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From One Pandemic to Another Through Women's Eyes: An Analysis of The Impacts of Kenya's Responses to HIV/AIDS and Covid-19

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Abstract

By the time the COVID-19 pandemic hit Kenya in March 2020, the country had made great strides in handling HIV. However, the COVID-19 pandemic has threatened the gains that the country has made in this fight. A major drawback that was caused in this regard is in the context of addressing the gender dimensions of HIV/AIDS. For close to 40 years, Kenya has been dealing with HIV/AIDS and has gained significant experience in addressing a pandemic. However, Kenya failed to draw on this experience in dealing with COVID-19. Consequently, Kenya's failure to apply the useful experience gained in the context of HIV/AIDS in the containment of the COVID-19 pandemic resulted in gendered impacts of the country's COVID-19 responses. The responses that were put in place to contain COVID-19 were reactionary, gender-blind and fluid, and resulted in creating greater vulnerability among women and girls. These gendered impacts of Kenya's COVID-19 responses were particularly adverse to women and girls living with HIV/AIDS. This article is, therefore, concerned with the intersections between HIV/AIDS and COVID-19 in Kenya, and how they have impacted women and girls. Using a desk review of various studies that have addressed the gender dimensions of COVID-19 and HIV-AIDS, the article highlights the adverse impacts that the COVID-19 containment measures had on women and girls in Kenya. These adverse gendered impacts of the COVID-19 pandemic could have been avoided if Kenya had been more prepared and the lessons learnt from the HIV-AIDS pandemic had been applied. The article, therefore, argues that Kenya needs to be more prepared for any future pandemics and to have in place measures that will prevent women from bearing the brunt of any future Pandemics. A key lesson is that there is a need to understand and document how past pandemics have affected women and girls and to use the lessons from those Pandemics in informing policies on pandemic preparedness.

Key words: *COVID-19, gender, HIV/AIDS, Kenya, women.*

1.0 Introduction

Kenya has borne the brunt of the Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome HIV/AIDS pandemic from the 1980s to the early 2000s. The devastation was particularly severe before anti-retroviral (ARV) medication became readily available (Roser and Ritchie, 2014). Indeed, a positive HIV/AIDS test was tantamount to a death sentence – death of relationships as

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people thought transmission occurred through contact or sharing spaces and ultimately physical death from opportunistic infections on an already immune-compromised body. The country has since made great strides towards addressing issues such as stigma, violence, and discrimination which persons living with HIV suffered (Avert, 2020). The efforts at the national level have been supported by international initiatives, such as United Nations-AIDS, where programs such as the Kenya HIV Situation Room have been developed in order to improve reporting and service delivery in HIV programming (UNAIDS, 2015).

The lessons that Kenya had learnt from dealing with HIV/AIDS should have informed the responses put in place to address the Corona Virus Disease-2019 (COVID-19) pandemic when the cases were presented in March 2020. However, this did not happen. In HIV programming, both government and non-governmental actors have over the years struggled to address marginalization based on gender through legal, policy and other interventions, and have made great strides in promoting gender-sensitive policies in the area (NGEC, 2012). Yet, despite having dealt with HIV/AIDS for close to 40 years through policy and law, health interventions, including reproductive health and maternal and child health measures, and amassing a lot of knowledge and experience in this (National AIDS Control Council, 2014), Kenya did not utilise the lessons learnt from the HIV/AIDS pandemic but instead adopted a gender-neutral approach in dealing with COVID-19. The country failed to pay special attention to the inordinate burden that women bear, as individuals who are affected by the pandemic, and also as caregivers for others affected by the Pandemic (Kameri-Mbote & Meroka-Mutua, 2020). However, in the same way, Kenya's HIV responses have been strengthened by international mechanisms, it is also envisioned that Kenya's domestic responses to future pandemics could be strengthened by international initiatives such as One Health and the ongoing negotiations for 'WHO Pandemic Preparedness Treaty' (WHO, 2023).

This article analyses Kenya's responses to the HIV/AIDS and COVID-19 pandemics through women's eyes. The article is divided into seven parts. Part one is the introduction while Part two provides the contextual background for both the HIV/AIDS and the COVID-19 Pandemics. Part three lays out the conceptual and analytical frameworks that undergird the discussion on women's experiences during Pandemics in Kenya. It includes African Feminism; Marxist Feminism; Capability Approach; Development as Freedom; Women's Health Perspective; Women's Empowerment Framework; and the Gender Planning Framework. Part four describes the methodology used in putting the article together while part five looks at the experiences of women during the HIV/AIDS and COVID-19 pandemics, highlighting the negative effects that both pandemics have had on women and girls. Part six looks at Kenya's responses to the pandemics generally and through women's eyes specifically, and demonstrates that where responses have been gender blind, the impacts of the pandemics on women and girls have been worsened. Part seven concludes and makes a case for using the lessons from the HIV/AIDS and COVID-19 pandemics in preparing for any future pandemics. The failure to take such a policy direction is likely to result in losing any gains made in dealing with past pandemics.

2.0 Contextual Background

As of February 2020, the Kenya Population-Based HIV Impact Assessment (KENPHIA) showed that the country's HIV prevalence stood at 4.9% (Ministry of Health, 2020). The KENPHIA data further showed that prevalence among women stood at 6.6%, which was twice that of men, which stood at 3.1%. In 2016, estimates indicated that 1.6 million people were living with HIV in Kenya, and 910,000 were women (Avert, 2020). This means that there were more infections among women than there were among men, and women remain disproportionately affected. The higher prevalence among women as compared to men is attributable to forms of gender discrimination that limit women's access to education, employment and business opportunities, health services, economic resources such as land and other forms of property (Avert, 2020) and (Sia, et al, 2014). Further, issues such as gender-based violence, harmful cultural practices such as female genital mutilation (FGM), widow inheritance, and early and forced marriage, limit the extent to which women can

exercise agency over their sexuality and bodies (Avert, 2020). Thus, for instance, when women experience domestic, spousal, and sexual violence, they are less likely to negotiate for condom use (Avert, 2020; Kako, et al, 2012). Further, women who are not economically empowered are less likely to participate in decision-making at the family level, and this includes decisions such as getting tested for HIV/AIDS, using ARVs, reproduction and breastfeeding (Avert, 2020). Girls who are subjected to FGM are also likely to experience early and forced marriage to much older men, often in polygamous settings, and this, in turn, limits the extent to which they can negotiate with their husbands and co-wives for safe sex practices (Maroncha, 2015).

