



OFFICE OF THE PRESIDENT

## First Kenya Women's HIV Prevention Symposium

August 31st to 1st September, 2010 Panari Hotel, Nairobi



**Making HIV Prevention Responsive  
To Women's Needs**

**maisha!**  
National AIDS Control Council

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## **MAKING HIV PREVENTION RESPONSIVE TO WOMEN'S NEEDS**

*Organized under the Gender Technical Committee  
for the national response to HIV and AIDS, Kenya*

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## List of Acronyms

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- **AAK** Action Aid Kenya
  - **AIDS** Acquired Immune Deficiency Syndrome
  - **ART** Antiretroviral Therapy
  - **CACC** Constituency AIDS Control Committee
  - **CEDAW** Convention on the Elimination of all forms of Discrimination against Women
  - **CHIVPR** Centre for HIV Prevention and Research, University of Nairobi
  - **CSO** Civil Society Organizations
  - **FGM** Female Genital Mutilation
  - **GBV** Gender-Based Violence
  - **GCM** Global Campaign for Microbicides
  - **GIPA** Greater Involvement of People Living with HIV and AIDS
  - **GTC** Gender Technical sub-committee
  - **HIV** Human immune-deficiency virus
  - **ICC** Inter-agency Coordinating Committee
  - **JAPR** Joint Annual HIV and AIDS Programme Review
  - **KAIS** Kenya AIDS Indicator Survey
  - **KANCO** Kenya AIDS NGOs Consortium
  - **KNASP III** Kenya National HIV and AIDS Strategic Plan
  - **LGBT** Lesbian, gay, bisexual, and transgender
  - **LVCT** Liverpool VCT, Care and Treatment
  - **M&E** Monitoring & Evaluation
  - **MARPS** Most at Risk Populations
  - **MTEF** Medium Term Expenditure Framework
  - **NACC** National AIDS Control Council
  - **NASCOP** National AIDS and STI Control Programme
  - **NGO** Non Governmental Organizations
  - **PHDP** Positive, Health, Dignity and Prevention
  - **PLHIV** People Living with HIV
  - **PrEP** Pre-Exposure Prophylaxis
  - **PwD** Persons with Disabilities
  - **STIs** Sexually Transmitted Infections
  - **SWAK** Society for Women and AIDS in Kenya
  - **UNAIDS** The joint United Nations Program on HIV &AIDS
  - **UNDP** United Nations Development Program
  - **UNIFEM** United Nations Development Fund for Women
  - **VCT** Voluntary Counselling and Testing
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## Foreword

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The complex challenges caused by the HIV and AIDS epidemic call for an extraordinary response to the scourge. Globally, years of engagement in the control and management the epidemic have shown that HIV and AIDS programmes that address gender inequality as a central goal maximize their overall effectiveness. However, gender disparities in programme outcomes have remained pertinent as evidenced by recent studies including Kenya AIDS Indicator Survey (KAIS, 2007) and the Kenya Demographic and Health Survey data (KDHS, 2008/9).

The Kenya National AIDS Control Council (NACC) has taken cognizance of the importance of gender integration in programmes. To this end, the NACC established a Gender Technical Committee in 2001 to ensure that gender dimensions of the HIV and AIDS epidemic were translated into practical tools for decision-making and that programming promotes effective gender responsiveness within HIV and AIDS policy formulation and implementation in Kenya. The inclination to place primary emphasis on prevention has been driven by the reported disproportionate higher HIV infection rates and vulnerability among women. Thus, the National AIDS Control Council partnered with the Global Campaign for Microbicides and various co-sponsors to support the 2010 Kenya Women HIV Prevention Symposium. A report on this exercise has been developed to inform stakeholders on prioritized areas of focus in both programming and research.

It is hoped that this report will provide various actors including policy and senior level decision-makers, programme planners and implementers with an evidence-informed basis for priority-setting.

I wish to personally thank all those stakeholders who co-sponsored the Kenya Women HIV Prevention Symposium financially and those who actively participated in the preparations and execution of the very first such symposium in Kenya.



**Prof. Alloys S. S. Orago**

**DIRECTOR**

## Acknowledgements

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The Kenya Women's Symposium was organized under the auspices of the National AIDS Control Council (NACC) and the Global Campaign for Microbicides (GCM). The symposium was organized under the Gender Technical Committee (GTC) whose leadership is provided by the Head of the Stakeholder Coordination Division at NACC, Harriet Kongin. A task team for its development and delivery included: Pauline Irungu (Chair Taskforce - GCM), Eunice Odongi (Secretary, GTC), Dr. Nduku Kilonzo (LVCT), Anne Mumbi (KANCO), Prof. Elizabeth Ngugi (CHIVPR/UoN, SWAK, KVORC), Ruth Masha (UNAIDS), Sari Seppanen (UNAIDS), Pascaline Kang'ethe and Lucy Wanjiku (AAK), Ursula Sore-Bahati (UNIFEM), Lucy Ghati (NEPHAK), Renaldah Mjomba (VSO), Ludfine Anyango (UNDP), Wafula Wanjala (Co-Exist Kenya) and Rukia Yassin (GTZ Health Sector Programme), Rehab Mwaniki (NEPHAK), and Rosemary Mburu (KANCO).

The contributions of all participants including chief guests, speakers and presenters, session chairpersons, panellists, parallel session group leaders and rapporteurs is acknowledged and highly appreciated.

The conference would not have been possible without the financial contribution of the following co-sponsors: the National AIDS Control Council (NACC), International Partnership for Microbicides, UNIFEM, UNAIDS, UNDP, KANCO, Liverpool VCT, Action Aid Kenya and UNFPA.



**Dr. Sobbie Mulindi**

DEPUTY DIRECTOR COORDINATION AND SUPPORT

## Executive Summary

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The National AIDS Control Council in partnership with Global Campaign for Microbicides and with support from Action Aid Kenya, Kenya AIDS NGOs Consortium (KANCO), Liverpool VCT, the joint UN team (UNDP, UNAIDS, UNIFEM, UNFPA), German Agency for Technical Cooperation (GTZ), and Centre for HIV Prevention and Research of the University of Nairobi (CHIVPR), co-hosted the First Kenya Women's HIV Prevention Symposium, from 31 August to 1 September 2010, at the Panari Hotel, Nairobi.

The aim of the Symposium was to explore in-depth the HIV prevention needs for women. It provided the opportunity for HIV service organizations, women, men, PLHIV, Faith organizations, policy makers and HIV researchers to evaluate the current programming approaches and identify what needs to be done to make them more responsive to women's needs. The Symposium also offered a platform for identifying what needs to be done to develop an HIV prevention research agenda that addresses the real-life needs of women. The Symposium objectives were: (1) to explore HIV prevention needs for women; (2) to identify priorities for women's HIV prevention in current response (based on the Kenya National HIV and AIDS Strategic Plan III priorities); (3) and to identify research gaps to fill to better inform HIV-prevention interventions.

