REFLECTIONS ON THE MAISHA HIV AND AIDS CONFERENCE:
ADDRESSING THE HIV AND GBV DUAL EPIDEMIC IN KENYA

By Lucy Njuguna, Michael Gaitho, Dr. Lina Digolo

In May, the National AIDS Control Council (NACC) held the 4th bi-annual Maisha HIV and AIDS Conference in Nairobi, Kenya.

The conference whose theme was; “Translating the Science to End New HIV Infections in Kenya: Perspectives, Practices and Lessons” aimed at promoting public engagement in understanding existing and emerging HIV prevention, care and treatment research.

An adolescents and Youth pre-conference dubbed; Youth na Plan: Beyond science: Adolescents & Young People’s Perspectives on HIV Prevention, and Interventions, preceded the conference. See a related article – Youth involvement in HIV prevention http://www.lvcthealth.org/images/pdf/Blog-Maisha-Conference.pdf

LVCT Health hosts Experts to discuss HIV AND GBV dual Epidemic Kenya

On the last day of the conference, a two hour satellite session: “Addressing the HIV and Gender Based Violence (GBV) dual epidemic in Kenya” was convened by LVCT Health. It included expert panel discussions and oral presentations.

In line with the theme of the conference, the aim was to explore the utility of the research findings in identifying challenges and opportunities for implementing GBV programmes within HIV response and prevention.

This session brought together researchers, technical experts and health services providers who work in both HIV and GBV field to; discuss the impact of GBV on the uptake and retention of HIV services in Kenya. It explored the evidence, gaps in the evidence, challenges and opportunities to implementing GBV programs within the HIV response. It also identified opportunities to apply evidence-based practices that integrate GBV and HIV.

The evidence should inform decisions that impact implementation at health facility and community levels, financing decisions, planning by organizations and across sectors, to create the necessary ripple effect for HIV epidemic control in Kenya.

Background

World over, GBV and HIV are public health problems, but more so in Sub-Saharan Africa. GBV includes sexual, physical, emotional, financial abuse, structural discrimination, state-sponsored violence, and trafficking of women and girls[1]. GBV mainly affects women and girls, but men and boys, and minority groups are also affected.

Kenyan women and girls face the threat of GBV during their lifetime. Prevalence data on GBV in Kenya indicates that 1 in 5 girls and 1 in 10 boys have reported experiences of sexual abuse as children[2]. In addition, 39% of every married females (15-49yrs) in Kenya is reported to have experienced physical and sexual IPV[2]. The impact of gender based violence on health, productivity, economy, social life and, therefore, a country’s ability to achieve its goals is well documented[3][4].

The link between GBV and HIV is also well documented [5, 6]; with women and children experiencing more vulnerability. HIV risk may occur through direct infection due to rape or coerced sex or indirectly where women/ girls are unable to protect themselves, seek health care and exhibit risky behavior [7-10]. There is also reverse causality where women living with HIV experience higher risk of partner violence following sero-status disclosure [11].

“I think violence and how it can contribute to HIV...case scenario; a man beats a wife, wife wants to revenge, wife sleeps around, wife gets HIV, wife comes back to man, man gets HIV.”

(Male living/working near boda boda rider, Kikuyu)

Despite widespread provision of HIV services in Kenya, a number of barriers to testing, linkage and care persist, undermining the potential for epidemic control. Session participants and presenters agreed that, it is crucial to examine cultural gender concepts and practices while designing and implementing HIV/AIDS interventions such as HIV Testing and Counselling (HTC), Prevention of Mother to Child Transmission (PMTCT), care and
treatment, home-based care and support.

Gender plays a key role in determining an individual’s vulnerability to infection, his or her ability to access care and support and treatment. Gender power relations rooted in cultural, religious, norms, practices and attitudes and dependency that women experience within the households and community, often exposes them to the need to engage in risky behaviors thus exposing them to GBV. Other contributory factors include; poverty, linked to these power plays and relation issues, coupled with the overall failure of the protective environment by the community, Community Serving Organization (CSO’s) and the government.

In the background of a high HIV epidemic in Kenya and recognizing the higher prevalence of infections among women, it is highly important to develop harmonized and integrated policies and standards that provide guidance on the integration of GBV and HIV services.

Stakeholders agreed that strategic partnerships at national and county arena consisting of state and non-state government in policy formulation, and designing of gender sensitive prevention and implementation interventions would contribute to reduction of the dual epidemic of GBV and HIV.