While Kenya has made significant progress in the fight against HIV/AIDS, which includes having more people living with HIV on anti-retroviral (ARV) medication and reducing the viral load in persons living with HIV/AIDS to decrease their ability to transmit the virus to others, it is still estimated that more than half of the population of persons living with HIV does not know their status (Avert, 2020). Hence, a major focus of Kenya's HIV response has been to encourage testing. Relatedly, women tend to be tested for HIV more than men, particularly because of the country's policy on testing women for the virus when they present for ante-natal care. Consequently, in 2014, it was reported that 53% of women were tested for the virus over 12 months, compared to 45% of men (Avert, 2020).

Kenya's remarkable progress in addressing HIV has resulted in reducing the number of new infections annually, with the figure going down to 62,000 in 2016 from 100,000 in 2013 (Avert, 2020). As of 2019, the number of new infections stood at 42,000 (Ministry of Health, 2020).

In 2020, however, Kenya's fight against HIV/AIDS was affected by the COVID-19 pandemic. The first case of COVID-19 was reported in Kenya in March 2020, and this affected the country's economic, political, and cultural life. Several responses were adopted, including the closure of public spaces such as schools, churches and offices; restriction of movement in several counties including Nairobi, Mombasa, Kwale, Kilifi and Mandera; introduction of the national hygiene program; the introduction of economic stimuli packages; and the home-based care program for COVID-19 patients who were asymptomatic or who had mild symptoms (Kameri-Mbote & Meroka-Mutua, 2020). The responses to COVID-19, particularly the closure of public spaces and the restriction of movement contributed significantly to the rise in cases of gender-based, intimate partner and domestic violence, with women and children comprising the most victims (*Mutavati, Zaman, & Olajide, 2020).* The closure of public spaces and restriction of movement measures led to the merging of the public and private spheres of life, which affected the organisation of many families as work and education activities moved from the public spaces to the home. The closure of public spaces also had adverse economic impacts on many people, who were rendered unemployed or under-employed which, in turn, affected the extent to which people could provide for basic needs including food and water (Kameri-Mbote and Meroka-Mutua, 2020). Further, the restriction of movement affected the health-seeking behavior of expectant mothers and mothers of young children (Kimani, et al 2020). All these issues impacted the country's fight against HIV/AIDS because gender-based intimate partner and domestic violence made women more vulnerable to HIV infection; the lack of clean water and food also limited the extent to which people living with HIV/AIDS could take their ARV medication; and with fewer women seeking ante-natal, reproductive health and well-baby services, there was less testing for the virus among women, who until then were being tested more than men.

The country also witnessed an increase in the number of teenage pregnancies during the period when schools were closed (Mersie, 2020). One of the factors that contributed to this was the inability of girls to access sanitary towels outside of the school set-up, where they normally get them free. This pushed teenage girls into engaging in sex for money to purchase sanitary towels (Muiruri, 2020). Cases of FGM and early and forced marriages also increased, with teenage girls being forced to undergo these harmful cultural practices while they were out of school. The policy of universal primary education had been heralded for keeping track of girls to ensure that they

remained in school. The closure of schools removed this control and FGM and early and forced marriages increased.

These issues indicate that there was a very strong connection between HIV/AIDS and COVID-19 in Kenya. While the lessons Kenya had learnt in dealing with HIV could have been useful in addressing COVID-19, this was not the case and the country's responses to COVID-19 contributed towards clawing back on the gains made in the fight against HIV. Looking at it through women's lenses, COVID-19 responses in Kenya created conditions that either made women more vulnerable to HIV infection or if they were already living with the virus, the responses limited the extent to which women could access testing facilities and also keep up with their treatment and medication.

3.0 Conceptual and Analytical Framework

This study is based on a number of conceptual approaches, which undergird the analysis of women's experiences during pandemics in Kenya. These include African Feminism; Marxist Feminism; Capability Approach; Development as Freedom; Women's Health Perspective; Women's Empowerment Framework; and the Gender Planning Framework.

3.1 African Feminism

African feminism is important in studying the experiences of women in the African context. African women face unique experiences, which are informed by colonial histories and neo-colonial realities in most countries on the continent; globalization; and development ideology (Tamale, 2020). An African feminist approach is useful in identifying the limitations of mainstream feminist thought in addressing these unique experiences of the African woman, and, in turn, developing approaches that are true to those experiences. African feminism is concerned with re-positioning the African woman today within her history and understanding how that history informs her present experiences. The history of the African woman has, however, been one that has not been told, and where it has been told, it has been told by others, and not by her, thus leading to misrepresentation (Tamale, 2020). In seeking to understand the situation of the African woman in the context of pandemics, the much wider history of colonial injustice, neo-colonial under-development, imperialism, globalization, and marginalizing development ideology, must first be appreciated through the eyes of African women. Thus, African feminism is also concerned with allowing African women to tell their own stories, in their own words and their voices, and is thus empowering the African woman (Tamale, 2020). One of the most dominant narratives that African feminism challenges is that in plural legal systems that characterize most post-colonial societies, women are likely to face inequality, marginality, and discrimination in the context of customary African systems, while the more formal systems imposed by colonialists or indeed international law systems are likely to be emancipatory for African women (Kameri-Mbote, 2018) and (Kameri-Mbote, 2019). In the context of the pandemics that Kenya and other African countries have experienced in the past, this dominant narrative is misrepresentative and, therefore, a more nuanced narrative that looks at how each system contributes both to marginality and emancipation in different measures is the focus of African feminism (Tamale, 2020). This type of nuanced narrative is only achievable when African women are allowed to tell their stories in their own voice.

3.2 Marxist Feminism

The second approach is Marxist feminism, which is an important lens in analyzing women's unpaid care work (Armstrong, 2020). In the context of both HIV/AIDS and COVID-19, women provide care for those affected and infected, thereby subsidising the state. However, the state does not necessarily appreciate or give back to women, and instead, what we see is a situation where women's labour is exploited and unappreciated. In Kenya, an example of this is in the context of home-based care for COVID-19 patients who were asymptomatic or had mild symptoms. The idea of social reproduction - an integral part of Marxist feminism - is especially useful in the context of

both HIV/AIDS and COVID-19 because the work that happens within home supports and enables the work that happens within the public sphere (Armstrong, 2020). Women, in their roles as wives, mothers and daughters perform work which makes it possible for workers in various sectors of the capitalist economy to go out and work in order to contribute towards the growth and recovery of the economy that has been battered by a pandemic. While women's reproductive labour within the home has remained undervalued and unappreciated, the conditions created by both HIV/AIDS and COVID-19, worsened the situation by further increasing women's burden of work, for example by requiring the provision of care for the afflicted, in addition to all the other work that women continue to perform within the home. In Kenya, we also see that in the context of providing care within the home, there was an increase in cases of violence against women specifically (Armstrong, 2020). Hence, as women subsidise the state and capitalism, their specific concerns remain largely unaddressed and while both the state and the market take from women, they do not give back!