It was noted that Kenya has put in place HIV-prevention policies and guidelines, but it was recommended that these must be urgently implemented and monitored to track their impact. Also, the following priorities were identified for Kenya Women's prevention research agenda: Translation of policy and research into practice; Community based research: Formative, community-based, social, behavioral and operational research; Exploration of gender issues/ dynamics that impact on sexual relations; Disclosure among couples; Alignment of current research to KNASP III indices and Resource tracking.

The following were proposed as needful for women's prevention priorities: Political Commitment; Meaningful participation by women living with HIV; Capacity building and relevance to KNASP III; Prioritize gender issues as recommended by KNASP III and factor in opportunities provided by the new constitution; Strengthening coordination and linkages; Reconstitute, strengthen the GTC and align it with KNASP III; Program development; Prevention, diagnosis, treatment, and care programs; Services that are responsive to women and Equitable resource allocation:

The outcomes of the Kenya Women's HIV Prevention Symposium will inform key national HIV- prevention planning processes, including the National HIV Prevention Summit and the Joint AIDS Programme Review (JAPR)—both being held before the

end of 2010. Partners pledged to fully support implementation of the recommendations arising from Symposium.

## **1.0 Introduction**

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The Kenya AIDS Indicator Survey Report 2007 affirms the reality that HIV affects women disproportionately. For people aged 15-55 years, the national prevalence rate for women was 8.4%, compared to 5.4% for men.<sup>1</sup> Vulnerability to HIV infection among women is driven by gender inequalities and exclusions that are experienced differently by various categories of women based on age, socio-economic status, marital status, geographical location, and occupation, among others. HIV risk is also a result of multifaceted, context-specific interacting factors operating at policy and service-delivery levels, as well as the socio-cultural realities in the lives of women.

The Symposium provided an opportunity for grassroots organisations, civil society, policy makers, researchers, academics, and representatives of medical associations, funding agencies and the UN joint team to discuss factors that heighten women's vulnerability to HIV. Participants identified key women's needs and made recommendations for prioritisation in prevention and research agenda for women that require urgent action to turn the epidemic around.

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### **Expected Outcomes of the Symposium**

The Symposium outcomes were to inform key national HIV prevention planning processes including the National HIV Prevention Summit and JAPR among others, on women's HIV prevention priorities and provide a platform for achieving the following over the next one-year:

- Develop a research agenda for women.
  - Catalyze change in the way that interventions for prevention are done by developing standardized quality operational tools for women.
  - Challenge the current status quo in prevention for women by amplifying and disseminating what works best for women.
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### **Objectives of Symposium**

The objectives were:

- To explore HIV prevention needs for women.
  - To identify priorities for women's HIV prevention in current response (based on the Kenya National HIV and AIDS Strategic Plan III).
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<sup>1</sup> National AIDS and STI Control Programme, Ministry of Health, Kenya, (2009). [Kenya AIDS Indicator Survey 2007/8](#) Nairobi, Kenya

- To identify research gaps to better inform HIV-prevention interventions.

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## **2.0 Methodology of Symposium**

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The symposium adopted a participatory methodology to ensure optimum participation. A mix of facilitation strategies were utilized ranging from presentations, case studies, sharing of best practices, and group discussions on a variety of thematic areas focusing on HIV prevention among women and girls. Plenary and panel discussions were also employed with panellist from various sectors represented who provided clarification on queries from participants.

Participants included representatives from the government, civil society organizations drawn from the HIV arena including women's and men's movements, organizations of PLHIV, FBOS, private and public sector agencies, research, and academic institutions and development partners, involved in Kenya's HIV and AIDS response.

To capture the broad range of issues, participants were divided into groups with each having a facilitator and a rapporteur. Discussion guides and reporting templates had been pre-prepared in order to articulate the key issues and recommendations discussed during group work in the following thematic areas:

- HIV Counselling and Testing, test and treat, PMTCT
- STI detection and treatment; PEP/PRC
- BCC, Condoms (female and male), VMMC
- Male engagement
- PHDP and discordance, alcohol and substance abuse
- Current bio-medical interventions (HTC, PMTCT, STI, Treatment, Test and treat, TB etc)
- Complex social sexual issues (discordance, MCR, GBV)
- Structural interventions
- Emerging HIV prevention technologies: Microbicides, PrEP and HIV vaccine and VMMC
- Different categories of women

### **3.0 Feminization of the HIV Epidemic and the urgency for Commitment**

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#### **a) Opportunities for Women and HIV Prevention in the new constitution**

Hon. Njoki Ndung'u, a former nominated Member of Parliament and a member of the Committee of Experts on Kenya's new Constitution, made a presentation on opportunities created for women and HIV prevention in Kenya's new Constitution. She emphasized that violence was a huge contributor to HIV infection among women through rape, coerced sex, and other forms of violence including domestic violence. It is due to this reason that two bills; the Sexual Offences Act and the HIV and AIDS Prevention Bill were passed into law by the 9<sup>th</sup> Parliament.

Despite the high prevalence of violence against women and girls in Kenya, no cases have been taken to court to date. Therefore the law has not been applied. This is a major gap in the national response to HIV and addressing women's prevention needs. The new constitution provides an opportunity to remedy this since it will now be affordable to go to court, as there will be no fees associated with filing cases falling within the Bill of Rights. In the past, people shied away from going to court due to cost implications and lack of trust for fair judgment by the judiciary.

In addition, it was emphasized that the new constitution is the supreme law of the land and no other law can supersede it. She further noted that review of legislation and legal frameworks that support women's empowerment would strengthen efforts to address social and cultural issues that continue to increase women's vulnerability to HIV. The new constitution now allows Kenyans to take human rights cases to local and international courts. Although Kenya has signed on numerous international protocols, their implementation and follow up has been inadequate. The new constitution provides for enforcement of protocols such as Convention on the Elimination of all forms of Discrimination against Women (CEDAW). Kenyans can take the Government to task if it does not meet its obligations. For example, women can now take the government to task on the basis of discrimination for the subsidy on the cost of male condoms and not female condoms. As well, customary practices such as wife inheritance; cleansing (of HIV) and other practices that increase women's risk of HIV infection have been addressed by the new constitution.

Other key constitutional provisions that were highlighted include: upholding the rights of the child and equal parenting regardless of marital status; rights of PLHIV employees (including a section on hate speech) and protecting the rights of vulnerable groups such as domestic workers. All these can be applied to promote HIV prevention for women and girls.

Access to legal aid clinics should be scaled up and more awareness created on available legal structures established by both government and CSOs at the community level.

