy levels of the PwD thus enabling communication through the media. Secondly, it increases the capacity of PwD to make positive decisions about risky factors. Thirdly, education provides knowledge and skills that either enable learners to avoid preventable sources of disability or mitigate the impact of disability. Lastly, it pools PwD thus making it easy to reach and provide HIV &AIDS services and information to them.

Unfortunately, access to education among PwD is generally very low. Globally, it is estimated that a paltry 3% of the population of PwD is literate. According to Kenya National Survey for Persons with Disabilities (2008), about 67% of the PwD had primary education, 19% attained secondary education and only 2% had reached university level. Overall, only 4% of PwD had attended some form of special education. Most of the children with disabilities are hidden in houses by families to stave off perceived stigma. This has negative impacts on efforts to sensitize them on HIV & AIDS and attendant sexual and reproductive health issues.

Recommended mainstreaming actions

i. Enforcement of the policy of compulsory education for all children.
ii. Sensitize parents of children/learners with disability on the importance of taking them to schools/learning institutions (including special schools).
iii. Develop HIV & AIDS programmes that are appropriate for learners with disability taking into consideration the unique HIV & AIDS intervention needs of varied forms of disabilities.
iv. Develop HIV & AIDS programmes targeting teachers/lecturers to eliminate stigmatizing and discriminatory behavior and responding appropriately to the HIV & AIDS intervention needs of varied forms of disability.
v. Conduct SRH and HIV & AIDS campaigns including HCT in learning institutions of PwD.
vi. Put in place policies and operational arrangements on referral of PwD in need for HIV and AIDS services including ARV, PMTCT and HCT.

8.3.7 Mandate to cover disability in HIV & AIDS response

Strategic Goal 2: Integrate disability agenda into the mandate of agencies involved in the HIV and AIDS response

Situation

Most of the agencies that implement HIV & AIDS programmes/projects either do not develop strategic plans or if they do, either the plans don't capture disability agenda or are hardly implemented. This poses great challenges to mainstreaming disability in the HIV & AIDS programme agenda of these agencies.

Similarly, some agencies feel that addressing HIV & AIDS among PwD is not their core mandate; that this is the mandate of organizations that exclusively deal with disabled persons. Hence, most of these agencies do not target persons with disability in their HIV & AIDS programmes. Consequently, most of these agencies do not necessarily complete indicator provision on persons with disability in the Community Based Programme Activity Reporting (COPBAR*)* form. The low interest in disability issues could be attributed to inadequacy in the capacity of the agencies to address the needs of PwD. Research reports indicate that most AIDS service agencies do not have understanding of how to design and deliver HIV & AIDS information and support that is appropriate to PwD whilst taking into consideration the unique needs of different disabilities.

Similarly, because of the feeling by some agencies that disability issues are not part of their mandate, the HIV and AIDS needs of PwD are not addressed comprehensively in large overall programmes including APHIA-PLUS programme.

There is a feeling among some HIV and AIDS agencies that only agencies receiving Total War against AIDS (TOWA*)* funding through NACC are under obligation to target disabled persons and therefore, complete the COPBAR form. This means that there is a likelihood of underreporting on persons with disability reached by HIV & AIDS agencies through community programmes/projects.

Recommended mainstreaming actions:

i. Mobilize all agencies implementing community-based HIV and AIDS programmes (whether or not funded by NACC) to complete the COPBAR form accordingly.
ii. NACC to formulate a policy that compels all HIV and AIDS agencies implementing programmes at community level to complete the COPBAR form.
iii. Capacity building programmes for agencies involved in HIV & AIDS interventions.

8.3.8 Stigma and discrimination associated with HIV & AIDS and disability

Strategic Goal: Fight stigma and discrimination against persons with disability

Situation

The impact of stigma and discrimination in HIV and AIDS response efforts is well documented. PwD living with AIDs experience double stigma based on their disabilities and the HIV condition. Research information indicates that persons with intellectual disability avoid disclosing their conditions to healthcare providers for fear of stigmatization. As a result of external stigma, most of the PwD in need of HIV and AIDS services including ARVs keep away from health facilities.