In addition, Marxist feminism allows for an analysis of economic interventions in the context of pandemics. This is useful because in Kenya specifically, economic factors informed key decisions on the containment of the COVID-19 pandemic. Thus, for instance, the introduction of credit guarantee schemes in Kenya (The National Treasury and Planning, 2020) was informed by the need to allow businesses to recover after having suffered adverse effects due to the COVID-19 restrictions. However, few women-owned businesses were actually able to benefit from these schemes, mainly because they are small and informal (Kameri-Mbote and Meroka-Mutua, 2020). Thus, decisions that are based primarily on economic factors may not be beneficial to women.

3.3 The Capacity Approach

The capability approach propounded by Amartya Sen (1984, 1985 and 2005) and Martha Nussbaum (2000 and 2003) is also relevant as it allows us to analyse how women can be free from disease, infirmity, poverty, marginality, stigma, and discrimination that come about because of pandemics. It also allows for an analysis of the sets of conditions that exist that allow women to be free from disease. Thus, what real opportunities do women have that can enable them to be free from the burden of pandemics? In Kenya, for example, factors such as gender inequality resulting in women's unequal access to education, employment, and economic resources including property, in turn, have the effect of limiting women's ability to make decisions concerning their bodies and sexuality, and in particular to negotiate for practices that may prevent them from contracting HIV/AIDS, such as condom use. The responses to the COVID-19 pandemic also created conditions that made women more vulnerable to HIV infection, thus limiting their ability to be free from disease.

3.4 Development as Freedom

Closely related to the capability approach is the development as freedom approach, which is propounded by Amartya Sen (1999). The premise of this approach is that freedom and the enjoyment of human rights are both a means to achieving (economic) development, as well as an end of (economic) development. Thus, where individuals and communities can enjoy fundamental rights and freedoms, it creates a conducive environment for the attainment of development (Sen, 1999). On the other hand, economic development aims to facilitate the enjoyment of fundamental rights and freedoms, bearing in mind that human rights and freedoms do require financing if individuals and communities are to fully enjoy them (Sen, 1999). Thus, in the context of pandemics, this framework allows for an analysis of how the ability of women to enjoy rights and freedoms, such as freedom from violence and gender discrimination will eventually contribute toward development. This is because, when women enjoy these freedoms, they have a greater ability to avoid disease, which in turn will reduce the disease burden on the economy. Such a disease burden results from having a large section of the population who may be unable to work and contribute to economic growth due to illness; and another section of the population who may be unable to contribute more hours towards income-generating activities due to having to care for those who are

ill. On the other hand, where development is attained, a state has more resources to invest towards better health systems and provision of care for the infirm. It also has more resources that may be used to promote freedom from violence and discrimination.

3.4 Women's Health Perspective

The women's health perspective is also an important analytical approach. Here, we look at how women are treated when they present as patients within health care systems. The focus here is on highlighting the gendered nature of medical practice, and how this affects women (Rogers, 2006) Some of the notable issues in this regard include: the marginalization of women's health concerns; lack of investment in illnesses that affect women specifically, for example the struggle that many countries have faced in terms of investing in maternal health; and the failure by medical professionals to take female patients and their concerns seriously. In the context of pandemics, this has meant, for example, that gender-specific effects of COVID, such as the effect of COVID on the menstrual cycle (D'Ambrosio, 2020) and the link between menopause and COVID-19, may have been neglected in the same way all gendered issues are ignored (Basile, 2020). The women's health perspective helps us understand the gender bias in critically ill patients, both regarding HIV/AIDS and COVID-19. Aside from facing gender bias when women present as patients in health care systems, there are also economic arrangements that make it difficult for women who become sick with these illnesses. In the case of HIV, before ARV medication became readily available, the drugs were protected by patents that made them out of the financial reach of most people (Castro and Westerhaus, 2007), especially from the reach of women who were already economically marginalized (Bertozzi, et al, 2006). Thus, in cases where a man and his wife were infected, the man would in many instances purchase the medication for himself and neglect his wife, and for women who did not have their own sources of income, this nearly always meant death. Thus, gender discrimination and unequal access to economic resources, coupled with unfair global practices in the context of access to essential medication, meant that women have always fared worse than men.

At the onset of the COVID-19 pandemic in Kenya, medical insurers, including the National Hospital Insurance Fund (NHIF) which is the universal healthcare provider subscribed to by most Kenyans, were not covering treatment for COVID-19, meaning that where one was critically ill and required hospitalization, they had no insurance cover for COVID-19 (Ouma, Masai and Nyadera, 2020). This, therefore, means that just as it was in the case of HIV/AIDS before the availability and affordability of ARV, treatment for critically ill COVID-19 patients was financially prohibitive.

The women's health perspective here allows for an analysis of whether the practice of medicine responds to men's and women's health issues with the same tenacity (Govender and Penn-Kekana, 2007). It also problematizes the fact that women are not seen as patients in their own right, and in many instances, women's health issues are conflated around childbearing, so that investments around women's health are justified on the basis of women's reproductive function, and not the fact that women as individuals also have the right to enjoy the provision of health care services (Namasivayam, Osuorah, Syed, & Antai, 2012). Consequently, women will mainly be treated when they take their children to the hospital and not necessarily as individuals. Culturally, many women who become unwell are abandoned, because they are seen as a burden on the household, as they are unable to provide reproductive labour within the home, while at the same time needing the provision of care (Govender and Penn-Kekana, 2007).

3.5 Women's Empowerment Framework

The women's empowerment framework developed by Sarah Longwe is useful in understanding how women may be empowered by approaching women's inequality and poverty from the structural oppression that they face (March, Smythe, & Mukhopadhyay, 1999). The framework highlights five levels of equality and how they lead up to empowerment. *Welfare* is seen as the first and most basic level, and it emphasizes the improvement of the socio-economic status, for example, through earning income, while this may be useful in allowing women to escape poverty, it does not

actually lead to empowerment. In Kenya for example, the early women's movement, championed by *Maendeleo ya Wanawake* (Women's Progress) took this welfarist approach and its main aim was to implement social and economic projects among its women's groups at the grassroots (Maatahi, 2006). While this may have improved the economic situation of women, it did not result in empowerment, particularly in the political context, where women continued to be excluded from political representation and decision-making during the KANU one-party rule in the 1980s and 1990s.