## Recommendations

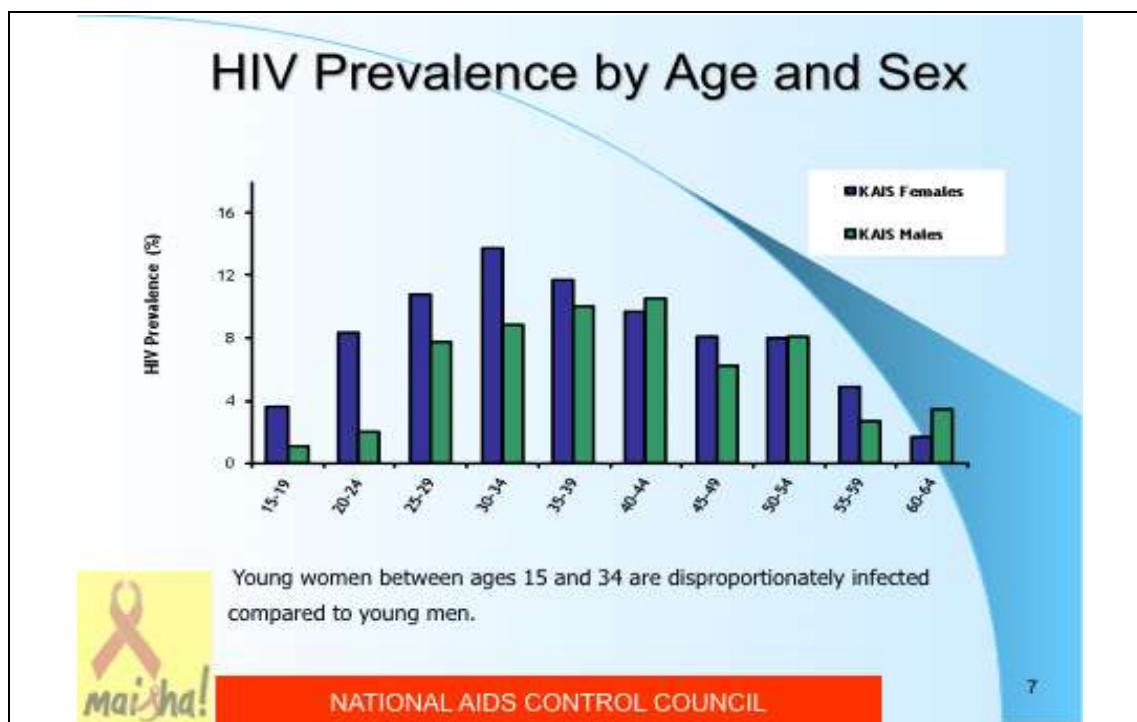
The following recommendations were made:

- The implementation of the new Constitution as a tool to deter behavior that continues to subject women to increased risk of HIV should be fast tracked.
- Intensify advocacy for Government to implement national laws and international conventions to create an enabling environment to address women's vulnerabilities to HIV.
- Continuous monitoring of the utilization of the Sexual Offences Act and HIV Prevention Bill is critical to understand lack of application to date since presenter regarded the biggest influence of behavior change is the law.

### b) Women's Vulnerability to HIV

The NACC Director Prof. Alloys Orago laid the ground for discussion on vulnerability of women by highlighting the gender disparities in HIV infection. He noted that the number of women infected in the ages 15 – 49 almost double that of men (8% women and 4.3% men). This is more pronounced in the younger ages 15 – 24 where girls are four times more infected compared to boys (Figure 1).

Figure 1: HIV Prevalence by Age and Sex



The causes of vulnerability among women and girls were identified as: income disparities and gender norms, roles and relations; gender based and sexual violence including rape and defilement; and policy and structural environments that are not sensitive to women's needs. It is therefore imperative that the country addresses these challenges in order to realise the targets set in the Kenya National HIV and

AIDS Strategic Plan (KNASP III) of: reducing by half the current 134,000 new infections per year by 2013; reducing AIDS related deaths by 25%; ensuring interventions that effectively reach of the most at risk population (MARPs), and couples in long term relationships.

### ***Recommendations***

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To achieve the above targets it is necessary to:

- Create an AIDS-competent community.
  - Address stigma, which hampers women's access and uptake of services.
  - Address institutional factors that hinder HIV positive women from seeking medical interventions.
  - Identify barriers to HIV prevention among women and girls.
  - Intensify research to understand underlying social issues in the shift of the modes of HIV transmission to inform evidence based program design and to help determine successful innovative HIV prevention models.
  - Accelerate the KNASP III operational plan to address individual and social factors which contribute to vulnerability of women and girls.
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### **c) National HIV Response: Policy and Programs**

Kenya has developed and implemented policies unfortunately their implementation lack follow-up to establish their effectiveness in responding to women and girls' needs in the context of HIV prevention. Several sector specific policies are not engendered and if they are, implementation is biased against women.

The major causes of poor policy implementation highlighted included inadequate research to identify gaps; limited co-ordination, networking and weak partnerships; limited capacity and resources to integrate gender at all levels of planning and structures; new and un-equitably distributed programs for special categories of women and girls and clients of female sex workers; limited capacity to implement policies that respond to gender issues; unwritten cultural practices which continue to negatively impact women and girls; inadequate empowerment programs involving men to address the power imbalances and promote rights of women and girls, and limited resources and capacity to co-ordinate, monitor and address identified policy gaps.

The *Three Ones Principles* was seen as crucial to delivering the national response. To this end NACC, the coordinating body for HIV and AIDS in the country, has established a national Monitoring and Evaluation framework that captures information/data from implementing organizations to annually track progress in the national response. This was lauded as an important process that provides justification for programming and negotiation for resources.

Although Kenya has made commendable progress in its HIV and AIDS response, the following challenges/gaps were identified in delivering a national response that is tailored to women's HIV prevention needs: heavy dependence on external funding (80-90%) and reliance on global directions and externally driven policies. This complicates matters especially at the local level because numerous implementing partners are funded by a wide range of partners. Furthermore, there is minimal funding for gender related factors and there is hardly any emphasis on gender indicators by donors. Also noted was the inadequate evidence to inform programming.

### ***Recommendations***

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In order to deliver the national response as it relates to women and HIV prevention it is important to:

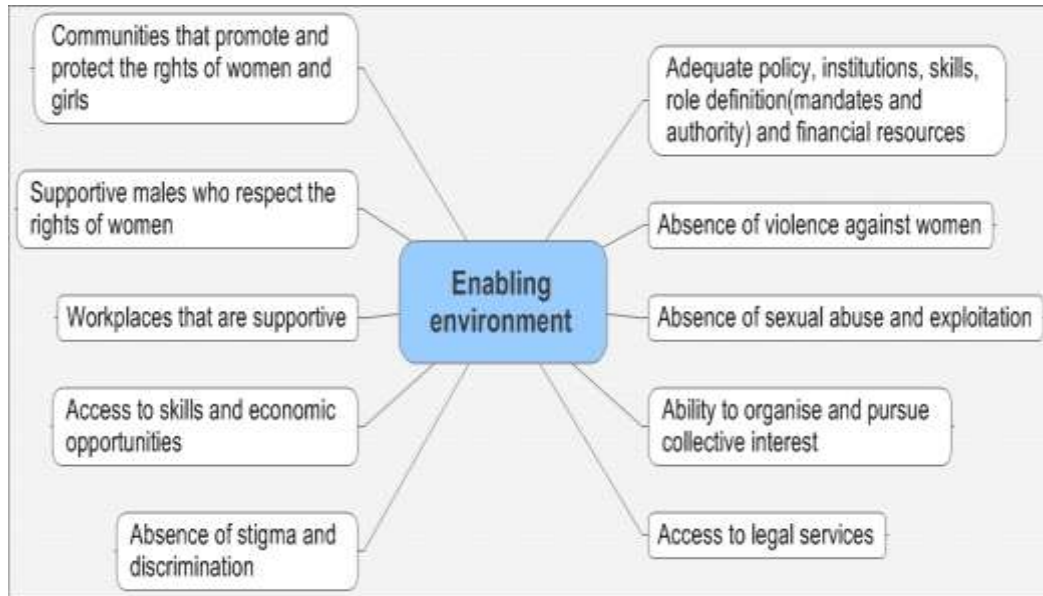
- Strengthen the national capacity to address gender issues. As such, the National Gender Technical Committee (GTC) should be strengthened.
  - Intensify investment in research on gender related aspects and scaling up of bio-medical interventions to enhance a HIV prevention response that takes into account women issues.
  - Lay strong emphasis on accountability for results by defining specific indicators for performance and ensuring gender analysis and follow up of recommendations.
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### **d) International and regional frameworks guiding HIV Prevention for Women**

The session drew heavily from the UNAIDS action framework for women and girls and HIV and AIDS. The framework provides clear action points on how the UN can work together with governments, civil society and development partners to produce better information on the specific needs of women and girls in the context of HIV ("*knowing your epidemic and response*"); turn political commitments into increased resources and actions so HIV programmes can better respond to the needs of women and girls; and support leaders to build safer environments in which women's and girl's human rights are protected.

Cultivating a conducive environment that ensures women's participation and developing mechanisms to address current weaknesses in the implementation and follow-up of national policies is crucial. It was noted that better governance, strong and supportive leadership, upholding human rights, empowerment of women and girls would aid in achieving these objectives (see illustration below).

## Enabling Environment



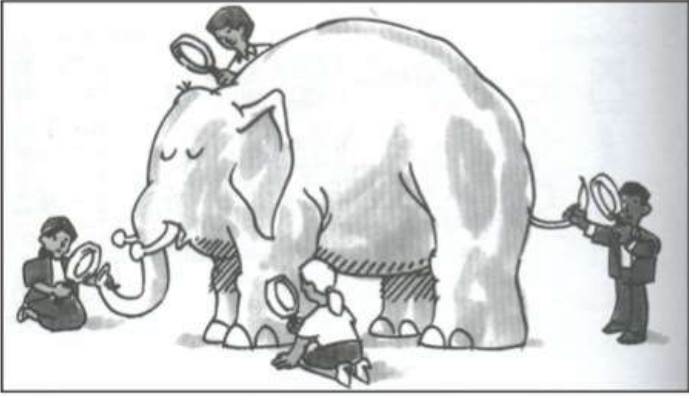
### ***Recommendations***

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- Engagement of men and boys as partners in women and girls' HIV prevention to drive the transformation of social norms and power dynamics especially in addressing violence against women including sexual abuse and exploitation.

## 4.0 Issues, Challenges and Gaps in HIV Prevention for Women

**Multiple Why's**




Why women?

Why girls?

Why female?

**Action Now!**

 **UNAIDS** UNICEF UNFPA UNODC WHO UNDP UNHCR UNWFP UNWOMEN UNWOMEN UNWOMEN UNWOMEN  
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

### a) HIV Testing and PMTCT Adolescence and Youth

Testing of adolescents and youth was indicated as challenging due to the generic programming and messaging as well as the long procedures and referrals. Stigma from health care workers was also cited as a major drawback to testing. Follow-up for youth post testing was noted as being weak and disclosure to parents remains a challenge. Successful disclosure models after testing HIV positive are not available and close monitoring and evaluation of interventions to ascertain their success and limitations are lacking. This is compounded by inadequate systems to generate timely and accurate data and under utilization of this data to inform programmes.

#### ***Recommendations***

- Establish youth friendly integrated services at one service delivery point that includes counsellor supported disclosure.
- Develop a community strategy aimed at building strong PLHIV networks to help ease the challenge of referrals and follow-up and ensure that those tested find necessary psychosocial support within the community.

- There is need for continued training of service providers to ensure provision of quality youth friendly services.

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## **b) Gaps in STI Detection and treatment- PEP/PRC**

Women and girls do not have comprehensive messages that specifically target them on issues of sexuality and STIs including HIV and AIDS. This leads to lack of awareness of STI symptoms. Also some STIs remain asymptomatic for long periods and therefore women and girls do not seek care in a timely manner.

There is limited discussion between parents and youth on sexuality issues leading to young girls turning to peers for advice and not reporting cases of sexual abuse that may lead to contracting STIs and or HIV. Therefore girls do not receive early diagnosis and treatment for these infections. Furthermore, the environment at the service delivery points is not conducive for open and honest discussions with girls and women. Medical professionalism and ethics required of health personnel have been eroded creating a non-conducive environment for women and girls seeking services for STI and HIV. Those seeking these services experience stigma from the health providers, for example older women feel uncomfortable seeking medical assistance from younger medical personnel. In some areas, religion plays a great role in influencing treatment access with some people preferring spiritual healing to medical assistance.

### ***Recommendations***

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Responding to the above issues will require:

- Health personnel to provide comprehensive services.
- Intensified awareness raising and education on PEP including service delivery points for easy access.
- Gender based violence survivors should be placed on PEP immediately for three days and the health sector to institute a **trace system** to facilitate follow-ups
- Inclusion of a training component in addressing GBV and PEP in the curricula for health personnel to improve the attitudes of the health personnel towards clients seeking STI treatment especially among young girls and older people; and strategies to ensure adherence to the Health Care Code of conduct by health personnel will result in improved service delivery.
- A client satisfaction survey that includes an opportunity to give confidential feedback immediately after a particular service has been received by a client should be initiated
- Culture and religion plays a big role in the way women and girls' rights are violated necessitating mechanisms for dealing with cultural and religious attitudes that negatively impact women and girls.

- Assigning more female doctors to provide health services to older women as a measure to encourage more women to seek treatment and be more open
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### **c) Gaps in Prevention Strategies:**

#### **Behaviour Change Communication (BCC), Male and Female Condom promotion and Voluntary Medical Male Circumcision (VMMC)**

Behaviour Change Communication, use of both male and female condoms and VMCC are among the key prevention strategies promoted in Kenya. Gaps identified in these prevention mechanisms range from erratic supply of male condoms and little if any supply of female condoms; high cost of female condoms making them inaccessible; low knowledge and information on use; lack of programs addressing school going and HIV-positive youth.