Recommended mainstreaming actions

i. Intensify sensitization of PwD on the importance of seeking HIV and AIDS services.
ii. Sensitize healthcare professionals on disability issues including the rights of PwD as enshrined in UN-CRPD, Constitution of Kenya 2010 and the Persons with Disabilities Act 2003 to eliminate ignorance and misconceptions that underlie stigma and discrimination directed to PwD.
iii. Provide psychosocial support to PwD on living positively with disability

8.3.9 Profile of disability in HIV & AIDS programmes

Strategic Mainstreaming Goal: Raise profile of the disability agenda in HIV & AIDS programming

Most HIV & AIDS agencies ignore disability in their programmes. They claim it is not part of their mandate while others think that disabled persons are sexually inactive hence no need to focus on them. Further, some agencies believe that providing SRH information to PwD may enhance their vulnerability to HIV infection. These actions suppress the profile of disability agenda in HIV and AIDS response, yet, in the general population, PwD are more prone to HIV infection and its socio-economic impact than their able-bodied counterparts.

Recommended mainstreaming actions

i. Identify and involve high profile champions such as celebrities and well-respected statesmen in raising awareness and profile of HIV and AIDS among PwD
ii. Profile disability and HIV and AIDS as part of World AIDS Day and World Disability Day
iii. Intensify sensitization of the general population and the relevant government agencies on critical aspects of HIV and AIDS among PwD.

8.4.0 Synergy in HIV & AIDS and disability response

Strategic Goal: Enhance collaboration among agencies involved in overall HIV and AIDS and disability response

Situation

There are numerous agencies working on different aspects of HIV and AIDS. Moreover, there are many organizations working on different disability issues. These include specialist disability agencies such the Association of Physically Disabled of Kenya (APDK), Kenya Society for the Blind (KSB), among others. While planning for services for persons with disability, it is also important to take into account the likely occurrence of conditions of multiple disabilities among persons with disability. An example is a person with physical disability who is blind and deaf. This person may also be infected with HIV.

Such challenges as multiple disability and the fact that there may be different agencies addressing various disability issues, call for enhanced collaboration among the disability and HIV and AIDS stakeholder agencies to mount high-impact programme interventions.

Recommended mainstreaming actions

i. Organisations working on HIV and AIDS and disability agenda to develop joint programme strategies including establishing referral mechanisms for persons with disability who may need services across the HIV and AIDS and disability sectors
ii. Organisations working on HIV and AIDS and disability to source for funds from HIV and AIDS development partners as well as those funding disability programmes.

8.4.1 Funding for HIV & AIDS programmes with disability component

Strategic Goal 1: Enhance funding for HIV & AIDS programmes with disability component

Situation

Most HIV & AIDS programmes by organisations are funded by development partners. The level of funding of an organisation determines depth and scope of programme implementation. The assessment on disability mainstreaming established that a number of agencies that were implementing HIV and AIDS activities targeting PwD wound up the projects when they could not attract additional funding. It is important therefore, that development partners enhance funding for HIV and AIDS for effective mainstreaming of disability agenda in HIV and AIDS programme portfolios.

Recommended mainstreaming actions

i. Enhance funding for HIV and AIDS programmes/projects/activities to enable disability mainstreaming

Strategic Goal 2: Integrate disability agenda into HIV & AIDS funding criteria

Situation

The fact that disability agenda is not a mainstream programme area in such large scale programmes as APHIA Plus is an indication that it is not a main focus area for the development partners who fund the programmes. Such programmes present enormous opportunity for mainstreaming the disability agenda.

Recommended mainstreaming actions

i. Integrate disability dimension into existing criteria for funding large scale HIV and AIDS programmes.
ii. Involve persons with disability in determining funding priorities and in the design of funding guidelines for HIV and AIDS programmes.
iii. Establish mechanisms for assessing impact of addressing disability in HIV and AIDS programme implementation

9.0 IMPLEMENTATION OF STRATEGY

9.1 General Implementation Approach

NACC will play a lead role in ensuring that the disability agenda is mainstreamed into the overall HIV and AIDS response efforts by the public and private sectors, civil society, and development partners within the existing coordination mechanisms. The multi-stakeholder approach anticipated in this process calls for collaboration between HIV and AIDS sector stakeholders.