The second level that Longwe identifies is *access to resources*, which she sees as the first step toward empowerment. The third level is *conscientisation*, where there is recognition of structural barriers that result in the forms of discrimination that women face, and this recognition comes with the willingness to address such structural inequality. The fourth level is *mobilization*, which entails the implementation of specific actions that have been designed as a result of the conscientisation having occurred. The final level is *control of resources*, which is achieved as a result of making collective claims and taking collective action. This, in turn, allows women to make decisions and exercise autonomy. This framework is useful in analyzing where societies have reached in their quest for women's empowerment. Regarding HIV/AIDS and COVID-19, a welfarist approach that simply focuses on meeting the basic needs that women may have, such as access to medication, food, and water, is not empowering. This framework, therefore, pushes for more in terms of addressing the gender dimensions of pandemics, beyond the provision of the basic needs that women may have.

3.6 Gender Planning Framework

Finally, Caroline Moser's (March, Smythe, and Mukhopadhyay, 1999) gender planning framework is also used to amplify the fact that in the context of Pandemics, the multiple roles that women perform are also affected. Moser advances the idea that women perform three key roles, including the productive roles that generally include income-generating activities, through employment and entrepreneurship; reproductive roles that entail the provision of care and domestic labour within the home; and community work, which involves the collective organization of social events, participation in groups such as women's groups, political activities, and activities aimed at improving the community (March, Smythe, & Mukhopadhyay, 1999).

In this way, Moser challenges traditional assumptions that women are generally not involved in the public sphere where productive work and community work occur. The Moser framework sees women as being involved both within the public and private spheres, but women's activities in both these spheres remain undervalued and unappreciated. Thus, in responding to the effect of pandemics on societies, it is necessary to plan for interventions that will empower women in each of the triple roles that they play. In Kenya, as in many other countries, COVID-19 devastated economies and left many people without a source of income, and many interventions were aimed at addressing the impacts of the pandemic on productive work. It is also necessary to understand how the pandemic affected women's reproductive roles as well as their role in community work and put in place measures to mitigate these impacts as well. In Kenya, COVID-19 measures were intended to address the impacts the pandemic had on productive work. There were few efforts to address the impact that the pandemic had on women's reproductive roles in particular. The emphasis on productive roles is indicative of the masculine and gender-blind nature of Kenya's COVID-19 responses.

4.0 Methodology

This study undertakes a comparison of responses to HIV/AIDS and COVID-19 in Kenya. The aim of carrying out such a comparison is to understand how the responses to HIV/AIDS informed the responses to COVID-19. Issues such as stigma, violence and discrimination are key to both pandemics, but with close to 40 years of experience in the context of HIV/AIDS, the assumption is that Kenya should have been equipped to deal with the COVID-19 pandemic, considering how it affected men and women. On the contrary, however, the country was caught flat-footed when

COVID-19 hit, and women again bore the brunt of this pandemic, as they continued to do as they did regarding HIV/AIDS. A comparison is, therefore, useful in understanding the factors that limit Kenya from effectively applying her experience in dealing with HIV/AIDS to the fight against COVID-19.

The comparison is undertaken by reviewing literature relating to HIV/AIDS and COVID-19 in Kenya. This review includes a textual analysis of policies and legislation governing the country's responses to both pandemics.

A gender analysis of the interventions for both HIV/AIDS and COVID-19 is also undertaken. This gender analysis aims to understand how responses to each of the pandemics have impacted women. This analysis also focuses on how, if at all, women's concerns have been addressed within the responses the country has taken to the pandemics.

Finally, and in line with the African feminist approach of documenting the experiences of African women based on the stories that African women tell in their own voices, this study draws from women's experiences of pandemics in Kenya. This method is also rooted in the grounded theory approach, which emphasizes the need to use data on the experiences of women in order to theorize and develop conceptual approaches.

5.0 Experiences of Women During HIV/AIDS and Covid-19 Pandemics

This section then broadly applies a feminist lens in setting out the impacts that both pandemics have had on women by organizing the themes identified from the reviewed studies.

5.1 Telling Her Story: The Impacts of HIV/AIDS and COVID-19 on Women in Kenya

Drawing on the accounts of women in Kenya, this section documents the specific ways in which HIV/AIDS and COVID-19 have impacted women in Kenya. These impacts are drawn from reviews of studies that have been conducted on the experiences of women in Kenya with both HIV/AIDS and COVID-19. This method is based on the African feminist and grounded theory approaches, which emphasize the need to allow women to tell their own stories, and to use those accounts to build theories from the ground up.

5.2 Worsening Existing Gender Inequalities and Creation of New, Intersectional and Unique Forms of Gender Inequality: From Struggle to Resilience

A 2012 study by (Kako, et al, 2012) collected qualitative data from 20 women living with HIV/AIDS in rural Kenya, using interviews. The interviews were conducted in 2006. Through these interviews, the women were able to tell their stories, and one of the major themes that is evident from that study is that women in rural areas living with HIV/AIDS face unique forms of gender inequality, brought about by the interaction between the virus and social-cultural norms around sexuality and access to resources. Women living with HIV/AIDS face a higher risk of domestic and gender-based violence, which is the result of the intersection between their gender, their health status, and their geographical positioning. This, in turn, takes away their ability to make decisions concerning their sexuality and health. However, the study also tells the story of resilience among these women, because they find ways to overcome the challenges that come with a lack of agency. Furthermore, their resilience is evident in their determination to protect not just themselves, but also their families from the ravages of HIV/AIDS.