#### ***Recommendations***

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- Intensified knowledge and information on female condoms as well as a consistent supply of both female and male condoms.
  - Make female more accessible through reduction of cost or available at no cost similar to male condoms.
  - Training more staff on VMMC in response to the increasing number of men seeking VMMC and sensitizing older married men on the benefits of VMMC.
  - Intensifying mobile VMMC and integration with other services e.g. mobile VCT.
  - Training caregivers on disclosure and addressing related stigma.
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### **d) Male Engagement**

Studies conducted show that women access services more than men. Male-specific interventions that could help address inherent male attitudes' around reproductive health as a woman's issues are inadequate. In addition, access to male-friendly reproductive health services is minimal and many men seeking HIV testing and counseling services fear results especially in the context of high-risk behavior.

#### ***Recommendations***

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- Deliberate engagement of men and establishment of male friendly health services including reproductive health coupled with provision of mobile services is essential.
  - Outreaches targeting men with tailored messages to address issues of masculinity and femininity should be encouraged including strategies that enhance communication in marriage and during courtship.
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### **e) Positive, Health, Dignity and Prevention (PHDP) for PLHIV and engagement of women and young girls**

There is a paucity of information targeting youth especially girls living with HIV. Although centres that target youth in general for HIV and AIDS awareness and education exist, lack of health centres providing services to young PLHIV prevents full participation by the girls. There is also a general assumption that PLHIV will automatically adopt behaviour change after receipt of prevention messages that are not tailored to their specific needs.

#### ***Recommendations***

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- Provision of sexual and reproductive health information and services should start at a young age; sex and sexuality programs in schools are vital and early character formation/ education by parents and guardians is essential.
- Empowerment programs for HIV positive couples or those who aspire to get married are needed that provide intensive counselling around relationships including rights and obligations among other services.
- Linking HIV prevention programmes with other livelihood interventions must take place.
- There is a need to build capacity around PLHIV disclosure as well as prevention programs in the context of PHDP in order to prevent HIV transmission.

## 5.0 Role of Research in HIV Prevention among Women

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It was noted that KNASP III<sup>2</sup> emphasized the need for evidence-based interventions that are informed by sound research. The Symposium recognized research as a vital process in the identification of women's prevention needs and in determining effective interventions for women and girls.

There are various types of research including behavioral, socio-cultural and biomedical research.

- **Behavioral Research** in HIV and AIDS prevention and control is the part of social science research that helps to reveal the determinants of sexual risk behaviors and identify the factors that motivate or influence behavior change related to the prevention and/or transmission of HIV and AIDS and other STIs.
- **Socio-cultural Research**, for the purpose of this symposium and report, is defined as the study of attitudes, behaviours, cultural norms and practices and social conditions which either protect people or make them more vulnerable to HIV.
- **Biomedical Research** for the purpose of this report is defined as researches conducted to aid and support the body of knowledge in the field of medicine. It is important to note that the Symposium concentrated on clinical research that is, involving human participants.

It is important to ask the following questions to ensure that any research that is undertaken is not only answering the research questions, but is relevant to the target community and especially to women:

- Who are the target community?
- How is the research relevant to women in Kenya?
- What are some of the advantages the research will bring?

In addition, positive outcomes of research at the community level including improvement of services and infrastructure such as laboratories and clinics should be shared with participants. It was noted that when participants understand research to have potential benefit for them, they could be motivated to participate through volunteering for clinical trials. Motivating factors that clinical trial participants have identified include: desire to do something to end the epidemic, and to do something that helps their families who have been affected by HIV and to protect themselves.

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<sup>2</sup> Kenya National Strategic Plan (KNASP-2009/10-20012/13)

### **a) Challenges that face Clinical trials**

Clinical trials face various challenges. Among communities, clinical trials are not always popular due to some negative perceptions often based on insufficient information. Media can also play a major role in acceptance by participants and any form of misreporting may negatively affect the clinical trial. Participation in clinical trials is not easy, as volunteers are often required to disclose very intimate personal details about their sex life.

### **b) Women's meaningful involvement in research: Ethical and practical considerations**

Ethical considerations in meaningful involvement of participants in clinical trials centre on the informed consent process. Getting informed consent from women is particularly complex due to various reasons such as gender power relations, educational levels that influence understanding of the informed consent forms and even the power relations between the researchers and the women.

Some key challenges in involving women in clinical trials include: ensuring that trial participation will not increase risk of exposure to HIV; reinforcing unknown efficacy of test product; ensuring participants do not feel a false sense of protection or "therapeutic misconception" which could lead to increased risk behavior.

Other factors that influence informed consent and women's participation were: women are not sufficiently empowered to have the autonomy or legal right to make the kind of decisions required in the informed consent process; the premise that individuals make their own decisions regarding consent is normally not the case; in many occasions, a family member, family group, employer and even the community is responsible for the decision taken by the participant; personal gain through remuneration and fair compensation often present themselves as undue inducement that influences the decision of the participant; defining "trial participant (s)" in Microbicide trials – partners/couples act as bystander participants resulting in loss of autonomy and confidentiality by female participants.

Factors external to the trial process may also have implications to the trial success/results for example: inherent beliefs, stereotypes, judgment, vulnerability due to poverty, sexual orientation, education, injecting drugs, sex work, institutional powers, real or imagined and inaccurate media information. All these may increase stigma and create fear among participants, which may lead to discontinuation.

### ***Recommendations***

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To address gaps in the Informed consent process especially among women the following was suggested:

- The process should not be mechanistic, legalistic and signature-centered approach but should embrace new forms of consent such as an agreement

between researcher and participant based on dialogue reinforced through an ongoing and dynamic process throughout the trial

- One-on-one counseling and support for trial participants by well-trained staff.
- Development and use of supplemental tools such as audio visual equipment and booklets to ensure that participants and community fully understand the process followed by a systematic assessment of comprehension.

## 6.0 The Kenya HIV and AIDS Strategy: Does it work for Women?

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Presentations outlined the major objectives of HIV and AIDS research as follows:

- **Research Priority Setting**-intended to promote priority biomedical and social science HIV and AIDS research.
- **Capacity Building**-aimed at building capacity for HIV and AIDS research through collaboration and resource mobilization.
- **Coordination** – aimed at strengthening the co-ordination of HIV and AIDS research and tracks all the related undertaken research.
- **Evidence to inform and influence Policy**-intended to provide a platform for policy dialogue on HIV and AIDS research and create evidence that would influence appropriate HIV and AIDS policies and programs for community and institutions.
- **Community Participation and Communication**-intended to enhance community participation in the planning and execution of HIV and AIDS research and ensure widespread and timely dissemination of research results at various levels.

There are diverse knowledge gaps that require research. Finding out the implications on behaviour change when people test negative is not well understood, currently, the focus has mainly been on positive persons. There is need for better understanding of what influences the behaviour in persons exposed to HIV but not infected. New testing methodology, which focuses on 'window period', is necessary. There is minimal understanding of why men prefer the option of vaccine and why more men participate in clinical trials targeting both men and women. Operational research is needed to understand various issues in the HIV response for example we know PMTCT works but not all women have access, what is the reason?