Fr. Angelo Munduni from St. Joseph’s Uzima programme, one of the projects of St. Joseph the Worker Catholic Parish in Kangemi indicated that while there has been some success in integrating GBV into HIV/AIDS programming, there were challenges of implementing interventions including: the tenacity to biased cultural practices and norms; wife beating, wife inheritance and the presumed cultural roles of both men and women.

There are knowledge gaps among members of the community in linking HIV/AIDS to gender issues. Other challenges to program implementation include; the culture of corruption and red tape that leads to impeding justice, religious paralysis, poverty and unemployment, and support group attendance often pegged on to benefits, and the donor dependency syndrome.

There is need for meaningful engagement of men in addressing the dual epidemic of GBV and HIV for better achievement of goals was emphasized. Multi-pronged survivor-centered approaches and needs prioritization would also be a reinforcement in addressing root causes of gender discrimination and also enhance GBV/HIV response mechanisms that embrace Human-Rights Based (HRB) approaches. Ultimately, interventions geared towards enhancing the capacity of health workers should be emphasized, as well as accountability checks.

Mary Ndungu of Better Poverty Eradication Organization (BPEO), an NGO that is working in the community, intimated that her organization utilizes meaningful engagement of men in addressing the dual epidemics of GBV and HIV. The project has so far; trained 55 VAW/HIV champions; champions held 6 session trainings reaching 303 boda-boda riders and 105 women, 5 community activities conducted in markets and boda-boda stages; and distribution of 600 brochures and 10,000 condoms.

Sexual and reproductive health (SRH) programs must also integrate GBV and HIV interventions that address roots causes which are sometimes deeply intertwined to risks and vulnerabilities that perpetuate the dual epidemic.

Virginia Nduta presenting from Women’s Empowerment Link (WEL) intimated that violence against women is both a cause and consequence for HIV: VAW limits women access to HIV information, HIV treatment, and speeds onset of AIDS, IPV increases the risk of HIV infection for women, and women living with HIV are vulnerable to Violence. Nduta presented an intervention by WELs link with the goal of ensuring women and girls have greater access to timely, quality and effective GBV and HIV response services. Key considerations for integration shared included: partnerships and networking with stakeholders ensuring holistic and inclusive advocacy; capacity building of community leaders, police and gender officers on holistic response; advocacy with county government towards policy implementation; and male engagement.

**Challenges to integration of GBV and HIV programs**

- Low technical capacity of local organizations
- A multidimensional approach is crucial but complex
- Attribution of economic empowerment to gains in HIV response or prevention
- Lack of data collection tools that have been tested within the local context
- Considerations for programming to Link GBV and HIV
- Lack of clear referral pathways for women found to be experiencing IPV
- GBV
- Lack of knowledge among women: understanding their SRH rights and that they can negotiate for condom use
- Lack of services or appropriate interventions targeted towards men who are experiencing violence from their partners

**LVCT Health Intimate Partner Violence (IPV) Study**

Margaret Kababu presented a study on Intimate Partner Violence (IPV) conducted by LVCT Health which indicated that, about half of women accessing HTC services are...
Local-led interventions can fast-track and address reduction of the dual epidemics. Opportunities and strategies of implementing partners need to be harnessed by development partners to advance the issues of governance, policy and legal framework that provides an enabling environment for response.

**Increasing response mechanisms as an approach to reduce women and girls vulnerability to the dual epidemic of HIV/GBV and the Way forward**

Development partners are increasingly shifting focus to response mechanisms that use women empowerment as an approach to reduce women and girls vulnerability to the dual epidemic of HIV/GBV. Different approaches are also being designed to address the power relations that perpetuate GBV and subsequently HIV or vice versa such as:

i. Engaging social norms and cultural practices using transformative methodologies e.g SASA (Start, Awareness, Support, Action) model

ii. Women’s participation to, and influence in decision making processes in all levels of the social spectrum, household, community, society. This is will ensure that women are knowledgeable and equipped with skills to engage and also have access to those skills

iii. Supporting women to build social capital within safe spaces, especially for those experiencing IPV. This will build their confidence and self-esteem thus engage well with their partners

iv. Economic empowerment to address the inequalities in resource allocation for women. The disparities in gender: property and labour relations makes women more vulnerable

v. Ensuring women have knowledge and access to; education, vocational skills, access to capital, and their rights at work place are not violated

The figure describes the dual relationship between HIV and GBV attributing possible zero-conversion (0.67%) and (0.40%) in the years 2015 and 2016 respectively. Clinical and policy recommendations by WHO argue that HIV transmission post sexual abuse is estimated at 0.01% per sexual contact.

### References