Regarding lack of agency among HIV-positive women, particularly those living in rural areas, prevents them from taking action to lower their risk of transmission and re-infection of the virus (Kako, et al, 2012). From this study, we see that when rural women test positive for HIV, they are educated on how to lower the risk of transmitting the virus to their sexual partners, how to avoid re-infection and the importance of ARV use (Kako, et al, 2012). While women would want to adhere to these instructions from healthcare providers, however, their male sexual partners are often resistant. In particular, men resist the use of condoms as a means of reducing the risk of transmitting the virus, even where they know of their partner's HIV status; they also have multiple sexual

partners which in rural areas is largely informed by socio-cultural norms as well as alcohol abuse; and rural to urban migration (Kako, et al, 2012). What we see is that women living with HIV/AIDS experience unique forms of marginality in the context of HIV/AIDS infection, thus calling for innovative approaches to dealing with that marginality. Some excerpts from the (Kako, et al, 2012) study are illustrative of this:

> *"My husband was thinking the way I tell him I am positive is not the truth, and he misused the condom. The way it is supposed to be used; he was not comfortable with it. After 3 months I found out I was pregnant. That child is here. Last month she was tested and was found to have the HIV problem."* ***(Kako, Stevens, Karani, Mkandawire-Valhmu, Banda, 2012)***
>
> *"At times he can come in the house drunk, he finds me asleep, he removes my clothes. I mean, he wants us to have sex without a condom. It is just like raping. Him, he would be raping me at times."* ***(Kako, Stevens, Karani, Mkandawire-Valhmu, Banda, 2012)***

In addition to the resistance women living with HIV in rural areas face from their male sexual partners in adhering to health care instructions, these women also lack access to and control over economic resources. This means that they are forced to rely on men for economic provision, and where this happens, they also face sexual exploitation which again limits their agency in making decisions concerning their health and sexuality. Despite this, women can come up with ways to circumvent situations that may lead to sexual exploitation as this excerpt from a woman who was to be inherited by her husband's younger brother after she was widowed illustrates:

> *"When my husband died, I was left with his younger brother. That younger brother, I told him my HIV status so that we could have friendship, so that in the society I am not forced into the traditions. You see, among Akamba people we have the practice of kũtũania."* ***(Kako, Stevens, Karani, Mkandawire-Valhmu, Banda, 2012)***

In this excerpt, the woman tells her potential inheritor that she is HIV positive to dissuade him from insisting on the traditional practice of widow inheritance that involves sexual relations. In so doing, she indicated that she not only wanted to protect herself but also her husband's younger brother. Here, what we see is the narrative of resilience, where women come up with strategies to address the unique forms of marginality that they face because of their gender, HIV status and geographical positioning. This is an important narrative because often, the story of the African woman is told from a one-sided perspective, that of victimhood and powerlessness (Chimamanda, 2009). However, the story of the African woman is more than that of victimhood, and it is also one of resilience and strength (Kabira, W., Kameri-Mbote, P., Kabira, N. and Meroka-Mutua, 2018) and (Win, 2004).

Regarding COVID-19, women experienced the worsening of existing forms of gender inequality and the clawing back on gains made toward gender equality (Kameri-Mbote and Meroka-Mutua, 2020). Thus, COVID-19 was a threat multiplier for women, as is evidenced by increased domestic and gender-based violence, with women as the primary victims; increased cases of sexual exploitation of teenage girls; and increased cases of girls experiencing harmful cultural practices (National Crime Research Centre, 2020). Further, COVID-19 has had a negative impact on

women's reproductive health rights, because it limited the extent to which women were seeking reproductive health services in clinics and hospitals (Baswomny, 2020).

In addition, Kenya's COVID-19 responses resulted in the social isolation of many women, because of the closure of public spaces, including churches and schools in the early days of the pandemic and this, in turn, limited the social support structures that women largely rely on when dealing with adverse situations (Kameri-Mbote and Meroka-Mutua 2020). Thus, for example, women's church groups, investment groups or *chamas* and welfare groups offer support to various categories of women, including those living with HIV (Eudaimonia, 2017) but the closure of public spaces and the banning of group gatherings meant that these groups could not meet, hence limiting the social support measures available to women (Kameri-Mbote and Meroka-Mutua 2020).

Women who were widowed during the onset of the COVID-19 pandemic also faced limited support, due to the burial protocol, which allowed a maximum of 15 people to attend burials (Kameri-Mbote and Meroka-Mutua, 2020). The result was that few women attended burials and most of those who attended were kinsmen of the deceased, meaning that widows did not have other women to support them at a crucial time. Further, the burial protocol required burials of persons who died of COVID-19 to be held within 48 hours. In contexts such as Kenya, where burials are closely connected to succession and inheritance (Stamp, 1991), this would have harmed the rights of women to inherit, again because of the limited time availed to address succession issues before burial and also because of the general exclusion of women from the burials due to the limiting of the number of people who could attend burials (Kameri-Mbote and Meroka-Mutua, 2020). Although this burial protocol has been lifted, the impacts that it had on women will be felt for a long time to come. All these gender-specific impacts of the COVID-19 pandemic created vulnerability in women and predisposed them to increased risk of HIV infection, and for those who are already infected, they limited the extent to which they can continue taking their medication (Abimanyi-Ochom, 2011).

5.3 Worsening of Poverty among Women

A study by Amuyunzu-Nyamongo, et al (2007) also found that HIV/AIDS worsened women's experiences of poverty. This study was conducted in five informal settlements in Nairobi, and it found that in cases where there was pre-existing poverty due to the general conditions in slums, which include lack of basic services such as clean water, sanitation, security, and land tenure security, HIV/AIDS can worsen the situation of women in these already dire settings. Women in informal settings do not have adequate opportunities that allow them to limit the transmission risk of the virus, avoid reinfection and stay true to their ARV therapy. Thus, for instance, insecurity in informal settlements increases women's risk of experiencing sexual violence which, in turn, means that they can transmit the virus to their attacker or even become re-infected.

Regarding COVID-19, the pandemic had adverse economic impacts due to loss of employment and business opportunities. The Kenya National Bureau of Statistics (2020) reported that the COVID-19 pandemic resulted in loss of employment, with women accounting for 51.2% of those who became unemployed due to the pandemic. This is mainly because most women are employed in the services sector which was the most negatively impacted by COVID-19 measures (Kiriti-Ng'ang'a, 2022). In addition, businesses run by women were also adversely affected, as reported by women who spoke to Relief Web (2020) in their *series of stories in Voices from the Frontline. Below is an excerpt by a Maasai woman from their twelfth series:*

> *"Our main income was selling Maasai beads to the tourists, but they are not coming here anymore. We have the beads but there are no customers." (Relief Web, 2020)*

What we see, therefore, is that COVID-19 worsened the pre-existing situation of women. Before the onset of this pandemic, women already experienced unequal access to employment and business opportunities. They worked under precarious conditions in the informal sector, and often in roles informed by the gender norms that undergird the gender division of labour, meaning that women tended to take up work as domestic labourers providing care in the informal sector. COVID-19 meant that women lost even these precarious forms of employment (Kenya National Bureau of Statistics, 2020; Kameri-Mbote and Meroka-Mutua, 2020).