### a) Priority socio-cultural and behavioral research issues that would contribute to better planning for women in the context of HIV

The priority research areas that were highlighted included the following:

- Research that is required to determine the best models for negotiating safe sex practices for women and girls.
- Research to inform roll out of emerging women's HIV prevention methods like Microbicides when they become available.
- Research on gender related aspects in the scaling-up of bio-medical interventions.

## b) Emerging HIV prevention tools for women

One volunteer in a clinical trial was asked to what extent she would go to access a microbicides and she said, *–“I would travel further for microbicides than male condoms because with the microbicide, it is mine. With condoms I still have to negotiate with my partner”*.

General rationale for developing new HIV prevention tools include the fact that new HIV infections are still occurring despite the efforts to stem the epidemic. For every two patients started on treatment five people are newly infected despite an unprecedented outpouring of resources and proliferation of programs. Kenya has estimated that new infections range from 55,000 to 110,000 (KAIS 2008) per year, providing justification for development of new HIV prevention tools since treatment will not be affordable in the long term.

### **Microbicides**

A microbicides is a substance that can reduce the transmission of HIV and other STI pathogens when applied vaginally and, possibly, rectally. Microbicides were still under trials and therefore

not yet available for use. Currently, Microbicides are being developed in the form of gels creams and rings. Other methods of delivery are also being explored to ensure that women have options that meet their needs. While there have been a lot of setbacks in the research for a Microbicide, a clinical trial in South Africa called CAPRISA 004 showed 39% effectiveness. This for the first time proved that it is

Vulindlela a rural area in South Africa, where prevalence is nearly 51.1%, a study conducted indicated that, by age 24, the probability for a woman of being infected is 1 in 2' it was found that Tenofovir Gel is used due to various reasons including that it is an effective therapeutic agent; it has a good safety profile; is currently used for PMTCT; is rapidly absorbed and has a long half-life; is also known to have low systemic absorption and therefore fewer side effects; and is also known to protect against SIV in studies conducted among monkeys. Impact of adherence on effectiveness of Tenofovir gel was given as 54% for the high adherers; 38% for the intermediate adherers and 28% for low adherers.

possible to prevent HIV infection among women using a topical (vaginal) product. The trial tested an ARV based Microbicide – Tenofovir gel among women at high risk in Kwa-Zulu Natal, South Africa.

Once confirmed and implemented, Microbicide has the potential to alter the HIV epidemic. In modeling studies, it is estimated that Tenofovir gel could prevent 1.3 million new HIV infections and over 800,000 deaths in South Africa alone.

Plenary discussion on what the CAPRISA Study results meant for Kenya highlighted the following:

- Confirmation through research that indeed young women especially in sub-Saharan Africa are at greater risk of acquiring HIV than their male counterparts.
- Now more than ever, researchers have hope that they are close to getting a product that works well for women.
- Additional studies are urgently needed to confirm and extend the findings of the CAPRISA 004 trial.

Prof. Elizabeth Ngugi, a well known advocate for women's rights and HIV, summed up sentiments of many people in the HIV prevention research field saying that, "I fully support the need for additional studies and pledge to support research by mobilizing women for a similar study when the time comes."

### ***Pre-Exposure Prophylaxis (PrEP)***

PrEP was defined as taking medical products to prevent (rather than treat) a disease or condition before one is exposed to it. In HIV field, it means HIV uninfected individuals taking ARVs to reduce the risk of getting infected with HIV.

#### ***Why PrEP?***

It is a product that is Individual-controlled, and more importantly, may be women-controlled and women-initiated as well as no known interference with fertility intentions. The currently tested products have well known safety profiles among HIV infected individuals.

Studies in non-human primates have shown both oral and topical applications of ARVs before exposure reduces risk or completely prevent infection with animal version of HIV (SIV); Truvada has high concentrations in vagino-cervical area, thus could be effective in reducing risk of heterosexual transmission; ARVs are already used to prevent vertical transmission and infection after medical accidents or rape.

#### ***Challenges Facing PrEP***

- PrEP vs. treatment – will there be sustained funding for both?
- How do we justify giving ARVs to uninfected people when there are still huge numbers of people who are infected and do not have access to treatment.
- Would the pills/gel be safe for adolescents, pregnant women, and breastfeeding women?
- Is a daily pill a feasible regimen? How fast will fatigue set in? (i.e. how much room do we have for compliance?)
- The roll-out will be challenging and needs more work: which population, How often will we need to test for safety, for HIV, What will be the distribution points?

### ***HIV Vaccines***<sup>3</sup>

A vaccine is described as a product that works by triggering the body's immune system to produce antibodies and cells that recognize and destroy invading pathogens before they cause disease.

An HIV and AIDS vaccine was described as necessary because despite an unprecedented outpouring of resources and proliferation of programs, there are still new infections; basic and epidemiology research in HIV and AIDS indicates that it is possible to discover a HIV vaccine; the RV144 trial in Thailand demonstrated for the first time modest protection against HIV infection.

There is also a new and exciting discovery that shows that neutralizing antibodies which revealed vulnerable targets on the virus that are now being explored for vaccine design; acceleration of candidates to clinical trials and advancing the most promising of these candidates to efficacy trials is critical and sustaining interest from communities, policy makers and all other stakeholders for a HIV vaccine while ensuring sustained funding for intensifying research trials globally.

#### **c) New HIV Technologies: how will they be incorporated into the daily lives of women?**

Women have proved themselves as adopters of technologies especially those they understand and/or perceive to make a positive difference in their lives. It is therefore important for researchers, policy makers, and other stakeholders to consider the incorporation of emerging HIV prevention technologies in the everyday lives of women. It is therefore important to consider the following questions even as the research advances:

- Will the products be available within the locality of the target users?
- Will the products be affordable?
- How easy will the product be to use/apply?
- Comfort in storing the products: – does the packaging afford women the privacy they desire?
- Are there any negative myths especially linked to fertility of women that may lead to women not using the product even if it poses no safety issues scientifically?
- Are there any social influences around the woman e.g. the family and friends that might affect usage?

#### ***Group work discussion considered the following questions:***

- What are the areas/gaps that require further (consider action, behavioural and clinical research)?

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<sup>3</sup> This Presentation was made by Prof. Omu Anzala of KAVI

- How do we generate and utilize sex disaggregated HIV clinical data for effective prevention programming for women (testing and treatment data on women).