The implementation mechanism of this strategy shall be oriented to fit into the county office establishments.

The recommended mainstreaming actions of the HIV and AIDS stakeholders are spread over a period of three years. The recommended mainstreaming actions prioritized by stakeholders are to be implemented in years 1, 2 and 3. Of the prioritized recommended mainstreaming actions, only year 1 actions are costed in the action plan.

9.2 Costed Action Plan

This strategy has two main components - disability mainstreaming within NACC and in the overall response to HIV and AIDS. Under each component, there are internal and external mainstreaming sub-components. The costed action plan is based on internal mainstreaming actions within NACC that have been prioritized for implementation in year 1. The costing is restricted to internal mainstreaming actions because these are in-house issues within NACC's control and hence will be implemented.

9.3 Monitoring and Evaluation

The monitoring and evaluation (M&E) of disability mainstreaming in HIV and AIDS response shall be organized to fit into the broader M&E framework of the Kenya AIDS Strategic Framework (KASF). The disability mainstreaming M&E shall target the internal and external mainstreaming components. NACC will play the lead role in identifying performance indicators for disability mainstreaming. These will be integral M&E indicators of the KASF M&E framework.

Explanations on costed action plan

The following notes help the reader to understand the basis for costing the action plan.

i. General approach

It has been stated that the activities costed in the action plan are those on internal mainstreaming in NACC. However, not all internal mainstreaming activities within NACC have been included because the costed action plan carries actions/activities and their corresponding sub-activities for which additional funds will be needed. Activities which can be implemented as part of NACC's on-going activities on already committed funds are excluded from the costed action plan. However, such activities are listed here as reminder to NACC to ensure that they are implemented as part of the costed action plan.

ii. Mainstreaming actions that are part of on-going NACC activities

- Training/sensitization of 13-member NACC disability mainstreaming committee**:** Training takes 4 days; it addresses basic issues on disability mainstreaming: Rights of PwDs, laws and policies on disability, guidelines on disability mainstreaming. *NB/.The costs for this training have already been factored into the current NACC work plan.*

- Ensure that job advertisements are sent to NCPWD, organizations for PwD and other communication channels**:** *NB/ NACC's existing mail costs will be used for this purpose.*

- Maintain a disaggregated database of PwD who are beneficiaries of NACC services: *NB/ This will be done by the M&E Division as part of its mandate.*

- Allocate a minimum of 5% of IEC budget for the production of IEC materials at NACC in PWD accessible formats and technologies**:** This represents 5% of the population of persons with disability in Kenya.

- Review field operations guidelines to include PwD in the NACC devolved committees: *This will be done as part of on-going NACC activities.*

- Put in place HIV&AIDS programme for staff; both able-bodied and those with disabilities: *These are to be implemented by NACC's AIDS Control Unit (ACU)*

(iii) Explanation notes on costing selected mainstreaming sub-activities derived from major activities

Main Action 1: NACC to establish disability desk/programme handled by a PwD or a person well versed with disability issues.

- **Sub-activity 1: Training/sensitization of personnel/NACC staff in charge of disability Issues in NACC**: The training takes 4 days covering the following areas; Rights of PwD, laws and policies on disability, guidelines on disability mainstreaming, designing disability intervention projects and programmes, disability and gender, monitoring & evaluation of disability mainstreaming programmes. The training is organized by NCPWD in collaboration with Ministry responsible for Gender and Social Services

- **Sub-activity 2: Training/sensitization of devolved staff in disability issues:** Training takes 4 days on basic issues on disability mainstreaming *(see content of basic disability mainstreaming in sub-activity 1).*

- *Scenario 1*: The 384 staff members will be trained in 10 groups of about 39 members. The training will take place at the county headquarters level. One facilitator will carry out the training for the 10 groups. Or 10 facilitators will each carry out the training simultaneously. The bottom line is that 10 different trainings will be conducted.*(290 CACC coordinators and 2 NACC County coordinators per county (94))*

- Hence, the costs of the training are calculated as follows;

- Conference package for NACC county coordinators is: 384 pax x Kshs 3000 per day x 4 days: *(Kshs 3000 is NACC's standard conference package per person per day)*