5.4 Feminization of Stigma

A 2014 study by Colombini, et al (2014) found that women living with HIV/AIDS experienced stigma, which was founded both on their gender as well as their HIV status. Thus, for instance, where a couple is found to be HIV positive, the woman may be blamed for having 'brought the virus' into the home, as this excerpt from that study illustrates:

> *I: "So why have you not told him?*
> *R: Now it is that fear. I do not have a way of explaining to him.*
> *I: Ehe? What are you afraid of?*
> *R: t … that his parents know me, and they do not know about my status, they may say: 'Our son was infected by that girl', I do not know what… Mm. And it may be possible that he is the one who … infected me. No one knows who infected the other".* ***(Colombini, Mutemwa, Kivunaga, Moore and Mayhew 2014, pp 4)***

Aside from being blamed for bringing the virus into the home, women whose HIV status becomes known to their family or who become critically ill also face abandonment, as is illustrated below:

> *I: "And why haven't you told anyone else?*
> *R: They* [people] *can do bad things to you […]. They can tell my husband. […] If my husband got to know about it* [that she is positive] *he will be mad with me and quarrel […] He can tell me to go back home so that [we] separate. I don't want that to happen."*
> **(Colombini, Mutemwa, Kivunaga, Moore and Mayhew 2014, pp 4)**

In addition, Colombini, et al (2014) document the specific form of stigma that women with HIV face in the context of seeking reproductive health services. What we see here is that health care service provision that caters specifically to women can create an environment that allows women to face stigma again based on their gender and their HIV status. This is because HIV/AIDS services offered to women are often linked to other services which women are likely to seek, such as ante-natal care, post-natal care, and family planning. This means that when women present for these services and they turn out to be HIV positive, they can face gender-based stigma.

> *R: "I had to tell her [mother-in-law], she is the one who took me to the hospital, and she was there when I was giving birth. She knows that a woman is supposed to breastfeed after she has given birth, something she never saw happening because I was told not to breastfeed the baby she saw the service provider administering some drugs to the baby and she could not understand what was happening and therefore I had to tell her the truth.*" **(*Colombini*, et al 2014, pp 4).**

Further, women also face stigma related to breastfeeding. Because of Kenya's policy on promoting exclusive breastfeeding for the first six months so as to limit mother-to-child transmissions, women's breastfeeding practices can be monitored in order to "determine" their HIV status. For women who are HIV-positive, there is mixed messaging as to the feeding program that they should use for their infants (Colombini, et al 2014). Consequently, some are told to exclusively breastfeed and stick strictly to this in order to avoid the risk of mother-to-child transmission through breast milk, while others are told not to breastfeed their babies at all, or to discontinue breastfeeding once other feeds are introduced before six months because they are unable to breastfeed for various reasons, for example, if they become ill or have to go back to work. These women will generally stop breastfeeding their infants altogether, rather than continue with complementary breastfeeding as HIV-negative women are likely to do. This creates a situation where the feeding program a mother chooses to use for her infant is used to determine her HIV status. Thus, when a mother does not breastfeed her infant, this is seen as a confirmation that she is indeed HIV positive. These breast-feeding practices create conditions for stigma (Colombini et al., 2014).

Regarding COVID-19, the Population Council (2020) reported that more women in Kenya feared they would face stigma if infected with COVID-19, as compared to men. Thus, 85% of women compared with 74% of men feared they would face stigma if infected with COVID-19, while 77% of women compared with 66% of men feared they would be treated badly if infected (Population Council, 2020). These figures may be explained by the women's health perspective, where we see that women are likely to face discrimination when seeking treatment in healthcare facilities (Rogers, 2006) and are also likely to be abandoned if they fall ill (Govender and Penn-Kekana, 2007). Consequently, even in the context of COVID-19, what we see is that women were likely to experience more stigma as compared to men.

5.5 Strengthening Women's Mobilization and Civil Society Action

Because women have borne the brunt of both the HIV/AIDS and COVID-19 pandemics, this has resulted in stronger women's mobilization for purposes of implementing actions to address their unique challenges. This is a positive impact of the pandemics and one of the silver linings that has resulted from the negative impacts that the pandemics have had on women. Thus, in the close to 40 years that Kenya has had to deal with HIV/AIDS, there has emerged a strong movement comprising women who are self-advocates; women's organizations that deal specifically with gender and health rights; and women's groups that offer support at different levels to women who have been infected and affected by the virus. This women's movement has worked closely with other civil society organizations that deal with the right to health more generally to further strengthen women's right to health. Thus, for instance, the civil society organizations concerned with the right to health have worked closely with women self-advocates to litigate issues relating to HIV/AIDS, resulting in the development of jurisprudence in this area (KELIN and UNDP, 2018).

6.0 Kenya's Responses to HIV/AIDS and Covid-19

This section looks at Kenya's responses to the pandemics generally and through women's eyes and demonstrates that where responses have been gender blind, the impacts of the pandemics on women and girls have been worsened.

6.1 Responses to HIV/AIDS

There is an established HIV/AIDS legal environment in Kenya. Article 27(4) of the Constitution prohibits discrimination based on one's health status, and this provision was largely informed by the country's experiences relating to discrimination because of a person's HIV status. In addition, Articles 2(5) and (6) provide for the domestic application of customary International Law and International Law instruments that Kenya is a party to. Kenya has ratified all major International Human Rights Law instruments, and this, therefore, allows for the domestic application of these instruments in the context of HIV/AIDS. The main legislation that addresses HIV/AIDS in Kenya is the HIV and AIDS Prevention and Control Act, which was passed in 2006. The Sexual Offences Act of 2006 and the Health Act of 2017 also contain provisions that are relevant in dealing with HIV/AIDS. Kenya also has in place the National AIDS Control Council, established as a state corporation through the National AIDS Control Council Order of 1999 (National AIDS Control Council). The National AIDS Control Council is the main institution that is mandated to deal with the prevention and control of HIV/AIDS.

Kenya has also put in place health interventions aimed at the prevention and control of HIV/AIDS. These include leveraging opportunities for testing for HIV, for example, during ante-natal clinics, addressing mother-to-child transmissions through testing, promoting exclusive breast feeding, and addressing opportunistic infections such as tuberculosis (National AIDS Control Council, 2014).