### ***Key Identified Research Gaps***

The research gaps identified are as listed below:

- Low utilization of modern family planning technologies by positive women resulting in an unmet need for contraception.
- Limited understanding of re-infections among couples living with HIV.
- Low adherence to PMTCT guidelines on breastfeeding requires further investigation to inform appropriate interventions.
- Gaps in strategies on how to reach the different categories of women
- Need to explore why some individuals in a discordant relationship continue to remain HIV negative?
- Lack of enough data on practices such as anal sex; group sex (“swinging as is commonly known”), men who have sex with men (MSM) and bisexuality in Kenya. These practices and preferences impact on HIV risk for women.
- Need to understand risk factors associated with *religious/spiritual rituals and cultural practices* such as inheritance of widows and cleansing.
- Further research is needed to lead to understanding masculinity norms that encourage risk behaviour such as that of boys who have been recently circumcised being encouraged by older men to have sex (normally with older – sexually experienced – women) in order to test one’s “new tool”.

## 7.0 Proposals for Women's Prevention Priorities

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- *Political Commitment*: need for political commitment and improved visibility to translate technical assistance and resources for prioritizing women's issues and HIV. This will be achieved through advocacy to strengthen political commitment and increase visibility aimed at translating resources into action. Commitment is required from stakeholders including development partners, donors and civil society, private and public sector.
- *Meaningful Participation by Women Living with HIV*: Should be present all levels of decision-making regarding policies that affect their lives. This is necessary to determine the elements that will be used to implement the pillars of KNASP III. Meaningful involvement means that *HIV-positive women and girls are involved in all levels of policy decision-making and program design that impacts their lives.*
- *Capacity Building and Relevance to KNASP III*: strengthen capacity of stakeholders at all levels to translate gender guidelines into practice.
- *Prioritize Gender Issues as Recommended by KNASP III* and factor in opportunities provided by the new constitution.
- *Strengthening Coordination and Linkages*-deepen linkages of HIV to other services such as sexual and reproductive health. Strengthen linkages across and within all stakeholders in coordinating partnerships across CSOs.
- Reconstitute, strengthen the GTC and align it with KNASP III by:
- Positioning GTC to be recognized as one of the sub-committees for coordination under Pillar 4. This will require institution and financial support from NACC and partners.
- Advocating for a member of GTC to sit on the Inter-agency Coordinating Committee (ICC).
- Develop ToR that will guide the recruitment of GTC members and define the mandate of GTC.
- *Program development* -Gender issues/ dynamics that impact on sexual relations and how these can be manipulated to inform ongoing scale up interventions (VMMC, couples interventions etc)and effectively address the needs of women. Strengthen coordination and integration of sexual and reproductive health services and HIV across prevention, diagnosis, treatment, and care programs. Intensify female condom distribution mechanisms that ensure all priority target groups are reached.
- *Services that are Responsive to Women*: Women specific HIV prevention, care and support services to cater for their unique needs must be holistic and integrated based on models that respect women's' rights to dignity, body autonomy, and relevant information that influence voluntary medical decisions. Currently, most areas lack women-specific services highlighting huge disparities in access to effective and culturally appropriate care for women.

- *Equitable resource allocation:* Data collection and risk assessment often underestimate the population of women at risk and living with HIV resulting in inequitable resources allocation and distribution for programming including service provision, and capacity building especially for women living with and affected by HIV.

## 8.0 Key Recommendations from the Symposium

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- Intensify advocacy for Government to implement national laws and international conventions to create an enabling environment to address women's vulnerabilities to HIV.
- Continuous monitoring of the utilization of the Sexual Offences Act and HIV Prevention Bill is critical to understand lack of application to date since the presenter regarded the biggest influence of behavior change is the law.
- Engage with the Parliamentary Health Committee among others in order to enhance advocacy for women's health issues.
- Economic empowerment should be used, as a broader strategy for prevention by having affirmative action that ensures that women-owned small businesses are financed.
- The need to strengthen representation of PLHIV rights at policy levels such as parliament to address the high level of stigma.
- Create an AIDS competent community.
- Address stigma, which hampers women's access to and uptake of services e.g. PMTCT because they fear the outcomes of disclosing an HIV positive status to their male partners.
- Ensure provision of holistic literacy.
- Increase efforts to retain girls in school.
- Address institutional factors that hinder HIV positive women from seeking medical interventions.
- Improve access to SRH (including family planning) services and revise current PMTCT guidelines to facilitate intended pregnancies among women living with HIV.
- Identify barriers to HIV prevention among women and girls.
- Examine uptake of female and male condoms to enhance availability, accessibility, and utilization of female condoms by women.
- Intensify research to understand underlying social issues in the shift in modes of HIV transmission to inform evidence based program design and to help determine successful innovative models for negotiating safe sex for women and girls.
- Accelerate the KNASP III operational plan to address individual and social factors contributing to women's and girls' vulnerability including: biological and socio-cultural issues with younger females, disability as an added vulnerability for women and girls, economic disempowerment which accounts for a large number of girls aged 10-18 entering sex work.
- Strengthen the national capacity to address gender issues, through reinforcing the National Gender Technical Committee (GTC) by establishing a 'think tank' to guide strategic thinking. In addition, a 'watch dog' committee should be created

to ensure accountability as well as acceleration of the implementation of KNASP III. A strong GTC will drive capacity building initiatives informed by the recently concluded gender analysis aimed at generating gender responsive programming and involvement of women by all stakeholders. This coupled with an intensified investment in research on gender related aspects and scaling up of bio-medical interventions will be necessary to enhance an HIV prevention response that takes into account women issues. More emphasis should also be placed on accountability.

- Engagement of men and boys as partners in women and girls' HIV prevention to drive the transformation of social norms and power dynamics especially in addressing violence against women including sexual abuse and exploitation
- Establish youth friendly integrated services at one service delivery point that includes counsellor supported disclosure.
- Develop a community strategy aimed at building strong PLHIV networks to help ease the challenge of referrals and follow-up and ensure that those tested find necessary psychosocial support within the community.
- There is need for continued training for service providers to ensure provision of quality youth friendly services.
- Health personnel to provide comprehensive services STI detection and treatment
- Intensified awareness raising and education on PEP including service delivery points for access.
- Gender based violence survivors should be placed on PEP immediately for three days and the health sector to institute a trace system to facilitate follow-ups.
- Inclusion of a training component in addressing GBV and PEP in the curricula for health personnel to improve their attitudes towards clients seeking STI treatment especially among young girls and older people; and strategies to ensure adherence to the Health Care Code of conduct by health personnel will result in improved service delivery.
- A client satisfaction survey that includes an opportunity to give confidential feedback immediately after a client has received a particular service should be initiated.
- Culture and religion plays a big role in the way women and girls' rights are violated necessitating mechanisms for dealing with cultural and religious attitudes that negatively impact women and girls.
- Assigning more female doctors to provide health services to older women as a measure to encourage more women to seek treatment and be more open.
- Intensified knowledge and information on female condoms as well as a consistent supply of both female and male condoms.
- Training more staff on VMMC in response to the increasing number of men seeking VMMC and sensitizing older married men on the benefits of VMMC.
- Intensifying mobile VMMC and integration with other services e.g. mobile VCT.