- Per diem for participants is: 384 pax x Kshs 6000 day x 4 days: *(Kshs 6,000 is the NACC's grade 4 per diem rate in rural county setting)*

- Transport for NACC county coordinators in the county: 384 pax x Kshs 2000 round trip: *(Kshs 2000 is the highest amount one can spend traveling to any point within any county)*

- Facilitator's fee is: 1 pax x Kshs 30,000 per day x 4 days x 10 trainings: *(Kshs 30,000 falls within NACC's USD 350-400 per day consultancy rate for grade 4 consultants)*

- Transport for facilitator: 1pax x Kshs 42 per km round trip x 10 trainings: *(Kshs 42 is the NACC's mileage rate per km covered by the consultant to the consultancy site and back as determined by AA)*

- *Scenario 2:* Sensitize 94 NACC county coordinators (2 per county) for 4 days to in turn, sensitize 290 CACCs. The sensitization will be carried out in three (3) groups of 31 members.

The training will take place at county headquarters levels. Either one (1) facilitator will conduct three trainings of three days each or three (3) different facilitators will carry out one training each simultaneously.

- Hence, the costs of the training are calculated as follows;
- Conference package for NACC county coordinators is: 94 pax x Kshs 3000 day x 4 days
- Per diem for participants is: 94 pax x Kshs 6000 per day x 4 days
- Transport for NACC county coordinators is: 94 pax x Kshs 2000 round trip
- Facilitator's fee is: 1 pax x Kshs 30,000 per day x 4 days x 3 trainings
- Transport for facilitator: 1pax x Kshs 42 per km round trip x 3 trainings

Main Action2: NACC to package IEC materials and other documents it produces in accessible formats and technologies for PwD

i. Explanations on printing of materials in Braille:

a. Disability mainstreaming strategy

- A page of ordinary text is equivalent to 2.5 pages in braille *(Source: UPDK/NCPWD, 2013)*
- A page of braille costs Kshs 40.00 to produce *(Source: UPDK/NCPWD, 2013)*
- Disability mainstreaming strategy is 50 pages
- 50 pages of disability mainstreaming strategy would give rise to 50x 2.5 pages=125 pages of braille
- Producing a copy of disability mainstreaming strategy in braille would cost: 50x2.5x 40= Ksh 5000
- The target is to produce 52 copies in braille: 52 copies x Kshs 5000= **Kshs 260, 000**

b. Greater Involvement of People Living with HIV & AIDS (GIPA) guidelines

- Target is 2 copies per county (94 copies); 6 copies for NACC headquarters: Total is 100 copies
- The 100 copies will be produced once.
- A copy is 30 pages: This is equivalent to 30 x 2.5 pages of braille = 75 pages of braille

- 75 pages of braille x Kshs 40.00 per page x 100 copies **=Kshs 300,000**

c. Code of conduct

- Target is 2 copies per county (94 copies); 6 copies for NACC headquarters: Total is 100 copies
- The 100 copies will be produced once.
- A copy is 38 pages: This is equivalent to 38 x 2.5 pages of braille = 95 pages of braille
- 95 pages of braille x Kshs 40.00 per page x 100 copies **=Kshs 380,000**

d. Gender mainstreaming guidelines

- Target is 2 copies per county (94 copies); 6 copies for NACC headquarters; Total is 100 copies
- The 100 copies will be produced once
- A copy is 45 pages (including cover page): This is equivalent to 45 x 2.5 pages of braille =112.5 pages of braille
- 112.5 pages of braille x Kshs 40.00 per page x 100 copies =**Kshs 450,000**

(NB/The cost does not include pictures in the documents)

ii) Explanation on packaging IEC materials into audio formats

Disability mainstreaming strategy; GIPA guidelines; Code of conduct & Gender mainstreaming guidelines

a. Disability mainstreaming strategy

- Number of pages is 50.
- It takes at most 10 minutes to record someone reading out the content of one (1) page.*(Estimate by Recording Studio in Nairobi: April, 2013)*
- It will take 50 x 10 = 500 minutes to record 50 pages
- Recording studio charges Kshs 1,200 for recording someone for one (1) hour. This includes editing the output. *NB/ Kshs 1200 is the rate*
- The recording studio will charge a total of Kshs 1200 x 500/60 =Kshs 10,000
- Target is 400 copies of audio formats; 8 copies (4 in English; 4 in Swahili) for each county; 24 copies for NACC headquarters
- NACC will buy 400 blank CDs at Kshs 30.00 each. The total cost shall be 1, 200
- The total for recording and purchasing the CDs is Kshs 10,000 + 1,200= **Kshs 11,200**

b. GIPA guidelines

Number of pages of GIPA guidelines is 30.