Further, there has been effective use of media campaigns to promote HIV prevention and control messaging (Onsomu, et al, 2013). For example, campaigns to promote condom use, voluntary testing, and exclusive breast feeding. The media has, therefore, played a fundamental role in creating awareness around HIV/AIDS, addressing stigma, and promoting non-discrimination.

Government support for civil society organizations that work towards promoting the right to health and prevention of HIV/AIDS has also been provided (National AIDS Control Council, 2014). While Kenya has witnessed periods of autocratic and authoritarian rule, which have had adverse effects on civil society and activism (Mati, 2020), the government has generally supported organizations that work on issues concerning the right to health and the control and prevention of HIV/AIDS in particular (UNAIDS, 2018) and this has had a positive impact in the fight against HIV/AIDS.

6.2 Responses to the COVID-19 Pandemic

Kenya's responses to the COVID-19 pandemic were reactionary because the country did not have in place preparedness mechanisms to deal with a pandemic other than HIV/AIDS. Thus, interventions were put in place in an ad hoc and evolving manner. The COVID-19 responses were not as established as those relating to HIV/AIDS, and although they were anchored in law, these responses were temporary and in a constant state of fluidity. Indeed, through the regular briefings by the Ministry of Health and the occasional Presidential Speeches, new interventions were introduced, varied, or phased out, and although comprehensive legislation on the pandemic was proposed, the same was never passed by Parliament (Kameri-Mbote & Meroka-Mutua, 2020).

In addition to being ad hoc and fluid, the Kenya COVID-19 responses were also gender-neutral and were introduced in the context of prevailing gender inequalities. For these reasons, few responses were specifically aimed at addressing the gender impacts of the Pandemic, and further, the responses themselves produced gendered experiences (Kameri-Mbote & Meroka-Mutua, 2020).

6.3 Analysis of Kenya's HIV/AIDS and COVID-19 Interventions through Women's Eyes

In both cases of HIV/AIDS and COVID-19, women bore the brunt of the pandemic. In the case of HIV/AIDS, not only is the prevalence higher among women in Kenya (Ministry of Health, 2020), but the pandemic has also resulted in women's marginality and exclusion due to the worsening of already existing forms of gender inequality and discrimination (Avert, 2020). Indeed, in the years when the HIV/AIDS pandemic ravaged the country and resulted in the deaths of adults of childbearing age, children who were left orphaned were cared for by their grandmothers. Here we see the intersection between age and gender, where older women were saddled with the burden of caring for young children, (Mishra and Assche, 2008). The need for gender sensitivity in responses to pandemics and disasters in Kenya is not a new reality. Indeed, HIV/AIDS and responses to it over time should have resulted in the creation of awareness on the part of decision-makers of the fact that pandemics and other disasters occur in gendered contexts. Consequently, they cannot be addressed adequately through gender-neutral interventions.

Regarding COVID-19, while statistics indicated that there was a higher prevalence among men as compared to women (Ministry of Health, 2020), the pandemic still affected women disproportionately, primarily due to the gender-neutral containment measures that were adopted in the country (Kameri-Mbote & Meroka-Mutua, 2020). These measures failed to consider women's experiences because they were framed from a masculine perspective (Kabira and Kameri-Mbote, 2020). For this reason, the forms of exclusion that women faced in the context of COVID-19, such as the increased burden of unpaid care work, allocation of resources and labour towards supporting national hygiene, greater vulnerability to violence and sexual exploitation, increased threat of women and girls undergoing harmful cultural practices, were not adequately addressed. In the case of COVID-19, therefore, women's burden from their triple roles intersected with the threat the Pandemic posed to the enjoyment of their human rights.

Using Sen's (1999) analysis of development as freedom, whereby the protection of human rights has a direct impact on promoting development, the COVID-19 threat to women's human rights was likely to undermine the country's recovery efforts. In this regard, statistics from the Kenya National Bureau of Statistics (2020) showed that women were more adversely affected by job losses and loss of income. At the same time, Kameri-Mbote and Meroka-Mutua demonstrate that COVID-19 measures were not responsive to gender-specific concerns, even though women were more adversely affected.

Despite the lessons Kenya has learnt from HIV/AIDS on the need to promote gender equality to effectively address the factors that create vulnerability in the context of the pandemic, the country's COVID-19 measures were distinctly gender-neutral. This is illustrative of the apathy and lack of gender awareness that exists among policy makers. It is also illustrative of the need to address gender inequality generally as a means of ensuring the country's overall preparedness to deal with pandemics. While Kenya has robust constitutional provisions aimed at addressing gender inequality, which we have seen have a direct impact in creating vulnerabilities among women in the context of pandemics, these constitutional provisions have not been fully implemented. In particular, provisions such as those on equal representation which require that not more than two-thirds of persons in elective or appointive office shall be of the same gender, have not been implemented since the Constitution was promulgated in 2010 despite numerous attempts by Parliament and challenges in court (Maraga, 2020).

Equal representation may be viewed in terms of Sen's (1999) analysis of freedom being both a means and an end to development. In this sense, equal representation is a means to women's equality in other spheres of life, including freedom from the factors that create gender vulnerability in the context of pandemics. It is also an end to gender equality because women have as much right to hold political and other offices as men do. Enhanced women's representation in politics is likely to promote women's enjoyment of socio-economic rights, such as the right to clean water, food security, and gender-sensitive health care provision which includes reproductive health services in

line with the women's health perspective and education. The enjoyment of these socio-economic rights is necessary in containing and preventing the spread of HIV/AIDS and COVID-19, as well as in promoting recovery efforts following the devastation caused by the pandemics. Gender equality is, therefore, a pre-condition in the fight against both pandemics, yet Kenya has failed to implement constitutional provisions aimed at achieving this ideal.

Kenya's experience with HIV/AIDS underscored the need for a comprehensive institutional, policy and legislative framework to address pandemics. In the case of HIV, the framework was established several years after the onset of the pandemic. Yet, when COVID-19 hit Kenya, the country had no overarching law and policy mechanisms to deal with the emerging pandemic. Despite having four decades of experience dealing with the HIV/AIDS pandemic, Kenya was unprepared to deal with another pandemic. This lack of preparedness worsened the situation of women by creating conditions that allowed for the clawing back of the gains that the country had made towards dealing with HIV/AIDS. Furthermore, the lack of preparedness exacerbated the marginality and exclusion that women face in the context of pandemics. For instance, while women are vulnerable to gender-based violence, harmful cultural practices, and sexual exploitation, the COVID-19 pandemic increased women and girls' susceptibility to these issues.