- Training caregivers on disclosure and addressing related stigma.
- Deliberate engagement of men and establishment of male friendly health services including reproductive health coupled with provision of mobile services is essential.
- Outreaches targeting men with tailored messages to address issues of masculinity and femininity should be encouraged including strategies that enhance communication in marriage and during courtship.
- Provision of sexual and reproductive health information and services should start at a young age
- Sex and sexuality programs in schools are vital and early character formation/ education by parents and guardians is essential.
- Empowerment programs for HIV positive couples or those who aspire to get married are needed that provide intensive counselling around relationships including rights and obligations among other services.
- Linking HIV prevention programmes with other livelihood interventions must take place.
- There is a need to build capacity around PLHIV disclosure as well as prevention.
- Programs in the context of PHDP are necessary in order to prevent transmission of HIV.
- The research consent process should not be mechanistic, legalistic and signature-centered approach but should embrace new forms of consent such as an agreement between researcher and participant based on dialogue reinforced through an ongoing and dynamic process throughout the trial.
- One-on-one counseling and support for trial participants by well-trained staff
- Development and use of supplemental tools such as audio visual equipment and booklets to ensure that participants and community fully understand the process followed by a systematic assessment of comprehension.

## 9.0 Proposals for Research Agenda

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**a) In order to provide accountability for results for women, we must translate policy and research into practice through:**

- Through the review of the national M&E framework for HIV and health.
- Gender analysis: required for the response within planning processes and M&E systems at all levels.
- Enhancing understanding of the new constitution and its implication for women and girls.
- Provision of guidance by the GTC around new constitutions and implication on programming.
- Community based research: Formative, community-based, social, behavioral and operational research is needed to identify and improve structural factors such as poverty, housing instability, violence, and mental health status, which increase vulnerability for women living with and affected by HIV.
- Explore gender issues/ dynamics that impact on sexual relations and how these can be manipulated to inform ongoing scale up of interventions (VMMC, couples interventions etc).
- Disclosure among couples: Commission research to understand, design, and implement successful models for disclosure among sexual partners, couples, and families.
- Align current research to KNASP III indices.
- Resources tracking to understand whether interventions are providing value for money, determine what works for women, and analyze the results.
- Exploring models to strengthen the integration of HIV and SRH services for women and especially those living with HIV.
- Need for social behavioural research to inform prevention programs for PLHIV especially women through operational research.
- Targeted research and programming for the different categories of women particularly those at high risk.
- Intensified research to understand both behavioural and scientific factors why persons exposed to HIV in discordant relations remain HIV negative to inform program design.
- Identify successful models to facilitate disclosure among couples and especially discordant couples.
- Need to intensify education on HIV and AIDS aimed at addressing risk factors for MARPs by changing negative societal attitudes and integrating a human rights approach to service delivery assuring their health needs are met.
- Research to understand behavioural practices, myths and misconceptions associated with MARPs including MSM, sex workers, bisexual individuals, group

sex including 'spousal exchange for sex' is crucial to inform design of appropriate interventions.

- Research to understand why religious and cultural practices continue within communities despite knowledge on their increasing risk to HIV infection as a result of these practices.
- Research is required in order understand why men who have undergone VMMC and know the risk of sexual activity prior to the recommended 6-week period still engage in sex.

**b) In working towards a gender responsive research agenda: What are the different categories of women?**

In designing research protocols, it is important to take into account the different categories of women to ensure that any research carried out responds to the special needs of all women.

The different categories of women were described as follows:

- Geographic categorization - urban and rural
- *Socio-economic status* e.g. low-domestic workers, *chang'aa* brewers, casual labourers; middle -contractual sex e.g. for job promotion and high income; *age-girls/adolescents*; the young; the elderly
- *Marital status*- single, married, separate and widowed.
- *Education level* – primary, secondary, colleges and universities.
- *Sexual diversity* – heterosexual, lesbian, bi-sexual, trans-sexual, trans-gender.
- *MARPs*: sex workers, women truck drivers, bar hostesses, injecting drug users, street girls and women, persons with disability
- Women in fishing industry
- Women in institutions of higher learning
- Women as care-givers of PLHIV
- Women in the armed forces.

## **10.0 Conclusions and the Way Forward**

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It was unanimously agreed the momentum that had begun with the Women's HIV Prevention Symposium should be sustained. The recommendations will be shared during the prevention summit with the aim of inclusion in the national HIV and AIDS prevention priorities. Various organizations pledged to support the implementation of the recommendations from the symposium as indicated below:

### **1. National AIDS Control Council's Commitment**

- Ensure that the priority areas identified will inform programming thus ensuring women and girls' prevention issues are recognized.
- Support evidence based activities to meet agreed upon indicators.
- Coordinate implementation of meeting recommendations.

### **2. Global Campaign for Microbicides**

- Ensure that the steering group stays active.
- Promote stronger civil society involvement to engage with research and clinical trials in Kenya especially in determining implications of the CAPORISA 004 trials in Kenya.
- Mobilize and sustain the existing political good will especially with the new constitution in order to ensure that it responds to issues affecting women and their vulnerability to HIV infection.

### **3. UNAIDS' Commitment**

- To champion issues of women and girls, gender equality and HIV and AIDS.
- To provide global leadership in advocating for a multi-stakeholder HIV prevention response for women and girls.
- Continue to pressure the international community to act based on evidence – know your epidemic and your response.
- Always ask where is the money for women?
- Focus on where the resources are and commit to turn around the resources to benefit women and girls.
- Address factors underpinning risk for girls and women to respond to the questions:
  - What do we really believe is the problem?
  - Why are young girls affected earlier than their male counterparts?
  - Why are younger girls engaging into inter- generational sex?
  - What is the role of older men having resources and this facilitating sex with the young girls?
- By age 20, more than 50% of Kenyan girls are married, how do we keep them from getting married so early and retain them to in school?

#### **4. NASCOP's Commitment**

- NASCOP commits to become available and give all the necessary support in addressing women's issues.
- Making available and accessible new technologies to women as soon as they are proven efficacious through research.

#### **5. HIV Prevention Champion**

As a strategy to intensify HIV prevention efforts that take into account women and girls vulnerabilities, the GTC envisioned identifying a young lady advocate to provide visibility to women's issues in prevention and Ms. Sharon Mina Olago, a 28-year old artist and community activist and a Masters Degree student was commissioned and awarded a trophy as the 2010 HIV Prevention Champion

***Final Quotes***

“We at NASCOP are committed to availing new technologies to women as soon as they are proven through research.... the Kenya Women’s HIV Prevention Symposium should be an annual event”---Dr. Peter Cherutich, Head of Prevention-NASCOP.

“This Symposium should have happened a long time ago so that we can understand how to deal with the epidemic. Women should have been involved a long time ago”-  
--Dr. Sobbie Mulindi-Deputy Director Coordination and Support NACC



Global Campaign  
FOR Microbicides



actionaid

**maisha!**

National AIDS Control Council



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