- It takes at most 10 minutes to record someone reading out the contents of one (1) page.
- It will take 30 x 10 = 300 minutes to record 30 pages
- Recording studio charges Kshs 1,200 for recording someone for one (1) hour/60 minutes. This includes editing the output. *NB/ Kshs 1200 is the rate*
- The recording studio will charge a total of Kshs 1200 x 300/60 =Kshs 6,000
- Target is 400 copies of audio formats; 8 copies (4 in English; 4 in Swahili) for each county; 24 copies for NACC headquarters
- NACC will buy 400 blank CDs at Kshs 30.00 each. The total cost shall be Kshs 1, 200
- The total for recording and purchasing the CDs is Kshs 6,000 + Kshs 1,200= **Kshs 7,200**

c. Code of Conduct

Number of pages of the Code of Conduct is 38.

- It takes at most 10 minutes to record someone reading out the contents of one (1) page.
- It will take 38 x 10 = 380 minutes to record 38 pages
- Recording studio charges Kshs 1,200 for recording someone for one (1) hour/60 minutes. This includes editing the output. *NB/ Kshs 1200 is the rate*
- The recording studio will charge a total of Kshs 1200 x 380/60 =Kshs 7,600
- Target is 400 copies of audio formats; 8 copies (4 in English; 4 in Swahili) for each county; 24 copies for NACC headquarters
- NACC will buy 400 blank CDs at Kshs 30.00 each. The total cost shall be Kshs 1, 200
- The total for recording and purchasing the CDs is Kshs 7,600 + Kshs 1,200= **Kshs 8,800**

d. Gender Mainstreaming guidelines

Number of pages of Gender Mainstreaming guidelines is 45.

- It takes at most 10 minutes to record someone reading out the contents of one (1) page.
- It will take 45 x 10 = 450 minutes to record 45 pages
- Recording studio charges Kshs 1,200 for recording someone for one (1) hour/60 minutes. This includes editing the output. *NB/ Kshs 1200 is the rate*
- The recording studio will charge a total of Kshs 1200 x 450/60 =Kshs 9,000
- Target is 400 copies of audio formats; 8 copies (4 in English; 4 in Swahili) for each county; 24 copies for NACC headquarters
- NACC will buy 400 blank CDs at Kshs 30.00 each. The total cost shall be Kshs 1, 200
- The total for recording and purchasing the CDs is Kshs 9,000 + Kshs 1,200= **Kshs 10,200**

Main Action 3: Carry out annual review of internal policies and strategies to respond appropriately to changing HIV&AIDS intervention needs among PwD in the agency

Sub-activity: Contract consultant to conduct desk top review and interview at NACC headquarters:

- The consultancy will last for 10 days
- Consultancy fee: Kshs 30,000 x 10 days
- Transport cost: Kshs 42 x total distance in km to NACC headquarters
- Per Diem: Kshs 6,000 x 10 days

Main Action 4: Conduct assessment of progress in addressing HIV&AIDS needs of staff members who have disabilities

- ***Scenario 1*****:** Conduct review of consolidated reports on HIV&AIDS services to PwD at NACC headquarters
- A consultant will be hired to conduct this review. The consultancy period will be 10 days. The work will be done twice a year- after every six months
- Consultancy fee: is Kshs 30,000 per day x 10 days x 2(twice a year)
- Transport cost: Kshs 42 x distance to the venue x 2 (twice)
- Per Diem: Kshs 6,000 x 10 days x 2

- ***Scenario 2*****:** Visit 47 counties to review reports and interview County coordinators HIV&AIDS service to PwD:
- A consultant will be hired to conduct this review and interview. The consultancy period will be 20 days. The work will be done twice a year.
- Consultancy fee: is Kshs 30,000 per day x 20 days x 2(twice a year)
- Transport cost: Kshs 42 x distance to the venue x 2 (twice)
- Per Diem: Kshs 6,000 x 20 days x 2