In line with Caroline Moser's Gender Planning Framework, a comprehensive disaster and pandemic preparedness mechanism informed by the country's experiences in dealing with HIV/AIDS would have allowed for planning and preparedness taking into account gender-specific concerns. This would have, in turn, mitigated the adverse effects that COVID-19 had on women and girls in Kenya. A comprehensive pandemic and disaster preparedness mechanism anchored in policy and legislation would also have allowed the country to address stigma more holistically, as opposed to the current siloed approach that only targets HIV/AIDS. Because Kenya lacks such a mechanism, she was unable to harness the experience acquired in stigma related to HIV/AIDS to address stigma in the context of COVID-19.

While Kenya has taken specific legislative and policy measures to mitigate the effects of HIV/AIDS and also to prevent its transmission, some of these are yet to be fully implemented. One such measure is the breast-feeding policy which promotes exclusive breast feeding to prevent mother-to-child transmission of HIV/AIDS. Exclusive breast feeding for mothers who are HIV-positive is in line with the World Health Organization's (WHO) best practices (WHO, 2019), but as we have already seen, there is mixed messaging in Kenya, so that HIV-positive mothers are sometimes discouraged from breastfeeding their infants, based on their HIV status (Colombini, et al 2014). The country has yet to put in place measures that allow women to breast feed exclusively for the required six months. Childcare initiatives, such as the provision of crèche facilities receive little attention and investment, and indeed, there is little state support for childcare, so the burden is primarily on women to provide care for their infants. In addition, the Employment Act, 2007 and revised in 2012, provides for a maximum of three months of paid maternity leave for employed mothers, which means that after three months, employed mothers have to return to work, thus making it difficult for them to breast feed exclusively for the required six months.

In addition, Kenya has in place the Breast Milk Substitutes (Control) Act, 2012 which limits the marketing of breast milk substitutes in the country. This Act aims to promote exclusive breast feeding by limiting access to breast milk substitutes. However, it is, in fact, counter-productive to have in place a negative measure aimed at promoting breast feeding such as the limiting of access to breast milk substitutes by banning their marketing, while at the same time failing to put in place positive measures to promote breast feeding such as investing in state-supported child care initiatives for infants and maternity leave provisions that support mothers to breast feed exclusively for six months.

Other problematic legislative interventions include the criminalization approach to dealing with pandemics. In the context of HIV/AIDS, the use of criminal law in dealing with the willful transmission of the virus to one's sexual partners was problematic. In 2015, the High Court (AIDS Law Project v Attorney General & 3 Others) declared unconstitutional section 24(1) of the HIV and

AIDS Prevention and Control Act, which provided that a person aware of being HIV-positive would *"take all reasonable measures and precautions to prevent the transmission of HIV to others"* and to *"inform, in advance, any sexual contact or persons with whom needles are shared"* of their HIV-positive status. Subsection (2) prohibited *"knowingly and recklessly, placing another person at risk of becoming infected with HIV".* Contravention of these provisions was a criminal offence punishable by imprisonment for up to seven years, and/or a fine. Under section 24(7), a medical practitioner who became aware of a patient's HIV-status could inform anyone who had sexual contact with that patient of their HIV-status.

This provision was particularly prejudicial to women living with HIV for a number of reasons. Firstly, women are more likely to be tested and to know their status, because of Kenya's policy to test women when they present for ante-natal care. This means that it is more likely for women to have knowledge of their status, which is a necessary ingredient of the criminal provisions of the impugned section 24(1). Further, the provision assumed that persons in sexual relationships have equal bargaining and negotiation power, as to allow for a situation where an infected person is able to disclose their status to their sexual partner. In reality, many women in abusive relationships actually do not have such bargaining and negotiation power to disclose their HIV status to their sexual partners without facing the threat of violence. Finally, section 24(7) was a breach of doctor-patient confidentiality and was more likely to affect women disproportionately, given that women are tested more than men are. Thus, the use of criminal sanctions as a way of containing pandemics may have gendered outcomes.

Despite these lessons from HIV/AIDS, Kenya continued to use criminal law approaches in the context of COVID-19, for example, by criminalizing the failure to wear facemasks in public spaces (Kenya Human Rights Commission, 2020).

It is also important to highlight the significance of tuberculosis (TB) in the context of both HIV/AIDS, where it is an opportunistic infection and COVID-19 because TB is also a respiratory illness. Due to the relationship of TB to both HIV/AIDS and COVID-19, there is a stigma around seeking treatment for it. In the case of HIV/AIDS, this is likely to claw back on the great strides that have been made in dealing with stigma, which has allowed more TB patients to seek treatment. Stigma related to COVID-19 clawed back on gains made towards the eradication of TB. The failure to address the intersections between HIV/AIDS and COVID-19 was likely to affect the extent to which TB was addressed given the new dimensions introduced by COVID-19. Further, there may also have been claw backs to gains made regarding treatment, management, and containment of TB. This represented a gap in the health interventions for both HIV/AIDS and COVID-19.

7.0 Conclusion And Way Forward

Lessons learnt in dealing with HIV/AIDS did not inform Kenya's approach to handling COVID-19, specifically regarding the gendered impacts of both the pandemic and responses to it. pandemics are threat multipliers and find men and women as they are. In contexts of gender inequality and discrimination, the impacts of pandemics are greatly amplified. As illustrated in this article, both HIV/AIDS and COVID-19 have made women's situation worse, both at the public and private spheres. Kenya has had experience with the gendered impacts of HIV/AIDS and put measures in place to counter these. Kenya also has robust equality and non-discrimination provisions in the Constitution which proscribe discrimination based on gender and health status. These provisions and the experience with HIV/AIDS did not influence Kenya's responses to COVID-19. The way COVID-19 unfolded calls for a re-evaluation of the framework for addressing pandemics at national and county levels. This framework must allow for cumulative learning from experiences the country has had and depart from the silo approach. It must also take on board the experiences of men and women.

The very gendered context in which pandemics happen calls for the adoption of a grounded approach as recommended by African feminists. This will allow women to tell their own stories rather than have them told by others. The removal of unfreedoms as proposed by Sen must be

informed by the lived realities of women and interventions to address pandemics must address gendered contexts in a way that empowers women and addresses their specific concerns.

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