COSTED ACTION PLAN

	INTERNAL DISABILITY MAINSTREAMING IN NACC											
Main Activities	**Sub-activities**	**Expense/Planned input**	**Unit of measure**	**Unit**	**Freq.**	**Rate**	**Total**	**Remarks/explanation**	**Assumption**	**Yr1**	**Yr 2**	**Yr 3**
NACC to establish disability focal point who is well versed with disability issues.	***Scenario.1***: Recruit Programme Officer for disability mainstreaming.	Advertise in radio and print media	Number	1	1	500,000	500,000	Advert rate based on NACC projection for year 2013				
		Salary	Number	1	12	167,141.67	2,505,700	The salary rate is NACC grade 4 salary				
		4 day Training of 1 staff on disability mainstreaming by NCPWD & Min responsible for Gender	Number	1	1	70,000	70,000	The training package includes tuition, accommodation and meals for trainees minus NACC per diem for trainees.				
	Scenario.2:Assign 2 existing NACC staff to handle disability portfolio	4 day Training of 2 staff on disability mainstreaming by NCPWD & Min responsible for Gender	Number	2	1	140,000	140,000	The training package includes tuition, accommodation and meals for trainees minus NACC per diem for trainees.				
	Train devolved staff on disability issues: ***Scenario1***: Sensitize 290 CACC coordinators (1 per constituency) and 94 NACC county coordinators (2 per county; total 384 pax) on disability issues for 4 days	Conference package	Number	384	4	3000	4,608,000	The conference package is NACC's standard package.				
		Per diem for staff	Number	384	5	6000	11,520,000	The rate is NACC's grade 4 per diem in rural county.				
		Transport for participants	Number	384	1	2000	768,000	The rate is maximum travel cost round-trip estimation within county.				

		Facilitators fee	Number	1	10*4	30,000	1,200,000	Rate is within recommended NACC USD 350-USD 400 per day range.				
		Facilitators per diem*	Number	1	10	6000	240,000	The per diem is NACC's grade 4 rate				
	Scenario 2: Sensitize 94 NACC county coordinators (2 per county) for 3 days to, in turn, sensitize 290 CACCs.	Conference package	Number	94	3	3000	1,128,000	Rate is NACC's standard conference package.				
		Per diem for staff	Number	94	3	6000	1,128,000	The rate is NACC's grade 4 per diem in rural county.				
		Transport for participants	Number	94	3	2000	188,000	The rate is maximum travel cost round-trip estimation within county.				
		Facilitators fee	Number	1	3	30,000	360,000	Rate is within recommended NACC USD 350-USD 400 per day range.				
		Facilitators transport	Number	1	3	42	NB/Will depend on the km covered to the training venue	Kshs 42 is the rate charged per km; AAR rate; car not exceeding 1800 cc.	The consultant will use his personal car			
		Facilitators per diem	Number	94	4	6000	2,256,000	The rate is NACC's grade 4 per diem in rural county.				
NACC to package IEC materials and other documents it produces in accessible formats and	Produce the following documents in accessible formats and technologies for PWD:											
	(i) Disability Mainstreaming Strategy	Print 1 copy for each of 47 counties in Braille and 5 copies in Braille for NACC HQ	copies	52	125	40	260,000	Each page is equal to 2.5 pages in braille. Each braille page costs kshs 40 to produce: *NCPWD/UPDK*				

technologies for PwD		Produce audio copies in English & Kiswahili (50%:50%)	copies	400	1	1200	480, 200	Rates based on quotation from recording studio in Nairobi: *March 2013*				
	(ii) GIPA Guidelines	Print in Braille 100 copies for counties and NACC HQ	copies	100	75	40	300,000					
		Produce 400 audio copies for counties and NACC HQ	copies	400	1	1200	480,000	Rates based on quotation from recording studio in Nairobi: *March 2013*				
	(iii) Code of Conduct for stakeholders	Print in Braille 100 copies for counties and NACC HQ	copies	100	95	40	380,000					
		Produce 400 audio copies for counties and NACC HQ	copies	400	1	1200	480, 000	Rates based on quotation from recording studio in Nairobi: *March 2013*				
	iv) Gender Mainstreaming Guidelines	Print in Braille 100 copies for counties and NACC HQ	copies	100	112.5	40	450,000					
		Produce, 400 audio copies for counties and NACC HQ.	copies	400	1	1200	480, 000	Rates based on quotation from recording studio in Nairobi: *March 2013*				
Carry out annual review of internal policies and strategies to respond appropriately to changing HIV and AIDS intervention needs among PwD	Contract consultant to conduct desk review and interviews	Consultancy fee	Number	1	1	30,000	300,000		The consultant will use his personal car			
		Transport	Number	1	1	Kshs 42 per km to the venue and back	NB/ Will depend on the km covered	Kshs 42 is the rate charged per km; AAR rate for car not exceeding 1800 cc.				
		Per diem										

in the agency												
Conduct assessment of progress in addressing HIV and AIDS needs of staff members who have disabilities	*Scenario 1*: Conduct review of consolidated reports on HIV and AIDS services to PwD at NACC HQ.	Consultancy fee	Number	1	20	30,000	600,000	Rate is within recommended NACC USD 350-USD 400 per day range				
		Consultant's transport	Number	1	2	42	NB/depend on Km covered to the county	Kshs 42 is the rate charged per km; AA rate; car not exceeding 1800 cc.	The consultant will use his personal car			
		Consultant's per diem						The rate per diem rate is grade 4 rate				
	Scenario 2: Visit 47 counties to review reports and interview county coordinators on HIV&AIDS service to PwD	Consultants fee	Number	1	20	30,000	1,200,000	Rate is within recommended NACC USD 350-USD 400 per day range				
		Consultant's transport	Number	1	2	42	NB/depend on Km covered to the county	Kshs 42 is the rate charged per km; AAR rate; car not exceeding 1800 cc.	The consultant will use his personal car			
		Consultant's per diem	Number	1	20	6000	240,000	The per diem rate is grade 4 rate by NACC				

10. SOME OF THE MATERIALS REVIEWED

1. Baseline Survey on the status of Disability Mainstreaming in Kenya,2009
2. Constitution of Kenya, 2010
3. Disability Mainstreaming Hand Book: National Council of Persons with Disability; 2011
4. Disability Mainstreaming Strategy: Ministry of Gender, Children & Social Development
5. Guidelines for Mainstreaming GIPA in Kenya's National Response to HIV&AIDS
6. HIV&AIDS Mainstreaming: Guide for AIDS Control Units in the Public Sector, 2011
7. Kenya HIV&AIDS Strategic Plan 2009/10-13/14
8. Kenya Overall AIDS Commission Bill, 2012
9. Kenya National Survey for Persons with Disabilities Report, 2008
10. Persons with Disabilities Act, 2003
11. Policy on Disability, 2006
12. The National Code of Practice on HIV&AIDS in the workplace
13. UN-Convention on the Rights of persons with Disabilities

11. Annexes

Annex i : List of Interviewees

	Name	NACC Region	Agency/Organization
1.	Michael Aduol	Nyanza	Disciples of Mercy
2.	Isaac Otieno	Nyanza	Association of Physically Disabled of Kenya (APDK)
3.	Alex Mwaki	Nyanza	Care International Kenya
4.	Yatich	Nyanza	NACC
5.	Cheruiyot	Nyanza	Ministry. of Gender, Children & Social Development
6.	Stephen Kathaka	Western	NACC
7.	Olaki	Western	CACC Coordinator
8.	Lavendar Ingati	Western	Jipangeni Disabled Self-Help Group
9.	Phillip Luseno	Western	PASCO
10.	Linda Oketch	Western	VCT Nurse, Mumias Sugar Company.
11.	Victor Apolo		Young Women Campaign Against AIDS
12.	Esther Wabuge	Nairobi	Kenya HIV&AIDS Business Council
13.	Joab Khasewa	Nairobi	NACC
14.	Edwin Kimtai	Nairobi	NACC HQ
15.	Gregory Were	Nairobi	NACC HQ
16.	Jennifer Wambua	Nairobi	NACC, Head of Communications
17.	Mary Kariuki	Nairobi	Pathfinder International
18.	Hulda Awino	Nairobi	Pathfinder International
19.	Irene Mwaponda	Nairobi	Pathfinder International
20.	Robert Mwai	Central	Tender & Care of PLHIV
21.	Ann Wangui Migwi	Central	Ambassadors of Hope
22.	Rosemary Muthoni	Central	Ambassadors of Hope
23.	Paul Kamau Chege	Central	Ambassadors of Hope
24.	Elizabeth Nduta	Central	Kenya Network of Women with AIDS (Kenwa)
25.	Nancy Macharia	Central	Kenya Network of Women with AIDS (Kenwa)

26.	Joseph Otieno	Central	Kenya Network of Women with AIDS (Kenwa)
27.	Peter Mwangi	Central	Central Kenya region Deaf Development group
28.	Rahab Wairimu	Central	Central Kenya region Deaf Development group
29.	Faith Ngima	Central	Central Kenya region Deaf Development group
30.	Josephine Asker	Central	Central Kenya region Deaf Development group
31.	Jane Mukami	Central	Central Kenya region Deaf Development group: *(Translator)*
32.	James Kiiru	Central	NACC M&E Officer
33.	Njiru Kathambela	Eastern	APDK
34.	Cecilly Mureithi	Eastern	SWAK
35.	Thomas Mugambi	Eastern	Embu Local Authority (Programme Officer, HIV&AIDS)

Annex ii: List of NACC Mainstreaming Committee

	NAME	**TITLE**
1.	Mr. John Kamigwi Ag. Director	Chairperson
2.	Dr. Bathsheba Osoro Head, Stakeholders' Coordination	Secretary
3.	Ms. Jeniffer Wambua Head Communication	Member
4.	Mr. Gregory Weere Head, HR & Administration	Member
5.	Mrs. Regina Ombam Head, Strategy Division	Member
6.	Dr. Patrick Muriithi Head, Monitoring & Evaluation	Member

	NAME	TITLE
7.	Dr. Francis Muu Head, Technical Support	Member
8.	Mr. Daniel Konyango Head, Legal Service	Member
9.	Mr. Joseph Chacha Admin Officer	Member
10.	Lilian Langat Programme Officer – Key Populations	Member
11.	Clauder Musi Ag. Senior Procurement Officer	Member
12.	Mr. Edwin Kimutai Ag. Head Special Programmes	Member
13.	Mr. Jeniffer Ndegwa Secretary	Administrative Support

Annex iii: List of Validation Workshop Participants (Merica Hotel Nakuru Feb 2013)

	Name	Organization
1.	Dr.Abdulrahman.S. Kassim,	NACC
2.	Hannington O. Onyango	NACC
3.	Charles Kariuki	NACC
4.	Mercy Kavengi	NACC
5.	Okiya Bryan	NACC
6.	Steve Kathaka	NACC
7.	Joseph Chacha	NACC
8.	Gregory J. Weere	NACC

9.	Tungani A. Leunce	NACC
10.	Augustine Ngatia	NACC
11.	Mathew Ashers	Proudly Kenyan
12.	Joseph Njenga,	UDPK
13.	Esther Wairimu	UDPK
14.	Martin Pepela from*;*	UDPK
15.	Stephen Ogutu Obama,	PwD Representative
16.	Phoebe Awidhi Agutu	PwD Representative
17.	Njoki Kariuki	*KANCO*
18.	Rose Gichanah	*MACODE*
19	Major Rose Mbula Musyoka	The Salvation Army
20.	Lilian Langat	NACC
21.	Bathsheba Osoro	NACC
22.	Gabriel Muswali	Consultant
23.	Peter Musakhi	Consultant

Annex iv: List of Review Workshop Participants (Milele Hotel, Nakuru, Dec 2013)

	Name	**Title**	**Organization**
1.	Lilian Langat	Programme Officer	NACC
2.	Vincent Boronji	Intern	NACC
3.	Florence Njambuya	Executive Receptionist	NACC
4.	Bathsheba Osoro	Head, Stakeholders' Coordination	NACC
5.	Cyphrene Wasike	Communication Officer	NACC

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